[Report 1957] / Medical Officer of Health, Aberdeen City.

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CITY OF ABERDEEN.

REPORT

BY THE

MEDICAL OFFICER OF HEALTH

FOR THE YEAR

1957

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ABERDEEN:
PRINTED BY G. CORNWALL & SONS.

MCMLVIII.

CONTENTS.

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SUMMARY OF STATISTICS.

The following is a summary of the principal statistics for the years 1953-57:—

	1953.	1954.	1955.	1956.	1957.
Population estimated to middle of year . .	185,232	185,725	186,352	186,396	186,190
Marriage rate per 1,000 population . . .	10·4	10·2	10·6	10·5	10·6
Birth rate per 1,000 population	16·6	17·4	17·2	17·5	18·1
Illegitimate birth rate per 100 births . . .	4·5	4·3	5·4	5·3	5·1
Still-birth rate per 1,000 total births . . .	20	19	12	21	15
Infant mortality rate per 1,000 live births .	27	22	21	22	24
Neo-natal mortality rate per 1,000 live births .	19	15	11	14	17
Death rate per 1,000 population	11·3	11·1	11·5	11·6	11·4
Malignant diseases death rate per 1,000 population	2·00	1·80	2·19	2·07	2·25
All tuberculosis death rate per 1,000 population	0·16	0·12	0·09	0·10	0·06
Respiratory tuberculosis death rate per 1,000 population	0·14	0·10	0·08	0·10	0·05
Principal epidemic disease death rate per 1,000 population	0·02	0·03	0·04	0·02	0·11
Average age at death (in years) . . .	65·1	66·3	66·7	65·9	66·2

PREFACE.

If colours were employed instead of words to depict the good and bad features of 1957, the painting would contain relatively little grey or brown. Black and gold would predominate—burnished gold to indicate the remarkable success of the health guidance project (the "thousand salvo blitz on disease," in the phrase of the Aberdeen **Press & Journal,** a mammoth health education scheme that is already attracting considerable attention in other areas); gold for the record-breaking mass radiography campaign (in which 78·6 per cent. of eligible citizens were examined); bright colours for the relaxation exercises at various ante-natal clinics, for the continuation and development of work for the promotion of mental health, for the extension of home visiting of school children by health visitors, and for the further development of services for the elderly; sombre black for the grave and increasing shortage of health visitors; black for duties not being undertaken (*e.g.*, in the field of after-care, physical and mental) as a consequence of continued lack of staff; black for the lack of purpose-built modern clinics (of which there are only two in the City); black for the shortage of dental officers; black for the administrative accommodation of the Health and Welfare Department (so overcrowded that some of the staff have had to be housed in condemned property in Broad Street, with the result that principles of healthy living are inculcated by persons who themselves work in a slum); and gold for the gallant efforts of the staff to minimise by sheer enthusiasm and hard work the detrimental effects to the people of staff shortages and poor accommodation.

The vital statistics of the year would—as might be expected amid a mixture of black and gold—appear as an intermediate colour. For example (as was forecast in the Annual Reports for 1955 and 1956) the infant death rate and the neo-natal death rate are higher than in 1956 and still higher than in 1955, and the average age at death is less advanced than in 1955. Nevertheless, it would be a mistake to regard the vital statistics as bad: certainly the deterioration that was anticipated as a consequence of staffing shortages has occurred—to a small extent in 1956 and to a greater extent in 1957; but the deterioration has been less than had been feared; and Aberdeen has not yet lost its claim to be regarded as the healthiest of the Scottish cities.

The Report here presented discusses the health of the City and the work of the Health and Welfare Department during the calendar year 1957, except that the portion relating to the school health service covers the school year 1956-57. In general, the lay-out follows the same lines as in the Report for 1956; and, for the convenience of those who may not wish to read each chapter in its entirety, most of the chapters are prefaced by an introductory paragraph which outlines the main features of the year.

The remainder of this preface is divided into four sections which deal respectively with the purposes of an annual report, the statistics of the year, some features of the year, and miscellaneous matters.

THE PURPOSES OF AN ANNUAL REPORT.

Among Medical Officers of Health there is a sharp cleavage of view about Annual Reports. The majority (including many of the older and perhaps wiser officers) regard them as important in the highest degree, but a minority (possibly consisting mainly of younger and less experienced officers) condemn them as a weary chore that consumes energies which could more usefully be directed to other channels. Among the public, too, there is a certain confusion: it is not unknown for the whole purpose and nature of these reports to be misunderstood. A few minutes may therefore be well spent on considering the purposes of these reports.

STATUTORY DUTY TO PRODUCE REPORTS.

Under the Local Government (Scotland) Act, 1947, and under legislation existing earlier, **every Medical Officer of Health is under an obligation to submit an Annual Report to the Secretary of State for Scotland.** The Department of Health for Scotland each year specifies subjects—generally a fairly comprehensive list—with which the Medical Officer of Health must deal, but he is of course free—and indeed encouraged—to include other items at his discretion. The minimum number of copies to be sent to the Secretary of State for the use of his officers is also specified. In addition to these mandatory requirements, it is traditional that copies of the report should also be sent to Medical Officers of comparable areas, to all members of the Town or County Council, to appropriate officers of the Regional Hospital Board and the Executive Council, to University Departments of Public Health and Social Medicine, to the press, and to various other persons and organisations with an interest in health matters. The sending of copies to national and local public libraries is perhaps more than a tradition, in that the report is a public document.

So far as the writer has been able to ascertain, copyright is vested not in the writer or the Secretary of State but in the Medical Officer of Health *ex officio*, so that any request for permission to quote extensively from the report of a Medical Officer of Health who has subsequently retired or moved is addressed not to him but to his successor in office.

M.O.H. HAS TO SURVEY ENTIRE DEPARTMENT.

Some of the main purposes served by an Annual Report may be thus summarised:—

(1) **The need to produce an annual report forces a Medical Officer of Health to survey the whole of the services for which he is responsible.** In this connection it is worth while to reflect on the tremendous breadth of a modern Health and Welfare Department. Someone has suggested that, since prevention is as important and as complex as treatment, the work of a Medical Officer of Health covers a sphere as wide as that of the surgeon, the physician, the gynæcologist, and the pathologist combined; but that is something of an understatement, since

THE REMARKABLE BREADTH OF THE DEPARTMENT.

it includes only preventive work and ignores care, after-care, and social welfare. A few examples will illustrate the breadth and variety:—

(*a*) The responsibilities and duties of the matron and staff of a day nursery are not unlike those of the headmistress and staff of a nursery school or infant school; and group health teaching is further education work very similar to that conducted in evening classes, a total of 1,144 talks in a year corresponding roughly with 58 separate evening classes each meeting twenty times: so, in respect of these services a Medical Officer of Health has analogies with a Director of Education. (*b*) The work of meat detention officers, Shops Acts Inspectors, port health inspectors and to some extent district sanitary inspectors is not unlike that of the police force: so the Medical Officer of Health has analogies with a Chief Constable. (*c*) A health visitor training school undertakes the full-time training of students who already possess professional qualifications; the students correspond to post-graduates rather than to undergraduates, and the number is greater than in some University Departments under the charge of full-time professors: so a Medical Officer of Health with responsibility for a Training School has analogies with the head of a University Department. (*d*) Health visitors approximate numerically to general medical practitioners, and the duties of the former in prevention of disease have often been compared with the duties of the latter in its treatment: so the Medical Officer of Health has responsibilities resembling those of an Executive Council. (*e*) The superintendent or matron of an Old People's Home can be considered as undertaking functions similar to those discharged by the manager of a hotel: so the Medical Officer of Health is in effect responsible for the functioning of a group of hotels. (*f*) He has the control of a considerable number of professionally qualified staff (*e.g.*, medical officers, dentists, midwives, physiotherapists, &c.) and of a very large number of less highly trained persons (*e.g.*, home helps, rodent officers, staff of common lodging-house, &c.): so he comes into comparison with the personnel manager of a curiously complex industrial organisation.

In view of the complexity of a Health and Welfare Department it would be very easy for the chief officer to overlook some portion of the work in which he was not personally particularly interested: to forget, for example, about smoke abatement or mental after-care or audiometric services. The need to produce a complete annual report ensures that no portion is inadvertently overlooked: if, by personal predeliction or in consequence of public demand, the Medical Officer of Health has devoted disproportionate attention to certain aspects of his work, the compilation of the report serves as a yearly reminder to him that there are other aspects which cannot be neglected.

VALUE TO THE CENTRAL DEPARTMENT.

(2) A detailed annual report from each Health Department **enables the officers of the Secretary of State to form a true picture of the health and health services of the various areas.** Without such information these officers would

depend on the rather inadequate information that they could acquire by individual visiting of the 55 local health areas in Scotland.

VALUE TO OTHER M.Os.H.

(3) Probably the most avid readers of Annual Reports are Medical Officers of Health. By studying the reports of his colleagues an officer can **see exactly how a particular problem,** with which he is having difficulty, **is being tackled in comparable areas.** Most Medical Officers of Health receive from time to time letters from colleagues saying "With reference to the scheme outlined on page X of your last Annual Report, I should be very grateful for any additional information . . . "

VALUE TO COUNCIL.

(4) Ordinary reports on special subjects by Medical Officers are submitted to the Health Committee (and may never be read by members of the Council not on that Committee). Moreover, they are in a sense special pleading: they are generally produced because of a particular need and confine themselves to establishing that need and to making recommendations for coping with it. **It is extremely useful that Councillors should each year receive a report which is not devoted to setting out a particular lack but attempts to give a broad picture** of the health and health services of the area. It has to be remembered, too, that, human nature being what it is, in any special report the financial implications tend to receive major attention: it is useful that there should be one report in the year in which there are no direct and immediate financial implications.

VALUE IN FORMING PUBLIC OPINION

(5) When a chief officer submits a special report, his Council expects, rightly, that he will make specific recommendations which they can approve or reject; but, before the stage of concrete recommendations, it is often desirable that Councillors—and for that matter members of the general public—should give some consideration to a matter involving a major issue of policy. For example, before a Council is asked to consider whether it wishes to spend a certain sum of money on bringing the fluoride content of its water supply up to normal level, it is useful that it should have a chance to think about the pros and cons of fluoridation. The Annual Report affords a medical officer an opportunity to set out some of the arguments without necessarily making a recommendation. As a Health and Welfare Department is coming more and more to be concerned mainly with social problems and with the teaching of health, it is clearly important that public opinion should be formulated or crystalised on broad issues before an officer makes specific recommendations. The Annual Report can be of great value in **helping to form local public opinion.**

HISTORICAL VALUE

(6) Annual reports over a series of years are **social documents** of very considerable value to the student of history.

VALUE TO STUDENTS.

(7) To **doctors and nurses specialising in public health**—taking the D.P.H. Course or the Health Visitors' Course—annual reports are of considerable value, because they give a reasonably complete picture of the services in a particular area.

VALUE AS A BULWARK AGAINST REACTION.

(8) It can occasionally happen that a Council becomes so keen to save the pockets of its ratepayers that it fails to provide services that are both needed and desired by the community. In such circumstances, a special report, submitted by the Medical Officer of Health to the Council, can be deferred or even suppressed; but since the Council has no power to suppress or to delay the Annual Report, this Report can be used to **invite the attention both of the Secretary of State and of the general public** to the point in question. As an example, there may be mentioned an area (not Aberdeen) where in time past the Council had an infectious diseases hospital which was ludicrously small; after submitting various special reports in vain, the Medical Officer of Health indicated in his Annual Report that for some years he had pointed out the need for an adequate hospital in very definite terms, that the existence of this pressing need was undeniable, but that the Council had year after year declined to take action; thereafter, whether following press comment or questions by the Central Authority, a proper hospital was built.

Incidentally, it is perhaps because of the necessity for the M.O.H. at times to use his Annual Report to stimulate action in this way that he is given—unlike most other officers—security of tenure.

VALUE IN INDICATING ERRORS IN NATIONAL HEALTH POLICY.

(9) National policy in matters of health and disease must, of course, be determined by the elected representatives of the people; but since Medical Officers of Health are the officials responsible for the efficient functioning of the services aiming at promotion of health and prevention of disease, they are in a particularly good position to recognise errors or defects in the national provisions. They can seldom usefully point out such errors in reports to their own Councils, since a Town Council is largely limited, in respect of matters pertaining to salaries and conditions of service, for example, by nationally determined policy. An Annual Report can be most useful as a means of **drawing attention to errors in national policy.**

For instance, for a number of years Britain has been training just over one half of the health visitors needed (on a very stringent estimate of needs), and the lack of recruits has been manifestly due to gross underpayment of these key health teachers and social advisers: a veterinary officer of the Ministry or Department of Agriculture (with five years' training) receives a salary rising to £1,540, but—by a paradoxical inversion of the relative values of the health of children and old people on the one hand and of cows and sheep on the other—a health visitor (with practically the same length and intensity of training) receives less than half that salary; and even the top-ranking officers responsible for supervising large numbers of health visitors or teaching student health visitors are paid less than two thirds of the salary of a basic grade veterinary officer. This dangerous anomaly has so far persisted because (*a*) the particular Whitley Council responsible for determining the remuneration of health visitors is composed mainly of representatives of hospitals (both on management side and staff side), and (*b*)

certain people have for some years expressed the view that the economic state of the United Kingdom would not permit of an extra couple of thousand health visitors being employed—a view that sounds peculiar when one remembers that neither the Ministry of Education nor the Scottish Education Department has sought to stop the very much larger increases that have occurred in the number of school teachers, that neither the Home Office nor the Scottish Home Department has suggested that there could be no attempts to remove shortages of policemen or of visitors for deprived children, and that continued large increases have occurred in hospital staffs, such increases being necessitated in considerable measure by the lack of an adequate number of disease-preventing officers.

The tide of public opinion is turning so strongly in favour of prevention, and alarm at the steadily rising cost of treatment is so widespread, that it seems likely that in the near future real efforts will be made to render health visiting as attractive in terms of salaries and promotion prospects as are other professions, the Whitley Council being either stimulated to drastic action by the force of public opinion or superseded by a body more interested in the preventive services; but, if such efforts are made (with consquent reduction of unprevented illness and of the cost of treating such illness), no small portion of the credit will be due to the various Medical Officers of Health who made the public aware that shortage of disease-preventing officers was harming the community in health and in pocket. For instance, considerable attention was aroused when one of the acknowledged leaders in the public health field in England inserted the following paragraph in his Annual Report for 1956:—

> "In spite of Working Party Reports on sanitary inspectors and health visitors, little has been done nationally to improve the situation. This is rather deplorable, particularly in these days when many voices are being raised at the high cost of hospital treatment and the difficulties of getting a hospital bed. The country faces an over-all shortage of eligible woman power for nursing services. One strong incentive to health visitor recruitment would undoubtedly be higher salaries for, as the years go by, the health visitor's salary, in spite of her long training and high qualifications, compares increasingly unfavourably with those of hospital sisters, children's officers, and social welfare workers. The health visitor is the acknowledged spearhead of the attack in the preventive field, and this 'laissez-faire' policy in regard to recruitment may be regretted in the years to come."

Undoubtedly, the task of surveying the entire Health Services each year and writing up the survey in book form is a heavy one, but the nine examples given above perhaps demonstrate that the preparation of an Annual Report is an important duty, not a needless chore. It follows, of course, that a Medical Officer of Health has a moral obligation to try to make his report readable.

SOME STATISTICS OF 1957.

GENERAL SLIGHT WORSENING.

It is fair to say that in 1953, 1954, and 1955 (the years of expanding staff and extending services) the vital statistics were each year better than ever before, new record after new record being set up. In 1956 there was a slight worsening following an exacerbation of the shortage of qualified professional staff (especially health visitors), and in 1957 the deterioration has on the whole continued. Increases in the infant death rate and the infectious diseases death rate, together with other evidence, show that **Aberdeen, a little less healthy in 1956 than in 1955, was again a little less healthy in 1957 than in 1956.**

Detailed study of the various factors in the Report for 1955 led to the conclusion that **"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"** and led to a warning about **the danger of collapse of the preventive service through qualitative and quantitative inadequacy of recruits.** 1956 and 1957 have, unfortunately, shown that the warning was justified: with increased shortages—both of quantity and quality—the professional staff have been unable to maintain fully the level of services given hitherto.

Undoubtedly, the policy of decentralisation (which saves health visitors much travelling time) and the introduction of the health guidance scheme (very economical in that health education is imparted to a group of people simultaneously) have minimised the regression, but it would be idle to deny that a regression has occurred.

HIGH BIRTH-RATE.

The birth-rate was 18·1 per thousand population (a total of 3,379 births), being the **highest birth-rate since 1948.** The birth-rate for the previous year was at that time the highest since 1949. Needless to say, increases in the number of young children and increases in the proportion of old people, combine to press hardly on the disease-preventing officers since these are the sections of the community that occupy the greatest amounts of professional time.

GENERAL DEATH-RATE.

The general death rate is 11·4 per thousand and the death rate adjusted for age and sex is also 11·4. This is a reasonably low figure, but the general death rate is in any case not a good index of the health of a community.

ILLEGITIMATE BIRTH-RATE.

5·1 per cent. of all births were illegitimate (as compared with 5·3 in 1956). Aberdeen has for many years had a high illegitimate birth-rate.

RISING INFANT DEATH-RATE.

At first glance the **increase in the baby death-rate** looks small—from 21 per thousand live births in 1955, to 22 in 1956, and 24 in 1957; or in actual figures from 66 baby deaths in 1955, to 73 in 1956, and 82 in 1957. A little consideration reveals, however, that the increase is quite serious. In the present state of civilisation and of knowledge, about 13 baby deaths per thousand births can be regarded as unpreventable—the present irreducible minimum. (Some Swedish cities now record baby death-rates of 13 and 14 per thousand, and British cities like Bristol, Croydon and Plymouth, with rates of about 19, do not claim that

they have approached the limits of prevention.) It would therefore be reasonable to apply this figure to Aberdeen, and to say that baby deaths in recent years could be approximately divided thus:—

	Unpreventable.	Other.
1955 . .	41	25
1956 . .	42	31
1957 . .	44	38

When all due allowance has been made for the vagaries of chance variation, an increase in "preventable" baby deaths from about 25 in 1955 to about 38 in 1957 is somewhat alarming.

SHARP RISE IN NEO-NATAL DEATHS.

The neo-natal death-rate per thousand live births has increased steeply—from 11 in 1955, to 14 in 1956, and 17 in 1957. There were in all 58 neo-natal deaths in 1957, as compared with 45 in 1956, and 36 in 1955.

VERY LOW TUBERCULOSIS DEATH-RATE.

For several years the tuberculosis death-rate has been dropping almost year by year, and in 1957 it again fell sharply—to 0·06 per thousand population, or—in actual figures—a total of twelve deaths. It is, of course, fair to mention that there is no connection between this reduction and the X-ray campaign in November: as mentioned elsewhere, the radiography campaign in Aberdeen was not a desperate effort to cope with an increasing menace but rather an attempt to deliver the "coup de grace" to an old enemy already reeling before the sustained attack of the preventive services.

DEATHS FROM VIOLENCE.

A saddening feature of the year is that the City which had been a pioneer in home safety had a **sharp rise in the death-rate from violence.** Of the 108 deaths ascribed to violence, 20 were the result of road accidents, 27 were from suicide, and 61 were due to other causes.

MISCELLANEOUS.

There were also **increases in the death-rates from the principal infectious diseases, from cancer and other tumours, and from respiratory diseases.** There were **no maternal deaths,** and the **still-birth rate** was lower than in 1956 but higher than in 1955.

More detailed information about the year's statistics will, of course, be found in the chapter of the report dealing with the subject.

FEATURES OF 1957.

Some of the main features of the year are summarised below.

HEALTH GUIDANCE—A SPECTACULAR SUCCESS.

(1) Pride of place must be given to **the tremendous success of the Health Guidance Project,** which was launched in November, 1956. Courses of instruction for expectant mothers, health clubs for parents of young children, and sporadic addresses to pre-formed audiences all proved even more popular than had been anticipated, and long before the end of 1957 it was clear that a major weapon had been forged for the battle against disease. Instead of the thousand addresses forecast (and immortalised in the newspaper headline, "Thousand salvo blitz on

disease''), actually **1,144 talks were given during the year,** but the demand was so great that more could easily have been delivered if sufficient suitable individuals had been available as lecturers.

The work was certainly hard: perhaps, indeed, the education of groups of adults of varying background is the hardest type of all teaching. The popular demand was, however, gratifying in the extreme, and the development of group health teaching on an unprecedented scale undoubtedly helped to minimise the harmful effects of staff shortages.

A tribute to the two health visitor tutors and five health visitors involved appears later. It may be appropriate to mention here that the project attracted more attention from other areas than did any other development in recent years: the persons responsible for the organisation of the scheme found themselves invited to take part in a broadcast; to address refresher courses for Medical Officers of Health, for Departmental Medical Officers, and for Health Visitors; to write articles for various journals; and to answer innumerable queries. Owing to lack of time, not all of these invitations could be accepted.

X-RAY CAMPAIGN—A RECORD.

(2) Second only to the health guidance project among the features of the year stands the **Mass Radiography Campaign.** The Aberdeen attack on tuberculosis, which was brought to a successful conclusion at the end of November, had several unique features (notably complete reliance on professional staff for preliminary visiting of households) and the precentage examined (78·6 per cent. of all eligible adults) was the **highest yet achieved in any similar campaign.**

The all-out struggle against tuberculosis imposed a very heavy strain on the entire health and welfare staff, and also on the staff of the Publicity Department; and it must be kept in mind that the accepted methods of controlling tuberculosis—contact tracing, B.C.G. vaccination, health education and social advice—had already reduced the incidence of the disease very greatly; there was an almost year-by-year fall in the number of notified cases from 316 in 1948 to 220 in 1956; and this reduction increased the difficulty of the campaign. Nevertheless, it is anticipated that the X-ray success will (at the least) halve the incidence of tuberculosis: if so, it will save a vast amount of human suffering and will also save the community over £50,000 each year, or roughly three times as much money every year as was spent on the campaign.

PREVENTION OF DELINQUENCY AND MALADJUSTMENT.

(3) It has been pointed out in previous Annual Reports that it is now universally accepted that **the modern family health visitor can do much to prevent maladjustment, child neglect, broken homes, juvenile delinquency, antisocial behaviour and many of the psychoneurotic and psychosomatic diseases;** and the Health and Welfare Department's work in this field in 1954-56 has been described as **"incomparably the most important development in any recent year."** In 1957, group teaching on mental health developed enormously, and individual teaching in the homes of the people continued to as large an extent as staff shortages permitted.

CLEAN FOOD GUIDE.

(4) Early in 1957 some 3,000 copies of a **Clean Food Guide** (a fifty page book prepared by senior members of the medical and health visiting staff) were distributed to catering establishments, clinics, &c. The Guide—the first (as far as is known) to be issued by any Scottish local authority—was produced without any cost to the Corporation.

RELAXATION EXERCISES.

(5) 1957 was the first full year during which **relaxation exercises were available for expectant mothers.** These exercises were very popular with future mothers and are regarded by the professional staff as definitely useful.

MEAT INSPECTION.

(6) The work of the detention officers continued to extend. There was a considerable **increase in the number of cattle slaughtered,** but a slight **decline in the number of carcases condemned.**

SANITARY INSPECTION.

(7) **Housing duties and recent food legislation** occupied much of the time of the sanitary inspectors and also considerable portions of the time of health visitors and of one of the medical officers.

STAFF SHORTAGES—ESPECIALLY OF HEALTH VISITORS AND DENTAL OFFICERS.

(8) **Staff shortages, grim at the beginning of the year, were even more acute at its close.** There were unfilled vacancies on the sanitary inspecting, physiotherapy, and clerical establishments, but the gravest scarcities were of health visitors and dental officers. **The severe national shortage of health visitors**—a shortage occasioned primarily by inadequate pay and poor promotion prospects—**is pressing even more hardly on Aberdeen than on other areas,** because (*a*) the City has amalgamated its Health and Welfare Departments in the interests of efficiency and economy, and has for some years employed its health visitors as general purpose family health teachers and social advisers—a policy which is completely in line with the recommendations of official bodies but makes the increasing shortage of health visitors even more serious than it would be if groups of social welfare visitors and school nurses were also employed, and (*b*) the City has for some years developed its disease-preventing services and has thereby been able to save expenditure on supportive and treatment services (the total cost per head of population for the entire Health and Welfare Services is, for example, less in Aberdeen than in Dundee or Glasgow), and now the increasing lack of health visitors is seriously endangering the entire services.

A special chapter in the report that follows is devoted to a detailed consideration of the shortage of health visitors. The writer will therefore merely indicate here that in the days when health visitor staffing was expanding the proportions of baby deaths and still-births declined, and that, as these key professional workers fall into shorter supply, the proportions of needless deaths that occur are again increasing.

RE-ORGANISATION OF STAFF.

(9) To save the time of highly qualified staff a decision was taken in 1957 to employ **three clinic assistants and one clinic sister.** This should not be regarded as dilution but rather as an attempt to use less trained staff for simple duties and to reserve health visitors for work demanding their special skills. Again, as

an inevitable corollary to the policy of **decentralisation** (which, as mentioned in the Report for 1956, enabled a decreased number of health visitors to undertake an increased number of visits), a number of health visitors were appointed as centre superintendents with very small responsibility allowances. Certain re-organisation of the duties of medical officers was also in process at the end of the year.

VACCINATION AND IMMUNISATION.

(10) **Increasing shortage of health visitors adversely affected vaccination and immunisation.** The numbers of children protected against smallpox, diphtheria, and whooping cough were in each case below those in the previous year. The decline is not catastrophic if it can be arrested in 1958, but whether it can be arrested is not yet known.

MIDWIFERY.

(11) During the year all the domiciliary midwives were trained in the use of the Emotril Inhaler.

CLINIC ATTENDANCES.

(12) **The number of clinic attendances was higher than ever.** In this connection particular attention may be drawn to the year by year increase in the number of children aged 1-5 years attending the child welfare clinics (from a total of 610 in 1951 to 4,881 in 1957).

VISITS BY HEALTH VISITORS.

(13) **The total number of visits paid by health visitors was 165,605,** an apparent increase on the 143,185 visits paid in 1956, which in turn represented a rise of nearly 20 per cent. on the figures for 1955 and of over 30 per cent. on the figures for 1954. It is fair to mention, however, that the total for 1957 included special evening visits paid in connection with the X-ray campaign, and that the real total (exclusive of these special visits) was very close to that for 1956 despite the increasing numbers of young and old to be visited. Indeed, since the policy of decentralisation of staff had achieved its full effects by 1956, reduced number of available staff inevitably meant fewer visits—so much so, in fact, that early in 1958 a local newspaper gave prominence to complaints by mothers of young children about not seeing their family health visitor often enough.

However, there was at least **a further rise in the number of visits paid to expectant mothers:** until a few years ago these visits were regarded as a low priority in most areas, whereas to-day they are recognised as among the most important of all visits paid by any members of the entire National Health Service.

LOW INCIDENCE OF INFECTIOUS DISEASES.

(14) On the whole the **incidence of infectious diseases was low.** Certainly there were increases in dysentery, influenza, and (following the influenza outbreak) influenzal pneumonia, but there was again **not a single case of diphtheria,** there were **only 5 cases of poliomyelitis,** there were only 5 cases of cerebrospinal fever, and **only 28 cases of whooping cough** were notified. For the fourth consecutive year there were **no cases of ophthalmia neonaturum:** it is interesting to reflect that twenty years ago the annual number of cases of that grave disease usually exceeded a hundred.

Equally interesting is **the decline of infective jaundice:** until 1953 the annual number of cases varied from 4 to 13; in 1954 there were 2 cases; in 1955 one; in 1956 and 1957 none.

SERVICES FOR THE ELDERLY.

(15) Investigation in previous years had suggested that **the commonest unmet need of elderly citizens was for visits by health visitors** (to advise on measures to maintain or promote physical and emotional health, to offer guidance on social problems, and to act as initiators and co-ordinators of health services and social services needed by the individuals). Although over 10,000 visits were paid to elderly citizens by health visitors in 1957, a survey of 1,005 old people showed that visits by health visitors remained the commonest unmet need of the elderly, with **chiropody as the second commonest unmet need. Expansion of the health visitor service in 1953 and 1954 probably did more than any other single measure to improve the health of old people,** but, with increasing shortage of staff, it is proving well nigh impossible for the health visitors to pay enough visits.

The number of persons on the **register of elderly persons** increased, and the **home help service** was slightly enlarged.

TRAINING OF HOME HELPS.

(16) In 1957 one week **courses of training were held for three groups of home helps.** So far as is known these are the first courses of this nature held in Scotland.

TASKS NOT TACKLED.

(17) Owing to lack of staff and shortage of accommodation nothing was done to implement suggestions in a Department of Health circular about vision-testing of young children; the diphtheria immunisation campaign that was postponed in 1956 was again postponed in 1957; after-care was not undertaken in cases of diabetes, peptic ulcer, cardiac diseases, &c.; no duties in respect of after-care of mental patients were carried out; the study of children born in 1953 was discontinued; a research project on cancer and smoking—proposed near the beginning of the year—was postponed; an investigation into the cost of Pitfodels Nursery was postponed month after month; the report on the School Health Services (required by the Department of Health for Scotland by 1st December) was not completed till February of 1958; and various other duties were not undertaken or were undertaken to an inadequate extent.

ACCOMMODATION—ANTIQUATED CLINICS.

(18) Only two of the Corporation's clinics are purpose-built. All the others are adapted buildings and some are very antiquated indeed. Castlegate (a child welfare clinic, a chiropody clinic, and the main centre for sale of Welfare foods) is particularly decrepit: the roof is alleged to leak in fifteen places and to be beyond repair. The former maternity hospital (which houses the health visitor training school, the central ante-natal and post-natal clinics, and the gynæcological advisory clinic) is also in considerable disrepair and regarded as in the last few years of its life as a building. The main dental clinic is an old and unsatisfactory building.

GRAVE LACK OF OFFICE ACCOMMODATION.

All these, however, pale into insignificance by comparison with the plight of the administrative and central clerical staff. As successive duties were placed on the Health and Welfare Department, more and more staff were crammed into

the administrative headquarters at Willowbank House until at last in 1956 that building became so full that human ingenuity could devise no means of accommodating even one more officer. In these circumstances, the Corporation sanctioned the building of a prefabricated annexe adjacent to Willowbank House at a cost of about £6,000; but the Department of Health for Scotland was unable to authorise the necessary borrowing. More duties fell to be undertaken—*e.g.*, poliomyelitis vaccine became available and schemes for the mentally and physically handicapped waited to be carried out—but there was insufficient staff to perform the duties already being discharged and no space in which to house additional staff. In the summer of 1957 the Corporation realised that the X-ray campaign could not be carried out unless some additional rooms were procured; and—failing better premises—condemned property in Broad Street awaiting demolition was taken over as campaign headquarters. At the end of the year, as there was still no accommodation available, the Health and Welfare Department retained possession of the condemned slum, which at 31st December housed some ten members of staff.

MISCELLANEOUS.

AWARDS.

During the year Miss D. J. Lamont (Principal Health Visitor Tutor and Senior Health Guidance Lecturer) was awarded the first prize in the Royal Society of Health Competition for an essay on "The Advantages and Disadvantages of Amalgamation of Health Departments and Welfare Departments," this being the first occasion on which a Royal Society of Health prize has come to Scotland. Miss M. M. Byrne (Assistant Health Visitor Tutor and Junior Health Guidance Lecturer) visited Holland as holder of a National Association for Prevention of Tuberculosis Scholarship. The Medical Officer of Health held (until October) a Nuffield Research Grant (for an investigation of home accidents) and a Medical Research Council Grant (for study of combined immunisation). Mr. S. Howell (Port Sanitary Inspector) was awarded second prize in the Sanitary Inspectors' Association Medallist Competition for a paper on "Commercial Fish Inspection."

For the fifth consecutive year the Health Visitor Training School secured a hundred per cent. pass in the national examination for the health visitor's certificate.

POSTS HELD.

During the year Dr. MacQueen was appointed by the Secretary of State as a member of the Scottish Clean Air Council, and continued to serve as a member of the Building Legislation Committee, as Hon. Secretary of the Scottish Branch of the Society of Medical Officers of Health, as a Vice-President of the Women Public Health Officers' Association, as a member of Committee of the County Burgh Group of the Society of Medical Officers of Health, and as a member of the Scottish Public Health Committee of the British Medical Association. Mr. A. Hay (Chief Dental Officer) continued to serve as Hon. Secretary of the Public Health Group of the British Dental Association. Dr. D. Younie (Senior Assistant Medical Officer) was President of the Scottish Child Health Group of the

Society of Medical Officers of Health. Miss D. J. Lamont (Principal H.V. Tutor) was appointed Chairman of the Health Visitor Tutors Group of the Royal College of Nursing, acted as Chairman or Secretary of several Committees of the Scottish Health Visitors' Association and was elected President of the Aberdeen Branch of that Association. Miss M. M. Byrne (Assistant H.V. Tutor and Health Guidance Lecturer) resigned the post of Hon. Treasurer of the Scottish Health Visitors' Association on obtaining an appointment in Uganda, and was succeeded as Hon. Treasurer by Miss M. Nairn (Centre Superintendent H.V.). Dr. MacQueen and Miss Lamont served on a Regional Working Party on the Elderly; Dr. MacQueen and Mrs. Bell (Social Worker) continued as directors of the Aberdeen Association of Social Service; Miss Lamont was a member of the Area Nurse Training Committee; and representation on various local committees was as specified in the 1956 Report.

ADDRESSES TO CONFERENCES, ETC.

Miss D. J. Lamont spoke in a radio programme in Woman's Hour about the health services of Sweden. Dr. MacQueen and Miss Lamont delivered two papers on health education at a refresher course for Medical Officers of Health (at Peebles). Miss Lamont discussed mental health at a refresher course for Health Visitors (at Dundee); and Miss Sangster (Health Visitor) opened a discussion on handicapped children at the Congress of the Royal Sanitary Association (at Dunoon).

PUBLICATIONS.

Published articles by members of staff in 1957 included—a study of vaccination in Scotland, by Dr. MacQueen and Dr. J. Riddell (M.O.H., Midlothian) *(Health Bulletin of Department of Health for Scotland);* and advantages and disadvantages of amalgamation of Health Departments and Welfare Departments, by Miss Lamont *(The Nursing Times).*

TRIBUTE.

While thanking the Convener and members of the Health and Welfare Committee for continued interest and help, and officers of other Corporation Departments and of other branches of the National Health Service for generous co-operation, the writer would like to pay particularly warm tribute to his colleagues in the Health and Welfare Department. He would like to express his appreciation in respect of the following points and persons:—

(1) **The staff in general.** In 1957 as in previous years further duties were placed on the department and the staff had to try to help more people—in particular, the proportions both of children and of the elderly continued to rise. To undertake increasing work there were even fewer staff than in the past: the number of vacancies for sanitary inspectors and clerical staff was appreciable and the shortage of health visitors and dental officers was tremendous. Moreover, many members of staff had the additional handicap of having to work under very unsatisfactory conditions. In an extremely difficult year nearly all members of staff—medical officers, dental officers, health visitors, midwives, sanitary inspectors, meat inspectors, clerks, staffs of nurseries and homes, &c.—worked with praiseworthly energy and enthusiasm, devoting much unpaid overtime work to

endeavouring to minimise the effects of staff shortages on the health and well-being of the people. Certainly there are a few exceptions: the occasional member of staff who habitually avoids extra work; the occasional medical officer who, on being given an additional task, looks for someone on whom to dump it; the occasional health visitor who practically never finds it necessary to pay an evening visit; the occasional clerical officer who tends to be last in each morning and first out each evening; the individual who is prepared to give a lecture for which a fee is payable but is too busy to undertake any unpaid extra work. These, however, are rarities. In general the staff toiled strenuously and deserve the highest praise.

(2) **The persons particularly concerned in the X-ray campaign.** The health visitors, with their 20,000 hours of additional work, come immediately to mind, as do the four medical officers and ten health visitors who acted as local organisers. Even more praiseworthy are those who played major parts in the organisation of the campaign—Mr. Worling (Assistant Administrative Officer) and Miss Macfie (Superintendent H.V.) on whom perhaps fell the heaviest tasks of all; Mr. Grainger (Administrative Officer), Miss Lamont (Senior Health Guidance Lecturer), Dr. Barclay (Deputy M.O.H.), and—in the Publicity Department—Colonel Webber and Mr. Leiper; and equally worthy of mention are some who toiled incessantly in the background, *e.g.*, Miss Ledingham (Secretary to the M.O.H.).

(3) **Those who undertook research work in their scanty leisure.** In particular Dr. Wallace (Principal Assistant Medical Officer), Dr. Younie (Senior Assistant Medical Officer), Dr. M'Gregor (Departmental Medical Officer), and the various persons who assisted them. The writer would wish, incidentally, to thank Mr. Tait (Statistician) and Miss Taylor (Health Visitor) for help in connection with the home safety research. In an understaffed and overworked department the conduct of research is far from easy, and much credit is due to those who persevered with their projects.

(4) **Those who contributed to the saving of professional time** by re-organising duties or re-designing records.—The work of Miss Macfie (Superintendent Health Visitor) and Dr. Ormiston (Departmental Medical Officer) in the last few months of the year deserves special mention, and others who played notable parts included Mr. Grainger, Miss Lamont, Miss Stephen, and Dr. Brunton.

(5) **The Health Guidance Team.** The crowning achievement of the year was the firm establishment of group health teaching in Aberdeen—so firm that not only was the initial target exceeded by nearly 15 per cent., but Miss Lamont and Dr. MacQueen were invited to address medical officers of health on health education; and Miss Hay, Miss Lamont, and Dr. MacQueen were (after the close of the year) invited to broadcast in Woman's Hour on the same subject. The Corporation was singularly fortunate in the initial members of the team: Miss Lamont,

whose outstanding abilities are shown by the fact that she was the first health visitor in this country to obtain the high honour of a World Health Organisation Senior Travelling Fellowship and the first person in Scotland to secure a Royal Society of Health Prize, and whose recognition by her colleagues nationally is revealed by the various offices she has held in the Royal College of Nursing and the Scottish Health Visitors' Association; as Deputy Leader, Miss Byrne, who has been a Member of Council of the Royal College of Nursing, Treasurer of the Scottish Health Visitors' Association, and holder of an N.A.P.T. Scholarship; Miss A. Hay, first holder of the Aberdeen Corporation Prize for the best all-round student health visitor of the year; Miss M. Nairn, present Treasurer of the Scottish Health Visitors' Association, who joined the team after visiting Canada as holder of a British Red Cross and Empire Scholarship; and Miss M. Taylor, who at one time shared with Miss Lamont the distinction of being one of the only two health visitors who had given an opening address at a Congress of the Royal Sanitary Association of Scotland. These five gave of their best, generously sacrificing much of their scanty leisure to prepare and deliver lectures, as indeed did the two later additions to the team, Miss Greig and Miss Sutherland, both of whom maintained the high standard set by their colleagues. The tremendous success of the Health Guidance Scheme is due to the enthusiasm, ability, and hard work of these seven.

IAN A. G. MACQUEEN,
Medical Officer of Health.

Health and Welfare Department,
Willowbank House,
Willowbank Road,
Aberdeen, 20*th March*, 1958.

CITY OF ABERDEEN.

REPORT BY THE MEDICAL OFFICER OF HEALTH

For the year 1957.

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

Since an annual report inevitably consists largely of figures, and since figures can give useful information only when interpreted in the light of the social economic, industrial, and climatic circumstances of the area to which they relate, it is perhaps worth while to set down some background data against which the health and welfare services can be studied. The short chapter that follows is on the same lines as in the report for 1956, except that housing and the social problems related to housing are mostly omitted: these problems do not change greatly in a single year, and in the 1956 report eighteen pages were devoted to them.

Some features of Aberdeen.

The most northerly large town in the British Commonwealth, Aberdeen (population 187,000) is the third biggest city in Scotland and contains one twenty-seventh of the population of the country. A seaport with an extensive fishing fleet, Aberdeen is also the natural commercial and industrial centre for a considerable agricultural hinterland. Some of the main industries include—granite quarrying; manufacture of agricultural implements; fishing; shipbuilding; and manufacture of textiles, paper, woollen and flax materials. In summer the City, which has a bracing climate of the east coast type, is a very popular holiday resort.

Aberdeen is rich in educational and research institutions. Mention may be made of the University (formed in 1860 by the amalgamation of two universities which had existed for centuries within a mile of each other); the Marine Laboratory and the Torry Research Station under the jurisdiction of the Department of Scientific and Industrial Research; the North of Scotland College of Agriculture and the Rowett Research Institute; the Macaulay Institute for Soil Research; a Social Medicine Research Unit of the Medical Research Council (attached to the Midwifery Department of the University); the Health Visitor Training School (attached to the Health and Welfare Department of the Corporation); the Dunfermline College of

Physical Education (which trains all the women gymnastic teachers of Scotland); a College of Domestic Science, a Technical College, a College of Art, and a District Nurse Training School.

The density of population (16·4 persons per acre) is greater than that of Edinburgh or Dundee but less than that of Glasgow. Socio-economic classification of adult males shows that Aberdeen and Glasgow have considerably higher proportions in Social Class V (*i.e.*, unskilled workers) than have other Scottish cities or Scotland as a whole.

Despite a vigorous housing policy in recent years, there is still much overcrowding: at the last census 12·6 per cent. of the population were living more than two per room (as compared with 9·4 per cent. in Scotland and 2·0 per cent. in Britain as a whole), and Aberdeen was less favourably placed than any other Scottish city in respect of families lacking exclusive use of each of the following facilities—piped water supply, water-closets, kitchen sink, and cooking stove or range. In January, 1957, the list of applicants for Corporation houses comprised some 11,000 families (or roughly a fifth of the population of the City) of whom approximately 3,200 were sub-tenants, 4,800 were in unfit houses, and 3,000 were in overcrowded but fit houses.

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 1956 was 186,396, and the estimated population at the middle of 1957 was 186,190.

Growth of the Population.—The growth of the City may be 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 1957 was 56,427, an increase of 732 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 . .	4,050	No. 7—Rosemount . .	3,666
No. 2—St. Nicholas . .	5,161	No. 8—Rubislaw . .	3,820
No. 3—St. Andrew's . .	4,459	No. 9—Holburn . .	4,406
No. 4—St. Machar . .	3,902	No. 10—Ruthrieston . .	4,691
No. 5—Woodside . .	4,872	No. 11—Ferryhill .	4,620
No. 6—Cairncry . .	8,508	No. 12—Torry . . .	4,272

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 (186,190) for the middle of 1957, and the City Assessor's return as to the number of houses in the City, is 3·30.

Rateable Value (1956-57)—£2,360,088.

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

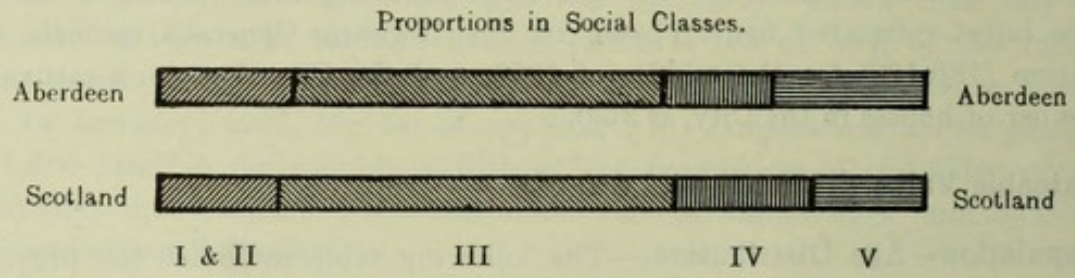
	Under 1 year.	1 and under 5 yrs.	5 and under 15 yrs.	15 and under 25 yrs.	25 and under 45 yrs.	45 and under 65 yrs.	65 yrs. and upwards.
1911 . .	2·23	9·03	22·13	19·13	26·84	15·31	5·33
1921 . .	2·35	6·66	19·41	20·00	27·00	18·42	6·16
1931 . .	1·75	6·81	17·22	18·65	28·51	19·81	7·25
1951 . .	1·63	7·44	14·14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

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



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 Scottish city, very much higher than in Scotland as a whole, and appreciably higher 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.

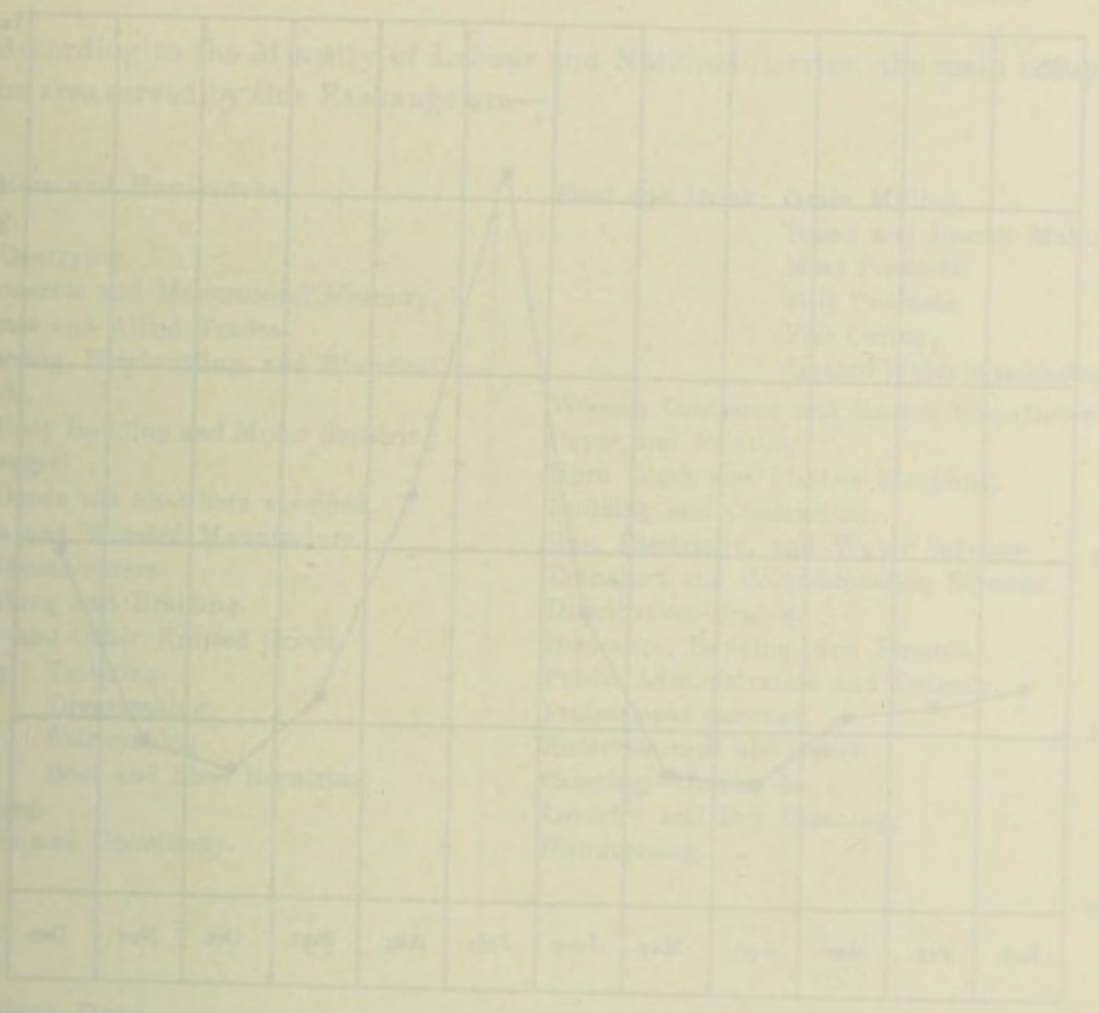
(4) Aberdeen has a higher proportion of inhabitants in Class I than any city except Edinburgh.

Unemployment.—Unemployment during most of 1957 was not very extensive, though a shade more than in the previous year. At the latest date for which information is easily available (30th December, 1957) the numbers of unemployed persons in the area covered by the Aberdeen Employment Exchange were—

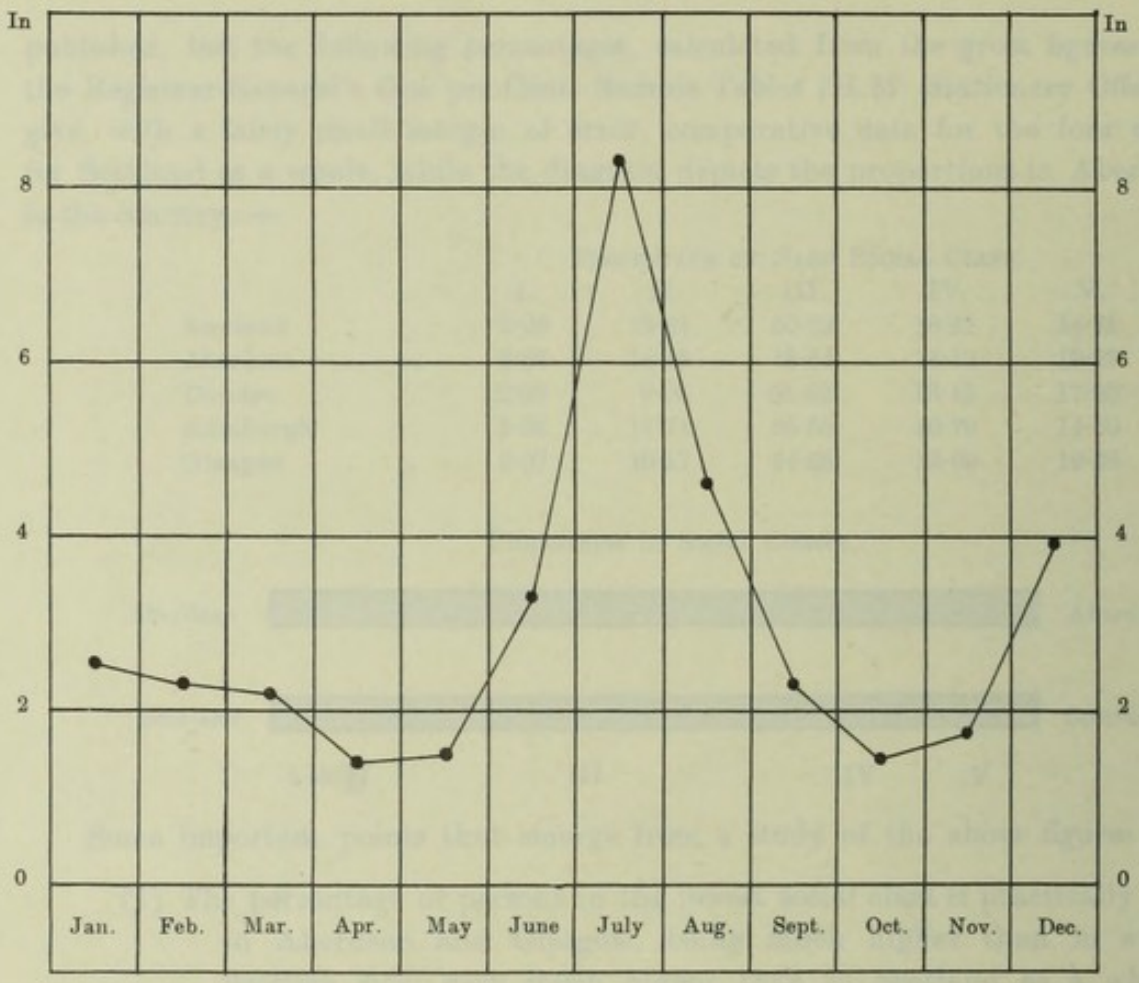
Men, 2,565; Boys, 45; Women, 848; Girls, 49; Total, 3,507.

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.

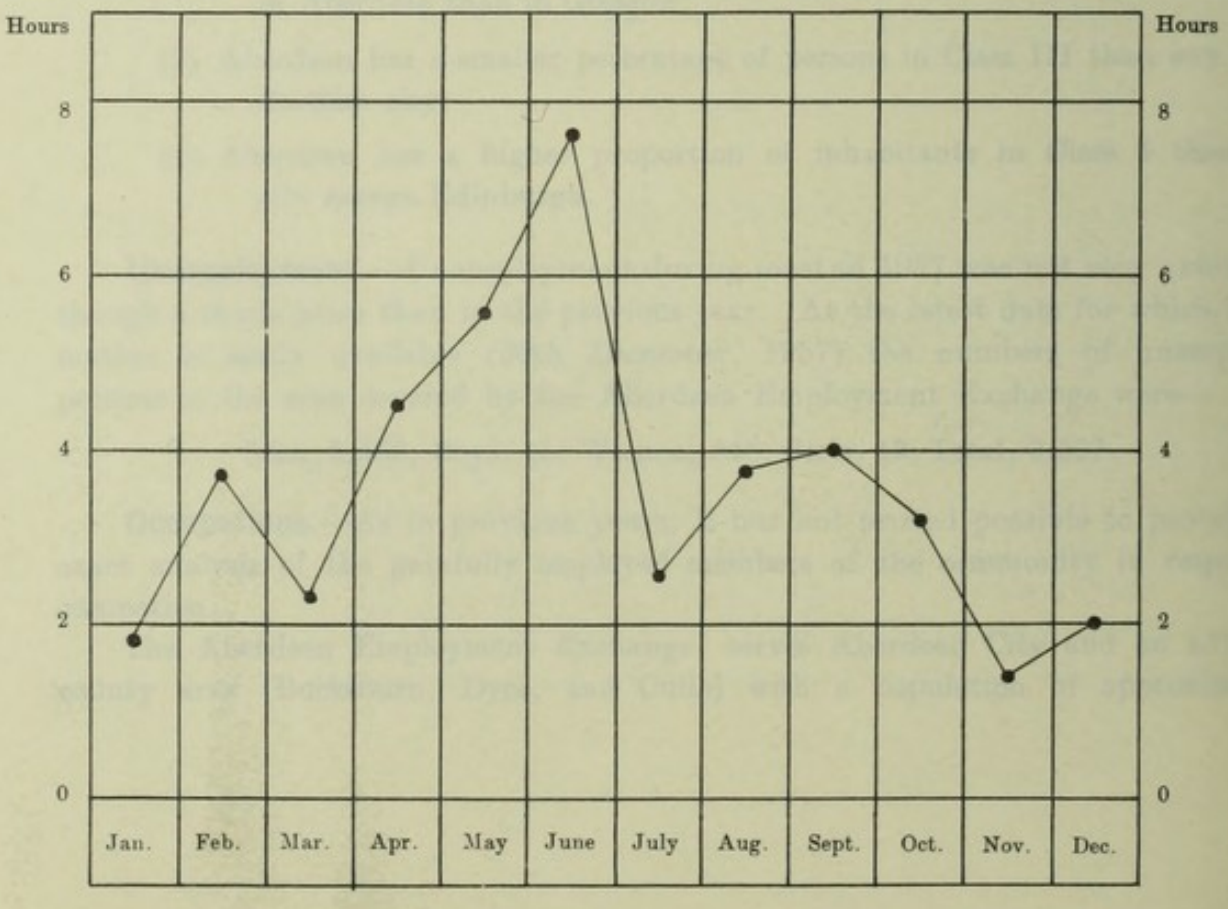
The Aberdeen Employment Exchange serves Aberdeen City and an adjacent county area (Bucksburn, Dyce, and Cults) with a population of approximately



TOTAL RAINFALL AND OTHER FORMS OF PRECIPITATION. YEAR 1957.



BRIGHT SUNSHINE—HOURS PER DAY. DAILY MEAN. YEAR 1957.



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.

Temperature.—The lowest temperature registered during the year was 24°F (in the week ended 14th December). In the previous year, the lowest temperature recorded was 15°F, and in 1955 the lowest was 14°F.

The highest temperature registered was 74°F (during the week ended 29th June). The highest temperature recorded during the previous year was 76°F, and in 1955 the highest was 79°F.

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

Rainfall.—The total rainfall during the year (at Craibstone, just outside the City) was 35·32 inches, as compared with 33·73 inches in 1956, and 28·10 inches in 1955. As recorded at Craibstone, it was the wettest July since records began in 1917. The distribution of rainfall in the different months is shown in diagrammatic form.

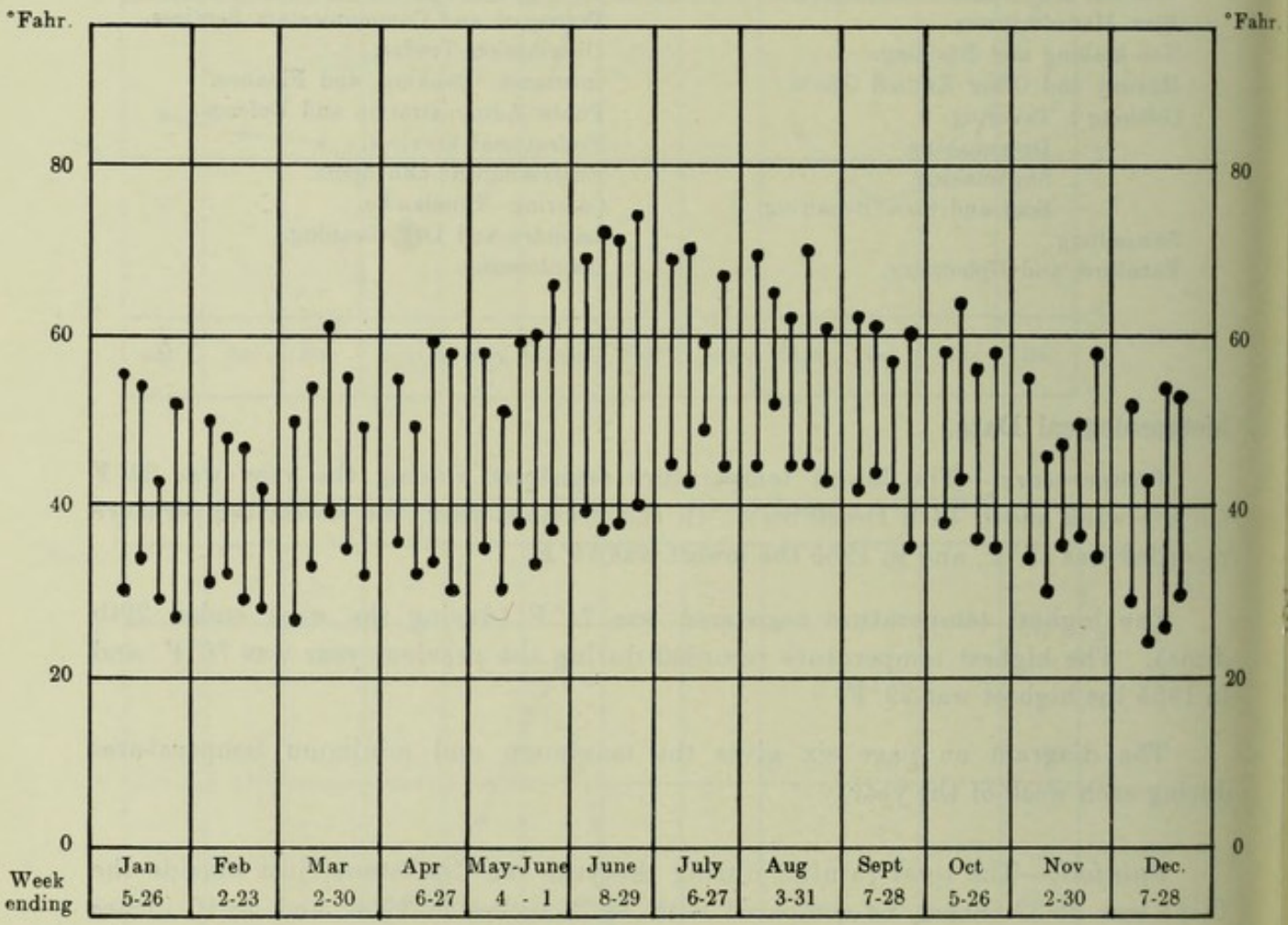
Sunshine.—As recorded at Craibstone, it was the dullest July since 1925. The average daily hours of sunshine are shown in the diagram.

CITY OF ABERDEEN.

TEMPERATURE OF ATMOSPHERE—WEEKLY MAXIMA AND MINIMA

°FAHR.

YEAR, 1957.



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 33.	22-33.	11-21.	1-10.	Calm.
January	0	17	45	39	23
February	2	3	40	44	23
March	0	2	46	56	20
April	0	3	39	60	18
May	0	1	27	65	31
June	0	0	18	71	31
July	0	0	21	77	26
August	0	2	29	72	21
September	0	8	40	56	16
October	0	2	30	70	22
November	0	4	24	57	35
December	0	3	52	48	21

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	6	0	0	9	33	24	17	12
February	6	1	2	11	25	13	17	14
March	4	1	3	16	51	7	14	8
April	22	1	3	5	24	9	12	26
May	16	3	10	15	18	2	5	24
June	21	5	8	9	14	5	12	15
July	22	5	18	12	10	5	3	23
August	13	5	4	14	17	6	17	27
September	5	3	7	9	17	9	17	37
October	2	0	0	1	25	34	22	18
November	11	1	6	4	20	7	21	15
December	10	2	5	5	21	25	21	14

2.—VITAL STATISTICS OF 1957.

Some of the main features of the year are as follows—

(1) Although the live-birth rate for 1956 had been the highest recorded for a number of years, the rate for 1957 is still higher.

(2) The illegitimate-birth rate, the third lowest in the history of the City, the only years with lower rates being 1953 and 1954.

(3) The still-birth rate is lower than has ever been achieved by any other Scottish city and lower than the rates in comparable English cities. The rate for 1957 is, however, only the second lowest in Aberdeen's history, being higher than that for 1955.

(4) For the second consecutive year the infant-death rate has risen. It is now identical with the rates in Edinburgh and Dundee, slightly higher than the average for England and Wales, though far below the Scottish average, and very much higher than the rates in Scandinavian cities.

(5) The neonatal-death rate has risen steeply for the second consecutive year. It is now the same as the rate in Edinburgh but lower than the rates in other Scottish cities and in Scotland as a whole.

(6) In 1957 there were no maternal deaths, as compared with 1 in each of the two previous years.

(7) The average age at death is the third highest on record, being lower than the rates for 1955 and 1954.

(8) The proportion of deaths in persons under the age of 45 years is slightly higher than in 1956—10 per cent. as against 9 per cent.

(9) The proportion of deaths in persons over the age of 75 years, after reaching a new high level of 40 per cent. in 1956, has fallen slightly to 39 per cent.

(10) The "health indicator" suggested by the World Health Organisation gives 1955 as the healthiest year in Aberdeen's history, 1956 as the second healthiest year, and 1957 as the third healthiest.

(11) The slight regressions shown in items (4), (5), (8), (9), and (10), all for the second consecutive year, undoubtedly imply some deterioration in the health of the community—a deterioration which has been forecast since 1955 owing to the shortage of qualified professional staff, especially health visitors.

(12) The deterioration has, however, been less than had been anticipated, and Aberdeen's vital statistics still compare favourably with those of the other Scottish cities.

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

LIVE BIRTHS.

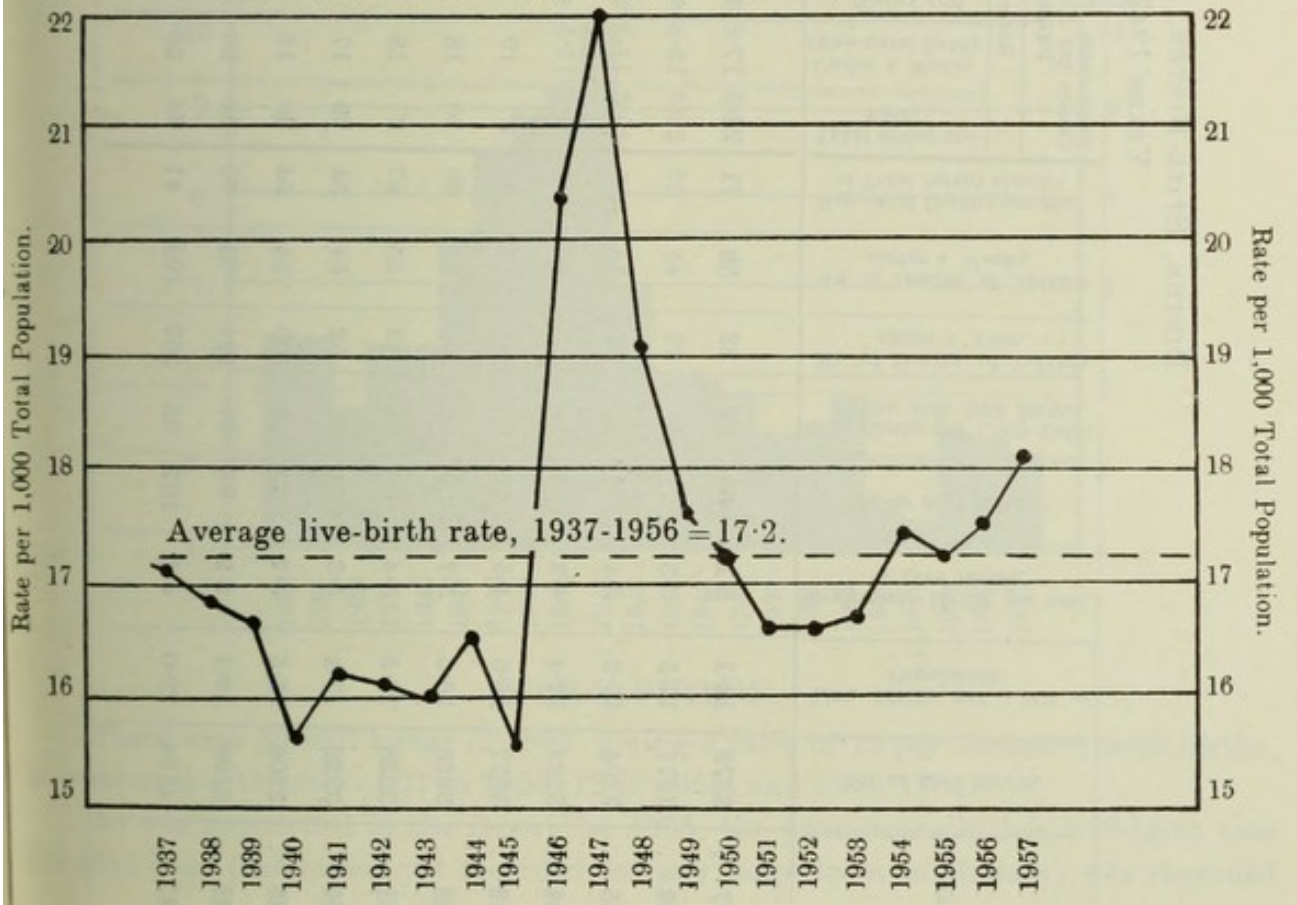
The total number of live births in Aberdeen during 1957, corrected for "transfers," was 3,379, of whom 3,206 were legitimate and 173 illegitimate. The live birth-rate was 18·1 per thousand of population, the highest figure recorded since 1948.

The following table shows the rates for Aberdeen and Scotland over a period of ten 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.
1957	18·1	19·0
1956	17·5	18·5
1955	17·2	18·0
1954	17·4	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

In 1957, the birth-rates in the other principal cities were:—Glasgow, 20·8; Edinburgh, 16·9; and Dundee, 19·3.

ABERDEEN.—LIVE-BIRTH RATE—1937-1957.



Births, Still-Births, Infant Mortality.

Years 1947-1957.

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.
1957 .	**3379**	**18·1**	**5·1**	**50**	**15**	**82**	**58**	**71**	**24·3**	**17·2**	**4·7**	**2·3**	**0**	**0·3**	**5**	**0·3**	**4**	**1**	**6**	**5**	**1**	**1**
1956 .	3271	17·5	5·3	71	21	73	45	62	22·3	13·8	6·1	2·4	0	0	5	1	3	1·5	2·8	5	2	2
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

*Including under 4 Week

The natural increase for the year (*i.e.*, the excess of births over deaths) was 1,258, as compared with 1,116 in 1956, 1,069 in 1955, 1,172 in 1954, and 986 in 1953.

Sex-ratio of births.—Of the total 3,379 live births, 1,733 were males and 1,646 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 1956, 1·05 in 1955, 1·10 in 1954, 1·07 in 1953, and 1·09 in 1952.

ILLEGITIMATE LIVE BIRTHS.

In 1957 there were 173 illegitimate live births, representing a rate of 5·1 per cent. of the total live births. For Scotland, the rate was 4·1 per cent.

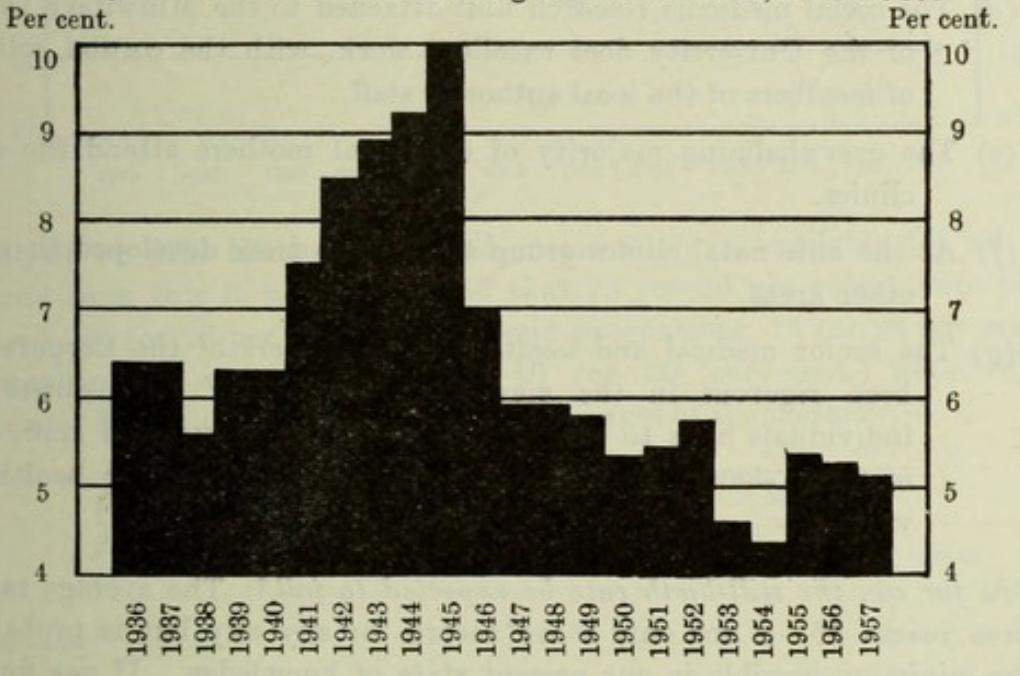
For many years illegitimacy has been a very grave social problem in Aberdeen, and the illegitimate-birth rate has been high. The rate for 1957 is the third lowest in the history of the City.

Some possible explanations of the high illegitimacy rate in Aberdeen were suggested in the report for 1955.

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

ABERDEEN.

Illegitimate Births as Percentage of Live Births, 1937-1957.



STILL BIRTHS.

There were 50 still births in 1957, giving a ratio of 15 per thousand total births, as compared with rates of 21 in 1956, 12 in 1955, and 19 in 1954.

As was mentioned in the report for 1955, the phenomenally low still-birth rate for that year (the lowest yet recorded for any large town in Britain) was regarded

as being in some part due to chance, just as the relatively high rate for the following year was deemed to be in part attributable to chance fluctuation. Apart from the 1955 figure the rate for 1957 is by far the lowest on record. No other Scottish city has yet recorded a rate below 19 (and indeed only once has any other Scottish city been below 21), and the writer knows of only one large town in England which has ever recorded a figure of less than 19. Yet in the last four years Aberdeen's still-birth rate has only once exceeded 19.

Important factors for the achievement and maintenance of Aberdeen's very low still-birth rate include the following:—

(*a*) There is excellent co-operation between hospital and local authority staff, *e.g.*, the clinics are conducted jointly, and the hospital clinicians and midwives and local authority doctors and health visitors work in complete harmony and endeavour to synchronise their advice.

(*b*) The general standard of midwifery and obstetrical care are very high in Aberdeen, due in no small measure to the leadership of Professor Baird.

(*c*) Standards of ante-natal care and health teaching—both as provided by health visitors and midwives in the home and as provided by medical officers, health visitors, and midwives in the clinics—are very high.

(*d*) The social medicine research unit attached to the Midwifery Department of the University does excellent work, with the cordial collaboration of members of the local authority staff.

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

(*f*) At the ante-natal clinics group teaching is more developed than in many other areas.

(*g*) The senior medical and health visiting officers of the Corporation have been rigorous in the view that, no matter what duties or what individuals have to be neglected owing to shortage of staff, expectant mothers should be regarded as a high priority for health visitors' visits.

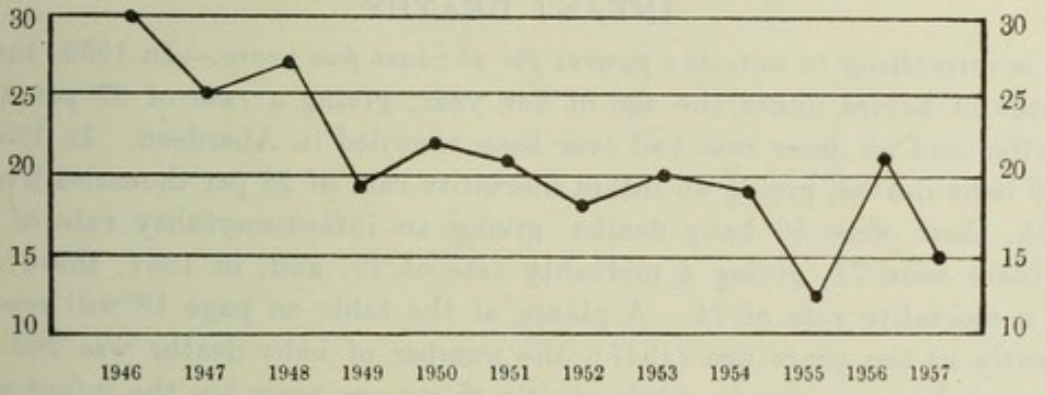
How far can the still-birth rate be expected to fall? The average rate for the last three years—16—is not only a low record for any city but is probably fairly near the minimum possible in our present state of knowledge. If one finds a peak of still-births in elderly mothers (especially in their fourth or subsequent pregnancy), one can look to the obstetrical services for possible improvement; if one finds a similar peak in young mothers (especially in their first pregnancy), one can look to the health teaching and social advisory services for useful action; but if, as in Aberdeen over the last three years, there is no peak, one cannot but feel that prevention of still-births is nearing the limits at present possible.

In any case, the question is at present purely academic. The real question awaiting an answer is this—in view of grave staff shortages, can the low still-birth rate be maintained, or will the 1956 and 1957 increase in the baby death-rate be followed by a rise in the still-birth rate?

The following table gives comparative figures for the Scottish cities for the last five years, and the graph shows the reduction of the rate in Aberdeen over the last twelve years.

	Still-birth Rate per 1,000 Total Births.				
	1957.	1956.	1955.	1954.	1953.
All Scotland . .	24	24	25	25	25
Glasgow . . .	26	26	27	29	27
Edinburgh . . .	19	23	24	21	22
Dundee . . .	24	23	24	28	25
Aberdeen . . .	**15**	**21**	**12**	**19**	**20**

ABERDEEN.—STILL-BIRTH RATE—1946-1957.



Analysis of Still Births.—Detailed information is available for all the still births, and from this it was ascertained that 13 (or 26 per cent.) were primipara pregnancies, 13 (or 26 per cent.) were second pregnancies, 14 (or 28 per cent.) were third pregnancies, and the remaining 10 (or 20 per cent.) were subsequent pregnancies. The following summary shows the ages of the mothers:—

	TOTAL	AGE OF MOTHER					
		Under 20 years	20-24	25-29	30-34	35-39	40 +
1st Pregnancy	13	—	8	4	1	—	—
2nd Pregnancy	13	—	5	2	3	2	1
3rd Pregnancy	14	—	3	8	1	1	1
Subsequent Pregnancies	10	—	—	4	2	3	1
TOTAL ...	50	—	16	18	7	6	3

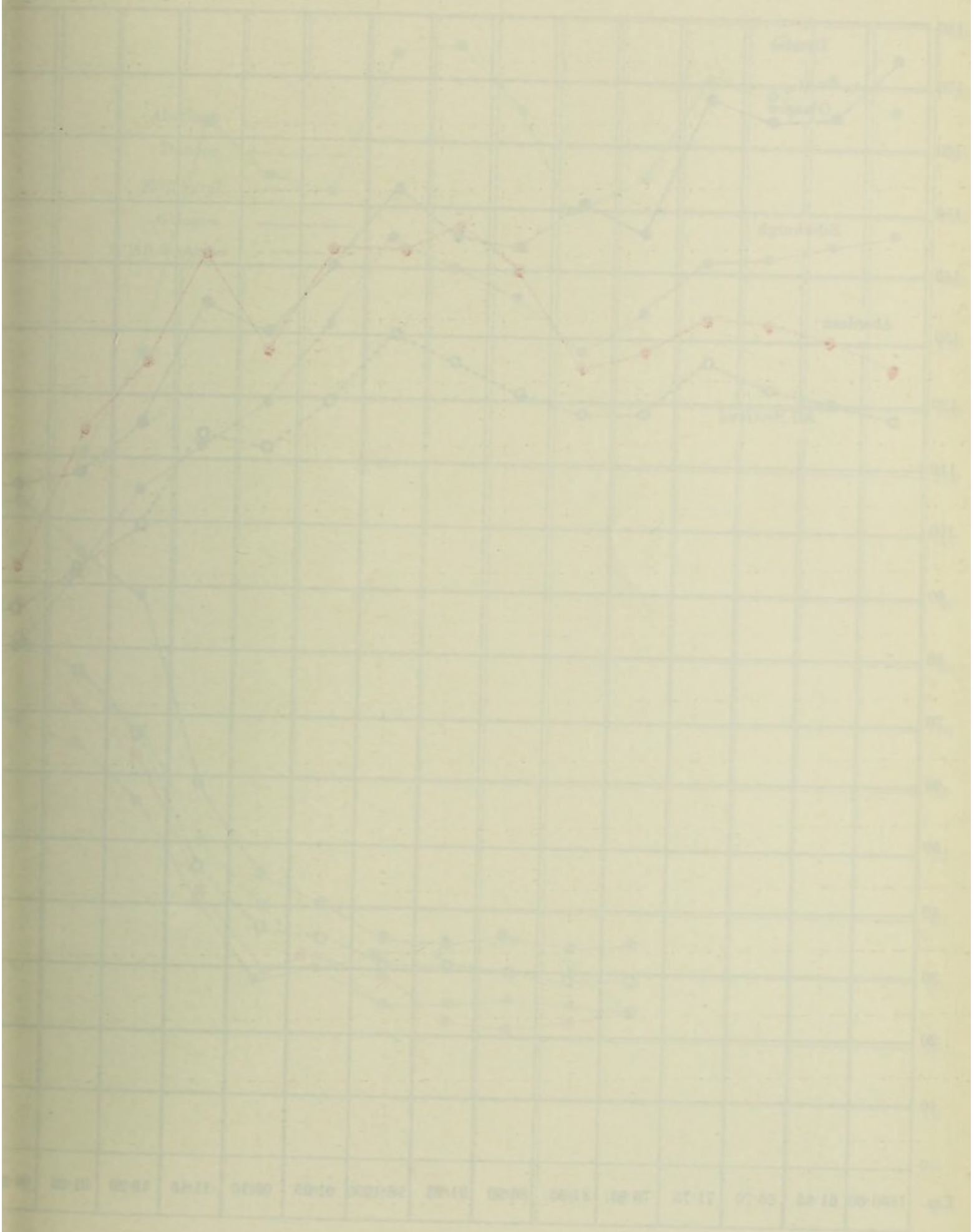
The causes of the still births were as follows:—

Chronic disease in mother—		
Chronic nephritis	1	
	—	1
Diseases and conditions of pregnancy and childbirth—		
Antepartum hæmorrhage	6	
Toxæemia of pregnancy	4	
	—	10
Trauma	3	
Trauma—Cord conditions	4	
	—	7
Congenital malformation of fœtus		9
Diseases of fœtus and ill-defined causes—		
Rhesus incompatibility	5	
Prematurity—Cause unknown	13	
Full term—Cause unknown	5	
	—	23
		—
		50
		=

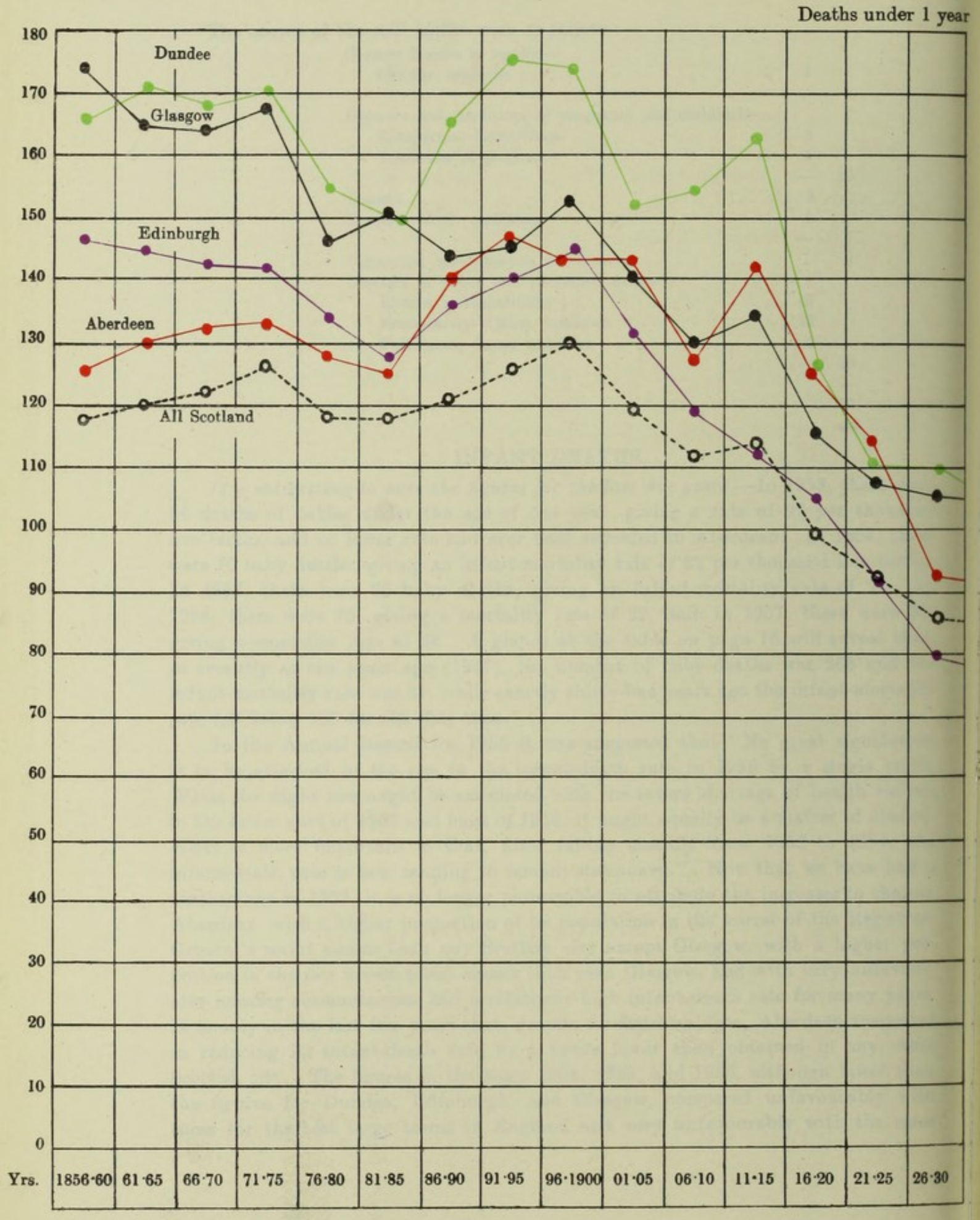
INFANT DEATHS.

It is interesting to note the figures for the last five years.—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. In 1956, there were 73, giving a mortality rate of 22, and, in 1957, there were 82, giving a mortality rate of 24. A glance at the table on page 18 will reveal that, as recently as ten years ago (1947), the number of baby deaths was 263 and the infant-mortality rate was 64, while exactly thirty-one years ago the infant-mortality rate fell below 100 for the first time.

In the Annual Report for 1956 it was suggested that "No great significance is to be attached to the rise in the infant-death rate in 1956 by a single point. While the slight rise might be associated with the severe shortage of health visitors in the latter part of 1955 and most of 1956, it might equally be a matter of chance. What is more important is that, after falling steadily from 1952 to 1954, the infant-death rate is now tending to remain stationary." Now that we have had a further rise in 1957, it is no longer permissible to attribute the increases to chance. Aberdeen, with a higher proportion of its population in the lowest of the Registrar-General's social classes than any Scottish city except Glasgow, with a higher proportion in the two lowest social classes than even Glasgow, and with very unfavourable housing circumstances, had a relatively high infant-death rate for many years. It is only in the last few years that, despite its disadvantages, Aberdeen succeeded in reducing its infant-death rate to a figure lower than obtained in any other Scottish city. The figures in the years 1954, 1955, and 1956, although lower than the figures for Dundee, Edinburgh, and Glasgow, compared unfavourably with those for the best large towns in England and very unfavourably with the rates

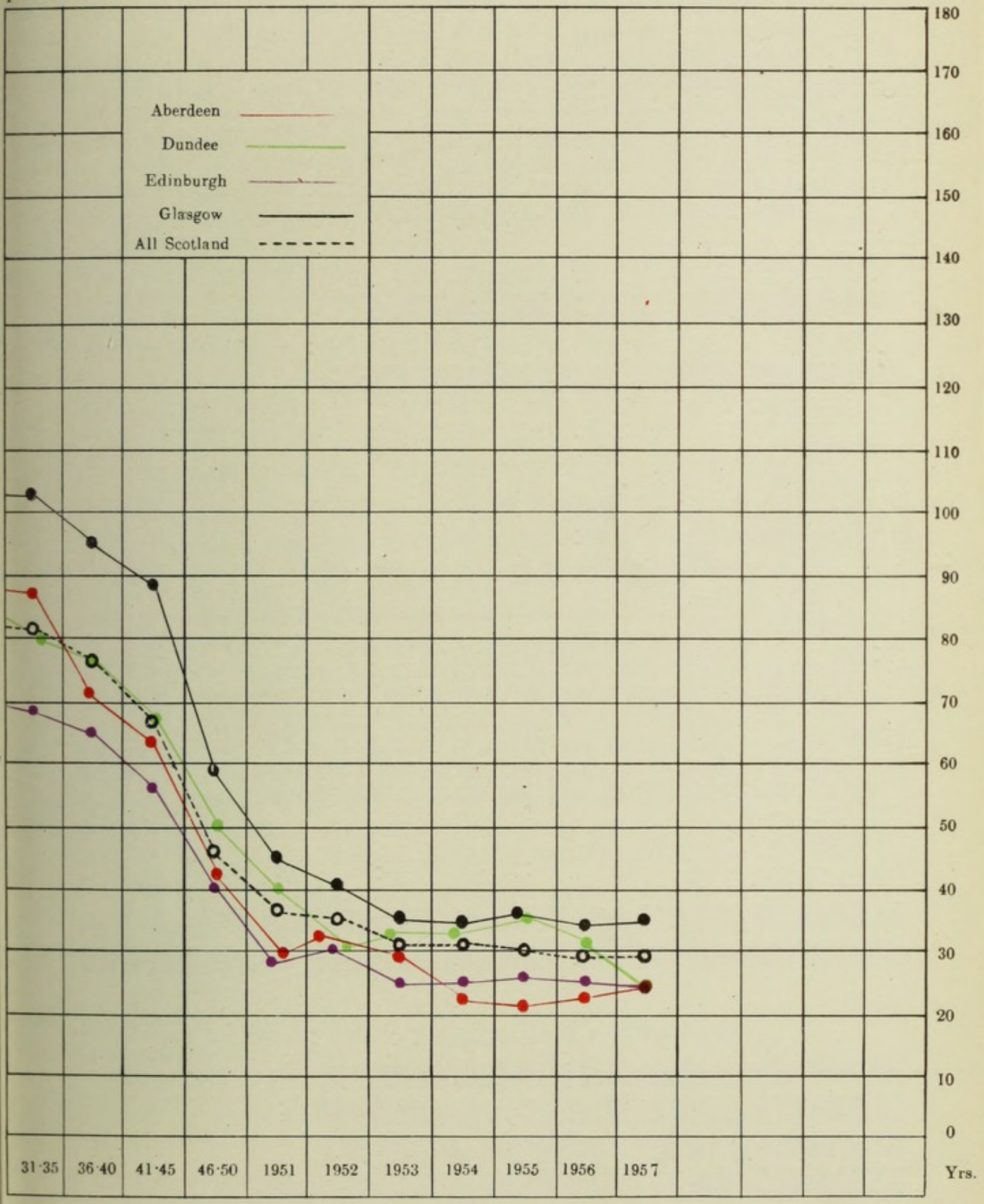


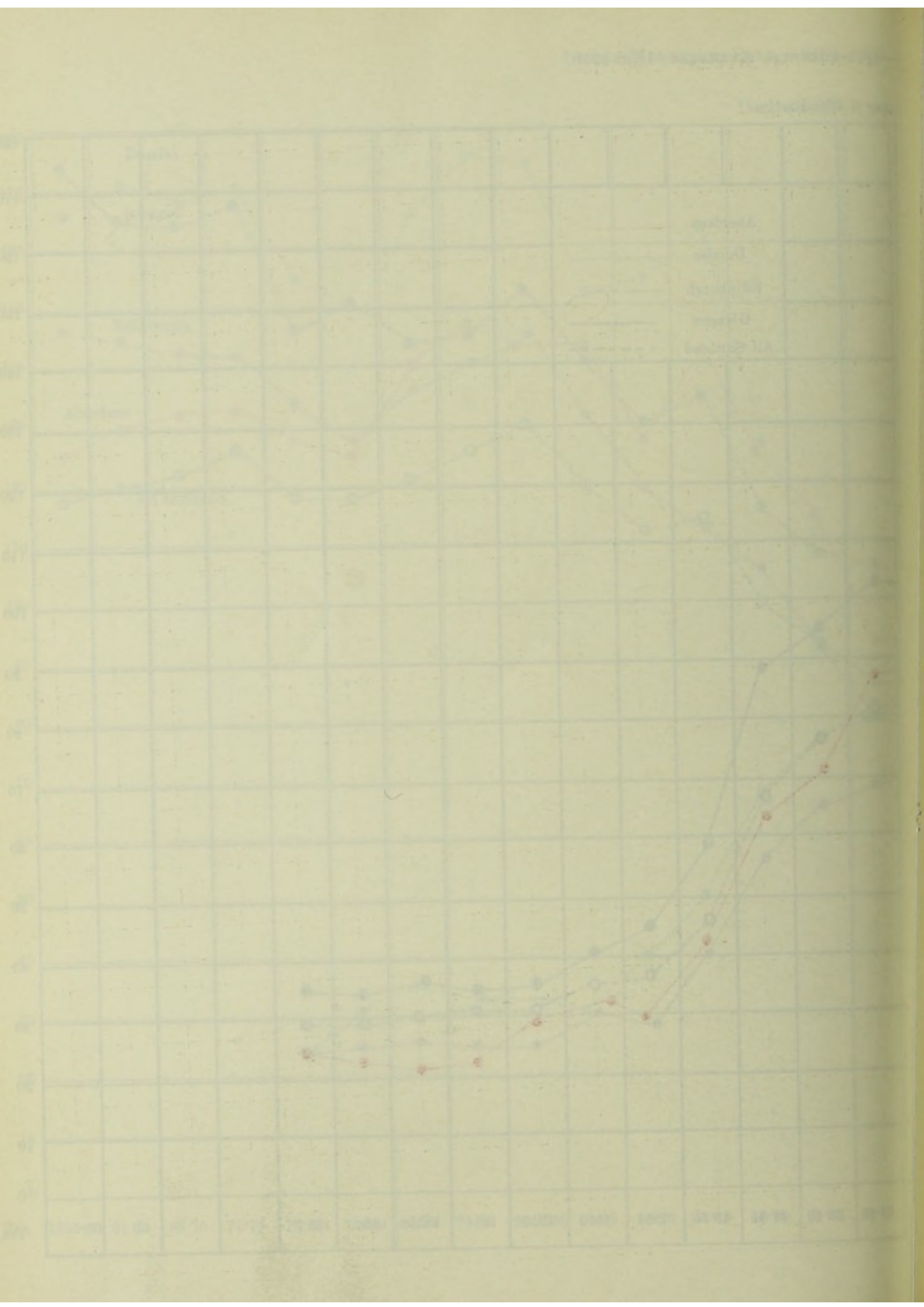
Infant Mortality Rate— 1856-1957



—Quinquennial Averages, 1856-1950.

per 1,000 Births.

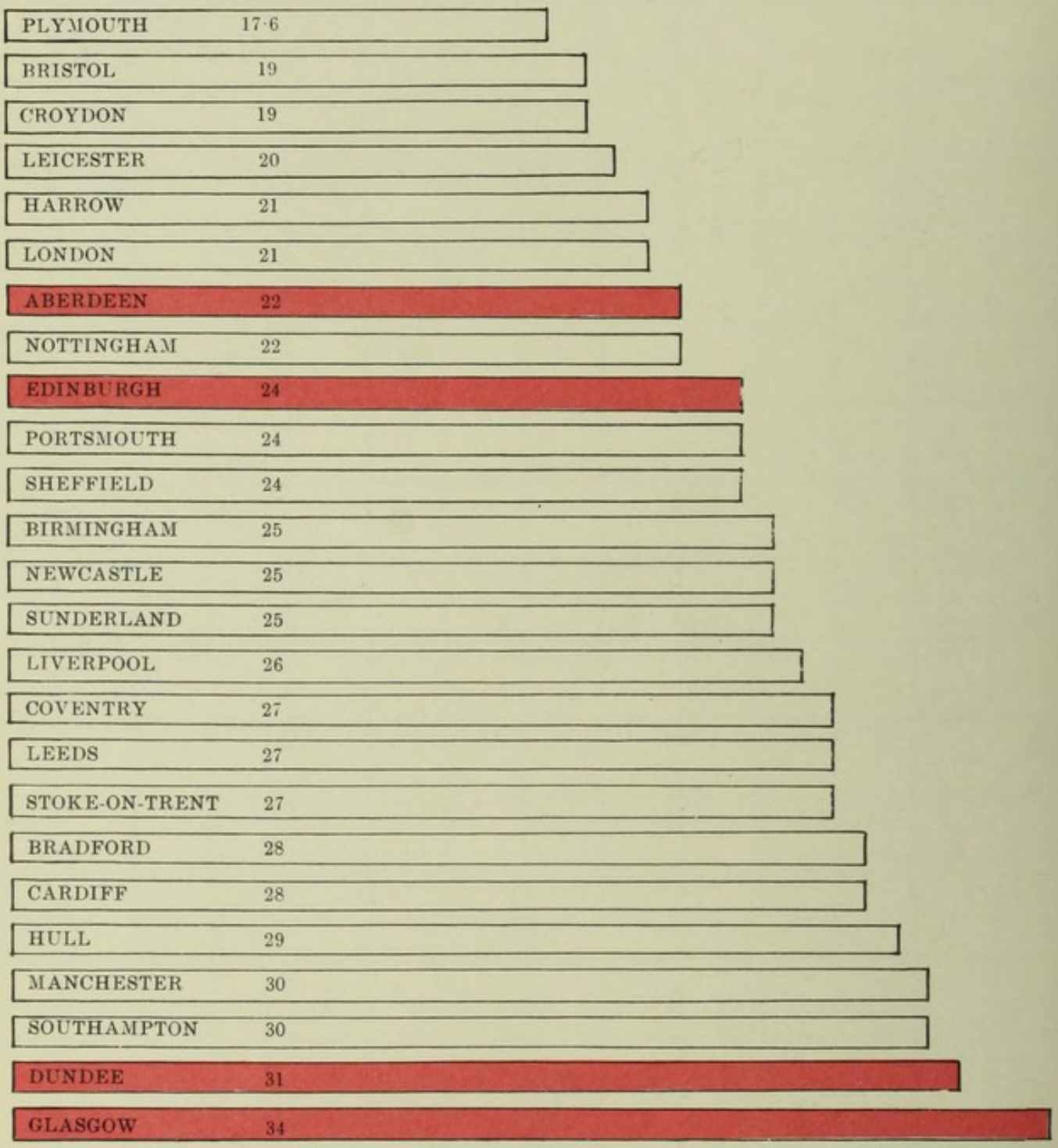




INFANT DEATH RATES IN 25 LARGE TOWNS.

(PER THOUSAND LIVE BIRTHS.)

1956.



1957—SCOTTISH CITIES ONLY.

obtaining in Sweden and New Zealand. Aberdeen's success (by Scottish standards) was due in large measure to the development of its disease-preventing services and, in particular, to the expansion of its health visiting service; but, in the last couple of years, recruitment of health visitors has fallen, the number in post has decreased, the high birth-rates and the increasing number of both the very young and the elderly have combined to throw more work on a dwindling staff, and Aberdeen's infant-death rate has risen to the level of that of Edinburgh and may well continue to rise unless the shortage of health visitors can be reduced. Nevertheless, while shortage of key professional workers is an important factor, it is not necessarily the only factor involved.

Comparison with national figures and with other cities.—The accompanying diagram shows the rates in 25 large towns in Britain in 1956 and the rates in the four Scottish cities in 1957. The table below gives, for a period of five years, the rates for England and Wales, Scotland, and the four Scottish cities.

	Infant Death-rates (per 1,000 births).				
	1957.	1956.	1955.	1954.	1953.
England and Wales .	23	24	25	26	27
Scotland . . .	29	29	30	31	31
Glasgow . . .	35	34	36	35	36
Edinburgh . . .	24	24	25	25	24
Dundee . . .	24	31	36	33	32
Aberdeen . . .	**24**	**22**	**21**	**22**	**27**

The Annual Report of the Department of Health for Scotland for 1957 says—"The mortality figures, so far as known, point to an interruption—temporary, it is hoped—in the downward trend in infant mortality." In Aberdeen, unfortunately, there is not merely an interruption but a deterioration.

The accompanying coloured chart shows the infant-death rate in Scottish cities and in Scotland as a whole since 1856, and a table (inserted after the sub-section on mortality in pre-school children) gives 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 five years reveals that the death rates from various causes were as follows:—

	Infant Death Rates per 1,000 Live Births.				
	1957.	1956.	1955.	1954.	1953.
Congenital malformations . .	4	3	3	3	4
Atelectasis	6	2·8	3·4	7	8
Birth injuries	1	1·5	0·3	1	2
Diarrhœa and enteritis . .	0·3	1	0	0	0·3
Pneumonia and bronchitis . .	5	5	4	5	6
Common infections . . .	0·3	0	1	0	0
Tuberculosis	0	0	0	0	0
Asphyxia and other accidents .	1	2	2	0·3	1
Immaturity	5	5	4	2	3
Other causes	1	2	3	4	3
Total . .	24	22	21	22	27

Neo-Natal Deaths.—In 1957, the number of deaths of infants under the age of four weeks was 58, as compared with 45 in 1956, 36 in 1955, and 50 in 1954. The neo-natal death-rate was 17 per thousand live births. The neo-natal death-rates for Scotland and for the four principal cities in 1953-1957 are indicated below, and the accompanying diagram gives figures for a number of large towns.

	Neo-natal Death Rates.				
	1957.	1956.	1955.	1954.	1953.
Scotland	20	19	20	21	19
Glasgow	23	21	23	21	22
Edinburgh . . .	17	18	18	19	16
Dundee . . .	18	21	21	23	20
Aberdeen . . .	**17**	**14**	**11**	**15**	**19**

Post-Natal Deaths.—In 1957, there were 24 deaths of infants aged 4 weeks to 12 months as compared with 28 in 1956. For further analysis, reference may be made to Table I at the end of this chapter.

In 1953, Aberdeen's post-neonatal death-rate fell from 12 to 8, and since then the rate has varied between 7 and 10. By comparison, Plymouth, in 1956, recorded a rate of 4·5, Bristol one of 4·8, Harrow one of 5·1, and Sheffield one of 5·6.

Deaths under the age of one week.—Although the conventional division of infant deaths is into neonatal (under one month) and post-neonatal, it is also useful to separate out the deaths occurring before the age of one year. From the coloured chart that follows, it will be seen that, in four of the last five years, more babies died in the first week than in the remaining fifty-one weeks.

Perinatal Mortality.—Addition of the still births and neonatal deaths gives a total perinatal mortality rate of 32. This seems good enough when compared with the appreciably higher rate for Edinburgh and the much higher rates for Dundee and Glasgow; but two years ago—1955—Aberdeen achieved the remarkable perinatal mortality rate of 23. By Aberdeen standards, the perinatal mortality—or, more specifically, the neonatal fraction of it—is not satisfactory. To reduce perinatal mortality, which accounts for three-quarters of the total loss of baby lives, it is essential to think not in terms of service for mother and child, but of services for prospective mothers and unborn child, *e.g.*, provision of more or better advice to expectant mothers by health visitors in the privacy of the home, provision of courses of instruction for prospective parents, and measures to induce an even higher proportion of expectant mothers to attend antenatal clinics.

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

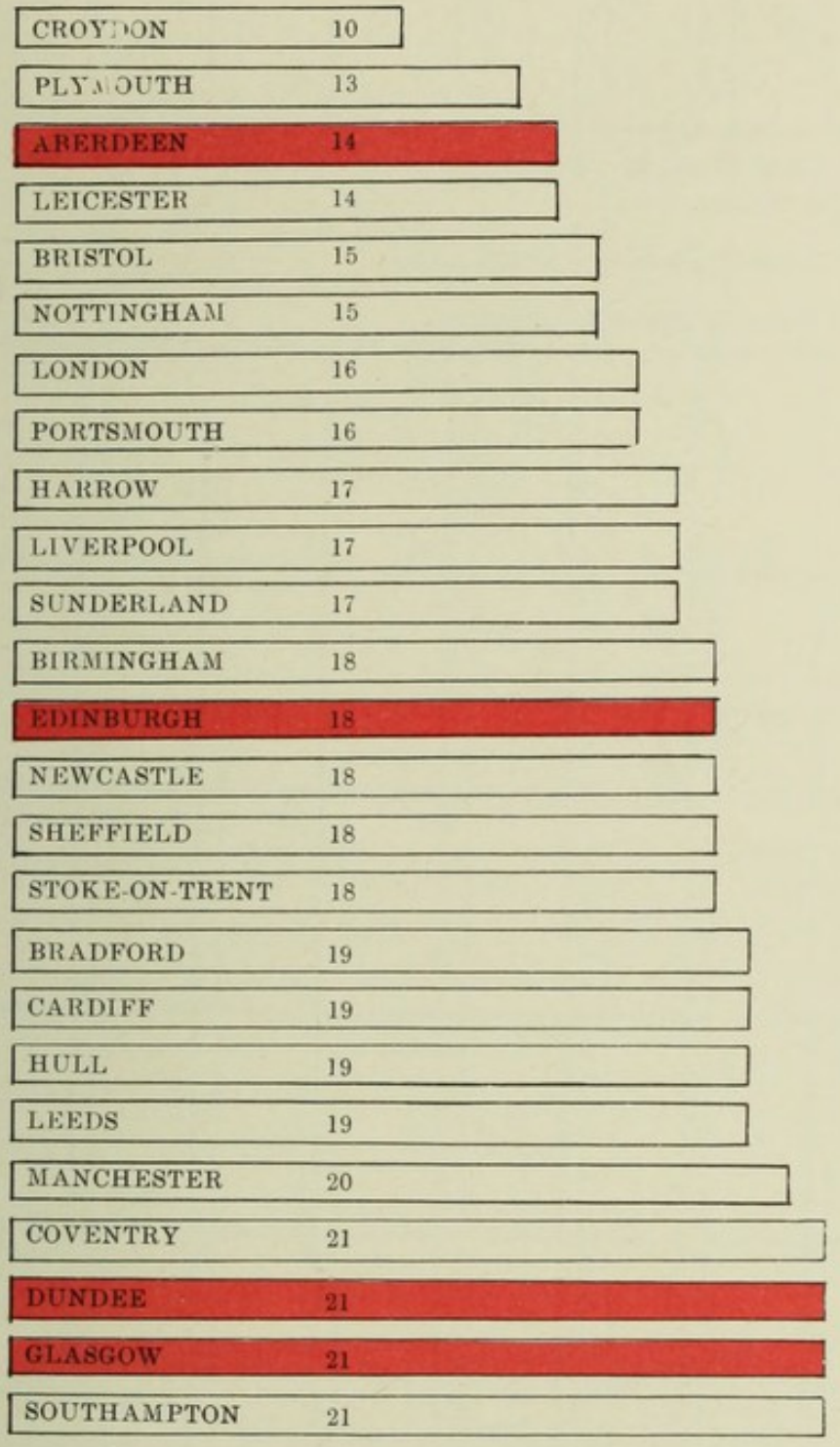
During 1957, 7 children, aged 1-5 years, died. Comparative figures are—

	Number of deaths in			
	1957.	1956.	1955.	1954.
1 - 2 years . . .	3	4	4	2
2 - 3 years . . .	1	—	1	3
3 - 4 years . . .	3	2	6	2
4 - 5 years . . .	—	3	2	1
	—	—	—	—
	7	9	13	8
	=	=	=	=

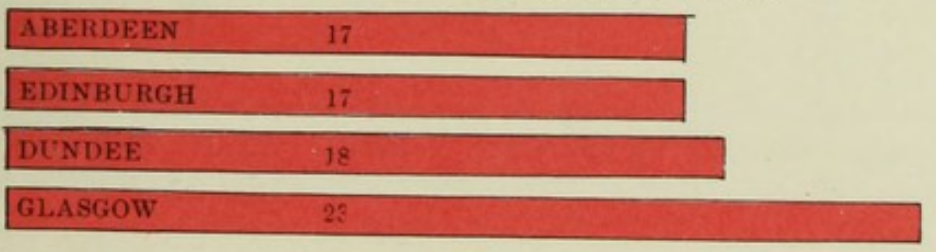
NEO-NATAL DEATH RATES IN 25 LARGE TOWNS

(PER THOUSAND LIVE BIRTHS.)

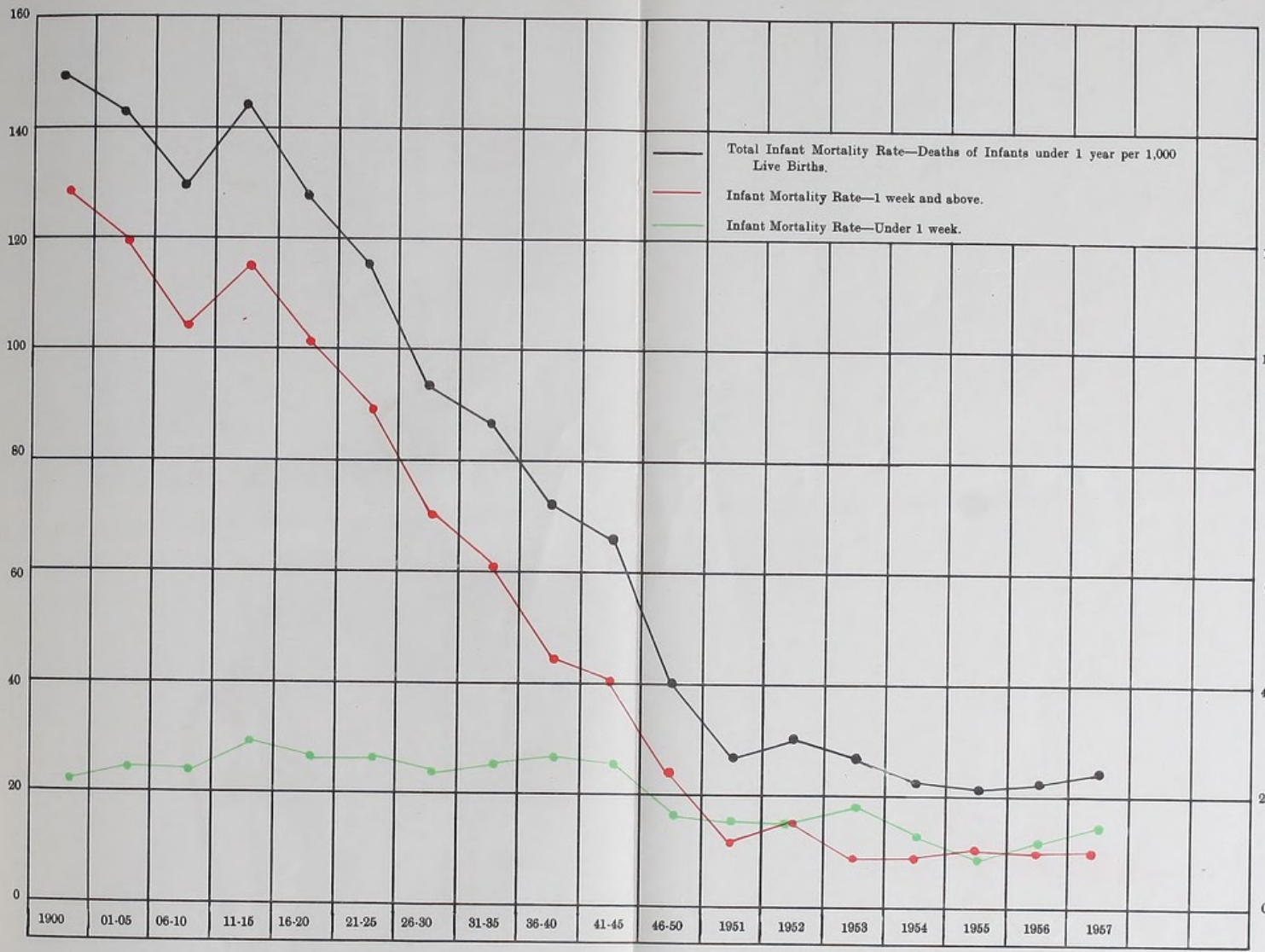
1956.

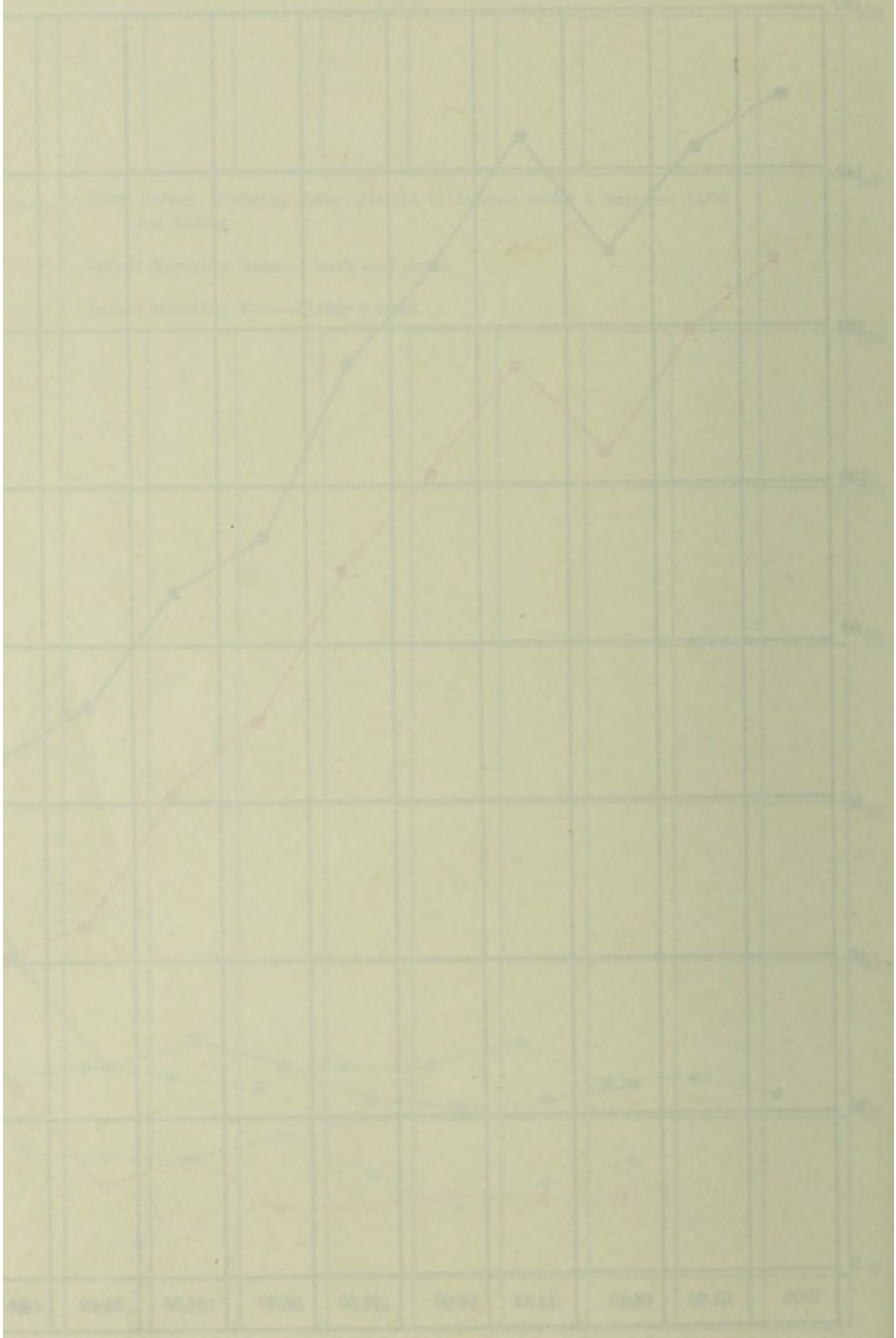


1957—SCOTTISH CITIES ONLY.



City of Aberdeen—Infant Mortality—1900-1957.





Of the 7 deaths in 1957, 2 were due to accidents (both on roadway), 3 to respiratory diseases, and 2 to miscellaneous causes. There has now been only one death from home accidents in four consecutive years.

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 1957, there were 82 deaths of infants under 1 year and 7 of children aged 1-5 years, a total of 89. Although (as indicated elsewhere) there is a slight regression in 1957, the general trend over many years is in the right direction.

Some of the main factors in the decline were given in last year's report 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, perhaps, the most important facet of the work of a Health Department). Both group teaching and the teaching of individuals are included under this head.

(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	1956	22	73	9	82
					1957	24	82	7	89

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—a decline (with occasional interruptions) until about 1954, and then a slight regression.

MORTALITY IN SCHOOL PERIOD.

In 1957 there were 10 deaths of children of school age (as compared with 11 in 1956). The causes were as follows:—drowning accident, 1; respiratory diseases, 4; nervous diseases, 2; and miscellaneous causes, 3.

MARRIAGES.

During 1957 there were 1.975 marriages within the City. This is equivalent to a rate of 10·6 per thousand of the population. The rates in previous years were—1956, 10·5; 1955, 10·6; 1954, 10·2; 1953, 10·4; 1952, 10·5; and 1951, 10·0.

MATERNAL MORTALITY.

In Aberdeen, during 1957, there were no deaths from causes related to pregnancy and childbirth. In 1956 and 1955 there was 1 death, in 1954 there were 2, 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
1957	**0·5**	**0·0**	**0·2**	**0·0**	**0·3**	**0·0**
1956	0.51	0·3	0·15	0·0	0·36	0·3
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
Average 1953-1957	**0·6**	**0·7**	**0·17**	**0·1**	**0·45**	**0·6**

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 1951-1957 are given in the following table:—

Year.	Number.	Rate per 1,000 of Population.	Average age at Death.
1957	2,121 ...	11·4 ...	66·2
1956	2,155 ...	11·6 ...	65·9
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

For all Scotland, the death rate was 11·9 in 1957, 12·0 in 1956, 12·0 in 1955, 12·0 in 1954, and 11·5 in 1953.

AGE AT DEATH.

The average age at death of all persons dying during 1957 was 66·2 years, as compared with 65·9 in 1956, 66·7 in 1955, 66·3 in 1954, and 65·1 in 1953. (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 thirteen years ago (1944), it was 58·4 years.

Of the 2,121 deaths, 204 (or 10 per cent.) were in persons below the age of 45 years. In 1956 the figure was 188 (or 9 per cent.); in 1955, 190 (or 9 per cent.); in 1954, 193 (or 9 per cent.); and in 1953, 233 (or 11 per cent.). An analysis of these 204 young deaths by cause is as follows:—

Malformations and diseases of early infancy	63
Violence	26
Malignant neoplasms	25
Disease of the circulatory system	24
Pneumonia and bronchitis	20
Diseases of nervous system	10
Diseases of digestive system	6
Tuberculosis	2
Diseases of genito-urinary system	4
Infectious and parasitic diseases	6
Miscellaneous	18

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

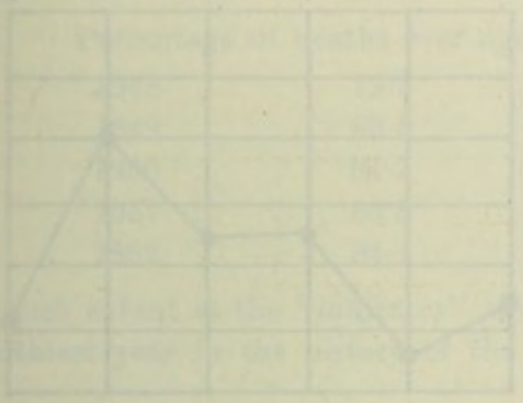
533 (or 25 per cent.) of all deaths occurred in the age-period 45-64 years, so that a total of 737 fatalities (or 35 per cent.) occurred before the age of 65 years. 552 deaths (or 26 per cent.) occurred in the age-period 65-74 years, and 832 (or 39 per cent.) occurred at ages of 75 and over. The percentages of all deaths occurring at ages of 75 and over were 39 in 1957, 40 in 1956, 39 in 1955, 39 in 1954, 38 in 1953, and 37 in 1952.

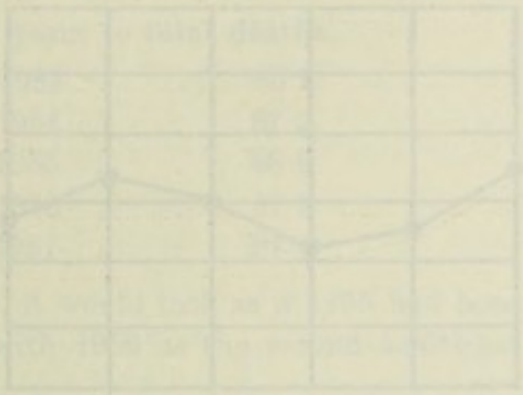
The World Health Organisation's "Health Indicator."

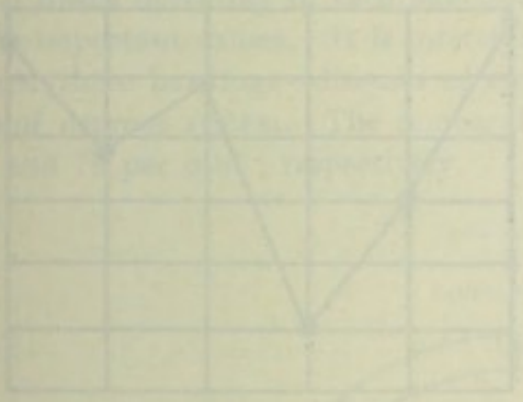
The infant mortality rate, for many years regarded as the most sensitive index of the health and health services of a community, is still a very sensitive index, but—now that the number of infant deaths has become small—is liable to distortion from chance events. For example, in 1935, when 286 Aberdeen babies died (giving a rate of 91), if an extra ten babies had died as a result of an outbreak of measles, there would have been only a slight increase in the infant death date; but in 1955, when only 66 babies died (giving a rate of 21), an extra ten deaths from a single outbreak would have altered the rate appreciably.

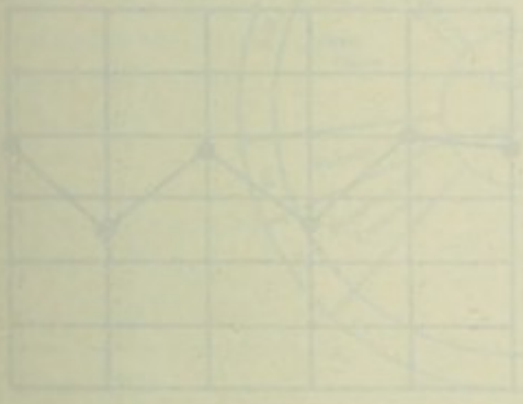
In consequence, various attempts have been made to devise an alternative index. About the beginning of 1957, the World Health Organisation tentatively suggested as such an index the proportion of deaths occurring above the age of 50 years to all deaths.

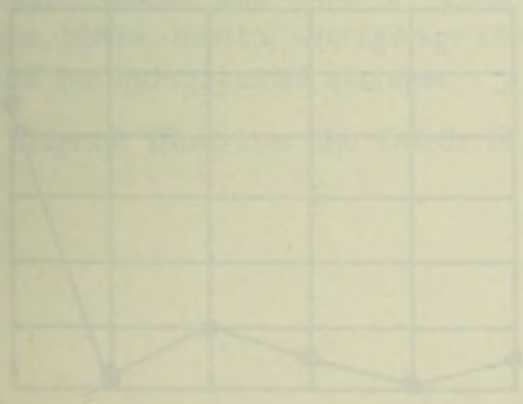
This "indicator" is not wholly satisfactory: if a residential community (with 25 per cent. of its inhabitants of pensionable age) and an industrial community (with only 8 per cent. of its inhabitants of that age) were equally healthy, one would









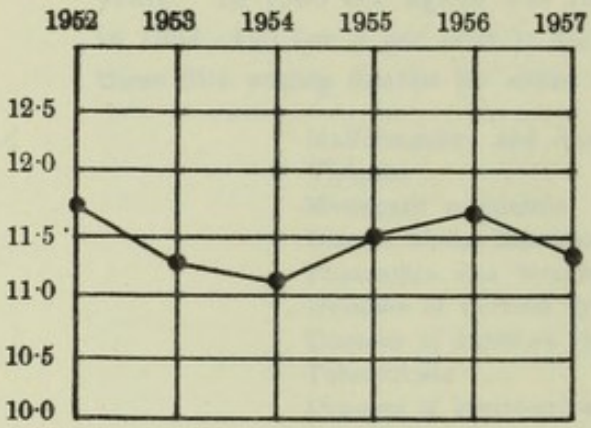


CITY OF ABERDEEN.

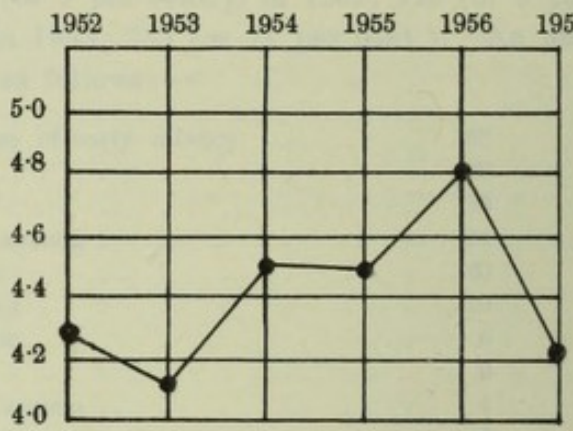
TRENDS OF MORTALITY, 1952-57.

DEATHS PER 1,000 POPULATION.

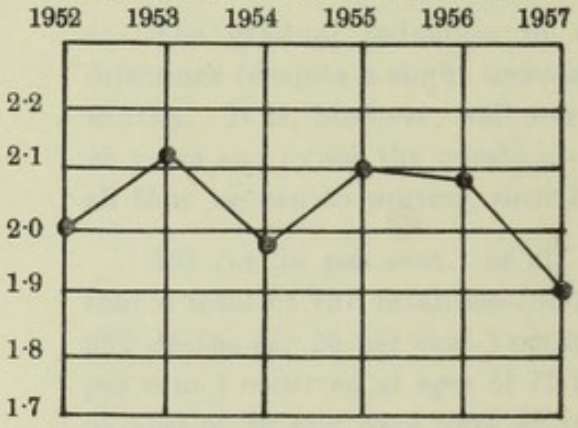
ALL CAUSES.



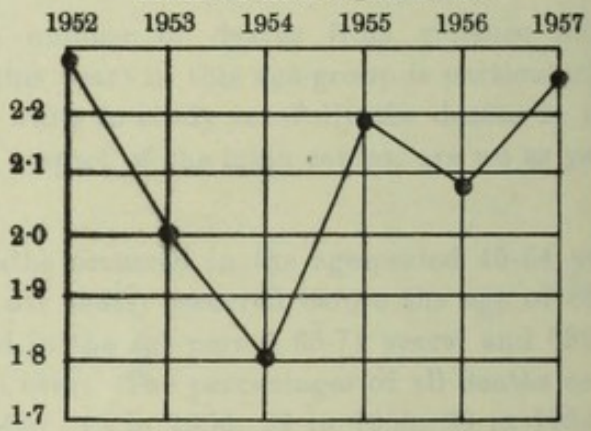
DISEASES OF CIRCULATORY SYSTEM.



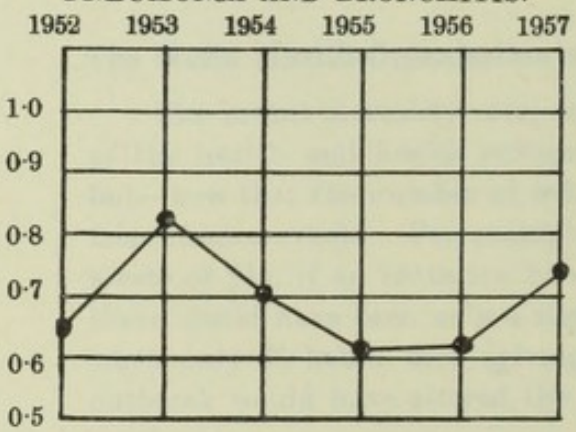
DISEASES OF NERVOUS SYSTEM.



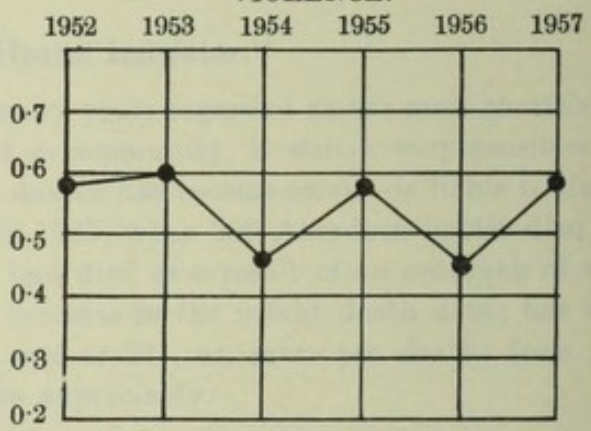
MALIGNANT DISEASES.



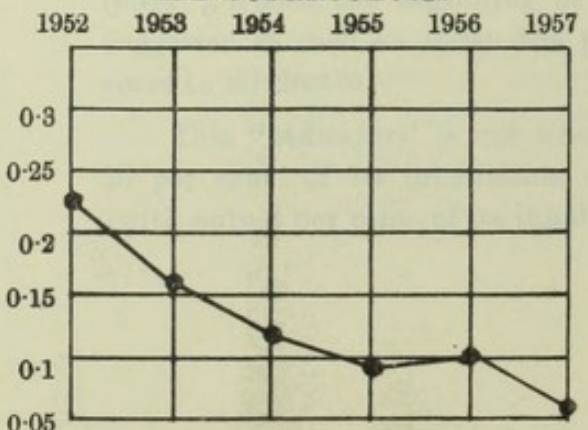
PNEUMONIA AND BRONCHITIS.



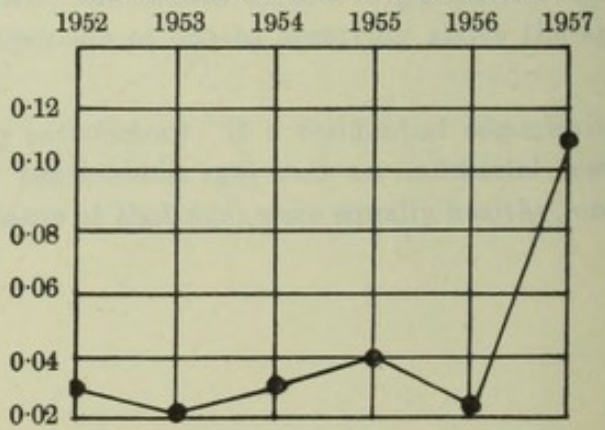
VIOLENCE.



ALL TUBERCULOSIS.



PRINCIPAL EPIDEMIC DISEASES.



expect a far higher proportion of deaths over the age of 50 in the former area. However, for what the figures are worth, here are the data for Aberdeen in recent years:—

Percentage of deaths over age of 50 years to total deaths.

1948 . .	79·4	1953 . .	85·9
1949 . .	83·6	1954 . .	87·2
1950 . .	84·2	1955 . .	88·6
1951 . .	85·8	1956 . .	87·9
1952 . .	84·1	1957 . .	87·4

To such extent as the "indicator" is reliable, it would look as if 1955 had been the healthiest year in the history of the City, with 1956 as the second healthiest year.

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 73 per cent. of all deaths fall under three headings—diseases of circulatory system, malignant diseases, and diseases of nervous system. The comparable figures for 1956, 1955, and 1954 were 78, 77, and 75 per cent., respectively.

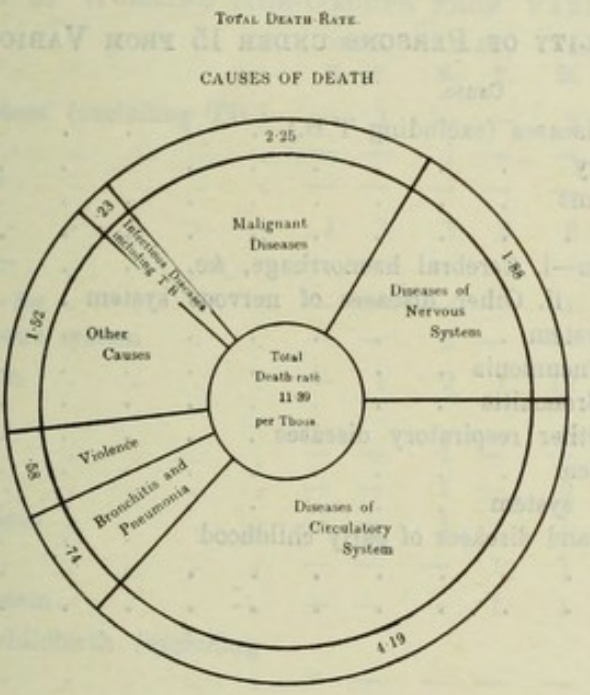


Table III gives, for a number of successive years, the death rates at all ages from selected causes, and Table IV gives, in summary form, details of population, marriages, births, deaths, average age at death, and infant deaths for a number of years and for quinquennial averages.

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

LOSS OF WORKING YEARS BY DEATH.

Although study of causes of death and trends of mortality indicates the relative importance of various conditions in respect of loss of life, it does not give a true picture of the effects of different diseases on the community. If, for example, one disease kills thirty persons aged 75-90 years and a second disease kills ten 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, as indicated in the Report for 1955, plenty of minor fallacies; but, on balance, the hypothesis gives a reasonably accurate picture of the effects of various diseases.

Here are the figures (for males and females separately) for the mortality and the loss of working years occasioned by various diseases in 1957—

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

Cause.	Male.	Female.	Total.
Infectious and parasitic diseases (excluding T.B.)	2	—	2
Tuberculosis—i. Respiratory	—	—	—
ii. Other forms	—	—	—
Malignant diseases	—	1	1
Diseases of nervous system—i. Cerebral hæmorrhage, &c.	1	—	1
ii. Other diseases of nervous system	2	1	3
Diseases of circulatory system	—	—	—
Respiratory diseases—i. Pneumonia	9	5	14
ii. Bronchitis	1	—	1
iii. Other respiratory diseases	1	—	1
Diseases of digestive system	3	—	3
Diseases of genito-urinary system	—	—	—
Congenital malformations and diseases of early childhood	38	25	63
Violence	4	1	5
Miscellaneous	2	3	5
	63	36	99
(Comparable figures for previous year	54	39	93)

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 for males, and from 15 to 60 years of age, *i.e.*, of 45 years' duration for females.

Cause.	Working Years lost. Male.	Female.	Total.
Infectious and parasitic diseases (excluding T.B.)	100	—	100
Tuberculosis—i. Respiratory	—	—	—
ii. Other forms	—	—	—
Malignant diseases	—	45	45
Diseases of nervous system—i. Cerebral hæmorrhage, &c.	50	—	50
ii. Other diseases of nervous system	100	45	145
Diseases of circulatory system	—	—	—
Respiratory diseases—i. Pneumonia	450	225	675
ii. Bronchitis	50	—	50
iii. Other respiratory diseases	50	—	50
Diseases of digestive system	150	—	150
Diseases of genito-urinary system	—	—	—
Congenital malformations and diseases of early childhood	1,900	1,125	3,025
Violence	200	45	245
Miscellaneous	100	135	235
	3,150	1,620	4,770
(Comparable figures for previous year	2,700	1,745	4,445)

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

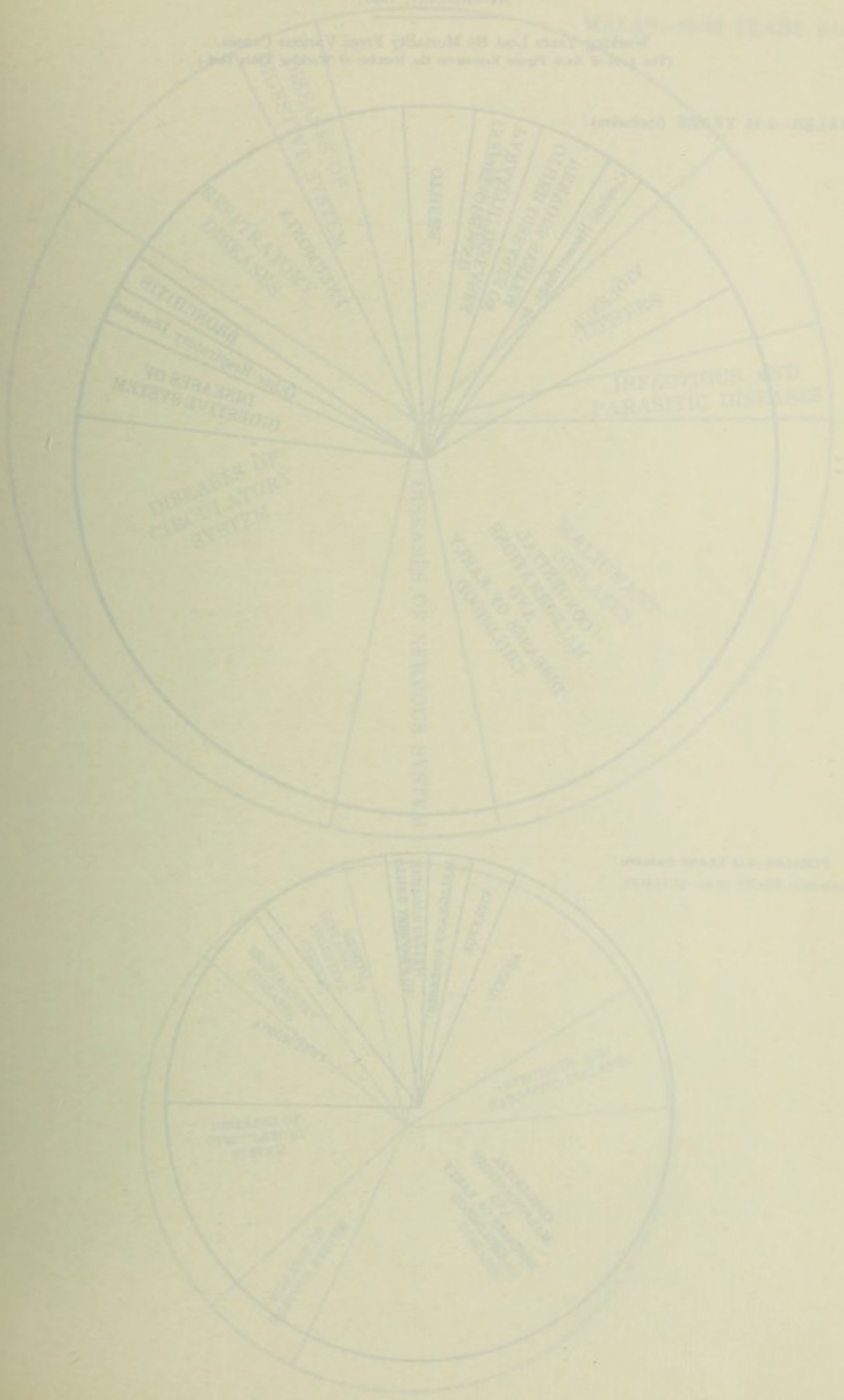
Cause.	15-24. M.	15-24. F.	25-34. M.	25-34. F.	35-44. M.	35-44. F.	45-54. M.	45-54. F.	55-64. M.	55-64. F.
Infectious and parasitic diseases (excluding TB.)	—	1	—	—	1	2	2	3	5	2
Tuberculosis—i. Respiratory	—	—	1	—	—	1	2	—	2	1
ii. Other forms	—	—	—	—	—	—	1	—	—	—
Malignant diseases	1	1	1	2	6	13	27	25	62	43
Diseases of nervous system—										
i. Cerebral hæmorrhage, &c.	—	—	—	—	1	1	3	5	21	27
ii. Other diseases of nervous system	—	—	2	—	—	2	2	—	2	2
Diseases of circulatory system	—	1	2	1	12	8	38	16	80	42
Respiratory diseases—										
i. Pneumonia	—	—	1	—	—	1	—	2	4	4
ii. Bronchitis	—	—	1	—	2	—	4	3	12	4
iii. Other respiratory diseases	—	—	1	—	1	—	1	—	2	2
Diseases of digestive system	—	—	—	1	1	1	7	6	5	3
Diseases of genito-urinary system	—	—	—	1	1	2	1	—	3	2
Diseases of pregnancy and childbirth (excluding puerperal sepsis)	—	—	—	—	—	—	—	—	—	—
Violence	4	1	8	—	6	2	7	3	7	11
Miscellaneous	—	1	3	1	2	3	5	2	9	11
	5	5	20	6	33	36	100	65	214	154
	10		26		69		165		368	
(Comparable figures for previous year	12		19		64		174		364)	

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 T.B.)	80	110	190
Tuberculosis—i. Respiratory	75	20	95
ii. Other forms	15	—	15
Malignant diseases	945	610	1,555
Diseases of nervous system—i. Cerebral hæmorrhage, &c.	175	70	245
ii. Other diseases of nervous system	110	40	150
Diseases of circulatory system	1,340	390	1,730
Respiratory diseases—i. Pneumonia	55	40	95
ii. Bronchitis	205	30	235
iii. Other respiratory diseases	85	—	85
Diseases of digestive system	155	110	265
Diseases of genito-urinary system	55	70	125
Diseases of pregnancy and childbirth (excluding puerperal sepsis)	—	—	—
Violence	750	110	860
Miscellaneous	275	150	425
	4,320	1,750	6,070
(Comparable figures for previous year	4,340	1,620	5,960)

In calculating working years lost by female mortality, the latter age-group 55-64 has been omitted—60 generally being the retiral age for women. A more accurate approximation would be slightly higher than that given.

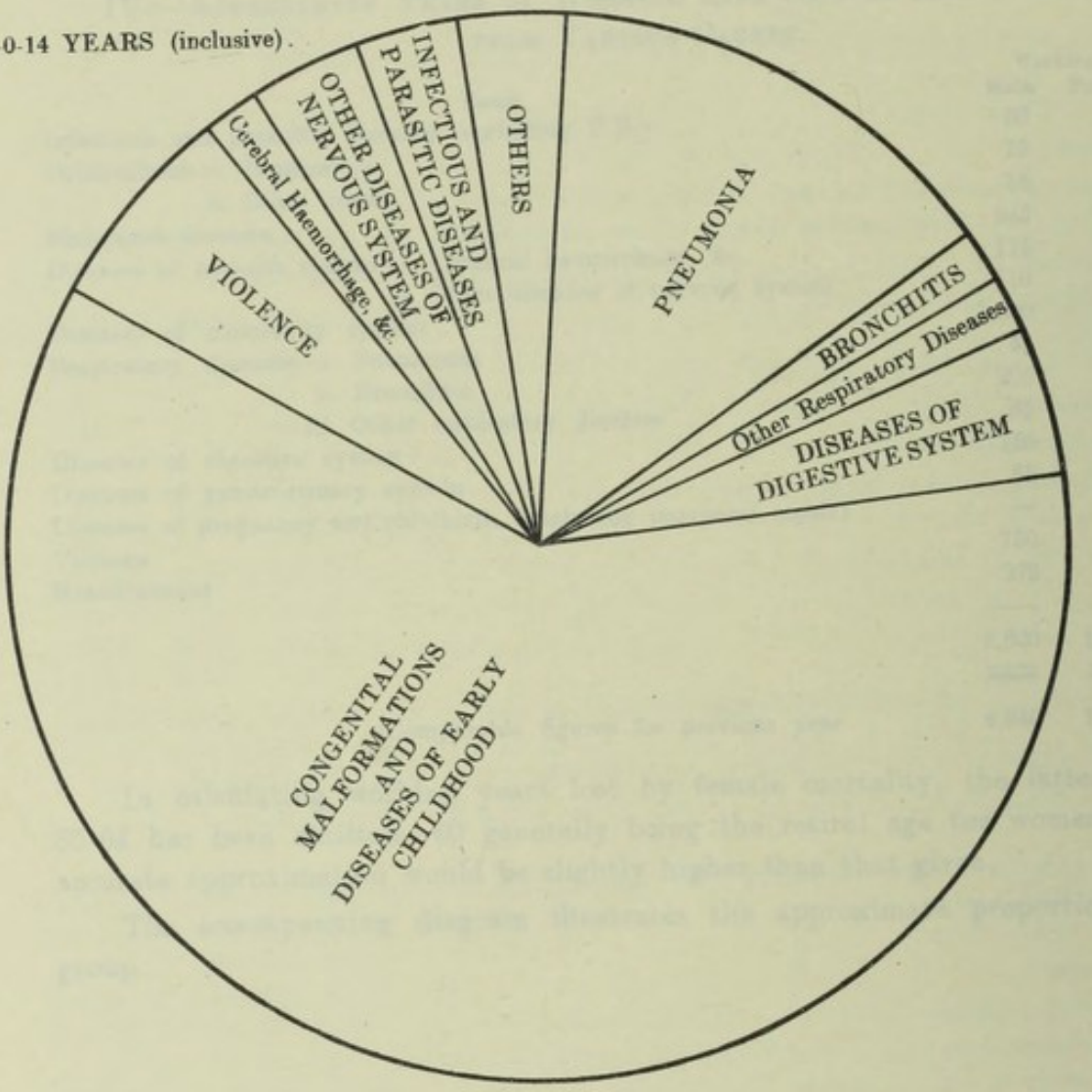
The accompanying diagram illustrates the approximate proportions in each group.



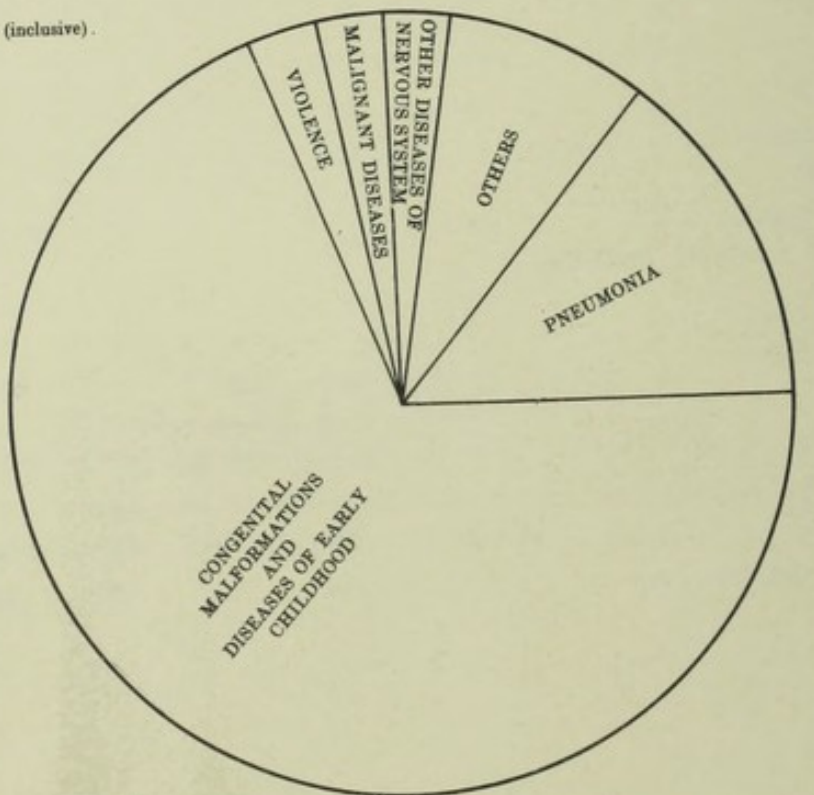
Working Years Lost By Mortality From Various Causes.

(The Area of Each Figure Represents the Number of Working Years Lost.)

MALES—0-14 YEARS (inclusive).



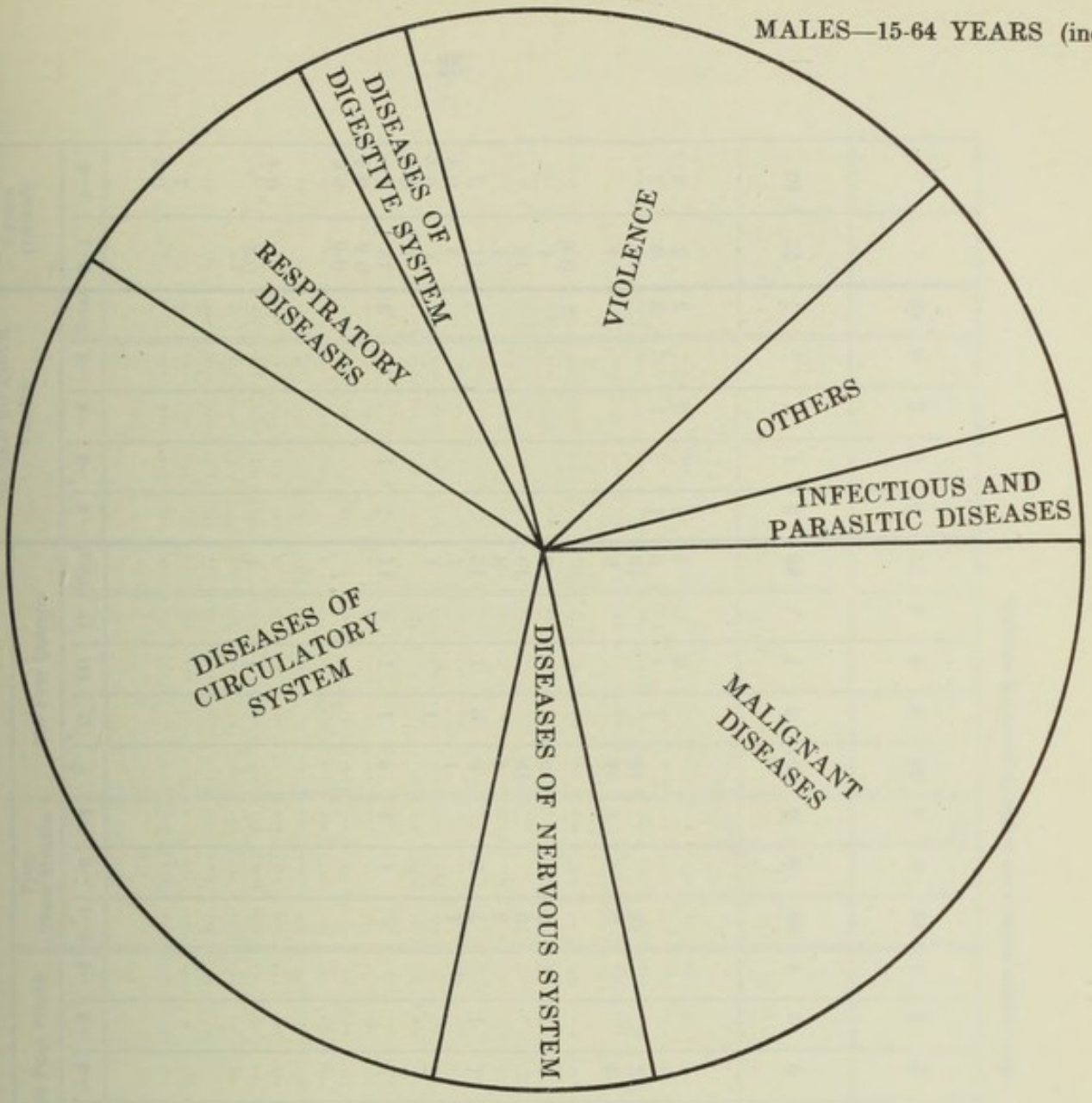
FEMALES—0-14 YEARS (inclusive).



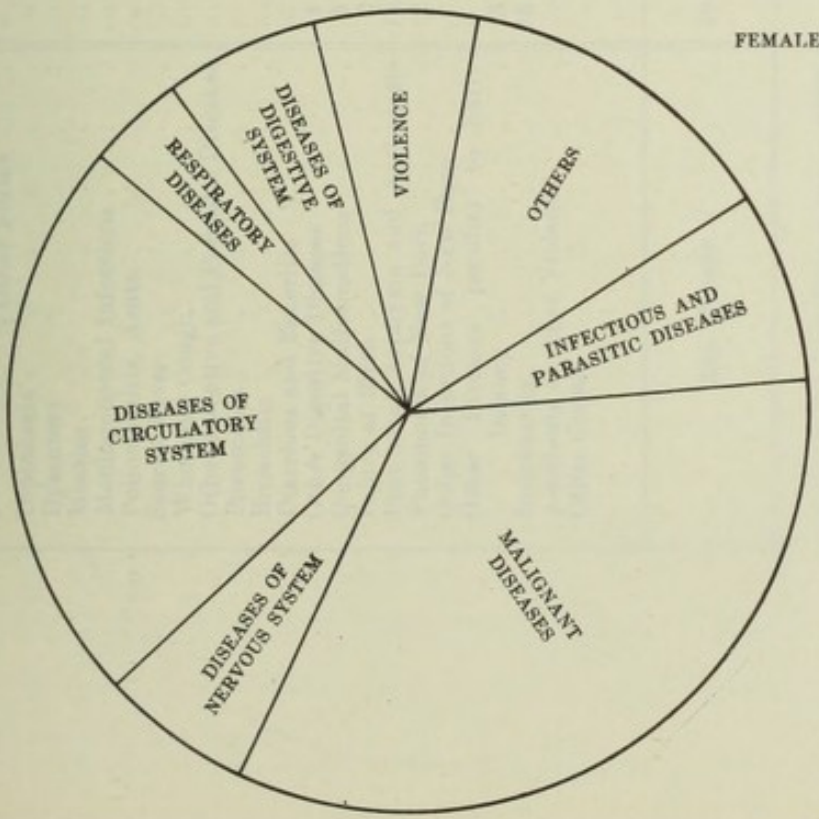
Working Years Lost By Mortality From Various Causes.

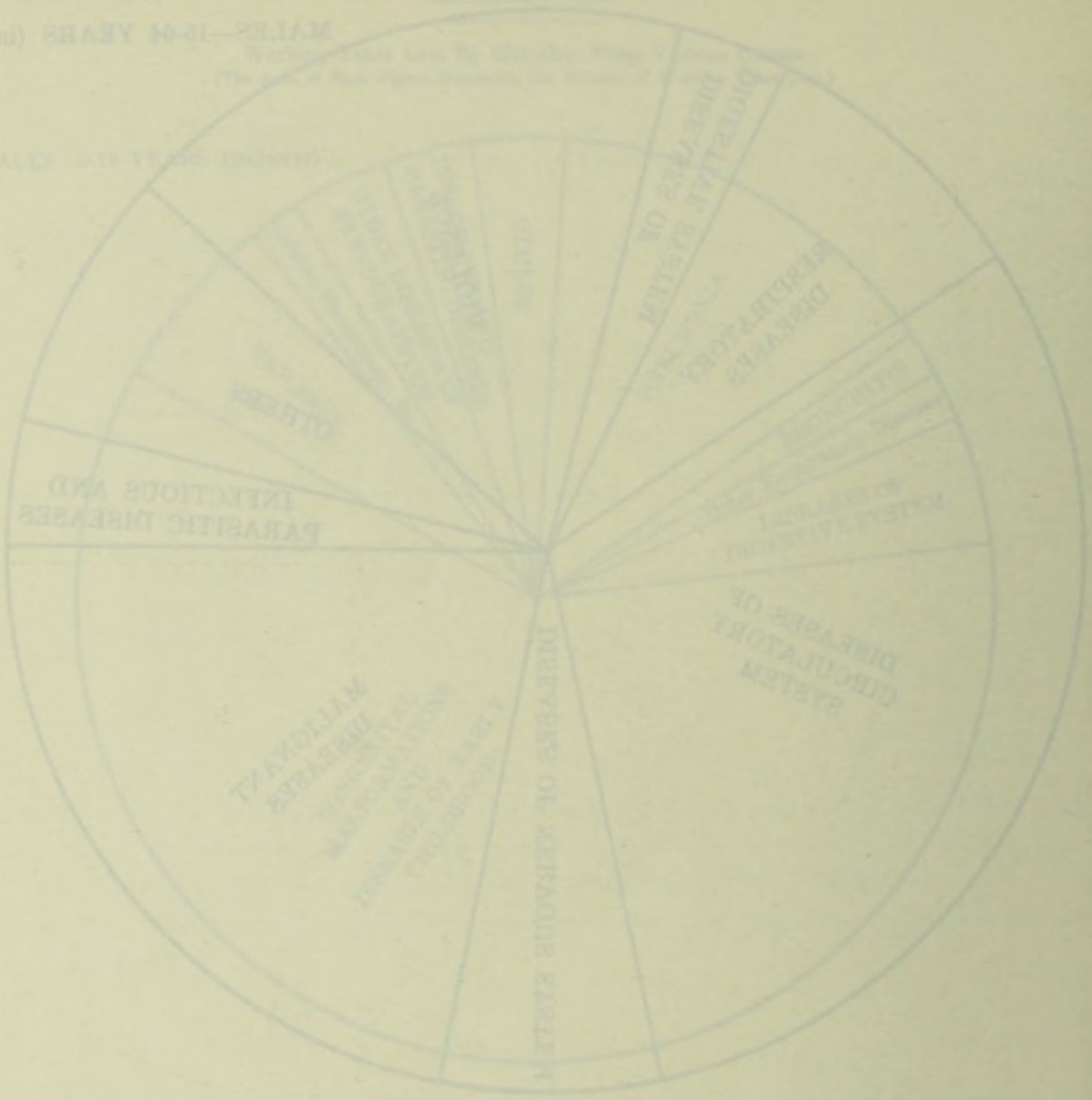
(The Area of Each Figure Represents the Number of Working Years Lost.)

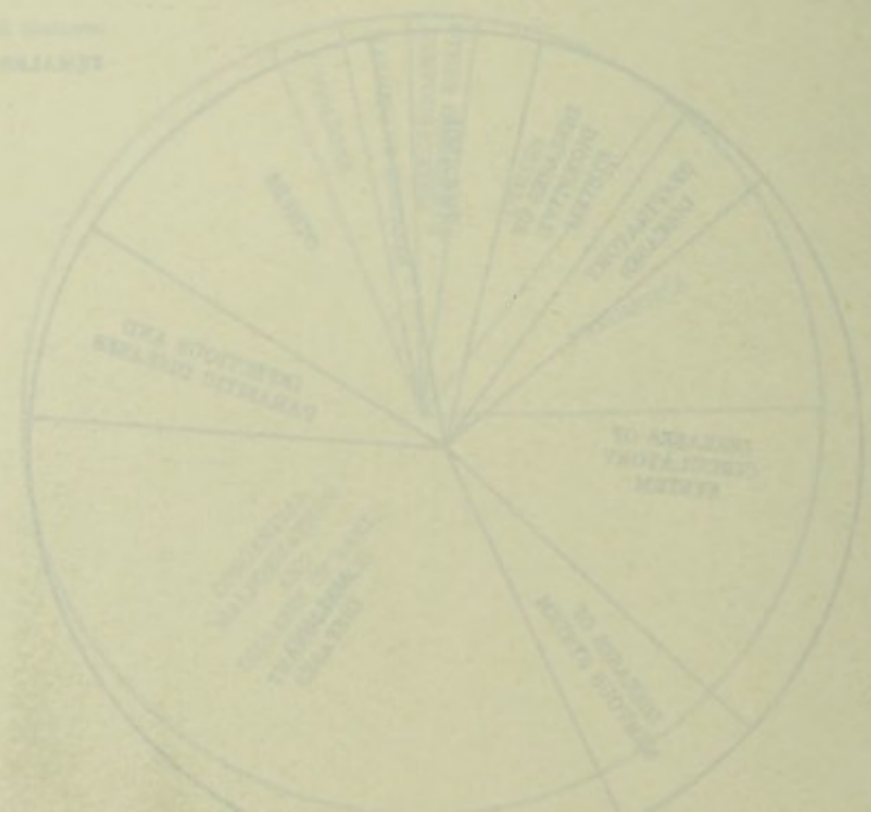
MALES—15-64 YEARS (inclusive).



FEMALES—15-59 YEARS (inclusive)







CAUSES OF DEATH	AGE																	Average for preceding 5 years (1952-56)	
	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	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	1
Diphtheria	..	..	..	..	...	...	...	...	...	...	..	...	...	...	...	...	...	...	...
Dysentery	...	...	...	...	..	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Measles	..	...	..	.	...	...	...	...	...	1	...	1	...	...	..	...	...	0·2	...
Meningococcal Infections	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	0·4
Poliomyelitis, Acute	...	...	...	...	...	...	...	...	..	...	...	...	...	...	...	...	...	...	..
Scarlet Fever	...	...	...	...	..	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Whooping Cough	..	...	...	...	..	...	...	...	...	...	...	...	...	...	...	...	...	0·6	0,6
Other Infective and Parasitic Diseases	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	0·6	0·2
Pneumonia	...	...	...	...	...	4	4	8	1	1	1	11	1	1	...	...	2	12	1
Bronchitis	...	...	...	...	...	...	...	...	..	..	...	..	...	...	...	...	...	1	0·4
Diarrhœa and Enteritis	...	...	...	...	...	...	..	...	1	...	...	1	...	...	...	...	...	1	0·2
Other Digestive Diseases	1	...	...	...	1	...	...	1	...	...	...	1	...	...	...	...	...	2	0·4
Congenital Malformations	5	1	1	...	7	2	...	9	2	1	...	12	...	...	...	...	...	11	2
Injury at Birth	3	...	...	..	3	...	...	3	...	...	...	3	...	...	...	...	..	4	...
Post-natal Asphyxia and Atelectasis	19	...	...	...	19	...	...	19	...	...	...	19	...	...	...	...	...	18	...
Pneumonia of New Born	2	1	1	1	5	...	...	5	...	...	...	5	...	..	...	...	...	4	...
Other Infections of New Born	...	...	...	...	..	...	...	...	...	...	...	...	...	...	...	...	...	0·6	...
Other Diseases peculiar to Early Infancy	3	2	...	...	5	...	1	6	...	...	...	6	...	...	...	...	...	4	...
Immaturity	16	2	...	...	18	...	...	18	...	...	...	18	...	...	...	...	...	10	...
Accidents or other Violence	...	...	...	...	...	...	...	...	1	1	...	2	1	...	1	...	2	5	3
Other Causes	....	...	...	..	...	...	...	...	...	3	...	3	1	...	2	...	3	3	3
All Causes	49	6	2	1	58	6	5	69	5	7	1	82	3	1	3	...	7	77	12
Average for preceding 5 years, 1952-1956	43	2	3	1	49	6	4	59	8	6	4	77	5	2	3	2	12	...	...

* 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 1957.																				
Under 1 year . . .	82	1	—	—	—	—	—	—	—	11	—	1	2	—	—	—	63	—	2	2
1-4 years . . .	7	—	—	—	—	—	—	2	—	2	—	—	—	—	—	—	—	—	2	1
5-14 „ . . .	10	—	1	—	—	1	1	1	—	1	1	—	1	—	—	—	—	—	1	2
15-24 „ . . .	10	1	—	—	—	2	—	—	1	—	—	—	—	—	—	—	—	—	5	1
25-34 „ . . .	26	—	—	1	—	3	—	2	3	1	1	1	1	1	—	—	—	—	8	4
35-44 „ . . .	69	2	1	1	—	19	2	2	20	1	2	1	2	3	—	—	—	—	8	5
45-54 „ . . .	165	3	2	2	1	52	8	2	54	2	7	1	13	1	—	—	—	—	10	7
55-64 „ . . .	368	4	3	3	—	105	48	4	122	8	16	4	8	5	—	—	—	—	18	20
65-74 „ . . .	552	7	3	2	1	123	100	3	209	14	12	3	19	19	—	—	—	—	17	20
75-84 „ . . .	616	1	1	1	—	97	134	10	262	28	15	1	14	18	—	—	—	—	18	16
85+ „ . . .	216	2	—	—	—	17	29	2	109	12	3	1	5	5	—	—	—	5	19	7
All Ages . . .	2121	21	11	10	2	419	322	28	780	80	57	13	65	52	—	—	63	5	108	85
B.—Death-Rate per 100,000.																				
1957	1139	11	6	5	1	225	173	15	419	43	31	7	35	28	—	—	34	3	58	45

TABLE III.—ABERDEEN.—DEATHS AT ALL AGES FROM SELECTED CAUSES. (per 100,000 of population).—*Years* 1856-1957.*

Year.	Smallpox.	Scarlet Fever.	Diphtheria and Croup.	Measles.	Whooping Cough.	Influenza.	Typhus Fever.	Typhoid and Paratyphoid Fever.	Tubere. Dis. Respiratory.	Tubere. Dis. Other Tuberculosis.	Dis. of Digestive System (inc. Diarrhœa).	Cancer and other Malignant Diseases.	Bronchitis.	Pneumonia.	Diseases of the Circulatory System.
1957 . . .	0	0	0	1	0	11	0	0	5	1	35	225	31	43	419
1956 . . .	0	0	0	0	0	2	0	0	10	0	32	207	31	31	484
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
Mean of 1952-56 .	0	0	0	0·2	0·4	2	0	0	12	1	40	207	28	40	445
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
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
Mean of 1947-51 .	0	0·2	0·2	1	1	4	0	0·2	28	4	56	186	37	55	413
Mean of 1946-50 .	0	0.2	0	1	1	4	0	0 2	32	5	60	182	37	54	400
,, ,, 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 1957.
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
1957	186,190	1,975	10·6	3,379	18·1	5·1	2,121	11·4	66·2	1,258	24
1956	186,396	1,965	10·5	3,271	17·5	5·3	2,155	11·6	65·9	1,116	22
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
Mean of 1952-1956	185,466	1,939	10·4	3,161	17·0	5·0	2,117	11·4	65·7	1,044	24
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
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
Mean of 1947-1951	187,425	1,944	10·4	3,456	18·5	5·6	2,200	11·7	62·7	1,256	37
1946-1950	†	2,015	10·7	3,603	19·2	6·0	2,189	11·8	61·7	1,414	40
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	103,959	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.—HEALTH EDUCATION.

The education of the community in matters of physical, emotional, and social health is unquestionably the biggest task confronting all health departments, and Aberdeen made very large advances in 1957. Consequently, it is not possible in a single chapter to give more than a very inadequate summary. In the outline of salient features that follows, the smallest items are mentioned first.

(1) Early in 1957 some 3,000 copies of the Aberdeen Clean Food Guide were distributed to clinics, parents' clubs, catering establishments, &c. The Guide was a 50-page illustrated booklet, produced without any cost to the Corporation. The Guide was composed by members of the Health and Welfare staff (mainly by the Medical Officer of Health and the Principal Health Visitor Tutor) in their scanty leisure time, and, so far as is known, it was the first publication of this nature issued by any health department.

(2) To such extent as staff shortages permitted, there was a continuation of the long-term campaign for the reduction of home accidents. Until October, 1957, this work was undertaken largely without cost to the Corporation, being financed by a research grant from the Nuffield Trust held by the Medical Officer of Health.

(3) There was a further intensification of the individual health education of persons of ripe years: during 1957 some 3,000 persons of pensionable age were visited by health visitors, as compared with 2,320 in 1956 and 1,238 in 1955.

(4) In the summer and autumn months there was considerable concentration on the education of the public as to the desirability of x-ray examination. The health visitors visited 57,000 households to explain the radiography campaign, and paid another 25,000 visits to households which were empty at the time of the first visit; on this enormous task they spent some 20,000 hours, largely consisting of evening work generously undertaken without any additional remuneration. In addition, members of the health guidance team, supplemented by a few other medical officers and health visitors, addressed 133 meetings about the campaign. It is worth mentioning that, before press publicity and display of posters and banners had begun and before the recruitment of volunteers had commenced, approximately 75 per cent. of the adult citizens had—as a result of the efforts of the health visitors and other members of staff—declared their intention of attending for x-ray examination.

(5) Despite the campaigns for clean food, home safety, and mass radiography, increasing attention was devoted to the promotion of emotional health and the prevention of diseases of emotional and mental origin. It has been indicated in previous reports that incomparably the biggest advance in any recent year has been the sustained drive for the improvement of mental health, and in particular the full recognition of the rôle of the family health visitor in the teaching of emotional and social health.

(6) 1957 witnessed the development of group teaching of prospective parents and young parents on a previously unprecedented scale. In previous years a number of talks on health topics had been given both at clinics and to pre-formed audiences in the evenings; but the Health Guidance Scheme (which came into operation in November, 1956) was unique in its magnitude and in its attempt to provide not merely single talks but systematic courses of instruction. When the scheme was launched, it was forecast that there might be as many as a thousand talks in a year—so the Aberdeen "Press & Journal" picturesquely termed the scheme the "Thousand Salvo Blitz on Disease." In 1957, the total number of talks given was 1,144, and the public demand was so great that it was clear from the beginning that the limiting factor was simply the availability of suitable instructors.

The Clean Food Guide, the measures for health maintenance of the elderly, the prevention of home accidents, and the X-ray campaign are discussed in other portions of this report. The present chapter is divided into three sections, dealing, respectively, with Aberdeen and other areas, Individual Teaching, and Group Teaching. The last two sections are in many ways a repetition or slight amplification of what appeared in the 1956 report (when the Health Guidance Scheme had just started), but it is felt that the general picture may be of even greater interest now, when the scheme has become well established.

I. HEALTH TEACHING IN ABERDEEN AND OTHER AREAS.

While Aberdeen has perhaps already carried group health teaching further than other areas except Birmingham and Buckinghamshire, and while the Aberdeen scheme possesses various special features (*e.g.*, it is conducted much more inexpensively than various other schemes, it integrates very closely group teaching and individual health teaching, it attempts to teach by systematic courses rather than by isolated talks, and it seeks to meet the ascertained needs of the community rather than simply teaching to a predetermined pattern), it would be a mistake to think that the City was a pioneer in the field of group health teaching. The truth is that Aberdeen lagged behind various other areas and has now caught them up (or perhaps outstripped them: for example, Edinburgh had a senior medical officer for health education for several years before Aberdeen began to consider its health guidance project, and Stirlingshire has, for about a couple of years, had a full-time health education officer.

Since our first parents' clubs and courses for prospective parents were started as recently as November, 1956, it is a little salutory to read the following paragraph from the report of the health education officer of a city of southern England for the year 1955:—

> "Probably the most important health educator we have is the health visitor. In the home and in the clinic, through the medium of personal advice, talks, demonstrations, and discussions, she lays down the basic health principles to the young mother. Acting as school nurse, she can influence

the attitudes of the school-age child. On many occasions the health visitor is called upon to give talks to young wives' guilds, women's institutes, parent-teacher associations, and many such audiences containing people who, in her normal work, she would not meet. The health visitor, too, takes a leading part in the parentcraft clubs which are attended by expectant mothers and their husbands. It has been said that this particular form of teaching is really "preaching to the converted," but, during the year, we have seen many instances of expectant mothers attending the parentcraft classes on the recommendation of their friends who have previously attended. These classes are becoming increasingly popular, and young parents-to-be are able to see at work the team of the local authority medical officer, midwife, health visitor, and nutritionist."

II. INDIVIDUAL TEACHING—BUILDING STABLE PERSONALITIES.

(1) The family health visitor as a teacher.

The authoritative report of the Working Party set up by the Ministers of Health and Education and the Secretary of State for Scotland defined the health visitor's primary functions as health teaching and social advice. There are, of course, quite a number of other people who can help with the health education of individuals and families—the public health medical officer, the general practitioner, the clergyman, the district nurse, the midwife, the school teacher, the social worker, the sanitary inspector, and sundry others; but the health visitor has certain profound advantages:—

(*a*) She shares with doctors and with other trained nurses a professional knowledge of disease and disease-processes and therefore a certain authority in the eyes of the community.

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

(*c*) Unlike the others (except the school teacher and the clergyman), she has received in her training a good deal of instruction in the arts of teaching and persuading.

(*d*) Unlike most other workers, she has access to the ordinary home before any 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, her visits are accepted by over 99 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 should

be 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, a third will be prone to inconsistency, and a fourth will be over-ambitious and disposed to force their child beyond his capacity.

(*g*) By reason both of her training and of her experience, she should have an unrivalled knowledge of normality and should be in a position to detect deviations from normality at a stage when they are still imperceptible to less experienced workers.

In view of these assets, she is already generally recognised as the main agent for teaching physical health and hygiene to individuals and families.

(2) The need for a teacher of emotional health.

Diseases of mental and emotional origin constitute a growing menace to our civilisation. Already mental diseases and mental deficiency take up 47 per cent. of the beds provided by Regional Hospital Boards; already neurotic diseases are the commonest cause of absence from work; already an incalculable amount of suffering and distress is created by psychosomatic disorders; and to these can be added a vast number of cases of abnormal and anti-social behaviour—chronic alcoholism, drug addiction, juvenile delinquency, truancy, petty crime, sex perversions, prostitution, &c. "Treatment of a fully developed case of psychoneurosis 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."

At least one-half of all human disease and suffering has its origin in faulty human relationships, especially in childhood, and particularly in the formative pre-school years. 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, hysterias, sex perversions, delinquency and crime.

To prevent faulty human relationships in the important early years, we clearly need a person to guide prospective parents and parents of young children about the emotional and social needs of children and about the ways of avoiding such dangers as making the child feel insecure or unwanted, failing to demonstrate affection sufficiently, mollycoddling, forcing, repressing, or being guilty of inconsistency in the handling of the child. Manifestly, to advise successfully, the person concerned must have access to the normal home before faulty situations exist and must be acceptable to parents or prospective parents.

(3) Modern and older health visitors.

It is becoming increasingly appreciated that the modern, recently trained health visitor is the member of the community in the best position to undertake individual teaching about emotional and social needs of children. 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 detailed study by a London County Council working party (which consisted of public health medical officers, psychiatrists, health visitors, and a psychiatric social worker).

Criticisms of the modern health visitor's competence for this work usually emanate only from people who are unaware of the extent to which the health visitor's training has altered in recent years. The student health visitor of to-day starts her post-qualification training with some rudimentary knowledge both of psychology and of social aspects of disease (these subjects being now included in the general nursing curriculum), and in her health visiting training she has at least thirty formal lectures on mental health (not mental disease), supplemented by case-studies and tutorials; moreover, many other lectures in her training are on subjects allied to mental health work. She also, of course, receives theoretical and practical instruction in teaching methods.

In general, then, the modern health visitor has the knowledge and the teaching skill to help parents to appreciate more fully the emotional needs of children (*e.g.*, the need for a proper balance between over-strictness and licence, and for the measures that can usually prevent sibling jealousy). And she has the necessary access to the home before any faulty situation exists and the necessary acceptance by the persons to be taught.

Apart, however, from the grave national shortage of health visitors, there is the difficulty that health visitors of an older vintage received very little instruction in mental health and social needs during their training, although some of them have become—by reason of vast experience of the problems of normality—good practical psychologists.

(4) Bridging the gap.

Aberdeen's primary specific contribution to individual teaching on mental health was an attempt to bridge the gap by providing in two consecutive years intensive post-qualification courses in mental health for older health visitors. All the health visitors (except two on highly specialised duties) have now received a fair amount of education on personality development and the promotion of emotional health, the younger ones as part of their professional training and the older ones by attending an intensive course.

Despite the many vacancies on the establishment, the health visitors are devoting more and more of their time to the teaching of emotional health—to helping to build in children robust personalities able to withstand the strains and minor frustrations of life. Their work should in course of time do much to improve

parent-child relationships and to reduce the prevalence of neurotic diseases, psychosomatic illnesses, delinquency, and maladjustment. It may indeed be that Aberdeen's relatively low juvenile delinquency rate and the reduction in the number of cases referred to the child guidance clinic (first noted in 1956) are early indications of success; but the promotion of mental health is essentially a long-term project, and its full effects will not be visible for years.

(5) The Health Visitor's Work.

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 antenatal 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 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 unsuccessful—are being made to secure, over a series of years, the necessary staff to fill the vacancies.

III. GROUP TEACHING—THE HEALTH GUIDANCE PROJECT.

(1) The Need for Health Education of Groups.

Health education is 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 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 cost of the National Health Service in Britain has risen steadily from £175,000,000 ten years ago to over £700,000,000 to-day. More than three-fifths of this vast sum is spent on the hospital treatment of disease, and most of the remainder is expended on treatment of illness at home. 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."

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.

In areas where the health visiting staff is even more numerically inadequate than in Aberdeen, group health teaching has sometimes proved a bit unsatisfactory —because it is essentially a supplement to individual health teaching, rather than a substitution. When properly used, group teaching can form a most valuable supplement and reinforcement to individual teaching in the home or in the clinic. Some people learn better in groups; some learn best by the aid of appropriate visual aids (films, film-strips, charts, flannelgraphs, &c.) which cannot well be exhibited in the home; and those of a sceptical frame of mind pay more attention when similar advice is given by the family health visitor in the home and by a doctor or another health visitor at a parents' club. Moreover, in terms of money and of the time of professional staff, group teaching is very economical: it clearly costs far less to teach 14 people as a group than to teach 14 separate individuals in their homes.

(2) The Pattern of the Health Guidance Section.

When the Health and Welfare Committee began to consider the possibility of establishing a health guidance section, it was already obvious, as a result of unpaid evening work by several members of staff, in particular the two health visitor tutors who had generously given up many evenings to lecturing on health topics, that there was likely to be a considerable demand for group teaching and that the expansion of such teaching would be emphatically 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 impart-

ing 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 extra remuneration) 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.

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

(*a*) 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.

(*b*) 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.

(*c*) 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.

(*d*) The Corporation had 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 Assistant Health Visitor Tutor the Corporation had again been fortunate in securing an 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).

When the proposal was submitted to the Secretary of State for Scotland, he declined to approve the portion relating to the additional payments for the five health visitors, on the ground that such payment might be regarded as determining the amount of additional salary to be paid to a promotion grade of Group Adviser (advocated by the Working Party on Health Visiting) in advance of any decision by the appropriate Whitley Council. However, a number of health visitors generously volunteered to take part in the scheme without any immediate payment, on the understanding that, if the proposed grade of Group Adviser came into being, the individuals selected for the health guidance work would be among the first Aberdeen health visitors considered for appointment to the new grade.

(3) Courses of lecture-discussions for expectant mothers.

In November, 1956, four courses were started—two at Holburn Clinic and two at Castle Terrace Clinic. In December, 1956, courses were started at Northfield Clinic, and the number of courses at Castle Terrace was increased. To meet the steadily increasing demand, further courses were added from time to time: during most of 1957, nine simultaneous courses were being conducted (with a deliberate slight reduction during the fourth quarter of 1957, during and immediately before the x-ray campaign).

These courses continue throughout the year, apart from short breaks at holiday periods. At present, each course is divided into three separate parts, so that an expectant mother who starts to attend a clinic after a particular course has begun can attend, say, parts II and III of that course and part I of the following course.

In 1957 there were in all 388 meetings for expectant mothers.

(4) Evening meetings for parents of young children.

Parents' Health Clubs were started at Holburn Clinic (in November, 1956) and at Northfield Clinic (in January, 1957). These clubs have met weekly, except during the three summer months. The Holburn Club was well attended from the outset. The Northfield Club started poorly but became well established within a few months. At both clubs, the average attendance is about 20.

A third club was started at View Terrace Clinic in February, 1957. It is conducted by three medical officers and meets fortnightly. The average attendance is about 10-14.

At the three clubs, while efforts are made to provide a talk on any health topic specifically requested by those attending, the programmes are in general so constructed that a series of meetings are devoted to a particular subject (*e.g.*, a series on the development and needs of children aged 2-5 years, or a series on the prevention of maladjustment).

(5) Afternoon meetings for health teaching at child welfare clinics.

During the latter months of 1957 there was some development of health teaching at the various child welfare clinics, the instruction being, to a considerable extent, given (by deliberate policy) by health visitors normally working at the particular clinic, although the health guidance team advised as necessary on suitable topics and demonstration material; in addition, of course, members of the health guidance team themselves on occasion took part in the teaching.

Considerable further development in this field is desirable: instead of about 30 talks in the city clinics during a winter quarter and none in a summer quarter, we should aim at something like 80 talks in a winter quarter and 30 in a summer quarter.

To prevent confusion, it may be useful to point out that the afternoon talks at clinics and the more formal instruction at evening meetings meet different needs: the mother who attends a clinic during the afternoon (and generally has to return home before her older children come back from school) wants a very short talk and highly informal discussion in a small group (preferably not over a dozen); the parents who come to an evening meeting (either engaging a babysitter or one parent only attending) are prepared to remain longer and, provided the information is imparted in an interesting way and with good demonstration material, can be given something in the nature of a formal lecture.

(6) Sporadic Health Teaching—Mainly evening meetings.

Lists of topics on which members of the staff were prepared to speak were sent to local organisations, *e.g.*, church guilds and co-operative guilds. [No comprehensive list of such organisations is known to exist; if any organisations were omitted, the omission was unintentional.] By January, 1957, the demand for speakers was embarrassingly high; and by September, 1957, it had grown to such proportions that a few requests had to be refused. The demand for speakers is still increasing.

(7) Specific Campaigns.

Without in any way detracting from the tremendous achievement of the ordinary health visitors in explaining the X-ray campaign to every individual household, it is fair to say that a very important part in that campaign was played by those who addressed pre-formed audiences. Of the 133 meetings addressed (128 by members of staff and 5 by others), a high proportion were addressed by members of the health guidance team.

In addition, much useful material was prepared by senior members of the team, *e.g.*, the twelve-page booklet which was printed for the use of medical officers, general practitioners, health visitors, sanitary inspectors, and district nurses, was largely compiled by Miss Lamont (Principal H.V. Tutor and Senior Health Guidance Lecturer).

(8) Health Education of the Staff.

Although health education of the staff is not counted in the summary of meetings given on next page, it may be appropriate to mention as an example the course

of instruction arranged for home helps; three such courses—each consisting of about 15 meetings—were conducted in 1957.

(9) Number of Meetings Addressed.

The original forecast was for 1,000 talks annually—approximately 570 during working hours and 430 outside normal working hours. These estimates were exceeded by nearly 12 per cent. in 1957: in that year 641 talks were given during working hours and 503 outside working hours, making a grand total of 1,144. The figures for evening talks could have been even higher if sufficient suitable speakers had been available: as already mentioned, a few requests for talks had to be refused.

The following summary may be of interest:—

I. Meetings during working hours.

Type of Audience	1957				Total 1957
	1st qr	2nd qr.	3rd qr.	4th qr.	
Expectant Mothers	102	96	101	89	388
Parents	40	61	—	44	145
Miscellaneous Preformed Groups	12	50	17	15	94
Audiences for Special Campaigns	—	—	—	14	14
Total Meetings	154	207	118	162	641
Total Audience Numbers	1,770	2,574	1,179	2,853	8,376
Average Audience	11.5	12.4	10.0	17.6	13.1

(In connection with the size of the average audience, it will be remembered that, at the courses for expectant mothers, a deliberate effort is made to restrict the maximum number to about a dozen.)

II. Meetings outside working hours.

Type of Audience	1957				Total 1957
	1st qr.	2nd qr.	3rd qr.	4th qr.	
Parents of Young Children	47	41	20	53	161
Miscellaneous Preformed Groups	65	50	38	70	223
Audiences for Specific Campaigns	—	—	—	119	119
Total Meetings	112	91	58	242	503
Total Audience Numbers	3,024	2,661	1,363	5,813	12,861
Average Audience	27.0	29.2	23.5	24.0	25.6

III. Total Meetings and Audiences.

	1957				Total 1957
	1st qr.	2nd qr.	3rd qr.	4th qr.	
Meetings	266	298	176	404	1,144
Audiences	4,794	5,235	2,542	8,666	21,237

4.—MATERNITY AND CHILD WELFARE.

Some salient features of the year were—

(1) The number of women attending the ante-natal clinics was a little higher than in 1956, but they made rather fewer attendances.

(2) The number of women attending post-natal clinics and the number of attendances at these clinics were even higher than in 1956, although the figures for that year had been higher than ever before.

(3) Relaxation exercises made available for expectant mothers late in 1956 were developed considerably during 1957.

(4) The number of women attending the gynæcological advisory clinic and the number of attendances constituted further new high records.

(5) The number of babies under one year attending child welfare clinics was higher than ever before.

(6) The number of children aged 1-5 years attending child welfare clinics was higher than ever before. The year by year increase in the number of children over the age of one year attending the clinics is startling and may be summarised thus:—

Year.	No. of children aged 1-5 years attending.	No. of attendances by such children.
1951 . .	610	8,776
1952 . .	799	10,468
1953 . .	3,861	19,275
1954 . .	3,842	16,119
1955 . .	4,136	17,133
1956 . .	4,203	17,431
1957 . .	4,881	18,220

(7) The development of facilities for instruction of prospective parents in parentcraft and the provision of talks for parents on physical and emotional health were intensified. This was indeed probably the biggest advance of the year, but it is discussed more fully in another section of this Report.

(8) Another development in child care was the inauguration of special sessions at welfare clinics for the discussion of problems arising in the family by parents, departmental medical officers and health visitors.

(9) The number of pre-school children receiving dental inspection was higher than in 1956 despite the shortage of dental officers.

(*a*) EXPECTANT AND NURSING MOTHERS.

(1) Ante-Natal Clinics.

As in past years, these clinics, although held in local authority premises, were conducted jointly by hospital and local authority staff; the presence of hospital consultants and midwives on the one hand and of medical and health visiting specialists in health on the other hand ensured that the best practical advice was

available both on clinical and on medico-social points.

This year, 3,279 expectant mothers, 80 more than last year, availed themselves of the Corporation's ante-natal services. No new clinics were opened.

Those already established functioned in five areas and the two opened last year—Northfield and Holburn—obviously met a public demand, eased the pressing load on the Central Ante-natal Clinic at Castle Terrace, and allowed more time for adequate health teaching and medico-social investigation.

First visits could be made at either Castle Terrace or Northfield Clinics where, in addition to the normal medical, health visiting, midwifery, and clerical staff, a hospital almoner attended for the purpose of "booking" the confinements in the maternity hospital or homes.

After her initial visit to either of these two centres, a mother was normally directed to her nearest clinic or to an appropriate session at Castle Terrace for continuation of ante-natal care under the supervision of the Assistant Medical Officer who would eventually look after the baby at the local child welfare clinic.

Ante-natal care covered obstetric consultation, medical supervision, health visitor's advice on the hygiene of pregnancy and the needs of the baby, information about the statutory benefits and welfare foods, and educational talks on such subjects as diets, physiology of pregnancy, and the elements of parentcraft.

Through the clinics, X-ray and laboratory services were provided to all, and a physician's advice at specialist clinics was available where necessary.

Unfortunately, many patients required extensive dental treatment, which it was impossible to give, owing to the continued severe shortage of dental officers.

Patients referred by general practitioners for obstetric consultation alone or for obstetric consultation and health teaching were welcomed. It is highly satisfactory that for five consecutive years over 3,000 expectant mothers have attended the clinics each year.

As previously, an appointment system was in operation at all clinics, and the recently introduced policy of allowing fifteen minutes in each hour for new patients proved very satisfactory.

Altogether, 31 single sessions were provided weekly and the distribution and medical staffing of the clinics were:—

Castle Terrace—5 sessions—staffed by 1 consultant, 1 public health medical officer, and 1 junior medical officer from the hospital.
Castle Terrace—2 sessions—staffed by 3 hospital doctors investigating special problems of pregnancy.
Holburn—1 session—staffed by 1 public health medical officer and 1 registrar.
Holburn—1 session—staffed by 1 public health medical officer.
Northfield—1 session—staffed by 1 senior registrar and 1 public health medical officer.
Northfield—1 session—staffed by 1 public health medical officer.
Torry—1 session—staffed by 1 public health medical officer and 1 registrar.
Hilton—1 session—staffed by 1 public health medical officer and 1 senior registrar.

In other words, the sessions were the equivalent of 31 single doctor sessions. At each session, health visitors were, of course, present for health teaching, &c.

At Castle Terrace, pupil midwives attended for instruction under the supervision of a Regional Hospital Board Midwife.

Relaxation Exercises.

It is now possible to give a fuller account of the work of the physiotherapist, part of whose time was devoted to ante-natal patients.

Relaxation classes were inaugurated in October, 1956.

In the first instance, classes were run chiefly for primigravida, who were thought to benefit most, but eventually women in their third or even fourth pregnancy were granted their desire to attend. Instruction started at the 7th month, courses of eight sessions being given.

Each course was comprehensive and carefully planned, and covered anatomy, pelvic exercises, the mechanics, signs, and sensations of labour, "rehearsal of labour," controlled breathing, relaxation, and post-natal exercises. The last meeting of each course was a popular and eagerly anticipated conducted tour of the Labour Ward and Nursery at Foresterhill, with an opportunity to try out the trilene machine, which most patients did.

Sessions expanded from one a week at Castle Terrace to ten per week covering four centres.

At the end of the year classes were held at—

6, Castle Terrace—Two sessions per week.
46, Charlotte Street—One session per week.
Northfield Clinic—One session per week.
Holburn Clinic—One session per week.

Two classes were held at each session at 2 p.m. and 3.15 p.m. lasting approximately one hour.

Up to 10 women could be accommodated at each class.

Numbers were satisfactory, those attending being most regular.

(ii) Post-Natal Clinics.

Post-natal care was available at the following sessions and the staff was:—

Castle Terrace .	Monday morning .	Public Health M.O. Registrar. Junior M.O. from hospital.
Hilton . . .	Thursday afternoon .	Senior Registrar. Public Health M.O.
Holburn . .	Thursday afternoon .	Public Health M.O. Registrar.
Northfield . .	Tuesday afternoon .	Senior Registrar. Public Health M.O.
Torry . . .	Monday afternoon .	Public Health M.O. Registrar.

In addition, consultants undertook post-natal examinations in selected cases at the Maternity Hospital on Saturday mornings.

All mothers were encouraged to attend the Post-Natal Clinic and were given appointments for post-natal examinations and advice. Although the attendance was (for the fourth successive year) higher than ever before, it is not yet regarded as satisfactory: a number of mothers still fail to appreciate that the origin of many subsequent gynæcological complaints can be attributed to pregnancy.

(iii) Teaching of Parentcraft.

A health visitor attended at all ante-natal and post-natal sessions to explain general principles and give advice on parentcraft.

A very large scale development (starting in November, 1956) was the introduction of a number of courses of systematic instruction, each course lasting for nine weeks at one meeting weekly. Those sessions were extremely popular. (For further information see the chapter on Health Education.)

Previously medical officers from the hospital staff had given a talk once a fortnight at the central clinic, and had aimed at giving two talks to each expectant mother attending that clinic. The numbers attending, however, dwindled, and the talks were discontinued, the detailed systematic courses being regarded as providing a more than adequate alternative.

(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 1957, with, for comparison, similar figures for 1956, 1955, 1954, and 1953:—

	Ante-Natal Clinics.		Post-Natal Clinics.	
	No. of Women.	No. of Attendances.	No. of Women.	No. of Attendances.
1957 . .	3,297	20,901	3,605	5,733
1956 . .	3,217	21,919	3,495	5,696
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

(v) Gynæcological Advisory Clinic.

As before this clinic was held in the basement of 6 Castle Terrace, a specialist health visitor being in attendance from 9 a.m. to 5 p.m. from Monday to Friday. A departmental medical officer was present for consultations on Monday and Tuesday mornings and on Wednesday afternoons.

The number of new cases attending was 1,559 and total visits numbered 3,188.

For comparison figures for previous years are given:—

	New Patients.	Attendances.
1956 . .	1,547	3,124
1955 . .	1,162	2,976
1954 . .	671	2,702

(vi) Supply of Maternity Outfits and Layettes.

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

Mothers were expected to provide their own layettes, but a layette was supplied free in exceptional circumstances. In certain cases, mothers were given wool to make garments for the baby. Where a mother was entitled to receive maternity benefit, a minimum charge of £2 was made for a complete layette. The approximate cost to the Corporation of providing a complete layette was £10.

(vii) Arrangements for Care of Unmarried Mothers.

(i) *Aberdeen Mother and Baby Home.*

The Corporation has continued its arrangement with the Aberdeen Association of Social Service whereby unmarried mothers were accommodated in the Aberdeen Mother and Baby Home, Richmondhill House, 22, King's Gate.

The weekly maintenance contribution paid by the Corporation was fifty-two shillings and sixpence per patient dating from six weeks prior to the expected date of delivery till four months afterwards.

The Corporation accepted responsibility for twenty women admitted to the Home.

As before, the actual confinements took place in the Maternity Hospital.

(ii) *Salvation Army Homes.*

The arrangement continued under which certain expectant unmarried mothers were sent by the Corporation to Salvation Army Homes in either Dundee or Glasgow. The payment to be made by the Corporation was 14s. per week for six weeks before the expected date of confinement and 24s. per week for four months thereafter. However, during the year, the Corporation did not require this service.

The total number of illegitimate births for the City during the year under review was 173, as compared with 172 in 1956, 172 in 1955, 140 in 1954, and 138 in 1953.

(*b*) CHILD WELFARE.

(i) Child Welfare Centres.

Certain general points may first be mentioned—

(*a*) During 1957 there has been considerable consolidation in the services already established for child care.

(*b*) The scope of a child welfare clinic continues to widen, and now includes far more than just advice on physical health.

(*c*) As in most other areas, the public demand for child welfare clinics is continuing to increase: the total number of children attending clinics has shown a steady increase each year from 1951 to 1957.

(*d*) The development of new housing areas on the periphery of the town is making the provision of peripheral clinics a continuing necessity.

(*e*) As an interim measure, until peripheral clinics can be established, the mobile health unit continues to provide clinic facilities in the new housing areas. During the year the sessions were increased from seven to nine.

(*f*) At the end of 1957 there were eleven child welfare centres in the City, apart from the mobile unit.

Seven full-time Child Health Centres are maintained at Castlegate, Charlotte Street, Hilton, Torry, View Terrace, Holburn, and Northfield, respectively. These are open daily (Monday to Friday) from 9 a.m. to 5 p.m. with health visitors constantly in attendance, so that mothers may attend at any time for skilled advice. At all clinic sessions where a departmental medical officer is in attendance, vaccination against smallpox and immunisation against diphtheria and whooping cough are carried out. Sessions are also held for baby weighing and advice on infant feeding and care of children.

Weekly clinics are held at four centres, viz., Powis Community Centre; Lads' Club, Gallowgate; Craigiebuckler; and Nigg (latter discontinued during the year). A registrar from the Royal Aberdeen Hospital for Sick Children attends the Craigiebuckler Clinic weekly.

At Hayton, a clinic is conducted thrice weekly.

(ll) Mobile Health Unit.

A mobile unit has now been in operation for over five 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. 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 1957, the clinic was operating nine sessions as follows:—Kaimhill (Monday afternoon), Mastrick Community Centre (Tuesday morning), Smithfield (Tuesday afternoon), Castlehill (Wednesday morning), Seaton (Wednesday afternoon), Kincorth (Thursday morning), Stockethill (Thursday afternoon), Muirfield (Friday morning), and Mastrick Community Centre (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 to anything like the same extent as a purpose-built clinic. The attendances outlined below stress the need for clinics in the new housing areas:—

Total number of children under five years of age who first attended the Mobile Health Unit during the year—

(*a*) Under 1 year of age, 723; (*b*) Over 1 year of age, 1,211.

Total number of attendances made by children to the Mobile Health Unit during the year—

(*a*) Under 1 year of age, 3,696; (*b*) Over 1 year of age, 2,539.

(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, 4,460; (*b*) Over 1 year of age, 4,881.

Total number of attendances made by children during the year—

(*a*) Under 1 year of age, 22,663; (*b*) Over 1 year of age, 18,220.

The total number of children attending is a new record showing an increase of 38 per cent. over the 1956 total which was itself a new high record.

(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. Treatment is afforded to children recommended to the Centres by general practitioners and pædiatricians. 144 children made 1,650 such attendances.

(vi) Remedial Exercises.

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.

(vii) Special Clinics.

(*a*) *Orthopædic Clinic.*

Pre-school children suffering from 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. During 1957, thirty-five pre-school children were referred.

(*b*) *Ophthalmic Clinic.*

Pre-school children suffering from eye defects are referred to the ophthalmologist in attendance at the eye clinic for school children. Fifty-two children under school age were referred during 1957.

(*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.

The main centre for issue of welfare foods continued to be a portion of the child welfare clinic at Castlegate. In addition, welfare foods are supplied at each full-time child welfare centre. 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 shopkeepers 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 1955, 1956, and 1957 was as follows:—

	National Dried Milk.		Cod Liver Oil.	Vitamins A & D (expectant mothers).	Orange Juice.
	Full Cream.	Half Cream.			
1957 . .	65,623	5,913	18,104	7,143	146,315
1956 . .	86,276	6,660	20,992	8,094	136,967
1955 . .	92,291	6,839	23,737	8,309	129,866

(*e*) DENTAL CARE.

Out of the authorised establishment of seven dental officers, the number employed throughout the year was three full time and one part time for the first six months of the year.

Despite the severe shortage, the present dental staff managed to undertake more work than in previous years for expectant mothers and young children 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 recent years:—

	Examined.			Found to need Treatment.			Treated.		
	1957.	1956.	1955.	1957.	1956.	1955.	1957.	1956.	1955.
Expectant and nursing mothers	23	36	12	19	36	11	11	30	10
Pre-school children . . .	462	324	464	277	265	270	121	197	136

(*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 deliberately 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.

A further extension in this field was begun during the year by (i) the inauguration of special sessions at two welfare centres where problems arising in the family could be discussed by the parents, the Departmental Medical Officer, and the Health Visitor, and (ii) the setting up of a Case Conference Committee which looks at the problem from all angles in the interests of the child and the family.

Members of this Committee include representatives from—

1. Health and Welfare Department	Departmental medical officer and a health visitor.
2. Prevention of Cruelty to Children	One representative from the Local Association and one representative from the National Association.
3. Association of Social Service .	One representative.
4. Education Department . .	One representative.
5. Housing Department . . .	One representative.
6. Ministry of Labour and National Insurance	One representative.
7. National Assistance Board . .	One representative.
8. Probation Service . . .	One representative.

In addition, of course, the policy-making Co-ordinating Committee, representing all statutory and voluntary bodies and associations interested in the welfare of children in their homes, continued to function.

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

(1) Residential Nursery.

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 (1) young children taken into care by the Children's Committee; (2) children of parents who are temporarily unable to look

after them at home (*e.g.*, mother in hospital and father unable to cope); and (3) debilitated children.

(ii) Day Nurseries.

The Corporation provide four day nurseries in the City. All four are approved for the training of nursery nurses. The largest, Charlotte Street, continues to cause disquiet because of its unsuitability as premises for a day nursery. From the table below it will be noticed that the demand for vacancies continues to exceed the number of places available.

Day Nursery	Number of approved places		Number of children on register at end of year		Average daily attendance during year		Waiting List at end of year	
	0-2 yrs.	2-5 yrs.	0-2 yrs.	2-5 yrs.	0-2 yrs.	2-5 yrs.	0-2 yrs.	2-5 yrs.
Charlotte Street . .	30	30	31	32	17	20	45	32
Deeside . . .	20	25	18	26	13	19	30	26
Linksfield . . .	—	30	—	30	—	24	—	32
View Terrace . .	20	24	21	26	13	18	31	25

5.—DOMICILIARY MIDWIFERY.

There were no important changes during the year. In all, there were 437 domiciliary confinements, as compared with 452 and 444 in the two previous years.

The broad picture of midwifery in Aberdeen in recent years is:—About 86 per cent. of Aberdeen births take place in hospital and about 14 per cent. at home. Nearly all the home cases are conducted by midwives alone. In 1957, doctors were present at only 26 confinements, and figures for previous years were similar (31 in 1956, 21 in 1955, 29 in 1954, and 31 in 1953), giving an average over the last five years of 28 confinements a year at which a doctor was present.

General.

The midwifery staff at the end of 1957 consisted of a Supervisor of Midwives (who also functioned for the greater part of her time as Deputy Superintendent Health Visitor) and eight whole-time midwives. (There were vacancies on the establishment for two other midwives.)

For practical purposes, the City was divided into nine districts, one being allocated to each midwife and the ninth to the Board of Management for the Aberdeen Special Hospitals. This latter district was used for the practical training of Part 2 pupil midwives under the instruction of the hospital staff's trained midwives, the Corporation making a payment of £930 towards the salaries of the qualified midwives on the district.

During the year, 343 confinements were attended by municipal midwives, 92 confinements by midwives employed by the Board of Management for the Aberdeen Special Hospitals, 1 by a general practitioner alone, and 1 by private midwife with doctor—a total of 437.

The responsibilities of the Supervisor of Midwives include supervision of all practising midwives in the City—private midwives, hospital staff, and Corporation staff.

At the end of the year there were 2 private midwives, 42 Regional Hospital Board midwives, and the 8 municipal midwives.

Births.

Particulars of the births, including still-births, which occurred in the City during 1957 are as follows:—

(i) Total number of births occurring in the area during year, that is before correction for mothers' residence:—Live births, 4,218; still-births, 88. Total	4,306
(ii) Total number of above births occurring in institutions (including private maternity homes)	3,869
(iii) Total number of above births occurring at home	437

These 437 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	21 ...	319 ...	3 ...	343
Hospital midwives "on district"	3 ...	76 ...	13 ...	92
Private practising midwives	1 ...	— ...	— ...	1
No midwife	1 ...	— ...	— ...	1
Total, 1957	26 (5·9%)	395 (90·4%)	16 (3·7%)	437
Comparable figures for 1956	31 (6·8%)	399 (88·4%)	22 (4·8%)	452
Comparable figures for 1955	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 (6·6%)	412 (86·7%)	32 (6·7%)	475

Administration of Analgesics.

(1) *Trilene.*

All the domiciliary midwives are trained in the use of trilene analgesia, the four recently appointed members of staff having been trained during the year. However, not all midwives had the facility to administer trilene as the Corporation so far possesses only 6 machines.

Each machine spends one month in maintenance every six months, so, until the Corporation possesses about 11 machines, trilene will not be available to all mothers. It should be mentioned that the first three machines were obtained only in 1957 and the next three later in the year. The number of cases receiving trilene was 80.

(2) *Gas and Air.*

Three sets of gas and air apparatus were in use at 31st December; 287 patients received gas and air analgesia. Pethedine was given in 262 cases. The comparable figures for 1956 were 375 and 225, respectively.

Use of Cars.

One municipal midwife received an allowance for the use of her own car. In emergency and at night, taxis were used by the other midwives.

Arrangements for ante-natal supervision by Midwives.

When a confinement is expected to take place at home, ante-natal supervision is undertaken by the midwife concerned either in a duty room set aside for that purpose in the midwife's house or at the patient's 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. Subsequently, where any personal or environmental circumstances make a home confinement undesirable, the general practitioner and the midwife jointly recommend the woman to have institutional care. However, arrangements for admission to hospital on social grounds or because of anticipated obstetrical difficulty are normally made early in the pregnancy.

Refresher Course for Midwives.

One midwife attended a refresher course at Dunblane.

Training of Pupil Midwives.

Aberdeen Maternity Hospital is a training school for both Parts 1 and 2 midwifery. Part 2 midwives must obtain experience in domiciliary confinements under supervision, and this is offered by the Corporation allocating a district for this purpose.

The practical supervision in the home is given by the hospital midwives centred at 32, Carden Place, while certain lectures in the systematic course are given by the Supervisor of Midwives.

6.—HEALTH VISITING.

Some of the main features of the year may be outlined thus:—

(1) While the annual number of visits paid had risen (largely as a result of the policy of decentralisation) from 108,418 in 1954 to 143,185 in 1956, the grand total of visits in 1957 is apparently very much higher, namely, 165,605, or, counting visits by state-registered nurses who were temporarily employed as "acting health visitors," 220,110. Actually, however, this total is inflated by special visits paid (mostly in the evenings in the case of health visitors' visits) in connection with the X-ray campaign. The figures are best indicated thus—

(*a*) Ordinary visits by health visitors (the X-ray campaign being mentioned if visit was in the months of June to September, but the visit being made primarily for other purposes) . .	147,469
(*b*) Special visits made solely in connection with X-ray campaign .	18,136
(*c*) Visits by "acting health visitors" in connection with X-ray campaign	36,371

These totals do not include unsuccessful visits (in which a house was found temporarily empty.)

(2) Both the number and the proportion of visits paid to expectant mothers continued to increase (from 7,335 in 1952 to 11,412 in 1956, and to 11,473 in 1957) —an indication of the modern view that advice to expectant mothers, both about their own physical and mental health and social needs and about the physical and emotional requirements of children, constitutes one of the most important aspects of a health visitor's work.

(3) A total of 10,666 visits (a considerably greater number than in any previous year) were paid to elderly persons—a further indication of the extension of the work of the health visitor to the elderly population. Nevertheless, a survey during the year showed that the biggest unmet need of old people was still for visits by health visitors.

(4) The grave shortage of health visitors continued during the year, and special reports were submitted to the Corporation. On no day during the entire year were there fewer than 18 vacancies on the establishment. Eleven health visitors left during the year, and only seven recently qualified health visitors joined the staff to fill the vacancies; and there were further resignations soon after the close of the year. (The shortage is discussed in more detail in a later chapter of this Report.)

(5) Other features of the year included continuation of the use of heatlh visitors in the training both of medical students (begun in 1952) and of student nurses (begun in 1954) as well as in the post-graduate training of the Diploma in Public Health students (begun in 1957); continuation of the efforts (begun in 1954) to improve liaison between general practitioners and health visitors; increasing attention by health visitors to mental and emotional health; and increasing efforts to prevent broken homes and the deterioration of potential problem families —including, for example, the introduction of case conferences.

Visitation by Health Visitors.

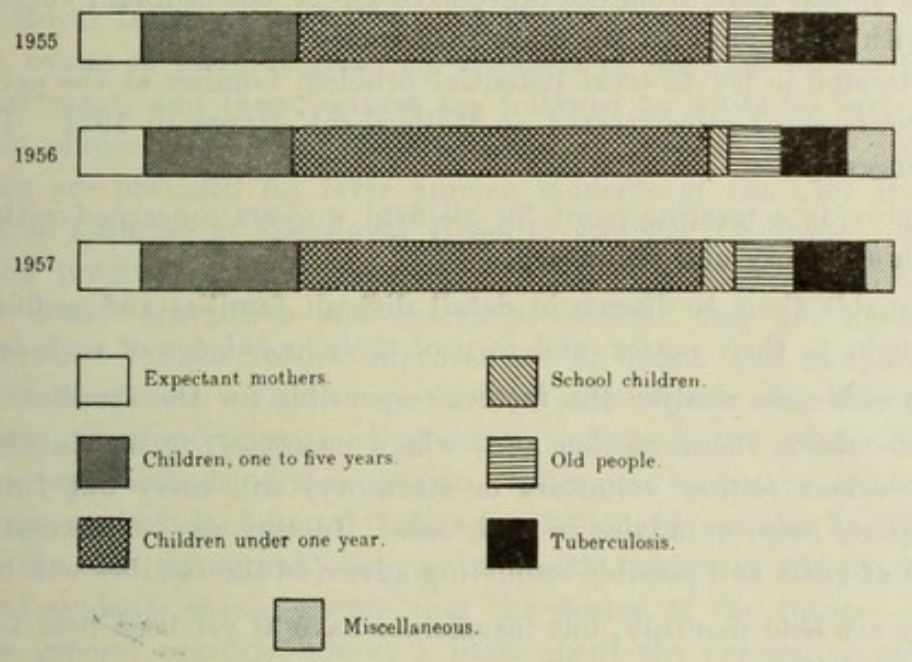
An analysis of the number of home visits made by health visitors during the year is given below, the total visits for 1956 and 1955 being also stated for purposes of comparison:—

	No. visited in 1957.	Total visits		
		1957.	1956.	1955.
(*a*) Maternity and Child Welfare—				
Expectant mothers	2,905	11,473	11,412	9,473
Children under 1 year	3,308	28,581	26,283	24,144
Children aged 1-5 years	14,403	72,405	73,098	62,858
(*b*) Cases of tuberculosis	1,809	13,251	11,172	11,799
(*c*) Other cases (*e.g.*, elderly, handicapped, &c.)	7,659	15,583	17,916	13,239

In all, 165,605 home visits were paid, as compared with 143,185 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, a feature which increased considerably in 1956 and 1957).

The diagram depicts the changes in visiting over the last three years.

VISITING BY HEALTH VISITORS.



Mothers and Young Children.

All families with young children were visited during the year, the frequency of the visits being at the discretion of the health visitor and adjusted according to the need and the clinic contact. Increasing attention was paid not only to the physical health of the family unit, but also to psychological and social factors.

School Children.

An increasing number of visits (6,176 in 1957) were paid to the homes of school children, so that the health visitor to some extent really acted as a link between home and school. In the old days, visits were paid only when physical defects were found. Particular attention was again paid to the mental and emotional health of the school child, and visits were made to the homes of all new school entrants, further visits being paid according to the needs of the individual family and according to the amount of time available.

Elderly.

During the year, 10,666 visits were paid to elderly citizens, of whom 849 were new registrations. A small number of old people in need of help were found during the intensive visiting prior to the tuberculosis campaign. Visits paid were at the discretion of the health visitor and adjusted according to the needs of the individual and according to time available.

Handicapped.

As in previous years, a specialist health visitor and a social worker were engaged on the visiting of physically handicapped persons.

Problem Families.

It would appear that, from the preventive aspect, the ordinary current methods of dealing with these families are quite inadequate.

In an attempt to try to treat potential problem families at the early or acute stage, case conferences were started at Willowbank House in 1957. The aims of these conferences are—

(1) To provide a meeting-point for all field workers concerned with families—both statutory and voluntary.

(2) To enable them to discuss in detail difficult families and problem families brought to their notice, and to pool their knowledge of such families.

(3) If possible, to analyse the factors responsible for the families' difficulties.

(4) To decide on future action and, where necessary, to decide which worker or workers (either voluntary or statutory) will carry out future action, support, help, or advice in each case. In this way, unnecessary duplication of visits and possible conflicting advice to the families will be obviated.

Meetings are held monthly, but insufficient have as yet been held to make any assessment of results.

Liaison with Hospitals.

Liaison 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 Nursing Superintendent 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 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. Since 1954, student nurses at the combined training school of Aberdeen Royal Infirmary and Woodend Hospital have received, 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. Similar but shorter courses are provided for fever nursing students at the City Hospital and student children's nurses at the Royal Hospital for Sick Children. 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 department 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 scheme—which, after three years, can now be regarded as established—should complete the circle by enabling the hospital nursing administrators and ward sisters of the future to understand something of the aims and methods of their colleagues in the preventive field.

Liaison with General Practitioners.

Although all degrees of co-operation and lack of co-operation are found, 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 which were mentioned in the report for 1955 may be briefly repeated:—

(*a*) In each of the last five 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*) A few years ago 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, a detailed 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 was printed in full in the Report for 1955.)

Status of the Health Visiting Service.

In recent years there have been considerable extensions in the field of work of health visitors, some enlargement of the work of midwives, large-scale increases in the teaching duties undertaken by the Health and Welfare Department and con-

siderable enlargement of the numbers of staff employed. Steps taken during the year and approved by the Corporation to meet changing and expanding needs were as follows:—

1. Instead of the Superintending Nursing Officer having one assistant, she was given a second assistant; the two assistants were of equal rank and status, but one was designated Assistant Nursing Officer (*i.e.*, acting as a deputy in respect of midwives as well as health visitors), while the other was designated Assistant Superintendent Health Visitor (*i.e.*, acting as a deputy in respect of health visitors but not of midwives).

2. When the Superintending Nursing Officer resigned on grounds of matrimony, her post was re-designated as Superintendent Health Visitor and Co-ordinating Nursing Officer: in other words, the senior administrator continued to be responsible for the direct control and supervision of health visitors and for the general co-ordination of the work of health visitors, midwives, district nurses, &c., but she ceased to be responsible for the direct supervision of midwives. The Superintendent Health Visitor and Co-ordinating Nursing Officer is directly responsible for the health visiting service and is directly answerable to the Medical Officer of Health—a recommendation of the authoritative Report of the Working Party which is mentioned later.

3. A new grade of clinic superintendent health visitor was created, eleven appointments being made to this grade.

4. Three new posts of clinic attendant were created, the duties being largely selling and accounting for food, and setting up and clearing away, routine clerical duties—thus relieving the health visitor of unskilled tasks in the organisation of the clinics.

The Working Party Report in relation to Aberdeen Services.

An official Working Party, set up by the Ministers of Health and Education and the Secretary of State for Scotland, under the chairmanship of one of Aberdeen's most distinguished graduates, Sir Wilson Jameson (former Chief Medical Officer of the Ministry of Health), reported in 1956. The report was not revolutionary—except in its strongly worded recommendations about salaries and promotion avenues. In general, it advocated things that were already in being in the best areas.

It is perhaps useful, however, to summarise the main recommendations of the report and to consider how Aberdeen stands in relation to each of them:—

(A) Field of Work.

(1) GENERAL.

The health visitor is essentially a general purpose family visitor whose main tasks are health education and social advice (social advice being defined as including remedial action taken).

In Aberdeen she has acted for several years as the general purpose family visitor of the Health and Welfare Departments, and her main functions have been recognised as health education and social guidance. A health visitor is responsible for visiting expectant mothers, pre-school children, old people, &c., in her area; she normally acts as school nurse for the school in her area and visits school children at home, and, to a large extent, she also acts as social welfare visitor for her area.

(2) Child Welfare.

General visitation of children is desirable, not just concentration on selected families.

In Aberdeen such general visitation is the rule, although (as indeed is implied in the report) a health visitor adjusts the frequency of her visits to different families at her discretion.

(3) Ante-natal.

At ante-natal clinics the health visitor's job is health teaching: she is better able than the midwife to assess social and psychological factors. She should also be free to visit expectant mothers at home.

In Aberdeen the health visitor's rôle in ante-natal clinics is as indicated.

With regard to home visiting of expectant mothers, Aberdeen (like other progressive areas) places much stress on ante-natal visits—not merely for the well-being of the future mother but also for the sake of inculcating right attitudes and right ideas about child care even before the baby is born. [Several experts have publicly suggested that one of the blind-spots of the report was lack of appreciation of the importance of home visiting in the ante-natal period: for example, when the Working Party assess staffing standards, they assume that health visitors will pay, on the average, about one visit per expectant mother, whereas, in progressive areas, it is appreciated that a single lesson on health—or on any other subject—is of little value, and that a number of visits should be paid to each expectant mother. In Aberdeen, despite severe staffing shortages, about four such visits per expectant mother are made on the average.]

(4) School Health.

(a) The multi-purpose health visitor is desirable, not the separate school nurse; and home visiting of children is important.

In Aberdeen the family health visitor undertakes school work. Efforts have been made in the last three or four years to step up the amount of home visiting of school children, but—in consequence of staff shortages—such visiting is as yet woefully inadequate.

(b) Work in school should include attendance at medical inspections, health visitors' health surveys, discussions with teachers, and group-teaching—parentcraft, &c.

In Aberdeen the work is on the lines indicated, except for parentcraft teaching in schools. The Corporation, a number of years ago, appointed a group of full-time teachers of mothercraft (all or most of whom were recruited from the health visiting staff). Since a full-time teacher of parentcraft, who is not herself visiting families in their homes, cannot easily keep in touch with the constantly changing problems of the community, it may be that, at an appropriate time, the Corporation should review its policy in respect of the teaching of parentcraft in schools.

(c) The work should not include certain tasks requiring less skill—e.g., *attendance at minor ailment clinics* (where a nursing sister without a health visiting qualification can do the job) or *cleanliness inspections.*

In Aberdeen various appointments of nursing sister and clinic attendant have been authorised. Nevertheless, cleanliness inspections now form such a minute fragment of the work that it is sometimes administratively convenient to have them undertaken by the school health viistors.

(d) The school health visitor has an important rôle in respect of behaviour difficulties and emotional disorders.

In Aberdeen this function has been stressed for some years.

(e) Health visitors should play a part in child guidance.

While health visitors play an important part in preventing maladjustment and in helping children who are in process of becoming maladjusted, it must be appreciated that, in Scotland, child guidance clinics (for maladjusted children) form part of the education department (whereas in England they normally form part of the health department): hence it is difficult to implement the recommendation.

(5) After-Care.

(a) The family health visitor can cover tuberculosis work.

In Aberdeen six specialist health visitors are still employed for work in connection with tuberculosis: the principle of the recommendation is accepted, but, when six individuals have for years devoted their time exclusively to contact-tracing, after-care, and social work in connection with tuberculosis, it is not possible suddenly to transfer them to the wide duties of family health visitors.

(b) Both general practitioners and health visitors should receive information from hospitals about individuals with heart disease, diseases of the stomach, &c.

In Aberdeen duties in respect of after-care are not yet being undertaken—through sheer lack of staff.

(6) Mental Health.

(a) The health visitor needs even more training in psychology and more time to know her families.

The training of student health viistors in Aberdeen is very much oriented to psychology and mental health, and Aberdeen has been a pioneer in the organisation

of courses in mental health to gear up older health visitors for this important work. The need for more time to know families intimately is appreciated—but there are many vacancies on the Corporation's establishment.

(b) One of the tasks of the health visitor is to steer the family clear of obvious social difficulties.

This is accepted and undertaken.

(7) The Elderly.

The health visitor has an important part to play. She should have a recognised place in all schemes.

For some years the health visitor's part in maintaining the health and well-being of the elderly has been receiving increasing attention in Aberdeen. Health visitors now pay over 10,000 visits a year to old people in the city, but a study of a random sample consisting of 5 per cent. of all old people shows that the commonest unmet need of the aged is still for visits by health visitors.

(8) The Handicapped.

(a) The health visitor needs to know about rehabilitation, welfare services, &c.

This is accepted. Nevertheless, during the phase of development of services for the handicapped, it is felt that the present Aberdeen practice of employing a specialist health visitor and a social science graduate has advantages.

(b) Stress is laid on the health visitor's rôle with adolescent mental defectives.

In Aberdeen this work is not yet being attempted—through lack of staff.

(9) Miscellaneous.

(a) The health visitor is a general-purpose family visitor, but observation and co-ordination of services are subsidiary to her main functions of health teaching and social advice.

These points are in accord with local policy.

(b) It will probably be necessary to raise the minimum intellectual standard for acceptance of students.

It is accepted in Aberdeen that the student health visitor should be of no lower intellectual and educational standards than the student in other professions.

(c) The number of health visitors must be increased.

Aberdeen has increased its establishment but cannot fill the vacancies. (The point is discussed later.)

(B) Status and Relationships.

(1) Status.

(a) The health visitor is largely independent of the doctor.

Since most of her work concerns those who are not ill, the point is indisputable.

(b) She is truly a medico-social worker—playing a full part in both preventive medicine and social action.

This is in line with local policy.

(c) The health visitor should be responsible to the superintendent health visitor, and she in turn should be responsible to the M.O.H.

This is standard practice in Aberdeen. The old concept of the health visitor as working to a departmental medical officer is quite outmoded: the trainings of the two officers are dissimilar; they must therefore work in parallel, not with one responsible to the other.

(2) The General Health Visitor.

(a) She is a qualified professional worker exercising her talents over the whole range of her profession.

This is fully accepted.

(b) For formation and preservation of good human relationships, stability of a health visitor's area is necessary.

This is appreciated. Nevertheless, the growth of new suburbs from time to time makes alteration of health visitors' districts inevitable.

(c) It is useful to have a team of two in adjacent districts, relieving each other.

This is being attempted.

(d) The health visitor should have clerical help if possible.

As yet, very little such help is provided in Aberdeen.

(e) She must have a proper base (where people can contact her) and a telephone.

This is in line with local practice.

(f) Some evening sessions are desirable.

At present health visitors pay evening visits at their discretion; and parents' clubs meet in the evenings.

(3) Organisation of Clinics.

The health visitor should not act as chaperon and surgery nurse, should not do clerical work, and should not sell food or set trays. Retired nurses might be employed part-time for these jobs.

Consideration will be given to this useful suggestion.

(4) Co-operation.

(a) The health visitor should be allowed to use her own discretion.

This is regarded as essential and obvious.

(b) There should be co-operation with midwife and home nurse on the basis that the health visitor is a trained health educator.

This is accepted.

(c) While largely independent of the doctor (e.g., in respect of healthy people) she is also a member of his team.

It is accepted that, where both general practitioner and health visitor are attending a household, they must co-operate; it is, however, fair to point out that

various experts have condemned the phrase about membership of the practitioner's team—since the two workers have essentially different training, each possessing skills that the other lacks. In general, co-operation is good in Aberdeen.

(d) Combined posts—health visitor and home nurse. Where combination cannot be avoided—and statistics show that the areas using "combined" nurses are dwindling—the multi-purpose nurse should have the full H.V. qualification.

The point is not applicable in Aberdeen.

(e) The relationship between general practitioner and health visitor should resemble that between consultant and almoner. Personal contact is essential. General practitioners should be informed about the functions and training of health visitors. Requests to the Health Department by practitioners should normally be channelled through health visitors.

These are in line with local policy. In connection with information to general practitioners, it may be mentioned that a detailed memorandum was sent out three years ago.

(f) There should be liaison with almoners. Hospital staff should contact health visitors directly.

Direct two-way communication is encouraged.

(g) Health visitors should be in touch with Care Committees and represented on them.

Health visitors are well represented on the Tuberculosis Care Committee. Aberdeen has very few Care Committees.

(h) It is important to reduce duplication of visits by health visitors and social workers, and to avoid creation of new types of staff. There should be mutual recognition of each other's functions by these workers. If a social case-worker is called to a family which is being visited by a health visitor, she should inform the health visitor.

This is desirable but its establishment implies a willingness of various departments to co-operate and an absence of "empire-building."

(5) Specialisation.

While specialisation is not generally desirable, it may be necessary to employ on specialised work a few health visitors—e.g., with special aptitudes for group-teaching or after-care work.

This is completely in line with local policy.

(C) A Higher Grade of Field-worker.

(1) *There is a need for a senior grade with partly administrative but mainly field-work duties, with entry by merit promotion. The grade should be reached*

fairly early by outstanding health visitors and should be a step towards either administrative or teaching posts. The £30 responsibility at present paid to certain staff is not sufficient for the proposed grade.

Aberdeen not only accepts the recommendation: it tried to create such a grade by seeking to pay five selected health visitors £75 per annum for additional duties and responsibilities—and its proposal was disallowed by the Secretary of State.

(2) *The tasks of this "intermediate grade" include—difficult cases, advice to recently qualified health visitors, and area case-conferences. Some supervision of newly-trained health visitors is necessary.*

The points are noted but not yet applicable since the grade does not exist.

(3) *There might be a one-year University course for this grade, or possibly the same training as for intending tutors.*

Whether the grade is to be a merit promotion (as recommended in paragraphs 338-9 of the Report) or to demand an extra training will have to be determined nationally; but two points may be mentioned—(1) if there is a training it must be in case work and minor administration, whereas the tutor's training must continue to be primarily in teaching and educational psychology; (2) If the scheme is so operated as to equate the new grade with junior tutors (instead of being a step below the assistant superintendent and assistant tutor), the existing shortage of tutors would increase—since very few people would be willing to have the strain of, and the constant reading required for, advanced teaching if they could secure equal status and remuneration in the new grade.

(D) Training.

(1) *Full nursing training remains necessary both for knowledge and for status.*

(2) *A shortened midwifery training might be arranged, Health Visitor Training Schools and Maternity Teaching Hospitals sharing the responsibilities.*

(3) *Co-ordination of earlier training and later public health training is necessary.*

These points are for national determination. Recent local steps to teach the rudiments of public health to student nurses are, however, worth mentioning.

(4) Health Visitor Training.

(a) Training bodies should study the content of courses.

This is done systematically in Aberdeen. The Medical Officer of Health and the Principal Health Visitor Tutor are members of the Standing Conference on Health Visitor Training Schools, and the recommendations made by Standing Conference from time to time are fully implemented in Aberdeen. The Principal Health Visitor Tutor is also at present Chairman of the Health Visitor Tutors Group of the Royal College of Nursing.

(b) Students should be carefully selected on personality and educational background: in general, students should have been able to reach the General

Certificate of Education or its Scottish equivalent (i.e., four years of secondary education).

These points are accepted.

(c) Important subjects in training include family welfare, human relationships, techniques of interviewing, elements of social case work, and developmental psychology.

In Aberdeen due attention is paid to each of these.

(d) The values of tutorials, case-studies and group discussions is emphasised.

To a limited extent these are undertaken in Aberdeen. If more are to be attempted, the tutorial staff may have to be enlarged.

(e) The course must include training in the techniques of health education.

In Aberdeen methods and techniques of health teaching are already regarded as a very important part of the training.

(f) Students should be trained in the art of detailed report writing.

The principle is accepted, but limitation of number of available tutors must be kept in mind.

(g) Students could beneficially participate in research surveys.

No such participation has yet taken place in Aberdeen. The point is, however, a useful one.

(h) The duration of training should be 9-12 months.

Aberdeen has recently extended its course to 9 months—the proposed minimum duration.

(i) Integrated courses might be arranged for candidates straight from school or straight from University, e.g., it might be possible with carefully selected students to complete the entire training (nursing, midwifery, and health visiting) in under four years.

This is a point for national decision.

(E) Further Training of Ordinary Health Visitors.

(1) *Local authorities should provide library facilities and professional journals.*

This is done to a very limited extent but may have to be increased.

(2) *There is a need for in-service refresher courses.*

Aberdeen has been a pioneer in the organisation of such courses.

(3) *Experienced health visitors should have a chance to attend national conferences.*

In Aberdeen this opportunity is provided to a moderate extent.

(4) *Each health visitor should attend a refresher course every five years.*

Aberdeen has hitherto sent only an average of two or three health visitors to refresher courses each year. Clearly a considerable increase is needed.

(5) *Senior staff might attend administrative courses along with heads of other sections of health and welfare services.*

Within limits, this already happens in Aberdeen; *e.g.*, the Superintendent Health Visitor and the Principal Health Visitor Tutor normally attend the annual congress of the Royal Sanitary Association, and one or other of them attends the annual conference of the Royal Society of Health.

(F) Advanced Training.

(1) Intermediate Grade—"Group Adviser."

A one-year University course is desirable, largely in social work.

The point is one for national decision; but it may be pointed out that the Corporation (like many other bodies) has taken the view that—

(*a*) a group adviser, a merit promotion which should be a step towards administrative and teaching posts, should not require further training;

(*b*) further training should take place for the step above that of group adviser—training in educational theory and practice in the case of the intending tutor, and training in administration and staff management in the case of the intending superintendent; and

(*c*) it would seem strange if health visiting were the one profession in which a further training was essential for even the first step on the promotion ladder.

(2) Tutorial Staff.

(*a*) *Adequate tutorial staff should be provided.*

This is an obvious point, but there is at present a national shortage of tutors even greater than the national shortage of health visitors. Until the remuneration and conditions of service of tutors are substantially improved it will be difficult to secure enough tutors to train the existing number of students, and impossible to train the larger numbers of students proposed in the Report.

The point is a national one, but is mentioned here because lack of qualified tutors is the rock on which all efforts to increase and improve the disease-preventing service may well founder.

(*b*) *The Tutors require wide knowledge.*

This is unquestionable: an outstanding health visitor who subsequently takes the full-time training for the tutor's certificate at London acquires sufficient knowledge to start her work, but the real problem is how she is to keep her knowledge up to date in a rapidly changing field. Periods of sabbatical leave and study leave (as in comparable University posts) may be the answer, but to a considerable extent the problem is bound up with that of shortage of tutors.

(c) The existing shortage of qualified tutors will be felt very acutely if recruits increase; therefore special university courses are necessary to train more tutors.

The point is a national one, but it may be mentioned—

(1) that not only will the shortage be felt very acutely, but the whole policy of materially increasing the number of student health visitors will be nullified unless there are first sufficient qualified tutors to train the students;

(2) that the increase in the total number of health visitor tutors required will be from about 31 in Britain to about 62, so that they could be trained in two or three batches of 10-15 in successive years in the existing course at London without the expense and trouble of setting up other courses; and

(3) that the basic need is not to provide more courses but to make tutoring attractive to a few more outstanding health visitors.

(d) The courses for Group Advisers might be used for tutors; this would facilitate exchange between teaching and administrative staff.

This is again a national matter, but all the professional bodies concerned have pointed out that the training required by an intending tutor (whose life work is to be advanced further education) differs radically from any training needed by the intermediate grade, and that, since the aptitudes and trainings of administrators and tutors must differ, the suggested interchange might well be unsatisfactory.

(3) SUPERINTENDENTS.

(The Report does not mention the training of superintendents. Presumably, the present course in public health administration, in London, is regarded as satisfactory.)

The Corporation endeavours to appoint as superintendent and assistant superintendent persons who have taken the higher qualifications. It may, however, be noted that, whereas the nationally determined salary of a tutor is paid only to tutors who possess the appropriate higher qualification (or who were in posts before a specified date in the past), there is as yet no parallel regulation for superintendents—a superintendent or assistant superintendent without additional qualification receives the full salary.

(G) Organisation and Finance of Training.

(1) *All Health Visitor Training Schools should be in or near Universities whose co-operation in training is valuable.*

The Aberdeen Training School, of course, conforms, and the help of various University Departments is recognised as valuable. Similarly the staff of the Training School play some part in the teaching of certain University students.

(2) *Central training bodies should devise the national syllabus, approve, and inspect training schools and appoint examiners. In the composition of the central training bodies (which might be the Royal Society of Health and the Royal Sanitary Association of Scotland, both broadened) a majority of members should be from Health Visitors' professional organisations, representatives of staff of training schools, and representatives of Universities.*

These points are for national determination.

(3) *A regulation should be made in Scotland banning (as in England) future appointments of unqualified acting health visitors.*

In Aberdeen, despite staff shortages, no such appointments have been made in the last seven years except for the engagement of a number of state-registered nurses for a few months to assist in the x-ray campaign.

(H) Training Schools.

(1) *The usual size should be 25-50 places.*

This is completely accepted in Aberdeen: it has to be kept in mind that student health visitors are the analogues not of University undergraduates but of post-graduates, and that a school of over 50 places would require a very large staff and very elaborate arrangements for practical instruction.

The Aberdeen school has 26 places but may need to be extended: if Scotland is to train the necessary quota of health visitors, either the three schools in the country must expand slightly or a fourth school must be created; and the former of these alternatives is the more economical and probably the more efficient.

(2) *The Training School Committee—a small committee which should include the Medical Officer of Health, the Superintendent Health Visitor, and representation of the teaching staff of the School—should be responsible for staffing, premises, organisation of practical training, and final selection of students.*

This is a matter for national decision. In Aberdeen at present—

(*a*) The Health and Welfare Committee is responsible, subject to approval by the Corporation, for expenditure on staffing, premises, &c.

(*b*) The Medical Officer of Health is responsible for the appointment of the Principal Tutor and her Assistant.

(*c*) The Principal Health Visitor Tutor is responsible for the selection of part-time lecturers and the allocation of time to them.

(*d*) The Principal Health Visitor Tutor and the Superintendent Health Visitor in collaboration organise the practical training.

(*e*) Selection of students is in the hands of a panel consisting of the Medical Officer of Health, the Principal Tutor, the Superintendent Health Visitor, and the Assistant Tutor.

The present arrangements function satisfactorily.

(I) Finance of Training.

(1) *Local Authorities should contribute to the cost of training on a population basis.*

This is a matter for national decision.

(2) *The maintenance allowances of students should not be unduly below the starting salary of qualified staff.*

Aberdeen recently raised the grants to £7 4s. weekly, but it would seem that a substantial further increase is indicated.

(3) *Local Authorities should pay for refresher courses.*

In Aberdeen this is already the case.

(J) Man-power—Case-loads.

(1) *Estimates of need vary from slight expansion to more than doubling: the great majority of employing bodies want more health visitors. Each area should work out its required establishment.*

In Aberdeen this has been done.

(2) *The minimum requirement is about 1 Health Visitor per 4,300 population, based on the following assumptions—*

(a) decentralisation (to save time in travelling);

(b) provision of transport facilities;

(c) provision of telephone facilities;

(d) use of less highly trained staff for certain work;

(e) an average of only 1 home visit per expectant mother; and

(f) an average of only 1 home visit annually per old person.

This minimum standard is only an immediate one and may be altered in the light of experience.

This "minimum standard" was of course advocated before the Guillebaud Committee recommended the amalgamation of Health Departments and Welfare Departments. As is indicated in the next chapter, when allowance is made for welfare functions and for the proportion of young children and old people in Aberdeen, the "minimum standard" is not far from Aberdeen's previously calculated requirement of 85 health visitors.

(K) Prospects of Recruitment.

(1) *At present 640 students are trained annually in Britain, whereas the aim should be 1,100.*

This is a national point but it may be mentioned that the situation is worsening, *e.g.*, only about 600 students were trained in each of the last four years.

(2) *The general woman-power shortage is not significant in relation to health visiting, since numbers required are tiny.*

This is a point for national consideration, but the shortage of health visitors is harming Aberdeen.

(3) *Health visitors must be recruited from trained nurses with a particular standard of intelligence and aptitude: of the 11,000 nurses who qualify annually, about 6,500 are needed for hospital replacement; and of the remaining 4,500, about half are fit to enter health visiting—i.e., there could be a pool of 2,200 for 1,100 places. Other recruits can come from Universities. There is therefore a good prospect of getting enough health visitors if a determined effort is made.*

This is a point for national determination, though it seems clear enough.

(4) *To stimulate recruitment we need better publicity for health visiting, directed to trained nurses; and also an approach to school leavers.*

The Corporation has produced a small brochure as its contribution.

(5) *Essentials for good recruitment include—*

(a) full range of work for health visitors;

(b) full measure of independence to health visitors;

(c) health visitors answerable to their own professional head;

(d) no constant detailed supervision;

(e) proper communication;

(f) adequate transport;

(g) relief from unnecessary duties—chaperonage, clerical work, &c.; and

(h) case-load small enough to enable work to be done with full professional satisfaction.

Aberdeen has fully achieved the first five of these points.

(L) Financial Incentives.

(1) *A strongly worded recommendation is for an immediate review of salaries.*

This is a point for national action.

(2) *Salary comparison of Health Visitor and ward sister is pointless, since duties differ.*

(3) *The type of woman required for health visiting is one who would go far in either nursing or social work.*

(4) *The salary scale of the ordinary Health Visitor should be attractive to nurses capable of being ward sisters and above.*

These are points for national action.

(5) *Salaries of Superintendents should be based on establishments, not on numbers of staff in post.*

This is a matter for national action.

(6) *Higher tutorial grades are roughly equated with Superintendents of large authorities, and there is merit in this parity.*

While this is a point for national consideration, it may be mentioned (1) that the statement is not true—a principal health visitor tutor is at present paid less than the superintendents of the largest, second largest, and even third largest population units; (2) that a large body of opinion favours paying tutors on the scales of advanced further education teachers, since the work is similar; and (3) that Health Visitors' organisations have themselves pointed out that tutors are underpaid in relation both to superintendents and to health visitors.

(7) *The Group Adviser and the Junior Tutor should have parity.*

While this is again a point for national consideration, it may be mentioned that it appears to be in conflict with the recommendation that the Group Adviser grade should be a step towards either tutoring or administration; and no woman is likely to work as a tutor if she could earn as much as a group adviser.

(8) *Health Visitors who take out students for practical work should be paid an allowance.*

Aberdeen proposed to pay such an allowance, was told by the Secretary of State that it would not rank for grant, and is seeking the views of the Association of the Counties of Cities.

7.—THE SHORTAGE OF HEALTH VISITORS.

Shortly after the close of 1957 a local newspaper gave publicity, quite legitimately, to complaints by mothers of pre-school children about receiving insufficient visits from their family health visitors: these mothers clearly felt that the physical and emotional health of their children was endangered by inadequacy of home visits by the professional workers responsible for health teaching and social advice.

About the same time, the Report on the School Health Service for 1956-57 revealed that, during that year, the health visitors paid home visits in respect of 5,873 school children and paid no visits in respect of the remaining 25,230 school children: in other words, they visited the homes of 19 school children out of every hundred.

During 1957 a Working Party on the Elderly, appointed by the North-Eastern Regional Hospital Board, followed the lead of the British Medical Association (which had described the elderly and the handicapped as two of the seven groups in which "the health visitor can play a most important part") and of the

Department of Health for Scotland (which had stressed the rôle of the health visitor in a circular on the welfare of old people as early as 1950). The Hospital Board Working Party said—

> "Adequate visiting by health visitors can do much to maintain the physical and mental health of many elderly people, and health visitors can also play an important part as social advisers and in initiating or co-ordinating social action. The Working Party endorses what has been said in many authoritative reports about the clamant need for adequate health visitor staffs."

During 1957, too, the British Council for Rehabilitation decided to hold a conference in Aberdeen early in 1958, presumably to direct attention to the needs of the physically handicapped.

While these evidences of inadequacy of health visitors for work in connection with pre-school children, school children, the elderly, and the handicapped, respectively, were appearing locally, a national committee—the Maternity Services Review Committee—was considering an allegation by the Guillebaud Committee on the Finance of the National Health Service that many expectant mothers were not receiving the health teaching to which they were entitled; the circular of the Department of Health for Scotland about the prevention of the break-up of families (with considerable stress on the rôle of the health visitor) had been followed by the Report of the Royal Commission on Mental Illness (with great emphasis on after-care of persons discharged from mental hospitals) and by a circular of the Department of Health for Scotland about the wellbeing of mentally handicapped persons; the Scottish Health Visitors' Association was organising a study day on the needs of the adolescent; and a Working Party, set up by the Minister of Health, the Minister of Education, and the Secretary of State for Scotland, had reported—in 1956—that Britain was each year training a grossly inadequate number of health visitors.

During the years of expanding staff and extending services, the vital statistics of Aberdeen (*e.g.*, infant death-rate) improved from year to year, but in 1956 there was a slight worsening following an increase in the degree of shortage of qualified professional staff, and in 1957 the shortage increased and the deterioration continued.

In view of these local and national indications that much valuable work is not being undertaken, it is desirable to consider the Aberdeen position in some detail, to make clear that blame cannot reasonably be attributed to the Corporation of Aberdeen or to the staff of Aberdeen Health and Welfare Department.

Tasks not carried out.

Some health functions are not being discharged at all, and others are not being undertaken fully. A few examples will illustrate—

(*a*) *Care and After-care in various physical illnesses.*

For nearly ten years every local health authority has had a statutory duty to make provision for home visiting by health visitors to give advice as to the care

of persons suffering from illness, and a power to make arrangements for the after-care of such persons. In a few areas the use of specialist health visitors for diabetic patients, persons suffering from duodenal and gastric ulcers, cardiac patients, and various other groups has materially reduced re-admissions to hospital: in other words, it has saved the community's purse as well as benefiting the individuals concerned.

In Aberdeen, as in many other areas, such services are as yet non-existent.

(*b*) *After-care in mental illnesses.*

While the National Health Service (Scotland) Act merely mentions "illness or mental deficiency," a circular of the Department of Health for Scotland has specifically indicated, in relation to the work of the health visitor, that "illness" includes "mental illness."

At the end of 1957 Aberdeen Corporation still provided no mental after-care.

(*c*) *Health and wellbeing of the elderly.*

Although Aberdeen has been described as "the pacemaker in local authority services for the elderly," a recent study of a five per cent. sample of elderly citizens showed that 20 per cent. were in need of visits by health visitors, but only 8 per cent. were actually receiving such visits. At the close of 1956 (when that study was begun), approximately 2,300 elderly people were receiving regular visits; but, if the sample is representative, over 5,000 old persons should in fact be having these visits.

(*d*) *Linking of home and school.*

In the school health service much stress is now placed on the health visitor's rôle as a link between home and school; but, in Aberdeen (as in many other areas), the link is somewhat weak: on average, a child's home is now being visited (in respect of that child) only twice during his school life.

(*e*) *Prevention of emotional and physical illness in pre-school children.*

For nearly ten years every local health authority has had a statutory duty to make provision for home visiting by health visitors to advise as to the care of young children.

During 1957 over 90 per cent. of all children aged 1-5 years were visited, but only 72,405 visits were paid to 14,403 such children, an average of 5·0 visits to each child.

(*f*) *Welfare of the handicapped.*

Under the National Assistance Act, 1948, a local authority has power to make arrangements for promoting the welfare of persons "who are substantially and permanently handicapped by illness, injury, or congenital deformity," and the power specifically includes provision for informing persons about available services and for instructing persons in their own homes in methods of overcoming the effects of their disabilities.

For this work, Aberdeen at present employs only two people—one health visitor and one social worker. If these two officers concentrate on 900 handicapped persons, they can give each of them merely four hours of advice, information, and instruction in a year.

(*g*) *Visitation of expectant mothers.*

The National Health Service Act is very specific here: *e.g.*, "It shall be the duty of every local health authority to make arrangements for the care . . . of expectant and nursing mothers and of children who . . . have not attained the age of five years"; "it shall be the duty of every local health authority to make provision for the visiting of . . . expectant or nursing mothers."

In Aberdeen such visits have been regarded as supremely important for the subsequent mental health of children, for instance, for the inculcation of right ideas and attitudes before the parents have developed faulty ones. Nevertheless, the figures for recent years are hardly satisfactory.

Year.	Total births.	No. of expectant mothers visited.	No. of visits.	No. of visits per person visited.
1954 . .	3,228	2,447	8,745	3·6
1955 . .	3,204	2,328	9.473	4·1
1956 . .	3,271	2,629	11,412	4·3
1957 . .	3,379	2,905	11,473	3·9

In other words, out of every eight expectant mothers, one has never been visited, and the other seven have each been visited only about four times.

From these seven examples, it is clear that some duties are not being undertaken at all, and that some duties are being undertaken only to a very limited and partial extent. It might therefore be imagined either that the Corporation has wilfully neglected its duties (colour being possibly lent to this suggestion by the fact that the total cost of health and welfare services per head of population is appreciably less in Aberdeen than in such cities as Dundee and Glasgow) or that the Medical Officer of Health (as chief officer of the Health and Welfare Department) has failed to inform the Corporation that various duties were not being carried out; in actual fact, however, as will be shown presently, either belief would be completely wrong. The blame must rest squarely, not on the Corporation or any of its officers, but on the national bodies—particularly the Nurses' and Midwives' Whitley Council—which have repeatedly failed to bring the remuneration, promotion avenues, and conditions of service of health visitors into proper relationship with those obtaining in other professions.

The Number of Health Visitors Required.

(*a*) *Optimum standards.*

At least four attempts have been made in recent years to indicate a standard of reasonable adequacy.

(1) Dr. Peters (Deputy Chief Medical Officer of the Department of Health for Scotland) calculated the requirements for a population unit of 10,000 as 4-6

health visitors. On this basis, Aberdeen would need between 75 and 112 health visitors, irrespective of welfare visiting.

(2) Professor Brockington, of Manchester University, reckoned that the number of health visitors required was about the same as the number of general practitioners. On this basis, Aberdeen would need about 85 health visitors.

(3) The Scottish Branch of the Society of Medical Officers of Health accepted, for a health department *simpliciter*, a standard of one health visitor for every 2,500 population. On this basis, Aberdeen would need 75 health visitors for health duties and an unspecified number for welfare duties.

(4) Dr. I. A. G. MacQueen, in a detailed calculation, first submitted to the Scottish Branch of the Society of Medical Officers of Health, and subsequently published in "Public Health," assessed the need at one health visitor for every 2,100 population. (This detailed calculation is specifically mentioned, firstly because it is more recent than the other three assessments, and, secondly, because the entire calculation was published—not just the conclusion—and no person has subsequently queried any portion of the reasoning.) On this basis, Aberdeen would require 89 health visitors.

(5) As early as 1942, the official view in the United States was that there should be one public health nurse for every 2,000 population. On this basis, Aberdeen would need about 94. Swedish standards are appreciably more generous.

(*b*) *Minimum standards.*

The Working Party on Health Visiting in 1956 tried to produce a minimum standard for health departments *simpliciter*, namely, one per 4,300 population. It is important, however, to note certain points:—

(1) The Working Party concluded its report before the Guillebaud Committee had recommended the amalgamation of health departments and welfare departments. The Working Party, although appreciating that the health visitor's main functions are health teaching and social advice, did not make allowance in their minimum standard for health visitors undertaking additional duties as welfare visitors in a combined health and welfare department.

(2) The Working Party postulated in its minimum standard that certain duties traditionally undertaken by health visitors (*e.g.*, work at clinics and chaperoning of medical officers during school medical inspections) would in future be undertaken by less highly trained staff. Quite apart from the desirability of this recommendation (which has had a somewhat mixed reception from the professional organisations concerned), it would clearly be impossible for a local authority to appoint clinic sisters (*i.e.*, trained nurses without the health visitor's qualification) for work at clinics as long as the Whitley Council specifies that almost the only way in which an experienced health visitor can secure a small responsibility element in her remuneration is by being appointed to work at a clinic for not less than seven sessions weekly: when recruitment to the profession is alarmingly low and when the Working Party has itself argued strongly both for a raising of salaries and for the creation of adequate promotion channels, it would

manifestly be suicidal for a local authority to remove virtually the only slight promotion avenue, at least until after new and more adequate promotion avenues have been created.

(3) The Working Party's minimum standard is again based on the hypothesis that adequate clerical help and transport facilities are provided.

(4) Several members of the Working Party have drawn attention publicly to the fact that the Working Party's standard (for health departments *simpliciter*) was simply a minimum standard that could obtain in the best areas, and that unfavourably placed areas might well need to go above the standard.

Aberdeen is, of course, unfavourably placed in a number of ways, *e.g.*—(*a*) the minimum standard was presumably based on the housing circumstances of the best placed areas in England; but housing problems are much more acute in Scotland than in England, and more acute in Aberdeen than in many Scottish counties and towns. (*b*) The minimum standard was presumably based on the best climatic conditions obtaining in the south of England; Aberdeen is the most northerly large city in the British Commonwealth. (*c*) Aberdeen has (as compared with, say, Bournemouth and Eastbourne) a relatively high proportion of pre-school and school children. (*d*) Social problems are perhaps more numerous in persons in low income groups, and Aberdeen has a relatively high proportion of its population in these groups. (*e*) Clearly a city containing a port and with an airport adjacent has problems that do not exist to the same extent in inland towns or counties remote from ports and airports. (*f*) Similarly, a city that has an enormous influx of summer visitors has again problems of its own.

(5) The Working Party's standard—even as a minimum for the most favourably placed areas—has been very sharply criticised by the profession concerned. For example, attention has been directed to the fact that the Working Party allowed for an average of one visit per expectant mother, whereas five visits would be a more reasonable average.

(*c*) *Application of these standards to Aberdeen.*

To apply the Working Party's standard to Aberdeen, a few simple calculations are necessary:—

(1) The birth-rate in Aberdeen has for some years been about 12 per cent. above that of England and Wales (on which the standard is presumably reckoned): *e.g.*, in 1956 it was 17·5 as compared with 15·7, and in 1955 it was 17·2 as compared with 15·0. If one assumes that three-quarters of the time of health visitors —in a health department without additional welfare functions—is devoted to children, one can compensate for the higher proportion of children by adding 9 per cent (*i.e.*, three-quarters of 12) to the number of health visitors required.

(2) About 20 per cent. of all Aberdeen families are on the housing list—broadly, 3,000 families in furnished rooms or with in-laws, 5,000 in unfit houses, and 3,000 in overcrowded but fit houses. If one assumes that these 20 per cent. require roughly double the normal amount of health visiting, one has to increase the minimum number of health visitors by 20 per cent.

(3) Since the Working Party does not specify the numbers of clinic sisters and other ancillary staff, it is reasonable to assume that it would imply the presence of a clinic sister at each main clinic and of an assistant with each school medical officer.

(4) An arbitrary allowance of 10 per cent. might be regarded as balancing the port and airport problems, the problems of summer visitors, and the climatic problems.

Hence the figure for health (including school health) duties would be—

	Health Visitors.	Clinic Sisters, &c.
Working Party minimum	44	12-13
Allowance for high proportion of children . .	4	—
Allowance for housing, &c.	9	—
Allowance for points in (4) above . . .	4	—
Allowance for adequate ante-natal visiting .	5	—
	66	12-13

For welfare duties in connection with the elderly, the handicapped, the problem families, and the persons rendered homeless by fire or flood, an allocation equal to one-seventh of the total health visiting staff would seem reasonable, *i.e.*, 9 health visitors (as welfare visitors) and 2 assistants.

Hence the Working Party standard as applied to the Aberdeen Health and Welfare Department would necessitate about 75 health visitors and about 14 or 15 assistants.

The needs of Aberdeen, allowing nine health visitors for welfare duties where these have not been included in the standard, would therefore be—

(1) Peters' standard—between 84 and 121.
(2) Brockington's standard—about 94.
(3) M.Os.H. standard—about 84.
(4) MacQueen's standard—about 89.
(5) Working Party standard (with appropriate adjustment)—about 75, plus 14 assistants.

(*d*) *The Corporation's establishment.*

In 1953 the Corporation increased its establishment from 65 to 75. In 1954 it further increased its establishment to 85, and it is worthy of note that the proposal for this increase was *approved unanimously* by the Health and Welfare Committee, and *approved unanimously* by the Town Council. Authority exists to-day to employ the full establishment.

Further, the Corporation has secured the sanction of the Secretary of State to an ultimate establishment of 100 health visitors. (In point of fact, the writer does not think that such an establishment will be required within the measurable future: the present establishment of 85 health visitors—including clinic superintendents—and 7 ancillary staff is probably just about adequate for current needs —if only the requisite number of appropriately qualified persons could be secured.)

It is therefore fair to say that the existing tremendous shortage of health visitors is in no way due to the Corporation or to any of its officers. The hard-headed citizens of Aberdeen have appreciated that prevention is cheaper—as well as pleasanter—than cure, and have signified their desire for an adequate health visiting staff by the unanimous voice of their elected representatives.

Indeed, Aberdeen has been an active protagonist of prevention for many years. Three quotations from widely separated points of time may be illustrative.

(1) In 1909, when health visiting was in its infancy, Professor Matthew Hay, Medical Officer of Health for Aberdeen, wrote—

> "The work of the health visitors among infants is greatly appreciated by mothers, and constitutes, in my opinion, one of the most valuable branches of the work of the Health Department. Like all educative work, especially among grown-ups, it must produce its effect slowly, but I entertain no doubt as to its great ultimate value, not merely in regard to the case of infants, but as concerns the whole sphere of domestic hygiene—a sphere in which the main part of future progress in public health must be looked for."

(2) In 1951, Dr. H. J. Rae, Medical Officer of Health, wrote—

> "It is an unfortunate fact that the functions and duties of health visitors are not fully understood or appreciated. It must be realised that, in dealing with members of the community, the curative and the preventive aspect must go forward side by side."

(3) After the last increases in the health visiting establishment, the Annual Report of the Medical Officer of Health for 1954 contained the following statement:—

> "*Financial Gain from Staff Increases.*
>
> It would be a profound mistake to imagine that the appointment of disease-preventing officers costs the community money in salaries without any corresponding financial gain. Three examples will perhaps illustrate the point.
>
> (1) A considerable amount of attention is now being devoted by the disease-preventing officers in Aberdeen to the health-care of the elderly—to trying to ensure that old people are enabled to live happily and healthily in their own homes for as long as possible, instead of having to be admitted to hospitals or residential institutions.
>
> Even if one ignores hospitals (as a charge on the taxpayer, not the ratepayer), the saving on residential hostels is startling. The official report on *the ageing population* assessed hostel needs at 2½ places per 100 old people, *i.e.*, roughly 500 places for Aberdeen. Because of the vigorous policy of maintaining the health of old people, the Aberdeen requirement of hostel places has been assessed at approximately 350 places (including places in "voluntary" hostels). In other words, the City's requirements are being planned on the assumption that improved health-care of the elderly is reducing by 150 places the total hostel accommodation needed.

To keep 150 old people in residential homes would cost slightly more than £30,000 a year, from which might be deducted approximately £10,000 that the hostel inmates would contribute towards their maintenance. Hence, development of services for the health-care of the aged is saving the City £20,000 a year—a sum considerably greater than the cost to the City of all the staff increases sanctioned.

(2) Since the prevention of accidents is still in its early stage, it is perhaps best not to give an estimated figure but to make a theoretical calculation. If a health visitor in the course of a whole year's work prevents only four serious accidents, the victims of which would otherwise have had to spend seven weeks each in hospital at a weekly cost of £15, the saving is £420 (or about the whole of the health visitor's initial annual salary), to say nothing of the saving of human suffering.

(3) To quote from a distinguished health visitor speaking at a conference on health education, "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." In this connection, it will be remembered that the Secretary of State for Scotland, in a recent circular about the prevention of broken homes, advised local health authorities to consider the appointment of specialist health visitors or social workers, and the possible expansion of their health-visiting service and their home-help service *as a matter of long-term economy.*"

The Corporation's Staff.

Year after year, the Corporation continues to have over twenty vacancies on its health visiting establishment: one post in every four remains unfilled.

Moreover, the situation worsened in 1956, and is further worsening in 1957 and 1958.

In session 1957-58, the Corporation has only four student health visitors in training for subsequent work in Aberdeen; and the following extract from a special report to the Health and Welfare Committee (dated 23rd January, 1958) reveals the losses:—

"In the last eleven months (March, 1957, to January, 1958, inclusive), the Corporation has lost one superintendent health visitor, one health visitor tutor, and thirteen health visitors—very nearly a quarter of the total health visiting staff.

It is important to note three points—

(1) As indicated below, the overwhelming majority of resignations have not been because of marriage, and none has been because of a person reaching the normal age of retirement.

(2) The majority of the people who left the Corporation's service were good health visitors with 3 or 4 years' experience—the very people who, in most other professions would be starting to look for possibilities of promotion.

(3) While the numerical shortage is very serious, the increasing qualitative shortage is equally alarming. If the Corporation each year takes on 9 or 10 newly qualified health visitors (except in 1958, when it has only 4 students in training) and each year loses a corresponding number of its best health visitors, then, inevitably, not only do the many vacancies on the establishment remain unfilled, but, in addition, the department comes to be staffed largely by inexperienced officers. This situation has, indeed, now arisen: the loss of 15 in the last eleven months is only slightly greater than the loss in 1956.

An analysis of the fifteen losses in the last eleven months is as follows:—

1 health visitor tutor (4 years' experience in Aberdeen) took a similar post abroad—at a salary of about 50 per cent. above that obtainable in a tutor's post in Britain.

1 health visitor (1 year's experience in Aberdeen) took a similar post abroad—at higher salary.

4 health visitors (3 years', 3 years', 4 years', and 4 years' experience, respectively) changed their occupations.

4 health visitors (2 years', 1 year's, 1½ years', and 4 years' experience, respectively) moved to counties—Surrey, Fife, and Aberdeenshire (2)—possibly attracted by car allowances or provision of houses.

1 superintendent health visitor (9 years' experience in Aberdeen) and 3 health visitors (2½, 3, and 11 years' experience, respectively) resigned on marriage.

1 health visitor (18 years' experience) resigned owing to home commitments.

In the last three years the Corporation has secured the services of 29 newly qualified health visitors. The present danger is therefore twofold—

(1) There are (on 23rd January, 1958) 22 vacancies in a total establishment of 85 health visitors and 5 senior ranks—approximately one post in every four is vacant.

(2) Following heavy losses of good health visitors of 2-4 years' experience in several successive years, the staff now has a disproportionate number of junior health visitors (approximately two-fifths of the staff have less than three years of health visiting experience) and a disproportionate number of "elderly" health visitors, with far too few active health visitors of 4-14 years' experience."

Aberdeen Efforts to Cope with Shortage.

The Corporation has tried to cope with the shortage by at least five separate measures.

(1) *Dilution with less highly trained staff.*—The appointment of clinic nurses (without the post-qualification training for the health visitor's certificate) and of certain clinic assistants has helped for a time to stem the tide. There is, however, a limit to the amount of dilution that is practicable. Further dilution would probably be contrary to the public interest: unqualified health teachers and social advisers are no more desirable than unqualified dental officers or unqualified school teachers. Moreover, excessive dilution naturally raises considerable resentment in the profession affected.

(2) *Decentralisation to reduce travelling time.*—The Corporation has, in the last three years, based a large number of health visitors on peripheral clinics. This policy has been useful, but has been carried as far as is at present practicable.

(3) *Development of group teaching on a very large scale.*—Although the teaching of groups can never wholly replace health teaching and social advice in the privacy of the home, group teaching is a most useful and financially economical measure. The Corporation has, in its Health Guidance Scheme, developed group teaching on a hitherto unprecedented scale: in 1957 no fewer than 1,144 talks were given to total audiences of 21,237.

Nevertheless, important though group teaching is, and successful though the Health Guidance Scheme has been, it is important to realise that the scheme was initially frustrated by the attitudes of the Department of Health for Scotland (or of the Whitley Council) and has so far been carried out only through the generosity of certain members of the health visiting staff. The Corporation decided in 1956 to pay five selected health visitors £75 per annum for group teaching, largely undertaken during evenings; but the Department of Health for Scotland declined to approve for grant purposes of anything in the nature of an overtime rate for health visitors or in the nature of a new grade not specifically designated by the Whitley Council. [It will be noted that, in other occupations, no parallel difficulty appears to exist: for example, the Corporation employs two medical officers who are paid on a non-Whitley scale (actually a scale intermediate between that for medical officer and for senior medical officer), the Corporation regularly pays school teachers additional money for taking evening classes; and the Corporation is at liberty to pay members of the clerical staff for overtime worked. The Nurses' and Midwives' Whitley Council seems to stand alone in its attitude.]

(4) *Attempts to improve recruitment.*—The Corporation has twice raised the maintenance allowance payable to trained nurses with the necessary midwifery qualification taking the further full-time training for the health visitor's certificate —in 1956 to £5 15s. weekly and in 1957 to £7 4s. weekly. The first increase was too small: the Corporation and its officers perhaps relied too much on the admittedly high reputation of the Aberdeen Health Visitor Training School, but the second increase has brought the maintenance allowance to a reasonable sum.

(5) *Attempts to improve promotion prospects.*—The Corporation was frustrated in its attempt to create an intermediate grade paid at £75 per annum above the basic grade. The Corporation, however, succeeded in creating eleven posts of clinic

superintendent, with £30 responsibility, although (as the Working Party on Health Visiting points out) a small allowance of £30 does not constitute a real promotion grade.

It is obvious, however, that these measures are not, by themselves, sufficient to attract recruits of adequate quality and in satisfactory numbers. The shortage remains and, indeed, is increasing.

Inviting Attention to the Situation.

Two instances may be cited.

(1) *In the Annual Report of the M.O.H. for 1955*, fourteen pages of the preface were devoted to the problem. Among points made were the following:—

1. *Impending Collapse of Preventive Services.*

The biggest single factor in reducing preventable deaths is a public health service adequate in both quantity and quality. There is a qualitative and a slight quantitative shortage of health medical officers, and a shortage of dental officers, but these shortages pale into relative insignificance when compared with the tremendous qualitative and quantitative shortage of health visitors and also of qualified tutors to train student health visitors. On the least generous of four modern assessments, Scotland requires ten health visitors for every six at present employed.

2. *Causes of shortage.*

Women's professions (*e.g.*, nursing and teaching) were formerly paid much less than men's professions (*e.g.*, law and architecture), but, as more professions opened their doors to women, the salaries of most women's professions began to rise, while nursing and social work lagged behind. The adoption of equal pay in such professions as medicine, dentistry, and teaching further substantially increased the salaries of women—to the extent that basic grade posts in these professions came to be paid as highly as the top-ranking posts in the purely female professions. Recruitment failed because of (*a*) inadequate basic grade salaries, (*b*) scanty promotion avenues, and (*c*) the extreme smallness of responsibility pay in such senior posts as existed.

3. *Basic grade salary comparisons.*

A health visitor (with nearly 5 years' professional training) is paid about £100 a year less than an assistant sanitary inspector with the meat certificate (with shorter training); her maximum used to be £82 below that of an ordinary graduate assistant teacher in Scotland, but is now (in 1956) £352 below that maximum; she gets less than half of the salary of an assistant dental officer; and, despite her three professional qualifications, she is paid less than a driving test examiner.

4. *Comparisons involving senior grades.*

An assistant health visitor tutor (after six years of professional training culminating in the stiffest examination in the entire field of nursing) is paid about £230 less than a teacher of carpentry at a trades college. A principal

health visitor tutor (at the very top of her branch of her profession) is paid about half the salary of a senior lecturer in a social science department (undertaking very similar work) and less than half the salary of the principal of a teachers' training college. A superintendent health visitor in charge of 45 health visitors gets about half the salary of a chief sanitary inspector in charge of 45 inspectors. A senior tutor and a top-ranking superintendent have trainings almost as long as a doctor and greater responsibilities than a basic grade medical officer, and yet receive many hundreds of pounds less.

5. *The key position of tutors.*

Tutors (essential if students are to be trained) are underpaid even in relation to administrators. The Scottish Health Visitors' Association, in an excellent memorandum, have claimed that "in many ways health visitor tutors are the key persons for the preventive service of the future" and that "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."

While advocating a material increase in basic grade salaries, a large increase in the salaries of superintendents, and the creation of a grade intermediate between the ordinary health visitor and the assistant superintendent and assistant tutor, the Association has maintained that tutors need even larger increases than superintendents. It adds—"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."

6. *Attitudes to shortage.*

Quotations from various newspapers reveal that the public is not unsympathetic to the claims of health visitors, that health administrators actively support these claims, and that our legislators are themselves aware of the dangerous quantitative and qualitative shortage of health visitors. Girls leaving secondary schools are particularly aware of the position, and are avoiding the profession.

7. *The types of increase needed.*

The kind of increase needed is from about £200 in the basic grade to £500 for a superintendent and £550 for a principal tutor; although even these increases would leave health visitors considerably behind various other professions.

8. *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.

(2) *In the Annual Report for 1956*, it was pointed out that "the qualitative and quantitative shortage of professional staff, especially of health visitors, continue"; during part of the year "the Corporation had actually fewer health visitors than at any time since the middle of 1954"; "the year's vital statistics were less good than in 1955 and in some cases less good than in 1954"; and that—

"The policy of the Aberdeen Health and Welfare Committee has paid dividends both in respect of improving health and in respect of keeping down expenditure. It is a supreme tragedy that national neglect of the disease-preventing services—and in particular national reluctance to specify salaries and conditions of service attractive enough to make another two per cent. of trained nurses willing to transfer from hospital to public health work—should be in process of rendering the Committee's policy ineffective."

The Report of Working Party on Health Visiting, 1956.

In 1956, the Working Party, set up by three Ministers concerned, said, *inter alia*—

(1) "We recommend most strongly that a review of salaries should now be made in the light of the pressing problem of recruitment. It should not wait on the implementation of our other recommendations." (Paragraph 408.)

(2) "We have noted the lack of attractive promotion prospects. We do not regard the posts carrying small responsibility allowances as a sufficiently attractive promotion for these purposes. . . . We should like to see recognised a senior grade, intermediate between the general duties staff and administrative appointments." . . . The grade "should be a step towards administrative and teaching posts." (Paragraphs 338 and 339.)

(3) "If health visitor training is to be fully effective, it is essential that adequate tutorial staffs should be provided. The work of the tutor calls for wide knowledge . . ." (Paragraph 368.)

Subsequent Developments.

(1) *Stimulation of the Department of Health for Scotland.*

About six months after the publication of the Working Party's report, the Corporation requested the Association of the Counties of Cities to remind the Secretary of State that consideration of that report was a matter of urgency.

It is now nearly two years since the report was published.

The position in regard to senior grades of staff at the beginning of 1958 can be indicated by the following comparisons:—

(*a*) Principal lecturer in handwork at a teachers' training college, £1,405-£1,605, plus up to an additional £215 for extra qualifications (an appropriate university degree or a higher national diploma to count as an extra qualification); principal health visitor tutor in charge of an H.V. training school, £746-£877.

(*b*) University lecturer (not senior grade), rising to £1,650; lecturer at teachers' training college, rising to £1,480; assistant H.V. tutor, rising to £789.

(*c*) Assistant dental officer in a local authority, maximum £1,575; deputy superintendent health visitor (in charge of forty officers of training comparable to that of a dental officer), maximum £740.

(2) *Stimulation of the Whitley Council.*

In the summer of 1957 (a year after the Working Party had pressed strongly for an immediate review of salaries) the salaries of basic grade health visitors was increased by a small amount—£80 at the maximum—and this increase was awarded not by the Whitley Council but by the Industrial Court. Subsequently, the Whitley Council did not even apply the same increase to the senior grades (despite the Working Party's advocacy of an "intermediate" grade which could not be fitted in unless the salaries of the lowest senior grade—*i.e.*, assistant superintendents and junior tutors—were first raised), but awarded to the top-ranking posts only the 5 per cent. cost-of-living increase that has been granted to members of many professions: so that the relative underpayment of superintendents and tutors remained as great as ever.

The effect of recent increases in a few occupation groups can be thus summarised:—

	Maximum salary at 1/1/56.	1/1/58.	Actual increase over two years.
Assistant S.I., without extra qualification	£577 10/-	£750	£172 10/-
Assistant S.I., with meat certificate . .	612 10/-	795	182 10/-
Local government officer, A.P.T. VI . .	815	935	120
Local government officer, A.P.T. IV . .	660	750	90
General division clerk (female) . . .	390	490	100
Health visitor	570	690	120
Assistant H.V. tutor	685	789	104
Principal H.V. tutor	785	877	92
Superintendent H.V. (100-149 staff) . .	790	882	92

In other words, despite the strong recommendation of the Working Party about salary increases and despite the fact that Britain is each year training just over one-half of the annual number of health visitors required, basic grade health visitors have had little more than the ordinary cost-of-living increase, and the top-ranking leaders have actually received smaller increases than members of other occupation groups. Moreover, by narrowing differentials that were already too small (*e.g.*, by giving an assistant tutor a maximum of only £99 above that of a health visitor), the Whitley Council has rendered more difficult the creation of the intermediate grade advocated by the Working Party.

In these circumstances, the Health and Welfare Committee, shortly after the close of 1957, passed the following resolution:—

> "That the Committee report to the Finance Committee that they are of opinion that the Town Clerk should be instructed (*a*) to invite the attention of the Management Side of the Nurses' and Midwives' Whitley Council to the after-mentioned paragraphs of the report of the Working Party on the recruitment and training of health visitors, viz., paragraphs 398 and 399 (which suggest as a target an increase from approximately 640 to 1,100 in the annual number of recruits to the health visiting service in Great Britain) and paragraphs 408 and 412 (which recommend a review of salary scales of health visitors and contain observations as to the introduction of the grade of group adviser); (*b*) to draw the attention of the said Management Side to the adverse effect upon the differential between the salary scales of senior and junior staff in the health visiting service which has resulted from an increase in the basic salary scale applicable to health visitors which was awarded by the Industrial Court subsequent to the publication of the said report and which has not been reflected by the Whitley Council into the salary scales of senior staff of the service; and (*c*) to request the Management Side to consider, as a matter of urgency, as to the advisability of an early review being undertaken, with due regard to the remuneration applicable to certain comparable posts in other ocupations, of the salary scales applicable to the said service and as to the introduction within the salary structure of the service of an appropriate intermediate grade."

Subsequently the Finance Committee concurred in the recommendation and the Town Council resolved accordingly.

Possible Future Developments.

Various courses are possible, for example—

(*a*) Even though both the Management Side and the Staff Side of the Whitley Council are in the main representative of hospital interests, they may, as a result of pressure, be induced to take drastic action in respect of the various grades of health visitor before recruitment, already in a desperate state, collapses completely.

(*b*) The Local Authority Associations, appreciating that the collapse of the preventive services through lack of the key field-workers will gravely damage the community in health and in pocket, may take the steps of requesting that responsibility for the salaries and conditions of service of health visitors and other domiciliary nurses be transferred from the Nurses' and Midwives' Council to the Joint Industrial Council, so that the A.P.T. scales will come to apply as in the case of other professional and technical officers of local authorities.

(*c*) The professional associations representing health visitors may request that, since the health visitor's main functions have been defined as health *teaching* and social advice, health visitors be transferred from the jurisdiction of the Nurses' and Midwives' Whitley Council and regarded as teachers.

(*d*) None of these steps may be taken, the preventive service may collapse completely, and the country may have to enlarge enormously its treatment services to cope with the mass of unprevented disease.

However, the purpose of this chapter is not to forecast the future, but merely to make it crystal clear that blame for the present unsatisfactory situation cannot legitimately be attributed to the Corporation or to its officers. Certainly various statutory duties are not being undertaken; certainly the infant death rate is increasing; but the Corporation is not at fault.

8.—TRAINING OF HEALTH VISITORS.

Some salient features of the year were as follows:—

(1) Continued Modernisation of Equipment of Training School.

If the health visitor is recognised as the general purpose family health teacher and the key social field worker in Health and Welfare Departments (and the list of authoritative reports affording such recognition to her is already lengthy), then it is important that her training should be in no respect inferior to that of architects, engineers, doctors, school teachers, and members of other professions. The Corporation, appreciating this, transferred the training school to more satisfactory premises in 1955, and modernisation of equipment and furnishings was begun in 1955-56 and completed in 1956-57.

(2) Extension of Duration of Training.

In the past the health visitor has been in an almost unique position in that she devoted four years of her life to "background training" (*i.e.*, nursing and midwifery), and subsequently, after some years of consolidating experience in hospital or domiciliary posts, only six or seven months to specialised education of her life-work. In most of the training schools in England and Wales the post-qualification

course for the Health Visitor's Certificate was extended during recent years to an academic year (or in some cases a shade longer); and in 1957 the three Scottish training schools came into line by increasing the course to an academic year. Since the general nursing syllabus has also been altered in such a way that the student receives some instruction in the rudiments of public health, psychology, and sociology during her years of nursing training, the health visitor of the future should have a double advantage: she should start her health visitor course with more awareness of the social and preventive aspects of disease than in the past, and she should benefit from the increased duration of the health visitor course.

(3) Continuation of Change of Emphasis.

With the increased time available it has been possible to place even more emphasis on the aims and techniques employed in teaching emotional and physical health, on the emotional and social needs of various age-groups (from baby to grandparent) and on the elements of case work. Every effort has been made to ensure that the course is geared to the problems and needs of to-day—not to the problems of the past—and that practice and theory are well integrated.

(4) Prizes.

In 1957 a fourth prize was available for the first time: the school now has four prizes—for all-round distinction, health teaching, family case-work, and public speaking, respectively.

(5) Examination Results.

All eighteen students in 1957 passed the national examination at the first attempt, Aberdeen being again the only training school to secure a hundred per cent. pass. The school has now reported this success for five years in succession.

(6) Maintenance Grants.

In 1957 the maintenance grant payable to students accepted on undertaking to work subsequently for Aberdeen Corporation was increased from £5 weekly to £5 15s. weekly. This allowance—much lower than the comparable allowances in various other schools—proved completely unattractive to trained nurses and midwives of the requisite calibre, and recruitment (unsatisfactory in almost all areas) collapsed catastrophically: in 1957-58 there are only 9 students, exactly half the number that trained in 1956-57 and considerably less than half the number in 1955-56 and 1954-55. Of these nine, four are under contract to work in Aberdeen, as compared with ten in 1956-57 and ten in 1955-56.

However, shortly after the close of 1957, the maintenance allowance was raised to £7 4s. weekly.

(7) Refresher Courses and Study Days.

No refresher course was held in 1957 because (*a*) the grave and increasing scarcity of health visitors made it impracticable to release them from ordinary

duties; (*b*) from June to November the health visitors were pre-occupied with the radiography campaign; (*c*) in the same period the tutors were heavily involved with the campaign; and (*d*) at the end of the year the junior tutor was in process of leaving for a post in Uganda.

However, various single session meetings were devoted to discussion of current problems and developments.

(8) Distinctions.

In 1957 there were some additions to the considerable list of distinctions gained by staff and recent students of the school. During the year Miss D. J. Lamont, Principal Health Visitor Tutor, was awarded the Royal Society of Health Prize for an essay on "The Advantages and Disadvantages of Amalgamation of Health and Welfare Departments," the award coming to Scotland for the first time; Miss M. M. Byrne, Assistant Health Visitor Tutor, visited Holland as holder of an N.A.P.T. Scholarship; Miss Lamont was appointed Chairman of the Health Visitor Tutors Group of the Royal College of Nursing (U.K., not Scotland) and served on a Working Party on the Elderly set up by the North-Eastern Regional Hospital Board; and Miss Byrne served as Hon. Treasurer of the Scottish Health Visitors' Association, being succeeded in that post at the end of the year by Miss M. Nairn, a former student of the School.

Origin and Growth of the Training School.

Before 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 aegis 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.

During 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 and study week-ends for health visitors on individual subjects were introduced.

In 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.

During 1953-56 the furnishings and equipment were gradually brought up to a standard of reasonable adequacy; and in 1957 the course of training was extended from seven months to one academic year, thus coming into line with the training in most schools in England and Wales.

Prizes and Prizewinners.

The Aberdeen Health Visitor Training School must, until 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. In 1957 a fourth prize, the Baillie Violet Roberton Memorial Prize became available through the generosity of the Western Division of the Scottish Health Visitors' Association.

The prize-giving ceremonies have now for three years been held at Balnagask House, the premises occupied by the School being too small for such a ceremony, and the prizes have been presented in the respective years by Dr. May D. Baird

(Chairman, Regional Hospital Board, and former Convener of Health and Welfare Committee), Rev. Professor J. M. Graham, C.B.E. (Convener, Health and Welfare Committee), and Miss M. C. Lamb (Education Officer, Royal College of Nursing).

The prize-winners in the three years were:—

1955—

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.

1956—

Corporation of Aberdeen Prize	Miss Rachel Simpson, R.G.N., Part I C.M.B.
Proxime Accessit	Miss Sheila E. Paterson, R.G.N., S.C.M.
Medical Officer's Prize for Case Work	Miss Malina Campbell, R.G.N., S.C.M., S.R.C.N., Q.N.
Tutors' Prize for Health Teaching	Miss Muriel Tocher, R.G.N., S.C.M., Q.N.

1957—

Corporation of Aberdeen Prize	Miss Ann F. Aitken, R.G.N., S.C.M., Q.I.D.N.S.
Proxime Accessit	Miss Rosalind Gatt, R.G.N., S.C.M., Q.I.D.N.S.
Medical Officer's Prize for Case Work	Miss Barbara J. MacLean, R.G.N., S.C.M., R.S.C.N.
Tutors' Prize for Health Teaching	Miss Rosalind Gatt, R.G.N., S.C.M., Q.I.D.N.S.
Violet Roberton Prize for Public Speaking	Miss Margaret W. Johnston, R.G.N., S.C.M., R.S.C.N.

9.—HOME NURSING.

During the year there was, for the second successive year, a slight increase in the number of visits paid by the day nursing service, and (again for the second successive year) a slight decrease in the numbers of patients reported as requiring 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, one other Councillor, and the Medical Officer of Health are members of the Committee of the District Nursing Association, and during the last four years the Superintendent Health Visitor 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 at present 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.

Type of Nursing.

Almost 65 per cent. of all visits are now paid to persons over the age of 65 years, and the percentage is rising year by year.

The day nursing service paid a total of 115,875 visits to 2,231 persons over 65 years and 2,542 persons under 65. (In the previous year 109,410 visits were paid to 2,163 persons over 65 and 2,413 persons under 65.)

The night nursing service paid a total of 2,860 visits to 237 patients over 65 years and 68 persons under 65. (By contrast, in 1956, 3,128 visits were paid to 266 persons over 65 and 71 persons under 65.)

Classification and proportions of main types of cases.

The number of patients visited during the year was 5,078, as compared with 4,913 in 1956, 5,205 in 1955, 4,920 in 1954, and 4,373 in 1953; and the total visits numbered 118,735, as compared with 112,538 in 1956, 111,638 in 1955, 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:—

Classifications and Proportions of Main Types of Cases in 1957.

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	Co... in 31s
Abdominal	307	478	785	6,929	4,530	11,459	470	315	600	71	32	
Accidents	50	105	155	1,153	1,938	3,091	82	73	108	14	7	
Amputations	10	4	14	334	119	453	8	6	7	1	2	
Anæmia	38	232	270	1042	4,630	5,672	117	153	118	14	15	
Cancer	105	160	265	3,087	5,203	8,290	126	139	48	29	143	
Cardiac	266	401	667	8,661	15,075	23,736	234	433	203	64	106	
Cerebral Hæm.	110	170	280	3,521	6,415	9,936	67	213	48	44	110	
Diabetes	13	82	95	2,109	15,022	17,131	27	68	23	8	7	
Gynæcological	—	68	68	—	603	603	52	16	60	2	3	
Miscellaneous	286	608	894	3,083	6,477	9,560	686	208	767	48	10	
Nervous	30	73	103	978	2,091	3,069	73	30	58	5	3	
Respiratory	346	450	796	3,662	4,261	7,923	531	265	672	47	37	
Rheumatism	10	84	94	371	4,134	4,505	36	58	33	15	5	
Senility	56	152	208	1,404	5,158	6,562	—	208	30	39	75	
Varicose Ulcers	15	64	79	264	3,621	3,885	33	46	45	5	—	
Total	1,642	3,131	4,773	36,598	79,277	115,875	2,542	2,231	2,820	406	555	

Staff.

The staff of the day nursing service totalled 36 full-time nurses at the end of the year (including the Superintendent and one assistant) and three part-time relief nurses. The night nursing staff are mentioned separately below.

Night Nursing Service.

The night nursing service (inaugurated early in 1952, and slightly extended and somewhat reorganised during 1953 in the light of the experience gained during the first year of operation) underwent little alteration during 1957. 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 1957 the staff employed on night work amounted to three trained nurses and two assistant nurses on a full-time basis and four trained nurses on a part-time basis. In all, 305 cases were attended during the year, and 2,860 visits were made.

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.	Private Nurse	Died	Continuing at 31st Dec.
minal . .	4	7	11	12	25	37	2	9	4	2	—	5	—
ia . .	1	2	3	8	3	11	—	3	—	1	—	2	—
r . .	44	38	82	431	604	1,035	37	45	5	3	—	70	4
ic . .	24	36	60	167	254	421	10	50	17	11	1	24	7
ral Hæm. .	19	41	60	52	337	389	9	51	10	11	—	30	9
llaneous .	3	8	11	4	32	36	—	11	3	1	—	5	2
us . .	1	4	5	5	62	67	2	3	2	1	—	1	1
ratory .	8	16	24	27	68	95	8	16	9	6	—	9	—
natism .	1	3	4	3	34	37	—	4	1	—	—	3	—
ty . .	12	33	45	171	561	732	—	45	10	11	—	22	2
Total . .	117	188	305	880	1,980	2,860	68	237	61	47	1	171	25

Training of District Nurses.

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

The Report of the Working Party on District Nurses—published just before the end of 1955—has recommended certain changes, including a reduction in the length of training of trained nurses taking the district nursing course, although the recommendation has not yet been implemented.

10.—DOMESTIC HELP SERVICE.

Salient features of the year were—

(1) a further increase in the number of elderly persons assisted by home helps, such increase being a feature that had been anticipated;

(2) an increase (for the fifth successive year) in the total number of households assisted;

(3) as an inevitable concomitant to (1) and (2), a rise in the number of domestic helps employed; and

(4) the introduction of refresher courses for domestic helps.

In view of the increasing demands for the services of domestic helps, a report was submitted to the Corporation recommending that authority be given for the

employment of 150 full-time helps or the equivalent number of part-time helps. The recommendation was approved, and towards the end of the year consideration was being given as to whether a further application should be made to the Corporation for an increase in the establishment. Approval of the Secretary of State has been obtained for an ultimate extension of the number to be employed to 200.

During the year three refresher courses for domestic helps were held. These courses, which were organised by the Principal Health Visitor Tutor and Senior Health Guidance Lecturer, were attended by 66 home helps. The speakers were all members of the Health and Welfare Department, and the courses were much appreciated by the persons who attended.

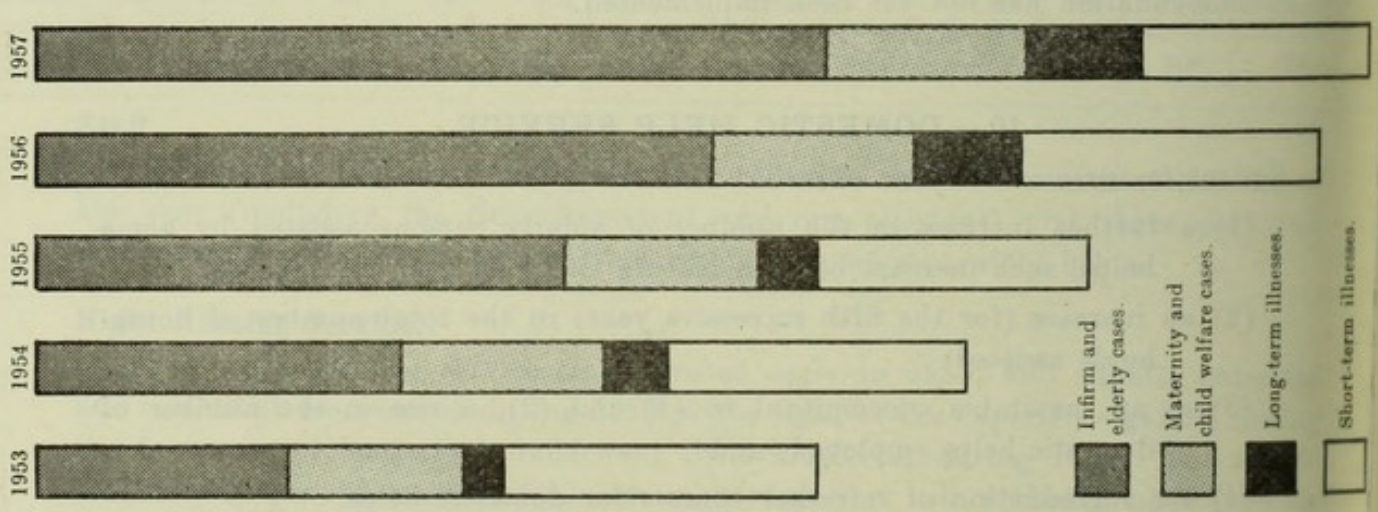
The following table shows the number of domestic helps in the service at December, 1957, as compared with the previous four years:—

	1957.	1956.	1955.	1954.	1953.
Whole-time . .	57	51	48	44	36
Part-time . .	175	148	132	97	52

The demand in Aberdeen is mainly for part-time service, especially in the mornings. The following statement shows the distribution of the cases attended during 1957 as compared with the previous four years, and the same information is given in diagrammatic form:—

	1957.	1956.	1955.	1954.	1953.
Total number of cases for which helps were provided .	1,561	1,494	1,214	1,070	899
(*a*) Maternity and Child Welfare cases . .	234	235	226	236	208
(*b*) Infirm and elderly cases (over 65) . . .	906	778	608	420	287
(*c*) Long-term illnesses (other than (*b*)) . .	136	128	71	75	53
(*d*) Short-term illnesses (other than (*a*) or (*b*)) .	285	353	309	339	351

CASES FOR WHICH HOME HELPS WERE PROVIDED, 1953-57.



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

11.—VACCINATION AND IMMUNISATION.

Since there have been no cases of smallpox in Aberdeen in the last two decades and no cases of diphtheria in the last two years, and since whooping cough is in process of becoming something of a rarity, the levels of immunity can be maintained only by increased efforts on the part of the public health staff. In 1957 the grave shortage of health visitors and the strain of the mass radiography campaign reacted unfavourably on vaccination and immunisation.

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

1. The proportion of babies receiving vaccination against smallpox fell very slightly to 72 per cent., as compared with 73 per cent. in 1956. Figures for previous years were 70 per cent. for 1955 and 71 per cent. for 1954.

2. The proportion of pre-school children immunised against diphtheria was 64 per cent., the same as in the previous year—the figures for consecutive years being 51 per cent. in 1952, 56 in 1953, 59 in 1954, 62 in 1955, and 64 per cent. in 1956. Hence, 1957 is the first recent year in which the proportion has failed to rise.

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), and the number receiving reinforcing injections was slightly less than in the previous year.

4. The number of babies inoculated against whooping cough was slightly less than in the previous year.

5. During the year the Health and Welfare Department continued to hold 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. As in other areas, vaccination against poliomyelitis was available to a limited extent for children aged 2-9 years.

7. In 1957, 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 proportions for the last three years are—

	1957.	1956.	1955.
General practitioners . . .	44%	43%	43%
Local authority staff . . .	56%	57%	57%

For primary immunisation against diphtheria the proportions are—

	1957.	1956.	1955.
General practitioners . . .	30%	30%	33%
Local authority staff . . .	70%	70%	67%

For inoculation against whooping cough the proportions are—

	1957.	1956.	1955.
General practitioners . . .	35%	36%	39%
Local authority staff . . .	65%	64%	61%

For reinforcing injections against diphtheria the figure for 1957 was similar to that in 1956, namely, 96 per cent. by local authority staff and 4 per cent. by general practitioners. In 1955, 95 per cent. of reinforcing injections were given by public health medical officers and 5 per cent. by general practitioners.

(1) VACCINATION AGAINST SMALLPOX.

Compulsion is perhaps an indication of national immaturity; as civilisation progresses, persuasion can frequently replace compulsion. Vaccination against smallpox is certainly as necessary as ever, or even 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 in 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.

In 1957, 2,532 primary vaccinations were performed, as compared with 2,738 in 1956, 2,493 in 1955, and 2,640 in 1954. Of these 2,532, 1,122 were notified by general practitioners and 1,410 were done at local authority clinics. The comparable figures for 1956 were 1,171 by general practitioners and 1,567 at clinics. The following table gives an analysis of primary vaccinations by year of birth and type of reaction, the totals for 1956 and 1955 being appended for purposes of comparison;—

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
1957	1,462	6	1	54	1,523
1956	759	3	1	47	810
1955	53	...	...	2	55
1954	24	...	...	1	25
1953	14	...	...	1	15
1952	11	...	...	...	11
1951	5	...	...	...	5
1950	2	...	...	...	2
1949	3	...	...	...	3
1948 or earlier . . .	83	...	...	...	83
Totals . . .	2,416	9	2	105	2,532
Totals for 1956 . . .	2,516	6	19	197	2,738
Totals for 1955 . . .	2,349	9	11	124	2,493

Before the abolition 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 1956, the proportion successfully vaccinated by the end of 1957 was 72 per cent. and from the table it would appear that this figure is likely to be maintained in the case of children born during 1957.

For propaganda purposes, reliance in Aberdeen has in recent years been placed almost exclusively on the influence of the family health visitor. (A recent study of vaccination in Scotland tends to show that this policy is wise, and that leaflets and posters are of relatively little value.)

(2) IMMUNISATION AGAINST DIPHTHERIA.

(a) Cases of Diphtheria.

No cases occurred in 1957. Aberdeen has now had only two cases in the last five years, both in persons who had never been immunised. There has been no fatal case of diphtheria in the City since 1950, when a non-immunised child died.

(b) Propaganda employed for Primary Immunisation.

As in the case of vaccination against smallpox, the health visitors during their home visiting make a strenuous effort to ensure as far as possible that all children

are immunised against diphtheria in their first year of life. While leaflets and posters may have their uses, it is felt that the personal approach by the health visitor is the thing of supreme value, and that all other measures of propaganda are merely supplementary and cannot replace individual persuasion in home and at clinic.

(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. 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 1957 are given in the accompanying tables. Figures for 1956, 1955, and 1954 are also provided for purposes of comparison.

DIPHTHERIA IMMUNISATION.

	Primary Immunisation				Reinforcing Dose			
	1957	1956	1955	1954	1957	1956	1955	1954
Number Immunised—								
(*a*) By General Practitioners	920	969	1,074	1,031	208	194	223	200
(*b*) At Child Welfare Clinics	1,715	1,719	1,573	1,639	229	242	201	166
(*c*) By School Health Service	483	577	613	630	4,264	4,617	4,205	3,614
	3,118	**3,265**	**3,260**	**3,300**	**4,701**	**5,053**	**4,629**	**3,980**

In other words, just under 30 per cent. of primary inoculations were carried out by general practitioners and 55 per cent. by doctors at child welfare clinics, while 15 per cent. of primary inoculations were undertaken at school (about four years late). The school health service also carried out over 90 per cent. of the reinforcing injections.

A more detailed breakdown of the immunisations performed during 1957 is given in the table on the next page.

Diphtheria Immunisation.

The following tabulated statement shows the number of children immunised each year since 1948:—

Age in years on 31st December of the corresponding year.	1948	1949	1950	1951	1952	1953	1954	1955	1956	1957	Total Immunised at 31st December, 1957.
Under 1 Year . . .	119	88	103	140	169	334	438	550	700	640	
1 Year	1,171	1,270	1,345	1,506	1,511	1,686	1,688	1,696	1,594	1,572	Aged under
2 Years	268	426	671	418	351	398	253	188	239	260	5 Years
3 ,, ...	87	138	216	116	115	193	128	76	69	74	10,082
4 ,, ...	64	50	106	79	72	130	85	63	43	40	
5 ,, ...	220	196	230	236	281	266	206	153	152	125	
6 ,, ...	382	428	438	427	563	575	355	340	305	292	
7 ,, ...	32	25	32	16	16	27	17	6	11	4	
8 ,, ...	22	9	15	13	6	10	6	7	8	6	Aged 5 Years
9 ,, ...	350	236	142	209	171	164	119	169	127	98	and over
10 ,, ...	7	4	3	4	3	4	1	4	4	2	22,054
11 ,, ...	9	2	4	3	2	3	...	1	7	4	
12 ,, ...	16	3	3	9	2	3	1	...	4	...	
13 ,, ...	1	1	...	2	...	...	1	...	1	1	
14 ,, ...	2	1	...	...	...	1	...	1	...	...	
15 Years and over . .	9	3	3	2	5	2	2	6	1	...	
Immunisations	2,759	2,880	3,311	3,180	3,267	3,796	3,300	3,260	3,265	3,118	**Grand Total—1948-1957** 32,136
Reinforcing Injections . .	2,998	2,855	3,189	3,210	3,941	4,184	3,980	4,629	5,053	4,701	38,740

(e) Percentage of Pre-School Children who were immunised against Diphtheria at end of 1957.

For five years the percentage of children aged 0-5 years recorded as being protected against diphtheria has risen steadily—from 51 in 1952 to 56 in 1953, 59 in 1954, 62 in 1955, and 64 in 1956. In 1957, the percentage has remained stationary at 64. This is not a satisfactory level. 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 a number of other areas.

(f) Percentage of School Children immunised against Diphtheria.

As mentioned in the section of this report dealing with school health services, 90·8 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 some 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 table gives the numbers immunised against whooping cough during 1955, 1956, and 1957:—

	1955.	1956.	1957.
By general practitioners .	1,016	978	917
At clinics	1,563	1,733	1,698
	2,579	2,711	2,615

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

The department continued to hold a research grant from the Advisory Council for Medical Research to pay in full for the cost of an investigation into the efficacy of combined immunisation against diphtheria, whooping cough, and tetanus. This investigation concerns children immunised in 1954 and 1955: one group received three injections of a combined diphtheria, whooping cough, and tetanus prophylactic; the other group received three injections of whooping cough prophylactic, followed by two injections of a diphtheria-tetanus prophylactic, making five injections in all. These injections were given by arrangement with (and by the consent of) the parents, who responded very well to the invitation to take part.

Each child taking part in the survey has been visited monthly for two years from the date of immunisation, with the intention of identifying and recording the occurrence of cases of whooping cough, and of contact with whooping cough, within the two groups.

This has now been completed, and the information gleaned will be put together with information from a similar survey in Edinburgh and analysed statistically to identify differences between the two groups.

The results will not be fully known until the end of 1958.

(5) COMBINED IMMUNISATION AGAINST DIPHTHERIA, WHOOPING COUGH, AND TETANUS—ROUTINE PROCEDURE.

It was decided in 1956 that combined immunisation against diphtheria, whooping cough, and tetanus become a routine procedure at welfare centres from 1st January, 1957.

This reduces the number of injections required for protection against these diseases from a possible of eight to three.

After twelve months the absence of unpleasant reactions has fully corroborated the safety of such combined immunisation.

(6) VACCINATION AGAINST POLIOMYELITIS.

As in 1956, the Department of Health for Scotland continued to make available poliomyelitis vaccine for children aged 2-9 years, but supplies were very short throughout the year. The actual number of children protected during 1957 was 2,808. General practitioners gave inoculations to 383 of these children.

(7) 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 also undertaken 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, 1956, and 1957, 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.

(8) 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 undertaken at the City Hospital.

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

Under this heading, during the year, the activities of the Health and Welfare Department took forms more clearly visible than usual.

The mass miniature radiography campaign made it abundantly clear that health is no longer solely a matter of a health department having a care for the environment of the individual or a personal matter between the individual and his physician, but calls for the active co-operation of the community. The outstanding success of the campaign is a shining example of what a health and welfare department can achieve given the necessary public co-operation.

Encouraged by such wholehearted public support, the department began to make plans which should lead to a big improvement in the environment of the citizens of the city, again given the necessary public co-operation. For some time it had been apparent that the atmosphere of the city was becoming polluted with smoke to an extent which called for study. Plans were made for submission to the Health and Welfare Committee, which, on being approved, will enable the department to carry out a thorough investigation of the situation. The solving of this problem should lead to improvement in community health and well-being, to a great saving in housewifely effort, and to a considerable saving in money for householders and ratepayers.

By the end of the year the continued efforts to find suitable accommodation for an occupation centre for the mentally handicapped looked like being crowned with success. Premises were found which offered scope for the development of a scheme, but legal difficulties prevented a start being made before the end of the year. However, the prospects seemed bright enough to warrant sending the Deputy Medical Officer of Health and the City Architect on a fact-finding visit to centres in Scotland and England where work of a somewhat similar nature was being undertaken.

At the end of the year measures were being devised (despite shortage of staff) to enable the Corporation to undertake duties in respect of visiting in their homes persons discharged from mental hospitals.

Since it had been felt for some time that more precise and early investigation of hearing defect would lead to prevention or minimising of handicap, a scheme was prepared, in consultation with Regional Board E.N.T. consultants, for presentation to the Corporation. As a result, suitable premises were acquired, and conversion of the building was well advanced by the end of the year.

The health guidance project, the biggest feature of the year, is discussed in a separate portion of the report.

The year 1957 closed with hopeful signs of an even better service to the public,

(A) TUBERCULOSIS.

(a) General Outline.

While it is the duty of the Regional Hospital Board to provide institutional care and appropriate medical and nursing services, all the functions relating to prevention, care, and after-care are entrusted by statute to the local health authority. Some of these functions may be thus summarised:—

(i) *Contact tracing and follow-up.* A patient may be notified by a general practitioner or (more usually) 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 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.

(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. He is thus in a very strong position to make a sound decision about the relative needs of different patients for admission.

(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, to allow segregation of the infectious case. It should, however, be appreciated that, with about 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, and, by no means least, advice about purchasing and budgeting.

(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.

(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 108. Co-operation is assured, since the Honorary Secretary, one of the three 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, 888 contacts were examined. The number of contacts who, during the year, were clinically examined, skin tested, and found to have tuberculosis was 26. The comparable figures for 1956 were 1,380 and 17.

(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, 1957.

Return for Period 1st January, 1957, to 31st December, 1957.

GROUP	Tuberculin Tested		Negative Re-actors		Vaccinated during 1957	
	M.	F.	M.	F.	M.	F.
(1) Nurses	39	209	8	60	6	60
(2) Medical Students	45	12	25	6	8	2
(3) Contacts	236	224	201	196	190	191
(4) Special Groups:—						
(a) School leavers	1,178	1,148	640	611	623	590
(b) New born babies	—	—	—	—	84	81
(5) Others	4	41	3	8	3	6

(e) 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, 345 patients received milk free of charge at a cost to the Corporation of approximately £3,245.

(f) Notification.

As a result of the mass miniature radiography campaign, the number of notifications shows an increase over the number notified in 1956. The notifications for 1957 cannot, therefore, be regarded as normal or typical.

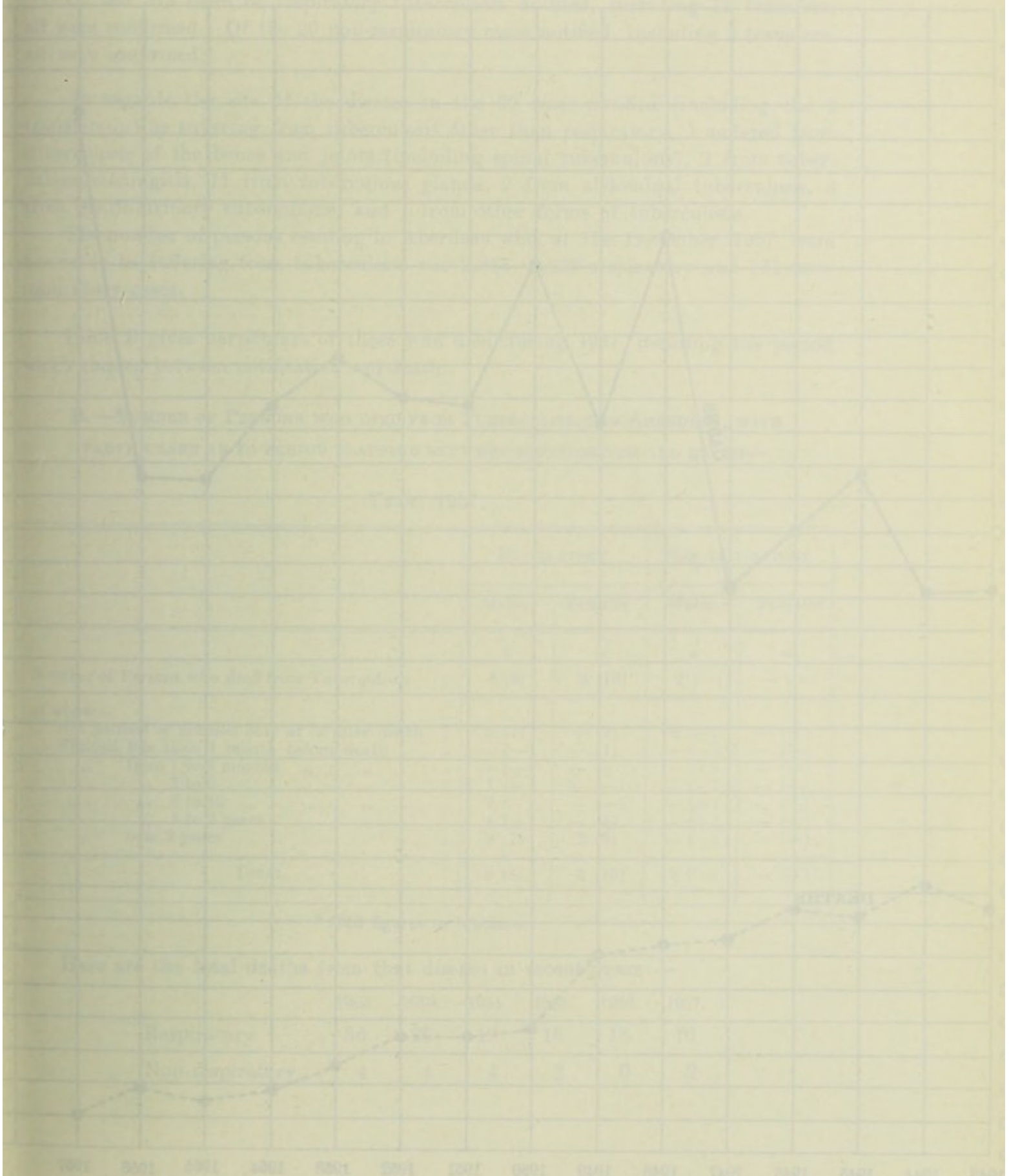
Table A, below, gives the number of tuberculous cases notified during 1957 and, for comparative purposes, the figures for 1956 and 1955 are also given. These are divided into respiratory and non-respiratory and arranged according to age-period and sex.

(g) Tuberculosis Care Committee.

This committee, a voluntary body set up in 1955, continued throughout the year to ease the load which tuberculosis throws on the sufferers and their families. This service is much appreciated.

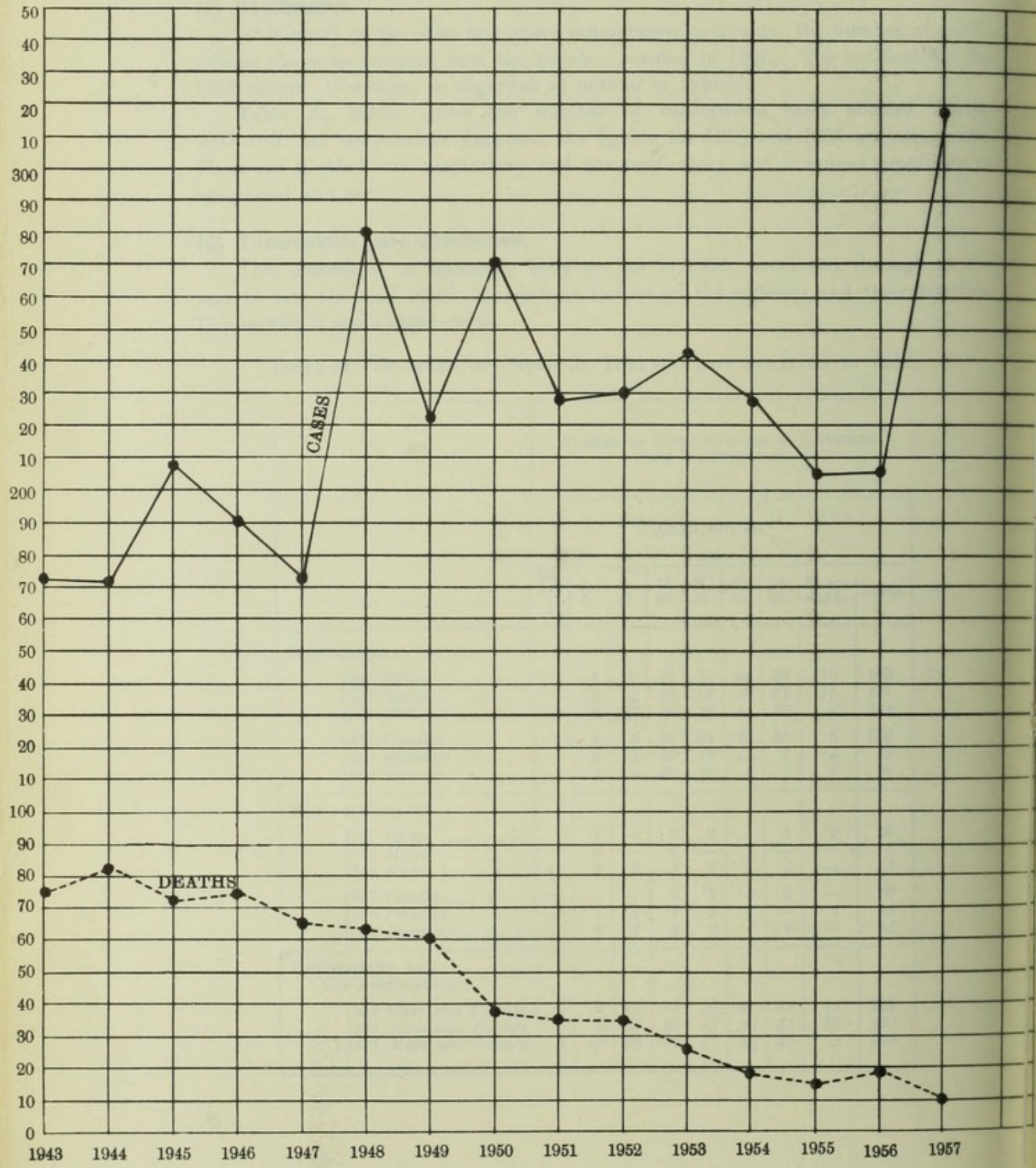
TABLE A.—NUMBER OF CASES OF TUBERCULOSIS NOTIFIED IN 1957.

	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.									
1957 Males	—	4	3	15	31	34	58	15	**160**
1956 Males	*1*	*4*	*4*	*34*	*23*	*19*	*24*	*17*	*126*
1955 Males	*2*	*3*	*12*	*26*	*16*	*14*	*29*	*6*	*108*
1957 Females	1	4	8	37	34	23	31	8	**146**
1956 Females	—	*2*	*4*	*23*	*28*	*11*	*7*	*4*	*79*
1955 Females	*1*	*3*	*9*	*38*	*27*	*8*	*7*	*3*	*96*
NON-RESPIRATORY.									
1957 Males	1	1	—	2	2	1	1	2	**10**
1956 Males	—	*2*	—	*2*	—	*1*	—	—	*5*
1955 Males	—	*2*	*3*	*1*	*2*	*1*	*2*	—	*11*
1957 Females	—	—	—	2	3	3	2	—	**10**
1956 Females	—	*1*	*2*	*3*	*2*	*1*	—	*1*	*10*
1955 Females	—	*2*	*2*	*4*	*2*	*1*	*2*	—	*15*
RESPIRATORY AND NON RESPIRATORY.									
1957 Male and Female	2	9	11	56	70	61	92	25	**326**
1956 Male and Female	*1*	*9*	*10*	*62*	*53*	*32*	*51*	*22*	*220*
1955 Male and Female	*3*	*10*	*26*	*69*	*47*	*24*	*40*	*9*	*228*



City of Aberdeen.

Cases and Deaths from Respiratory Tuberculosis, 1943-1957.



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

Of the 318 cases of respiratory tuberculosis notified, including 12 transfers, all were confirmed. Of the 20 non-respiratory cases notified, including 2 transfers, all were confirmed.

As regards the site of the disease in the 20 cases notified (including the 2 transfers-in) as suffering from tuberculosis other than respiratory, 1 suffered from tuberculosis of the bones and joints (including spinal tuberculosis), 2 from tuberculous meningitis, 11 from tuberculous glands, 2 from abdominal tuberculosis, 3 from genito-urinary tuberculosis, and 1 from other forms of tuberculosis.

The number of persons residing in Aberdeen who, at 31st December, 1957, were known to be suffering from tuberculosis was 2,366, 2,235 respiratory and 131 non-respiratory cases.

Table B gives particulars of those who died during 1957, detailing the period which elapsed between notification and death.

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

Year, 1957.

	Respiratory.		Non-respiratory.	
	Males.	Females.	Males.	Females.
	*	*	*	*
Number of Persons who died from Tuberculosis .	8 (8)	2 (10)	2 (—)	— (—)
of whom—				
Not notified or notified only at or after death .	2 (1)	— (2)	2 (—)	— (—)
Notified less than 1 month before death . .	— (—)	— (1)	— (—)	— (—)
,, from 1 to 3 months ,, ,, . .	— (—)	— (—)	— (—)	— (—)
,, ,, 3 to 6 ,, ,, ,, . .	1 (—)	— (—)	— (—)	— (—)
,, ,, 6 to 12 ,, ,, ,, . .	1 (—)	— (—)	— (—)	— (—)
,, ,, 1 to 2 years ,, ,, . .	4 (—)	— (1)	— (—)	— (—)
,, over 2 years	8 (7)	2 (6)	— (—)	— (—)
Total	8 (8)	2 (10)	2 (—)	— (—)

* 1956 figures in brackets.

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

	1952.	1953.	1954.	1955.	1956.	1957.
Respiratory .	36	26	19	15	18	10
Non-respiratory .	4	4	4	2	0	2

The death-rates per 1,000 of population from tuberculosis in Scotland and in the four large cities for the years 1957, 1956, and 1955 are given in the following table:—

	1957			1956			1955		
	Total	Resp.	Other	Total	Resp.	Other	Total	Resp.	Other
All Scotland .	0·14	0·13	0·01	0·16	0·14	0·02	0·19	0·17	0·02
Glasgow . .	0·26	0·24	0·02	0·42	0·38	0·04	0·36	0·33	0·03
Edinburgh .	0·08	0·07	0·01	0·11	0·09	0·02	0·12	0·10	0·02
Dundee .	0·11	0·09	0·01	0·17	0·14	0·03	0·18	0·15	0·03
Aberdeen .	0·06	0·05	0·01	0·10	0·10	0·00	0·09	0·08	0·01

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

(B) MASS RADIOGRAPHY CAMPAIGN AGAINST TUBERCULOSIS.

The incidence of respiratory tuberculosis has declined sharply in Aberdeen in recent years: *e.g.*, 270 cases were notified in 1950, 243 in 1953, 228 in 1954, 204 in 1955, 205 in 1956, and 318 in 1957. Nevertheless, when the Department of Health for Scotland offered to make available seven radiography units for the period from 28th October to 30th November, the Corporation gladly undertook the organisation of an intensive X-ray survey.

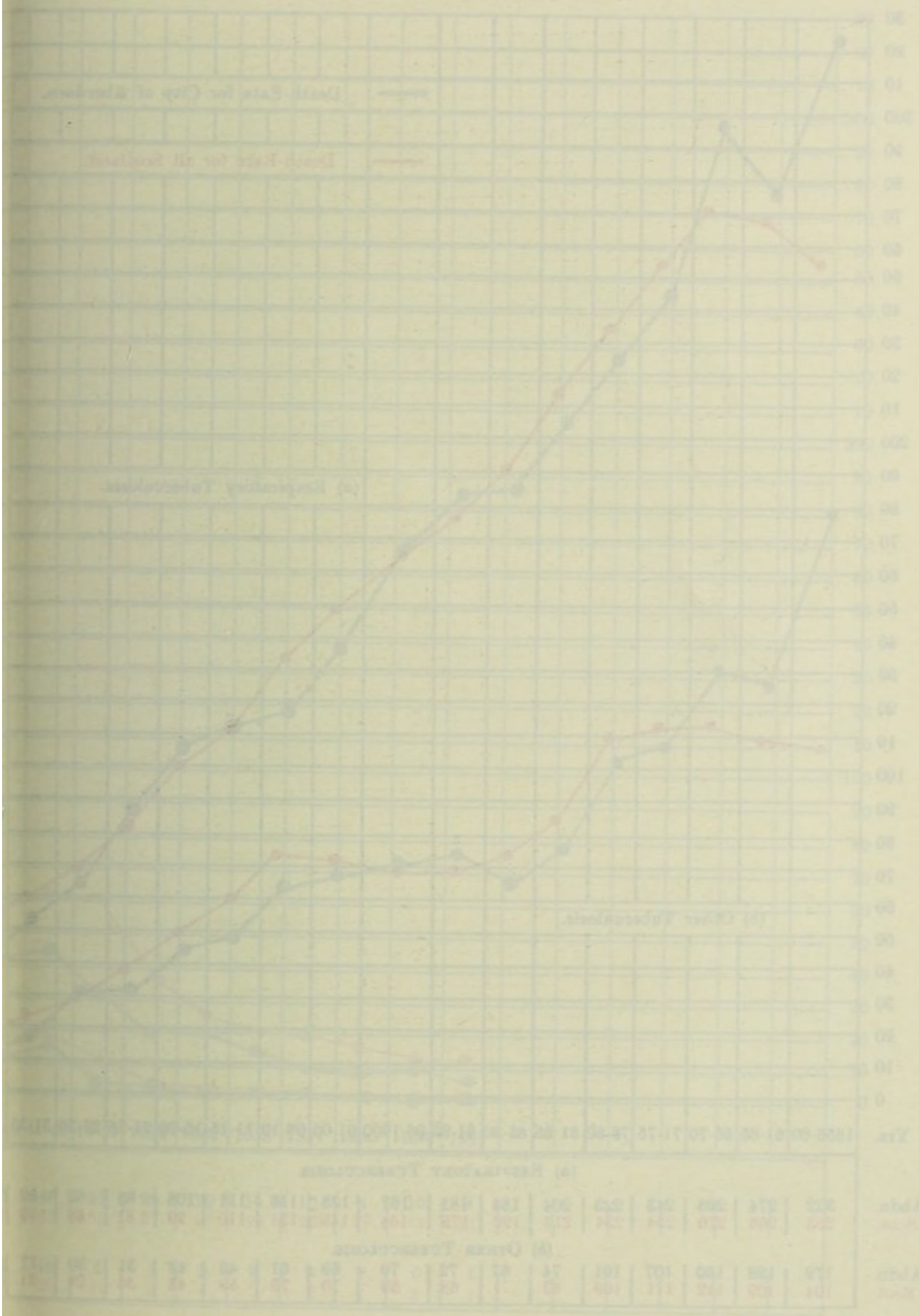
A detailed report on the campaign was submitted to the Health and Welfare Committee in December, 1957, and it may be sufficient to append here a brief article by the writer of this Report. The article appeared in "The Medical Officer" of 7th March, 1958, and is here reprinted by kind permission of the editor of that journal.

Some Features of Aberdeen's X-ray Campaign.

When the Aberdeen radiography campaign ended on 30th November, 1957, 78·6 per cent. of the eligible adult population had been examined, the highest figure yet attained in any short-term campaign in Britain. The numerical success is especially interesting because of (*a*) certain local factors which might have been expected to have adverse effects, and (*b*) some special features—notably primary reliance on household visiting by health visitors, supplemented by vigorous publicity work, and no recruitment of volunteers except at a late stage and for limited functions.

Local Factors.

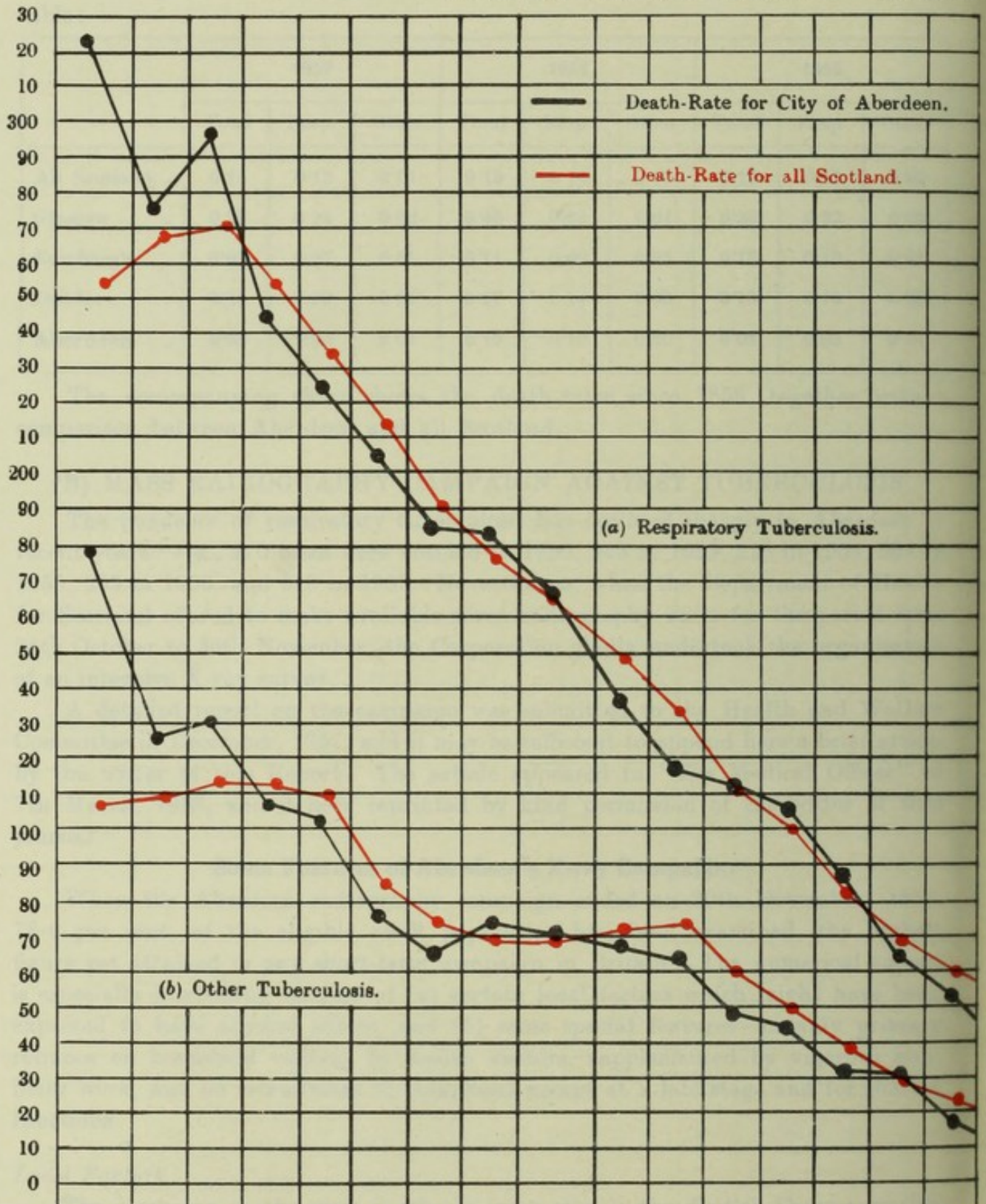
The campaign in the most northerly large city in the British Commonwealth was conducted in unusually inclement weather and was perhaps rendered more difficult by the fact that Aberdeen already had an incidence of tuberculosis lower



TUBERCULOSIS, 1856-1957—

ALL AGES

Deaths per 100,000 of Population. (Civilian

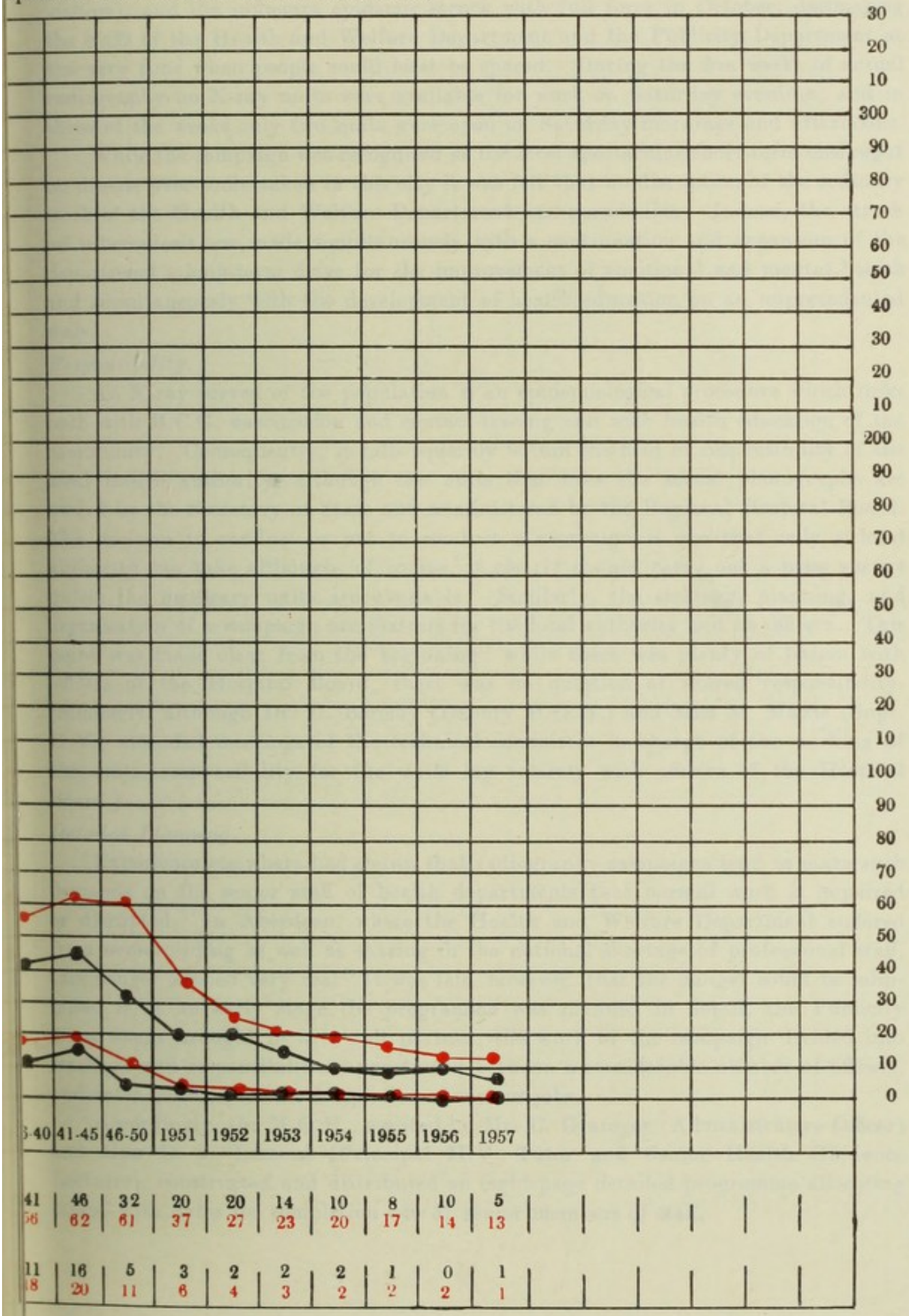


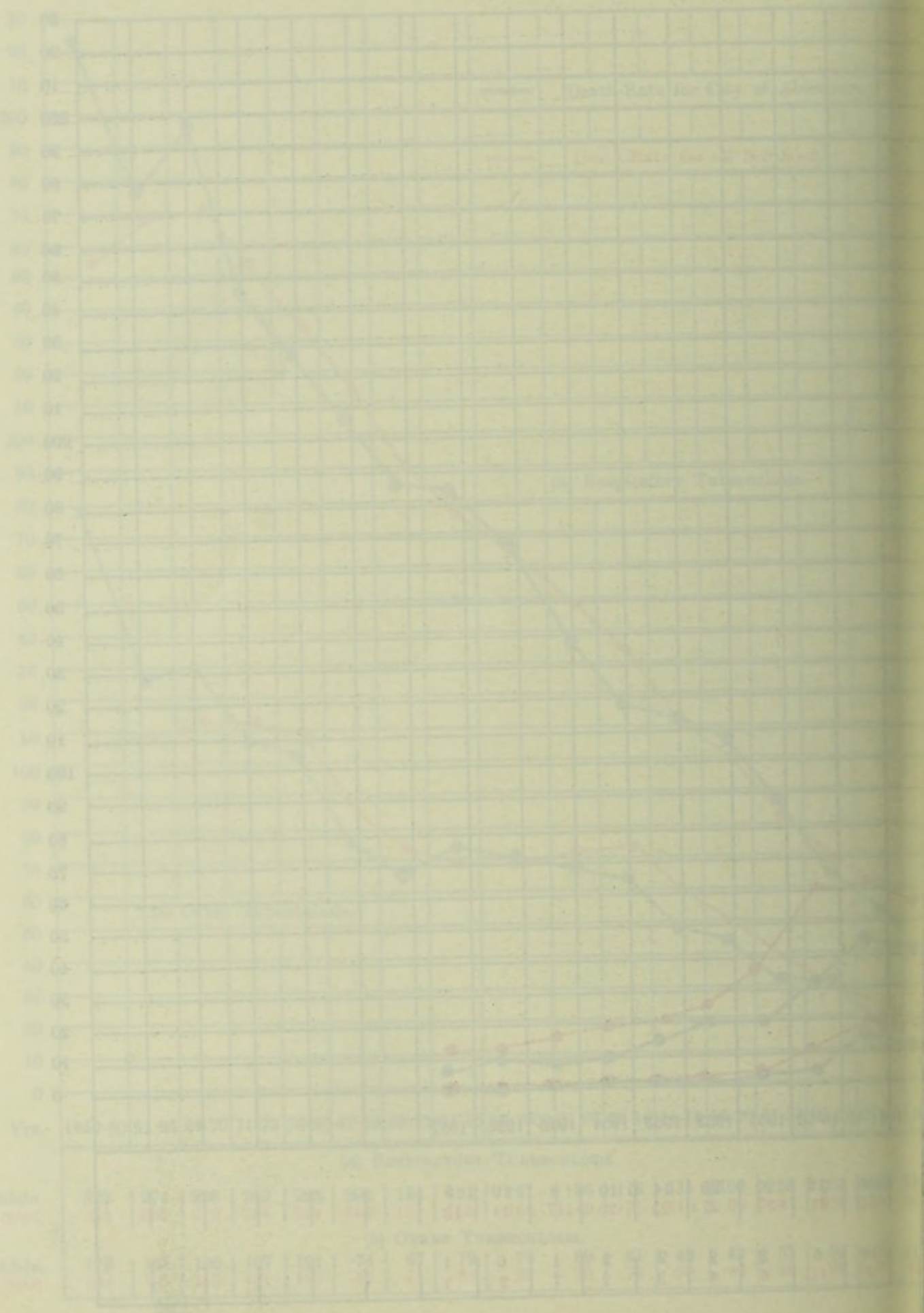
Yrs.	1856-60	61-65	66-70	71-75	76-80	81-85	86-90	91-95	96-1900	01-05	06-10	11-15	16-20	21-25	26-30	31-35
(a) RESPIRATORY TUBERCULOSIS.																
Abdn.	322	274	298	243	223	204	184	181	167	138	116	111	106	88	62	52
All Scot.	253	266	270	254	234	213	190	175	166	148	131	110	99	81	68	59
(b) OTHER TUBERCULOSIS.																
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

-Quinquennial Averages to 1950.

oth Sexes.

opulation and Civilian Deaths 1940-1946.)





than any other Scottish city. There were serious staff shortages (especially of health visitors), and the influenza epidemic struck with full force in October, decimating the staffs of the Health and Welfare Department and the Publicity Department at the very time when people could least be spared. During the five weeks of actual radiography no X-ray units were available for work on Saturday evenings, and in three of the weeks only two units were open on Saturday mornings and afternoons.

While the campaign was recognised as the most spectacular short-term onslaught on disease ever undertaken in this city it was felt that no disruption of the ordinary work of the Health and Welfare Department was permissible. Indeed, the attack on tuberculosis was made simultaneously with a continuation and expansion of the department's long-term drive for the improvement of emotional and mental health and simultaneously with the development of health education on an unprecedented scale.

Responsibility.

An X-ray survey of the population is an epidemiological procedure which links both with B.C.G. vaccination and contact-tracing and with health education of the community. Consequently, it falls squarely within the field of responsibility of the local health authority, although the units that take the actual photographs are owned by the Secretary of State and administered by the Regional Hospital Board. The decision to conduct or not to conduct a campaign is one that only a local authority can take although, of course, it clearly cannot carry out a mass survey unless the necessary units are available. Similarly, the strategy, planning, and organisation of a campaign are matters for the local authority and its officers. This point was made clear from the beginning: while there was plenty of liaison with officers of the Hospital Board, there was no question of shared responsibility. (Similarly, although Dr. D. Barclay (Deputy M.O.H.) and Miss M. Macfie (Supt. H.V.) attended meetings of the technical committee in charge of the working of the units, responsibility for the units lay entirely with officers of the Hospital Board.)

Detailed Planning.

Experience elsewhere had shown that radiography campaigns tend to make such demands on the senior staff of health departments that normal work is impaired or disrupted. In Aberdeen, where the Health and Welfare Department suffered from overcrowding as well as sharing in the national shortage of professional staff, this danger seemed very real. It was felt, however, that the danger could be minimised if at an early stage the programme was planned in detail, the Publicity Department brought in as a full partner, the work of the campaign divided into fractions and responsibilities apportioned between a considerable number of officers, and dates specified for the completion of various jobs.

Accordingly, the M.O.H., assisted by Mr. C. Grainger (Administrative Officer) and Miss D. J. Lamont (Principal H.V. Tutor and Senior Health Guidance Lecturer), constructed and distributed an eight-page detailed programme allocating tasks—with dates for completion—to 37 senior members of staff.

Briefing the Staff.

Since visits to every household by health visitors and talks to preformed audiences by members of the medical and health visiting staff were to form the backbone of the campaign, it was clearly necessary to "gear up" the professional staff. In this connection it had to be borne in mind that, although medical officers and health visitors had learned much about tuberculosis in their medical and nursing training, and about the prevention of the disease in their post-qualification training, many of them had little recent experience in the tuberculosis field.

A 12-page booklet was therefore compiled, largely by the Senior Health Guidance Lecturer, printed, and issued to medical officers, health visitors, and sanitary inspectors. The booklet discussed:—

(1) the extent of tuberculosis in Aberdeen, including details of notifications and deaths in recent years;
(2) ordinary methods of controlling the disease, including paragraphs on contact-tracing, improvement of social conditions, health education and social advice, and specific protection with B.C.G.;
(3) the need for a special campaign;
(4) desiderata for the campaign;
(5) the aim of the campaign;
(6) the method of the campaign;
(7) reasons why an apparently healthy person should attend for examination; and
(8) some miscellaneous points about tuberculosis, including brief references to recent advances in treatment, provisions for after-care, and financial allowances.

The booklet served a dual purpose: it provided a short "refresher course" for members of the staff who had to some extent lost contact with tuberculosis; and it formed a ground work for the many talks later given to various audiences, as well as for the information conveyed by health visitors to 57,000 households.

Visiting of Households.

The reasons for the decision to rely on health visitors for dissemination of information, and not to use volunteers for this purpose, were—

(1) other campaigns in Scotland had relied on volunteers, but only one of these was regarded as an outstanding success;
(2) the low incidence of tuberculosis in Aberdeen and the climatically difficult season made it seem unlikely that a campaign based mainly on volunteers would succeed;
(3) in some areas it had been suggested that the use of volunteers to spread information had impaired the relations between health department and community, since, when members of the public had sought information beyond the knowledge of a volunteer, some volunteers had, on the impulse of the moment, given faulty advice which had later been attributed to the health department;

(4) Aberdeen was in the fortunate situation of having a fully combined Health and Welfare Department, with its health visitors already undertaking work in the fields of school health, the health of the elderly, social welfare, &c., so that there existed in Aberdeen (to a greater extent than in many areas) family health visitors whose influence on their districts should be considerable; and

(5) the tremendous success of the Corporation's Health Guidance Scheme was a factor which could not be ignored.

The health visitors, supplemented by a few specially appointed nurses, tackled with tremendous enthusiasm the enormous task of visiting every household in the City. By 10th October they had completed the job, involving nearly 57,000 initial visits, and some 25,000 revisits to houses found empty at the first visit. In all, the health visitors devoted fully 20,000 hours to this primary visiting of households, and they completed their assignments by generously devoting many evenings to unpaid overtime work.

As a result of their visits the health visitors were able to state that about three out of every four adults proposed to attend for examination, and the target figure for the campaign was fixed at 100,000 or approximately 75 per cent. of all adults in the City, other than those who had already been examined during 1957.

Supplementary Measures.

At an early stage letters were sent to clergymen, general practitioners, district nurses, pharmacists, and head teachers of secondary schools, seeking co-operation and goodwill. About a fortnight before the radiography began, individual letters were sent to every householder.

To supplement visits by health visitors and letters sent to householders, talks were offered to virtually every organisation in Aberdeen. For obvious reasons most of the talks had to be given in the last fortnight of October, and at one period the demand—presumably stimulated by the health visitors' preliminary visits—threatened to overwhelm the Health and Welfare staff. In all 133 meetings were addressed. Incidentally, these meetings proved a fruitful source of volunteers for staffing units and for other appropriate tasks.

Local Organisation.

For organisational purposes the City was divided into seven areas, based on main clinics. Four medical officers and ten health visitors were appointed as local organisers, two to each area—a precaution which proved useful when the influenza epidemic arrived. Among other duties local organisers had to recruit and brief volunteers to a total number of 800 for the City. The volunteers were employed (*a*) as receptionists and marshals at X-ray units; (*b*) for card-collecting (see below); and (*c*) for distribution of posters.

Revisiting of Houses.

The individual letters issued to households (after the preliminary visiting by health visitors) contained cards with spaces for the number of persons over 14 years

of age in the household and the number proposing to attend for examination. From 20th October some of the 800 volunteers, supplemented to some extent by the temporary "acting" health visitors and by other members of staff, collected most of these cards, although the public were informed repeatedly that any household with cards not yet collected was perfectly free to attend for examination.

Where a partly or wholly negative card was returned or where a household declined to return a card, the volunteer inquired whether transport to the nearest unit created difficulty (*e.g.*, in the case of a cripple or a very old person) and, if so, reported the case to the local organiser for provision of transport; and all other negative cases the volunteer reported to the district health visitor, who could, in her discretion, revisit the household to see whether any removal of misconceptions or difficulties could induce the family to attend.

Broadly, about 75 per cent. of householders stated their intention of attending after the health visitor's initial visit; about 83 per cent. filled in cards declaring that they proposed to be examined (the 8 per cent. being presumably induced to change their mind by general and local publicity efforts); and of the 17 per cent. whose cards (or refusal to complete cards) indicated that they would not attend, about a third agreed to attend after being revisited by health visitors. The figure of 88 (*i.e.*, 75 + 8 + 5) is, of course, slightly higher than the actual final attendance.

It may be worth while to mention, as relevant to the formerly popular idea of using volunteers for household canvassing, the experience of one area, where because the number of negative cards was unusually high, several temporary "acting" health visitors were promptly allocated to supplement the efforts of the family health visitors. Revisiting by the family health visitors (who had the advantages not only of a professional training in techniques of health teaching but also of knowing and being personally known by the families) induced nearly half of those revisited to cancel their refusals; by contrast revisiting by temporary "acting" health visitors was so unsuccessful that they were ultimately taken off the district.

Publicity.

The Publicity Department, under the direction of Colonel H. Webber, took full charge of the publicity side of the campaign. There was practically no apparent publicity until about four days before the radiography began, and then an intense and sustained barrage. For example, 10,000 posters were distributed, 230 banners were placed in position, 15,000 car stickers were issued, a number of special window displays were arranged, and short films were exhibited in various cinemas. Advertising in local newspapers was on a generous scale.

Press co-operation was, of course, secured beforehand, and special care was taken to provide adequate material for use by newspapers and the B.B.C. (Sound and Television). For instance, a colourful opening ceremony was arranged; prizes were distributed (*e.g.*, to the first person wearing an X-ray badge who passed a preselected point or to the individual whose X-ray number chanced to be 10,000) not so much to attract the public as to give the press a peg on which to hang another

article about the campaign; a number of "stunts" were introduced (*e.g.*, the Skeleton Man and the Devil Man), again largely to provide varied "copy" for the press; and the Director of Publicity and the Medical Officer of Health held daily press conferences which were on occasion also attended by the Senior Administrative Medical Officer of the Regional Hospital Board. With regard to prizes it should be noted that large prizes were deliberately avoided on the ground that they led to individuals visiting more than one unit—to their own danger and to the cost of the community.

Day-to-day analysis of attendances by unit and week-to-week breakdown by sex and age-groups enabled supplementary publicity measures to be suitably directed: *e.g.*, a loudspeaker car could be sent to a lagging area, Mr. X-ray could be asked to distribute his prizes in the vicinity of an inadequately used unit, or the journalists could be invited to appeal specifically to a particular age-group.

Results.

The target of 100,000 was easily exceeded. In all 111,519 Aberdeen citizens and 15,000 other persons were examined, the figure for Aberdeen adults being, as already mentioned, 78·6 per cent. of the possible. The exact number of cases of tuberculosis found is not yet known but appears to be about 150.

A detailed account of the operation cannot be given in a single article, but the writer hopes that the points mentioned may be of some use to any colleagues who are planning or contemplating similar campaigns."

(C) RESEARCH.

The long-term research projects in connection with home safety (financed by a grant from the Nuffield Trust) and combined immunisation (financed by a grant from the Advisory Council for Medical Research) have been described in previous reports; and a survey of a five per cent. sample of elderly persons is considered elsewhere in this report, as is an investigation of smallpox vaccination rates.

While shortage of staff militated against research projects during the year, it may be appropriate to state that the department nevertheless took part in various national projects. As an example the Scottish survey of leukæmia in childhood may be mentioned.

During 1957 a country-wide survey of leukæmia was carried out. The survey was sponsored by the Department of Health for Scotland and by the Medical Research Council, the field work being organised by the Oxford Department of Social Medicine and supervised by a Medical Research Council Committee.

In Aberdeen, two medical officers of the Health and Welfare Department participated in this survey. Parents of young children recently affected were interviewed, and a six-page questionnaire was completed in respect of each case. Similar information was obtained in respect of an equal number of "control" children.

(D) OTHER DISEASES.

Prevention—General Points.

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

(2) Health education, including the very important aspect of the promotion of mental health, is discussed in a separate chapter.

(3) Various general measures for the prevention of diseases in children have been outlined in the chapters on maternity and child welfare and the school health service.

(4) The prevention of home accidents is also discussed in a separate chapter.

(5) A small book on food hygiene (the Aberdeen Clean Food Guide) is described in the chapter on Food Supply and Food Hygiene.

(6) Since prevention, after-care, and social welfare are inevitably closely linked in the case of old people, it is convenient to discuss measures for the health and welfare of the elderly in a subsequent section.

Care and After-Care.

The scope of the local health authority has 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, and cancer. After-care of patients discharged from mental hospitals is also needed but not yet provided, although at the end of the year plans for such provision were being made.

13.—PREVENTION OF HOME ACCIDENTS.

To such extent as staff shortages permitted, the campaign against home accidents continued in 1957 on the same lines as in 1956 and 1955.

Need for Preventive Measures.

Domestic accidents are still nationally (and were locally until 1954) a leading cause of death and disability in children, and a frequent cause of death or disablement in old people. Indeed, as has often been stated publicly, home accidents cause more deaths in Britain than do road accidents.

The causes of home accidents can be investigated by ordinary epidemiological techniques, and the well-tried methods of health education (individual and group) can be applied to the problems of accident prevention.

Home Safety Campaign.

The Corporation's campaign for the reduction of home accidents has now extended over nearly four years. The campaign can be outlined under four headings:

(1) *A Home Safety Week.*—To focus public attention not only on the frequency of home accidents but also on the fact that many accidents were preventable, a home safety campaign was organised in the spring of 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 considerably less than the cost to the community of two serious accident cases each treated in hospital for seven weeks at £16 a week.

(2) *Work in the Homes.*—From 1954 onwards, the health visitors and other health workers have quietly but persistently pointed out potential causes of accidents. While group teaching (which underwent tremendous expansion in 1957) has been extremely useful, it must be recognised that the most effective agent for accident prevention is the family health visitor in the privacy of the home.

In this connection it may be worth while to repeat a point that has been made previously: if, during a whole year, a health visitor prevents four serious accidents (each of which would have required seven weeks of hospital treatment) and four milder accidents (each of which would have necessitated a fortnight in hospital), then—even if she does no other work—she saves the community more than her total salary, in addition to saving much needless suffering.

(3) *Booklet on Home Safety.*—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.

(4) *Research into accidents.*—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 and continued till the autumn of 1957. Analysis of the cases is now in progress.

Results.

The home safety campaign has certainly produced results; in particular, there has been a sharp decrease in the number of home accidents in elderly people, and in the age-group 1-15 years there has been only one death due to a home accident in a period of four years.

While the results of the long-term campaign are satisfactory, home accidents are far from being completely conquered. According to the Registrar General's figures, there were in 1957 44 deaths attributed to home accidents (as against 34 in the previous year). The increase may be associated with the increased shortage of health visitors, and with the fact that additional duties (*e.g.*, in connection with vaccination against poliomyelitis or with the mass radiography campaign) left less time available for the teaching of home safety.

14.—CONTROL OF INFECTIOUS DISEASES.

The main features of the year in respect of infectious diseases were: (1) a sharp increase in the incidence of dysentery, (2) a high prevalence of influenzal pneumonia (associated with the widespread influenza epidemic of the autumn), (3) a remarkably low prevalence of whooping cough in a year when an epidemic was anticipated (the obvious explanation being that the majority of children are now immunised against whooping cough), (4) the continued complete absence of diphtheria, and (5) the continued very low incidence of poliomyelitis.

The following table indicates the prevalence of infectious diseases during the year:—

	No. of Cases.			
	1957.	1956.	Increase.	Decrease.
Cerebro-spinal Fever	5	4	1	—
Chickenpox	7	8	—	1
Diphtheria	—	—	—	—
Dysentery	328	100	228	—
Erysipelas	18	22	—	4
Infective Jaundice	—	—	—	—
Measles	64	53	11	—
Acute Influenzal Pneumonia	169	17	152	—
Acute Primary Pneumonia	221	217	4	—
Poliomyelitis	5	5	—	—
Puerperal Fever	9	8	1	—
Puerperal Pyrexia	2	2	—	—
Scarlet Fever	42	44	—	2
Paratyphoid Fever	—	4	—	4
Whooping Cough	28	9	19	—
Food Poisoning	10 (not previously notifiable.)			

Cerebro-spinal Fever.

Five cases were notified in 1957, as compared with four in 1956, six in 1955, and eight in 1954. None of the five cases was fatal.

Chickenpox.

In 1957, seven 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).

One case was notified during the year.

Diphtheria.

No cases occurred in 1957.

A tabular statement of cases and deaths in recent years may be of interest.

	Cases.	Deaths.
1957 . . .	0	0
1956 . . .	0	0
1951-1955 . .	5	0
1946-1950 . .	86	1
1941-1945 . .	1,148	53
1936-1940 . .	2,548	97

The tremendous year by year reductions from 586 cases and 21 deaths in 1940 (and even higher figures earlier, *e.g.*, 719 cases and 25 deaths in 1934) 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 1957, there were 328 notified cases of this disease, as compared with 100 in 1956 and 262 in 1955. One death occurred in 1957—an elderly person, aged about eighty.

Encephalitis Lethargica.

No cases were notified during 1957.

Erysipelas.

There were 18 cases of erysipelas in 1957, as compared with 22 in 1956, 18 in 1955, and 33 in 1954. It is interesting to note that, as recently as twenty years ago, the annual number of cases normally exceeded 100.

Infective Jaundice.

During the years 1956 and 1957 there were no confirmed cases of infective jaundice.

Before the Aberdeen study of infective jaundice in 1934, cases were often not reported. Since the time when that study focussed attention on the disease and thereby ensured more adequate reporting, not a year passed without cases. 1957 and 1956 are the only years in which the City has been completely free from the disease, and the two previous years, 1955 and 1954, are the only years in which the number of cases was less than four.

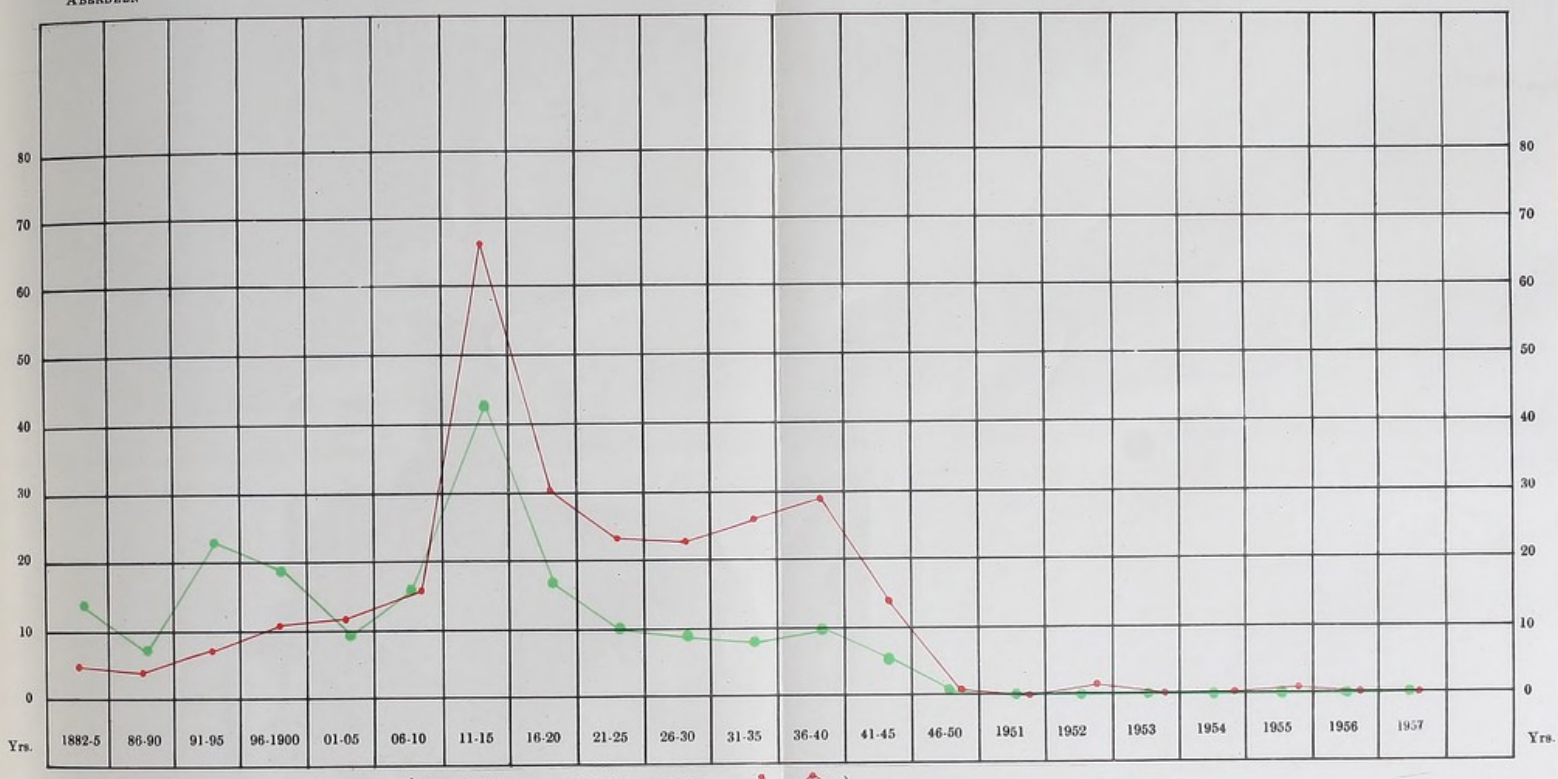
Leprosy.

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

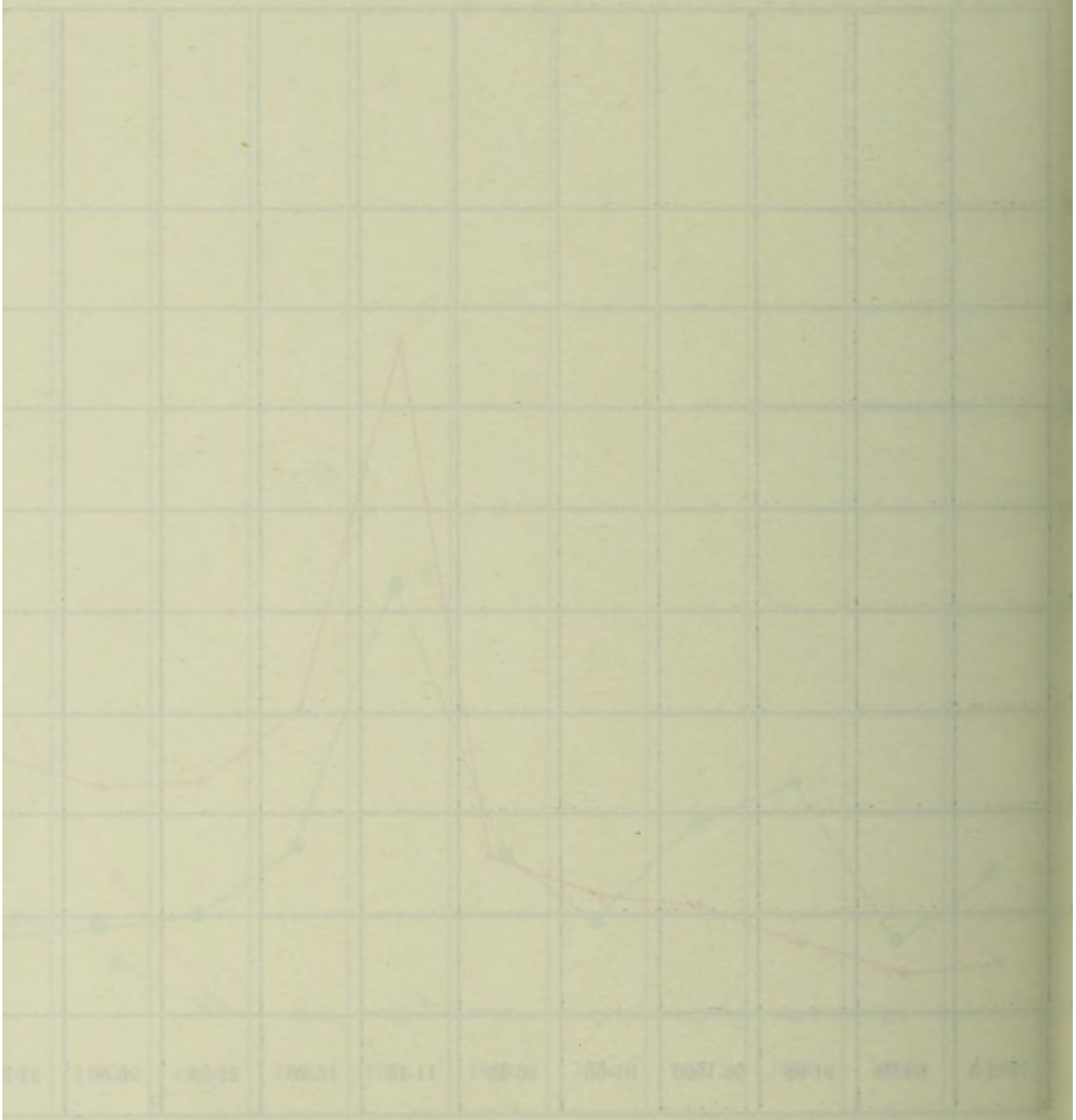
Malaria.

In 1957 no cases were notified. In the previous year, one fatal case—a seaman —was notified.

ABERDEEN



DIPHTHERIA— { Attack Incidence per 10,000 of population
Deaths per 100,000 of population } **1882 - 1957**: QUINQUENNIAL AVERAGES to **1950**.



Measles.

Compulsory notification of this disease in Aberdeen was, after a very short trial, discontinued in 1903, and has not as yet been reinstated. General practitioners are, however, encouraged to intimate cases to the department. In 1957, 64 cases were voluntarily intimated by doctors. There was one death—a child of eight months. Corresponding intimations for previous years were: 1956—53; 1955—351; 1954—72; 1953—247; 1952—801; and 1951—824.

Ophthalmia Neonatorum.

No case was notified in 1957, 1956, 1955, or 1954. There was a case in 1953, and this was the only one notified during the last eight years.

The eradication of this formerly serious cause of blindness is one of the major triumphs of preventive medicine. Before the second world war the annual number of cases notified commonly exceeded a hundred.

Pneumonia, Acute Influenzal.

An epidemic of influenza in October, 1957, accounted for the high increase in the number of notifications of influenzal pneumonia in 1957 as compared with 1956 —there being 169 notifications in 1957, as against 17 in 1956. There were 12 deaths in 1957, as compared with 4 in 1956.

Pneumonia, Acute Primary.

During 1957, 221 cases were notified, with 20 deaths, as compared with 217 cases and 12 deaths in 1956. During the ten years 1947-1956, the annual average number of cases was 327, and the annual average number of deaths was 30. Of the 221 cases in 1957, 198, or 86 per cent., received institutional treatment.

Poliomyelitis (Infantile Paralysis).

In 1957, as in 1956, five cases of this disease were notified, as compared with 10 in 1955, 34 in 1954, and 12 in 1953.

There have been no deaths from this disease during the last three years. It may be worth while to mention that, in the 56 cases occurring in the years 1953-1957, there were only two deaths. Vaccination against poliomyelitis is mentioned elsewhere in this report.

Puerperal Fever and Puerperal Pyrexia.

Eleven cases of puerperal fever and puerperal pyrexia were notified. Nine were confirmed as suffering from puerperal fever. No deaths were registered from this cause.

Two cases were classified as cases of puerperal pyrexia, being the same number as in 1956.

All the cases received institutional treatment in the City Hospital.

It is interesting to note that, in a typical pre-war year (1934), there were 91 cases of puerperal fever and 8 deaths.

Scarlet Fever.

In 1957, 42 cases of scarlet fever were notified, as compared with 44 in 1956 and an annual average of 239 in the decennium 1947-1956. There were no deaths, for the ninth consecutive year. A typical figure for a quarter of a century ago would be 2,000 cases and 16 deaths.

Smallpox.

Aberdeen has remained free from smallpox since 1930.

Analysis of the vaccinations carried out in 1957 is given in an earlier section of this report.

Typhoid and Paratyphoid Fevers.

No cases of typhoid fever or paratyphoid fever were notified in 1957. In 1956 there were four cases of paratyphoid fever B.

Whooping Cough.

On 1st January, 1950, this disease became compulsorily notifiable. The number of cases notified during 1957 was 28, as compared with 9 in 1956, and 398 in 1955. No deaths occurred during the last two years. 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 1957, the number of children so immunised was 2,615.

Food Poisoning.

Under Section 22 of the Food and Drugs (Scotland) Act, 1956, food poisoning became notifiable on 1st August, 1956. In 1957, 10 cases were reported, 5 of which occurred in one household, the others being sporadic cases.

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 1947 to 1957.

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.

Table I.—Progress of Infectious Diseases (excluding Tuberculosis) during Twelve Months—Year, 1957.

Disease.		1957. Jan.	Feb.	Mar.	Apr.	May.	June.	July.	Aug.	Sept.	Oct.	Nov.	Dec.	Whole Year.
Cerebro-spinal Fever	Cases	2	—	—	1	1	—	—	—	—	1	—	—	5
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
*Chickenpox	Cases	—	2	2	1	—	1	—	—	—	—	—	1	7
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Continued Fever (Undulant)	Cases	—	—	—	1	—	—	—	—	—	—	—	—	1
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Diphtheria	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Dysentery	Cases	71	69	70	51	18	7	2	5	14	10	8	3	328
	Deaths	—	—	—	*1*	—	—	—	—	—	—	—	—	*1*
Encephalitis Lethargica	*Cases*	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Erysipelas	Cases	1	1	2	1	—	3	1	4	3	1	1	—	18
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Jaundice, Acute Infective	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Leprosy	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Malaria	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
*Measles	Cases	19	18	7	8	5	4	3	—	—	—	—	—	64
	Deaths	—	—	*1*	—	—	—	—	—	—	—	—	—	*1*
Ophthalmia Neonatorum	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
Plague	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Pneumonia Acute Influenzal	Cases	2	1	2	—	—	—	—	1	9	140	13	1	169
	Deaths	—	—	—	—	—	—	—	—	—	*11*	*1*	—	*12*
Pneumonia, Acute Primary	Cases	25	25	25	15	22	14	10	11	16	24	10	24	221
	Deaths	*2*	*5*	*3*	*4*	*3*	—	—	*1*	—	—	—	*2*	*20*
Poliomyelitis, Acute	Cases	—	—	—	—	—	1	—	—	—	—	3	1	5
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Puerperal Fever	Cases	1	1	—	3	1	—	2	1	—	—	—	—	9
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Puerperal Pyrexia	Cases	—	1	—	—	—	—	1	—	—	—	—	—	2
Scarlet Fever	Cases	6	6	6	2	3	1	3	2	4	3	3	3	42
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Smallpox	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Typhoid Fever	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Para-Typhoid A.	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Para-Typhoid B.	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Typhus Fever	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Whooping Cough	Cases	2	3	3	1	2	3	1	4	3	5	1	—	28
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Food Poisoning	Cases	—	1	—	3	—	—	5	—	—	1	—	—	10
Total	Cases	129	128	117	87	52	34	28	28	49	185	39	33	909
	Deaths	*2*	*5*	*4*	*5*	*3*	—	—	*1*	—	*11*	*1*	*2*	*34*
Influenza, excl. Influenzal Pneumonia	*Deaths*	—	—	—	—	—	—	—	—	—	*6*	—	—	*6*

*Not compulsorily notifiable.

TABLE II.—MORBIDITY AND MORTALITY FROM INFECTIOUS DISEASES (EXCLUDING TUBERCULOSIS) DURING 1957.

DISEASE		No. of Cases and Deaths at various Age-Periods									Cases removed to Hospital	Cases not removed to Hospital
		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	5	2	2	—	1	—	—	—	—	5	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
*Chicken Pox	Cases	7	—	3	4	—	—	—	—	—	7	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Cholera	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Continued Fever (undulant)	Cases	1	—	—	—	—	1	—	—	—	—	1
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Diphtheria	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Dysentery	Cases	328	15	146	63	30	25	13	18	18	50	278
	Deaths	*1*	—	—	—	—	—	—	—	*1*	—	*1*
Encephalitis Lethargica	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Erysipelas	Cases	18	—	—	—	2	2	1	9	4	4	14
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Infective Jaundice	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Leprosy	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Malaria	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
*Measles	Cases	64	7	28	14	12	3	—	—	—	53	11
	Deaths	*1*	*1*	—	—	—	—	—	—	—	—	*1*
Ophthalmia Neonatorum	Cases	—	—	—	—	—	—	—	—	—	—	—
Plague	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Pneumonia, Acute Influenzal	Cases	169	—	3	9	26	17	16	63	35	127	42
	Deaths	*12*	—	—	*1*	*1*	—	*2*	*3*	*5*	*10*	*2*
Pneumonia, Acute Primary	Cases	221	18	16	18	10	13	16	72	58	190	31
	Deaths	*20*	*4*	*3*	—	—	—	*1*	*1*	*11*	*19*	*1*
Poliomyelitis, Acute	Cases	5	—	2	2	1	—	—	—	—	5	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Puerperal Fever	Cases	9	—	—	—	5	3	1	—	—	9	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Puerperal Pyrexia	Cases	2	—	—	—	1	1	—	—	—	2	—
Scarlet Fever	Cases	42	—	10	29	3	—	—	—	—	1	41
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Small-pox	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Typhoid Fever	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Paratyphoid A	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Paratyphoid B	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Typhus Fever	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Whooping Cough	Cases	28	3	19	6	—	—	—	—	—	2	26
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Food Poisoning	Cases	10	—	4	1	—	1	1	3	—	6	4
Total	Cases	909	45	233	146	91	66	48	165	115	461	448
	Deaths	*34*	*5*	*3*	*1*	*1*	—	*3*	*4*	*17*	*29*	*5*

* Not compulsorily notifiable.

Table III.—Morbidity and Mortality from Infectious Diseases, including Tuberculosis, during each year from 1947 to 1957.

Disease.		1957	1956	1955	1954	1953	1952	1951	1950	1949	1948	1947	Annual Average 1947 to 1956.
Cerebro-Spinal Fever	Cases	5	4	6	8	10	7	24	14	9	5	12	9·9
	Deaths	*0*	*0*	*0*	*1*	*0*	*0*	*0*	*0*	*1*	*2*	*2*	*0·6*
*Chickenpox	Cases	7	8	4	11	12	48	16	26	23	62	23	23·3
	Deaths	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0·0*
Continued Fever (Undulant)	Cases	1	0	0	2	0	1	0	9	4	1	3	2·0
	Deaths	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0·0*
Diphtheria	Cases	0	0	2	0	0	3	0	2	3	4	9	2·3
	Deaths	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*1*	*0*	*0*	*0*	*0·1*
Dysentery	Cases	328	100	262	129	110	14	225	67	34	137	13	109·1
	Deaths	*1*	*0*	*0*	*0*	*0*	*0*	*1*	*0*	*0*	*1*	*0*	*0·2*
Encephalitis Lethargica	Cases	0	0	0	0	0	0	0	1	0	0	0	0·1
	Deaths	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*1*	*0*	*0*	*0*	*0·1*
Erysipelas	Cases	18	22	18	33	27	32	23	37	48	64	65	36·9
	Deaths	*0*	*1*	*0*	*0*	*1*	*0*	*1*	*0*	*0*	*0*	*0*	*0·3*
Infective Jaundice	Cases	0	0	1	2	13	10	4	10	11	10	6	6·7
	Deaths	*0*	*0*	*0*	*0*	*0*	*1*	*2*	*0*	*1*	*3*	*0*	*0·7*
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	0	1	3	1	6	2	1	8	9	4	9	4·4
	Deaths	*0*	*1*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0·1*
*Measles	Cases	64	53	351	72	247	801	824	26	402	199	527	350·2
	Deaths	*1*	*0*	*1*	*0*	*0*	*0*	*1*	*1*	*1*	*1*	*3*	*0·8*
Ophth. Neonatorum	Cases	0	0	0	0	1	0	0	0	1	3	7	1·2
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	169	17	7	23	5	18	10	32	10	7	4	13·3
	Deaths	*12*	*4*	*1*	*2*	*1*	*5*	*2*	*7*	*4*	*3*	*2*	*3·1*
Pneumonia, Acute Primary	Cases	221	217	235	294	263	301	242	422	443	444	404	326·5
	Deaths	*20*	*12*	*11*	*19*	*9*	*13*	*43*	*58*	*41*	*42*	*53*	*30·1*
Poliomyelitis, Acute	Cases	5	5	10	34	12	18	4	36	3	5	48	17·5
	Deaths	*0*	*0*	*0*	*1*	*1*	*1*	*0*	*2*	*0*	*0*	*6*	*1·1*
Puerperal Fever	Cases	9	8	5	2	26	17	13	35	46	25	42	21·9
	Deaths	*0*	*0*	*0*	*0*	*1*	*0*	*1*	*0*	*1*	*0*	*1*	*0·4*
Puerperal Pyrexia	Cases	2	2	3	10	13	13	10	11	13	34	33	14·2
Scarlet Fever	Cases	42	44	69	178	239	314	299	513	275	252	205	238·8
	Deaths	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*1*	*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	318	205	204	228	243	230	226	270	222	279	172	227·9
	Deaths	*10*	*18*	*15*	*19*	*26*	*36*	*36*	*38*	*60*	*62*	*65*	*37·5*
Tuberculosis, Non-Respiratory	Cases	20	15	24	26	31	30	31	31	28	37	53	30·6
	Deaths	*2*	*0*	*2*	*4*	*4*	*4*	*5*	*5*	*6*	*8*	*12*	*5.0*
Typhoid and Paratyphoid Fevers	Cases	0	4	1	16	3	10	4	2	4	30	6	8·0
	Deaths	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*1*	*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	28	9	398	284	175	549	551	449	58	194	176	284·3
	Deaths	*0*	*0*	*4*	*0*	*0*	*0*	*3*	*0*	*0*	*2*	*5*	*1·4*
Influenza, excl. Influenzal Pneumonia	*Deaths*	*6*	*0*	*0*	*1*	*2*	*0*	*7*	*6*	*6*	*1*	*0*	*2·3*

*Not compulsorily notifiable.

15.—MENTAL HEALTH.

Before 1957 the Corporation's mental health services (in the real sense of the word "health") had undergone very considerable development: a Senior Assistant Medical Officer had been appointed at the end of 1953 with duties primarily in the mental field, and in 1954 and 1955 some forty-six health visitors had attended intensive post-qualification courses in mental health to equip them more fully in their work in the promotion of mental health and the prevention of diseases of emotional and mental origin. (It may be noted in passing that the health visitors now being trained receive fairly adequate instruction in psychology and mental health—a total of about thirty lectures supplemented by case-studies and tutorials, and superimposed on some rudimentary information about mental aspects of disease now included in the general nursing training.) While 1957 saw little expansion of individual work for the promotion of mental health, it witnessed (as mentioned in the chapter on Health Education) a great extension of group teaching.

Most of the chapter that follows deals not with mental health but with mental disease, but it will be appreciated that the prevention or reduction of the psychoneuroses, psychosomatic diseases, anti-social behaviour, juvenile delinquency and so forth, constitute one of the main tasks—probably indeed the biggest task—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, numerous 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 Deputy 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.*—As mentioned above, very extensive duties in respect of prevention of emotional and mental diseases, care and after-care devolve on the health visitors, especially the 49 health visitors in charge of districts of the City.

(*d*) *Other Mental Health Workers.*—At present, 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, and supervise adult defectives placed under guardianship. The Senior Assistant Welfare Officer is assisted by three Assistant Welfare Officers, who are all well versed in mental health certification procedure, &c.

(*f*) *Occupation Centre Supervisors, &c.*—As yet, none is employed. (The Corporation some time ago approved of the provision of an occupation centre for the mentally handicapped, 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 liberated on licence from a certified institution, or a mental patient is released on probation from a mental hospital, or placed under guardianship, supervision and maintenance, although legally a matter for the hospital authorities, is undertaken by members of the Corporation staff on an agency basis. 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.

Arrangements made have included (*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 and increasing 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 enlarged.

The particular importance of the rôle of the family health visitor—an expert in normality, skilled in the art of persuasion, and recognised by the family as a health counsellor and social adviser—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 was 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 often 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 some assistance to families in situations of abnormal physical, mental, or financial strain is the existence of a Joint Committee to deal with measures for the assistance of children 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, certain children leaving the special schools at 16 years of age may continue 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.

(*c*) *Occupation Centre.*

At the end of the year a property was in process of being obtained. There is a possibility of suitable premises becoming available to meet this need in the ensuing year, whereby parents who have had to cope with their mentally handicapped offspring daily, in their own homes, will be given a desirable and well-earned respite from the physical and mental strain they are at present experiencing and which, in some cases, has been borne for a considerable period of time. The obtaining of these premises will also make available to the Department the necessary means of opportunity to fully assess the potential needs and capabilities of those handicapped persons as to training.

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	54	87	141
Cases admitted as voluntary boarders, following medical examination	76	82	158
Cases where no action was recommended following medical examination	2	6	8
	132	175	307

Number of patients on probation from mental hospitals who are under supervision.

Males.	Females.	Total.
4	13	17

Number of mental patients boarded-out from mental hospitals under private guardianship who are under care and supervision.

Males.	Females.	Total.
6	—	6

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.
4	12	16

Mental Deficiency and Lunacy (Scotland) Acts, 1913-1940.

Number of cases reported by the Education Department	2	4	6
Number of cases committed to certified institutions by the department	7	6	13

Number of cases under guardianship as at 31.12.1957.

In the City	10	4	14
Outwith the City	7	6	13

(There were, at the end of 1957, 71 mentally-handicapped persons in the City awaiting admission to certified institutions.)

16.—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 (i) 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.

17.—SCHOOL HEALTH SERVICE.

As an introduction to the Report for 1955-56, the general functions and field of work of the School Health Service and the functioning of the service in Aberdeen were discussed in some detail. It may, therefore, be permissible in this Report merely to mention the main functions of the service and to refer anyone seeking fuller information to pages 110-117 of the previous report. The functions (starting with those in which the health service must play the leading rôle and passing later to those in which its rôle, though important, is not necessarily dominant) include—

1. Appraisal of health status of pupils, "health" having, of course, emotional and social aspects as well as physical aspects.
2. Counselling of pupils and parents concerning appraisal findings.
3. Advising teachers about appraisal findings.
4. Linking home and school.
5. Correction of remediable defects.
6. Health education in schools.
7. Participation in the health care and education of handicapped children.
8. Provision of a healthy environment.

SOME FEATURES OF 1956-57.

(1) Staffing shortages—the dominant feature of the year—are briefly indicated later.

(2) The number of school entrants with defects sufficiently serious to call for notification of parents (other than defects of teeth or cleanliness) underwent a further startling reduction: the number has fallen steadily from 326 in 1951-52 to 99 in 1956-57, a decline which has occurred simultaneously with the fuller development of the Corporation's services for pre-school children.

(3) Nits and vermin continued to be rarities: out of 9,001 children examined by medical officers, only 52 had infected heads; and during their 53,147 inspections the school health visitors encountered only 1,261 cases (as contrasted with 1,515 in the previous year and 2,023 in 1954-55).

(4) Scabies and impetigo became even more infrequent: in 53,147 inspections, the health visitors encountered no cases of scabies and 29 of impetigo (compared with 4 and 71 in the previous year).

(5) As defects of cleanliness declined, the health visitors' inspections have become increasingly real health surveys, concerned with both physical and emotional health,

(6) There was an increase in the number of children found in health visitors' surveys to be suffering from diseases of physical or mental origin—from 2,873 in 1954-55 and 3,161 in 1955-56 to 3,393 in 1956-57.

(7) Despite staff shortages, the number of home visits paid by school health visitors rose from 2,053 in 1954-55 and 2,377 in 1955-56 to 5,426 in 1956-57—an increase of more than a hundred per cent. in a single year.

(8) The number of children examined by school medical officers rose slightly but the number inspected by school health visitors fell.

(9) Attendances at minor ailment clinics underwent a further decline—from 1,237 in 1955-56 to 891 in 1956-57.

(10) For the first time, school leavers were re-inspected within three months before they were due to leave school.

(11) An interesting experimental development during the year was that two primary schools and one secondary school were visited regularly each month for the purpose of seeing children specifically referred in advance by the teaching staff.

STAFFING.

(*a*) *Medical Officers.*—In recent years, the Corporation's policy has been to appoint medical officers with appropriate post-graduate qualifications and experience to general duties in the Health and Welfare Department (including the School Health Section). In 1956-57, four medical officers (appointed to the service before the change of policy) devoted practically their whole time to school health work, and four general medical officers devoted part of their time to the work. The total medical staff was equivalent to 4 6/11ths full-time school doctors, or one for every 6,853 children.

The medical staffing, although rather less generous than in some areas, can be regarded as reasonably adequate.

During the year, the medical staff carried out the additional tasks of vaccinating children aged 13 years against tuberculosis, and immunising (usually by reinforcing injections) younger children against diphtheria; but, by way of compensation for the time thus spent, an additional doctor was employed for four months.

(*b*) *Dental Officers.*—The total dental staff (for school work and work in connection with expectant mothers and pre-school children) continued at the low total of 3. The authorised establishment is seven, but advertisements failed to attract applicants.

While there is undoubtedly a grave and even alarming shortage of school dental officers, it may be worth while to indicate that the exact need for dental officers (to undertake treatment) must to some extent vary inversely with the strength of the preventive service. The old idea of assessing the need at, say, one dentist for every 3,000 school children is obsolete. If, for example, the preventive services managed to reduce greatly the incidence of dental caries (*e.g.*, by successful

advice about diet, sweet-eating, and the hygiene of the mouth, supplemented perhaps by fluoridation of water), Aberdeen might find five dental officers sufficient; if, on the other hand, the preventive services suffered serious reduction (*e.g.*, by a further increase in the shortage of health visitors or by the collapse of the health guidance scheme), the City might need 15 or more dental officers. The writer knows, for instance, of one British area, with a population just over one-half of that of Aberdeen, which has an extreme shortage of health visitors and other disease-preventing officers, and which already employs—and appears to need—11 dental officers.

(*c*) *School Health Visitors.*—For some years, to prevent needless breaks in the continuity of health supervision of children, the work of school health visitors has been undertaken by the Corporation's general duty health visitors—a combination that was expressly advocated in the 1956 Report of the Working Party on the Recruitment, Functions, and Training of Health Visitors.

Expressed in terms of full-time school nurses, the health visiting staff in the middle of the school year amounted to 10·8 officers, or, roughly, one for every 2,880 pupils, as compared with one for every 2,800 in the previous year. As was mentioned in the Report for 1955-56, the shortage is more severe than in some British areas (*e.g.*, by 1955 Glasgow had one nurse for every 2,225 pupils), and in urban areas in Sweden the recognised standard is one full-time school nurse, with special post-graduate training, for not more than 2,000 pupils.

The shortage of health visitors is very grave and is still increasing—both in Aberdeen and nationally. The Corporation has secured the sanction of the Secretary of State for Scotland for an ultimate establishment of 100 health visitors, and has set an *interim* target of 85 (about 70 of whom would devote approximately 20 per cent. of their time to the School Health Service), but there are no immediate prospects of filling the vacancies; the Working Party on Health Visitors has estimated that (on a standard that certainly does not err on the side of generosity) Britain needs 1,100 new health visitors annually, as compared with about half that number at present completing their post-qualification training in any one year.

(*d*) *Ancillary Workers.*—A full-time audiometrician was employed during most of the year but resigned in June. A full-time orthoptist was employed during part of the year.

A physiotherapist (added to the Health and Welfare establishment during the previous year) was employed for half of her time at Beechwood School (and for half her time on health and welfare duties). The Corporation's ultimate requirement will be three physiotherapists, the time of one such officer being needed for the School Health Service.

(*e*) *Staffing and School Population.*—In 1952 the establishment of the Health and Welfare Department included—

13½ medical officers (occupied to the extent of 4 on School Health Services);
7 dental officers (occupied to the extent of about 6 on School Health Services);
65 health visitors (occupied to the extent of about 11 on School Health Services).

Subsequently, mainly in 1954, the establishment was adjusted, in view of many new duties, to include—

14½ medical officers (occupied to the extent of 4·6 on School Health Services);
7 dental officers (occupied to the extent of about 6 on School Health Services);
85 health visitors (occupied to the extent of about 14 on School Health Services).

These numbers were reasonably adequate for the populations at that time (and efforts are still being made—so far with no success in respect of dental officers and health visitors—to fill the many vacancies on the staff); but, if the population continues to expand, a parallel increase of staff will clearly become necessary.

The steady increase of the school population is shown in the following table:—

Year.	School Population.
1951-52 . .	28,646
1952-53 . .	29,324
1953-54 . .	29,978
1954-55 . .	30,301
1955-56 . .	30,754
1956-57 . .	31,103

GENERAL STATISTICS.

Some details for the last three years are as follows:—

	1954-55.	1955-56.	1956-57.
Number of Schools—			
(*a*) Primary—Under Education Authority . . .	43	43	44
(*b*) Junior Secondary— do. do. . . .	10	10	11
(*c*) Senior Secondary— do. do. . . .	3	3	3
(*d*) Nursery— do. do. . . .	4	4	4
(*e*) (i) Special Schools do. do. . . .	3	3	3
(ii) Special classes in ordinary schools . .	—	—	—
(iii) Nursery classes	7	7	7
(*f*) In receipt of grant and under School Health Service	2	2	2
Number of children on registers	30,301	30,754	31,103
Number of children in average attendance . . .	28,914	29,086	29,181

SANITARY CONDITION OF SCHOOLS.

On the whole, the conditions under which the children are educated are satisfactory from the health point of view. In Aberdeen in recent years a good deal of building of new schools and reconstruction of older schools has been undertaken, and during the school year under review the following work has been in progress:—

(*a*) *New Schools*—

Byron Park Infant . .	Work almost completed.
Greenfern Infant . .	Do.
Kirkhill Primary . .	Do.
Rosewood Infant . .	Do.
Northfield Secondary . .	Work completed.

(*b*) *Reconstruction, &c.*—

Middle Secondary . .	Work still in progress.
Woodside Primary . .	Do.

Schools repainted during the year included Powis Secondary (part), Hilton Secondary (part), Queen's Cross, Causewayend, Girls' High (part), Skene Square, Sunnybank (part), and Trades College (part).

Repairs to lavatories, &c., were carried out in the following schools:—St. Clement Street, Broomhill, and provision of additional basins and of hot water to wash-hand basins was completed in Hanover Street, St. Mary's R.C., and shower baths were provided for Rubislaw Occupational Centre.

The school doctors and health visitors continued to pay attention to ventilation, heating, and hygienic conditions generally of classrooms, cloakrooms, and lavatories, and, in addition, inspectors from the Sanitary Section of the Health and Welfare Department visited the schools periodically. During the year, several defects in schools were notified to the City Architect's Department. These defects—usually minor defects in sanitary conveniences, drinking fountains, washing facilities, &c. —were duly rectified.

The sanitary conveniences continue to be kept in a satisfactory condition and the regulations for disinfection and cleansing of the schools are adequately implemented. The policy of providing fluorescent lighting in the new and reconstructed schools continues to be an improvement on the older forms of artificial lighting.

ORGANISATION AND ADMINISTRATION.

A. System and Extent of Medical Inspection and Treatment.

(1) *Routine Medical Overhauls.*—Circular 47/1957 of the Department of Health for Scotland designated the following groups for obligatory medical examination:—

Entrants (approximately 5 years of age);
Pupils born in 1947 (9 years of age);
Pupils born in 1943 (13 years of age);
Pupils born in 1940 (16 years of age);
Pupils born in 1949 (visual acuity and hearing only).

These groups were duly examined. The only additional—non-obligatory—medical inspections carried out were (as in several recent years) a rapid survey of school entrants as soon as possible after their initial entry.

The purpose of these routine medical overhauls is fourfold:—

(*a*) the detection of early defects, often at a stage where their existence is still unsuspected by pupils and parents, as well as the identification of more obvious conditions of disease and disability;

(*b*) the advising of pupils and parents about the most appropriate measures by which the defects can be rectified;

(*c*) the identification of pupils whose educational programmes may need modification; and

(*d*) the inculcation of ideas of health maintenance and of active promotion of health. This last function is probably the most important of all, and forms a valuable facet of health education work in schools.

It is interesting to note that, as the health of the community improves and as the health services for pre-school children develop, the detection of defects becomes a steadily decreasing portion, while health promotion and health maintenance begins to assume more and more importance.

(2) *Re-inspection.*—Re-examination of nearly 6,000 children in whose cases defects had been discovered at earlier examinations was carried out during the year. Certain additional features of—and new developments in—re-inspection are discussed under "Findings."

(3) *Treatment.*—Two factors that have materially reduced the need for treatment by the School Health Service are—

I. The development of the Corporation's services for the health promotion of pre-school children. The best evidence of the effect of such services is the startling year by year reduction in the number of school entrants notified to parents as requiring treatment. Here, for example, are the figures for the number of entrants who in various recent years were found to need treatment (other than treatment for uncleanliness or for dental caries):—

326 in 1951-52
315 in 1952-53;
200 in 1953-54;
173 in 1954-55;
143 in 1955-56; and
99 in 1956-57.

II. The provision of "free' treatment under the National Health Service Act. Since 1948, in practically all cases of disease or defects, the parents are advised to consult their general practitioner.

Nevertheless, there is still a place for the various school clinics—*e.g.*, for minor ailments, orthopædic defects, orthoptic defects, skin diseases, dental defects, and diseases of the eye, ear, nose, and throat. It is, however, pleasant to record the gradual decrease in the numbers attending the minor ailments clinics and the skin diseases clinic. Here are the totals for the minor ailments clinics in recent years:—

Year.	Number of Children.
1953-54	1,492
1954-55	1,343
1955-56	1,237
1956-57	891

B. System and Extent of Dental Inspection and Treatment.

The report of the Chief Dental Officer is given later.

C. System and Extent of School Nursing Inspection and Arrangements for "Following Up."

The work of school health visitors is undertaken by the Corporation's health visitors who are, as far as is practicable, allocated to schools serving their particular districts.

(1) *Attendance at Medical Inspection.*—According to a practice that used to be almost 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.

Nevertheless, attendance at medical inspection is certainly the least important of the school health visitor's duties, and it may well be that in the future less highly trained staff will have to take over this work.

(2) *Health Surveys by Health Visitors in Schools.*—These inspections have in the past been known as "hygiene inspections" and the name still lingers. It may therefore be useful to indicate here how very small a part of these inspections is nowadays occupied by the finding of defects of personal hygiene. Here are some figures for three consecutive years:—

	1954-55.	1955-56.	1956-57.
Total number of H.V. inspections . .	54,003	54,118	53,147
Number of cases of nits and/or vermin .	1,806	1,515	1,261
Cases of emotional and physical diseases .	3,704	3,161	3,393

Health inspections (which are perhaps the most important part of the whole school health service) 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 continuing shortage of staff still renders this ideal impracticable; an attempt is made to inspect each child twice annually.

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 out, given any necessary advice, and, where needful, referred to the school medical officers or to general practitioners. At these inspections, children found to be malnourished, 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.

In the course of 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, and although due attention must still be devoted to these matters, there is nowadays an increasing concentration upon physical defects and behaviour problems.

(3) *Follow-up and Home Visiting.*—An important duty of the school health visitors is to follow-up—at school or at home—children found to need either 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. Visits are also undertaken to obtain any necessary information about a child's home circumstances.

An important duty devolving upon the school health visitor is that 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 degree of adequacy or inadequacy of the staff.

The male inspector attached to the school health service also carries out home visitation when it is required in connection with arrangement for treatment of scabies and verminous cases, failure to provide spectacles, or other prescribed treatment, and investigation of family circumstances for various reasons.

While, owing to shortage of health visitors, the number of home visits to school children is still very inadequate, the number of such visits is at least increasing:—

In 1953-54 the health visitors paid 2,264 visits.
In 1954-55 the health visitors paid 2,053 visits.
In 1955-56 the health visitors paid 2,377 visits.
In 1956-57 the health visitors paid 5,426 visits.

D. Co-ordination with the Public Health Service and with other Departments of the Authority which render Services to Children.

Co-operation with the other departments of the public health service in Aberdeen Burgh is ensured by the School Health Section being part of the Health and Welfare Department, by the health visitors acting also as school health visitors, and by some of the medical officers undertaking general duties. Appropriate cases are referred to the School Eye and Dental Clinics by the Maternity and Child Welfare Sections, 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. As for the control of infectious diseases, information about the incidence of the non-notifiable infections (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 were transmitted to the head teachers through that department until January, 1956.

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, as do children who are referred for investigation at the Child Guidance Clinic.

E. Co-operation with Voluntary Bodies and other Outside Agencies.

There is full co-operation between this department and certain voluntary agencies which render services to children. Although, as noted before, children in need of medical and surgical treatment are in the first place normally referred to the family doctor, there are certain types of cases which are referred directly to either Aberdeen Royal Infirmary or Royal Aberdeen Hospital for Sick Children, according to circumstances. There is, for example, a long-standing arrangement with the Skin Out-Patient Departments of these institutions to treat children suffering from ringworm (particularly those who are 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 management 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.

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, malnutrition, debility, or convalescent from illness are given a period in the Home, the length of stay varying according to the circumstances of the case. The children who have greatest priority in being sent to Linn Moor Home are those who are contacts with tuberculosis, and particularly those where infection from tuberculosis in the home is likely to be difficult to avoid.

All children who, by reason of the mother's removal to hospital, &c., are being temporarily cared for in the Children's Shelter, managed by the Aberdeen Association of Social Service, are examined by the school medical officers prior to admission in order to exclude the possibilities of infectious or contagious diseases.

The School Health Service also co-operates in appropriate cases with the Societies for the Prevention of Cruelty to Children.

During the school year, the co-operation with the Regional Hospital Board Blood Transfusion Unit in research into the distribution of the blood groups in the community, in so far as school children are concerned, was continued. The procedure indicated in last year's Report was continued in modified form—the main difference being that children of all age-groups were given the opportunity of having their blood group determined.

National Survey of the Health and Development of Children.—As indicated in previous reports, an enquiry into the growth, health, and development of children is still being carried out by the Joint Committee of the Institute of Child 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 followed up during the early years of their lives, and a unique amount of information has been collected on their home conditions, their illnesses, accidents, growth, and development. The children are drawn from all social classes and their experiences will, it is hoped, give an unbiassed picture of the health and environment of all children in Great Britain. These children are now aged 11 years, and the work is being continued during their school lives. During the past year, a thorough medical examination of the children concerned and also of an equal number of control children born at the same time has been carried out. At the same time, the school health visitors paid a visit to the home of each child and obtained certain additional information required for the inquiry. 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 children.

F. Co-operation with Teachers and Parents.

The relations of the school health service and the teaching staff remain cordial and mutually helpful. The teachers are usually willing to co-operate in any measure taken for improving the health of the children under their care. The school medical officers and health visitors are frequently consulted by the teachers on aspects of the health education curriculum which continues to be a feature of class education from the five-year-old stage onwards.

The attendance of parents at the routine medical inspection of the children varies according to the age-groups being examined. A total of 94·7 per cent. of the parents of the five-year-old children was present when their children were inspected; 88·3 per cent at the inspection of the nine-year-olds; 64·3 per cent. at the inspection of the thirteen-year-olds; and 23·6 per cent. at the inspection of the sixteen-year-olds, giving an over-all percentage of 81·1 per cent. The scheme of medical inspection is now completely accepted as part of the school routine, and parents of children in the older age-groups are quite content to allow their children

to come unattended unless there is some known defect about which they desire advice. Advantage is taken as much as possible of the attendance of the parents at these inspections to instil principles of health education in both parent and child, and to inculcate the idea of maintenance of health as part of one's duty to oneself and to the community. Talks are also at times given to parent-teacher associations by members of the Health and Welfare Department's health guidance team and, occasionally, by the health visitor or medical officer attached to a particular school, and (although the usefulness of these talks is probably limited because usually the parents to whom one most desires to talk are not present) these talks certainly have a part in the health education of the community.

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 to examine the vision and hearing of children entering school for the first time, the vision-and-hearing-testing is also carried out in the case of the 7-year-old children. Owing to the fact that the audiometrician was employed during only part of the year, audiometric testing of the hearing of five-year-old children was not possible during 1956-57. In addition, a superficial inspection of five-year-old children when they enter school is carried out as soon as possible after their entry to school.

Four hundred and seventy-two 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 school entrants for detection of obvious physical defects and verminous conditions revealed the following details:—

Total number inspected	2,470
Dirty heads—	
Nits	35 or 1·4 per cent.
Vermin	—
Squints	104 or 4·2 per cent.
Other diseases	55 or 2·2 per cent.
Number excluded for various infections	7 or 0·3 per cent.
Unsatisfactory clothing	—
Unsatisfactory footgear	—

While it is unwise to draw conclusions from this very rapid survey, it is at least interesting to note the trend over recent years:—

	1953-4.	1954-5.	1955-6.	1956-7.
Total inspected	2,790	2,559	2,518	2,470
Number with vermin or nits . .	71	57	41	35
Number with squint	125	124	107	104
Number with clothing or shoe defects	3	7	0	0
Number with infections . . .	7	10	4	7
Number with other diseases . .	33	34	81	55

Systematic Medical Examination.

The number of children examined was 364 more than in the previous year, and 1,167 more than 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, followed by a few comments.

Comments on the Defects Found.

Most of the figures show only the usual year-to-year chance variations, but a few points may be worth mentioning.

(1) Unsatisfactory clothing or footwear remains a rarity—9 cases in 1956-57 and also an average of 9 cases annually over the last three years.

(2) Uncleanliness of head and body would at first glance appear to be increasing—an incidence of 6 children in every thousand in 1956-57 as compared with about 3 per thousand in each of the three previous years. However, the numbers are small, and a better picture of the prevalence of uncleanliness is probably given by the school health visitors' surveys:—

	Total Inspection.	Cases showing Nits or Vermin.	Percentage.
1956-57 . .	53,147	1,261	2·4
1955-56 . .	54,118	1,515	2·8
1954-55 . .	54,043	1,806	3·3
1953-54 . .	55,241	2,023	3·7
1952-53 . .	54,168	2,268	4·2
1951-52 . .	64,491	2,679	4·2

(3) For the fourth consecutive year there were no cases of ringworm of the head.

(4) There were three cases of body ringworm as compared with 2, 2, and 0 in the three previous years.

(5) Impetigo—26 cases in 1956-57, 31 in 1955-56, and 43 in 1954-55—is becoming a rarity.

Nature of Defect.	Number Examined.	Number Defective.	Percentage Defective.
1. Clothing unsatisfactory	9,001	5	·1
2. Footgear unsatisfactory	,,	4	·04
3. Cleanliness—			
(*a*) Head: Nits	,,	52	·6
Vermin	,,	—	—
(*b*) Body: Dirty	,,	1	·01
Vermin	,,	—	—
4. Skin—			
(*a*) Head: Ringworm	,,	—	—
Impetigo	,,	24	·3
Other diseases	,,	54	·6
(*b*) Body: Ringworm	,,	3	·03
Impetigo	,,	2	·02
Scabies	,,	2	·02
Other diseases	,,	202	2·2
5. Nutritional State—			
Slightly defective	,,	167	1·9
Bad	,,	2	·02
6. Mouth and teeth unhealthy	,,	456	5·1
7. Naso-pharynx—			
(*a*) Nose:			
(i) Obstruction requiring observation	,,	412	4·6
(ii) Obstruction requiring operative treatment	,,	17	·2
(iii) Other conditions	,,	12	·1
(*b*) Throat:			
(i) Tonsils requiring observation	,,	770	8·6
(ii) Tonsils requiring operative treatment	,,	59	·7
(*c*) Glands:			
(i) Requiring observation	,,	351	3·9
(ii) Requiring operative treatment	,,	5	·1
8. Eyes—			
(*a*) External diseases:			
Blepharitis	,,	127	1·4
Conjunctivitis	,,	9	·1
Corneal opacities	,,	3	·03
Strabismus	,,	306	3·4
Other diseases	,,	49	·5
(*b*) Visual acuity with/without glasses:			
Fair	6,200	1,106	17·8
Bad	,,	316	5·1
Recommended for refraction	,,	317	5·1

Nature of Defect.	Number Examined.	Number Defective.	Percentage Defective.
9. Ears—			
(*a*) Diseases:			
Otorrhœa	9,001	62	·7
Other diseases	,,	136	1·5
(*b*) Defective hearing:			
Grade I	6,200	18	·3
Grade II*a*	,,	7	·1
Grade II*b*	,,	—	—
Grade III	,,	—	—
10. Speech—			
Defective articulation	9,001	73	·8
Stammering	,,	28	·3
11. Mental and Nervous Condition—			
(*a*) Backward	,,	7	·1
(*b*) Dull	,,	1	·01
(*c*) Mentally deficient (educable)	,,	—	—
(*d*) Do. (ineducable)	,,	—	—
(*e*) Highly nervous or unstable	,,	134	1·5
(*f*) Difficult in behaviour	,,	48	·5
12. Circulatory System—			
(*a*) Organic heart disease:			
(i) Congenital	,,	29	·3
(ii) Acquired	,,	13	·1
(*b*) Functional conditions	,,	24	·2
13. Lungs—			
Chronic bronchitis	,,	20	·2
Suspected tuberculosis	,,	68	·8
Other diseases	,,	162	1·8
14. Deformities—			
(*a*) Congenital	,,	90	1·0
(*b*) Acquired (infantile paralysis)	,,	20	·2
(*c*) Acquired (probably rickets)	,,	286	3·2
(*d*) Acquired (other causes)	,,	107	1·2
15. Infectious disease	,,	4	·04
16. Other diseases or defects	,,	1,102	12·2
17. Classification:			
Group I	,,	4,063	45·1
Group II*a*	6,200	784	12·6
Group II*b*	9,001	123	1·4
Group II*c*	6,200	4	·1
Group III	9,001	3,192	35·5
Group IV*a*	,,	597	6·6
Group IV*b*	,,	238	2·6
Number notified to parents as suffering from defects	,,	491	5·5
Number under observation	,,	3,949	43·9
Number of parents present at inspection (7,303)	,,	—	81·1
Number wearing glasses	,,	907	10·1

(6) Scabies—four cases in the last three years—is almost extinct.

(7) The number of cases of unsatisfactory nutrition is slowly declining: the percentage of children unsatisfactorily nourished was 2·5 in 1953-54, 2·3 in 1954-55, 2·0 in 1955-56, and now 1·92 in 1956-57. Inadequate nutrition has for long been commoner in entrants than in other age-groups (possibly because older children had been eligible for school meals), and it is therefore interesting to analyse the year-by-year situation in respect of school entrants:—

	Percentage of Entrants Inadequately Nourished.			
	1953-54.	1954-55.	1955-56.	1956-57.
Boys .	3·7	2·8	2·9	1·7
Girls .	4·7	4·6	4·8	4·1
Total .	4·4	3·7	3·8	2·9

The trend in entrants is probably associated with the expansion of advisory health services for pre-school children.

(8) Unhealthy mouths are tending to increase numerically: from 3·6 per cent. in 1953-54 and 4·0 per cent. in 1954-55, to 4·4 per cent. in 1955-56 and 5·1 per cent. in 1956-57. The source is to be found in the distressingly high incidence in entrants:—

	Percentage of Entrants with Unhealthy Mouths.			
	1953-54.	1954-55.	1955-56.	1956-57.
Boys .	4·7	6·1	8·0	6·8
Girls .	4·9	5·5	8·4	9·2
Total .	4·8	5·9	8·2	8·0

Probably the shortage both of health visitors and of dental officers is the basic factor.

(9) After an apparent recession (probably due to chance fluctuation) in 1955-56, it is pleasant to note a continuation of the declining trend of nasal obstruction:—

Percentage of Children with Nasal Obstruction.			
1953-54.	1954-55.	1955-56.	1956-57.
8·1	4·3	5·7	4·8

Here again the school entrants predominate:—

	Percentage of Entrants with Nasal Obstruction.			
	1953-54.	1954-55.	1955-56.	1956-57.
Boys .	11·6	6·5	7·8	6·8
Girls .	8·9	3·8	7·1	7·2
Total .	10·3	5·2	7·5	7·0

(10) It is very pleasant to record that the incidence of unhealthy tonsils continues to decline:—

	Percentage of Children with Unhealthy Tonsils.			
	1953-54.	1954-55.	1955-56.	1956-57.
Needing observation .	15·5	12·0	10·0	8·6
Needing treatment . .	0·9	1·1	0·9	0·7

(11) The research conducted into the rising incidence of squint by the Health and Welfare Department some years ago suggested that, as the housing programme gained momentum, the incidence would again decline. It is pleasant to note that this prediction is being fulfilled.

Year.	Percentage of all Children with Squint.	Percentage of Entrants with Squint.
1944-45 . .	3·6	3·5
1945-46 . .	3·8	5·3
1946-47 . .	4·2	7·1
1947-48 . .	5·3	9·7
1948-49 . .	5·0	9·8
1949-50 . .	5·1	9·0
1950-51 . .	5·0	7·0
1951-52 . .	5·1	7·2
1952-53 . .	4·3	6·7
1953-54 . .	4·6	6·4
1954-55 . .	4·7	6·8
1955-56 . .	4·1	6·8
1956-57 . .	3·4	5·7
Typical figure before increase	3·6	3·5
Average 1945-48 .	4·4	7·4
Average 1948-51 .	5·0	8·6
Average 1951-54 .	4·7	6·8
Average 1954-57 .	4·1	6·4

(12) The percentage of children recommended for refraction is tending to decline—from an average of 7·2 in 1953-55 to 7·1 in 1955-56 and 5·1 in 1956-57.

(13) The proportion of children found to be unstable or nervous is increasing sharply—a steady rise from 0·3 per cent. in 1953-54 and 0·5 per cent. in 1954-55 to 1·1 per cent. in 1955-56 and 1·5 per cent. in 1956-57. Better diagnosis may, however, be the answer. One has to remember that the Health and Welfare Department in recent years has made special efforts for the promotion of emotional and mental health and that, possibly as a result of these efforts, a decrease was reported last year in the number of children needing referral to the child guidance clinic.

(14) The percentage of children with deformities is high:—

	Percentage of Children with Deformities.			
	1953-54.	1954-55.	1955-56.	1956-57.
Congenital . .	0·4	0·6	0·6	1·0
Acquired . .	5·9	4·5	4·3	4·6

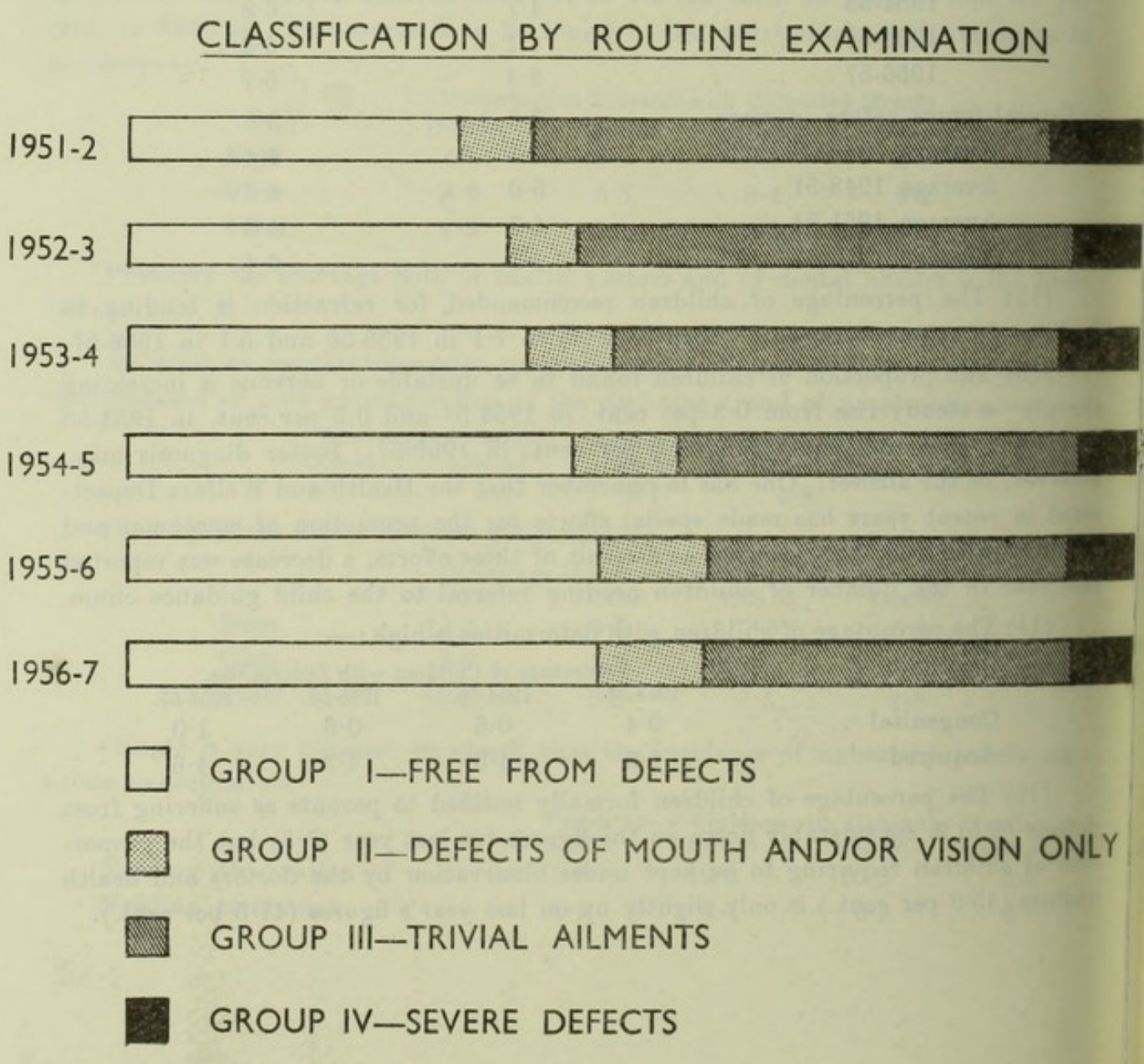
(15) The percentage of children formally notified to parents as suffering from defects (5·5) is considerably down on the figures for last year (7·3) but the proportion of children requiring to be kept under observation by the doctors and health visitors (43·9 per cent.) is only slightly up on last year's figures (41·5 per cent.).

Classification on Routine Examination.

Figures for 1956-57 and percentages for the last four years are given below in tabular form and then in pictorial form.

Classification.	No.	1956-57. %	1955-56. %	1954-55. %	1953-54. %	1952-53. %
I. Free from defects	4,063	45·1	45·3	42·7	38·4	36·4
*IIA. Defective vision but otherwise free from defects	784	12·6	14·9	14·0	11·4	9·4
IIB. Mouth and teeth unhealthy but otherwise free from defects	123	1·4	1·3	1·6	1·5	1·1
*IIC. Combination of IIA and IIB . . .	4	0·1	0·1	0·1	0·2	0·2
III. Children with ailments from which recovery is expected in a few weeks .	3,192	35·5	35·1	38·1	42·7	48·1
IV. Children with more serious defects—						
(*a*) Where cure is considered possible .	597	6·6	6·6	6·2	7·6	6·5
(*b*) Where only improvement is considered possible	238	2·6	2·8	2·6	2·7	2·1

* 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	1,154	5^3	42·5	42·3	1,013	5^2	42·1	41·0
9—10	1,720	9^4	51·9	64·6	1,670	9^4	51·4	63·6
13—14	1,217	13^5	60·0	96·9	1,136	13^4	60·3	100·9
16—17	227	16^1	67·7	136·4	167	16^6	63·5	121·9

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 5,679, as compared with 6,916 in 1955-56, and 5,410 in 1954-55. Details of re-inspections are as follows:—

	No. Re-examined.	Treatment completed.	2nd Notice.	No. Improved but kept under observation.
Dirty heads	59	15	24	20
Defective vision	662	436	71	155
Enlarged tonsils	334	189	91	54
Skin diseases	38	31	7	—
Scabies	2	2	—	—
Other diseases	161	63	81	17
Number under observation	5,873	3,041	2	2,830
Total	7,129	3,777	276	3,076

It will be observed that it is stated that 5,679 represents the total number of children re-inspected, whereas in the table the number is given as 7,129. The difference is due to the fact that some of the children examined had more than one defect.

In addition to the above re-inspection, a new feature was introduced during the school year in that the school leavers were re-inspected within three months of their actually leaving school. The total of "leavers" so inspected was 918. Advice on points affecting employment was given in a few cases to the Youth Employment Officer.

Individual reports on 34 children leaving special schools were submitted to the Youth Employment Officers, and a case conference was held on each. Three

children leaving the special schools were reported for the purposes of the Mental Deficiency Acts under Section 57; one of these was considered suitable for admission to an adult day occupational centre if such were available, and was recommended for admission to the present centre for under 16's meantime.

For the past year one infant school, two primary schools, and one secondary school have been visited regularly each month by the school medical officer and the school health visitor for the purpose of seeing children specifically referred in advance by the teaching staff and for following up the defects observed at previous routine inspections by the school doctor or the school health visitor. An opportunity was also afforded for interviewing parents who, like the teachers, are aware of the regularity of these visits. As a measure of the co-operation between the teaching staff and the School Health Service, 91 children were referred with a note of the specific irregularity noted in class, and, as an indication of the extended co-operation between the parents and the school health staff, 6 parents attended for interview, and 67 homes were specially visited by the health visitor. Moreover, 48 pupils were referred to school clinics, and in 7 instances personal letters were sent to family doctors. Where specific difficulties exist as regards a school situation, long term or short term, it is felt that these periodic inspections carried out in school premises over the whole year greatly improve co-operation between home, school, and the school services. In all, 599 children were seen in this way: of these, 30 behaviour difficulties were brought to notice.

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, 239 such visits were paid by the medical officers (as compared with 241 in 1955-56, 238 in 1954-55, 231 in 1953-54, and 162 in 1952-53).

(2) *Unannounced Visits by Health Visitors.*

Ideally, the health visitor 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 totally insufficient for this purpose. Instead of being inspected thrice annually, most children were seen only twice and some only once.

Inadequacy of inspection by school health visitors remains one of the grave weaknesses of the School Health Service.

In the old days, when standards of hygiene were lower and when the number of inspections was even less adequate, the stress was laid on "cleanliness," which, of course, must never be neglected. Nowadays, however, even greater emphasis during these inspections is placed by the health visitors on such features as—

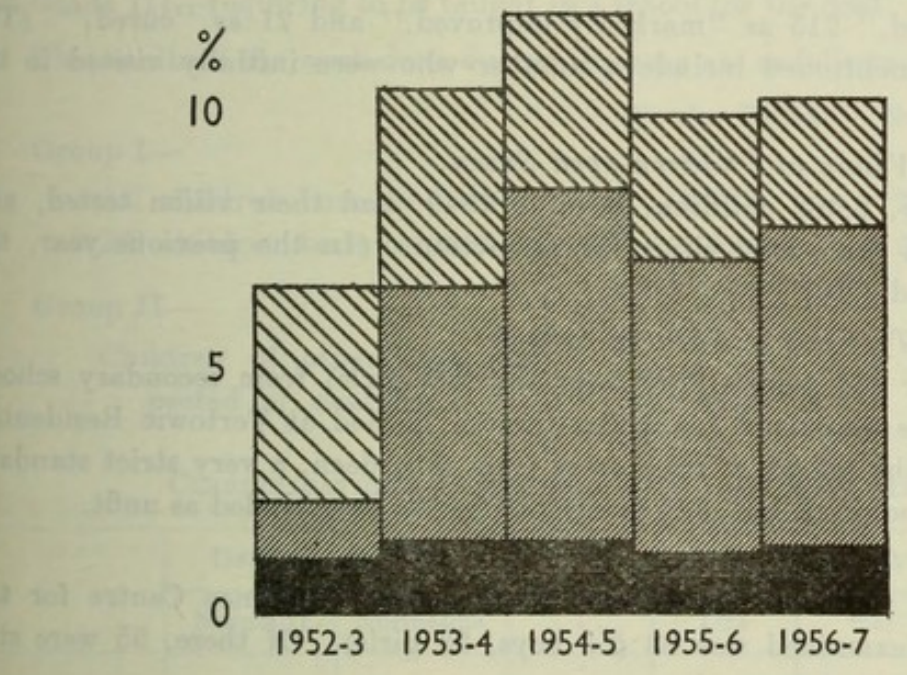
nervousness, fatigue, behaviour difficulties, debility, nutrition, and posture. These conditions, in the aggregate, are about twice as common as defects of "hygiene."

Here are the figures for 1956-57, with, for comparison, data for earlier years.

	1954-55.	1955-56.	1956-57.
(*a*) Total number of inspections	54,003	54,118	53,147
(*b*) Total number showing defects of hygiene—			
Vermin	137	114	110
Nits	1,669	1,401	1,151
Impetigo	84	71	29
Scabies	1	4	0
Bad clothing	446	388	488
Bad footwear	252	202	212
Total	2,589	2,180	1,990
(*c*) Total number showing other diseases or defects	3,704	3,161	3 393

The above table and the diagram below show, when studied, the changing trends and emphasis of the School Health Service.

PERCENTAGES OF TOTAL NUMBER OF ORDINARY INSPECTIONS IN RECENT YEARS



In addition, the health visitors examined 12,449 "selected" cases, many of whom had previously been found to have some defect of cleanliness. Of these, 143 (or 1·1 per cent.) were found to have live head vermin, and 1,539 (or 12·4 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. These visits are time-consuming, but, in spite of shortage of staff, more than double the number of visits to homes were paid by the health visitors than in any previous year.

The health visitors paid 5,426 visits to homes to give advice about school children. The total number of children involved was 5,873. During the year, the classification of the visits of the health visitors continued to be divided into "visits for purely medical reasons" and "visits for reasons of defective cleanliness in some form," and the following table gives figures for three years:—

	"Medical."		"Cleanliness."	
	1st Visits.	Re-visits.	1st Visits.	Re-visits.
1954-55 . . .	903	476	379	542
1955-56 . . .	1,280	647	355	443
1956-57 . . .	3,517	1,597	249	549

As a result of "cleanliness" re-visits, the health visitors reported 206 children as "slightly improved," 213 as "markedly improved," and 21 as "cured." (The 440 children above mentioned include a number who were initially visited in the previous year.)

(4) *Examination of Vision of Children aged Seven.*

During the year, 2,462 children, born in 1949, had their vision tested, and 166 were referred to the school clinic for refraction. (In the previous year, the figures were 2,475 and 220.)

(5) *Examination for Tertowie Residential School.*

During the year 433 pupils (230 boys and 203 girls) from 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) *Child Guidance.*

The number of pupils in attendance at the Child Guidance Centre for the first time who were examined was 83 (55 boys, 28 girls). Of these, 55 were still in attendance at the end of the session.

Reasons for Referral—

Backwardness—general and specific . .	16
Behaviour disorder	65
Enuresis	1
Speech	1

Age-groups of Referrals—

5-10 years—Boys, 37; Girls, 16; Total, 53.
11-15 years—Boys, 21; Girls, 9; Total, 30.

(7) *Audiometric Examination of Seven-year-old and other Children.*

Systematic audiometric testing for the early and scientific detection of hearing defects (which was commenced in 1953) was continued during the year under review. The children tested were those born in the years 1949 and 1946, 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 in previous reports, and the cases of apparent defective hearing were followed up medically (including the use of the auroscope). 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 are as follows:—

	Number Tested.	Normal.	Defective.
Group I—			
All children born in 1949 .	2,726	2,603	123
All children born in 1946 .	2,918	2,798	120
Group II—			
Children of other ages suspected of deafness . .	838	500	338

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 1949	72	9	36	4	2	—	—
,, 1946	79	15	13	6	6	—	—
Group II—							
Other ages	156	58	84	14	21	—	—

NUMBER OF CHILDREN REFERRED FOR INVESTIGATION AND/OR TREATMENT AFTER EXAMINATION BY SCHOOL MEDICAL OFFICERS.

	Group I. 1949.	Group I. 1946.	Group II. Other ages.
Number referred to Hospital for Sick Children . .	—	2	17
Number referred to School Ear, Nose and Throat Clinic	7	14	37
Number referred to own doctor	6	3	26
Number where no action was necessary	61	47	146
Number absent	10	2	15
Number left district	2	—	3
Number awaiting examination by school medical officers	37	52	94

In addition to the above, 348 children at Beechwood School had their hearing tested. Of these, 51 were found to have defective hearing and appropriate action was taken. Also, 10 children were tested at Polmuir Road School for the Deaf.

PROVISIONS FOR HANDICAPPED CHILDREN.

Special educational treatment is provided for the several statutory categories of handicapped children as follows:—

(1) *Deaf* pupils. 24 Grade III deaf pupils attend Linksfield School for the Deaf, as do 4 Grade III pupils of pre-school age.

(2) *Partially-deaf* pupils. 8 Grade IIB deaf pupils attend Linksfield School for the Deaf. There are no Grade IIB deaf pupils attending the ordinary schools.

(3) *Blind* pupils. 5 pupils attend Craigmillar School for Blind, Edinburgh.

(4) *Partially-sighted* pupils. 14 partially-sighted pupils attend the partially-sighted class at Beechwood School.

(5) *Mentally-handicapped* pupils. 251 pupils (141 boys, 110 girls) attend Beechwood School. 69 pupils (trainable) attend Rubislaw Occupational Centre.

(6) *Epileptic* pupils. 12 pupils attend Beechwood School because of epilepsy—all are also mentally-handicapped. 32 epileptic pupils attend the ordinary schools.

(7) *Speech*. 42 pupils attending Beechwood School also have defects of articulation or stammers.

(8) *Maladjusted Pupils.*

175 pupils attend the Child Guidance Centre, 15 attend a special class for maladjusted, and 4 attend a residential school for maladjusted children. 83 examinations were carried out by the medical officer.

(9) *Physically-handicapped Pupils.*

46 pupils attend Beechwood School for the following reasons:—

Cerebral Palsy	26
Poliomyelitis	7
General (heart and lung)	5
General (orthopaedic)	8

Of these 46 physically-handicapped children, 22 are mentally handicapped.

Home Visits.

For the purposes of ascertainment, 43 home visits were made to pre-school children and children of school age not yet attending any school.

Home Tuition.

During the year, 54 children were absent from school for a period of three months or longer for the following reasons:—tuberculosis, 15; orthopaedic conditions, 7; rheumatic infections, 12; nephritis, 4; debility, 9; general heart and lung conditions, 3; other conditions, 4.

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 Charlotte Street Clinic, 46, Charlotte Street, on Mondays at 2 p.m. and Thursdays at 10 a.m., and at Northfield Clinic on Thursdays at 2 p.m. (the clinic formerly held at Powis Secondary School having been discontinued during the year). Children are referred from various sources, such as health visitors, school welfare officers, and head teachers. During the year, 891 children were referred, and made 1,053 attendances: both figures represent a decrease from those for the previous year, which in turn showed a decrease on the year before.

(3) *Diseases of the Ear, Nose, and Throat.*

The Ear, Nose, and Throat Clinic is held at Charlotte Street Clinic, 46, Charlotte Street, 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 years 1955-56 and 1956-57 were as follows:—

	1955-56.	1956-57.
Number of new cases	58	43
Number referred to hospital	12	19
Number referred to own doctor . . .	13	4
Number treated at clinic	13	10
Number discharged requiring no treatment .	20	10
Number of re-attendances	18	23
Total attendance at clinic	568	590
Number discharged cured	38	19

At least 85 per cent. of the new cases are cases of diseases of the ear alone. In addition, there were 8 children referred to the clinic from Aberdeen Hospital for Sick Children and Aberdeen Royal Infirmary for daily treatment.

(4) *Diseases of the Eye, excluding Defective Vision.*

These cases continue to be referred, by arrangement, to the Eye Institution, 142, King Street, Aberdeen. The number of cases so referred was 9 of acute conjunctivitis and 86 of mild conjunctivitis, 8 of severe blepharitis, and 15 of mild blepharitis.

(5) *Diseases of the Skin.*

Three cases of ringworm of the body were found, as compared with no cases last year. Cases of ringworm are referred, by arrangement, for treatment at the Skin Out-Patient Department, Aberdeen Royal Infirmary, Woolmanhill.

As for impetigo, 114 children were treated at the School Skin Clinic, Dispensary Buildings, Guestrow, Aberdeen; 757 attendances were involved. (The figures for the previous year were 145 children and 1,204 attendances, and for 1954-55 were 216 children and 1,635 attendances.) These figures show that the relatively high prevalence of impetigo noted in 1953-54 has gradually been decreasing year by year since then. It is possible now that the bacteria which cause this disease are again becoming rather less 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. Thirty-six 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 2 adults, 81 school children, and 7 children under school age. These figures show a slight increase on the figures for last year.

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:—

Discoid eczema	1
Lichen simplex	1
Molloscum contagiosum . .	1
Pityriasis rosea	1
Warts	92

B—Defective Vision and Squint.

As a result of vision-testing in schools, 2,331 children (1,140 boys and 1,191 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 2,331 children mentioned above, 122 pre-school children were also examined at the clinic. These figures compare with 2,279 school children and 99 pre-school children in the previous year.

Treatment of Squint—Orthoptic Department.

The work in the Orthoptic Department has been hindered this year by the absence of an Orthoptist from 7th September, 1956, until 3rd January, 1957. During this period, the conditions of some of the patients, especially those attending for occlusion, deteriorated. However, none of these suffered permanent harm, and within a month or two of further occlusion the previous standard of vision was again obtained.

Children requiring operations have had to wait only for a short time (*i.e.*, 1-2 months) before being admitted to hospital. During this time, they continued to attend the Orthoptic Department for occlusion or pre-operative treatment.

Co-operation between the child, parents, teachers, school health visitors, and the ophthæmologist and orthoptist is essential in order to obtain good results from orthoptic treatment.

Attendances.

The figures for the Orthoptic Clinic are as follows:—Total number of cases seen, 1,720, of whom 334 were new cases and 1,386 were return cases. Of the 334 new cases, 172 were suitable for treatment, 121 were unsuitable, and 41 had no defect. For "cosmetic" reasons, 33 children underwent operations, 2 of whom had two operations, 1 had three operations, and 3 had four operations before being considered satisfactory, and, for functional results (*i.e.*, cured with orthoptic treatment and operation), 7 children underwent operations, one of whom had two operations.

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, 71 children were examined by the orthopædic surgeons, and 9 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 24; and no action, further than the slight raising of soles and heels of shoes in some cases, was considered necessary in the case of 38 children.

In addition to the above-mentioned cases, 90 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 42 from special schools and 415 from ordinary schools. At the end of the school year, there were 742 cases on the waiting list for speech therapy.

DENTAL INSPECTION AND TREATMENT.

Mr. A. Hay, Chief Dental Officer, reports as follows:—

The scheme of dental service proceeded as previously, within the limits imposed by an understaffed Dental Section.

Staffing.

Once again, it is necessary to report a further decrease in staff. At the beginning of the school year, there were the equivalent of 3 and 8/11 dental officers, instead of an establishment of 7 dental officers. Mrs. Shepherd, employed on a part-time basis of 8 sessions weekly, was obliged, for health reasons, to decrease this to 5 sessions at the end of October, and to 4 at the end of January. Mrs. Shepherd finally resigned her appointment at the end of June, and the effect of this further loss will be very evident in the months to come.

With 3 dental officers, Aberdeen has now the unenviable distinction of being, with Glasgow, one of the two Scottish authorities with the worst staffing/schoolchild ratio. With only 1 dental officer for every 10,000 school children, they compare badly with the Scottish average of 1 : 5,000 or of 1 : 6,500 prevailing in England and Wales. In actual fact, the ratio is even worse, since each dental officer devotes part of his time to the local health authority's service for mothers and pre-school children.

Shortage of Dentists.

Aberdeen is suffering from the inability of local authorities to recruit dentists for their services, coupled with the national shortage. This shortage and the lack of recruits to the profession have been the subject of a government enquiry, under the chairmanship of Lord M'Nair. This Committee, reporting in October, repeated

the warning given some ten years ago by the Teviot Committee. This warning was unheeded, and it is now estimated that, in the next ten years, the number of dentists in the register will drop by a nett 2,000, or one-eighth of the present number.

School Dental Service.

The aim of a satisfactory school dental service, as part of the school health service, is "to ensure that, as far as possible, children shall leave school without loss of permanent teeth, free from dental disease and irregularity, and trained in the care of the teeth."

The preventive methods of controlling dental disease are strict oral hygiene, attention to diet (particularly carbohydrate intake), and regular dental treatment. These means, unfortunately, impose a discipline which is unpopular with the individual. To these means could be added the fluoridation of water supplies, as is being done experimentally in Britain at the present time.

Regular dental inspections, prophylactic treatment and orthodontia to those children accepting, supplemented by instruction in oral hygiene and propaganda by posters and leaflets, are some of the means adopted for dental health education. However, as dental health education is a part of general health education, it is not solely the concern of the dental officer, but is also the responsibility of the parent and of all connected with the health and education of the child.

Dental Inspection.

Children are examined in school, and the parents of those found to require treatment are notified. The parent has then the option of having the child treated by the school dental service, or of arranging for treatment by the general dental service. Ideally, every child should be examined on entry into school, and have the benefit of an annual re-examination up to the end of school life. A school dental scheme is not complete unless this provision can be made for each child.

Inevitably, this is impossible in Aberdeen, although some schools have been inspected annually during the past three years.

19,363 (19,425) children were examined, and 14,461 (14,484) were found to require treatment—a percentage of 75 (75). (Figures in brackets indicate the corresponding figure for previous year.)

The parents of 5,510 (5,959), or a percentage of 36 (41), accepted treatment by the school service. This drop in the acceptance rate can be accounted for in that (*a*) not all the same schools were examined in the two years, and that (*b*) more older children were examined this year. It is a known fact that the acceptance rate falls in the higher age-groups. It should also be pointed out that the number inspected depends on the number of acceptances, and a lower acceptance rate allows for more inspections, since these are done systematically.

Dental Treatment.

This is carried out in the clinic nearest the school and, as far as possible, is along conservative lines. In this connection, it is gratifying to report that 5·3 (4·3) permanent fillings were inserted for every permanent tooth extracted. There

is a reduction in the number of both permanent and temporary teeth extracted, and 29 (43) partial dentures were supplied in the course of a year.

The administration of a general anæsthetic numbered 229 (369). In 1955 and 1954, these numbers were 473 and 811, respectively.

These points would appear to indicate some little progress.

Orthodontic Treatment.

As previously reported, Aberdeen school children have now the benefit of diagnosis by a consultant orthodontist as part of the school service. Formerly, children were referred to hospital, and there was a considerable time-lag before treatment. The necessary treatment is now carried out at all school clinics without delay.

Some 200 children have now benefited by the service, and during the year 77 new cases, together with 122 continued from the previous year, have been treated. 59 appliances were supplied, and treatment completed on 36 cases.

Clinics.

The modernisation policy, begun in 1955, was further advanced when the remaining surgery at the Central Clinic and that at Hilton were re-equipped. The Torry Clinic is now the only one awaiting improvement.

The Northfield Clinic, opened in June, 1956, enabled children in this area to be treated locally, instead of having to attend at the Central Clinic, as formerly. The Northfield Clinic, while serving the Northfield area, is not well sited for the Mastrick area.

General Anæsthetics.

The dental section used to administer its own general anæsthetics, but two years ago, because of staff shortage, these administrations were made by a medical officer. Arrangements have now been completed witih the Regional Hospital Board, and the services of an anæsthetist will shortly be available on a sessional basis at the Central Clinic.

Maternity and Child Welfare Service.

The necessary treatment was given to those mothers referred from the ante-natal and post-natal clinics. In addition, the children in the four nursery schools and the four day nurseries were again examined and treatment given to those whose parents accepted, together with those referred from the Welfare clinics.

Progress and the Future.

While it is gratifying to report on the improvements effected during the past two years on clinic and treatment facilities, it should not be forgotten that, during this same period, there has been a serious deterioration in the staffing position. Until this is remedied, the service can only be regarded as unsatisfactory.

Acknowledgments.

Grateful thanks are due to members of the Section for their enthusiasm and assistance, to Head Teachers for their co-operation, and to other departments for their help during the year.

DENTAL INSPECTION AND TREATMENT, 1956-57.

	Systematic.	Emergency.	Total.
Number Inspected	19,363	—	19,363
Number found to require treatment	14,461	—	14,461
Number accepting treatment	5,150	—	5,150
Number treated	4,531	387	4,918
Number of attendances for treatment	9,432	429	9,861
Fillings—			
(*a*) Permanent teeth	7,349	88	7,437
(*b*) Temporary teeth	1,016	35	1,051
			8,488
Extractions—			
(*a*) Permanent teeth	1,207	185	1,392
(*b*) Temporary teeth	3,393	249	3,642
			5,034
Number of administrations of a general anæsthetic	209	20	229
Other Operations—			
(*a*) Permanent teeth	2,645	43	2,688
(*b*) Temporary teeth	1,910	76	1,986
			4,674
Inspection sessions	111	—	111
Treatment sessions	1,342	—	1,342

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 four years are given for comparison.

	1957.	1956.	1955.	1954.	1953.
Total number of visits paid to schools	102	104	127	101	88
Number of school children fully immunised for the first time (*i.e.*, 2 injections)	483	577	613	661	1,006
Number of school children who have received a reinforcing injection	4,264	4,617	4,205	3,714	3,504

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, 1957, 27,823 children of school age (or 90·8 per cent. of all children attending infant, primary, and secondary schools) had been immunised at some time.

(*b*) *Vaccination against Tuberculosis.*

The campaign to offer protection against tuberculosis to all pupils of 13 years was carried out in the autumn term, 1956. The children for whom consents were received in this age group were first tuberculin tested (Heaf's multiple puncture method) and those found to be negative inoculated with B.C.G. X-ray appointments were arranged for those whose skin-test was found to be positive. Of those recalled for a large X-ray, 3 were referred to the Chest Clinic at the City Hospital, 3 have been kept under observation by the medical officer of the mass radiography unit, and 4 others were found to have chest lesions for which no further action was necessary. In all these cases, the appropriate medical practitioners were notified.

Actually, 1,856 pupils were tested for susceptibility to tuberculosis. Of these, 984 (or 53·0 per cent.) were tuberculin positive, *i.e.*, they had already acquired a "natural" immunity sufficiently high to make artificial immunisation unnecessary.

The remaining 872 (or 47·0 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) 91 (a sample 10 per cent. of the immunised pupils) were re-tested and 80 were found to have been converted to tuberculin-positive reactors, *i.e.*, they had now become "insusceptible" to tuberculosis. It is sometimes found that conversion takes longer than six weeks and the 11 children found to have negative reactions will be re-tested during the campaign in 1957.

ARRANGEMENTS FOR PHYSICAL EDUCATION AND PHYSICAL HYGIENE.

The following information is presented by courtesy of the Director of Education.

Staffing.

The Physical Education staff consists of one male organiser, one female assistant organiser, twenty female, and eighteen male teachers. One female and one male teacher were employed for the major part of the session in a full-time temporary capacity. In addition, four accompanists and one swimming instructor were employed.

Six female teachers were fully employed in primary schools, eleven women and five men were employed part-time in secondary and primary schools, whilst twelve women and thirteen men were fully engaged in secondary schools.

Mr. T. S. Fairley, Superintendent of Physical Education since 1931, retired from service on 22nd April, 1957, and was succeeded by Mr. J. C. Hunter. During Mr. Fairley's 25 years of service, physical education in schools developed from a minor subject to one which now rightly claims its proper place in the school curriculum, and much of the popularity which the subject enjoys in Aberdeen schools can be attributed to the skill, enthusiasm, and devotion with which Mr. Fairley carried out his duties. Mr. Hunter entered the service of Aberdeen Education Committee in May, 1946. He was employed in Aberdeen Grammar School, firstly as an assistant and subsequently, since April, 1947, as Principal Teacher of Physical Education.

A large number of students from the Dunfermline College of Physical Education carried on teaching practice in various primary and secondary schools.

Primary Schools.

As far as it was practicable, the time allocation of three periods of thirty minutes per week was adhered to in all infant and primary schools.

Draft copies of the Primary Syllabus of Physical Education have been available to all teachers in primary schools, and it is hoped that the full comprehensive scheme of physical training, dancing, and games will be available early in the new session.

Specialist teachers of physical education paid weekly visits to all infant and primary schools and taught demonstration lessons as a guide to the class teacher, who is responsible for teaching the two remaining weekly periods.

Without exception, the work done in the infant and primary schools is of a high standard and is much enjoyed by the children. Generally, the physique and re-actions of the pupils are good and their attitude to physical education is entirely satisfactory.

Secondary Schools.

During this session, there has been no major change in the content of the schemes of work for girls and boys nor have any new instructions been issued by the department, but the work done by the two sexes is, rightly so, becoming less closely connected than in the past and is now more suited to the needs of the pupils. In girls' work, the movements are based on dancing, giving opportunities for individual interpretation and self-expression in movement and in activities performed on or with apparatus. In boys' work, the movements are vigorous and manly, offering definite challenges to strength, co-ordination, agility, and courage. The exercises are objective rather than subjective and are based upon the developing of good muscular habits and skills which lead to greater health and efficiency in ordinary everyday life.

Indoor Accommodation.

The facilities for the indoor lesson in primary schools are in all cases adequate, and in the majority are excellent. In some of the older schools, although the hall or gymnasium may be reasonable, dressing accommodation is entirely lacking.

All secondary schools have fully equipped gymnasia and, when the reconstruction work at the Middle School is completed, all will have properly appointed ancillary accommodation.

Playing Fields and Out-door Activities.

A full-scale review of the existing school playing field facilities has recently been carried out and the findings have shown that the over-all position is good and the majority of the schools are able to carry out the normal out-door activities.

The usual extensive programme of primary and secondary school games competitions was carried out on Saturdays and during the evenings throughout the session. Keen competition and a high standard of play were the outstanding features of all of these inter-school contests.

Remedial Work—Treatment of Physical Defects.

The Remedial Clinic at the College of Physical Education, Woolmanhill, continues to function satisfactorily. Sixty children of school age received treatment for a variety of physical defects and the pre-school children's class continues to be well attended.

An orthopædic surgeon visits the clinic regularly and examines the children.

Swimming.

Throughout the session, swimming classes for beginners were held in the Middle School pond. In addition, advanced swimming and instruction in the art of life-saving was given to secondary school pupils who had gained the Committee's elementary certificate. The attendance for the session was 12,783, representing an average weekly attendance of 609.

Similar classes for beginners were arranged at the Bon-Accord and Beach Baths from October to March. The total attendance at both ponds was 16,548, and the weekly average attendance 534.

The highly satisfactory progress made in swimming in Corporation schools throughout the session is shown by the very creditable performance in the various local and Royal Life-saving Society tests.

801 pupils gained the Education Committee's Elementary Certificate.
128 pupils gained the Education Committee's Advanced Certificate.
4 pupils gained the R.L.S.S. Elementary Certificate.
19 pupils gained the R.L.S.S. Intermediate Certificate.
68 pupils gained the R.L.S.S. Bronze Medallion Award.
6 pupils gained the R.L.S.S. Bar to Bronze Medallion Award.
13 pupils gained the R.L.S.S. Bronze Cross Award.
11 pupils gained the R.L.S.S. Award of Merit.

Following a full-scale swimming gala in the Bon-Accord Baths on the 28th March, 1957, a team was selected to represent the North-East area at the Scottish Schools' Swimming Championships. This is the first time such a gala has been

held for this purpose and undoubtedly it acted as a great stimulant to school swimmers.

Five girls and one boy from Aberdeen Corporation Schools represented the district at the Championships in Perth. Two girls were successful, each gaining second place in their events.

Athletics.

All Secondary and a good number of Primary schools held individual Sports Meetings and all entered representatives in the Annual Secondary and Primary Schools' Sports. These Sports were held at Linksfield Stadium on Tuesday and Wednesday, 18th and 19th June, respectively, and were marked by many closely-contested events. The new Secondary Schools' Athletic Trophy presented by the Education Committee was competed for for the first time and was won by Rosemount School who had won the Sports Championship on the three previous occasions.

Scottish Schools' Athletic Championships.

Twelve girls from the Academy and fifteen from the High School for Girls represented Aberdeen Corporation Schools at the Scottish Schools' Championships in Glasgow on 15th June, 1957. Three girls gained places in their events and were selected to represent the Scottish Schools in an athletic contest against Northern English Counties at Durham on 29th June, 1957.

Twenty-four boys, fifteen from the Grammar School and nine from the Academy, represented Aberdeen Corporation Schools at the Schools' Championships at Edinburgh on 15th June, 1957. One boy gained a place in his event and five others gained Scottish Standard medals.

Spray Baths.

The Corporation Spray Baths at Hanover Street were used on alternate weeks by boys and girls from three Secondary and six Primary schools in the east side of the City. The total attendance for the session under review was 14,417, representing an average weekly attendance of 379 pupils.

Winners of Trophies.

	Secondary.	Primary.
Football . . .	Hilton	Cummings Park
Basketball . .	Kaimhill	——
Cricket—		
"A" League .	Powis	Quarryhill
"B" League .	Powis	——
Netball . . .	Torry	Tullos
Swimming . .	Ruthrieston	Ashley Road
Athletics . . .	Rosemount	Mile-end

OTHER ACTIVITIES IN RELATION TO SCHOOL CHILDREN.

(*a*) *Linn Moor Convalescent Home, Culter.*

During the year, 73 children (42 boys and 31 girls) were sent to this Home, as compared with 63 in the previous year. In addition, three batches of 54 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, 1957.*

During the months of June and July, medical officers visited ten secondary schools and four primary schools for the purpose of inspecting batches of children who proposed going to the holiday camps. Each batch was inspected twice. Of 723 children finally examined, one had to be rejected because of an unclean head, one because of conjunctivitis, and 7 because of failure to attend final inspection. This compares with the figures for the corresponding period last year of 817 children examined, no failures because of unclean heads, and 11 because of absence.

(*c*) *Junior Club Camps, 1957.*

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, 171 children were finally examined, and none had to be rejected because of unclean heads.

(*d*) *Senior Club Camps, 1957.*

Two 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 113 breakfasts were supplied each day (as compared with 178 in 1955-56). The price of a two-course lunch was increased to one shilling per meal during the year. Two-course lunches have been supplied daily during the year to an average of 4,900 pupils (as compared with 5,771 in 1955-56). Three-course lunches to the daily average number of 82 were supplied to pupils attending the Trades College.

(*f*) *Milk.*

The average number of bottles (one-third pint) of pasteurised milk supplied daily was 26,225, as compared with 27,738 in the previous year.

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 1936-57.

Table I.

Total number of children examined at—

(*a*) Systematic examinations—

Ordinary schools—	
Entrants	2,801
Second age-group	3,439
Third age-group	2,363
Fourth age-group	—
Secondary schools—Age-group	398
	9,001

(*b*) Other examinations—

Special cases	2,534
Re-inspections by medical officers	5,679
	8,213

Number of individual children inspected at systematic examinations who were notified to parents as requiring treatment (excluding uncleanliness and dental caries):—

Entrants	99
Second age-group	216
Third age-group	152
Fourth age-group	—
Secondary age-group	24
	491

TABLE

SYSTEMATIC

Return of number and percentage of individual children

NATURE OF DEFECT.	Total Examined. All ages.	ENTRANTS.			
		Boys 1,490		Girls 1,311	
1. Clothing unsatisfactory	9,001	2	·1	1	·1
2. Footgear unsatisfactory	,,	1	·1	2	·2
3. Cleanliness—					
(*a*) Head: Nits	,,	3	·2	14	1·1
Vermin	,,	—	—	—	—
(*b*) Body: Dirty	,,	—	—	1	·1
Vermin	,,	—	—	—	—
4. Skin—					
(*a*) Head:					
Ringworm	,,	—	—	—	—
Impetigo	,,	4	·3	4	·3
Other Diseases	,,	4	·3	8	·6
(*b*) Body:					
Ringworm	,,	—	—	—	—
Impetigo	,,	2	·1	—	—
Scabies	,,	1	·1	—	—
Other Diseases	,,	41	2·8	43	3·3
5. Nutritional state—					
Slightly defective	,,	25	1·7	54	4·1
Bad	,,	—	—	2	·2
6. Mouth and Teeth Unhealthy	,,	101	6.8	121	9·2
7. Naso-Pharynx—					
(*a*) Nose:					
(i) Obstruction requiring observation	,,	96	6·4	88	6·7
(ii) Obstruction requiring Operative Treatment	,,	6	·4	6	·5
(iii) Other Conditions	,,	—	—	2	.2
(*b*) Throat:					
(i) Tonsils requiring observation	,,	211	14·2	206	15·7
(ii) Tonsils requiring Operative Treatment	,,	17	1·2	18	1·4
(*c*) Glands:					
(i) Requiring observation	,,	114	7·7	106	8·1
(ii) Requiring Operative Treatment	,,	2	·1	—	—
8. Eyes—					
(*a*) External Diseases:					
Blepharitis	,,	5	·3	15	1·1
Conjunctivitis	,,	4	·3	2	·2
Corneal Opacities	,,	—	—	1	.1
Squint	,,	56	3·8	87	6·6
Other Diseases	,,	9	·6	7	·5
(*b*) Visual Acuity (Snellen):					
Defective—Fair	6,200	—	—	—	—
Bad	,,	—	—	—	—
Recommended for Refraction	,,	20	1·3	19	1·4
Number wearing Glasses	9,001	39	2·6	49	3·7
9. Ears—					
(*a*) Diseases;					
Otorrhœa	,,	12	·8	8	·6
Other Diseases	,,	37	2·5	23	1·8

II.

EXAMINATIONS.

in each age-group suffering from particular defects.

SECOND AGE-GROUP.				THIRD AGE-GROUP.				FOURTH AGE-GROUP.				ALL AGES.			
Boys 1,733		Girls 1,706		Boys 1,218		Girls 1,145		Boys 227		Girls 171		Boys 4,668		Girls 4,333	
1	·1	—	—	—	—	1	·1	—	—	—	—	3	·1	2	·05
—	—	—	—	1	.1	—	—	—	—	—	—	2	·04	2	·05
—	—	20	1·2	—	—	15	1·3	—	—	—	—	3	·1	49	1·1
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	·02
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
8	·5	7	·4	—	—	1	·1	—	—	—	—	12	·3	12	·3
3	·2	8	·5	6	·5	18	1·6	3	1·3	4	2·3	16	·3	38	·9
2	·1	—	—	1	·1	—	—	—	—	—	—	3	·1	—	—
—	—	—	—	—	—	—	—	—	—	—	—	2	·04	—	—
1	·1	—	—	—	—	—	—	—	—	—	—	2	.04	—	—
35	2·0	26	1·5	24	2·0	26	2·3	6	2·6	1	·6	106	2·3	96	2·2
29	1·7	41	2·4	13	1·1	5	·4	—	—	—	—	67	1·4	100	2·3
—	—	—	—	—	—	—	—	—	—	—	—	—	—	2	·05
77	4·4	90	5·3	22	1·8	44	3·8	1	·4	—	—	201	4·3	255	5·9
95	5·5	53	3·1	28	2·3	46	4·0	3	1.3	3	1·8	222	4·8	190	4·4
3	·2	1	·1	—	—	1	·1	—	—	—	—	9	·2	8	·2
3	·2	1	·1	2	·2	2	·2	2	·9	—	—	7	·1	5	·1
120	6·9	147	8·6	10	·8	72	6·3	1	·4	3	1·8	342	7·3	428	9·9
10	·6	10	·6	2	·2	2	·2	—	—	—	—	29	·6	30	·7
56	3·2	44	2·6	17	1·4	14	1·2	—	—	—	—	187	4·0	164	3·8
—	—	3	·2	—	—	—	—	—	—	—	—	2	·04	3	·1
32	1·8	31	1·8	6	·5	35	3·1	1	·4	2	1·2	44	·9	83	1·9
2	·1	1	·1	—	—	—	—	—	—	—	—	6	·1	3	·1
—	—	1	·1	—	—	1	·1	—	—	—	—	—	—	3	·1
43	2·5	60	3·5	19	1·6	38	3·3	1	·4	2	1.2	119	2·5	187	4·3
5	·3	14	·8	6	·5	7	·6	1	·4	—	—	21	·4	28	·6
230	13·3	236	13·8	252	20·7	268	23·4	74	32·6	46	26·9	556	17·5	550	18·2
78	4·5	97	5·7	54	4·4	57	5·0	18	7·9	12	7·0	150	4·7	166	5·5
70	4·0	98	5·7	53	4·4	72	6·3	18	7·9	6	3·5	141	4·4	176	5·8
169	9·8	174	10·2	168	13·8	204	17·8	58	25·6	46	26·9	434	9·3	473	10 9
17	1·0	9	·5	4	·3	10	·9	1	·4	1	.6	34	·7	28	·6
25	1·4	19	1·1	11	·9	19	1·7	—	—	2	1·2	73	1·6	63	1·5

TABLE

SYSTEMATIC

Return of number and percentage of individual children

NATURE OF DEFECT.	Total examined. All ages.	ENTRANTS.			
		Boys 1,490		Girls 1,311	
9. Ears—(Continued)—					
(*b*) Defective Hearing :					
Grade I	6,200	—	—	—	—
Grade IIA	,,	—	—	—	—
Grade IIB	,,	—	—	—	—
Grade III	,,	—	—	—	—
10. Speech—					
Defective articulation	9,001	36	2·4	17	1·3
Stammering	,,	9	·6	5	·4
11. Mental and Nervous Conditions—					
(*a*) Backward	,,	2	·1	1	·1
(*b*) Dull	,,	1	·1	—	—
(*c*) Mentally deficient (Educable)	,,	—	—	—	—
(*d*) Mentally deficient (Ineducable)	,,	—	—	—	—
(*e*) Highly nervous or unstable	,,	31	2·1	27	2·1
(*f*) Difficult in behaviour	,,	19	1·3	14	1·1
12. Circulatory System—					
(*a*) Organic heart disease :					
(i) Congenital	,,	5	·3	4	·3
(ii) Acquired	,,	2	·1	4	·3
(*b*) Functional conditions	,,	6	·4	2	·2
13. Lungs—					
Chronic bronchitis	,,	9	·6	7	·5
Suspected tuberculosis	,,	14	·9	11	·8
Other diseases	,,	47	3·2	32	2·4
14. Deformities—					
(*a*) Congenital	,,	21	1·4	17	1·3
(*b*) Acquired (Infantile paralysis)	,,	5	·3	3	·2
(*c*) Acquired (Probably rickets)	,,	91	6·1	58	4·4
(*d*) Acquired (Other causes)	,,	21	1·4	13	1·0
15. Infectious diseases	,,	—	—	1	·1
16. Other diseases or defects	,,	270	18·1	194	14·8
17. Classification :					
Group I	,,	549	36·8	477	36·4
Group IIA	6,200	—	—	—	—
Group IIB	9,001	24	1·6	26	2·0
Group IIC	6,200	—	—	—	—
Group III	9,001	728	48·9	641	48·9
Group IVA	,,	159	10·7	133	10·1
Group IVB	,,	30	2·0	34	2·6
Number Notified to parents	,,	59	4·0	40	3·1
Number under observation	,,	861	57·8	774	59·0
Number of Parents present	,,	1,400	94·0	1,252	95·5

II (Continued.)

EXAMINATIONS.

in each age-group suffering from particular defects.

SECOND AGE-GROUP.				THIRD AGE-GROUP.				FOURTH AGE-GROUP.				ALL AGES.			
Boys 1,733		Girls 1,706		Boys 1,218		Girls 1,145		Boys 227		Girls 171		Boys 4,668		Girls 4,333	
6	·3	1	·1	6	·5	4	·3	1	·4	—	—	13	·4	5	·2
2	·1	—	—	2	·2	2	·2	1	·4	—	—	5	·2	2	·1
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
12	·7	6	·4	1	·1	1	·1	—	—	—	—	49	1·0	24	·6
8	·5	3	·2	2	·2	1	·1	—	—	—	—	19	·4	9	·2
3	·2	—	—	—	—	1	·1	—	—	—	—	5	·1	2	·05
—	—	—	—	—	—	—	—	—	—	—	—	1	·02	—	—
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
37	2·1	23	1·3	8	·7	7	·6	1	·4	—	—	77	1·6	57	1·3
5	·3	5	·3	2	·2	3	·3	—	—	—	—	26	·6	22	·5
5	·3	5	·3	5	·4	4	·3	—	—	1	·6	15	·3	14	·3
3	·2	—	—	1	·1	3	·3	—	—	—	—	6	·1	7	·2
4	·2	9	·5	2	·2	1	·1	—	—	—	—	12	·3	12	·3
—	—	—	—	3	·2	—	—	1	·4	—	—	13	·3	7	·2
17	1·0	17	1·0	—	—	8	·7	—	—	1	·6	31	·7	37	·9
38	2·2	22	1·3	6	·5	14	1·2	1	·4	2	1·2	92	2·0	70	1·6
24	1·4	13	·8	9	·7	5	·4	—	—	1	·6	54	1·2	36	·8
4	·2	4	·2	2	·2	1	·1	1	·4	—	—	12	·3	8	·2
38	2·2	46	2·7	13	1·1	34	3·0	2	·9	4	2·3	144	3·1	142	3·3
29	1·7	22	1·3	11	·9	11	1·0	—	—	—	—	61	1·3	46	1·1
—	—	2	·1	1	·1	—	—	—	—	—	—	1	·02	3	·1
192	11·1	193	11·3	83	6·8	144	12·6	6	2·6	20	11·7	551	11·8	551	12·7
822	47·4	795	46·6	720	59·1	497	43·4	118	52·0	85	49·7	2,209	47·3	1,854	42·8
145	8·4	125	7·3	243	20·0	151	13·2	80	35·2	40	23·4	468	14·7	316	10·5
19	1·1	24	1·4	10	·8	19	1·7	1	·4	—	—	54	1·2	69	1·6
—	—	1	·1	—	—	3	·3	—	—	—	—	—	—	4	·1
591	34·1	621	36·4	164	13·5	389	34·0	21	9·3	37	21·6	1,504	32·2	1,688	39 0
92	5·3	101	5·9	58	4·8	46	4·0	6	2·6	2	1·2	315	6·7	282	6·5
64	3·7	39	2·3	23	1·9	40	3·5	1	·4	7	4·1	118	2·5	120	2·8
103	5·9	113	6·6	61	5·0	91	7.9	18	7·9	6	3·5	241	5·2	250	5·8
715	41·3	722	42·3	340	27·9	432	37·7	61	26·9	44	25·7	1,977	42·4	1,972	45·5
,533	88·5	1,505	88·2	760	62·4	759	66·3	42	18·5	52	30·4	3,735	80·0	3,568	82·3

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	1,026	36.6	1,617	47·0	1,217	51·5	203	51·0	**4,063**	**45·1**
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	—	—	270	7·9	394	16·7	120	30·2	**784**	**8·7**
(*b*) Oral Sepsis, etc.	50	1·8	43	1·3	29	1·2	1	·3	**123**	**1·4**
(*c*) Both (*a*) and (*b*)	—	—	1	·02	3	·1	—	—	**4**	**·04**
Total	50	1·8	314	9·1	426	18·0	121	30·4	**911**	**10·1**
III. Children suffering from ailments (other than those mentioned in II.) from which complete recovery is anticipated within a few weeks	1,369	48·9	1,212	35·2	553	23·4	58	14·6	**3,192**	**35·5**
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	292	10·4	193	5·6	104	4·4	8	2·0	**597**	**6·6**
(*b*) Where improvement only is considered possible, *e.g.*, without complete restoration of function	64	2·3	103	3·0	63	2·7	8	2·0	**238**	**2·6**
Total	356	12·7	296	8·6	167	7·1	16	4·0	**835**	**9·3**
Total number of children examined	**2,801**	**100%**	**3,439**	**100%**	**2,363**	**100%**	**398**	**100%**	**9,001**	**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	—	5	—	5
2. Partially sighted—				
(*a*) Refractive errors in which the curriculum of an ordinary school would adversely affect the eye condition	—	2	—	2
(*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	—	12	—	12
3. Deaf—				
Grade I	381	—	—	381
Grade IIA	45	—	—	45
Grade IIB	—	8	—	8
Grade III	—	24	—	24
4. Defective Speech—				
(*a*) Defects of articulation requiring special educational measures	760	64	—	824
(*b*) Stammering requiring special educational measures	355	20	—	375
5. Mentally defective children (between 5 and 16 years)—				
(*a*) Educable (I.Q. approx. 50-70)	—	251	—	251
(*b*) Trainable	—	69	3	72
(*c*) Ineducable	—	—	16	16
6. Epilepsy—				
(*a*) Mild and occasional	32	12	—	44
(*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)	6	—	—	6
(*b*) General orthopædic conditions	130	34	3	167
(*c*) Organic Heart Disease	141	5	—	146
(*d*) Other causes of ill-health	—	7	—	7
8. Multiple defects—				
(*a*) Mentally defective and deaf	—	29	—	29
(*b*) Physically defective and mentally defective	—	22	1	23
(*c*) Mentally defective (ineducable) and blind	—	—	2	2

Table V.—Heights and Weights, 1936-1957.

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.		
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
1955-56	5 3	42·5	42·2	9 4	51·7	64·3	13 5	59·5	94·4	16 5	67·8	134·4
[illegible]	5 3	42·5	42·2	9 4	51·8	64·6	13 5	60·0	96·0	16 4	67·7	136·4

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.		
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
1955-56	5 3	42·1	40·7	9 4	51·3	62·6	13 5	59·9	99·4	16 5	63·8	126·6
1956-57	5 2	42·1	41·0	9 4	51·4	63·6	13 4	60·3	100·9	16 6	63·5	121·9

18.—PORT HEALTH ADMINISTRATION.

The control of port health and port sanitary work is a duty of the Medical Officer of Health in his capacity as Port Medical Officer.

Work involving the inspection of fish, markets, premises, fishing vessels, and other shops is carried out by the staff of the Sanitary Section of the Health and Welfare Department, and the duties now take the full time of two District Sanitary Inspectors. During the year, ships from foreign countries entered the port on 432 occasions, and on 342 of these occasions were boarded by a sanitary inspector. A review of this part of the work will be given by the Chief Sanitary Inspector in his Annual Report.

The Public Health (Ships) (Scotland) Regulations, 1952, describe the action to be taken by the master of a ship if infectious disease on board is known or suspected or if the ship has come from an infected port, and also deal with the action to be taken by the Port Medical Officer under these circumstances. A list of countries considered infected by plague, cholera, yellow fever, smallpox, typhus, and relapsing fever is compiled weekly by the Medical Officer of Health from information furnished by the World Health Organisation, and copies of this list are supplied to the customs authorities, sanitary inspectors, and medical officers of the department. During the year, 19 ships from these infected areas entered the port. Satisfactory declarations of health were received from all, all were boarded by appropriate officers, medical examinations were conducted when deemed necessary, and no cases of infectious disease were found.

19.—FOOD SUPPLY AND FOOD HYGIENE.

This year was the first full year of the Food and Drugs Act, 1956. The main provision of that Act brought up to date the procedure for dealing with the composition and labelling of food and drugs, the procedure to be taken in connection with the prohibition of food unfit for human consumption, and the registration of certain manufacturers and traders. The Act also made it compulsory for all cases of food poisoning to be notified to the Medical Officer of Health, and it is interesting to note that, during the year, there were ten cases of food poisoning in the City.

In the report for 1956 reference was made to the special Clean Food Guide—an illustrated booklet of some fifty pages prepared by the staff of the Health and Welfare Department and published by Batiste Publications, Limited, containing information and guidance on clean food; and during the year under review 3,000 copies of this booklet were distributed at clinics and parents' clubs and to catering establishments and similar agencies.

In the examination of food samples, the bacteriologist has begun to play an even bigger part than the biochemist in advising on the important subject of food hygiene, and it has become imperative that the medical officer takes an active part instead of delegating this work entirely to the sanitary inspector. Also, since the

biggest normal handler of food is the housewife, it has become obvious that the 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. All three—medical officer, health visitor, and sanitary inspector—must work as a team.

It may be noted in passing that no case of food-borne disease during the year has been attributed to defects of food-handling in shops.

It is not proposed to discuss here certain matters which are, in the main, undertaken by the Sanitary Section but 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 certain information about food premises inspected, defects found and remedied, and assessments of hygienic standards attained.

Mention may, however, be made of some points in connection with meat and other foods. Of the four private slaughter-houses licensed within the Burgh, two belong to the Flesher Incorporation, and all were in operation during the year, either continuously or intermittently.

In 1957 slightly more animals were slaughtered than in the previous year, but the number of carcases condemned was less. 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	79,968	195	335	155,795
Sheep	104,243	207	143	16,802
Pigs	3,447	41	149	8,916
Calves	525	64	2	3,473
	188,183	507	629	184,986

In addition, 773 lots of organs or offal were condemned, and these weighed 105,491 lbs. The total weight of condemned meat and offal thus amounted to 290,477 lbs.

During the year, there were no prosecutions under the Slaughter of Animals (Scotland) Act, 1928. Some eighty 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 1957, there was no outbreak of swine fever.

During the year, no particular food hygiene campaigns (apart from the distribution of the booklet) 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.

20.—SERVICES UNDER NATIONAL ASSISTANCE ACT, &c.

This section of the report deals with services provided to maintain the physical and emotional health and social well-being of elderly persons and to meet the needs of the aged and infirm.

The care of the aged is a developing field, and during 1957 there was steady progress in the build-up of the various services provided by the Corporation for the benefit of the elderly. There was a further substantial increase in the number of names on the department's register of old people. By the end of the year the register stood at a total of about 2,500, which represents more than one in ten of all old persons in the City deriving benefit from domiciliary services, and, to summarise the position in 1957 as compared with the year previous—

(1) More old people received visits from health visitors.

(2) About the same number required the attention of home nurses.

(3) More needed the services of home helps, who attended 906 households of elderly persons, as compared with 778 in 1956.

(4) More had meals supplied by the meals-on-wheels service.

(5) More than ever before were dealt with by the chiropody service.

As regards residential accommodation, a small number of additional places were made available at Newhills Home, but the main feature was the advancement of the work at Thorngrove Home to near completion by the end of the year.

The year 1957 also saw the completion of the field work on the comprehensive survey of the elderly, and a preliminary report drawn up by the Principal Assistant Medical Officer is appended to this section.

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 have been indicated in previous reports.

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 accom-

modation would remain available for aged and infirm persons until 31st December, 1959.

Since 1948, the Corporation have acquired or built hostels as follows:—

(1) Balnagask House, opened in 1950—(25 persons).
(2) Nos. 3-5, Ferryhill Place, 1951-1953—(24 persons).
(3) Northfield Lodge, 1953—(40 persons).
(4) No. 30, Albyn Place, 1954—(24 persons).
(5) Newhills Home, 1955—(59 persons, plus 6 temporary cases).
(6) No. 19, Polmuir Road, 1955—(32 persons).

During 1957, additional accommodation for residents was provided at Newhills Home. By the end of the year, the total accommodation available in local authority homes, other than Glenburn Wing, was, therefore, 204 places, and work was well advanced on the conversion of the former residential nursery at Thorngrove into an old persons' home to accommodate a further 50 residents.

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 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, 1957, 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	6	15	21
Balnagask House	12	13	25
Nos. 3-5, Ferryhill Place	10	12	22
Newhills Home	26	28	54
Northfield Lodge	10	28	38
No. 19, Polmuir Road	6	18	24
Glenburn Wing of Woodend Hospital	14	8	22
Voluntary Homes—			
Aberdeen Old People's Welfare Council	10	15	25
Church Homes	3	5	8
King Street Hostel	—	1	1
St. Margaret's Hostel	—	12	12
Homes in other Areas	1	—	1
Totals	98	155	253

These figures do not include residents temporarily in hospital whose places in the homes are reserved pending their return. As compared with the totals at the end of 1956, there was no significant change in the numbers accommodated, apart from a small increase in the number of residents at Newhills Home.

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 1957, as in past years, it was necessary, owing to the deterioration in the condition of some few residents, to have them transferred to the chronic sick wards of one of the hospitals. In close liaison with the hospital authorities, suitable two-way arrangements were made in one or two cases whereby convalescent patients were transferred from hospital to hostel and sick patients from hostel to hospital.

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, and some provisions made by the Corporation for the health and welfare of the elderly in their own homes are here summarised:—

(1) *Visitation of the elderly by health visitors.*—On the health visitor rests the statutory duty of advising the whole family on many matters of physical, mental, and emotional health, and in recent years an increasing proportion of her work has been devoted to the care of the elderly. The health visitor's advice on diet, clothing, proper balance on rest and exercise, and about the development of leisure interests in preparation for retirement can be of supreme importance in maintaining the health of persons of ripe years; where an old person is beginning to need material assistance (*e.g.*, a home help, or the mobile meals service, or chiropody) the health visitor can assess the need and initiate any necessary action; when an old person becomes perplexed about the various allowances possibly available to him the health visitor can frequently remove his confusion. During 1957, more than 2,500 elderly citizens received visits from health visitors.

(2) *Home Help Service.*—The bulk of the work of this service is now performed in the homes of the elderly, usually on a basis of two or three mornings per week per person, and the amount of this work is still increasing steadily. During 1957, 906 households of persons over 65 years of age received such assistance as compared with 778 in 1956—an increase of 16 per cent.

(3) *Home Nursing Service.*—Nearly half of all cases now dealt with by the district nurses on the day service, and about three-quarters of the cases of nurses on the night service, are persons over 65 years of age. Further details are given in an earlier section.

(4) *Chiropody Service.*—This service is described in the section relating to care and after-care, but it may be noted here that by the end of 1957 the work occupied the equivalent of three full-time chiropodists, and about 1,700 old persons living at home were receiving chiropody treatment either at the clinic or in their own homes.

(5) *Meals-on-wheels Service.*—This service is run by the W.V.S. and subsidised by the Corporation, who paid £270 6s. 8d. for 8,110 meals supplied during the year, as compared with £243 6s. 8d. for 7,300 meals in 1956—an increase of 11 per cent. To meet the expansion of the meals service, the Corporation also paid £40 8s. for additional food containers for use by the W.V.S.

(6) *The Register of Old Persons.*—The register is of invaluable assistance in the co-ordination of services for old people and in the follow-up of cases. The number of old people registered is also a general guide to the scope of services for the elderly. During 1957, over 800 names were added and by the end of the year the register stood at a total of about 2,500 elderly persons.

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 four years. There are at present 316 persons on the register (as compared with 325 in 1956), but a total of 381 have been registered since the commencement of the scheme. The reduction in numbers is accounted for by deaths and removals to other areas.

The visiting pattern for these people remained much the same during the last year as in the three previous years.

A proportion still required frequent visiting. Occasionally, material help was obtained from other public and voluntary organisations; for example, a few people benefited from holidays which afforded them a complete change from their normal environment. The money was provided, in the main, by one of the local voluntary organisations.

After initial enquiries and requests by the local authority, the National Assistance Board, in some cases, granted special allowances to meet additional expenses such as removal costs.

With regard to housing, there is still a need for more ground-floor accommodation, including special purpose dwellings for single handicapped persons. Many on the register are waiting to be re-housed. Certain adaptations to existing dwellings have been made to suit the needs of disabled tenants.

The arrangement has continued whereby severely handicapped sighted persons or partially sighted persons may be given the opportunity of training and employment in the Aberdeen Asylum for the Blind if they are suitable and other means of employment are found impossible.

Financially, 1957 proved a difficult year for many handicapped persons and there were again a few who were helped to obtain practical assistance by the local authority from voluntary and other sources. The long term unemployed disabled find budgeting on a permanently low income to be most trying and often need guidance.

A building suitable for use as an Occupational Centre has been acquired by the local authority. It is hoped that this will be opened within the next few months. It will serve to provide a place where physically handicapped adults will meet and occupy their time by doing various handcrafts. It is likely that many disabled people not yet known to the department will attend the centre as well as those on the register. This centre will be provided in order to fill in one of the gaps in existing local social services. It will serve the needs of the group who have never been fit enough to work or will never work again but there are others who will also be helped by it. These are disabled persons searching for suitable work but unable to be fitted into ordinary employment locally.

As with each Local Authority Welfare Service, close contact has been maintained with other interested organisations.

(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, 1957, the Corporation paid to the Royal Aberdeen Asylum for the Blind the sum of £300 10s. 8d. in respect of each City worker registered under the Disabled Persons (Employment) Act, 1944. There were 55 workers employed and the total cost to the Corporation was £15,287 13s. 7d., of which sum a grant at the rate of £100 per annum (increased to £150 per annum from 1st

April, 1957) 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 £9,753 15s. 11d. In respect of two partially-sighted persons likewise employed, the Corporation paid the sum of £225 19s. 7d. and grant at the same rate as for blind workers was recovered, making the net expenditure £163 4s. 10d.

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 last financial year there were 281 certified blind persons on the roll, including 4 home workers, and the sum of £1,133 15s. 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 £325.

Book Production Grant.—£90 per year.

Donation to the National Library for the Blind.—£32 10s. per year.

Holiday Home of the Edinburgh Society for the Blind, Ceres, Fife.—In 1956, a holiday period was arranged for one blind person, but no applications were received by the Corporation during 1957.

The number of blind persons on the Register of the Blind as at 31st December, 1957, was 351. The numbers according to the different age-groups are as follows:—

	Under 2	2-4	5-15	16-17	18-20	21-29	30-39	40-49	50-59	60-64	65-69	70-79	80-84	85-89	90 and over	Total	
Male	—	—	4	—	2	4	15	21	19	18	14	28	12	8	2	147	351
Female	—	—	5	—	—	2	5	21	41	16	18	50	23	18	5	204	

During 1957, 34 persons were examined for the first time, 23 at the Blind Persons' Clinic and 11 at their homes. Re-examination was made of 24 persons.

The total number of persons examined was 58 as compared with 65 in 1956.

Of the 34 persons examined for the first time, 25 (or 74 per cent.) were certified blind within the meaning of the Blind Persons Act.

Of the 9 children registered blind, 6 were attending school at Craigmillar and 3 were ineducable.

The following statement gives the number of blind persons of 16 years and upwards who were in employment at 31st December, 1957:—

	Males.	Females.
(*a*) *In Institutions for the Blind*—		
Undergoing industrial training	4	1
In workshops	43	13
(*b*) *Outwith Institutions for the Blind**	10	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 £438 15s. was made to the Aberdeen Deaf and Dumb Benevolent Society for the year 1956-57 in respect of certain welfare services provided by the Society.

(d) Provision of Temporary Accommodation for Persons in Urgent Need, and Sundry Other Services.

During the year temporary accommodation was provided for 11 persons in urgent need arising in circumstances which could not reasonably have been foreseen.

In addition, 628 cases of casual nature were dealt with, arising from domestic upset, acute housing needs, &c., and requiring general welfare services and assistance to meet their needs or overcome their specific difficulties.

(e) Registration and Inspection of Homes for Disabled Persons and the Aged.

Under Section 37 of the National Assistance Act, 1948, no person may carry on a disabled persons' or old persons' home without being registered by the appropriate local authority. During the year there were no further applications for registration and homes registered in the City remain as follows:—Fountville, and St. Aubins Group; the Hostel of St. Margaret; Mitchell's Hospital; Nazareth House; Royal Aberdeen Asylum for the Blind Hostel; St. Nicolas House.

(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 211 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, 453 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, 70 persons—35 men, 25 women, and 10 children—were dealt with under this section.

(h) Reception Centre—Section 17 (2) and 25 (1) (2), National Assistance Act, 1948.

Cases now arising are, by arrangement, referred to the National Assistance Board for direct attention.

(i) Removal of Person by Sheriff's Order.

The power to secure, under Section 47 of the Act, compulsory removal of certain persons in need of care and attention is a necessary provision which must be interpreted with the utmost discretion and humanity, and utilised only after all powers of peaceful persuasion have failed. Dealing with such cases may entail lengthy and patient visitation by experienced officers. During 1957, it was not found necessary to invoke the powers of this section, peaceful persuasion having achieved the acceptance of care and attention in 7 cases where the need was really pressing.

Survey of Old Persons, City of Aberdeen, 1956.

(Preliminary Report by Dr. James M. Wallace, Principal Assistant Medical Officer.)

Introduction.

In the latter part of 1956, a survey was commenced with a view to more precise ascertainment of the circumstances and needs of old persons in Aberdeen. A representative sample comprising five per cent. of all old people living in their own homes was obtained by investigation of every twentieth house on the Valuation Roll, the domiciliary investigation being carried out by the District Health Visitors. At the same time, a census was carried out of Aberdeen old persons resident in hospitals, homes, hostels, and lodging-houses. By these methods and by certain ancillary investigations, an overall picture has been obtained of the mode of life of elderly citizens—a picture more panoramic in scope, and yet sharper in focus, than anything hitherto achieved. The main outlines of this picture of urban old age are sketched below in a brief preliminary report of survey findings.

Unless otherwise stated, the term "old persons" refers to persons of pensionable age, *i.e.*, males of 65 years and over and females of 60 years and over.

The Household Investigation.

At the end of 1956, the total number of houses in the City was about 56,000, and the number obtained by extracting every twentieth house from the Valuation Roll was 2,806. The total of 2,806 houses investigated comprised 781 (28 per cent.) where there were one or more old persons, 1,977 where there were no old persons, and 28 unoccupied, uninhabitable, or demolished. In only 20 cases (less than 1 per cent. of the total) was no information obtained as to age of residents—this was usually because there was no reply to repeated visits.

In the 781 households referred to above there lived 1,051 old persons of whom 1,005 (over 95 per cent.) supplied information for the purposes of the survey. The

difference comprises 36 persons who were unwilling to co-operate plus 10 old persons who were not interviewed, some being away from home. These totals do not include old persons who were temporarily in hospital at the time of the domiciliary survey and who would, therefore, be enumerated in the hospital census, nor do they include the very few instances (perhaps half-a-dozen) where an occupant stated to be not old was believed to be in fact old.

The following table shows the sex and age distribution of the 1,005 old persons who co-operated in the domiciliary survey:—

Age in Years.	Males.	Females.	Both Sexes.
60-64	—	186	186
65-74	197	316	513
75-84	91	173	264
85+	15	27	42
Totals	303	702	1,005

The sex distribution, 30 per cent. male and 70 per cent. female, is in close agreement with the 1951 Census findings, and in age distribution the sample is similar to, but very slightly older than, the 1951 Census population.

Old persons in differing residential circumstances were grouped in four categories as under:—

1. *Old Persons residing with younger relatives.*—This group comprises households of one or more old persons living with younger relatives, usually their own family. It is the largest single group and includes 47 per cent. of males and 44 per cent. of females.

2. *Old Persons residing with other old persons.*—This group includes elderly couples, &c., where there are no younger persons in the household. Of males 42 per cent. fall in this category as compared with only 30 per cent. of females, but the actual total number of females in this group exceeds that of males.

3. *Old Persons residing alone.*—Females in this group outnumber males more than 8 to 1. Only 6 per cent. of elderly males live alone as compared with 21½ per cent. of females.

4. *Old Persons residing with younger non-relatives.*—This group comprises old persons living with lodgers or as lodgers, with housekeeper, companion, nurse, &c., or with employer. Only about 5 per cent. of both sexes are in this category.

When the physical capabilities of the survey group were analysed it was found that 57 per cent. of the old people were perfectly capable, a further 14 per cent. required only minor help with heavier tasks, 22 per cent. were limited in their mobility, and the remaining 7 per cent. were housebound or confined to bed. Males were apparently in rather better shape than females; for instance, 67 per cent. of

males were reckoned to be perfectly capable as compared with 52 per cent. of females. Of all elderly males, 31 per cent. were still working, the majority having full-time employment. There was however, with advancing age, definite deterioration in physical capabilities.

The following table shows their disabilities as stated or ascertained but it must be remembered that many old persons suffered from more than one complaint so that figures given are not additive:—

Nature of Disability.	Males 65 years and over.	Females 60 years and over.	Both Sexes.	Percentage of all persons affectel.
Blind	1	2	3	$3\frac{1}{2}\%$
Part Blind	5	27	32	
Deaf, with hearing aid	4	7	11	4%
No hearing aid	13	17	30	
Cardiovascular conditions, including H.B.P.	51	107	158	16%
Arthritis	20	93	113	11%
Bronchitis	25	39	64	6%
Physical senility	5	30	35	$3\frac{1}{2}\%$
Old fracture	6	26	32	3%
Gastro intestinal conditions	14	18	32	3%
Mental senility	7	19	26	$2\frac{1}{2}\%$
Varicose Ulcers, &c.	3	18	21	2%
Hemiplegia, &c.	3	16	19	2%
Anxiety state	—	17	17	$1\frac{1}{2}\%$
Anaemia	4	11	15	$1\frac{1}{2}\%$
Diabetes	5	9	14	$1\frac{1}{2}\%$
Other conditions	38	73	111	Each under 1%

The 1,005 old persons who co-operated in the survey lived in 744 houses of which 388 (52 per cent.) had a fixed bath. This is to be compared with 1951 census findings when 48·6 per cent. of all households in Aberdeen had exclusive or shared use of bath, but of course the vigorous housing programme in intervening years will have increased the census figure. It can, therefore, be said that, in general, households occupied by old persons are about average in so far as possession or non-possession of bath is concerned. On the other hand, of old persons living alone, only 25 per cent. possess a bath, so that old persons living alone live in the worst houses.

The Requirements of Elderly Persons Living at Home.

The following table shows the main needs of old persons as ascertained by the domiciliary survey. The table has been arranged in descending order of frequency but it should be noted that the figures given are not additive and the sections overlap to greater or less extent. For example, the 203 requiring the services of

health visitors and the 174 requiring visits of general practitioners have an overlap of only 62. Of all old persons in the survey, 57 per cent. had no requirements whatsoever.

Requirement.	Need Met.	Need Unmet.	Total Requriement.	Percentage of Total Old Persons.
Health Visitor Service . .	80	123	203	20%
General Practitioner Visits .	165	9	174	17%
Chiropody	84	66	150	15%
National Assistance . .	78	11	89	9%
Re-housing	—	44	44	4%
Home Help Service . .	27	4	31	3%
Club membership . .	23	2	25	2½%
Home nursing . . .	18	0	18	2%

Other needs were in smaller percentages, and included such things as laundry, shopping, meals, and visits by members of voluntary organisations. Out of the total of 1,005 old persons, only two were found to be requiring admission to geriatric wards, and only one old person required admission to a hostel.

The Census of Old Persons in Institutions.

The use made of institutional services by old people was ascertained by means of a questionnaire sent to all hospitals, etc., which might have been accommodating Aberdeen citizens. The total number of old persons actually accommodated in different types of institutions on a certain date in November, 1956, was thus obtained, together with the sex, age-group, and probable duration of stay of each person, and these totals are set out in the following table:—

Situation.	Males, 65+	Females, 60+	All Old Persons.	Percentage of total elderly population.	
In mental hospitals	82	218	300	1·3%	764
In geriatric and chronic sick wards . .	75	205	280	1·2%	3·3%
In other hospitals, *e.g.*, general, T.B., I.D. .	69	115	184	0·8%	
In convalescent and nursing homes . . .	7	33	40	Under 0·2%	
In local authority hostels	71	114	185	0·8%	370
In voluntary hostels	48	137	185	0·8%	1·6%
In lodging-houses	96	3	99	0·4%	

Out of an estimated total of 23,000 persons of pensionable age in the City, 1,174 (5·1 per cent.) were in hospitals, convalescent or nursing homes, or eventide homes.

Mental hospitals harboured 1·3 per cent. of old persons, of whom the vast majority were considered to be permanent cases likely to remain in hospital till death. There was no waiting-list of cases for admission.

Geriatric wards and chronic sick wards accommodated 1·2 per cent. of all old persons, and again the vast majority were permanent cases. There was a waiting-list of 23 males and 17 females for this type of accommodation.

Other hospitals, convalescent and nursing homes harboured about 1·0 per cent. of all old persons, of whom nearly half were short-term, likely to remain in hospital under one month till discharge or death. Awaiting admission to general hospitals were 31 males and 150 females.

Eventide homes accommodated 1·6 per cent. of old persons. The number of Aberdeen citizens resident in voluntary hostels is unexpectedly high, but, of course, there was, previous to this survey, nothing but guesswork as to this total. Voluntary hostels had a total waiting-list of 8 males and 45 females, but not much can be said about this waiting-list because some persons in comfortable circumstances may elect to enter a voluntary home from desire rather than from actual need, and if the need were really pressing the chances are the applicant would appear also on the local authority waiting-list, which, at the time of survey, stood at 18 males and 22 females.

Lodging-houses accommodated 99 persons of pensionable age, nearly all males. The percentage of elderly males in this type of accommodation is still fairly high at 1·4 per cent.

Summary.

The survey of old persons was carried out in two main sections—(*a*) domiciliary investigation and (*b*) institutional investigation. The domiciliary survey was based on a random 5 per cent. sample of all houses in the City, and involved investigation of 2,806 households and 1,051 old persons living in their own homes, of whom 1,005, or over 95 per cent., were willing to supply information for the purposes of the survey. The institutional investigation was based on a census of all old persons actually accommodated in different institutions on a certain date, and covered a total of 1,273 old persons.

In this paper the aims, method, scope, and some findings of the survey are outlined. The main needs of old persons living at home were found to be, in descending order of frequency of requirement, health visiting, general practitioner visits, chiropody, national assistance, re-housing, home help, club membership, and home nursing. The main unmet needs, also in descending order of frequency, were health visiting, chiropody, and re-housing.

Acknowledgments.

My thanks are due to Dr. I. A. G. MacQueen for his advice and criticism, to the health visitors who performed the spade-work of the door-to-door investigation, to the matrons and superintendents of institutions participating in the survey, to the Rating Department, to the area officers of the National Assistance Board, and, not least, to the elderly citizens themselves who co-operated so willingly in this study.

21.—WORK UNDER NURSING HOMES REGISTRATION ACT.

There were no applications for registration during the year.

22.—SANITATION, WATER SUPPLIES, AND ANALYTICAL WORK.

Such matters as water supplies, sewage disposal, nuisances, and offensive trades will be discussed in the annual report of the Chief Sanitary Inspector and need not, therefore, be outlined here. Two points, however, may be selected for mention—

(a) Water Supplies.

The City has an ample supply of water, obtained from the upper reaches of the River Dee. 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.

(b) Work of Analyst's Department.

The laboratory has continued to provide the analytical service required to deal with samples submitted under the Food and Drugs Acts and related legislation, the Fertilisers and Feeding Stuffs Act and the Rag, Flock and Other Filling Materials Act. A number of samples concerned with the water supply and effluents have been analysed.

The swimming baths, controlled by the City, have been visited once per week in order to take samples for bacteriological examination. The bath waters are also tested chemically to ensure that effective chlorination conditions are maintained.

The samples submitted by the Police or Procurator Fiscal cover a wide range of subjects, for example, specimens submitted to ascertain cause of death where poison is suspected or specimens of urine for alcohol determination in cases of persons charged with driving under the influence of drink.

This year's major addition to the law relating to food was the Colouring Matter in Food Regulations which comes into force by stages over the next two years. These regulations adopt an entirely new approach to the control of colours used in food. In the past, apart from five prohibited coal tar colours, any other coal tar colours could be used in food. The new regulations restrict the list of coal tar colours permissible in food to some thirty substances which have been proved harmless.

The total number of samples analysed was as follows:—

Food and Drugs Acts	1,026
Milk tested for effective pasteurisation	346
Fertilisers and feeding stuffs	20
Rag flocks	6
Swimming bath waters	266
Police and Procurator Fiscal specimens	88
Waters and effluents	20
Miscellaneous	6
	1,778

The total number of samples analysed is some four hundred greater than that for the previous year.

The laboratory also provided a biochemical service within the framework of the Regional Laboratory for the Hospital Board.

23.—SUPERANNUATION EXAMINATIONS.

Year by year the number of medical examinations of Corporation staff carried out continues to rise. In 1957 the total number of medical examinations carried out in connection with appointment under superannuation schemes and sick pay schemes, in connection with persons seeking to retire due to illness, and in connection with fitness to resume duty amounted to 925. Of these examinations, 635 were males and 290 were females.

24.—STAFF as at 31st DECEMBER, 1957.

Medical Officer of Health	Ian A. G. MacQueen, M.A., M.D., D.P.H.
Deputy 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.
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	Dodson P. Brunton, M.B., Ch.B., D.P.H. Mary Hunter, M.B., Ch.B., D.P.H. Elizabeth C. Laing, M.D., D.P.H. Margaret Ormiston, M.B., Ch.B., D.P.H. Jean Pattullo, M.B., Ch.B., D.P.H. William J. W. Rae, 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. Agnes E. Whitter, M.B., Ch.B., D.R.C.O.G. Margaret S. M. M'Gregor, M.D., D.P.H. (part-time).
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. Three vacancies.
Public Analyst	Thomas M. Clark, O.B.E., B.Sc., F.R.I.C.
Lay Administrative Officer	Colin C. Grainger.
Assistant Administrative Officer	Ernest B. Worling.
Statistician (part-time)	John B. Tait, B.A.
Principal Health Visitor Tutor and Senior Health Guidance Lecturer	D. Joan Lamont, S.R.N., S.C.M., Health Visitor's Certificate, Health Visitor Tutor's Certificate.
Assistant Health Visitor Tutor and Health Guidance Lecturer	M. Monica Byrne, S.R.N., Part I, C.M.B., Health Visitor's Certificate, Health Visitor Tutor's Certificate.
Superintendent Health Visitor and Co-ordinating Nursing Officer	Mary Macfie, R.G.N., S.C.M., Health Visitor's Certificate, Public Health Administrator's Certificate.
Deputy Superintendent Health Visitor and Supervisor of Midwives	Lisetta J. Stephen, S.R.N., S.C.M., Health Visitor's Certificate.
Deputy Superintendent Health Visitor	Vacant.
Centre Superintendents	11 (including 5 vacancies).
Health Visitors	74 (including 14 vacancies).
Midwives	10 (including 2 vacancies).
Nursing Sister	1 (vacant).

illary Nursing Staff . . .	3 (including 1 vacancy).
-time Nurses	3.
il Worker (part-time) . . .	Margaret Bell, B.A. (Admin.).
rvisor of Nurseries	Elizabeth C. Jackson, S.R.N., S.C.M., Health Visitor's Certificate.

eries—

) RESIDENTIAL—

Pitfodels . .	Matron—Elizabeth C. Jackson, S.R.N., S.C.M., Health Visitor's Certificate (also Supervisor of Nurseries), 2 Deputy Matrons, 9 Staff Nurses, 12 Certificated Nursery Nurses, 1 Enrolled Assistant Nurse, 4 Nursery Assistants, 14 Probationer Student Nurses.

) DAY—

Charlotte Street .	Matron—Penelope Sandison, R.G.N., 1 Deputy Matron, 4 Certificated Nursery Nurses, 1 Enrolled Assistant Nurse, 1 Nursery Assistant, 10 Student Nurses, 2 Probationer Student Nurses.
Linksfield . .	Matron—vacant; 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, 12 Student Nurses, 3 Probationer Student Nurses.
View Terrace . .	Matron—Christina Milne, S.R.N., 1 Deputy Matron, 4 Certificated Nursery Nurses, 10 Student Nurses, 2 Probationer Student Nurses.

eople's Homes—

LNAGASK—

Superintendent and Matron . .	Mr. and Mrs. F. W. Gibson.

S. 3 AND 5, FERRYHILL PLACE—

Matron	Elizabeth J. Dawson.

RTHFIELD LODGE—

Matron	Alice M. S. Duguid.

. 30, ALBYN PLACE—

Superintendent and Matron . .	Mr. and Mrs. John C. Wilson.

whills Home—

Superintendent and Matron . . .	Mr. and Mrs. D. Adam.

19, Polmuir Road—

Superintendent and Matron . .	Mr. and Mrs. W. G. Low.

Sanitary Section—

Chief Sanitary Inspector . . .	Herbert B. Parry, Sanitary Inspector's Certificat Meat Certificate.
Senior Assistant Sanitary Inspector .	William Jackson, Sanitary Inspector's Certificat Meat Certificate.
Fish Inspector	Sydney Howell, Sanitary Inspector's Certificat Meat Certificate.
District Sanitary Inspectors . .	5.
Assistant District Sanitary Inspectors .	8 (including 3 vacancies).
Apprentice Sanitary Inspectors . .	4 (including 3 vacancies).
Probationer Sanitary Inspector . .	1.
Shops Act Inspectors	2.

Meat Inspection Section—

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 f Health; V. Anderson; M. M. Barry; A. Gall; C. P. Gibson; A. E. Munro; M. Veitch; M. A. Wilson.
Other Clerical Staff	General, 17; Clinics, 2; Dental Clinic, 1 Sanita 3; Welfare, 3.

Miscellaneous—

Audiometrician	Vacant.
Orthoptist	Christine H. Gordon.
Chiropodist	Albert R. Loomes.
Physiotherapist	Clare Smith.
Assistant Nurses	3.
Dental Attendants	6 (including 4 vacancies).
Male Visitor, School Health Service .	1.
Domestic Helps	Full-time, 57; part-time, 175.
Drivers and Porters	4.
Rat-catchers	5.
Civil Defence Welfare Officer . .	R. M. Kirton.

Lodging House—

Superintendent and Matron . . .	Mr. and Mrs. C. Greig.