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CITY OF ABERDEEN.

REPORT

BY THE

MEDICAL OFFICER OF HEALTH

FOR THE YEAR

1962

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CONTENTS.

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SUMMARY OF STATISTICS.

The following is a summary of the principal statistics for the years 1956-62:—

	1956.	1957.	1958.	1959.	1960.	1961.	1962.
Population (estimated) . . .	186,396	186,190	186,350	186,796	187,308	185,222	185,678
Marriage rate (a)	10·5	10·6	9·9	9·5	9·0	9·5	9·3
Birth rate (a)	17·5	18·1	17·4	17·9	17·5	17·6	17·5
Illegitimate birth rate (b) . . .	5·3	5·1	4·5	5·3	5·1	5·2	5·1
Still-birth rate (c)	21	15	16	18	21	15	18
Infant Mortality rate (d) . . .	22	24	18	23	19	22	17
Neo-Natal Mortality rate (d) . .	14	17	14	14	14	15	12
Death rate (a)	11·6	11·4	11·3	12·3	11·7	12·1	11·6
Malignant diseases death rate (a) .	2·07	2·25	2·31	2·32	2·15	2·38	2·22
All tuberculosis death rate (a) . .	0·10	0·06	0·08	0·07	0·05	0·06	0·03
Respiratory tuberculosis death rate (a)	0·10	0·05	0·07	0·06	0·05	0·05	0·02
Principal epidemic disease death rate (a)	0·02	0·11	0·01	0·07	0·02	0·05	0·02
Average age at death (in years) .	65·9	66·2	67·3	66·7	67·1	67·5	67·5

(a) = per thousand population; (b) = per hundred births;
(c) = per thousand total births; (d) = per thousand live births.

PREFACE.

"In 1961 *there was an increase of approximately* 13% *Health Visitors over the* 1954 *figure. Perhaps this should be gratifying except for the fact that the volume of work has increased in excess of this amount . . . . . The increase in the number is not commensurate with the increasing volume of the work."*—Miss E. Robinson, Chief Nursing Officer, London County Council.

In Aberdeen in recent years the segments of population that make the biggest demands on both preventive and supportive services have risen sharply (e.g. old age pensioners, expectant mothers, pre-school children, school pupils and persons recently discharged from hospital). Simultaneously many additional duties have devolved on health and welfare workers (e.g. in the field of prevention—reduction of maladjustment, delinquency, child neglect, home accidents, road accidents, rent arrears, whooping cough, poliomyelitis and the effects of phenylketonuria). Also in 1962 a national decision increasing annual leave reduced by more than two per cent. the effective working time of health visitors, midwives, &c. The disease-preventing and health-promoting staff in Aberdeen has not yet been increased to cope with enlarged populations, new duties and reduced working time: for instance, the establishment of health visitors has not been raised for eight consecutive years. The following table gives seven illustrative examples of of staff actually employed.

	In post at the end of		
	1956	1959	1962
Medical Officers	14½	15½	14½
H.V. Tutors	2	3	2
Dental Officers	3½	5	4½
Supt. Nursing Officers . . .	2	3	3
Health Visitors	68	72	72½
Clinic Sisters	4	5	5
Sanitary Inspectors . . .	12	15	13

For workers in Aberdeen's Health and Welfare Department, 1962 was therefore a grim year—a year of strenuous improvisation and reallocation of priorities to minimise the harmful effects on the people of continued staff inadequacies; a year—in consequence of relative decrease of preventive services—of steeply rising demands on the supportive services; a year of continuation and acceleration of the disquieting trends mentioned in the Report for 1961.

It was not easy for officers who had themselves been pioneers in the promotion of mental health and the creation of services for mental after-care to make a conscious decision that, in the staffing circumstances of 1962, the physical health of the baby must (to some extent and for the time being) take precedence over the emotional well-being of the toddler or the care of the mentally handicapped adolescent; and it was hard for persons who had been leaders in home safety to accept deliberately that it was more important to maintain adequate control over

infectious diseases than to initiate further efforts to reduce accidents. In some respects, too, the reassessment of priorities perhaps went too far and produced curious effects.

Thus, at a time when Aberdeen's health statistics in general were deteriorating (as had been forecast) there was established the lowest infant death rate—17 per thousand live births—ever achieved by any of the four Scottish cities; the tuberculosis death-rate and the incidence of new cases of tuberculosis were both lower than ever before recorded in Aberdeen; and the total of all notifiable infectious diseases was lower than even the 1961 low record.

In the main, of course, the deteriorating trend that was foreshadowed in the Report for 1961 was all too obvious. The still-birth rate rose (and Aberdeen, for years possessor of the lowest rate in the Scottish cities, had a rate higher than Edinburgh and no lower than Dundee). The perinatal death rate increased. The number of deaths in children aged 1-5 years, while still fairly low, was greater than the combined total for 1960 and 1961, and higher than in any single year since 1953. Deaths due to accidents in children aged 1-15 years almost doubled, rising from 6 in 1961 to 11 in 1962. The maternal death rate rose to above the average for Scotland. Dysentery (116 cases) increased sharply. Poliomyelitis (3 cases) reappeared.

Reduction in the amount of health-promoting and disease-preventing services available for each thousand of population inevitably caused an increase in the pressure on supportive services. The waiting list for old people's homes grew longer (even though the opening of a new hostel during the year added about 14 per cent. to the available accommodation); the demands on the home help service rose sharply (and just after the end of the year the Health and Welfare Committee recommended that the establishment of home helps be increased by twenty—an extension of more than 10 per cent); for the second successive year there was a steep rise in the number of old people requiring home nursing; the number of persons on the register of old people rose to 4,101—but almost a quarter of them could not be visited by health visitors; the waiting list for day nurseries (which had previously been falling) rose to 84; and the number of children in the residential nursery (after decreasing for some years) began to rise sharply about the end of the year.

AN EXPLANATION OF THE REGRESSIONS.

To ensure that no blame falls on hard-working members of staff, for whose efforts indeed no praise can be sufficiently high, a paragraph is here quoted from the first page of the preface to the report for 1961.

> "A certain lopsidedness of development, however, that had already begun to hinder progress in 1960 became even more apparent in 1961. While more and more staff were occupied in providing desirable services for the support of persons handicapped by age, disease or disability, there were—for the third successive year—not only virtually no extensions in the staff available for promotion of health, health education of the people and

prevention of disease, but also, as supportive and social welfare services for the increasingly numerous groups of the young and the old consumed more time, actual and appreciable decreases in the professional staff available for health maintenance and disease-prevention; and difficulties were increased by persisting shortage of accommodation for doctors, health education lecturers, health visitors, midwives and other staff. It is not suggested that Aberdeen is suddenly going to revert to the infant death rate; infectious disease incidence or home accident frequency of a dozen years ago; but, as 1961 wore to a close, it became obvious that the reluctant but ruthless pruning of important tasks mentioned in the Report for 1960 was already beginning to have detrimental effects, that Aberdeen would have to pay in 1962 and 1963—both in poorer health statistics and in considerably increased cost of supportive services—for its qualitative and quantitative shortages of preventive staff in 1960 and 1961, and that the old saying "prevention is cheaper and better than cure" would in due course be demonstrated here in the shape of higher incidence and higher cost of unprevented preventable conditions."

INCREASING DUTIES AND POPULATIONS, BUT UNCHANGED NUMBERS OF PREVENTIVE STAFF.

1962, in fact, demonstrated in reverse the financial value of prevention. **In 1962, as in the two previous years, developments involving new staff or new buildings were in general restricted to the supportive and welfare components of the combined Health and Welfare Department. For the fourth successive year there were—despite increasing duties and larger populations to be served—in effect no additions in the sections of staff concerned with promotion of health, health education of the public, individual health teaching, staff education and prevention of disease, no measures adopted to counteract staff shortages in these sections, and no improvement in the accommodation provided for preventive staff.** Some examples may be useful.

HEALTH VISITORS: (1) FAR MORE WORK;

(1) For the health teaching and social counselling of families in their homes the existing establishment of **health visitors** (unanimously approved by the Corporation in 1954) has not been increased during the last eight years. The number of old people has risen to over 26,000 pensioners (so that much more health visiting time should be devoted to the well-being of veterans); the number of births has risen, the average for 1961 and 1962 being 6.7 per cent. above the average for 1952 and 1953 (so that more health visiting time should be spent on babies, pre-school children and expectant mothers); the school population has risen and the school health service has undergone considerable development (so that more health visiting time is needed for school children); there have been various new duties, in mental health for instance (so that more health visiting time is required); useful but time-consuming case conferences have been instituted, and useful but time-consuming co-operation with general practitioners; the health visitors have been required to advise tenants in arrears of rent about budgeting; the services for the physically handicapped have been extended; and (as already mentioned) a national agreement increasing annual leave has reduced the total working time of health visitors by more than 2 per cent. The establishment, however, has not yet been raised (and in recent years the total of health visitors

(2) LESS WORKING TIME;

employed has approached the authorised establishment each July, when the newly qualified ex-students take up duty, and has had about a dozen vacancies by the following June). The Annual Reports for 1959 and 1960 stressed that **increase in the health visiting establishment was an urgent need.** The 1961 report additionally drew attention to the **qualitative shortage:** some authorities have created senior posts at salaries far above those in Aberdeen; many authorities have established an intermediate promotion grade of Group Adviser (a grade "pending" in Aberdeen for several years); and some have devised a means of paying appreciably higher scales for ordinary medico-social workers or have provided generous car allowances. It is, of course, the health visitors with most initiative who are attracted to posts in other areas or to posts overseas: the 1961 report pointed out that of the twenty prizewinners in the health visitors' course in the four years 1956-1959 only three remained on the Aberdeen staff at the close of 1961.

(3) QUALITATIVE SHORTAGE.

The increased number of old people requiring hostel accommodation and the sharply increased number needing home helps may perhaps be related to the decrease in visiting of veterans by health visitors. The rise in the stillbirth rate may perhaps be connected with the decline in visits to expectant mothers. The increase in accident deaths in children may perhaps be associated with the fall in the number of home visits by health visitors. In 1962 for the second successive year there was a decrease in the proportion of total net Departmental expenditure devoted to health visiting.

HEALTH EDUCATION STAFF: (1) NO EXTENSION;

(2) **Health education of groups,** developed in 1956-59, has been acclaimed by many experts as Aberdeen's most significant health development, and **has beyond question produced financial savings many times greater than the expenditure involved.** The reports for 1960 and 1961 pointed out the urgent need both for extension of the health education staff and for financial measures to decrease the frequency of staff changes by raising remuneration to levels as high as is paid to health education officers in other areas and as high as is paid in other posts for which the officers are qualified. Unfortunately, measures were not taken to combat staff shortages in 1961 and 1962. In September, 1962, the M.O.H. reported in writing that the Health Education Section was in danger of collapse through unfillable vacancies, and shortly after the end of the year one new post (part-time) was created, the salary of a long vacant post was increased and the salaries of three non-vacant posts were raised by £20, £14 and £21 per annum respectively. At the time of writing there are as yet no applicants for that vacant post or that new post. In 1961-62 less than one half of one per cent. of the total net expenditure of the Health and Welfare Department was spent on health education.

(2) ENDANGERED THROUGH PERSISTING STAFF SHORTAGES.

SANITARY INSPECTORS.

(3) Shortage of **Sanitary Inspectors** reached its peak in 1962, but it is pleasing to record that about the beginning of 1963 the shortage was greatly lessened: two apprentices qualified and joined the staff, and another inspector was recruited from outside Aberdeen.

MEAT INSPECTION.

(4) In 1962 Aberdeen remained the only Scottish city without a full-time **Veterinary Surgeon** on its staff.

(5) **Increasing number of births brought further pressure on midwives.** It should be remembered that, apart from home confinements, midwives have to undertake the care of women and babies discharged from hospital during the lying-in period. Before the end of 1962, however, the pressure on midwives had become unsupportable, and the care of women discharged on the 6th day or later had been passed to the health visitors (who, of course, are qualified midwives)—constituting yet another appreciable incursion on their time. MIDWIFERY.

(6) One of the most urgent needs in Aberdeen is more **staff education.** Courses in mental health for health visitors (in which Aberdeen was a pioneer as early as 1954) had to be abandoned for three main reasons. (a) Even in the relatively few periods when the three combined posts of Health Visitor Tutor and Health Education Lecturer were simultaneously filled, the tutors were fully occupied with the course for nurses seeking to qualify as health visitors, the new course for male nurses in preparation for certification as male health visiting officers, and the organisation of health education of the public. (b) With increasing duties and larger population groups the health visitors had no time available in which to attend courses. (c) With the lengthening of the course for student health visitors (in 1956) and the starting of the parallel course for student male health visiting officers (in 1961) the accommodation in the Health Visitor Training School was used to capacity—and indeed beyond capacity. STAFF EDUCATION—URGENTLY NEEDED.

A shorter course in Health Education for 11 health visitors was conducted in 1961, but in 1962 shortage of tutorial staff effectively prevented any repetition.

Before the opening of 1962 the M.O.H. had suggested in writing the provision of additional accommodation and an extra member of the teaching staff, and the supplying of courses in mental health for health visitors, midwives, welfare officers and nursery matrons and deputy matrons. These matters, however, still remain for future consideration.

(7) In the important field of **Mental Health** the two years from mid-1961 to mid-1963 have represented a period of apparent passivity. Certainly there were some redesignations: soon after the end of 1962 Dr. Rae ceased to be Senior Assistant M.O. for mental health and became Junior Depute M.O.H., and earlier certain specialist health visitors working in the field of mental after-care were renamed Mental After-care Officers. Essentially, however, the same people have been employed and the services have remained unchanged except for such alterations as are due to staffing shortages. In particular since the issue of Circular 75/1960—pointing out the duties of local health authorities under the Mental Health Act in the provinces of prevention and after-care—there have been **no developments in preventive services and no increases in preventive staff; and Aberdeen,** once a pioneer in staff education, **is as yet providing no mental health courses for doctors, health visitors, midwives, or welfare officers.** MENTAL HEALTH—NO PROGRESS.

The positive side of mental health work is particularly important and particularly neglected. What Professor G. M. Carstairs said in the Reith lectures about the country as a whole is very applicable to Aberdeen.

"We are neglecting some of the greatest health problems of our contemporary society, the problems of faulty psychological and social adjustment."

SOME FEATURES OF 1962.

MATERNITY AND CHILD WELFARE.

In the field of **antenatal and child health care** an attempt was made to counteract lack of health visitors by a massive extension of group health education at clinics. Antenatal attendances rose by 8 per cent., and attendances of babies rose by nearly 13 per cent., about two thirds of all babies being brought to clinics. Unfortunately, however, attendances at the post-natal clinic fell for the second successive year and attendances at the gynaecological advisory clinic fell for the third successive year: the latter reduction is thought to be an indirect consequence of the lack of health visitors for home visiting. The sale of Welfare Foods declined somewhat. Despite the complete absence of physiotherapists, **relaxation exercises** for expectant mothers continued, being taken over by health visitors.

MIDWIFERY.

Although there were only 337 domiciliary confinements, the hospital policy of early discharge continued, throwing **more work on municipal midwives.** For example, 61 women were discharged on or before the fourth day.

HEALTH VISITING—DELIBERATE DECREASE IN HOME VISITING BECAUSE OF EXTENDING DUTIES AND RISING POPULATION.

In health visiting 1962 witnessed a further increase in duties (e.g. the starting of after-care for diabetics), **a considerable development of the school health services, a rise in the time spent on case-conferences and discussions, and—in view of staffing shortages—a deliberate increase in the proportion of time devoted to health education and social counselling at clinics, and an appreciable decrease in the number of home visits** paid respectively to old people, expectant mothers, babies and pre-school children. As already mentioned, the pattern of staff-shortage was the same as in most recent years: in the summer and autumn (after recently qualified health visitors joined the staff) the establishment was about full and there were nearly enough health visitors to tackle the increased duties and increased population groups; but by the end of the winter there were again about a dozen vacancies.

HEALTH EDUCATION—A DRAMATIC ACHIEVEMENT.

The most significant achievement of 1962 was a successful attempt to meet the public demand for group health education (and incidentally to minimise the harmful effects of insufficient staff for home visiting) by **extension of health education courses.** The total number of meetings for prospective parents rose from under 400 in 1959 and previous years, 466 in 1960 and 602 in 1961 to 862 in 1962—**a rise of 89 per cent. in two years. For health education meetings of all types the grand total of meetings (1,446) and of attendances (31,410) were considerably higher than ever before.** As is mentioned in the chapter on Health Education, these increased numbers were achieved despite considerable staff shortages—at considerable sacrifice by the members of the depleted staff.

FLUORIDATION OF WATER.

The question of fluoridation of the water supply was under consideration during the latter half of 1962.

STAFF EDUCATION.

The first male health visiting officers obtained their qualification and started work in 1962. **The Health Visitor Training School** situated in Aberdeen and administered as part of the Health and Welfare Department (although financed mainly from national funds) conducted one of the three courses in Scotland for student health visitors and the only course yet existing in Britain for male health visiting officers. While one study week-end was held for medical officers and health visitors, and while inservice training was attempted where practicable, shortage of tutorial staff in the latter part of the year necessitated a policy of curtailment rather than extension.

HOME NURSING—RISING DEMAND FROM OLD PEOPLE.

For the second successive year there was a very steep rise in the number of elderly persons requiring home nursing (a rise perhaps associated with decrease in health visitors' home visits). About 70 per cent. of the work of the home nursing service is now related to persons over the age of 65 years. For persons under that age the trend of decreasing need for nursing continued: in the day service the total visits to persons under 65 years, after falling steadily from 2,730 in 1954 to 1,645 in 1961, dropped to 1,221 in 1962.

HOME HELPS—SWEEPING INCREASE IN DEMAND.

In respect of the **home help service** there was an unprecedented increase in the number of old people requiring help; and just after the end of the year the Health and Welfare Committee decided to recommend an increase of 20 home helps—the biggest increase in any year since the inception of the service—to cope with the rising number of persons in need of help.

PREVENTION OF NEGLECT OF CHILDREN.

While prevention of neglect of children and prevention of break-up of families are essentially a major function of health visitors and other social workers, it may be mentioned that both the **Co-ordinating Committee** (at chief officer level) and the **Case Conferences** (at field-worker level) continued as before: in all there were 68 discussions on 27 families brought before these bodies for the first time, together with a review of the 32 cases that remained under consideration at the end of 1961.

VACCINATION AND IMMUNISATION.

Vaccination against **smallpox** remained satisfactory, with 71.2 per cent. of all children aged 1-5 years protected. **For diphtheria immunisation the percentage of pre-school children immunised,** after rising year by year from 51 in 1952 to 72 in 1961, **rose again to 73.** By the end of the year 75 per cent. of all persons under 30 years had been vaccinated against **poliomyelitis** and 56 per cent. had received a maintenance dose. Advertisements, posters and leaflets have been completely discontinued: for all forms of vaccination and immunisation reliance is placed on the health visitor's individual persuasion and on group health education.

INFECTIOUS DISEASES.

The total number of **notifiable infectious diseases,** after falling to 499 in 1960 and 348 in 1961, underwent a slight further reduction to 324. Diphtheria remained absent, and whooping cough fell to 36 cases.

TUBERCULOSIS —CONTINUED DRAMATIC REDUCTION.

One of the most pleasing features of the year was the **further reduction of tuberculosis.** The table on next page gives the number of cases notified in every third year to 1959 and every year since then, with an indication of the main relevant developments in the Health and Welfare Department.

Year.	New Cases.	Notes.
1950	301	1950-55 H.V. service expands: more contact-tracing and individual health teaching.
1953	274	1953 B.C.G. vaccination starts.
1956	220	1956 Group Health Education develops. 1957 X-ray campaign.
1959	154	
1960	101	
1961	94	
1962	80	

Apart from the obvious direct effect (fewer cases of a serious and unpleasant disease) and the obvious indirect effect (decreased emotional and socio-economic repercussions on relatives and dependents), **the quartering of the incidence over the last dozen years** has saved the community much money. To mention one small example as an illustration, here is the cost of supplying free milk to victims of tuberculosis in recent years.

Year.	No. of persons supplied.	Cost of milk.
1957	345	£3,245
1958	364	£3,036
1959	311	£2,592
1960	285	£2,364
1961	262	£2,432
1962	183	£1,631

MENTAL HEALTH.

As is explained in the chapter on **Mental Health,** 1962 and the months on either side of it can be regarded either as 24 months of passivity or as two years of careful consideration prior to initiation of measures designed to improve the pre-existing mental services.

THE ELDERLY.

The number of old people rose and the figure of those on the **register of old people** (i.e. seeking services) increased to 4,101. Almost a quarter of these could not be visited by health visitors, and the frequency of visits to other old people tended to decrease. The numbers receiving chiropody rose sharply. The demands on the home help service soared as already mentioned. A new home, **Rosewell,** was opened, but the waiting list was higher at the end of the year than before the home was opened.

PHYSICALLY HANDICAPPED.

The number on the register of handicapped persons rose to 451. Fifty persons attended the **Occupational Therapy Workshop.**

THE BLIND.

While the number of blind people remained fairly constant, the total of young blind persons continued to fall. Of the 356 registered blind persons, only 27 were under forty years of age and only another 36 under fifty years.

PORT HEALTH.

Twenty-six of the 436 vessels from overseas were from infected areas. Just under a thousand vessels were inspected, with medical examination of crews and passengers where appropriate.

FOOD HYGIENE.

There was no serious outbreaks of food-borne disease in persons or animals. Shortages of health education lecturers, health visitors and sanitary inspectors again prevented the mounting of any extensive food hygiene campaign. For the second successive year a useful course for food handlers was arranged under the auspices of the Education Department, which also continued to take responsibility for the course in meat inspection for persons proposing to sit the examination of the Royal Sanitary Association of Scotland.

CLEAN AIR.

Aberdeen remained in 1962 the only Scottish city with no clean air zones. A further report was submitted by the M.O.H. during the year.

HOME SAFETY

There were no developments in home safety work during the year.

COSTS OF SERVICES.

Analysis of the cost of the services shows (a) that less than half of one per cent. of the net expenditure of the Health and Welfare Department was devoted to health education; (b) that for the second consecutive year there was a decrease in the proportion spent on health visiting; (c) that the proportion devoted to clinics fell sharply; (d) that the fraction spent on old people's homes rose from 7.1 per cent. in 1961 to 9.7 per cent.; and (e) that (although the big rise in home helps did not occur till after the end of the year) the proportion spent on home helps rose from 13.6 per cent. to 14.4 per cent.

ACKNOWLEDGMENTS.

The writer seeks to express gratitude for help generously given—to the Lord Provost (himself a former Convener of the Health and Welfare Committee with still, despite his many official duties, a keen interest in services for the promotion of health and social well-being), the Magistrates, the City Treasurer, and the Conveners and Members of the Health and Welfare Committee and other Committees; to officials of the Scottish Home and Health Department for encouragement and advice on countless occasions; to colleagues in other Corporation Departments, in other branches of the National Health Service and in the University; and—most of all—to the staff of the Health and Welfare Department. If the staff deserve gratitude in the years of triumph when new health records were being set up and new schemes initiated, still more do they merit a word of appreciation at the close of a singularly hard year in which essentially the same number of workers (or in some sections fewer workers) strove to tackle their previous duties and additional duties and to provide services for a steadily rising number of people.

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Aberdeen, *9th May*, 1963.

CITY OF ABERDEEN.

REPORT BY THE MEDICAL OFFICER OF HEALTH

For the year 1962.

1.—POINTS DEEMED SPECIALLY IMPORTANT BY THE SECRETARY OF STATE.

In Circular 133/62 (dated 31st December, 1962) it is indicated that, while the Annual Report should cover the work of the Department, the Secretary of State would especially value information on six subjects: (a) Future of local health authority services (an appraisal of broad changes to be expected in the public health service in the future); (b) Community care (an estimate of the extent to which domiciliary services have reduced the need for admission of patients to hospital); (c) Health visitors (any arrangements for work in conjunction with general practitioners, and indication of methods employed to follow up persons discharged from hospital); (d) Health education (particular subjects covered and some estimate of the results achieved); (e) Noise Abatement Act (any progress made in noise control); and (f) Clean Air Act (any progress made in smoke control). On the last two there was little progress during 1962, although the Medical Officer of Health submitted a further report on Clean Air just before the end of the year. In respect of the first four items, however, it may be convenient to summarise a few points here.

(a) Future of Local Health Authority Services.

1. *Basic Factors.*

Some of the factors likely to affect the health services during the next ten years are as follows:—

(1) *Increased survival of the elderly.* As the number of pensioners rises there will be increased pressure on old people's hostels and geriatric wards, but economic and humanitarian reasoning will both point to the paramount importance of enabling the vast majority of veterans to live healthily and independently in their own homes. It will become more and more obvious that the two key workers are the family health visitor and the family doctor working in greater and greater collaboration, and that there is also a considerable role for voluntary

effort. As early as 1958 an official circular indicated the health visitor's five-fold task in this field—maintenance of physical and emotional health, e.g. by guidance on diet, exercise, rest, budgeting and leisure interests, and removal of needless fears; advice about services and allowances; initiation of services to meet particular needs; after-care and rehabilitation, and securing information on which social policy can be based—but very considerable expansion of the health visiting service will be needed before these duties can be fully undertaken. To save the time of skilled personnel it may be necessary to introduce a grade of assistant health visitor, and it will certainly be necessary to apply to persons at the onset of old age the techniques of group and mass health education.

(2) *Anticipated higher birth-rate in the period* 1963-70. This, especially when taken in conjunction with the trend towards earlier marriage and the increasing mobility of population, will imply a need for more health education lecturers, more health visitors, more midwives and more home helps. It should be noted that in 1961 and 1962, the increase in birth-rate had begun, but the establishment has not yet been increased to take account of the rise.

(3) *Increased material prosperity and greater literacy.* Problems of malnutrition, of faulty hygiene and of slums are already decreasing. The sanitary inspector may have a diminishing role as an enforcer of regulations but perhaps as time passes he will come to function rather as an adviser on environmental problems. If so, however, changes may be required in his training.

(4) *Altering pattern of disease.* With the virtual eradication of most infectious diseases and of diseases associated with dirt and destitution, the local health authority services will be increasingly concerned with other conditions—with the reduction of the psychoneuroses, of maladjustment, of juvenile delinquency, of alcoholism, of antisocial behaviour; with the prevention of home accidents and road accidents; with the reduction of diseases of maturity (e.g. coronary thrombosis, bronchitis, pneumonia and rheumatism); and with the promotion of physical and emotional health. These tasks may be made even more difficult by certain social trends (e.g. greater equality of opportunity, however desirable, will tend to increase strain on children of ambitious parents; more women at work will create problems of "latch-key children"; financial prosperity may lead to excessive drinking and excessive smoking). One implication for the Health Department would seem to be developments in the preventive and social fields parallel with those that have already taken place in the clinical field: just as the general practitioner is in Britain the central officer for clinical work but must have available to him the specialised skills of may consultants, so in preventive and social work the centrally placed family health visitor will require to have available to her similar specialised skills. Some of these experts are likely to be former family health visitors who have taken a further training (health education lecturers and mental after-care officers are examples already extant) or have by experience attained particular competence in a restricted field (e.g. geriatrics, work with unmarried mothers, or social care of physically handicapped persons); and others may have different backgrounds (the Department's social adviser for

problem families, &c., is a case in point, and it may be desirable in the near future to appoint a clinical psychologist). It seems inevitable that the number of specialists employed in the Department will rise.

(5) *Effects on staff of equality of opportunity.* Until after 1948 a Health Department could recruit an occasional outstanding medical officer who had been financially unable to enter a clinical specialty; until about 1956 a Health Department could recruit for health visiting or midwifery an occasional nurse of outstanding intelligence and personality who had been unable for monetary reasons to become a doctor, or lawyer, or secondary school teacher. With better opportunities available to all young people of ability these sources of recruitment have dried up. Every profession needs a sprinkling of people capable of becoming leaders, but the various local authority health professions are no longer attractive to persons with the qualities to rise high in whatever profession they enter. This point is the more important because our civilisation seems to be in process of becoming increasingly materialistic, so that reliance cannot be placed on vocational urge. Quantitative shortages of professional staff are widely recognised (e.g. existing national shortages of health visitors and psychiatric social workers), but qualitative shortages perhaps constitute a graver danger. Unless the local authority services can recruit a small number of first class individuals— to become in due course the leaders and pace-makers among medical officers of health, superintendent health visitors, health education lecturers, health visitor tutors, teachers of psychiatric social workers, chief sanitary inspectors, and so on— initiative and experimentation will gradually be lost.

2. *Possible developments.*

(1) *Considerable expansion of health education.* Future improvements in health will in general require the active co-operation of the citizens. Without such co-operation (which implies both some knowledge and willingness to apply it) we cannot reduce the fatigue or emotional upset that causes home and road accidents, the over-smoking that may cause lung cancer, or the over-discipline or over-indulgence that may lead to maladjustment. Since habits are altered and prejudices removed more by group discussion than by formal lectures, health education will presumably develop mainly on the lines of the existing courses for prospective parents and discussion clubs for parents of young children, with—when staff extensions permit—increase in the amount of health education offered to older school children, adolescents and persons about retirement age.

Increasingly selected health visitors and selected male health visiting officers will have to devote portions of their time to group education; and the 1961 course for eleven health visitors who were already playing appreciable parts in health education should be repeated when the staffing position permits. It might also be useful to have a course for medical officers: it is often said that the medical training makes doctors too "authoritative" for group discussion, but, while that may in large measure be true, most doctors (like the writer) have received no training whatever in the techniques of health teaching, so that the allegation about excessive authoritarianism is largely mere speculation.

To co-ordinate health education work, to organise and conduct refresher courses, to evaluate methods and to conduct sociological investigations so as to ensure that health education alters with the problems of the community, sufficient well-qualified senior officers will be needed. The experiment of creating combined posts of health visitor tutor and health education lecturer has been a tremendous success, but instead of three such senior officers we will ultimately need more than twice that number to take charge of two of the biggest jobs in the Department, the development of group health education and the professional training of the next generation of health visitors. It should of course be remembered that, just as health education has already produced financial savings, so its expansion should in turn produce further savings.

(2) *Increase in health visiting staff.* Four developments seem obvious. (a) The establishment of health visitors and male health visiting officers will have to be increased to cope with more old people, more pre-school children, and new duties; (b) There will have to be an extension of specialised posts with presumably a salary structure to make such specialisation attractive; (c) Since the health visitor's teaching and social counselling duties are of growing complexity, some lengthening of her post-nursing course will be essential: the health visitor is already—for numerical reasons—the main field-worker of any Health Department, and to keep her period of post-graduate education restricted to a single year is probably a false economy; (d) Since the health visitor is a highly qualified officer, it may well become necessary to train some officers as "health assistants" and to let them undertake some of the duties that do not require the full professional skills of a health visitor.

(3) *Development of mental health services.* Five types of development will be needed—(a) provision and staffing of occupation centres, nurseries, &c.; (b) increase in number of mental after-care officers; (c) resumption when senior staff and accommodation become available—of post-basic courses in mental health for health visitors (in which Aberdeen was a pioneer in 1954 and 1955); (d) provision of courses for midwives, welfare officers, nursery staff, &c.; and (e) arrangements of inter-disciplinary meetings (e.g. on the lines of a study week-end which was conducted jointly for medical officers and health visitors). It should, incidentally, be noted that items (c), (d) and (e), being on the borderland of health education and mental health, might be classed under either heading.

(4) *Possible contractions.* Consequent on lessening demands in certain directions there may perhaps be slight reductions in the numbers of medical officers, home nurses and sanitary inspectors required; but these contractions are possibilities, not certainties.

(b) Community Care.

The saving on hospitals from the development of community care was extensively discussed in the Report for 1961 (pages 4-5). One point may be briefly repeated here. It has been calculated that but for the home help service

450-500 extra hospital beds and 450-500 extra hostel places would be needed in Aberdeen; and that the home nursing service and the portion of health visiting time devoted to after-care are together saving the need for another 300 hospital beds.

(c) Health visitors.

(1) *Work in conjunction with general practitioners.* Two health visitors are attached full-time to practices. The many advantages of the arrangement are obvious, but its main disadvantages should also be noted:—I. An ordinary practice does not provide sufficient expectant mothers, for example, to constitute an efficient group for health education, so that the individuals have in most cases to be referred for group education in a clinic. II. Since "practice" children attend various schools and since health visitor/school teacher co-operation is no less important than general practitioner/health visitor co-operation, the school health work has to be undertaken separately—so that the families do not in fact have a family health visitor. III. Since "practices" are scattered all over the city, the two health visitors have to be given special car allowances and spend a considerable portion of their working time at the wheel. Consequently, quite apart from the development of specialisation in various branches of health visiting, extension of the general practitioner/health visitor linkage would demand either a drastic rationalisation of practice areas or a very considerable increase in the number of health visitors.

(2) *After-care of persons discharged from hospital.*

I. Mental hospitals—Mental after-care officers (i.e. former health visitors with a further training and paid an increased salary) are based on the hospitals, become acquainted with the patients in hospital, normally visit the families before patients are discharged, pay follow-up visits at their discretion, and in due course pass the recovered individual to the district health visitor.

II. Other hospitals—Liaison health visitors are attached to the Children's Hospital, the Diabetic Clinic, &c. They, too, follow up at their discretion, ultimately passing the case to the district health visitor.

See also the chapter on health visiting.

(d) Health Education—subjects and results.

(1) With 1,466 meetings in a year it is not possible to summarise the subjects, except to say that the entire field of physical, emotional and social health is deemed within the purview of group health education, and that to a very large extent the members of any group indicate topics on which they would like information.

(2) Perhaps the best way to indicate the results is to append the text of an address given by the Medical Officer of Health at the 1962 Annual Congress of the Royal Society for the Promotion of Health.

APPENDIX—THE VALUE OF HEALTH EDUCATION IN AN URBAN AREA

In the first four decades of this century and perhaps more recently few exponents of health education possessed adequate knowledge of the basic requirements for physical health, and fewer still had much insight into the needs for mental health or grasp of the psychology of learning and the techniques of teaching. Inevitably misconceptions arose and lingered in the mind of the public. For clarity let me indicate four common errors. Some people still think that the aim of health education is to impart information—whereas its real aim is to change values and alter behaviour; some believe that its primary concern is with hygiene—whereas it is at least equally concerned with improving human relations, promoting emotional health and stimulating proper use of the various health and social services; some hold that its main method is the formal lecture—whereas change of attitudes is more usually achieved in the give-and-take of informal discussion; and some imagine that it is easy, requiring merely the "gift of the gab" and a superficial knowledge of anatomy and pathology—whereas it is perhaps the most difficult variety of further education, and its practitioners need, as Burton[1] has pointed out, to combine medical knowledge, teaching skills, and insight into the social sciences.

Health Education and Health Educators.

Probably the best document on health education yet produced north of the Cheviots, is the evidence submitted to the Cohen Committee by the Scottish Association for Mental Health. In a printed summary of that document[2], after health education has been described as a process whereby conscious effort is made to foster (in individuals, or groups, or the community) attitudes and behaviour conducive to physical and emotional health, it is further defined as including—

"(a) Individual teaching of clients or patients by health visitors, physicians, psychiatric social workers, &c.;
(b) teaching of groups—formally or by discussion; and
(c) use of publicity materials."

There is much confusion about these three branches of health education. so let me elaborate a little. The first and biggest branch is the teaching and counselling of individuals and families on physical, emotional and social health. The main professional agent here is clearly the health visitor, since by official definition her primary duties are health education and social advice, and since, after she acquires essential knowledge of health and disease processes in her nursing and midwifery trainings, her post-basic education is expressly designed to give her interviewing, teaching and counselling skills, to widen her knowledge of psychology, and to fit her for work as the health teacher and medico-social adviser of individual families and small groups. Other members of the health team actively involved in this branch are the general practitioner, the public health medical officer, the midwife and the home nurse. The second branch, supplementing but not replacing the first, is health education of groups—by discussion methods, didactic teaching, demonstrations, or a combination of

methods. Some of the workers involved are health education officers, public health medical officers, health visitors, parentcraft teachers, and public health inspectors. The third branch, possibly capable of independent and separate existence but so far mostly used to reinforce the other two, is mass publicity. It includes such things as the production and use of leaflets, brochures, films, exhibitions, newspaper articles, and TV and radio talks.

Perhaps the most important parapgraph in the document produced by the Association of Mental Health[2] is this:—

> "To be effective it (i.e. health education) must satisfy six criteria:— (1) that the educator has adequate technical knowledge for work at the particular level (e.g. midwife could remove misconceptions about child-birth but could not without subsequent health visitor training explain developmental stages and emotional needs of child); (2) that he has adequate teaching skill (highest level being that of school teacher, health visitor tutor and nurse tutor, next that of health visitor, &c.); (3) that he knows something of the temperaments, attitudes, prejudices, problems and back-grounds of the people taught (e.g. radio talks and press articles rouse interest but are too general to change attitudes, since they must say the same thing to mollycoddling, over-strict and over-ambitious parent); (4) that there are adequate opportunities of contact between the educator and persons taught (e.g. a single lesson does not eradicate an unhealthy habit: little real health education is possible if health visitor or general practitioner sees client only thrice annually; and similarly for groups a course of six meetings is far more valuable than six isolated talks. The Association suggests that the best practical means of improving mental health would be by large-scale development of group health education—in schools, ante-natal clinics, child welfare clinics, &c., although the Association would also like to see a substantial increase in individual health teaching); (5) that conditions and equipment are satisfactory; and (6) that each local health authority employs at least one senior health education officer (to plan and co-ordinate health education services, advise on visual aids, and encourage experimentation). This officer could have the background of a health visitor with traditionally a tutor's qualification, or a doctor or health visitor with a health education diploma, or a biology teacher with further training in health, but in any case should not be paid less than persons responsible for other further education work or persons in charge of other sections of the Health Department."

Evaluations of Health Education.

Irrespective of the extent to which they and their working conditions measure up to these six criteria, practitioners of health education must expect to have their efforts subjected to critical scrutiny more often than those of persons engaged in curative, palliative or supportive services. Infrequent—perhaps too infrequent—are studies of the benefits produced by appointing an extra hospital registrar or an additional social welfare officer or a new child care officer, or

assessments of the effects on the community of erecting another old people's home or enlarging a child guidance clinic; but, because prevention of disease and improvement of health produce results that are not immediately visible, because nobody can identify the person who was saved from developing diphtheria or dental caries, evaluation of preventive services in general and of health education in particular, has for years been a favourite pastime of statisticians and financial experts.

Out of a mass of published findings, five broad points emerge.

First, where health education is considered as a whole, without differentiation of its branches, its value is established beyond shadow of doubt. There have been so many investigations, with such uniformity of results, that no well-informed person would nowadays question the value of health education in general.

Second, where mass publicity efforts have been undertaken alone, without simultaneous individual or group teaching, the findings are less encouraging: there may be a place for the use of large-scale techniques by themselves, but the existing evidence seems to suggest that they are most likely to succeed when employed in association with group and individual teaching—to supplement and reinforce them or to arouse initial interest.

Third, where individual and group teaching have been used together, without the employment of mass media, the results have been very good—so good, indeed, that some investigators have questioned the need for mass media at all.

Fourth, because group health teaching is in the main a recent development, assessments made in the past have demonstrated the value of individual health education by itself. Typical examples are a finding in sixteen towns, studied over two separate periods of three years, of a significant association between the case-loads of health visitors and the infant death rates[3], or the discovery of a relationship in some 28 local authority areas between decreased numbers of children immunised against diphtheria and decreased numbers of public health staff employed[4].

Fifth, owing to the fact that the particular local authorities in Britain that have been to the fore in group health education have in general also had reasonably well developed services for individual teaching, there exists in this country curiously little evidence about group health education by itself. It is because the peculiar chronological circumstances of Aberdeen's health developments facilitate a partial filling of that gap that I venture to quote figures for a single city.

Salient Features of Aberdeen.

In the period 1950-60 Aberdeen's vital statistics improved to a greater extent than did those of the country as a whole. To cite only one illustrative example, taking averages for three years to minimise chance variation, here are the infant death rates per thousand live births for England and Wales, Scotland, the two Scottish cities larger than Aberdeen and Aberdeen itself, for 1950-52 and 1958-60, with the percentage reduction indicated:—

TABLE 1—INFANT MORTALITY RATES.

	1950-52	1958-60	Reduction.
Eng. and Wales . .	29	22	24%
Scotland . . .	37	27	27%
Glasgow . . .	44	34	23%
Edinburgh . . .	28	24	14%
Aberdeen . . .	29	20	31%

[This paper had to be prepared for printing in January, 1962, before 1961 data were available for other areas: hence the ending of the above table at 1960, whereas later—for Aberden alone—figures for 1961 are included].

The standard of living did not alter more in Aberdeen than elsewhere; there were no great variations of population or social stratification to explain the alterations; employment was fairly full at the beginning of the decade, and in the last years rather more unemployment existed in Aberdeen than in most places; the city's housing situation was bad at the beginning of the period and still bad at the end. Since Aberdeen's hospital services were already very well developed at the beginning of the decade and since its general practitioner services were also regarded as very good, it is highly unlikely that Aberdeen benefited more than other areas from advances in medical treatment or extensions of facilities for such treatment. Since there were considerable changes in the services provided by the Health and Welfare Department and no other obvious beneficial changes, it would seem logical to assume that the improvements in health statistics were casually related to alterations in the services.

Broadly, the twelve years 1950-61 can be considered as falling into three segments of equal length:—

(a) 1950-53 was the period of rapid increase in the services for individual health teaching. 1952 was the first year in which the average number of health visitors employed exceeded 45; in 1953 it reached 55 (and by 1954 it had reached 60). In these four years there was also an increase in the medical officers from 11 to 14.

(b) 1953-57 was the period of stable, reasonably well-developed services for individual health teaching and of little in the way of group health education. Aberdeen's large-scale efforts in group health education started at the end of 1957, and could have little effect on the figures before 1958.

(c) In 1958-61 there were only trivial increases in the numbers of health visitors and medical officers (and these increases were fully balanced by new duties, such as mental after-care), but group health education was in full stride.

It would therefore seem reasonable to take the first quadrennium as a base line, to attribute improvements in the second quadrennium to individual teaching by health visitors and medical officers, and to attribute additional improvements in the third quadrennium to the effects of group health education.

Two general points may be mentioned first. If 60 health visitors in 1954 or 68 in 1962 appear generous for a city of 186,000 population—we actually have an establishment of 83 but still have unfilled vacancies—it should be remembered that Aberdeen has a combined Health and Welfare Department, and that the health visitors (in addition to their normal duties in respect of expectant mothers, pre-school children, school pupils, the elderly, etc.) undertake many tasks which in some areas are discharged by other social workers. On the usefulness of this policy let me quote, with wholehearted approval, the words of a distinguished colleague in an essay that was awarded the first prize of the Royal Society of Health[5]:

> "Amalgamation, both at field level and at administrative level, benefits the individual in need, saves the community a good deal of money and provides the administrator and the general field worker with more interesting, varied and satisfying fields of work. Not least, in areas where it has been tried, amalgamation has passed the acid test—it has worked successfully."

As for the group health education scheme, it has been fully described elsewhere[6]. Suffice it here to say that there are 1100-1400 meetings annually, mostly in systematic courses rather than sporadic "lectures", that the total attendances are 20,000-27,000 a year, that the main concentration is on emotional and social health, that the individual in charge of the scheme is the Principal Health Visitor Tutor and Senior Health Education Lecturer who is assisted by two health visitor tutors and a number of selected health visitors (and, on request, by other members of the professional staff), and that maximal attention is paid to expectant mothers (and latterly also to their husbands) and to parents of pre-school children.

Assessment of health education in Aberdeen.

A detailed evaluation of the Aberdeen health education scheme[7], published two years ago, may be briefly summarised.—(a) It analysed the subjective impressions of present and past members of the health education team, of other members and ex-members of the staff of the Health and Welfare Department, and of the public ; (b) it indicated various semi-objective factors tending to corroborate these favourable impressions ; (c) it gave a year-by-year analysis, up to 1959, of five sets of figures of mental health significance ; (d) it provided a similar year-by-year analysis of cases of various preventable infectious diseases ; (e) it gave an indication of the amount of reduction of home accidents ; (f) it analysed for a series of years certain findings in schoolchildren at health visitors' surveys, medical officers' examinations and dental officers' inspections respectively ; (g) it provided some data about pre-school children ; (h) it listed various mortality figures (e.g. neonatal and post-neonatal death rates) for a series

of years; (i) it demonstrated that in four unconnected features—attendance of adults in a mass radiography campaign, attendance of adolescents at the first "open" sessions for vaccination against poliomyelitis, state of immunisation of pre-school children against diphtheria, and state of teeth of school entrants—sectors of the city where group health education had started by 1957 compared favourably with portions where it started later; and (j) it concluded that "the value of the Aberdeen health education scheme in the conditions and circumstances of that city is proved beyond shadow of doubt."

Anyone who cares to study the data for 1960 and 1961 can satisfy himself that the trends did not undergo sudden reversal after 1959. It is perhaps more instructive to take a couple of indices that were not used in the 1959 evaluation and to see whether they have varied in accordance with the postulates of an improvement in community health about 1954 through increased individual health education and another improvement about 1958 through expanded group health education.

I mention first an index of mortality, the World Health Organisation's suggested "health indicator", i.e. deaths over the age of 50 years expressed as a percentage of total deaths. As will be seen from Table II, the percentage rose by about 2.8 from 1954 onwards and then by almost half that amount from 1958 onwards.

TABLE II—DEATHS OVER 50 YEARS AS PERCENTAGE OF ALL DEATHS.

1950 and 1951	85.0	85.0
1952 and 1953	85.0	
1954 and 1955	87.9	87.8
1956 and 1957	87.7	
1958 and 1959	88.8	89.0
1960 and 1961	89.2	

Incidentally, the same thing holds with that useful but seldom employed index, the average age at death, the figures being : 1950 and 1951—65.3 years; 1952 and 1953—64.9 years; 1954 and 1955—66.5 years; 1956 and 1957—66.1 years ; 1958 and 1959—67.0 years ; and 1960 and 1961—67.3 years.

Second, an index of morbidity, the number of patients under 65 years visited by the home nurses, starting with 1954 because of different classification in earlier years:—

TABLE III—PATIENTS UNDER 65 VISITED BY HOME NURSES.

Year.	Number.	Year.	Number.
1954	2730	1958	2125
1955	2638	1959	1973
1956	2413	1960	1703
1957	2542	1961	1645

Plenty other indices could be cited, e.g. the two widely different ones given in Table IV.

TABLE IV.

	Total of all infectious diseases notified in 4 years.	Total of all deaths at 1-5 years in 4 years.
1950-53	5,454	67
1954-57	2,910	37
1958-61	2,182	29

In every single case the increase in individual health teaching (i.e. the expansion of the health visitor and medical officer services) was followed by a considerable improvement, and the large-scale development of group health education by further improvement.

The L.S.D. of health education.

What evidence can be adduced by the financial value of group and individual health education?

(1) It has been calculated[8] that if six preventable infectious diseases—smallpox, enteric fever, diphtheria, whooping cough, ophthalmia neonatorum and tuberculosis—had in Aberdeen maintained the incidence that obtained for each disease when preventive measures against it started, the cost of treating these conditions would in 1959 have exceeded the actual cost in that year by £274,051, or rather more than three times the combined salaries of the city's public health medical officers, health education officers, health visitors, public health inspectors and midwives.

(2) For two diseases for which individual and group health education have been employed nationally, it has been reckoned[9] that in Scotland on 1961 values the elimination of diphtheria is saving £900,000 a year after allowance has been made for national and local expenditure of about £130,000 on persuasion of parents, actual immunisation, cost of immunising agents and syringes, transport, clerical work, and maintenance at appropriate hospitals of a few empty, staffed beds in readiness for possible outbreaks and that the reduction of poliomyelitis is saving Scotland £200,000 a year after allowance has been made for expenditure of about £100,000.

(3) Returning to Aberdeen figures, a further calculation[10] has attempted to set out a profit and loss account for 1954-59 on the assumption that reductions in infectious diseases, home accidents, amount of home nursing required, &c., were directly related to extensions of the preventive services. The account is summarised in Table V. It should be noted that this Table relates to the gains and losses up to 1959 only; since then there have been appreciable further gains.

TABLE V.—ABERDEEN GAINS AND LOSSES, 1954-59.

Annual Gain.		Annual Loss.	
To taxpayer: reduction of hospital costs . .	£69,932	Salaries of additional health education officers, health visitors, &c. in 1959 as compared with staff in 1954 . .	£4,420
To ratepayer: reduction of services for cripples .	2,450		
places in residential nursery . . .	10,638		
home nursing . .	4,500		
dental staff . . .	1,700		

People tend to imagine that treatment and supportive services are a cost solely to the taxpayer, while preventive and health education services are borne (apart from grant) by the ratepayer. It is therefore important to point out that many local health authority services are essentially supportive (e.g. home nursing, home helps, day and residential nurseries, and occupation centres) as are all local welfare authority services. The savings to the ratepayer mentioned in Table V above are not simply hypothetical: for instance, Aberdeen was enabled, through falling demand, to reduce the number of places in its residential nursery, with an actual saving greater than the total salaries of a dozen health visitors; and to reduce, through similar falling demand, its home nursing service, with a saving considerably greater than the total expenditure on group health education.

National Value of group and individual health education.

Since in Aberdeen group and individual health education have together reduced the incidence of home accidents by one third and have enabled the establishment of dental officers (employed mainly on detection and treatment of diseased teeth) to be reduced while the proportion of children with unhealthy teeth has continued to fall yearly, it may be permissible to quote an interesting comment by Dr. Campbell, M.O.H. of the town that will sooner or later have to be recognised as the fifth city of Scotland[11]:—

> "The Health Visitor is a highly trained social worker as well as a Nurse, and if her skills are used properly and in increasing volume the cost of the Health Service could be reduced, e.g. if the number of home and other accidents were reduced by only 10% an approximate reduction of 50 Million Pounds could be made in the national costs. In the same way the prevention of dental caries could result in a saving of many millions of pounds yearly to Local Authority and Hospital Services. The Health Visitor can effect these reductions by proper health education techniques, but only if she has the time to do this work properly and not if she were doing it at the expense of her other duties. The establishment of Health Visitors will have to be raised at some future date to enable them to undertake this most important work."

Let me turn to another example—the elderly. Since 1954, when a leading health visitor published an epoch-making article[12] on the role of the health visitor in the health maintenance of the elderly, views that were then revolutionary have gained acceptance, and have even been incorporated in an official central government circular[13]. In Britain approximately 700,000 people reach pensionable age each year, and half of these will end their lives in a hospital or an old people's home: indeed that is probably an underestimate, for it has already been ascertained in one city that in recent years 46% of all deaths over the age of 65 years occurred in hospital[14]. If by group and individual health education we could delay the average entry of these 350,000 old people each year to homes and hospitals by three months, then—in addition to materially increasing their happiness—we should save 90,000 beds or, in monetary terms, about £50,000,000 a year.

No estimate is here made of the national value of the biggest function of health education—the reduction of maladjustment, delinquency, anti-social behaviour, psychoneurotic disorders and psychosomatic diseases, and the improvement of emotional and social health. Substantial and in part measurable results are already being obtained in a few areas, including Aberdeen; but no local health authority is as yet doing more in mental health education than skimming the surface. Whether adequate development of services for individual and group health education in this field would save the country £70 millions or £170 millions a year is anybody's guess. What is beyond the stage of guesswork is that mental health education can reduce the incidence of maladjustment, &c., and therefore can save money as well as increasing human happiness.

Conclusion.

The value of individual and group health education is conclusively proved. The biggest failures of the national health service have been (a) a penny-wise, pound-foolish attitude to the appointment and remuneration of health education officers to organise, stimulate, direct and co-ordinate health education of groups, and (b) a similar penny-wise, pound-foolish attitude to the development of the health visiting service for individual health education and medico-social work. Every year these failures are costing Britain many millions of pounds.

Let me end by inviting each Chairman of a Health Committee and each Medical Officer of Health to ask himself two questions.—(1) Has *my own local authority* fully developed services for group and individual health education? (2) If not, is it so wealthy that it can afford the extravagance of neglecting services which pay rich dividends both in increased health and happiness and in decreased cost of expensive services for treatment, palliation and support?

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(7) MacQueen, I. A. G. (1960), *The Medical Officer*, 103, 295.

(8) Annual Report of M.O.H. of Aberdeen (1959), xv.

(9) MacQueen, I. A. G. (1961), *Health and Welfare* (Quarterly Bulletin of Aberdeen Health & Welfare Department), 12, 7.

(10) Annual Report of M.O.H. of Aberdeen (1959), xvii.

(11) Annual Report of M.O.H. of Paisley (1960), 14.

(12) Lamont, D. J. (1954), *The Medical Officer*, 92, 162.

(13) Department of Health for Scotland, Circular 60/1958.

(14) McIntosh, A. W. (1962), Personal Communication.

2.—THE COST OF THE SERVICE.

The net costs given below are calculated *after* deduction of revenue (e.g. payments made by parents for children in nurseries) but do not take account of block grants from central government funds.

(a) Health Services alone.

The net cost of the Health Services (as distinct from Welfare Services and School Health Services) is £340,117 or the equivalent of 8⅓ pence weekly for each inhabitant of the city: this cost is met partly from the rates and partly from exchequer grant.

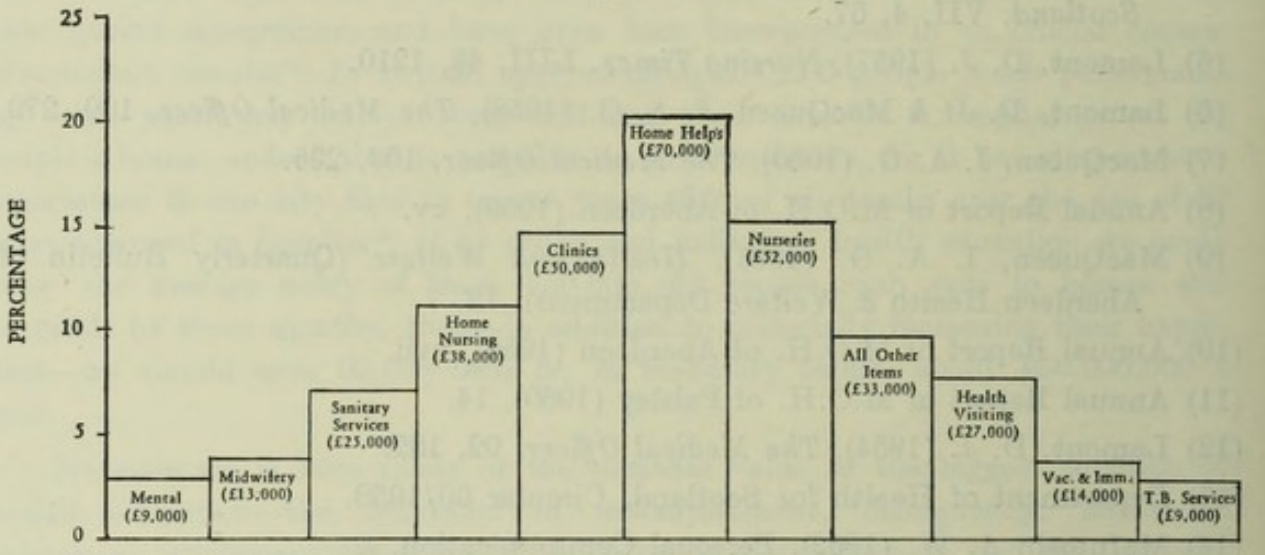
The following table gives the main items as percentages of the total net cost and the diagram lists the ten largest contributors.

Item.	Percentage.	Item.	Percentage.
Home Helps	20.48	Tuberculosis	2.69
Nurseries	15.30	Administration, &c.	2.66
Clinics	14.72	H.V. Training (largely national expenditure and refunded to Corporation)	2.64
Home Nursing	11,31	Chiropody	1.54
Health Visiting	7.97	Pensions, &c.	0.91
Sanitary Services	7.26	Linn Moor Home	0.62
Vaccination and Immunisation	3.99	Welfare Foods	0.55
Midwifery	3.76	Health Education	0.52
Mental Services	2.71		
All other items	0.37		

The 1961/62 proportions are illutsrated in the diagram on next page.

COSTS OF HEALTH SERVICES

(COSTS OF INDIVIDUAL ITEMS AS PERCENTAGES OF TOTAL HEALTH COSTS)



(b) Entire Services of Health and Welfare Department.

The net cost of the Health, Social Welfare, School Health and other services is £484,735, which is almost exactly equal to one shilling weekly for every inhabitant of the city.

The following table gives some items as percentages of total expenditure.

(1) *Health*		70.16%
Home Helps	14.37%	
Nurseries	10.73%	
Clinics	10.32%	
Home Nursing	7.93%	
Health Visiting	5.59%	
Sanitary Inspection	5.09%	
Vaccination and Immunisation	2.80%	
Midwifery	2.64%	
Mental Health	1.90%	
Tuberculosis	1.89%	
(2) *School Health*		9.64%
(3) *Welfare*		17.17%
Old People's Homes	9.70%	
General Welfare	3.47%	
Blind	2.26%	
Physically Handicapped	1.15%	
Old People's Welfare Council	0.59%	
(4) *Miscellaneous* (e.g. Meat Inspection, Lodging House)		3.03%

(c) Appropriateness of the Balance.

Attention was drawn in the Report for 1960 and again in the Report for 1961, to the fact that services for health-promotion and disease-prevention were faring very badly by comparison with supportive services. In 1962 this disparity continued and indeed increased. For instance—

(a) Less than one half of one per cent of the Department's total net expenditure was allocated to health education;
(b) for the second consecutive year there was a decrease in the proportion of total net expenditure devoted to health visiting;
(c) the proportion of expenditure apportioned to clinics fell sharply;
(d) there was a very sharp rise (from 7.14 to 9.7 per cent. of the total net expenditure) in the cost of old people's homes; and
(e) there was an appreciable rise (from 13.6 to 14.37) in the proportion of total net expenditure devoted to home helps.

It was pointed out in the 1961 Report that six supportive services that operate mainly for the benefit of old people (home helps, hostels, home nursing, general welfare, chiropody and payments to the Old People's Welfare Council) had risen to constitute more than a third of the entire expenditure of the Department; these six items now account for more than 37% of the total net expenditure.

As was suggested last year, a policy of quadrupling expenditure on health education and special campaigns and slightly increasing expenditure on health visiting, might in due course permit considerable reductions in some of the supportive services.

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

In interpreting the vital statistics of any locality regard must be had to the background data obtaining. Certain basic information is therefore given below. For further details of general features of Aberdeen (such as industries, growth of population and socio-economic classificatiion of adult males) the reader is referred to the fuller report for 1958; and a comprehensive study of housing circumstances and related social problems will be found in the 1956 report.

GENERAL DATA.

The most northerly large city in the Commonwealth, Aberdeen is the third biggest city in Scotland about 4 per cent. of the population of the country. A considerable seaport with an extensive fishing fleet, Aberdeen is the commercial, educational and industrial centre for a large agricultural hinterland. In summer the city is also a very popular seaside resort. The city has the features and problems of a regional "capital", a University town, a seaport and a holiday resort, with, in addition, considerable geographical isolation from other centres of population.

Area of city (exclusive of inland tidal water and foreshore)—11,362 acres.

Population (estimated)—mid-1961, 185,222; and 1962, 185,678.

Density of population—16.3 persons per acre. This is greater than that of Edinburgh or Dundee, but less than that of Glasgow.

Number of houses—1961, 58,318; 1962, 58,624.

Average number of persons per house (estimated, mid-1962)—3.2.

Facilities available—At the 1951 census Aberdeen was more unfavourably placed than any other Scottish city in respect of families lacking exclusive use of water closets, kitchen sinks, &c. Figures for the 1961 census will be available shortly.

Socio-economic classification of adult males—At the 1951 census Aberdeen and Glasgow were found to have higher proportions in Social Class V (i.e. unskilled workers) than other cities or Scotland as a whole. Aberdeen had a higher proportion in Classes IV and V combined than had Glasgow.

Unemployment—The high unemployment figure of 1961 rose by 468 in 1962. At 10th December, 1962, the numbers of unemployed persons in the area covered by the Aberdeen Employment Exchange were:—

Men, 2,698; boys, 34; women, 682; girls, 28; total 3,442.

METEOROLOGICAL DATA.

Temperature—During the past four years the lowest temperature recored was 18°F in each year. The weeks during which this occurred have varied from December to February.

The highest temperature registered was 75°F (during the week ending 9th June). (In 1961 the highest registered was 73°F and in 1960 73°F).

The diagram facing this page gives the maximum and minimum temperatures for each week of the year.

Rainfall—The total rainfall during the year (at Craibstone, just outside the city) was 34.26 inches. (Total in 1961, 30.70 inches, and in 1960, 42.82 inches). The distribution of rainfall in different months is shown diagrammatically.

Sunshine—The average daily hours of sunshine are shown in the diagram.

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

WIND VELOCITIES AND DIRECTIONS.

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

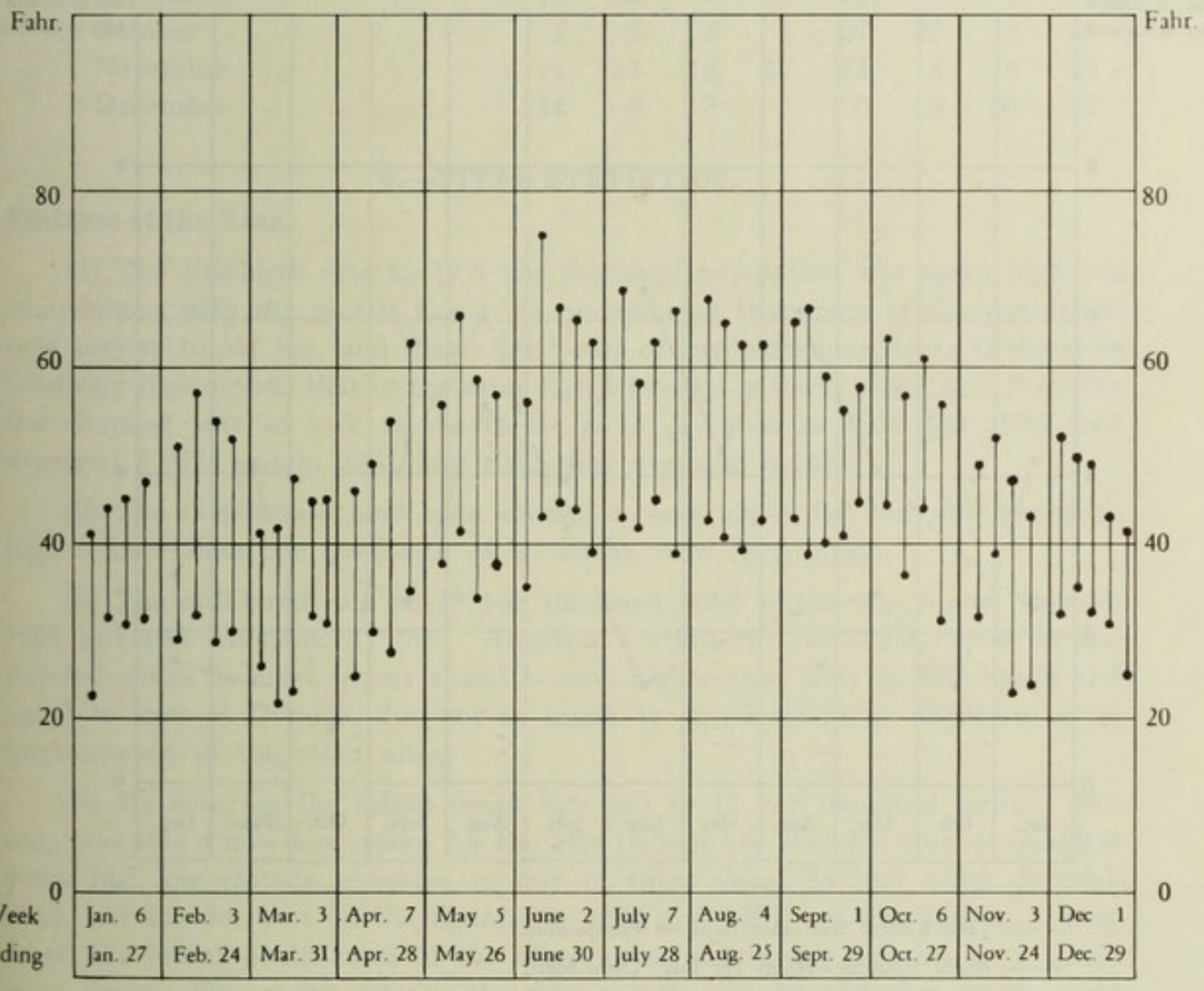
Month.	Number of Gusts at Various Speeds (in Knots)				
	Over 34	22-33	11-21	1-10	Calm
January	1	6	66	37	14
February	3	10	36	54	9
March	0	2	39	67	16
April	0	9	37	61	13
May	0	13	39	55	17
June	0	6	49	51	14
July	0	2	32	79	11
August	0	5	32	70	17
September	0	3	24	78	15
October	0	3	32	70	19
November	0	0	33	65	22
December	0	3	44	65	12

CITY OF ABERDEEN.

TEMPERATURE OF ATMOSPHERE—WEEKLY MAXIMA AND MINIMA

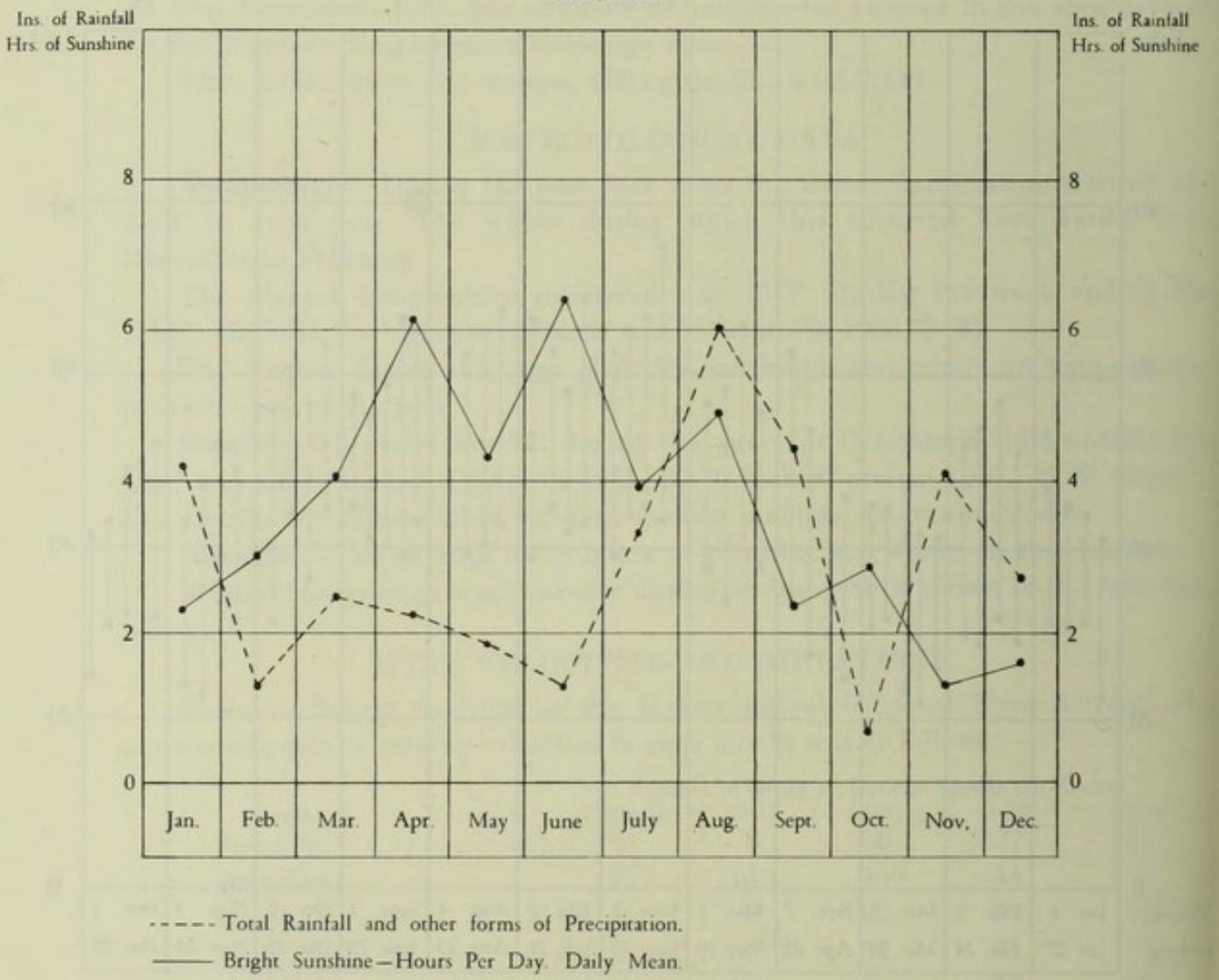
°FAHR.

YEAR, 1962.



BRIGHT SUNSHINE – HOURS PER DAY. DAILY MEAN.
TOTAL RAINFALL AND OTHER FORMS OF PRECIPITATION.

YEAR, 1962.



- - - - - Total Rainfall and other forms of Precipitation.

—— Bright Sunshine – Hours Per Day. Daily Mean.

The directions of the various gusts each month were:—

Month.	Number of Gusts from							
	North	N.E.	East	S.E.	South	S.W.	West	N.W.
January . . .	5	0	1	4	33	24	35	8
February . . .	8	3	10	3	11	19	29	20
March	18	2	0	9	10	4	15	50
April	14	13	7	13	16	5	15	24
May	28	3	5	9	9	10	11	32
June	4	0	2	7	33	16	19	25
July	26	6	14	19	10	3	10	25
August	10	2	2	9	21	17	26	20
September . . .	14	2	3	8	28	12	9	29
October . . .	5	2	4	1	37	23	18	15
November . . .	11	1	12	17	14	8	13	22
December . . .	14	0	8	3	30	9	26	22

4.—VITAL STATISTICS.

Features of the Year.

(1) The live-birth rate at 17.5 per thousand population was again high: in comparisons with the past it has to be remembered that more of the population now survive to old age, and that a birth-rate of any particular figure is therefore relatively higher than that of the same figure twenty or thirty years ago. Probably the simplest way to look at the births is to say that in 1951 and 1952 they averaged 3,027, and in 1961 and 1962 they averaged 3,254.

(2) The illegitimate birth rate showed a very slight fall but still remained high : more than one twentieth of all births were illegitimate.

(3) The still-birth rate at 18 per thousand total births was higher than in 1961 but still satisfactorily low. Aberdeen's still-birth rate (the lowest in the Scottish cities in most recent years) is now higher than that of Edinburgh and equal to that of Dundee, due not so much to deterioration in Aberdeen as to improvement in the other cities.

(4) By contrast the infant death rate fell to 17 per thousand births. Not only was this a new low record for the city (which has now for nine consecutive years had low records unbeaten in any of these years by any other Scottish city), but the decrease on the figures for 1960 and 1961 was startling at a time when the infant death rates in the other cities and in the country as a whole were rising. The death rate in the first month was 12 and that in the next eleven months was 5, both figures being lower than in any other Scottish city.

(5) The number of deaths at 1-5 years—15—was greater than in 1960 and 1961 combined : one has to go back nine years to find a year with as many deaths of pre-school children. Of the 15 deaths, 6 were due to accidents, suggesting that the lessons of the safety campaigns of 1955-60 were now being forgotten.

Births, Still Births, Infant Mortality.
Years 1952-1962.

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.				Death-rates among Infants under 1 Year of Age from Various Causes per 1,000 Live Births.								
									Total under one Year.	Rates.			Tuberculosis.	Common Zymotic Diseases.	* Pneumonia and Bronchitis.	Diarrhœa and Enteritis.	Congenital Malformations.	Injury at Birth.	Atelectasis.	Immaturity.	Accidents.	Other causes.
										Under 4 Weeks (Neo-natal Rate).	4 Weeks and under Six Months.	Six Months and under One Year.										
1962 .	3245	17·5	5·1	58	18	55	40	73	16 9	12·3	2·5	2 2	0	0·3	2	0	3	2	4	2	0.6	3
1961 .	3263	17 6	5·2	51	15	72	50	69	22·1	15·3	5·8	0·9	0	0	2	0	5	0	5.5	3	2·5	4
1960 .	3280	17.5	5.1	69	21	63	46	73	19·2	14·0	3·0	2·1	0	0·3	2	0·3	2	3	5.5	1	2	3
1959 .	3345	17·9	5·3	61	18	76	47	62	22·7	14·1	5·4	3·3	0	0·3	4	1	4	2	4	4	2	2
1958 .	3243	17·4	4·5	52	16	57	44	77	17·6	13·6	3·4	0·6	0	0	4	0	2	2	4	3	1	2
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

*Including under 4 Weeks

(6) As in 1961 there were 9 deaths in school children : 5 of these were due to accidents.

(7) The maternal mortality rate (0.6 per thousand total births or in all two deaths) was higher than in the last two years and well above the average for Scotland.

(8) The tuberculosis death rate was the lowest ever recorded.

(9) The death rates from malignant diseases and diseases of the circulatory system both fell slightly.

(10) The average age at death (67.5) equalled the previous year's record figure.

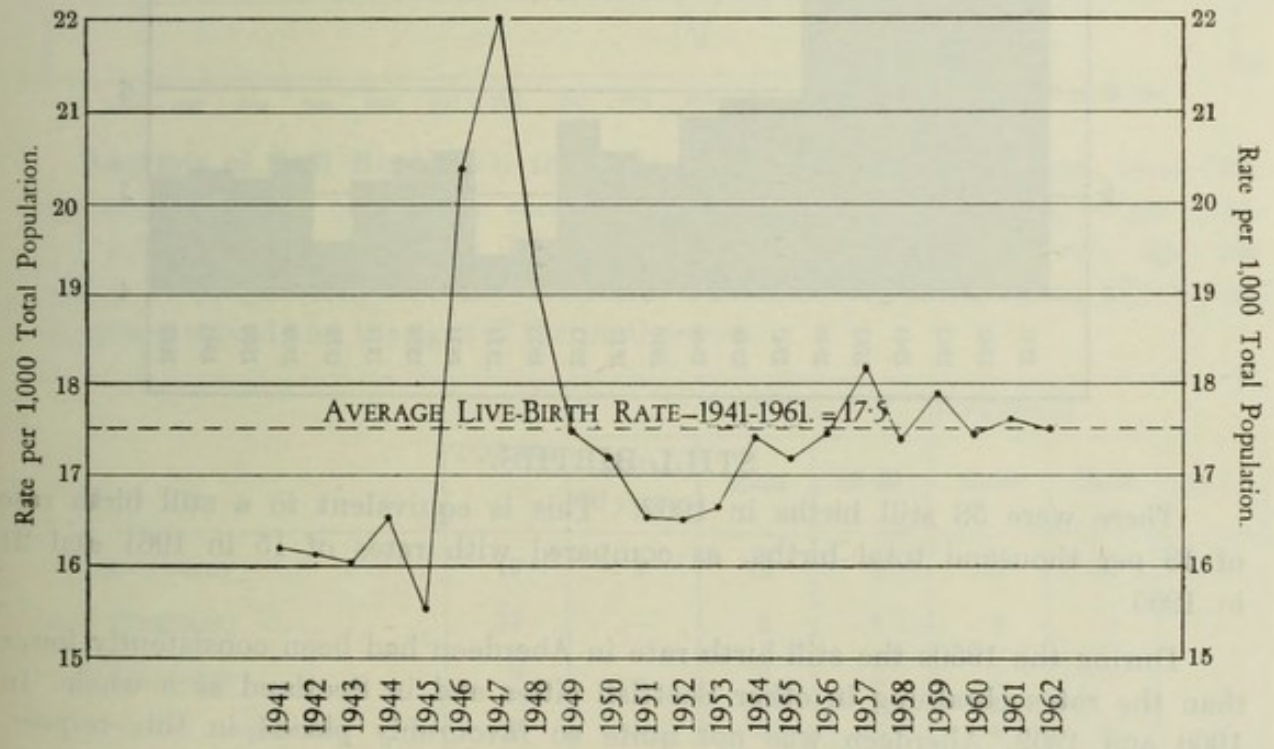
(11) The proportion of deaths in persons over the age of 75 years was 41 per cent, the highest figure ever recorded in the city.

(12) The World Health Organisation's "Health Indicator"—i.e. the proportion of deaths occurring in persons over 50 years of age—was, at 89.5 per cent, the highest on record.

LIVE BIRTHS.

The total number of live births in Aberdeen during 1962, corrected for "transfers" was 3,245, of which 3,078 were legitimate and 167 illegitimate. The live-birth rate was 17.5 per thousand of population.

ABERDEEN.–LIVE-BIRTH RATE–1941-1962.



The natural increase for the year (i.e. the excess of births over deaths) was 1,097, as compared with 1,030 in 1961 and 1,091 in 1960.

In 1962 the birth rates in the other principal cities were:—Glasgow, 22.3; Edinburgh, 18.4 ; and Dundee, 20.4. The birth rate in Scotland was 20.1.

Sex-ratio of births.—Of the total 3,245 live births, 1,699 were males and 1,546 were females, giving a ratio of 1.10 (i.e. 110 males per 100 females).

ILLEGITIMATE BIRTH RATE.

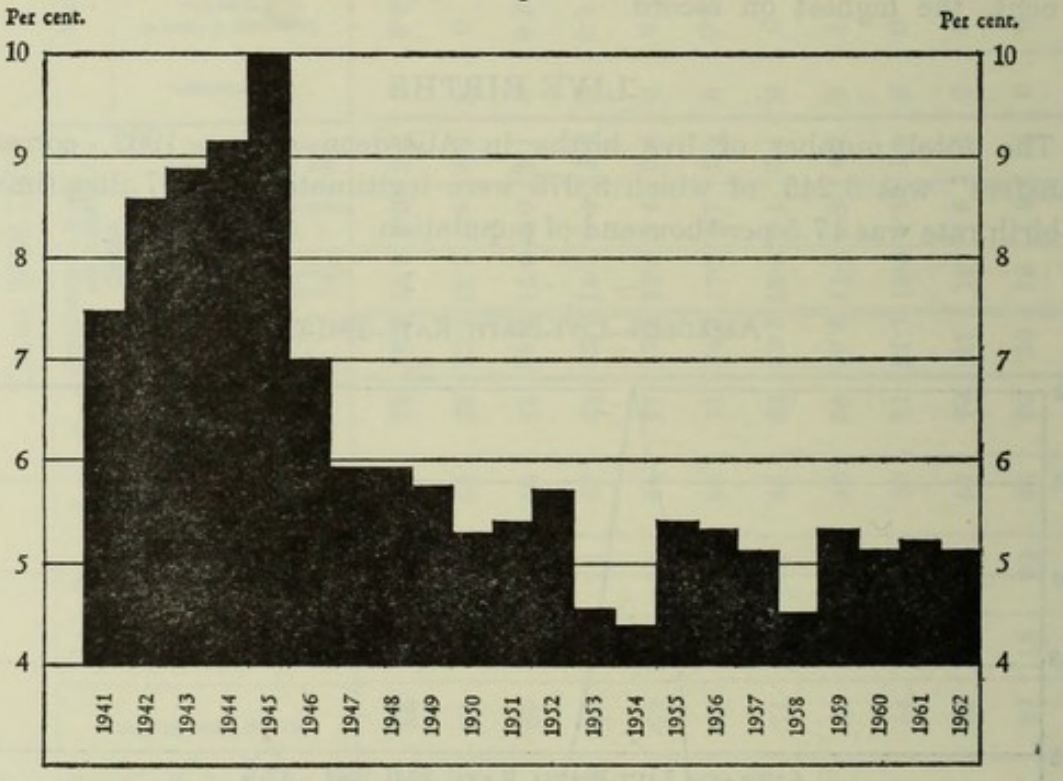
In 1962 there were 167 illegitimate live births, a rate of 5.1 per cent. of the total live births as compared with 5.2 per cent. in 1961.

For further comparison, the illegitimate birth rate in the Scottish cities in 1962 was 6.1, and for the whole of Scotland it was 4.8 per cent.

The diagram illustrates how the illegitimate birth rate in Aberdeen has changed over the years.

ABERDEEN.

Illegitimate Births as Percentage of Live Births, 1941-1962.



STILL BIRTHS.

There were 58 still births in 1962. This is equivalent to a still birth rate of 18 per thousand total births, as compared with rates of 15 in 1961 and 21 in 1960.

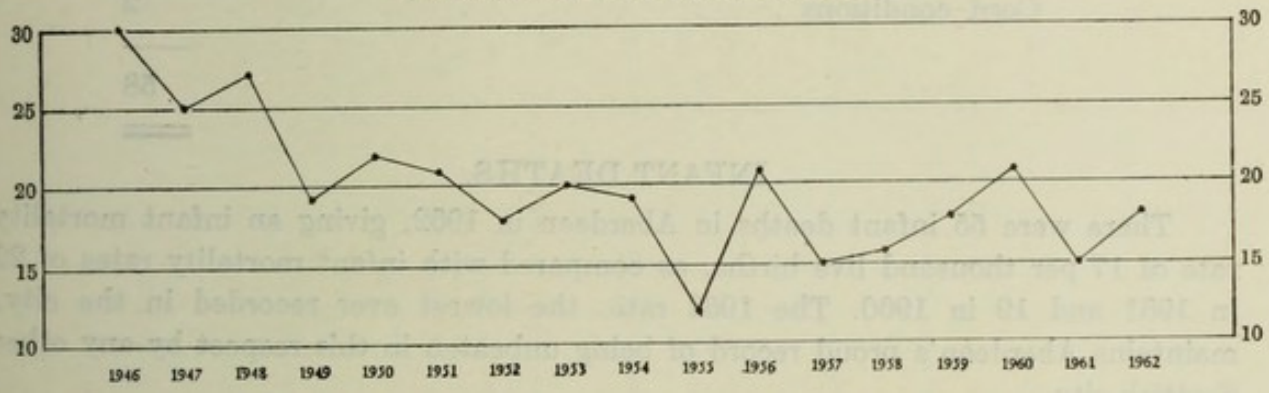
During the 1950s the still-birth rate in Aberdeen had been consistently lower than the rates obtaining in other Scottish cities and in Scotland as a whole. In 1960 and 1962, Aberdeen was not quite so favourably placed in this respect. But, until 1962, no other Scottish city had recorded a rate below 18, and only once in the past six years has the Aberdeen rate been higher than this.

Some of the factors responsible for the achievement and maintenance of Aberdeen's previously unique record have been discussed in previous reports, but special mention may be made here of the excellent co-operation which exists between hospital and local authority staff, the high standards of midwifery and obstetrical care under the leadership of Professor Sir Dugald Baird, the high standards of ante-natal care and health teaching, and the development of group teaching at the ante-natal clinics. Staff shortages may well explain the deterioration in 1962.

The following table gives comparative figures for the Scottish cities for the past five years ; and the graph shows the rate in Aberdeen since the early post-war years.

	Still Birth-Rate per 1,000 Total Births.				
	1962.	1961.	1960.	1959.	1958.
All Scotland .	20	21	22	22	23
Glasgow . .	23	23	25	28	25
Edinburgh . .	16	19	19	19	19
Dundee . .	18	21	18	20	23
Aberdeen . .	18	15	21	18	16

ABERDEEN.–STILL-BIRTH RATE–1946-1962



Analysis of Still Births—Of the total 58 still births, 33 per cent. were first pregnancies, 33 per cent. were second, 16 per cent. were third and 16 per cent. were subsequent pregnancies. In two cases information on mother's age and number of pregnancies was not available. The following table shows the actual numbers involved and the ages of the mothers : —

	TOTAL.	AGE OF MOTHER					
		Under 20 years.	20-24	25-29	30-34	35-39	40+
1st Pregnancy . . .	19	2	11	6	—	—	—
2nd Pregnancy . . .	19	—	6	8	3	2	—
3rd Pregnancy . . .	9	—	2	3	2	1	1
Subsequent Pregnancies .	9	—	2	1	4	2	—
TOTAL . . .	56	2	21	18	9	5	1

The causes of the still births were as follows:—

Mother—Chronic disease—		
Diabetes	1	
Anaemia	1	
		2
Diseases and abnormalities of pregnancy and child-birth—		
Ante-partum haemorrhage	14	
Toxaemia of pregnancy	5	
Eclampsia of pregnancy	1	
		20
Trauma		1
Foetus—Congenital malformations		7
Diseases of foetus—		
Rhesus factor		2
Ill-defined causes—		
Prematurity—Causes unknown	15	
Full term—Causes unknown	9	
		24
Cord conditions		2
		58

INFANT DEATHS.

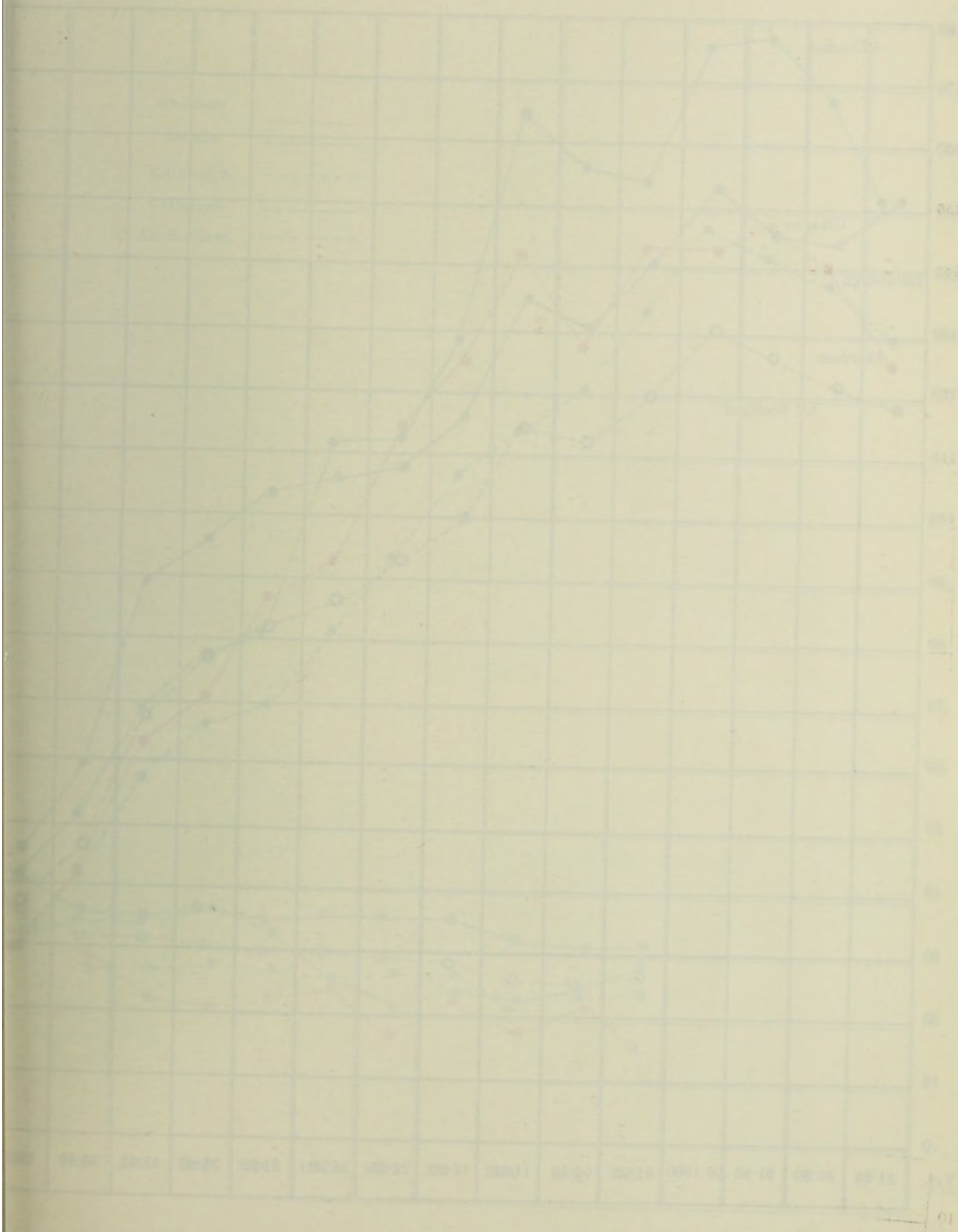
There were 55 infant deaths in Aberdeen in 1962, giving an infant mortality rate of 17 per thousand live births, as compared with infant mortality rates of 22 in 1961 and 19 in 1960. The 1962 rate, the lowest ever recorded in the city, maintains Aberdeen's proud record of being unbeaten in this respect by any other Scottish city.

A brief historical discussion of trends in infant mortality in Aberdeen was included in last year's Annual Report.

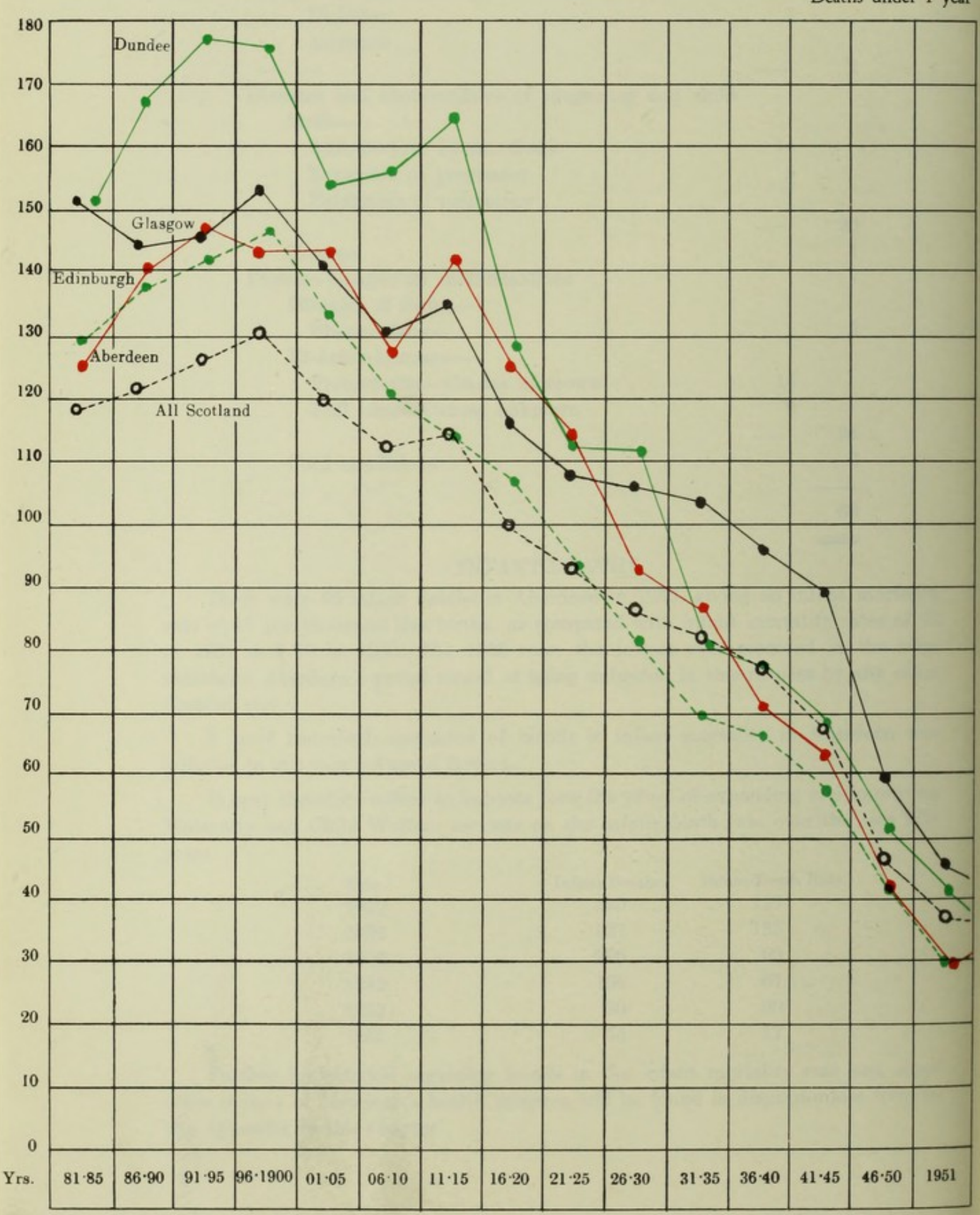
It may therefore suffice to indicate here the effect of expanding and improving Maternity and Child Welfare services on the infant death rate over the last fifty years.

Year.	Infant Deaths.	Infant Death Rate.
1912	530	127
1922	527	133
1932	296	93
1942	194	67
1952	90	30
1962	55	17

Further information regarding trends in the infant mortality rate and some other indices of Aberdeen's health progress will be found in diagrammatic form in the Appendix to this chapter.

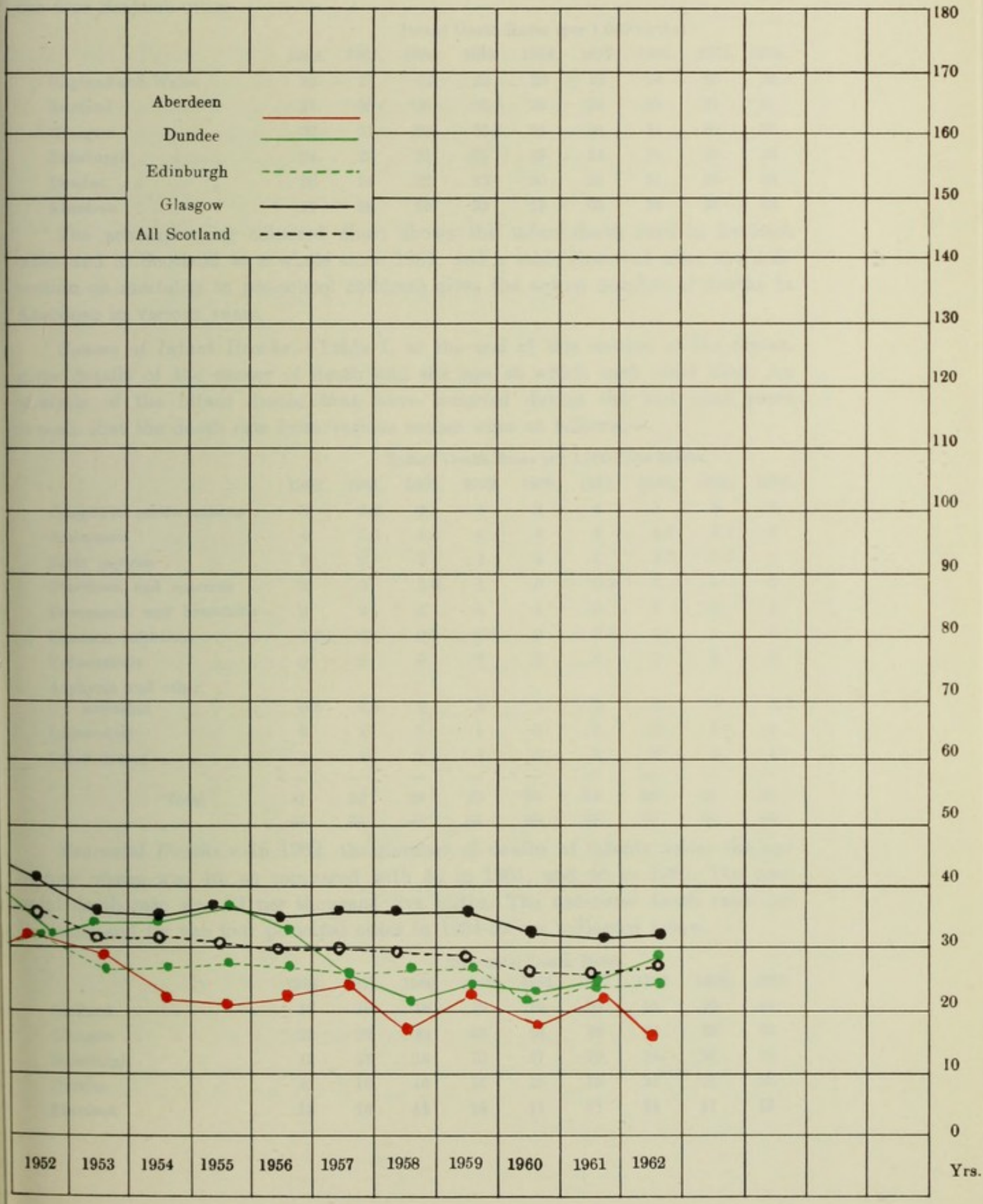


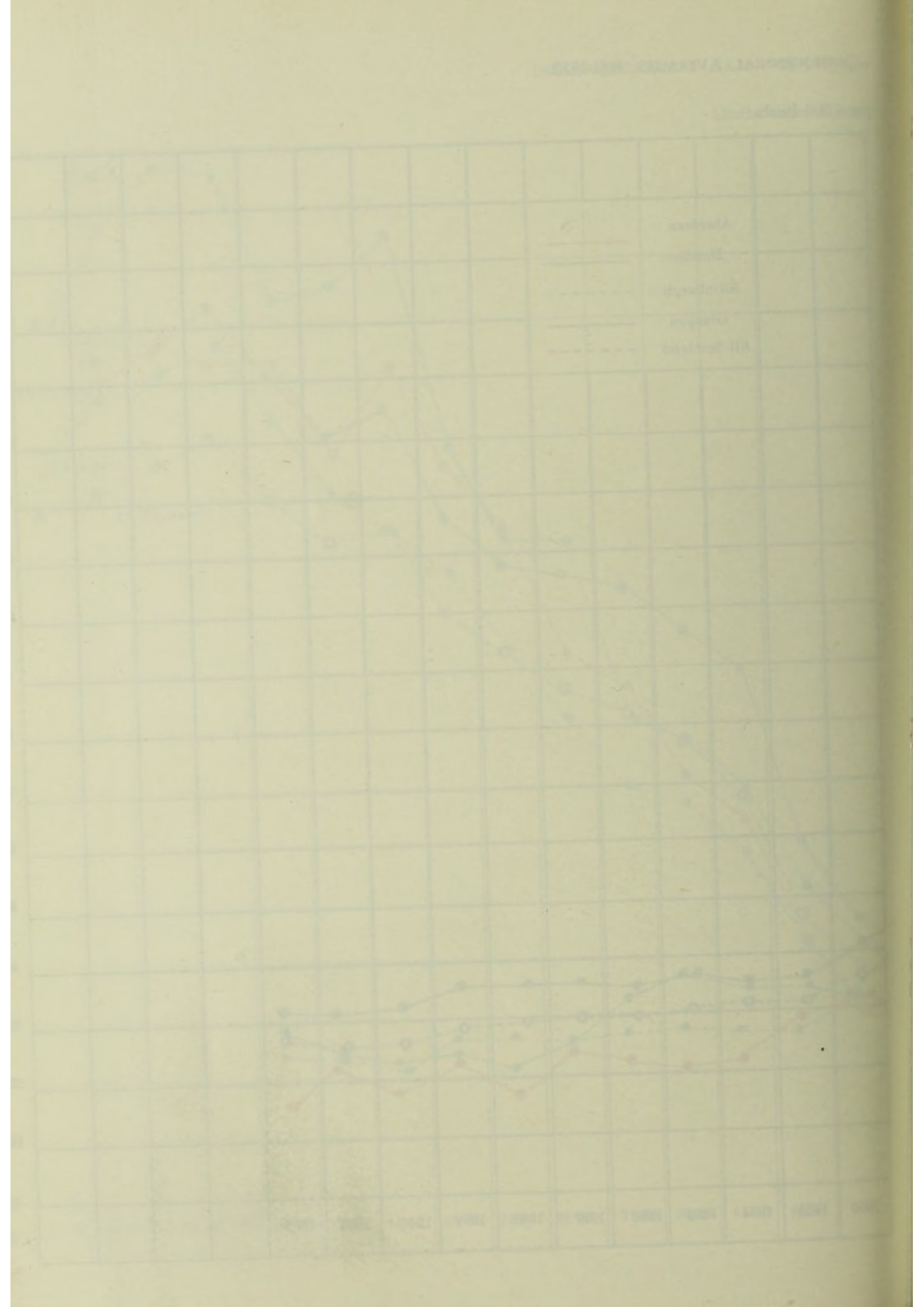
INFANT MORTALITY RATE— 1881-1962—



—QUINQUENNIAL AVERAGES, 1881-1950.

per 1,000 Births.





Comparison with national figures and with other cities.—The table below gives, for a period of nine years, the rates for England and Wales, Scotland, and the four Scottish cities.

	Infant Death Rates (per 1,000 births).								
	1962.	1961.	1960.	1959.	1958.	1957.	1956.	1955.	1954.
England and Wales . .	22	21	22	22	23	23	24	25	26
Scotland	27	26	26	28.4	28	29	29	30	31
Glasgow	32	31	32	35.5	35	35	34	36	35
Edinburgh	24	23	21	25	25	24	24	25	25
Dundee	28	24	22	23	20	24	31	36	33
Aberdeen	**17**	**22**	**19**	**23**	**18**	**24**	**22**	**21**	**22**

The accompanying coloured chart shows the infant-death rate in Scottish cities and in Scotland as a whole since 1881, 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 nine years reveals that the death rate from various causes were as follows:—

	Infant Death Rates per 1,000 Live Births.								
	1962.	1961.	1960.	1959.	1958.	1957.	1956.	1955.	1954.
Congenital malformations .	3	5.2	2	4	2	4	3	3	3
Atelectasis . . .	4	5.5	5.5	4	4	6	2.8	3.4	7
Birth injuries . . .	2	0	3	2	2	1	1.5	0.3	1
Diarrhoea and enteritis .	0	0	0.3	1	0	0.3	1	0	0
Pneumonia and bronchitis	2	2	2	4	4	5	5	4	5
Common infections . .	0.3	0	0.3	0.3	0	0.3	0	1	0
Tuberculosis . . .	0	0	0	0	0	0	0	0	0
Asphyxia and other accidents . . .	0.6	2.5	2	2	1	1	2	2	0.3
Immaturity . . .	2	3	1	4	3	5	5	4	2
Other causes . . .	3	4	3	2	2	1	2	3	4
Total . .	17	22	19	23	18	24	22	21	22

Neo-natal Deaths.—In 1962, the number of deaths of infants under the age of four weeks was 40, as compared with 50 in 1961, and 46 in 1960. The neo-natal death rate was 12 per thousand live births. The neo-natal death rates for Scotland and for the four principal cities in 1954-62 are indicated below.

	Neo-natal Death Rates.								
	1962.	1961.	1960.	1959.	1958.	1957.	1956.	1955.	1954.
Scotland	18	18	18	19	19	20	19	20	21
Glasgow	22	22	22	24	26	23	21	23	21
Edinburgh	17	17	16	18	17	17	18	18	19
Dundee	21	16	16	16	15	18	21	21	23
Aberdeen	**12**	**15**	**14**	**14**	**14**	**17**	**14**	**11**	**15**

Post-natal Deaths.—In 1962, there were 15 deaths of infants aged 4 weeks to 12 months as compared with 22 in 1961 and 17 in 1960. For further analysis, reference may be made to Table I at the end of this chapter.

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

Perinatal Mortality.—The perinatal mortality rate (i.e. the number of still births and deaths under one week per thousand live and still births in the year) is 28.

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

During 1962 15 children, aged 1-5 years died. Comparative figures are—

	1962.	1961.	1960.	1959.	1958.	1957.	1956.	1955.
1 - 2 years . . .	7	1	3	3	2	3	4	4
2 - 3 years . . .	2	2	3	—	3	1	—	1
3 - 4 years . . .	5	—	1	5	1	3	2	6
4 - 5 years . . .	1	1	2	2	—	—	3	2
	—	—	—	—	—	—	—	—
	15	4	9	10	6	7	9	13

Of the 15 deaths in 1962, 6 were due to accidents (three in the home), 5 to pneumonia, 2 to congenital malformations, 1 to malignant neoplasm and 1 to meningococcal infections.

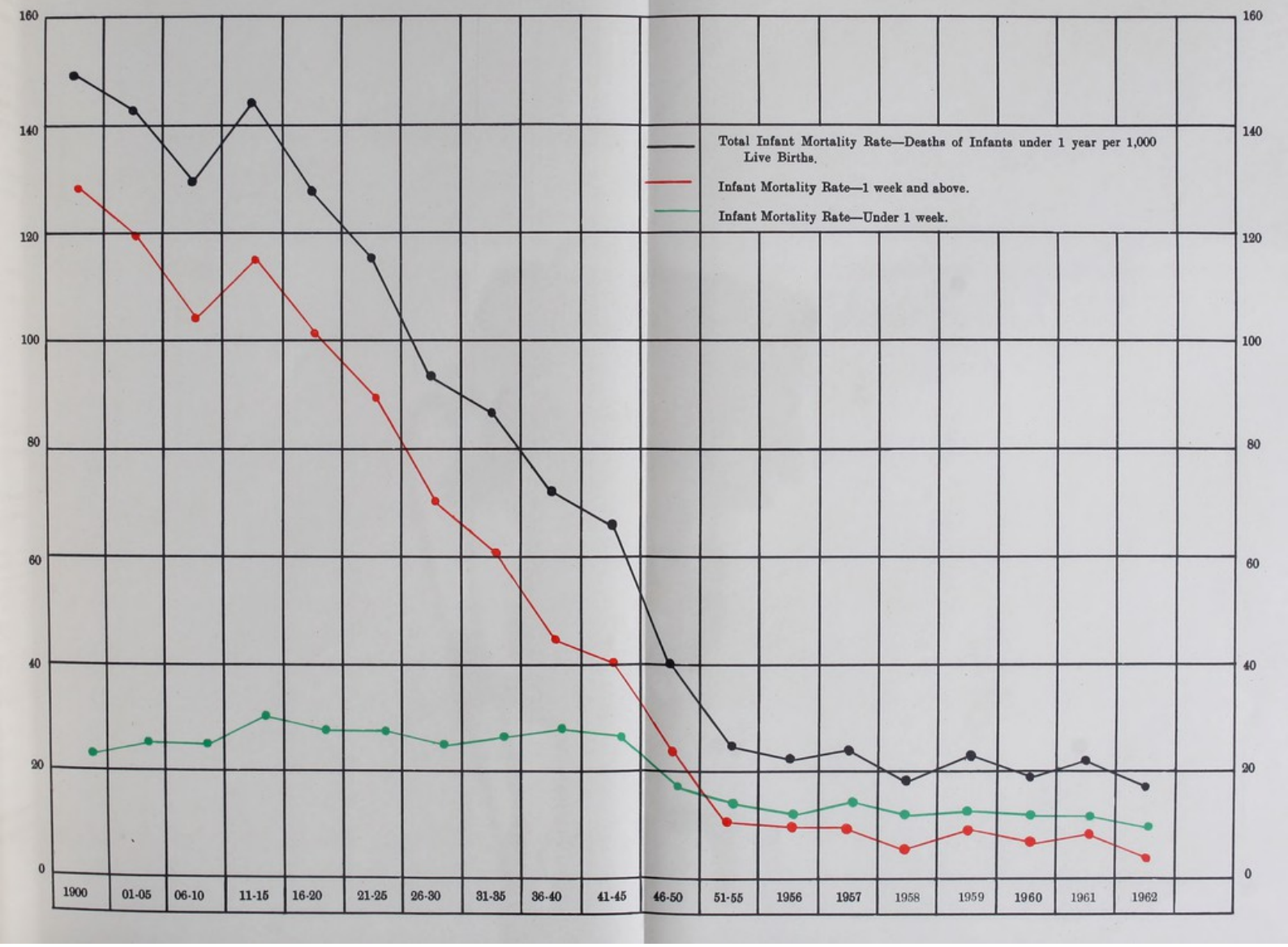
The following table gives the infant death rate in various years and the actual number of children aged 0-1 year and 1-5 years dying in these years.

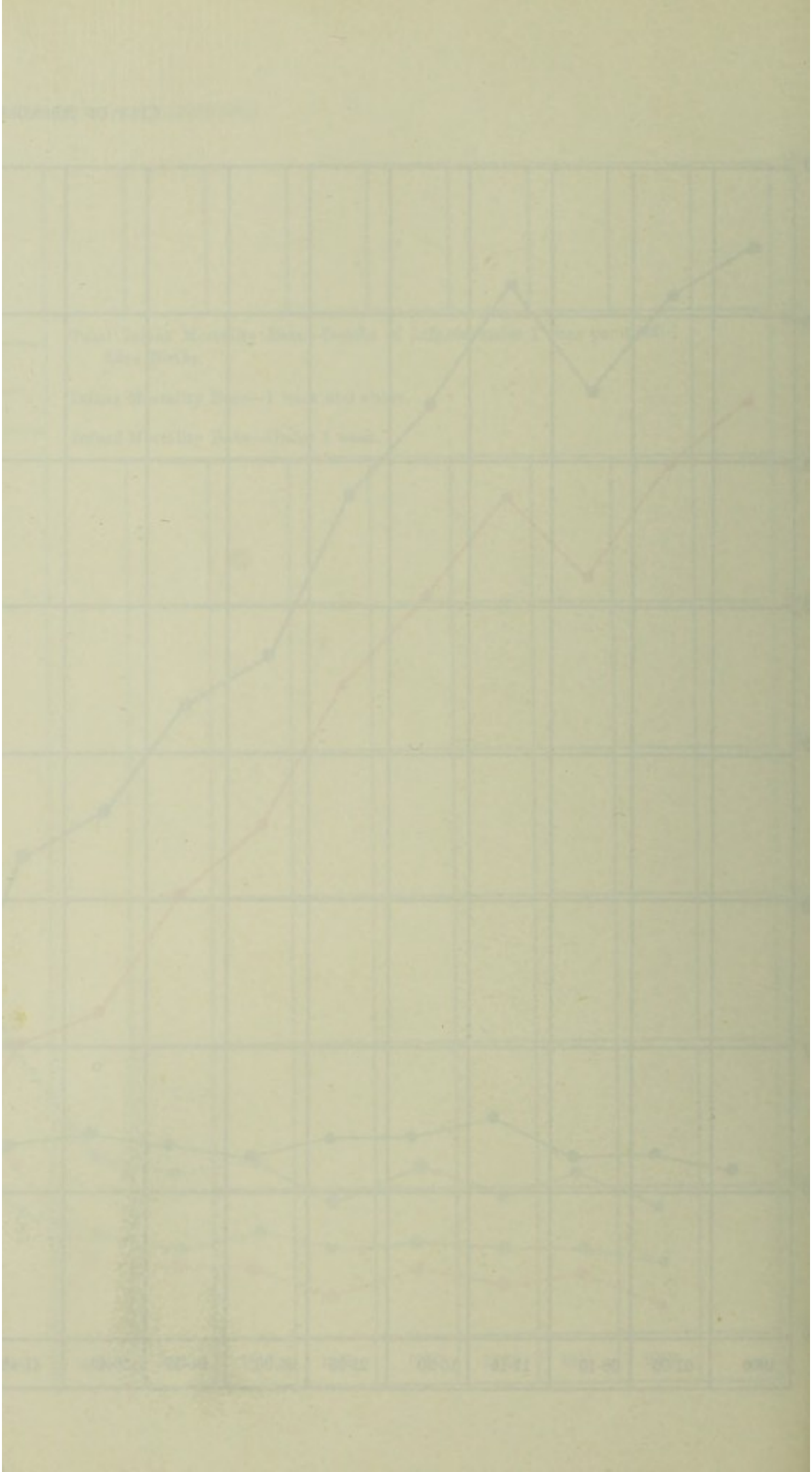
Year.	Infant Mortality Rate.	Actual Deaths under 1 year.	Actual Deaths, 1-5 years.	Actual Deaths, 0-5 years.	Year.	Infant Mortality Rate.	Actual Deaths under 1 year.	Actual Deaths, 1-5 years.	Actual Deaths, 0-5 years.
1911 .	139	563	285	848	1952 .	30	90	13	103
1912 .	127	530	232	762	1953 .	27	84	19	103
1921 .	108	460	80	540	1954 .	22	70	8	78
1922 .	133	527	284	811	1955 .	21	66	13	79
1931 .	90	292	69	361	1956 .	22	73	9	82
1932 .	93	296	98	394	1957 .	24	82	7	89
1941 .	77	224	39	263	1958 .	18	57	6	63
1942 .	67	194	39	233	1959 .	23	76	10	86
1948 .	34	121	14	135	1960 .	19	63	9	72
1949 .	30	100	23	123	1961 .	22	72	4	76
1950 .	29	92	19	111	1962 .	17	55	15	70
1951 .	27	82	16	98					

MORTALITY IN SCHOOL PERIOD.

In 1962 there were 9 deaths of children of school age (as compared with 9 in 1961 and 13 in 1960). The causes were as follows:—accidents 5; malignant diseases 3; and pneumonia 1.

CITY OF ABERDEEN—INFANT MORTALITY—1900-1962





MARRIAGES.

During 1962 there were 1,723 marriages within the City. This is equivalent to a rate of 9·3 per thousand of the population. The rates in previous years were—1961, 9·5; 1960, 9·0; 1959, 9·5; 1958, 9·9; 1957, 10·6; 1956, 10·5; 1955, 10·6; 1954, 10·2; 1953, 10·4; and 1952, 10·5.

MATERNAL MORTALITY.

In 1962 there were two deaths from causes related to pregnancy and child-birth. When deaths are down to small numbers, as they have been in recent years, it is probably wiser to study the average figures over a series of years, and the last line of the table below gives a comparison between Aberdeen and all Scotland over the period since 1953:—

Rates per 1,000 live and still births

Year	Maternal Mortality		Puerperal Sepsis		Other Puerperal Conditions	
	Scotland	Aberdeen	Scotland	Aberdeen	Scotland	Aberdeen
1962	**0·4**	**0·6**	**0·14**	**0·0**	**0·25**	**0·6**
1961	0·4	0·3	0·15	0·0	0·21	0·3
1960	0·3	0·3	0·07	0·0	0.26	0·3
1959	0·4	0·6	0·11	0·3	0·25	0·3
1958	0·5	0·3	0.1	0·0	0.4	0·3
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 1953-1962	**0·51**	**0·55**	**0·14**	**0·09**	**0·36**	**0·46**

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 1953-1962 are given in the following table:—

Year.	Number.	Rate per 1,000 of Population.	Average age at Death.
1962	2,148	11·6	67·5
1961	2,233	12·1	67·5
1960	2,189	11·7	67·1
1959	2,296	12·3	66·7
1958	2,113	11·3	67·3
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

For all Scotland, the death rate was 12·2 in 1962, 12·3 in 1961, 11·9 in 1960, 12·1 in 1959, 12·0 in 1958, 11·9 in 1957, 12·0 in 1956, and 12·0 in 1955.

AGE AT DEATH.

The average age at death of all persons dying during 1962 was 67·5 years, as compared with 67·5 in 1961, 67·1 in 1960, 66·7 in 1959, 67·3 in 1958 and 66·2 in 1957. 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 eighteen years ago (1944), it was 58·4 years.

Of the 2,148 deaths, 169 (or 8 per cent.) were in persons below the age of 45 years. In 1961 the figure was 176 (or 8 per cent.); in 1960, 165 (or 8 per cent.); in 1959, 199 (or 9 per cent.); in 1958, 162 (or 8 per cent.); in 1957, 204 (or 10 per cent.); in 1956, 188 (or 9 per cent.); and in 1955, 190 (or 9 per cent.). An analysis of these 169 young deaths by cause is as follows:—

Malformations (under 1 year) and diseases of early infancy	41
Violence	47
Malignant neoplasms	21
Diseases of the circulatory system	14
Pneumonia and bronchitis	13
Diseases of nervous system	14
Diseases of digestive system	2
Tuberculosis	1
Diseases of the genito-urinary system	3
Infectious and parasitic diseases	2
Miscellaneous	11

The gradual reduction in the number of deaths from infections in this age-group is noteworthy. It is, however, 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?

564 deaths (or 26 per cent. of all deaths) occurred in the age-period 45-64 years so that a total of 733 fatalities (or 34 per cent.) occurred before the age of 65 years. 537 deaths (or 25 per cent.) occurred in the age-period 65-74 years and 878 (or 41 per cent.) occurred at ages of 75 and over. The percentage of all deaths occurring at ages of 75 and over were 41 in 1962, 40 in 1961, 39 in 1960, 40 in 1959, 40 in 1958, 39 in 1957, 40 in 1956, 39 in 1955, 39 in 1954, and 38 in 1953.

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 some distortion from chance events.

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 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 the age of 50 years to total deaths.

1948 . .	79·4	1956 . .	87·9
1949 . .	83·6	1957 . .	87·4
1950 . .	84·2	1958 . .	89·1
1951 . .	85·8	1959 . .	88·5
1952 . .	84·1	1960 . .	89·1
1953 . .	85·9	1961 . .	89·3
1954 . .	87·2	1962 . .	89·5
1955 . .	88·6		

Causes of Death.—Table II at the end of this section gives full details of the causes of death operating in each age-group, and the diagram below shows some of the more important causes. It is interesting to note that 77 per cent. of all deaths fall under three headings—diseases of circulatory system, malignant diseases, and diseases of nervous system. The comparable figures for 1961, 1960, 1959, 1958, 1957, 1956, and 1955 were 77, 75, 75, 76, 73, 78, and 77 per cent., respectively.

TOTAL DEATH-RATE.
Causes of Death.

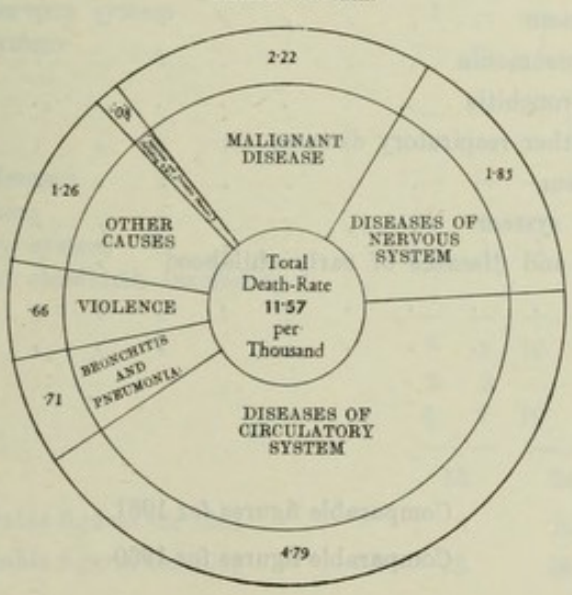


Table III gives, for a number of successive years, the death rates at all ages from selected causes, and Table IV gives, in summary form, details of population, marriages, births, deaths, average age at death, and infant deaths for a number of years and for quinquennial averages.

LOSS OF WORKING YEARS BY DEATH.

Study of causes of death and trends of mortality shows the relative importance of various conditions in respect of loss of life, but gives a false picture of the effects of different diseases on the community. If, for example, one disease kills thirty persons aged 90 years and another kills ten young adults, the second disease is of greater importance to the community, but a study of causes of death would put the emphasis on the first disease.

It is interesting 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 kills 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 plenty of minor fallacies; but, on balance the hypothesis gives a reasonably accurate picture.

Here are the figures (for males and females separately) for the mortality and the loss of working years occasioned by various diseases in 1962:—

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

Cause.	Male.	Female.	Total.
Infectious and parasitic diseases (excluding T.B.)	1	1	2
Tuberculosis—i. Respiratory	—	—	—
ii. Other forms	—	—	—
Malignant Diseases	1	3	4
Diseases of nervous system—i. Cerebral haemorrhage, &c.	—	—	—
ii. Other diseases of nervous system	1	1	2
Diseases of circulatory system	—	—	—
Respiratory diseases—i. Pneumonia	7	4	11
ii. Bronchitis	1	—	1
iii. Other respiratory diseases	—	—	—
Diseases of digestive system	1	1	2
Diseases of genito-urinary system	—	—	—
Congenital malformations and diseases of early childhood	29	14	43
Violence	9	4	13
Miscellaneous	1	—	1
	51	28	79
Comparable figures for 1961	51	34	85
Comparable figures for 1960	54	31	85

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.)	50	45	95
Tuberculosis—i. Respiratory	—	—	—
ii. Other forms	—	—	—
Malignant Diseases	50	135	185
Diseases of nervous system—i. Cerebral haemorrhage, &c.	—	—	—
ii. Other diseases of nervous system	50	45	95
Diseases of circulatory system	—	—	—
Respiratory diseases—i. Pneumonia	350	180	530
ii. Bronchitis	50	—	50
iii. Other respiratory diseases	—	—	—
Diseases of digestive system	50	45	95
Diseases of genito-urinary system	—	—	—
Congenital malformations and diseases of early childhood	1,450	630	2,080
Violence	450	180	630
Miscellaneous	50	—	50
	2,550	1,260	3,810
Comparable figures for 1961	2,550	1,530	4,080
Comparable figures for 1960	2,700	1,395	4,095

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 T.B.)	—	—	—	—	—	—	—	1	2	—
Tuberculosis—i. Respiratory	—	—	—	—	—	—	1	—	2	—
ii. Other forms	—	—	—	—	—	1	—	—	—	—
Malignant diseases	—	1	3	1	2	10	31	29	66	53
Diseases of nervous system—										
i. Cerebral haemorrhage, &c.	—	1	2	1	2	2	2	7	14	14
ii. Other diseases of nervous system	1	—	—	—	2	1	1	1	5	9
Diseases of circulatory system	—	—	1	1	11	1	35	17	104	59
Respiratory diseases—										
i. Pneumonia	—	—	—	—	—	—	1	1	3	1
ii. Bronchitis	—	—	—	—	1	—	3	2	16	3
iii. Other respiratory diseases	—	—	—	—	—	—	1	—	3	1
Diseases of digestive system	—	—	—	—	—	—	1	2	8	6
Diseases of genito-urinary system	—	1	1	—	1	—	—	3	3	6
Diseases of pregnancy and childbirth (excluding puerperal sepsis)	—	—	—	—	—	1	—	—	—	—
Violence	3	2	12	1	13	3	11	4	10	5
Miscellaneous	2	2	—	1	1	1	—	3	5	9
	6	7	19	5	33	20	87	70	241	166
	13		24		53		157		407	
Comparable figures for 1961	8		24		59		150		401	
Comparable figures for 1960	5		26		49		174		387	

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.)	10	10	20
Tuberculosis—i. Respiratory	25	—	25
ii. Other forms	—	20	20
Malignant diseases	950	560	1,510
Diseases of nervous system—i. Cerebral haemorrhage, &c.	220	180	400
ii. Other diseases of nervous system	135	30	165
Diseases of circulatory system	1,355	220	1,575
Respiratory diseases—i. Pneumonia	30	10	40
ii. Bronchitis	150	20	170
iii. Other respiratory diseases	30	—	30
Diseases of digestive system	55	20	75
Diseases of genito-urinary system	75	70	145
Diseases of pregnancy and childbirth (excluding puerperal sepsis)	—	20	20
Violence	1,095	210	1,305
Miscellaneous	140	160	300
	4,270	1,530	5,800
Comparable figures for 1961	4,275	1,400	5,675
Comparable figures for 1960	4,000	1,610	5,610

In calculating workings 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.

To summarise the information provided in the above tables—

Total working yrs. lost in 1962—9,610 Total working yrs. lost in 1961—9,755

Total working yrs. lost in 1960—9,705 Total working yrs. lost in 1959—11,170

Total working yrs. lost in 1958—9,475 Total working yrs. lost in 1957—10.840

TABLE I.—CAUSES OF DEATH AMONG CHILDREN UNDER FIVE YEARS OF AGE.
YEAR 1962.

CAUSES OF DEATH	AGE																	Average for preceding years (1957-1961)	
	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	—5
Tuberculosis { Respiratory	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	0·2
Tuberculosis { Other Forms	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	—	...
Diphtheria	..	...	..	..	...	...	...	...	...	...	..	...	...	...	...	...	...	...	...
Dysentery	...	...	...	...	..	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Measles	..	...	...	...	...	...	...	...	...	...	...	...	...	...	..	...	...	0·2	0·2
Meningococcal Infections	...	...	...	...	...	...	...	...	1	...	...	1	1	...	...	...	1	0·4	...
Poliomyelitis, Acute	...	...	...	...	...	...	...	...	..	...	...	...	...	..	...	...	...	...	..
Scarlet Fever	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	.	...
Whooping Cough	..	...	...	...	..	...	...	...	...	...	...	...	...	...	...	...	...	..	...
Other Infective and Parasitic Diseases	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	0·2
Pneumonia	.	...	.	...	...	1	..	1	3	...	1	5	2	2	1	...	5	8·2	1·0
Bronchitis	...	...	...	...	...	...	...	...	...	...	1	1	...	...	...	...	...	0·6	0·2
Diarrhœa and Enteritis	...	...	...	..	...	...	...	...	..	...	...	...	...	...	...	...	...	0·8	...
Other Digestive Diseases	...	...	...	...	...	.	...	...	...	1	1	2	...	...	...	...	..	2·2	...
Congenital Malformations	4	1	2	...	7	1	...	8	1	...	...	9	2	...	...	..	2	11·2	0·8
Injury at Birth	8	...	...	...	8	...	...	8	...	...	...	8	...	...	...	..	..	5·2	...
Post-natal Asphyxia and Atelectasis	14	...	...	...	14	...	...	14	...	...	...	14	...	...	...	...	...	16·4	...
Pneumonia of New Born	1	...	...	..	1	...	...	1	...	...	...	1	...	...	...	...	...	3·4	...
Other Infections of New Born	...	...	...	...	...	..	...	..	..	...	...	..	...	...	...	..	...	0·8	...
Other Diseases peculiar to Early Infancy	4	...	...	...	4	...	...	4	...	...	...	4	...	...	...	.	...	3·0	0·2
Prematurity	4	1	...	...	5	...	...	5	...	...	...	5	...	...	..	...	...	10·8	...
Accidents or other Violence	....	...	...	...	...	..	...	...		1	1	2	2	...	3	1	6	4·8	2.2
Other Causes	...	...	1	...	1	...	...	1	1	1	...	3	...	...	1	...	1	2·0	2.2
ALL CAUSES	35	2	3	...	40	2	...	42	6	3	4	55	7	2	5	1	15	70·0	7.2
Average for preceding 5 years, 1957-1961	42	4	2	1	49	4	6	59	5	4	2	70	2	2	2	1	7	...	...

* 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 1962.																				
Under 1 year . . .	55	1	—	—	—	—	—	2	—	5	1	—	2	—	—	—	41	—	2	1
1-4 years . . .	15	1	—	—	—	1	—	—	—	5	—	—	—	—	—	—	—	—	6	2
5-14 „ . . .	9	—	—	—	—	3	—	—	—	1	—	—	—	—	—	—	—	—	5	—
15-24 „ . . .	13	—	—	—	—	1	1	1	—	—	—	—	—	1	—	—	—	—	5	4
25-34 „ . . .	24	—	—	—	—	4	3	—	2	—	—	—	—	1	—	—	—	—	13	1
35-44 „ . . .	53	—	—	—	1	12	4	3	12	—	1	—	—	1	—	1	—	—	16	2
45-54 „ . . .	157	—	1	1	—	60	9	2	52	2	5	1	3	3	—	—	—	—	15	3
55-64 „ . . .	407	1	1	2	—	119	28	14	163	4	19	4	14	9	—	—	—	—	15	14
65-74 „ . . .	537	1	3	—	—	119	77	9	238	9	23	3	18	11	—	—	—	—	14	12
75-84 „ . . .	606	—	—	1	—	79	116	9	286	25	10	1	16	25	—	—	—	1	19	18
85+ „ . . .	272	—	—	—	—	15	63	3	137	12	9	—	4	5	—	—	—	—	13	11
All Ages . . .	2,148	4	5	4	1	413	301	43	890	63	68	9	57	56	—	1	41	1	123	68
B.—DEATH-RATE PER 100,000.																				
1962	1,157	2	3	2	1	222	162	23	479	34	37	5	31	30	—	1	22	1	66	37

TABLE III.—ABERDEEN.—DEATHS AT ALL AGES FROM SELECTED CAUSES. (per 100,000 population). Years 1856-1962*

Year.	Smallpox.	Scarlet Fever.	Diphtheria and Croup.	Measles.	Whooping Cough.	Influenza.	Typhus Fever.	Typhoid and Paratyphoid Fever.	Tuberc. Dis.		Dis. of Digestive System (inc. Diarrhœa).	Cancer and other Malignant Diseases.	Bronchitis.	Pneumonia.	Diseases of the Circulatory System.
									Respiratory.	Other Tuberculosis.					
1962 . . .	0	0	0	0	0	1	0	0	2	1	31	222	37	34	479
1961 . . .	0	0	0	0	0	5	0	0	5	1	42	238	35	38	491
1960 . . .	0	0	0	1	0	0	0	0	5	0	45	215	36	33	448
1959 . . .	0	0	0	0	0	7	0	0	6	1	39	232	38	55	478
1958 . . .	0	0	0	0	0	1	0	0	7	1	34	231	39	39	439
1957 . . .	0	0	0	1	0	11	0	0	5	1	35	225	31	43	419
Mean of 1957-61 .	0	0	0	0·4	0	5	0	0	6	1	39	228	36	42	455
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
Mean of 1951-55 .	0	0	0·2	0·4	1	3	0	0	14	2	42	204	30	45	439
,, ,, 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	9	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.

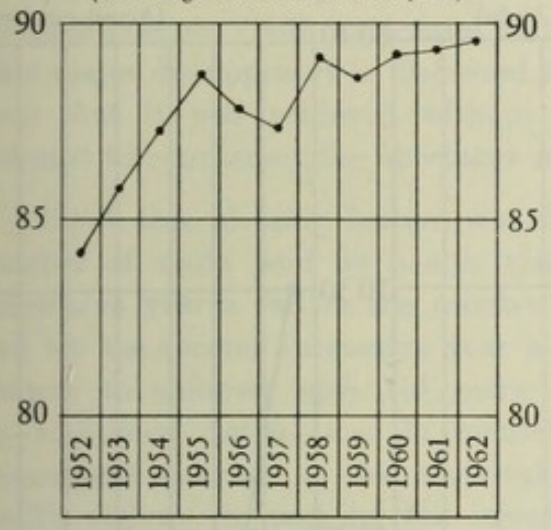
TABLE IV.—ABERDEEN.—MARRIAGE, BIRTH AND DEATH RATE—1856 TO 1962.
Per 1,000 of population.

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
1962	**185,678**	**1,723**	**9·3**	**3,245**	**17·5**	**5·1**	**2,148**	**11·6**	**67·5**	**1,097**	**17**
1961	185,222	1,752	9·5	3,263	17·6	5·2	2,233	12·1	67·5	1,030	22
1960	187,348	1,690	9·0	3,280	17·5	5·1	2,189	11·7	67·1	1,091	19
1959	186,796	1,782	9·5	3,345	17·9	5·3	2,296	12·3	66·7	1,049	23
1958	186,350	1,841	9·9	3,243	17·4	4·5	2,113	11·3	67·3	1,130	18
1957	186,190	1,975	10·6	3,379	18·1	5·1	2,121	11·4	66·2	1,258	24
Mean of 1957-1961	**186,381**	**1,808**	**9·7**	**3,302**	**17·7**	**5·0**	**2,190**	**11·8**	**67·0**	**1,112**	**21**
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**
1951-1955	**184,837**	**1,913**	**10·3**	**3,112**	**16·8**	**5·1**	**2,122**	**11·5**	**65·7**	**990**	**25**
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**	**3,752**	**16·8**	**38·1**	**1,207**	**143**
1906-1910	**163,620**	**1,360**	**8·3**	**4,505**	**27·5**	**9·7**	**2,512**	**15·4**	**37·6**	**1,993**	**128**
1901-1905	**158,082**	**1,428**	**9·0**	**4,872**	**30·8**	**8·5**	**2,763**	**17·5**	**34·9**	**2,109**	**143**
1896-1900	**145,740**	**1,356**	**9·3**	**4,636**	**31·8**	**8·3**	**2,644**	**18·1**	**33·3**	**1,992**	**144**
1891-1895	**131,627**	**1,099**	**8·4**	**4,114**	**31·3**	**9·8**	**2,539**	**19·3**	**32·9**	**1,575**	**147**
1886-1890	**117,587**	**911**	**7·8**	**3,827**	**32·5**	**10·4**	**2,370**	**20·2**	**...**	**1,457**	**140**
1881-1885	**108,959**	**848**	**7·8**	**3,712**	**34·1**	**10·6**	**2,159**	**19·8**	**...**	**1,553**	**126**
1876-1880	**100,419**	**788**	**7·9**	**3,480**	**34·7**	**10·9**	**2,100**	**20·9**	**...**	**1.380**	**129**
1871-1875	**91,941**	**705**	**7·7**	**3,169**	**34·5**	**12·1**	**2,063**	**22·4**	**...**	**1,106**	**133**
1866-1870	**84,234**	**684**	**8·1**	**3,010**	**35·7**	**12·9**	**1,978**	**23·5**	**...**	**1,032**	**133**
1861-1865	**77,040**	**624**	**8·1**	**2,663**	**34·6**	**...**	**1,915**	**24·9**	**...**	**748**	**130**
1856-1860	**73,458**	**524**	**7·1**	**2,397**	**32·6**	**...**	**1,772**	**24·1**	**...**	**625**	**126**

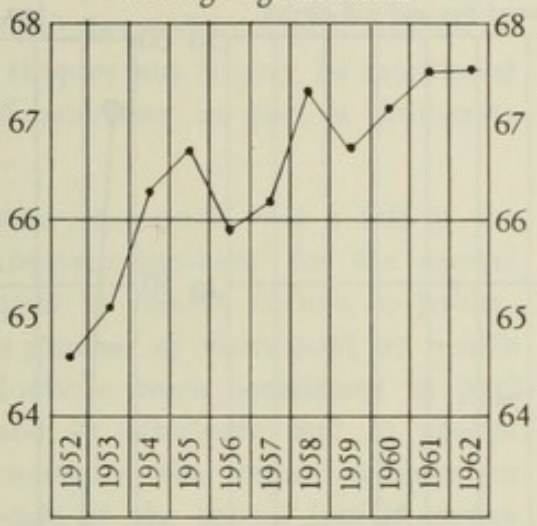
*Corrected for transferred births for 1911 and for transferred deaths for 1904 and subsequent years.
† Civilian Population from 1940 to 1946 inclusive used for death-rate only.

ABERDEEN'S HEALTH PROGRESS AT A GLANCE

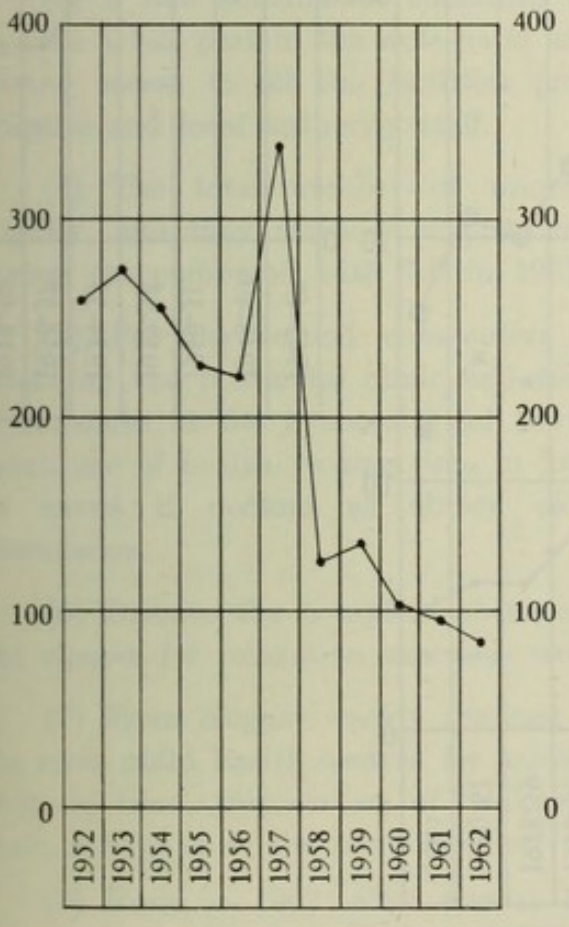
World Health Organisation
Health Indicator
(Percentage of deaths above 50 years)



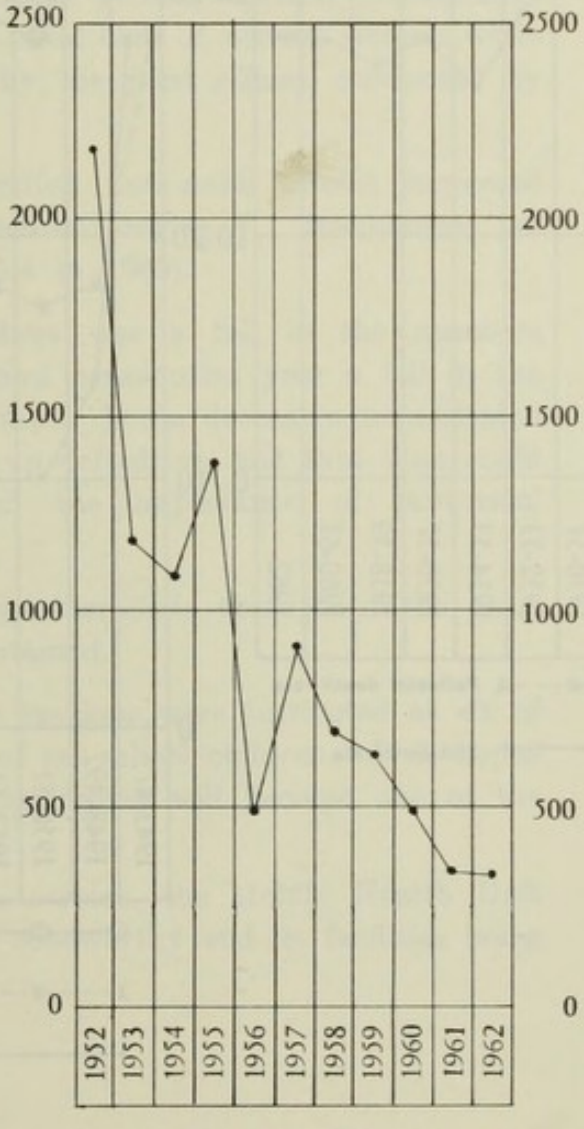
Average age at death



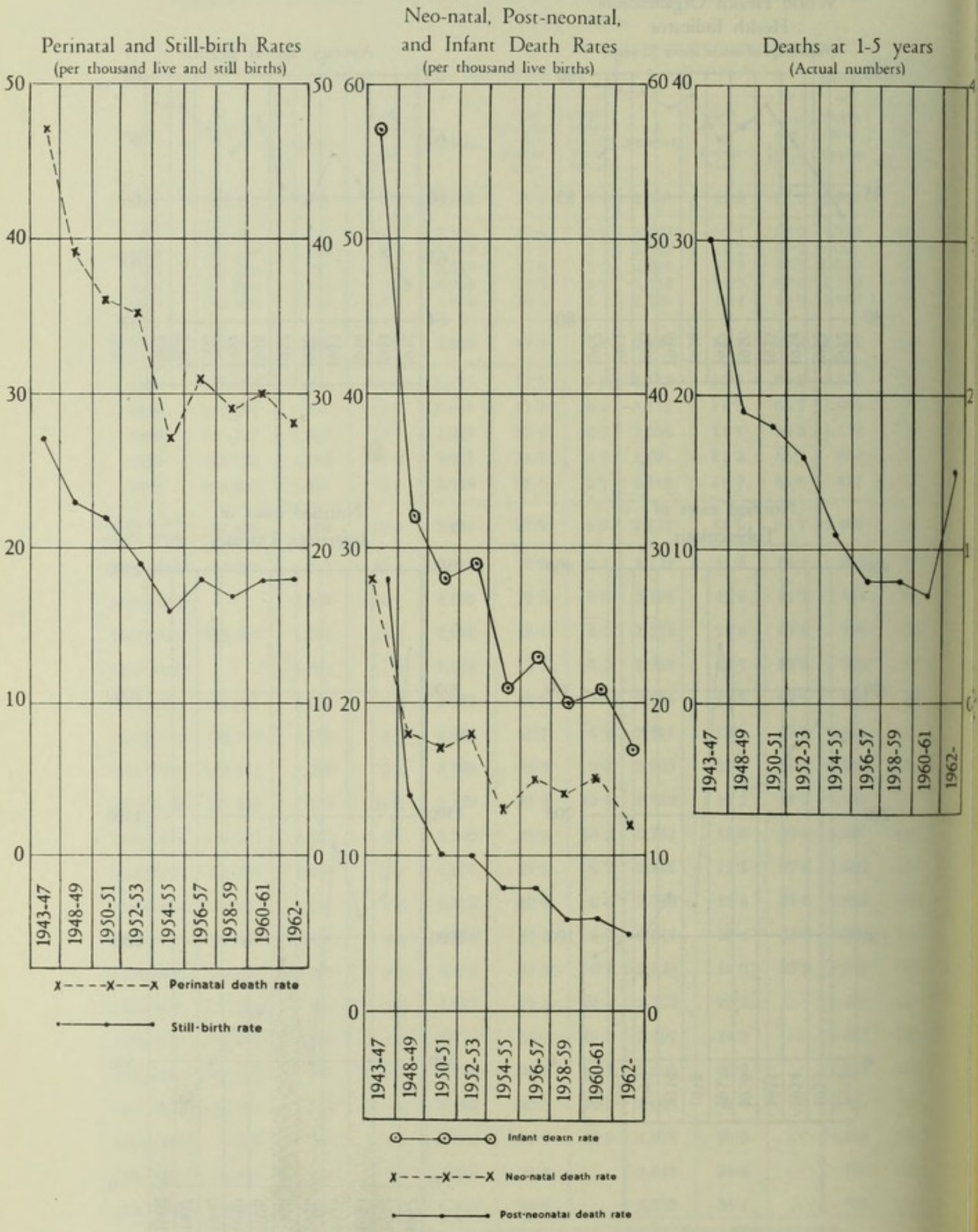
Notified cases of
Tuberculosis



Notified cases of
Infectious Diseases



ABERDEEN'S HEALTH PROGRESS AT A GLANCE (contd.)



5.—CARE OF MOTHERS AND YOUNG CHILDREN.

Features of the Year.

(1) Unquestionably the biggest feature of the year was massive extension of clinic sessions (both ante-natal and child welfare) devoted to health education. This major development is discussed in another chapter but it may be mentioned here that it was achieved without extra staff and was in part a deliberate attempt to counteract the shortages mentioned.

(2) A less pleasing feature was for the second successive year a fall in the number of visits paid by health visitors to expectant mothers, for the second successive year a fall in the number of visits paid by health visitors to babies, and for the second successive year a fall in the number of visits paid by health visitors to children aged 1-5 years. These reductions were occasioned in part by additional duties—e.g. in mental health and in after-care and in special assessment—having to be undertaken by essentially the same numbers of health visitors, in part by the increasing demands of the school health service on health visitors' time, in part by the ever-extending elderly population, and in part by health visitors being employed to undertake other duties in the absence of other staff (e.g. undertaking relaxation exercises for expectant mothers because there were no physiotherapists). These reductions, however, are also considered in another chapter.

(3) A new scheme for combined care enabled general medical practitioners to take a full part in the ante-natal and post-natal care of normal women while having access to all the facilities provided by the joint clinics conducted by hospital and local authority staff.

(4) The total number of women attending ante-natal clinics increased slightly, and they attended slightly more often—averaging 7.1 attendances per person (as compared with 7.0 in 1961 and 5.4 in 1960).

(5) For the second consecutive year there was a fall in the numbers attending the post-natal clinic and for the third consecutive year a fall in the attendances at the gynaecological advisory clinic. These decreases necessitated much use of health visiting time in following up defaulters, and that time could be saved if doctors at clinics emphasised the importance of post-natal attendance.

(6) Despite the complete absence of physiotherapists throughout the year, the classes for relaxation exercises were maintained.

(7) From August weekly sessions or part sessions were instituted at six of the main child health centres for assessment of pre-school children. It is hoped that, in time, this service of "selective" examination will become one of the main functions of the clinic medical officers.

(8) Early in 1962, after almost 10 years service, the Mobile Health Unit was discontinued, the vehicle being no longer roadworthy and its facilities being

in any case unsatisfactory by modern standards. The child health clinic in the peripheral areas was consequently transferred to four static centres, accommodated within two community centres, a school and a maternity home.

(9) The number of clinics for the child health care service during 1962 was sixteen. In 1961 there were twelve static centres and four weekly sessions contained within the Mobile Unit.

(10) The number of pre-school children, both under and over the age of 1 year attending child health centres, increased during the year. The total increase was over 12 per cent. It should, however, be noted that the attendances at clinics now represent 4 expectant mothers out of 5, 2 babies out of 3, and 1 child of 1-4 years out of 4: in other words, once children can walk the majority of mothers seem to be satisfied with health visitors' visits and to be reluctant to attend the clinics.

(11) For the seventh year in succession there was a decrease in the amounts of National Dried Milks and dietary supplements issued.

(12) There was a decrease in the number of expectant and nursing mothers and pre-school children receiving dental care in 1962 compared with the previous year, in which the highest figures for several years were recorded.

(13) The number of places available at the residential and day nurseries was unchanged in 1962.

(a) EXPECTANT AND NURSING MOTHERS.

Ante-natal Care.

(i) *General.*

As in previous years four-fifths of the expectant mothers elected to attend the Corporation clinic.

One central and five peripheral clinics provided services appropriate to the local demand. Despite (or because of) the introduction of the Combined Care Scheme (see later) most women attended oftener than last year.

Although the internal arrangements at each clinic were in process of minor alteration during the year, some changes may be listed:—

1. From May patients were, in the first instance, normally referred to the clinics by general practitioners.
2. Special forms were issued by the Corporation to general practitioners for this purpose.
3. On receipt of a request form the patient was notified by post of the time of her appointment.
4. Meantime any relevant documentation was done in readiness for the patient's first visit, e.g. information about previous pregnancies and deliveries in Aberdeen.

5. With this information available to the examining doctor at the first visit a more complete medical and obstetrical assessment could be made than had hitherto been possible.

6. The combined care scheme was introduced. This allowed a normal woman beyond her first pregnancy to have the care services of both of her general practitioner (provided he was willing to participate) and of the health educative, medico-social and specialist services provided at the clinic, and to be "booked" for hospital confinement. (The base clinic visits were to be on booking and at the 34th week, additional visits being arranged where deemed necessary on medical or social grounds.) The patient's ante-natal record was sent by post from the clinic to the general practitioner and back as necessary.

(ii) *Staffing and Sessions.*

As before, staff were provided jointly by Local Authority and Regional Hospital Board. Hospital obstetricians, hospital midwives, public health medical officers, health education officers, health visitors, etc. each brought to the team their own professional skills.

(a) Clinically—the equivalent of 33 single doctor sessions were provided. The distribution of staff is exactly as in the report for 1961.

(b) For health education—a deliberate attempt was made to counteract the general shortage of health visitors' time for home visits (through multiplying duties) by increasing the proportion of sessions devoted to group teaching.

(c) For social and medico-social guidance—while all clinics were kept adequately staffed with health visitors, a new development was introduced at the main centre at Castle Terrace. Here a senior health visitor devoted much of her time to assisting the health visitor who acts as Centre Superintendent. From the clinic point of view the development was excellent: it increased the speed, smoothness and efficient functioning of the clinic. It has to be realised, however, that it took yet another health visitor off home visiting, and that, if the establishment of health visitors remains restricted, the development may well have to be discontinued.

(d) In respect of midwives and of the hospital almoner—the arrangements were as in 1961.

(iii) *Functions.*

Essentially these were unchanged.

Associated Services.

(i) *Local Authority.*

1. *Anti-poliomyelitis Immunisation.*—This continued as before, oral vaccine chiefly being used.

2. *Dental Treatment.*—Within the limits of staff shortages this was provided. (Figures for expectant mothers are given later—along with pre-school children).

3. *Literature.*—A variety of literature on many aspects of pregnancy and motherhood was available at all clinics.

4. *Health Education at Clinics by Health Visitors.*—Teaching of expectant mothers (in discussion groups and individually) about preparation for confinement and about the psychosocial and physical needs of young children continued to be one of the most important functions of ante-natal clinics, and as already mentioned expansion here was the most significant development of the year. Both group counselling and individual teaching were undertaken primarily by health visitors because (a) they are, of course, trained for the work, (b) the doctors are thereby enabled to concentrate more on the clinical aspects for which they are trained, and (c) the health visitors can—within limits—visit clients in their homes to reinforce the teaching and social counselling given at clinics.

5. *Home visits by Health Visitors.*—District health visitors visited all booked clients (despite shortages of staff) and gave constructive social and medico-social guidance on personal matters, on the preparation of the home for the reception of a new baby, on the physical and emotional needs of the child, and on the adjustments required from different members of the family.

6. *Dietetic advice.*—Unfortunately the dietitian resigned during the year and for many months her post was vacant, advertisements securing no candidates.

(ii) *North Eastern Regional Hospital Board.*

The following departments co-operated in providing medical services ancillary to clinical care:—

1. Records Office, Maternity Hospital.—Due credit has perhaps not been given in past years to this useful service which makes available on request a wealth of classified information.

2. The Blood Transfusion Centre at Foresterhill determined the blood group, rhesus factor, &c. of all patients.

3. The Regional Laboratory estimated the haemoglobin percentage in all patients and performed further tests where anaemia existed. The pathologists also reported on any specimens submitted.

4. The Bacteriology Department cultured mid-stream urine specimens of all patients—this examination having become a routine service.

5. The Radiological Department at Foresterhill maintained its efficient appointment system started the previous year, patients being radiologically examined almost without delay and reports received forthwith. Modern techniques, and the Consultant Radiologist's professional judgment contributed largely to the subsequent management of many cases.

6. The Mass Radiography Unit at King Street carried out the chest X-ray of patients when requested.

7. Medical clinics, whose services should be included:—

(1) Chest Clinic at City Hospital, which gave valuable help in the few remaining tuberculosis patients.

(2) General Medicine Clinic—specially arranged for pregnant women at the Maternity Hospital.

(3) Medical Clinic at Woolmanhill where heart cases were investigated and supervised.

(4) Diabetic Clinic, Woolmanhill.

(5) Special (V.D.) Clinic, Woolmanhill.

8. Ante-Natal Beds.—Adequate ante-natal care demands a sufficient supply of beds for patients with conditions not responding to clinical care and domiciliary measures, and for those requiring further investigation. All available beds were again used to capacity.

Attendances at Ante-natal Clinics.

In 1962 3,614 clients made 25,797 attendances. [In 1961 3,596 attended 25,308 times].

Post-natal Care.

Centres for post-natal advice and examination and for the preventive services associated therewith, were provided as shown in the report for 1961.

In addition to the six clinics, special sessions were arranged at the Maternity Hospital for patients with obstetric complications, foetal death or abnormality, or for those co-operating in other fields of investigation.

The figures again dropped. It is important to note that much valuable health visiting time—devoted to defaulters—could be saved if hospital and local authority doctors impressed on expectant mothers at ante-natal clinics the importance of attending for post-natal examination.

The cytological examination of cervical smears in the age-group of 28 years and over has continued at all clinics.

Attendances at Post-natal Clinics.

	No. of Clients.	No. of Attendances.
1962	1,634	2,194
1961	1,938	2,566
1960	2,138	2,554
1959	1,987	2,326

The decrease speaks for itself.

Arrangements for the Care of Unmarried Mothers.

Aberdeen Mother and Baby Home.

The Corporation continued its arrangement with the Aberdeen Mother and Baby Home whereby unmarried mothers were accommodated there.

The weekly maintenance contribution paid by the Corporation was fifty-two shillings and sixpence per patient, dating from six weeks pior to the expected date of delivery till up to four months afterwards. During the year the Corporation helped 10 women in this way, and 2 others in homes outside Aberdeen.

The obstetric arrangements were as before—the patients attending the central ante-natal and post-natal clinic and being confined in the Maternity Hospital or one of the Homes.

During 1962 a health education lecturer attended at the home each week to undertake health education of unmarried mothers.

The total number of illegitimate births in the year was 167 (as compared with 157 in 1961 and 163 in 1960).

Gynaecological Advisory Clinic.

The clinic was held in the basement of 6, Castle Terrace, a specialist health visitor being in attendance from 9 a.m. to 5.30 p.m. from Monday to Friday. A medical officer was present for consultations on Monday and Tuesday mornings and on Wednesday afternoons. For the convenience of patients and staff alike, an appointment system was maintained throughout the year. While a considerable number of patients continued to be referred to the clinic by general practitioners, gynaecologists, psychiatrists and health visitors on medical, social and financial grounds, the number referred directly from post-natal clinics continued to fall during 1962.

There has been a disquieting decrease in numbers attending over the past three years as shown below:—

	Patients Attending			No. of
	New.	Old.	Total.	Attendances.
1962 . . .	345	1,017	1,362	2,482
1961 . . .	425	1,012	1,437	2,640
1960 . . .	479	1,048	1,527	2,847
1959 . . .	556	1,121	1,677	3,220
1958 . . .	562	1,071	1,633	3,350

(b) CARE OF YOUNG CHILDREN.

For half a century it has been realised that child health services (home visiting and clinics) are vital for the promotion of physical health: it is in the first five years of life that the foundations of a strong or weak constitution are laid. In the last ten years it has been appreciated that this period is no less important for personality development, for prevention of maladjustment, and for emotional and social well-being. To ensure that the foundations for physical and emotional health are adequate is the responsibility of all parents. The role of workers in the field of Child Health—medical officers, health education lecturers, health visitors and others—is to assist parents and prospective parents by giving skilled advice and guidance on child development in all its aspects (physical, social emotional and intellectual), and preferably in advance: "anticipatory guidance" is increasingly recognised as fundamental.

Although "child welfare" still includes detection of defect and deviation from normality in physical development and environmental health, the promotion and maintenance of mental and emotional health is now its prime objective. Recent concern over the apparent failure of individuals of all ages to establish adequate human relationships within the family circle and within the community points to a national awareness that increased help and guidance is required in the early stages of family life. A considerable contribution can be made, and is being made, by health workers in helping to establish sound principles of family and community life and to lay foundations for responsible citizenship. Demands on the child health service are still increasing, and the need is perhaps greatest in the new housing areas (not only because the majority of the rehoused families are young themselves, but because these new communities are only now reaching stability).

Three general points may first be mentioned:—

(a) With increasing duties falling on health visitors and with the total establishment unaltered for many years, an increase in unsolved emotional and physical problems is inevitable; to some extent this can be countered by increased group health education (if staff vacancies can be filled) but there is no complete substitute for adequate home visiting by professionally qualified staff.

(b) In six of the main child health centres a session or part session was set aside weekly for use by medical officers solely for the extended examination of the pre-school child, to include, as well as general physical and emotional fitness, the ascertainment of hearing, visual and intellectual abilities. These "selective" examinations, by appointment, commenced in August and are an attempt at least to identify troubles at an early stage.

(c) The Mobile Health Unit was abandoned early in the year, because after almost ten years, it was no longer roadworthy and no longer served any useful purpose in the modern set-up. Static clinics, housed in community centres, a school and maternity home, though accommodation was limited and far from ideal, enabled the clinic service to continue in the peripheral housing areas previously served by the Mobile Unit.

(I) Child Health Centres.

With the abandonment of the Mobile Health Unit four weekly centres were established raising the total number of clinics from twelve plus the Mobile Health Unit to sixteen.

Eight full-time centres were maintained at Castlegate, Charlotte Street, Hilton, Torry, View Terrace, Holburn, Northfield and Mastrick respectively. In general these clinics are open daily, Monday to Friday, from 9 a.m. to 12.30 p.m. and from 2 p.m. to 5.30 p.m. "Selective" examinations are held weekly at Charlotte Street, Hilton, Torry, Holburn, Northfield and Mastrick.

Clinics are held weekly at seven centres: on Tuesday afternoon at Smithfield School and at Craigiebuckler Church Hall, when a registrar from the Royal Aberdeen Hospital for Sick Children is in attendance; on Wednesday morning at

Kaimhill Community Centre; on Wednesday afternoon at Seaton Community Centre; on Thursday morning at Kincorth Church Hall; on Thursday afternoon at Powis Community Centre and at Summerfield Maternity Home.

At Hayton a clinic was conducted thrice weekly.

At all clinic sessions health visitors are in attendance so that mothers may come at all times for skilled advice on all aspects of child health care. When a departmental medical officer is present vaccination and immunisation procedures are carried out, in addition to medical examination of the child, and sometimes discussion with the parent about the child's developmental progress in the physical, mental and emotional fields.

(II) Attendances at Child Health Centres.

The number of children who attended child health centres during 1962, and the number of attendances made, were as follows:—

(a) Children who, at their first attendance during the year, were under 1 year old: 4,182 children (65·6 per cent. of potential) made 26,578 attendances. [In 1961 3,053 children (47·5 per cent.) made 27,538 attendances.]

(b) Children who, at their first attendance during the year, were over 1 year old: 3,449 children (26·7 per cent. of potential) made 14,785 attendances. [In 1961 2,981 children (22·9 per cent.) made 12,581 attendances.]

(c) Total of pre-school children, aged 0-5 years: 7,631 children (39·5 per cent. of potential) made 41,363 attendances.

For 1962, there was an overall increase of 12·6 per cent. in the total number of pre-school children attending clinics, each group showing a marked increase as compared with the 1961 figures.

(III) Facilities for Consultant Advice.

Child Health Centres are regarded essentially as "well baby" clinics and clinical consultants do not attend. If any condition needs expert clinical advice, the mother is asked to take her child to her general practitioner, who is advised of the condition, and may, thereafter, seek the advice of an appropriate consultant. This system works satisfactorily, but, under arrangements made in 1961, departmental medical officers, can, at discretion, refer children direct to the Ear, Nose and Throat, the Skin and Orthopaedic Out-patients sessions of the Royal Aberdeen Hospital for Sick Children.

(IV) Special Clinics.

(a) *Ultra-Violet Radiation Clinics.*—Ultra-violet radiation treatment is provided, twice weekly during the winter months, at Charlotte Street, Hilton and Torry Child Health Centres. Treatment is offered to debilitated children on recommendation from departmental medical officers, general practitioners and paediatricians. During 1962, 66 children made 689 attendances for ultra-violet radiation. (In 1961, the numbers were 69 and 681 respectively).

(b) *Deafness Diagnosis Clinic.*—Pre-school children suspected of deafness are referred to this special clinic at View Terrace. A Regional Hospital Board otologist, a senior medical officer and a audiometrician are in attendance. During 1962, 31 pre-school children were referred, of whom 2 were issued with hearing aids. (In 1961 the numbers were 30 and 8 respectively).

(c) *Ophthalmic Clinic.*—Pre-school children suffering from eye defects are referred to the Regional Hospital Board ophthalmologist in attendance at a special ophthalmic clinic for school children. In 1962, 41 pre-school children were referred. (In 1961 the number was 46).

(V) Remedial Exercises.

An arrangement made with the Dunfermline College of Physical Education whereby the Corporation's Medical Staff may send children suffering from postural defects to classes held in the College at Woolmanhill continued throughout the year.

(C) OTHER PROVISIONS FOR EXPECTANT OR NURSING MOTHERS AND YOUNG CHILDREN.

(I) Supplies of Welfare Foods.

The main distribution centre for welfare foods continued to be located in the Castlegate Clinic, with subsidiary centres in the full-time child health centres. In addition, some shopkeepers throughout the town continued voluntarily to distribute welfare foods.

Certain proprietary milk foods and dietary supplements are issued at the discretion of the clinic medical officers at reduced prices.

The amount of National Dried Milks (full-cream and half-cream) issued during 1962, showed a further slight decrease. Proprietary dried milks are taking the place of "Welfare" dried milks where improvement in the family income allows it.

From June, 1961, when a charge for Cod Liver Oil and Vitamins A & D was introduced, along with an increase in the cost of Orange Juice, the amounts of these dietary supplements issued fell markedly. This reduction in sales continued througout 1962. "Welfare" dietary supplements are—according to the enquiries of health visitors—being replaced by proprietary concentrates.

The amounts of welfare foods, &c., issued during the last seven years have dropped by more than half:—

	National Dried Milk.		Cod	Vitamins A & D (Expectant	
	Full Cream.	Half Cream.	Liver oil.	Mothers).	Orange Juice.
1962 . .	44,935	4,108	4,334	2,241	35,617
1961 . .	45,063	4,507	9,211	5,273	62,625
1960 . .	56,105	5,363	12,440	7,056	94,116
1959 . .	59,964	5,468	12,650	6,849	94,012
1958 . .	60,638	5,509	11,573	6,493	89,830
1957 . .	65,638	5,913	18,104	7,143	146,315
1956 . .	86,276	6,660	20,992	8,094	136,967

(II) Dental Care.

During 1962, dental care for expectant and nursing mothers and young children was undertaken by four dental officers—two less than the authorised establishment—and there was again no dental hygienist. Some patients were referred by medical officers at ante-natal, and child health clinics, but the majority came from direct inspection by dental officers at ante-natal clinics, nursery schools and day nurseries.

The amount of work undertaken is set out below. The figures for 1961 and 1960 are given for comparison.

	Expectant Mothers.			Nursing Mothers.			Pre-School Children.		
	1962.	1961.	1960.	1962.	1961.	1960.	1962	1961.	1960.
Number Examined .	1,269	1,847	1,228	17	35	11	217	592	286
Requiring Treatment	761	1,005	942	17	35	10	150	359	159
Accepted Treatment .	64	167	291	17	35	8	52	358	106
Number Treated . .	45	135	120	17	35	8	42	221	94

(III) Nurseries.

(a) *Residential Nursery.*

The Corporation's residential nursery (Pitfodels) provides accommodation for children up to the age of 5 years who are in the care of the Children's Department, either permanently or temporarily, as well as debilitated children, who, in the opinion of the Corporation's medical staff, would derive benefit from a temporary residence in the nursery.

The number of available places was 75 and the average daily occupation throughout 1962 was 55 of whom 36 were aged 0 to 2 years, and 19 were aged 2 to 5 years. In August the M.O.H. recommended a further reduction of the number of places in the light of decreasing demand, but decision was deferred.

The residential nursery is approved for the training of nursery nurses.

(b) *Day Nurseries.*

The Corporation provide four day nurseries. To these are admitted children aged 6 weeks to 5 years, whose mothers are in full-time employment. The nurseries are open from 7 a.m. to 6 p.m., Monday to Friday, and are approved for the training of nursery nurses.

The number of children on the waiting list for vacancies, having fallen in 1961 to 63, rose again during 1962 and at the end of the year was 84.

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	28	30	18	21	23	9
Deeside . . .	20	25	15	29	14	23	18	8
Linksfield . . .	—	30	—	27	—	22	—	4
View Terrace . .	20	24	22	27	14	21	13	9

(IV) Care of Premature Infants.

Arrangements whereby all premature infants born at home are immediately transferred to the special ward at Royal Aberdeen Hospital for Sick Children continued as previously. When the infant is discharged from hospital the district health visitor visits the home to ensure that progress is maintained. In certain instances equipment is issued on loan to the mother.

(V) Prevention of Break-up of Families.

This is one of the most important facets of the health visitor's work and is discussed in a separate chapter.

6.—DOMICILIARY MIDWIFERY.

Features of the Year.

(1) There were 337 domiciliary confinements—a decrease of 15 on last year's figures (which was, however, higher than in most recent years).

(2) Midwives continued to be in sole clinical charge at almost all confinements, a doctor being present at the delivery of only 27 babies.

(3) Medical aid was required in 121 cases, and 63 women for whom arrangements were made for home confinement were transferred to hospital for delivery.

(4) Domiciliary maternity nursing increased. 61 women who were delivered in hospital were discharged home to the care of the domiciliary midwife between the first and fourth day after delivery.

(5) Trilene anaesthesia was universally used.

(6) Eight of the Corporation's midwives were again recognised as teachers of pupil midwives.

Staff.

(a) Corporation—Supervisor, 10 midwives (and 2 vacancies).

(b) Allocated from Regional Board—2 midwives.

(c) Other practising midwives—1 private, 67 in hospital (a sharp increase over 1961) and 2 at Castle Terrace.

Midwifery Districts.

The districts were increased to eleven. Although Part II pupil midwives attended confinements and did ante-natal and post-natal visits with all domiciliary midwives, one district was allocated to the Regional Hospital Board for practical training of pupils by their own staff, under the general direction of the Corporation's Supervisor of Midwives. The Corporation paid £862 towards the salaries of the two midwives concerned.

Ante-natal and Post-natal Supervision by Midwives.

Persons choosing home confinement and also a small number of others for whom hospital confinement was considered medically and socially unnecessary received their ante-natal care by the midwife, either in her duty room or at the patient's home.

Some 63 cases had to be transferred by the general practitioner and the midwife to hospital for delivery.

The midwives' individual and personal attention to the patients was supplemented by clinic facilities, e.g. medical consultation, anti-poliomyelitis protection and group teaching were available to all requiring it.

Administration of Analgesics.

(1) *Trilene.*

During the year 300 patients (89 per cent.) received trilene (as compared with 86 per cent. in 1961).

(2) *Gas and Air.*

Gas and air anaesthesia remained available, but was not requested. Curtailment of this service is contemplated.

(3) *Pethedine.*

Pethedine was given in 114 cases, as compared with 145 in 1961 and 158 in 1960.

Drugs.

There was no change in procedure.

Births.

Particulars of the births, including still-births, which occurred in the City during 1962 are as follows:—

(i) Total number of births occurring in the area during the year, that is before correction for mothers' residence—live births, 4,483; still-births, 100. Total 4,583

(ii) Total number of births occurring in institutions (including private maternity homes)—live births, 4,149; still-births, 97. Total 4,132

(iii) Total number of above births occurring at home—live births, 334; still-births, 3. Total 337

These 337 may be further sub-divided thus to show professional attendance at birth:—

	Doctor engaged and present.	Doctor engaged but not present.	No Doctor engaged.	Total.
Municipal midwives . . .	17	259	—	276
Hospital midwives "on district"	10	40	—	50
Private practising midwives .	—	—	—	—
No midwife	—	—	11	11
Total 1962 . .	27 (8·0%)	299 (88.7%)	11 (3·3%)	337
Comparable figures for 1961 .	26 (7·4%)	317 (90·0%)	9 (2·6%)	352
Comparable figures for 1960 .	34 (10·6%)	278 (86·9%)	8 (2·5%)	320
Comparable figures for 1959 .	17 (4·4%)	356 (91·5%)	16 (4·1%)	389
Comparable figures for 1958 .	31 (8·6%)	324 (89·5%)	7 (1·9%)	362
Comparable figures for 1957 .	26 (5·9%)	395 (90·4%)	16 (3·7%)	437

Use of Cars.

Four municipal midwives received allowances for the use of their private cars. One municipal midwife received an allowance for the use of her scooter. In emergency and at night, taxis were used by the other midwives.

Refresher Course for Midwives.

Two midwives attended the Refresher Course held in Queen's College, Dundee, from 24th-31st March, 1962.

Training of Pupil Midwives.

Part I and Part II pupil midwives are accepted by Aberdeen Maternity Hospital, which uses the Corporation's Domiciliary Service for the practical training of the latter group.

The midwives reside at 32, Carden Place, while they acquire their practical experience. They accompany their own two instructresses and the municipal midwives to all cases. The provision of each pupil with the required number of cases was made easier by a ruling of the Central Midwives Board, coming into operation in March, 1962. This demanded only five cases per pupil and stipulated that eight weeks be spent on district acquiring these.

For systematic teaching, the Supervisor of Midwives and an Assistant Medical Officer were recognised by the Central Midwives Board as lecturers and they gave lectures to both groups at the Maternity Hospital.

7.—HEALTH VISITING.

Features of the Year.

(1) *Continued pattern of winter and spring staff shortages.* The reports for 1960 and 1961 referred to health visitor shortages being as severe at the ends of these years as in 1959, although duties were growing steadily. In 1962 the same pattern continued: the year opened with 11½ vacant posts (including 2

temporarily filled by dilutees of lower qualification); 12 health visitors and 2 male health visiting officers joined the staff which in July approximated (as in previous years) to full complement; but 14 health visitors left (including 6 who quit the profession, 3 who switched to district nursing and 2 who left because of marriage)—so that the position at the end of 1962 was exactly the same as in 1961 and 1960. It may be noted that (a) in most years one or two Aberdeen health visitors are attracted to posts abroad (e.g. in S.S.A.F.A.); (b) in most years one or two move out of health visiting to other professions in this country; (c) as the average age of qualification drops—it is now only about 27—the loss from matrimony is tending to rise; and (d) some health visitors are attracted from Aberdeen to areas where promotion posts are more numerous or more amenities are provided. [Assuming that on (d) above Aberdeen ultimately comes into line with other areas, the pattern of an annual loss of about 10-12 can probably now be taken as standard: in other words, if we aim at having the complement of 85 at the busiest period of the year we should have about 95 each July, and conversely if we aim at having 85 each July we should be preparaed to make do with about 75 at the busiest period of the year.]

(2) *Qualitative. staff loss.* As was pointed out in last year's report, it is often the health visitors with greatest initiative who move out to other professions (e.g. to become teachers of mothercraft or teachers of student nursery nurses) or take posts abroad: this was again the case in 1962.

(3) *Continued increase of duties.* Every new duty (e.g. the starting of after-care for diabetic patients in 1962) takes up additional health visiting time. By the end of 1962 there were 10½ individuals on specialised duties, leaving correspondingly fewer for ordinary district work.

(4) *More time spent on case-conferences and discussions and on clinic work.* In 1962 (and to some extent in 1961) more time was spent on case-conferences. consultations with general practitioners and other workers and clinic duties, leaving less time available for home visiting.

(5) *More time spent on school health duties.* The development of the school health service in the last three years has again reduced the time available for home visiting.

(6) *Less total time available.* The extra week's holiday annually, granted by the Whitley Council in 1962, represented a reduction of over 2 per cent. in health visitors' total working time.

(7) *Changing emphasis in health visiting.* In view of the increased duties mentioned above, the increased time demanded by case-conferences and consultations, and—as indicated later—the extending number of people requiring help from health visitors, there has been a deliberate attempt in 1961 and 1962 to increase the proportion of time spent in health education and social counselling at clinics—although this has meant a further diminution in the amount of home visiting possible.

(8) *Appreciable decrease in home visiting.* Over the last two years the total of home visits paid has fallen by over 8 per cent (from 145,052 in 1960 to 136,751 in 1961 and 133,987 in 1962). This reduction, regrettable at a time when there are more young children than ever and more old people than ever, was inevitable, and has been fairly evenly spread over prospective parents, babies, toddlers, handicapped adults and elderly persons.

(9) *More persons requiring visiting.* In the last four or five years the birth rate has been high (so that the number of children to be visited has risen) and simultaneously there has been a steady increase in the number of surviving old persons.

(10) *Increased stress on budgeting and home economics.* While the main trend of the period 1955-60 was perhaps increased stress on emotional health (e.g. attempts—not unsuccessful—to reduce the causes of maladjustment and juvenile delinquency), the last year or so has witnessed a slight shift of emphasis to socio-economic matters, although this certainly does not mean that the health visitor is ceasing to concern herself with the prevention of maladjustment. The systematic notification of health visitors about housing tenants in arrears of rent is an example of the trend.

(11) *Decrease in staff sickness.* In recent years the loss of working time through sickness among health visitors has been disquietingly high—e.g. 631 days in 1960 and 557 in 1961. It is pleasing to record that in 1962 only 206 days were lost.

(12) *Intermediate promotion grade.* Despite the recommendation of the Health and Welfare Committee three years ago, no Group Advisers have yet been appointed in Aberdeen.

The Changing Pattern of Health Visiting.

With increased emphasis on psycho-social factors health visitors are tending to undertake home visits of longer duration. Faced with constant additions of duties and increases of population (especially increase in old people) they are also seeking to conserve time by doing more health teaching and social counselling at clinics. The biggest change in recent years, however, has been the proliferation of specialist health visitors, with consequentially a decrease in the number of health visitors available for ordinary district work: the number of district health visitors has actually fallen from 58 in 1960 to 51 in 1962. Here is the distribution of staff in December, 1962:

Clinic superintendents (about half time on district)	10
District health visitors	46
Tuberculosis health visitors	4
Health visitors solely on school functions	2
Specialist H.Vs. and male H.V.Os.	10½
	72½

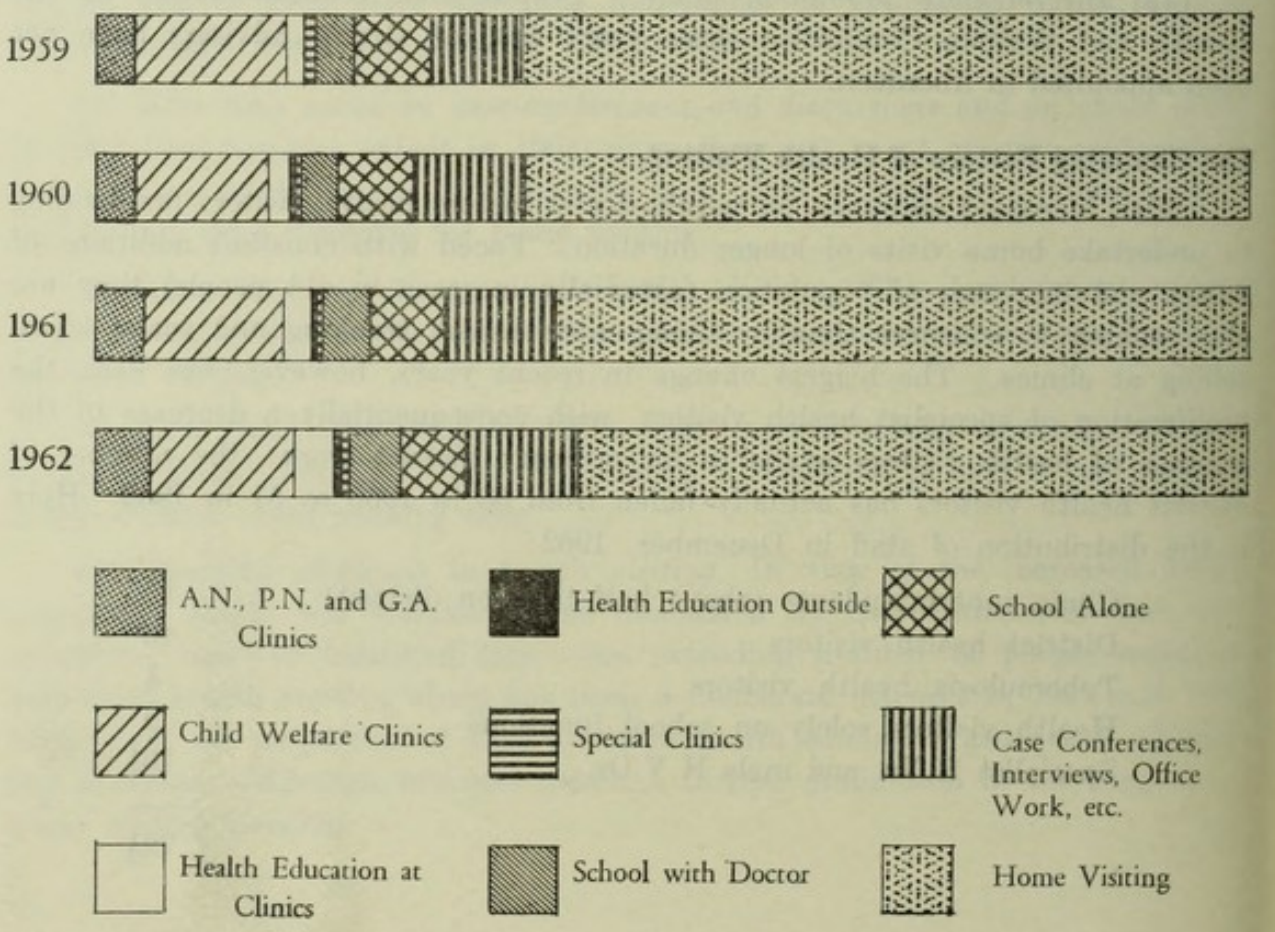
The following table gives the number of health visiting sessions devoted to various tasks, and the diagram depicts the same information. It should be noted that the figures refer to sessions spent by health visitors, not to total sessions held (e.g. if three health visitors attended one clinic or one health education session, that clinic or session is here reckoned as three).

Health Visitors' Sessions—distribution (excluding tuberculosis health visitors)

Year	A.N. & P.N. Clinics	C.W. Clinics	H.E. at Clinics	H.E. Outside	Special Clinics	School with Doctor	School alone	Consultns, Office work, etc.	Home visiting	Total
1960	1,065	3,426	532	102	189	941	1,942	2,876	18,710	29,783
1961	1,245	3,589	621	87	123	1,208	1,844	2,805	18,285	29,807
1962	1,400	3,645	966	140	186	1,286	1,692	2,889	17,641	29,845

Assuming 520 available sessions (i.e. 10 per week) and assuming that an average health visitor misses 60 sessions through annual leave (5 weeks plus statutory holidays) and about 30 sessions for other reasons (sickness, attendance at refresher courses, paid or unpaid compassionate leave, etc.), the total of 29,845 sessions worked corresponds to an average of 70 health visitors (plus 4 on tuberculosis) and 1 on long-term unpaid leave.

THE DISTRIBUTION OF HEALTH VISITORS' SESSIONS.



An Assessment of the Staffing Needs.

(1) *Estimate of needs.*

The establishment of 85 health visitors (unanimously approved by the Corporation in 1954) was of course based on statistics for 1952 and 1953 and on duties then recognised. Since then the annual number of births has risen by nearly ten per cent. (e.g. 3,055 for 1952-53 and 3,313 for 1959-60) and a further sharp rise is anticipated; the number of old people has increased by considerably more than ten per cent. (even the average age at death has advanced by about three years); and a multitude of new duties have fallen to health visitors. A rough and ready assessment of present day needs would therefore be 96 health visitors and male health visiting officers (i.e. ten per cent. above the 1954 estimate together with an additional two per cent. to correspond with longer annual leave.

It is more satisfacory, however, to take the 1962 average of 75 health visitors employed, and to reckon for different duties the additions that would be needed to cope with these duties in the anticipated circumstances of 1967:—

(a) Increase in the number of staff employed on specialised duties (e.g. services for the physically and mentally handicapped, services for unmarried mothers, and after-care in respect of various diseases) has certainly facilitated the development of after-care and supportive services and has led to good two-way co-operation with hospital staffs and general practitioners. Having regard to (1) the rise in the number of specialist health visitors from 5 to 10½ in the last five years, (2) various after-care services already needing expansion, and (3) population trends, it is reasonable to assume that in the next five years we will require another 5 specialist health visitors.

(b) Clinic work and health education sessions (both useful as tending to save health visitors' time) have increased by just over a quarter in the last four years (from 4,813 health visitors' sessions to 6,151). Since (a) clinic attendances and demands for health education are very high in areas with local clinics (e.g. Northfield and Mastrick) and will presumably rise correspondingly in other areas as clinics open, and (b) the numbers of prospective parents and of pre-school children are rising and are expected to rise, it would be reasonable to postulate a continued increase of the same 6¼ per cent. annually—or about another 2,050 sessions by 1967, corresponding to the full-time of 4½ health visitors.

(c) Home visiting. Here is a tabular statement giving (1) total visits in 1962, (2) where appropriate, highest figure in any recent year, (3) a reasonable optimum for 1962 had staff been available, and (4) a figure for 1967 (bearing in mind population trends and also saving of visiting time through extension of clinic work and health education services).

	1962 visits.	Highest previously.	1962 "optimum".	1967 forecast.
Expectant mothers	10,907	12,281	12,980	13,600
Pre-school children	86,755	92,608	97,500	102,000
Tuberculosis patients	5,451	11,444	5,500	4,800
Old people	14,697	15,272	21,000	23,100
School children	7,910	—	10,200	10,600
Handicapped persons	1,635	—	1,800	2,000
Mental disorder	3,234	—	4,500	4,700
Miscellaneous	3,398	—	3,600	3,800
	133,987		157,080	164,600

The increase of 30,613 visits corresponds to 4,373 sessions or about 10 health visitors.

Assuming no other extensions (e.g. of sessions in schools) the requirement for 1967 would therefore be 19½ more health visitors than in 1962, or an *average* staff during the year of 94½. An average staff of 94½ throughout the year implies, of course, that about 100 would be employed at maximum point and about 88 at minimum point during the year. Not all of the additions need, however, have full health visiting qualifications.

(2) *Meeting the needs.*

There are certain duties at clinics, schools, parents' clubs, &c. which less highly qualified staff might undertake satisfactorily. It is suggested for consideration that over the next five years the establishment might be raised thus:

Health Visitors —from 85 to 90 (an increase of one per year);

Clinic Sisters (R.G.N. only)—from 3 to 8 (an increase of one per year);

Clinic Assistants —from 8 to 18 (an increase of one per year).

[It may be noted that there are at present 5 Clinic Sisters on the staff, but 2 of these posts are temporary until such time as the number of health visitors exceeds 83.]

Antenatal Visits.

There was a very slight decrease in the number of expectant mothers referred to the health visitors for home visits—from 2,647 in 1961 to 2,532.

The total number of visits was 10,907 as compared with 11,238 in 1961—a decrease of 331 home visits. The average number of visits paid to each expectant mother remains virtually unchanged, but because of the immense opportunity to advise and provide health education to this group, more home visits should be possible and encouraged.

Visits to the Elderly.

In 1962 there was a decrease in the number of elderly referred to the health visitor; 2,818 in 1962, as compared with 3,041 in 1961. The total number of home visits was 14,697 as compared with 15,720—a decrease of 573 home visits.

Visitation by Health Visitors.

	No. visited in 1962.	Total Visits. 1962.	1961.	1960.	1959.
I. (a) Expectant mothers	2,532	10,907	11,238	12,281	9,941
(b) Children under 1 year	7,033	37,619	39,845	43,518	40,231
(c) Children aged 1-5 years	11,319	49,136	51,197	53,829	52,377
II. Cases of Tuberculosis	1,261	5,451	6,350	7,853	11,444
III. Elderly	2,818	14,697	15,720	15,272	13,935
IV. Domestic Help	—	1,168	1,115	1,289	—
Total		118,978	125,465	134,042	127,928
Waste Visits		24,302	25,678	28,781	

It will be noted that the total visits enumerated in the table above come to 118,978 whereas the grand total of visits is stated elsewhere to be 133,987. The difference is explained as follows:—

(a) Visits to the homes of school children—7,910 in 1962 are not included (since they are mentioned in the report of the school health service);
(b) the 1,635 visits paid by health visitors to the physically handicapped are counted elsewhere;
(c) similarly the home visits paid by health visitors to patients requiring mental after-care (3,234 visits) are discussed elsewhere;
(d) 2,230 visits were paid in connection with housing, infectious diseases, nursery investigations, &c. and are not included in the table.

Liaison Services.

Unmarried Mothers.

Because of the many emotional and social problems which arise before and after the birth of an illegitimate child, it was decided in January, 1962, that for a trial period of one year a mental after-care officer (Miss Slater) would include the ante-natal visiting of unmarried mothers with her other work in the mental field.

Although the experiment has been useful, for complete success it would need a health visitor or an after-care officer working full-time in this field. Miss Slater's work with the Ross Clinic in the past six months has increased by leaps and bounds, thereby decreasing her time available for work with unmarried mothers. In the latter part of the year, the number of visits she was able to pay to some of the girls was less than they would have received if visited by the district health visitor.

Co-operation with the Almoner from the Maternity Hospital and the Social Worker at the Mother and Baby Home has not been altogether satisfactory: there has been some duplication of work, and occasionally conflicting opinions over admission of girls to hostel accommodation.

As the number of illegitimate births is relatively small, and as staff shortages make specialisation difficult, one wonders if this group in Aberdeen under present circumstances fully justifies a specialist health visitor.

The initial idea of specialist work with this group was sound enough, not only because of supportive visits but also because of the need for research into the emotional problems of unmarried mothers. Unfortunately, however, staff are scarce and the scheme may have to be abandoned.

Ante-natal Clinics at G.Ps.' Surgeries.

As from 1st May, 1962, a number of General Practitioners undertook to carry out part of the ante-natal care of expectant mothers booked for hospital. This resulted in many enquiries about the availability of health visitors to attend ante-natal clinics at G.P. surgeries for the purpose of giving social advice and health education. Apart from two health visitors who are already working full-time with general practitioners, two other health visitors each spend one session per week at ante-natal clinics attached to two group practices. They provide social guidance and health teaching for the pregnant women and act as a very useful link between the General Practitioner and the district health visitors. Such liaison is to be encouraged as personal contact is enlightening to both sides.

Royal Hospital for Sick Children.

One health visitor continues to spend one morning each week visiting the Sick Children's Hospital. Before visiting, she collects queries from the district health visitors regarding the children on their districts who have been admitted to hospital. Similarly, she returns to the district health visitors hospital information about children who are to be discharged. Such information is vital to the district health visitors if they are to encourage the mothers to continue in the home the measures started in hospital. There is no doubt that this service could be further extended if staff were available.

The Aged in Hospital.

A similar liaison is carried out in respect of the care of the elderly at Glenburn Wing.

Diabetic After-care.

In August, 1962, at the request of the hospital, a health visitor was allocated part-time to the Diabetic Clinic for the follow-up of diabetic patients in their own homes. Miss Downie has been given selected cases of patients living at home who had difficulty in maintaining the necessary diet. She instructs these patients on diet, cooking and budgeting, and if necessary may pay daily visits to stabilise their condition. This work is very time-consuming, as the causes of a patient's dietetic "upset" may be multiple and may include many social and economic factors.

Mental After-care.

With the appointment of four Mental After-Care Officers (health visitors with further advanced training in mental health) in January, 1962, the Corporation's after-care services made a considerable step forward—although it should be remembered that previously the duties had been undertaken by the same officers under a different designation. During the year three after-care officers—two at

Kingseat Hospital and one at the Ross Clinic—cared for many of the patients discharged from these units. The fourth mental after-care officer and a male health visiting officer carried out duties in connection with the follow-up of mental defectives over the age of 16 years. The Mental After-care Officer dealing with mental defectives also acted as a liaison between Woodlands Home and the Local Authority.

In-service training for health visitors in mental after-care continues at Kingseat Hospital. For a period of six months, two health visitors spend four sessions weekly at Kingseat, gaining experience in the after-care of mental patients.

Special Clinics—Woolmanhill.

As in previous years, follow-up visits from this Clinic were to patients who failed to keep their appointments. A number of the patients were in full employment, so that evening visits by the district health visitors were necessary.

School Health Service.

A Clinic Nurse was appointed in October, 1962, to assist in the routine health inspections of school children, and where possible to relieve health visitors of a number of unskilled tasks. In large schools it is impossible for a health visitor to perform a health survey of each child per term and she is fortunate if she is able to see each child even twice per year. Attaching a clinic nurse to such a school enables each child to have a cleanliness inspection once in each term, and allows the health visitor more time to carry out her health surveys, health education programmes and consultations with teachers during the year. To establish such a programme in each school would require a considerable increase in the clinic nurse establishment.

Refresher Courses and In-service Training.

Fourteen health visitors attended approved refresher courses arranged by the Royal College of Nursing, the Health Visitors' Association and Regional Hospital Boards. Nine health visitors at their own expense attended the International Conference on Health Education arranged by the W.P.H.O.A. at Brighton in October, 1962.

Lectures, films and talks of interest were given to all health visitors at staff meetings held throughout the year.

A Study Day was held in June, 1962, the topic being "The School Health Service". We were fortunate in obtaining Dr. Burn from Salford and Miss Beattie from Edinburgh as speakers.

Training of Students.

Fifteen post-graduate students spent days or weeks observing the work of the Department and paid a number of visits to homes and clinics with appropriate health visitors. These students also met sectional heads of the Education Department and Health and Welfare Department for general discussion. A number of these students were from overseas and the entire staff benefitted to a certain extent through mutual discussion.

A number of nurses from nurse training schools in Aberdeen also accompanied the health visitors and attended child welfare clinics.

Health visitors also co-operated in the training of health visitor students, medical students, pupil midwives and student district nurses.

Research.

The health visiting staff were asked to assist in two research projects during the year—Cancer Research carried out by Dr. MacGregor of the Midwifery Department of the University, and an investigation into the possible causes of rent arrears undertaken by Miss Nairn, Superintendent Health Visitor.

8.—PROFESSIONAL EDUCATION OF HEALTH VISITORS.

Features of the Year (1961-62).

(1) 1962 saw the passing of the Health Visiting & Social Work (Training) Act which must in due course have enormous influence on the preparation of student health visitors. A National Council for Health Visitor Training was set up by the appropriate Ministers under the Act, and Miss Lamont was appointed as one of its members. A Scottish Advisory Committee was also created by the Secretary of State for Scotland and Dr. MacQueen and Miss Lamont were appointed members.

(2) Locally the big development of the year was the organisation and conduct of the first course in Britain for student male health visiting officers. This is discussed more fully below.

(3) There had been considerable deepening and widening of the health visiting course in 1960-61, and in 1961-62 there were few changes—partly because major innovations can hardly be introduced every year and partly because of an anticipated staff shortage (this shortage duly developed, and at the time of writing there has been an unfilled vacancy for a tutor for ten months).

(4) Other educational activities are described in the text. The joint study weed-end for medical officers and health visitors is an innovation, and the request to take student health visitor tutors from London and student hospital tutors from Edinburgh is worthy of special mention.

The Course for Male Health Visiting Officers.

The course (organised without any increase in staff) whereby qualified male nurses with an additional qualification can receive a post graduate course in health education and medico-social work on the broad lines of that for student health visitors has been mentioned in last year's report; but since 1961-62 was the first year of the actual course, and since the first Male Health Visiting Officers in Britain qualified in June, 1962, a few words may be useful here.

Rather more than two thirds of the course is taken along with the parallel course for student health visitors. Hence both groups of students receive the same professional education in respect of psychology, sociology, social services, health education and the physical and mental growth and development of children.

In respect of practical work, the students are at first placed with health visitors (as are their female colleagues), but when they are ready to undertake district work unaccompanied—supervised visiting—rather different arrangements are necessary, involving higher proportions of time spent with the elderly, with problem families and with mentally and physically handicapped persons.

In 1961-62 the male students spent more time than their female counterparts on psychiatric after-care (but this has been deemed so useful that in 1962-63 the course for student health visitors is being brought into line, and indeed the amount of psychiatric after-care is being extended for students of both sexes). More time was also spent with the Welfare Section, with workers specialised on handicapped persons, with the rehabilitation officer and with the mental after-care officers.

The special case studies (which are an important feature of courses for both men and women) naturally related in the case of the men to the sections of population with which they would be mainly concerned.

The men participated in all discussion work and role-play activities of the female students, and it is worth noting that the intermixture of the sexes was extremely valuable for both groups—the quality of discussion improved greatly.

The examination was on the same lines as for the women. Dr. E. Neil Reid (M.O.H., Stirlingshire) acted as external examiner and Miss Lamont as internal examiner. All three students passed and duly started work, two with Aberdeen Corporation and one with the North-Eastern Regional Board.

For 1962-63 there have been many enquiries from local authorities and from individuals, but the number of students accepted has been deliberately restricted to four—one for Clackmannanshire (the first county to institute enquiries), one for one of the African countries and two for Aberdeen.

Prizewinners.

1962 being the centenary year of health visiting and health visiting having started in Salford and Manchester, the Superintendent Health Visitor of Salford was the obvious person to present the prizes. The awards were presented by Miss Beatrice M. Langton, M.B.E., S.R.N., Dip.N., H.V.

The prizewinners were:—

(1) Corporation of Aberdeen Prize for the Best All-Round Student—Miss Jean Grime, S.R.N., S.C.M.
(2) Proxime Accessit—Mrs. Maisie Abbot, R.G.N., S.C.M.
(3) Tutors' Prize for Health Education—Miss Catherine Smith, R.G.N., S.C.M.
(4) Prize of Medical Officer of Health for Family Casework—Miss Jean Grime, S.R.N., S.C.M.
(5) Violet Roberton Memorial Prize for Health Teaching—Miss Sally-Ann Jack, R.G.N., S.C.M.
(6) Special Child Study Prize—Mrs. Maisie Abbot, R.G.N., S.C.M.

Further Courses for Qualified Staff.

(a) In May, a study week-end was arranged jointly for medical officers and health visitors. The subject chosen was (in view of recent developments) the School Health Service, and the lecturers were Dr. Burn (M.O.H., Salford) and Miss Beattie (Superintendent H.V., Edinburgh).

(b) The Corporation had sanctioned the holding of a course for prospective Group Advisors, and proposals for conducting extensive courses in Mental Health (on broad lines worked out in 1954 and 1955, but with allowance for advances since then) were laid before the Corporation. To conduct such courses, however, there must be sufficient staff in post not merely when the course takes place but during the period of planning and organisation. In view of the impending vacancy in 1962 neither course could be arranged. As already mentioned, the vacancy remains in April, 1963.

Additional Educational Activities.

(a) The Health Visitor Tutors continued to undertake teaching of student nurses on the social aspects of disease in the Royal Infirmary, the City Hospital and the Children's Hospital.

(b) The tutors also gave lectures, followed by field work, to final year student domestic science teachers at the College of Education, and took part in a short course for third year student domestic science teachers.

(c) They took part also in a refresher course for ward sisters and charge nurses arranged by the Regional Hospital Board.

(d) Participation in the teaching of student district nurses and in the training of nursery nurses continued as in previous years.

Participation in Advanced Courses.

At the request of the organisers of the respective advanced courses two student health visitor tutors from London visited the School to study its administration and methods; and two student tutors from the Nursing Studies Unit of Edinburgh University similarly spent a period at the School.

Student youth organisers from Edinburgh also visited the school.

As in previous years there were many visitors from overseas.

The Accommodation Problem.

Year after year the new school—originally visualised for 1959—is postponed, and inadequacy of accommodation is definitely hampering the work of the School. Modern use of discussion work, projects and assignments makes it imperative that a further education unit should have a few quiet rooms (where a student or a small group of students can work uninterrupted), together with a library, a common room, a visual aids workroom and a couple of classrooms. At present there are no quiet rooms; one not very large room has to serve as library, students' common room and second classroom; and the demonstration material work room (in the attic) is tiny—although its equipment in 1961 certainly improved the quality of the visual material used by students in their teaching.

9.—HOME NURSING.

Features of the Year.

(1) The number of patients under the age of 65 years requiring nursing visits underwent a further sharp reduction—from 1,645 in 1961 to 1,221 in 1962. This is the eighth consecutive year in which there has been a drop, and the figure for 1962 is less than two fifths of the total (2,730) for 1954. As was suggested in last year's report this continued appreciable reduction is a measure of the efficacy of the health services, and in particular of the services for health education of individuals and groups.

(2) After falling in 1960 and rising slightly in 1961, the number of elderly patients requiring visits rose sharply in 1962—from 2,144 in 1960 and 2,294 in 1961 to 2,619 in 1962. It may be noted (a) that, with the continued reduction of patients under 65 and the increase in patients over 65, nearly 70 per cent. of the work of the service now relates to the elderly; and (b) that the rise in old people needing nursing may be related to the reduction in health visitors' visits for social counselling and health advice.

(3) Although the total of patients visited by the day service was lower than in 1962, old people on average need more visits than younger persons with the same illness. The total number of visits by the day service is actually down by over 3,000 but would have shown a rise but for a change in the method of treatment of diabetics. Replacement in appropriate cases of insulin injections by chlorpropamide tablets reduced visits to diabetics by 6,919.

(4) Since visits to old people tend to occupy rather more time, the service was as busy as ever in 1962.

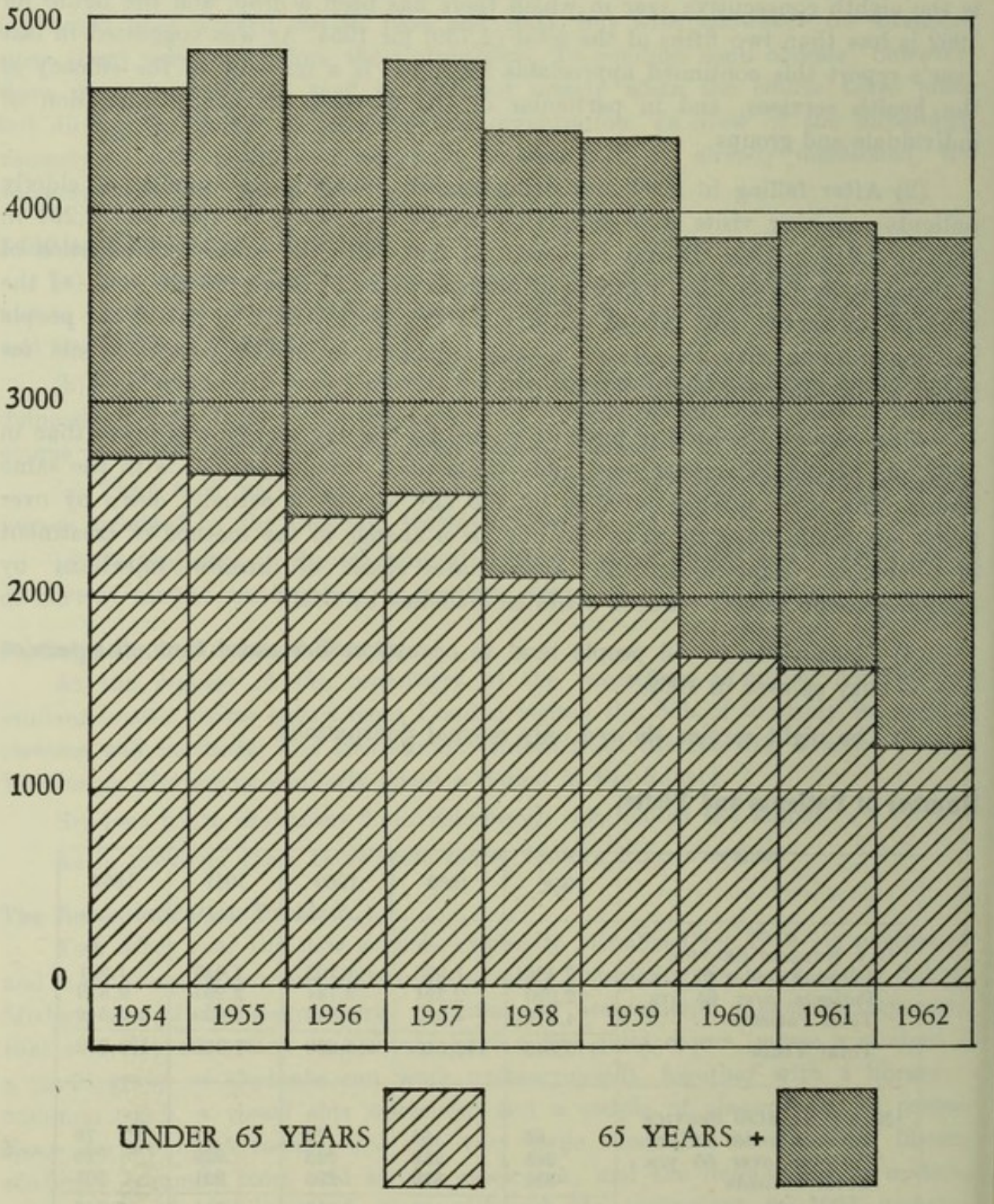
(5) The night service showed only normal fluctuations.

Number of Patients and Visits.

	1958	1959	1960	1961	1962
DAY NURSING SERVICE					
Patients under 65 yrs.	2,125	1,973	1,703	1,645	1,221
Patients over 65 yrs.	2,290	2,394	2,144	2,294	2,619
Total Patients . .	4,415	4,367	3,847	3,939	3,840
Total Visits . .	115,046	116,540	110,628	107,605	104,012
NIGHT NURSING SERVICE					
Patients under 65 yrs	66	56	70	71	76
Patients over 65 yrs.	265	259	225	250	225
Total Patients . .	331	315	295	321	301
Total Visits . .	2,903	2,549	2,912	3,551	3,046

The diagram shows the age distribution of patients nursed by the day service in recent years.

DAY NURSING SERVICE PATIENTS
1954-1962.



General.

Aberdeen is one of the twelve local health authorities in Scotland that do not themselves employ district nurses. The Corporation discharge their duty through the agency of the Aberdeen District Nursing Association, the expense being met by the Corporation.

Staff at end of 1962.

One Superintendent and one Assistant Superintendent: they also act as part-time tutors to students.

Day Service:—33 full-time and 4 part-time nurses, and 1 full-time enrolled nurse.

Night Service:—1 full-time and 6 part-time nurses, and 1 part-time enrolled nurse.

Training.

At the end of the year ten students were receiving training.

Types of Cases.

Details are given in the two tables following.

DAY NURSING SERVICE.

Diseases	No. of Patients			No. of Visits			Age		Termination of Cases			
	M.	F.	Total	M.	F.	Total	-65	65+	Conv.	Transfer to Hosp.	Died	Continuing at 31st Dec.
Abdominal	214	323	537	2,881	4,773	7,654	338	199	417	55	12	53
Accidents	47	113	160	810	2,379	3,189	70	90	106	16	4	34
Amputations	13	11	24	383	534	917	4	20	6	6	3	9
Anæmia	53	377	430	1,131	8,206	9,337	171	259	187	33	11	199
Cancer	135	142	277	2,860	4,098	6,958	122	155	53	59	121	44
Cardiac	163	313	476	5,654	10,262	15,916	136	340	141	112	70	153
Cerebral Hæm.	106	180	286	3,549	6,902	10,451	36	250	44	67	76	99
Diabetes	14	84	98	2,309	11,524	13,833	15	83	41	19	4	34
Gynæcological & Obstetrical	—	45	45	—	535	535	33	12	36	3	1	5
Miscellaneous	206	410	616	2,338	6,081	8,419	336	280	463	79	5	69
Nervous	33	82	115	1,277	2,920	4,197	75	40	47	27	8	33
Respiratory	152	193	345	1,951	2,804	4,755	183	162	257	33	26	29
Rheumatism	22	118	140	437	5,250	5,687	36	104	41	18	12	69
Senility	41	141	182	1,337	5,339	6,676	—	182	32	58	36	56
Varicose Ulcers	13	78	91	560	4,388	4,948	26	65	44	10	2	35
Tuberculosis	9	9	18	325	215	540	16	2	11	1	—	6
Total	1,221	2,619	3,840	27,802	76,210	104,012	1,597	2,243	1,926	596	391	927

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.
Abdominal . .	5	14	19	15	57	72	1	18	16	2	—	—	1
Accidents . .	—	6	6	—	25	25	1	5	3	2	—	1	—
Anæmia . .	—	2	2	—	2	2	—	2	2	—	—	—	—
Cancer . .	57	42	99	1,165	681	1,846	54	45	6	15	—	73	5
Cardiac . .	18	31	49	146	184	330	4	45	9	14	—	25	1
Cerebral Hæm .	24	24	48	140	186	326	3	45	7	11	—	25	5
Miscellaneous .	5	19	24	31	81	112	6	18	4	9	—	9	2
Nervous . .	1	6	7	2	37	39	4	3	5	—	—	1	1
Respiratory .	10	13	23	64	51	115	3	20	5	6	—	12	—
Rheumatism .	2	1	3	2	1	3	—	3	—	—	—	3	—
Senility . .	9	12	21	34	142	176	—	21	5	5	—	9	2
Total . .	131	170	301	1,599	1,447	3,046	76	225	62	64	—	158	17

10.—DOMESTIC HELP SERVICE.

Features of the Year.

(1) The dominant feature for the past decade has been the steady increase in the number of elderly persons assisted by Corporation home helps, so that they now outnumber all other cases nearly three to one.

(2) During 1962 this trend continued, and although there was a decrease in cases other than the elderly, the net result was a further rise in the grand total of all households helped.

(3) The increase in the total of households assisted was achieved without increase in the number of home helps employed. The recent appointment of two Home Help Supervisors has helped to produce this improved case/staff ratio.

(4) The number of old people in the general population continues to rise, however, and it is difficult to see how the home help service can be maintained to the same level of efficiency without increasing staff to cope with increasing clientele.

(5) The informal list of persons available for private full-time or part-time work of a domestic help nature also renders useful service. If, for example, a family doctor has a patient who wishes to obtain domestic help and is willing to pay the full charge, then on contacting the Home Help Organisers he will be given the name and address of a suitable person, should there be one available. It is emphasised that the department accepts no responsibility towards these private and informal appointments beyond merely putting a would-be employer in touch with a would-be employee. During 1962 the names of 59 private helps were furnished to applicants under this scheme.

Numbers of Home Helps and Number of Cases Helped.

All home helps were employed whole-time or part-time, none being engaged on a retaining fee basis. The following table shows the numbers at the end of various years:—

Year	1962	1961	1960	1959	1958	1957	1956
Whole-time	61	62	63	79	64	57	51
Part-time	259	251	233	206	197	175	148

The table below indicates the distribution of cases in recent years:—

Year	1962	1961	1960	1959	1958	1957	1956
(1) Maternity Cases	119	127	130	170	209	234	235
(2) Long-term illness (under 65)	133	106	125	132	165	136	128
(3) Short-term illness (under 65)	280	347	357	288	272	285	353
Total of (1), (2) and (3)	532	580	612	590	646	655	716
(4) Infirm and Elderly	1,440	1,346	1,234	1,195	986	906	778
Grand Total	1,972	1,926	1,846	1,785	1,632	1,561	1,494

No sitter-in service has been established by the Corporation.

11.—HEALTH EDUCATION.

Features of the Year.

(1) Since the prospective parent combines to an unique extent eagerness to learn about the emotional and physical needs of children, leisure to listen and to discuss, and relative absence of preconceived notions and prejudices, it has been Departmental policy to extend this portion of health education at all costs; and rising demands by the public have made extension more a matter of finding staff than of attracting audiences. Incidentally such extension may have lessened the harmful effects of the decrease in individual visiting mentioned in another part of the report. The total number of meetings for mothers-to-be has increased by 89 per cent. in the last two years, as the following table shows:

Total meetings for expectant mothers (including evening meetings jointly with prospective fathers).

Year.	Number.	Year.	Number.
1957	388	1960	466
1958	395	1961	602
1959	381	1962	862

By the end of 1962 courses for expectant mothers were available at all clinics except one (where accommodation is lacking).

(2) The total number of meetings for parents of young children, after rising from 214 in 1960 to 298 in 1961, remained high despite gaps in the staff—276 meetings in 1962.

(3) Although staffing difficulties limited development of health education in schools, slight progress was made. There were 33 sessions of formal health teaching in schools, the concentration being on the older schoolgirls. Useful work was also done outside school hours—courses on "health and beauty" related to the Duke of Edinburgh award.

(4) Shortage of staff necessitated a very slight limitation of meetings for miscellaneous groups: 295 in 1962 as compared with 349 in 1961. For these meetings (and for the smallness of the reduction in numbers) tribute must be paid to the district health visitors who undertook most of them.

(5) The grand total of meetings (1,466) and the grand total of attendances (31,410) were both by far the highest yet recorded. The figures are the more remarkable since there was no special campaign in 1962 to inflate them; and to have reached these figures during a year of severe staffing shortages is no mean achievement.

(6) In the summer of 1962 Miss Brown (H.V. Tutor & Health Education Lecturer) left to take charge of the Health Visitor Training School in Surrey, and up to the time of compilation of this report advertisements have failed to produce any qualified candidate for the vacancy; in the same summer, immediately before Miss Brown's resignation, another member of the health education staff, Miss Maxwell, was given leave of absence for an academic year to study in London for a higher qualification; and several health visitors who had played important parts in health education left during the year. Consequently a great deal of strain fell on a seriously depleted team.

(7) Efforts had been made in 1960 and 1961 to develop health education in three directions apart from simple quantitative expansion: (a) to deepen and widen the scope of the teaching; (b) to stress group discussion and audience participation (or audience decision) as opposed to formal lecturing; and (c) to make greater use of ordinary members of staff in group education, and to utilise the health education lecturers primarily as organisers and consultants—planning evaluating, co-ordinating, advising and supporting rather than actually conducting meetings. In the 1962 shortages of staff, progress along the first and second of these lines probably varied from clinic to clinic.

(8) An evaluation of Aberdeen's health education is printed in full elsewhere in this report.

(9) The M.O.H. and the Health Education Lecturers prepared during 1962 a fairly detailed Guide to the Health & Welfare Services. This small handbook, produced without cost to the Corporation, should be published in the summer or early autumn of 1963.

Meetings.

The success or failure of health education rests on the extent to which it changes attitudes, not on the number of meetings held or the total of people taking part. Nevertheless the following figures are interesting.

Meetings during "office" hours.

	Meetings.	Total attendances.
(a) Prospective parents . .	822	7,507
(b) Parents	208	2,926
(c) School children . . .	33	892
(d) Miscellaneous	192	7,812
Total "day" meetings . .	1,255	19,137

Meetings outside "office" hours.

(a) Prospective parents . .	40	687
(b) Parents	68	1,959
(c) Miscellaneous	103	9,627
Total "evening" meetings .	211	12,273

Grand Totals.

The totals for six years are given below, the letter "C" indicating that there were special campaigns in a year. The rise in 1962 is the more satisfactory in that it emanates not from sporadic meetings but from systematic courses.

Year	Meetings	Audiences
1957	1,144 C	21,237 C
1958	1,089C	20,121 C
1959	1,032	20,809
1960	1,320 C	27,925 C
1961	1,249	25,595
1962	1,466	31,410

Distribution of Meetings Addressed.

Of the 1,466 meetings, 385 were addressed by the health education staff, 269 by a small group of health visitors and one medical officer, 760 by ordinary health visitors, 47 by medical officers and 5 by other members of staff.

12.—HOME AND ROAD SAFETY.

Aberdeen's work was fully described in the report for 1961. In 1962 there were no fresh developments, but merely continuation—to such extent as staffing shortages permitted—of the measures instituted in earlier years.

13.—PREVENTION OF BREAK-UP OF FAMILIES.

While many aspects of public health work, both preventive and supportive, may help to prevent the break-up of families, there are certain specific matters relating to multi-problem families which fall to be dealt with under this heading.

The Co-ordinating Committee on Neglected Children and the Case Conferences of field workers continued as before.

During 1962 there were 11 Case Conferences, and 68 separate discussions were held on the problems of 27 different families, comprising 13 new cases plus 14 under review from previous meetings. By the end of the year, out of the 27 cases dealt with at conference level, 10 had been closed (2 completely sucessful, 3 showing definite improvement, 2 cases where the children involved had been taken into care, 2 out of town and one recalcitrant case which was left with the caseworker). Of the 17 families still under review, in 5 cases there was definite improvement and in 3 other cases action had been taken with the possibility of improvement, in 8 cases there was no change in the situation and one case showed definite deterioration.

There were, in addition, 32 former cases still remaining on the files from previous years, and, as last year, the district health visitors were asked for an up-to-date report. As a result of this review, 24 of these cases were closed (6 definitely improved, 3 with possible improvement, and one left town, while 14 showed no significant change and were also left with the health visitor). This concludes the examination of all former cases, and the eight cases outstanding will be further considered at case conference level.

Mention may also be made of the innovation during the year of notifying to the Health and Welfare Department, Corporation tenants in arrears of rent, so that the district health visitor could advise on budgeting. A study of 283 such families was undertaken by the Superintendent Health Visitor and the Statistician and published in "The Medical Officer" shortly after the end of the year.

14.—VACCINATION AND IMMUNISATION.

Despite smallpox outbreaks in England and Wales and poliomyelitis out-breaks also in Scotland, Aberdeen remained free from smallpox and had only three cases of poliomyelitis. Although demands for protection against both diseases rose slightly, no special sessions had to be arranged. Aberdeen was virtually able to disregard the out-breaks—in part because of its relatively isolated geographical position, but mainly because of the adequate levels of immunity already existing. For this very satisfactory state of affairs and with no smallpox for thirty years, no diphtheria for seven years, three cases of poliomyelitis and a greatly reduced incidence of whooping cough, particular credit must be given to the health visitor for the support she has given to the vaccination and immunisation service in spite of the increased volume of work undertaken by her. She, it is, with her teaching skills and entry to the home that is far and away the most effective of all the channels of persuasion open to us.

Features of the Year.

(1) The main feature of the year was the advent of an oral poliomyelitis vaccine (given in syrup or on a sugar lump). It was issued to general practitioners and clinics from May.

(2) At the close of the year the Department decided not to introduce as yet the combined "quadruple" antigen against diphtheria, whooping cough, tetanus and poliomyelitis (because of uncertainty about adequate response from the poliomyelitis portion). It was, however, made available to general practitioners and a few commenced to use it.

(3) The proportion of pre-school children successfully vaccinated against smallpox continued at a satisfactory level. Of all children aged 1-5 years in 1962, 71.2 per cent. had been vaccinated. The following table gives the proportions by year of birth over the past three years.

Year of Birth.	Percentage Vaccinated by		
	End of 1962.	End of 1961.	End of 1960.
1961	48·2	7·1	—
1960	70·0	55·2	23·5
1959	75·8	71·4	67·2
1958	79·1	76·3	75·2
1957	82·2	80·5	80·1

(4) The proportion of pre-school children immunised against diphtheria rose from 72 per cent. in 1961 to 73 per cent. in 1962. Over the past decade this level has risen steadily from 51 per cent. in 1952 to the present figure.

(5) The number of children given a reinforcing injection against diphtheria was 25 less than in 1961.

(6) The proportion of children inoculated against whooping cough was 8 per cent. lower than the 1960 figure, which was the highest on record.

(7) The number of children given a reinforcing injection against whooping cough was the highest yet recorded being 16.8 per cent. above the 1961 figure.

(8) Of all immunisations against tetanus, recorded separately for the first time, 98 per cent. were given to children aged 0-5 years.

(9) Of all reinforcing tetanus injections given, 92 per cent. were received by pre-school children.

(10) Immunisation against poliomyelitis has now become a well established routine measure and the "campaign atmosphere" of 1959 and 1960 has died away.

By the end of 1962, of all persons under 30 years of age 75.1 per cent. had completed primary immunisation and 55.7 per cent. had received a maintenance dose.

(11) As in previous years the general practitioners undertook a smaller proportion of vaccination and immunisation than local health authority staff.

Over the past four years the proportions were:—

	1962	1961	1960	1959
(a) Vaccination against smallpox—				
General Practitioners	51%	49%	44%	47%
Local Authority Staff	49%	51%	56%	53%
(b) Primary immunisation against diphtheria—				
General Practitioners	33%	31%	26%	27%
Local Authority Staff	67%	69%	74%	73%
(c) Reinforcing injections against diphtheria—				
General Practitioners	7%	7%	6%	4%
Local Authority Staff	93%	93%	94%	96%
(d) Primary inoculation against whooping cough—				
General Practitioners	36%	35%	29%	30%
Local Authority Staff	64%	65%	71%	70%
(e) Reinforcing injections against whooping cough—				
General Practitioners	22%	29%	43%	35%
Local Authority Staff	78%	71%	57%	65%
(f) Primary inoculation against tetanus—				
General Practitioners	37%	—	—	—
Local Authority Staff	63%	—	—	—
(g) Reinforcing injections against tetanus—				
General Practitioners	22%	—	—	—
Local Authority Staff	78%	—	—	—
(h) Primary immunisation against polioymelitis—				
General Practitioners	54%	33%	15%	24%
Local Authority Staff	46%	67%	85%	76%
(i) Maintenance doses against poliomyelitis—				
General Practitioners	41%	21%	20%	29%
Local Authority Staff	59%	79%	80%	71%

(1) VACCINATION AGAINST SMALLPOX.

In the propaganda field, reliance has been placed in Aberdeen on the persuasive efforts of the local health staff, mainly through health education programmes for groups and individual teaching by health visitors in homes and clinics. As already mentioned, it was possible practically to ignore the outbreaks in other areas because the local level of vaccination was high.

Vaccination is performed either by the child's general practitioner (who receives a standard fee for notifying vaccination to the Medical Officer of Health) or by a local authority doctor at child health centres. In these clinics, primary vaccination was not undertaken until the infant had reached the second year of life in accordance with the policy adopted in 1959—a policy which was endorsed during 1962 by a recommendation issued by the Ministry of Health and the Home and Health Department for Scotland.

The primary vaccinations performed during 1962 are enumerated below. Totals for 1961, 1960, 1959 and 1958 are appended for comparison. In any comparison differing birth rates in the stated years, the change in "vaccination age" since 1959, and the smallpox outbreak this year should be borne in mind.

PRIMARY VACCINATION.

Year of Birth	Typical Reaction	No Local Reaction	Not Examined	Total
1962	171	14	...	185
1961	1,261	34	13	1,308
1960	453	14	4	471
1959	127	7	3	137
1958	74	8	1	83
1957	52	2	1	55
1956	32	2	...	34
1955 or earlier . . .	481	11	6	498
Totals for 1962 . . .	2,651	92	28	2,771
Totals for 1961 . . .	1,474	62	...	1,536
Totals for 1960 . . .	2,010	59	...	2,069
Totals for 1959 . . .	2,202	70	...	2,272
Totals for 1958 . . .	2,423	106	...	2,529

The number of revaccinations against smallpox are detailed below for the first time.

REVACCINATION.

Year of Birth	Typical Reaction	No Local Reaction	Not Examined	Total
1962	2	...	...	2
1961	8	1	...	9
1960	6	2	...	8
1959	12	...	2	14
1958	21	3	...	24
1957	23	6	7	36
1956	24	4	1	29
1955	22	3	3	28
1954	26	5	1	32
1953	19	1	4	24
1952 or earlier	3,456	256	262	3,974
TOTALS FOR 1962	3,619	281	280	4,180

The following table shows the number of primary vaccinations performed by general practitioners and local authority medical staff over the last four years and the number of revaccinations for the current year.

VACCINATION AGAINST SMALLPOX.

	Primary Vaccination				Revaccination
	1962	1961	1960	1959	1962
Number Vaccinated—					
(a) By General Practitioners	1,425	747	906	1,074	4,121
(b) By Local Authority Staff	1,346	789	1,163	1,198	59
Total . .	2,771	1,536	2,069	2,272	4,180

(2) IMMUNISATION AGAINST DIPHTHERIA, WHOOPING COUGH AND TETANUS.

It is convenient to consider protection against diphtheria, whooping cough and tetanus under one heading as the use of triple vaccine is almost universal.

Though cases of whooping cough and of tetanus still occur in the community no case of diphtheria has been notified in Aberdeen for the past seven years. The percentage of pre-school children protected against the disease mentioned remained at a satisfactorily high level during 1962. This is due, almost entirely, to the unsparing efforts made by the health visitor, both in the home and at the clinic, to persuade parents to have their children immunised. Posters and leaflets they have been found to be limited in value and cannot replace individual personal persuasion. Strenuous efforts are also made to ensure that as many children as possible receive reinforcing injections during the pre-school and early school life.

Primary and reinforcing immunisation against diphtheria, whooping cough and tetanus is performed by the child's general practitioner—a standard fee being given for each completed course notified to the Medical Officer of Health—and by local health authority doctors.

In clinics, primary immunisation is commenced when the infant reaches the age of 2-3 months and maintenance doses are given at the age of 15-24 months and again prior to school entry. In schools medical officers perform primary immunisation at the age of 5-6 years and give reinforcing doses (against diphtheria) at 5-6 years where required, and at 8-9 years of age.

The numbers of primary reinforcing injections are set out below.

PRIMARY IMMUNISATION.

Year of Birth.	Number who have completed a full course of primary immunisation against					
	Diphtheria.	Pertussis.	Tetanus.	Diphtheria and Pertussis.	Diphtheria and Tetanus.	Diphtheria Pertussis & Tetanus.
1962	—	2	—	1	4	1,012
1961	3	—	1	2	6	1,460
1960	—	—	1	—	—	120
1959	—	—	—	—	3	50
1958	—	—	—	—	4	31
1957	—	—	1	1	6	12
1956	156	—	2	—	2	3
1955 or earlier	84	—	41	1	3	3
Total	243	2	46	5	28	2,691

REINFORCING INJECTION.

Year of Birth.	Number receiving maintenance inoculations against					
	Diphtheria.	Pertussis.	Tetanus.	Diphtheria and Pertussis.	Diphtheria and Tetanus.	Diphtheria Pertussis & Tetanus.
1962	—	—	—	—	—	—
1961	—	—	—	—	1	148
1960	—	—	1	3	6	474
1959	—	—	1	1	14	235
1958	1	—	—	—	6	62
1957	3	2	4	5	152	400
1956	1,281	—	—	—	14	47
1955	6	—	3	—	3	3
1954	1	—	3	—	1	6
1953	2,372	—	6	2	4	21
1952 or earlier	20	—	18	1	2	3
Total	3,684	2	36	12	203	1,399

A more detailed breakdown of diphtheria immunisation is given in the table on next page.

Diphtheria Immunisation.

Number of children immunised each year since 1955:—

Age in years on 31st December of the corresponding year.	1955	1956	1957	1958	1959	1960	1961	1962	Total Immunised at 31st December, 1962.
Under 1 Year . . .	550	700	640	797	1,101	1,122	1,056	1,017	
1 Year	1,696	1,594	1,572	1,688	1,530	1,430	1,473	1,471	Aged under
2 Years	188	239	260	179	196	247	145	120	5 Years
3 ,, ...	76	69	74	73	83	87	60	53	11,657 (72.8%)
4 ,, ...	63	43	40	36	50	49	52	35	
5 ,, ...	153	152	125	106	47	93	91	19	Aged 5 Years
6 ,, ...	340	305	292	265	133	219	197	161	and over
7 Years and over . .	194	163	115	134	70	106	93	91	13,961
Immunisations	3,260	3,265	3,118	3,278	3,210	3,353	3,167	2,967	**Grand Total 1955—1962** 25,618
Reinforcing Injections . .	4,629	5,053	4,701	4,809	5,046	4,866	5,323	5,298	39,725

The following two tables show the number of primary inoculations and reinforcing injections completed by general practitioners and local authority medical staff during the last four years for diphtheria and whooping cough. A third table gives details of tetanus immunisation for the first time.

Diphtheria Immunisation.

	Primary Inoculations				Reinforcing Injections			
	1962	1961	1960	1959	1962	1961	1960	1959
Number Inoculated—								
(*a*) By General Practitioners	982	978	862	880	357	384	298	181
(*b*) At Child Welfare Clinics	1,745	1,856	2,107	2,106	1,282	957	416	354
(*c*) By School Health Service	240	333	384	224	3,659	3,982	4,152	4,511
Total	2,967	3,167	3,353	3,210	5,298	5,323	4,866	5,046

In 1962, the proportion of primary inoculations carried out by general practitioners, by doctors at child welfare clinics and in schools was 33 per cent., 59 per cent., and 8 per cent. respectively; the proportion of reinforcing injections undertaken by these three groups was 7 per cent., 24 per cent., and 69 per cent.

Whooping Cough Immunisation.

	Primary Inoculations.				Reinforcing Injections.			
	1962	1961	1960	1959	1962	1961	1960	1959
Number Inoculated—								
(a) By General Practitioners	978	972	858	872	306	355	274	159
(b) By Local Authority Staff	1,720	1,838	2,073	2,036	1,107	854	363	293
Total . .	2,698	2,810	2,931	2,908	1,413	1,209	637	452

In 1962, 36 per cent. of primary inoculations and 22 per cent. of reinforcing injections against whooping cough were undertaken by general practitioners.

TETANUS IMMUNISATION.

	Primary Inoculations	Reinforcing Injections
	1962	1962
Number Inoculated—		
(a) By General Practitioners	1,023	357
(b) By Local Authority Staff	1,742	1,281
Total . .	2,765	1,638

In 1962, 37 per cent. of primary inoculations and 22 per cent. of reinforcing injections against tetanus were undertaken by general practitioners.

(3) INOCULATION AGAINST POLIOMYELITIS.

By April, 1962 the Home and Health Department for Scotland had made available to local health authorities, and, through them, to general practitioners, supplies of oral poliomyelitis vaccine for the protection of persons aged 6 months to 40 years and others who were at risk. The vaccine is given in syrup or on sugar.

In the early summer there was an outbreak of cases of poliomyelitis in two of Scotland's Cities, but while demand for protection rose generally, it was not necessary in Aberdeen to organise special clinics or sessions because the population was already well protected, especially the under thirties. Only 1 case of poliomyelitis was notified during 1962, that of a non-immunised pre-school child.

As in other immunising procedures the persuasive effort of the health visitor is recognised to be the propaganda measure par excellence.

The numbers of primary courses and reinforcing doses given during 1962 are enumerated in the following tables.

PRIMARY INOCULATION.

Year of Birth	Salk Vaccine	Oral Vaccine	Total
1962	10	364	374
1961	375	1,281	1 656
1943-60	283	1,148	1,431
1933-42	206	872	1,078
Prior to 1933 and persons whose age is not known.	367	1,906	2,273
Total . .	1,241	5,571	6,812

REINFORCING DOSES.

Year of Birth	SALK VACCINE		ORAL VACCINE		TOTAL
	Third Injection	Fourth Injection	Third dose oral after two Salk.	Fourth dose oral after three Salk.	
1962	14	1	2	—	17
1961	477	7	174	5	663
1943-60	1,739	3,576	242	1,187	6,744
1933-42	705	33	119	81	938
Prior to 1933 and persons whose age is not known.	1,419	40	206	73	1,738
Total . .	4,354	3,657	743	1,346	10,100

Since the inception of anti-poliomyelitis protection in 1956 Aberdeen can show a response worthy of recording. The detailed statistics are therefore given on the next page.

The accompanying table shows the number of primary courses completed and the number of reinforcing doses given by general practitioners and local authority staff during the past three years.

POLIOMYELITIS IMMUNISATION.

	Primary Inoculation			Reinforcing Doses		
	1962	1961	1960	1962	1961	1960
Number Inoculated—						
(a) By General Practitioners	3,684	2,783	2,203	4,129	4,045	7,390
(b) By Local Authority Staff	3,128	5,735	12,667	5,971	15,102	29,564
Total . .	6,812	8,518	14,870	10,100	19,147	36,954

In 1962, 54 per cent. of primary inoculations and 41 per cent of reinforcing doses against poliomyelitis were given by general practitioners.

(4) IMMUNISATION AGAINST TUBERCULOSIS.

Protection against tuberculosis by B.C.G. vaccination is carried out, in the case of all contacts of the disease, under the direction of the Chest Physician at the City Hospital. This procedure may be performed in the maternity ward, in the home or at the Chest Clinic.

Detailed statistics of anti-poliomyelitis inoculations from 1956 to 1962 are given below.

Poliomyelitis Inoculation—Detailed Statistics 1956-62.

Year of Birth.	Estimated Population.	Number Completed Primary Inoculation.	Percentage.	Number completed three Reinforcing doses.			Percentage.	Number completed four Reinforcing doses.			Percentage.
				Salk 3 Injections.	Oral after two Salk.	Total.		Salk 4 Injections.	Oral after three Salk.	Total.	
1962	1,590	374	23·52	14	2	16	1·01	1	—	1	0·06
1961	3,191	2,158	67·63	495	174	669	20·97	7	5	12	0·38
1943-60	57,421	54,464	94·85	40,561	242	40,803	71·06	15,553	1,187	16,740	29·15
1933-42	30,066	12,309	40·94	9,790	119	9,909	32·96	33	81	114	0·38
Total	92,268	69,305	75·11	50,860	537	51,397	55·70	15,594	1,273	16,867	18·28
Prior to 1933 and persons whose age is not known	Not Estimated	14,097	—	9,056	206	9,262	—	40	73	113	—
Grand Total	—	83,402	—	59,916	743	60,659	—	15,634	1,346	16,980	—

In schools B.C.G. vaccination is offered to all pupils of 13 years of age after tuberculin skin-testing. Particulars of the work done are recorded in the "School Health Service" section of this report.

A summary of immunisation against tuberculosis is given in the section of this report dealing with Prevention of Illness, Care and After-Care.

(5) OTHER IMMUNISATIONS.

Persons going abroad to certain countries require immunisation against such diseases as typhoid, yellow fever, &c. In Aberdeen these procedures are normally undertaken at the City Hospital.

15.—CONTROL OF INFECTIOUS DISEASES.

Features of the Year.

(1) The grand total of all infectious diseases notified fell to 324 as compared with 348 in 1961, 499 in 1960 and over 2,000 ten years ago.

(2) There was a complete absence of diphtheria (for the seventh successive year).

(3) Notifications of scarlet fever fell to 10, a new low record.

(4) There were substantial decreases in acute primary pneumonia—62 cases—and acute influenzal pneumonia—1 case—in each instance the lowest number ever recorded.

(5) Only six cases of food poisoning were notified, the lowest (equal) number recorded since food poisoning became notifiable.

(6) Notifications of whooping cough and infective jaundice fell to 36 and 18 respectively.

(7) There were 3 cases of poliomyelitis, the first since 1959.

(8) There was a considerable increase in the prevalence of dysentery. 116 cases were notified.

The followng table indicates the prevalence of infectious diseases during the year.

	No. of Cases.			
	1962.	1961.	Increase	Decrease.
Cerebro-spinal fever	6	3	3	—
Chickenpox	6	5	1	—
Diphtheria	—	—	—	—
Dysentery	116	26	90	—
Erysipelas	7	15	—	8
Infective jaundice	18	24	—	6
Malaria	—	—	—	—
Ophthalmia neonatorum	—	—	—	—
Acute influenzal pneumonia	1	16	—	15
Acute primary pneumonia	62	114	—	52
Poliomyelitis	3	—	3	—

	No. of Cases. 1962.	1961.	Increase.	Decrease.
Puerperal fever	—	—	—	—
Puerperal pyrexia	—	3	—	3
Scarlet fever	10	13	—	3
Paratyphoid fever	1	—	1	—
Whooping cough	36	42	—	6
Food poisoning	6	29	—	23

Cerebro-spinal Fever.

Six cases were notified in 1962 as compared with three in 1961, three in 1960, five in 1959, nine in 1958 and five in 1957. There were two deaths in 1962.

Chickenpox.

In 1962, six cases were notified. As this disease is not compulsorily notifiable, the number of cases intimated offers no real indication of the prevalence of chickenpox in the City.

Continued Fever (Undulant).

No cases were notified during the year. No case has been reported since 1957.

Diphtheria.

For the seventh successive year, no cases were reported. A tabular statement of cases and deaths in recent years may be of interest.

	Cases.	Deaths.
1962	0	0
1961	0	0
1956 - 1960	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 reduction 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 bears 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.

Dysentery.

In 1962 there were 116 notified cases of this disease, as compared with 26 in 1961, 186 in 1960, 57 in 1959, 41 in 1958, and 328 in 1957. There were no deaths in 1962.

Encephalitis Lethargica.

No cases were notified in 1962, as compared with one case in 1961, two cases in 1960, none in 1959, 1958 or 1957.

Erysipelas.

There were 7 cases of erysipelas in 1962, as compared with 15 in 1961, 11 in 1960, 14 in 1959, 12 in 1958 and 18 in 1957. It is interesting to note that as recently as twenty years ago the annual number of cases normally exceeded 100.

Infective Jaundice.

In 1962, 18 cases were notified, as compared with 24 in 1961, 16 in 1960, 8 in 1959 and none in 1958 or 1957.

Before the Aberdeen study of infective jaundice in 1934, cases were often not reported. Since the time when that study focused attention on the disease and thereby ensured more adequate reporting, scarcely a year passed without cases. 1958, 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 has been less than four.

Leprosy.

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

Malaria.

In 1962, no case was notified as compared with none in 1961, one in 1960, two in 1959, three in 1958 and none in 1957.

Measles.

In 1962, 52 cases were notified, but the disease is not compulsorily notifiable.

Ophthalmia Neonatorum.

No cases were notified in 1962 as compared with none in 1961 and 1960, one in 1959, one in 1958 and none in 1957.

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.

1 case was notified in 1962, as compared with 16 cases in 1961, 4 cases in 1960, 152 in 1959, 2 in 1958 and 169 in 1957. There were, of course, influenza epidemics in 1957 and 1959. The 1962 case was not fatal but there were seven deaths from influenzal pneumonia in 1961, none in 1960, 11 in 1959, one in 1958 and 12 in 1957.

Pneumonia, Acute Primary.

During 1962, 62 cases were notified, and there were 7 deaths, as compared with 114 cases and 11 deaths in 1961, 181 cases and 16 deaths in 1960, 236 cases and 54 deaths in 1959, 241 cases and 15 deaths in 1958, and 221 cases and 20 deaths in 1957. During the ten years 1952-61, the annual average number of cases was 230 and the annual average number of deaths was 18. Of the 62 cases in 1962, 47 or 76 per cent. received institutional treatment.

Poliomyelitis.

Three cases, one of which was paralytic, were notified in 1962, as compared with none in 1961 and 1960, one in 1959, 10 in 1958 and 5 in 1957. There has been one death—in 1958—from this disease in the last seven years. Vaccination against poliomyelitis is mentioned elsewhere in this report.

Puerperal Fever and Puerperal Pyrexia.

In 1962, no case of puerperal fever was notified, as compared with none in 1961 and 1960, three in 1959, seven in 1958 and nine in 1957.

No case of puerperal pyrexia was notified in 1962, as compared with three cases in 1961, none in 1960, 1959 or 1958 and 2 cases in 1957.

Scarlet Fever.

In 1962, 10 cases of scarlet fever were notified as compared with 13 in 1961, 38 in 1960, and an annual average of 111 in the decennium 1952-61. There were no deaths for the fourteenth consecutive year.

Smallpox.

Aberdeen has remained free from smallpox since 1930.

Analysis of the vaccinations carried out in 1962 is given in another section of this report.

Typhoid and Paratyphoid Fevers.

One case of paratyphoid B was notified in 1962 as compared with no case of typhoid or paratyphoid fevers in 1961, 1960, 1959 and 1957. In 1958 there was an outbreak of Paratyphoid B and 25 cases were notified.

Whooping Cough.

36 cases were notified in 1962, as compared with 42 cases in 1961, 10 in 1960, 31 in 1959, 234 in 1958 and 28 in 1957. No deaths occurred in the last seven 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 clinics and at home by general practitioners.

Food Poisoning.

Under Section 22 of the Food and Drugs (Scotland) Act, 1956, food poisoning became notifiable on 1st August, 1956. In 1962, 6 cases were reported, as compared with 29 cases in 1961, 9 in 1960, 6 in 1959, 15 in 1958 and 10 in 1957.

Infections generally.

The following tables deal with the various infectious diseases. Table 1 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 treatment. In Table III, the cases and deaths are detailed for each of the years from 1952 to 1962.

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 1962.

Disease.		1962. Jan.	Feb.	Mar.	Apr.	May.	June.	July.	Aug.	Sept.	Oct.	Nov.	Dec.	Whole Year.
Cerebro-spinal Fever	Cases	—	2	—	—	2	—	—	—	1	—	1	—	6
	Deaths	—	—	—	—	*1*	—	—	—	*1*	—	—	—	*2*
Chickenpox	Cases	1	3	—	—	1	—	—	—	—	—	—	1	6
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Continued Fever (Undulant)	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Diphtheria	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Dysentery	Cases	26	3	12	1	5	2	8	6	3	6	10	34	116
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Encephalitis Lethargica	*Cases*	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Erysipelas	Cases	1	—	—	—	2	—	1	—	—	—	1	2	7
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Jaundice, Acute Infective	Cases	2	4	3	1	1	2	—	—	—	3	—	2	18
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Leprosy	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Malaria	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
*Measles	Cases	29	9	2	2	—	2	—	7	—	—	1	—	52
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Ophthalmia Neonatorum	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
Plague	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Pneumonia Acute Influenzal	Cases	—	—	1	—	—	—	—	—	—	—	—	—	1
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Pneumonia, Acute Primary	Cases	2	9	14	12	7	5	1	2	6	—	2	2	62
	Deaths	*1*	—	*1*	*1*	*2*	*1*	—	—	—	—	*1*	—	*7*
Poliomyelitis, Acute	Cases	—	—	—	—	1	1	—	—	—	1	—	—	3
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Puerperal Fever	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Puerperal Pyrexia	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
Scarlet Fever	Cases	—	5	1	—	—	—	—	—	—	3	1	—	10
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Smallpox	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Typhoid Fever	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Para-Typhoid A.	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Para-Typhoid B.	Cases	—	—	—	—	—	—	—	—	1	—	—	—	1
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Typhus Fever	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Whooping Cough	Cases	5	2	7	4	6	1	3	4	2	2	—	—	36
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Food Poisoning	Cases	—	3	—	—	1	—	—	—	1	1	—	—	6
Total	Cases	66	40	40	20	26	13	13	19	14	16	16	41	324
	Deaths	*1*	—	*1*	*1*	*3*	*1*	—	—	*1*	—	*1*	—	*9*
Influenza, excl. Influenzal Pneumonia	*Deaths*	2	—	—	—	—	—	—	—	—	—	—	—	2

*Not Compulsorily Notifiable.

Table II.—Morbidity and Mortality from Infectious Diseases (Excluding Tuberculosis) during 1962.

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	6	—	4	1	1	—	—	—	—	4	2
	Deaths	*2*	*1*	*1*	—	—	—	—	—	—	*2*	—
Chicken Pox	Cases	6	—	2	2	2	—	—	—	—	6	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Cholera	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Continued Fever (Undulant)	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Diphtheria	Cases	—	—	—	—		—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Dysentery	Cases	116	9	51	31	5	11	4	4	1	14	102
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Encephalitis Lethargica	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—		—	—	—	—	—	—	—	—	—
Erysipelas	Cases	7	—	—	—	1	—	—	3	3	4	3
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Infective Jaundice	Cases	18	—	—	12	3	2	—	1	—	4	14
	Deaths	—	—		—		—	—	—	—	—	—
Leprosy	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Malaria	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Measles	Cases	52	2	31	14	3	2	—	—	—	18	34
	Deaths	—	—	—	—		—	—	—	—	—	—
Ophthalmia Neonatorum	Cases	—	—	—	—	—	—	—	—	—	—	—
Plague	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Pneumonia, Acute Influenzal	Cases	1	1	—	—	—	—	—	—	—	—	1
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Pneumonia, Acute Primary	Cases	62	16	7	2	1	2	3	11	20	47	15
	Deaths	*7*	—	—	—	—	—	—	*5*	*2*	*5*	*2*
Poliomyelitis, Acute	Cases	3	—	1	—	—	1	1	—	—	2	1
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Puerperal Fever	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Puerperal Pyrexia	Cases	—	—	—	—	—	—	—	—	—	—	—
Scarlet Fever	Cases	10	—	6	3	1	—	—	—	—	—	10
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Smallpox	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Typhoid Fever	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Paratyphoid A	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—		—	—	—	—	—	—	—	—
Paratyphoid B	Cases	1	—	—	—	—	—	—	—	1	—	1
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Typhus Fever	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Whooping Cough	Cases	36	8	16	11	1	—	—	—	—	7	29
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Food Poisoning	Cases	6	1	1	2	—	—	1	1	—	2	4
Total	Cases	324	37	119	78	18	18	9	20	25	108	216
	Deaths	*9*	*1*	*1*	—	—	—	—	*5*	*2*	*7*	*2*

TABLE III.—MORBIDITY AND MORTALITY FROM INFECTIOUS DISEASES, INCLUDING TUBERCULOSIS, DURING EACH YEAR FROM 1952 TO 1962.

Disease.		1962	1961	1960	1959	1958	1957	1956	1955	1954	1953	1952	ANNUAL AVERAGE 1952 to 1961.
Cerebro-Spinal Fever	Cases	6	3	3	5	9	5	4	6	8	10	7	6·0
	Deaths	*2*	*0*	*2*	*1*	*0*	*0*	*0*	*0*	*1*	*0*	*0*	*0·4*
Chickenpox	Cases	6	5	0	0	8	7	8	4	11	12	48	10·3
	Deaths	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0·0*
Continued Fever (Undulant)	Cases	0	0	0	0	0	1	0	0	2	0	1	0·4
	Deaths	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0·0*
Diphtheria	Cases	0	0	0	0	0	0	0	2	0	0	3	0·5
	Deaths	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0·0*
Dysentery	Cases	116	26	186	57	41	328	100	262	129	110	14	125·3
	Deaths	*0*	*0*	*0*	*0*	*0*	*1*	*0*	*0*	*0*	*0*	*0*	*0·1*
Encephalitis Lethargica	Cases	0	1	2	0	0	0	0	0	0	0	0	0·3
	Deaths	*0*	*0*	*1*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0·1*
Erysipelas	Cases	7	15	11	14	12	18	22	18	33	27	32	20·2
	Deaths	*0*	*0*	*0*	*0*	*0*	*0*	*1*	*0*	*0*	*1*	*0*	*0·2*
Infective Jaundice	Cases	18	24	16	8	0	0	0	1	2	13	10	7·4
	Deaths	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*1*	*0·1*
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	0	1	2	3	0	1	3	1	6	2	1·9
	Deaths	*0*	*0*	*0*	*0*	*0*	*0*	*1*	*0*	*0*	*0*	*0*	*0·1*
Measles	Cases	52	57	38	39	0	64	53	351	72	247	801	172·2
	Deaths	*0*	*0*	*1*	*0*	*0*	*1*	*0*	*1*	*0*	*0*	*0*	*0·3*
Ophth. Neonatorum	Cases	0	0	0	1	1	0	0	0	0	1	0	0·3
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	1	16	4	152	2	169	17	7	23	5	18	41·3
	Deaths	*0*	*7*	*0*	*11*	*1*	*12*	*4*	*1*	*2*	*1*	*5*	*4·4*
Pneumonia, Acute Primary	Cases	62	114	181	236	241	221	217	235	294	263	301	230·3
	Deaths	*7*	*11*	*16*	*54*	*15*	*20*	*12*	*11*	*19*	*9*	*13*	*18·0*
Poliomyelitis, Acute	Cases	3	0	0	1	10	5	5	10	34	12	18	9·5
	Deaths	*0*	*0*	*0*	*0*	*1*	*0*	*0*	*0*	*1*	*1*	*1*	*0.4*
Puerperal Fever	Cases	0	0	0	3	7	9	8	5	2	26	17	7·7
	Deaths	*0*	*0*	*0*	*1*	*0*	*0*	*0*	*0*	*0*	*1*	*0*	*0·2*
Puerperal Pyrexia	Cases	0	3	0	0	0	2	2	3	10	13	13	4·6
Scarlet Fever	Cases	10	13	38	84	88	42	44	69	178	239	314	110·9
	Deaths	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0·0*
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	68	86	89	118	99	318	205	204	228	243	230	182·0
	Deaths	*4*	*9*	*9*	*12*	*13*	*10*	*18*	*15*	*19*	*26*	*36*	*16·7*
Tuberculosis, Non-Respiratory	Cases	14	10	12	15	22	20	15	24	26	31	30	20·5
	Deaths	*1*	*2*	*0*	*2*	*1*	*2*	0	*2*	*4*	*4*	*4*	*2·1*
Typhoid and Paratyphoid Fevers	Cases	1	0	0	0	25	0	4	1	16	3	10	5·9
	Deaths	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0·0*
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	36	42	10	31	234	28	9	398	284	175	549	176·0
	Deaths	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*4*	*0*	*0*	*0*	*0·4*
Influenza, excl. Influenzal Pneumonia	*Deaths*	*2*	*2*	*0*	*2*	*0*	*6*	*0*	*0*	*1*	*2*	*0*	*1·3*

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

It is convenient to divide this chapter into two portions, dealing respectively with tuberculosis and other diseases.

(A) TUBERCULOSIS.

(a) Features of the Year.

The trends during 1962 were, in general, continuations of those noted in recent years, subsequent to the Mass Radiography Campaign in 1957. There was a further substantial decline in notifications of tuberculosis to a new low total of 80, including transfers-in.

There were remarkably few deaths from this disease, only five in all in 1962, and not a single woman has died from consumption in Aberdeen in the past two years.

(b) General Outline.

The functions of the local health authority have been fully described in previous annual reports, and only a brief summary of main headings is here given:—

(i) *Contact tracing and follow-up*—done mainly by health visitors.

(ii) *Co-operation with consultants and general practitioners* in determining the need of patients for admission to hospital.

(iii) *Assisting households with a tuberculous member* to obtain adequate accommodation.

(iv) *Advice by health visitors* to persons suffering from tuberculosis and living at home.

(v) *Treatment and after-care*—to ensure that the patient on domiciliary chemotherapy follows the course of treatment conscientiously.

(vi) *Arranging, where necessary, for boarding-out of child contacts.*

(vii) *Providing beds, bedding and nursing requisites* on loan where required.

(viii) *Co-operation with Ministry of Labour* in resettlement of tuberculous persons.

(ix) *Co-operation with the voluntary after-care committee* for tuberculosis and other chest diseases.

(x) *Administration and execution of a B.C.G. vaccination scheme* in respect of school children.

(c) 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 four health visitors are employed full-time on tuberculosis work.

Such an arrangement greatly facilitates the work of co-ordination. In practice it functions smoothly and effectively, thanks largely to the painstaking efforts of the health visitors in this vitally important aspect of tuberculosis prevention and control.

(d) Mass Miniature Radiography.

The national community X-ray campaign which took place in Aberdeen in October/November, 1957, during which 126,000 adults were X-rayed with the result that some 200 hitherto unknown cases of active pulmonary tuberculosis were discovered, was undoubtedly a mile-stone on the road to the elimination of this disease.

Since it is not considered practicable, for various reasons, to repeat this particular form of blitz campaign, much consideration is now being given to devising alternative plans for the deployment of this method of case finding in the most precise and profitable manner.

(e) Examination of Contacts.

The patient's household is regarded as a unit and an endeavour is made to have all members of the family and other close contacts tuberculin tested where indicated and 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 or other contacts.

During the year under review 585 new contacts were examined out of a total of 597 due to attend (98% acceptance rate) and 459 out of 541 other contacts kept under observation from previous years were also seen (85% acceptance rate). Seven of these contacts were found to have active pulmonary tuberculosis.

(f) B.C.G. Vaccination.

The following is a copy of the return submitted to the Department of Health, giving particulars of the B.C.G. vaccinations performed in 1962.

RETURN FOR PERIOD 1ST JANUARY, 1962 TO 31ST DECEMBER, 1962.

GROUP	Tuberculin Tested		Negative Re-actors		Vaccinated during 1962	
	M.	F.	M.	F.	M.	F.
(1) Nurses	31	243	7	62	7	52
(2) Medical Students† .	65	37	34	17	—	—
(3) Contacts . . .	202	220	199	218	194	214
(4) Special Groups not included in (1) to (3) above:—						
(a) School leavers* .	1,261	1,252	992	1,026	982	1,015
(b) New born babies* .	—	—	—	—	—	—
(c) Students . .	—	—	—	—	—	—
(5) Others	36	44	6	6	3	5

†Students vaccinated early in 1963 will be included in the 1963 return.

*School children and new born babies dealt with as contacts are included in item (3).

(g) 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. During the year 183 patients received milk free of charge at a cost to the Corporation of £1,630 12s. 3d.

(h) Aberdeen Tuberculosis and Chest Diseases 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. Its work is also extended to include patients suffering from other chronic chest disease, such as chronic bronchitis and emphysema.

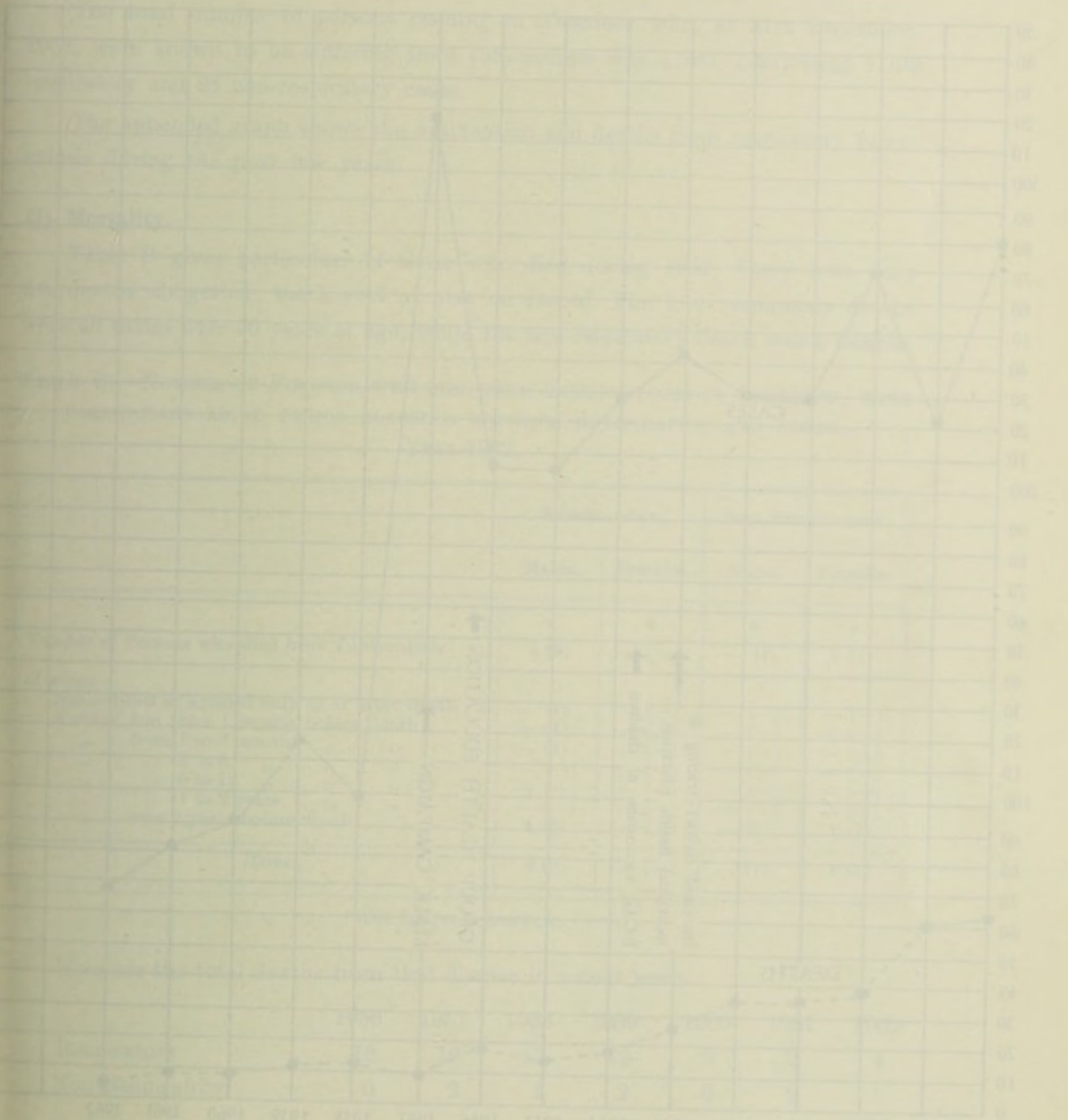
(i) Notification.

Table A below gives the number of tuberculosis cases notified during 1962 and, for comparative purposes, the figures for previous years. These are divided into respiratory and non-respiratory and arranged according to age-period and sex.

TABLE A—NUMBER OF CASES OF TUBERCULOSIS NOTIFIED IN 1962.

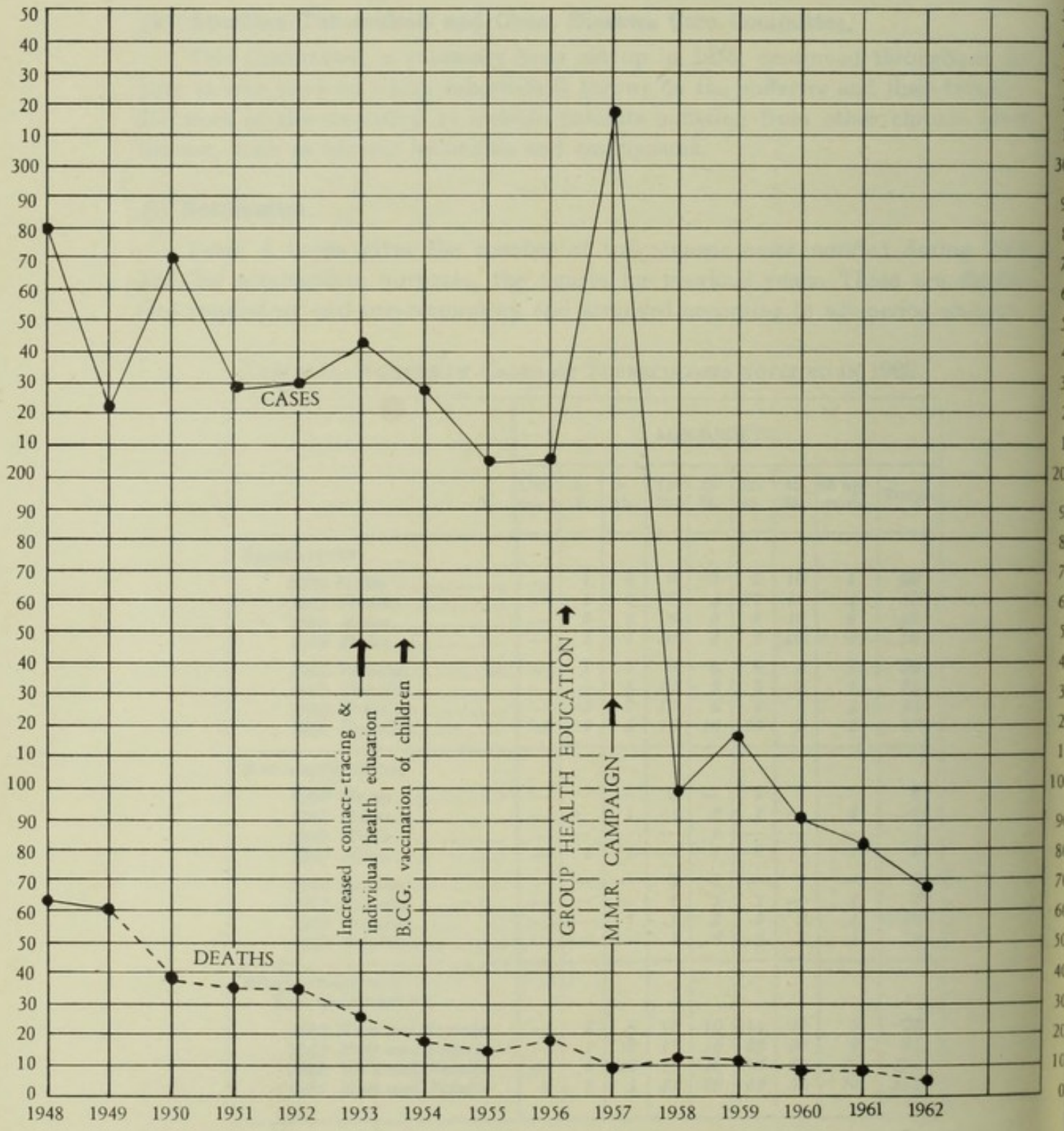
	AGE-GROUPS.								
	Under 1	1-5.	5-15.	15-25.	25-35.	35-45.	45-65.	65 upwards.	TOTAL.
RESPIRATORY.									
1962 Males	—	1	5	5	3	5	16	4	**39**
1961 Males	—	*1*	*6*	*6*	*4*	*12*	*15*	*4*	*48*
1960 Males	—	*2*	*4*	*6*	*5*	*8*	*15*	*9*	*49*
1959 Males	—	*1*	*1*	*16*	*8*	*7*	*40*	*6*	*79*
1962 Females	—	1	1	5	6	6	4	1	**24**
1961 Females	—	—	*5*	*10*	*3*	*8*	*7*	*1*	*34*
1960 Females	—	*4*	*7*	*11*	*8*	*2*	*5*	*4*	*41*
1959 Females	*2*	*1*	*2*	*14*	*16*	*12*	*9*	*2*	*58*
NON-RESPIRATORY.									
1962 Males	—	—	—	2	—	3	1	—	**6**
1961 Males	—	—	*1*	—	*2*	*1*	—	*2*	*6*
1960 Males	—	—	—	—	*1*	—	—	—	*1*
1959 Males	—	*1*	*1*	—	*1*	*2*	*2*	*1*	*8*
1962 Females	—	—	—	3	1	—	2	—	**6**
1961 Females	—	—	—	*1*	*1*	*1*	—	*2*	*6*
1960 Females	—	—	*1*	*1*	*2*	*3*	*2*	*1*	*10*
1959 Females	—	—	—	*1*	*3*	*1*	*3*	*1*	*9*
RESPIRATORY AND NON RESPIRATORY.									
1962 Male and Female	—	2	6	15	10	14	23	5	**75**
1961 Male and Female	—	*1*	*13*	*17*	*10*	*22*	*22*	*9*	*94*
1960 Male and Female	—	*6*	*12*	*18*	*16*	*13*	*22*	*14*	*101*
1959 Male and Female	*2*	*3*	*4*	*31*	*28*	*22*	*54*	*10*	*154*

There were 68 cases of respiratory tuberculosis notified (including 5 transfers) of which two were not confirmed. The 12 cases of non-respiratory tuberculosis



City of Aberdeen.

Cases and Deaths from Respiratory Tuberculosis, 1948-1962.



(including no transfers) were all confirmed, and, as regards the site of disease 6 suffered from tuberculosis of superficial glands, 3 had genito-urinary tuberculosis, and there was one case each of abdominal, bone and joint, and meningeal tuberculosis.

The total number of persons residing in Aberdeen who, at 31st December, 1962, were known to be suffering from tuberculosis was 1,793, comprising 1,705 respiratory and 88 non-respiratory cases.

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

(j) Mortality.

Table B gives particulars of those who died during 1962. There were only five deaths altogether, the lowest number on record. The four respiratory deaths were all males over 50 years of age, while the non-respiratory death was a female.

TABLE B.—NUMBER OF PERSONS WHO DIED FROM TUBERCULOSIS IN ABERDEEN, WITH PARTICULARS AS TO PERIOD ELAPSING BETWEEN NOTIFICATION AND DEATH— YEAR 1962.

	Respiratory.		Non-respiratory.	
	Males.	Females.	Males.	Females.
	*	*	*	*
Number of Persons who died from Tuberculosis .	4 (9)	— (—)	— (1)	1 (1)
of whom—				
Not notified or notified only at or after death .	— (1)	— (—)	— (—)	— (—)
Notified less than 1 month before death . .	— (1)	— (—)	— (—)	— (—)
,, from 1 to 3 months ,, ,, . .	— (1)	— (—)	— (—)	— (—)
,, ,, 3 to 6 ,, ,, ,, . .	— (—)	— (—)	— (—)	— (—)
,, ,, 6 to 12 ,, ,, ,, . .	— (—)	— (—)	— (—)	— (—)
,, ,, 1 to 2 years ,, ,, . .	— (—)	— (—)	— (—)	— (—)
,, over 2 years before death . . .	4 (6)	— (—)	— (1)	1 (1)
TOTAL	4 (9)	— (—)	— (1)	1 (1)

*1961 figures in brackets.

Here are the total deaths from that disease in recent years.

	1956	1957	1958	1959	1960	1961	1962
Respiratory . .	18	10	13	12	9	9	4
Non-Respiratory . .	0	2	1	2	0	2	1

The death rates per 1,000 of population from tuberculosis in Scotland and in the four large cities for the years 1962, 1961 and 1960 are given in the following table:—

	1962			1961			1960		
	Total	Resp.	Other	Total	Resp.	Other	Total	Resp.	Other
All Scotland .	**0·08**	0·08	0·01	**0·09**	0·08	0·01	**0·10**	0·09	0·01
Glasgow . .	**0·18**	0·18	0·01	**0·19**	0·18	0·01	**0·21**	0·19	0·01
Edinburgh .	**0·03**	0·03	0·00	**0·04**	0·03	0·01	**0·05**	0·05	0.00
Dundee .	**0·04**	0·03	0·01	**0·08**	0·06	0·02	**0·05**	0·05	0·005
Aberdeen .	**0·03**	0·02	0·01	**0·06**	0·05	0·01	**0·05**	0·05	0·00

(B) OTHER DISEASES.

Prevention.

Since prevention of disease shares with promotion of health the place of supreme importance in the work of any modern Health Department, it is not possible to discuss preventive work in a single chapter, except to say that all preventive services suffered from staffing shortages. Health education of the community, prevention of diseases by individual health counselling, prevention by specific immunisation, health maintenance of the elderly, and port health services to reduce the risk of importation of disease from overseas are considered in the chapters dealing respectively with Health Education, Health Visiting, Vaccination and Immunisation, the National Assistance Act (under which all services for old people have been grouped together as a matter of convenience) and Port Health Services.

Care and After-Care.

As was mentioned in the 1960 and 1961 Annual Reports, shortage of professional staff (particularly health visitors) has, as yet, prevented the full implementation of the duties imposed on the local health authority under the National Health Service (Scotland) Act, 1947. This state of affairs continued during 1962. Moreover, the advent of the Mental Health (Scotland) Act, 1960, aggravated the shortage of professional staff, since the Department now has much increased responsibility for the care and after-care of patients discharged from mental hospitals. Immediate hospital after-care of mental patients is undertaken by Mental After-Care Officers of the Corporation, together with their hospital colleagues, Psychiatric Social Workers. When this active after-care of a discharged mental hospital patient ceases, in most instances the district health visitor must undertake long-term, less intensive after-care and seek to prevent the future recurrence of mental illness. Care and after-care are closely linked to the prevention of mental ill health, the promotion of mental health and individual and group health education which are discussed elsewhere.

Features of the Year.

(1) After-care services for the elderly continue despite staff shortage. Hospital staff, general practitioners and district nurses refer to the Department elderly persons who, in their opinion, would benefit from home visits by health visitors, and supportive services are brought in as required. Action to initiate such services is taken either by the district health visitor or by the individual's doctor. The Deputy Superintendent Health Visitor and a Specialist Health Visitor co-ordinate the work of the district health visitors and act as a link with the geriatric hospital. Increase in the proportion of old people and staff shortages together make it impossible for the existing staff of health visitors to undertake as much after-care work as is desirable.

(2) A Specialist Health Visitor continues to attend the Royal Aberdeen Hospital for Sick Children and, with the hospital almoner, provides a valuable link between the district health visitor and the hospital.

(3) The after-care service for patients discharged from mental hospitals has continued, and was achieved by the part-time secondment to Kingseat Hospital of two health visitors (a different two every six months) in addition to the full-time mental after-care officers already based there. Staff shortages, however, militate against the full development of after-care services.

(4) A specialist health visitor is seconded full-time to the Ross Clinic where she co-operates with psychiatrist and psychiatric social worker in the after-care of mental out-patients attending that clinic.

(5) A specialist health visitor and a male health visiting officer deal with the after-care and follow-up of mentally handicapped adolescents leaving Beechwood Special School and Rubislaw Occupation Centre. The specialist health visitor also attends Woodlands Home and the Hospital Clinic held there for handicapped children and she provides a valuable link between the Regional Hospital Board and the Department.

(6) In 1959 a health visitor was attached to a three-doctor general practice to facilitate co-operation and to improve after-care work. This experiment was for one year in the first place but the trial proved to be so successful that the health visitor has continued to work with this practice. Since 1961 two other doctors in partnership who had asked for a similar linkage have had a second health visitor attached to their practice. Additionally, two health visitors attend two general practitioner ante-natal clinics.

(7) A health visitor is now attached to the Diabetic Clinic of the North-Eastern Regional Hospital Board, part-time, for the after-care of treated diabetic patients.

Owing to shortages of health visitors there is as yet no after-care service for many conditions in which it would be of value (e.g. cardiac diseases and peptic ulcer).

17.—MENTAL HEALTH SERVICES.

Features of the Year (and of 1961).

1962 and the adjacent portions of 1961 and 1963 can be regarded either as two years of passivity in mental health or as two years of prolonged consideration as a preliminary to initiation of measures aimed at improving the pre-existing mental health services. The main features of the period were (a) formal submission to the Secretary of State of a scheme on the lines demanded by the Mental Health Act, 1960; (b) redesignation of certain specialist health visitors as mental after-care officers; (c) gradual decrease in existing mental health services (especially preventive services) in consequence of staffing shortages, further duties in mental and other fields, and increase in various population groups; and (d) submission to the Health and Welfare Committee of a series of reports by the Medical Officer of Health and deferral of decision on the recommendations in these reports.

Background Features.

To appreciate the significance of the two years of passivity or prolonged consideration it is important to realise that many significant developments in mental health services had taken place in Aberdeen in the period 1954-60.

(a) *Staff education in mental health.*

Staff education is mentioned first, because neither preventive nor supportive services can function without properly equipped staff.

(1) Basic training.—While the Corporation is not responsible for the training of medical and nursing students, the psychosocial elements in these trainings increased considerably in the later 1950s.

(2) Post-graduate training.—In the course for student health visitors the Aberdeen Training School played a leading part in the period 1954-60 in curtailing to the minimum education in environmental hygiene (in respect of which the students should have adequate knowledge and skill from their previous trainings) and in placing more and more emphasis on psychology, mental health and human relations. To a limited extent the D.P.H. course at Aberdeen University shared in the same trend.

(3) Further training.—As early as 1954 prolonged "refresher" courses were arranged for health visitors at the H.V. Training School, the courses being organised and co-ordinated by the health visitor tutors, while the teaching staff included psychologists, psychiatrists, the M.O.H. and the health visitor tutors. These courses, which to a very considerable extent served as a model for other areas, had to be discontinued for three reasons:—(I) With the extension of the course for student health visitors the Training School was crammed to capacity and no accommodation was available for an additional course. (II) Even if there had been accommodation the frequently recurring shortages of H.V. Tutors would have made addional courses impossible: the Annual Report for 1961 pointed out that only once had there been a period of twelve months in which the Training

School was fully staffed; and by the summer of 1962 there was again a vacancy (which still exists in May of 1963). (III) Even if there had been sufficient health visitor tutors in post, increasing duties falling on a relatively static number of health visitors would have made it very difficult to release health visitors to attend any considerable course.

(4) Advanced training.—From 1957 the Corporation has several times seconded outstanding health visitors to take a year's further training in London. Also from the inception of the seven months course in mental health for selected health visitors at Glasgow University the Corporation has each year seconded a health visitor (and in one year two health visitors) to take this very useful training.

(5) Shorter courses.—In 1961 the Corporation seconded its Senior Medical Officer for mental health to attend a one month's course at Glasgow University, and it has from time to time seconded medical officers, health visitor tutors, superintendent health visitors and health visitors to attend shorter refresher courses.

(6) From time to time study days and study week-ends have been organised in Aberdeen.

(b) *Promotion of mental health and prevention of mental illness.*

(1) From the time of the first long refresher course on mental health and from the time of the last increases in the health visiting establishment (both in 1954) the family health visitors devoted considerable portions of their professional time to promotion of mental health and prevention of neglect of children, broken homes, maladjustment, delinquency, psychosomatic diseases, neurosis and anti-social behaviour. By reason of new duties outside the mental health field and increasing numbers of children and old people, the quantity—and perhaps also the quality—of preventive work has tended to decrease in the last two years or so.

(2) From 1956 group health education (largely slanted towards mental health) was undertaken on a very considerable scale. Aberdeen's not inconsiderable success in health education, especially its psychosocial facets, has led to—(a) an almost embarrassing number of visitors from other countries or other areas seeking to study the health education unit in action—the most remarkable period being six weeks in 1960 during which the unit was visited by experts from Europe, Asia, America, Africa and Australia; and (b) a plethora of requests to the M.O.H., the Principal Health Education Lecturer and other members of staff to take part in post-graduate refresher courses in other areas and to produce articles for professional journals. In recent years not only have many of these requests had to be refused (because of shortage of health education lecturers in post) but there has been an inevitable reduction in the psycho-social component of our group health education: if a fairly inexperienced doctor or health visitor has to confront an audience with little or no previous guidance or support from persons of experience in health education, the doctor or health visitor tends to

give a straight talk on physical topic (e.g. "the prevention of tuberculosis" or "postural defects in children") rather than to lead a discussion or series of discussions on, say, causes of aggressive behaviour in children and methods of coping with such behaviour.

(3) A sustained attempt was made to re-orientate the outlook of medical officers at child welfare clinics, replacing the old concentration on the physical with more appreciation of the constant inter-action of body and mind. As one experiment in this direction it was arranged that a medical officer should work half-time in the local authority field and half-time in a mental hospital, but the particular experiment was not wholly successful and was ultimately discontinued.

(4) The school health service has been increasingly geared to mental health in the last three or four years, and the work of Dr. Younie (Senior Assistant M.O.) deserves special mention.

(5) Appreciation that men as well as women would be required for skilled work in fostering mental health, the Corporation decided in 1960 to initiate (in 1961) the first course of training in Britain for male nurses aspiring to a health teaching and social counselling career similar to that of female health visitors. The experiment has already proved very successful.

(c) *Administration of mental services.*

By 1958 and the beginning of 1959 the administrative position could be thus summarised—(1) The M.O.H. had a particular interest in mental health and had some claim (e.g. from selection as one of three representatives of the United Kingdom at an international seminar) to expertise, but, in a large department combining health, social welfare, school health and port health functions, could not personally undertake the administration of what promised to become one of the major sections of the Department's work. (2) While the administrative control and development of group health education (with a very large psychological component) could safely be left to the Principal Health Education Lecturer (who had established an international reputation in this field) and while the expansion of the school health service (again with a large psychosocial component) could well be left to Dr. Younie (Senior Assistant M.O.) whose expertise in mental health was widely recognised, neither of these acknowledged pioneers in mental health had time to take control of other parts of the developing mental health services: indeed both officers would be increasingly preoccupied with the organisation and administration of their own fields. (3) Although the Prinicipal Assistant M.O. (Dr. Wallace) had for some years successfully combined certain administrative responsibilities in mental health with other duties, these other duties were steadily expanding, and it would be unreasonable to ask him also to take charge of developing services for support and after-care. (4) The Superintendent Health Visitor, with a considerable interest in mental health-promotion and mental after-care, was nevertheless the head of a very large and extremely efficient section with extending duties, and it would again be unreasonable to ask her to take

charge of all services for after-care and support. Accordingly in 1959 the Corporation created, at the request of the M.O.H., a new post of Senior Assistant M.O. with duties primarily in the organisation, control and administration of mental health services. Dr. Rae was appointed to this post and soon began to prove his worth and to establish a reputation that bids fair to equal those of the other persons mentioned above.

(d) *After-Care Services.*

In 1958 a specialist health visitor (Miss Cheyne) was based on Kingseat Hospital for care and after-care services. In 1959 and 1960 additional specialist health visitors were employed on this work and a start was made with the follow-up of handicapped adolescents leaving the special school. Subsequently the officers involved were re-designated Mental After-Care Officers.

(e) *Occupation Centre for Mentally Handicapped Adults.*

As early as 1957 the Corporation had prepared proposals, but after a public enquiry and considerable delay the proposed site was rejected by the Secretary of State in 1961; and no other suitable site was at first found.

(f) *Co-operation.*

In 1960 the Professor of Psychiatry and the M.O.H. jointly invited representatives of various services to form a local study group to foster co-operation in the mental health services. The Study Group, with Professor Millar as chairman and Dr. Rae as secretary, met frequently and in due course produced a very useful unanimous report, the recommendations of which were very much in line with those in the series of reports mentioned below.

These points about the background are deliberately set down here, because otherwise the "two years of inactivity" would have an entirely different meaning. It is important in considering that "inactivity" to realise that (although mental health services decreased a bit in 1961 and 1962) Aberdeen already had considerable services before 1961 and several members of staff had established national or in some cases international reputations in the mental health field.

The Series of Reports.

(1) Following the issue of Circular 75/1960 (dealing specifically with prevention and after-care) the M.O.H. presented a report, dated 12th September, 1961, recommending—

(a) for prevention—appointment of two additional clinic assistants (to free some health visiting time);
(b) for health promotion and staff education—appointment of an additional full-time health education lecturer with increase of salaries (to enable the new post and an existing vacancy to be filled);
(c) for after-care—appointment of six mental after-care officers;
(d) for welfare functions—appointment of one additional assistant welfare officer; and
(e) for clerical duties—appointment of two extra female clerks.

(2) The Health and Welfare Committee requested further information, and the M.O.H. produced a supplementary report, dated 8th November, 1961. In respect of the officer for advanced health education work this report outlined her duties (including organising and in part conducting further courses for health visitors, midwives and welfare officers, and taking part in health education of the public) and expressed agreement with a suggestion (attributed by the local press to the convener) that the new post should be inserted at the top of the existing posts, with the designation Director of Advanced Nursing Education and Health Education. The report also outlined the duties to be undertaken by the Mental After-Care Officers and by the additional assistant welfare officer.

The Committee accepted the six after-care officers, the officer for advanced health and staff education work and one clerk, but not the other recommendations. The Finance Committee reduced the number of after-care officers to four (though they were later again raised to six) and returned the question of the officer for advanced education to the Health and Welfare Committee for clarification of the post.

(3) On 9th January, 1962, the M.O.H. reported on the two concepts of the advanced education post, recommended a designation and a salary, suggested one consequential change of designation in an existing post, and pointed out that

> "Since the Committee did not see fit, for the present, to accept the other preventive measure advocated in my report of 12th September, the appointment now under consideration will constitute the Corporation's sole action in respect of the direction by the Secretary of State to make arrangements for the prevention of mental disorder."

However, the Mental Health Sub-Committee on 2nd February, decided by a majority to defer consideration of the officer for staff education.

(4) By this time Circular 38/1961 had been issued, and the Health and Welfare Committee asked for a comprehensive report on mental health requirements. On 24th January, 1962, the M.O.H. produced a detailed report (nine pages plus and appendix) containing *inter alia* the following recommendations:—(A) To complete arrangements under Circular 75/1960—(1) determine status, designation and remuneration of Director of Advanced Nursing Education and Health Education; (2) alter as required the designations of the other health education lecturers and determine salary increases necessary to provide reasonable stability of staff; (3) adjust salaries of mental after-care officers; (4) deal with the long-delayed appointment of group adviser health visitors; (5) in due course provide accommodation for advanced courses for health visitors, midwives, &c.; (6) in due course increase establishments of after-care officers, health visitors and assisting grades; and (7) in due course make advanced courses available to adjacent authorities, thereby recovering part of the extra cost. (B) For administration and planning—(1) determine the designation and salary of a senior member of the medical staff, since he and the proposed Director of Advanced Nursing Education will both be involved in the planning arrangements; and (2) subsequently decide as to additional numbers of other staff (lay administrators, mental health

officers, clerical staff) required, (C) For services for the mentally handicapped—to facilitate planning it would be helpful if the Committee could indicate whether (after staff education, prevention and after-care—under (A)) it agrees that a senior occupation centre and a day nursery for mentally handicapped children are the highest priorities.

(5) The Committee ultimately decided that it would start with the post mentioned in (4) (B) (1) above, i.e. the senior member of the medical staff. A decision was taken in November, 1962, to appoint a Junior Depute M.O.H. largely for mental health work, and in April, 1963, Dr. Rae (formerly Senior Assistant M.O. engaged largely on mental health duties) was appointed. Decision on most of the other recommendations has not yet been taken.

The Present Position.

To bring the story up-to-date (although going beyond the limits of 1962) the position may be thus summarised.

(1) Dr. Rae was translated from Senior Assistant M.O. to Junior Deputy M.O.H. in April, 1963.

(2) As already indicated decision on most of the recommendations has still to be taken.

(3) The rise in status of the senior person handling mental health services may well prove useful in many respects.

(4) Nevertheless that rise has the defect of appearing to convert Senior Assistant Medical Officer posts in other specialities in Aberdeen into "blind alley" jobs. In particular the Senior Assistant M.O. for Child Welfare decided to move to another area, and at the time of compilation of this Report applications for the two vacant senior medical posts do not appear to be forthcoming.

The Mental Health Services.

(1) *Duties.*

The Corporation's duties include—promotion of mental health; prevention of mental disease; ascertainment, care and after-care of mentally handicapped and mentally ill persons in their own homes; and provision of suitable training and occupation for the mentally handicapped over the age of 16 years and for the ineducable mentally handicapped under that age.

(2) *Staff Employed.*

(a) *Medical Officers.*—Numerous duties in prevention, ascertainment, supervision, and after-care devolve on the Corporation's four Responsible Medical Officers and on other medical officers of the Health and Welfare Department, most of whom hold the post-graduate certificate in mental assessment.

(b) *Psychiatric Social Workers.*—The Corporation has not so far sought to appoint any psychiatric social workers, and—apart from these being in short supply—it may be that their training equips them for hospital rather than for

local authority work, and that it is better to give selected health visitors additional training in mental illness than to give selected psychiatric social workers additional training on the problems of ordinary households and the techniques of handling persons who are not ill.

(c) *Mental After-Care Officers.*—There are at present four Mental After-Care Officers (i.e. health visitors with further qualifications) employed. Two are based full-time at Kingseat Hospital; a third After-Care Officer and a Male Health Visiting Officer deal largely with the after-care of mentally handicapped adolescents, though the former also attends Woodlands Home and the Regional Hospital Board Clinic held there. Two health visitors now work part-time from Kingseat Hospital, and the fourth Mental After-Care Officer works full-time from the Ross Clinic on the care and after-care of mental out-patients.

(d) *Health Visitors.*—Very extensive duties in respect of prevention of emotional and mental diseases, care and after-care, devolve on the district health visitors. Their role as the general purpose qualified professional workers for both preventive and social duties is increasingly appreciated.

(e) *Other Mental Health Workers.*—One male health visiting officer is now employed full-time on mental health duties.

(f) *Mental Health Officers.*—Four mental health officers carry out certain statutory duties. They correspond to the authorised officers under previous legislation and continue their long-established function of setting in motion the procedure for compulsory admission to hospital, or reception into guardianship when the patient's relatives are unable or unwilling to take appropriate action. In addition, they assist relatives when recommended patients (and occasionally informal patients) are admitted to hospital. These officers hold dual appointment as Assistant Welfare Officer under the National Assistance Act provisions and Mental Health Officer.

(g) *Occupation Centre Supervisors, &c.*—As yet none is employed. (The Corporation has still been unsuccessful in attempts to secure premises for a Senior Occupation Centre for the mentally handicapped.)

(4) *Co-ordination.*

Close liaison is maintained with the North-Eastern Regional Hospital Board and with the Board of Management for the Mental Hospitals, and reference has been made to the work of the Mental Health Study Group, which may, in the future, bring together, for the purposes of discussion of common problems, various officials from different bodies concerned with mental health and mental after-care.

In respect of a hostel for ex-patients, administered by the Hospital Board, the Corporation makes a financial contribution and provides the services of a health visitor for social work.

(5) *Duties delegated to Voluntary Associations.*

No duties in relation to mental cases have been delegated to any voluntary associations.

(6) *Training of Staff.*

Arrangements made have included (a) the provision of post-qualification courses in mental health for health visitors (temporarily in abeyance), (b) sending of staff to advanced courses, and (c) the occasional sending of senior medical and health visiting officers to short refresher courses on mental health. In the main, however, arrangements for training are still for future consideration.

Amount of Work Undertaken.

(1) Under Section 27 of the National Health Service (Scotland) Act, 1947.

(a) *Measures for prevention of Mental Illness.*

(i) *Health Education by Health Visitors and by Departmental Medical Officers.*

This has for some years constituted a considerable part of the Department's health education work. As more and more physical diseases are conquered, proportionately more attention is focussed on mental health.

The particular importance of the preventive and social role of the family health visitor—an expert in normality, skilled in the art of persuasion, and recognised by the family as a health counsellor and social advisor—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 77/1954, and various subsequent documents; and her positive role in inculcating sound attitudes and in helping to reduce tensions to bearable limits is even more important.

(ii) *Attempts to assist families placed in situations of abnormal physical, mental or financial strain.*

For households under physical strain, help is available (as indicated elsewhere). Physical strain on parents is frequently relieved by the admission of young children to day or (less often) to residential nurseries. Financial strain is often relieved by the same means, the mother being enabled to work for a time to obtain sufficient money to pay off debts. Health visitors give much useful advice and guidance on family budgeting and on general domestic problems; and there is good liaison with the National Assistance Board and with various voluntary societies.

Another factor of assistance to families in situations of abnormal strain is the existence of a Joint Committee to consider children neglected in their own homes. This Committee, by co-ordinating the efforts of health visitors and school health visitors, school welfare officers, the National Society for the Prevention of Cruelty to Children, the National Assistance Board, and so on, as well as bodies like the Aberdeen Association 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. Quite equally important is the Case Conference of field workers—mentioned in the section on prevention of broken homes.

(b) *Care and After-Care of the Mentally Ill and the Mentally Handicapped.*

Patients released from hospitals for the mentally ill are visited regularly by mental after-care officers. A guide to the extent of after-care work during 1962 is that 3,075 visits were made during the year by staff engaged on mental health duties. These visits are often as time-consuming as those made to the elderly by health visiting staff.

Those under guardianship—mentally ill or mentally handicapped patients—are supervised by the responsible medical officers and the mental health officers of the department.

Although the Regional Hospital Board is increasing its accommodation there are still not nearly enough institutional places for mentally handicapped persons requiring institutional care and supervision; and there is also a grave and very urgent need for a Senior Occupation Centre for the mentally handicapped living at home and for a special day nursery for mentally handicapped children up to the age of five years.

(2) Under the Mental Health (Scotland) Act, 1960.

(i) The work undertaken by After-Care Officers, Health Visitors, &c. is discussed elsewhere.

(ii) Work undertaken by Mental Health Officers includes simple guidance on budgeting and general domestic problems; reference to psychiatric clinic to secure early treatment; close liaison with general medical practitioners, psychiatric specialists, health visitors and other departments to ensure help of any nature required for mentally disordered persons; completing and negotiating claims for all types of statutory benefits; ensuring adequate protection for property prior to admission to hospital and throughout any period of hospitalisation; and ensuring the proper care and supervision of all patients boarded out under guardianship or leave of absence from hospital.

The following is a short statement of the cases dealt with during the year:—

Number of Mental Cases dealt with during the period from 1/1/1962 *to* 31/5/1962, *in terms of the Ninth 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	8	18	26
Cases admitted as informal patients, following medical examination	36	42	78
Cases where no action was recommended following medical examination	—	1	1
	44	61	105

Number of Mental Cases dealt with during the period 1/6/1962 *to* 31/12/1962 *in terms of the Mental Health (Scotland) Act*, 1960:—

	Males.	Females.	Total.
Recommended Cases where a Mental Health Officer had to act in the absence of, or on behalf of relatives .	2	5	7
Recommended Cases where a Mental Health Officer had to assist relatives with the application to the Sheriff .	6	13	19
Informal Cases where a Mental Health Officer had to give assistance initially	2	6	8
	10	24	34

Since the 1st of June, 1962, the admissions of informal cases to mental hospital do not require to be notified to the Corporation's Mental Health Officers unless specific assistance is requested with such cases.

In addition to the above figures, assistance has been given freely by the Mental Health Officers, within the spirit of the new Mental Health Act, to the Physician Superintendents and Consultant Psychiatrists, in many ways (e.g. helping to trace nearest relatives).

Number of patients on probation from mental hospitals under supervision between between 1/1/1962 *and* 31/5/1962:—

Males.	Females.	Total.
6	11	17

Number of mental patients boarded-out from mental hospitals under care and supervision by the department between 1/1/1962 *and* 31/5/1962:—

Males.	Females.	Total.
3	1	4

Number of patients on licence from certified institutions, under care and supervision by the department between 1/1/1962 *and* 31/5/1962:—

Males.	Females.	Total.
2	—	2

Number of patients on leave of absence from hospital, under care and supervision by the department between 1/6/1962 *and* 31/12/1962:—

Males.	Females.	Total.
2	—	2

Number of reports to Physician Superintendents between 1/1/1962 *and* 31/5/1962, *on home conditions prior to release of patients on probation, in terms of the Ninth Schedule of the National Health Service (Scotland) Act*, 1947:—

Males.	Females.	Total.
3	—	3

The Mental Health (Scotland) Act, 1960, became fully operative on 1st June, 1962, the first six months being an "initial period" during which certified patients already under guardianship remained subject to guardianship. During that period

the condition and circumstances of all such patients were reviewed, and classifications were made as prescribed in the Act, in order that authority for guardianship might be continued.

This transfer of patients was effected smoothly and without difficulty. All major statutory documentation relating to these patients is now dealt with directly by the Health and Welfare Department instead of, as formerly, by the Board of Control.

Patients under guardianship are now being visited in accordance with the terms of the Mental Health (Guardianship) (Scotland) Regulations, 1962, and no particular problems arose during the year.

Mental Deficiency and Lunacy (Scotland) Acts, 1913-40, *and Mental Health (Scotland) Act*, 1960:—

	Males.	Females.	Total
Number of cases reported by the Education Department during the period 1/1/1962 to 31/12/1962 . . .	8	11	19
There were no admissions of informal patients to certified institutions during the period 1/1/1962 to 31/5/1962	—	—	—
Number of patients under guardianship as at 31/12/1962:—			
In the City	11	5	16
In the County	9	4	13

At the end of 1962, there were 52 mentally handicapped persons in the City awaiting admission to suitable hospitals, i.e. Woodlands Home, Cults, and Ladysbridge Hospital, Banff. Certain of the patients on the waiting list are for short term care.

Number of reports to the General Board of Control, Edinburgh, during the period 1/1/1962 *to* 31/5/1962, *on parental home circumstances where statutory revision of Detention Order fell due.*

Males.	Females.	Total.
8	4	12

18.—SERVICES UNDER NATIONAL ASSISTANCE ACT, 1948, &c.

While this chapter should strictly include only services for the Physically Handicapped and Welfare Services for the Elderly, it is not easy to divide into portions the various services provided to maintain the physical and mental health and the social well-being of veterans. For this reason, all services for the elderly are included here as a matter of convenience.

Features of the Year.

(1) Local Authority services for the aged continued to expand during 1962 with two exceptions—Health Visiting to veterans and the Home Nursing of the aged.

(2) The number of old people visited by health visitors fell in 1962, and the average number of visits dropped from 5.9 to 4.4 per person visited. There are now 932 unvisited veterans on the register. These reductions are a consequence

of (a) more duties falling on the same number of health visitors, and (b) improved annual leave without any compensatory increase in staff.

(3) The increase in the Home Help Service, Meals on Wheels Service and the Chiropody Service are consistent with the increasing frailness of an ageing population and it is expected that this trend will continue. At the time of writing, the Chiropody Service is severely hampered by the fact that, temporarily, there are no full-time chiropodists on the establishment of the Department. If applicants cannot be attracted to fill these vacancies this very valuable service will obviously suffer severely.

(4) The value of the Old People's Register has been emphasised in previous reports and the numbers on this register continue to increase.

(5) The Corporation's eighth hostel—Rosewell House—was opened in the autumn. This 36 bedded Home contains two 4-bedded wards for the frail aged who require more care than is ordinarily given in an Old People's Home but who are not so frail as to require geriatric hospital care. Lessons learned in the running of previous Homes have been applied in the construction of Rosewell House which features ample lounge accommodation, single bedrooms and kitchenettes, where residents may prepare tea for themselves and their friends.

(6) The waiting list for Old People's Homes has undergone reorganisation during 1962, for administrative convenience, and now a separate list is maintained for those applicants who are temporarily in hospital but who are waiting admission to an Old People's Home. This change has one disadvantage in that it is more difficult to compare the figures on the waiting list for the end of 1962 with those for the end of 1961.

(7) The Aberdeen Scheme for Physically Handicapped Persons has continued to thrive. The Occupational Therapy Workshop, which was opened in 1959, has proved to be of great benefit to the handicapped.

(8) There were no major alterations in Services for the Blind and the Deaf during 1962.

(9) The findings of a Medico-Social Survey of residents of Local Authority and Voluntary Homes, carried out by Dr. W. J. W. Rae, Senior Assistant Medical Officer, and Assisted by a Research Grant from the Scottish Advisory Committee on Medical Research, were published during 1962 in "The Medical Officer".

(10) The current shortage of geriatric hospital beds is becoming more acute. In the latter half of 1962 it had become practically impossible to admit a resident of an Old People's Home for geriatric hospital treatment without first taking a rehabilitated case from that hospital to free a bed for the person to be admitted. This does not occur with other hospitals in the area and such exchanges deprive the elderly of the knowledge that a place is waiting for them on recovery from illness. Additionally, rehabilitated exchange cases may not have been long on the waiting list for admission to a Home.

SERVICES FOR THE ELDERLY.

Provision of Accommodation for Elderly, &c.

By the end of 1962 the Corporation were providing 291 places in eight Old People's Homes, consequent upon the opening of Rosewell House during the year. In addition the Corporation contributes to the maintenance of 32 people in other homes.

At 31st December, 1962, the number of aged and infirm persons maintained in residential accommodation was:—

Opened.	Homes.	Male.	Female.	Total.
Local Authority Homes—				
1950	Balnagask House (26 beds)	11	13	24
1951-53	Ferryhill Home (24 beds)	7	14	21
1953	Northfield Lodge (40 beds)	9	30	39
1954	Albyn Home (24 beds)	7	16	23
1955	Newhills Home (59 beds)	29	30	59
1955	Polmuir Home (32 beds)	12	20	32
1958	Thorngrove Home (50 beds)	8	39	47
1962	Rosewell House (36 beds)	8	26	34
Voluntary Homes—				
	Aberdeen Old People's Welfare Council	5	15	20
	Church Homes	4	3	7
	St. Margaret's Hostel	—	7	7
	British Legion Village, Maidstone, Hert.	1	—	1
	Local Authority Homes in other areas	2	—	2
		103	213	316

The above figures do not include residents, temporarily in hospital, whose places in the Homes are reserved for a period pending their return.

The total 316 compares with 283 at the end of 1961. At the end of the year 9 residents were in hospital and one place was reserved for a resident temporarily away from a home.

During the year there were 190 admissions to Local Authority Homes—118 new admissions, 18 transfers between Homes, 23 for holiday periods, and 31 readmissions from hospital. There were 10 admissions to Voluntary Homes.

Waiting List for Admission to Old People's Hostels.

The administration and maintenance of this waiting list has been fully described in previous reports.

At the end of 1962, 69 old people (24 males and 45 females) were on the urgent waiting list for admission to a Home; 51 other applicants were in hospital (16 males and and 35 females); and the non-urgent list totalled 122 old people (29 males and 93 females).

The number of applicants continues to increase and by the end of 1962 there were 242 old people on all branches of the waiting list compared with 190 on the waiting list at the end of 1961.

The provision of accommodation for the elderly is a developing field and the provision of two or three more old people's homes will do little to meet this increasing problem. The three possibilities would appear to be (a) the construction of larger homes (which would inevitably be institutional in nature); (b) the provision of a large number of flatlets centrally heated and with a warden service (which would be expensive); and (c) a massive increase in the Home Help Service (the economics of which would be open to doubt as it is obviously cheaper financially to maintain a group of people under one roof with a small staff caring for them). The choice is not an easy one.

Old People's Hostels.

No major change has occurred during the year in the method of administration of these Hostels.

Cottages for the Elderly.

The Corporation continues to provide special purpose houses for elderly couples as a feature of its housing schemes.

In the grounds of Balnagask Home, 14 special purpose houses for the aged are centrally heated from the adjoining Old People's Home, and a warden service is available to help the old folk in cases of emergency. Emergency bells have been fitted between these special purpose houses and Balnagask Home. A similar scheme is being constructed in the grounds of Thorngrove Home.

Supportive and Preventive Services for the Elderly.

Measures for the health and welfare of the elderly in their own homes include:—

1. *Visitation of the elderly by Health Visitors.*

The health visitor advises the whole family on matters of physical, mental and emotional health, and an increasing proportion of her work is now devoted to the care of the elderly. She advises on diet, clothing, proper balance of rest and exercise and psychological problems, and about the development of leasure interests in preparation for retirement. When an old person is beginning to require material assistance (e.g. a home help, mobile meals service, or chiropody) the family health visitor assesses the need and initiates any necessary action. During 1962 the health visitors paid a total of 12,359 visits to 2,818 elderly persons (compared with 15,720 visits to 3,337 veterans during 1961). The significance of these figures has already been discussed.

2. *Home Help Service.*

In 1962, 1,440 households of persons of pensionable age received assistance from the Home Help Service compared with 1,346 households in 1961. With the increase in the number of elderly citizens in the community has come a rise in the number of frail elderly persons. Some further expansion of the Home Help Service will be required in the future.

3. *Home Nursing Service.*

Details of the Home Nursing Service for 1962 are as follows:—

	Total—All ages.	Total of pensionable age.	Total of pensionable age (1961).
No. of patients attended—Day Nursing Service .	3,840	2,243	(2,294)
No. of patients attended—Night Nursing Service	301	225	(250)
Total number of patients attended—Day and Night Nursing Service	4,141	2,468	(2,544)

4. *Meals on Wheels Service.*

This service is run by the W.V.S. and subsidised by the Corporation by paying a proportion of the cost of the meals supplied during the year. Eighty-nine old people and four physically handicapped persons received 7,813 meals during 1962. (7,286 meals were supplied during 1961).

5. *Chiropody Services.*

This very beneficial service again showed expansion during the year. A total of 3,303 old persons (2,856 in 1961) living at home received chiropody treatment, 1,991 of them at the clinic and 1,312 in their own homes. In addition, 264 persons (242 in 1961) were receiving treatment while resident in Old People's Hostels.

6. *Register of Old Persons.*

The register is valuable for the co-ordination of services for old people, the assessment of needs of the aged and the follow-up of cases. During 1962, 937 names were added and, by the end of the year, after adjusting for deaths and movements from the district, the register stood at a total of 4,101 elderly persons, compared with 3,590 in 1961.

Physically Handicapped Adults.

(i) *Domiciliary Arrangements.*—Aberdeen's scheme for physically handicapped persons has now been in operation for nine years. There are at present 451 persons on the register (compared with 436 in 1961). A proportion were registered following discharge from hospital. There has been little change in the pattern of home visitation; special cases require more intensive visiting, but the advisory service has been maintained for all, by assessment of needs in the widest possible sense, and by helping patients to use their residual ability.

The Corporation's holiday scheme, which began in 1959, has proved most beneficial and the help received has been appreciated by the patients and their families. One of the local voluntary associations also financed holidays for several disabled people who were recommended by the local authority.

The need for ground floor accommodation has not lessened, and physically handicapped single persons have found it virtually impossible to obtain suitable housing accommodation unless they have been due for rehousing as a result of demolition of their former accommodation. Many adaptations have been made to patients' homes in order to increase their independence.

The arrangements with the Royal Aberdeen Asylum for the Blind, whereby a certain number of severely disabled, sighted persons receive training and are later given employment, has continued. By the end of 1962, 18 such people were either training or employed under this scheme, 4 more had actually begun training but had been unable to continue with it for various reasons. The vacancies available continue to be only for males.

Close liaison has been maintained with other interested people and organisations.

(ii) *Occupational Therapy Workshop.*—During the year fifty patients attended the Workshop, eighteen being female and thirty-two male. There were five deaths, one patient progressed to paid employment (at Remploy), and one suceeded in obtaining temporary employment work during the summer months.

Several have been interviewed by the Disablement Resettlement Officer and they are encouraged to attend as often as possible with a view to increasing their fitness for any vacancy which may occur.

The making of bulky articles is avoided because of problems of space. The mainstay, as before, is wirework, jewellery, leatherwork; cane and mosaic work also find a place.

In November the Occupational Therapist had the opportunity of addressing the members of the Rotary Club.

Social evenings continued to be popular despite television and inclement weather. Thus in mid-January twenty people turned out for a social evening while the Christmas Party brought thirty people to Linksfield Place.

Entertainment is provided from time to time by local amateur groups whose services are hereby acknowledged. The recent provision of a stage curtain does much to provide the right atmosphere on these occasions and is much appreciated by visitors and patients alike.

Blind Persons.

A clinic for ascertainment of blind persons is held monthly at Woolmanhill. This is staffed by a consultant from the North-Eastern Regional Hospital Board and by a Corporation Health Visitor. The Corporation carries out its statutory responsibility for the blind through the agency of the Royal Aberdeen Asylum for the Blind, which supplies training in its workshops for the blind, and the Aberdeen Association for the Teaching of the Blind in their Homes, which employs home teachers for the training of the blind and also provides certain welfare services. In addition, the Corporation utilises services provided by certain other voluntary organisations as follows:—

Royal Aberdeen Asylum for the Blind.—The Corporation makes a financial contribution to this Asylum in respect of each worker employed and registered under the Disabled Persons (Employment) Act, 1944. During 1962, fifty-five workers were so employed.

Aberdeen Association for Teaching the Blind in their Homes.—A financial contribution is paid in respect of each certified blind person from Aberdeen on the roll of this Association. In addition, an annual grant is made to the Association in respect of home workers who are assisted financially by the Association. In 1962, there were 288 certified blind persons on the roll, including 3 home workers.

Royal Blind Asylum, Edinburgh.—One home worker is employed in Aberdeen but is attached to the Edinburgh Home Workers' Scheme and a grant in respect of him was paid to the Edinburgh Royal Blind Asylum.

Thomas Burns Home, Edinburgh.—One Aberdonian resides in the Home and is maintained by the Corporation.

Grant and Donation.—During 1962 a book production grant and a donation to the National Library for the Blind were made by the Corporation.

Holiday Home of the Edinburgh Society for the Blind, Ceres, Fife.—No applications were received during 1962 for holiday arrangements in this Home.

Register of the Blind.—The number of blind persons on the register of the Blind on 31st December, 1962, was 356. The numbers according to different age groups were 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	—	—	1	2	1	6	5	21	24	18	16	31	16	5	4	150	356
Female	—	—	2	2	—	1	7	15	36	25	20	49	24	19	6	206	

Blind Persons' Clinic.—

Examinations—1962.	Clinic.	Own Home.	Total.
First examinations . . .	19	33	52
Re-examinations . . .	31	15	46
	50	48	98

The total number of persons examined was 98, as compared with 82 in 1961.

Of the 52 persons examined for the first time, 36 (69 per cent.) were certified blind within the meaning of the Blind Persons Act, 1920.

Of the 3 children on the Register of the Blind, two were attending school at Craigmillar and one was ineducable.

The following statement gives the number of blind persons of 16 years and upwards who were employed at 31st December, 1962.

	Male.	Female.
(a) In Institutions for the Blind undergoing industrial training	3	1
In workshops	42	11
*(b) Outwith Institutions for the Blind	7	1

(*Including 4 Home Workers—3 males and 1 female.)

Deaf and Dumb Persons.

Under the National Assistance Act, 1948, the Corporation is empowered to make provision for the training of deaf and dumb persons, and also for their welfare. The Corporation made a payment to the Aberdeen Deaf and Dumb Benevolent Society during the year in respect of certain welfare services provided by the Society.

Provision of Temporary Accommodation for Persons in Urgent Need, and Sundry Other Services.

During 1962, temporary accommodation was provided for 19 women with 29 children in urgent need, arising in circumstances which could not reasonably have been foreseen. Accommodation was provided at Newhills Home, where six "Fire and Flood" beds are maintained for such temporary accommodation.

In addition, 618 cases of a casual nature were dealt with, arising from domestic upset, acute housing needs, &c. Those cases required general welfare services and assistance to meet their needs and to overcome their specific difficulties.

Reception Centre. (Sections 17 and 25, National Assistance Act, 1948.)

Cases now arising are, by arrangement, referred to the National Assistance Board for direct attention.

Registration and Inspection of Homes for Disabled Persons and the Aged. (Section 37, National Assistance Act, 1948.)

Under this section of the Act, no person may carry on a Disabled Persons' or Old Persons' Home without being registered by the local authority. During the year there were no applications for registration, and Homes registered in Aberdeen are as follows:—Fountville and the St. Aubins Group; The Hostel of St. Margaret; Mitchell's Hospital; Nazareth House; Royal Aberdeen Asylum for the Blind Hostel; and Ashley Lodge.

Removal of Persons by Sheriff's Order. (Section 47, National Assistance Act, 1948.)

It was not found necessary during 1962 to invoke the powers of this Section.

Care and Protection of Property of Persons admitted to Hospital or to Local Authority or Voluntary Hostels. (Section 48.)

Care, protection and storage was provided in 181 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, 419 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.

Burial or Cremation of the Dead. (Section 50, National Assistance Act, 1948.)

During 1962, the burial or cremation of 56 persons—32 men, 15 women and 9 children—was arranged by the department.

These burials are arranged under a great variety of circumstances and are a time-consuming task for the Welfare Section, especially so when relatives have to be traced and when relevant documents are not always readily available. In addition to the above figures, advice was given to many relatives of deceased persons, especially where funds were limited.

Apart from deaths in hospitals, 15 residents died in Old People's Homes during 1962.

Relief for Persons caring for the Elderly in their own Homes.

A limited number of places in the Emergency Rooms of the Old People's Hostels is available for the temporary accommodation of elderly people, to allow those who look after them to go on holiday, or to enter hospital for treatment.

19.—PORT HEALTH ADMINISTRATION.

Features of the Year.

In 1962, as in many previous years, work at the Port proceeded smoothly and there were no importations of disease. Nevertheless, since the absence of dramatic occurrences not only indicates that the services are efficient but also tends to mask the very real work done, it may be worth while to give a very brief indication of the work undertaken. In 1962 there arrived at the Port 436 vessels from overseas (including 26 from areas infected by plague, cholera, smallpox, &c.), and 1,725 commercial vessels from Britain. (These figures are quite normal, e.g. in the previous year there were 473 vessels from overseas, including 22 from infected areas). 939 vessels were inspected (a rather smaller number than in most years), with medical examination of crews and passengers where appropriate.

There were 176 vessels based on Aberdeen and almost 11,500 landings from British and foreign fishing vessels, and the total quantity of fish condemned as unfit for human consumption was 189,318 pounds, this figure being only about one third of the total in the previous year.

General.

The control of port health and port sanitary work is one of the functions of the Medical Officer of Health in his capacity as Port Medical Officer. Inspection of fish, markets, premises, fishing vessels and shops is carried out by appropriate members of the Sanitary Section of the Health and Welfare Department, and these duties occupy the full time of two District Sanitary Inspectors.

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 they also deal with the action to be taken by the Port Medical Officer under these circumstances. A list of countries regarded as 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 the list are supplied to the Medical Officers of the Health and Welfare Department, Customs Authorities and Sanitary Inspectors.

Commercial Shipping.

	No. of Vessels entering Port.	Tonnage.
Foreign Arrivals	436	309,211
Coast-wise Arrivals	1,725	803,745
Totals . .	2,161	1,112,956

As compared with previous years there was a further decrease in foreign and coast-wise arrivals and an overall decrease from 1961 in number of vessels and total tonnage.

During the year vessels arrived from ports listed in the weekly infected area list, as follows, and medical examinations were carried out as appropriate:—

Nauru Island	3	Sfax	5	Kenitra	3
Aden	1	Nemours	7	Panama	1
Suez	1	Constanza	5		

Fishing Vessels.

No. of landings from British fishing vessels	11,040
No. of landings from foreign fishing vessels	370

The following changes have taken place in the fishing fleet during the year:—

No. of vessels scrapped	2
No. of vessels lost	1
No. of vessels laid up pending scrapping	1
No. of vessels sold or transferred	2
No. of new vessels	3
No. of vessels transferred from other ports	2

The number of vessels based on Aberdeen at the end of the year is:—

No. of trawlers	142

No. of liners—

Line fishing over 9 months/year	15
Line fishing 6-9 months/year	11
Line fishing under 6 months/year	8

Particulars of Inspection of Vessels.

Inspection in respect of foreign arrivals	411
Inspection in respect of coast-wise arrivals	276
Inspection in respect of British fishing vessels	236
Inspection in respect of foreign fishing vessels	16
	939

Particulars of De-ratting Certificates.

No. of De-ratting Certificates issued	Nil
No. of De-ratting Exemption Certificates issued	39
No. of Rodent Control Certificates issued	19

Fish Inspection.

Amount of fish found to be unfit for human consumption during the year is:—

	1960.	1961.	1962.
General	1,163½ cwts.	4,559¼ cwts.	1,647 cwts.
Halibut	62 cwts. 4½ sts.	83 cwts. 6 sts.	43 cwts. 2¾ sts.

20.—FOOD HYGIENE.

Features of the Year.

(1) *Absence of outbreaks of food-borne diseases.*—In 1962 there were no serious outbreaks of disease among animals (such as the 1961 epidemic of foot-and-mouth disease) and, as indicated in the chapter on infectious diseases, there were few cases of food-borne diseases in human beings.

(2) *Staff shortages.*—Five groups of officers are involved in food hygiene—doctors, health education lecturers, health visitors, sanitary inspectors and meat inspectors. During the year staff shortages were disquieting among health education lecturers, health visitors and sanitary inspectors, although about the end of the year the last named group—sanitary inspectors—improved greatly in numbers, two apprentices gaining their qualifications and another inspector being recruited from outside the Health and Welfare Department.

(3) *Continued absence of a food hygiene campaign.*—Shortages of health education lecturers, health visitors and sanitary inspectors precluded for yet another year the mounting of any extensive food hygiene campaign.

(4) *Course for prospective meat inspectors.*—For the second consecutive year the course for intending meat inspectors was—at the request of the Royal Sanitary Association for Scotland—organised by the Education Department and conducted by medical officers, health education lecturers and meat inspectors. During the year the Secretary of the Royal Sanitary Association of Scotland wrote to the Medical Officer of Health to point out that the continued reluctance of the Chief Sanitary Inspector to allow any of the sanitary inspectors to take part in the course was placing the Aberdeen course at some disadvantage, and a meeting was arranged between the Chief Sanitary Inspector and representatives of the Royal Sanitary Association for Scotland.

(5) *Food hygiene education for food handlers.*—For the second consecutive year a course of instruction for food handlers was organised by the Further Education Section of the Education Department and conducted by medical officers and other staff from the Health and Welfare Department. The course was again well attended.

General.

It is not proposed to discuss here detailed points relating to inspectorial and advisory functions, 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 described 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.

Meat Inspection

The four slaughterhouses, privately owned, licensed within the Burgh, were in operation either continuously or intermittently. In 1962 there was a considerable increase in the number of cattle and pigs slaughtered but there has been a decrease in the number of sheep and calves. The overall number of animals slaughtered was less than in 1961.

Class of Animal.	Total Slaughtered.	Carcases Totally Condemned.	Carcases Partially Condemned.	Weight (in lbs.) of Meat and Offal.
Cattle . .	109,315	89	207	64,558
Sheep . .	106,704	333	204	22,102
Pigs .	5,721	78	127	18,221
Calves . .	297	17	5	1,023
	222,037	517	543	105,904

In addition, there were 711 lots of offal with a total weight of 104,309 lbs. The total weight of condemned meat and offal is thus 210,213 lbs.

During the year, there were no prosecutions under the Slaughter of Animals (Scotland) Act, 1928. Some 93 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. There were 2 cases of swine fever confirmed in the City.

Under the Public Health Meat Regulations, 1961, ante-mortem inspection of all animals has to be carried out. This section of the Regulations came into effect on 1st September, 1961, and since then, the number of animals segregated under instruction for emergency slaughter was 58. This additional inspection of live animals adds considerably to the work of the Meat Inspectors.

Export Licences.

During the year, 70,246 pounds of roast beef were exported to countries overseas. The Export Licences are granted by a veterinary surgeon of the Department of Agriculture acting for the Local Authority.

21.—ENVIRONMENTAL HYGIENE AND ANALYTICAL WORK.

The laboratory is responsible for the examination of samples submitted under the Food and Drugs Acts, and related legislation. Fifty-seven samples were the subjects of adverse reports.

In addition to analytical determinations, food samples are also examined for contamination of insect or animal origin. A routine sample of dried figs was found to be grossly contaminated with mites *Carpoglyphus Lactis*. There are many species of mites and it proves helpful when the particular variety can be identified as this often indicates the source of contamination. Certain species are cosmopolitan and may be associated with bad storage conditions whereas others are restricted to particular products. Carpoglyphus Lactis is found almost exclusively in dried fruit such as figs. A County Council submitted a sliced pan loaf containing numerous small black specks. On examination, these black specks were found to be fragments of *Tribolium Confusum*, the "confused flour beetle". Twenty six fragments of this insect were detected in this loaf. Such a finding indicated unsatisfactory storage conditions in the bakehouse.

Samples submitted under the Fertilisers and Feeding Stuffs Act are examined to check that these conform with their statutory statement of contents.

Samples submitted under the Rag Flocks and other Filling Material Act are examined to ensure that such materials have been adequately cleaned and fit for use in upholstery.

The public and school swimming baths controlled by the City are visited once per week to take samples for bacteriological examination and to ensure by chemical analysis that satisfactory chlorination conditions are maintained.

The City's water supply and effluents from the catchment areas are examined for the Water Department.

Urine specimens for the determination of alcohol are submitted by the Police in cases of offences under the Road Traffic Acts. The Road Traffic Act, 1962, establishes the taking of such specimens as a routine procedure. Previously such specimens were almost entirely confined to those submitted by the City of Aberdeen Police but in future the departmnt will be responsible for specimens submitted by Police authorities in the Counties of Kincardine, Aberdeen, Banff, Moray and Nairn, Inverness, Ross and Cromarty, Sutherland, Caithness, Orkney and Shetland.

Toxicological specimens submitted by Procurators Fiscal or Police in order to establish cause of death, where analytical investigations may prove helpful, have shown a considerable increase compared with any previous year.

Investigation of Atmospheric Pollution.

The measurement of atmospheric pollution at selected sites in the city has continued.

Samples Analysed.

The total number of samples analysed was as follows:—

Food and Drugs Act	1,000
Milk tested for effective pasteurisation	265
Fertilisers and Feeding Stuffs	27
Rag Flocks	8
Swimming Bath Waters	340
Urines for alcohol contents	103
Toxicological specimens	105
Waters and Effluents	22
Miscellaneous	30
	1,900

Atmospheric Pollution—

Sulphur Dioxide by volumetric method . . .	620
Smoke deposits	620
Lead Peroxide Cylinders	96
Deposit Gauge Rain Waters	24
	1,360

Clean Air Act, 1956.

The Corporation has not as yet taken any definite action beyond seeking information on various points and considering a further report submitted by the Medical Officer of Health.

22.—NOISE ABATEMENT ACT, 1960.

Members of staff continued their endevours to obtain a reduction of noise for citizens. It was not found necessary to take legal action under the Act as persuasion gained the required results. It may be useful to repeat the warning of complications if the aggrieved person, becoming annoyed at apparent delay, takes impetuous action.

23.—FACTORIES ACTS, 1937 TO 1959.

In accordance with these Acts, visits of inspection are made to factories and workshops to enforce (a) provisions relating to cleanliness, overcrowding, temperature, ventilation and drainage of floors in factories where mechanical power is not used, and (b) provisions relating to sanitary conveniences in all factories.

In 1962 there were 1,459 factories registered in the City, and 1,446 visits of inspection were paid by the Sanitary Inspectors. The premises were, generally speaking, satisfactorily maintained. The majority of the 1,819 defects found were not serious, and 1,795 of these were remedied in the course of the year. In 324 cases formal written notices had to be served, but in no case was it necessary to institute prosecution. Further particulars, in the prescribed form, are supplied in the Appendix to this section of the Annual Report.

Under Section 110 of the original Act, lists are kept of outworkers in certain trades. In August, 1962, the total number of outworkers was 116, comprising 63 employed in the net industry, 22 in the making, &c., of wearing apparel and 31 in the manufacture of paper bags. These figures tend to fluctuate. In no instance was the work carried out in unwholesome premises.

Appendix.

1. Inspections for provisions as to health (including inspections made by Sanitary Inspectors).

Premises. (1)	Number on Register. (2)	Number of		
		Inspections. (3)	Written notices. (4)	Occupiers prosecuted. (5)
(i) Factories in which Sections 1, 2, 3, 4, and 6 are to be enforced by Local Authorities	188	178	29	—
(ii) Factories not included in (i) in which Section 7 is enforced by the Local Authority	1,177	1,025	289	—
(iii) Other Premises in which Section 7 is enforced by the Local Authority (excluding outworkers' premises)	94	243	6	—
Total . .	1,459	1.446	324	—

2. Cases in which defects were found.

Particulars. (1)	Number of cases in which defects were found.				Number of cases in which prosecutions were instituted. (6)
	Found. (2)	Remedied. (3)	Referred		
			To H.M. Inspector. (4)	By H.M. Inspector. (5)	
Want of cleanliness (S.1) .	580	578	—	7	—
Overcrowding (S.2) . .	—	—	—	—	—
Unreasonable temperature (S.3)	6	5	—	—	—
Inadequate ventilation (S.4)	1	1	—	—	—
Ineffective drainage of floors (S.6)	1	1	—	7	—
Sanitary Conveniences (S.7)—					
(a) Insufficient . .	7	4	—	—	—
(b) Unsuitable or defective . .	194	184	—	4	—
(c) Not separate for sexes . .	9	5	—	2	—
Other offences against the Act (not including offences relating to outwork) . . .	21	17	—	1	—
Total . .	819	795	—	21	—

3. No. of defects found in previous year and remedied in current year=43.

4. Outworkers.

Nature of Work.	Number in List.	Cases of default.	Unwholesome premises.
Making, &c., of wearing apparel	22	—	—
Nets, other than wire . .	63	—	—
Paper bags	31	—	—
Others	—	—	—
Total . .	116	—	—

24.—THE AGRICULTURE (SAFETY, HEALTH AND WELFARE PROVISIONS) ACT, 1956.

This Act has only a very limited application within the City of Aberdeen. Further reference will be made to it in the Annual Report of the Chief Sanitary Inspector.

25.—NURSERIES AND CHILD-MINDERS' REGULATIONS ACT.

The Nurseries and Child-Minders' Regulations 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.

The application which was granted in 1958 in respect of a nursery for 20 children is still in operation and the nursery was inspected and found satisfactory on three occasions during the year. No applications were received in 1962.

26.—NURSING HOMES REGISTRATION ACT.

There were no applications for registration during the year.

27.—SUPERANNUATION EXAMINATIONS.

In 1962 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 785. Of these examinations, 486 were males and 299 were females. The corresponding total for 1961 was 933 (561 males and 372 females).

28.—SCHOOL HEALTH SERVICE.

"Health is the best gift anyone can have and the finest investment we can make" (*The Will to Health*, Harley Williams, 1962).

"The School Health Service performs a special and valuable function" (*A Review of Medical Services in Great Britain—Report of the Medical Services Review Commission*, 1962).

GENERAL REVIEW.

The needs to be met by the School Health Service change as social conditions change so that the traditional methods of estimating and promoting the health of school children require to be reviewed from time to time; and the current year provided both growing points and growing pains.

To mention first the older indices of progress—cleanliness, clothing, nutrition, weight, &c.—1961-62 showed a continuation of the favourable trends of recent years. Yet we have not reached the stage of disregarding these indices. It is easy to say that nits or vermin were found in only one child in 200 at medical officers' routine inspections and in only one child in 60 at health visitors' surveys; but considerable professional time was devoted to follow-up inspections of these children in school, and 294 children (from 125 families) came to Charlotte Street Clinic for treatment, while 49 required cleansing at the City Hospital. Again, while the percentage of children with defective clothing or shoes looks tiny, 265 necessitous cases had to be provided with shoes or articles of clothing by the School Welfare Department. Yet again, average weight in relation to height is becoming a doubtful index, since it takes account neither of the increasing number of over-weight children nor of the weight-increase associated with earlier maturation; and actually 370 children were medically re-examined because of poor nutrition.

The most spectacular achievement of the year is a further reduction in the number of children needing dental treatment—a further demonstration of the value of health education: a fall from 91% to 56% over ten years is no mean achievement.

While knowledge of the epidemiology of behaviour disorder is not yet fully adequate, it is interesting to note the following figures: at routine medical examinations only 111 pupils were found significantly disturbed; at non-routine sessions (examination of children selected by health visitors and teachers) 244 were identified; and 51 other children were examined after being referred to the child guidance clinic from sources other than the School Health Service, and 408

children attended the clinic during the year. 356 cases of truancy were known to the School Welfare Department (as against 307 in the previous year) and the number of children appearing before Aberdeen Courts increased from 564 to 579. In residential schools for the maladjusted there were 17 children, and 27 were detailed in approved schools.

From these and other figures it is clear that (while routine examination of "entrants" and "leavers" may still be necessary) for intermediate groups routine medical overhaul is less satisfactory than selection by health visitors and teachers of children for examination. Under the new pattern (to some extent anticipated during the year) the school health record card will be revised to provide more adequate information, routine examinations will be confined to "entrants" and "leavers", there will be careful selection of children of all ages deemed to need medical examination, and more medical and health visiting time will be devoted to prevention of disease and to health education. It has been well said that medical care and the promotion of health are inseparable from education. Health education is now nationally regarded as one of the chief functions of the School Health Service and, although in schools it is not normally responsible in Aberdeen for planned programmes of instruction, all contacts with parents, teachers and children provide opportunities for health teaching.

It is gratifying that home visits by health visitors increased from 6,955 to 7,721 over the year (regaining much of the ground lost in the previous year) and in certain schools, at the invitation of head teachers, a beginning has been made with group-teaching. With the introduction of male health visitors such teaching need no longer be confined to girls.

The School Health Service is an occupational health service with hazards to be recognised, anticipated and where possible avoided. In preparation for school life questions of heredity, developmental progress, quality of home environment and the implications of any congenital defect or earlier illness may need consideration in relation to a child's teachability, his activity and his capacity for relationships. The vulnerability of certain young children is increasingly identifiable as knowledge grows. The pre-school records, therefore, compiled by health visitors for every child, along with information available from clinics and other medical sources about certain children, may be of much significance to school doctors, health visitors and teachers. It is now the practice that before an Entrant's routine medical examination his pre-school record is made available. The names of children who may have special difficulties are put on a Handicapped List by health visitors, and in this connection 143 records were submitted to a senior medical officer; the cases were discussed with the health visitors, and 74 home assessment visits paid.

No longer, therefore, is the School Health Service mainly a defect-finding device. Rather is it concerned, following a full clinical examination on entry, with the continuous health supervision of children in the setting of school, recognising that to promote fitness of body and mind school conditions and school atmosphere are of much importance and that school doctors and school health visitors require

time, training and opportunity to become still further integrated into the school system, thereby increasing their usefulness to parents, teachers and children.

STAFFING.

The staffs of medical officers, dental officers, health visitors and ancillary workers were broadly as described in the previous report: in other words vacancies were still numerous.

Particular attention may be invited to (1) the absence of any dental hygienist for another complete year; and (2) the fact that, although the number of health visitors employed is at last beginning to approach the total establishment at present authorised by the Corporation, increasing duties devolving on health visitors have made the real shortage greater than ever. For example, for school health surveys (certainly one of the most important parts of the school health service) the total number of children examined fell from 45,164 in 1959-60 to 39,191 in 1960-61 and 36,034 in 1961-62.

GENERAL STATISTICS.

Number of schools—	
Primary	46
Secondary	12
Senior Secondary	3
Nursery	4
Special Schools	3
Special classes in ordinary schools	1
Nursery classes in ordinary schools	4
In receipt of grant and under School Health Service	4
Number of children on the registers	32,560
Number of children in average attendance	30,676

Further Education—

Pre-Nursing College.
Commercial College.

SCHOOL PREMISES.

In general, doctors and health visitors continued to find the sanitary conditions in schools satisfactory. In recent years a good deal of building of new schools and reconstruction of older schools has been undertaken, and during the year under review three new schools have been opened, namely Deeview Infant, Fernielea Primary and Summerhill Secondary, and three additional classrooms have been provided for Aberdeen Academy.

The premises for the School Health staff, however, are not always satisfactory. Sufficient space for the testing of vision and hearing is too often not available within the medical rooms; often there is no adjoining ante-room for

changing and interviewing; and in the newer schools there has been a tendency to place the medical suite in proximity to gymnasium or music room. It is suggested that in future new buildings the siting and extent of the accommodation for the school health service should be a matter for joint discussion.

ORGANISATION AND ADMINISTRATION.

A. System and Extent of Medical Inspection and Treatment.

(1) *Periodical Medical Overhauls.*—In accordance with Circular 69/1961 systematic medical inspection was provided for the following groups:—

(a) Entrants (and pupils not previously examined in school). Where practicable this examination was undertaken in the child's second term; this allowed time for the child to become accustomed to school and for his teacher to know him better. Generally speaking it also allowed audiometric examination to have been undertaken before the full-scale examination. Prior to the Entrants' examination the medical officers consulted each child's pre-school records and transferred the relevant information to the school medical record card. In the appraisal of the child as a whole such details as may have bearing on the child's well-being, his learning capacity and his behaviour in school, are of increasingly recognised value.

(b) Pupils due to leave a Primary School within six months of the examination.

(c) Pupils due to leave Secondary or Senior Secondary Schools within six months of the examination.

These amendments which were introduced last year have worked satisfactorily.

(2) *Non-Routine Examination.*—Re-examination of children who had been found to have defects at earlier examinations was mainly carried out at the monthly visits along with the examination of pupils referred by health visitors and teachers, and the routine vision-testing of the selected age-groups. The regular monthly visit at which a variety of children are seen and sufficient time can be given to particular conditions and situations is the chief means by which the school doctor becomes closely associated with his schools. He becomes regularly available for consultation and so increase his usefulness to head teachers and staff. The partnership of school doctor and school health visitor is also more closely integrated and better understood by others.

(3) *Treatment.*—Reference is made later to the Dental, Minor Ailment, Deafness Diagnostic, Eye and Remedial Clinics. Close association is maintained with the general practitioner service.

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"

(1) *Medical Inspection.*—The school health visitor, who is in most cases also the family health visitor for the district, still accompanies the medical officer at routine inspections, although—with increasing demands on the health visitors' skills—it is becoming obvious that it is uneconomic to use for this "chaperoning" and for weighing and measuring of children an officer with five years of full-time professional education. However, in view of other changes that were being made in 1961-62, only tentative experiments were attempted here.

(2) *The Medical Monthly Visit.*—The doctor's monthly visit to see selected children was generally arranged to coincide with one of the health visitor's weekly or fortnightly visits, so that the two could consult together at need.

(3) *Health Surveys by Health Visitors in Schools.*—While sheer shortage of health visitors again made it impossible to attain the ideal of each child being carefully studied once each term, surveys were nevertheless carried out slightly oftener than once annually on each child. For identifications of early deviations from emotional and physical normality these services are very important.

(4) *Health Visitor/Teacher Consultations.*—In many schools these took place regularly and were found of great value. The co-operation between teachers and health visitors is good and is improving.

(5) *Vision Testing.*—The vision testing of five-year-olds was again undertaken in all schools.

(6) *Health Education.*—While health visitors (and medical officers) have opportunities for health teaching in all their contacts with children, parents and teachers, the important function of health education requires further recognition and development as does the role of the health visitor as a qualified health teacher with a nursing background. There are still some educationalists who think of health visitors as nurses and seek their help only when things go wrong, but seldom or never when projects for further promotion of well-being are under consideration. Gratifying as it is that school health visitors have been invited in certain schools to undertake more formal group instruction, this might well be extended. The entire School Health Service indeed might become more intimately connected with such things as recreational schemes, regulations regarding school clothing and footwear, the school meals service, and the teaching of parentcraft. Any situation where health and education can combine provides an opportunity for furthering the principles which underlie the promotion of good health.

(7) *Follow-up and Home Visiting.*—An important duty of the school health visitor is to visit the homes of children found by doctors or health visitors to be in need of medical and/or social advice or treatment, and to keep these children under such degree of observation as they may deem necessary. This entails not only visits to homes and follow-up in schools, but also the use of clerical time to maintain adequate records. By home visitation health visitors discover whether

treatment recommended for particular children has in fact been carried out, and whether parents fully understand the need for such further examination or treatment; and they obtain additional information about the child's home and background. While, owing to shortage of health visitors, the number of home visits to school children is still inadequate for present needs, it is gratifying to note that the number has increased by 766 this year, i.e. 7,721 as compared with 6,955 in 1960-61—although the 1961-62 figure is still below that for 1959-60. (496 home visits were also carried out by the male inspector attached to the School Health Service chiefly in connection with arrangements for the treatment of scabies or pediculosis, parental failure to provide spectacles, &c.)

D. Co-ordination with the Public Health Service and with other Departments of the Authority which renders Services to Children.

There is no change from the excellent co-ordination mentioned in previous reports.

E. Co-operation with Voluntary Bodies and other Outside Agencies.

The value of the school medical record card is being increasingly recognised by research workers and others.

F. Co-operation with Teachers and Parents.

It is being increasingly recognised by both teachers and parents that members of the School Health Service are available for consultation and advice in all matters affecting the physical and mental well-being of the school child. The continued high attendance of parents at routine medical inspections as set out below is in part an indication of the need parents have to be reassured about the health of their children, particuarly those in the younger age-groups.

The attendance of parents at Routine Medical Inspections was as follows:—

Entrants	95·6 per cent.
Second Age-group	81·0 per cent.
Third Age-group	42·8 per cent.
Senior Secondary Age-group	16·0 per cent.
Overall average	68·5 per cent.

THE FINDINGS AT EXAMINATION.

(1) Systematic Medical Inspection.

The number of children examined was 314 more than in the previous year and 729 less than in 1959-60. In all 8,289 children were medically inspected. In this connection it should be noted that owing to illness there was shortage of medical staff in the previous year and, to cover the routine medical inspection programme, some examinations were carried over into the present year.

Four hundred and eighty-nine visits were paid to schools by the medical officers in connection with systematic medical inspection as compared with four hundred and twenty-four for the previous year.

Details of the number and percentage of individual children in each age-group found to be suffering from particular defects are given in Table II at the end of this section of the Report. A summary is presented here:—

Nature of Defect.	Number Examined.	Number Defective.	Percentage Defective.
1. Clothing unsatisfactory	8,289	3	·04
2. Footgear unsatisfactory	,,	4	·05
3. Cleanliness—			
(*a*) Head: Nits	,,	45	·5
Vermin	,,	—	—
(*b*) Body: Dirty or Verminous	,,	5	·06
4. Skin—			
(*a*) Head: Ringworm	,,	—	—
Impetigo	,,	13	·2
Other diseases	,,	58	·7
(*b*) Body: Ringworm	,,	1	·01
Impetigo	,,	—	—
Scabies	,,	5	·06
Other diseases	,,	315	3·8
5. Nutritional State—			
Slightly defective	,,	190	2·3
Bad	,,	7	·08
6. Mouth and teeth unhealthy	,,	391	4·7
7. Naso-pharynx—			
(*a*) Nose:			
(i) Obstruction requiring observation	,,	347	4·2
(ii) Obstruction requiring operative treatment	,,	18	·2
(iii) Other conditions	,,	18	·2
(*b*) Throat:			
(i) Tonsils requiring observation	,,	382	4·6
(ii) Tonsils requiring operative treatment	,,	297	3·6
(*c*) Glands:			
(i) Requiring observation	,,	110	1·3
(ii) Requiring operative treatment	,,	52	·6
8. Eyes—			
(*a*) External diseases:			
Blepharitis	,,	59	·7
Conjunctivitis	,,	4	·05
Corneal opacities	,,	1	·01
Squint	,,	223	2·7
Other diseases	,,	62	·7
(*b*) Visual acuity with/without glasses:			
Fair	,,	1,166	14·1
Bad	,,	172	2·1
Recommended for refraction	,,	253	3·1

Nature of Defect.	Number Examined.	Number Defective.	Percentage Defective.
9. Ears—			
(*a*) Diseases:			
Otorrhœa	8,289	36	·4
Other diseases	,,	87	1·0
(*b*) Defective hearing:			
Grade I	,,	22	·3
Grade II*a*	,,	5	·06
Grade II*b*	,,	—	—
Grade III	,,	1	·01
10. Speech—			
Defective articulation	,,	90	1·1
Stammering	,,	24	·3
11. Mental and Nervous Condition—			
(*a*) Backward	,,	20	·2
(*b*) Dull	,,	—	—
(*c*) Mentally deficient (educable)	,,	1	·01
(*d*) Do. (ineducable)	,,	—	—
(*e*) Highly nervous or unstable	,,	54	·7
(*f*) Difficult in behaviour	,,	57	·7
12. Circulatory System—			
(*a*) Organic heart disease:			
(i) Congenital	,,	20	·2
(ii) Acquired	,,	6	·07
(*b*) Functional conditions	,,	14	·2
13. Lungs—			
Chronic bronchitis	,,	8	·1
Suspected tuberculosis	,,	37	·4
Other diseases	,,	169	2·0
14. Deformities—			
(*a*) Congenital	,,	51	·6
(*b*) Acquired (infantile paralysis)	,,	16	·2
(*c*) Acquired (probably rickets)	,,	8	·1
(*d*) Acquired (other causes)	,,	263	3·2
15. Infectious diseases	,,	2	·02
16. Other diseases or defects	,,	742	9·0
17. Classification:			
Group I	,,	3,783	45·6
Group II*a*	,,	964	11·6
Group II*b*	,,	148	1·8
Group II*c*	,,	31	·4
Group III	,,	2,678	32·3
Group IV*a*	,,	439	5·3
Group IV*b*	,,	246	3·0
Number notified to parents as suffering from defects	,,	594	7·2
Number under observation	,,	3,025	36·5
Number of parents present at inspection, 5,680 (68·5%)	,,	—	—
Number wearing glasses	,,	932	11·2

Most of these findings show only the normal year-to-year variation, but a few points of note have been selected for mention elsewhere in this Report.

Classification on Routine Examination.

Classification.	No.	1961-62 %	1960-61 %	1959-60 %	1958-59 %	1957-58 %
I. Free from defects	3,783	45·6	45·8	49·5	46·6	44·6
*II(A). Defective vision but otherwise free from defects	964	11·6	10·6	10·9	9·4	11·8
II(B). Mouth and Teeth unhealthy but otherwise free from defects . . .	148	1·8	2·5	1·6	1·3	1·7
*II(C). Combination of II(A) and II(B) . .	31	0·4	0·3	0·2	0·1	0·2
III. Children with ailments from which recovery is expected in a few weeks .	2,678	32·3	31·1	33·6	37·9	35·4
IV. Children with more serious defects—						
(a) Where cure is considered possible	439	5·3	6·7	5·8	5·5	7·1
(b) Where only improvement is considered possible . . .	246	3·0	3·0	2·1	2·4	3·1

*From 1957-58 to 1959-60, the percentage with eye defects refers to children receiving visual tests, i.e. a different total from number having routine medical overhauls. Hence the percentages when added will not come to exactly 100. Since 1960-61 all children having routine medical overhauls have vision testing.

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	1,007	5^3	43·1	43·2	920	5^4	42·8	41·9
11—12	1,334	11^3	55·7	77·3	1,206	11^5	56·1	81·0
14—15	1,265	14^5	62·6	109·4	1,350	14^3	61·5	110·5
16—17	217	16^6	68·0	138·7	198	16^7	63·6	125·5

For comparison with previous years, reference should be made to Table V at the end of the Report.

RE-INSPECTION.

Six hundred and thirty-four sessions were devoted by school medical officers accompanied by health visitors to monthly visits and re-examination. At the monthly visits 2,089 pupils were referred (by health visitors and teachers) as compared with 1,716 in the previous year. The total number of non-referred children seen at the above-mentioned sessions was 10,972 (cases for vision-testing and children with defects previously noted) and the number of defects followed up was 12,191.

	Referred.	Other.
Behaviour	71	173
Skin	436	476
E.N.T.	175	1,814
Visual	427	5,785
Nutrition	18	352
Orthopaedic	92	432
Hearing	134	860
Speech	69	240
Cleanliness	148	154
General	519	1,343
Health Education	—	15
Special Examinations (Further education, &c.)	—	547

Resulting from the above sessions—

378 special home visits were paid by the Health Visitors.

512 children were referred to General Practitioners.

737 children were referred to Clinics.

58 parent interviews were arranged.

5 cases were referred to the Association of Social Service.

In addition 32 medical interviews were arranged at the request of the Education Department.

OTHER EXAMINATIONS AND SURVEYS.

(a) *Unannounced Visits by Health Visitors.*

Ideally, health visitors should inspect every child each term (with the possible exception of children who are receiving a routine medical overhaul during the term) and selected children at more frequent intervals. As in previous years, the available staff was quite insufficient for this purpose. Instead of being inspected thrice annually, most children were seen only once.

The following are the figures for 1961-62:—

	Ordinary.	Selected.
(i) Total number of inspections	36,034	15,479
(ii) Total number showing defects of hygiene:—		
Vermin	81	83
Nits	525	791
Impetigo	8	23
Scabies	5	12
Bad Clothing	107	102
Bad Footwear	51	34
	777	1,045

(iii) Total number showing physical, mental or behaviour defects	2,087	1,286
(iv) Number treated in schools	534	3,949

In respect of the health visitors' surveys it is interesting to notice the continued decrease in defects of hygiene (from 1,250 in 1959-60 and 950 in 1960-61 to 777 now) and the increases in other physical and emotional disorders noted.

(b) *Home Visits by Health Visitors.*

These visits are invaluable in helping to link home and school for the benefit of both.

The health visitors paid visits to 7,721 homes to give advice about school children. The classification of the visits is as follows:—

	First Visits.	Re-vists.
Physical	752	1,123
"Settling-in", behaviour, &c. .	2,299	3,100
Cleanliness	219	228

As a result of "cleanliness" re-visits, the health visitors reported 78 children as "slightly improved", 60 as "markedly improved" and 54 as "cured".

(c) *Vision Testing.*

During the year pupils born in the years 1954 and 1949 had their vision tested and pupils born in the year 1950 had their colour-vision tested at the routine medical inspections.

(d) *Examinations for Tertowie Residential School.*

During the year 564 pupils (343 boys and 221 girls) from Secondary Schools were inspected before departure for varying periods at Tertowie Residential School. A proportion of the pupils were taking part in the Duke of Edinburgh Award Scheme and consequently a high standard of fitness was required. Three only had to be excluded as unfit. As older pupils begin to understand the ingredients of fitness and what is required of them out of consideration for others in the community life offered by residential camps, &c., it is expected that it will become unnecessary to devote so much medical and health visiting time to inspections on this account. With better recording of each pupil's overall health at earlier examinations and with the opportunities for maintaining health supervision provided by the weekly visits of school health visitors and the monthly visits of school doctors, it should not much longer be necessary to continue this added inspection. When pupils are already in full attendance at school in the ordinary way, and the health of school children in general is now so satisfactory, it is perhaps becoming pointless to have to allay the apprehension of others about the health and infectivity of pupils about to go to camps or on residential courses

(e) *Child Guidance.*

In connection with children referred by teachers and others to the psychologist in charge of the Child Guidance Centre, 51 special medical examinations in schools were carried out, i.e. 6 fewer than last year. As previously, most of the children referred were boys under 10 years of age. The age-groups were as follows:—

Boys aged 5-10 years .	30	Girls aged 5-10 years .	6
Boys aged 11-15 years .	14	Girls aged 11-15 years .	1

(f) *Provisions for Handicapped Children.*

"The Handicapped List" compiled by health visitors continues to be a very useful means of identifying children who may require special educational provision. During the year 74 pre-school children were visited in their homes by a medical officer for assessment and 73 school visits on behalf of older children were paid to ordinary schools. The health supervision of children attending special schools involved 72 medical sessions at Beechwood School, 25 sessions at Rubislaw Occupational Centre and 11 at Linksfield School for the Deaf.

ASCERTAINMENT OF DEAFNESS.

A. Audiometric Testing in Schools.

This was undertaken by a qualified audiometrician using a pure-tone audiometer. As far as possible testing was undertaken prior to the routine medical examinations so that the results could be available to the school doctors. Children found to have impaired hearing at previous examinations were re-tested and several individual children were also tested at the request of school medical officers and head teachers. In all, 10,303 children were tested, i.e. 9,858 in ordinary schools, 370 in Beechwood Special School and 75 in Rubislaw Occupational Centre. Of these, 859 children (7.9 per cent. in ordinary schools and 16 per cent. in Beechwood and Rubislaw) gave an inadequate response and were then followed-up by the school medical staff. Causes were investigated, clinical treatment initiated as necessary and the effects of any residual deafness were related to the quality of the child's speech and his/her educational progress, special arrangements being made as required.

Classification of Children with Impaired Hearing.

	One ear affected.				Both ears affected.				
	Normal/I	Normal/II	Normal/III	I	I/II	II	I/III	II/III	III/Both
In ordinary schools .	435	56	4	247	13	17	7	4	3
Beechwood School .	27	9	—	18	2	4	1	—	—
Rusbislaw Occupational Centre	9	1	—	1	—	1	—	—	—
Linksfield School for the Deaf	—	—	—	—	—	11	—	—	22

B. The Deafness Diagnostic Clinic.

Thirty-seven weekly sessions were held. Ninety-six children from Aberdeen were examined and sixteen from neighbouring areas. This included certain

children attending Linksfield School for the Deaf who are periodically assessed. Sixty-one children were seen for the first time and nine children were issued with hearing-aids. In Aberdeen the total number of children wearing hearing-aids is:— Pre-school 7, in the ordinary schools 21, Beechwood Special School 5, and Linksfield School for the Deaf 33.

It is a measure of the value of the screening procedures over the years that there has been a falling-off in the numbers of children found to be deaf at over five years, and that no child already at school has been transferred for special educational treatment to Linksfield School for the Deaf, which at present has 33 city children and 27 from outwith the city.

C. Other Services for the Deaf.

The specialist health visitor attached to Linksfield School is greatly involved in the guidance of parents of young deaf children.

The services of a peripatetic teacher of the deaf for partially-deaf children in the ordinary schools are invaluable both to the pupils themselves and to their teachers.

TREATMENT OF DISEASE.

(1) Cuts, Bruises, Sprains, Minor Injuries, &c.

Cases occurring in schools while any of the medical or nursing staff are in attendance are dealt with by them, otherwise the children are given first-aid treatment by the school 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. Head teachers are obliged to report accidents which occur in schools and it is to be noted that during the year 347 such accidents occurred as compared with 295 last year—an appreciable increase which may be coincidental or may indicate that the effects of Aberdeen's long-term campaign against accidents are beginning to wear off (in which case a further campaign may be needed when sufficient health education staff are available).

(2) The Charlotte Street School Clinic.

The Clinic is open from 4.30 p.m. each afternoon after school. Pupils are referred from various sources, i.e. health visitors, school welfare officers and head teachers. As far as possible cases of pediculosis, scabies and impetigo are dealt with on a family basis.

The following table shows the attendances at the minor ailment clinic during the year:—

	Pediculosis.	Scabies.	Impetigo.	Miscellaneous.
Number of families involved . . .	125	45	63	106
Number of families visiting more than once	18	4	2	6
Number of children in families . . .	294	94	78	126
Number of schools involved	44	24	28	33

(3) Treatment at City Hospital.

This involved 45 families including 93 school children for treatment of scabies and 26 families including 49 school children for the treatment of pediculosis.

(4) Treatment at Skin Out-Patient Department.

The number of children known to the Department to have been treated for warts was 16 (as compared with 28 in the previous year).

(5) Defective Vision and Squint.

As a result of vision-testing in schools 3,004 children were referred to the School Eye Clinic which is staffed by consultants appointed by the North-Eastern Regional Hospital Board.

In addition, 158 pre-school children were also referred from Child Welfare Clinics. These figures compare with 2,866 school children and 116 pre-school children in the previous year, and 2,089 school children and 113 pre-school children in the year before.

(6) Speech Defects.

The School Health Service continued to co-operate with the Speech Therapy Department in referring appropriate cases and in undertaking special clinical examinations including audiometric examination when necessary. 1,211 school children and 91 pre-school children were treated by speech therapists throughout the year.

(7) Dunfermline College of Physical Education.

A valuable service is provided for pupils with postural defects. During the year 74 pupils referred by school medical officers attended for remedial exercises, only 31 of whom required treatment to be continued into the next school year.

IMMUNISATION.

(a) Diphtheria Immunisation.

Primary and re-inforcing doses were given as follows:—

	1962	1961	1960	1959
Total number of visits paid to schools	108	104	103	110
Number of school children fully immunised for the first time (i.e. two injections)	240	333	384	224
Number of school children who received a reinforcing injection	3,659	3,982	4,152	4,511

(b) Prevention of Tuberculosis.

3,054 pupils aged thirteen were tested for susceptibility: 811 (or 25.5 per cent.) were found to already have acquired an immunity while the 2,364 (or 74.5 per cent.) who were tuberculin negative were given B.C.G. vaccine. Chest X-rays were carried out as required. 205 pupils who had been given B.C.G. vaccine a year ago were found to have a positive skin reaction persisting.

(c) Poliomyelitis Vaccination.

At 59 sessions in Infant and Primary Schools 8,840 pupils were given fourth injections.

DENTAL HEALTH EDUCATION.

(a) Before school entry.

As the Chief Dental Officer has pointed out in an earlier report, since only a few hundred children attend nursery schools and day nurseries, since routine dental inspection of pre-school children is not possible, and since the only normal contact of the pre-school child with the Health Department is through the health visitor, the main hope of improvement of the dental condition of school entrants lies in the work of the health visitors with parents. This work continued during the year—both in respect of individual health teaching in the homes of the people and in respect of health education of groups (at clinics) and the beneficial results of sustained effort are beginning to become clear, as indicated in the figures given below. Nevertheless, shortage both of health education staff and of health visitors limits these effects.

(b) After school entry.

Despite shortages of health education staff and health visitors and despite the continued lack of a dental hygienist, as much dental health education as was practicable was done.

(c) Results.

The percentage of children judged by dental officers to need treatment fell during the period of expansion of the health visitor service (1952-55) from 91 per cent. in 1952-53 and 88 per cent. in 1953-54 to 75 per cent.; remained around 75 per cent. for a few years; and has fallen steadily since the introduction of group health education in 1956. Recent figures are:—

1957-58—72 per cent. needing treatment;
1958-59—65 per cent. needing treatment;
1959-60—60 per cent. needing treatment;
1960-61—59½ per cent. needing treatment;
1961-62—56 per cent. needing treatment.

DENTAL INSPECTION AND TREATMENT.

The Chief Dental Officer reports as follows:—

The work of the Dental Section proceeded as usual, within the limitations of the staff shortage.

Staffing.

Once again it is necessary to report a reduction in the number of dental officers. Mr. I. H. Lawrence, after serving on the staff for about eight years, resigned in March to take up an appointment with another authority. Miss F. Mitchell, appointed at the beginning of the year, resigned seven months later.

For the last four months of the year, therefore, the section comprised only three dental officers, instead of an establishment of six, a figure, incidentally, which has yet to be attained.

The filling of vacancies is not easy, and the loss of two full-time officers is serious, and will greatly restrict the work of the Section.

Dental Inspection and Treatment.

As the majority of parents now elect to have their children treated by the general dental service, this allows the perennially short-staffed section to examine more children than if the converse applied.

While national statistics show that more children are treated by practitioners than by the local authority services, it must be stated that too many Aberdeen parents are apathetic about the dental condition of their children, and do nothing apart from refusing the offer of treatment by the auhority's service. This core of resistant parents is a perpetual problem for the dental officers who can do nothing if parental consent is withheld.

Slightly fewer children had a routine examination than in the previous year, and the number with defects (56 per cent.) is about the same as last year. Although the number of children with defects has fallen over the past few years, this does not indicate any reduction in caries.

The treatment figures show an increase of both permanent and temporary teeth extracted, and a reduction in the filling : extraction ratio of permanent teeth.

Dental Health Education.

In view of the high incidence of dental decay in the teeth of children, efforts have been made recently to make the public more conscious of the need for dental health. Following the Dundee Dental Health Campaign of last year, a further campaign, aimed at 200,000 children, and their parents, from Fife to the Borders, took place in the spring. This again, was reported as being successful.

The long-term value of such campaigns has yet to be proved, but it must be admitted that the efforts of the dental officers in Aberdeen have met with singularly little success. The simple but effective rules of good oral hygiene, restriction of sugar intake and regular supervision, do not greatly appeal to children as they interfere too much with established habits. In addition, local children are now subjected to the blandishments of commercial T.V. advertising, and in the course of the year a number of schools were found to be retailing biscuits for consumption by the children during school intervals. As long as this is condoned in schools, and until parents exercise more supervision over the eating habits of their children, then so long will dental decay remain a health problem.

Fluoridation as a Preventive Measure.

As children and parents appear reluctant to accept the simple but effective rules of dental health, some improvement may be effected by the fluoridation of the water supply. This measure is again news following the publication of the

Report on the Conduct of Fluoridation Studies in the U.K. The results achieved after five years study confirm previous experience of fluoridation in America, showing a substantial improvement in the teeth of children by a reduction in the incidence of decay and an increase in the number of sound teeth.

In view of these findings, local authorities would now seem to be able to implement this as a preventive measure.

Dental Inspection and Treatment—1961-62.

(1) Number of children examined by Dental Officers—	
(a) At routine inspections	26,937
(b) As specials	592
(2) Number of children with dental defects	15,297
(3) Number of children offered treatment	14,948
(4) Number of children accepting treatment	4,861
(5) Number of children treated	4,411
(6) Attendances for treatment	9,856
(7) Fillings—	
Permanent teeth	7,618
Temporary teeth	1,254
(8) Extractions—	
Permanent teeth	1,121
Temporary teeth	2,754
(9) Number of administrations of a general anaesthetic	278
(10) Other Operations—	
Permanent teeth	2,446
Temporary teeth	911
(11) Orthodontic Treatment—	
(a) Number of cases continued from previous year	76
(b) New cases	52
(c) Cases completed	39
(d) Cases discontinued	15
(e) Cases continued at end of year	68
(f) Pupils treated with appliances	81
(g) Attendances for treatment	536
(h) Consultations with R.H.B. orthodontist	223
In addition, 16 pupils were having their treatment completed at the Orthodontic Clinic, Royal Aberdeen Hospital for Sick Children.	
(12) Number of pupils supplied with artificial dentures	33

ARRANGEMENTS FOR PHYSICAL EDUCATION AND PHYSICAL HYGIENE.

The following information is presented by courtesy of the Director of Education:—

Session 1961-62 has been a most satisfactory one as far as the subject of Physical Education is concerned. Valuable work has been done in all branches of the subject by specialist and non-specialist teachers and a fully comprehensive programme has been carried out. Emphasis was again placed on the work of each individual pupil and the lessons were planned and presented in such a way that pupils were given opportunities of working independently and of developing their personal skill and ability. Due regard was paid to the comprehensiveness of the Physical Education programme and an adequate allowance of time was allocated to each branch of the subject.

Staffing.

The Physical Education Staff consists meantime of a male Organiser, a female Assistant Organiser, thirty-five female and twenty-three male teachers, one swimming instructor and four accompanists.

All schools, including Special Schools and Further Education Centres, had the services, part-time or whole-time, of specialist teachers of Physical Education, and students from Dunfermline College of Physical Education carried on teaching practice in various Primary and Secondary Schools.

Primary Schools.

As far as it was practicable all classes had three periods of thirty minutes duration each week. Inclement weather curtailed outdoor activities but full use was made of playing-fields and playgrounds during periods of fine weather.

Specialist teachers of Physical Education paid weekly visits to all Infant and Primary Schools and taught demonstration lessons for the guidance of class-teachers. Of the three periods allocated to Physical Education each week, one was taught by a specialist teacher and the remaining two by the class-teacher. The work done was from the Syllabus of Physical Education for Primary Schools, augmented by work on the climbing/heaving frames with which all Infant and Primary Schools have been supplied. The principal aims of the lessons were to make the children as physically capable as possible, to test them and to make them aware of what they can do with their bodies, and to give them enjoyment and satisfaction through using their bodies. The high standard of work achieved and the unlimited enthusiasm of the children indicated that the teachers had been successful in their efforts.

Secondary Schools.

The work in the Secondary Schools has followed the same pattern as in recent years. Emphasis was again placed on the work of each individual pupil

rather than on the class as a whole and pupils were encouraged to be versatile, to test themselves and to work as near the top of their ability as possible. The indoor work for boys included a wide range of vigorous, purposeful activities intended to give mobility, strength, stamina and skill, whilst the work for girls included movement training, apparatus work and dancing, designed to give poise, graceful movement, skill, adequate strength and stamina.

Out-of-doors, inclement weather curtailed the winter programme, but much valuable work was done in teaching the basic skills of the major team-games and athletics. Facilities for the playing of tennis were again made available at public tennis courts for the pupils of eight Secondary Schools, one Senior Secondary School and Aberdeen School for the Deaf.

Pupils of Secondary Schools continued to show considerable interest in extra-curricular activities connected with Physical Education. Badminton groups met regularly, classes of instruction were held for pupils who wished to take part in the Duke of Edinburgh Award Scheme, judo, fencing, rowing and ski-ing groups were formed, and 191 pupils from nine Secondary Schools and three Senior Secondary Schools received instruction in golf from professional golfers. A table tennis tournament for Secondary Schoolboys was held in the Middle School during the Easter vacation, and 214 boys took part.

Indoor Accommodation.

With the exception of St. Peter's R.C. School and Frederick Street Secondary School, all Primary and Secondary Schools have adequate facilities for carrying out the indoor part of the Physical Education programme. The position at St. Peter's R.C. School and Frederick Street Secondary School has been noted in previous reports and, although there is no immediate solution, due regard has been taken of the difficulties, in the long term planning for Secondary Education in the eastward part of the City.

The indoor provision for Physical Education at Summerhill Secondary School is excellent and permits of a fully comprehensive programme being carried out, but out-of-doors, although the hard playing-area is very good, there will be a shortage of playing pitches when the school roll reaches the 850 mark.

The work on the new swimming pond at Aberdeen Grammar School is progressing satisfactorily and it is hoped that the pond, and the additional changing accommodation, spray-baths and storage-room for the existing gymnasium, will be available for use at the start of the second term.

Playing Fields.

All school playing-fields have been used extensively throughout the year.

The pavilion at Kaimhill Field was opened officially on Friday, 2nd March, 1962, by John M. Bannerman, Esq., and the field is now being fully used by Kaimhill and Ruthrieston Secondary Schools, and Abbotswell, Broomhill and Inchgarth Primary Schools.

The pupils of Aberdeen Academy have again been accommodated at Seaton Park and Harlaw Field, and Aberdeen Grammar School has again had the use of additional facilities at the Links, Harlaw Field and Mannofield.

The turf at Aberdeen Academy's new playing-field at Groat's Road is now reasonably well established but it has been decided that the field will not be available for play during the next school session. Part of the new playing-field at Northfield will be available for play from September, 1962, but as there will be no changing-accommodation available, it will be used only by the schools in the immediate vicinity. The work on the new extension to Rubislaw Field is well advanced; the upper part of the field has been sown and preparatory work on the remaining part should be completed in time for it to be sown this year.

Outdoor Activities.

The usual extensive programme of Primary, Secondary and Senior Secondary School games competitions was carried out on Saturdays and during the evenings throughout the session. In all these competitions the standard of play was high and the competition keen.

Hockey has now become firmly established as a game for boys and teams from six Secondary Schools participated regularly in inter-school matches. Rugby has continued to be well supported at Northfield Secondary School and a representative team has engaged in regular fixtures against teams from the Senior Secondary Schools in the City.

During the summer term considerable interest was shown in netball, cricket and athletics. The majority of the Primary Schools held individual sports meetings and eleven area inter-school sports meetings were held. All Secondary Schools held individual sports meetings and the Secondary Inter-School Sports Meeting was held at Linksfield Stadium on Wednesday, 13th June, 1962. The standard of performance at the inter-school meeting was very creditable and ten new records were established.

The summer activities in the Senior Secondary Schools were adversely affected by the fact that the examinations for the Leaving Certificate were held during the summer term, but all three schools managed to complete their programmes and held athletic sports meetings.

Thirty-four boys and twenty-one girls from the Senior Secondary Schools and three girls from Northfield Secondary School represented Aberdeen Schools at the Scottish Schools' Athletic Championships. It should be noted that this is the first time that girls from a Secondary School in Aberdeen have taken part in the Scottish Championships. One boy, Andrew Leach of Aberdeen Grammar School, gained first place in the 200 yards Hurdles in the senior group and several of the Aberdeen representatives contested the finals of their events.

Remedial Work.

Throughout the session approximately seventy children of school age attended the remedial clinic at Dunfermline College of Physical Education for treatment for a variety of physical defects.

Swimming.

Throughout the session swimming classes for beginners and classes for advanced swimming and life-saving were held in the Middle School Pond. The attendance for the session was 24,513, representing an average weekly attendance of 628.

Swimming classes for beginners were also conducted at the Bon-Accord and Beach Baths from October, 1961, to March, 1962. The total attendance at both ponds was 16,566 and the average weekly attendance was 690.

The swimming pond at Summerhill Secondary School has been in use during the summer term only, and all pupils have had one swimming lesson each week as part of their normal Physical Education programme. The pond has also been used by school pupils for organised recreational purposes during school hours, on Saturday forenoons and on certain evenings throughout the term.

Satisfactory progress was made in all swimming classes and excellent results were obtained in the various local tests and in those of the Royal Life-Saving Society.

Spray Baths.

The Corporation Spray baths at Hanover Street were used throughout the session by pupils from two Secondary and four Primary Schools in the east side of the City. The total attendance was 7,133 and the average weekly attendance 205.

OTHER ACTIVITIES RELATING TO SCHOOL CHILDREN.

(a) Linn Moor Convalescent Home, Culter.

During the year 69 children (51 boys and 18 girls) were sent to this Home as compared with 82 boys and 36 girls respectively in the previous year. In addition, two batches of 35 children all told were sent to Linn Moor Home under the auspices of the Aberdeen Association of Social Service.

(b) School Holiday Camps and Residential Courses, 1962.

1,151 pupils were examined by school health staff prior to attending school holiday activities and other residential courses.

(c) 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 107 breakfasts were supplied each day (as compared with 120 in 1960-61). The price of a two-course lunch remained at one shilling per meal during the year. Two-course lunches have been supplied daily during the year to an average of 5,375 pupils (as compared with 5,289 in 1960-61).

Three-course lunches to the daily average number of 33 were supplied to pupils attending the Trades College.

(d) School Milk.

The average number of bottles (one-third pint) of pasteurised milk daily was 27,678 as compared with 26,073 in the previous year.

TABLE I.

Total number of children examined at—			
(a) Systematic examinations—			
Entrants	2,306		
Eleven-year-olds	2,758		
Fourteen-year-olds	2,703		
Sixteen-year-olds	522		
		8,289	
(b) Re-inspections, Eye-testing and referrals to Monthly Visits	13,061		
Special Cases—			
Camps, Residential Schools, &c.	1,819		
Minor Ailments Clinic	294		
Child Guidance	51		
Handicapped Children, transfer requests, &c.	179		
		15,404	
			23,693

Number of individual children inspected at systematic examinations who were notified to parents as requiring treatment (excluding uncleanliness and dental caries)—

Entrants	234
Eleven-year-olds	172
Fourteen-year-olds	162
Sixteen-year-olds	26
	594

TABLE

SYSTEMATIC

Return of number and percentage of individual children

NATURE OF DEFECT.	Total Examined. All ages.	ENTRANTS.			
		Boys 1,176		Girls 1,130	
1. Clothing unsatisfactory	8,289	1	·09	1	·09
2. Footgear unsatisfactory	,,	—	—	—	—
3. Cleanliness—					
(a) Head: Nits	,,	2	·2	6	·5
Vermin	,,	—	—	—	—
(b) Body: Dirty or Verminous	,,	—	—	—	—
4. Skin—					
(a) Head:					
Ringworm	,,	—	—	—	—
Impetigo	,,	2	·2	3	·3
Other Diseases	,,	3	·3	3	·3
(b) Body:					
Ringworm	,,	—	—	1	·09
Impetigo	,,	—	—	—	—
Scabies	,,	—	—	2	·2
Other Diseases	,,	37	3·1	14	1·2
5. Nutritional state—					
Slightly defective	,,	39	3·3	46	4·1
Bad	,,	—	—	—	—
6. Mouth and Teeth Unhealthy	,,	85	7·2	86	7·6
7. Naso-Pharynx—					
(a) Nose:					
(i) Obstruction requiring observation	,,	91	7·7	68	6·0
(ii) Obstruction requiring Operative Treatment	,,	3	·3	3	·3
(iii) Other Conditions	,,	2	·2	2	·2
(b) Throat:					
(i) Tonsils requiring observation	,,	121	10·3	103	9·1
(ii) Tonsils requiring Operative Treatment	,,	102	8·7	82	7·3
(c) Glands:					
(i) Requiring observation	,,	38	3·2	36	3·2
(ii) Requiring Operative Treatment	,,	16	1·4	9	·8
8. Eyes—					
(a) External Diseases:					
Blepharitis	,,	8	·7	9	·8
Conjunctivitis	,,	—	—	1	·09
Corneal Opacities	,,	—	—	—	—
Squint	,,	53	4·5	51	4·5
Other Diseases	,,	6	·5	3	·3
(b) Visual Acuity (Snellen):					
Defective—Fair	,,	205	17·4	233	20·6
Bad	,,	33	2·8	32	2·8
Recommended for Refraction	,,	60	5·1	60	5·3
Number wearing Glasses	,,	37	3·1	41	3.6
9. Ears—					
(a) Diseases:					
Otorrhœa	,,	4	·3	5	·4
Other Diseases	,,	17	1·4	19	1·7

II.

EXAMINATIONS.

in each age-group suffering from particular defects.

SECOND AGE-GROUP.				THIRD AGE-GROUP.				FOURTH AGE-GROUP.				ALL AGES.			
Boys 1,393		Girls 1,365		Boys 1,295		Girls 1,408		Boys 248		Girls 274		Boys 4,112		Girls 4,177	
1	·07	—	—	—	—	—	—	—	—	—	—	2	·05	1	·02
2	·1	—	—	2	·02	—	—	—	—	—	—	4	·1	—	—
6	·4	23	1.7	—	—	8	·6	—	—	—	—	8	·2	37	.9
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
3	·2	—	—	—	—	2	·1	—	—	—	—	3	·07	2	·05
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
4	·3	3	·2	—	—	1	·07	—	—	—	—	6	·1	7	·2
4	·3	12	·9	11	·8	18	1·3	7	2·8	—	—	25	·6	33	·8
—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	·02
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
1	·07	—	—	1	·08	1	·07	—	—	—	—	2	·05	3	·07
63	4·5	38	2·9	68	5·3	56	4·0	32	12·9	7	2·6	200	4·9	115	2·8
28	2·0	33	2·4	25	1·9	19	1·3	—	—	—	—	92	2·2	98	2·3
1	·07	—	—	2	·2	2	·1	2	·8	—	—	5	·1	2	·05
55	3·9	38	2·9	58	4·5	54	3·8	15	6·0	—	—	213	5·2	178	4·3
49	3·5	39	2·9	44	3·4	38	2·7	3	1·2	15	5·5	187	4·5	160	3·8
4	·3	2	·1	2	.2	4	3	—	—	—	—	9	·2	9	·2
6	·4	2	1	1	.08	2	·1	3	1·2	—	—	12	·3	6	·1
40	2·9	52	3·8	17	1·3	43	3·1	2	·8	4	1·5	180	4·4	202	4·8
42	3·0	43	3·2	9	·7	15	1·1	3	1·2	1	·4	156	3·8	141	3·4
15	1·1	12	·9	1	·08	6	·4	—	—	2	·7	54	1·3	56	1·3
9	·6	7	·5	3	·2	8	·6	—	—	—	—	28	·7	24	·6
12	·9	16	1·2	7	·5	7	·5	—	—	—	—	27	·7	32	·8
—	—	2	·1	1	·08	—	—	—	—	—	—	1	·02	3	·07
1	·07	—	—	—	—	—	—	—	—	—	—	1	·02	—	—
34	2·4	41	3·0	14	1·1	22	1·6	1	·4	7	2·6	102	2·5	121	2·9
12	·9	14	1·0	13	1·0	13	·9	1	.4	—	—	32	·8	30	·7
163	11·7	208	15·2	140	10·8	159	11·3	22	8·9	36	13·1	530	12·9	636	15·2
28	2·0	33	2·4	23	1·8	18	1·3	3	1·2	2	·7	87	2·1	85	2·0
31	2·2	33	2·4	23	1·8	39	2·8	3	1·2	4	1·5	117	2·8	136	3 3
161	11·6	219	16·0	151	11·7	195	13·8	52	21·0	76	27·7	401	9·8	531	12·7
5	·4	3	·2	8	·6	7	·5	3	1·2	1	·4	20	·5	16	·4
9	·6	12	·9	6	·5	21	1·5	—	—	3	1·1	32	·8	55	1·3

TABLE

SYSTEMATIC

Return of number and percentage of individual children

NATURE OF DEFECT.	Total examined. All ages.	ENTRANTS.			
		Boys 1,176		Girls 1,130	
9. Ears—(Continued)—					
(*b*) Defective Hearing :					
Grade I	8,289	3	·3	5	·4
Grade IIA	,,	—	—	—	—
Grade IIB	,,	—	—	—	—
Grade III	,,	—	—	—	—
10. Speech—					
Defective articulation	,,	56	4·8	19	1·7
Stammering	,,	4	·3	—	—
11. Mental and Nervous Condition—					
(*a*) Backward	,,	9	·8	3	·3
(*b*) Dull	,,	—	—	—	—
(*c*) Mentally deficient (Educable)	,,	—	—	—	—
(*d*) Mentally deficient (Ineducable)	,,	—	—	—	—
(*e*) Highly nervous or unstable	,,	11	·9	5	·4
(*f*) Difficult in behaviour	,,	19	1·6	12	1·1
12. Circulatory System—					
(*a*) Organic heart disease :					
(i) Congenital	,,	6	·5	4	·4
(ii) Acquired	,,	1	·09	—	—
(*b*) Functional conditions	,,	3	·3	1	·09
13. Lungs—					
Chronic bronchitis	,,	2	·2	1	·09
Suspected tuberculosis	,,	5	·4	4	·4
Other diseases	,,	32	2·7	22	1·9
14. Deformities—					
(*a*) Congenital	,,	14	1·2	6	·5
(*b*) Acquired (Infantile paralysis)	,,	1	·09	1	·09
(*c*) Acquired (Probably rickets)	,,	2	·2	—	—
(*d*) Acquired (Other causes)	,,	31	2·6	36	3·2
15. Infectious diseases	,,	1	·09	1	·09
16. Other diseases or defects	,,	131	11·1	90	8·0
17. Classification :					
Group I	,,	386	32·8	412	36·5
Group IIA	,,	81	6·9	120	10·6
Group IIB	,,	23	2·0	36	3·2
Group IIC	,,	7	·6	4	·4
Group III	,,	567	48·2	464	41·1
Group IVA	,,	86	7·3	76	6·7
Group IVB	,,	26	2·2	18	1·6
Number Notified to parents	,,	127	10·8	107	9·5
Number under observation	,,	643	54·7	551	48·8
Number of Parents present	,,	1,129	96·0	1,076	95.2

II (Continued.)

EXAMINATIONS.

n each age-group suffering from particular defects.

SECOND AGE-GROUP.				THIRD AGE-GROUP.				FOURTH AGE-GROUP.				ALL AGES.			
Boys 1,393		Girls 1,365		Boys 1,295		Girls 1,408		Boys 248		Girls 274		Boys 4,112		Girls 4,177	
5	·4	—	—	5	·4	4	·3	—	—	—	—	13	·3	9	·2
—	—	2	·1	1	·08	1	·07	—	—	1	·4	1	.02	4	·1
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
—	—	—	—	1	·08	—	—	—	—	—	—	1	·02	—	—
8	·6	2	·1	3	·2	2	·1	—	—	—	—	67	1·6	23	·6
6	·4	1	·07	10	·8	2	·1	1	·4	—	—	21	·5	3	·07
1	·07	—	—	3	·2	4	·3	—	—	—	—	13	·3	7	·2
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
—	—	1	.07	—	—	—	—	—	—	—	—	—	—	1	·02
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
8	·6	12	·9	12	·9	5	·4	—	—	1	·4	31	·8	23	·6
5	·4	12	·9	4	·3	4	·3	—	—	1	·4	28	·7	29	·7
1	·07	3	·2	3	·2	3	·2	—	—	—	—	10	·2	10	·2
1	·07	—	—	1	·08	3	·2	—	—	—	—	3	·07	3	·07
1	·07	—	—	6	·5	2	·1	1	·4	—	—	11	·3	3	·07
1	·07	1	·07	2	·2	—	—	1	·4	—	—	6	·1	2	·05
4	·3	5	·4	9	·7	10	·7	—	—	—	—	18	·4	19	·5
43	3·1	16	1·2	32	2·5	15	1·1	4	1·6	5	1·8	111	2·7	58	1·4
7	·5	13	1·0	3	·2	5	·4	2	·8	1	·4	26	·6	25	·6
3	·2	5	·4	1	·08	3	·2	1	·4	1	·4	6	·1	10	·2
—	—	3	·2	1	·08	1	·07	1	·4	—	—	4	·1	4	·1
49	3·5	47	3·4	43	3·3	42	3·0	12	4·8	3	1·1	135	3·3	128	3·1
—	—	—	—	—	—	—	—	—	—	—	—	1	·02	1	·02
148	10·6	115	8·4	111	8·6	108	7·7	8	3·2	31	11·3	398	9·7	344	8·2
640	45·9	630	46·2	690	53·3	746	53·0	129	52·0	150	54·7	1,845	44·9	1,938	46·4
160	11·5	175	12·8	166	12·8	184	13·1	35	14·1	43	15·7	442	10·7	522	12·5
21	1·5	11	·8	22	1·7	26	1·8	9	3·6	—	—	75	1·8	73	1·7
4	·3	5	·4	4	·3	5	·4	2	·8	—	—	17	·4	14	·3
435	31·2	427	31·3	308	23·8	359	25·5	54	21·8	64	23·4	1,364	33·2	1,314	31·5
74	5·3	69	5·1	55	4·2	56	4·0	12	4·8	11	4·0	227	5·5	212	5·1
59	4·2	48	3·5	50	3·9	32	2·3	7	2·8	6	2·2	142	3·5	104	2·5
93	6·7	79	5·8	78	6·0	84	6·0	14	5·6	12	4·4	312	7·6	282	6·8
546	39·2	447	32·7	325	25·1	385	27·3	57	23·0	71	25·9	1,571	38·2	1,454	34·8
,088	78·1	1,146	84·0	514	39·7	643	45·7	42	16·9	42	15·3	2,773	67·4	2,907	69·6

Table III.

Systematic Medical Examinations.

Classification	Entrants		Second Age-group		Third Age-group		Fourth Age-group		Total	
	No. of Children	Percentage of the Children examined in this Group	No. of Children	Percentage of the Children examined in this Group	No. of Children	Percentage of the Children examined in this Group	No. of Children	Percentage of the Children examined in this Group	No. of Children	Percentage of the Children examined in this Group
I. Children free from defects	798	34·6	1,270	46·0	1,436	53·1	279	53·5	**3,783**	**45·6**
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	201	8·7	335	12·1	350	13·0	78	14·9	**964**	**11·6**
(*b*) Oral Sepsis, etc.	59	2·6	32	1·2	48	1·8	9	1.7	**148**	**1·8**
(*c*) Both (*a*) and (*b*)	11	·5	9	·3	9	·3	2	·4	**31**	**·4**
Total	271	11·8	376	13·6	407	15·1	89	17·0	**1,143**	**13·8**
III. Children suffering from ailments (other than those mentioned in II.) from which complete recovery is anticipated within a few weeks	1,031	44·7	862	31·3	667	24·7	118	22·6	**2,678**	**32·3**
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	162	7·0	143	5·2	111	4·1	23	4·4	**439**	**5·3**
(*b*) Where improvement only is considered possible, *e.g.*, without complete restoration of function	44	1·9	107	3.9	82	3·0	13	2·5	**246**	**3·0**
Total	206	8·9	250	9·1	193	7·1	36	6·9	**685**	**8·3**
Total number of children examined	**2,306**	**100%**	**2,758**	**100%**	**2,703**	**100%**	**522**	**100%**	**8,289**	**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	—	4	—	4
2. Partially sighted—				
(*a*) Refractive errors in which the curriculum of an ordinary school would adversely affect the eye condition	—	7	—	7
(*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	—	4	—	4
3. Deaf—				
Grade I	96	—	—	96
Grade IIA	49	—	—	49
Grade IIB	—	11	—	11
Grade III	—	22	—	22
4. Defective Speech —				
(*a*) Defects of articulation requiring special educational measures	995	70	—	1,065
(*b*) Stammering requiring special educational measures	126	20	—	146
5. Mentally defective children (between 5 and 16 years)—				
(*a*) Educable (I.Q. approx. 50-70)	—	274	—	274
(*b*) Trainable	—	55	—	55
(*c*) Ineducable	—	—	16*	16
6. Epilepsy—				
(*a*) Mild and occasional	29	9	—	38
(*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)	12	—	—	12
(*b*) General orthopædic conditions	74	33	—	107
(*c*) Organic Heart Disease	78	6	—	84
(*d*) Other causes of ill-health	18	13	—	31
8. Multiple defects—				
(*a*) Mentally defective and deaf	—	2	—	2
(*b*) Physically defective and mentally defective	—	7	—	7
(*c*) Mentally defective (ineducable) and blind	—	—	—	—

*44 ineducable children of school-age are in Institutions.

Table V.—Heights and Weights, 1941-1962.

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.		
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
1956-57	5 3	42·5	42·3	9 4	51·9	64·6	13 5	60·0	96.9	16 4	67·7	136·4
1957-58	5 3	42·5	42·2	9 4	51·8	64·5	13 5	59·6	97·5	16 4	67·3	135·9
1958-59	5 2	42·5	42·2	9 4	51·6	64·0	13 2	60·1	96·5	16 6	67·6	133·5
1959-60	5 2	42·5	42·1	9 4	51·3	64·2	13 3	59·9	96·6	16 6	67·9	138·7
1960-61	5 3	42·8	42·9	11 6	55·9	78·6	14 6	62·9	111·4	16 6	67·8	138·7
1961-62	5 3	[illegible]	[illegible]	GROUP II.—11 Years			GROUP III.—14 Years					

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.		
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
1957-58	5 1	42·4	41·3	9 4	51·3	63·5	13 3	60·1	100·7	16 4	64·1	125·7
1958-59	5 2	42·1	41·6	9 4	51·1	63·0	13 4	60·4	101·2	16 5	63·6	122·3
1959-60	5 2	42·2	41·0	9 3	51·3	63·3	13 4	61·1	103·2	16 6	62·8	123·5
1960-61	5 3	42·4	41·5	11 6	56·2	81·1	14 6	61·6	112·7	16 7	63·4	123·9
				GROUP II.—11 YEARS			GROUP III.—14 YEARS					
1961-62	5 4	42·8	41·9	11 5	56·1	81·0	14 3	61·5	110·5	16 7	63·6	125·5

29.—STAFF AS AT 31ST DECEMBER, 1962.

Medical Officer of Health and Director of Welfare	Ian A. G. MacQueen, M.A., M.D., D.P.H., F.R.S.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.D., D.P.H., D.I.H.
Senior Assistant Medical Officers .	Dorothy Younie, M.D., D.T.M. & H. Margaret Ormiston, M.B., Ch.B., D.P.H. William J. W. Rae, M.D., D.P.H.
Honorary Deputy Medical Officers of Health	Professor Edward M. Backett, B.Sc., M.B., B.S. M.R.C.P., D.P.H. Douglas Bell, M.D., D.P.H. (Tuberculosis). James G. Henderson, M.B., Ch.B., Dipl. Psych. E Ian M. Richardson, M.D., Ph.D., F.R.C.P.E., D.P.H Leslie A. Wilson, M.A., M.D., M.R.C.P. (Geriatrics
Honorary Assistant Medical Officer .	Roy D. Weir, M.B., Ch.B., D.P.H.
Departmental Medical Officers . . (all M.B., Ch.B., D.P.H. unless otherwise stated)	Dodson P. Brunton, Mary Hunter, Elizabeth C. Lain M.D., D.P.H., Alexander W. McIntosh, M.I D.P.H., Jean Pattullo, George N. Summers, M.I Ch.B., D.P.H., D.T.M. & H., Marie S. Suth land, Doreen G. Warnock, M.B., Ch.B., D.P.I D.R.C.O.G., Margaret S. M. McGregor, M.I D.P.H. (part-time)
Chief Dental Officer	Archibald Hay, L.D.S.
Dental Officers . . . . . (all L.D.S. unless otherwise stated)	Hugh Clunas, Rosalind A. Russell, B.D.S., Elizab S. Walker, Hilda C. Blair, (part-time) 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	John B. Tait, B.A. (Oxon).
Principal Health Visitor Tutor and Senior Health Education Lecturer	D. Joan Lamont, S.R.N., S.C.M., Health Visito Certificate, Health Visitor Tutor's Certificate.
Health Visitor Tutor and Junior Health Education Lecturer	Alice M. G. Hay, R.G.N., S.C.M., R.F.N., Hea Visitor's Certificate; Health Visitor Tutor's Ce ficate.
Health Visitor Tutor and Assistant Health Education Lecturer	Vacant.
Superintendent Health Visitor and Co-ordinating Nursing Officer	Margaret Nairn, R.G.N., S.C.M., Health Visit Certificate; Public Health Administrator's Cer cate.

puty Superintendent Health Visitor and Supervisor of Midwives	Lisetta J. Stephen, R.G.N., S.C.M., Health Visitor's Certificate.
puty Superintendent Health Visitor	Annie Bennet, R.G.N., S.C.M., Health Visitor's Certificate.
sistant Health Education Lecturer and Centre Superintendent	Agnes W. Maxwell*, R.G.N., S.C.M., R.F.N., Health Visitor's Certificate.
ntre Superintendents (all R.G.N. S.C.M., H.V. Cert.)	Isabella Campbell, Mary F. Deans, Marjorie Galloway, Catherine Greig, Maragaret C. P. Mair, Mary J. Ness, Margaret T. Sheridan, Margaret Scott, Nan Sutherland*, Elizabeth J. Thow, Catherine Wilson.
ntal After-Care Officers	4
alth Visitors	73 (including 10½ vacancies).
miciliary Midwives	12 (including 2 vacancies).
dwife employed in Clinic	1
nic Sisters	5
cial Adviser	Margaret Bell, B.A. (Admin.).
cial Worker (part-time)	Freda Ogston, Social Science Certificate.
pervisor of Nurseries	Elizabeth C. Jackson, S.R.N., S.C.M., Health Visitor's Certificate.

rseries—

	Matrons.		*Staff.*
a) Residential—			
Pitfodels	Elizabeth C. Jackson, S.R.N., S.C.M., H.V. Cert. (also Supervisor of Nurseries)		42
b) Day—			
Charlotte Street	Penelope Sandison, R.G.N.	(including 1 vacancy)	18
Linksfield	Elizabeth A. D. Stobo, S.R.N., S.C.M.	(including 1 vacancy)	9
Deeside	Grace Florence, S.R.N., R.S.C.N., S.C.M.		13
View Terrace	Christina Milne, S.R.N.		14

) People's Homes—

ALNAGASK	Superintendent and Matron	Mr. and Mrs. F. W. Gibson	6
ERRYHILL	Matron	Annie F. Sutherland	5½
ORTHFIELD	Matron	Alice M. S. Duguid	8
LBYN	Superintendent and Matron	Mr. and Mrs. John C. Wilson	5
EWHILLS	Superintendent and Matron	Mr. and Mrs. W. G. Low	14
OLMUIR	Superintendent and Matron	Mr. and Mrs. D. Duthie	6½
HORNGROVE	Matron	Mary H. Middleton	12
osewell	Matron	Jessie N. Mundie	10

Supernumerary—1 Assistant Matron, 1 Ward Orderly (both vacant).
Night Attendants—2.

*On long-term leave of absence.

Sanitary Section—

Chief Sanitary Inspector	Herbert B. Parry, Sanitary Inspector's Certificate, Meat Certificate.
Senior Assistant Sanitary Inspector	William Jackson, Sanitary Inspector's Certificate, Meat Certificate.
Fish Inspector	Sydney Howell, Sanitary Inspector's Certificate, Meat Certificate.
District Sanitary Inspectors	5.
Assistant District Sanitary Inspectors	8 (including 3 vacancies).
Apprentice Sanitary Inspectors	4 (including 1 vacancy).
Probationer Sanitary Inspector	1.
Shops Act Inspectors	2.

Meat Inspection Section—

Senior Meat Inspector and Disease of Animals Inspector	William M'Donald, Meat Inspector's Certificate
Senior Assistant Meat Inspector and Disease of Animals Inspector	William Lorimer, Meat Inspector's Certificate
Meat Inspectors	4.

Welfare Section—

Assistant Welfare Officer	Norman W. Strath.
District Welfare Officers	3.

Clerical—

Senior Clerical Staff	A. M. Ledingham, Secretary to Medical Officer of Health; V. Anderson; M. M. Barry; A. G. Gall; D. R. Gibb; A. E. Munro; C. Ritchie; H. Taylor; M. Thomson.
Other Clerical Staff	33 (including 5 vacancies).

Miscellaneous—

Dietitian	Vacant.
Audiometrician	M. I. Durno.
Orthoptist	Vacant.
Senior Chiropodist	J. Ramsay. A. Cormack (part-time). 3 Vacancies.
Senior Physiotherapist	Vacant.
Physiotherapist	Vacant.
Senior Occupational Therapists	Jas. T. Lauder. 1 Vacancy.
Occupational Therapist	Vacant.
Occupational Workshop Storeman/Attendant	1.
Dental Attendants	6 (including 1 vacancy).

Dental Hygienist	Vacant.
Clinic Attendants	7
Male Visitor, School Health Service	1.
Practical Supervisors of Domestic Helps	2.
Domestic Helps	Equivalent to 190 full-time.
Drivers and Porters	4.
Rat-catchers	5 (including 1 vacancy).
Civil Defence Welfare Officer . .	R. M. Kirton.
Laboratory Technician . . .	1.

Lodging House—

Superintendent and Matron . .	Mr. and Mrs. C. Greig (Staff 14).

30.—A HUNDRED YEARS OF HEALTH WORKERS IN ABERDEEN.

As 1962 is the centenary year of public health services both in Scotland and in Aberdeen, a short historical outline may be of some interest.

If, in the sketch that follows, I appear to concentrate largely on the medical officers of health, and almost to ignore the contributions made by meat inspectors, sanitary inspectors, health visitors, and other workers, the explanation is two-fold: first, that I have tried to sail along the central stream of health, avoiding excursions into side-channels, and second, that the early medical officers of Aberdeen were a curiously distinguished series: there must be few cities that can claim to have had before the end of the 19th century two M.Os.H. who were subsequently knighted and four who achieved international reputations.

Aberdeen in 1862.

A hundred years ago Aberdeen was in the full flood of the industrial revolution. Less isolated than formerly (for the railway had crossed the Dee in 1850), the city occupied a small geographical area (not yet including within its boundaries the semi-rural district of Rosemount or the large village of Torry); but the population had tripled in the last sixty years (rising from 26,992 in 1801 to 73,805 in 1861) and was to double in the next forty. Rapid increase of population, open sewers, impure water, growing overcrowding and absence of health services—preventive, educational, sanitary and social alike—had combined to produce a disease picture that today is almost incredible. The infant death rate (uncorrected for residence) averaged 126 per thousand births: in other words one baby in every eight died in infancy (a figure that was to go on rising for the next forty years). The average age of all persons who died was under thirty years. One fifth of all deaths were due to tuberculosis—about 375 tuberculosis deaths annually in a population of 74,000. Typhus and typhoid fever (not yet differentiated) between them killed a hundred citizens annually, and the estimated total of cases each year was around a thousand. Diphtheria and Scarlet Fever each killed off more than a hundred Aberdonians every year: in the decade 1856-65 scarlet fever deaths averaged 125 annually and diphtheria deaths averaged 106. Smallpox was another common killer and cholera an occasional but dreaded visitor.

The same revolution that increased the squalor of cities and the ravages of infectious disease aroused the social conscience of the country: it is perhaps more than coincidental that Lord Provost Sir Alexander Anderson brought forward his scheme for a proper water supply taken from the upper reaches of the Dee in the very year (1859) that Rathbone was producing his project for home nursing of the poor in Liverpool; and that the year (1862) that saw the setting up of health visitors (in Salford) witnessed the appointment of Henry Littlejohn in Edinburgh and Francis Ogston in Aberdeen as the first medical officers of health in Scotland.

The dawn of public health services.

If we exclude police surgeons, Aberdeen's first paid health worker was not a medical officer, nor a sanitary inspector, nor a health visitor, nor a clerk, but a meat inspector—Mr. Mellis, who was appointed inspector of unwholesome meat under an Act of 1856 and served until his death in 1865. He had two part-time colleagues, Messrs. Cruickshank and Watson. In 1862, however, the Town Council succeeded in getting a special Act of Parliament passed. The Act for Paving, Cleansing, Lighting, Watching, Draining & Improving the City of Aberdeen (7th August, 1862) containing the following section:—

> "130. The Commissioners may, if they think fit, appoint . . . . . a person of competent skill and experience, who shall be styled "the Officer of Health", and whose duty it shall be to ascertain the existence of diseases within the limits of this Act, especially epidemics of contagious diseases, and to point out any nuisances or other local causes likely to cause and continue such diseases or otherwise injure the health of the inhabitants, and to point out the best means of checking or preventing the spread of such diseases within the limits of the Act, and the best means for the ventilation of churches, chapels, schools, registered lodging houses and other public buildings . . . . . "

Thereafter Professor Francis Ogston, aged 59, was appointed Officer of Health for the city in 1862.

The Ogstons—Francis Alexander and Francis Junior.

Francis Ogston (1803-87) was an expert on forensic medicine—his *Lectures on Medical Jurisprudence* (1878) was for a generation the standard text-book—and it is probably fair to say that, without neglecting public health work, he regarded it very much as a side-line. The son of an Aberdeen soap manufacturer, he attended the Grammar School, took his M.A. at Marischal College in 1821 and completed his medical studies in Edinburgh where he graduated M.D. in 1824. After a period of study on the continent he returned to his native city, where he acquired a large practice and was appointed police surgeon in 1831. Additionally he held the lecturership in medical jurisprudence from 1839 and this was converted into a professorial chair in 1857. He held the chair in Marischal until the union of the two universities in 1860 (following the Act of 1858) and thereafter continued to hold the chair in the University of Aberdeen until 1883. He was for a time Dean of the Faculty of Medicine, and he received an honorary LL.D. in 1885.

Although (as indicated presently) it may be arguable whether Ogston was sole M.O.H. for nineteen years or joint M.O.H. for part of that period, there is no shadow of doubt as to his appointment in 1862 (very shortly after Littlejohn in Edinburgh and earlier than Gairdner in Glasgow) and as to his resignation at the beginning of 1881. Comrie's *History of Scottish Medicine* (a book of remarkable accuracy) says, "He also held the post of Medical Officer of Health for Aberdeen from 1862 to 1881"; and the *Medical Directory*, presumably using information supplied by Ogston himself, calls him M.O.H. for these nineteen years, while the *Dictionary of National Biography* concurs, as does Rodger's *Aberdeen Doctors*. The absence of doubt is here stressed because anyone who dips casually into the Corporation Minutes—extant only in hand-written form—is liable to be misled into believing that no M.O.H. existed.

Salient points to be kept in mind by persons studying the Minutes are these:—(a) There were a series of different part-time posts—e.g. Officer of Health, Police Surgeon, Medical Superintendent of Fever Hospital and Medical Officer at Gas Works—which were sometimes in part combined, sometimes filled by entirely different people, and sometimes in part left in abeyance during the absence of cholera; (b) none of these posts had at that time any security of tenure; (c) for a quarter of a century the Town Council contained a group (initially led by Sir Alexander Anderson) who wanted a full-time M.O.H. (and subsequently also a full-time S.I.) and another group opposed to such appointments; and (d) while the Minutes utterly fail to differentiate between full-time and part-time posts, it can be assumed that proposals involving payments of £200 p.a. or more to the M.O. and £60 or more to the Meat Inspector, or the Sanitary Inspector, relate to full-time work, and that proposals involving substantially smaller sums relate to part-time work. [Incidentally printed Minutes exist from 1883 onwards and Annual Reports of Medical Officers of Health are available from 1900.]

Here are some examples from 1866. In June the Lord Provost gives notice of motion to appoint an M.O.H., and the Clerk is instructed to enquire from Dr. Ogston as to his views regarding the performance of medical duties "in addition to those he presently discharges"; in July the motion to appoint an Officer of Health is carried and the salary fixed at £200 p.a.; in August four applications are considered—one being from Professor Ogston now aged 63—but a motion to delay the appointment is carried by a narrow majority, the Minute added "Dr. Ogston to continue his services through the courses of the cholera visitation"; and three months later Ogston is presenting his annual report as police medical officer, while the Council, after fixing the salary of a full-time S.I. at £75, decide to defer any appointment of an S.I. "until they should be better advised of the conditions as to the appointment of Medical Officer".

After the 1867 Public Health Act to some extent superseded the Local Act, the question of part-time or full-time appointment was complicated by the question of a substitute to act in the absence of the M.O. In February, 1868, Ogston is appointed M.O.H. at a salary (made retrospective to first January) of £43 10s. p.a., with no fees payable to him; and a month later he and his eldest son,

Alexander (later Professor Sir Alexander) Ogston, are appointed jointly at salaries of £33 10s. and £10 respectively. Four years later (August, 1872) there is a dispute between the Local Authority and Alexander Ogston over a claim by the latter for fees for services at the smallpox hospital: the Council refuse to pay and Alexander declines to continue work at the hospital, whereupon the appointments of both Francis and Alexander are cancelled. A week later wiser counsels prevail: Alexander receives £230 in recompense for his services at the smallpox hospital, the amount being apparently determined by an arbiter. Next month both Francis and Alexander resign; and two months afterwards Francis accepts the joint posts of M.O. and Police Surgeon at a salary of £63 p.a. (backdated for four months), and a month later (February, 1873) Dr. Patrick Smith is named as substitute for Professor Ogston, and there is no further mention of Alexander Ogston. A third Ogston—Francis junior—replaced Dr. Smith in 1878. Finally in December, 1880, Professor Ogston tenders his resignation at the age of 77.

The expert in forensic medicine, Professor Francis Ogston, was clearly the first M.O.H. of Aberdeen. Was his eldest son Deputy M.O.H. from 1868-1872 or joint M.O.H.? From the distribution of the salary in 1868 it would seem that the intention was to pay Alexander as deputy, but a Minute of 16th March, 1868, specifically refers to them as Joint Medical Officers. It has also to be remembered that by 1870 Professor Francis Ogston was well beyond what we nowadays term the "age of retirement"; and the 1872 dispute makes it clear that it was the son who did the work and received £230 in compensation. Moreover the Post Office Directory of 1872-73 gives F. Ogston as police surgeon and A. Ogston as M.O.H.; and W. H. Ogston's biography of his father (Aberdeen University Press, 1943) is equally specific, as is an article in the *Lancet* (1929). It is therefore fair to regard Alexander Ogston as the second M.O.H. of the city, acting jointly with his father for some years.

A contemporary of Sir Patrick Manson (the "father of tropical medicine" who—with all due respect to Sir William Simpson and to the Jamesons and Campbells of a later generation—is probably Aberdeen's most distinguished medical graduate) Alexander Ogston (1844-1929) entered Marischal College from the Grammar School in 1859, gaining twelfth place in the Bursary Competition, subsequently interrupted his course to study in Vienna, returned to Aberdeen and graduated M.B., C.M. with Honours in 1865, and M.D. with Honours in 1866. As already stated he served as joint M.O.H. from 1868 to 1872, became more and more interested in surgery, was appointed professor of surgery at Aberdeen in 1882, was made an LL.D. in 1910, and was knighted in 1912. He retained some interest in public health, however: for instance, in 1902 he accepted appointment as a member of the Royal Commission on Physical Education—the Commission that led to the creation of the School Health Service.

The third member of the Ogston family, Francis junior (son of the first M.O.H. and younger brother of Alexander) was deputy M.O.H. from 1878 to 1881, and later became Professor of Public Health and Medical Jurisprudence

at the University of Otago, New Zealand. (It is interesting to mention at this point that, exactly a hundred years after Francis became Medical Officer of Health, the wife of Alexander's grandson joined the staff as a social worker.)

Aberdeen's first M.O.H. had an international reputation in forensic medicine. The second M.O.H. went to the top of the tree in surgery, and the third (as will be mentioned presently) became world-famous for work on tropical hygiene. But we must look at other early appointments.

Meat Inspector, Sanitary Inspector and Veterinary Surgeon.

As already mentioned, Mr. Mellis's appointment as Inspector of Unwholesome Meat antedated that of the first M.O.H.; and Mr. George Thomson was appointed as Meat Inspector in succession to Mr. Mellis in June, 1865.

In November, 1867, the Council decided to appoint a Sanitary Inspector and fixed the salary at £75 p.a.; and a month later Mr. Thomson was so appointed. his duties to include those of his former post, at the same £75 a year. The dual job at the single salary seems harsh treatment, but worse was to follow. In 1869, the Council came to the conclusion that both jobs could be more efficiently performed by the Superintendent of Police with skilled assistance when he needed it. Accordingly, they appointed Mr. Swanson, Superintendent of Police, as Sanitary Inspector (at £20 p.a. extra) and as Inspector of Unwholesome Food (at £5 extra), allowed £25 for skilled assistance for not more than twelve hours per week, and terminated Mr. George Thomson's appointment, giving him a certificate of service. Shortly afterwards they appointed Mr. James Thomson, Veterinary Surgeon, as Inspector under the Contagious Diseases (Animals) Act, at £25 p.a.

The unfortunate George Thomson sued the Local Authority for deprivation of office without sufficient notice, but lost his case.

In 1874, following representations to the Police Committee by the Home Office that it was inexpedient for the Superintendent to hold the office of S.I., the appointment (at the same £20 p.a. as before) was transferred to Mr. James Minty, Assistant Surveyor of Police. Superintendent Swanson, however, continued to hold the post of Food Inspector.

Four years later (1878) the Council decided to appoint a full-time C.S.I. and assistant, but to leave the M.O.H. on a part-time basis. Investigating the existing position they

> "find that the present Sanitary Staff consists besides the Medical Officer and Mr. James Minty, Sanitary Inspector, who is also Assistant Surveyor and devotes only part of his time to Sanitary work for which his salary is £20 per annum, of Joseph Cumine, Sanitary Visitor and Disinfector who devotes his whole time to his duties and who receives £1 5s. per week of wages."

Accordingly they appointed Mr. Minty as C.S.I., conditional on his resigning his other appointments, and took over Mr. Cumine as assistant. The same Minute expressly stated that the Superintendent of Police continued as Inspector of Unwholesome Food, with the aid of the Veterinary Surgeon.

Incidentally Mr. Minty (1827-1902), a native of Portsoy, gave Aberdeen almost half a century of loyal service in various capacities—as Inspector of Police Works, 1848-71, a post in which he succeeded his father; as Assistant Surveyor (with responsibility for cleansing and the fire service), 1871-74; as Assistant Surveyor & Sanitary Inspector, 1874-78; as full-time Sanitary Inspector, 1878-82; and (a transfer at his own request) as Inspector of Cleansing, 1882-97.

By the date of Professor Ogston's resignation the new Fever Hospital had been opened, the Health Office had been moved from Marischal Street to 30, Castle Street, and there was a C.S.I. and an assistant.

A full-time M.O.H.

In February, 1881, the Public Health Committee recommended that the posts of M.O.H., Police Surgeon, Fever Hospital Superintendent, M.O. at the Gas Works and Inspector under the Dairies & Milkshops Order (apart from the veterinary surgeon's part) be combined and held by a full-time M.O. at a salary of £300 p.a., and four months later they terminated various part-time medical appointments. They also specified that the M.O. "shall be head of the Sanitary Department of the Town Council and shall carry out all the duties devolving on a Medical Officer" and that he shall "have the charge and direction of the other members of the Council's Sanitary staff".

Thereafter they appointed Dr. W. J. R. Simpson as M.O.H. at a salary of £300 (later raised to £430), and in the same year Mr. Minty was transferred to the post of Inspector of Cleansing, and (in February, 1882) Mr. Kenneth Cameron of Glasgow, was appointed as S.I. at £80 p.a. with a house, rent free, at the City Hospital. His salary was later increased to £120.

William John Ritchie Simpson (1855-1931), a Glaswegian by birth, graduated M.B., C.M., at Aberdeen in 1876, and M.D. in 1880, obtaining his D.P.H. at Cambridge in the latter year, became M.O.H. of Aberdeen in July, 1881, left to become M.O.H. of Calcutta early in 1886, was knighted and achieved an international reputation as M.O.H. of Calcutta (1886-97) and later as Professor of Hygiene at King's College, London, and Director of the Ross Institute of Tropical Medicine. His *Maintenance of Health in the Tropics* was a standard work until well after the first World War. During his 4½ years in Aberdeen he showed promise of his later brilliance. [The present writer about five years ago studied an article on the main causes of death in Aberdeen from 1858-1883, written in the latter year by W. J. Simpson, and—while then completely unaware that the Simpson in question was the man who later became the famous Sir William—regarded the article as the most penetrating 19th century analysis that he had encountered.]

One would like to know what drove Simpson away from Aberdeen and away from British public health. Was it simply the hostility of the group who had been opposed to the appointment of a full-time M.O.H.? Or was there internal warfare between Simpson and Kenneth Cameron, the S.I.? Or did Simpson in some way come into conflict with a Council geared to a slower rate of progress than he was prepared to accept?

Whatever the cause or causes, the final stroke seems to have occurred at the beginning of 1886. At some time between 1882 and 1885 the duties of Inspector of Unwholesome Food, previously under the Control of the Police Superintendent, had come under the jurisdiction of the M.O.H.; but in January, 1886, they were removed, and the salary of the M.O.H. reduced by £30, being the fraction previously allocated to these duties. A month later Simpson resigned.

The whole-time, part-time struggle.

It would seem that in 1886 the struggle between those who wanted a part-time officer (on the lines of the Ogstons) and those who preferred to continue to have a full-time M.O.H. resulted in a highly unsatisfactory situation. The advocates of whole-time employment won to the extent that the post was so advertised, but many duties previously allocated to the M.O.H. were removed from him, and the remuneration was cut back to £300—a full-time salary unlikely to attract an experienced doctor of high ability.

One candidate was Professor Matthew Hay (who had succeeded Francis Ogston as Professor of Medical Jurisprudence in 1883) who indicated in his application that he proposed, if appointed, to retain his University post. By a small majority (13 to 10) it was decided that the application be not considered.

As would be expected from the conditions of appointment and the salary, the doctor appointed was fairly junior in his profession. Theodore Thomson, who had been born at Belhelvie in 1858, had taken his M.A. at Aberdeen in 1877, his L.R.C.P. at Edinburgh in 1883, and his M.B. at London in 1884. At the time of his appointment as M.O.H. in 1886 he was an assistant M.O. in the South-Eastern Fever Hospital, London.

After less than one and a half years in Aberdeen, Thomson resigned on being appointed M.O.H. of Sheffield, at nearly twice the Aberdeen salary. In view of the reputations of Sheffield and Aberdeen in health education three quarters of a century later, one would like to be able to say that in both cities the initial spark came from Thomson; but for Aberdeen at least there is no shadow of evidence.

Thomson took his D.P.H. at Cambridge in 1888, the year in which he became M.O.H. of Sheffield, and subsequently graduated M.D. (State Medicine) in 1892, and took a Barrister's qualification in 1894. After doing good work in Sheffield he moved to Whitehall as Inspector under the Local Government Board, and received a C.M.G. in 1905.

To return to the Aberdeen story, in the early months of 1888 the whole or part-time battle raged, while Dr. Mackenzie Booth acted as interim M.O.H. The Health Committee decided that the post should be a full-time one with the additional requirement that the new M.O.H. should reside at the City Hospital. The latter requirement was rejected by the Town Council after a series of votes, and feeling ran so high that the Convener of the Health Committee resigned. The Aberdeen, Banff and Kincardine Branch of the B.M.A. supported the majority of the Health Committee by submitting a petition that the M.O.H. devote the whole of his time to the duties of his office.

Professor Matthew Hay again applied, stating in his application that he would retain his Chair but would give up private practice. After a series of votes as to whether his application should be considered or not, he was eventually appointed M.O.H. (at a salary of £300) by a resounding majority; and a public meeting of ratepayers registered a protest at the appointment of a part-time M.O.H.

It must have looked in 1888 as though the forces seeking public health progress had lost decisively: the M.O.H. had lost control both of Meat Inspectors and of Sanitary Inspectors (i.e. he had no staff at all), his salary was that of a part-timer, he was already a distinguished professor of a subject separate from public health, he was likely—like Ogston—to treat his local authority duties as a sideline, and, if he sought to develop the health services, he had 'all the disadvantages both of an incomer to Aberdeen and of the expressed hostility of the B.M.A. and of many ratepayers, including a minority of the Town Council. In point of fact Matthew Hay, by sheer personal brilliance, was to regain control of the Department, to come perhaps the leading M.O.H. in Scotland, and to inaugurate a pattern where (instead of a University teacher devoting a little time to local authority duties) the M.O.H. was primarily a local authority officer but permitted to devote a portion of his time to University teaching—a pattern that still exists. It should perhaps be added that the pattern was not completely new: Simpson, the first full-time M.O.H., had been permitted to hold part-time lecturerships.

Professor Matthew Hay.

Matthew Hay had graduated M.B., Ch.B. with first class honours at Edinburgh in 1878, and had been Ettles Prizeman (i.e. the top student of his year at Edinburgh University). In 1881 he had obtained his M.D. with a gold medal, and in 1883 he had been awarded a Sanitation Research Scholarship. In the same year he had succeeded Francis Ogston as professor of Medical Logic and Medical Jurisprudence at Aberdeen, and before his appointment as M.O.H. he had published articles on saline cathartics and on the use of sodium nitrite in angina.

In his first dozen years as M.O.H. he reorganised and improved the work of the City Hospital (which in 1890 began to admit County as well as City cases), tackled—along with Kenneth Cameron—the terriffic problem of slums and overcrowding, made himself so popular as an M.O.H. that Aberdeenshire asked that he be allowed to act for the County also (a request that the City refused), had the establishment adjusted until there were two assistant M.Os. and seven assistant S.Is., gained 50 per cent. increases in his own salary and that of the C.S.I., was appointed by his colleagues President of the Scottish M.Os.H. (an honour that did not again fall to Aberdeen until another sixty years had passed), and published articles—e.g. "Vital Statistics of children of school age"—that did much to lead to the creation of the School Health Service.

When the 20th Century dawned, however, Hay was still only in his middle forties and much of his best work lay ahead—including the inducing of the Corporation to acquire land at Foresterhill (where the Medical School, Infirmary, Children's Hospital and Maternity Hospital are now sited) and creating the health visitor service in Aberdeen.

The start of health visiting.

Health visitors had already existed in some areas for forty years before they reached Aberdeen, and a cursory inspection of the infant death rates reveals how badly they were needed. Despite all the work of Hay and his medical and sanitary colleagues, the infant death rate (uncorrected for residence) had risen from 126 per thousand births (in 1856-60) to 144 (in 1896-1900).

On 15th December, 1902, the Aberdeen Union of Women Workers submitted a representation suggesting the appointment of Female Sanitary Inspectors (by which designation health visitors were then often known); on 19th January, 1903, the Committee approved the appointment of a Female Sanitary Inspector; and on 16th February, Miss Marjory J. Crichton, Certificate of Sanitary Institute, was appointed at a salary of £65 p.a. The speed is, of course, an indication of a carefully planned campaign.

Hay, faced with the difficulty that he had not yet formally regained control of the Meat Inspectors and Sanitary Inspectors, solved the problem in characteristic fashion—by getting Miss Crichton placed under the control of the C.S.I. From his writings it is clear that he visualised something of the future of health visiting, and that placing the first H.V. under the C.S.I. was a piece of deliberate planning to facilitate the regaining of control.

In 1906, shortly after a veterinary officer, Mr. J. M. Young, had been appointed to take charge of Inspection of Unsound Food and of Dairies, Miss Crichton resigned, and the establishment was increased to two health visitors (the term female sanitary inspector being dropped). Miss Jessie C. Macmillan was paid £70—soon after raised to £80—while her colleague, Miss Mary S. Carmichael, was paid £65, so that Miss Macmillan was in effect the first Superintendent H.V.

The estblishment was increased to three in 1909, but the big battle of 1909-10 was over qualifications. In October, 1909, the Trades Council sent in a letter stating—

> "That this Trades Council condemns the action of the Town Council Public Health Committee in appointing unqualified women as Health Visitors and holds that administration of this kind does not tend towards carrying out the purpose of the Notification of Births Act, namely the reduction of infant mortality."

Two further letters from the Trades Council in 1910 demanded that appointments as health visitors be given only to persons "holding the degree of the Central Midwives Board", and the second letter threatened that unqualified women would be refused admission to houses.

Following these letters and the most lyrical praise of health visitors in Hay's Annual Reports, arrangements were made for students to have a course of training in preparation for the examination of the Royal Sanitary Institute. [Subsequently, of course, national requirements made it obligatory that health visitors be qualified nurses with a midwifery training and a subsequent course in health visiting; and students were sent to the training schools of Edinburgh and Glasgow until the Aberdeen Training School opened in 1948, the first tutor being Miss Isobel Milne, R.G.N., S.C.M., H.V. Cert., H.V. Tutor's Cert., who took up office in 1949.]

Other developments, 1910-23.

The School Health Service in Aberdeen was set up in 1910 under Dr. George Rose. It consisted initially of two doctors (Dr. Rose and Dr. Hunter), three nurses (Miss Mary Frost, Miss Martha Croll and Miss Muriel Duguid—the last two being still alive, residing in Stonehaven and Rosehearty respectively), one clerk (Miss Anne S. McMillan—at present living in Culter—who continued in post until 1945 when she was succeeded by Miss Alice M. Ledingham) and one inspector (Mr. John D. Gilbert). The first dental officer, Mr. James Grosert, appointed after the first World War, is probably the senior public health worker now residing in Aberdeen.

The School Medical Service—as it was first termed—was initially quite separate from the Public Health Department, and was at first concerned primarily or entirely with inspection and treatment, with great concentration on the eradication of vermin. There was no attempt at home visiting, and the idea of preventing disease and of educating children in healthy living only emerged gradually.

In 1913 the redoubtable Mr. Kenneth Cameron, C.S.I., retired, and Mr. James Cumming, previously chief clerk in the Public Health Department, was appointed Sanitary Inspector for the City. Three points may be noted about his appointment—that the designation "Chief Sanitary Inspector" disappeared, that his salary (£225) was very much lower than that of Mr. Cameron, and that (in a typical Hay style) the relationship with the M.O.H.—which had been distorted in 1886 as a result of the struggle for a whole-time or part-time officer—was left unspecified, to be duly re-specified later (in 1938) on the lines of 1881. Although Mr. Cumming had no sanitary experience before taking up his appointment, he rapidly became one of the leaders in Scotland, and his *Digest of Sanitary Legislation* was used by students right up to the second World War.

It is difficult to date the beginning of the Maternity & Child Welfare Service, since the work of health visitors and medical officers gradually became more and more devoted to the health of children. However, in 1919, Professor Hay acquiesced—apparently reluctantly—in the erection of a temporary hutted clinic at Castlegate. [It was still in use at the close of 1962.]

While Hay's greatest achievements may have been in the fields of sanitation and social economics, control of infectious diseases, the starting of health visiting and the planning of the future site of the city's main hospitals, some of the other

developments of his later years strike a remarkably modern note—propaganda by health visitors about need for fireguards (in 1912), investigations by health visitors into how the maternity benefit was used (in 1913), and arrangements for some health lectures for voluntary social workers and for mothers (in 1915).

In 1922 he tendered his resignation owing to illness and the resignation was not accepted, but in May, 1923, he indicated that he was unfit to resume the onerous duties of M.O.H. and resigned after being M.O.H. for 35 years. He lived in retirement in Aberdeen until 1932. By the end of Hay's period of office the Health Department was beginning to assume its modern shape—though there were, of course, as yet no social welfare section and no health education section. Perhaps his work can be best assessed by quoting two sets of figures: when he took up office the infant death rate per thousand live births was 140 (for 1886-90), and when he retired it had fallen to 118 (for 1920-24); when he was appointed the average age at death was under 33 years, and in 1923 it reached 45 years for the first time.

An interim summary.

The diamond jubilee of public health in Aberdeen (1922) makes a convenient point for an interim summary.

There had been five Medical Officers of Health:

(1) Professor Francis Ogston, M.A., M.D. (1862-81)—a man with an international reputation in forensic medicine;

(2) Alexander Ogston, M.D. (joint M.O.H., 1868-72)—subsequently professor of surgery at Aberdeen and knighted.

(3) W. J. R. Simpson, M.D., D.P.H. (1881-86)—subsequently M.O.H. of Calcutta, Director of Ross Institute, and knighted;

(4) Theodore Thomson, M.A., M.B., (1886-87)—subsequently M.O.H. of Sheffield, Inspector under the Local Government Board, and made a C.M.G.;

(5) Professor Matthew Hay, M.D. (1888-1923)—perhaps the leading M.O.H. in the country (with all respect to Littlejohn of Edinburgh and Russell and Chalmers in Glasgow).

At least one Deputy M.O.H., Francis Ogston Junior, had risen high in public health work—to the Chair of Public Health and Medical Jurisprudence in the University of Otago; and another, John Parlane Kinloch, was (after becoming M.O.H.) to end his life as Chief Medical Officer of the Department of Health for Scotland.

The Aberdeen public health school had begun to produce a quite remarkable series of future leaders (the Wilson Jamesons, Andrew Toppings, Matthew Fyfes, James Stirlings, Nora Watties and Robert Sutherlands, who were to occupy top-ranking posts twenty or thirty years later).

The first Sanitary Inspector, George Thomson, had been appointed in 1867, and—after a period in which sanitary duties were undertaken by the Superintendent of Police—a full-time S.I., James Minty, had been appointed in 1878.

The first Veterinary Surgeon, James Thomson, had taken up his duties in 1867; the first Health Visitor, Miss Marjory J. Crichton, had been appointed in 1903; and the School Health Service had started in 1910 with the appointment of George Rose as medical officer.

The last forty years.

A briefer sketch must suffice for recent decades where historical perspective is less easy to achieve.

John Parlane Kinloch (1885-1932) graduated M.B. in Glasgow in 1909 and M.D. (with commendation) in 1913. He gained his D.P.H. at Cambridge with distinction in 1910. In 1914 he was appointed Deputy M.O.H. in Aberdeen, served in France in the first World War, and in 1923 succeeded Matthew Hay. Kinloch, a man of outstanding brilliance, became Chief Medical Officer of the Department of Health for Scotland in 1929 but died suddenly in January, 1932, at the age of 46.

In Aberdeen he produced a series of important reports on insanitary areas and housing requirements, blind persons, municipal health services, &c. To Kinloch we owe, among other items, these three: (1) considerable developments in health education groups (in connection with this, those interested should read not merely various references in Minutes but Chapter 2 of Kinloch's Annual Report for 1925—with its vigorous advocacy of health education, its stress on press co-operation, and its lucid description of Aberdeen's first health exhibition, organised at a cost of £25); (2) the starting of refresher courses for health visitors (in 1926); and (3) the idea of a regional Public Health Scheme. In respect of the last of these, however, it is fair to add that, contrary to public belief, the Regional Scheme never really existed: what existed from 1930 was simply a combined M.O.H. and latterly a combined M. & C. W. doctor for three areas with different staffs and different policies. [For example, in the last years of the so-called Regional Scheme, Aberdeenshire had a Health Department without Welfare services attached, and employed its own multi-purpose nurses for health visiting and home nursing; Kincardineshire had a combined Health and Welfare Department, and employed its own multi-purpose nurses for health visiting, home nursing and social work; and Aberdeen City had a combined Health and Welfare Department, employed health visitors for preventive and social work but for home nursing just paid a voluntary agency. It is important to appreciate these points in order to avoid (1) any claim that a regional scheme cannot work—it might or might not work but has not been tried, and (2) any attribution of blame to the late Dr. H. J. Rae for the disruption of the "scheme" at his retirement.] Kinloch also continued and greatly extended Hay's attack on slums and overcrowding.

Harry J. Rae, M.C., M.B., Ch.B., D.P.H., himself an Aberdeen graduate and from the Aberdeen area, was M.O.H. and lecturer in Public Health from 1929 to 1952. Among the many events during his twenty three years of office were the virtual eradication of bovine tuberculosis, the introduction of immunisation against diphtheria, the beginning of a vast expansion of the health visiting service (including a formal decision, incorporated in the Council's official scheme, that the ultimate establishment should be one hundred), the starting of the home help service, the major reconstruction following the passing of the National Health (Scotland) Act of 1947, the opening of the Health Visitor Training School in 1948, and the amalgamation of the Health Department and the Social Welfare Department also in 1948. The latter years of Dr. Rae's period also witnessed extensive development of Maternity Services and Child Welfare Services under the successive influences of Dr. Jean Mackintosh (later of Birmingham), Dr. Mary Gorrie (later of the Ministry of Health), Dr. Mabel Mitchell (later of the Department of Health for Scotland), and of successive Chief Nursing Officers of whom perhaps the most outstanding was Miss E. M. Himsworth (later of the Department of Health for Scotland). Dr. Rae was succeeded in 1952 by the present writer whose period of office has so far witnessed a large scale expansion of social and supportive services for the elderly and the handicapped, a continuation of the extension of the health visiting service, the setting up of a unit for group health education, successful campaigns against home accidents and against respiratory tuberculosis, extension of immunisation to a number of diseases, developments in the field of mental health and the introduction of male health visiting officers.

Since the first holders of various posts have been mentioned, it would be ungenerous to end this sketch without including the names of persons who have in recent years become the first occupants of new posts—Mr. C. Grainger, the first Administrative Officer of the Health and Welfare Department (1950); Mrs. D. M. Brebner, M.A., Dip.Ed., the first statistician (1953); Miss D. J. Lamont, S.R.N., S.C.M., H.V. Cert., H.V. Tutor's Cert., the first Principal Health Visitor Tutor (1954) and also the first Health Education Lecturer (1956); Mrs. M. Bell, B.A.(Admin.), the first Social Adviser (1960); and Mrs. V. L. Kinghorn, the first dietitian (1960).