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Somerset County Council.

THE COUNTY EDUCATION COMMITTEE

Annual Report

OF THE

SCHOOL MEDICAL OFFICER

For the Year 1951

J. F. DAVIDSON, O.B.E., M.B., Ch.B., D.P.H.,

**County Medical Officer of Health.
County School Medical Officer.**

CONTENTS

	PAGE
Artificial Light treatment	16
Attendance of Parents	5
Audiometer Survey	35, 43, 46
Breathing Exercises Clinic ... ..	... 35, 44
Causes of Death	29
Child Guidance	21
Children's Shoes	27
Cleanliness Scheme	16
Dental Service	18
Diphtheria Immunisation	30
Divisional Medical Officers' Reports	34—46
Employment of Children	45
General Condition	5
Handicapped Children	33, 37
Heart Defects	37
Hygiene in School Buildings	30
Infectious Diseases	28
Liaison with Hospitals	37
Mass Radiography	31, 42, 45
Medical Inspection	5
Medical Treatment and follow up	5
Milk in Schools Scheme	6
Minor Ailment Clinics	11—15, 41
Organisation	3
Orthopædic Service	26, 45
Physical Education	17
Prevention of Tuberculosis	37
School Meals	8
School Nurses	41
School Ophthalmic Service	9
Speech Therapy	23
Statistical Tables	47—49
Swimming Baths	30
Transport of School Children on medical grounds	28
Verminous Condition	17
Vision and Eye defects	8

To the Chairman and Members of the Education Committee
of the Somerset County Council.

Madam Chairman, Ladies and Gentlemen,

I have the honour to submit my Fifteenth Annual Report which covers the work of your School Health and allied services during the year, and which includes the essential statistical information.

This Report sets out a very satisfactory state of affairs and Somerset may well be proud of the generally excellent condition of her school children.

I have been associated with these services for over twenty-five years and, in that quarter of a century, the steady and continuous improvement in the health, well-being and general state of the children is, indeed, a striking result. The provision of adequate preventive services, together with readily available curative services, and with the onward widening of public interest and conscience, allied to greater knowledge in the wise nurture of pre-school and school children, have combined together to give the happy standards which we have reached to-day. And in this respect, too great emphasis cannot be placed on the importance of school milk and school dinners.

In this Report, a number of special articles by various Medical Officers is included and I feel that these contributions are at once interesting and valuable.

Our relations in Somerset with all the many other branches of medical practice are extremely good, and we do work together in the general interest.

A special word of praise is due (and it is cordially given) to the Headmasters and Headmistresses in Somerset for all their goodwill and splendid work in helping all branches of these health services. Without their essential and willing aid the service would be a poor empty shell and we are indeed most grateful to them all.

I continue to be greatly assisted by all members of your staff, and I acknowledge especially the work of Dr. Fay in compiling the details of this Report.

I am,

Yours faithfully,

J. F. DAVIDSON,

County School Medical Officer.

County Hall,
Taunton.

May, 1952.

ORGANISATION.

STAFF.

County School Medical Officer.

J. F. DAVIDSON, O.B.E., M.B., Ch.B., D.P.H.

Deputy County School Medical Officer.

L. FAY, M.D., D.P.H.

Senior Medical Officer.

B. M. SMITHIES, M.R.C.S., L.R.C.F., D.P.H.

Divisional Medical Officers.

L. FAY, M.D., D.P.H. (Taunton).

P. P. FOX, M.B., Ch.B., D.P.H. (Yeovil).

R. H. WATSON, M.B., Ch.B., B.A.O., D.P.H. (Bridgwater).

D. McGOWAN, M.B., Ch.B., D.P.H. (Acting), (Weston-super-Mare).

Assistant County Medical Officers.

M. J. COOKE, M.B., B.S., D.P.H.

A. M. McCALL, M.R.C.S., L.R.C.P., D.P.H.

D. G. EVANS, M.R.C.S., L.R.C.P., D.P.H.

R. H. G. DENHAM, M.D., D.P.H.

M. L. STEWART, M.B., Ch.B., D.P.H.

I. M. SCOTT, M.D. (from 3.9.1951) (part-time).

E. S. ELLIOTT, M.B., B.S., D.R.C.O.G.

E. L. FAWSETT, M.R.C.S., L.R.C.P., D.P.H.

M. I. ROSS, M.B., Ch.B., D.P.H.

T. S. STIRLING, M.B., Ch.B., D.P.H.

H. M. HALLIDAY, M.R.C.S., L.R.C.P., D.P.H.

C. M. ROOKE, M.B., B.S.

} Attached to
Divisional
Executive
Areas.

Resignation.

H. W. MURPHY, M.B., D.P.H. (31st July, 1951).

Schools Ophthalmologists.

O. HALSTEAD, L.M.S.S.A.

R. L. N. STEWART, M.B., Ch.B., D.O.

} By arrangement with
Regional Hospital Board.

Chief Dental Officer.

QUENTIN DAVIES, L.D.S., R.C.S. (Eng.).

County Orthodontist.

N. M. FOULTER, L.D.S., D.D.O.

Dental Officers.

A. J. PERCY, L.D.S.

L. E. SCULL, L.D.S.

W. E. ROE

R. B. STILES, L.D.S.

E. E. JACKSON, L.D.S.

A. C. S. BARNARD, L.D.S.

E. R. HEATHCOTE, L.D.S.

H. F. METCALF, L.D.S.

M. D. SIBSON, L.D.S.

Resignations.

Miss P. RYAN, B.D.S., L.D.S. (4th March, 1951).

R. H. COATES, B.D.S., L.D.S., R.C.S. (18th October, 1951)

Child Guidance Team.

FRANK BODMAN, M.D., D.P.M. (Director).

R. SESSIONS HODGE, M.R.C.S., L.R.C.P., D.P.M. (Consultant Psychiatrist)

Miss G. E. NEAL (Senior Psychiatric Social Worker).

Miss M. PHILLIPS (Psychiatric Social Worker).

Mrs. C. L. FARMER (Social Worker).

Speech Therapists.

Miss A. CARRUTHERS.

Miss N. COGGON.

Mrs. M. MOSSMAN (part-time).

Visiting Orthopaedic Surgeons.

T. PRICE, M.B., M.Ch. (Orth.).

HEDLEY HALL, F.R.C.S. (from February, 1951). }

By arrangement with
Regional Hospital
Board

Resignation.

Miss M. FORRESTER BROWN, M.S. (February, 1951).

MEDICAL INSPECTION.

16,749 routine medical inspections were carried out on the prescribed age groups, i.e., entrants, intermediates (10-11), and leavers (14-18). In addition 32,903 re-examinations and special examinations, i.e., examinations particularly requested by the School Medical Officer, the teacher, or the parent, were also carried out. The fact that the number in this latter group is nearly double that in the prescribed age groups may be taken as evidence of the interest taken in the individual child by those concerned.

Attendance of Parents.

No less than 75 per cent. of parents attended the routine medical inspections of entrants in the "County" areas, and although the percentage drops to 43 for intermediates, and is only 5 for leavers, nevertheless these figures indicate the interest taken by the parents in the medical examination of their children. The value or necessity of school routine medical inspections in these days of a comprehensive medical service is often questioned. Those actively engaged in the school health service are not troubled by these doubts at all, but to others, these statistics may indicate the value that is placed by the parents on the opportunities so given of discussing with a doctor experienced in children the various "pre-disease" tendencies which their children exhibit from time to time.

General Condition.

These figures show a continuous improvement. 29 per cent. are classified as above normal and only 1.7 per cent. as below normal. These figures are very good; indeed, they have never been better, but they will come as no surprise to those who are familiar with the appearance of the modern child and can remember the all too numerous crocks and cripples of thirty years ago.

Many factors have contributed over the years to this happy result. Improved standards of living, diminution in poverty and better housing are all important environmental factors. The services described in this Report, coupled with those of the Maternity and Nursing Services, have made a substantial contribution and have provided an ample dividend on their cost, but probably the greatest single factor is educational. Public opinion has been educated up to demanding much higher standards of child health than those acceptable thirty years ago and in this essential preliminary, the medical, nursing and teaching professions have quite rightly led the way.

MEDICAL TREATMENT AND FOLLOW-UP.

Much medical treatment of an advisory and preventive nature is instituted directly by the School Doctor discussing the child's health with the parent at the time of the examination.

If the parent is not present, a letter is written by the School Doctor and a home visit is paid by the School Nurse; 12,481 such visits to 5,086 cases being paid in 1951.

Where the necessary treatment is other than advisory, i.e., necessitating a prescription or attendance at a hospital or clinic (other than Minor Ailment, Ophthalmic or Orthopædic) the School Doctor writes to the family doctor drawing his attention to the defect. In many areas where a close relationship exists between the family doctor and the School Doctor a less formal procedure is used.

The notification by the hospitals to the School Medical Officer of the discharge of school children after hospital treatment continued to be very unsatisfactory in many areas during 1951. Such notification to be of value must be prompt, as frequently, in the essential "follow-up", the supervision by the School Health Service can play a vital part. Recently, however, a marked improvement has occurred throughout the County and in the great majority of cases the school doctor is now supplied via central office with a copy of the discharge note which is forwarded to the family doctor by the Hospital Consultant, and the School Nurse is immediately notified whenever domiciliary after care is indicated, subject to the assent of the family doctor.

MILK-IN-SCHOOLS SCHEME.

The position in the County as at 31st December, 1951, respecting the types of milk consumed and the number of children taking milk is set out in Tables I and II.

Milk supplies to schools in the County up to 31st October, 1951, were 100 per cent. Pasteurised or Tuberculin Tested. Unfortunately, due to the curtailment of the Brushford Kitchen Meals Van and the installation of individual school canteens at several schools in the Dulverton area, it was found necessary to revert to Undesignated milk for three schools in this district. The main difficulty with regard to these schools is their completely isolated position in relation to premises where Designated milk is produced or processed.

Notwithstanding this set-back, the Scheme generally has functioned satisfactorily during the year. Some difficulties have arisen, however, especially with regard to the smaller type of school where attendance figures are between ten and thirty. It is becoming increasingly difficult to maintain supplies to these schools, as the miles covered by the supplier are quite frequently greater than the number of one-third pint bottles delivered. Needless to say, the small purveyor is finding it extremely difficult, and to maintain supplies the use of the School Meals Service Vans is essential. Unfortunately, some Headmasters/mistresses are averse to the somewhat late arrival of the milk, which reaches the schools nearer lunch hour than the mid-morning break.

In spite of an all-round increase in the cost of plant, machinery and other dairy equipment, the majority of school suppliers are maintaining the deliveries.

Abbreviations.

Past. = Pasteurised.

U.D. = Undesignated.

T.T. = Tuberculin Tested.

Table I.

Types of Schools (including Divisional Executive Areas).	Total No. of each type.	Number of Schools and Types of Milk— With percentages.					
		Past.	%	T.T.	%	U.D.	%
Primary	408	308	75.5	97	23.8	3	0.7
Secondary Modern ...	36	33	91.7	3	8.3	—	—
„ Grammar ...	18	15	83.3	3	16.7	—	—
„ Technical...	2	2	100.0	—	—	—	—
Nursery	10	6	60.0	4	40.0	—	—
Totals ...	474	364	76.8	107	22.6	3	0.6

The result of the annual survey to ascertain the number of children taking milk as against those on the register is set out in Table II. It will be observed that of the 57,025 registered children, 44,081 or 77.3 per cent. were taking milk compared with 78.9 per cent. in 1950. The survey was carried out during the months of October and November and the fall in consumption could be attributed, to a certain extent, to seasonable absenteeism. The quantities normally consumed at Secondary Modern and Grammar Schools are always well below the attendance figures.

Table II.

Types of Schools (including Divisional Executive Areas).	No. of Regis- tered Children	Children taking milk.		Types of Milk consumed with percentages.					
		No.	%	Past.	%	T.T.	%	U.D.	%
Primary	40,964	34,118	83.3	28,998	85.0	5,066	14.8	54	0.2
Secondary Modern ...	10,603	6,685	63.0	6,265	93.7	420	6.3	—	—
„ Grammar...	4,869	2,752	56.5	2,268	82.4	484	17.6	—	—
„ Technical...	245	182	74.3	182	59.0	—	—	—	—
Nursery	344	344	100.0	203	100.0	141	41.0	—	—
Totals ...	57,025	44,081	77.3	37,916	86.1	6,111	13.8	54	0.1

Sampling of milk for liquid consumption and cooking purposes has been continued throughout the year and where advisory visits to dairies or schools have been necessary these have had most beneficial results.

This report on the Milk-in-Schools Scheme has been supplied by the County Sanitary Inspector who is mainly responsible for the results achieved. Although it has not been possible to maintain the 100 per cent. supply of "safe" milk which was reached last year, nevertheless the fall to 99.4 per cent. is very small, and only those engaged in the task of keeping up this high percentage can realise all the difficulties.

PROVISION OF MEALS FOR SCHOOL CHILDREN.

The following memorandum has been supplied by the Chief Education Officer:—

Since the last Annual Report the School Meals Service has continued to provide daily meals for nearly three-fifths of the school population, thereby making a considerable contribution to children's health, as the following figures show:—

	Year ended 31.12.51		Year ended 31.12.50	
	No. of schools.	No. of meals per day.	No. of schools.	No. of meals per day.
Grammar Schools	18	3,460	18	3,276
Modern Schools	36	6,197	36	6,012
Junior Technical Schools	2	185	2	150
Primary Schools	407	22,602	414	21,118
Nursery Schools	10	403	11	384
	473	32,847	481	30,940
Number of children on books	56,231		54,165	
Percentage of children taking dinners at school	58.41		57.06	
Number of grants of free meals current	2,766		1,833	

Notwithstanding a further increase in price to 7d. per meal which came into effect in April, 1951, the number of parents taking advantage of this service for their children has remained approximately the same. This shows the appreciation of the value of the school meal. The increased charge to parents still covers only the cost of the food in the meal. In order to obviate hardship when the price was increased, approval was obtained from the Ministry of Education to relax slightly the Committee's scale which is used as a basis for the award of free meals in necessitous cases. The consequential rise in the number of children receiving free meals daily in the County is shown in the above figures.

In the course of the past year self-contained canteens have been established at a further 13 schools. These are much appreciated and are able to supply the children of the schools concerned with a meal which is better than a meal carried from a central kitchen, because it is cooked on the spot and served immediately after cooking. Most schools in the Exmoor area now have their own canteens; in the past supplying them from a central kitchen involved very heavy transport costs.

VISION AND EYE DEFECTS.

In accordance with the terms of the National Health Service Act in respect of specialist services, the two School Ophthalmologists, Dr. O. Halstead and Dr. R. L. N. Stewart, were taken over by the South-West Regional Hospital Board as from the 1st September, 1950. The general arrangements for the refraction of school children at various centres throughout the County, however, remain for the time

being with the Local Education Authority. As the care of the eyes is essential to a child's education, the closest co-operation should be maintained between the Ophthalmic Service and the Education Authority, and it is desirable, therefore, that this method should continue.

During the year the two Specialists examined 4,272 school children, prescribing glasses for 1,721. In addition 228 pre-school children were examined, chiefly for squint. It was not possible for the Somerset Executive Council to give information as to the children who obtained glasses through the Supplementary Ophthalmic Service but since the provision of glasses came under the Hospital Management Committees of Taunton and Bath, information is now forthcoming and from June to the end of the year under review 709 pairs of glasses (or lenses to new prescriptions) were provided through these two Hospitals. Information as to the provision of glasses is not nearly so easy to obtain as it was when the Authority provided the spectacles under contract, but the new arrangement with the Hospitals is an improvement over the Supplementary Ophthalmic Service.

54 children were referred by the Specialists to Eye Hospitals or Eye Departments—45 for opinions as to squint treatment or operation and 9 for other conditions. In addition 128 children were referred to the Orthoptic Department of the Taunton and Somerset Hospital.

Facilities for the treatment of squint still leave much to be desired. At present Orthoptic treatment is available at Taunton, plus a very limited amount at Yeovil. For the rest of the County it is non-existent except for children living near Bristol or Bath. For a scattered county like Somerset it is obvious that a number of Orthoptic Centres is required, situated at convenient points, where Orthoptists could hold regular weekly clinics.

SCHOOL OPHTHALMIC SERVICE.

The following notes on this Service are contributed by the Schools Ophthalmologists, Dr. R. L. N. Stewart and Dr. O. Halstead.

Dr. Stewart.

The School Ophthalmic Service has now spent one complete year under the direction of the Regional Hospital Board. Some of the clinics have moved into the Out-Patient Departments of the Hospitals with their rather better facilities, others remain under somewhat poor conditions. General arrangements remain as before. Ideal conditions existing in many parts of the country, where members of the School Ophthalmic Service hold part-time appointments in the Ophthalmic Departments of local hospitals are not yet at hand; consequently children requiring hospitalisation as part of their treatment are still passed from hand to hand.

Facilities for orthoptic treatment consist of a full-time orthoptist at Taunton and a part-time orthoptist at Yeovil. Both of these are shared with the Regional Consultants, and both are fully extended with the work in hand. It is planned to employ another orthoptist in the near future and to hold orthoptic clinics at various centres in the county. This should make treatment available to children living in all parts of South Somerset. A great step forward, if it materialises.

Delay in the supply of spectacles has decreased considerably and the average supply period is now in the region of four weeks, compared with that of six months or more of a year or two ago. There is, however, a considerable discrepancy among opticians regarding the time of supply of spectacles. This is a state of affairs which did not exist when all spectacles ordered through the School Health Service were supplied by one particular contractor to the County Council. It seems that the latter was therefore a more satisfactory arrangement. Moreover, the School Ophthalmologist was in constant contact with the contractor, and any queries or errors could easily be straightened out and a constant check on spectacles ordered and supplied could be maintained. To do this with the large number of opticians concerned at present is, of course, quite out of the question.

The chief conditions dealt with in the School Ophthalmic Clinics are :—

- (1) Refractions
- (2) Amblyopias
- (3) Squints (in conjunction with orthoptic department)
- (4) Other conditions, such as—
 - Accommodation Spasms and Deficiencies and other conditions;
 - Congenital Defects;
 - Blepharitis;
 - Convergence Deficiencies.

The percentage of each type of case shows no appreciable change from previous years, with one exception—accommodation spasm. This has shown a marked increase and has occurred mainly in the 10-11 years age group, and is almost exclusively confined to girls. As girls are regarded as the more conscientious sex at this age, one wonders if there is any relation between this condition and the secondary school allocation examinations taking place at this age period.

It is gratifying that infants and school children attending the Ophthalmic clinics for eye defects are seen at a lower average age than ever before. The chance of curing existing defects is thus greatly facilitated.

In the case of infants, where squints are of primary importance, this satisfactory state of affairs is due to the vigilance of District Nurses, Health Visitors and Medical Officers at Child Welfare Clinics.

In the case of school children, inspection at routine school medical examination and testing of visual acuity by Snellen's Test Types is essential for the early detection of ocular defects. In this respect, the teacher's help is also of considerable importance. Teachers are in constant touch with children at work and play and are thus in a far better position to detect symptoms than anyone else. Defective vision and some types of squint are frequently first detected by the school teacher. Ocular defects may manifest themselves in many ways, such as holding books too close, difficulty in reading the blackboard, headaches brought on or aggravated by close work, abnormal character or direction of handwriting, abnormal head posture, abnormal position at the desk, general educational backwardness. The whole character of a child may be moulded by its ocular defects; witness the often shy and introspective nature of an uncorrected myopic (short sighted) child and the truculent, aggressive attitude of so many squinting children, a common psychological reaction to the "ragging" at the hands of their school fellows.

Early diagnosis and early treatment is the only effective remedy for the great majority of ocular defects in school children. Fortunately there is now general realisation that a child with a squint or obvious defect is never too young to be seen by an ophthalmologist. The result will show itself in the next few years, when cases of deep amblyopia and loss or failure of development of Binocular Stereoscopic Vision should become as rare as they are common to-day.

Dr. Halstead.

A modern trend in child behaviour is shown by the difficulty parents and teachers have in making children wear their glasses constantly. As soon as Authority's back is turned, off they come. Only those children with high refractive errors and poor vision without glasses will wear them all day.

Systematic questioning establishes that in older children it arises from vanity, vanity seemingly starting earlier in life than hitherto, while in younger children it is due to jeers from their luckier school mates. Neither of these causes would seem capable of elimination.

Cases of blepharitis are on the decline, due to the use of antibiotic drugs. Mild squamous blepharitis is still common but the severe ulcerative type is rare. Even so, when treatment is stopped, children living in conditions that are poor in every sense of the word often relapse, environment having the last word in this complaint.

The County contains a large number of children with squints, and fresh cases are constantly being added, but effective treatment in North Somerset is severely restricted by having no orthoptic clinic available. At present one can strive only to obtain good vision in the squinting eye by the occlusion of the better one, and ultimate binocular vision is an unobtainable goal. Under these conditions also, operation can be only cosmetic, with no guarantee that the eye will not eventually diverge, with added unsightliness.

Among older children, especially those studying hard in the Grammar Schools, eyestrain occurs from ocular muscle imbalance, which glasses do not often help, but which can be cured or relieved by orthoptics.

Although it is probably not practical to organise an orthoptic service for all rural areas, there is an undeniable need in Weston-super-Mare for an orthoptist who could also report on selected cases from other districts in North Somerset.

Many parents now demand "eye exercises" for their children, and it is difficult to explain away the absence of facilities which are available in South Somerset and in most other counties.

MINOR AILMENT CLINICS.

Despite the full medical attention now available for school children the attendances at the six minor ailment clinics continue to be maintained, the total attendances for 1951 being 14,243 as against 13,510 in 1950.

Impetigo. 138 cases were treated as against an average of 200 for the previous five years.

Otorrhœa. The small but steady decline in this condition continues, there being 249 cases as against 280 five years ago. This is probably due to the increasing use of penicillin and the sulphanomides.

Scabies. Once the War and its aftermath had ceased, Somerset regained its normal freedom from this disease, the school service treating an average of 33 cases per year only throughout the County.

Ringworm. This disease having been notifiable in school children for many years, our returns are complete and it is interesting to note the progressive and substantial diminution. Thirty years ago the annual figure averaged 225; in the last five years it is below 30. The resulting diminution in school absenteeism is even greater, as thirty years ago cases were absent as many weeks as the modern case is days.

BRIDGWATER SCHOOL CLINIC.

Reason for examination or treatment.	Examined only.	Treated.					Total examined or treated.	Attendance at Clinics.
		Cured.	Improved	Un-relieved.	Under treatment, &c.	Total treated.		
Fitness for school or special schools ...	2	0	0	0	0	0	2	2
Vision testing ...	7	7	0	0	5	12	19	19
External eye diseases ...	18	90	0	0	1	91	109	330
Ear defects:								
Otorrhœa, etc. ...	9	141	0	0	0	141	150	279
Deafness ...	0	0	0	0	0	0	0	0
Ringworm ...	0	2	0	0	0	2	2	4
Impetigo ...	0	70	0	0	0	70	70	222
Scabies ...	2	4	0	0	0	4	6	13
Minor skin injuries and septic sores ...	0	515	0	0	4	519	519	1,502
Other skin diseases ...	3	121	0	0	3	124	127	613
Other conditions ...	167	225	0	0	0	225	392	790
TOTALS ...	208	1,175	0	0	13	1,188	1,396	3,774

FROME SCHOOL CLINIC.

Reason for examination or treatment.	Examined only.	Treated.					Total examined or treated.	Attendance at Clinics.
		Cured.	Improved	Un-relieved.	Under treatment, &c.	Total treated.		
Fitness for school or special schools ...	2	0	0	0	0	0	2	2
Vision testing ...	12	0	0	0	0	0	12	13
External eye diseases ...	1	0	0	0	0	0	1	1
Ear defects:								
Otorrhœa, etc. ...	0	16	0	0	0	16	16	36
Deafness ...	0	2	0	0	0	2	2	5
Impetigo ...	0	3	0	0	3	6	6	9
Scabies ...	0	2	0	0	0	2	2	2
Minor skin injuries and septic sores ...	2	7	0	0	2	9	11	22
Other skin diseases ...	1	3	0	0	5	8	9	23
Other conditions ...	15	23	6	0	3	32	47	63
Verminous conditions ...	6	6	0	0	0	6	12	12
TOTALS ...	39	62	6	0	13	81	120	188

WESTON-SUPER-MARE SCHOOL CLINIC (BOURNVILLE).

Reason for examination or treatment.	Examined only.	Treated.					Total examined or treated.	Attendance at Clinics.
		Cured.	Improved	Un-relieved.	Under treatment, &c.	Total treated.		
Fitness for school or special schools ...	0	0	0	0	0	0	0	0
Vision testing ...	6	0	0	0	0	0	6	6
External eye diseases ...	0	26	0	0	0	26	26	76
Ear defects:								
Otorrhœa, etc. ...	2	17	0	2	0	19	21	35
Deafness ...	1	1	0	0	0	1	2	2
Ringworm ...	0	1	0	0	0	1	1	4
Impetigo ...	0	21	0	0	2	23	23	83
Scabies ...	0	0	0	0	0	0	0	0
Minor skin injuries and septic sores ...	4	290	0	0	10	300	304	1,040
Other skin diseases ...	0	45	0	2	2	49	49	125
Other conditions ...	6	60	20	0	4	84	90	152
Vermineous conditions ...	0	9	4	0	0	13	13	28
TOTALS ...	19	470	24	4	18	516	535	1,551

Total individual children examined or treated—360 (112 infants, 248 juniors).

WESTON-SUPER-MARE SCHOOL CLINIC (BOULEVARD).

Reason for examination or treatment.	Examined only.	Treated.					Total examined or treated.	Attendance at Clinics.
		Cured.	Improved	Un-relieved.	Under treatment, &c.	Total treated.		
Fitness for school or special schools ...	78	0	0	0	0	0	78	96
Vision testing ...	22	0	0	0	0	0	22	22
External eye diseases ...	6	11	0	0	0	11	17	56
Ear defects:								
Otorrhœa, etc. ...	9	6	2	0	2	10	19	111
Deafness ...	77	14	0	0	0	14	91	103
Ringworm ...	0	2	0	0	0	2	2	9
Impetigo ...	0	19	0	0	0	19	19	95
Scabies ...	0	0	0	0	0	0	0	0
Minor skin injuries and septic sores ...	0	110	0	0	5	115	115	310
Other skin diseases ...	14	80	7	0	6	93	107	526
Other conditions ...	121	20	3	0	2	25	146	267
Vermineous conditions ...	0	8	0	0	0	8	8	29
TOTALS ...	327	270	12	0	15	297	624	1,624

Total individual children examined or treated—467.

TAUNTON AND WELLINGTON SCHOOL CLINICS.

Reason for examination or treatment.	Examined only.	Treated.					Total examined or treated.	Attendance at Clinics.
		Cured.	Improved	Un-relieved.	Under treatment, &c.	Total treated.		
Fitness for school or special schools ...	2	0	0	0	0	0	2	2
Vision testing ...	16	0	0	0	0	0	16	16
External eye diseases ...	0	41	0	0	0	41	41	282
Ear defects:								
Otorrhœa, etc. ...	0	36	0	0	0	36	36	248
Deafness ...	0	0	0	0	0	0	0	0
Impetigo ...	0	13	0	0	0	13	13	89
Scabies ...	1	1	0	0	0	1	2	7
Minor skin injuries and septic sores ...	0	440	0	1	4	445	445	3,063
Other skin diseases ...	0	143	0	0	11	154	154	1,058
Other conditions ...	99	146	0	0	1	147	246	1,009
Verminous conditions ...	0	0	0	0	0	0	0	0
Ringworm ...	0	2	0	0	1	3	3	21
TOTALS ...	118	822	0	1	17	840	958	5,795

YEOVIL SCHOOL CLINIC.

Reason for examination or treatment.	Examined only.	Treated.					Total examined or treated.	Attendance at Clinics.
		Cured.	Improved	Un-relieved.	Under treatment, &c.	Total treated.		
Fitness for school or special schools ...	78	0	0	0	0	0	78	84
Vision testing ...	28	0	0	0	0	0	28	28
External eye diseases ...	9	23	0	1	3	27	36	74
Ear defects:								
Otorrhœa, etc. ...	8	25	2	0	0	27	35	56
Deafness ...	21	0	0	0	0	0	21	22
Ringworm ...	2	2	0	1	0	3	5	9
Impetigo ...	2	4	2	0	1	7	9	36
Scabies ...	0	0	0	0	0	0	0	0
Minor skin injuries and septic sores ...	9	56	4	2	4	66	75	195
Other skin diseases ...	13	40	0	1	0	41	54	161
Other conditions ...	179	54	13	3	53	123	302	460
Verminous conditions ...	0	48	2	0	4	54	54	186
TOTALS ...	349	252	23	8	65	348	697	1,311

TREATMENT WITH ARTIFICIAL LIGHT.

Centre.	Number of Clinics held.	New cases seen.	Total Attendances.				
			Infant.	Educa- tion.	Tuber- culosis.	From outside areas.	All.
Bridgwater ...	101	37	98	711	35	0	844
Yeovil ...	63	40	335	605	0	49	989
Totals ...	164	77	433	1,316	35	49	1,833

	Tuber- culosis.	Rickets.	Debility and Malnu- trition.	Glands (not Tuber- culosis).	Other.	Total (all cases).
Cured or improved ...	1	1	69	1	15	87
Unaltered ...	0	0	3	0	2	5
Worse ...	0	0	0	0	0	0
Still under treatment...	1	1	30	0	12	44
Totals ...	2	2	102	1	29	136

CLEANLINESS SCHEME.

In order to secure and maintain cleanliness amongst school children, the County Health Visitors make regular systematic inspections in the schools.

Where a child is found to have a verminous head, the Health Visitor visits the home and contacts the mother with a minimum of delay in order to explain the position to her as tactfully as possible. A supply of benzyl benzoate emulsion, lethane or D.D.T. cream is given to the mother by the Health Visitor together with detailed instructions on its use.

Children are excluded from school on the authority of the Health Visitor who informs the Divisional School Medical Officer, where appropriate, or the Health Department, County Hall, the same day of all such exclusions, and the date on which re-examination will take place at the school. This period does not normally exceed three days.

Only in persistent and extreme cases may it be necessary to take further action. Parents cannot be brought to Court until a child has first been effectively cleansed by the Local Authority, and is again found to be verminous in school.

Children found to be verminous by a School Medical Officer are excluded on the authority of that officer, and reported for immediate action by the Health Visitor.

Verminous condition.

As is the general experience throughout the country, there has been disappointingly small improvement in this condition during recent years and the number of individual school children in Somerset found to be infested continues to average approximately 1,300 per annum. It is only by constant vigilance on the part of the school nurses that much greater numbers are not infested. The nurses can and do reduce the number of secondary cases in the schools but they are handicapped in preventing the school child being infested in the home. "Problem families" do not provide all the cases by any means, and it is a sad commentary on the enormous increase in "permanent waves" that it is not accompanied by the virtual disappearance of lousy heads.

REPORT OF THE CHIEF ORGANISERS OF PHYSICAL EDUCATION for the year ending 31st December, 1951.

Continued liaison has been maintained between the School Medical Officers and the Physical Education Organisers, although there have been changes in the staff.

Posture.

Cases where children have been reported for attention and postural defects have been followed up and a series of exercises taught. These are of special value when they are related in the children's minds with the work done in the normal daily physical education lesson. Special emphasis has been laid on the following points in teachers' training sessions:—Posture training, prophylactic foot exercises, relaxation, training in light landings after vaulting and in dropping off climbing apparatus.

Visual Aids.

In order to give both children and teachers a clear picture of good movement and style, a number of films and film strips on physical education, games, athletics, swimming and diving have been made available to both individual schools and teachers' courses.

Parent - Teacher Associations.

Organisers have given a number of talks on posture, physical development and the modern trends in physical education to groups of parents who have shown interest and co-operation by their participation in discussions.

Hygiene.

Parents are in the main realising the value of children removing surplus clothing for active physical work. Two changing rooms were equipped and physical education kit provided for boys and girls in another two modern schools this year. Changing for this subject is a real problem in the all-age school in the rural areas where cramped old buildings are still in use. Adequate washing facilities are still very scarce in such schools. However, in a number of infant classes a praiseworthy effort is made for children to provide individual towels. Nearly all children wear plimsolls for physical education.

Agility Apparatus.

To give outlet to the natural urge to climb amongst young children and to compensate for the lack of facilities provided in a gymnasium in a fully equipped secondary school, the supply of a variety of fixed outdoor agility apparatus has continued.

A recent survey shows that 140 out of a possible 464 schools have been equipped during the last six years with apparatus suitable for nursery, infant, junior and senior children according to the type of school.

The improvement in physique and self-confidence of children who have used this apparatus is most marked.

Swimming.

A survey this year has shown that children from all eighteen grammar schools in the county are able to attend swimming baths and 90 per cent. could swim on leaving school. Of all other children in the county (including those in attendance at 21 all-age and 6 secondary modern schools which are not near a bath), 50 per cent. learnt to swim.

Transport is only allowed up to a distance of seven miles to a bath. In all-age primary schools where expenditure on transport is involved, instruction is limited to 24 lessons spread over two summer terms. In all other cases, swimming instruction may be given throughout the pupil's life in a grammar or modern school, or senior stage of an all-age primary school. Instruction is given by the normal class teachers in the case of all-age schools and by the part or full-time gymnastic teachers in modern and grammar schools.

G. J. G. FITZGERALD.

E. C. KENYON.

ANNUAL REPORT OF THE CHIEF DENTAL OFFICER, 1951.

Twelve months ago we were hopeful that the Whitley Council award increasing the salaries scale for Public Dental Officers would prove attractive and would resolve some of our staffing problems. Far from improving matters, however, the situation has worsened to the extent that we now have only 11 Dental Officers as against 13 in 1950. (Miss P. Ryan transferred to the London County Council in March and Mr. R. H. Coates transferred to the Regional Hospital Service in October, 1951.)

The position is uncertain and conflicting at the moment for, while private practitioners are experiencing a falling off in the public's demand for their services (and so would offer less opportunities to the newly qualified dentist) our advertising of vacancies has met with little or no success. Furthermore, while the fees paid to the private practitioner in the National Health Service have been considerably reduced, the gap between the remuneration of the dental officer in the local authority services and that of the dental officer in allied services is still wide, with the result that the School Dental Service remains less attractive financially to the younger newly qualified dentist as a career.

It cannot be stressed too strongly that the similarity between the School Dental Service and the National Health Dental Service is more apparent than real. The former is essentially a preventive service which normally is based on a systematic inspection of every child in the schools designed to prevent caries by early treatment. The National Health Service in the majority of cases only functions when the damage is done.

The policy of offering a full preventive service where the dental officers are available, with a service for emergency cases in other parts of the County, has continued to be the objective. The demands of emergency cases, however, have shown a further marked increase in those areas which are without a full routine service. As an illustration of this, the number of emergency cases treated at a clinic in such an area rose from the very high figure of 1,070 in 1950 to 1,701 in 1951 (or an average of almost 8 cases each day the clinic was open). This figure would be 200-300 per annum in normal circumstances. While referring to this clinic it might also be pointed out that it has been unable to offer routine treatment on a proper basis since 1948.

The above circumstances have necessitated a limited objective in the matter of a "full preventive service" in the covered areas in order to provide dental time for the emergency work given to uncovered areas. This has been achieved by firstly, some reconsideration about the filling of deciduous teeth especially the deciduous first molar, and secondly, the restriction of orthodontic treatment to selected cases only. In spite of this hateful discrimination, it is felt very strongly that the importance of maintaining a good temporary dentition cannot be exaggerated—for masticating efficiency during that important period of development from 4 to 10 years of age, for the prevention of malocclusion and irregularity of the permanent dentition, and for making conservation of the teeth a natural and happy part of growing up. The restriction of orthodontic treatment is very regrettable, especially as parents and patients are becoming so aware of the advantages from such treatment.

This modified interpretation of a "full preventive service" has been successful in its aims. In the other parts of the County which are without this service, school dental facilities are confined to the relief of pain, and limited, moreover, to localities where clinic premises are available. In one or two of these areas a small amount of routine treatment may be carried out, and here the unpleasant task of having to select patients is forced upon the dental officer. Whether this selection is from the younger age groups or the older ones is the subject of much argument. The staff difficulties are of a temporary nature and the constant hope is that before long we shall be able to offer a complete preventive service to every school child. Is it not wiser then, in the meantime, to pay attention to the younger age groups (who will be under our care for their school life) than to the older ones who will soon leave us and be cared for by the private practitioner?

The orthodontic scheme has continued to function very successfully in spite of restrictions. Although there is very little change in the numbers of cases treated, the efficiency of the scheme, under the County Orthodontist, has been increased, so that there is now a better co-ordination of the work and, to some extent, co-operation with other branches of the medical and dental professions in those cases where dental orthopaedics can benefit the general health and the development of the child patient.

During the year 101 fixed appliances and 349 removable appliances have been inserted. It is the policy that only the Chief Dental Officer, the County Orthodontist and the Area Dental Officers should use fixed appliances while all dental officers may use removable appliances. All the latter are made at our own dental laboratory and checked by the County Orthodontist in the course of their construction.

The laboratory has continued its work with the high standard it has set itself in previous years, and all our dental officers speak very highly of the quality of the service it provides.

The following figures relate to the output of the laboratory so far as the School Dental Service is concerned :—

Dentures, full	...	...	...	...	...	...	—
Dentures, partial	...	...	...	...	...	...	128
Orthodontic appliances	...	...	...	...	...	...	349
Reference models	...	...	...	...	...	...	859
Repairs	...	...	...	...	...	...	86
Jacket crowns	...	...	...	...	...	...	23
Inlays	...	...	...	...	...	...	6

The following figures relate to dental inspection and treatment carried out during the year:—

Number of children attending nursery, primary, secondary and technical schools in the County ... 57,025

(1) Number of pupils inspected by the Authority's Dental Officers:—

(a) Periodic age groups	...	...	...	...	...	...	13,045
(b) Specials	...	...	...	...	...	...	3,859

Total (1) 16,904

(2) Number found to require treatment	...	...	...	...	...	...	12,948
(3) Number referred for treatment	...	...	...	...	...	...	10,172
(4) Number actually treated	...	...	...	...	...	...	10,763
(5) Attendances made by pupils for treatment	...	...	...	...	...	...	19,380

(6) Half-days devoted to—

Inspection	...	...	...	...	...	...	188
Treatment	...	...	...	...	...	...	4,290

Total (6) 4,478

(7) Fillings—

Permanent teeth	...	...	...	...	...	...	10,157
Temporary teeth	...	...	...	...	...	...	5,005

Total (7) 15,162

(8) Number of teeth filled :—

Permanent teeth	9,723
Temporary teeth	4,710
Total (8)	<u>14,433</u>

(9) Extractions :—

Permanent teeth	2,258
Temporary teeth	11,697
Total (9)	<u>13,955</u>

(10) Administration of general anæsthetics for extraction 3,031

(11) Other operations :—

Permanent teeth	14,652
Temporary teeth	5,880
Total (11)	<u>20,532</u>

The following figures relate to orthodontic treatment :—

Number of cases treated	358
Number of attendances	2,593
Number of appliances fitted :—	
(a) Removable type	349
(b) Fixed type	101
	<u>450</u>

CHILD GUIDANCE.

The year's results show an increase in work by the Social Workers and reflect the additional support by recruitment to the team of Miss C. Bluett, Social Worker, and Miss M. Phillips, Psychiatric Social Worker. It is now possible to recommend intensive work with the parents of children referred to the team and this should relieve the other members of the team.

The drop in the number of cases seen by the Psychologists is also to be attributed to the fact that Mrs. Sheale left the team last year and, for more than six months, two Educational Psychologists have been dealing with all the work.

The work of the Hostels has been continued throughout the year and reference was made to the Somerset Hostels in the Annual Report of the Chief School Medical Officer to the Ministry of Education.

An attempt has been made to discover at what point the problem of the child attending the clinics first arises and who was responsible for taking the first step.

School and Hostel Visits paid by Psychologists	...	...	...	606
Home Visits and Clinic Interviews by Psychiatric Social Workers	...	...	...	1,230
Schools, Hostels and Children's Homes visited by Psychiatric Social Workers	...	...	...	49

*This figure includes 151 electro-encephalographic examinations.

Treatment.

Psycho-therapy by Psychiatrists	...	...	...	...	80
*Drug-therapy by Psychiatrists	...	...	...	...	209
Remedial coaching by Psychologists	...	...	...	...	2

*This figure includes 83 cases subsequently found to be epileptic.

SPEECH THERAPY.

The increasing use made of this service is shown in the fact that practically all clinics now have waiting lists and in certain areas, notably Weston-super-Mare, the Speech Therapist can only keep down her waiting list by being selective in the type of case accepted for treatment.

Details of individual cases treated by Miss Carruthers and Miss Coggon are included in the report, as thereby a more true insight into the value and scope of the service is given than is shown by a statistical table.

Miss Carruthers.

John, aged 11, was referred by the Educational Psychologist on account of a severe stammer at times, which was accompanied by behaviour difficulties. He was slightly below average intelligence but it was more his "temperamental" behaviour than his educational retardation which caused anxiety in school. He was emotionally immature and irresponsible. He was deeply antagonistic towards his parents probably chiefly as a result of rejection by them.

He attended the Speech Clinic regularly for nine months after which he was discharged as cured.

During these visits he was encouraged to discuss his worries and difficulties and he began to feel that someone was taking an interest in him. He became more self-confident and gradually his behaviour improved. Consequently he became more popular in school and at home and his stammer was less apparent. At last the vicious circle was broken.

His parents were delighted with the improvement he made—their original rejection of him was chiefly their disappointment in their only child whom they wished to be perfect.

They are now a happy and united family.

Miss Coggon.

This has been an extremely busy year for Speech Clinics in the South-Western Area of the County. Minehead and Yeovil, where Speech Therapy Service only

began in September, 1950, have now become very well aware of the existence of this branch of the School Health Service; in fact, school visits about one patient often produce five more names for the waiting list.

CASE I. Master D, a 10 year old stammerer, was brought to see me for the first time in March, 1951. He was quite a big lad for his age but, from his history, appeared to live the life of a recluse. He was really afraid of speaking to anyone and the thought of shopping, or asking for a 'bus ticket worried the child greatly. He was given a weekly appointment at the Speech Clinic. At first the mother attended with the boy and learnt how to help him with relaxation exercises. D. and the therapist had long talks about his fears of speech and gradually the boy's confidence developed. In two months he was travelling alone to the clinic. In six months he was made chief monitor at the school. Now, he is always bright and cheerful, he can keep the waiting room entertained for an indefinite period and is a general chatterbox. The parents, who have been most co-operative throughout, are very proud of him.

CASE II. Miss F. is a small six year old. When she first attended the Speech Clinic at the end of 1950 she could make nothing more than animal noises. Reports led one to believe she was a hopeless case. The mother was most distressed and convinced that nothing could be done. However, with gentle persuasion, regular weekly attendances were made. The child learnt many sounds, built up words and is now making short sentences and learning to read. She can make herself understood by most people and is no longer frustrated in this way. The mother is joyful that, after all, her child is not "mad", as so many of her neighbours had tried to convince her previously. There is much more work to be done, of course, but I am confident that the home is now a happier place for the patient, parents and brothers and sisters.

CASE III. Miss C. first attended the Speech Clinic in June, 1950. She was then a shy 7 year old with a severe hearing loss. Her parents being intelligent and co-operative made the work of the Speech Therapist a joy. From vowels, to consonants, words, sentences and always intonation practice, we worked regularly with this child. She has demonstrated her ability to talk before visitors at my clinic, at concerts and anniversaries. Lip reading still proved difficult and the child found great difficulty in holding her own in her little school. Application was made for her entrance to a residential school for partially deaf children. When interviewed by the headmaster the parents were told that the child did not appear to have sufficient hearing loss to warrant education in a Special School. However, after seeing the child's audiogram the headmaster realised that despite considerable hearing loss the child could not only speak but had a clear voice with a considerable range of tones. The result of much hard work on her behalf.

Speech Therapy, 1951.

Clinic Centres.	No. of Sessions.	No. of children under treatment		Admittances.	Discharges.	Total Attendances.	Home visits.	School visits.	No. on waiting list.
		1.1.51.	31.12.51.						
Bath	88	8	10	14	10	310	2	5	0
Bridgwater	90	19	19	22	22	512	20	12	15
Clevedon	92	14	16	11	9	463	7	9	5
Frome	83	13	14	13	12	415	4	12	9
Glastonbury	88	13	13	15	12	409	7	9	7
Minehead	92	10	12	13	11	384	14	41	2
Radstock	88	13	15	18	11	461	13	16	8
Shepton Mallet	83	8	12	12	5	289	8	9	6
Taunton	142	20	28	39	31	732	6	5	4
Weston-super-Mare	90	18	17	14	15	507	5	21	22
Yeovil	90	12	18	17	11	487	3	5	2
Totals ...	1026	148	174	188	149	4969	89	144	80

Speech Therapy, 1951.

Clinic Centres.	Children receiving treatment 31.12.51						Children discharged during 1951									
	Stammerers	Dyslalias	Sigmatisms	Cleft palates	Cerebral palsies	Other defects	Stammerers	Dyslalias	Sigmatisms	Cleft palates	Cerebral palsies	Other defects	Normal	Much improved	Some improvement	No improvement
													A	B	C	D
Bath	4	2	1	1	2	0	2	8	0	0	0	0	5	4	0	1
Bridgwater	9	9	0	1	0	0	7	14	1	0	0	0	14	5	3	0
Clevedon	9	4	0	1	1	1	2	6	0	1	0	0	5	2	2	0
Frome	8	6	0	0	0	0	4	6	1	0	1	0	2	4	2	4
Glastonbury	2	6	1	2	1	1	4	7	0	1	0	0	2	4	2	4
Minehead	6	6	0	0	0	0	2	6	1	2	0	0	5	4	2	0
Radstock	5	8	0	0	2	0	2	7	0	2	0	0	4	4	2	1
Shepton Mallet	3	4	0	1	1	1	1	3	1	0	0	0	2	2	0	1
Taunton	12	12	2	1	1	0	11	16	2	1	1	0	15	6	3	7
Weston-super-Mare	8	8	0	0	0	1	6	8	0	0	0	1	10	3	2	0
Yeovil	4	9	2	1	1	1	4	7	0	0	0	0	4	3	3	1
Totals ...	70	74	6	8	9	5	45	88	6	7	2	1	68	41	21	19

ORTHOPÆDIC SERVICE.

The County Council continue to run this service as agents of the Regional Hospital Board.

Miss M. Forrester Brown, the Orthopædic Surgeon, retired in February, 1951, and her place was taken by Mr. Hedley Hall. The clinics are now divided as follows:—

Mr. Tom Price.	Mr. Hedley Hall.
Yeovil	Taunton
Weston-super-Mare	Glastonbury
Bridgwater	Frome
Minehead	Radstock
	Bath (Manor Hospital)

Through the co-operation of the Secretary of the Yeovil Hospital and Dr. Fox we now have the use of the Yeovil Swimming Baths on Saturday mornings for polio and posture cases. Average attendance is 25. Several children have learnt to swim as a result of this, and others have shown marked improvement in posture.

198 school children have received treatment in the Bath Orthopædic Hospital during 1951.

Number of New Cases (Children of school age) seen at Surgeons' Clinics during 1951.

T.B. joints	—
Infantile paralysis	10
Other paralytic conditions	—
Osteomyelitis	—
C.D.H.	—
Club feet	3
Torticollis	4
Other congenital deformities	21
Deformities of spine, Kyphosis, Scoliosis	52
Hallux Valgus	45
Knock knee	15
Bow leg	3
General defects in posture	34
Injuries and accidents	2
Other defects and deformities including arthritis	58
Spastics	2
Total	249

Mr. Hedley Hall, the Orthopædic Surgeon, submits the following interesting communication on the working of the Service during 1951:—

“The figures for the year 1951 closely follow the pattern of the year 1950 and, apart from the miscellaneous group of cases, deformities of the spine and feet still form the bulk of the cases referred to the clinics. These deformities are part of the price the human animal pays for adopting the erect attitude.

When the child leaves school at the age of fifteen to seventeen, the spinal curves are fixed; the curves on leaving school are the curves for life. As a general statement the alterations in shape of the spine are slow when growth is slow and rapid when growth is rapid. Vertebral growth is slow from the age of four to ten and in that period deformities increase slowly. From the age of ten to fifteen vertebral growth is rapid and this is the period at which a scoliosis which has remained stationary for several years may advance at an alarming rate.

Our treatment of the severe postural defects of the spine is disappointing and with many we have to be content with the fact that the deformity does not worsen during the critical years. This makes it all the more important that the early deviations from normal should be discovered and not allowed to progress to the fixed, irreducible deformity.

In none of the deformities can the clinic serve a more useful purpose than in the deformities of the spine; in picking out early those deformities which may progress and lead to serious disabilities in adult life. But it is important that they are seen early and watched throughout the growing period. The late arrivals are already fixed and no known treatment will straighten the crooked fixed spine. They can be improved, but often only after extensive operative repair, demanding perhaps twelve months away from a child's normal educational and social surroundings. This if made inevitable by our ignorance is a tragedy; if forced on us by our negligence is criminal.”

CHILDREN'S SHOES.

Recent surveys in various parts of the country have shown that, by the age of 15,

- four children out of five have big toes bent over, and even more have other toes crooked;
- two out of five have corns on the little toes;
- one girl in five has blisters on her feet;
- three out of ten have stiffness of one or more joints, mainly toes.

Other foot defects, some even more serious than these, are common. Scientists and doctors agree that many of these foot ills are due to unsuitable footwear, especially shoes which are the wrong size or do not fit properly. In a local survey carried out in one part of the county it was found that, out of over 1,800 children whose footwear was examined for size alone—without taking into account the suitability of the fitting—only 27 per cent. were wearing shoes of the correct size! Of the remainder 60 per cent. were wearing shoes varying between $\frac{1}{2}$ and $2\frac{1}{2}$ sizes too short, and 13 per cent. were wearing shoes $\frac{1}{2}$ to 2 sizes too long.

If not corrected, foot disorders which may seem trifling in a child can become painful or serious handicaps in later life. Copies of a pamphlet giving advice to

parents on the problem of correct footwear for children are supplied in appropriate cases in the course of routine medical inspections.

It is suggested that teachers should take every opportunity of training in hygiene and prevention and treatment of minor foot defects, by giving barefoot inspections and exercises in the classroom. Useful consultations with parents of children with "poor posture" (so often attributable to foot defects), may be made individually, or at Parent - Teacher Association meetings.

TRANSPORT OF SCHOOL CHILDREN ON MEDICAL GROUNDS.

Transport to school is provided by the County Education Committee for any children who are certified by the County School Medical Officer as being physically unfit to walk to and from school, irrespective of the distance involved. These cases are regarded as "re-examinations" and are examined by the School Doctor on each occasion a medical inspection is carried out at the school, and/or immediately prior to the termination of the period for which transport was recommended.

At the end of the year, 108 children out of a school population of approximately 56,000 were being conveyed to school on medical grounds. 65 of these were using existing conveyances without any additional cost to the Committee and out of the remaining 43, a number were using an existing conveyance for a part of the journey.

As the transport of some of these children is often very costly, a very close scrutiny is given to each case. Following the recommendation of the School Medical Officer, the family doctor and/or the Orthopædic Surgeon is consulted in all borderline cases prior to the recommendation being confirmed at central office.

The additional cost at present involved in conveying children to school on medical grounds is approximately £1,600.

INFECTIOUS DISEASES.

In 1951 six schools or departments were closed for outbreaks of infectious diseases. The particular diseases for which closure was advised were Measles 2, Influenza 2, Mumps 1, Coughs and Colds 1.

Acute Poliomyelitis.

19 cases of this disease in school children occurred during 1951, but fortunately the majority were abortive and non-paralytic, and there were no deaths. Geographically, the cases were all single with the exception of two at Clevedon and six at Stoke-under-Ham. All the cases at Stoke-under-Ham were school children and all were abortive.

Causes of Death at age 5 and under 15 years.

Causes of Death	Year																			
	1932	1933	1934	1935	1936	1937	1938	1939	1940	1941	1942	1943	1944	1945	1946	1947	1948	1949	1950	1951
Tuberculosis, respira- tory ...	4	3	3	0	0	3	3	1	3	1	1	0	2	3	0	0	1	0	1	0
Tuberculosis, other ...	5	5	6	2	3	5	4	4	6	7	4	7	8	8	7	8	3	3	2	0
Syphilitic disease ...	0	1	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0
Diphtheria ...	9	6	6	8	8	4	5	2	7	8	4	0	1	1	0	0	0	0	0	0
Whooping cough ...	1	1	1	0	1	3	0	0	0	2	0	0	0	1	0	0	0	0	0	0
Acute poliomyelitis ...	—	—	—	—	—	—	—	—	—	—	1	0	1	0	0	0	1	3	2	1
Measles ...	2	1	3	1	4	0	1	1	0	9	0	0	0	0	0	1	0	0	0	1
Other infective and parasitic diseases ...	2	2	1	1	4	5	1	0	4	4	0	1	0	1	0	2	0	0	1	2
Malignant neoplasms...	2	1	2	1	1	2	2	0	0	1	6	1	0	0	3	3	0	2	1	2
Leukæmia ...	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	2	2
Diabetes ...	0	1	1	2	1	3	0	1	2	2	1	0	0	0	0	0	0	1	0	1
Heart disease ...	1	5	3	5	4	3	0	2	1	6	3	4	4	2	1	0	0	0	2	1
Other circulatory diseases ...	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	2	0	1	0
Influenza ...	4	3	2	4	1	3	4	4	1	0	0	5	2	0	0	0	0	0	1	1
Pneumonia ...	9	3	5	7	5	4	2	3	3	5	3	2	5	2	0	2	1	1	3	1
Bronchitis ...	1	1	0	1	2	1	1	0	1	2	1	2	1	0	1	0	0	1	1	0
Other diseases of the respiratory system...	1	1	1	0	0	1	2	0	2	1	1	0	0	1	1	1	0	0	0	0
Diarrhœa, etc. ...	1	0	2	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Appendicitis ...	4	5	8	1	1	7	10	3	5	2	2	4	4	3	4	4	3	1	0	0
Other digestive diseases ...	4	4	4	2	4	2	4	2	6	5	2	3	4	1	2	1	0	1	0	2
Nephritis and nephrosis ...	2	2	3	3	3	2	2	4	1	1	1	1	4	2	2	1	0	1	2	1
Congenital malforma- tions ...	1	1	2	0	0	1	1	1	5	2	2	4	1	7	3	2	3	3	2	6
Other defined and ill- defined diseases ...	10	18	23	15	13	13	9	16	13	18	2	7	17	12	6	8	6	9	5	4
Motor vehicle acci- dents ...	—	—	—	—	—	—	—	—	6	16	9	7	11	3	5	9	5	9	8	2
All other accidents ...	15	7	11	9	13	11	14	13	8	13	10	7	15	9	3	5	4	7	6	4
Totals ...	78	71	88	62	69	74	65	57	74	105	53	56	80	56	38	47	29	42	41	32

The decade 5 - 15 is one of the safest periods in life and, therefore, the numbers of deaths are small. Nevertheless, the above table is not without interest.

Tuberculosis shows a definite decline. There have been no deaths from diphtheria for five years. Poliomyelitis only raised its head in 1942 and, rather surprisingly, has only killed half the number of school children who have died of cancer in that period; and finally, the table shows that motor accidents are the greatest single cause of death to school children, only approached by "other accidents" and it is clear, therefore, that "safety lessons" in the schools continue to be as important as ever.

SWIMMING BATHS.

All the fifteen baths in the County and those outside, in Bristol and Bath, used by school children for swimming instruction were sampled at regular intervals, the results of the tests being as follows:—

	Samples taken.	Satisfactory.	Suspicious.	Unsatisfactory.
Inside County ...	247	233	4	10
Outside County ...	69	65	3	1
	<hr/> 316	<hr/> 298	<hr/> 7	<hr/> 11

Appropriate action was taken in every case where unsatisfactory results were obtained.

HYGIENE IN SCHOOL BUILDINGS.

Definite progress has been made during 1951, although there is still far too much to be done. 71 improvements were completed during the year involving a cost of £9,300, i.e., an average of £131 per school. The improvements ranged between the modernisation of lavatory systems costing £414 at Bathford V.C. School and the supply of a wash basin costing £10.

In addition 45 projects costing £16,443 have been authorised but not completed during the year.

For the financial year 1952-53 a ceiling of £8,000 has been imposed for this type of work and it would appear that many years will elapse before all our schools have sanitary conveniences conforming to modern ideas of hygiene.

DIPHTHERIA IMMUNISATION.

The good results of this scheme continue to be reflected in the vital statistics of the County.

Only 659 children received primary injections, but this is largely due to the fact that two out of every three children are immunised prior to entering school. 6,602 school children received reinforcing injections, this work being carried out almost entirely by the school medical officers.

If immunisation can be continued at its present level there seems to be no reason why diphtheria should not be almost stamped out in this country.

In 1951 only one case of diphtheria in school children was notified throughout the County. The child, aged six, was immunised in infancy, but had not received a reinforcing dose on entering school. Nevertheless she made a complete recovery.

The figures show that most of the arrears in this work which accumulated in 1950 owing to the poliomyelitis outbreak were cleared off.

It cannot be stressed too strongly that we can only remain in our present happy state of being practically free from this disease by maintaining the immunisation service at its present high level.

Immunisation is a typical example of the Public Health Service inasmuch as it is continuous, inconspicuous, and usually the only apparent result is that nothing happens.

Reinforcement injections given during the year ended 31st December, 1951.

Urban Districts.				Total.	Rural Districts.				Total.
Bridgwater	...	...	...	344	Axbridge	...	...	...	387
Burnham-on-Sea	...	...	...	113	Bathavon	...	...	...	331
Chard	...	...	...	0	Bridgwater	...	...	...	226
Clevedon	...	...	...	78	Chard	...	...	...	223
Crewkerne	...	...	...	27	Clutton	...	...	...	285
Frome	...	...	...	131	Dulverton	...	...	...	48
Glastonbury	...	...	...	29	Frome	...	...	...	68
Ilminster	...	...	...	3	Langport	...	...	...	142
Keynsham	...	...	...	109	Long Ashton	...	...	...	246
Minehead	...	...	...	70	Shepton Mallet	...	...	...	116
Norton-Radstock	...	...	...	159	Taunton	...	...	...	374
Portishead	...	...	...	45	Wellington	...	...	...	167
Shepton Mallet	...	...	...	124	Wells	...	...	...	102
Street	...	...	...	8	Williton	...	...	...	274
Taunton	...	...	...	382	Wincanton	...	...	...	328
Watchet	...	...	...	68	Yeovil	...	...	...	292
Wellington	...	...	...	79					
Wells	...	...	...	98					
Weston-super-Mare	...	...	...	431					
Yeovil	...	...	...	695					
Total				2,993	Total				3,609
Total Administrative County					...	6,602			

MASS RADIOGRAPHY.

A Mass Radiography Unit visited various Centres in the County during the year and comprehensive arrangements, with the ready help of the Education Department, were made for school teachers and other schools' staffs to be examined. The arrangements, which were entirely voluntary, resulted in a 75 per cent. acceptance rate from the teachers.

The following are the results of the survey:—

				Male.	Female.	Total.
Miniature Films				453	1,077	1,530
Tuberculous Conditions.				Disposal.		
	Male.	Female.	Total.	N.A.	Dr.	San.
Active	3	4	7	—	—	6
Inactive	10	19	29	11	9	9

KEY.

N.A. = No action.
 Dr. = Patient's own doctor.
 Disp. = Under observation at dispensary.
 San. = Sanatorium treatment required.

				Male.	Female.	Total.
Non-Tuberculous Conditions.				5	13	18

School Children.

Facilities were provided at the following centres:—Taunton, Weston-super-Mare, Bridgwater, Yeovil, Crewkerne, Street and Ilminster for the Mass Radiography of school children aged 13 and over, who were living in the near vicinity of the centre.

The following table shows the results, i.e., 3 cases of active tuberculosis in a total of 3,535 children examined and in addition 10 instances of pathological conditions (non-tubercular) were detected:—

					Male.	Female.	Total.	
Miniature Films ...					2,083	1,452	3,535	
Tuberculous Conditions.					Disposal.			
					N.A.	Dr.	Disp.	San.
Active ...					—	—	1	2
Inactive ...					3	—	1	—
					Male.	Female.	Total.	
Non-Tuberculous Conditions.					7	3	10	

Although, as might be expected, the ratio of active cases in children, approximately one per thousand, is much less than that found in the teachers and other staff, i.e., approximately four and half per thousand, nevertheless, it is considered that the detection of these early and unsuspected cases fully justifies the effort involved. Furthermore, the negative results include many instances where the parent has been anxious for various reasons and has welcomed the resulting reassurance.

HANDICAPPED CHILDREN.

Handicapped Pupils requiring Education at Special Schools
or Boarding in Boarding Homes,
year ending Dec. 31st, 1951.

	(1) Blind.	(2) Partially Sighted.	(3) Deaf.	(4) Partially Deaf.	(5) Delicate.	(6) Physically Handicapped.	(7) Educationally sub-normal.	(8) Maladjusted.	(9) Epileptic.	TOTAL 1-9.
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
In the calendar year :—										
A. Handicapped Pupils <i>newly placed</i> in Special Schools or Homes.	1	1	6	4	5	9	54	38	3	121
B. Handicapped Pupils <i>newly ascertained</i> as requiring education at Special Schools or boarding in Homes.	2	2	1	1	8	11	38	6	—	69
On or about December 31st :—										
C. Number of Handicapped Pupils from the area—										
(1) attending Special Schools as—										
(a) Day pupils ...	—	—	1	—	—	—	3	—	—	4
(b) Boarding pupils ...	20	4	25	4	3	14	137	2	5	214
(2) Boarded in Homes ...	—	—	—	—	—	1	—	27	—	28
(3) attending assisted schools (under approved arrangements) ...	—	—	—	—	1	—	2	5	—	8
Total (C) ...	20	4	26	4	4	15	142	34	5	254
D. Number of Handicapped Pupils receiving home tuition (including those also returned in E).	—	—	—	—	2	10	—	—	—	12
E. Number of Handicapped Pupils from the area requiring places in special schools or Homes but remaining unplaced.	2	1	6	6	14	26	171	6	1	233

Number of children reported as ineducable during the Calendar Year under
Section 57 (3) of the Education Act, 1944 ... 43.

EDUCATIONALLY SUBNORMAL CHILDREN WHO LEFT SCHOOL IN 1950.

In 1950, there were 115 children whose mental incapacity was such that they were reported to the Local Health Authority as requiring care and supervision, who left school at the age of fifteen. There were 75 boys and 40 girls with intelligence quotients ranging from 52 to 82, only 18 out of 115 having intelligence quotients above 70.

Their subsequent history, checked in May, 1952, after leaving school, is interesting and thought-provoking. Of the 40 girls, ten are engaged in factory work and eight in domestic service, the remaining 22 apparently are not "gainfully employed". 58 of the 75 boys are still in employment of various types, although 17 are engaged in farm work. The average weekly wage of the 76 children employed is 47/- but the individual variations are very marked; thus there are two boys with intelligence quotients of 58 and 59 earning 69/- and 70/- in farming and engineering respectively.

Three boys still attend Occupation Centres and ten boys and nine girls were admitted to Mental Hospitals and Institutions.

Whether the above figures are a reflection of a period of maximum employment, or whether the intelligence quotient is a very inadequate indication of wage-earning capacity, are two of the queries which arise in one's mind. Studying the details on the files one is impressed by the large proportion who are still in the same post after the expiration of one year or more. This happy result is probably due to the care and discrimination exercised by the Mental Health Officers in arranging and approving the type of work. For this purpose a knowledge of the intelligence quotient is most helpful.

In many respects, however, the intelligence quotient is not as important a factor as the stability and social adaptability of the child. The Child Guidance Team has recently been assessing the "Social Quotient" of many problem children and it would appear that the judicious use of both the Intelligence Quotient and the Social Quotient may go a long way to reduce the number of social misfits who are such a costly nuisance in these days. The careful selection of careers for these handicapped children may well convert them into assets to society rather than liabilities.

DIVISIONAL MEDICAL OFFICERS' REPORTS.

"Field" Reports are again submitted by Drs. Fox, McGowan and Watson. The report on the Breathing Exercise clinic at Bridgwater is most encouraging and interesting, and I would like to stress Dr. McGowan's comment on the Audiometry Service that its chief value is in detecting cases of slight deafness which are likely to respond to treatment. Such work is the very essence of the School Health Service.

It is hoped to institute a Breathing Exercises clinic and an audiometry survey in the Taunton Division in mid-1952.

DR. R. H. WATSON.

School Audiometer Survey.

A reliable method of testing the hearing of children in school has been lacking for a long time. The method which was most generally used was the forced whisper, which depended on the response of an individual to the examiner's forced whisper at varying distances. Naturally, the results were influenced by many factors, and comparison of the findings of different examiners, under varying conditions, were seldom valid. In practice, this method of testing hearing was limited to children who were known, or suspected, to have some impairment of hearing.

A gramophone audiometer was obtained in September, 1950, and an audiometric survey was carried out in the Divisional Area from December, 1950, to November, 1951. Children aged 9 years and over were included in the survey, as it was considered that children of this age would be able to co-operate most readily in group testing.

The advantages of using this type of Audiometer are:—

- (1) It permits of group testing. It was found in practice that up to a maximum of 20 children could be tested at the same time, and this was a very considerable time-saving factor.
- (2) Impairment of hearing can be measured in definite terms, i.e., decibels, and future progress accurately assessed.
- (3) Hearing acuity of each ear can be tested separately.

Procedure.

The apparatus being portable, the tests were carried out at the schools. All children were given an initial test, and those who failed were, for the greater part, re-tested on the same day, the last group of the day usually being composed of these children.

Some children fail in the first test, however, not because of deafness, but for any of the following reasons:—

- (1) Failure to understand fully what is required.
- (2) Nervousness, or lack of concentration.
- (3) Slowness in reaction, or low grade of intelligence.
- (4) Temporary indisposition, e.g., catarrh, or colds.

Children failing the second test were medically examined to exclude minor causes of deafness such as wax in the ears, colds, etc., and arrangements were made for these children to receive appropriate treatment. In Bridgwater, this was carried out at the Minor Ailments Clinic, and in rural schools, it was found expedient to arrange for a Health Visitor to call at the school, and carry out treatment. In all cases parents were informed, and advised either to consult their family doctor, or to avail themselves of the facilities provided by the School Health Service.

Children failing the second test, and showing no obvious minor cause of deafness, were, with the approval of parents and family doctors, referred to Ear, Nose and Throat Specialists. By far the greater number of these children were seen at Bridgwater Hospital at special sessions which were devoted entirely to investigating these cases, when the School Medical Officer was also in attendance. It is considered that this arrangement was a most satisfactory one, and the exchange of information which was possible, between Specialist and the School Medical Officer, was particularly valuable.

153 children were found to have some loss of hearing not amenable to minor ailment treatment, and were referred to the Ear, Nose and Throat Specialist. Of these, 94 had impaired hearing in one ear, and 59 had impaired hearing in both ears. Three children were supplied with hearing aids.

Observations.

The great majority of cases of impaired hearing brought to light by the survey were children in whom the defect was previously unknown, or who were not receiving treatment for a suspected disability.

Response from parents was very good, and necessary treatment or Specialist advice has in all cases been obtained.

Co-operation and help from teachers have been excellent, often despite very real inconvenience.

Family doctors have been kept fully informed at all stages of the survey. An initial letter was sent to them, informing them of our intention to carry out the survey, and they were later informed of the findings relating to any of their patients who were found to have a defect. Finally, they received the report of the Specialist on cases referred to him.

Although children under the age of 9 years were excluded from the survey, many younger children were tested individually, either to confirm and assess a suspected impairment of hearing, or to assess response to treatment. A number of children have been referred by General Practitioners for individual testing.

Children with partial loss of hearing, which did not respond to treatment, have been placed in the most advantageous position in the classroom.

The results of the survey are illustrated in the following table:—

A.	Number of schools visited	...	...	...	...	48	
B.	Total number of children examined	...	...	...	...	3,776	
C.	Total number re-examined once	...	...	...	...	655	17.3% of "B"
D.	Number found to have a hearing defect	...	...	...	...	290	7.7% of "B"
E.	Number treated at Minor Ailment Clinic	...	...	...	...	137	47.4% of "D"
F.	Number referred to Specialists	...	...	...	...	153	52.6% of "D"
G.	Number requiring re-testing after treatment	...	...	...	...	147	
H.	Number found to have normal or much improved hearing after treatment	...	...	...	...	218	75.2% of "D"
I.	Number referred for further observation	...	...	...	...	50	17.2% of "D"
J.	Number for whom no treatment was recommended	...	...	...	...	22	7.6% of "D"

Summary.

3,776 children were examined with Audiometer, and 290 were found to have a significant degree of hearing loss, i.e., 12 or more decibels. Of these, 137 responded to minor treatment, and 153 were referred for Specialist advice or treatment. Of the latter, 81 responded to treatment, 50 were referred for further observation, and in 22 cases the hearing loss was the result of permanent damage to the ear, and no improvement could be obtained, although the defect was insufficient to warrant the provision of a hearing aid. These children were placed in the most advantageous position in the class. Three children were supplied with hearing aids.

Heart Defects.

As described in a previous report, arrangements have been made for all school children in this area, who have a heart defect, to receive injections of penicillin before dental extractions are carried out by the school dental officers. However, it was appreciated that children leaving school, or attending private dentists, might not receive this prophylactic treatment, particularly if the heart defect was a mild one. All school children, therefore, having a heart defect are now supplied with a card, which they are advised to show to their dentists before treatment is commenced. This card states the nature of the defect, and recommends that the family doctor should be consulted before dental extractions are carried out.

Liaison with Hospitals.

Arrangements previously made for this department to receive copies of medical reports on children seen at the pædiatric department of Bridgwater General Hospital continue to work satisfactorily, and have now been extended to include children seen by the Medical Specialist at Burnham War Memorial Hospital.

Prevention of Tuberculosis.

A Mass Radiography Unit visited Bridgwater during July, 1951. Once again, arrangements were made for school leavers to attend. 126 boys and 80 girls attended. Of these, one boy was found to have active tuberculosis, and was admitted to a Sanatorium.

Acquired immunity to disease is usually obtained either by an attack of the disease, or by exposure to minimal doses of infection, which are not in themselves sufficient to bring on the symptoms of disease, but which in their cumulative effect are sufficient to stimulate the body defensive mechanisms. The majority of people acquire a degree of immunity to tuberculosis by the latter method, and usually this happens during their school life.

By means of a simple skin test, it is possible to demonstrate whether a child has reacted to infection by the tubercle bacillus, and arrangements are therefore being made for an investigation to be carried out, on entrants to infant schools, to determine what percentage of children at that age have been exposed to infection. It is expected that the number of positive reactors will be small. Children are likely to be positive reactors either because they have consumed infected milk, or because they have been fairly close contacts of people suffering from tuberculosis in an infectious state. In the town of Bridgwater, at any rate, the number of children consuming milk which is neither Tuberculin tested nor Pasteurised is considerably decreasing, and therefore the second cause of a positive reaction is the more important.

The survey will be purely a pilot one, and its value cannot be assessed until results can be studied. It is being carried out with two objects in view.

- (1) It will give information as to the number of children at a given age who give a positive reaction to the skin test. This information is not at present known for children in the area.
- (2) At least some of the positive reactors will have been exposed to infectious cases of tuberculosis. Searching investigation of close contacts will be carried out wherever possible, and by this means it is hoped to bring to light unsuspected cases of adult tuberculosis. It may be found, therefore, that this method of investigation is a useful addition to Mass Radiography.

Breathing Exercises Clinic.

The following account has been written by Dr. C. M. Rooke, who supervises the day to day running of the clinic:—

“This Clinic has now been functioning for nearly eighteen months, and a survey of the present position, and of the results obtained, presents many points of interest and encouragement.

With a few exceptions, the initial enthusiasm shown by both children and parents has been maintained. In contrast to the School Minor Ailments Clinic, which almost ceases during school holidays, the attendance at the Children's Breathing Exercises Clinic drops very little. Children expecting to be away on holidays or expeditions tell us which weeks they will miss, and continue their exercises even when away from home.

In a small minority of cases, co-operation has been poor and the results disappointing. Owing to the large number of children requiring treatment at the Clinic, it has been found necessary to discharge those who fail to attend regularly, after every effort has been made to encourage them, and to secure the co-operation of the parents. Numerous visits to children's homes have been made by Health Visitors and District Nurses for this purpose, and it is only after all efforts have failed that this measure has been put into force.

The number of children who have received treatment, together with the length of time they have attended, is as follows:—

Over 12 months	...	...	...	...	17
9—12 ,,	...	...	...	...	15
6—9 ,,	...	...	...	...	7
3—6 ,,	...	...	...	...	6
Under 3 ,,	...	...	...	...	3
Ceased treatment	...	...	...	...	6
Excluded from survey	...	...	...	...	5
Total					59
On waiting list					9

Of the six children who have ceased treatment, one child suffering from chronic pulmonary catarrh was discharged as cured, by Dr. Coates, after five months. One child left the district. One child developed active tuberculosis of glands, and was admitted to Compton Bishop Children's Home. One child has ceased temporarily on account of domestic difficulties and will be placed on the waiting list again when once more able to attend regularly. Two children have been discharged as having failed to attend sufficiently regularly to benefit from treatment.

Those excluded from the survey are five children who for various reasons were unable to attend regularly, and in whom, therefore, the results of treatment could not be compared with those of the other children. Although co-operation has been good, and the exercises have been practised at home under the supervision of the parents, it is noticeable that their progress has been less satisfactory than that of children who have been able to attend the Clinic each week.

Including the children on the waiting list, and all those who have received treatment, just over half (36 cases) are suffering from asthma. The other group (32 cases) is mainly composed of children suffering from chronic pulmonary catarrh (21 cases), but includes also 7 cases of bronchiectasis, 2 cases of partial collapse of the lung due to enlargement of glands in the chest, and 2 cases of bony deformity of the chest with no lung affection.

The results of treatment are encouraging. These are expressed only partially in the figures of chest movements given below. Perhaps even more significant are the reports of parents and teachers, and the reactions of the children themselves. With very few exceptions, parents have realised in a short time the possibilities of improvement which the treatment holds, and their co-operation and help has been invaluable. Teachers have reported not only improvement in school attendance, but also in lessons and general interest, and in many cases a totally changed outlook on life. The children have found others similarly afflicted, have entered into competition with them, and have found real satisfaction in working hard at their exercises in order to excel in a group. Their half hour's treatment on Wednesday afternoons is a treat anticipated with pleasure. After a few months the sounds of

wheezing and coughing are replaced by peals of laughter and merry shouts, as they enjoy the fascinating "games" which can be invented from such simple materials as match boxes, ping-pong balls and drinking straws; and which teach them how to empty their lungs to the greatest possible extent by prolonged and steady blowing. These "games" are preceded by the more serious matters of relaxation and correct use of the abdominal muscles; then exercises designed to improve the shape of a deformed chest.

All these exercises can be easily practised at home by any child of average intelligence. A record card is provided, on which the parent is requested to write each week the number of times the exercises have been done at home; together with notes of colds, coughs, and asthma attacks, so that a detailed record can be made at the Clinic. It soon becomes evident that head colds are less frequently accompanied by coughs and asthma attacks; and that when present these become progressively less severe and of shorter duration.

The monthly clinical examination by the Medical Officer confirms these encouraging results. The whole appearance of the children changes. Pale strained faces and drooping posture give place to cheerful smiles, rosy cheeks and greatly improved posture. Children with coughs no longer have sounds of catarrh in the chest, and even soon after an asthma attack, wheezing cannot be heard. Parents, who are encouraged to be present at the clinical examination, report increased energy, amounting even to high spirits, and greatly reduced tendency to shortness of breath when climbing hills or running. The opportunity is taken to discuss a large variety of small problems, relating to diet, rest, activities, general management and difficulties in school. Reassured parents encourage their children to persevere, and the many confidences which pass from the children to the Health Visitors emphasise the friendly relationships which are such a marked feature of this Clinic.

The only result of treatment which can be readily expressed in figures is the increase in movement of the chest. The figures given represent not the actual difference in measurement when the chest is filled and then emptied, but the added movement obtained after treatment, e.g., if before treatment the actual difference is 1 inch and after treatment 3 inches, the increase is 2 inches.

After 3—6 months' treatment	an average increase of	$\frac{3}{4}$ in.
„ 6—9 „ „ „ „	„ „	$\frac{3}{4}$ in.
„ 9—12 „ „ „ „	„ „	1 in.
„ 12 months or longer	„ „	2 in.

Before treatment some children had as little actual movement as $\frac{1}{2}$ inch, while after 12 months some children have an actual movement of $3\frac{1}{2}$ to 4 inches. Before treatment 78 per cent. of children had incorrect abdominal breathing, using the abdominal muscles either not at all or actually the reverse of the correct way. In every case this was corrected by the end of the first three months.

The reports from Dr. Coates, Consultant Pædiatrician, who sees the children every three to six months according to their progress, are equally encouraging. They confirm the improvement in general health, and in physical signs in the chest, as well as in increased chest movement.

The figures given show clearly the need for prolonged treatment, and the rapid increase obtained when a certain point is reached. The stage at which the child is able voluntarily to control coughs and asthma attacks by the use of relaxation and correct abdominal breathing is very variable, depending on his intelligence and on the age at which treatment is started, older children arriving at this much more rapidly than the very young. As this is one of the great aims of treatment, to continue until this is achieved is highly desirable. It is anticipated that most children will need to attend the Clinic for two years before they can be considered to have obtained the greatest possible benefit."

DR. D. McGOWAN.

1. School Nurses.

During 1950, the Health Visitors in Weston-super-Mare took over the additional duties of School Nurses and wherever possible were given the care of schools situated in their particular Health Visiting areas of the town. For the schools in Axbridge Rural District a full-time school nurse continued to work.

1951 was the first full year during which the new scheme was in action, and it has proved very successful. The main advantage of the scheme is that the work of the Health Visitor - School Nurse has now increased in scope and interest and she now has under her care all children in a household from infancy to school leaving age. Another advantage is that there is no duplication of visits to any one household by separate Health Visitors and School Nurses.

2. Minor Ailment Clinics.

The Minor Ailment Clinic at 46 The Boulevard, Weston-super-Mare, continued as in previous years, a session being held on three mornings in the week. The School Medical Officer and School Nurse attend the Tuesday and Saturday Clinic, while the Nurse only is present on Thursday morning.

Attendances at this Clinic have shown a steady decline since the end of the war as the following table shows:—

Year.	Somerset Children.	Evacuees.	Total.
1939	1,766	2,822	4,588
1940	1,737	4,509	6,246
1941	1,484	6,920	9,404
1942	2,782	2,503	5,285
1943	4,032	1,545	5,577
1944	4,928	1,562	6,490
1945	5,423	—	5,423
1946	4,669	—	4,669
1947	3,590	—	3,590
1948	2,808	—	2,808
1949	2,632	—	2,632
1950	2,052	—	2,052
1951	1,624	—	1,624

With regard to possible causes of this fall in attendances, I do not think there is any doubt that the family doctors are now seeing more children, even for minor illnesses and injuries. One of the other causes, however, has been a real reduction

in the amount of minor septic skin conditions, impetigo and scabies. For example, the number of attendances for impetigo in 1945 was 813, while in 1951 the corresponding number was only 95. Scabies attendances in 1945 were 157, whereas in 1951 no children with scabies were seen at the School Clinic (11 children were treated at Drove Road Hospital Cleansing Centre for scabies, having been referred there directly by their own doctors). Attendances for other minor septic skin conditions in 1945 were 1,350, and in 1951, 310. Ringworm of the scalp is now rarely seen, and ringworm of the body is also uncommon.

Mothers still bring their children to the Clinic for consultation, i.e., to discuss with the School Medical Officer the child's general health and any particular defect which the child may have, such as ear, nose, throat or chest troubles. Attendances for this reason have not shown the same decline.

Towards the end of 1950, a Minor Ailment Clinic was opened in the new school on the Bournville Housing Estate. Previously, it had always been difficult to get children from this area of the town to attend the Minor Ailment Clinic at 46 The Boulevard, as the Estate is 2 miles from the centre of the town. This clinic is attended by a School Nurse each morning during the school term for about half an hour. A doctor does not attend, and any children who require the services of a doctor are either referred to their family doctor or to the Central School Clinic.

During 1951, 360 individual children attended this clinic and the total number of attendances was 1,551. This number is surprisingly high considering that the total child population of the two schools served by the clinic is only 622. A very large proportion of the children treated have minor septic skin conditions, and many of these are very slight indeed. Normally they could easily be treated by simple measures at home, and it is a debatable point whether such good facilities for the treatment of minor ailments do not relieve the mother of too much responsibility. On the other hand it can be argued that treatment of such minor ailments prevents the development of more serious lesions.

3. Mass Radiography.

A Mass Radiography Unit visited Weston-super-Mare in February, 1951, and arrangements were made for children of school leaving age to be examined.

The following are the results of the survey:—

	Male.	Female.	Total.
Miniature films	296	363	659

Tuberculous conditions:

	Male.	Female.	Total.	N.A.	Disposal.		
					Dr.	Disp.	San.
Active ...	1	—	1	—	—	1	—
Inactive ...	1	—	1	1	—	—	—

Non-tuberculous conditions:

Male 1.	Female 1.	Total 2.
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KEY.

N.A. = No action.

Dr. = Patient's own doctor.

Disp. = Under observation at dispensary.

San. = Sanatorium treatment required.

4. Gramophone Audiometry.

In May, 1951, a Gramophone Audiometry survey of school children was started, children above the age of 8 years being examined. The survey was carried out by Miss B. M. Webber, School Nurse, assisted by Miss P. T. Board, Junior Clerk in the Divisional School Health Office.

The standard of pass or failure was taken at the 6 decibel (G.A.) level, i.e., children with a hearing loss of 9 or more decibels (G.A.) in one or both ears were considered to be suffering from deafness. To eliminate lack of understanding and temporary causes of deafness such as colds, children who failed in the first test were re-examined about a month later, and if they did not pass the second test, their parents were invited to bring them to the School Clinic for clinical examination by the School Medical Officer. At the School Clinic, minor remediable causes of deafness, e.g., wax, were dealt with, but the majority of children were referred to Mr. Dennis Clark, the Ear, Nose and Throat Surgeon at Weston-super-Mare General Hospital, for further examination, pure tone audiometry and treatment if required.

By the end of the year 1,558 individual children had been tested and of these 304 were re-tested because of failure in the first test. 98 (6.3 per cent. of the total) children failed the second test.

The following tables show the results of the hearing tests.

Tables II and III have been set out in the same manner as the tables shown in pages 114 and 115 of the Report of the Committee of Enquiry into problems relating to Children with Defective Hearing (Board of Education Report, H.M. Stationery Office, 1938, reprinted 1950).

TABLE I.
Distribution of Deafness in 1,558 Children examined.

	No. of Children.
No deafness present	1,460
Left ear only affected	37
Right ear only affected	33
Both ears affected	28

TABLE II.
Acuity of Hearing of 3,116 "ears" examined.

Db Loss (G.A.)	No. of Ears.	Percentage.
-3 to 6	2,990	95.95%
9 to 18	113	3.62%
21 to 30	13	0.42%

TABLE III.
Acuity of Hearing in the Better Ear of 1,558 Children examined.

Db Loss (G.A.)	No. of Children.	Percentage.
-3 to 6	1,530 or	97.81%
9 to 18	28 or	2.19%
21 to 30	Nil.	—

TABLE IV.
Probable Causes of Deafness in 98 Children.

Chronic infection of nose and throat	...	...	...	...	...	...	...	...	17
(Infected tonsils and adenoids, sinus infection, etc.)									
Chronic suppurative otitis media	...	...	...	...	...	...	...	...	13
Otitis media, active at time of test	...	...	...	...	...	...	...	...	8
Healed otitis media producing cicatricial changes in drum									16
Previous mastoid infection (now healed)	...	...	...	...	...	...	...	...	4
Auditory nerve deafness (post-influenzal)	...	...	...	...	...	...	...	...	1
Otomycosis	...	...	...	...	...	...	...	...	1
Wax	...	...	...	...	...	...	...	...	8
No cause found	...	...	...	...	...	...	...	...	9
No cause found but child has low I.Q.	...	...	...	...	...	...	...	...	3
Not attended for examination or investigation not yet completed by end of 1951	...	...	...	...	...	...	...	...	16
Left district	...	...	...	...	...	...	...	...	2
									98

To explain these results, it should be remembered that a Db loss (G.A.) of -3 to 6 is considered to be good hearing, a loss in the range 9 to 18 is slight deafness, i.e., the child can still hear ordinary conversation and a forced whisper at over 20 feet, and it is only above a loss of 21 Db that the ear is likely to fail at the forced whisper standard of 20 feet.

It will be seen, therefore, from Tables II and III that, although there were 13 children with a serious defect in hearing in one ear, there were no children with a really serious defect in both ears. It is probable that none of the children found to be deaf by Gramophone Audiometry in this series suffered any appreciable social or educational disadvantage from their deafness. Children with defects of hearing so serious as to interfere with their progress at school are usually found by the school teacher or at routine medical inspections. The value of the Gramophone Audiometer is that it will find cases of defective hearing at an early stage when medical treatment may be able to stop the progress of the deafness and so prevent serious deafness in later life.

DR. P. P. FOX.

Asthma Breathing Exercises Clinic.

During the year the total number of children who attended was 30, of whom 10 were new cases. The total number of attendances was 311. It has been found that attendances tend to fall during the school holidays, but in general the parents and the child have co-operated extremely well and in such cases steady improvement has been indicated.

The children are reviewed by a Medical Officer at periodic intervals and, depending on the improvement achieved, the interval between attendance at the clinic is changed to once a fortnight or once a month. In some cases it has been found that

the child need only attend once in every three months, merely to check that the child is still carrying out the exercises in the correct manner.

As was stated in the previous annual report the purpose of these exercises is not to cure asthma, but by teaching the child to control its breathing, to abort an attack or to minimise the severity of an attack.

The details of the following cases are indicative of the value of these exercises :—

1. *Michael B.* Aged 12 years. Before commencing treatment his chest expansion was 1 inch and there was a history of asthma attacks every three to four weeks. He commenced attending the clinic in September, 1950. Chest expansion is now $2\frac{3}{4}$ inches and the total number of attacks during the past 20 months has been 16 and these attacks have been much less severe.

Miss Waltham reports that the child is now very much more self-confident and has won a scholarship to the Yeovil Boys' Grammar School. He has also become a very keen swimmer.

2. *Valerie M.* Aged 8 years. Before commencing treatment her chest expansion was 1 inch and there was a history of attacks of asthma every 3 months, the child having to be confined to bed. She commenced attendance in October, 1950, her chest expansion is now 3 inches. There have been no attacks this winter and the number of attacks since she started the exercises has been only 3. Her general posture is excellent and she now attends the clinic once a month, but she carries out the exercises daily at home.

Employment of Children.

64 children were examined in connection with the above; two were found unfit for employment out of school hours.

Orthopædic Treatment.

After discussion with the County School Medical Officer, the South Somerset Hospital Management Committee were approached with a view to the use of the Borough Swimming Bath in connection with the rehabilitation of children suffering from orthopædic defects, especially those defects following Anterior Poliomyelitis and postural defects. Arrangements were made by the South Somerset Hospital Management Committee with the Yeovil Borough Council whereby the swimming bath was reserved on Saturday mornings for such cases. The rehabilitation class commenced on 4th August, 1951, the average attendance being 17 per session. These swimming classes, under the supervision of the Orthopædic Sister, have proved very beneficial.

Mass Radiography.

During the year, 556 school children were examined by the Mass Radiography Unit of whom one child was found to have active tuberculosis. It was not found possible for the mobile unit to visit the Rural District schools but by special arrangement the Mass Radiography Service arranged for transport to be provided for the staff and senior scholars of Stoke Secondary Modern School to attend the unit in Yeovil.

Gramophone Audiometer.

During the year, 292 children were tested for the first time and a further 117 children were re-tested who had been tested in previous years, making a grand total of 409 children. The total number of schools visited for examination purposes during the year was 24. 24 of the 70 children who failed were referred for minor ailment treatment, either to their own private doctors or to the clinic. A further 12 were referred to the hospital for treatment or observation by the E.N.T. specialist; the remaining 34 children are under observation and will be re-tested during the coming year.

In all cases the parents and school teachers were informed where this was considered advisable.

To date, as a result of audiometric examinations, two children have been fitted with hearing aids and a third child has been referred to Bristol with a view to being fitted with a hearing aid.

An analysis of children tested by the Gramophone Audiometer, who were found to have defective hearing due to wax, showed that the average loss of hearing ranged from 3 to 21 decibels. After removal of the wax the average improvement in each ear was 8.3 decibels; this represents approximately a 30 per cent. improvement in the range of hearing.

A more practical appreciation of the above is obtained if it is realised that a child, who has a loss of hearing in both ears of 6 to 12 decibels, would have slight difficulty in hearing with a consequent tendency to inattention if seated at the back of the classroom, particularly if the schoolroom abutted on to a noisy street. A child with a loss of hearing of 12 to 21 decibels would almost inevitably have difficulty in hearing the teacher, unless the difficulty was recognised, and even so would entail continuous concentration on the part of the child—a handicap which would not be reasonable to expect the child to shoulder. Further degrees of loss of hearing verge almost on complete deafness.

Fortunately, in a considerable percentage of those children examined, and who have been found to have loss of hearing, the loss of hearing has been unilateral, and by the co-operation of the teaching staff, which has always been willingly extended, a considerable improvement has been effected by placing the children at lessons to a particular side of the teacher. Where the deafness has been bilateral the child has been placed in the front of the class as near as convenient to the teacher.

TABLE I.

MEDICAL INSPECTION OF PUPILS ATTENDING MAINTAINED
PRIMARY AND SECONDARY SCHOOLS IN 1951.

A.—Periodic Medical Inspections.

Number of Inspections in the prescribed Groups—

Entrants	...	...	...	...	...	...	...	7,257
Second Age Group	...	...	...	...	...	...	...	5,199
Third Age Group	...	...	...	...	...	...	...	3,611
Total								16,067

Number of other Periodic Inspections ... 682

Grand Total ... 16,749

B.—Other Inspections.

Number of Special Inspections	...	...	...	...	...	...	7,519
Number of Re-inspections	...	...	...	...	...	...	25,384
Total							32,903

C.—Pupils found to require Treatment.

Number of individual pupils found at Periodic Medical Inspection to require treatment (excluding Dental Diseases and Infestation with Vermin).

Group.	For defective vision (excluding squint).	For any of the other conditions recorded in Table IIA.	Total individual pupils.
(1)	(2)	(3)	(4)
Entrants ...	190	1,539	1,631
Second Age Group ...	375	852	1,134
Third Age Group ...	233	466	643
TOTAL (prescribed Groups) ..	798	2,857	3,408
Other Periodic Inspections ...	120	231	331
Grand Total ...	918	3,088	3,739

TABLE II.

A.—Return of Defects found by Medical Inspection in the year ended
31st December, 1951.

DEFECT or DISEASE. (1)	Periodic Inspections.		Special Inspections.	
	No. of Defects.		No. of Defects.	
	Requiring Treatment. (2)	Requiring to be kept under observation, but not requiring treatment. (3)	Requiring Treatment. (4)	Requiring to be kept under observation but not requiring treatment. (5)
Skin	137	329	848	203
Eyes—(a) Vision	918	688	717	654
(b) Squint	226	163	108	112
(c) Other	100	317	189	209
Ears—(a) Hearing	49	164	68	128
(b) Otitis Media	28	331	44	196
(c) Other	102	201	111	164
Nose or Throat	608	2,605	774	1,469
Speech	54	186	67	110
Cervical Glands	55	737	69	573
Heart and Circulation	44	314	73	275
Lungs	150	928	180	586
Developmental—(a) Hernia	35	80	18	37
(b) Other	65	292	75	119
Orthopædic—(a) Posture	382	760	469	643
(b) Flat Foot	386	420	273	269
(c) Other	514	880	358	542
Nervous system—(a) Epilepsy	19	24	15	25
(b) Other	74	269	71	328
Psychological—(a) Development	152	404	101	360
(b) Stability	28	295	37	202
Other	189	555	332	676

B.—Classification of the general condition of pupils inspected
during the year in the Age Groups.

Age Groups. (1)	Number of Pupils Inspected (2)	A. (Good)		B. (Fair)		C. (Poor)	
		No. (3)	% of col. 2. (4)	No. (5)	% of col. 2. (6)	No. (7)	% of col. 2. (8)
Entrants	7,257	2,237	30.8	4,884	67.3	136	1.9
Second Age Group	5,199	1,386	26.7	3,733	71.8	80	1.5
Third Age Group	3,611	1,050	29.1	2,505	69.4	56	1.5
Other Periodic Inspections	682	208	30.5	466	68.3	8	1.2
Total	16,749	4,881	29.1	11,588	69.2	280	1.7

TREATMENT TABLES.

Group I.—Diseases of the Skin (excluding Uncleanliness).

							Number of cases treated, or under treatment during the year.	
							By the Authority.	Otherwise.
Ringworm—Scalp	...	...	...	...	...	...	1	6
Body	...	...	...	...	...	...	17	6
Scabies	...	...	...	...	...	...	33	13
Impetigo	...	...	...	...	...	...	214	6
Other Skin Diseases	...	...	...	...	...	...	941	83
Total							1,206	114

Group II.—Eye Diseases, Defective Vision and Squint.

							Number of Defects dealt with.	
							By the Authority.	Otherwise.
Errors of Refraction (including squint)	...	...	...	...	...	...	—	4,165
Other defects or diseases of the eye	...	...	...	...	...	...	169	133
Total							169	4,298

Number of Pupils for whom spectacles were—

(a) Prescribed	...	...	...	...	...	...	1,721
(b) Obtained	...	...	...	...	...	...	718

Group III.—Diseases and Defects of Ear, Nose and Throat.

							Number of cases treated.	
							By the Authority.	Otherwise.
Received operative treatment—								
(a) for diseases of the ear	...	...	...	...	...	...	—	10
(b) for adenoids and chronic tonsillitis	...	...	...	...	...	...	—	956
(c) for other nose and throat conditions	...	...	...	...	...	...	—	20
Received other forms of treatment	...	...	...	...	...	...	285	573
Total							285	1,559

Group IV.—Orthopædic and Postural Defects.

*(a) Number treated as in-patients in hospitals	235
(b) Number treated in clinics	2,839

*As far as can be ascertained.

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