[Report 1948] / Medical Officer of Health and School Medical Officer of Health, West Riding of Yorkshire County Council.

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COUNTY COUNCIL OF THE WEST RIDING
OF YORKSHIRE

SIXTIETH
ANNUAL REPORT

OF THE

County Medical Officer

AND FORTY-FIRST ANNUAL REPORT

OF THE

School Medical Officer

FOR THE YEAR 1948

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INTRODUCTION

The Origins of County Public Health

Fifty years social medicine and the future.

The County Health Department has continually changed and adapted itself to meet a growth of knowledge of how to prevent disease and protect health. It began in 1889 with a County Medical Officer and a clerk and some time in 1947 reached its limit of physical size, but not of beneficial influence. In the year 1948 considerable changes have been brought about, both by Act of Parliament and by the Council's own progressive developments. It is the purpose of this statement to show what the changes have meant, both in the central department and to the new divisional offices, and it is my hope that you will gain from it an idea of the possibilities for the health of the West Riding which the department now holds in its grasp and for the development of which the County Public Health Committee has a sacred trust. You should say to yourself "Disease is not inevitable" and see in the services outlined something of the great hope for the future when the people of the West Riding, despite their hard work and industrial toil, are able to achieve full health and strength for a long life of service to mankind and to God.

Slow growth of services and present statutory changes.

During this half century the Council has evolved services for school health, including dentistry; midwifery; care of mothers and young children, including child life protection and nurseries; tuberculosis prevention and treatment; venereal diseases prevention and treatment; the supervision and licensing of special grades of milk; hospitals; a laboratory for public health, also giving free service to doctors; and other activities of varying character. Much of the work has been optional and awaited the 1946 Act to become statutory. It can be regarded as a piecemeal application of knowledge to the preservation of health, with emphasis upon what we now call the 'priority classes'; it had the special feature that it had progressively built up treatment alongside prevention, and that in its last few years it had included general hospitals as within its scope. This joining together of the administration of curative and preventive medicine had advantages, the chief of which resulted from the emphasis given to the need for a preventive outlook to take at least equal place in all medical planning. The new arrangement makes an almost complete separation between provision for curative and preventive medicine by the removal of hospitals, sanatoria, maternity homes and mental deficiency colonies to the Regional Hospital Boards.

Part III of the N.H.S.A. is a "Charter" in Social Medicine.

This has relieved the Health Department of both planning responsibilities and day-to-day administrative cares. But Part III of the National Health Service Act has made other changes which, together with divisional administration, increase the responsibilities of the Committee and their officers. Part III of the Act, and the Council's enlightened policy of divisional administration, taken together, represent a full scale attempt to put social medicine into operation in the West Riding; all that which executive action, based upon medical science, makes possible today in the West Riding will be given its full scope; all that has been begun in the past fifty years is to be brought to perfection through careful and detailed operation with planning on a County basis and execution in units of 50,000, sufficiently small to permit each divisional health office and its team to know in detail the conditions and circumstances prevailing. Detailed consideration for every handicapped scholar; the tracing of tuberculosis and venereal diseases contacts; the final eradication of diphtheria and food poisoning; the evolution of new standards of after care and home care in partnership with the general practitioner; the creation of a new relationship with hospitals and other institutions, so that no-one shall leave their doors, be they premature babies or aged chronic sick, without the opportunity of care in the community to meet their particular needs; and a new relationship with the general practitioner so that he and the health department together can strive to a common end, a healthy community (among much else this means health centres); and with it all the constant regard always for new possibilities of prevention of disease. These are a few facets in a many faced lens through which this vast operation of executive social medicine can be viewed. In brief, the Act has taken away the responsibility of hospital administration and with the relief thus afforded has imposed a further trust and duty, that of making executive social medicine a reality.

Some Details of the Work of Modern Executive Social Medicine

The scope of Executive Social Medicine.

As this is an important landmark in the history of the department I am amplifying the account of our work and needs by the few following details of the scope and purpose of executive social medicine. The application of medical and scientific knowledge can prevent disease either by stopping its onset (A), or by checking its progress (B), or by means of rehabilitation (C) it can ensure speedy recovery of those falling sick and prevent relapse.

Environmental hygiene; still important in the West Riding.

(A) The Diseases which can be prevented before the onset. Environmental conditions are still at the bottom of much illness despite the operation of sanitary legislation for a hundred years; bad housing, with inadequate ventilation, dampness, overcrowding and congested sleeping quarters, absence of proper water supplies and baths; diseased and infected foods; adulterated foods; insanitary work places and offices with harmful dusts and spreading infections; smoky atmospheres and lack of sunlight; overflowing dustbins and cesspools; insanitary earth closets; polluted water and milk supplies; all these make the conditions in which disease flourishes. The first responsibility for their eradication is firmly laid upon the shoulders of the smaller authorities and it is one of the happiest features of our divisional scheme that the medical officer of health of the local sanitary authority is also our divisional medical officer; it is quite impossible to separate environmental hygiene from the wider issues of personal hygiene for which the County is responsible. But it must not be thought that the County Council can regard itself as a disinterested onlooker at the long drawn out battle in which man seeks to raise himself from the terrible slums created by the industrial revolution, and which were probably worse in the West Riding than elsewhere in England. Even if the continuance of bad environmental conditions did not in themselves serve to make a mockery of the County Council and Regional Boards' services, hindering the teaching in the schools, engendering the homeless child, and filling the hospitals; even if this were not reason enough to be deeply interested, the major authority cannot itself escape from statutory responsibility. The County Medical Officer of Health is required by law to inform himself as far as practicable respecting all matters affecting or likely to affect the public health in the county and be prepared to advise the County Council on any such matter, and his employing authority must see that he can discharge this duty. So also under the Housing Act, 1936, it shall be the duty of the council in every county, as respects each rural district within the county, to have constant regard to the housing conditions of persons of the working classes, the extent to which overcrowding or other unsatisfactory housing conditions exist and the sufficiency of the steps which the council of the district have taken, or are proposing to take, to remedy those conditions and to provide further housing accommodation.

The need for skilled technical officers in discharging responsibilities for environmental hygiene.

It is true that the greatest form of sanitary administration for which the County Council has at any time been responsible, the licensing of graded milks, is about to be removed, leaving the supervision of heat treatment (in the hands of the food and drugs authority), and the important task of supervising school milks. This will be a relief from a task of such detail that it prevented the County Health Department from giving proper attention to environmental hygiene in general. The minor local authorities in the West Riding, covering 1½ millions of the most highly industrialised acres in the country, employ approximately 170 sanitary inspectors, a large number of whom look to the County Health Department for advice and guidance on a multitude of problems from the advisability of action in the case of an individual unfit house to advice in difficult cases of seizing unsound food. In the matter of smoke pollution, housing and water, we are bound to set an example of keen interest, sympathy and constructive action.

Prevention by immunisation, contact tracing, epidemiology, and importance of good team work in small health units.

Much illness can be directly prevented by more precise scientific action. No child need die today from diphtheria and few, if any, need contract the disease; I want to see it go from the West Riding within ten years and this will call for intensive work by doctors and health visitors. Now that the obsolete machinery of vaccination has gone (with the 1946 Act), with its suggestion of compulsion, the new health departments can make an approach to this problem along the same lines as diphtheria. Any day now effective methods will be at hand for preventing whooping cough and tuberculosis; for these our divisional health officers will be ready in action. Venereal disease, apart from the impossibility of its propagation in a spiritually healthy land, can be attacked by a direct personal approach to sufferers and wonderful work is being done by our four venereal disease health visitors working hand in glove with V.D. specialists, general practitioners and hospitals; this work must be given every encouragement. Tuberculosis can be tackled along the same lines; whenever a case is detected its source should be traced whether to a human being or to an infected cow, and action taken to check a further spread; this is most delicate work for which the medical officer of health may need to rely on several members of his team working together, the sanitary inspector, the health visitor, the tuberculosis visitor, and the doctor, not to mention the veterinary officer. These are special examples; all infectious disease needs to be traced, particularly the food poisoning group, and the health team in each division, with the willing assistance of the bacteriologist at the laboratory, can do valiant work to protect the people among whom they live. Such work is given its greatest opportunity in the smaller health units which you have established and in the circumstances that the work of a local sanitary authority and the County Council is continued in one executive medical officer.

Prevention by health education and the need for a Central Health Education section with an Organiser.

Much more illness could be prevented by teaching the individual where to find the weakest link in the chain of causation. This is the great justification of education in how to prevent frank disease, as it is also to teach the meaning and value of positive health. This work, as already indicated, is one of the fundamental aims of all

your professional public health staffs; all can in their turn and in different places and circumstances, give skilled advice and guidance in health matters. This can be done by individual counsel in homes and clinics, by grouped counsel in special meetings, or to ready made audiences (as in the teaching given to canteen staffs), by assisting the teaching staff in health education at schools (as in mothercraft) and in discussion groups. But there is another aspect of health education, the visual aid, which has been developed in the past few years; teaching by health exhibit, by pamphlet, by film strips, by newspaper, and by radio and cinema. The health exhibit can include such aids to "knowledge at a glance" as the chart, graph, diagram, transparency and machine, and the chart can be made understandable by the new symbolism which was well demonstrated in the publication produced by the Bureau of Current Affairs of "Meet your County Council." There are still great possibilities in the teaching of the application of scientific medical knowledge to health; much more can be done by what the Americans call "selling health." All this is capable of wide application in clinics, halls, hospitals and elsewhere; much of the detail will fall to the divisional office but it requires a central organisation to feed it which should be under an organiser of health education with appropriate supporting staff.

Dietetics.

The modern development of the science of dietetics has an important application to the prevention of illness and the maintenance of positive health. The Council recognised this when in 1947 they appointed two dietitians each with half the County in which to advise and guide in hospitals and institutions, to undertake teaching dietetics as part of health education and to take part in dietary surveys which would provide knowledge of the dietary state of different parts of the West Riding and form the basis of teaching. In taking this step the Council placed itself in the forefront of enlightened health authorities. Now that hospitals, sanatoria and maternity homes are no longer the responsibility of the Council it remains equally important that the work should continue; the work of health education and dietary surveys has not been altered and many institutions such as nurseries, children's homes and homes for the aged remain in need of advice, as do the many other types of institution in the County such as industrial canteens and British restaurants.

New schemes for preventing ill-health.

Section 28 of the National Health Service Act, which says a local health authority "may with the approval of the Minister, and to such extent as the Minister may direct shall, make arrangements for the purpose of the prevention of illness," widens the responsibility of the local health authority. To some extent this gives statutory recognition to a function which has long since been accepted as a duty. Many such schemes can be operated through other enactments, as, for example, the recent scheme for care of the unmarried mother and her child. Nevertheless, it does emphasise the great importance of local health authorities examining with care any developments for applying knowledge to prevention of ill-health. A first step under this section might well be a scheme to deal with the problem family, the great source of the homeless child and of other evils. This would require a careful ascertainment, methods for which have been recently investigated by the Eugenics Society (we participated as one of six pilot surveys); it would need to be followed by active measures of rehabilitation. I have been awaiting the final results of the Eugenics Society survey to report more fully on this important matter.

The School Health Service and its expanding scope.

(B) The Diseases which can be prevented by checking their progress. The services which have been built up for the detection of early defects are, of course, well known; but what is not generally understood is their expanding character. The importance of the school health service has grown greatly in recent years, including the need for detailed medical examinations and continuous supervision by the school nurse, which was strongly recommended in the Report of the Central Advisory Council of the Ministry of Education. The increase in our staff of doctors and health visitors year by year helps towards this end, and there are various proposals for extending the work in other ways; for example, for the detection and elimination of shoe defects (which give rise to so many preventable foot disorders), and for extending orthopaedic care back into the schools (which will make the teacher a close ally of the orthopaedic surgeon); the perfection of such schemes calls for much detailed work at both headquarters and in divisions. The Act of 1944 has made the Council responsible for free treatment of school children and the detection and treatment of eleven classes of handicap; under Section 48(3) it remains responsible to see that full facilities for treatment are available. A hostel for maladjusted children (at Wentworth) opened on 2nd September, 1948; to this children are admitted through a case conference of the teacher in charge, a children's physician, the psychiatrist, a member of the education department, and my senior assistant for the school health service (Dr. Turner); case histories are supplied by the divisional health officer, who also undertakes the necessary follow-up work. There are approximately 1,000 handicapped children dealt with yearly as personal problems by the headquarters school health section. The position with regard to special schools and special clinics is very little different from that given in my report last year. It is hoped that shortly there will be more special schools (for delicate, physically handicapped, educationally subnormal and maladjusted (as well as hostels)) and that specialist clinics now available (orthopaedic, paediatric, ear, nose and throat) will be followed by

child guidance centres. The advantages of such specialist clinics can be great provided they are staffed and run in the correct manner. The children's specialist added to our team of experts in 1947 gives time to discussion at headquarters and in divisions on matters concerning individual children and new measures for the protection of child health.

A modern school health service is no matter of mere inspection, valuable as this no doubt is; it entails a close relationship with hospitals, specialists and general practitioners; the carrying back of the teaching to the homes; the maintenance of a complete health record such as will allow confidential advice and guidance to juvenile employment committees, when the scholar leaves to go into industry, or to hospitals when he is unfortunate enough to need their treatment; above all it must produce that close understanding with the schools which makes the school "health conscious," willing and able to teach positive health and to be on the look out for defects. This calls for personal relationships between doctors and nurses and the teachers; with understanding based upon confidence in professional standards. It calls for a particularly close relationship with the education department, a keen divisional staff, both professional and clerical, an alive and responsive central staff. Two hundred and forty thousand school children depend on it. What has been said of the school health service must be taken to include the dental service which the West Riding has developed to a finer state of perfection than most, if not all, other counties; our dental service has up to date specialist developments, as in orthodontics. It is sad to contemplate the devastation which the National Health Service Act has wrought in this fine preventive service. The number of dental staff has fallen from 59 to 50 and many of the new dental clinics which have at last opened can now be only partially staffed. The importance of the preventive outlook can be seen in dentistry more clearly than in the rest of medicine. What matters to a nation, speaking broadly, is that its children should reach adult life with a complete set of healthy teeth and a knowledge of how to maintain them; in comparison with this need it is of less importance what care the adult gets. The National Health Service has reversed this process; free treatment with a shortage of dentists, coupled with attractive rates of pay for unlimited piece work, has forced us to witness a decline in school dentistry of such alarming proportions that if nothing is done to counteract it the work of thirty years will be cast away; thirty years of steady education from the days when ninety per cent. of parents refused treatment for their children to the time when ninety per cent. consent. Are we now to accept that our children's teeth shall be neglected to swell the numbers of adults who year by year seek treatment for conditions that need never have occurred.

The care of mothers and young children; expanding scope of work.

All that has been said about the school health service can equally be said of midwifery, and the care of mother and young children. It likewise is expanding and altering; dental care for the expectant mother has come to take a place alongside that for children (I only hope its development will be physically possible with a decline in the staff of dentists); day nurseries are extending and will bring with them further benefits to health and educational development of the young child; a successful nursery nursing training scheme is in operation; a new scheme for the care of illegitimate pregnancies is about to begin; routine blood tests for haemoglobin estimation, Wassermann reaction and Rhesus factor are a modern feature of our ante-natal clinics; new schemes for safeguarding premature babies are under way; rest hostels for pregnant and nursing women, already begun, have further great possibilities in cutting down maternal mortality and morbidity; the specialist obstetrician in areas covering the whole County is about to begin to add his weight to the creation of the high standards in the preventive aspects of midwifery; all this and very much more is part of an all out plan to eliminate the waste of infant life and death and crippling of our West Riding mothers. It can only be accomplished by the highest professional skill, ably backed by loyal clerical staff at both divisional and County headquarters. I wish I could say more about the prevention of ill-health by detection of early signs and how the health centres might be the means of applying this technique to all age groups, but time does not allow. Suffice it to say that it is urgently needed for the adolescent and for industry.

Rehabilitation and the importance of convalescence.

(C) Preventing Disease by Rehabilitation. The use of social medicine by rehabilitation is in its infancy. Industry, hospitals, general practitioners and local authorities have been slow to realise its possibilities. One of its earliest forms was the development of after-care of the tuberculous and an illustration of its possibilities is the home nursing developed by voluntary associations. Rehabilitation has, of course, many implications and it can be developed in such widely different forms as "the industrial injuries unit" and the "illegitimate mother and baby scheme." It implies anything, in fact, which carries the medical care and treatment of persons to the point at which they can once more take a full share in the national life. Rehabilitation is not the sole concern of the local authority; regional hospital boards, executive councils and many other agencies will be concerned. But there is much that the local health authority can do; more, in fact, than can be outlined here. One important development of rehabilitation will be that of convalescence, the form of convalescence which does not require normal nursing care; a magnificent example of this has already been developed by the Council in their ante-natal hostel at Brighouse, which I hope to see repeated

soon elsewhere. Such provision for convalescence can be extended to the post-natal period, the mother and baby, the child and the adult. Apart from its value in preventive medicine such provision would also have the advantage of saving hospital beds.

"After-care" one of the hopes for the future.

I want here to outline what I conceive to be the responsibilities of the local health authority for care and after-care under Sections 24, 25, 28 and 29 of the National Health Service Act; that part of rehabilitation which will be described under "after-care" and "home care." This includes the socio-medical work of which I spoke in my last report. In the past fifty years, during which the modern hospital has been developed, little has been done for the after-care of hospital patients. A hospital has been a monastic institution; patients have entered its portals into another world where there was little concern for what they did outside; and when their belongings were once again in their suitcases, they said goodbye to the other patients and the staff, returned to the outside world and were forgotten. For the majority of persons this did not matter but for the few it was often attended by unfortunate consequences. The loving care with which they had been treated, the many investigations, and the time and thought which had gone to the making of a diagnosis were often wasted for want of proper application. For those persons some organisation of after-care is needed. This lack of after-care applies equally to industry where medical care cannot be regarded as complete until the patient is once again doing a job of work suitable to his physical and mental conditions. It applies equally to the patients of the general practitioner whose social problems are often beyond the capacity of a family doctor to solve without the help of a health visitor. Indeed there comes a time for many persons, whether treated in industry, at a hospital or by general practitioners, when the health visitor can do a great deal to help. The health visitor will be acting in the extended function suggested in Section 24 of the National Health Service Act, and in this capacity she will be the community family case worker forging a link between the hospital, the family doctor and industry. This is going to be a big advance in social medicine; it is one of the most enlightened provisions of the National Health Service Act, but it cannot be achieved overnight and its organisation will add appreciably both to the work of the central and divisional health offices.

Hospitals are already collaborating with us in the after-care of school children; this must be extended to the whole of their clientele from babyhood to age. The advantages of such care and after-care should be extended to the aged, as Beatrice Webb inspired her husband to write in the Minority Report 1905-1909—"Just as that Authority already exercises what is, in effect, a kind of general guardianship over infants, in order to be able to step in where there is neglect, so it must exercise a similar guardianship over the citizen falling into second childhood. By the staff of Health Visitors and Sanitary Inspectors, daily going their rounds, the Public Health Authority will become aware of cases in which the helpless deserving aged, notwithstanding their little pensions or the attentions of the charitable, are suffering from neglect or lack of care." I have recommended elsewhere the services of a geriatric specialist. The use of selected senior health visitors from my staff to act as social workers in the smaller hospitals (as already demonstrated at Otley Hospital) can provide a valuable link for all after-care work. Miss Carey, one of my superintendents, as indicated in my Report of 1947, is now engaged on the hospital relationship problem and the training of existing health visitors in the new work.

Care and after-care of mental health.

The care and after-care of mental patients, including the development of preventive work, will also constitute one of the important services of the future. At present this work is limited mainly to the mental defective, for which the authority has built up a strong team of social workers and home teachers with a steady expansion of facilities for occupational therapy, with this work under the immediate direction of Dr. O'Loughlin (whose services we are happily sharing with the Leeds Regional Board). It is hoped also to develop child guidance as referred to elsewhere, but the precise form to be taken by the extension of such work to include all other forms of mental health cannot yet be clearly seen. The Council have extended their establishment to include six psychiatric social workers, a step which has been advocated because of the need to ensure that any persons undertaking such delicate work should be sufficiently trained; it would be dangerous to do otherwise. Such workers do not now exist in any numbers and the universities are finding difficulty in securing sufficient applications from suitable persons to fill the training courses. In these circumstances our best course is to proceed with caution awaiting the completion of our present establishment before making further plans.

"Home Care"; another hope for the future.

There is another aspect of rehabilitation which is capable of development; I refer to home care. This is the special field of the general practitioner who is, of course, a responsibility of the executive council. Yet his work and his welfare are of the utmost importance to the local health authority and the regional hospital board, for he is at the root of social medicine and many of the services for which the authority is responsible can develop to the full only from action in partnership with him. The regional hospital boards and local health authorities should have the welfare of the general practitioner constantly in mind, for in as much as this is neglected their task will be

The importance of the general practitioner.

made both more difficult and less valuable. The general practitioner should represent the practice of medicine at its fullest and finest. The emphasis now placed upon hospitals by the establishment of 14 regional hospital boards, directly supported by the state purse, with management committees each staffed with officers of many different kinds, and also the publicity of the Spens Report on specialist salaries with its dazzling prospect of large incomes, these, and other happenings, have tended to obscure the fact that medicine can survive and flourish only if general practice survives and flourishes. It is quite useless to have hospitals without general practice and the replacement of general practice by a number of different specialists would end in the creation of a wilderness in which the public would wander seeking health but never finding it. Hospitals are necessary evils and not essential blessings; both hospitals and specialists must be regarded as adjuncts to a medical service and not the medical service itself. The most important one element in any medical service is the general practitioner, who sees the individual as a member of a family, in the community setting and over the years. For some years now the general practitioner has worked single handed, much overburdened and little assisted by auxiliary personnel to relieve him of routine duties; he has been doing much that a nurse could do and leaving much untaught that a health visitor could teach; many of his patients have gone to hospital because of his inability to cope, and not because of his lack of skill to deal with their illnesses. The effect of this is bad both for society and medicine. It is a difficult situation and the remedy is not easy to find.

His welfare.

Everything must be done to make possible the practice of medicine in the fullest sense by the general practitioner. If this were not true for the welfare of medicine, the patient and the family it would still be true for the welfare of the state finances. Hospital treatment is now so costly that some means must be found to check its growth. Everyone in need of treatment which can be provided only in an institution must have it; but we cannot permit the congestion of our hospital wards with those who would be better nursed at home. What is being done to help the general practitioner, even to compensate for the addition of duties which he cannot properly now take on without detriment to its quality? Is all the nation's money and most of its time and energy to be spent on making hospitals and specialists before we have made that essential part of the service without which it is useless to have hospitals and specialists? Give the general practitioner the necessary assistance and the necessary weapons and he can accomplish much. Why is there yet no pathological service for the general practitioner? Pathology is one of the modern weapons without which the practice of medicine is handicapped; the regional hospital boards must make the provision of a good pathological service for the home a first call upon them. Where is the secretarial assistance, the home nursing, the health visiting, the home help, the health centre? In 1946, the home nursing service in the West Riding attended 19,123 persons in the Administrative County; this is clearly only a small fraction of the total of nursing which could be done in the community; home nursing indeed will need to be expanded with emphasis on acute nursing, nursing surgeries and collaboration with the general practitioner. Furthermore, the home help, who can make home care possible, must be created against many difficulties; this homely member of the health team is in fact essential to success of the home care services. The health visitor must extend her work, as indicated earlier, to be the family case worker and the health teacher of the general practitioner. With this trio, the home nurse, the home help and the health visitor, much may be accomplished; so much indeed that I feel powerless to depict the importance of this new aspect of the work of home care (one of the most striking advances of the National Health Service Act) or able to convey the vastness of the problem. It will not be easy; it will cost money, which will come from the rate-payer, and it is never easy to spend the rate-payer's money to ease the burden of the state.

Health Centres.

Another remedy will be the development of the "health centre" from which domiciliary medical care can be organised with a full team of workers. It is, of course, not the building itself but the quality of the work within it which is important, nevertheless the health centre can act as the focal point of the services of health and will in time come to be of more importance than the hospital; we must pursue the ideal energetically with the collaboration of the doctors, who unfortunately have to pay rent. The provision of health centres is urgent, more so than many hospital extensions. It is important to make the national drive one towards health rather than towards more provision for sickness, to achieve a proper balance of constructive effort and to secure that the health centres which will be the key to the preventive services will have their share of a straitened public purse. The hospital can never be more than a place to treat with loving care the failures of preventive medicine; the health centre can be much more. There are now signs that the Ministry of Health will give local authorities every encouragement in building them. In its fully developed form (under the terms of Section 21 of the National Health Service Act) it will be comprised of four elements each distinct in origin and working harmoniously together to one end. These four elements are the domiciliary services for general medical, dental and pharmaceutical practices, the clinics for local health and local education authority services, specialist clinics whether for local authority or other services, and health education. The health centre will comprise the functional element previously in course of development by the

Council as a multi-clinic plus a surgery unit for grouped practices. The precise number required for the West Riding has not yet been ascertained since it depends to a considerable extent upon an unknown factor, namely, how wide an area can a surgery serve. In London this may be a two mile diameter circle which might mean anything up to 400 centres in the West Riding, a figure which could not be contemplated. The recently published plans for one London centre estimate a cost of £187,000 (approximately), again a figure which might call for some adjustment to meet local circumstances in the West Riding. This is a matter upon which I hope to be able to report more fully as soon as reliable information of the scope of the new service can be obtained.

No further need for antagonism between the G.P. and "Public Health."

In the past there has been antagonism between general practitioners and local authorities and the work of the local authority often seemed to the general practitioner to encroach upon his own work. I am convinced that this was never more than a little true but henceforth there need be no more misunderstanding and only the rivalry of two partners striving for a common end; the local authority and the general practitioner have been placed by the National Health Service Act in harness together. The school health service, the infant welfare and ante-natal clinic, the midwifery, home nursing, health visiting, home help services, and all else that the local health authority is responsible for, must now be seen in correct perspective as an aid to the general practitioner. The general practitioner of the future will be the family doctor perhaps more completely than ever before; all services of the local authority, whether in the clinic or the school or the home, must be regarded as accessories to his general care provided to meet some special need. Every woman can now book a doctor for her confinement and the ante-natal clinic assumes a new importance, as a place where continous routine supervision and education can be conducted; were this not so the general practitioner would be overwhelmed with additional work, since the continuous teaching of pregnant women on how to live, how best to organise their lives during gestation and the puerperium, and regular supervision against mishaps in labour, is a lengthy task. And in the truest sense so should the hospital be regarded as an accessory to the general practitioner, a place at which those of his patients can be cared for who cannot be nursed at home.

Success in developing after-care and home care will depend upon the missionary spirit of the suggested Senior Medical Officer.

Success or failure of this new form of social medicine will mean much to the community and to the public purse; the present growth of institutional care must be counter-balanced by a renewal of belief in the home. One of the most important aspects of this work will be the regeneration of confidence of the general practitioner in the services of the local health authority, as it will be also in the building of an understanding with the hospitals. The last thing which I wish to do in this sketch of our work present and future, is to suggest to you any facile developments of new social services. Such developments come, not from easy phrases in a report, but by painstaking and personal application of individuals with a missionary spirit and knowledge resulting from long training. I do not despair that we can build up this new service but I do want most earnestly to emphasise that I shall need the full backing and sympathy of the Council. I believe the problem of home care taken as a whole, if it is to be developed properly, will be a full time job for a senior medical officer on my staff.

Professional Standards

The importance of high professional standards.

For success social medicine needs high standards of medicine and nursing which in itself calls for enlightened expenditure by the Council. At the root of all social medicine lies teaching; the doctor, the midwife, the health visitor, are spreading up-to-date knowledge about the prevention of illness and the maintenance of health, and to make their work effective they must be both inspired to see the true meaning of their work in the community service and also instructed in up-to-date methods. Medicine, particularly social medicine, is a living and growing science; those who do not go on learning get rusty. Thus an indispensable function of my department is the organisation of instructional meetings for all types of staff, for doctors, dentists, home nurses, health visitors, midwives, nursery matrons and mental health workers, at County level, and by group meetings in divisions. In a County of the size of the West Riding this is a big task; in the three years I have been in charge slow progress only has been made towards it, for the enormous operation which has been superimposed of delivering a service of divisional administration has made it difficult to accomplish; nevertheless, health visitors now take part in a regular County programme at Wakefield, of which benefits are already evident, and doctors in a large part of the County are closely linked with a university teaching centre (Sheffield) with a regular programme. It is in this same light that the employment of specialist staffs must be seen (see later) for all specialists must play their part in social medicine by helping to maintain professional standards. Our health services are very like a school; if the teachers are bad the school fails. The maintenance of high professional standards is our target flag. All this costs money. On the other hand it is, to my mind, a waste of public money to do less; the salary cheque for 70 or 80 doctors, 200 to 300 health visitors, 200 to 300 midwives, 200 to 300 district nurses, etc. is so great that the employing authority has

a clear duty to pay the relatively small extra sums necessary to keep professional standards at a high level. It is just in this that the large county can do what the small county borough cannot; it is just in this that the large county may fail through a desire to stream-line expenditure, without a careful consideration of the full meaning of the service.

The Ambulance Service equally in need of the highest standards of Social Medicine.

One of the problems of modern social medicine is the achievement of these ideals in circumstances when Parliament, or the Authority, has made separate arrangements for administration. This is encountered in the ambulance service, in the services for deprived children and in those for the welfare of the aged and handicapped. I do not wish to enter that battle-weary territory of lay versus medical administration upon which a variety of different views has been held since the days of Chadwick and Simon and is likely to continue until the time 50 or so years hence when all major disease will have disappeared and with it the main point of such controversy. But I do wish to emphasise that the standards to be achieved in the ambulance service are the highest medical standards possible to ensure that the care of the patient shall be undertaken from the moment the vehicle arrives at his door. The same is true for our residential nurseries where the professional standards are those of medicine and where so much of risk and danger can creep in, unless there be the continuous vigilance of a medical man trained in social medicine. Social medicine is also involved in much of the work for boarded out and fostered children. I make a plea here that we in the West Riding set up no administrative barriers but use all our resources to the one end, the welfare of the public, and I hope that this subject will be closely studied by the Council.

The Training of Public Health Nurses

The important function of training Health Visitors, Midwives and Nursery Nurses; assistance to Universities and other bodies in teaching and examination.

One of the important requirements of a large professional organisation is, of course, trained workers; as in so many branches of our national life they are in short supply. In the training of some we can ourselves give assistance and are actively so engaged; we have a training scheme for Part II midwifery in which Dr. Anderson is lecturing; we collaborate with the education department in the training of nursery nurses, which gives an opportunity to girls leaving school to start on a nursing or nursery nursing career; and with Leeds University in the training of health visitors. We shall almost certainly need to undertake the training of our own home nurses. Miss Clarke is acting whole-time for half the year as a Leeds University tutor for the health visitors' course; I am a part-time lecturer on the Leeds University staff, and each of ten divisions gives practical training and instruction. The training of nursery nurses is made possible by the use of day nurseries and a residential hostel at Ilkley, and by the employment of a supervisor and also a tutor. I regard the training activities as a most important function of my department, not only in the production of persons who are of value to social medicine but because the link with the university, and other forms of teaching and examination, helps us to keep up to date ourselves and to know the value of different forms of learning. It is unfortunate that the Council should have recently decided that staff taking part in much of this work must do so either in their own time or without salary; this seems to suggest that such work is not of the utmost interest to the Council which, of course, it is. Moreover it is important in the cause of education that universities and examining bodies should be able to draw for certain purposes upon the staffs of departments actively engaged in health work.

Research

The importance of knowledge.

Modern social medicine must comprehend the whole of health and sickness, not accepting that any condition to which the flesh is heir shall be disregarded. For much that still afflicts mankind no preventive weapon of defence has yet come to hand. For some, like coronary thrombosis, rapidly assuming the role of executioner to social class I, we stand aside powerless to prevent a steady increase in their onslaught. But offence is often the best form of defence and health departments, under the new charter of social medicine with which they have been so generously equipped by Parliament, must take the offensive on all fronts by field studies and statistical examination appropriate to the circumstances of their areas. We must not be content to stand aside as often in the past. "Disinterested intellectual curiosity is the life blood of real civilisation" Trevelyan tells us; such curiosity specifically applied to the why and wherefore of man's ailments is the life blood of social medicine. Every disease has a chain of causation, long or short, and there can be little doubt that every such chain has a weak link; we must look to the time when these have all been found and complete and positive health achieved by appropriate action.

Research and statistics and appointment of a Statistician.

Research has been made one of the duties of Divisional Medical Officers as it is the concern of the central office. The search for knowledge by means of field work of which we are capable is to be encouraged but, of course, it is not possible without some available hours. I hope the Council will not lose sight of it; it may not yield immediate dividends but in the long run it can pay a handsome reward in health and happiness.

In the matter of statistics, may I refer you to my report for 1947. In a large health department such as the West Riding it is essential to use statistics to the full and there is much that modern methods in the hands of a competent mathematician can do, both in research and reports and in the preparation of material for committees and commissions, and in the use of trends of mortality and sickness in the preparation of material for health education.

Administration.

The cure for adminstrative difficulties.

This account of the present and future possibilities of executive social medicine will have served to emphasise some of the disadvantages arising from the administrative framework of the National Health Service Act. In my report of 1946 I mentioned three characteristics of the National Health Service which might present difficulties. One of these, the "non-elective character" of the executive councils and the regional hospitals boards, with its corollary the absence of a local rate, places great power in the hands of the central authority. In this centenary year of Public Health it is perhaps salutary to remember that 1848 likewise saw the birth of a centralised administration for the nation's health. "The Times" of that year said prophetically "One begins by centralising functions and ends by centralising discontent"; the Board of Health of 1848 lasted, under the martinet Edwin Chadwick, less than a decade. There may be comfort in the knowledge that there are no difficulties which Parliament and time cannot heal; there is no point in dwelling further upon this now.

The other two characteristics, the "Tripartite administration" (being the split of the health service among three different governing bodies) and the "separation of preventive and curative medicine," can be helped by administrative action; both must be kept continuously in mind if a health service of real value to the nation is to be created out of the 1946 Act. Health is one whole; it cannot be dealt with in water-tight compartments by three different administrative bodies. When a woman is pregnant the preservation of her life and health cannot be regarded as in three parts; the executive council is responsible for ensuring that she can have the free service of a "general practitioner obstetrician;" the local health authority that she has continued attention and teaching at an ante-natal clinic, rest in a hostel and delivery by a midwife; the regional board must supply a specialist if complications arise and must accommodate her in an institution when her home circumstances do not allow delivery at home. This does not make her any less an individual, or more capable of division into parts, and the fact of such unnatural administrative boundaries demands that committees and officers must continually strive to produce unity of thought and action in the patient's and the community's interest. This means long and delicate negotiations with ministries, with the West Riding Executive Council, and with two regional hospital boards.

When, for example, we have comprehended the importance of the general practitioner to medicine, and to the nation, there still remains the problem of how to build up the necessary relationship between him and both the medical officer of health and the hospitals in the circumstances that their affairs are governed by different bodies. The regional hospital boards and the local health authorities should confer together with executive councils on this important issue. Particularly should it be one of the first concerns of the regional hospital board to see that the work of the general practitioner is not allowed to be entirely dissociated from that of the hospitals and to ensure that the present emphasis on specialism, which is abolishing the traditional staffing of hospitals by general practitioners of the area, is carefully balanced by an equal concern to find for him a new relationship of equivalent status. In my 1947 Report I spoke of two important links which could be forged between the three authorities to bring about the desired result; one by the use of specialists in all branches of medicine working both on the curative and preventive side, and the other by the establishment under the local health authority of a service for socio-medical work which would link together the preventive and after-care services of the local health authority with the work of hospitals and general practitioners. During the year both these desirable objects have come a little nearer to our grasp; I have spoken earlier of the development of socio-medical work and more will be said about specialists later. Much of what has happened in the past year will not, happily, take place every year; it has been in the nature of delivery pains. I say happily, because it has imposed a severe strain on a small headquarters team which could not properly be long undertaken. But much of the work has come to stay. Four administrative machines dealing together and independently with health in the West Riding will not continue in smooth operation without continued consultation at officer level. This requires administrative medical staff, keen, willing and enlightened, with the spirit of social medicine within them.

Divisional Scheme.

The divisional scheme for the preventive medical services will help to overcome many difficulties. This decentralises day to day administration to relatively small areas of roughly 50,000 population and makes it possible for the divisional medical officer to maintain a close personal relationship with the practitioners and hospitals in his area. The value of such an arrangement can be seen in all forms of the local authority's

work, as, for example, in the service for home helps, about which a more detailed account is given elsewhere. It will suffice to say here that divisional medical officers have begun to get something going in circumstances of great difficulty. It will take time and effort to produce the sort of service which will once more make it possible to be ill at home; it is certain that this new social service will have its greatest chance to succeed in measure as it is related to the work of the family doctor. It is too early to say whether the divisional scheme is to fulfil the high hopes with which it was born, but there are encouraging signs of increasing appreciation by general practitioners of which I spoke last year. It came fully into operation with the appointment of the last divisional medical officer in July, 1948, and by the end of the year nearly all divisions had been able to take over the detailed administration of services previously centralised. An unexpected difficulty has been the low grading to the chief clerk in the divisional public health office. In an expanding service of this character where so much depends upon personal initiative it is important that the divisional medical officer should have a keen right hand man or woman as his chief clerk; this particular difficulty has been exaggerated by the large number of comparatively highly paid jobs which have become available at the same time in many other services which recent legislation has created; during the year 6 chief divisional clerks left to better paid posts.

In creating a divisional scheme by placing nearly all day to day administrative functions away from the County office to 31 divisions, there has been no simple transfer. A new machine has been created, more efficient and with an increase in detailed consideration for personal problems. The divisional scheme cannot be regarded solely as a means of disposing of the responsibilities of the County Central Health Department. Indeed, quite the opposite. Day to day duties it loses; but the development and operation of schemes, the appointment of staff, the checking of estimates and a wide range of advice and guidance has equally increased. The Health Department has never been more busy; the removal of administrative responsibility for hospitals produced a welcome relief but made no difference in the "all out" work of the department. The slack was taken up before almost its existence was known. The work at headquarters falling upon the medical staff particularly is much greater, for they are now responsible for the supervision and co-ordination of the largest scheme of its kind in England, and as it is my firm conviction that real progress in health administration develops through consultation, persuasion and conviction, and not by dictation, we at headquarters have been heavily involved with our 31 divisional offices. Much that we are doing now through democratic methods to tend our divisional tree cannot hope to yield its full fruit for many years to come. Happily it is, I believe, a well planted tree which, through the Chairman's wisdom and encouragement, has already grown good roots. What's more, it finds itself in good soil and it will flourish in a climate of trust and confidence. Monthly meetings of our divisional staffs are proving an indispensable element in producing this spirit and securing the smooth working of something at once so wide in scope and so different in component parts.

Staffing

The Headquarters Medical Staff.

I have asked for one further senior assistant medical officer at headquarters, who will undertake the development of those vital aspects of our work in relation to home care, including home nursing and the extension of health visiting to work with the general practitioner and in after-care schemes in relation to hospitals; into this group I place the home help. Thus, Dr. Wood Wilson will be in general charge of the operation of the divisional scheme, assisting in the work of visiting divisional areas, and he will be closely concerned with the negotiations and meetings with regional hospital boards, specialists, management committees and in our work with the executive council. Dr. Anderson will be in charge of the care of mothers and young children, including midwifery and the training of nursery nurses; Dr. Turner with the school health service, and Mr. Townend with the dental service; Dr. Burgess (half) with the epidemiological aspects of venereal disease; Dr. Johnston (half) with the prevention and after-care of tuberculosis; Dr. O'Loughlin (4/10ths) with the mental deficiency scheme; Dr. X. (half) psychiatrist, with the prevention and after-care of lunacy; Dr. Y. with home care (including home nursing and home helps); and Dr. Z. (child guidance psychiatrist) with child guidance within the school health service. This is a small team for so large a task.

Professional Staff generally.

Staffing difficulties have been no less since the Act came into force. The number of whole-time medical officers engaged in school medical and infant welfare work at the end of the year 1948 was 39 out of an establishment of 65. This is no mean achievement, since many of the influences of the National Health Service Act are opposed to the continuance in a flourishing state of the local authority services; the young doctor wants to be a hospital specialist with its glamour and attractive salaries. The linking of our services with hospital work by the appointment of children's specialists as senior officers in our school health and child welfare services (about which an account was given in my last Report) has helped to maintain the service; the granting of one session a week for every medical officer for hospital or other specialist work

has also helped. The separation of preventive obstetrics and preventive paediatrics, about which an account was given last year, has not yet taken place except in one division (30) and details of this are given under the section of this Report dealing with the care of mothers.

The number of health visitors at the end of the year was 246; very little better despite the training scheme entered into with Leeds University; this is a serious difficulty in view of the expanding scope of the health visitor's work, particularly in relation to the general practice mentioned previously in this introduction and in relation to hospitals outlined here and last year. Strenuous efforts are being made to recruit students for the annual 60 approved for training at Leeds but it is obvious that some years must pass before a real improvement in numbers will occur. The number of home nurses was 268; a small number still being engaged also in midwifery and health visiting. This is, of course, much less than will be needed to make home nursing a true partner of the general practitioner service. This problem including the need to train our own home nurses will need most careful scrutiny.

Specialists.

There remains only to mention the steps which have been taken during the year to put into operation the proposals for bringing specialists into all branches of preventive work, to which reference has been made earlier and in previous Reports. The complete schedule of requirements for specialists, together with a detailed account of their duties, is given on pages 88 to 90 of the Report. Briefly, in terms of a crude yardstick, it is an amount of time equivalent, in whole-time or part-time service, to 1 session per week per 10,000 children (paediatricians), per 20,000 children (orthopaedic surgeons), per 30,000 children (psychiatrists in child guidance), per 40,000 children (oto-rhino laryngologists); per 1,000 births (obstetricians), per 75,000 population (venereologists and tuberculosis officers), per 175,000 population (geriatricians), per 300,000 population (psychiatrisits in lunacy and mental deficiency), per 500,000 population (ophthalmologists), per 1,500,000 population (dermatologists). Friendly discussions have taken place with the specialists themselves and with officers of the two regional boards affected. Agreement must now be reached between the authorities as to the method of application for this big advance in our services to be put into operation.

Conclusion

The Health of the West Riding.

A study of the figures in this Report cannot but give rise to the most lively satisfaction to all lovers of the West Riding. How well our mothers have done to achieve an infant mortality as low as 39 per 1,000; a figure such as ten years ago seemed to belong only to more favoured lands, sparsely populated agricultural countries of sunshine and butter, and to be unattainable in a congested region of smoke and slums. The decline in death rates for old and young is marked by so steady and even a flow as to take upon itself the character of a habit. We must beware lest, as happens so often, a habit leads to complacency, for nowhere more than in the West Riding is there less justification for acceptance of things as they are. These figures, which show improvement in the health of West Riding dwellers, sufficiently clothed by imagination, speak eloquently of the enduring qualities of Yorkshire folk to take on new ways and to live healthier lives according to modern teaching. But figures must not blind us to the continued existence of much that is prejudicial to health; evils of man's own making in a land naturally lovely and abundantly full of the sources of health. "There is a wisdom in this beyond the rules of physic;" said Francis Bacon in his *Of Regimen of Health*, " a man's own observation what he finds good of, and what he finds hurt of, is the best physic to preserve health; but it is a safer conclusion to say, 'This agreeth not well with me, therefore I will not continue it.....' " What man has changed he can change again; slag heaps, smoke and slums, can give way to green lawns and village settlements in a clear sparkling air. Where there is a will there is a way.

I am,

Yours faithfully,

FRASER BROCKINGTON.

PART I

VITAL STATISTICS

Area (acres)—Urban, 380,334; Rural, 1,230,495—Total, 1,610,829.

Population (mid. 1948)—Urban, 1,157,204; Rural, 407,796—Total, 1,565,000

Summary for 1948

The birth rate was 18.5; the still birth rate 24; the live premature birth rate 42. The death rate from all causes was 11.3; enteric fever 0.002; smallpox and scarlet fever nil; whooping cough 0.02; diphtheria 0.01; measles 0.01; zymotic diseases 0.12; tuberculosis of the lungs 0.37; other forms of tuberculosis 0.07; respiratory diseases 1.29; cancer 1.74; heart disease 3.33; diarrhoea in infants under 2 years 4.38. Infant mortality was 39 and maternal mortality 1.15. A comparison with the figures for the past 59 years is given in the following table:—

Year	Birth Rate	Death Rate All Causes	Zymotic Death Rate	Tuberculosis of lungs Death Rate	Other Tuberculous Diseases Death Rate	Respiratory Diseases Death Rate	Cancer Death Rate	Still Births per 1,000 total births	Maternal Mortality per 1,000 live births	Infant Mortality
1890-1909	28.9	16.7	1.89	1.19	0.52*	3.20	0.77*	†	†	147
1910-1919	22.5	14.5	1.26	0.84	0.41	2.58	0.98	†	4.81	112
1920	25.1	12.6	0.94	0.71	0.28	2.26	1.07	†	5.26	92
1921	23.3	12.6	0.78	0.74	0.29	2.20	1.11	†	5.04	97
1922	20.9	12.2	0.58	0.68	0.30	2.07	1.15	†	4.16	81
1923	20.6	12.2	0.53	0.71	0.28	2.11	1.16	†	4.32	81
1924	20.4	12.8	0.48	0.70	0.25	2.43	1.19	†	4.57	83
1925	20.1	12.3	0.53	0.70	0.26	2.15	1.22	†	5.12	81
1926	19.4	11.6	0.46	0.62	0.22	1.78	1.24	†	4.82	73
1927	17.7	12.6	0.51	0.65	0.21	2.12	1.28	†	5.18	79
1928	17.7	11.5	0.28	0.61	0.22	1.46	1.29	†	5.45	62
1929	16.7	13.6	0.54	0.66	0.21	2.22	1.28	47	5.24	89
1930	16.9	11.4	0.33	0.57	0.20	1.35	1.33	45	6.25	65
1931	16.1	12.4	0.38	0.57	0.16	1.64	1.32	45	5.82	74
1932	15.8	12.1	0.39	0.52	0.17	1.33	1.46	48	5.22	70
1933	15.0	12.2	0.30	0.49	0.14	1.36	1.42	47	6.24	70
1934	15.2	11.7	0.41	0.44	0.12	1.16	1.44	48	5.81	58
1935	15.0	11.9	0.28	0.48	0.10	1.13	1.48	47	4.55	58
1936	15.1	12.3	0.29	0.44	0.12	1.25	1.51	45	4.35	63
1937	15.2	12.7	0.21	0.46	0.11	1.23	1.60	45	3.92	60
1938	15.5	11.6	0.23	0.38	0.11	0.99	1.55	44	3.74	51
1939	15.2	12.2	0.18	0.41	0.10	1.01	1.52	42	3.05	54
1940	15.3	13.4	0.18	0.42	0.11	1.94	1.58	40	3.26	56
1941	15.4	12.3	0.22	0.42	0.12	1.43	1.68	39	2.72	57
1942	17.0	11.7	0.18	0.42	0.12	1.26	1.65	36	3.36	49
1943	17.8	12.7	0.19	0.43	0.12	1.63	1.72	34	2.48	50
1944	20.2	12.1	0.12	0.37	0.09	1.32	1.79	31	1.98	44
1945	17.9	12.3	0.19	0.38	0.09	1.36	1.80	30	1.78	51
1946	19.7	11.9	0.13	0.36	0.08	1.31	1.72	29	1.86	44
1947	21.5	12.3	0.16	0.39	0.09	1.37	1.80	26	1.31	45
1948	18.5	11.3	0.12	0.37	0.07	1.29	1.74	24	1.17	39

Birth and death rates are per 1,000 estimated population; the zymotic death rate is combined death rate from smallpox, scarlet fever, enteric fever, diphtheria, whooping cough, measles and diarrhoea in infants under 2 years of age (except the rate for 1890—1909 in which deaths from diarrhoea at all ages are included); the respiratory diseases death rate is the combined death rate from bronchitis, pneumonia and other respiratory diseases excluding tuberculosis of the lungs; the premature birth rate, the mortality rate for diarrhoea in infants and the infant mortality rate are per 1,000 live births. The maternal mortality rate is stated in two ways (*a*) per 1,000 live births (*b*) per 1,000 live and still births. The latter is obviously the more correct way but the number of still births has been available only since 1929, therefore the rates in the above table are per 1,000 live births in order that a correct statistical comparison is shown between the size of the rates since 1929 with those for previous years. The rate of 1.15 given in the Summary is per 1,000 live and still births, as is also the still birth rate.

* This rate is for the 10 years 1900—1909.

† Figures not available.

Births and Infant Mortality

Live births in 1948 numbered 28,966 (18.5 per thousand) compared with 32,747 (21.5 per thousand) in the previous year. There were 720 still births (24 per thousand total births). Adwick-le-Street U.D. (24.0), Conisbrough U.D. (24.7), Cudworth U.D. (23.2), Hemsworth U.D. (24.3), Knottingley U.D. (23.3), Maltby U.D. (26.1) and Thorne R.D. (24.4), were the County Districts with the highest live birth rate and Earby U.D. (13.1), Ilkley U.D. (14.2), Kirkburton U.D. (14.4), Penistone U.D. (14.5), Ripponden U.D. (14.2), Sedbergh R.D. (13.5), Skipton R.D. (14.8) and Wharfedale R.D. (12.5), were the County Districts with the lowest.

1,129 infants died, the infant mortality rate being 39 compared with 45 last year and 44 two years ago. The rates for the past five quinquennial periods have been 81, 71, 61, 54 and 46 in Urban Districts and 76, 74, 62, 53 and 47 in Rural Districts. The highest rates in 1948 were Conisbrough U.D. (59), Hebden Royd U.D. (66), Heckmondwike U.D. (61), Maltby U.D. (59), Rawmarsh U.D. (62), Saddleworth U.D. (66), Wath-upon-Dearne U.D. (59) and Thorne R.D. (64); the lowest, Denholme U.D. (nil), Earby U.D. (15), Hoyland Nether U.D. (17), Ilkley U.D. (16), Meltham U.D. (12), Tickhill U.D. (nil), Hepton R.D. (16) and Osgoldcross R.D. (7). The number of births in individual districts is small and these rates for County Districts are not, therefore, of much value for comparison as between one district and another.

The mortality of infants at various periods in the first year of life is shown below. The decrease in 1948 in the deaths of infants during the first four weeks, per thousand live births is noteworthy, particular as over half of the total infant mortality rate is accounted for by deaths in the first four weeks of life.

	Number of Deaths				Deaths per 1,000 Live Births			
	1945.	1946.	1947.	1948.	1945.	1946.	1947.	1948.
Male Infants								
Under 4 weeks	407	455	450	339	30·3	29·6	26·7	22·9
4 weeks—3 months	130	124	147	112	9·7	8·1	8·7	7·6
3—6 months	116	104	130	99	8·6	6·8	7·7	6·7
6—12 months	107	75	117	80	7·9	4·9	7·0	5·4
Total under 1 year ...	760	758	844	630	56·5	49·4	50·1	42·6
Female Infants								
Under 4 weeks	273	317	353	266	22·0	22·2	22·2	18·8
4 weeks—3 months	76	82	82	84	6·1	5·8	5·1	5·9
3—6 months	103	82	103	85	8·3	5·8	6·5	6·0
6—12 months	101	65	80	64	8·2	4·6	5·0	4·5
Total under 1 year ...	553	546	618	499	44·6	38·4	38·8	35·2
All Infants								
Under 4 weeks	680	772	803	605	26·3	26·1	24·5	20·9
4 weeks—3 months	206	206	229	196	8·0	7·0	7·0	6·8
3—6 months	219	186	233	184	8·5	6·3	7·1	6·3
6—12 months	208	140	197	144	8·0	4·7	6·0	5·0
Total under 1 year ...	1,313	1,304	1,462	1,129	50·8	44·1	44·6	39·0

The table overleaf shows the infant mortality rate from the different causes during the last thirty-seven years. Approximately 15 out of every 1,000 babies born still die of infections of one sort or another during the first year of life. By modern teaching and techniques, and the assistance of new weapons of treatment it is reasonable to look forward in the near future to the complete elimination of this source of wastage. Afflictions loosely classed as "congenital debility, malformations and premature birth," and no doubt containing a variety of little understood disorders of neo-natal life, take a toll of approximately 21 out of every 1,000 babies born; the rate for 1948 from this group of causes is approximately half that for the decade 1912-21. Further reduction of this loss will not be accomplished so easily but modern research at Newcastle and other university departments of child health is slowly unravelling the problem and as time passes the results of such new learning may be seen in the field. Special training of our midwives, health visitors and home nurses, which is now available at different centres of learning, will no doubt do much to help; the advantage of this can already be seen in the case of premature babies since the Council adopted the practice of sending staff for special training to the Sorrento premature baby unit in Birmingham. I hope to see this practice extended to bring in other centres. Nowhere is the advantage of up-to-date teaching, and the keenness which follows it, so marked as in the field of infant care.

Year	Number of Deaths under One Year per 1000 live births from various causes																
	Infections																
	Enteric Fever	Smallpox	Scarlet Fever	Measles	Whooping Cough	Diphtheria	Influenza	Respiratory Tuberculosis	Other Tuberculous Diseases	Bronchitis	Pneumonia	Other Respiratory Diseases	Diarrhœa	Total	Con. Debility Malformations, Premature Birth *	Other Causes	TOTAL (All Causes)
1912-21 (Average)	0.00	nil.	0.06	2.48	3.65	0.14	1.05	0.25	2.46	9.80	11.92	0.53	12.54	44.88	38.48	20.21	103.57
1922-31 (Average)	0.01	0.02	0.03	1.36	2.71	0.12	0.79	0.18	1.42	5.38	12.63	0.39	5.86	30.90	32.95	13.20	77.05
1932-41 (Average)	0.00	nil.	0.01	0.68	1.35	0.13	0.66	0.06	0.63	2.73	9.69	0.17	3.59	19.70	32.89	6.99	59.58
1942	nil.	nil.	nil.	0.32	0.64	0.08	0.08	0.12	0.40	1.88	7.47	0.12	3.91	15.02	28.32	5.63	48.97
1943	nil.	nil.	nil.	0.50	1.63	0.23	0.47	0.04	0.54	2.71	10.11	0.16	2.98	19.37	25.46	4.84	49.67
1944	nil.	nil.	nil.	0.07	0.48	nil.	0.03	0.10	0.31	2.12	7.64	0.21	2.76	13.72	25.93	4.71	44.36
1945	nil.	nil.	nil.	0.89	0.73	nil.	0.42	nil.	0.39	1.78	11.03	0.12	5.88	21.24	24.42	5.14	50.80
1946	nil.	nil.	nil.	0.07	0.91	0.03	0.30	0.03	0.24	0.91	7.68	0.10	4.06	14.33	25.63	4.13	44.09
1947	nil.	nil.	nil.	0.52	0.61	nil.	0.37	0.15	0.31	1.10	7.82	0.09	5.13	16.10	24.52	4.03	44.65
1948	nil.	nil.	nil.	0.24	0.83	0.03	0.28	0.03	0.35	1.00	7.84	0.28	4.25	15.13	20.76	3.11	38.99

* From the year 1942 it is possible to give the infant mortality rate from premature birth separately; the figures are:—1942, 13.54; 1943, 13.41; 1944, 12.35; 1945, 11.30; 1946, 12.78; 1947, 11.51; and 1948, 9.36.

Excess of births over deaths (natural increase) in 1948 was 11,317 compared with 14,028 in 1947, with 9,308 for the 5 years average 1942-46, and with 4,536 for the 5 years average 1937-41.

The reduction in the infant mortality rate has appreciably offset the decline in the birth rate as will be seen from the figures below:—

Period.	Birth rate.	Average annual number of births.	Average Annual number of deaths of infants under one year of age.	The addition to the population at end of one year.
1895-1904	29.4	42,677	6,510	36,167
1905-1914	25.6	39,301	4,840	34,461
1915-1924	21.1	31,748	3,018	28,730
1925-1934	17.1	26,195	1,896	24,299
1935-1944	16.1	24,126	1,303	22,823
1945	17.9	26,637	1,313	25,324
1946	19.7	30,473	1,304	29,169
1947	21.5	33,614	1,462	32,152
1948	18.5	28,966	1,129	27,837

Thus, although the birth rate is now 37 per cent. less than in 1895-1904, the decline in the natural increase of the population (at the end of one year) is only 23 per cent.

The illegitimate live birth rate was 0.90 compared with 0.88 for the ten years 1938-47. This must of course be a source of serious concern to us all. It speaks of irresponsibility and a declining respect for family life. From the point of view of infant mortality, not in itself the gravest aspect of this evil, the mortality rate among illegitimate infants still remains higher than that for legitimate infants. Nevertheless the figure has shown, for the first time for many years, a substantial fall of 16 points from 67 to 51. It is never safe to predict much from one year's figures but at least we can hope that this may be the beginning of a solution to this intractable problem. For whether born in or out of wedlock every baby has a right to a healthy life towards which health departments can do much to help. The figures for the past 10 years are as follows:—

Year.	Number of illegitimate live births.	Number of deaths under 1 year of illegitimate infants.	Infant Mortality Rate.	
			Illegitimate infants.	Legitimate infants.
1938	870	54	62	51
1939	834	53	64	54
1940	827	68	82	55
1941	1,044	86	82	58
1942	1,181	72	61	48
1943	1,381	88	64	49
1944	1,720	107	62	43
1945	1,892	133	70	49
1946	1,739	112	64	43
1947	1,525	99	65	44
Average for 10 years 1938-47	1,301	87	67	49
1948	1,413	72	51	38

Deaths

There were 17,649 deaths from all causes (9,197 males, 8,452 females) the death rate per thousand estimated population being 11.3 (compared with 10.8 for England and Wales). The rate has been round about this level for the past twenty-five years and since we must all die sometime, and lengthening life does but postpone the end, it is a figure which is likely to remain fairly constant despite the steady improvement in particular mortalities. Over the last five quinquennial periods the rate for the Urban Districts has been 12.6, 12.6, 12.8, 12.7 and 12.8, and for the Rural Districts 11.5, 11.2, 10.7, 10.8 and 10.8. The lowest rates in 1948 were in Adwick-le-Street U.D. (8.6), Bentley-with-Arksey U.D. (9.0), Dodworth U.D. (7.3), Hoyland Nether U.D. (8.8), Maltby U.D. (8.5), Stocksbridge U.D. (7.5), Osgoldcross R.D. (8.5) and Wortley R.D. (8.6).

The figures do not show any marked difference from last year. A slight increase from 4 to 9 in deaths from diphtheria; a reduction from 35 to 10 in deaths from poliomyelitis; a reduction from 727 to 680 in deaths from tuberculosis. Cancer took the same high toll of 2,718 (2,739); respiratory diseases other than tuberculosis 2,021 (2,083); "strokes" 2,137 (2,258) and heart disease 5,211 (5,424). Heart disease in the form of coronary thrombosis, from the relatively early age of 40 years onwards, is an alarming feature of modern life; it takes upon itself increasingly the character of "executioner to the intelligentsia." Research is much needed into the reasons why the coronary vessels, which feed the heart muscle, should so suddenly and so disastrously fail; no doubt it is evidence of a general arterial change showing itself so to speak at the weakest spot, but there is so far as I am aware little or no understanding of what leads up to this. It has of course been shown to increase in frequency from class to class; in the Registrar General's five social classes. What a magnificent subject for philanthropy; a well endowed and equipped research unit at one of our universities might find the answer and prove an untold blessing to this nation which now more than ever can little afford the loss of men of intellectual capacity at the height of their power. A detailed statement of deaths and the causes is given in the following table:—

CAUSES OF DEATH	AGE AT DEATH						
	Under 1 year	1 and under 5	5 and under 15	15 and under 45	45 and under 65	65 and upwards	Total
1. Typhoid and paratyphoid fevers ...	—	—	—	—	3	—	3
2. Cerebro-spinal fever	6	6	2	—	—	1	15
3. Scarlet fever	—	—	—	—	—	—	—
4. Whooping cough	24	8	—	—	—	—	32
5. Diphtheria	1	4	3	1	—	—	9
6. Tuberculosis of respiratory system ...	1	7	6	310	186	63	573
7. Other forms of tuberculosis	10	28	13	35	14	7	107
8. Syphilitic diseases	6	1	—	5	47	14	73
9. Influenza	8	1	—	7	15	14	45
10. Measles	7	6	1	1	—	—	15
11. Acute poliomyelitis and polio enceph.	1	1	2	6	—	—	10
12. Acute infectious encephalitis	—	—	—	5	2	1	8
13. (a) Cancer of buc. cav. and oesoph (males)	—	—	—	4	21	64	89
13. (b) Cancer of uterus (females)	—	—	—	5	80	57	142
14. Cancer of stomach and duodenum ...	—	—	—	17	178	328	523
15. Cancer of breast	—	—	—	28	149	103	280
16. Cancer of all other sites	3	3	3	117	634	924	1684
Total—All Forms of Cancer	*3*	*3*	*3*	*171*	*1062*	*1476*	*2718*
17. Diabetes	—	—	—	8	39	104	151
18. Intracranial vascular lesions	2	1	—	28	476	1630	2137
19. Heart diseases	—	2	14	200	1054	3941	5211
20. Other diseases of circ. system	—	—	—	19	90	521	630
21. Bronchitis	29	9	4	28	293	794	1157
22. Pneumonia	227	40	8	39	108	230	652
23. Other respiratory diseases	8	6	—	14	85	99	212
24. Ulcer of stomach or duodenum ...	—	—	—	24	66	58	148
25. Diarrhoea under 2 years	123	4	—	—	—	—	127
26. Appendicitis	—	4	5	8	8	8	33
27. Other digestive diseases	9	10	4	32	98	178	331
28. Nephritis	2	—	3	73	136	268	482
29. Puerperal and post-abortive sepsis ...	—	—	—	3	—	—	3
30. Other maternal causes	—	—	—	31	—	—	31
31. Premature birth	271	—	—	—	—	—	271
32. Congen. mal., birth inj., infant diseases	330	14	4	22	8	1	379
33. Suicide	—	—	—	40	76	59	175
34. Road traffic accidents	—	13	19	45	28	28	133
35. Other violent causes	26	18	17	90	84	123	358
36. All other causes	35	20	41	156	229	939	1420
TOTAL—ALL CAUSES ...	1129	206	149	1401	4207	10557	17649

Child Mortality

In the popular mind, attention is focussed chiefly on the reduction in the rate of infant mortality. The decrease in the death-rate of children aged 1—5 years has, however, been greater; e.g. compared with 1935 the infant mortality in 1948 was 67 per cent. of that for 1935, and the death rate of children aged 1—5 years was 38 per cent. The saving of lives has been mainly in the field of the infectious diseases; in 1935 the deaths from these diseases numbered 225, and in 1948, 78. The two tables which follow give the death rates compared with England and Wales and also the actual number of deaths in the West Riding from each cause.

Deaths of children aged 1—5 years per 1,000 living in that age group.

Year.	West Riding.	England and Wales.
1935	5.44	5.08
1936	5.78	5.50
1937	5.28	5.11
1938	4.89	4.59
1939	4.04	3.49
1940	4.74	4.83
1941	4.93	5.30
1942	4.35	3.42
1943	4.05	3.34
1944	2.76	2.71
1945	3.08	2.64
1946	2.19	2.08
1947	2.44	2.18
1948	2.07	1.75

Number of deaths of Children aged 1 to 5 years from the Various Causes in the years 1935 to 1948.

	1935	1936	1937	1938	1939	1940	1941	1942	1943	1944	1945	1946	1947	1948
Scarlet Fever	19	16	8	8	7	3	3	—	3	2	—	—	—	—
Typhoid and Paratyphoid Fevers	—	—	—	—	—	—	—	—	—	—	—	1	—	—
Diphtheria	62	57	49	43	41	40	40	37	24	19	10	6	—	4
Encephalitis Lethargica ...	—	2	—	—	2	—	—	—	—	—	—	—	—	—
Cerebro-spinal Fever ...	9	4	6	4	3	11	18	6	6	9	4	3	9	6
Poliomyelitis and polio-encephalitis	1	2	—	3	—	1	—	—	—	2	—	—	5	1
Syphilitic diseases ...	1	—	—	—	—	1	—	—	—	—	—	—	—	1
Influenza	9	7	17	6	9	27	5	8	12	5	3	7	4	1
Whooping Cough ...	24	39	34	12	37	10	44	15	25	6	12	13	16	8
Measles	17	50	17	48	4	24	18	19	27	2	22	2	16	6
Bronchitis	9	14	11	10	7	25	21	14	17	7	11	7	11	9
Pneumonia	130	136	141	114	82	111	94	82	80	56	56	40	36	40
Other respiratory diseases	11	6	4	3	5	2	7	4	7	4	4	2	1	6
Respiratory tuberculosis	9	7	6	3	2	4	4	4	2	5	8	1	2	7
Other forms of tuberculosis	38	39	36	32	41	37	39	48	44	25	33	20	42	28
Heart and circulatory diseases	2	4	3	1	2	—	2	2	—	1	2	1	—	2
Diarrhoea and other digestive diseases ...	46	37	41	38	28	19	17	31	28	22	21	18	16	18
Nephritis	4	3	5	1	2	1	3	2	5	2	4	4	3	—
Diabetes	—	—	2	—	—	—	1	—	—	1	—	—	—	—
Cancer	5	5	2	4	2	2	7	7	6	8	3	4	6	3
Congenital debility, malformations, premature birth, etc.	8	6	4	9	10	12	14	9	4	12	8	16	8	14
Violence	49	50	57	50	41	44	55	68	42	28	52	31	36	31
Other causes	53	50	41	56	40	54	53	36	33	32	39	28	31	21
Totals ...	506	534	484	445	365	428	445	392	365	248	292	204	242	206

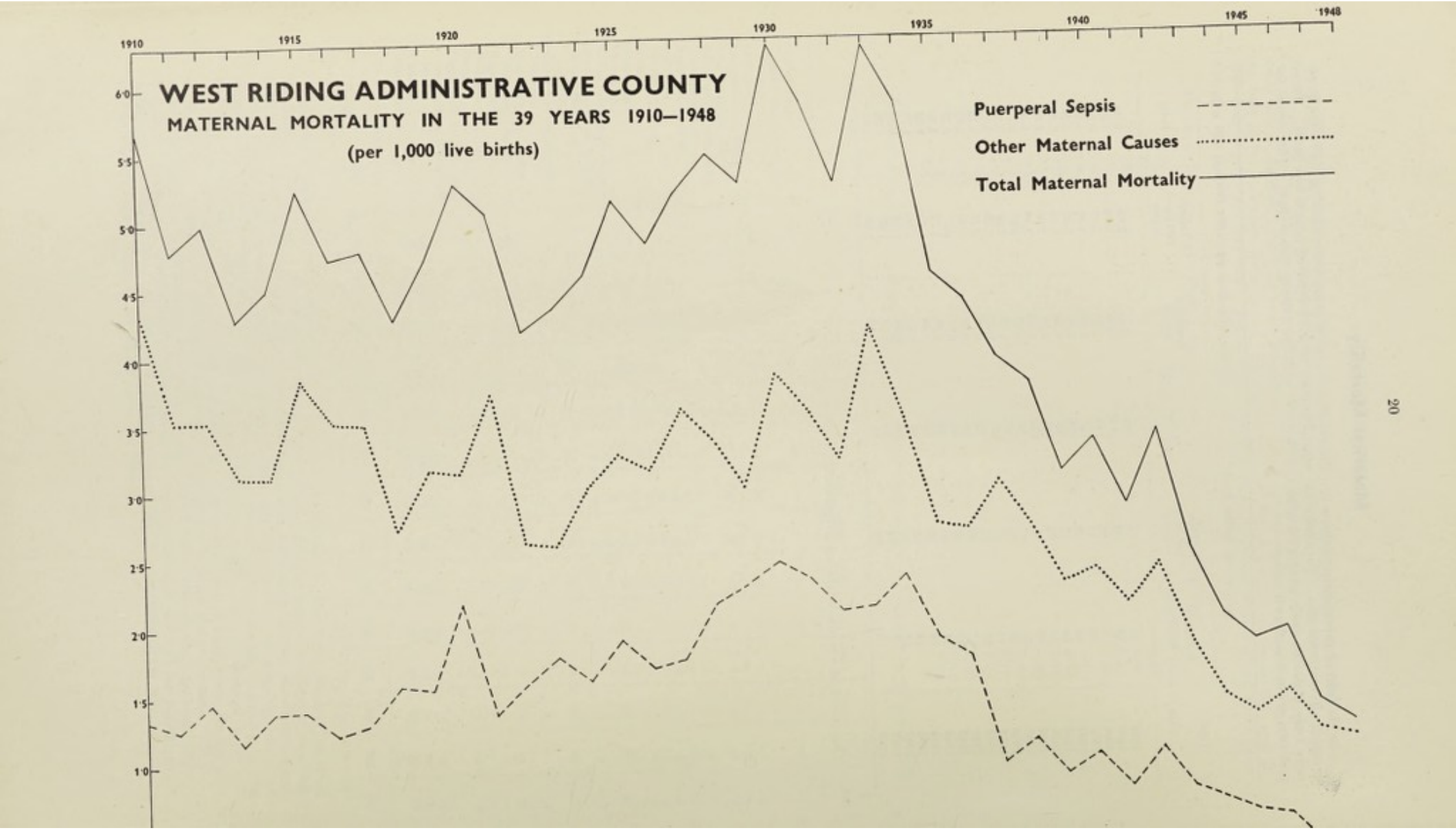
There is little doubt that deaths of our youngsters can be still further reduced particularly in the field of tuberculosis. Those due to bovine tuberculosis await the general pasteurisation of all milk which cannot now be much longer delayed; those due to the human bacillus constitute a more difficult field of endeavour and success will depend upon the improvement of housing, much of which is still very bad in the West Riding, and upon efficient contact tracing resulting in the removal of susceptible infants from open sources of infection; much also still depends upon efficient sanatorium treatment for open cases of phthisis. The new weapon of Mass Radiography used intelligently as a weapon of prevention and that now available through the application of B.C.G. vaccination to susceptible infants, necessarily exposed to infection, may do much to help. Nevertheless the problem of tuberculosis in childhood is far from solved and will call for patient work, unostentatious and positive, by all our divisional medical officers in collaboration with the tuberculosis officers whose services we share with the Boards.

Maternal Mortality

In no field of preventive medicine are the results of recent years so reassuring as in the preservation of maternal life. The maternal mortality rate of 1.15 reached a new low level. There were only 3 deaths from puerperal sepsis compared with 58 twenty years ago. The rates for previous years are shown below:—

Year	No. of deaths from			Mortality Rate per 1,000 live and still births		
	Puerperal Sepsis	Other puerperal causes	Total	Puerperal Sepsis	Other puerperal causes	Total
1929	58	76	134	2.16	2.83	4.99
1930	63	99	162	2.32	3.64	5.96
1931	57	88	145	2.19	3.37	5.56
1932	50	77	127	1.96	3.01	4.97
1933	48	96	144	1.98	3.96	5.94
1934	54	82	136	2.20	3.33	5.53
1935	43	62	105	1.78	2.56	4.34
1936	39	61	100	1.62	2.54	4.16
1937	21	69	90	0.87	2.87	3.74
1938	25	62	87	1.03	2.55	3.58
1939	19	51	70	0.79	2.13	2.92
1940	22	53	75	0.92	2.21	3.13
1941	17	48	65	0.68	1.93	2.61
1942	25	59	84	0.96	2.27	3.23
1943	18	46	64	0.68	1.72	2.40
1944	18	40	58	0.60	1.32	1.92
1945	14	32	46	0.53	1.20	1.73
1946	14	41	55	0.46	1.34	1.80
1947	7	36	43	0.21	1.07	1.28
1948	3	31	34	0.10	1.05	1.15

The trend of events is shown graphically overleaf:—


WEST RIDING ADMINISTRATIVE COUNTY
MATERNAL MORTALITY IN THE 39 YEARS 1910—1948
(per 1,000 live births)
Puerperal Sepsis
Other Maternal Causes
Total Maternal Mortality
1910
1915
1920
1925
1930
1935
1940
1945
1948
6·0
5·5
5·0
4·5
4·0
3·5
3·0
2·5
2·0
1·5
1·0

PART II

EPIDEMIOLOGY

Incidence and Notification of Infectious Disease

Smallpox, cholera, diphtheria, membraneous croup, erysipelas, scarlet fever, and the fevers known by any of the following names, *typhus, typhoid, enteric* or *relapsing,* are compulsorily notifiable under Section 144 of the Public Health Act, 1936; *chickenpox* is notifiable under Section 147 of the same Act in some West Riding County Districts; *food poisoning* under Section 17 of the Food and Drugs Act, 1938. The following communicable diseases are compulsorily notifiable under the regulations stated in brackets—*measles* and *whooping cough* (Measles and Whooping Cough Regulations, 1940); *cerebo-spinal fever* and *acute poliomyelitis* (Cerebro-Spinal Fever and Acute Poliomyelitis Regulations, 1912); *acute encephalitis lethargica* and *acute polio-encephalitis* (Acute Encephalitis Lethargica and Polio-encephalitis Regulations 1918 and 1919); *ophthalmia neonatorum* (Ophthalmia Neonatorum Regulations, 1926, 1928 and 1937); *puerperal pyrexia* (Puerperal Pyrexia Regulations, 1937); *tuberculosis* (Tuberculosis Regulations, 1930); *malaria, dysentery* and *acute primary and influenzal pneumonia* (Infectious Diseases Regulations, 1927); *plague* (Notification of Case of Plague (General) Regulations, 1900). The contagious diseases of syphilis, gonorrhoea and soft chancre (classed under the term venereal diseases) and scabies are not compulsorily notifiable.

The following table shows the number of cases in 1948 of each "notifiable" disease, being the numbers of cases originally notified and the final numbers after corrections subsequently made by the notifying medical practitioner or by the Medical Superintendent of the infectious diseases hospital:—

AGE GROUP	Scarlet Fever		Whooping Cough		Acute Poliomyelitis		Acute Polio-encephalitis		Measles		Diphtheria	
	M	F	M	F	M	F	M	F	M	F	M	F
Numbers originally notified (All Ages)	1776	2133	2918	3290	39	25	5	1	8441	8117	138	193
	3909		6208		64		6		16558		331	
Final numbers after correction												
0—	5	2	300	314	1	3	—	—	370	320	—	—
1—	139	129	855	900	5	3	—	1	1980	1837	3	5
3—	426	356	954	1121	2	4	1	—	2840	2725	11	12
5—	702	856	730	811	4	1	2	—	2906	2803	24	32
10—	293	502	51	64	4	5	1	—	242	268	11	13
15—	108	173	5	17	6	1	—	—	40	67	6	13
25 and over ...	64	82	11	40	5	2	1	—	22	55	5	17
Age unknown	10	16	7	12	—	—	—	—	37	33	1	—
Totals all ages	1747	2116	2013	3288	27	19	5	1	8437	8108	61	92
	3863		6201		46		6		16545		153	

AGE GROUP	Acute Pneumonia		Dysentery		Acute Encephalitis Lethargica		Typhoid and Paratyphoid Fever		Erysipelas		Cerebro-Spinal Fever	
	M	F	M	F	M	F	M	F	M	F	M	F
Numbers originally notified	747	566	98	115	—	—	15	22	195	216	50	33
	1313		213		—		37		411		83	
Final numbers after correction												
0—	152	139	36	37	1	—	2	3	2	2	13	8
5—	131	122	27	15	—	—	3	1	4	5	10	8
15—	176	124	20	27	—	—	3	7	53	60	7	3
45—	185	104	8	23	—	—	1	5	93	89	2	2
65 and over ...	98	69	3	9	—	—	1	2	40	55	—	1
Age unknown	6	2	1	2	—	—	—	—	2	4	—	2
Totals all ages	748	560	95	113	1	—	10	18	194	215	32	24
	1308		208		1		28		409		56	

	Number Originally Notified	*Number After Correction*
Puerperal Pyrexia	101	98
Ophthalmia Neonatorum	49	51
Chicken Pox	432†	not corrected

† Chicken pox is compulsorily notifiable only in certain County Districts.

The table below affords a comparison with the preceding three years:—

Disease	1945	1946	1947	1948
Scarlet Fever	3,109	2,369	2,764	3,863
Whooping Cough	2,844	4,451	3,424	6,201
Diphtheria	862	551	221	153
Measles	24,904	1,883	21,739	16,545
Acute Pneumonia (primary or influenzal).	1,347	1,324	1,188	1,308
Cerebro-Spinal Fever	67	71	78	56
Acute Poliomyelitis	7	1	351	46
Acute Polioencephalitis	1	—	49	6
Acute Encephalitis Lethargica	3	2	2	1
Dysentery	411	127	108	208
Ophthalmia Neonatorum	46	46	82	51
Puerperal Pyrexia	81	104	85	98
Smallpox	—	—	—	—
Enteric or Typhoid Fever (excluding Paratyphoid)	9	14	9	18
Paratyphoid Fevers	7	50	16	10
Erysipelas	383	366	347	409
Chicken Pox	310	443	550	432
Typhus Fever	1	—	—	—
Malaria	36	28	11	6
Tuberculosis:—				
Respiratory	1,229	1,244	1,288	1,372
Other Forms	457	437	400	424
Total	1,686	1,681	1,688	1,796

The number of cases of scarlet fever in 1948 shows a decided increase on the figures for the previous three years. Nevertheless it is considerably less than the figures for 1944 (4,730) and 1943 (6,539). The disease is usually mild in type. The incidence of whooping cough follows a fairly definite cycle of fluctuation, being higher every second or third year. The number of cases in 1948 (6,201) is the highest recorded since the disease became statutorily notifiable over the whole of England and Wales in the latter part of 1939. In the case of measles also, the incidence follows a cycle, being lowest every third year or so. There is nothing unusual in the incidence for 1948. The incidence of acute poliomyelitis (infantile paralysis) and polioencephalitis was somewhat higher than usual being, probably, the aftermath of the epidemic of the previous year. The incidence of diphtheria continues to decrease and the number of cases in 1948 (153) is the lowest ever recorded. The annual average number of cases in the five years immediately preceding the war (1934-38) was 2,679. Scabies is not compulsorily notifiable and, consequently, it is not possible to present any reliable statistics as to incidence. 570 cases were treated in 1948 under the County scheme.

Food Poisoning

Food poisoning continues to give rise to some anxiety. 20 investigations were made at schools and school meals canteens etc., following reports of suspected food poisoning among the scholars and staffs. These investigations were made with the co-operation of the Divisional Medical Officers, and Sanitary Inspectors of the County Districts. The outbreaks have been similar in type i.e., they have been of short duration, with symptoms of abdominal pain, diarrhoea and occasional vomiting. The onset occurred usually from 3—6 hours after the mid-day meal and the illness persisted until the next morning and occasionally for one or two days afterwards. Specimens of food, vomit and faeces have been examined bacteriologically on each appropriate occasion and in no instance were pathogenic bacteria of the food poisoning group isolated. The nature of the symptoms, the time of onset, and the short convalescence all point to a toxin formed by the staphylococcus, streptococcus, enterococcus or other common inhabitants of the respiratory system bowel or skin which has contaminated the food and liberated toxin. There is a possibility that some of the suspected cases are due to virus infections. The outbreaks which have occurred during the year are small in number compared with the total number of meals provided and the position can be regarded as fairly satisfactory bearing in mind the rapid expansion of the school meals service and the improvised nature of many of the school kitchens which make the implementation of good hygiene a very difficult matter. Under these conditions the onus on the kitchen supervisors has been heavy and due credit should be given to the way in which they have carried out their work. The school meals service is a vital factor in maintaining the improved standard of physique in the younger generation—these minor outbreaks of food poisoning are only teething troubles which will eventually be eliminated. Courses of instruction for food handlers have been arranged in collaboration with the Education Department, the Medical Research Council Laboratory and the Central Council for Health Education. Each divisional medical officer is assisting in this branch of health education in his area.

Diphtheria

Arrangements for protective treatment against diphtheria have been continued as in previous years, 27,178 children (0—5 years, 20,958: 5—15 years, 6,220) being immunised during the year. In addition 19,274 children received refresher injections. Although it is apparent from the rapid decline in recent years in the number of cases and deaths from diphtheria that immunisation is having effect, there is still need for publicity campaigns amongst parents to be maintained if we are to fulfil the aim of 75% immunisation of all children reaching the age of one year. The following figures show the immunisation state of children in the Administrative County as at the 31st December, 1948:—

Age at 31.12.48 i.e. born in year:—	Under 1 1948	1 1947	2 1946	3 1945	4 1944	5—9 1939-43	10—14 1934-38	Total under 15
Number Immunised	2,457	14,546	14,539	14,453	13,800	72,197	66,997	198,989
	Children under 5					Children 5—14		
Established mid-year population 1948	135,592					214,214		349,806
Percentage of population immunised	44·1%					65·0%		56·9%

During the year there were 8 deaths from diphtheria in children under 15 years of age, but in no case had the child completed a full course of immunisation.

Smallpox

Until the 5th July, 1948, vaccinations were performed by 163 Public Vaccinators and thereafter by any medical practitioner. The scheme approved by the Minister of Health under Section 26 of the National Health Service Act, 1946, provides that vaccination of the child is offered to the parent or guardian within one month of the child's birth. On receipt of a signed consent form the vaccination is performed either by a Medical Officer of the Local Health Authority or by a general medical practitioner. Medical practitioners then submit completed record cards to the Divisional Medical Officer in respect of the vaccinations performed. The figures for vaccinations are given below:—

Number of Persons Vaccinated

	Under 1	1 to 4	5 to 14	15 or over	Total
1st January to 4th July, 1948. (Public Vaccinators).	3,328	115	45	160	3,648
5th July, to 31st December, 1948 (Medical Practitioners).	1,053	93	46	85	1,277
TOTAL	4,381	208	91	245	4,925

Number of Persons Revaccinated

	Under 1	1 to 4	5 to 14	15 or over	Total
1st January to 4th July, 1948. (Public Vaccinators).	—	—	14	168	182
5th July, to 31st December, 1948. (Medical Practitioners).	14	6	25	160	205
TOTAL	14	6	39	328	387
Total number of Vaccinations and Revaccinations	4,395	214	130	573	5,312

Whooping Cough

Whooping Cough is now the cause of more permanent damage and ill health to children than any other infectious disease, in this country, and the various trials with vaccines to protect against or alleviate the effects of the disease are being closely watched by all Public Health Authorities. In order to assess the potency of a vaccine the trials take place as follows:—A large number of children, living under fairly similar conditions, who have not yet contracted the disease, are

selected and each alternate child is given the protective vaccine. All the children are then followed up for several years and the incidence and severity of attacks of whooping cough and resulting complications are noted. The results are then statistically analysed and will show conclusively or not whether the vaccine is effective. The vaccine is usually given in combination with diphtheria prophylactic, using the same injections; for this reason it is especially important to ensure that it is reliable before it is offered to the public, as parents will expect the same standard of success against whooping cough as they have become accustomed to get against diphtheria. It has been decided, therefore, not to recommend to the Committee a scheme for the wholesale immunisation of children against whooping cough until the necessary scientific evidence of its effectiveness has been produced.

523 children were immunised against whooping cough in the Borough of Keighley during 1948. There was no change in the incidence of the disease but this was to be expected as the percentage of the child population immunised was too small to be effective. In any case the results would need following up for several years to exclude epidemic variations and to give definite information. Notifications in the Borough for the last 4 years were as follows:—

	1945	1946	1947	1948
No. informally notified	87	46	105	80
Corrected notifications	87	46	105	79
No. of deaths	Nil	Nil	1	1

Venereal Diseases

On the 5th July, 1948, the responsibility for the diagnosis and treatment of venereal diseases passed from the County Council to the Regional Hospital Boards. The prevention of V.D. (including V.D. Health Education and case finding) and after-care of V.D. patients remained under the charge of the local authority. Until the end of the year no material change in the service took place as the work was continued by the County Council on an agency basis.

New cases of Venereal Disease attending Special Treatment Centres were less in 1948 than in the two preceding years. The apparent incidence in the Administrative County is now about the level appertaining during the middle years of the war and shows considerable improvement on the peak year of 1946. There has been a reduction also in the number of non-venereal cases. Information from the Treatment Centres reveals that the latter can be divided into two main groups, (1) patients with non-venereal conditions requiring treatment, e.g. Non-specific urethritis, Trichomonas Vaginitis, etc. (2) patients not requiring treatment, e.g. uninfected contacts of V.D. cases. About 40 per cent. of non-venereal cases are in group (1) and 60 per cent. in group (2):—

Year	Syphilis	Soft Chancre	Gonorrhoea	Total new V.D. cases	Non-Venereal	Total new patients	No. of out-patient attendances
1938	346	2	650	998	501	1,499	67,036
1939	403	4	678	1,085	589	1,674	52,771
1940	299	2	499	800	495	1,295	42,254
1941	331	2	552	885	585	1,440	39,865
1942	423	1	479	903	734	1,637	43,241
1943	487	2	654	1,143	1,342	2,485	52,569
1944	413	1	560	974	1,382	2,356	53,400
1945	473	2	767	1,242	1,417	2,659	53,208
1946	723	2	1,140	1,865	1,857	3,722	67,779
1947	573	1	729	1,303	1,510	2,813	56,838
1948	463	—	550	1,013	1,403	2,416	50,852

The County Scheme continues under the immediate direction of a County Venereologist, Dr. Burgess, whose services since the 5th July have been shared with the Board. No changes in Venereal Disease specialist medical staff serving the County took place during the year. There are 10 doctors working whole-time and 14 part-time in the 20 Treatment Centres serving the County. The following table gives details of new patients and attendances of residents of the Administrative County at these centres:—

	Syphilis	Soft Chancre	Gonorrhoea	Non-Venereal	No. of out-patient attendances
Barnsley Clinic, Queen's Road ...	32	—	30	95	4,104
Bradford, St. Luke's Hospital ...	30	—	18	82	1,557
Burnley Victoria Hospital	2	—	3	4	131
Dewsbury General Infirmary ...	32	—	66	78	5,229
Doncaster Royal Infirmary	51	—	87	28	6,898
Doncaster M. & C.W. Centre ...	2	—	1	49	77
Goole Bartholomew Hospital ...	12	—	16	49	936
Halifax Royal Infirmary	37	—	30	47	2,970
Harrogate General Hospital ...	21	—	21	113	2,278
Huddersfield V.D. Centre	21	—	43	50	2,133
Keighley Victoria Hospital	24	—	49	148	3,287
Leeds General Infirmary	68	—	58	282	9,884
Oldham Royal Infirmary	6	—	5	7	373
Rotherham W.R. Medical Centre ...	28	—	37	87	2,235
Sheffield Jessop Hospital	3	—	9	14	690
Sheffield Royal Hospital	—	—	2	12	304
Sheffield Royal Infirmary	7	—	6	12	905
Sheffield City General Hospital ...	2	—	1	—	62
Wakefield Clayton Hospital ...	76	—	50	217	5,947
York County Hospital	9	—	18	29	852
	463	—	550	1,403	50,852

Soft Chancre or Chancroid has always been a comparatively uncommon disease in the County. For the first time for many years, however, not a single West Riding case was diagnosed during 1948 at any of the Clinics.

General Practitioner V.D. Service—The General Practitioner service has continued unchanged and provides patients in rural areas with treatment facilities within a reasonable distance of their homes. Fifteen doctors work in this scheme and the County Venereologist acts as Consultant and advises on difficulties of diagnosis and treatment.

	1947				1948			
	Cases under treatment at 1st Jan. 1947	New Cases	Cases transferred to the General Practitioner	Total Attendances	Cases under treatment at 1st Jan. 1948	New Cases	Cases transferred to the General Practitioner	Total Attendances
Syphilis ...	64	49	22	1,477	86	42	17	1,773
Gonorrhoea ...	30	27	2	324	34	34	5	331
Non-Venereal and undiagnosed conditions ...	19	120	1	358	11	123	—	498

Venereal Diseases Social Work and Contact Tracing—The County Venereal Diseases Social Service was extended by the appointment of another whole-time Health Visitor (Miss G. E. Davie). The staff now consists of 4 whole-time Health Visitors who are trained nurses with Health Visitor's qualifications and special experience in Venereal diseases work. There is one confidential clerk-typist. The County has been divided into 4 areas and each Venereal Diseases Health Visitor is responsible for the tracing of contacts, follow-up of defaulters and venereal diseases social work at one or more of the Clinics in her own area. The County Boroughs of Doncaster, Dewsbury and Wakefield share in this service. When working at clinics within her area the health visitor comes under the immediate direction of the Venereal Diseases Specialist in charge of the clinic.

The table below gives statistics as to the investigation of contacts by the Venereal Diseases Health Visitors:—

Total number of contacts reported				143
Located and examined			116	
Not infected			63	
Infected			53	
Already under treatment		10		
Brought under treatment		43		
Syphilis	26			
Gonorrhoea	17			
Located and not examined			9	
Not located			18	
Insufficient information			5	
Unable to locate			4	
Transferred to other authority			9	

Number of ineffective visits	126
Number of re-visits	33

Contact investigation includes not only the bringing under treatment of contagious cases of early venereal disease but also arranging for the examination of any person who may have untreated venereal infection at any stage of the disease. For example, if a child is found to have congenital syphilis the parents and other children in the family are examined. In this way new cases may be found and treatment commenced before the development of gross and crippling physical signs. It will be noted that excluding 9 persons who had removed from the West Riding Administrative County only 9 cases out of 143 reported were not located. The ineffective visits were those in which the Venereal Diseases Health Visitor was unable to speak to the contact privately or the contact was away from home. Revisits refer to those in which a second or third visit was necessary before the contact attended for examination.

The value of contact investigation is illustrated by the following examples which are typical of many:—

A schoolboy was admitted to hospital for a condition which proved to be due to congenital syphilis. The case from the socio-medical angle was complicated by the fact that he was an adopted child. By tactful investigation, his natural mother was found and arrangements were made for her examination and that of her husband and four children. The mother was found to have late latent syphilis and three of the children had latent congenital disease. They are now attending for treatment at a Special Treatment Centre.

In another case a married man attended a V.D. Clinic and was found to be suffering from gonorrhoea. He at first denied any extramarital exposures to infection and arrangements were made for the examination of his wife. She was found to have the same disease. There was no history of any risk of infection therefore her husband was interviewed again. This time he admitted relations with a married woman friend. On looking up the records it was revealed that the latter and her husband were already attending the clinic and were under treatment for gonorrhoea. This husband on being questioned admitted extramarital intercourse with a young woman, who was persuaded to attend by the Social Worker. The young woman had gonorrhoea and gave descriptions of three men with whom she had had contact in the previous two months. The Social Worker arranged for the examination of these men and one of them was proved to have gonorrhoea.

DEFAULTERS:—

Total No. of defaulters	Returned to Clinic after visiting	Failed to return	Removed unable to locate	Transferred	No. of ineffective visits	No. of re-visits
446	227	155	39	25	670	412

The word "defaulter" refers to known cases of venereal disease who cease to attend for treatment before they are cured. They fall into two main groups (1) those who have been partially treated and (2) those who have finished treatment but cease to attend before the necessary periods of observation and tests of cure have been completed. It is the Social Worker's duty in her work at the Clinic to find out patients' home difficulties and by solving these problems remove conditions which might otherwise lead to patients defaulting. From the point of view of both public health and that of the individual group (1) is by far the most important and every possible step is taken to ensure that patients attend until they are rendered non-contagious.

Reasons for defaulting are legion and include domestic troubles, illness of the patient, awkward hours of work, fear of being seen attending the clinic, absence of symptoms and many others. The principle methods of getting in touch with the defaulting patient are by letters or by visits by Social Workers. In suitable cases other means are adopted but whatever method is used the greatest care and tact are necessary at all times.

The work of Prevention in relation to Positive Blood Tests for Syphilis—From the 4th May, 1946, to the 4th November, 1948, I received from the Pathologist of the Public Health Laboratory, Wakefield, a report in confidence of all the positive (V.D. Clinic reports and doubtful positives were omitted) tests for syphilis on specimens of blood serum received at the Laboratory from Ante-natal Clinics and General Practitioners. The information given was the patient's name or reference number, sex, and the name and address of the doctor submitting the specimen. The total number of positive reports was 318. Where the specimen came from a General Practitioner I wrote asking whether he would wish a County Social Worker to call and discuss the matter with him. Where the specimen of blood came from an Ante-natal Clinic the Social Worker got in touch with the Ante-natal Clinic Medical Officer and assisted in arranging for a second specimen of blood to be taken and sent to the Laboratory without delay. This was important because some Ante-natal Clinics are held once fortnightly or even once monthly, and without this service two valuable months might elapse before a pregnant syphilitic woman could be referred to a Special Treatment Centre for examination and treatment. The number of positive Ante-natal cases was 90; of this number 78 were referred to Special Treatment Centres, and in the remaining 12 cases the repeat blood test proved to be negative. 28 contacts were traced and examined following interviews between patients and the Social Workers. This work had the great advantage of bringing within the preventive sphere cases of V.D. not treated at clinics which would otherwise be missed. By following up positive Wassermann cases through our socio-medical section we were able to bring under treatment at least some of these unsuspected cases of syphilis and so prevent the development of late signs of the disease.

In this branch of work as in all others relating to venereal disease there is a particular need for secrecy. Dr. Burgess takes all possible steps to ensure that it is dealt with under the most strict rules to preserve this secrecy and no difficulties of any sort have been encountered as a result of the disclosure to him of essential names and addresses. However in order to make it still more difficult for vital information to fall into other hands, I have, since November, agreed with laboratories, undertaking biological tests, that they shall submit only the name of the doctor, hospital or clinic sending in the specimen. We have further impressed upon all practitioners the need to obtain the patients' consent before seeking our assistance. Arising out of this it has been arranged that Ante-natal Clinic Medical Officers, when they were sending samples of blood for Wassermann, quote on the form accompanying the specimen of blood to the Laboratory the patient's clinic reference number only and not the patient's name. It was considered that this system would have the further advantage that the Laboratory staff would not know the names of Ante-natal patients with positive blood tests for syphilis. I wish to express my thanks to all venereologists and pathologists serving the County who have collaborated with us in our work and who have met frequently to discuss mutual problems.

Tuberculosis

Notifications of cases of Tuberculosis—1,372 cases of respiratory and 424 non-respiratory were notified during the year. These figures exclude duplicate notifications but include supplemental notifications brought to the knowledge of the Medical Officer of Health otherwise than by formal notification, as follows:—

	AGE PERIODS													Total (all ages)
	0	1	2	5	10	15	20	25	35	45	55	65	75	
FORMAL NOTIFICATIONS:—														
Respiratory, Males ...	1	4	11	19	13	41	83	141	100	98	76	42	6	635
Respiratory, Females ...	3	4	19	18	24	65	96	133	67	27	28	12	2	498
Non-Respiratory, Males	4	2	43	46	25	15	9	11	12	7	7	2	1	184
Non-Respiratory, Females	3	7	22	58	26	12	17	14	14	8	1	1	—	183
														1500
SUPPLEMENTAL NOTIFICATIONS:—														
Respiratory, Males ...	—	1	2	5	2	3	11	30	18	16	26	22	3	139
Respiratory, Females ...	1	1	2	6	3	3	17	29	16	5	12	2	3	100
Non-Respiratory, Males	4	2	3	2	2	1	4	1	3	4	1	1	—	28
Non-Respiratory, Females	2	1	3	1	3	3	3	6	2	1	2	2	—	29
														296

The sources of information of the supplemental notifications were:—

Local Registrars (71 respiratory, 11 non-respiratory); transferable deaths from the Registrar General (31 respiratory, 23 non-respiratory); posthumous notifications (11 respiratory, 6 non-respiratory); transfers from other areas (115 respiratory, 16 non-respiratory); other sources (11 respiratory, 1 non-respiratory).

Mortality from Tuberculosis—There were 573 respiratory and 107 non-respiratory deaths from tuberculosis. The death rates from tuberculosis in the West Riding Administrative County for 1948 are 0.37 for pulmonary and 0.07 for non-pulmonary conditions as compared with rates for England and Wales of 0.44 and 0.07 respectively.

Ophthalmia Neonatorum

There have been 51 notified cases of ophthalmia neonatorum, 39 of which were treated at home and 12 in hospital. Of these the vision was unimpaired in 50, whilst one case was still under treatment at the end of the year. This is vastly different from the time in 1926 when this condition was first made notifiable and when it was one of the main causes of blindness. Improvements in prevention and treatment have almost eliminated blindness, although many notifications of ophthalmia continue to be received.

PART III

MIDWIFERY AND MATERNITY SERVICES

Introduction. The County Council is the local supervising authority under the Midwives Acts for the whole of the administrative county. 532 midwives notified their intention to practise in accordance with Section 10 of the Midwives Act of 1902. Of these 233 were employed by the County Council as whole-time midwives, 154 as part-time midwives undertaking dual duties of midwifery and home nursing, 25 were engaged in private practice, and 120 practised in institutions. A number of important changes have taken place as a result of the National Health Service Act. The duty to provide home nursing (since July 1948) has had an indirect effect since 156 nurses taken over from the nursing associations were doing part-time midwifery. In accordance with the plan outlined last year we are gradually separating the midwifery from home nursing with special regard for the rural areas. The County Council has taken over the functions relating to maternity and child welfare from the 19 previously autonomous areas of Batley, Brighouse, Goole, Harrogate, Keighley, Morley, Ossett, Pontefract, Pudsey, Todmorden, Bingley, Castleford, Heckmondwike, Ilkley, Rothwell, Shipley, Spenborough, Wombwell and the Rural District of Hemsworth. The chief change, however, is the separation of administrative responsibility for domiciliary from institutional midwifery and the further split of responsibility for domiciliary midwifery between the local health authority and the executive council. Institutional midwifery is now under the direction of the hospital board. Domiciliary midwifery, by means of health visitors, midwives and clinics, is run by the local health authority and that which concerns the general medical practitioner is under the executive council. This divided control makes the need for the closest co-operation between the respective authorities only too apparent. The local health authority must be made aware of all institutional bookings to ensure that adequate ante-natal care is provided; similarly, notification of discharge from the maternity unit at the end of the lying-in period is essential if the post-natal care of the mother, and the welfare of her infant, are to get the best out of the local authority services.

The difficulties of the local health authority have been increased due to the fact that the county is within an area of 2 Hospital Boards, namely Sheffield and Leeds, where detailed arrangements naturally vary. Thus all bookings for institutional midwifery in the Sheffield region have been taken out of our hands, but for Leeds a Central Booking Bureau still exists in my department for the beds which we previously supervised. There can be no doubt that the Leeds arrangement (although not applying to all beds in the area) is superior, since it allows the health authority to take mothers in order of priority depending on their home conditions. The selection of women for institutional delivery is subject to many difficulties. Maternity Homes should be regarded as essential to the community need and not subject to individual wishes. While there is insufficient accommodation the decision as to who should go into a Maternity Home can be made satisfactorily only by the Health Department. Some Management Committees think they can do the bookings better themselves and do not always appreciate the above facts nor that with an uneven distribution and shortage of beds the Central Booking Bureau can do much which is outside their sphere. The proper place for such a Bureau should be in the Health Department which should be given an allocation of beds on a statistical basis between the authorities.

I have dealt elsewhere with the new situation created by the fact that the control of specialists has virtually been taken out of the hands of the local authorities and the particular problem which this raises in regard to specialist obstetrics.

Domiciliary Midwifery

The local supervising authority under the Midwives Act must exercise general supervision of practising midwives within its area; the Central Department is under the direction of Dr. J. M. Anderson with Mr. Richardson as his chief sectional clerk; each divisional medical officer acts as the medical supervisor of midwives for the division under his control. There are two non-medical supervisors at county level, each of whom works in close co-operation with the divisional medical officers in the supervision of professional standards and in the maintenance of an efficient midwifery service. The non-medical supervisors made visits to 944 lying-in and ante-natal cases, 27 to cases in labour, 652 routine visits, and 45 special investigations. "Domiciliary confinement" means the attendance of a doctor, midwife or both (at the time of the confinement) in the home of the patient. Where a doctor has been engaged to deliver the patient, the midwife, for the purpose of the rules of the Central Midwives Board, acts as a maternity nurse so long as he continues to be responsible. The domiciliary midwifery staff attended 19,231 cases; of these 16,345 were in the capacity of midwives and 2,886 as maternity nurses. A midwife is required by the Central Midwives Board to call upon the services of a registered medical practitioner in all cases of illness of the patient or child or for any abnormality during pregnancy, labour or lying-in; 7,707 such notices were issued during the year. The following tables summarise the records received from midwives during the year:—

(i)	Summoning medical aid		7,707
	Deaths of (a) mothers		4
	(b) babies		170
	Stillbirths		271
	Laying out of the dead		42
	Substitution of artificial feeding		819
(ii)	Liability to be a source of infection		151
	Puerperal pyrexia	80	
	Pemphigus neonatorum	7	
	Scarlet fever	3	
	Erysipelas	2	
	Pneumonia	2	
	Diphtheria	1	
	Other causes	56	

(iii) Summary of cases for which medical aid was summoned.

Pregnancy

Abdominal pain	42	Hyperemesis	21	Rhesus negative	4
Ante-natal examinations	78	Malpresentation	39	Rheumatism	1
Ante-partum haemorrhage	233	Mental condition	5	Ruptured membranes	1
Abortion	353	Oedema	45	Retention of urine	1
Anaemia and debility	68	Post-maturity	14	Threatened abortion	193
Albuminuria	153	Prolapsed uterus	12	Twin presentation	10
Absence of foetal movements	7	Purulent discharge	12	Toxaemia	180
Contracted pelvis	29	Respiratory conditions	25	Varicose veins	22
Cardiac conditions	14	Renal conditions	14		
Eclampsia	13	Rash	5		

Labour

Acute pain	3	Midwife not available	4	Ruptured perineum	2326
Contracted pelvis	55	Obstructed labour	50	Retained placenta	183
Cardiac conditions	34	Premature labour	102	Toxaemia	8
Eclampsia	15	Precipitate labour	48	Uterine inertia	149
Emergency delivery	1	Prolonged labour	742	Uterine discharge	2
Foetal distress	35	Placenta praevia	15	Vomiting	1
Malpresentation	290	Post-partum haemorrhage	191	Vaginal lacerations	7
Maternal distress	66	Rigidity of perineum	4		
Multiple pregnancy	16	Rigidity of cervix	33		

Lying-in

Anaemia and debility	144	Headache	2	Respiratory conditions	46
Appendicitis	1	Haemorrhoids	1	Renal conditions	15
Advice on breast feeding	3	Insomnia	2	Secondary haemorrhage	19
Abdominal pain	2	Labial swelling	1	Skin conditions	9
Batholin abscess	2	Mastitis	138	Sore nipples	4
Cardiac conditions	6	Mental condition	7	Shock	3
Cause unstated	2	Offensive lochia	2	Subinvolution	34
Eclampsia	6	Pain in legs	6	Throat infection	2
Enteritis	1	Phlebitis	67		
Facial paralysis	1	Pyrexia	147		

The Child

Asphyxia	53	Haemorrhage	5	Retention of urine	2
Birth injury	22	Hernia	1	Respiratory conditions	30
Cardiac condition	3	Icterus	54	Still-birth	25
Convulsions	16	Malformation	86	Sore buttocks	2
Cyanosis	41	Melena	19	Tongue tie	17
Feebleness	157	Oedema	3	Twins	8
Death of infant	5	Pemphigus	21	Unsatisfactory umbilicus	12
Discharge from eyes	205	Phimosis	35	Vomiting and enteritis	30
Enlarged glands	3	Prematurity	159		
Erythema	1	Rash	37		

Domiciliary midwifery is very safe as long as efficient ante-natal supervision is provided right up to the time of the confinement and as long as confinements which are likely to be complicated have specialist care and facilities for institutional treatment. We would also like to see all first confinements, and fifth and subsequent confinements, delivered in maternity homes and in our booking bureau we give them a high priority. There has been a steady increase in the number of applications for maternity homes; half are primipara and the rest apply mainly on account of bad home conditions.

Gas and Air Analgesia. By the word analgesia is meant the absence of sensibility to pain. Such a definition gives to the public an erroneous impression of the state of consciousness of the patient. Analgesia may be said, therefore, to be the state wherein the patient is relieved from pain without loss of consciousness in contradistinction to anaesthesia, where complete unconsciousness gives insensibility to pain. Good analgesia abolishes the sense of pain in midwifery without diminishing

the strength of the normal contractions of the uterus; this means that the patient is still in a position to help herself towards a spontaneous delivery without the normal process of labour being checked in any way. This is in marked contrast with general anaesthesia which stops uterine contractions, and makes mechanical delivery essential.

The type of analgesic approved by the Central Midwives Board for use by practising midwives is a mixture of nitrous oxide in air (we use Minnitt's apparatus); such a method gives safe relief to the patient. The midwife has to be thoroughly proficient in its use and must undergo special training in an approved training establishment and must be in possession of a certificate awarded to successful candidates on completion of the course. The patient must be examined by a doctor within one month of the expected date of confinement and be certified as fit to receive the analgesic. We have been able to increase our arrangements for training and at the end of December 261 midwives, out of a total of 373, were in possession of the certificate of proficiency. The number of cases which received analgesia was 775.

Ante and Post Natal Services

Ante-natal Clinics. 83,162 separate attendances were made by expectant mothers to ante-natal clinics; of the total births roughly 73 per cent. of the women in this county attended clinics. The function of ante-natal clinics is twofold; first, to educate; second, to discover abnormalities. Health during pregnancy is largely a problem in education—to know what to do and what not to do, as gestation progresses. The expectant mother is encouraged to prepare as soon as possible for her child, look forward to its arrival and prepare for breast feeding. Instruction can be given on problems of diet, exercise, clothing and in the modern approach to relaxation during delivery which leads to more natural childbirth. The ante-natal clinic does much to encourage childbirth as a normal physiological process; at the same time considerable time and skill in midwifery is necessary to detect abnormalities.

This province has been further complicated by the operation of the Act; the regional hospital boards make their own arrangements for ante-natal care for cases booked to go into institutions; the local authority, or the medical practitioner, does the same for women having babies at home. Furthermore, the National Health Service Act has drawn the private practitioner into the field of midwifery to an extent greater than at any time since local authorities were required twelve years ago to establish a domiciliary service of midwives. Under the Act every woman on the list of a private practitioner may book him for her baby; he must give two ante-natal examinations, one at the time of booking and a second at the 36th week of pregnancy and, of course, any care necessary during the gestation, including any emergency. At the confinement the practitioner attends if he thinks it is necessary; otherwise the case will be managed by the midwife. The doctor then will be responsible for any medical supervision of the mother and child during the puerperium and, subsequently, one post-natal examination at about the sixth week of confinement. This great new opportunity for every woman to have her own doctor during her pregnancy without cost should not lead us to regard the ante-natal clinic as of any less importance. The practitioner service must be viewed in its correct perspective and not regarded as in opposition to the ante-natal clinics. The all important educative role which the clinic plays in relation to the hygiene of pregnancy and lactation is in danger of being overlooked and the fact that the busy private practitioner of today often has insufficient time to devote to this work, involving among so much else the taking of blood specimens, investigation of haemoglobins, Wassermann reaction and Rhesus factor, makes the continuance of such clinics of even greater significance.

Post-natal Clinics. 3,244 attendances by 2,886 women were made at post-natal clinics, representing 9.7 per cent. of the total of women confined. This is a service provided in an endeavour to reduce the high incidence of maternal disability which follows childbirth. There are not yet sufficient attendances made for this purpose to justify the establishment of separate sessions and, with one or two exceptions, post-natal cases are examined during an ordinary ante-natal clinic. There is still much to be done in relation to the after-care of the confinement, for the hospitals continue to cope with many gynaecological conditions which are the direct result of childbirth and, therefore, preventable. The role of the health visitor and midwife in promoting the health and well being of the expectant mother must be extended to a like degree in respect of the post-natal period.

Consultant Services. Consultant services are now the responsibility of the hospital board and the efficiency of their operation is dependent upon the closest co-operation of all concerned. Dr. Anderson and I have discussed this problem at length with the obstetricians of both the Leeds and Sheffield centres and a scheme has been formulated, with their full agreement, to establish obstetricians in a responsible position to advise and guide divisional medical officers in preventive obstetric work; the plan is designed to cover the whole County with obstetricians, each covering one or more administrative divisions of the County health services. Such a consultant would assist the divisional medical officer in planning preventive medicine in relation to obstetrics; he would carry out research into the causes of maternal disability peculiar to the area and advise on preventive measures over the whole field of obstetrics, including investigations of maternal deaths and the teaching of persons associated with midwifery. He would also be responsible for consultant ante-natal clinics, of which there should be at least one per division, and for helping general practitioners in difficult cases during pregnancy, labour or lying-in. Unfortunately the scheme

has not yet come into operation. The service, as it now operates, consists of specialist consultations at Leeds, Dewsbury, Wakefield, Barnsley, Doncaster and Sheffield, either at the hospital of which the consultant is a member of the staff or at his private rooms. One grave disadvantage of the present arrangement is that the divisional medical officer is unaware of any cases referred for consultant opinion other than those which are sent direct from the County clinics.

General Practitioner Obstetrician Lists. The Yorkshire Branch Council, British Medical Association, has approved the following recommendations for the information of Local Obstetrical Committees:—

1. That the applications of all general practitioners to be placed on General Practitioner Obstetrician Lists should be accepted to the end of 1949.
2. After January 1st, 1950, new applicants applying to be placed on the list should be required to have the following qualifications to have their names added to the list. Either
   (i) one of the higher obstetric qualifications or
   (ii) Post Graduate hospital experience in obstetric work for a reasonable period (no definite recommendation made regarding the length of this at present) or
   (iii) have been engaged in continuous obstetrical practice for the previous three years.

It was further recommend that the Obstetric Lists should be reviewed every five years.

Separation of Preventive Obstetrics from Preventive Paediatrics. The scheme for separating preventive obstetrics and paediatrics outlined in the introduction of my 1947 report has not yet come into operation, except for one area in the south of the county; this one area is Mexborough (Division No. 30) where Dr. J. C. A. Renshaw was appointed on 2nd August, 1948, jointly by ourselves and the Mexborough Hospital for work entirely in the obstetric field. He is a man with special qualifications and experience in obstetrics. The appointment has been an outstanding success, as the following note prepared by Dr. Leiper, Divisional Medical Officer of that area, serves to show:—

"The following statistics and appreciation show in detail the benefits derived from the appointment of a Junior Obstetrician to a Preventive Medical Division of the West Riding County Council of Yorkshire, Public Health Department. These statistics are supplied from a Medical Division with a total population of 60,150 people and at present 1,250 births per year.

1. STATISTICS SHOWING NUMBERS OF PATIENTS ATTENDING ANTE-NATAL CLINICS, NUMBERS OF CLINICS HELD AND FINANCIAL LIABILITY TO THE WEST RIDING COUNTY COUNCIL PRIOR TO APPOINTMENT OF OBSTETRICIAN.

Prior to the appointment of a Junior Obstetrician to this Medical Division, the following statistics were recorded:—

(a) Number of Clinics held—5:—

Location.	
Goldthorpe	2 half-days per month.
Thurnscoe	4 half-days per month.
Conisbrough	4 half-days per month.
Denaby	4 whole days per month.
*Swinton	4 whole days per month.

(b) Average attendances per month.

Goldthorpe	67
Thurnscoe	86
Conisbrough	58
Denaby	113
*Swinton	12
	336—67 per Clinic average.

(c) Financial liability to County Council.

	£	s.	d.	
10 Clinics at 2½ hour sessions at £2 5s. 0d. per session	22	10	0	
4 Clinics at 6 hour sessions at £7 10s. 0d. per session	30	0	0	
*plus Moiety of Clinics at Rock House, Swinton in respect of Mexborough patients	5	0	0	
Average total salary paid to Part-time Ante-Natal Medical Officers	57	10	0	per month

Therefore the cost per patient seen by a Part-time Ante-Natal Medical Officer is 3/5 per patient.

* Approximately 12 patients from this Division attended Rock House, Swinton Ante-Natal Clinic (Div. 26).

2. After appointment of Junior Consultant Obstetrician.

(a) Clinics held—5:—

Goldthorpe	4 half-days per month.
Thurnscoe	4 half-days per month.
Conisbrough	4 half-days per month.
Denaby	4 half-days per month.
*Mexborough	4 half-days per month.

(b) Average attendances per month.

Goldthorpe	100
Thurnscoe	82
Conisbrough	56
Denaby	85
*Mexborough	77
	400—80 per Clinic average.

* New Clinic commenced 20th April, 1949.

(c) Financial responsibility to County Council.

⅗rds Dr. J. C. A. Renshaw's salary ... ... £52 approx. per month.

Therefore cost per patient seen by Dr. J. C. A. Renshaw is 2/7 per patient.

(d) In addition to these figures Dr. J. C. A. Renshaw has a Clinic under the Regional Hospital Board, at which he interviews an average of 100 patients per month.

(e) The number of patients attending the West Riding Ante-Natal Clinics has considerably increased during the first quarter of 1949, as the following comparative figures show.

	March, 1948.	March, 1949.
Goldthorpe	38	130
Thurnscoe	67	105
Conisbrough	60	93
Denaby	127	134

Additionally a weekly Clinic has now commenced at the Mexborough Child Welfare Centre and numbers are averaging 77 per month.

Conclusion. From a purely financial aspect this means a gross saving of 10d. per patient to the West Riding County Council on the present figures, which taken over a period of 12 months would represent the sum of £200 0s. 0d. (approx.).

Clinic attendances—Mexborough Montagu Hospital Ante-Natal and Consultant Clinics. Since his appointment after the opening of the Maternity wing during late October, 1948, Dr. Renshaw has made 746 attendances at the Montagu Hospital for Ante-Natal Clinics or Consultant Clinics—an average of 25 per week. He has performed 15 emergency abnormal obstetric deliveries from the 1st January, 1949, to the present date, made 20 emergency night calls and 52 emergency day calls.

Further considerations from the point of view of (a) the patient (b) the Midwives (c) the General Practitioners (d) the Obstetrician (e) the Divisional Medical Officer.

(a) The Patient. The patient has benefitted by standardisation and more frequent—i.e. weekly clinics in accordance with the recommended number of visits during the later months of pregnancy. As most abnormal ante-natal cases are admitted to the Obstetrician's own beds, confidence—an essential part of the ante-natal care—is maintained. In a case where formerly the G.P. part-time Ante-Natal Officer has been succeeded, practice politics have been eliminated and patients are no longer dissuaded from attending the clinic lest they should fall into a competitor's hands. The advantage of expert opinion at the clinics saves mothers many unnecessary visits to the consultant's clinics with its attendant worry and anxiety.

(b) The Midwives. In general I think the midwives have welcomed a doctor who is experienced in his own speciality and with whom they know they can share their responsibility. I think the appointment has been a factor in improving team work amongst them, as in the past, their allegiance has been divided amongst the General Practitioners with whom they worked. I think also that they realise that their own work will be criticized by an expert, and this will stimulate an improvement in their practice. Midwives are interested in the follow-up of their cases they have to admit to hospital and appreciate the detailed report that an Ante-Natal Officer with a combined appointment can give them.

(c) The General Practitioner. The hospital appointment has done much to improve the status of the Public Health Doctor and leaves little room for ungrounded complaints to the Area Consultant about clinic practice. At present I think the General Practitioners find it a relief—both in work and responsibility—to be able to refer their cases (after booking) to the Clinic.

(d) The Obstetrician. Work in an ante-natal clinic is of necessity, monotonous and tends to detract from the constant vigilance required for successful prevention. The added interest given by hospital practice and first hand knowledge of results, is a spur to greater care. I have no doubt this improves the Ante-Natal care given by an officer holding a combined appointment.

The attendance at the consultant clinic has the advantage of keeping the officer abreast of modern trends and the consultant aware of hospital priorities for the preventive field as opposed to his natural tendency to give priority solely to the obstetric abnormality.

(e) The Divisional Medical Officer. The appointment of a Junior Obstetrician to this medical Division is of the greatest value in the working of the Divisional Preventive Medical Scheme. For all the Ante-Natal Clinics (W.R.C.C. and Regional Board) I have to deal with only one doctor instead of a maximum of six, and the information gained with regard to the working of the clinics, and the work of the Midwives, is more reliable and more easily assessed, in so far as it comes only from one person, who is a specialist in this work.

Since the start of Dr. Renshaw's work it has been possible in the Divisional Scheme to include the Expectant Mothers from Mexborough township, who previously travelled to Swinton in Division 26, in Mexborough Ante-Natal Clinic, and standardize all the sessions at all the Ante-Natal Clinics at weekly intervals. The number of attendances at the clinics at Thurnscoe, Goldthorpe, Denaby and Conisbrough last year totalled 3,800. The present year's total attendances are estimated at 5,500 at W.R.C.C. Clinics, together with over 1,000 attendances at the Out-patients' Department, Montagu Hospital, Mexborough. The combined appointment makes it possible for the preventive side of the Domiciliary Midwife to be stressed, i.e., social conditions, diet, necessary vitamin uptake, and proper diet of the expectant mother. All these are important and need attention. The total births in this Division last year was 1,258 and with 20 expectant mothers being examined by Dr. Renshaw for the first time each week, I feel that now about 85% of the expectant mothers in this Divisional area are being seen at these clinics, and this percentage I expect to rise gradually as the Midwives in the Conisbrough and Mexborough Urban areas are brought more within the scope of the Divisional scheme. The prevention of neo-natal mortality by means of the Ante-Natal Hostel (poorly take-up so far here), the Home Help, together with the advice of the Midwife is being brought to the fore, and it was hoped that ultimately the solution of infant wastage by prematurity will be found by the prevention of the arrival of a premature child rather than by the expensive method of the Sorrento treatment of the child which has already been born prematurely. Difficulties have arisen with regard to lack of adequate Midwifery staff for the lying-in beds at the Mexborough Montagu Hospital, but 16 such beds are now available, and are being used. The staff includes three full-time Midwives, and one part-time Midwife. During the present year, about 200-240 Hospital Confinements—the seeded obstetico—social hazards—will take place at the Montagu Hospital.

The appointment of a Junior Specialist Obstetrician especially with Dr. Renshaw's personality, will undoubtedly lead to a strong team spirit amongst the Midwives. By maintaining daily liaison with the office, Dr. Renshaw is brought into close touch with the figures notably those of the maternal and neo-natal mortality, still-birth rate from Divisional Statistics. In addition to this, I have noted recently in Dr. Renshaw's conversation an emphasis on the preventive side of district midwifery which I am sure is arising because of this day-to-day information on the follow-up of his cases. Through us both the idea is being broadcast that the Midwife is the Ante-Natal Health Visitor and Social Worker.

Financially, the appointment of a Junior Obstetrician is costing the County Council less than would have to be paid if the clinics were carried out by General Practitioners alone, and with the fact that he sees so many patients per week— probably between 100 and 150, in the West Riding Clinics, and about 30 per week for the Regional Board, the speed of his work is greatly in excess of that of a General Practitioner or an Assistant County Medical Officer—only carrying out say one clinic per week."

"Flying Squad" Arrangements. The "flying squad" or emergency unit service is one provided by staffs of the maternity departments of certain hospitals, so that facilities are available for the treatment of maternity cases within the home of the patient when her condition is too grave to justify her immediate removal to hospital. "Flying squads" are available for use in domiciliary midwifery from any of the undermentioned hospitals:—

Barnsley	St. Helen Hospital.
Bradford	St. Luke's Maternity Home.
Halifax	Halifax General Hospital.
Leeds	Leeds Maternity Hospital.
Sheffield	Jessop Hospital.
Wakefield	General Hospital.

Ante-natal Hostel. Negotiations were completed with the Brighouse Borough authority for a lease of the former Clifton Isolation Hospital by the County Council for the purposes of ante-natal accommodation (24 beds); no cases were admitted during 1948 pending adaptation and

decoration. Although hostels of this description were used extensively during the war in association with emergency maternity homes under the evacuation scheme, as a peace time venture it is a new service. It should not be confused with ante-natal accommodation in hospital. The hostel will accommodate women who are in need of rest at any stage during pregnancy, but who do not have a medical abnormality for which treatment is necessary in hospital. General fatigue, debility, anaemia, nervous strain, varicose veins are among the conditions for which rest in a hostel can do so much to help; a variety of other minor conditions may also be included. The expectant mother may stay as long as is necessary to regain her strength and vigour, in most cases a month or so. She may return home for delivery or be transferred to a lying-in bed of a maternity unit. A whole-time physiotherapist has been appointed to inculcate the new philosophy of relaxation. A consultant obstetrician will have general oversight of the hostel.

Institutional Midwifery

The Regional Hospital Boards are now responsible for institutional midwifery and the lying-in beds formerly controlled by the County Council have been transferred to the respective Boards. One immediate result of this change has been the loss of detailed information regarding confinements of West Riding mothers. Negotiations are being pursued with a view to breaching this gap for future years.

An examination of the notifications received at the Divisional Offices shows a total of 13,697 institutional births as follows:—

		No. of Births.
1.	In former County Maternity Homes	2,396
2.	In former County General Hospitals and Welfare Institutions	1,348
3.	In Maternity Homes and Hospitals	7,918
4.	In private Nursing Homes	2,035
5.	Total Institutional Births	13,697
6.	Percentage of Institutional to Total Births	46

PART IV

CHILD WELFARE

Infant Welfare Centres. There were 206 infant welfare centres operating in the administrative county area, at which the total attendances were 481,625; this was made up of 332,772 attendances by infants under one year of age, and 148,853 by infants in the age group one to five years. The work of the child welfare centre is essentially preventive and educational, the mother being taught to a full understanding of how to feed, clothe and rest her infant, how to avoid infections and how to develop healthy habits and a good well balanced mind. One of the main objects is the encouragement of breast feeding and facilities must be available for the test feeding of infants where difficulty is being encountered. Health talks and demonstrations on mothercraft covering the various aspects of infant hygiene are given at frequent intervals. The clinic doctor sees each child under one year of age every month, unless progress is unsatisfactory when there are more frequent consultations. Cases requiring treatment are referred to the private practitioner with the exception of a few minor ailments. There is still the danger of a welfare centre being regarded as a means of obtaining proprietary brands of dried milk foods at cheap rates and we shall only get the full benefit from our health teaching when infant welfare centres are entirely dissociated from the sale of food. Clinic premises remain a problem and, whilst it is said that "no centre is any worse for having begun modestly in whatever accommodation might be available", the continued use year after year of premises unadapted for the purpose and in a varying state of cleanliness is not conducive to health teaching.

Illegitimate Children. There were 1,413 illegitimate births; this is a high rate which is a continual source of anxiety; many spend the earlier months of their lives in very unfavourable surroundings. The death rate is much greater than that of children born in wedlock; and many die soon after birth for the want of proper attention. The mother herself is also in greater danger, maternal mortality of illegitimate babies being considerably higher than in the legitimate. The unmarried mother, married woman, or a widow with an illegitimate child constitutes such a complex and difficult social problem that it calls for the full resources of the public health department and any other social agencies which may be interested. To further this end it has been agreed to appoint a senior health visitor to be responsible for the many problems associated with illegitimate pregnancies. The basis of any such scheme is the careful ascertainment of illegitimate pregnancies with the active co-operation of doctors, midwives, welfare workers and moral welfare societies. With early information much can be done to safeguard the girl against the grave risks to life and health which the unwanted baby superimposes upon the normal risks of a pregnancy, including of course the particular risk of venereal disease. Where a woman's home conditions are found to be unsatisfactory she can be admitted to an ante-natal hostel, and later to an institution for confinement, with a period of post-natal care to follow. Personal attention can be given to all manner of troublesome social problems arising from the pregnancy and every effort made to enable the subsequent rehabilitation of the woman in the community; for the infant this may well be a life saving measure. This is one of the purposes to which the ante and post-natal hostel can be put and so supplement the homes for unmarried mothers and illegitimate children, most of which are now voluntary and often sectarian. The County Council already accept financial responsibility within prescribed limits for unmarried mothers admitted to moral welfare homes. The duration of stay is for a period of eight weeks and payment is based on an ascertained maintenance cost of the home concerned. There were 19 cases dealt with in this manner.

Premature Babies. It is very difficult to make any division between babies which are small but mature and those which are premature. Granted, there are very often certain clinical features evident but these vary with the foetal age at the time of birth, and as the period of gestation lengthens, these features become less distinct. It is necessary, however, to have some uniformity in the standard of diagnosis of prematurity not only for statistical purposes but also to assess by comparison the results of care. Such a standard has been agreed on an international basis and is governed by the weight at birth, so that any infant weighing 5½-lbs. or less is regarded as being premature. The following table shows the survival rates according to birth weight and gives a comparison with previous years.

THE FATE OF PREMATURE BABIES BORN IN THE WEST RIDING OF YORKSHIRE

Total unadjusted live births—22,235. Number of live premature births—941. Percentage of total live births—4·2.

Number born dead—101.

Weight Group lbs.	No. of Premature Births.						Number dying (days of survival).													Over 14 up to 28 days	Number surviving over 28 days.					Percentage Survival in 1948.	Percentage Survival in previous years.		
	Born Alive.					Born Dead	First Week.							Second Week.															
	A	B1	B2	C	Total		1	2	3	4	5	6	7	8	9	10	11	12	13	14		A	B1	B2	C	Total		1945.	1946.	1947.
5—5½	283	24	88	77	472	31	6	2	3	3	1	1	1	1	—	—	—	—	—	—	2	272	23	85	72	452	95·8	95·2	91·7	94·0
4½—5	90	5	33	37	165	11	4	2	3	1	1	—	—	—	1	—	1	—	—	—	2	81	5	29	35	150	90·9	89·8	87·0	86·2
4—4½	76	9	22	27	134	23	12	3	—	2	—	1	—	—	—	—	1	2	—	—	5	58	8	19	23	108	80·6	70·6	71·7	70·1
3½—4	39	2	11	13	65	7	9	5	2	2	3	—	1	—	—	—	—	—	—	1	1	24	2	6	9	41	63·1	58·9	58·9	54·3
3—3½	36	4	6	8	54	14	12	7	3	—	1	1	—	—	—	—	—	—	—	—	—	19	2	3	6	30	55·6	38·8	35·8	37·0
2½—3	11	—	5	7	23	4	10	4	1	—	—	1	—	—	—	—	—	—	—	—	2	2	—	1	2	5	21·7	20·7	25·0	12·9
2—2½	12	1	4	3	20	8	10	5	2	1	1	—	—	—	—	—	—	—	—	—	1	—	—	—	—	—	0·0	6·7	0·0	12·9
1½—2	5	—	—	1	6	2	3	—	—	1	—	—	—	—	1	—	—	—	—	—	—	1	—	—	—	1	16·7	0·0	0·0	0·0
1—1½	2	—	—	—	2	1	2	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	0·0	0·0	0·0	25·0
	554	45	169	173	941	101	68	28	14	10	7	4	2	1	2	—	2	2	—	1	13	457	40	143	147	787	83·6	77·1	75·9	77·8
							154																						

A —Born at home and attended by a midwife.
B1—Born in a Private Nursing Home.
B2—Born in a Maternity Home.
C —Born in a General Hospital.

THE FATE OF PREMATURE BABIES BORN IN THE DOMICILIARY PRACTICE OF MIDWIVES IN THE YEAR 1948

Table showing survival in the Urban and Rural Districts of the Administrative County.

(All the figures in this table relate to births in the domiciliary practice of midwives).

Total unadjusted live births:—born in U.D's. 10,170

born in R.D's. 4,614

Administrative County ... 14,784

	Number	Percentage to total live births.
Live premature births:—born in U.D's. ...	404	4·0
born in R.D's. ...	150	3·2
Administrative County	554	3·7

Weight Group lbs.	No. of Premature Births.				Number dying — days of survival (County)														Number surviving over 28 days.			Percentage survival		
	Born Alive.			Born Dead (County)	First Week.							Second Week.							Over 14 up to 28 days							
	U.D's.	R.D's.	County		1	2	3	4	5	6	7	8	9	10	11	12	13	14		U.D's.	R.D's.	County	U.D's.	R.D's.	County
5—5½	205	78	283	17	4	2	1	2	1	—	—	—	—	—	—	—	—	—	1	197	75	272	96·1	96·2	96·1
4½—5	69	21	90	6	3	2	1	—	—	—	—	—	1	—	1	—	—	—	1	62	19	81	89·9	90·5	90·0
4—4½	52	24	76	14	7	1	—	1	—	1	—	—	—	—	1	2	—	—	5	38	20	58	73·1	83·3	76·3
3½—4	31	8	39	5	5	4	1	1	2	—	—	—	—	—	—	—	—	1	1	19	5	24	61·3	62·5	61·5
3—3½	28	8	36	8	10	4	2	—	1	—	—	—	—	—	—	—	—	—	—	16	3	19	57·1	37·5	52·8
2½—3	9	2	11	1	7	1	—	—	—	—	—	—	—	—	—	—	—	—	1	2	—	2	22·2	0·0	18·2
2—2½	7	5	12	1	8	2	—	1	—	—	—	—	—	—	—	—	—	—	1	—	—	—	0·0	0·0	0·0
1½—2	3	2	5	—	2	—	—	1	—	—	—	—	1	—	—	—	—	—	—	1	—	1	33·3	0·0	20·0
1—1½	—	2	2	—	2	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	0·0	0·0	0·0
	404	150	554	52	48	16	5	6	4	1	—	—	2	—	2	2	—	1	10	335	122	457	82·9	81·3	82·5

There remains much yet to be done to save the lives of the premature babies whose deaths now account for at least a quarter of all babies dying in the first month of life and of which nearly half are dead within 24 hours of delivery. Nevertheless—these figures suggest some improvement chiefly marked among those born at home which speaks well for the success of many special schemes for their care which have come into operation through our divisional scheme since my last report. Each division has been charged with the duty of preparing and operating its own scheme and there has been no attempt to impose a uniform pattern from above. The advantage of such an arrangement is that the schemes can be easily adjusted to meet the special needs of the area which necessarily differ considerably. The following notes indicate very broadly the basis upon which such schemes should be built.

In the circumstances that half the premature babies dying within 24 hours it follows that any preventive measures must be organised to operate with speed and also that the midwife must be a willing and active member of the team. Domiciliary midwives should be instructed to inform the health department expeditiously of any premature baby born at home. The degree of urgency must vary but it is unwise to rely on a postal notification. Experience has shown that the risk increases rapidly with decreasing birth weight and it is important to have arrangements organised for the smaller babies, particularly those under 3½-lbs., which can operate without delay day or night. The standard issue of special equipment for use in the home, consisting among other things of a Sorrento cot with accessories and an oxygen apparatus, should be stationed in an ambulance depot or at some other place best fitted to serve the whole division. Where desired one health visitor or midwife can be appointed to be responsible to the Divisional Medical Officer for supervising domiciliary care; otherwise the care should remain with the midwife taking the delivery. Arrangements are being made to train selected midwives in the Birmingham Sorrento Hospital. (To 31/12/48 the number so trained was 23). Success will depend largely on the understanding and sympathetic co-operation of midwives and health visitors and it is suggested that joint staff meetings at the divisional level might be organised as occasion arises to discuss the problem of the premature baby. One or two meetings of midwives on a county basis are to be arranged to stimulate interest. Only limited facilities exist for the care of domiciliary babies in institutions and it may be some time before the Regional Boards can do anything effective to increase the accommodation for domiciliary cases. Removal from home must, therefore, be limited to the very small infant. For these, arrangements for transport will, of course, be of vital importance and each Divisional Medical Officer should take steps to see that the ambulance depot serving his area is fully instructed on this matter. The present arrangements in operation for direct notification to health departments from hospitals and maternity homes will it is hoped continue. This enables the health department to advise on the question of discharge of babies to unsatisfactory homes. Many hospitals and maternity homes are prepared to keep babies until they are stronger and more able to combat the undesirable home circumstances and a few days delay can often give the health department an opportunity to improve them or provide alternative arrangements including admission to a post-natal hostel. Finally success of the scheme will depend upon the co-operation and interest of the general practitioners of the area and of the children's specialist (when appointed) whose advice and guidance in this preventive service can be invaluable.

Day Nurseries

The taking over of the powers after July 4th from the 19 welfare authorities increased the establishment of nurseries from seven to twenty-four. This service provides for the care of the young child whose mother is ill; the illegitimate child whose mother goes out to work; the children of parents living in over-crowded and/or insanitary dwellings where such accommodation is likely to be injurious to health; the child of a widow who has to work to keep her family; the children of mothers engaged in essential industries. In May, 1948, the Government textile drive brought a suggestion from the Minister of Health that a further sixteen nurseries might be needed to release women for such work; this was approved by the Council and is proceeding. The nurseries provide an essential part of the training of the nursery nurse for the diploma of the National Nursery Examination Board; they give practical training in the health aspects of the care of the young infant. (The educational aspects of child development are taught in the nursery classes of the education department.) The difficulty in securing practical training of students from the south of the County where no day nurseries exist has been partly met by a hostel at Ilkley (twenty students) from which they can reach nearby nurseries. The hostel opened on 25th October, 1948, and eleven students completed their training on 2nd July, 1949; all were successful at the examination. Further 84 students are in process of being trained.

Nurseries and Child Minders Regulations Act, 1948

On the 17th August, the Ministry of Health issued circular 143/48 about the above-named Act, which places a duty upon the local health authority to keep registers of, and empowers them to supervise:—

(*a*) Premises (referred to in the circular as day nurseries) in their area, other than premises wholly or mainly used as private dwellings, where children are received to be looked after for the day or substantial part thereof or for any longer period not exceeding 6 days.

(*b*) Persons (referred to in the circular as daily minders) in their area who for reward receive into their homes children under the age of 5 to be looked after for the day or a for the day or substantial part thereof or for any longer period not exceeding 6 days.

The local health authority can impose conditions for registration covering such matters as the maximum number of children which can be received; the precautions which have to be taken against the exposure of children to infectious diseases; qualification and numbers of staffs; the maintenance of the premises; arrangements for medical supervision; provision of suitable and adequate food. The Council approved the registration of three child minders.

PART V

THE HEALTH OF THE SCHOOL CHILD

(This together with the following Part VI on the County Dental Services constitutes the report for the year 1948 on the School Health Services, being the 41st Annual Report of the School Medical Officer).

Introduction

The School Health Section of my Department is under the direction of Dr. A. F. Turner with Mr. J. H. Milne as Sectional Clerk. The organisation of the work on a divisional basis within the Divisional Public Health Scheme has continued successfully and the routine administration has now been taken over in all divisions. The increased number of Assistant County Medical Officers has made it possible to put practically all school medical duties in the hands of the full time permanent staff and the arrears of work which had been outstanding since the war have been overtaken. Routine medical inspections are now up to date in practically all divisions and the special examinations of handicapped pupils can now be dealt with as they arise. During the year the paediatric scheme (by which children's specialists have been given a full responsibility) has continued to develop satisfactorily; the resignations of Drs. Allibone and Beavan (Child Health Officers) caused a temporary setback, but the appointment of Dr. C. C. Harvey, to the area of the County covered by the Sheffield Regional Board, and of three part time paediatricians in the north have compensated to some extent for this. The scheme, especially in the south of the County, is giving great help to the school medical officers, general practitioners and health visitors in the proper discharge of their responsibilities, and is filling a need in the arrangements for child care. Dr. Harvey's appointment has been of the utmost value in guiding us in the problem of the handicapped pupil and on this score alone his services have been widely appreciated by the school doctors and nurses, the teachers, the family doctors and the Education Committee. It is greatly to be hoped that the appointment of paediatricians (in agreement with the Board) to cover the whole County will not be long delayed. Dr. Harvey has written his impressions of the year's work and of the health of children in South Yorkshire and the problems confronting the medical staff and general practitioners at the end of this section.

The Medical Inspection of School Children

The basis of the service is provided by routine medical inspection of all scholars three times in the school life with special examinations and re-examinations as necessary and with more frequent attention to secondary school pupils. The fact that a school child receives only three medical examinations throughout its normal school life, should not mean that the child is forgotten in the periods between examinations. Continuous effective supervision of the child's health can be carried out by nurses properly trained in social medicine who can with the co-operation of parents and teachers ensure such supervision. To achieve the best results it is desirable that the work of the school nurse and of the health visitor should be amalgamated and this is the Council's aim in their present policy. The Council employ 233 combined health visitors and school nurses and 13 who are school nurses only. The latter are employed in areas which until the 5th July, 1948, were autonomous areas for maternity and child welfare. Many of these will be accepted for training for the Health Visitor's Certificate.

The number of inspections carried out has risen perceptibly. There were 71,858 periodic medical inspections and 34,684 special inspections and re-examinations compared with 50,277 and 20,876 for the year 1947. The following statistical tables give details of this work and the number found to require treatment in the various age groups:—

Table I

Medical Inspection of Pupils Attending Maintained Primary and Secondary Schools

A. Periodic Medical Inspections

Number of Inspections in the prescribed Groups	
Entrants	29,669
Second Age Group	25,952
Third Age Group	12,576
Total	68,197
Number of other Periodic Inspections	3,661
Grand Total	71,858

B. Other Inspections

Number of Special Inspections	12,282
Number of Re-Inspections	22,402
Total	34,684

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 (1)	For defective vision (excluding squint) (2)	For any of the other conditions recorded in Table II A (3)	Total Individual Pupils (4)
Entrants	879	5,366	5,724
Second Age Group	1,980	3,531	5,014
Third Age Group	1,170	1,932	2,440
Total (prescribed groups)	4,029	10,829	13,178
Other Periodic Inspections	493	513	958
Grand Total	4,522	11,342	14,136

Table II

A. Defects found by Medical Inspection in the Year ended 31st December, 1948.

Note: All defects noted at medical inspection as requiring treatment are included in this table, whether or not this treatment was begun before the date of the inspection.

Defect Code No.	Defect or Disease (1)	Periodic Inspections — No. of Defects: Requiring treatment (2)	Periodic Inspections — No. of Defects: Requiring to be kept under observation, but not requiring treatment (3)	Special Inspections — No. of Defects: Requiring treatment (4)	Special Inspections — No. of Defects: Requiring to be kept under observation, but not requiring treatment (5)
4.	Skin	917	848	1,296	81
5.	Eyes—				
	a. Vision	4,522	1,968	1,344	823
	b. Squint	863	659	257	117
	c. Other	399	296	468	70
6.	Ears—				
	a. Hearing	263	273	58	38
	b. Otitis Media	370	304	113	46
	c. Other	231	270	238	49
7.	Nose or Throat	3,547	6,802	886	796
8.	Speech	189	370	74	70
9.	Cervical Glands	378	3,402	123	134
10.	Heart and Circulation	385	1,315	126	255
11.	Lungs	683	1,554	279	172
12.	Developmental—				
	a. Hernia	127	196	12	29
	b. Other	103	259	39	80
13.	Orthopaedic—				
	a. Posture	475	610	68	50
	b. Flat foot	1,297	1,248	134	98
	c. Other	543	838	220	125
14.	Nervous system—				
	a. Epilepsy	22	74	13	24
	b. Other	120	281	95	59
15.	Psychological—				
	a. Development	142	241	83	80
	b. Stability	86	207	39	48
16.	Other	1,542	1,300	1,854	356

B. Classification of the General Condition of Pupils inspected during the year

Age Groups	Number of pupils inspected	A (Good) No.	A (Good) % of Col. 2	B (Fair) No.	B (Fair) % of Col. 2	C (Poor) No.	C (Poor) % of Col. 2
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Entrants	26,669	10,814	36·4	17,329	58·4	1,526	5·2
Second Age Group	25,952	8,987	34·7	15,467	59·5	1,498	5·8
Third Age Group	12,576	4,641	36·9	7,285	57·9	650	5·2
Other periodic Inspections ...	3,661	1,635	44·6	1,795	49·1	231	6·3
Total	71,858	26,077	36·3	41,876	58·3	3,905	5·4

Table III

Treatment Tables

NOTES

(a) The tables deal with all defects during the year, however they were brought to the Authority's notice, i.e. whether by periodic inspection, special inspection, or otherwise, during the year 1948 or previously.

(b) Owing to the difficulty of distinguishing between cases treated under the Authority's schemes and those treated otherwise, the treatment tables (excluding dental) include all cases known to the Authority to have received treatment, whether at their own clinics or elsewhere.

GROUP I—MINOR AILMENTS (EXCLUDING UNCLEANLINESS, FOR WHICH SEE TABLE V).

(a)	Number of Defects treated, or under treatment during the year
Skin—	
Ringworm—Scalp—	
(i) X-Ray treatment	22
(ii) Other treatment	104
Ringworm—Body	165
Scabies	654
Impetigo	4,480
Other skin diseases	5,768
Eye Disease (External and other, but excluding errors of refraction, squint and cases admitted to hospital)	3,756
Ear Defects (excluding serious defects of the ear)	4,096
Miscellaneous (e.g. minor injuries, bruises, sores, chilblains, etc.)	56,969
Total	76,014

(b)	
Total number of attendances at Authority's minor ailments clinics	167,563

GROUP II—DEFECTIVE VISION AND SQUINT (EXCLUDING EYE DISEASE TREATED AS MINOR AILMENTS GROUP I).

	No. of defects dealt with
Errors of Refraction (including squint)	10,446
Other defect or disease of the eyes (excluding those recorded in Group I)	309
Total	10,755
No. of Pupils for whom spectacles were (a) Prescribed	8,113
(b) Obtained	5,462

GROUP III—TREATMENT OF DEFECTS OF EAR, NOSE AND THROAT

	Total number treated
Received operative treatment	
(a) for adenoids and chronic tonsillitis	3,043
(b) for other ear, nose and throat conditions	70
Received other forms of treatment	762
Total	3,877

GROUP IV—ORTHOPAEDIC AND POSTURAL DEFECTS

(a) No. treated as in-patients in hospitals or hospital schools	88
(b) No. treated otherwise e.g. in clinics or out-patient departments	2,836

GROUP V—CHILD GUIDANCE TREATMENT AND SPEECH THERAPY

No. of pupils treated (a) under Child Guidance arrangements	270
(b) under Speech Therapy arrangements	224

Table IV

Dental Inspection and Treatment

(1)	Number of pupils inspected by the Authority's Dental Officers—	
	(a) Periodic age groups	114,013
	(b) Specials	3,598
	(c) TOTAL (Periodic and Specials)	117,611
(2)	Number found to require treatment	70,589
(3)	Number actually treated	59,869
(4)	Attendances made by pupils for treatment	108,679
(5)	Half-days devoted to : (a) Inspection	1,397
	(b) Treatment	16,618
	Total (a) and (b)	18,015
(6)	Fillings:— Permanent Teeth	59,983
	Temporary Teeth	5,361
	Total	65,344
(7)	Extractions:— Permanent Teeth	11,894
	Temporary Teeth	76,676
	Total	88,570
(8)	Administration of general anaesthetics for extraction	9,670
(9)	Other Operations:— (a) Permanent Teeth	25,235
	(b) Temporary Teeth	8,595
	Total (a) and (b)	33,830

Table V

Infestation with Vermin

(i)	Total number of examinations in the schools by the school nurses or other authorized persons	560,631
(ii)	Total number of individual pupils found to be infested	27,361
(iii)	Number of individual pupils in respect of whom cleansing notices were issued (Section 54 (2), Education Act, 1944)	1,737
(iv)	Number of individual pupils in respect of whom cleansing orders were issued (Section 54 (3), Education Act, 1944)	118

The Care of the Handicapped Pupil

The Authority has a duty under the Education Act, 1944, to make provision in the form of special educational treatment, for all pupils in their area who are ascertained to be suffering some disability of mind or body to such an extent that they cannot be educated within the ordinary school curriculum. The categories of handicapped pupils requiring special educational treatment, as defined in the Handicapped Pupils and School Health Service Regulations, 1945, are the blind, the partially sighted, the deaf, the partially deaf, the delicate, the diabetic, the educationally sub-normal, the epileptic, the maladjusted, the physically handicapped and those with speech defects. Special educational treatment need not necessarily be given for all these children in special schools. Where the disability is not serious special arrangements can be made in the ordinary schools. For those that are in need of special schooling some progress has been made. The Hostel for maladjusted girls at Hoober House, Wentworth, was opened in September, and further progress was made towards the opening of Bridge House, Harewood, as a School for educationally sub-normal, or physically handicapped, deaf children; Ingleborough Hall as a School for delicate children; and Oak Bank, Keighley, as a Hostel for maladjusted boys. Buildings were also acquired for the establishment of two schools for the educationally sub-normal and these are at present in the process of adaptation.

The problem of the handicapped child has received special attention in another way. The register of physically handicapped pupils has been closely scrutinised with the object of discovering how many cases could be screened or treated to such an extent as to make special education unnecessary; this has been done by a closer examination of the dossier, or by fuller clinical examination, or both. This has been a great labour, much of the work falling on the paediatrician,

Dr. Harvey. Yet the results were well worth while for many children are now carrying on a normal life at the ordinary school who otherwise would be debarred from sport or receive less education at a Special School, and many others have been placed on the correct road to health and strength. Only those who deal with the details of this problem can realise how difficult it is in many cases to determine upon the proper course of action. The following are accounts, taken from Dr. Harvey's notes, of two typical cases:—

1. *S.O., a girl of twelve,* had a history of a heart murmur discovered in the nursery school. She was forbidden to play vigorous games or join in exercises at school. This restriction was continued throughout the infant school, the school doctor being convinced that the murmur was evidence of a serious heart condition. Dr. Harvey has satisfied himself that such restrictions are no longer necessary and the child has resumed a normal school life.

2. *R.F., a boy of eleven,* had been noted since earliest babyhood to have a congenital heart lesion and he is said to have been easily tired and out of breath. Games were, therefore, always curtailed; Dr. Harvey identified the heart lesion as a patent inter-ventricular septum without circulatory defect. He therefore, advised that the boy should resume full unrestricted exercise.

Despite the full and detailed consideration given to the handicapped pupils register there is, nevertheless, still a very serious waiting list of delicate children requiring residential schooling; places for the educationally backward and the epileptic child are also difficult to find. The placement of maladjusted pupils and for whom twice as many places are required by boys, has been considerably eased. Deaf, partially deaf, blind and partially sighted children are fairly easily placed and have not a long time to wait after ascertainment. The following table gives particulars of the medical examinations carried out by the School Health Medical staff during 1948, under the Handicapped Pupils Regulations, and numbers of children in Special Schools.

Category	No. of children examined	No. of children in Special Schools at 31.12.48.	No. of children awaiting admission to Special Schools at 31.12.48.
Educationally sub-normal	1,182	41	523
Physically handicapped and delicate	1,742	218	448
Epileptic	120	26	56
Deaf and partially deaf	48	144	54
Blind and partially sighted	54	63	39
Maladjusted	200	15	118
Speech defect (examined and treated by Speech Therapy staff)	224	—	—

At the end of the year 20 children were receiving home tuition with the approval of the Ministry of Education. A further 28 children had been recommended home tuition but this had not been provided by the end of the year.

The School Ophthalmic Service

With the addition to the staff of two oculists appointed towards the end of 1947, the waiting list of children was quickly reduced and by mid-year virtually non-existent. 10,755 cases were examined by the oculists during the year compared with 7,612 in 1947. Spectacles were prescribed in 8,113 cases, and provided in 5,462 cases up to the 5th July. As the provision of spectacles after that date was dealt with through the Supplementary Ophthalmic Services Scheme under the National Health Service Act there is no accurate record for the whole year of the total number of children provided with spectacles. This can only be regarded as most unsatisfactory.

The previous system of supplying glasses through a central contract was efficient, cheap, easily controlled and glasses were supplied without delay. Children now take their place in the national queue and wait 9-10 months for glasses. No one wishes to deprive the old people of the pleasure of reading, or even foreigners, but it is almost incomprehensible that a myopic child should not have priority over these types of case. It not uncommonly happens that the refractive error allowed for in the initial prescription changes with the growing eye before the school child finally gets its glasses and that in consequence they are often useless. This is a matter demanding urgent attention. It is also a matter of concern that the whole ophthalmic service is likely shortly to be related to the hospital system when I fear that it may lose its essentially preventive outlook and introduce to the child's mind a wholly wrong idea of where true health lies.

Speech Therapy

No service is of more real value to the development of a healthy mind than the prevention of speech defects and it is therefore distressing to record that the number of whole time speech therapists employed by the County Council declined during the year from two to nil. This is part of a general shortage in which the assistants in the West Riding left to take up more senior

posts with other Authorities. It will be impossible to fill the establishment until the students at present training under special awards made by the County Council qualify and take up duties from mid-1950 onwards. After that date the supply of qualified speech therapists should be assured providing the Council persists with its training scheme. It has been possible to appoint two part-time qualified, one whole-time and one part-time unqualified, speech therapists during the year but the number of cases dealt with at the clinics was only 224.

Child Guidance

In October, 1947, the Council resolved to appoint a whole time Child Guidance psychiatrist with an educational psychologist and 4 psychiatric social workers. The salary offered for the psychiatrist was not sufficient to attract any applicants and the matter has remained in abeyance pending the decision on specialist salaries following the Spen Report. This had not become known by the end of the year. The problem is one of some urgency in view of the present increase in child delinquency. It is part of the related problems of the homeless child for these children and the delinquents are both manifestations of the "problem family." For this work it is most desirable that the Council should employ a whole time specialist and the appointment becomes more urgent as the hostels for maladjusted children come into operation; their success depends largely upon the quality of expert advice made available. Cases requiring treatment have, as in previous years, been referred to the clinics of certain of the County Boroughs, chiefly the clinic belonging to the Barnsley Corporation where Dr. MacTaggart, the Corporation's psychologist, has continued to give most valuable help with the numerous cases referred to her. The total number of pupils referred to the clinics for examination and/or treatment during the year was 270. By the end of the year 23 girls were in residence in the hostel for maladjusted pupils at Hoober House, 17 of these being children from the Authority's area. The admission of children to the hostel is the subject of most careful study. Children considered as being suitable for admission are discussed by a panel consisting of Dr. M. Jeffrey, the visiting psychiatrist, Dr. A. F. Turner of my Department, Dr. M. MacTaggart, educational psychologist (who has previously examined each case at the child guidance clinic), Mr. H. G. Armstrong, the Council's educational psychologist, and Mrs. F. Brown, the Warden at the hostel. The percentage of maladjusted children needing treatment in a hostel is comparatively small. The hostel is most valuable in cases of unsatisfactory home conditions and valuable help can be given by the health visitors to remedy these during the child's absence. This is work in which the psychiatric social workers will be able to give valuable assistance when appointed. It is pleasant to record that Mr. H. G. Armstrong, educational psychologist, has been appointed to the Director of Education's staff and we look forward to the time when he will play a full part in our child guidance clinics when they are started.

Medical Treatment at Hospitals and Elsewhere

On the 5th July, 1948, the responsibility for the treatment of School Children in hospital passed to the Regional Hospital Boards. Nevertheless, Section 48 of the Education Act, 1944, still requires the Council to ensure that comprehensive facilities are available and it is hoped that the Education Committee will keep the matter in mind; much good may come of negotiation with Regional Boards on this important issue.

Apart from the numerous minor ailment clinics, the following specialist clinics were in operation during the year:—

Type of Clinic.	*Number.*
Consultant E.N.T.	22
,, Orthopaedic	14
,, Dermatological	1
Speech Therapy	5
Orthopaedic Treatment Centres	32
Chiropody	1
Ultra Violet Light	23
Paediatric	16

Arrangements for ultra violet light treatment have for some time been far from adequate and in many areas children have had to undertake lengthy journeys to hospitals for this type of treatment. To remedy this the Council in October, 1948, approved the provision of 26 new lamps in selected areas; these, together with the lamps already functioning will be sufficient to meet the needs of the whole County.

Orthopaedic Treatment

The Council's scheme for the treatment of orthopaedic defects was expanded during the year with the absorption on the 5th July, of the orthopaedic clinics and treatment centres formerly operated by certain of the Authorities in the County which were autonomous for maternity and child welfare. At the end of the year consultant clinics numbered 19 and a total of 265 sessions were held during the year.

The following are details of the year's work including particulars relating to pre-school children:—

	Pre-school children	*School children*	*Total*
Consultant Clinics.			
(a) First attendances during year	436	1,116	1,552
(b) Total attendances	2,099	3,738	5,837
Treatment Centres			
(a) First attendances during year	717	1,289	2,006
(b) Total attendances	7,768	16,066	23,834
Domiciliary treatment.			
No. of visits made by orthopaedic nurses and physiotherapists	185	338	523
Hospital Treatment.			
No. treated in hospitals and hospital schools ...	not known	88	88

Surgical appliances were provided in 188 cases.

In addition to the above, 212 tuberculosis patients were examined by the Orthopaedic Surgeons and/or supervised by the Orthopaedic Nurses.

Diphtheria Immunisation

Particulars relating to the number of school children immunised during the year and the immunisation state of the population of children of school age will be found on page 23 of this report. The schools have continued to play their essential role in furthering this valuable work and I wish to express my thanks to all teachers for their collaboration.

The Social Work and Follow-up of School Children

Since the 5th July, when the scheme of Divisional Health Administration had come fully into operation defects have been followed up much more easily and a closer contact between the Health Service and the family practitioner has been assured. The position of this important aspect of the work in relation to hospitals is far less satisfactory. One of the great advantages of free treatment under the Education Act, 1944, was the concurrent arrangement for care and after-care of children leaving hospital and also that for the completion of a confidential school health report. For the first time this produced that essential link between the School Health Service and the hospital system which had been asked for by the report "School and Life" of the Central Advisory Council for Education (England). It enabled the school doctor and school nurse to advise teachers how best to organise the child's life in school, and further it formed the basis of a complete health dossier upon which the School Medical Officer could advise the Education Officer about handicapped children, and the juvenile employment committees about placement in industry.

The scheme worked smoothly and no major difficulties were encountered, but after the 5th July, 1948, notifications of admissions and discharges and case reports were not received regularly from hospitals, with a few notable exceptions (the General Infirmary at Leeds continue to send very full and helpful reports). Miss Carey, Area Superintendent Health Visitor, has visited the Almoners in hospitals with a view to rectifying this but without any appreciable success. Many children are now having major operations and returning to school without the School Health Service knowing anything about them. It is vitally important that children who have been in hospital for relatively minor conditions, and even more for those who have had severe illnesses, should be carefully supervised at school and that all adolescents should be placed in industry on leaving school with full regard to their health. It would be a great advantage if firm instructions could be given to hospitals on this subject by the Ministry of Health, for it is vital to the development of a modern School Health Service. The School Health Service cannot carry on efficiently without hospital reports and it is distressing that a progressive measure, instituted so recently under the 1944 Education Act, should now be cast aside.

Cleanliness

With the introduction in 1944 of D.D.T. and other insecticides when the public could obtain an easily applied, inoffensive, and sure remedy, it was confidently expected that the incidence of infestation would show a considerable decrease. If the incidence of infestation in school children can be taken as a guide, the reverse may be happening; the number of individual pupils found to be infested during 1948 was 27,361 compared with 24,862 for the year 1947. One possible explanation of this is the increase in permanent waving of the hair. Many women who have had a permanent wave do not wash their heads so frequently and the "tightening" of the hair often aggravates the condition by preventing thorough combing.

There is a great need for propaganda on this subject, especially with reference to the use of insecticides.

Cleansing stations taken over from civil defence are now available in all divisions; there seems to be a certain reluctance to use them in the interests of hygiene generally. It is certain that they can play a wider part than that of cleansing scabies (now happily declining) and plans to this end are under discussion with the Director of Education.

Nutrition

There was little change in the general condition of the school children as compared with the year 1947, comparative figures being as follows:—

Year	Total number of pupils inspected	Classification					
		A (Good)		B (Fair)		C (Poor)	
		No.	% of Col. 2	No.	% of Col. 2	No.	% of Col. 2
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1947	50,277	19,497	38·8	28,343	56·4	2,437	4·8
1948	71,858	26,077	36·3	41,876	58·3	3,905	5·4

The average daily number of meals given to school children during 1948 was 126,897. Particulars relating to the supply of milk to school children can be found on page 80 of this report. An account of an inquiry into the uptake of milk by families is given at the end of this report.

Provision of Specialists for the School Health Service

Under the National Health Service Act the general provision of specialists became the responsibility of the Regional Hospital Boards who, it was said, should supply, as far as possible, the needs of Local Education Authorities; Circular 179 of the Ministry of Education pointed out that Local Education Authorities could themselves augment these services where necessary by direct employment of specialists. For many years this Authority has been building up specialist services for the prevention and diagnosis of disease, co-ordinated with the health services and now an integral part of the divisional scheme. The aim has been to secure that specialists in various branches of medicine and surgery should cover defined areas of the County. As part of this it was sought to provide a multi-clinic in each division. The whole emphasis of the service is upon prevention and even the clinics are not only for diagnosis and cure of disease; they are centres where specialists can inquire into the beginnings of illness and can, in co-operation with the Public Health staff, investigate the effects of environmental factors in disease. A full account of our needs in this respect is given on pages 88 to 90 of this report. It would be idle to pretend that the National Health Service Act has done anything but retard these modern developments and it is distressing to have to record that, although specialists in all branches have agreed to collaborate and detailed schemes have been worked out with the full agreement of the specialists in both the Leeds and Sheffield centres, nothing of advantage has taken place and we are worse off now than before the 5th July, 1948. This purely preventive aspect may well be under-estimated by the Regional Hospital Boards and in any case, it is hardly their responsibility to supply specialists for the full range of this work. It is, therefore, imperative that these schemes shall be continued and expanded by the Local Health Authorities. It is my earnest hope that the West Riding County Council will give their full support to such an important development essential to a modern School Health Service.

Lectures and Postgraduate Hospital Clinical Teaching for Assistant County Medical Officers

The scheme for bringing the school doctor into close touch with hospital has made some progress since my last report. The arrangement has been continued with Professor Illingworth, Professor of Child Health, Sheffield University, for Assistant County Medical Officers in the southern part of the County to attend at the University for organised post-graduate instruction amounting to one session a week and including a course of lectures and demonstrations of cases important in school health work. The lectures are prepared with the object of bringing the doctors fully up to date with the latest advances in child health and have been very successful. It has still not been possible to make similar arrangements in the northern two-thirds of the County largely owing to lack of facilities in the Leeds University. In other parts of the County six assistants have attended ward rounds held by Dr. C. Josephs, Medical Registrar at the Staincliffe General Hospital on Saturday mornings; three have attended the Bradford Children's Hospital; one has attended the Huddesfield Royal Infirmary; and one has attended the Whixley Mental Deficiency Institution. As part of the scheme several lectures have been given at the County Hall

by Dr. L. Wittels, Ophthalmologist, Mrs. J. E. Moss, Speech Therapist, and Dr. H. J. O'Loughlin, Psychiatrist in Mental Deficiency, on various aspects of their speciality which affected the Assistant County Medical Officers in their work. There is a need for a comprehensive arrangement with the University authorities in Leeds similar to that in Sheffield, if the Assistants are to be kept up to full efficiency. An attempt is now being made to give each medical officer an official assignment to cover one year.

Sanitary Conditions of School Premises

It is a continuing source of frustration to all interested in health education that the standards of hygiene in many of our own schools should be so deplorably low. When the influence of example runs contrary to that of teaching there is little chance of real and lasting success. How is it possible to teach effectively that hands should be washed after the bowels have been attended to if there is no water, or no soap or towel, with which to do it? These elementary needs are sometimes not available. It is to be hoped that the Education Committee will have this matter constantly in mind. We are still being guided largely by the building difficulties and only reporting the very worst cases. Rightly or wrongly we are also having regard to the Development Plan which, if it is not long delayed, will solve our difficulties; this Plan (or the relevant sections) has been circulated to all Divisional Medical Officers.

Special Investigations

During the year two special investigations were held; one on children's footwear and the other on the uptake of milk in families.

Children's Footwear. For some years the school medical staff have been concerned about the number of foot defects among school children. Early in 1948, Dr. Margaret A. Hillis, one of the Assistant County Medical Officers, made a survey in her area and below is her report:—

"It would appear that the number of children brought to me by their parents because of foot troubles is increasing—crooked toes, walking shoes out of shape, flat feet, blistered heels are everyday complaints. In seeking the cause of these complaints an examination of the children's shoes usually reveals the cause of the troubles, for in nearly every case it can be demonstrated that that the child is wearing a shoe too short for the foot. To obtain definite evidence of this fact I measured the feet of some 150 children. The standard of measurement adopted was:

(a) Measurement of the foot without stocking;

(b) Measurement of the shoe after deducting an adequate amount for the thickness of the welt—$\frac{1}{8}$, $\frac{1}{4}$ or $\frac{3}{4}$, as indicated.

If the shoe showed no increase in length as compared with the length of the foot, it was considered to be too short.

Of the 150 children measured, 100 were in infant school, aged 3 to 8 years. The remaining 50 were junior school children, aged 8 to 11 years. Of the younger group of children it was found that at least 40% were wearing shoes too short, and of the older group 30%. The percentage was higher among girls, especially in the older group.

From these observations it would appear to be useless to begin the treatment of these minor foot troubles until suitable footwear has been obtained, but the difficulty of obtaining children's shoes at the present time appears to be insurmountable, and many parents declare it is a "nightmare" to them.

It is understandable that owing to the difficulties created by war-time conditions, parents have been obliged to make their children's shoes last as long as possible, and one is prepared to find a number of children wearing out a pair of shoes which they have already grown out of in size. A disturbing feature of many short shoes, however, is that they are too short when the child leaves the shop with them. This is particularly so of the child with a long, narrow foot, and it is this type of foot for which no adequate provision is made.

It is often in the first fitting of a shoe that trouble arises—a shoe is fitted in width but not in length. If the shoe is a little too short, it is demonstrated that the next size larger is too big and slops off the heel, so that the short shoe is considered suitable. The toes—being short of length—obligingly turn round and accommodate themselves to the width. The big toe is placed in a position of *hallux valgus*, the tread of the foot is displaced, and the weight of the body falls on the inner border of the foot and the arch collapses.

Thus, it would appear that in childhood the foundation is laid for the many foot troubles that occur in adults, for whether it be a hammer toe, a bunion, flat feet, or the trivial corn, it can become a source of considerable distress and disablement in later life.

I should like to put forward the following suggestions:

1. A greater variety of fittings, with emphasis on a snug-fitting heel and a firm ankle support.
2. A sensible "school shoe," especially for girls; fewer fancy styles and flimsy summer shoes; more emphasis on quality and fit rather than on cheapness and style.
3. A more suitable type of winter footwear—a lined boot or bootee (waterproof) to take the place of the rubber Wellington which, with its lack of ventilation, keeps the feet cold and damp.
4. Special training for shop assistants in the fitting of shoes; a more accurate method of measurement than is at present used, and if possible X-ray apparatus for examining the foot after fitting the shoe.

Quality should be the keynote of production. The extensive range of cheap shoes should be eliminated—they are not cheap in the long-run—and parents would soon realise this if only good shoes were available."

The findings set out in the above report appeared of sufficient importance to warrant a systematic investigation and a copy of the report was sent to the British Boot, Shoe and Allied Trades' Research Association which is a non-profit making organisation, purely for research into problems connected with footwear, financed partly by the boot and shoe trade and partly by the Government. The Association proposed that one of their teams should visit the West Riding to find the precise facts regarding the type, fit and condition of shoes normally worn by school children in the Administrative County. It was agreed that an examination of their feet should be included so that the connection between the health and condition of feet and the shoes worn could be investigated. The report on the survey carried out by the team is a foolscap document of over sixty pages of which the following is a synopsis:—

"*Research Report R.R. 107.* "A survey of Shoes worn by children in the West Riding of Yorkshire" by K. L. C. Freeborn, B.Sc., A.M.I.E.E. A.M.I.Struct.E., J. C. R. Clapham, B.A. and Miss B. C. Bradley, B.A., M.C.S.P.

Condition of the feet.

Over 900 children were examined. A very high proportion of them had foot defects. Many of these were neither serious nor likely to be permanent. Thus many quite trivial faults such as skin roughness or slight curling of the toes were included; others were clearly temporary—blisters for example. Again knock knees, observed in 29% of the children under 5 years of age, are rarely permanent as they persisted in only 1% of those over ten years old. Eversion of the ankles was also slightly less prevalent among the older children. Making due allowance for these facts, the report nevertheless confirms the prevalence of serious or potentially serious foot troubles as indicated by the following data. The condition of the great toes was especially serious as 10% of the two-year old children showed signs of valgoid deformation, and this had increased to 88% of the girls and 67% of the boys over sixteen. Stiffness of one or more joints was common, and increased with age; the first joint of the big toe was most frequently affected (23% of the girls and 13% of the boys). Nearly all the feet examined had one or more toes with noticeable clawing or rotation, whilst 23% of the children had toes (other than the great toes) which were also in some degree stiff. Blisters were common (17.4%) among girls over fourteen. Corns on the little toes increased rapidly with age, and affected 38% of all children over fifteen. 5% of the children had flat longitudinal arches and another 23% were tending to flatness but were able to raise their arches. 10% had dropped transverse arches; this was most common among the older boys, often in conjunction with high longitudinal arches. Everted ankles were observed in 32% of the boys and 35% of the girls; this defect is clearly associated with flat or flattening feet since it was observed in 72% of the former and 60% of the latter.

Fit of the Shoes.

61% of the boys and 83% of the girls were wearing shoes too short for them, and these figures were roughly the same at all ages, except for the older Grammar School boys. Even among new and nearly new shoes 50% were too short.

30% of the shoes were a tight fit in girth, but many of these misfits were also short so that a larger size rather than a broader fitting was needed. This was borne out by the fact that, *when the length was satisfactory* only 9% of boys and 4% of girls had shoes which were too close fitting at the joint. On the other hand 16% of all shoes were too full at the joint, and for shoes of correct length this figure increased to 19% for boys and 25% for girls. Similar tendencies were observed in the new and nearly new shoes; 39% were satisfactory in joint fitting and were at the same time short, whilst 10% were both full at the joint and short in length.

An assessment of those shoes which were judged to be satisfactory in both length and joint fitting enabled a general criticism to be made of the fit of children's shoes in other respects. More than 50% of these shoes were full at the waist and instep. In a high proportion the fit at the quarters was not good and more than 50% of the girls' shoes had poor heel grip. Over 30% of all shoes had quarters which were too high for comfort. Toe and heel shapes were reasonably satisfactory.

Correlations between foot defects and the fit of the shoes.

Doubt was felt as to whether such correlations would be revealed because the only information available regarding the shoes worn related to those in use on the day of the examination. If it had been possible to ascertain which children had worn ill-fitting shoes for a long period, and to compare the condition of their feet with the feet of children who had regularly worn well-fitting shoes more numerous and positive conclusions could doubtless be reached. Despite the limitations imposed by lack of knowledge of the children's "shoe history" the methods of mathematical statistics showed that wearers of short shoes may have an increased tendency to develop clawed and stiff toes, hammer toes, stiff great toes or enlarged distal joints of the great toe. In addition, the expected connection between short shoes and valgoid great toes was amply confirmed. There is also an association between short toes and flat feet, though cause and effect may be reversed in this instance. Tight shoes tend to cause corns on the little toes, blisters on the forepart of the foot, general stiffness of the feet, stiffness of the great toes, and thickening of the skin under the great toes.

Reasons for ill-fitting shoes.

This survey was not intended to provide comprehensive data on the causes of mis-fitting but some comments based on conversation with the children and on general observations have been included in the report. Some shoes had been bought by parents without taking the children to the shop. Others had been purchased from market stalls and general stores without facilities for trying on the shoes. Vanity was a common cause of ill-fitting among older girls; those with large feet did not like to mention their shoe sizes for fear of being laughed at by the other girls present.

Passing on of shoes within a family was not found to be a serious factor in this area, but the number of children who said they had larger shoes at home indicated that there is a real problem in new shoes being kept "for best" for considerable time and not taken into general use until they are becoming too small.

It is obvious that these reasons for ill-fitting explain only a small proportion of the cases observed. Facts already mentioned in this summary indicate that insufficient shoes are available in varied fittings and that there is a tendency for children's shoes to be too full in girth, encouraging short fitting. Other factors which may be of greater importance are; retailers may be out of stock of certain sizes and fittings; rush-hour shopping sometimes makes it impossible for shop assistants to give adequate time to each customer; sales staff who have relatively little training and experience sometimes have to be employed; many parents do not know how to judge the fit of their children's shoes, or realise its importance; expensive shoes and frequent replacements are out of reach of many families, and so on."

The practical issues.

This brief review of the report is sufficient to reveal its importance to everyone interested in the welfare of children and in their feet and footwear. It will receive wide publicity, and it is a good thing for the footwear manufacturing and distributing industries that it should do so, for the problems raised cannot be solved until they are more widely appreciated and more fully understood by parents, by teachers and those engaged in various social services, and by the medical profession. Also the industry can properly take credit for sponsoring an investigation of this kind into an important social problem; it demonstrates the industry's active concern for the interests of the public.

The reasons for the present serious short-comings in children's shoe-fitting can be summed up under three headings—educational, economic and technical. The last of the three embraces research and development work connected with children's foot measurements, last design and allied subjects. Much has been and is being done in these fields by the Research Association and by manufacturers, frequently in collaboration. This is good and important work, but it is probable that the educational and economic problems which have been referred to are even more important. The work of the pioneers in these fields needs to be pressed forward and enlarged.

There is need for intensive propaganda among parents, in boot and shoe stores, and in the manufacturing trade itself to ensure that properly fitting footwear is supplied. This might do much to prevent the conditions for which orthopaedic schemes, and chiropody clinics to deal with foot defects, are now established. We are taking steps to ensure that the preventive care of the foot is made one of the first concerns of our health visiting and school nursing service.

Uptake of Milk in Families—The second investigation was carried out by the two Public Health Dietitians into the uptake of milk in families of various sizes. The object of the study was to determine to what extent increase in the size of families cut down the average amount of milk consumed. The survey was carried out in conjunction with the Assistant County Medical Officers at routine school medical inspections and the report of the dietitians is given below:—

"Information was obtained for 417 families with a total of 726 children between 1 and 16 years of age inclusive. These families can be taken as fairly representative of the County as a whole. Any children not living at home were excluded. 94.6 per cent. of the school children in the families investigated took school milk. The families were grouped as follows:—

Group	Constitution	No. of Families in Group
1	2 adults + 1 child of more than 1 year old	110
2	2 ,, + 2 children of more than 1 year old	164
3	2 ,, + 3 children of more than 1 year old	82
4	2 ,, + 4 children of more than 1 year old	29
5	2 ,, + 5 children of more than 1 year old	17
6	2 ,, + 6 children of more than 1 year old	15
	Total	417

COMPARISON WITH MINISTRY OF FOOD ALLOWANCES

UPTAKE OF FRESH MILK EXPRESSED AS PERCENTAGE OF RATION PERMITTED ON MINISTRY OF FOOD SCALE FOR NUMBER AND AGES OF FAMILY

Group	No. of families in group	Less than ½ ration		½ to 1 x ration		1 to 1½ x ration		1½ to 2 x ration		Over 2 x ration		Range
		No. Families	Percentage of families in group	No. Families	Percentage of families in group	No. Families	Percentage of families in group	No. Families	Percentage of families in group	No. Families	Percentage of families in group	
1	110	—	—	10	9	31	28	55	50	14	13	58-494%
2	164	2	1	39	24	82	50	30	18	11	7	45-466%
3	82	1	1	32	39	42	51	7	9	—	—	48-189%
4	29	1	3	20	69	5	17	3	11	—	—	47-171%
5	17	—	—	10	59	6	35	1	6	—	—	50-188%
6	15	4	27	6	40	4	27	1	6	—	—	24-152%

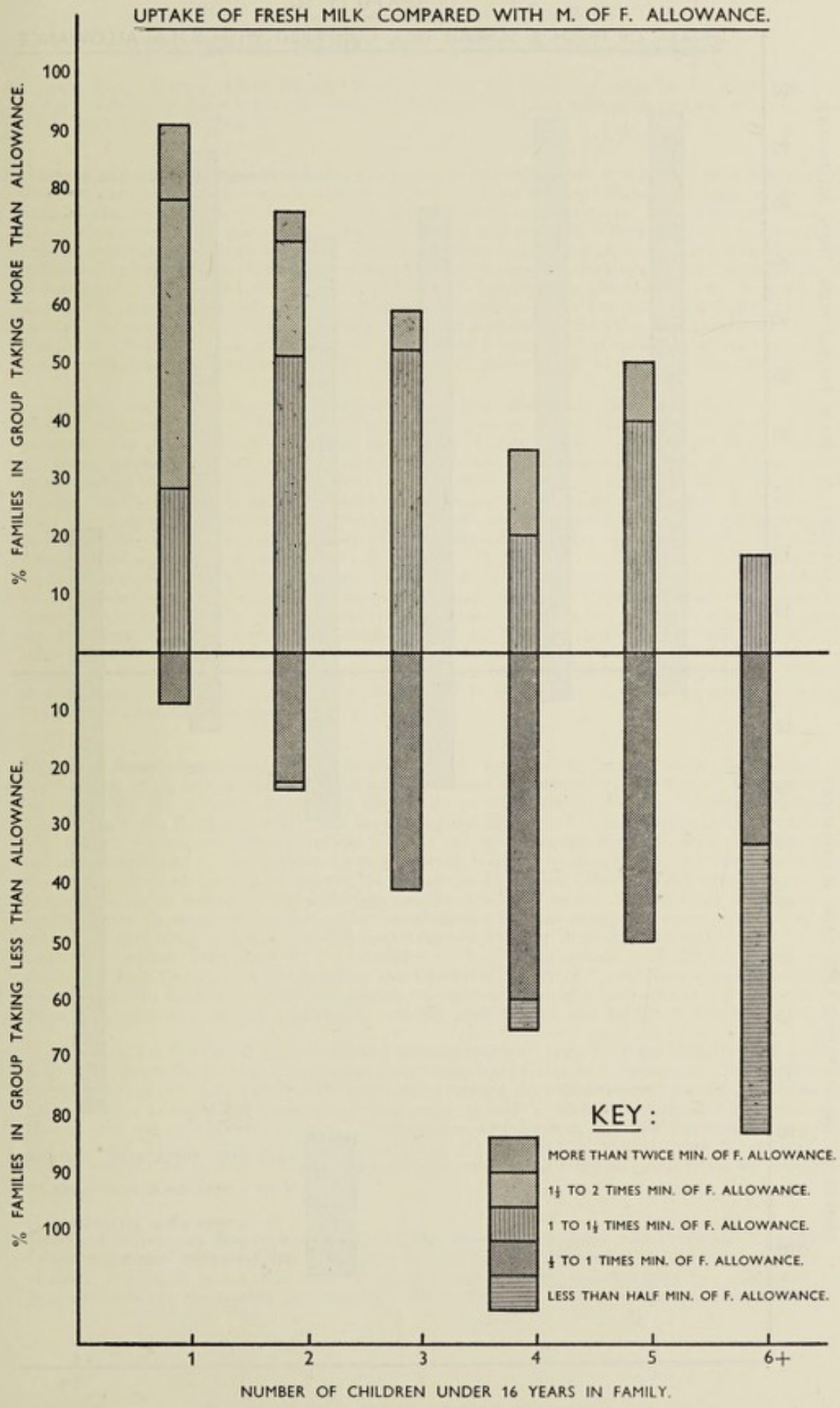
COMPARISON WITH BRITISH MEDICAL ASSOCIATION ALLOWANCES

UPTAKE OF FRESH MILK AND MILK OBTAINED AT SCHOOL EXPRESSED AS A PERCENTAGE OF ALLOWANCE SUGGESTED IN B.M.A. DIETARIES 1933
(FAMILIES AND INFANTS EXCLUDED).

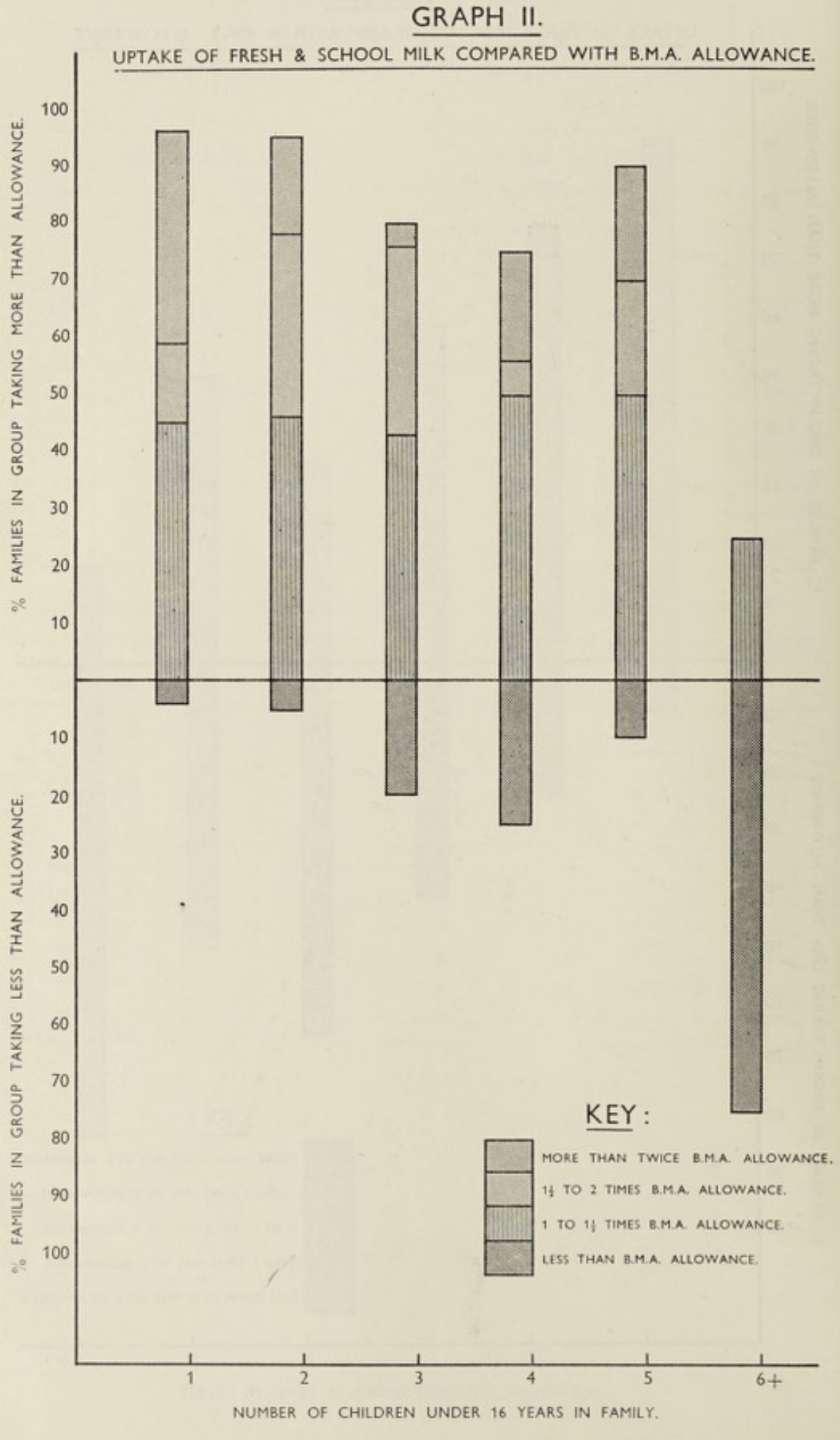
Group	No. of families in group	Less than ½ allowance		½ to 1 x allowance		1 to 1½ x allowance		1½ to 2 x allowance		Over 2 x allowance		Range
		No. Families	Percentage of families in group	No. Families	Percentage of families in group	No. Families	Percentage of families in group	No. Families	Percentage of families in group	No. Families	Percentage of families in group	
1	110	—	—	4	4	50	45	15	14	41	37	66-623%
2	155	1	1	8	5	73	47	48	31	25	16	41-564%
3	71	—	—	12	17	31	43	24	34	4	6	64-298%
4	24	—	—	4	17	10	42	7	29	3	12	74-271%
5	17	—	—	2	12	6	35	7	41	2	12	67-220%
6	11	—	—	7	64	2	18	1	9	1	9	66-219%

GRAPH I. Comparison of milk drunk with the allowance of milk by the Ministry of Food. The uptake of fresh milk in Groups 1-6 was compared with the allowances set out by the Ministry of Food when the sale of milk was restricted. Account was taken of the ages of the children and any special allowances for expectant mothers or invalids.

GRAPH I.



GRAPH II. Comparison of milk drunk with that in the B.M.A. 1933 Diets. The *actual* uptake of school milk was added to the fresh milk for comparison with the B.M.A. recommendations since school milk was not generally available in 1933 when the recommendations were made. Since the B.M.A. did not consider children under one year, families with such children have been excluded in compiling this graph.



CONCLUSIONS. Of the families investigated, the results show that there is slightly less fresh milk per head consumed in the homes of large families, but this is clearly less obvious than in similar surveys before the war. Very few families are taking less than the amounts of milk recommended by the B.M.A. in the 1933 Diets."

The work of a Children's Specialist in The School Health and Child Welfare Services

Dr. C. C. Harvey, Child Health Officer, submits the following notes on his work. It will be appreciated that these cover the whole age range of the child population and are not concerned solely with school children:—

"**Nature and Scope of Appointment**—The terms of advertisement of this post indicated that it would be closely integrated with the work of the Divisional Medical Officers and Assistant Medical Staff of the nine Health Divisions of the Southern Area of the County, with widening contacts to include nursing colleagues, family doctors, parents and teachers. Frequent visits to Divisional Offices, correspondence and telephone discussions serve to keep me in close touch with divisional problems, and the County Hall Conferences each month are exceptionally valuable for multi-lateral discussions. I am much indebted to the Consultant Tuberculosis Officers, Dr. H. A. Crowther and Dr. E. Ratner, not only for their counsel, case-consultations and numerous X-Ray reports, but for the hospitality of their consulting rooms at Rotherham, Barnsley and Thorne for regular Paediatric Clinics. At the Public Health Laboratory I have received valued help over equipment, and counsel, from Dr. Lane and from Dr. Auchinachie and the staff, as formerly from Dr. Colbeck.

Family doctors hitherto have been somewhat apart from our Welfare Clinics and School Medical Services. My aim has been to bridge the gap by a full case-report on each of their patients, even when referred (as usual) by another Medical Officer. As a result, direct contacts are being established in many places, and family doctors are beginning to refer their own cases to the clinics through Divisional Medical Officers. For instance, recently one family doctor sent me four of his patients in as many weeks, upon becoming aware of the services we can offer. This merely hints at the degree of "unsaturation" of paediatric needs throughout our population. At Wakefield General Hospital and the Montagu Hospital, Mexborough, such links with family doctors were already developed before my arrival. In four Divisions I have paid domiciliary visits in consultation with family doctors, and other doctors have discussed their cases by telephone. In two divisions I have visited four schools for discussions with Head Teachers over cases or general problems, and this type of contact will increase. I believe the Health Visitors who share the Paediatric Clinics appreciate the discussions of their cases. And there are links planned also with midwives and home nurses. Parents are approached mainly through individual chats at the Paediatric Clinics over their children. I anticipate some extension of influence to lantern demonstrations at Welfare Clinics (e.g., on Breast Feeding) and occasional meetings of School Parent—Teacher Associations.

Hospital Appointments—The co-ordination of my work with responsibilities in hospital is fundamental to its success and I look forward to further developments in the future. Unfortunately hospital beds are severely lacking in the south of the County. At the Montagu Hospital, Mexborough, the Paediatric Clinic had been inaugurated by Dr. T. E. D. Beavan before my arrival. The limited out-patient accommodation restricts us to a lengthy fortnightly session, which is seriously insufficient for the number of new patients referred by family doctors, notwithstanding that all school cases have been diverted to a separate Divisional Clinic. Ward admissions on the paediatric side are relatively few and more cubicles are badly needed. Attendance upon newborn babies in the Maternity Wards has so far not extended beyond emergency calls. Since July 1st as a temporary measure I have covered the Children's work at Wakefield General Hospital with a weekly out-patient and Ward visit. Professor C. W. Vining attends as Senior Consultant twice monthly. This Out-Patient Clinic serves the Paediatric needs of Pontefract, Ossett, Castleford and Hemsworth Divisions, which are outside my normal area, and thus affords me valuable and interesting extended clinical experience. Family practitioners also use the Clinic extensively.

My status at Doncaster Royal Infirmary remains nominal, apart from the Monthly Staff Clinical meetings. Early in the year I was called three times in consultation to Hemsworth County Welfare Institution, but not since July. Staff problems prevented the establishment of a definite Paediatric Unit. I have attended for consultations over cases at both Listerdale and Hallamshire Maternity Homes, but not as a weekly routine. Consultations at Infectious Diseases Hospitals have arisen at Grenoside, Swallownest and Wath Wood; and I have met Dr. Maclure with Dr. Penman at Conisborough. In general, I wish to acknowledge the cordial welcome given to me by colleagues on the Hospital Staffs.

Sheffield University Department of Child Health—The affiliation with Professor Illingworth's Department, as Honorary Clinical Assistant to the Sheffield Children's Hospital in the Department of Child Health, is in my view a most valuable aspect of my appointment; and this value has been enhanced by the cordial and ripening relationship into which Professor Illingworth, his

colleagues at the Hospital, and his staff in the Department have welcomed me. Since the close of my first year I have assumed a regular out-patient session every Friday morning at the Children's Hospital, in the Department of Child Health. The Department also affords invaluable opportunities for clinical and library study, working up cases, investigation of advanced case-problems as out-patients or in-patients, and the guidance of Professor Illingworth in major problems of preventive planning and policy. I have been able to participate in the beginnings of some field research into normal growth of children, which will develop further. The link with the Department of Child Health also helps the Assistant County Medical Officers who are now attending for Post-Graduate refresher lectures and out-patient experience.

Divisional Paediatric Clinics—The distinctive feature of this appointment is the scheme of holding monthly paediatric clinics in the territory of each Health Division, where school and pre-school children can be referred from our School Medical Inspections and Welfare Clinics, usually with the Health Visitors who know the homes in attendance. Family doctors have expressed appreciation of these Clinics held on "home ground", staffed by the Health Visitors who know the families and can take the paediatric teaching back into the homes. A surprising amount of neglected clinical material has thus come to the surface, which parents and doctors had in the past omitted to send the extra miles to hospital out-patient departments. In these specialised clinics it is possible to give consultations along lines precisely related to the school system, with advice regarding exercise, homework, and vocational guidance for handicapped groups. The emphasis is on maintaining positive health and normality. The Divisional Medical Officers and Assistant County Medical Officers commonly share the clinic, with increased mutual profit in discussion of their cases. Each session is a running commentary of clinical teaching and discussion with the Staff, medical and nursing.

In the earlier months two clinics monthly were held in most divisions, to work through the accumulated problems of several years. It is now generally practicable to keep level with one long session monthly. School children predominate over pre-school children, possibly because pre-school welfare clinics are conducted usually by part-time Medical Officers who do not know me personally. My hope is to meet them all in the course of the coming year. The sessions run for a full three hours or longer, and I find I can handle not more than six new cases in the time. This allows for taking blood haemoglobin and sedimentation tests and for discussion with parents. Case reports are dictated at the end of the clinic, or at the Divisional Office at a subsequent visit. Paediatric clinics are held in various premises. The most comfortable is our specially built multi-clinic building at Rawmarsh (Division 26), followed by the smaller Centre at Sprotborough (Division 28). The Tuberculosis Dispensary consulting rooms, and our own temporary clinic buildings rank second. Divisional offices and borrowed premises such as public halls and chapel school rooms are generally less convenient.

I have had very little cause to complain of the quality of the clinical material referred. It has been embarrassingly rich in problems, which have sometimes become aggravated during the past years without paediatric assistance on the spot. In the future we shall be able by early decision and reassurance to prevent some of the invalidism evident among older children. Increasing discussion with Assistant County Medical Officers will eliminate the few recurring pitfalls in the presentation of cases. These are—(1) Failure to obtain in advance from the family doctor some essential information, such as (a) the nature and dosage of drugs being taken for epilepsy or asthma (b) previous Consultants' reports to the family doctor, e.g., regarding fracture of skull prior to onset of epilepsy: (2) Failure to detect that another consultant already has the child under treatment elsewhere for the same complaint, e.g., at Hospital or Tuberculosis Dispensary, in arrangement with the family doctor: (3) Failure to carry out in advance some simple test, for the result of which we will be held up a further month, such as exclusion of feather bedding from an asthmatic child, or a tuberculin jelly test where appropriate. Such cases are few, and are becoming fewer. In short, the more closely the Assistant County Medical Officers and I can work together at clinics, the fewer cases they will need actually to refer to the Paediatric Clinics, as school doctors acquire greater confidence in their own standards; thus teamwork brings greater value to the children. I regard such a goal as desirable, in view of the several long-range projects which are beginning to take shape.

General Child Health and Physique—Nutrition and physique of our infants and school children generally are good, and there is negligible evidence of vitamin deficiency. I have seen only one definite case of rickets (actually combined with scurvy at 10 months of age) in the whole year. Radiographic evidence has in several cases disproved a clinical suggestion of rickets. The conditions which consistently cause under-nutrition in older children have been found to be:—severe asthma, bronchiectasis and the grosser congenital heart defects. Underweight in healthy children was often due to an energetic disposition (mis-named "nerves" by parents), or to prematurity at birth, or to inherited parental physique type. The Baldwin-Wood Tables (American) of weight and height used by some School Medical Officers are too complex for convenient use, and moreover do not tally with Holt's (American) tables which have been verified against the London school population. The use of the Baldwin-Wood tables has given an unjustifiably poor impression for our schools, as the standards are too high at certain ages. The little card of Holt's normals solves more parental headaches than any other item in my kit; marital discord had frequently arisen where one parent decided the child was not eating enough, but usually the weight proved to be well above average. In the Assistant County Medical Officers' returns of nutrition of school children, it is desirable that over-weight children should not be rated better than those of optimum weight.

Asthma—I believe that a lurking fear of tuberculosis has hitherto adversely affected the handling of asthmatic children. Parents and doctors have kept children off school much longer than necessary with attacks; and recommendation has often been made for admission to Open Air Schools. Actually the asthmatic is not more liable than others to "catch" infections, and will usually benefit more by fresh air than by coddling indoors. In my opinion the selection of the asthmatic for an open air school should be most careful since the asthmatic seldom requires the type of protection from environmental strain which these schools afford, and few cases are severe enough to justify the disruption of their education which this entails. Most of the severe cases I have seen have lacked adequate investigation or home treatment: e.g., still using feather quilt, or never yet tried on anti-spasmodic drugs. There is promise in the new Iso-propyl-adrenalin, e.g., "Neo-Epinine" (B.W.), of prompt relief of asthmatic spasm immediately by spray inhalation or in 7 minutes by sub-lingual absorption of a tasteless quarter tablet and I should like to see it tried for all our more severe asthmatics. I deprecate the vogue in certain engineering localities for expensive adrenalin mist machines, rigged upon huge oxygen cylinders beside children's beds. We might profitably give more emphasis to the emotional background of asthma.

Bronchiectasis—One of our greatest preventive tasks is to find how to anticipate the development of progressive lung disease from babyhood onwards. This will at least require vigilant examination for neo-natal atelectasis, elimination of serious attacks of measles and whooping cough, prevention and early treatment of suppurative nasal sinusitis, and expert radiographic study of all convalescent childhood "pneumonia". On the therapeutic side, there is scope for wider application of home exercises and postural drainage for children attending ordinary schools. We have a few encouraging examples of success following lobectomy; and the range of possibility of this operation needs further exploring with the more severe cases.

Tonsil Waiting Lists—In several divisions there are long waiting lists, first for aural consultation and second for operation when decided upon at examination. Many of these cases are paediatric problems. A very limited sampling of the lists awaiting consultation suggests that many children are referred, who are merely subject to simple recurrent upper respiratory infection, for which tonsillectomy could offer no benefit. Into another group fall the seductive large forthcoming tonsils, which attract notice at a school inspection more readily than post-nasal antrum discharge or incipient deafness. I am approaching our Aural Consultants further, regarding the types of case suitable for reference to them, in the hope of shortening the waiting lists at the point of origin. This problem is related to the prolonged incapacity suffered by children from nephritis, rheumatic carditis, otitis media with deafness, and lung sepsis, a reflection which may well stagger us. Success in the search for prevention of the causative upper respiratory infections and their complications is perhaps the greatest unclaimed prize in child welfare.

Circulatory Disorders—I have been deeply impressed by the value of paediatric consultation at the level of the Welfare and School Clinic. For lack of this, hitherto, many children have endured irreparable harm to their education and morale, notwithstanding that they all live within a dozen miles of hospital out-patient departments. Parents and family doctors have relinquished hope and initiative, sometimes from babyhood, under the mysterious terror of *"CONGENITAL HEART DISEASE."* The defeatism over heart murmurs is unjustified in the majority of our cases in school children. We have large numbers of able-bodied youngsters with roaring murmurs and thrills, whose hearts are not grossly enlarged and who are fit for full strenuous activity. I am anxious personally to examine every child with a congenital heart anomaly in South Yorkshire, for registration, reassurance where needed, and long-range follow-up. So far I have thirty-seven under study. For the minority with cyanosis and circulatory handicap it is now imperative to ascertain whether they could be relieved by the new surgical shunt of blood to the lungs: this concerns only cases with pulmonary artery stenosis.

Juvenile Rheumatism—In twelve months I have personally registered only seventeen cases of rheumatic heart involvement, as against thirty-seven congenital heart cases. These include several with unexpectedly severe mitral stenosis following minimal recognised rheumatic illnesses. Habit spasms in older children of obsessional parents are frequently mis-diagnosed and treated as chorea. Relapsing chorea is a troublesome problem of treatment and education, with our inadequate hospital facilities. The London County Council experience is that prolonged hospital treatment of all cases of rheumatism in children seems to be yielding a significant reduction of young adult mortality from heart disease. Adequate hospital care is estimated to average six months, and the children's education goes on during bed-treatment. Our dilemma is that prolonged treatment at home or in hospital, wrecks irretrievably the education of many rheumatic children, the very children who can least afford to go out into employment unequipped for sedentary or technical work. The few hospital school vacancies open to us are far from home, or too delayed, to be of much practical help. An adequate long-stay rheumatic hospital school unit in our area is greatly needed. Such a hospital as Wath Wood Infectious Diseases Hospital could well be developed for this purpose.

Alimentary Problems—I have seen two cases in which unboiled farm milk has caused tuberculous gland masses in the neck by the age of 3 months. In infancy the worries of parents are commonly due to over-rigid concepts of how Nature should operate, in the matter of feeding time-tables, bowel habit and appetite. In early childhood the commonest alimentary syndrome is that of negative appetite in reaction against food-forcing parents. Healthy, happy-go-mucky toddlers are subjected

to this artificially-induced neurosis. The family doctor often fails to break the obsessional sense of nattering duty in the mother or father, which has led to the cold war of the meal table. Where the parents accept the real explanation, the child's resistance usually ends at once. Evidence of normal weight is a ready help towards convincing such parents of the true state of affairs. A negative tuberculin jelly test, and occasionally a chest radiograph, afford corroboration.

Emotional Maladjustments—I have encountered numerous older children, referred mistakenly for organic disease (often after being proposed for residential open-air school), whose listlessness and anorexia were of emotional origin. Several have been victims of odious comparison with a bouncing, energetic and perhaps more intelligent younger child. Others have been step-children denied normal affection. One had a brutal ne'er-do-well father. Too often the emotional key to diagnosis has been missed in cases of so-called "General Debility". Under this heading I may refer to the miserable group of school-dodging older girls, aged from 13 to 15. Sometimes mothers use them at home while themselves employed elsewhere. The family doctors, or we ourselves, have helped to establish the complex by certifying school absence for "rheumatism", "anaemia", "debility" or "heart murmurs" and against such defences, once established, we appear powerless to intervene. Prophylaxis by more vigilant school attendance supervision of future incipient cases may be effective. I look forward to the appointment of a whole-time child guidance psychiatrist as an ally in this important field of work.

Cerebral Palsy—Apart from the varied problems of diagnosis and assessment of mental capacity in cerebral palsy, we need extended facilities for expert out-patient physiotherapy and residential school training, to afford these children a chance in life. Ascertainment and registration throughout our territory is a task to be undertaken in infancy, rather than at School age.

Epilepsy—The most noteworthy features of our epileptic cases are the general defeatism and neglect by doctors of any plan of regular sedative dosage aimed to suppress all major fits, and the resultant unwillingness of school authorities to retain epileptics in ordinary classes. Many such children are deteriorating, morally and scholastically, at home without education or treatment; for these the question of institutional care need never arise if adequately handled at school clinics, doctors' surgeries and where necessary in our own paediatric clinics.

Mental Defect—The most pressing clinical problem is that of counselling parents at the time of diagnosis, and especially regarding admission to an institution, in face of the shortage of available vacancies. The addition to our staff of Dr. O'Loughlin, a psychiatrist in mental deficiency, is proving most useful and in certain difficult cases, consultation with Dr. M. MacTaggart is proving most helpful.

Clinical Impression of Special Schools—We have available in my area one Open Air Day School at Wombwell, and are able to secure admission of children to a number of Residential Open Air Schools, Heart Hospital Schools and Convalescent Homes in other parts of the country. Personal visits to the latter would enable me to give a more adequate judgment as to the best way to use their facilities. Distance is in all cases a serious drawback. The Wombwell Open Air School, with its keen teaching staff, has nevertheless an impracticably wide age-range to embrace and it suffers somewhat in being unable to present candidates for Scholarship examinations. It is still unfortunately true that recommendation of a child, say 8 or 9 years old, for transfer to the Open Air School amounts to exclusion from the chance of a grammar school education. Yet asthmatic, bronchiectatic or rheumatic children are the ones who most need such education if they can rise to it. From another angle, it appears to me that this school has in the past been a dumping ground for much undiagnosed vague ill-health. We ought now to be able to sort out cases more precisely for candidature, and to resist the pressure of local mothers who esteem it a more fashionable school for their children than the ordinary schools. The better the paediatric service in the County, the fewer children we shall need to recommend for transfer to this type of school. A possible solution would be to concentrate on admitting a narrow age-group, say 5-8 only, transferring back at 9 all children with prospects in secondary education, and retaining only the few who could never hope to hold their own in ordinary schools.

Records and Stationery—The establishment of Registries of Juvenile Heart Disease, and perhaps other handicaps such as epilepsy, will help us to study our patients on the broad scale and to draw conclusions for treatment, and also to effect long-term follow-up study. I am impressed by the need for a continuous record of the child's health from birth to adolescence as recommended by the Ministry of Education in "School and Life". The new Ministry of Education Main School Record Card does not offer any space for transferred pre-school data—not even the essential figure of birth weight. At the infant level we have the confusion of two parallel cards, neither of which will carry the whole story:— the Infant Record Card for Home visits and the Child Welfare Clinic or "Centre Card". To a paediatrician, it would appear worth considerable trouble and inconvenience to unify these into a single complete record which could then be clipped inside the School Record folder at school entrance age. Divisions should contrive at an early date to amalgamate all outstanding infant and "Centre" cards with the Scholar's Record Cards. For this reason it is now impossible to get the full picture of past health at consultations. It is important that birth weight is recorded on all Infant Record (and Centre) Cards, and is transferred also to Scholar's Record Cards; it is often uncertain whether recorded weights are for birth or for Health Visitor's first visit. My work would be facilitated if I could have the services of a whole time clerk. In putting forward the suggestion I wish to take the opportunity of acknowledging the friendly efficiency and promptitude I have met in all the Divisional offices, with especial mention of Dr. Penman's staff who have executed my non-divisional secretarial work.

Baby Welfare—Normal Babies in our area frequently show minor maladjustments which might be reduced by instruction of parents at our clinics. Our proposals for establishing special clinics and organised teaching for breast feeding recently started absorb considerable time but should repay this with interest in reduced infant morbidity. Too rigid adherence to feeding time-tables (especially the 4-hourly schedule which economises nursing time) causes some babies to panic with frustrated hunger, and lose all dietetic equilibrium. Very energetic lean babies may have a high caloric requirement which falsifies the ordinary calculations. Over-fat placid babies are unduly flattered at the clinics in comparisons of weight-gain; and this is doubly unfortunate when the credit goes to artificial feeding. Much maternal distress is caused by over-emphasis on weekly or fortnightly weighings; in the absence of symptoms of disorder, quarterly weighings would be preferable and this might reduce our regrettable casualities of breast-feeding. The Infant Mortality rates will repay detailed study in each Division, with special reference to preventable deaths from respiratory infections and gastro-enteritis.

Premature Babies—The Premature Baby Service has so far proved elusive in my personal application, and requires more time devoted to individual cases, scattered though they be. The equipment for domiciliary care of prematures is only coming into circulation after the close of the year, and no experience has yet been gained in its use. Preliminary impressions gained here, and at the Sorrento Maternity Hospital, suggest that immediate transfer on the day of birth to an adequate Hospital Premature Unit must be the aim with the smaller and feebler prematures. To achieve early transfer it will be necessary to dispel defeatism in the minds of family doctors and midwives. The most promising single measure seems to be "Prophylatic" urgent hospital admission of mothers apparently going prematurely into labour, and of cases of early pregnancy toxaemia. Many divisional medical officers are now seeking to arrange this in collaboration with family doctors.

Gastro-Enteritis—The aetiology is varied and complex. Unawarenses of the danger in bowel disorders of babyhood seems to have contributed towards some deaths when the family doctor has been called in too late. We are now better placed than before July 5th, 1948, for skilled treatment of serious cases, which necessitate the resources of a good Isolation Unit with full-time resident medical care for intravenous fluid treatment. Promptitude of admission to hospital offers the best hope of success in acute cases.

Pink Disease—This tedious syndrome is common in South Yorkshire and when borne in mind it is usually recognisable at a glance, resolving much anxiety. Pink Disease may simulate several other conditions, with its onset usually between 6—24 months (with much wider extremes), and the picture of impaired sleep and appetite, misery, loss of weight, painful red hands and feet, hypotonia, photophobia, sweating, measly rash and often peeling. The possible relation to mercurial "teething powders" needs investigating.

Respiratory Disorders—Many doctors, both in private and public health practice, appear unfamiliar with the concept of "Simple Recurrent Upper Respiratory Infections" as an everyday syndrome in young children. Consequently many normal youngsters of nursery and infant school age are referred anxiously under one of three serious suspicions: (a) Asthma, (b) Tuberculosis, (c) Evil Tonsils. Healthy children can be reckoned to suffer several "common colds" each year, in which cough may be a feature, even leading to slight wheezing. This, if transient, need not be regarded as Asthma. The chronicity of the story and negative tuberculin jelly test rule out the likelihood of tuberculosis (assuming no contact history). And loyal tonsils, the worse for battle with invading organisms, deserve better of our judgment than to be regarded as "traitors to the cause.

In concluding this my first report, I should like to say how interesting and valuable I have found the work of a "Child Health Officer" and how much I look forward to the development of a pioneer effort in which I have the honour to serve."

C. C. H.

PART VI

COUNTY DENTAL SERVICE

The following is the report of the Chief Dental Officer, Mr. B. R. Townend, F.D.S., R.C.S. (Eng.), L.D.S. (L'pool.) :—

The year has been a memorable one in the story of dentistry in this country. The passing of the National Health Service Act with its provision of free dental treatment for the whole of the population has created certain temporary difficulties in that the demand for dental treatment has been much greater than was anticipated and the dental man power of the country, inadequate before the passing of the Act, has been virtually snowed under with the extra burden which has been placed upon its shoulders. One very unfortunate result of these events has been that the priority dental services, namely the services for expectant and nursing mothers, pre-school and school children have suffered from the fact that the grave shortage of dentists and the consequent high rate of remuneration which could be earned in private practice has caused a drift of men and women to private practice from these priority services which have always been for the most part carried on by whole-time dental officers employed by Local Health and Education Authorities. This drift is still going on and if it is allowed to continue unchecked the anomalous position will be reached in which a member of the priority classes will find it as difficult and in many cases much more difficult to obtain treatment than a member of the non-priority classes. It is a great pity that the dental needs of the children of to-day are being neglected at the expense of adults whose mouths are in a serious condition owing to years of neglect. Until we shift the emphasis of our dental programme from one of correction of adults to one of prevention and care for children the standards of dental health in this country will never be improved as the dental health of each generation will be no better than that of those that preceded it.

During the first six months of the year, recruitment of dental officers in the West Riding was very encouraging but since the 5th July, it has been impossible to keep pace by fresh recruitment with our losses of staff and we are faced at the end of the year with a net loss of 9. It is sincerely to be hoped that a solution will soon be found to this difficult situation. Apart from the fact that it is causing unnecessary suffering among the priority classes, many members of the public dental service who have done hard pioneering work in the past sustained by their own belief in public dentistry and their confidence that both Government and Public Authorities believed in it too, are feeling their faith seriously undermined, and are tending to develop a cynicism which will be hard to eradicate. The importance of faith and and a sense of dedication in children's dentistry cannot be exaggerated. It is one of the great sustaining things in life.

The Dental Treatment of Expectant and Nursing Mothers and Pre-School Children—The introduction of the National Health Act has placed the responsibility for the provision of dental care for expectant and nursing mothers and pre-school children upon the Local Health Authority. The Ministry of Health have asked Health Authorities to step up their provisions for such treatment and have recommended that every expectant mother shall receive an examination by a dental practitioner immediately following her first attendance at an ante-natal centre. Machinery has been devised in the West Riding to implement this instruction. The patient has the choice of having the inspection made and any necessary treatment carried out by either a private practitioner or one of the County Council's dental officers. In many areas of the West Riding private practitioners must be asked to do the work until clinics with whole-time dental surgeons are available. Experience has amply demonstrated that the treatment of these classes by officers of the Public Dental Service has much to recommend it by virtue of the facts that these officers are experts in their somewhat limited sphere, and, more important, they have behind them all the knowledge, expert advice and experience of the ante-natal centres and other services ancillary to their own speciality.

The dental treatment of the above class is likely to become a steadily increasing responsibility of the Health Authority. At the moment we are only scratching the surface of the problem of the dental care of approximately 30,000 expectant mothers and 145,000 pre-school children in the County area. Progress will probably be slow in the early stages partly because of the lack of facilities and manpower to carry out the work and partly because of a considerable amount of prejudice which exists concerning dental treatment during pregnancy and the need for dental supervision of very young children. These prejudices can and will be broken down but it will take time just as it has taken time in the case of the school dental sevice. Two encouraging facts are emerging from this service. First the large number of expectant and nursing mothers in areas where the dental clinic is in existence who elect to have the treatment carried out by one of the Authority's dental officers, and second the increasing number of teeth which by reason of an expert dental examination it is found possible to save by filling. It has not been possible yet to develop any routine dental service for pre-school children but when clinic facilities and manpower permit this very important branch of dental service will not be overlooked. At present these children are treated when they offer themselves or on the recommendation of Medical Officers, Health Visitors, etc.

The Dental Treatment of School Children—The difficulties arising from loss of staff have had serious effects upon the efficiency and smooth running of the school dental service. Before these losses in our dental staff occurred we were beginning to get on top of the arrears of work which had arisen during the war years. The whole of the County was covered with a dental service of at least one dental officer to every 5,000 school population and in several areas we had been able to attain our ideal of one dental officer to 2,500 school population. Our inability to maintain recruitment and our losses in staff during the year have made it impossible to cover the whole county completely and in certain cases we have had to abandon routine examination and treatment and establish a purely emergency service. This retrogression is of great disappointment and one can only hope that it will be of short duration. The value of our fixed clinics in providing this emergency service has been highly proved, particularly at Bonegate House, Brighouse. By an unfortunate coincidence our losses in the Halifax and Huddersfield areas have been particularly heavy but it has been possible to bring in emergency cases to Brighouse and give them treatment.

General Anaesthesia in Dentistry—The increase in the use of general anaesthesia has been very marked. It is largely tied up with improved clinic facilities and it is proving highly popular with patient and parents alike.

Orthodontic Scheme—We have again made rapid strides in the development of our orthodontic scheme. In addition to our centre at Wakefield, we now have sub-centres at Brighouse, Harrogate and Tadcaster where periodic visits are made by Miss Sclare. The appreciation of this service grows apace and both parents and children express great satisfaction and gratitude for what is being done for them. This appreciation is demonstrated by their eagerness to co-operate in every possible way and their readiness to travel long distances to obtain treatment. Among patients attending the Wakefield centre may be numbered children from Ingleton, Skipton, Bowland, Keighley, Goole, Doncaster, Sheffield, etc. I am glad to report on such a successful and worthwhile scheme which in addition to giving many children healthier and more functional dentitions is having a marked beneficial psychological effect. Many of these children with ugly crooked teeth are teased by their school mates and parents frequently tell us of sensitive children who have come home crying because of this teasing. It is very obvious that no child should have to carry such a burden of ridicule if it can be avoided. Many of the cases we treat are the result of various habits such as mouthbreathing, thumbsucking, incorrect swallowing, etc., and as time goes on the orthodontic service will take a more prominent place and become more and more interrelated with other activities of child health such as Ear, Nose and Throat treatment, Speech Therapy and Child Guidance. 897 new cases were accepted during the year and these together with cases already under treatment made 7,464 attendances. 273 fixed and 447 removable appliances were made.

Establishment of Dental Clinics—The programmes for the establishment of clinics has not progressed as quickly as one would have wished but the difficulties are manifold and obvious and I should like to take this opportunity of expressing my very deep and sincere appreciation of the co-operative, patient and very able assistance which has been freely given by the Architect's Department. Our clinics in the West Riding are as good as any in the country and better than most and a great deal of their excellence is due to the work and enthusiasm of the Architects. The provision of clinics is becoming more urgent as casual accommodation in which to set up portable clinics becomes more difficult to find owing to the increasing calls for Education and other purposes of Church Halls, Sunday Schools and the like. Full use has been made during the year of the dental caravans. Although in our opinion the caravan is at best a makeshift, yet under existing conditions and in all probability for some time to come it will be necessary and desirable.

Area Dental Officers—Two more Area Dental Officers have been appointed bringing the total to five. It is considered that the creation of these posts has been a very wise step. They have done much to co-ordinate the service and in the difficult times which we have been passing through they have been able to make arrangements on the spot to cope with the many emergencies with which we have been faced. An important function of the Area Dental Officers' activities is to maintain and raise the professional and clinical standards of the assistant officers by keeping themselves abreast of modern scientific trends in dentistry and so by counsel and precept help to develop the service along the best possible lines. I am grateful to them for their loyalty and their eagerness to shoulder responsibilities which in the past had to be carried—somewhat inadequately it is feared—by myself and the Headquarters Staff.

School Dental Service and the National Health Act—It is possible under the National Health Act for a child attending school to have free dental treatment through the general practitioner service, and some concern was felt that in the present somewhat under-developed state of the school dental service many parents might elect to have their children treated by private practitioners. To the contrary, however, the private practitioners have in many cases been too busy to give the additional time which is necessarily required in the treatment of children and the steadily increasing appreciation of the services provided by Local Education Authorities by the general public has shown that our concern was quite unwarranted. The general public are now seeking such treatment for their children in marked contrast to conditions in the past when we had to devote so much time and thought to propaganda in order to overcome prejudices against dental treatment in general and against that provided by the Education Authority in particular. This change of heart augurs well for the future when our present difficulties and growing pains are passed. We can safely go on with our development programmes with quiet optimism and confidence that our efforts are appreciated and our service has a firm place in popular recognition and esteem.

Investigation into the incidence of Dental Caries—During the current year an investigation was carried out at the request of the Ministry of Education by certain members of the staff into the incidence of dental caries in children of the two groups 5 and 12 years of age. The investigation was concerned with the numbers of teeth which were decayed (D), missing (M) or filled (F) in each child's mouth. This condition is expressed as D.M.F. In the case of the children aged 5 years old we are only concerned with the baby or deciduous teeth and in the 12 year old group we are only concerned with the permanent teeth. The results of the investigation are shown in the following table:—

	Aged 5.	Aged 12.
No. of children examined	5,034	1,876
No. of D.M.F. teeth	22,150	5,440
No. of children with no D.M.F. teeth (Intact mouths)	1,138	362
% of children with no D.M.F. teeth	22.6	19.3
Average No. of D.M.F. teeth per child	4.4	2.9

Although we have no exactly comparable figures for previous years, there is no doubt that the incidence of dental caries has dropped during the war and the percentage of children with sound mouths, i.e., 22.6% in the 5 year old group and 19.3% in the 12 year old group is much higher than the percentages before the war. A similar drop was noted after the 1914-18 war. What has caused this drop is a matter for speculation but it is likely to be concerned with the reduction in the intake of sweets and perhaps even more of sticky, starchy pastries. The reinforced and coarser loaf may also be a factor and some would argue that the increased consumption of milk has had a beneficial influence. Whatever the cause the fact is there and it will be interesting to see whether this very satisfactory state of affairs is maintained or whether we shall slip back as we did after the first World War, and it is our intention to carry out periodic surveys of a similar nature in the future. The figures for the West Riding differ little from the results of specimen surveys in other parts of the Country.

Analysis of the work carried out during the Year—The information concerning dental treatment provided for in Table IV of the Ministry of Education's returns (see page 42) gives a very limited picture of the actual work done and the following implementations and refinements to that Table (less treatment carried out in Keighley Municipal Borough) may be of interest.

Extractions—The total of 72,758 temporary teeth and 11,463 permanent teeth extracted does not represent as might be thought so many teeth which it has been found impossible to save. No less than 11,579 temporary teeth and 3,027 permanent teeth have been extracted with a view to making room for the other teeth or to ensure in various ways that succeeding teeth shall grow in a regular order. It will be seen from this that nearly one tooth in five is extracted with the object of preventing irregularity and ensuring the future health of the dentition.

Fillings—10,652 temporary teeth were conserved by the following means:—1,822 cement fillings, 1,775 amalgam fillings, 1,579 combined cement and amalgam fillings, and 6,573 treatment with silver nitrate which arrests decay. 33,952 first permanent molars and 15,513 other teeth, a total of 49,465 permanent teeth were conserved by the following means:—1,898 cement fillings, 18,162 amalgam fillings, 30,575 combined cement and amalgam fillings, 5,210 Silicate (porcelain) fillings and 966 treatment with silver nitrate. Every child treated had an average of 1.1 permanent teeth conserved.

Other treatments of a varied nature include 264 root fillings, 4,040 dressings, 218 crowns, inlays, etc., 9,090 scalings and gum treatments.

Dentures were provided in 224 cases to replace teeth lost by accident or disease, 672 attendances being made for the necessary work incurred in the fitting of these dentures.

In conclusion, I should like to express my very sincere and grateful thanks to the Dental Services Committee for their patient and sympathetic interest in the dental scheme. It is a great pleasure and privilege to be a servant of such a Committee. I also owe a debt of gratitude to Dr. Brockington for his guidance, philosophy and friendship. Lastly I want to pay a tribute to the dental officers who in spite of the temptations of rather spectacular financial inducements have remained faithful to the service of children's dentistry. One can only hope that in spite of the present difficulties and gloom the very fact that the work of the School Dental Officer is and must be the basis of any idea of preventive dentistry, the present somewhat Gilbertian situation will resolve itself and children's dentistry will come into its own as the spearhead of attack against dental disease.

Dental Treatment of Expectant and Nursing Mothers

No. of cases referred to private practitioners :—		
(a) Prior to 5th July, 1948	68	
(b) Subsequent to 5th July, 1948	32	
Total ...		100
No. of cases treated by private practitioners :—		
(a) Prior to 5th July, 1948	60	
(b) Subsequent to 5th July, 1948	20	
Total ...		80
No. of cases referred to County Dental Clinics	61	
No. of cases treated	58	
No. of general anaesthetics	74	
No. of extractions	901	
No. of Fillings	15	
No. of Dentures	73	

PART VII

CARE AND AFTER-CARE

Health Visiting

In the 1946 Act Health Visiting became a statutory duty for the first time since its origin three quarters of a century ago. Section 24 says "It shall be the duty of every local health authority to make provision in their area for the visiting of persons in their homes by visitors, to be called "health visitors", for the purpose of giving advice as to the care of young children, persons suffering from illness and expectant or nursing mothers, and as to the measures necessary to prevent the spread of infection." In the past the duties of the health visitor have to a certain degree been limited, insofar as she has been responsible for the well being of mothers and their children up to the age of five years. The Act widens the scope of her work to include the social influences associated with the family; broadly speaking, the duties should now be regarded as "the care of the family as a unit". The shortage of health visitors and an existing case load, with which she is unable to cope satisfactorily, make it certain that it will be some time before her services can be so fully used. We have taken over the health visiting staff from 19 former welfare authorities, so that at the end of the year the service consisted of 169 qualified health visitors, 44 unqualified and 20 part-time, making a total of 233 out of an establishment of 321. In addition, there is a superintendent health visitor with three assistants at headquarters. Miss Walker, the superintendent health visitor, was given leave of absence for six months to study public health nursing in America, with a scholarship granted by the British Red Cross Society. During her stay she spent three months doing supervisory work in Erie County Health Department, New York State. In addition to working as a supervisory nurse she also paid observation visits to maternity hospitals, State mental hospitals, tuberculosis sanatoria, homes for the aged, children's homes, etc. She learned much about health education in schools and in clinics, also about general administration in the States and was able to make comparisons between the English and American systems. Some of them were balanced on the side of the British methods and some on the American side. In general the place of the American public health nurse was more firmly established in the home, particularly was it evident that more teaching was given in the home in America than in this country. Again, in some States, all the teaching of infant welfare took place in the home (there being no "well baby clinics"), and it was here that the statistics were just as good, if not better, than in other parts. One of the reasons why the American work seemed to maintain its high quality lay in the high standard of supervision; the ideal there is one supervising nurse to eight staff, including student health visitors. Health education in the schools seemed to be more advanced than over here, the public health nurse being the consultant to the school on all matters relating to hygiene and health (an aspect which the report of the Central Advisory Council for Education—School and Life—wished to see better developed in England). Miss Walker feels that her trip to America has been a most valuable experience and that she has come back with useful ideas many of which she hopes to put into practice in the West Riding.

The three Assistant Superintendents have also undertaken special work during the course of the year. Miss Clarke was seconded to Leeds University to act as one of the two health visitor tutors in the training of student health visitors. The course was held for fifty-six students, twenty-eight of which had entered through the County Council's assisted training scheme, and Miss Clarke's work consisted of attending all lectures and the holding of discussion groups arising from them; the holding of tutorial classes and the setting and correction of test papers. She was responsible for the arrangement of the practical work, part of which was conducted within the administrative County area within easy access of Leeds and in divisional areas where good facilities were available for teaching purposes. Twenty-six of the West Riding students were successful in obtaining the certificate of the Royal Sanitary Institute from a total pass list of forty-nine; this result speaks for itself and should be of great encouragement to the tutors. Miss Carey has continued her work to bring about a closer link between the hospitals and health visiting services; this becomes increasingly necessary in view of the extended duties of the health visitor brought about by the 1946 Act and to which I made detailed reference in my last report. She has done much good work visiting hospitals and discussing outstanding problems with the staff and has also given a series of lectures, designed to give the health visitor information on the implications and responsibilities of the care and after-care of hospital patients and the provision of background reports for the hospital use. Almoners have been found to be most helpful and co-operative. Miss O'Brien has been conducting a survey of problem families on behalf of the Eugenics Society, to which reference is made in a separate section of the report.

The following is a summary of visits made by health visitors during the year:—

Expectant Mothers.		Children under 1 year of age.		Children between the ages of 1 and 5 years.		Other cases.
First visit.	Total visits.	First visit.	Total visits.	First visit.	Total visits.	Total Visits.
8,257	18,384	31,609	158,855	6,482	183,882	9,732

The hospital social work undertaken by my health visiting staff at the Otley Hospital, of which an account appeared last year, has continued. Miss Carey, after completing six months, was replaced on the 1st June, 1948, by Miss Cribb, a senior and experienced health visitor in the Pudsey area. The work has retained its high value both to the County health services and to the hospital. The medical superintendent of the hospital has expressed his great appreciation of the service and his hope that it will continue. The experience gained by the health visitors also does much to help the spread of the idea of the importance of developing a close relationship between health visiting and hospital work. It is hoped to give a more detailed account of this work again in next year's report.

Home Nursing

The National Health Service Act, 1946, for the first time made the local authority responsible for a Home Nursing Service. Section 25 of the Act says "It shall be the duty of every local health authority to make provision in their area, whether by making arrangements with voluntary organisations for the employment by those organisations of nurses or by themselves employing nurses, for securing the attendance of nurses on persons who require nursing in their own homes."

The Council therefore decided (a) to undertake the home nursing service as a county service and not to delegate the work to voluntary nursing associations; (b) to make arrangements as soon as practicable to separate midwifery from home nursing except in those areas where it would be in the best interests of the service to continue combined duties; (c) to place on record their sincere appreciation of the work carried out in the past by the West Riding County Nursing Association and the District Nursing Associations for the benefit of the people of the administrative county.

Before the appointed day, representatives of the County Council met the County Nursing Association, the District Nursing Associations and the district nurses at conferences and meetings and in this way many points of doubt and difficulty were explained. Undoubtedly these meetings did much to promote a smooth transfer of the home nursing service to the County Council on the 5th July. The following staff was taken over from the County Nursing Association :— One County Superintendent (Miss E. M. Greenwood), two Assistant County Superintendents (Misses G. Jones and W. Pallister), one relief nurse, one male clerk; and the following from the District Nursing Associations :—103 whole-time home nurses, 93 home nurse midwives, 62 home nurse midwives undertaking health visiting duties. It is with great pleasure that I welcome Miss Greenwood and her staff and it is my earnest hope that they will continue to find their lives and work as congenial with us as they were for so many years with the Nursing Associations. Of the 258 nurses approximately 176 were members of the Queen's Institute of District Nursing and many were anxious that their status as "Queen's Nurses" should not be affected by the transfer. To meet this difficulty the Council (following the recommendations of a joint conference of the County Councils Association and the Queen's Institute of District Nursing) recommended (a) That, the Minister of Health being the final judge of the efficiency of the nursing service in any area, the Institute shall be entitled to terminate the membership of any local authority only with his consent. (b) That the appointment of a Queen's nurse as superintendent, though desirable, shall not be obligatory, and, in cases where a Queen's nurse is not so appointed, the local authority shall give adequate facilities for the superintendent to undergo a Queen's Institute qualifying course of training. (c) That the superintendent shall be responsible, through the medical officer of health, only to the local authority by whom she is employed. (d) That visiting of local nursing staffs by the Queen's Institute shall be undertaken only by arrangement with the local authority concerned, and, when so undertaken, shall be solely advisory in character. (e) That a copy of the Queen's Institute visitor's report, together with such recommendations as the Institute may consider necessary, shall be supplied to the local authority. Subsequently the following resolution was passed by the County Council :—

> "That affiliation with the Queen's Institute of District Nursing be approved so far as District Nursing is concerned, but that, in the case of midwifery, such affiliation be only in respect of midwives now employed by District Nursing Associations and transferred to the service of the County Council on the 5th July, 1948, and for so long as such midwives remain in the County Council's service."

We are trying to give each nurse a telephone in her home; and where necessary a car. Nursing areas are being gradually re-arranged to fit into the divisional scheme and with the object of giving a full service for the whole of the county area. We are making reciprocal arrangements with neighbouring authorities.

The County Council's decision to undertake the home nursing service as a county scheme was sound; some of the reasons which led to this decision were the increasing financial difficulties being experienced by a number of the district nursing associations due to the increase in the salaries of nurses, etc., and the inability to obtain voluntary donations; furthermore, the most thickly populated portions of the county were often wholly or partly unserved by a nurse.

Early in the year the Council negotiated the purchase, or rental, of houses, furniture, household equipment, motor vehicles, and nursing equipment owned by the associations. The position now is as follows :—

			Furnished.	Unfurnished.
Houses and/or nurses homes ...	Purchase completed	9	4	5
,, ,, ,, ,,	Negotiating to purchase	28	17	11
,, ,, ,, ,,	Rented from owners	49	22	27
Furniture and furnishings ...	Purchased	43		
Motor Cars	Purchased from D.N.A's.	48		
	Purchased from other sources:— New cars	14		
	Second-hand cars	3		
Garages	Purchased from D.N.A's.	14		
	Rented from owners	52		
Equipment, nurses and nursing	With the exception of a free gift by 29 District Nursing Associations, the County Council purchased all nurses and nursing equipment from other D.N.A's at an agreed valuation.			

Some of the houses taken over are large, old-fashioned properties incurring heavy expenditure on heating and lighting; the County Council, therefore, approved of additional financial assistance being given to the nurses living in six of these until smaller and more compact houses or bungalows could be made available. Many of the motor cars taken over had already seen long service and were in need of replacement but in view of the difficulty in obtaining replacements they have had to be kept on the road. The County Council placed orders with various manufacturers for 82 new cars and up to date 14 of these have been delivered; three good second hand cars have also been bought. A comprehensive scheme for the servicing, maintenance, ordering of repairs, and replacement of tyres through "approved garages" throughout the county area has been brought into operation. Much of the equipment taken over from the district nursing associations was well worn and some of the larger items have already been replaced.

Towards the end of the year a scheme was submitted for the post-graduate training of nurses, wishing to take up home nursing as a profession; this scheme included the establishment of four county training homes in various parts of the county area with opportunities for practical training in the areas around. In view, however, of the great shortage of candidates, we decided to defer the scheme and try to increase our supply of trained home nurses by using the existing Queen's training homes in Leeds, Bradford, Huddersfield, Rotherham and Sheffield. We are paying a grant of approximately £48 to each training home for training fees and uniform for each student.

A series of refresher courses for the home nurses have also been arranged, the following being a typical programme:—

Modern district technique from the practical angle.
Treatment of some of the common gynaecological conditions.
Modern methods of treatment by sulphonamides, penicillin and insulin.
Care of the aged confined to bed.
The nursing of pneumonia in the young and old.
An outline of other branches of the health service.
Treatment of accidents occurring in the home.

Six of these courses have been held at the following main centres, thus providing facilities for attendance by nurses from practically all the 31 Public Health Divisions:— Harrogate: Keighley: Huddersfield: Wakefield: Doncaster: Rotherham.

Work done by Home Nurses—The home nurse midwives attended 3,018 cases of confinement (2,372 as midwives and 646 as maternity nurses) to whom 30,410 visits were made. Home nurses undertaking health visiting and school nursing duties in the rural areas of the county made 23,286 visits as health visitors and 1,329 visits as school nurses. In addition, the home nurses paid 228,417 visits to 10,676 patients, classified as under:—

Medical (7,617 cases).

Senility	646	Anaemia	148	Skin conditions	165
Cardiac	845	Influenza	43	Rheumatism	327
Cerebral	861	Bronchitis and Asthma	240	Fractures	157
Pneumonia and pleurisy	247	Mental defectives	8	Constipation	443
Intestinal obstruction	131	Kidney conditions	72	Uterine	788
Diss. and arterio sclerosis	53	Carcinoma	619	Tuberculosis	76
Diabetes	283	Threadworms	62	Miscellaneous	1403

Surgical (2,908 cases).

Empyema	19	Minor accidents	508	Gangrene	55
Burns and scalds	224	Ulcer of leg	188	Colotomy	92
Post operative	727	Tuberculosis	15	Supra pubic	82
Septic conditions, abscesses, etc.	965	Miscellaneous	33		

Eyes and Ears (151 cases).

Eyes	53	Ears	98

Home Help Service

The County Council began a home help service ten years ago to help when mothers had their babies at home. The National Health Service Act, 1946, made this a statutory (but not an obligatory responsibility) of the health authority and extended its scope to cover other groups of persons. Section 29 says "A local health authority may make such arrangements as the Minister may approve for providing domestic help for households where such help is required owing to the presence of any person who is ill, lying-in, an expectant mother, mentally defective, aged, or a child not over compulsory school age within the meaning of the Education Act, 1944." The Minister approved the employment of 310 whole-time helps, or their equivalent in part-time helps. This quota has been divided among the divisions on a population basis and the recruitment, supervision and day-to-day administration is under the control of the Divisional Medical Officer. It was early found to be necessary to define more precisely who is eligible and who is not for the new service. This was found on close examination to be incapable of precise definition but nevertheless the following statement has received the consent of the Council and is the basis of operation. Home helps are provided for cases coming within the following classifications:—

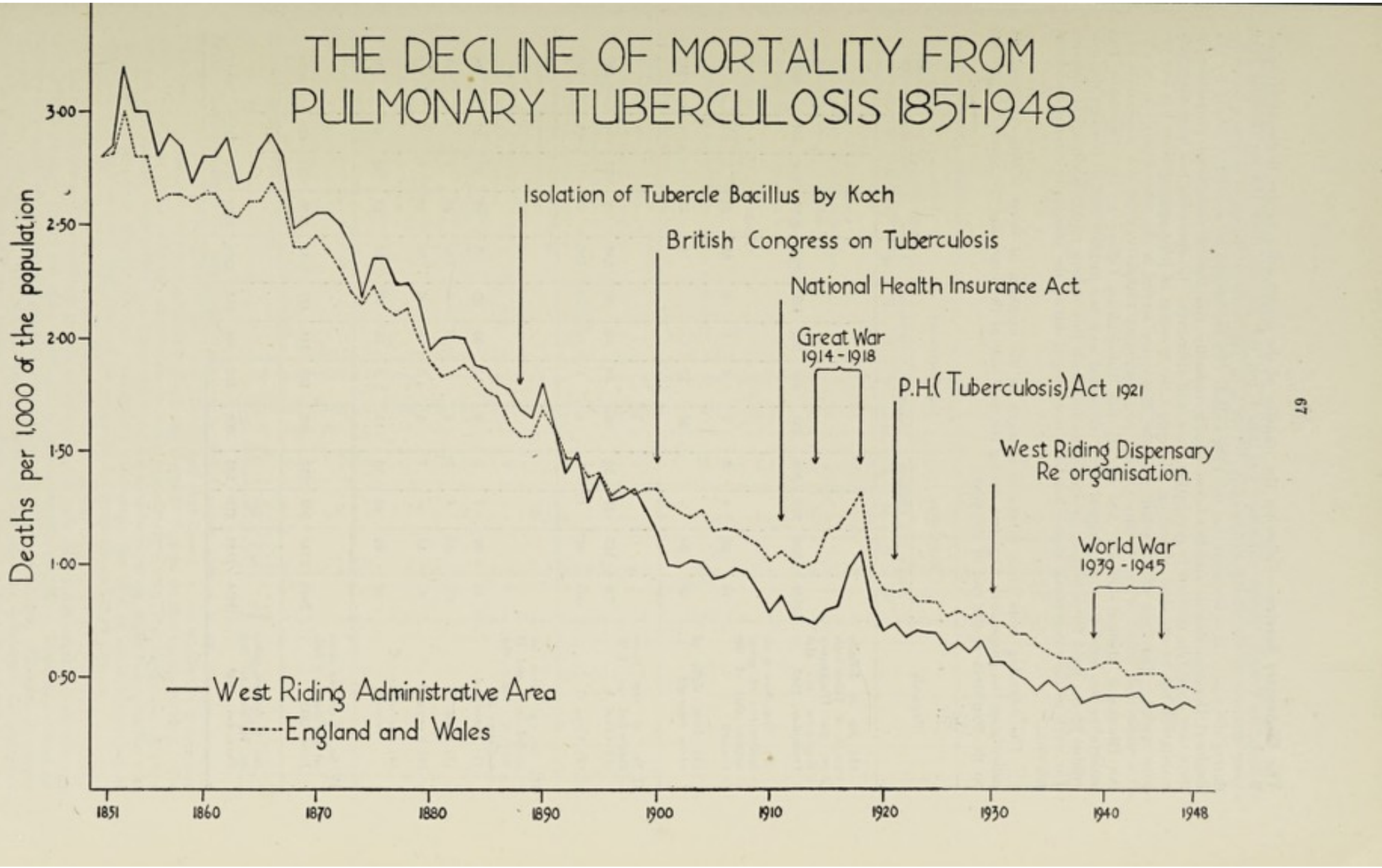
(A) ILL. Illness is defined in the Act as including "Mental illness and any injury or disability requiring medical or dental treatment or nursing." "Medical" is further defined as including "surgical". The definition is wide but excludes cases requiring "care and attention" as distinct from nursing. Another point is that the ill person must be in the home. If the ill person is removed to hospital then a home help can only be provided if there is a need under one of the other classes. A home help cannot be provided merely because a household offers to pay full cost of the service. Under this class there must be an ill person in the home. (B) AND (C) LYING-IN AND EXPECTANT MOTHER—"Lying-in period" is defined in the rules of the Central Midwives Board as being " not less than 14 days nor more than 28 days after the end of the labour during which the continued attendance of the midwife on the mother and child is requisite." There is no additional qualification required for the provision of a home help in a household where there is an expectant mother or a woman lying-in. Her attendance should generally be governed by the mother's physical condition coupled with consideration for the number of young children, the object being to promote normal childbirth. (D) MENTALLY DEFECTIVE—The definition of mentally defective persons is contained in the Mental Deficiency Acts. The principle to be followed in providing home help is to give assistance in those cases where the presence of a mentally defective person seriously handicaps the housewife in her household duties. (E) AGED—There is apparently no definition of "aged" and the application of the term must vary widely. In this case there is no need for an aged person to be ill to qualify for the provision of a home help. The extent of the need will depend upon the physical capacity of the aged person and the other persons in the household. If a home help is provided she should undertake domestic work or household management only and not be used as a "sitter-in." (F) CHILD NOT OVER COMPULSORY SCHOOL AGE—According to the Education Act, 1944, Section 35, "a person shall be deemed to be over compulsory school age as soon as he has attained the age of 15 years." There is also a proviso that the Minister may raise the age to 16 when he considers it practicable. In this class home helps may be provided when the mother falls ill and is removed to hospital. The home help should undertake domestic duties, family or household management only in the home and should not act as a "sitter-in" other than to allow other members of the household to carry on their own work. Briefly, a home help can attend in a household where there is sickness sufficient to require medical or nursing care; she cannot attend where a sick person is removed to hospital unless there is a child under school leaving age at home; she can attend the aged, mentally defective, and expectant of child, without stipulation as to sickness. The aged should generally be over 60 years of age, the mentally defective, such as have been reported to the Health Committee, and those expectant of child, would normally have some disability such as fatigue or varicose veins necessitating rest, or be the mother of young children. She should, as far as reasonably possible, give her time to domestic duties or to family or household management (as appropriate to the case) and not undertake the duties of a "sitter-in"; some relaxation of this rigid distinction will be needed where the aged, particularly aged couples, partially or wholly bed-ridden, are concerned, but each departure should be specifically authorised by the Divisional Medical Officer.

By the end of the year 128 whole-time and 167 part-time home helps had been employed, and these atended 841 cases between July (when the scheme began) and December.

Tuberculosis

With the transfer of the dispensary service, treatment and mass radiography to the Regional Hospital Boards much detailed information is no longer available. This is a matter upon which we can usefully negotiate with the Boards when time and opportunity permit. The following table gives the Tuberculosis Deaths in 1948 at different periods of life:—

	Sex	Age Groups.						Total all ages
		Under 1 year	1 and under 5	5 and under 15	15 and under 45	45 and under 65	65 and upwards	
Respiratory tuberculosis—								
Urban Districts	M	1	2	4	110	114	33	264
	F	0	3	2	117	31	9	162
Rural Districts	M	0	0	0	32	30	17	79
	F	0	2	0	51	11	4	68
Administrative County		1	7	6	310	186	63	573
Other tuberculous diseases—								
Urban Districts	M	4	14	5	10	8	4	45
	F	4	7	5	12	4	3	35
Rural Districts	M	1	2	1	6	1	0	11
	F	1	5	2	7	1	0	16
Administrative County		10	28	13	35	14	7	107


THE DECLINE OF MORTALITY FROM PULMONARY TUBERCULOSIS 1851-1948
Deaths per 1,000 of the population
3·00
2·50
2·00
1·50
1·00
0·50
Isolation of Tubercle Bacillus by Koch
British Congress on Tuberculosis
National Health Insurance Act
Great War 1914 - 1918
P.H.(Tuberculosis) Act 1921
West Riding Dispensary Re organisation.
World War 1939 - 1945
West Riding Administrative Area
England and Wales
1851
1860
1870
1880
1890
1900
1910
1920
1930
1940
1948

The Dispensary Service—Following the transfer of the dispensaries to the Regional Hospital Boards, the Wadsley Bridge dispensary was closed and the patients from the surrounding area were diverted to the Sheffield dispensary. This is the only material change of premises occurring during the year. It is intended that the Tuberculosis Officers should be appointed jointly by the Regional Hospital Boards and the Local Health Authority and that a recognised proportion of their time should be devoted to prevention, care and after-care. Co-operation has been effectively maintained but at the time of writing this report the question of joint appointments has not yet been settled. The most effective link with the dispensary service is the tuberculosis visitor who is a whole-time officer of the County Council and maintains liaison between the dispensary and the Divisional Medical Officer. She assists the Tuberculosis Officer at the dispensary and undertakes the domiciliary sociological work connected with her patients and so remains the sole symbol of the need for a unified service in dealing with this unique medico-sociological disease. The work of the tuberculosis visitor has been re-arranged during the year to fit into the divisional scheme.

The following table gives details of changes in the numbers of West Riding Tuberculosis patients on the Dispensary Registers during the first half of the year, and the number remaining on the Registers at the end of the year.

Diagnosis	Respiratory				Non-Respiratory				Total				Grand Total
	Adults		Children		Adults		Children		Adults		Children		
	M	F	M	F	M	F	M	F	M	F	M	F	
I (1) No. of definite cases of Tuber'losis on the Dispensary Registers at 31st December, 1947.	2504	1668	228	203	355	418	582	521	2859	2086	810	724	6479
(2) Transfers from Authorities of areas outside that of the Council	24	21	4	3	1	2	1	2	25	23	5	5	58
(3) Lost sight of cases returned ...	55	20	—	—	20	17	—	—	75	37	—	—	112
II No. of new cases diagnosed as T.B. (1) Class A	198	142	21	28	38	30	62	46	236	172	83	74	565
(2) Class B	105	84	1	1	1	1	—	—	106	85	1	1	193
III No. of cases included in I and II written off the registers as (1) Recovered ...	45	24	7	5	8	17	20	22	53	41	27	27	148
(2) Dead	127	93	1	1	6	2	3	5	133	95	4	6	238
(3) Removed	47	43	—	1	6	6	5	6	53	49	5	7	114
(4) For other reasons ...	18	40	44	16	13	8	76	69	31	48	120	85	284
IV No. of definite cases on registers at 30th June, 1948	2649	1735	202	212	382	435	541	467	3031	2170	743	679	6623
No. of definite cases on register at 31st December, 1948 ...	2814	1842	219	203	389	436	560	514	3203	2278	779	717	6977

Institutional Treatment—Sanatoria and hospitals providing treatment for West Riding patients suffering from tuberculosis, both respiratory and non-respiratory, and the numbers of admissions and discharges thereto are given in the following table:—

Institution.	Admissions				Discharges			
	Men	Women	Child'n	Total	Men	Women	Child'n	Total
(a) SANATORIA.								
Crookhill Hall, Conisborough	84	—	—	84	52	—	—	52
Middleton, near Ilkley	283	108	45	436	176	51	22	249
Scotton Banks, Knaresborough	—	269	53	322	—	139	33	172
Bradley Wood, Huddersfield	—	1	5	6	—	—	—	—
Crimicar Lane, Sheffield	1	—	—	1	—	—	—	—
Fairfield, York	—	—	6	6	—	—	—	—
Grassington, Nr. Skipton	1	—	—	1	—	—	—	—
High Carley, Ulverston	—	1	—	1	—	1	—	1
Highroyds, Menston	1	—	—	1	—	—	—	—
Killingbeck, Leeds	1	1	—	2	1	—	—	1
Mount Vernon, Barnsley	1	—	—	1	—	—	—	—
Mundesley, Norfolk	—	1	—	1	—	—	—	—
Nayland, Colchester	1	—	—	1	1	—	—	1
Oakwood Hall, Rotherham	5	14	5	24	3	7	1	11
Papworth, Cambridge	1	1	—	2	—	—	—	—
Preston Hall, Maidstone	1	—	—	1	—	—	—	—
Seaham Hall, Durham	—	1	—	1	—	—	—	—
Shelf, Halifax	4	2	—	6	—	—	—	—
Tickhill Road, Doncaster	7	5	—	12	6	5	—	11
Westmorland, Grange-over-Sands	3	4	—	7	1	1	—	2
Whitley Grange, Dewsbury	1	14	—	15	—	5	—	5
(b) ORTHOPAEDIC HOSPITALS.								
Adela Shaw, Kirbymoorside	—	—	1	1	—	—	1	1
Harlow Wood, Mansfield	2	—	—	2	1	—	—	1
King Edward VII, Sheffield	—	—	7	7	—	—	1	1
Leasowe, Cheshire	—	4	3	7	—	3	1	4
Marguerite Home, Thorp Arch	—	—	8	8	—	—	1	1
Robert Jones and Agnes Hunt, Oswestry	23	22	—	45	19	18	—	37
(c) MISCELLANEOUS.								
Barnsley, Kendray Hospital	—	—	1	1	—	—	—	—
Blackburn, East Lancs. Infirmary	—	—	1	1	—	—	1	1
Bradford, Royal Infirmary	2	1	1	4	1	1	1	3
Dewsbury, General Infirmary	2	3	3	8	2	3	3	8
Dewsbury, Staincliffe Hospital	6	3	1	10	6	3	1	10
Halifax, General Hospital	7	1	—	8	4	1	—	5
Harrogate and District General Infirmary	5	3	—	8	4	3	—	7
Huddersfield, Royal Infirmary	2	10	6	18	1	8	6	15
Keighley, St. John's Hospital	2	—	—	2	1	—	—	1
Leeds, General Infirmary	17	8	26	51	14	8	23	45
Leeds, Maternity Hospital	—	1	—	1	—	1	—	1
Leeds, St. James's Hospital	—	2	—	2	—	2	—	2
Otley, General Hospital	3	—	3	6	3	—	3	6
Pontefract Welfare Institution	15	—	—	15	12	—	—	12
Rotherham, Alma Road Hospital	1	—	—	1	1	—	—	1
Sheffield, Children's Hospital	—	—	1	1	—	—	—	—
Sheffield, General Hospital	7	11	—	18	6	7	—	13
Sheffield, Nether Edge Hospital	1	1	—	2	—	—	—	—
Sheffield, Royal Infirmary	15	5	—	20	15	4	—	19
Sheffield, Winter Street	—	1	—	1	—	—	—	—
Skipton and District General Hospital	—	1	—	1	—	1	—	1
Wakefield General Hospital	7	2	1	10	7	2	—	9
Wakefield, Municipal Hospital	8	10	—	18	7	6	—	13
Wakefield, Pinderfields Hospital	18	13	17	48	6	4	7	17
York, County Hospital	1	—	2	3	—	—	2	2
Ilkley Convalescent Home	—	1	—	1	—	1	—	1
Ormerod Home, St. Annes	—	—	1	1	—	—	1	1
Royal N.S. Bathing Infirmary, Scarborough	1	2	—	3	1	2	—	3
York Lodge, Seaford, Sussex	1	—	—	1	1	—	—	1
	541	527	197	1265	352	287	108	747

Mass Radiography—The two Mass Radiography Units which operate in the County area are that issued to the County Council (in April, 1948), and that issued to the Sheffield Corporation, both being transferred to the appropriate Regional Hospital Boards on the appointed day. The work of the two Units is being undertaken in close co-operation with the Divisional Medical Officers and recent consultation has taken place with a view to ensuring closer co-ordination with the County Preventive Health Service. Statistical information for 1948 is not available but an assurance has been received that this will be produced for inclusion in future reports.

Extra nourishment, comprising grants of two pints of milk daily, was issued to an average of 383 patients throughout the year, at a cost of approximately £6,000. Domiciliary open-air shelters, are available for use by patients living in overcrowded conditions. 32 were in use at the end of the year and 12 were then in storage available for issue as required. 26 had been placed in Sanatoria, Hospitals, and Welfare Institutions to provide special accommodation for tuberculous patients and were transferred to the appropriate Regional Hospital Boards. Clothing was issued to 37 patients—18 institutional and 19 domiciliary—to enable treatment to be undertaken

or to relieve immediate financial distress which would have had a deleterious effect on the patients progress. Advantage has been taken of the income available from the West Riding Distress Fund to assist low income patients in the provision of 15 bedsteads, 15 mattresses, 7 mattress covers, 5 counterpanes, 62 blankets, 52 sheets, 23 pillows, 40 pillow cases, travelling fares to visitors of 13 patients, pocket money for 3 patients in sanatoria, the expenses incurred by 2 patients in removing to more satisfactory houses, the cost of burying one patient, the cost of boarding out a child, and one spinal support.

As from the 5th July, 1948, certain cases which had been admitted to Papworth Hall and the British Legion Village for treatment and training were taken over by the Regional Hospital Board and a training case at St. Loyes College has been taken over by the Ministry of Labour. The following table shows the numbers receiving training under the Council's scheme for the institutional rehabilitation of tuberculous patients:—

Colony or Training College.	No. under training on 1. 1. 48.	No. admitted during 1948.	No. discharged during 1948.	No. remaining under training on 31. 12. 48.
Papworth Village Settlement ...	8	—	3	5
British Legion Village Preston Hall	1	—	1	—
Heritage Craft Schools ...	3	1	1	3
Derwen Cripples Training College	1	—	—	1
St. Loyes College	1	—	1	—
Stanmore Cripples Training College	1	—	—	1

Problem Families

Report of an Investigation in the West Riding of Yorkshire

Under the County scheme of divisional health administration it is the duty of the Divisional Medical Officer to maintain a register of problem families in his area, and to operate such arrangements for rehabilitation as may be approved by the County Council with a view to protecting the children in such families and maintaining the family as an effective unit. A first concern of any scheme for the care of these families must be "ascertainment." When, therefore, in January, 1948, upon the initiative of the Eugenics Society, a Problem Families Committee was set up consisting of Medical Officers of Health and others who had shown a special interest in the subject I welcomed the possibility of collaborating with it. This Committee decided that it would investigate as a first step a method of ascertainment by means of a pilot survey.

Six areas in the country are being surveyed, namely, a port (Bristol); a Metropolitan Borough (Kensington); two administrative counties in the Midlands (Warwickshire and the West Riding); a county borough in the Midlands (Rotherham); and an actively growing industrial town (Luton), a municipal borough. We agreed to investigate 100 such families and one of the area superintendent health visitors (Miss O'Brien) was appointed to carry out the field investigation.

Procedure of Investigation—We sent an explanatory memorandum to 22 Divisional Medical Officers describing the object of the enquiry, namely, to "devise a workable method of ascertaining the problem families in any area." This stated that a prominent feature of the problem family, one which the committee makes a basis of its method of investigation, is that it presents multiple social problems. For the purpose of this enquiry, problem families may be regarded as displaying in varying combinations two salient characteristics, in either or both heads of the household, but more commonly in the housewife than her husband. These characteristics are (1) intractable ineducability and (2) instability or infirmity of character. These together express themselves in the persistent neglect of children (if there are any), in fecklessness, irresponsibility, improvidence in the conduct of life, and indiscipline in the home, wherein dirt, poverty and squalor are often conspicuous.

The Divisional Medical Officers were asked to distribute inquiry forms (asking for the name and address of suggested problem families, together with a description of the home and nature of the problem) to school teachers, school attendance officers, probation officers, health visitors, police, district welfare officers, sanitary inspectors, labour exchanges, N.S.P.C.C. inspectors, midwives, school medical officers, and various voluntary societies. Details of the returns are given in Table I. Many of the organisations or individuals approached refrained from completing the forms; the police, the N.S.P.C.C. and labour exchanges were, to some extent, unable to give full information in all cases. Generally speaking, the highest percentage of individuals making returns were health visitors, head teachers and sanitary inspectors. A reasonably high percentage of returns were made by other nurses, including midwives, and occasionally by school enquiry officers. Of 31 divisions 22 were in being when the investigation began and returns were received from 19.

In all, 564 "possibles" were notified and out of this number 302 were considered to be "probables"; a figure which may be taken to include most of the actual problem families but cannot be regarded as wholly exhaustive (for example, those families which have already suffered dissolution, with the children in the care of the authority, will not be included).

Detailed study of 100 "Probable Problem Families"—To obtain a random sample (of 100) for further investigation by the field worker every third family was taken. Each such family was specially reported upon by the divisional health staff and individually visited by Miss O'Brien. Six had left the County area, and a further six were excluded on closer study as not being problem families within the terms of reference of the committee. Their characteristics can be summed up as follows:—

1. The average size of the family included in the 88 under consideration was 7, corresponding to husband, wife and five children (88 families, 619 individuals). The size of the average problem family exceeded the size of the average family of the same social strata; but size alone was not an over-riding factor for there are certainly many families of the same size in each social stratum which are not problem families. Further facts will need to be collected in order to establish accurately any correlation between status as "problem family" and number of children.

2. 69 families came from urban districts and 19 from rural districts in an area which varies from small townships of 40,000 persons down to districts with a very scattered and sparse population. Families appeared evenly throughout the whole area; the urban and rural locality had little bearing upon the incidence.

3. 53 families were found in block terrace houses, 24 in municipal estates, 9 cases in rural cottages, and only two as sub-tenants of another occupier. The type of dwelling did not seem to have much significance. In half the families the home was definitely in squalor, and in 78 both children and home were obviously neglected; thus, neglect involves the great majority of cases and is obviously of particular importance. It is clearly the most frequently recognised attribute of those families that the committee have set out to ascertain.

4. 33 families showed "fecklessness and irresponsibility", 26 "apparent mental subnormality", 19 "intemperance", and 12 "delinquency and truancy." Still smaller returns refer to "instability" —9; "improvidence"—8; "marital incompatibility"—8; "illegitimacy"—5; "separated parents" —2; and "low standard morality"—4. It is noticeable that each of these attributes is ascribed to less than half of the total number of families. The joint figures for "fecklessness, irresponsibility and apparent mental subnormality," which apparently do not overlap, amount to 59, representing therefore, a substantial proportion of the total. It is obvious that a majority of the families is characterised, therefore, by less than the normal amount of prudence, or sense of responsibility, or care for the future. In the absence of reliable intelligence tests it would not be advisable to attempt to evaluate more accurately the exact mental condition of these 59 families concerned. Thus, the main conclusions to be drawn are not dissimilar from those of previous studies; nearly all the "probable" problem families were characterised by neglect of children and home, and considerably more than half by something less than the normal amount of prudence, sense of responsibility, or mental stability.

5. Table II shows the sources of information of each of 88 families considered to be "authentic" problem families. It can be seen that in 35 instances the problem family was known to two or more sources of information, the figures being:—

Notified by four sources	...	...	2
Notified by three sources	...	...	7
Notified by two sources	...	...	26
Notified by one source	...	...	53 = 88

The health visitor notified the problem family in 55·7 per cent., the school nurse in 12·5 per cent., of the cases (63·6 per cent., were notified by either a health visitor or school nurse or both*), the head teacher in 26·1 per cent., the sanitary inspector in 18·2 per cent., and the school enquiry officer in 10·2 per cent. Of the 53 families notified by one source, 27 were notified by health visitors and school nurses, 8 by head teachers, 5 by sanitary inspectors, 4 by midwives, 3 by school enquiry officers, 2 by mental health social workers, and one each by the N.S.P.C.C., a district welfare officer, a housing manager, and a moral welfare worker.

It is hoped that this study of "ascertainment" (which seems to suggest that health departments will be able without great difficulty to complete a register of problem families with the assistance of staffs within their departments) will prove an initiative to further action in what must now be regarded as one of the outstanding items in the field of social medicine.

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*In this Authority the general practice is to appoint Health Visitors who also undertake the duties of School Nurses. In certain instances notification of a possible problem family was received from two Health Visitors one acting in her dual capacity as Health Visitor and School Nurse and the other acting in her capacity as School Nurse which brought her into touch with a member of the family.

In order to preserve the plurality of mention which was being investigated as a possible feature of a problem family these notifications have been shown by having separate columns for Health Visitors and School Nurses although in this county the offices are combined.

Table I.

Problem Families.

Div.	Population.	Reported by :— H.V.	H.T.	S.I.	M.H.S.W.	Mid.	N.S.P.C.C.	D.W.O.	S.N.	S.E.O.	C.D.C.	G.P.	P.O.	B.T.	H.M.	M.W.W.	B.L.	S.D.N.A.	Total Possible Problem Families.	Total Probable Problem Families.
1.	57,541	18	7	2	1	—	—	—	—	—	—	6	—	—	—	—	—	—	28	12
4.	66,653	12	—	20	—	5	1	3	5	—	—	—	—	—	—	—	—	—	29	19
7.	20,570	5	19	5	—	6	4	—	—	—	—	—	—	—	—	—	—	—	32	13
8.	70,330	5	3	—	1	—	—	2	—	—	—	—	—	—	—	—	3	—	14	7
9.	44,540	8	10	—	—	—	—	1	—	1	58	—	—	—	—	—	—	—	78	17
10.	44,090	—	4	5	—	—	—	—	2	—	—	—	2	—	—	—	—	—	10	9
11.	61,450	15	15	16	—	4	3	9	12	4	—	—	8	—	—	—	—	—	60	46
13.	40,657	4	8	8	1	3	5	4	—	3	—	—	2	1	—	—	—	—	38	17
16.	53,060	8	—	8	1	—	—	—	5	3	—	—	—	—	5	—	—	—	30	12
17.	48,230	6	—	5	—	—	—	—	4	—	—	—	—	—	3	—	—	—	25	15
18.	58,850	21	19	—	—	—	—	3	—	—	—	3	—	—	—	—	—	—	36	26
19.	56,375	7	24	5	—	—	—	—	—	—	—	—	1	—	3	—	—	—	27	17
20.	72,711	5	—	1	—	—	—	3	—	12	2	—	—	—	—	—	—	—	18	14
23.	59,500	16	10	2	—	4	4	4	2	—	—	—	—	—	—	—	—	—	42	26
24.	30,555	—	2	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	3	1
25.	42,783	3	—	4	—	9	2	—	—	3	—	—	—	—	—	4	—	—	18	12
26.	43,480	17	8	1	—	—	—	4	—	—	—	—	—	—	—	—	—	4	24	21
27.	38,980	10	7	6	—	—	—	—	8	7	—	—	—	—	—	—	—	—	36	11
28.	55,862	—	—	—	—	—	1	—	—	7	—	—	—	—	—	—	—	—	16	7
Total	966,217	160	136	89	4	31	20	33	38	40	60	9	13	1	11	4	3	4	564	302

H.V.—Health Visitor.
H.T.—Head Teacher.
S.I.—Sanitary Inspector.
M.H.S.W.—Mental Health Social Worker.
Mid.—Midwives.
D.W.O.—District Welfare Officer.
S.N.—School Nurse.
S.E.O.—School Enquiry Officer.
C.D.C.—Clerk to the U.D.C.
G.P.—General Practitioner.
P.O.—Probation Officer.
B.T.—Borough Treasurer.
H.M.—Housing Manager.
M.W.W.—Moral Welfare Worker.
B.L.—British Legion.
S.D.N.A.—Superintendent of District Nursing Association.

Table II
Sources of notification of "authentic" Problem Families.

Reference Number.	By whom notified.													Total
	Health Visitor	Head Teacher	Sanitary Inspector	Mental Health Social Worker	Midwife	N.S.P.C.C.	District Welfare Officer.	School Nurse	School Enquiry Officer	Police Officer	Housing Manager	Moral Welfare Worker	Secretary District Nursing Association	
3	1	1	—	—	—	—	—	—	—	—	—	—	—	2
6	1	1	—	—	—	—	—	—	—	—	—	—	—	2
12	1	—	—	—	—	1	—	—	—	—	—	—	—	2
15	1	—	—	—	—	—	—	—	—	—	—	—	—	1
18	1	—	—	—	—	—	1	—	—	—	—	—	—	2
21	1	—	—	—	—	—	—	1	—	—	—	—	—	2
24	1	—	1	—	—	—	—	—	—	—	—	—	—	2
30	—	1	—	—	—	—	—	—	—	—	—	—	—	1
33	—	1	—	—	—	—	—	—	—	—	—	—	—	1
36	—	1	—	—	—	—	—	—	—	—	—	—	—	1
39	1	—	—	—	—	—	—	—	—	—	—	—	—	1
42	—	1	—	—	—	—	—	—	—	—	—	—	—	1
45	1	1	—	—	—	—	—	—	—	—	—	—	—	2
48	—	—	—	1	—	—	—	—	—	—	—	—	—	1
51	1	1	—	—	—	—	—	—	—	—	—	—	—	2
57	1	—	1	—	—	—	—	—	—	—	—	—	—	2
63	1	—	—	—	—	—	—	—	—	—	—	—	—	1
66	—	—	1	—	—	—	—	—	—	1	—	—	—	2
69	—	—	1	—	—	—	—	—	—	—	—	—	—	1
72	—	—	—	—	—	—	—	1	—	—	—	—	—	1
75	—	—	—	—	—	—	—	1	—	—	—	—	—	1
78	—	—	1	—	—	—	—	—	—	—	—	—	—	1
81	—	—	—	—	—	—	—	1	—	—	—	—	—	1
84	—	—	1	—	1	—	—	—	—	—	—	—	—	2
87	—	—	—	—	—	—	—	1	—	—	—	—	—	1
90	—	—	—	—	—	—	—	1	—	—	—	—	—	1
93	—	—	—	—	—	—	1	—	—	—	—	—	—	1
102	—	—	—	—	—	—	—	1	—	—	—	—	—	1
105	—	—	—	—	—	—	—	1	—	—	—	—	—	1
108	1	—	—	—	1	—	1	—	—	—	—	—	—	3
111	—	—	—	—	—	—	—	—	1	—	—	—	—	1
114	—	—	—	—	—	—	—	—	1	—	—	—	—	1
117	1	—	—	—	—	—	—	—	—	—	—	—	—	1
120	1	—	—	—	—	—	—	—	—	—	—	—	—	1
123	1	—	—	—	—	—	—	—	—	—	—	—	—	1
126	—	—	1	—	—	—	—	—	—	—	—	—	—	1
129	—	—	—	—	1	—	1	—	—	—	—	—	—	2
132	—	1	—	—	—	1	—	—	1	—	—	—	—	3
135	—	—	1	—	—	—	—	—	—	—	—	—	—	1
138	—	—	—	1	—	—	—	—	—	—	—	—	—	1
144	—	1	—	—	—	—	—	—	—	—	—	—	—	1
147	—	—	1	—	—	—	—	—	1	—	1	—	—	3
150	1	—	1	—	—	—	—	—	—	—	—	—	—	2
153	1	—	—	—	—	—	—	—	—	—	1	—	—	2
156	1	—	1	—	—	—	—	1	—	—	1	—	—	4
159	—	—	—	—	—	—	—	—	—	—	1	—	—	1
162	1	—	—	—	—	—	—	—	—	—	—	—	—	1
165	1	—	—	—	—	—	—	—	—	—	—	—	—	1
168	1	—	—	—	—	—	—	—	—	—	—	—	—	1
171	1	1	—	—	—	—	—	1	—	—	—	—	—	3
174	—	—	—	—	—	1	—	—	—	—	—	—	—	1
177	1	—	—	—	—	—	—	—	—	—	—	—	—	1
180	1	—	—	—	—	—	—	—	—	—	—	—	—	1
183	1	1	—	—	—	—	—	—	—	—	—	—	—	2
186	1	—	—	—	—	—	1	—	—	—	—	—	—	2
189	1	1	—	—	—	—	—	1	—	—	—	—	—	3
192	1	—	—	—	—	—	—	—	—	—	—	—	—	1
195	1	1	—	—	—	—	—	—	—	—	—	—	—	2
198	1	—	—	—	—	—	—	—	—	—	—	—	—	1
201	1	—	1	—	—	—	—	—	—	—	—	—	—	2
204	—	1	—	—	—	—	—	—	—	—	—	—	—	1
207	1	1	—	—	—	—	—	—	1	—	1	—	—	4
210	—	1	—	—	—	—	—	—	—	—	—	—	—	1
213	1	—	—	—	—	—	—	—	—	—	—	—	—	1
219	—	—	—	—	—	—	—	—	1	—	—	—	—	1
225	—	—	—	—	1	—	—	—	—	—	—	—	—	1
228	—	—	—	—	1	—	—	—	—	—	—	—	—	1
231	1	—	—	—	—	—	—	—	—	—	—	—	—	1
234	—	1	—	—	—	—	—	—	—	—	—	—	—	1
237	1	1	—	—	—	—	—	—	—	—	—	—	—	2
240	1	—	—	—	—	—	—	—	—	—	—	—	—	1
243	1	—	1	—	—	—	—	—	—	—	—	—	—	2
252	—	—	—	—	1	—	—	—	—	—	—	—	—	1
255	1	—	1	—	—	—	—	—	1	—	—	—	—	3
258	—	—	—	—	—	—	—	—	—	—	—	1	—	1
261	—	—	—	—	1	—	—	—	—	—	—	—	—	1
264	1	—	—	—	—	—	1	—	—	—	—	—	1	3
267	1	1	—	—	—	—	—	—	—	—	—	—	—	2
270	1	1	—	—	—	—	—	—	—	—	—	—	—	2
273	1	—	—	—	—	—	—	—	—	—	—	—	—	1
276	1	—	—	—	—	—	—	—	—	—	—	—	—	1
279	—	—	1	—	—	—	—	—	—	—	—	—	—	1
285	—	1	1	—	—	—	—	—	—	—	—	—	—	2
288	1	1	—	—	—	—	—	—	—	—	—	—	—	2
291	1	—	—	—	—	—	—	—	—	—	—	—	—	1
294	1	—	—	—	—	—	—	—	—	—	—	—	—	1
297	1	—	—	—	—	—	—	—	1	—	—	—	—	2
300	1	—	—	—	—	—	—	—	1	—	—	—	—	2
Totals.	49	23	16	2	7	3	6	11	9	1	5	1	1	134
Percentage	55·7	26·1	18·2	2·3	8·0	3·4	6·8	12·5	10·2	1·1	5·7	1·1	1·1	

After investigation by the field-worker the following 6 families were found not to be Problem Families within the terms of reference of the Committee :— Nos. 9, 54, 60, 99, 141, 282.

The following 6 families had left the District and could not be traced :— Nos, 27, 96, 216, 222, 246, 249.

Removal to Suitable Premises of Persons in need of Care and Attention.

Section 47 of the National Assistance Act, 1948, provides that, "where a Medical Officer of Health of a county district certifies that a person is suffering from grave chronic disease or being aged, infirm or physically incapacitated is living in insanitary conditions and is unable to devote to himself, and is not receiving from other persons, proper care and attention the County District Council may apply to a court of summary jurisdiction for an order to remove the person to a suitable hospital or other place and be maintained there."

Action was taken under this section in the following five areas during 1948:—

SELBY U.D. An elderly infirm man living in insanitary conditions was removed to Brook Lodge, Selby, on 13th December, by an Order of the court for 3 months. The Order was renewed on 7th March, 1949.

MORLEY M.B. An elderly man living alone in filthy and insanitary conditions was removed to Beech Towers, Staincliffe, by Order of the court. It is intended to apply for renewal of the Order on the expiry date.

BATLEY M.B. An elderly infirm woman living alone in insanitary conditions and unfit to look after herself was removed to Beech Towers, Staincliffe.

WORTLEY R.D. An elderly couple, the husband a chronic invalid and the wife of strange behaviour, living in a dirty house were removed in October by Order of the court to the Grenoside Institution. The woman was later certified under the Lunacy Acts and died in a mental hospital in March, 1949. The man died in Grenoside Institution in November, 1948.

DONCASTER R.D. An elderly woman living alone in grossly insanitary conditions unable to look after herself, and with no relations living near, was removed by Order of the court in December to Springwell House, Doncaster, where she still is.

PART VIII

COUNTY AMBULANCE SERVICE

This service is under the charge of Mr. V. Whitaker, County Ambulance Officer. The proposals for a County Ambulance Service (under the National Health Service Act, 1946) were approved by the Minister of Health in June, 1948, with little modification, and on the 5th July, the scheme that had been originated and accepted by local authorities in October, 1947, and already in force, continued in operation. Until the whole of the approved scheme could be put into force, local authorities who owned ambulance services acted as agents for the County Council. Care was taken in framing the scheme to ensure that the service should be operated as a medical and not solely as a transport service. To ensure that the care given to the patient should be uniformly maintained at a standard equal to that given in hospitals, the divisional medical officer has been made responsible for the following duties:—

(a) To settle any question of use or abuse of ambulance facilities.

(b) To supervise standard and training of personnel in first aid, and in care of the patient.

(c) To supervise training in use and maintenance of special apparatus.

(d) To supervise and maintain standard of infectious disease precautions as laid down by the County Medical Officer of Health in relation to personnel and vehicles.

(e) To negotiate with hospitals and other institutions as to what patients may be conveyed and to settle any questions of difficulty in individual cases by personal contact.

During the year, various ambulance services and voluntary organisations were absorbed into the county service and set out below are the County ambulance depots and local authorities acting as agents.

County Ambulance Depots—There are now 16 depots as follows: Bentley—Yarborough Terrace, Doncaster; Conisborough (sub-depot)—The Priory, Conisborough: Birkenshaw—Oakroyd Hall, Birkenshaw, near Bradford: Boston Spa—Bramham House, Bramham, Boston Spa, Yorkshire: Brighouse—N.F.S. Station, Halifax Road, Brighouse: Goole—Highways Yard, Dunhill Road, Goole: Guiseley—White Cross, Guiseley: Harrogate—Leadhall Grange, Leadhall Drive, Harrogate: Hoyland—Swallows' Garage, Hoyland: Huddersfield—Springwood Street, Huddersfield: Keighley—Victoria Hospital, Keighley: Kippax—Cockram's Buildings, Butt Hill, Kippax, near Leeds: Pudsey—Westroyd House, Farsley, near Leeds: Settle—Cammock Lane, Settle: South Kirkby—Church Street, South Kirkby: Wakefield—Hyland's Garage, York Street, Wakefield: Wath—Dunford House, Wath-on-Dearne; Kiveton Park (sub-depot)—18, Wales Road, Kiveton Park.

Certain local authorities and voluntary organisations have continued to operate on an agency basis, as follows: Barnoldswick U.D.C., Bingley U.D.C., Castleford U.D.C., Cudworth U.D.C., Earby U.D.C., Featherstone U.D.C., Hebden Royd U.D.C. and Hepton R.D.C., Holmfirth U.D.C., Knottingley U.D.C., Morley M.B., Penistone Ambulance Committee, Pontefract M.B., Rothwell U.D.C., Shipley U.D.C., Todmorden M.B., Wombwell U.D.C., St. John Ambulance Brigade at Selby, Ripon, Grassington and Pateley Bridge, and Skipton Motor Ambulance Committee.

An innovation was made in the county service by the provision of radio-equipped ambulances, working from a central control. This enables ambulances to be diverted whilst on route to accidents, emergencies and can save life and time. At the end of the year, there were nine ambulances equipped and it is hoped shortly to provide more, and, possibly to cover the whole of the Riding.

The analysis of work undertaken falls into two parts. The first part is from 1st January to 4th July, 1948, being work done for county committees on a mileage basis, and the relevant statistics are shown in the following Table A. The service undertook 18,931 journeys conveying 32,941 patients a distance of 510,949 miles. The second part, from 5th July, 1948, to the end of the year, shows only the type of cases conveyed—see Table B. During this period 68,000 patients were carried a distance of 752,000 miles. For the whole year, 100,941 patients were conveyed, the distance being 1,250,050 miles. The question of the conveyance of county cases suffering from infectious diseases has been left over for further consideration when the respective regional hospital boards have designated the hospitals which are to be available for the treatment of infectious diseases.

Table "A."

County Ambulance Service—Mileage completed

Committee or Authority Chargeable	1948							Total
	Jan.	Feb.	Mar.	Apl.	May	Jun.	July 1st-4th	
County Hospitals	5,423	5,437	5,996	6,402	6,765	7,355	980	38,358
Other Hospitals	—	—	—	—	—	—	—	—
Treatment of Cancer	2,445	2,451	2,704	2,887	3,050	3,410	348	17,295
Treatment of Venereal Diseases ...	1,027	1,030	1,136	1,213	1,281	1,390	189	7,266
Treatment of Tuberculosis	5,089	5,102	5,627	6,008	6,349	6,902	920	35,997
Tuberculosis Dispensaries	335	336	371	396	418	455	60	2,371
County Welfare Institutions	4,286	4,298	4,740	5,061	5,347	5,814	774	30,320
County Welfare District Officers ...	1,974	1,979	2,183	2,331	2,463	2,678	356	13,964
County Children's Homes	307	308	339	362	383	416	56	2,171
Maternity and Child Welfare	3,406	3,415	3,766	4,021	4,249	4,619	616	24,092
Other Maternity Homes	2,534	2,541	2,802	2,992	3,161	3,437	458	17,925
Mental Deficiency Act Committee ...	143	143	157	168	178	197	22	1,008
Other Mental Deficiency Act Committees	1,371	1,374	1,516	1,619	1,710	1,859	248	9,697
Education	5,751	5,766	6,360	6,790	7,175	7,803	1,036	40,681
Orthopaedic	69	69	76	81	86	93	12	486
Blind Persons Officer	76	79	87	93	98	107	14	554
Police	243	243	268	287	303	329	44	1,717
Hospital Contributory Schemes ...	16,488	16,532	18,234	19,467	20,571	22,363	2,980	116,635
Private, etc, ...	18,804	18,854	20,794	22,201	23,459	25,561	3,342	133,015
County Ambulance Service	1,307	1,310	1,445	1,542	1,630	1,772	236	9,242
Public Health and Welfare	1,153	1,156	1,275	1,361	1,438	1,564	208	8,155
TOTALS ...	72,231	72,423	79,876	85,282	90,114	98,124	12,899	510,949

Table "B."

County Ambulance Service.

Details for period 5th July to 31st December, 1948.

Total number of calls	68,000.
Total number of miles	752,000.

Analysis of Calls.

Accident	1,218
Urgent	5,785
Maternity	3,015
Infectious	676
Mental	530
Out-Patients	45,718
General, School Children, etc.	11,058
TOTAL	68,000

Analysis of Types of Cases Conveyed.

Child	7,383
Baby	828
Stretcher Case	16,305
Sitting Case	51,346
Ambulance used	59,002
Car/Shooting Brake used	6,017
Relative conveyed with patient	17,527
Single cases conveyed	16,013
No. of vehicles empty one way	19,685
False Calls	443
Train	35

PART IX

MENTAL HEALTH

The local health authority has appointed a Mental Health Sub-Committee consisting of 24 members of the Health Committee, to which is referred the detailed administration of the mental health services of the County Council.

The mental health section of my department is under the immediate day-to-day supervision of a mental deficiency psychiatrist, Dr. H. J. O'Loughlin, whose services we use in accordance with an agreement between the County Council and the Leeds Regional Hospital Board. In virtue of a similar agreement, a psychiatrist in lunacy, the counterpart of Dr. O'Loughlin, is soon to be appointed. Mr. H. Bywater, as sectional senior clerk still performs the important duties that he discharged during the many years that the duties of the County Council under the Mental Deficiency Acts were the responsibility of the Clerk of the County Council, and the additional duties in connection with the care and after-care service so far as it relates to mental health. There are 2 petitioning officers in mental deficiency, 25 duly authorised officers under the Lunacy and Mental Treatment Acts (who also perform welfare duties under the National Assistance Act) and 12 social workers to be increased to 14 when suitable applicants can be obtained.

The social workers supervise defectives in the community; they also provide reports about the health, behaviour, activities and home conditions of defectives for the information of Hospital Management Committees (when they consider applications for leave of absence of patients from the Colony on licence or holidays or for the renewal of licences) and for the official visitors appointed under the Lunacy and Mental Treatment Acts (when they reconsider the cases of persons legally detained in a Mental Deficiency Colony). Furthermore, the social workers provide personal histories and background information relating to patients admitted to Mental Hospitals, on behalf of the Medical Superintendents of the Hospital; care and after-care for ex-service personnel (a function previously performed by the National Association for Mental Health) and, when requested, for persons on licence or discharged from mental hospitals. Thus, it will be realised that the duties of a social worker are wide and varied. Their role is not merely a passive one, recording facts in the form of a report, but is an active one too. This activity is to help the patient in the community to cope with his environment. This help may take many forms: it may be that the condition of the patient has to be explained to those around him, whether at home or at work, that they may adopt an understanding attitude to him thereby promoting his happiness, social efficiency and so diminishing the risk of recurrence or aggravation of mental ill health. Again, it may be that by reason of mental ill health or sub-normality a person has to search for fresh employment better suited to his condition or he may need advice about the various social benefits to be obtained; in such matters the social worker lends timely help.

It will be readily understood that such important duties require social workers to be well informed on matters of mental health, social conditions and legislation. Four of the twelve social workers possess diplomas in social science and most of the others have many years previous experience of social work. With few exceptions, for whom provision will be made, they have all attended extra-mural courses of study at the universities, as have six duly authorised officers. Additionally, the workers all meet once monthly to discuss social legislation and matters of difficulty or interest that arise in their work. Dr. O'Loughlin and Mr. Bywater attend these meetings regularly. It is to be noted that the social worker is one of a team, a member of the staff of the Divisional Medical Officer, and, therefore, under his immediate direction. Here it is fitting to record the great interest and activity shown by these officers in the realm of mental health.

Action taken under the Lunacy and Mental Treatment Acts by duly authorised officers after the 4th July, 1948, to the end of the year was as follows:—

Lunancy Act, 1890, as amended:— Sect. 16, 253 cases; Sect. 20, 48 cases; Sect. 21, 2 cases.

Mental Treatment Act, 1930:— Sect. 1, 46 cases; Sect. 5, 10 cases.

199 persons were referred to, or ascertained by, the local health authority as mentally defective persons, as follows:— 142 reported by local education authority; 3 Board of Control; 1 Home Office; 17 ascertained by social workers; 14 National Assistance Board; 22 reported by police, relatives, private medical practitioners, probation officers, etc.

Of these 199 persons referred or ascertained: 13 were admitted to institutions for defectives; 1 was placed under guardianship; 3 were admitted to "places of safety"; 117 were placed under statutory supervision; 3 died or removed from the area of the authority; 12 were found not to be defective within the meaning of the Acts; 8 were placed under voluntary supervision; 42 action was not completed by the end of the year.

Orders sending mentally defective persons to institutions were made as follows:— Orders on Petition 38; Orders under Section 8, 8; Orders under Section 9, 2; Varying Orders from Guardianship 10; Total 58. Guardianship:— 26 Orders were made placing patients under guardianship; 22 on Petition and 4 by varying Orders from institutions. Discharges:— From guardianship to institution 3; from institution 13; from guardianship 1. Lapse of Orders:— Patients in institutions 12; from guardianship 3.

On the 31st December, 1948, the ascertainment of mentally defective persons in the Riding was as follows:— (a) Mentally defective persons under guardianship 262; (b) in "places of safety" 6; (c) under statutory supervision 1,576; (d) mentally defective persons ascertained but action not yet completed 160; (e) mentally defective persons not at present "subject to be dealt with" but for whom the authority may subsequently become liable 438; (f) West Riding patients in Institutions for defectives, or on licence therefrom 1,298; Total 3,740.

Of the above there were 263 patients awaiting admission to institutions for defectives and 170 were under voluntary supervision. In addition to the above ascertainment, the medical superintendents of the principal mental hospitals serving the County area have reported that of the patients in their care some 347 would more appropriately be dealt with under the Mental Deficiency Acts, and the County Welfare Officer has reported that there are some 141 mentally defective persons maintained in accommodation provided under Part III of the National Assistance Act, 1948.

Of the 1,838 patients under guardianship and statutory supervision 111 were receiving some form of training, either at occupation centres or at home.

Premises for use as occupation centres have been obtained at Castleford and Keighley and suitable premises for use as centres are being sought in other areas. The Castleford centre was opened on the 3rd March, 1949.

PART X

ENVIRONMENTAL HYGIENE

Atmospheric Pollution

The results of the examination of the contents of deposit gauges installed under the arrangement whereby the County Council bears the cost of analyses, were as follows for the year 1948.

Situation of Deposit Gauge ‡	Average monthly rainfall (inches)	Mean monthly deposits recorded (in tons per sq. mile)		
		Insoluble	Soluble	Total Solids
Keighley M.B.—				
Morton Cemetery	1·99	6·02	5·35	11·37
Blackhill*	2·67	3·91	9·49	13·40
Oldfield†	2·19	2.54	6·27	8·81
Low Bridge	1·69	7·15	5·83	12·98
Library	2·05	11·23	7·25	18·48
Colne Valley U.D.	3·57	8·91	9·12	18·03
Horsforth U.D.	2·00	7·07	7·25	14·32
Otley U.D.	1·81	7·63	7·50	15·13
Skipton U.D.	2·96	7·29	10·74	18·03

* Average of three months only, i.e., January, March and April, 1948.

† Average of seven months only, i.e., May to November, 1948, inclusive.

‡ The gauge in the Morton Cemetery is in an open space 1¼ miles from the centre of the town in an easterly direction, the surrounding district being residential and in the path of prevailing winds from industrial area. The gauge at Black Hill was on an embankment of a reservoir in an exposed position with approximately twenty dwelling houses in the neighbourhood, the remainder of the land nearby being farmland; in May it was removed to an exposed site in the path of prevailing rain bearing winds, in the grounds of the Keighley Corporation waterworks filter beds at Oldfield. That at Low Bridge is on the flat roof of a textile mill in a built-up area on the north east side of a dense industrial area, whilst that at the Keighley Public Library is in a built-up area in the centre of the town with no trees, etc., near. The Colne Valley U.D. gauge is in Marsden Park in a residential and manufacturing area, seven miles south of Huddersfield. There are eight major factory chimneys within one mile of the gauge. The Horsforth U.D. gauge is situated at the rear of 78, Broadgate Walk, Horsforth, in the centre of the built-up area. The surrounding district is residential. The Otley U.D. gauge is in nursery gardens, 600 yards south west of the centre of the town. The district is a manufacturing one. The Skipton U.D. gauge is at the rear of the Town Hall in a residential and manufacturing district.

At present in operation in the Administrative County are 16 deposit gauges, 12 lead peroxide instruments for ascertaining the amount of sulphur dioxide in the atmosphere and one smoke filter for the measurement of smoke or suspended material. The County Council have decided to instal and maintain additional instruments and by the end of next year (1949) it is anticipated that there will be approximately 40 deposit gauges, 50 lead peroxide instruments and 30 smoke filters in operation in the Administrative County area.

Although the duties under the Public Health Act, 1936, in connection with smoke nuisances are placed on County District Councils, the County Sanitary Inspectors from time to time co-operate with the Sanitary Inspectors of such Councils in making observations of emission of smoke from works chimneys. During the year, 63 such observations were made. In the event of a nuisance being discovered, action is taken by the County District Council concerned. There is no doubt that much excessive smoke is produced at the present time because of the use of unsuitable fuels and overloading of boilers.

Spoil banks at collieries have given rise to complaints, and it is regretted that the methods employed during the late war to control tip fires as a defence measure are apparently not being continued in times of peace.

Milk.

Milk (Special Designations) Regulations—As in previous years the work devolving upon the County Sanitary Inspectors in connection with the above Regulations occupied a considerable amount of their time during the year, in the inspection of farms where applications had been made for "Tuberculin Tested" and "Accredited" licences and in the supervision of the licenced farms.

The following table shows the numbers of licencees over a period of eight years and it will be noted that "Tuberculin Tested" licencees have increased considerably in number.

Year.	*"Tuberculin Tested" Milk.*	*"Accredited" Milk.*
1941.	65	863
1942.	61	888
1943.	101	908
1944.	158	961
1945.	213	962
1946.	330	926
1947.	421	874
1948.	585	792

The large increase in the numbers of "Tuberculin Tested" licencees, together with a large number of herds which are "Attested" under the Ministry of Agriculture Attested Herds Scheme, shows that milk of an increasingly high standard is being produced in the County. Cattle forming a "Tuberculin Tested" herd are subjected to a tuberculin test every six months and any animals reacting to the tests are immediately removed from the herds. "Accredited" herds are subject to quarterly clinical examinations and action is taken when any animal appears to be suffering from an abnormal condition, as reported by the Veterinary Inspector. Particular attention is paid to animals suspected of suffering from tuberculosis.

Samples of milk have been obtained at the farms as follows:—

	Number.	*Satisfactory.*	*Unsatisfactory.*
"Tuberculin Tested"	723	597	126
"Accredited"	1,331	1,044	287

The number of samples could have been increased if additional staff had been available, but due to the expected transference of the duties in connection with the Milk (Special Designations) Regulations from the County Council to the Ministry of Agriculture and Fisheries (a matter which has been delayed since 1945) the provision of additional staff has not been considered advisable. A definite date (October, 1949) for transference of the duties has now been made known. Inspections and re-inspections show that in the majority there is an undoubted desire on the part of licencees to provide milk of the requisite standard.

Tuberculosis: Wherever a case of tuberculosis is thought to be bovine in origin, Divisional Medical Officers seek to trace the infection with the assistance of a County Sanitary Inspector and in co-operation with a Veterinary Inspector of the Ministry of Agriculture and Fisheries.

Supply of Milk to School Children—Under the existing scheme milk is supplied to school children in one-third pint bottles. The only exceptions to this arrangement are the more isolated schools, which of necessity, must be supplied with liquid milk or dried milk. The popularity of the scheme is evidenced by the continued increase in the amount of milk supplied. This amount has risen from 23,000,000 bottles in 1935 to 34,198,789 bottles in 1948, as detailed below:—

Total bottles supplied ...	34,198,789.	Average number of bottles per day ...	165,373
Total number of schools supplied with milk (a)	in bottles.	944	
(b)	in bulk.	9	
		1,003	

Each farm or dairy is inspected and approved before a contract is entered into for the supply of milk therefrom to schools and, subsequently, samples of the milk are regularly obtained from the schools. The statement given shows the results of examination of such samples during the year:—

	Numbers and Percentages.		
Class of Milk.	*Satisfactory.*	*Unsatisfactory.*	*Totals.*
Pasteurised	209 (84·6)	38 (15·4)	247
Other	95 (72·5)	36 (27·5)	131
Totals	304 (80·4)	74 (19·6)	378

Milk Samples under Regulation 55G.—Samples from "heat-treated" milk establishments have been collected on behalf of the Ministry of Food, and reports are forwarded each month to the Ministry, and immediately when an unsatisfactory sample is found. During the year samples were obtained as follows:—

	No. obtained.	Satisfactory.	Unsatisfactory.
Pasteurised	281	269	12
Heat-Treated	45	39	6
Tuberculin Tested—Pasteurised	56	51	5

Food and Drugs Act, 1938

All County Inspectors of Weights and Measures are appointed Sampling Officers for the purpose of the above Act, and the work of sampling is carried out under the control of the Chief Inspector of Weights and Measures, Mr. J. W. Hopkinson, who has compiled the following report.

"During the year 1st January to 31st December, 1948, 3,782 samples were procured and submitted to the Public Analyst for examination and report. A brief summary and classification of samples is given hereunder:—

Milk	3,011
Milk Products (Butter, cheese, etc.)	33
Meat Products	57
Oils and Fat Products	54
Soup and Vegetable Products	11
Cereals, etc.	123
Miscellaneous (Essences, Gravy Salts, etc.)	61
Beverages	122
Sauces and Condiments	125
Fruit Preserves and Sugar	85
Drugs	100
Total	3,782

Fifteen prosecutions were taken in respect of Milks alleged to contain added water and the total fines (including costs) imposed by the several Courts were £100 18s. 6d. Three prosecutions were taken in respect of fat deficiencies in Milk samples and total fines (including costs) imposed were £3 16s. 6d. A case against a butcher for selling sausages described as beef sausages and found to consist wholly or mainly of horseflesh resulted in the defendant being fined £22 13s. 6d. A sample submitted as coffee was reported by the Public Analyst to contain two parts coffee and one part chicory. The case against the sellers resulted in the imposition of fines and costs amounting to £4 12s. 6d.

In all nine districts milk sampling has been carried out frequently and approximately to a standard of three samples per 1,000 head of population. At several District Offices additional Inspectors have been stationed and private cars are being used in the work of sampling under the Food and Drugs Act, 1938. Improved adjustment of staff and better facilities for transport has enabled us to carry out systematic sampling throughout the administrative area. There is a high percentage of milk samples where solids not fat are reported by the Analyst to be below the presumptive standard but deemed insufficiently serious by the Clerk of the County Council to warrant the institution of proceedings. Enquiries revealed that this state of affairs is mainly created at the time when cows were having little pasture. Many farmers have indicated the difficulty in acquiring adequate fodder at the end of the winter feed.

Considerable attention was given by your Sampling Officers to the sale of mineral oil as a food substitute in the preparation of foods. One prosecution was taken, unsuccessfully, alleging the use of mineral oil in jam tarts. It is gratiying to learn that the Ministry of Food have now prohibited the use of the commodity in the preparation of food. It was easy to establish that mineral oil of the viscosity of the stuff being retailed as "Cooking Compound" had no food value, but it was another matter proving deleterious effect on consumers of pies, pastry, etc. in which this commodity had been used in preparation, mainly because it had some degree of refinement. Crude oil would have been described as injurious.

A scheme is in operation whereby the County Council pays the fees of the Public Analyst for all samples of milk taken by Sampling Officers of West Riding County District Councils in accordance with regulations made under the scheme, and also conducts all legal proceedings and defrays all consequential legal expenses. The number of samples of milk submitted for analysis under the scheme in 1948 was 563 of which 15 were found to be adulterated."

Sanitary Circumstances

Housing (Rural Workers) Acts—363 annual inspections of cottages (for which grants have been made under the above Acts) were made. Detailed reports as to tenancies, structural conditions, etc., are prepared and forwarded to the Clerk of the County Council; defective conditions are notified to the owners.

Housing—The County District Councils have continued under difficulties their schemes for re-housing. The numbers of new houses provided during the year are as follows:—

	Permanent Traditional.	*Permanent Prefabricated.*	*Permanent Aluminium Bungalows.*	*Temporary.*	*Total.*
Municipal Boroughs	954	289	19	—	1,262
Urban Districts	2,885	1,190	397	409	4,881
Rural Districts	1,030	528	542	60	2,160

No formal surveys by County Sanitary Staff under the Housing Act, 1936, were carried out but it is hoped to start this valuable work again in the near future.

Water Supplies—Investigations were carried out by the County Sanitary Inspectors in 41 instances, in connection with suspected water supplies.

During the year samples of water were obtained by the officers of Municipal Borough and Urban and Rural District Councils and at the time of compiling this report, the figures are as set out below:—

	Chemical Analysis.			Bacteriological Examination.		
	Number.	Sat.	Unsat.	Number.	Sat.	Unsat.
Municipal Boroughs and Urban District Councils	482	472	10	1,554	1,372	182
Rural Districts ...	106	97	9	565	425	140

Extensions to the existing water services were carried out to the number of 38 in the Municipal Boroughs and Urban Districts, in connection with new housing sites, and in the Rural Districts the number was 9 extensions.

The following schemes relating to water supply were submitted during the year under the Rural Water Supplies and Sewerage Act, 1944, to the County Council:—

Authority.	Scheme.	Amount. £.	Remarks.
Denby Dale Urban District	Water Supply to Birdsedge, High Flatts and Upper Denby	12,040	Forwarded to Ministry.
Goole Rural District	Water Supply, Marshland Area.	14,040	Amended Scheme submitted.
Kirkburton Urban District	Water Supply, Flockton Parish.	6,303	Forwarded to Ministry.
Penistone Urban District	Water Supply, Hoylandswaine.	9,625	Awaiting Report by Consulting Engineer.
Rotherham Rural District	Water Supply, Hooton Roberts Parish.	889	Forwarded to Ministry.
,,	Roofing-in of Dalton Reservoir.	2,500	Scheme amended to £1,739. No further information.
,,	Roofing-in of Wickersley Reservoir.	6,030	Scheme amended to £3,816. No further information
Settle Rural District	Water Supply to Helwith Bridge area.	3,176	Forwarded to Ministry.
,,	Purchase of Daw Haw Spring to augment Langcliffe supply.	1,653	Forwarded to Ministry.
Skipton Rural District	Water Supply to Embsay Parish.	2,914	Awaiting Report by Consulting Engineer.
,,	Water Supply to Grassington Parish	2,950	,,
,,	Development of existing water supplies.	260,000	Consulting Engineer has reported and Scheme forwarded to Ministry.
Tadcaster Rural District	Water Supply, Lumby Parish.	3,500	Ministry Grant: £1,500. County Council Grant: £1,094.
,,	Water Main Extension, Acaster Malbis and Copmanthorpe.	1,312	Ministry Grant: £200. County Council Grant: £200.
,,	Water Supply, Little Fenton.	3,843	Ministry Grant: £1,800. County Council Grant: £1,180.
,,	Water Supply, Acaster. Selby.	4,312	Ministry Grant: £1,500. County Council Grant: £1,349.
,,	Water Supply to outlying farms in Ryther.	—	Awaiting Report by Consulting Engineer.
Thorne Rural District	Water Supply, East and West Banks, Stainforth.	1,230	No Grants.
Wakefield Rural District	Water Supply, Woolley and Notton.	57,300	Forwarded to Ministry.
Wetherby Rural District	Water Supply, North Rigton.	14,313	Ministry Grant: £4,500. County Council Grant: £3,555.
Wharfedale Rural District	Water Supply, Blubberhouses, Fewston, Clifton-with-Norwood.	16,100	Forwarded to Ministry.

Many supplies in the County are known, or suspected to be plumbo-solvent and during the year 254 routine samples from 64 supplies were examined for the presence of lead, the samples being taken in pairs (a) after the water had stood in lead service pipes for 30 minutes, and (b) after standing in the pipes all night. In the case of only two supplies was lead found to be present in quantities considered to be injurious to health. Repeat samples taken from one of these two were found to be satisfactory.

Sanitary Accommodation at Schools—Difficulties in regard to modernising out of date sanitary accommodation in schools continues much as before and very little work has been done in this important field during the year. Recommendations for improvements were formally put to the Education Department in only 5 cases. It is of course evident that the teaching of hygiene is made more difficult in schools where poor sanitary arrangements and lack of washing facilities are in evidence. It is hoped that the time will shortly arrive when this important detail can receive more attention.

Co-operation with the Officials of County Districts—The County Sanitary Inspectors from time to time make frequent visits into the County Districts for discussions with the local officials regarding the general sanitary circumstances of the districts. Advice is given in connection with all technical matters appertaining to public health work. During the year 136 meetings were held.

Sewerage and Sewage Disposal—Schemes relating to sewerage and sewage disposal were submitted under the Rural Water Supplies and Sewerage Act, 1944, to the County Council as under :—

Authority.	Scheme.	Amount. £.	Remarks.
Doncaster Rural District	Sewerage and Sewage Disposal, Clifton Village.	4,200	Forwarded to Ministry.
Rotherham Rural District	Sewerage Scheme, Ravenfield Parish.	4,875	Following Consulting Engineer's Report—referred back to Rural Council.
,,	Sewerage Scheme, Hooton Roberts Parish.	5,260	,,
Tadcaster Rural District	Sewerage Scheme, Saxton, Barkston and Church Fenton Parishes.	65,000	Forwarded to Ministry.
Thorne Rural District	Sewerage Scheme, Kirton Lane.	13,650	Awaiting decision of Committee.
,,	Sewerage Scheme, Lane Ends, Thorne.	13,750	Forwarded to Ministry.
,,	Sewerage Scheme, Broadway, Hatfield.	21,000	Forwarded to Ministry.
,,	Sewerage Scheme, Dunscroft.	18,900	Awaiting Report by Consulting Engineer.
Wakefield Rural District	Sewerage Scheme, Notton.	—	Awaiting Report by Consulting Engineer.
Wetherby Rural District	Sewerage and Sewage Disposal, Thorp Arch.	—	Awaiting Report by Consulting Engineer.
,,	Sewerage Scheme (Western Area), Weeton and North Rigton.	12,300	Ministry Grant: £5,000. County Council Grant: £3,571.

Summary of visits and other duties carried out by the County Sanitary Inspectors:—

"Tuberculin Tested" Milk:—	
Survey of farms in connection with applications for licences	261
Re-visits to applicants' farms	210
Farm Visits	980
"Accredited" Milk:—	
Survey of farms in connection with applications for licences	126
Re-visits to applicants' farms	75
Farm Visits	1,617
Visits to "ordinary" milk farms	22
Visits in connection with school milk	46
Visit regarding tuberculous milk	1
Visits regarding undulant fever	2
Food and Drugs Act, 1938:—	
Wholesale storage of margarine	2
Suspected food poisoning	20
Unsound meat	3
Miscellaneous:—	
Pigkeeping nuisance	1
Water supplies and samples	41
Swimming pools	4
Sanitary accommodation at Schools	5
Smoke Abatement Meetings	2
Smoke observations	63
Ministry of Health inquiries attended regarding Water Supplies and Sewerage	11
Proposed public conveniences	1
Refuse Tips	3
Vermin infestation	1
Rats and Mice (Destruction) Act	4
Nuisances investigated	8
Housing conditions	9
Housing (Rural Workers) Acts	363
Interviews with officials of the County Districts	136
Appointment of Sanitary Inspectors	4
County Agricultural Executive Committee Meetings	11

PART XI

OTHER PUBLIC HEALTH SERVICES

Dietetics

During the year 1948 the dietitians continued to work in the County Hospitals, etc., supervising the diet, advising on equipment, seeing special diet patients and lecturing to nurses until the change over to the Regional Hospital Boards on July 5th. Since that date, in the absence of any definite arrangement with the Regional Boards they have continued to attend those hospitals etc. where their services have been requested by the Medical Superintendent or Matron to give advice or any assistance required. By arrangement with the County Welfare Officer the residential establishments and childrens homes have been visited and a report has been submitted to him, covering such points as general standards, menus, equipment, buildings and storage facilities, personnel and service. Where necessary improvements have been suggested and suitable specimen menus given. It is hoped that it will be possible to maintain contact with these establishments.

The day nurseries in the area, including those taken over on the 5th July, 1948, from certain County District Councils on the transfer of the functions relating to maternity and child welfare, have been visited. Special attention was given to equipment, the arrangement of the dietaries and the uptake of full allowances of food. Regular visits are being continued. The Dietitians have visited each of the Divisional Medical Officers to discuss the possibilities of extending their work within the divisions. It was agreed that the most effective ways of promoting nutritional education to the general public were as follows:—

1. By lectures on nutrition and advice as to methods of nutrition teaching to Health Visitors, Midwives and Home Nurses, these to be augmented in certain areas by personal visits of the Dietitians to ante-natal and infant welfare centres; 2. By arranging courses of lectures on nutrition, service of food and hygiene of food preparation, in industrial areas to which local employers would be invited to send their canteen workers; 3. It is hoped that special investigations will be carried out in the near future on the feeding problems of old people living alone.

A refresher course of three lectures on special diets has been given, in each of four areas in the County, to Health Visitors to help them in the extension of their duties in connection with the after-care of patients leaving hospital.

A series of talks has also been given to adults in an Evening Technical College. A pilot survey was made in the urban area of Pontefract and in the surrounding rural areas in which the extent to which families supplement their standard rations with unrationed and home produced foods was studied. The results of this survey, while giving a useful picture of food habits in the area, did not warrant an extension to a larger area. The Dietitians were invited to inspect and submit a report on a Colliery Canteen in the Rotherham area.

National Assistance Act, 1948

At a special meeting of the West Riding Health Committee on the 20th January, 1948, it was decided:—

(a) That, consequent upon the National Assistance Act, the existing Health and Welfare Departments be merged into a single Department to be known as the Health Department, with Medical and Welfare Divisions, joint office accommodation for health and welfare services being provided wherever possible.

(b) That the Medical Division, under the direction of the County Medical Officer, be responsible, in collaboration with the County Welfare Officer, for the following services under the National Assistance Act:—

1. The medical arrangements for all classes of persons in residential establishments, with a view to providing a complete health service, with special reference to the rehabilitation of the aged.
2. The appointment of local medical practitioners to attend at residential establishments.
3. The visitation of all residential establishments by the County Dietitians.
4. The attendance at the small Old People's Homes of district nurses to assist as may be required with minor illness not requiring hospital treatment.
5. The periodical examination of persons in the larger Homes (County Welfare Institutions) as to the necessity for optical, dental or other treatment.
6. The provision of Home Helps where required by blind, deaf or dumb, or other handicapped persons dealt with by the Welfare Division.
7. The inspection of Disabled or Old Persons' Homes, both prior and subsequent to registration.
8. The examination of and advice as to the type of work or employment suitable for blind, deaf, dumb or handicapped persons who desire to avail themselves of the County Welfare organisation.

(c) That the Welfare Division under the County Welfare Officer be responsible for all County Services under the National Assistance Act not referred to in (b) above.

The following is a brief outline of the duties concerning residential establishments to be rendered by the Medical Division:—

1. The duties of making the medical arrangements (including medical ancillary services for residential establishments) will be delegated to the Divisional Medical Officers in whose area the establishments are situated.

County residential establishments (if any) situated in County Boroughs will become the responsibility of Divisional Medical Officers as follows:—

In Wakefield	Division	No. 13.
In Dewsbury	,,	,, 15.
In Bradford	,,	,, 4.
In Huddersfield	,,	,, 20.
In Halifax	,,	,, 18.
In Barnsley	,,	,, 24.
In Rotherham	,,	,, 31.
In Doncaster	,,	,, 28.

The Divisional Medical Officer will undertake the general medical supervision of the premises; advise on any medical problems reported to him by a general medical practitioner or other person; advise (in collaboration with the Medical Officer of Health in those cases where he himself does not hold this position) on action to be taken on the outbreak of infectious disease; ensure that all services provided by the County Council (or a County Borough Council) under the National Health Service Act, 1946, or otherwise, are available to residents in the establishment; and generally satisfy himself that the medical welfare of the residents is kept at a high level.

The Divisional Medical Officer, if requested, will assist the Divisional Welfare Officer in determining whether a person is suitable for admission to a residential establishment.

2. M/H Circular 87/48 paragraph 18 states that residents in residential establishments "will have the same right to the services of a family doctor and the same freedom to choose a doctor as if they were living in their own homes." Thus it would appear that the Divisional Medical Officer will have general medical supervision of the premises and that any medical treatment in the residential establishment would be provided by practitioners undertaking service under the National Health Service Act. Where necessary the Divisional Medical Officer will assist in the appointment of local medical practitioners to attend at residential establishments.

3. Residential establishments will be placed on the list of the appropriate County Dietitian for regular visitation and a copy of her report will be sent to the Divisional Medical Officer. The Divisional Medical Officer may ask the County Dietitian to make additional or special visits.

4. The Divisional Medical Officer will arrange as required for services under the National Health Service Act to be available to persons in residential establishments. This will include the attendance of Home Nurses where necessary for the treatment of minor illnesses not requiring hospital treatment.

5. The medical practitioner is responsible for the medical care and treatment of his patient in the residential establishment and thus may call on the services of a geriatric or other specialist as he considers necessary.

It is intended in addition to recommend to the Health Committee that the Regional Hospital Boards be approached with a view to obtaining the services of one or more geriatric specialists who would be available at the various residential establishments to carry out medical examinations and conduct research into the problems of the aged.

Regular dental inspections will be carried out by the County Dental staff and regular ophthalmic inspections will be undertaken by the County oculist or by local ophthalmic surgeons.

Visits by other specialists will be arranged as necessary.

6. He will also arrange for the provision of Home Helps as necessary as part of his general duties to provide all services under the National Health Service Act.

7. He will also inspect Disabled or Old Persons' Homes and will report on their suitability for registration. Subsequent inspections of registered homes will be carried out at intervals of not more than one year.

8. He will also have the duty of arranging for the examination and advising as to the type of work or employment suitable for blind, deaf, dumb or handicapped persons who desire to avail themselves of the County Welfare organisation.

Medical Examination of County Staff

An appointment to a superannuable post is subject to the applicant providing a satisfactory medical certificate, completed on the prescribed form by his or her family doctor, and submitted to the County Medical Officer for approval. Any fee for this examination is payable by the person examined. Should the medical certificate prove inconclusive a specialist's opinion is obtained at the expense of the County Council and the findings are made available to the family doctor.

During the year, 2,466 medical certificates were submitted for approval and of these, 46 were not approved. In 28 cases, further enquiries were made from the medical practitioner completing the certificate, and 134 cases were referred for a specialist's opinion.

In addition, 89 special medical examinations of staff were arranged at the request of employing departments.

Health Centres

The date for submission of proposals under section 21 of the National Health Service Act, 1946, has not yet been given but Ministry of Health Circular 3/48 stated that urgent proposals could be put forward for consideration. A health centre, as defined in the Act, would include facilities for all or any of the following: general medical services by medical practitioners; general dental services by dental practitioners; pharmaceutical services by registered pharmacists; services provided by the local health authority; services provided by specialists. Therefore, although a comprehensive scheme for health centres cannot be formulated at the moment the waiting period until the submission of a plan is useful for considering and formulating the policy to be pursued. The local health authority services are mainly under section 22 of the Act and are concerned with making arrangements for the care of mothers and young children but, as an education authority, provision for minor ailment and specialist clinics is also necessary. It is thought that one main multi-clinic in each of the 31 divisions, with possible exceptions where a division has more than one large centre of population, would be the best foundation for a scheme on which to build a comprehensive service. Such a multi-clinic would be a nucleus to which to add as opportunity permitted and as the executive council and the hospital board agreed, facilities for general medical practitioners, dental practitioners, pharmacists and specialists thus constituting a main health centre. It is envisaged that round these main centres would be satellite centres where facilities would be provided on a lesser scale; for example, the local health authority services might be limited to an infant welfare centre and ante-natal clinic, and provision made only for medical practitioner services, the satellite centres looking to the main centre for specialist clinics and dental services. During the year two applications were submitted by medical practitioners in two areas of the county for health centre facilities and these are receiving careful consideration in view of the general position regarding the provision of health centres as outlined in the Ministry of Health Circulars. It is anticipated that the authority will consider a report on health centres during the year 1949 and decide on the principles to be adopted with regard to provision of multi-clinics in all divisions, obtaining sites sufficient for extension into health centres, submission of schemes for the erection of experimental health centres or for health centres urgently required in new housing estates.

Registration of Nursing Homes

(Public Health Act, 1936, Sections 187-195).

Eight Homes were first registered during the year. The number of Homes on the register at the end of the year was 46 providing 93 beds for maternity cases and 242 for other cases. No applications for registration were refused and one exemption was granted under the provisions of Section 192 (1) of the Act.

The Employment of Specialists in Preventive Medical Services

A conference between representatives of the Leeds Regional Hospital Board and Local Health Authorities was held on the 21st October, 1948, and certain general principles were formulated to guide the relationship of the Board and an Authority in respect of complementary medical services under the National Health Service Act, 1946.

With regard to specialists, other than tuberculosis specialists, the following general principle was agreed:—

> In regard to paediatrics, obstetrics, orthopaedics, oto-rhino laryngology, ophthalmology, dermatology, venereal diseases, psychiatry and mental deficiency, it is recommended that it should be sufficient if the Board, after consulting the Local Authority with regard to their specialist needs, makes the appointments in accordance with the terms of the N.H.S. (Appointment of Specialists) Regulations, 1948. In these cases the duties and responsibilities of the specialists in regard to the preventive and after-care services of the Local Authority will be clearly defined in the terms of the appointments. No question of the apportionment of remuneration between the Board and the Authority will arise in regard to those who hold full-time posts under the Board, but it would be open to Local Authorities to contract directly at their own expense with individual part-time specialists.

Thus, where the Board makes appointments of whole-time specialists (after consultation with the Local Health Authority) the duties which such whole-time specialists will undertake for the Authority will be defined in the terms of the appointments. The Authority can make part-time appointments by direct contract and will need to appoint a whole-time child guidance psychiatrist.

A statement of our needs is given below; the allocation to the school health service being shown where appropriate.

1. Paediatricians (Children's Specialists).

1 session per week per 10,000 children.	The equivalent in whole-time specialists—3. (2 to Education).

Duties and responsibilities.

(1) To hold paediatric clinics for handicapped and other children in need of specialist advice as to health or special educational requirements; to report to the authority on cases seen and, where necessary, discuss steps to be taken for special educational treatment.

(2) To hold special baby clinics if required.

(3) To be the guide, philosopher and friend of the medical staff engaged in clinical work in schools and child welfare clinics; to consult with them on difficult cases; to give time to special clinical meetings, ward rounds, or by other means maintain their interest and knowledge of children's diseases at a high level.

(4) To assist in research in problems of child health.

(5) To give time to discussion with the County and School Medical Officer or his staff on the measures to be taken to apply paediatric knowledge to the planning of preventive medicine in relation to children.

(6) To visit schools, child welfare centres, day and residential nurseries, children's homes, and special schools in agreement with the County Medical Officer.

(7) To act as consultant adviser in schemes for safeguarding premature babies and in any other measures to cut down infant mortality.

(8) To act as consultant adviser in paediatrics to any child guidance centres established in the area.

2. Obstetricians.

1 session per week per 1,000 births.	Equivalent in whole-time specialists—3.

Duties and responsibilities.

(1) To hold consultant obstetric clinics for difficult midwifery in divisions as necessary.

(2) To be the guide, philosopher and friend of the medical staff engaged in clinical work in ante-natal clinics; to consult with them in difficult cases; to give time to special clinical meetings, ward rounds or by other means maintain their interest and knowledge of preventive obstetrics at a high level.

(3) To assist in maintaining the standards of practice of midwives practising in the area.

(4) To investigate maternal deaths jointly with the County Medical Officer or his staff.

(5) To assist and advise on research into the causes of maternal morbidity and mortality special to the area.

(6) To give time to discussion with the County Medical Officer or his staff on the measures to be taken to apply obstetric knowledge to the planning of preventive medicine in relation to child-birth.

3. Orthopaedic Surgeons.

1 session per week per 20,000 children.	Equivalent in whole-time specialists—1½. (1 to Education).

Duties and responsibilities.

(1) To hold orthopaedic clinics in divisions for physically handicapped children and to advise the authority on children requiring special educational treatment for orthopaedic defects.

(2) To guide the medical staff and the physiotherapists engaged in school health and child welfare work in the requirements of good orthopaedics; in the diagnosis of early defects and the giving of preventive advice; to give time to occasional clinical demonstrations or ward rounds or in other ways to maintain the interest and knowledge of the staff at a high level.

(3) To visit schools and advise physical training organisers in the application of orthopaedics to physical training.
(4) To assist in research into orthopaedic defects.
(5) To be the consultant adviser to any school for physically handicapped children in the area.
(6) To give time to discussion with the County and School Medical Officer on the application of orthopaedic knowledge and the planning of preventive medicine in relation to crippling defects.
(7) To be consultant adviser in orthopaedics to any home for the aged or for the welfare of handicapped persons in the area.

4. Oto-rhino Laryngologists.

1 session a week per 40,000 children.	Equivalent in whole-time specialists—2/3. (All to Education).

Duties and responsibilities.
(1) To hold clinics for children with ear, nose and throat defects; to report to the authority on the measures to be taken for special educational treatment of handicapped children.
(2) To advise on the after-care of children in relation to physiotherapy and to consult with the dental officer on orthodontic problems.
(3) To assist in research.
(4) To give time to discussion with the County and School Medical Officer or his staff on measures to be taken to apply specialist knowledge to the planning of preventive medicine in relation to ear, nose and throat.
(5) To assist and advise in the ascertainment of the partially deaf in school.
(6) To visit schools from time to time on the problem of special education for the partially deaf.
(7) To act as consultant adviser to any school for partially deaf in the area.

5. Ophthalmologists.

1 session a week per 500,000 population.	Equivalent in whole-time specialists—3/10. (80% to Education).

Duties and responsibilites.
(1) To advise on the detection of visual defects in schools.
(2) To act as consultant adviser to any school for partially blind established by the authority.
(3) To advise in the ascertainment of blind and partially sighted children.
(4) To give time to discussion with the County and School Medical Officer or his staff on measures to apply specialist knowledge to the prevention of blindness in children and adults.
(5) To advise in the welfare of the blind handicapped under the National Assistance Act, 1948, and to make such examinations as are necessary in their ascertainment and supervision.
(6) To hold a clinic for any of the above purposes, if necessary, from time to time.

6. Dermatologist.

1 session a week per 1,500,000 population.	Equivalent in whole-time specialists—1/10. (60% to Education).

Duties and responsibilities.
(1) To give time to discussion with the County and School Medical Officer, on measures to be taken to apply specialist knowledge to the prevention of skin diseases.
(2) To hold a clinic as required.
(3) To visit areas and schools at which skin conditions may be prevalent for the purpose of advising on preventive measures.
(4) To guide the medical staff engaged in school health work on special aspects of skin diseases; to consult with them on difficult cases; to give time to clinical meetings, ward rounds, lectures or by other means maintain their interest and knowledge of skin diseases at a high level.

7. Venereologists.

1 session a week per 75,000 population.	Equivalent in whole-time specialists—2.

Duties and responsibilities.
(1) To be responsible to the County Medical Officer for the tracing of contacts and defaulters in the area covered.
(2) To guide the activities of the County V.D. social workers of the area.
(3) To give time to consultation with the County Medical Officer or his staff on the application of specialist knowledge in venereal diseases, to the planning of preventive medicine, in preventing the spread of venereal infection and its eradication.
(4) To give time to health education in relation to V.D. by speaking to ready-made audiences, special audiences or in any other way which seems suitable to the needs of the area.

8. Psychiatrists.

(a) For Lunacy:	1 session a week per 300,000 population.	Equivalent in whole-time specialists—½. (None to Education).
(b) for Mental Deficiency:	do.	Equivalent in whole-time specialists—½. (50% to Education).
(c) for Child Guidance:	1 session per 30,000 children.	Equivalent in whole-time specialists—1. (All to Education).

Duties and responsibilities.

Psychiatrist in Lunacy—The psychiatrist in lunacy will plan with the County Medical Officer the services of safeguarding the mental health of the community; advise on action to be taken under the Lunacy and Mental Treatment Acts; advise and teach the mental health workers engaged in the care and supervision of patients on trial or those boarded out from mental hospitals, including lectures and lecture demonstrations; advise the duly authorised officers engaged in the ascertainment of persons of unsound mind.

Psychiatrist in Mental Deficiency—The psychiatrist in mental deficiency will plan with the County Medical Officer all services in connection with mental subnormality, particularly for prevention; advise on the ascertainment of mental defectives; advise and guide professionally the Divisional Medical Officers and Assistant County Medical Officers approved for the purpose of certification of mental defectives, including the holding of professional meetings and practical demonstrations in the colony; assist in maintaining the professional status of the work of the mental health social workers and home teachers; assist in the planning of occupation centres and other forms of occupation and advise on the work undertaken in occupation centres or elsewhere; visit remand homes and report on the educationally subnormal matters; visit and report on the work of special schools for educationally subnormal children and, if the Regional Hospital Boards request the Local Health Authority to undertake those duties on behalf of the Hospital Management Committees, advise Divisional Medical Officers on the problems of patients on licence from mental deficiency colonies and institutions.

Special application to Education.

(1) To advise on, and examine, border line cases of educational subnormality.
(2) To give time to discussion with the County and School Medical Officer or his staff, on matters relating to mental deficiency in school children.
(3) To act as consultant adviser to any special schools for educationally subnormal or epileptic children.
(4) To assist in research on the prevention of mental deficiency.
(5) To assist the school medical staff engaged on clinical work, and consult with them on difficult cases.

Psychiatrist in Child Guidance.

(1) To hold four child guidance centres in different parts of the County.
(2) To supervise and control the work of the psychiatric social workers.
(3) To guide the work in the maladjusted hostels and schools.
(4) To visit schools and advise teachers; to visit problem homes if necessary.
(5) To co-operate with the paediatricians and educational psychologists in child guidance work.
(6) To take part in research into the prevention of maladjustment.
(7) To give time to discussion with the County and School Medical Officer or his staff on child guidance problems.

9. Geriatric Specialists.

3 sessions a week per 500,000 population. — Equivalent in whole-time specialists—1.

Duties and responsibilities.

(1) To undertake duties in the hostels and other residential establishments for the aged.
(2) To advise the County Medical Officer on problems peculiar to the aged.
(3) To undertake research.

10. Consultant Tuberculosis Officers.

1 session a week per 75,000 population. — Equivalent in whole-time specialists—2.

The principles agreed between the Leeds Regional Hospital Board and the Local Health Authorities are different for those relating to other specialists and are quoted below:—

(i) The chest physician shall be of full consultant status and be under the same conditions of remuneration as other specialists.
(ii) The chest physician shall be appointed by the regional hospital board in accordance with the terms of the N.H.S. (Appointment of Specialists) Regulations, 1948; i.e., before formal appointment by the board he shall have been selected by a committee that complies with the requirements laid down in the Regulations for an Advisory Appointments Committee.
(iii) Representatives of local health authority or authorities with whom the chest physician will be associated in community work will be invited to be present when the appointment is being made.
(iv) The chest physician shall also be appointed as consultant adviser to the local health authority or authorities concerned.
(v) The regional hospital board may be reimbursed by the local health authority for their share of the services of the chest physician in accordance with instructions which are expected from the Ministry on this subject. In agreeing to this principle, however, local health authorities are not deemed to have committed themselves to payment.

Duties and responsibilities.

(1) By personal contact with the Divisional Medical Officers in his area to act as guide, philosopher and friend on all matters relating to tuberculosis.
(2) To advise on preventive measures, e.g. the search for contacts for examination; the follow up of newly notified cases; the segregation of the infectious case; the housing of the tuberculous family; the provision of home nurses and home helps.
(3) To recommend such measures as are necessary for the care of the tuberculous patient and family, e.g. the provision of open-air shelters, beds and bedding, clothing, extra nourishment.
(4) To advise on the after-care of the tuberculous patient—problems of re-employment, training and resettlement, continued occupational therapy, and general rehabilitation measures.
(5) To notify the Divisional Medical Officers of patients recommended for sanatorium treatment and on their pre-sanatorium care.
(6) To co-operate with the Divisional Medical Officers to ensure an effective tuberculosis nursing service, to provide nursing assistance at the dispensaries and the domiciliary visiting of the tuberculous patient.
(7) To advise the Divisional Medical Officers of all changes affecting the notification register, i.e. recoveries, deaths, revision of diagnosis, etc. Similarly the Divisional Medical Officer will advise the Tuberculosis Officers of such changes as come to his notice.
(8) The foregoing duties relate specifically to suspected or notified cases of tuberculosis. A similar relationship will be established in reference to non-tuberculous chest conditions which may be referred to the dispensaries, i.e. bronchitis, bronchiectasis, lung growths, etc.

PART XII

STAFF

(December, 1948).

C. Fraser Brockington, M.A., M.D., B.Ch., D.P.H., M.R.C.S., L.R.C.P., Barrister-at-Law.
(County Medical Officer and School Medical Officer).

HEADQUARTERS

J. Wood Wilson, M.D., Ch.B., D.P.H. ...	Deputy County Medical Officer.
G. S. Johnston, M.D., Ch.B., D.P.H. ...	Tuberculosis—Prevention and After-Care. (Part-time).
J. M. Anderson, M.R.C.S., L.R.C.P. ...	Senior Medical Officer for Maternity and Child Welfare.
J. A. Burgess, M.D., Ch.B., D.P.H. ...	Venereologist (Part-time).
A. F. Turner, M.B., B.Ch., D.P.H. ...	Senior Medical Officer for School Health.
C. C. Harvey, B.Sc., M.D., B.S., F.R.C.S., M.R.C.P.	Paediatrician.
H. J. O'Loughlin, M.B., Ch.B., L.R.C.P., D.P.M.	Mental Health (Part-time).
B. R. Townend, F.D.S., R.C.S., L.D.S. ...	Chief Dental Officer.
Vacancy	Psychiatrist.
Miss D. Walker	Superintendent Health Visitor.
Miss A. Carey	Area Superintendent Health Visitor.
Miss A. M. Clarke	Area Superintendent Health Visitor.
Miss R. O'Brien	Area Superintendent Health Visitor.
Miss G. M. Harvey	Supervisor of Midwives.
Miss E. M. Taylor	Supervisor of Midwives.
Miss H. Brooks	Supervisor of Day Nurseries.
Miss E. M. Greenwood	Superintendent Home Nurse.
Miss G. Jones	Assistant Superintendent Home Nurse.
Miss W. Pallister	Assistant Superintendent Home Nurse.
Miss C. M. Wood	Public Health and Hospital Dietitian.
Miss E. Washington	Public Health and Hospital Dietitian.
Vacancy	Senior Speech Therapist.
Mrs. M. I. Morrison	Domestic Help Organiser.
L. Butterworth [1], [2], [4], [5]	Acting Chief County Sanitary Inspector.
H. Tayler [1], [2], [6]	County Sanitary Inspector.
R. D. Irving [1], [2], [7], [9]	County Sanitary Inspector.
F. C. Brookes [1], [2]	County Sanitary Inspector.

Clerical Staff.

J. Colman [1], [3], [8]—Chief Clerk

Senior Clerks—J. W. Beaumont [1], B. E. Allenby, H. Bywater, G. Richardson [7], A. Charlesworth.

DIVISIONAL MEDICAL OFFICERS (25% School Health).

M. Hunter, M.B.E., M.D., Ch. B., D.P.H.	Division	No. 1 (Skipton).
D. P. Lambert, M.D., D.P.H., D.T.M., D.T.H.	,,	No. 2 (Settle).
H. M. Holt, M.B., B.S., D.P.H.	,,	No. 3 (Keighley).
J. Battersby, M.B., Ch.B., D.P.H.	,,	No. 4 (Shipley).
G. P. Holderness, M.B., Ch.B., D.P.H.	,,	No. 5 (Pudsey).
R. A. W. Procter, M.C., M.A., M.B., Ch.B., M.R.C.S., L.R.C.P., D.P.H., D.T.M.	,,	No. 6 (Otley).
N. V. Hepple, M.D., B.S., B.Hy., D.P.H. ...	,,	No. 7 (Ripon).
D. D. Payne, M.D., B.S., M.R.C.S., L.R.C.P., D.P.H.	,,	No. 8 (Harrogate).
R. G. Smithson, M.D., Ch.B., D.P.H.	,,	No. 9 (Wetherby).
S. K. Appleton, M.D., Ch.B., D.P.H., D.T.M. ...	,,	No. 10 (Goole).
J. M. Paterson, M.B., Ch.B., D.P.H.	,,	No. 11 (Castleford).
J. F. Fraser, M.B., B.S., D.P.H., D.Obst.R.C.O.G.	,,	No. 12 (Pontefract).
W. G. Evans, M.A., M.B., B.Ch., M.R.C.S., L.R.C.P., D.P.H.	,,	No. 13 (Ossett).
F. G. E. Hill, D.S.O., M.B., Ch.B., D.P.H. ...	,,	No. 14 (Morley).
W. J. Frain, M.B., Ch.B., D.P.H.	,,	No. 15 (Batley).

(1) Sanitary Inspectors' Cert. Royal Sanitary Inst.
(2) Cert. as Inspector of Meat and Other Foods, Royal Sanitary Inst.
(3) Exam. in Sanitary Science as applied to Buildings and Public Works, Royal Sanitary Inst.
(4) Final Cert. Builders' Quantities, London City and Guilds.
(5) Final Cert. (Distinction) Builders' Quantities, Lancashire and Cheshire Inst.
(6) Testamur—Inst. of Municipal and County Engineers.
(7) Diploma in Public Administration.
(8) Associate Chartered Inst. of Secretaries.
(9) Sanitary Science Cert. (Liverpool University).

DIVISIONAL MEDICAL OFFICERS—continued.

A. L. Taylor, M.D., Ch.B., D.P.H., L.D.S.	Division	No. 16	(Rothwell).
W. M. Douglas, M.B., Ch.B., D.P.H.	,,	No. 17	(Mirfield).
F. Appleton, M.B., Ch.B., D.P.H.	,,	No. 18	(Brighouse).
J. Lyons, M.B., Ch.B., M.R.C.S., L.R.C.P., D.P.H.	,,	No. 19	(Todmorden).
E. Ward, M.R.C.S., L.R.C.P., D.P.H.	,,	No. 20	(Colne Valley).
H. S. Bury, M.R.C.S., L.R.C.P., D.P.H.	,,	No. 21	(Saddleworth).
J. Main Russell, M.B., Ch.B., B.Hy., D.P.H.	,,	No. 22	(Wortley).
J. Warrack, M.B., Ch.B., D.P.H.	,,	No. 23	(Hemsworth).
A. Reeves, M.A., M.D., B.Ch., B.A.O., D.P.H.	,,	No. 24	(Cudworth).
R. S. Hynd, M.B., Ch.B., D.P.H.	,,	No. 25	(Wombwell).
A. Eustace, B.Sc., M.B., B.Ch., B.A.O., L.M., D.P.H.	,,	No. 26	(Wath).
J. Ferguson, M.B., Ch.B., D.P.H.	,,	No. 27	(Adwick-le-Street).
A. Penman, M.D., Ch.B., D.P.H.	,,	No. 28	(Doncaster).
B. Schroeder, M.B., Ch.B., D.P.H.	,,	No. 29	(Thorne).
J. Leiper, M.B.E., M.B., Ch.B., M.R.C.S., L.R.C.P., D.P.H.	,,	No. 30	(Mexborough).
J. M. Watt, M.D., Ch.B., D.P.H., D.C.H., D.Obst.R.C.O.G.	,,	No. 31	(Rotherham).

ASSISTANT COUNTY MEDICAL OFFICERS (50% School Health).

K. E. M. Allen, B.A., M.R.C.S., L.R.C.P.	(Division	No. 28).	
P. A. G. M. Ashmore, M.R.C.S., L.R.C.P.	,,	No. 7).	
E. R. M. Bowker, B.A., M.B., Ch.B.	,,	No. 16).	
*H. M. Bryant, M.B., Ch.B.	,,	No. 8).	
G. M. Buckle, M.B., B.S.	,,	No. 4).	
*A. T. Burn, M.B., B.S., D.P.H.	,,	No. 31).	
M. A. T. J. Curtin, M.B., B.Ch., B.A.O., D.P.H.	,,	No. 26).	
R. C. Davison, M.B., B.S.	,,	No. 8).	
B. R. A. Demaine, M.B., Ch.B., D.P.H.	,,	No. 30).	
C. M. Dornan, M.B., B.Ch.	,,	No. 28).	
*W. Ferguson, M.B., Ch.B., D.P.H.	,,	No. 22).	
D. E. Gledhill, M.B., Ch.B.	,,	No. 3).	
J. C. Goldthorpe, M.R.C.S., L.R.C.P.	,,	No. 2).	
*H. Gray, M.B., Ch.B., D.P.H.	,,	No. 4).	
I. Hargreaves, M.B., Ch.B.	,,	No. 13).	
S. G. A. Henriques, M.B., Ch.B.	,,	No. 24).	
M. A. Hillis, M.B., Ch.B.	,,	No. 6).	
*F. M. L. Holt, M.B., Ch.B., D.P.H.	,,	No. 3).	
S. Kelly, M.R.C.S., L.R.C.P.	,,	No. 17).	
*G. W. Knight, M.B., Ch.B., D.P.H.	,,	No. 18).	
R. B. Laidlaw-Becker, M.D., Ch.B., M.R.C.S., L.R.C.P., D.P.H., D.P.M.	,,	No. 29).	
*T. M. Lennox, M.B., B.Ch., B.A.O., D.P.H.	,,	No. 5).	
H. F. Lindsay, M.B., Ch.B.	,,	No. 30).	
S. Lindsay, M.B., Ch.B.	,,	No. 22).	
A. Marshall, M.B., Ch.B.	,,	No. 15).	
E. G. Matthews, M.R.C.S., L.R.C.P.	,,	No. 25).	
G. M. Mayhall, M.R.C.S., L.R.C.P.	,,	No. 12).	
M. M. Neil, M.B., Ch.B.	,,	No. 4).	
A. Seelig, M.D. (Strasbourg).	,,	No. 18).	
J. J. Smith, M.B., Ch. B., D.P.H.	,,	No. 23).	
F. D. F. Steede, M.B., B.Ch., B.A.O.	,,	No. 27).	
D. M. Summers, M.B., Ch.B.	,,	No. 16).	
H. J. Twomey, M.D., Ch.B., D.P.H.	,,	No. 9).	
*J. S. Walters, M.B., Ch.B., D.P.H.	,,	No. 11).	
N. M. Whalley, M.B., Ch.B.	,,	No. 11).	
J. E. M. White, M.R.C.S., L.R.C.P.	,,	No. 31).	
E. M. Whitehead, M.B., Ch.B.	,,	No. 17).	
*G. A. Wilthew, B.Sc., M.B., B.S.	,,	No. 19).	
A. P. Gorrie, M.B., Ch.B.	,,	No. 31).	

* Deputy Divisional Medical Officer.

SCHOOL OCULISTS (100% School Health).

R. Burns, M.B., B.Ch., B.A.O.
F. Fischer, M.D. (Vienna).
J. V. Kirkwood, M.B., Ch.B., D.P.H.
L. Wittels, M.D. (Vienna), D.O.

AREA DENTAL OFFICERS (95% School Health).

J. M. Enderby, L.D.S.
O. A. Long, L.D.S.
H. Marshall, L.D.S.
R. Sclare, L.D.S.
A. N. F. Stannard, L.D.S.

SCHOOL DENTAL OFFICERS (95% School Health).

C. M. Armstrong, L.D.S.
H. Barber, L.D.S.
W. H. Blewitt, L.D.S.
M. E. Brechin, L.D.S.
W. J. Brown, L.D.S.
G. H. Bulcock, L.D.S.
T. M. Bulcock, L.D.S.
F. W. Buzza, L.D.S.
H. D. Cawthra, L.D.S.
B. C. Clay, L.D.S.
W. H. Dyke, L.D.S.
W. H. Etheridge, L.D.S.
M. M. Gibson, L.D.S.
V. F. H. Golledge, L.D.S.
J. S. Griffiths, L.D.S.
J. Haddow, L.D.S.
M. Hattan, L.D.S.
S. Henry, L.D.S.
E. E. Jackson, L.D.S.
R. Jackson, L.D.S.
D. C. King, L.D.S.
S. Levinson, L.D.S.
J. Mackay, L.D.S.
J. D. Manson, B.Ch.D., L.D.S.
E. S. Midgley, L.D.S.
R. T. Mosbery, L.D.S.
M. H. Platford, L.D.S.
F. H. Sanderson, L.D.S.
B. Sleight, B.Ch.D., L.D.S.
M. Thom, L.D.S.
E. Thornton, L.D.S.
J. Todd, L.D.S.
J. R. Tuxford, L.D.S.
F. G. B. Wilson, L.D.S.
G. O. Wood, L.D.S.
H. M. Yuile, L.D.S.
A. M. Holburn, L.D.S.
F. Kershaw, L.D.S.
D. B. Owen, L.D.S.
K. Sissons, L.D.S.
H. Taylor, L.D.S.

CONSULTANT TUBERCULOSIS OFFICERS (Part-time).

H. E. Raeburn, M.D., B.S., D.P.H.
V. Ryan, M.D., Ch.B., B.A.O., D.P.H.
E. Ratner, M.D., Ch.B., D.P.H.
H. A. Crowther, M.A., M.R.C.S., L.R.C.P.
B. T. Mann, B.Sc., M.D., Ch.B., D.P.H.

HEALTH VISITORS, MIDWIVES, MEDICAL AUXILIARIES, etc.

4 Psychiatric Social Workers (to be appointed).
246 Health Visitors and School Nurses.
4 Orthopaedic Nurses.
22 Tuberculosis Visitors.
4 Venereal Diseases Social Workers.
1 Supervisor of Home Teachers (to be appointed).
6 Mental Health Home Teachers (to be appointed).
13 Mental Health Social Workers.
233 Midwives.
268 Home Nurses.
48 Dental Attendants.
4 Speech Therapists (three part-time).
15 Ear, Nose and Throat Consultants (part-time, sessional).
8 Ophthalmologists (part-time, sessional).
5 Physiotherapists (part-time).
9 Orthopaedic Consultants (part-time, sessional).

COUNTY ANALYST (Part-time).

F. W. Richardson, F.R.I.C., F.R.M.S.
F. W. M. Jaffe, B.Sc., F.R.I.C. (Deputy).

DAY NURSERIES

24 Day Nurseries—total nursing staff 145.
1 Nursery Nurses Training Hostel, One Oak, Ilkley.

ANTE-NATAL HOSTEL

Clifton, Brighouse. Matron, Mrs. A. Pacey. Nursing Staff 1.

INDEX

INDEX—*continued.*