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COUNTY COUNCIL OF THE WEST RIDING  
OF YORKSHIRE

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SIXTY-SECOND  
**ANNUAL REPORT**

OF THE

County Medical Officer

AND FORTY-THIRD ANNUAL REPORT

OF THE

School Medical Officer

YEAR 1950

# WEST RIDING HEALTH COMMITTEE

(as at 1.7.51.)

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## VICE-CHAIRMAN

County Alderman N. Carter

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Cutts, W.	Mitchell, Mrs. M.	Thackray, C., B.A.
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		Whitlock, M.

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(as at 1.7.51.)

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Cornthwaite, F. J.	Lane, J. W., B.E.M.	Tomlinson, T., B.E.M. (Vice-Chairman of the County Council).
Cutts, H.	Runton, Mrs. Ryder, O.B.E.	Turner, W. H.
Flavell, A.		

## COUNTY COUNCILLORS

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Cloke, W.	Jackman, W. F.	Smith, Mrs. J.
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Crowther, A. C.	Medcalf, G. T.	Westerby, H.
Edwards, Lt.-Col. H. W., D.S.O., M.C., M.A., D.L.	Morton, F.	Whiteley, W.
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Fortune, Mrs. N.	Rastall, Mrs. A.	
	Rowley, E.	

## Added Members:—

Hardaker, Mrs. L.	Martin, Mrs. M.	Potter, Mrs. M. G.
Hepworth, B.	Masson, Dr. Irvine, M.B.E.	Sowden, P.
Jolley, R.	Morris, C. R., M.A.	Whitaker, J.

In this, my last Annual Report to you, I wish to thank all those of my staff who have helped me in the writing of this and the previous four reports. Besides the many signed statements which these reports have incorporated and which need no further comment, all or most of the reading matter owes much to the hard work of headquarters staff and their sectional clerks; Dr. Anderson with Mr. Richardson and Mr. Charlesworth (Maternity and Child Welfare); Dr. Turner and Dr. Gray with Mr. Milne (School Health); Dr. Burgess with Miss Godley (Venereal Diseases); Dr. Johnston with Mr. Richardson (Tuberculosis); Mr. Townend with Mr. Marshall (Dentistry); Miss Walker (Nursing); and Mr. Butterworth (Environmental Hygiene). To all these and to Dr. Wood-Wilson, my Deputy, I am deeply grateful. I reserve a special word of thanks for Mr. Beaumont, who has given the best part of his life to the figures of the West Riding. All the statistics of these reports and others dating back to the first world war are the result of his painstaking labour; no imaginable effort has been spared in their production. The people of the West Riding owe to Mr. Beaumont an enduring debt.



## INTRODUCTION

The family is the biological unit upon which the health of the community most depends. If this is to be more than a trite saying it must find expression in the form which our services are taking; whether these are for the prevention or the cure of illness they should be designed to ensure the integrity of the family as a unit. Whether we be in our first or, as is increasingly the case, in our second childhood and at all stages between these two extremes, as toddler, as school child, adolescent or industrial worker, the difficulties which need to be overcome if health is to be maintained and the problems which must be solved when sickness intervenes cannot, except rarely, be separated from the total picture of the family life. In no aspect is this more apparent than in our present concern for the older age groups, whose presence among us, with all that it gives to a community life of balance and wisdom, imposes upon our health services (as described elsewhere in this report) possibly one of the most difficult tasks yet encountered. The answer for the aged will not be found in the devising of separate machinery, however complete and ingenious this may be, and certainly not by the coining of new terms however descriptive; if and to the extent that a true answer can be found with which to counteract the disabilities of a fast ageing nation, and one that will enable us to extract the maximum of benefit from an occurrence so widespread as to be new to man's life on earth, it will be seen in an expansion and adaptation of the health services based upon the family unit; these will incorporate but not separately distinguish new forms of welfare for the aged.

Although the aged may present the most obvious example of the advantages of an application of the principle of health care in the setting of the family group, the same principle must be obvious to those who seek in all other health problems. Thus we should learn not to seek ways and means of caring for individuals and groups of individuals, except as part of the total family picture or that of groups of families. If we fail to reach this conclusion or if, having reached it, we ignore its lesson, then we shall increasingly multiply the agencies which impinge upon the family group and by their unco-ordinated and unrelated character we shall tend to disintegrate the basic framework upon which health ultimately depends.

There is, of course, nothing new in this restatement of an old truth. The characteristic features of the family have undergone changes and these changes have brought advantages and disadvantages. The greatest changes of all are derived from our increasing longevity and our declining fertility; these two together have quite altered the nature of the family group. Whereas in Britain in the recent past we had a relatively small number of large family groups predominantly young, we have today a relatively large number of small family groups predominantly old. But this and other variations in the character of the family leaves unaltered the main issue with which we are faced. It is still the family, however much altered, upon which our services should be focussed. Yet, although the fundamental importance and need of the family is not altered, it is certain that the relationship between medicine and the family has changed, mainly because of the great new weapons at man's disposal for promoting health and treating disease; it is the use to which these new ideas and devices individually have been put which carries with it the danger of neglect of the family. Little more than half a century ago before the hospital had come to dominate the health scene, in a time when the present wide range of physicians and surgeons with an expert knowledge of different aspects of medical science was as yet unknown, and before the age of the medical auxiliary whose invaluable services have come to swell the ranks and enormously expand the scope and capacity of medicine as a social weapon—before all this, what we think of today as the health service, it was the family doctor who surveyed the scene of those far off days and brought health giving teaching to the families in his care. We cannot, nor should we desire to, return to those times of relative ignorance and impotence but we can look back and learn from them how ourselves better to go forward.

In this light it is difficult to examine our present health service without some misgiving. We have accumulated much wisdom and yet are in danger of forgetting a simple truth. If we need to treat the family as a living and growing organism it must logically have a doctor; and the family physician armed with every reasonable aid should be paramount in the health scene. The most optimistic observer could hardly consider this now to be true; the family doctor of yesterday is the general practitioner of today and whereas he was first in our forefathers' minds he now ranks as second or third; much of his authority has passed to the hospital and his families are dissolving into individuals. Looking again at the family picture we see groups of families making up the community over which the Medical Officer of Health, as guardian of the Community Health, exercises jurisdiction in the preventive field. There is no absolute conflict here providing that the services of the health department and of the general practitioner are both integrated and together focussed upon the family. But are they? In the West Riding divisional scheme every effort has been made to ensure that each Divisional Medical Officer handles his ten (or so) thousand families as living units, and many effective steps have been taken to relate the preventive work to that of the general practitioner. Yet we are far from the desired goal. One example of relative failure to synchronise our efforts (given in illustration and not in criticism, for there are good and valid reasons for the present situation) is the fact that the health visitor, as the modern all-purpose social worker in the health field, is still handling areas of streets and parishes so that her work can seldom be correlated with that of one or more general practitioners. In the last analysis both the general practitioner and the health visitor are employed by the community to promote health, and these two should work in harness so that the health visitor acts as the right hand of the general practitioner. With the changed situation to which the National Health Service Act has given rise it should not be impossible now to think



in terms of relating the work of our health visitors to groups of families under the care of one or more limited number of general practitioners. There are difficulties about this (some related to, for example, freedom of choice, geography, lack of a whole-time service) but while the present relative disunion continues we cannot be satisfied that the family is obtaining the maximum benefit from expensive public services.

Look again for a moment at the health field and the development of social therapy. The realisation of the importance of social attributes in the maintenance of health and in the treatment of departures from normal physical and mental health has led to an increasing number of workers in the social field. Yet the problems of family life cannot be separated into watertight compartments so that Miss A can visit to deal with the problems of baby care, Miss B with little Tommy who has been found at school to have some defect, Miss C with the foster child, Miss D with the elder boy who is under the care of the mental health committee, and Miss E with the aged grandfather now beginning to fail. The social problems involved in all these, and other similar situations, are related one to another in such a way that they can rarely be dealt with separately. Our zeal for improvement in the social field may yet prove to be our own undoing. A variety of such social workers carries with it a new danger to the family unit. It is time to protect both the family unit from harassing contacts, and the public purse from extravagant expenditure, by accepting a common basic social worker throughout the whole field of socio-medical work—including maternity and child welfare, school health, general practice, hospital after-care, welfare of the aged and handicapped, care of foster and boarded-out children and, when it comes, the much needed after-care of the industrial worker. The person most fitted for such work is the health visitor. This suggestion fits into the general need, already expressed, for an overall family care by the general practitioner and health visitor in partnership. This would, of course, still leave a need for some specialist visitors whose position would be to handle more difficult problems in the mental and social field; these (with special qualifications as psychiatric social workers etc.) would be one removed from the basic worker.

If we seek to orientate our health services once more towards the family we shall recognise the pressing need for health centres. There is an increasing tendency for individuals to seek salvation in hospital out-patient departments where they feel sure they will find the last word in expert knowledge of their conditions. This has resulted in an overloading of out-patient departments with many who are more truly in need of social therapy best administered by the general practitioner with the backing of staff from the health department. The provision of health centres within the community and away from hospitals would do much to bring about a new balance in people's minds and to place the practitioner once again in his proper position. They would also help to bind together the work of general practitioners and health departments. These are but a few of the many considerations towards which respect for the family unit will lead; in short, the family should be the fulcrum of our health services. The divisional scheme for the administration of the preventive medical services under your control has tried to give effect to this by according full respect to the family unit. This has given it strong roots from which much good may come.

I now take my leave and say a sad farewell to the West Riding, its kindly, warm-hearted people, and the toil, sweat and tears of its industrial life. After five years dedicated to your better health I remain, if not dismayed, at least still most conscious of your many hazards to health. It is certain that preventive and social medicine is yet in its infancy and that you have great need of it; with sympathetic and careful nurture it will grow and serve you and your people generously and devotedly. Five years is little more than a moment in your long history; for me it has been rich in friendship and in service to a good and deserving cause and in the warmth of your kindness, sympathy and understanding. I wish to thank the Health Committee for their trust and all my staff for their great loyalty. To my 31 colleagues who, as Divisional Medical Officers, have given unselfishly and without reserve to our one impelling task that preventive medicine should live and thrive as one of the great benefits of our time, to you I pay homage, in your hands the success of preventive medicine in the West Riding ultimately lies.

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. 1950)—Urban, 1,169,570; Rural, 422,360—Total, 1,591,930

Number of Municipal Boroughs 10; Urban Districts 53; Rural Districts 21; Total 89

The above is acreage in 1950. As from 1st April, 1951, the acreage of the Administrative County is 1,609,759 due to changes in boundary.

#### Summary for 1950

The birth rate was 16.3; the stillbirth rate 2.4; the live premature birth rate 5.2. The death rate from all causes was 11.8; smallpox nil; diphtheria 0.001; whooping cough 0.01; measles 0.01; meningococcal infections (cerebral spinal or spotted fever, etc.) 0.01; acute poliomyelitis (infantile paralysis) 0.01; tuberculosis of the lungs 0.25; other forms of tuberculosis 0.04; respiratory diseases 1.18; cancer 1.83; heart and circulatory diseases 4.39. Infant mortality was 35 and maternal mortality 0.98.

A comparison with the figures for the past 61 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
1949	17.2	12.1	0.08	0.32	0.05	1.44	1.81	24	0.85	38
1950	16.3	11.8	0.10	0.25	0.04	1.18	1.83	24	1.00	35

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

† Figures not available.

Birth and death rates are per 1,000 estimated population; diseases, injuries, and causes of death are classified at international level so that the official statistics relating to mortality and diseases of each country adopting the international classification are comparable. The classified lists are known as "The International Lists of Diseases and Causes of Death" and the Sixth Decennial Revision thereof has been made by an International Expert Committee appointed by the World Health Organisation. The reason for revision of classification from time to time is so that the statistics conform to modern knowledge and usage. The Sixth Revised Classification comes into operation in England and Wales in connection with the statistics for the year 1950. The death rate from infectious diseases is, therefore, now shown on a new basis. Prior to 1950 it was the combined death rate (known as the zymotic diseases death rate) from what were formerly the principal infectious diseases, namely, scarlet fever, enteric fever, smallpox, diphtheria, measles, whooping cough, and diarrhoea under two years of age. Due to the public health services and advances in medical knowledge, the mortality from these diseases as compared with other infectious diseases is now almost negligible, as is also the incidence in some cases. The mortality from infectious diseases is now best expressed by a combined death rate from all infective and parasitic diseases excluding tuberculosis, influenza, pneumonia, enteritis, and certain localised infections. The rate for 1950 is shown on this new basis; 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 foregoing 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 0.98 given in the Summary is per 1,000 live and still births, as is also the still birth rate.

### Births and Infant Mortality

Live births in 1950 numbered 25,898 (16.3 per thousand population) compared with 27,176 (17.2) in 1949, 28,966 (18.5) in 1948 and 32,747 (21.5) in 1947. The birth rate has now fallen from the peak of 21.5 to almost, though not quite, the level of the years immediately preceding the war, and is following the trend evident all over the country.

Excess of births over deaths (natural increase of population) was 7,107 in 1950, 8,126 (1949), 11,317 (1948), 14,028 (1947), 9,308 (5 years 1942-46) and 4,536 (5 years 1937-41). The figures below show that the reduction in the infant mortality rate has appreciably offset the decline in the birth rate.

Period.	Birth rate.	Annual number of births.	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	25,846	1,313	24,533
1946	19.7	29,577	1,304	28,273
1947	21.5	32,747	1,462	31,285
1948	18.5	28,966	1,129	27,837
1949	17.2	27,176	1,037	26,139
1950	16.3	25,898	904	24,994

904 infants died, the mortality rate per 1,000 live births being 35 compared with 38 in 1949 and 160 in 1900. The death rate in the first 4 weeks of life was 20.1 per 1,000 live births in 1950 compared with 37.4 in 1930. The infant mortality rate in the period 1912-21 was 104 per 1,000 births. If this had been the rate in 1950 instead of the actual rate of 35 (904 deaths) the number of deaths would have been 2,682. The effect of the decrease in infant mortality in terms of infant lives can be demonstrated by the figures below:—

Period.	Average Annual deaths if mortality had remained at level of 1912-21.	Actual Annual number of deaths.
1922-31	2,947	2,192
1932-41	2,402	1,388
1942-48	2,919	1,288
1949	2,815	1,037
1950	2,682	904

The mortality of infants at various periods in the first year of life is shown below for the past six years:—

	Number of Deaths						Deaths per 1,000 Live Births					
	1945	1946	1947	1948	1949	1950	1945	1946	1947	1948	1949	1950
<b>Male Infants</b>												
Under 4 weeks ...	407	455	450	339	323	319	30.3	29.6	26.7	22.9	23.1	23.8
4 weeks—3 months ...	130	124	147	112	94	88	9.7	8.1	8.7	7.6	6.7	6.6
3—6 months ...	116	104	130	99	94	75	8.6	6.8	7.7	6.7	6.7	5.6
6—12 months ...	107	75	117	80	73	48	7.9	4.9	7.0	5.4	5.2	3.6
Total under 1 year ...	760	758	844	630	584	530	56.5	49.4	50.1	42.6	41.7	39.6
<b>Female Infants</b>												
Under 4 weeks ...	273	317	353	266	259	202	22.0	22.2	22.2	18.8	19.7	16.1
4 weeks—3 months ...	76	82	82	84	68	58	6.1	5.8	5.1	5.9	5.2	4.7
3—6 months ...	103	82	103	85	61	70	8.3	5.8	6.5	6.0	4.6	5.6
6—12 months ...	101	65	80	64	65	44	8.2	4.6	5.0	4.5	4.9	3.5
Total under 1 year ...	553	546	618	499	453	374	44.6	38.4	38.8	35.2	34.4	29.9
<b>All Infants</b>												
Under 4 weeks ...	680	772	803	605	582	521	26.3	26.1	24.5	20.9	21.4	20.1
4 weeks—3 months ...	206	206	229	196	162	146	8.0	7.0	7.0	6.8	6.0	5.6
3—6 months ...	219	186	233	184	155	145	8.5	6.3	7.1	6.3	5.7	5.6
6—12 months ...	208	140	197	144	138	92	8.0	4.7	6.0	5.0	5.1	3.6
Total under 1 year ...	1313	1304	1462	1129	1037	904	50.8	44.1	44.6	39.0	38.2	34.9



38 (or 4 per cent.) of the 904 deaths of infants in 1950 were due to infective and parasitic diseases, of which whooping cough accounted for 18 (2 per cent.); 116 (13 per cent.) were due to pneumonia and 34 (4 per cent.) to other diseases of the respiratory system; 78 (9 per cent.) to gastritis, enteritis or diarrhoea; 121 (13 per cent.) to congenital malformations; and 37 (or 4 per cent.) to accidents. Deaths in the first month of life have fallen this year as an increasing indication of the success of our schemes for premature baby care. The rate of infant mortality from the various causes is shown in the table below (with the modifications to which the new international classification has given rise.)

Year	Number of Deaths under One Year per 1000 live births from various causes																	
	Infections														Total	Gen. Debility Maternal Premature Birth	Other Causes	TOTAL (All Causes)
	Enteric Fever	Smallpox	Scarlet Fever	Measles	Whooping Cough	Diphtheria	Influenza	Respiratory Tuberculosis	Other Tuberculous Diseases	Other Infective and Parasitic Diseases	Bronchitis	Pneumonia	Other Respiratory Diseases	Diarrhoea				
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
1912-21 (Average)	0.00	nil.	0.06	2.48	3.65	0.14	1.05	0.25	2.46	0.00	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	0.00	5.38	12.63	0.39	5.86	30.90	32.95	13.20	77.06
1932-41 (Average)	0.00	nil.	0.01	0.68	1.35	0.13	0.66	0.06	0.63	0.00	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	0.00	1.88	7.47	0.12	3.91	15.02	28.32	5.63	48.97
1943	nil.	nil.	nil.	0.50	1.03	0.23	0.47	0.04	0.54	0.00	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	0.00	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	0.00	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	0.00	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	0.00	1.10	7.82	0.09	5.13	16.10	24.52	4.03	44.03
1948	nil.	nil.	nil.	0.24	0.83	0.03	0.28	0.03	0.35	0.00	1.00	7.84	0.28	4.25	15.13	20.76	3.11	38.99
1949	0.04	nil.	nil.	0.33	0.48	nil.	0.11	0.04	0.59	0.00	1.18	7.03	0.07	3.16	13.03	21.27	3.86	38.16
1950	*	*	*	0.23	0.70	nil.	0.15	0.08	0.12	0.35	0.97	4.48	0.19	3.01	10.28	4.67	19.96	34.91

\* Included in Col. 11—"Other Infective and Parasitic Diseases"

+ For 1950, includes "Gastritis, Enteritis and Diarrhoea"

† For 1950, includes "Congenital Malformations" only

‡ Figures not available.

Now that the total number of infant deaths has fallen to such a low level it is important to intensify our study of the circumstances which give rise to deaths in infancy. Unfortunately, however closely we study the circumstances of each infant death we cannot expect to arrive by this method alone at a true appreciation of the causes. To arrive at the truth we must study the circumstances that surround the birth and early care of every infant and seek to isolate the different factors present in those who died. This is a formidable undertaking but as I have said in previous reports to you we must not shrink from fundamental research in order to be able to acquire new knowledge upon which to base our services. It is only when we know the correct emphasis to give to each factor contributing to a death that we can be certain that we are developing our professional services and spending our money to the best advantage. This matter was discussed at length in a conference of Divisional Medical Officers and following this with Dr. Alice Stewart, Acting Director, and Dr. Russell, Statistician, of the Institute of Social Medicine, Oxford. In the result an enquiry form embodying all the various information which we now obtain in different ways, together with new information which it was felt to be indispensable to any such study, has been drawn up and tentative arrangements are being made to make a detailed study of a proportion of all births in South Yorkshire divisions; the total of births is expected to amount to approximately 3,000, being the figure which Dr. Russell indicated to us as a minimum for sound statistical analysis. This enquiry will place a heavy burden upon the Divisional Medical Officers in South Yorkshire and it can only be made with the complete collaboration of health visitors, home nurses and midwives, and general practitioners and hospitals in the area. Dr. Cedric Harvey is making himself personally responsible for the co-ordination of the work, particularly in so far as it relates to hospitals. The study will take 15 months, the whole of the analysis and valuation being covered by the Institute of Social Medicine, Oxford. It is confidently expected that in addition to whatever we may learn about the causes of infant death and the need for varying emphasis in the application of our services, we shall also evolve a better and more complete record form with which to start off the health record of West Riding babies.

The number of illegitimate births in 1950 was 1,170, a reduction of 153 on the number for 1949 and 722 on that for 1945 when the effect of the war years produced the highest figure. The 1949 figure is well above that of 870 for the pre-war year of 1938. The mortality rate among illegitimate infants remains higher than that for legitimate infants but is slowly approximating to it. The figures for the past fourteen years are given in the following table:—



Year.	Number of illegitimate live births	Percentage ratio to legitimate live births	Number of deaths under 1 year of illegitimate infants	Infant Mortality Rate.	
				Illegitimate infants	Legitimate infants
1937	855	3.86	72	84	59
1938	870	3.72	54	62	51
1939	834	3.79	53	64	54
1940	827	3.77	68	82	55
1941	1,044	4.71	86	82	58
1942	1,181	4.95	72	61	48
1943	1,381	5.65	88	64	49
1944	1,720	6.24	107	62	43
1945	1,892	7.90	133	70	49
1946	1,739	6.25	112	64	43
1947	1,525	4.88	99	65	44
1948	1,413	5.13	72	51	38
1949	1,323	5.12	66	50	38
1950	1,170	4.73	52	44	34

The social significance of illegitimate births is dealt with in the Child Welfare Section of this report.

### Deaths

There were 18,791 deaths (9,646 males, 9,145 females), 79 less than in 1949, the death rate being 11.8 (11.6 England and Wales) compared with 12.1 (11.7 England and Wales), for 1949. The slight decrease in the rate is of no special significance as the rate has varied between the limits of 11.5 to 12.5 for a number of years. Over 75 per cent. of the causes of death can be classified into four main groups as under:—

	Number of deaths	Proportion per 1,000 deaths from all causes
Malignant neoplasms (cancer) ... ..	2,908	15
Vascular lesions of the nervous system (e.g. cerebral haemorrhage) ... ..	2,530	13
Heart and circulatory diseases ... ..	6,981	37
Diseases of the respiratory system ... ..	1,976	11
		76

The table below gives the number of deaths and causes for 1950:—

Cause of Death		Age at Death									Total
		Under 1 year	1 and under 5	5 and under 15	15 and under 25	25 and under 45	45 and under 65	65 and under 75	75 and over		
1.	Tuberculosis, respiratory ... ..	2	1	1	44	136	151	59	10	404	
2.	Tuberculosis, other ... ..	3	15	13	7	14	14	1	—	67	
3.	Syphilitic disease ... ..	2	—	—	—	8	26	13	5	54	
4.	Diphtheria ... ..	—	1	—	—	—	—	—	—	1	
5.	Whooping Cough ... ..	18	3	—	—	—	—	—	—	21	
6.	Meningococcal infections ... ..	2	7	1	—	1	2	1	—	14	
7.	Acute poliomyelitis ... ..	1	5	4	4	8	—	—	—	22	
8.	Measles ... ..	6	3	—	—	—	—	—	—	9	
9.	Other infective and parasitic diseases ... ..	4	1	5	1	4	14	8	9	46	
	Total—Infective and Parasitic Diseases exc. Tub.	33	20	10	5	21	42	22	14	167	
10.	Malignant neoplasm, stomach ... ..	—	—	—	—	21	175	213	175	584	
11.	Malignant neoplasm, lung, bronchus ... ..	—	—	—	1	23	184	97	32	337	
12.	Malignant neoplasm, breast ... ..	—	—	—	—	22	129	66	34	251	
13.	Malignant neoplasm, uterus ... ..	—	—	—	—	10	76	37	19	142	
14.	Other malignant and lymphatic neoplasms ... ..	1	5	6	10	83	473	504	463	1545	
15.	Leukaemia, aleukaemia ... ..	—	3	6	4	7	22	6	1	49	
	Total—All forms of Cancer ... ..	1	8	12	15	166	1059	923	724	2908	
16.	Diabetes ... ..	—	—	—	1	3	36	75	34	149	
17.	Vascular lesions of nervous system ... ..	1	1	—	2	33	420	906	1167	2530	
18.	Coronary disease, angina ... ..	—	—	—	—	33	637	817	550	2037	
19.	Hypertension with heart disease ... ..	—	—	—	—	4	130	184	177	495	
20.	Other heart disease ... ..	—	—	2	21	113	478	1006	2131	3751	
21.	Other circulatory disease ... ..	1	—	—	—	20	91	203	383	698	
	Total—Heart and Circulatory diseases ... ..	1	—	2	21	170	1336	2210	3241	6981	
22.	Influenza ... ..	4	2	4	3	7	24	22	33	99	
23.	Pneumonia ... ..	116	24	8	5	30	108	130	160	581	
24.	Bronchitis ... ..	25	2	1	1	18	267	398	413	1125	
25.	Other diseases of respiratory system ... ..	5	6	1	1	17	56	40	45	171	
	Total—Diseases of the Res. Sys. incl. Influenza	150	34	14	10	72	455	590	651	1976	
26.	Ulcer of stomach and duodenum ... ..	—	—	—	—	13	65	47	19	144	
27.	Gastritis, enteritis and diarrhoea ... ..	78	3	—	3	7	16	20	23	150	
28.	Nephritis and nephrosis ... ..	—	2	6	12	25	91	101	66	303	
29.	Hyperplasia of prostate ... ..	—	—	—	—	—	15	46	101	162	
30.	Pregnancy, childbirth, abortion ... ..	—	—	—	4	21	1	—	—	26	
31.	Congenital malformations ... ..	121	9	10	5	12	20	1	—	178	
32.	Other defined and ill-defined diseases ... ..	477	29	35	22	118	348	321	539	1889	
33.	Motor vehicle accidents ... ..	—	15	8	30	31	23	18	8	133	
34.	All other accidents ... ..	37	23	15	22	71	79	75	134	456	
35.	Suicide ... ..	—	—	—	6	29	68	35	20	158	
36.	Homicide and operations of war ... ..	—	1	—	2	1	6	—	—	10	
	Total—Accidents, Poisonings and Violence	37	39	23	60	132	176	128	162	757	
	Total—All Causes ... ..	904	161	126	211	943	4245	5450	6751	18791	



## The Mortality of the Middle and Later Years of Life

The increasing proportion of older persons in the age constitution of the population will focus attention more and more on the diseases of middle and old age. To give an example, the increase in the proportion of persons in the population in the middle and later age groups together with the increased stress and intensity in the rate of living in the twentieth century among most persons has contributed to increase the death rate from heart and circulatory diseases. In the West Riding the death rate from this group of diseases has increased in the last twenty years from 308 to 439 per 100,000 of the population. The mortality from cancer has similarly increased from 132 to 183 and (in ten years) cerebral haemorrhage and associated causes from 145 to 159, moreover the mortality from all these causes is rising steadily. Health education, medical research, adequate diagnostic facilities and facilities for early treatment, particularly in the case of cancer, must all play their part in checking at least the increase in mortality from these causes.

The number of deaths and death rates per 100,000, according to age, from these diseases in the three years 1948 to 1950 are shown below, and emphasise their killing nature in the middle and later age groups.

			AGE GROUP — YEARS					
			Under 5	5 to 15	15 to 45	45 to 65	65 up	All Ages
Cancer ... ..	Deaths		21	21	561	3,162	4,710	8,475
	Rate		5	3	28	283	970	183
Cerebral Haemorrhage etc. ... ..	Deaths		6	—	88	1,314	5,626	7,034
	Rate		7	—	4	117	1,158	152
Heart and circulatory diseases ... ..	Deaths		6	26	597	3,774	15,021	19,424
	Rate		7	4	30	337	3,092	419

In the table below the figures for Coronary Thrombosis are again analysed according to age, sex and social class. No recent statistics are available as to the population in the different social classes and the above rates are based on the 1931 Census figures. These rates, therefore, should not be taken as absolutely accurate death rates, but they must give a fairly definite idea of the relative mortality in the several social classes. The deaths of housewives have been classed according to the social class of their husband, also for the purpose of arriving at the population of females in each social class, for calculation of the death rates according to social class, housewives have been allocated over the five social classes proportionately to the number of males in each social class. The death rates according to age can be taken as definite rates. The social class divisions used in the table are the classifications of the Registrar-General on which statistics relating to social class are usually based. The characteristics noted in last year's figures are again in evidence. Whatever may be the cause of this unfortunate occurrence it is most prevalent in social class I; the rate in each social class steps down evenly until in the 5th class it partly rises again. This is a little understood subject which health departments should study.

Age Group	Social Class														
	Males							Females							
	I	II	III	IV	V	Total	Death Rate per 1,000	I	II	III	IV	V	Total	Death Rate per 1,000	
Years															
35-45	1	8	10	3	2	24	0.20	—	—	1	1	—	2	0.02	
45-55	3	24	60	23	10	120	1.21	1	6	15	7	1	30	0.27	
55-65	6	67	114	60	34	281	3.74	3	16	59	32	11	121	1.37	
65-75	25	93	191	87	52	448	8.64	8	68	110	56	30	272	4.31	
75 and over	8	55	119	50	18	250	12.86	11	58	95	41	14	219	7.95	
Total all ages	43	247	494	223	116	1123	3.06	23	148	280	137	56	644	1.57	
Rate per 1,000 in social class	9.8	6.5	3.4	2.9	3.2			6.3	3.8	1.5	1.9	1.6			

## Child Mortality

There has been a further substantial reduction in the number of children dying between the age of 1 and 5 years, 161 children died compared with 191 in 1949 and 506 in 1935, the mortality rates being 1.41 (1950), 1.70 (1949) and 5.44 (1935). The principal causes of death in 1950, as in recent previous years, were infectious diseases 20 (0.18), respiratory diseases 34 (0.29), motor vehicle accidents 15 (0.23) and other accidents 23 (0.20). The mortality rates for the past 16 years are given below:—

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



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

Year.	West Riding.	England and Wales.
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
1949	1.70	1.56
1950	1.41	1.33

The number of deaths of children aged 1—5 years from the various causes in the past 16 years is shown in the table below:—

	1935	1936	1937	1938	1939	1940	1941	1942	1943	1944	1945	1946	1947	1948	1949	1950
Infective and parasitic diseases, excluding tuberculosis ...	133	170	114	118	94	90	123	77	85	40	48	25	46	26	20	20
Tuberculosis, respiratory ...	9	7	6	3	2	4	4	4	2	5	8	1	2	7	2	1
Tuberculosis, other ...	38	39	36	32	41	37	39	48	44	25	33	20	42	28	24	15
Cancer ...	5	5	2	4	2	2	7	7	6	8	3	4	6	3	5	8
Diabetes ...	—	—	2	—	—	—	1	—	—	1	—	—	—	—	—	—
Heart and circulatory diseases ...	2	4	3	1	2	—	2	2	—	1	2	1	—	2	2	—
Influenza ...	9	7	17	6	9	27	5	8	12	5	3	7	4	1	4	2
Pneumonia ...	130	136	141	114	82	111	94	82	80	56	56	40	36	40	39	24
Bronchitis ...	9	14	11	10	7	25	21	14	17	7	11	7	11	9	7	2
Other diseases of respiratory system	11	6	4	3	5	2	7	4	7	4	4	2	1	6	4	6
Diarrhoea and other digestive diseases*	46	37	41	38	28	19	17	31	28	22	21	18	16	18	13	3
Congenital debility, malformations, premature birth, etc. †	8	6	4	9	10	12	14	9	4	12	8	16	8	14	15	9
Accidents ...	49	50	57	50	41	44	55	68	42	28	52	31	36	31	37	39
Other Causes ...	57	53	46	57	42	55	56	38	38	34	43	32	34	21	19	32
Totals ...	506	534	484	445	365	428	445	392	365	248	292	204	242	206	191	161

\* For 1950, includes only gastritis, enteritis and diarrhoea.

† For 1950, includes only congenital malformations.

## Maternal Mortality

The number of deaths of mothers ascribed to complications of pregnancy, childbirth and abortion was 26, the mortality rate being 0.98 per 1,000 live and still births compared with 23 and a rate of 0.83 in 1949. Although the rate for 1950 shows an increase on that for 1949 it is still well below the rate of any previous year. A reference to Dr. Leiper's report on page 36 gives the interesting fact that 3 out of his 4 deaths occurred in the small group of women who had not attended any Ante-Natal clinic.

The number of maternal deaths and the mortality rate in the past 22 years are shown in the following table:—

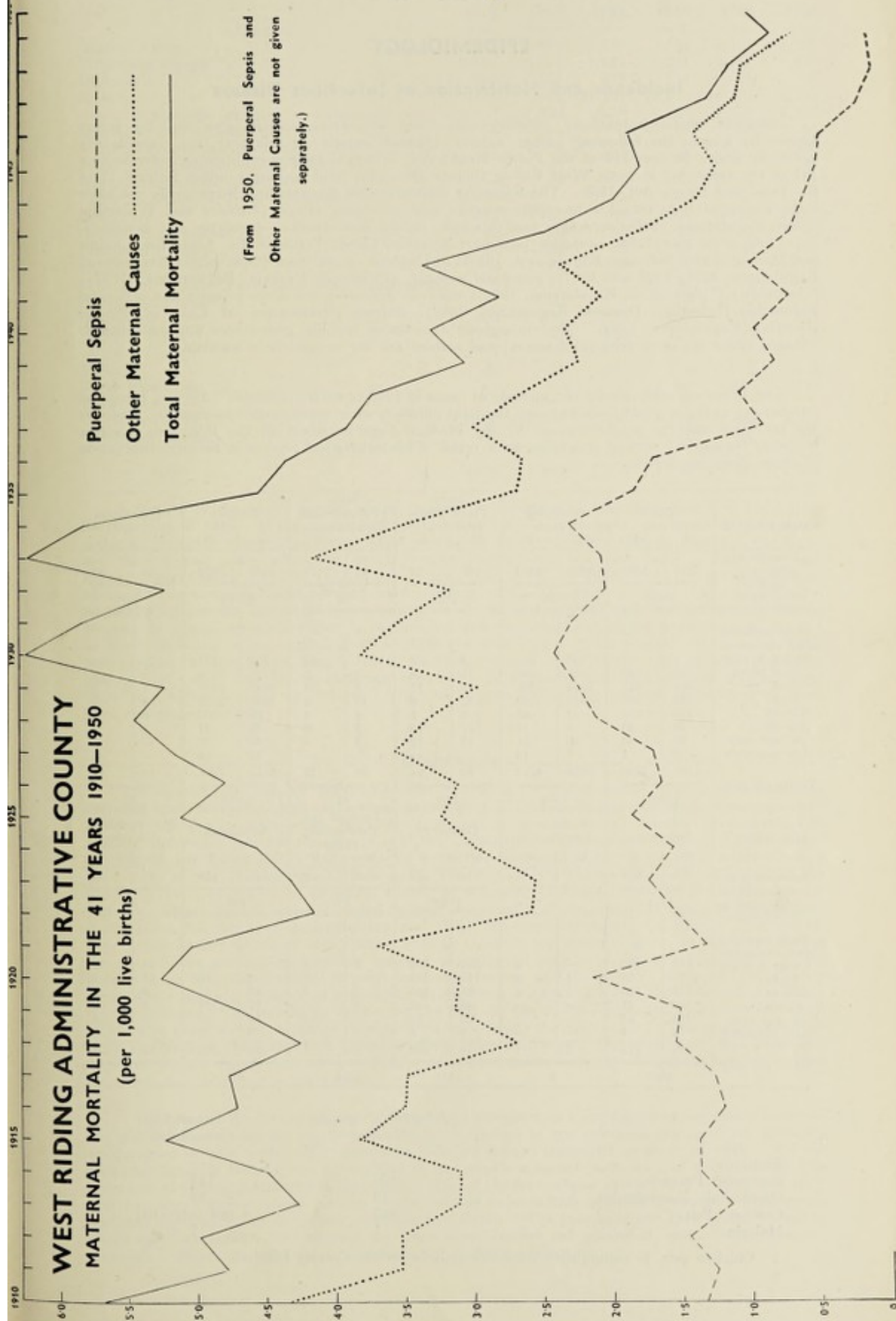
Year	No. of deaths from			Mortality Rate per 1,000 live and still births		
	Puerperal and post abortive sepsis	Other maternal causes	Total	Puerperal and post abortive sepsis	Other maternal causes	Total
1929	58	76	134	2.16	2.83	4.99
1930	63	99	162	2.32	3.64	5.96
1931	57	88	145	2.19	3.37	5.56
1932	50	77	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
1949	4	19	23	0.15	0.68	0.83
1950	*	*	26	*	*	0.98

\* Deaths from puerperal and post abortive sepsis are no longer given separately.

# WEST RIDING ADMINISTRATIVE COUNTY

## MATERNAL MORTALITY IN THE 41 YEARS 1910-1950

(per 1,000 live births)





## PART II

## EPIDEMIOLOGY

## Incidence and Notification of Infectious Disease

*Smallpox, cholera, diphtheria, membranous 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); meningococcal infection; acute poliomyelitis—paralytic and non-paralytic; and acute encephalitis—infective and post infectious (Acute Poliomyelitis, Acute Encephalitis and Meningococcal Infection Regulations, 1949); 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 1950 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, because of revised diagnosis as a result of bacteriological reports or further observation of cases since notification:—

AGE GROUP	Scarlet Fever		Whooping Cough		Acute Poliomyelitis (Paralytic)		Acute Poliomyelitis (Non-Paralytic)		Measles		Diphtheria	
	M	F	M	F	M	F	M	F	M	F	M	F
Numbers originally notified (All Ages)	1196	1339	3657	4019	100	72	44	18	8125	7659	40	49
	2535		7676		172		62		15784		89	
Final numbers after correction												
Under 1 year	4	5	344	300	5	3	1	—	319	353	1	—
1—2 years	102	129	1007	1088	11	14	3	—	1756	1714	2	—
3—4 ..	352	341	1204	1368	12	11	3	3	2673	2488	4	3
5—9 ..	546	583	1019	1120	21	6	12	2	3196	2915	4	8
10—14 ..	113	179	47	56	8	5	4	3	96	109	3	2
15—24 ..	39	49	5	17	11	13	1	3	35	37	1	3
25 and over	28	33	23	51	18	12	2	4	22	21	—	1
Age unknown	2	1	7	13	—	—	—	—	15	14	—	—
Totals all ages	1186	1320	3656	4013	86	64	26	15	8112	7651	15	17
	2506		7669		150		41		15763		32	
AGE GROUP	Acute Pneumonia		Acute Encephalitis		Dysentery		Typhoid and Paratyphoid Fever		Erysipelas		Meningococcal Infection	
	M	F	M	F	M	F	M	F	M	F	M	F
Numbers originally notified (All Ages)	695	516	1	7	570	572	8	9	192	216	41	26
	1211		8		1142		17		408		67	
Final numbers after correction												
Under 5 years	147	123	—	3	258	196	1	2	—	1	14	11
5—14 ..	81	75	1	2	147	135	—	3	6	6	11	3
15—44 ..	178	128	1	2	91	153	2	2	49	55	6	5
45—64 ..	168	91	—	—	34	46	3	—	87	104	3	2
65 and over	115	93	—	—	23	23	—	—	44	48	—	—
Age unknown	4	4	—	—	6	5	—	—	3	2	—	—
Totals all ages	693	514	2	7	559	558	6	7	189	216	34	21
	1207		9		1117		13		405		55	

	Number Originally Notified	Number After Correction
Smallpox	—	—
Puerperal Pyrexia	130	125
Ophthalmia Neonatorum	39	39
Chicken Pox	465	† not corrected
Malaria	1	1

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



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

Disease	1945	1946	1947	1948	1949	1950
Scarlet Fever ... ..	3,109	2,369	2,764	3,863	3,191	2,506
Whooping Cough ... ..	2,844	4,451	3,424	6,201	3,947	7,669
Diphtheria ... ..	862	551	221	153	66	32
Measles ... ..	24,904	1,883	21,739	16,545	16,489	15,763
Acute Pneumonia (primary or influenzal) ... ..	1,347	1,324	1,188	1,308	1,456	1,207
Meningococcal Infection ... ..	—	—	—	—	—	55
Acute Poliomyelitis (paralytic) } ... ..	—	1	351	46	224	150
Acute Poliomyelitis (non-paralytic) } ... ..	—	—	—	—	—	41
Acute Encephalitis (infective) ... ..	—	—	—	—	—	6
Acute Encephalitis (post infectious) ... ..	—	—	—	—	—	3
Dysentery ... ..	411	127	108	208	73	1,117
Ophthalmia Neonatorum ... ..	46	46	82	51	37	39
Puerperal Pyrexia ... ..	81	104	85	98	98	125
Smallpox ... ..	—	—	—	—	—	—
Enteric or Typhoid Fever (excluding Paratyphoid) ... ..	9	14	9	18	3	9
Paratyphoid Fevers ... ..	7	50	16	10	11	4
Erysipelas ... ..	383	366	347	409	429	405
Chicken Pox ... ..	310	443	550	432	827	465
Typhus Fever ... ..	1	—	—	—	—	—
Malaria ... ..	36	28	11	6	2	1
Food Poisoning ... ..	—	—	—	—	329	346
Tuberculosis:—						
Respiratory ... ..	1,229	1,244	1,288	1,372	1,526	1,414
Other Forms ... ..	457	437	400	424	456	372
<b>Total</b> ... ..	<b>1,686</b>	<b>1,681</b>	<b>1,688</b>	<b>1,796</b>	<b>1,982</b>	<b>1,786</b>

A feature of the above figures is the increase in incidence of whooping cough in 1950 after its recession in 1949. Whooping cough has a periodicity in prevalence, the peak of prevalence occurring roughly every third year. The number of notifications for 1950 is, however, the highest for any year since whooping cough became compulsorily notifiable early in 1940, the next highest figures being 7,102 in 1941, 6,201 in 1948 and 5,144 in 1943. As in previous years, about 97 per cent. of those affected were children under 10 years of age. Above that age, particularly from the age of 15 years and upwards, the appreciably larger number of cases among females as compared with males is noteworthy and the somewhat higher proportion of females in the population is not sufficient to explain the difference. The number of cases of acute poliomyelitis, although less than in 1949, was nevertheless much larger than in any year preceding 1947 when the serious outbreak occurred. It is possible that as a result of that epidemic there is a higher number of carriers. The single case of malaria notified is believed to have been contracted abroad.

### Diphtheria

The number of cases of diphtheria—32—in 1950 is the lowest annual number of notifications recorded and compares with an annual average of 371 cases in the preceding five years and 2,478 in the five pre-war years 1935-39. It points to the increasing success of immunisation against diphtheria and the benefits of a higher proportion of immunised children. The number of children who completed a full course of primary immunisation during the year, either through their own private medical practitioner or at the Authority's clinics and schools, was 18,889 (under 5 years, 14,835; 5 to 15 years, 4,054); in addition, 13,898 children received refresher injections. These figures show a sharp decline compared with the year 1949, when 27,890 children completed a full course of immunisation and 18,071 received refresher injections. The largest single contributory factor in this decline was undoubtedly the publicity given in the press during the year to the possible relationship between poliomyelitis and prophylactic inoculations. Fewer parents were bringing children forward for immunisation and in certain areas of the County where there was a prevalence of poliomyelitis, immunisation arrangements were suspended. There is also evidence of an increasing apathy on the part of the parents towards immunisation which is likely to grow as the memories of diphtheria as a deadly disease recede. This problem received close attention in the Castleford Division of the County, where Dr. Paterson, the Divisional Medical Officer, again conducted a highly successful mobile campaign during the summer months of which the following is an extract:—

"The plan of operations of our Mobile Unit Immunisation Campaign was essentially based on the pattern already set by our very successful campaign of the previous year and the problems encountered in 1950 were of a somewhat different nature compared to those of 1949. Of the two main adverse factors, one arising out of last year's success, early became obvious; our lists were now to consist essentially of the problem type of children whose parents had refused last year, and the few children whose parents whilst willing to have their children immunised, were unable to bring them along to the static immunisation clinics. The success of our 1949 campaign had so encouraged my Health Visiting staff that they made special and persistent, and in some measure successful, efforts to gain the co-operation of all these parents.



The second difficulty arose out of the press publicity connecting poliomyelitis and diphtheria immunisation. It is essential to success to hold this type of campaign during the summer months. But statistical evidence accumulates to show that trauma such as that sustained in immunisation, especially by the use of A.P.T., in a person incubating poliomyelitis, can, if only very remotely, predispose to paralysis in the affected limb. To lessen the danger we made use of T.A.F. (which carries a slightly lower immunising power and requires three injections instead of two).

Much spade work and detailed planning well before the campaign was launched was done by my Health Visiting and clerical staff. A Loud Speaker unit toured the area a few days in advance notifying parents of dates and times. The unit staff comprised a doctor, a nurse assisting the doctor, another acting as clerk whilst two nurses notified the parents of the presence of the van.

460 immunisations were done in 12 sessions; if A.P.T. had been used, the number of injections would have been reduced to 308 and the sessions to 8. Each session covering approximately 11 miles thus gave an average of 38 injections. With the appearance of poliomyelitis in August I stopped further immunisation sessions and in consequence failed to complete the immunisation of about 100 children. The results obtained in 1950 were such as to continue to convince me of the value of this type of auxiliary unit (despite the smaller number of children immunised per stop compared with last year).

The mobile unit immunisation van enabled me to reach children well off the beaten track who would otherwise be missed at least until they began school. As a generation grows up which cannot be expected to remember the awful ravages of diphtheria, both as regards the incidence of the disease and the wanton loss of human life accruing from it, I believe that mobile units of this nature supported by the propaganda value of the previous visit of the Loud Speaker unit, will prove increasingly useful. Static immunisation clinics are now catering for the maximum volume of immunisations that can possibly be undertaken by this type of clinic and if our present rate of immunisations is to be increased, the mobile unit provides a ready solution to the problem. The alleged relationship between trauma and poliomyelitis has also already introduced new difficulties which may be met by the skilful use of the mobile unit to save valuable months and to compress the work into a much shorter period of 8 or 9 months. If the mobile unit immunisation van is to be a complete success, the purchase of adequate sterilising equipment is a virtual necessity; I cannot rely indefinitely on the help of the local hospitals to sterilise needles, dressings, etc."

At the end of the year, 84 per cent. of the total child population in the Castleford Division between the ages of 0 and 15 had completed a full course of primary immunisation.

The immunisation state of children in the whole of the Administrative County as at the 31st December, 1950, was as follows:—

Age at 31.12.50. i.e. born in year:—	Under 1 1950	1 1949	2 1948	3 1947	4 1946	5—9 1941-45	10—14 1936-40	Total under 15
Number Immunised	1,391	11,756	15,991	20,704	16,642	80,160	70,019	216,663
Estimated mid-year child population ... ..	Children under 5 138,820					Children 5—14 223,980		362,800
Percentage immunised ...	47.9					67.1		59.7

27 notifications of diphtheria were received for children between the ages of 0 and 15; in 9 cases the children had previously completed a full course of immunisation. Only one child died of diphtheria, and he had not been immunised.

### Dysentery

There were 18,129 notifications of dysentery in England and Wales and 1,117 in the West Riding Administrative County, the highest figure ever recorded in both areas (compare the figures for the County for the previous five years:— 1949—73, 1948—208, 1947—108, 1946—127 and 1945—411).

The 1,117 notifications in 1950 were spread over the County as follows:—

Division	No. of Cases.	Division	No. of Cases.	Division	No. of Cases.
1.	138	11.	4	21.	95
2.	1	12.	10	22.	51
3.	48	13.	4	23.	47
4.	180	14.	55	24.	8
5.	17	15.	95	25.	26
6.	25	16.	1	26.	3
7.	3	17.	33	27.	—
8.	45	18.	133	28.	—
9.	18	19.	2	29.	39
10.	—	20.	5	30.	1
				31.	30



Towards the end of the year Divisional Medical Officers were asked to give their views on the reasons for the increased incidence in the County. In a number of cases the replies were to the effect that the increases were due to outbreaks in Nurseries, Hospitals, Schools, etc. The number of such outbreaks were as follows:— Day Nurseries 8; Residential Nurseries 2; Mental Hospitals 2; Children's Hospitals 2; General Hospital 1; Residential School 1; Infant School 1; Nursery School 1.

Dysentery often appears to be prevalent where people gather together in a close community; some regard this as the chief cause of spread. The disease does spread from one case to another in a household or hospital or nursery but it is nevertheless not established that these communities are the centres for the spread of epidemics of dysentery. The infection has to be introduced into a community and it may well be only a manifestation of a high local incidence when a case occurs in an institution which then is in a favourable position for a more rapid spread to the inmates.

Many Divisional Medical Officers give as their opinion (confirming the views given in Annual Reports in 1934 and 1935) that all cases of dysentery are not being notified in spite of the requirement to do so under the Public Health (Infectious Diseases) Regulations, 1927, possibly because a laboratory examination is not sought or a diagnosis of enteritis or gastric influenza is made. There is, however, some evidence that the increased number of cases has been due to increased notification.

The Director of the Public Health Laboratory, Dr. W. F. Lane, has kindly provided the following comments on the prevalence of dysentery:— The reports of the Public Health Laboratory Service show that almost all of the increase in incidence of dysentery has been due to infection with *Shigella sonnei*. There are good reasons to believe that the true number of cases is greatly in excess of the notifications.

Sonne dysentery is mainly a disease of children. Of a series of 356 cases in which *Sh. sonnei* was isolated at the Public Health Laboratory, Wakefield, 213 were aged 5 or under, 63 aged 6—11 and 80 of all ages over 12. Although the infection spreads most rapidly and produces its most severe symptoms in children the adult home contacts of infected children are frequently involved. Industrial areas of the country appear to have suffered more severely than others. There are many factors which may have a bearing on this, overcrowding of population and the employment of mothers in industry are perhaps two of the more important. There were several outbreaks of Sonne dysentery in day nurseries during the year and once *Sh. sonnei* is introduced into a nursery the infection spreads rapidly and very few children escape. This probably provides one source of infection for the community outside the nursery but day nurseries are by no means the only disseminators of *Sh. sonnei* as there have been several widespread outbreaks in areas where no day nursery could have been concerned. The spread of infection appears to be mainly by contact. The child with diarrhoea due to *Sh. sonnei* is excreting faeces in which the organism is present almost in pure culture and in very large numbers, such children readily infect not only their own hands and clothing but also their surroundings.

Sonne dysentery is usually regarded as a mild disease and in the majority of cases this is so; in young children the disease is frequently severe and some deaths have occurred; even in adults the symptoms have sometimes been very severe. Many cases, particularly in adults, are not diagnosed as dysentery because the classical symptoms of dysentery are not present. Vomiting may be a more predominant symptom than diarrhoea and unless bacteriological examination of the faeces is made such cases will often be labelled as food poisoning, gastro-enteritis or gastric influenza. In some cases school meals came under suspicion but after investigation Sonne dysentery was found to be present and to have been present in the community before the supposed outbreak of food poisoning. Although food can be responsible for the spread of Sonne dysentery contact spread infection can produce an explosive outbreak suggestive of food infection; in such cases it is found that diarrhoeal disease has been prevalent in the area some time before the sudden increase in incidence draws attention to it. In spite of the comparative mildness of the disease social results of such wide-spread infection must have been important. Apart from infection of adults, many mothers who would normally have been working must have been kept at home to look after sick children and children sent home from day nurseries closed as a result of an outbreak of dysentery.

Knowledge of the epidemiology of this disease is still very incomplete; little progress will be made until records of the extent of infection are more complete. A greater use of laboratory facilities in diarrhoeal disease, particularly in the comparatively mild disease of adults would almost certainly show that *Sh. sonnei* infection was more widespread than present notification suggests. In particular, some method of watching for the appearance of the first cases in any area is required as the presence of Sonne dysentery in an area is frequently not known to the Medical Officer of Health until some major outbreak occurs and infection is by then so widespread that control becomes exceedingly difficult.



## Food Poisoning

Section 17(1) of the Food and Drugs Act, 1938, provides that if a medical practitioner becomes aware, or suspects, that a patient whom he is attending within the district of any Local Authority is suffering from food poisoning, he shall forthwith send particulars of the case to the Medical Officer of Health of that district. Food poisoning is not defined in the Food and Drugs Act, 1938; it would be difficult to define it, as the symptoms can be so similar to those of the commencing stages of other diseases. The main object of Section 17 is to ensure that the Medical Officer of Health is informed of suspected outbreaks to enable him to make the necessary investigation without delay, and to bring to his notice circumstances requiring further investigation which may be of importance to the spread of disease and the protection of community health. The increase in the incidence of suspected outbreaks is related to the preparation of food in bulk and communal feeding both of which have become more prevalent.

The following statistical summary of the cases and outbreaks in 1950 is compiled from returns which Medical Officers of Health are asked by the Ministry of Health to submit. Cases of food poisoning are investigated by Divisional Medical Officers in their capacity as Medical Officers of Health, and the figures are shown on a Divisional basis only to give some indication of the geographical distribution of the cases over the Administrative County.

Division No.	Food Poisoning Notifications returned to R.G. (Corrected).					Number of outbreaks due to Identified Agents.							Outbreaks of Undiscovered Cause		Single Cases		
	Quarter of year				Total	Chemical Poisoning	Salmonella Organisms	Staphylococci (inc. Toxin)	Cl. botulinum	Other bacteria	Cases	No. of outbreaks	No. of Cases	Agent Identified	Unknown Cause	Total	
	1st	2nd	3rd	4th													
1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	
2	—	—	—	3	3	—	—	—	—	—	—	1	3	—	—	—	
3	—	1	1	1	3	—	—	—	—	—	—	—	—	—	3	3	
4	—	—	—	2	2	—	—	—	—	—	—	—	—	2	—	2	
5	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	
6	—	14	17	9	40	—	—	—	—	—	—	—	—	—	40	40	
7	—	—	4	1	5	—	—	—	—	—	—	1	4	1	—	1	
8	2	3	3	—	8	—	—	—	—	—	—	—	—	5	3	8	
9	—	—	1	1	2	—	—	—	—	—	—	—	—	2	—	2	
10	—	—	2	—	2	—	—	—	—	—	—	—	—	—	2	2	
11	1	1	—	—	2	—	—	—	—	—	—	—	—	2	—	2	
12	—	—	2	2	4	—	—	—	—	—	—	—	—	4	—	4	
13	—	—	—	3	3	—	—	—	—	—	—	—	—	—	3	3	
14	—	1	1	—	2	—	—	—	—	—	—	—	—	2	—	2	
15	—	—	1	—	1	—	—	—	—	—	—	—	—	1	—	1	
16	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	
17	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	
18	1	—	3	4	8	—	—	—	—	—	—	1	4	2	2	4	
19	—	—	—	5	5	—	—	—	—	—	—	1	5	—	—	—	
20	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	
21	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	
22	7	5	—	220	232	—	—	—	—	—	—	3	221	—	11	11	
23	1	—	—	4	5	—	—	—	—	—	—	—	—	—	5	5	
24	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	
25	—	—	2	—	2	—	—	—	—	—	—	—	—	—	2	2	
26	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	
27	—	—	1	—	1	—	—	—	—	—	—	—	—	—	1	1	
28	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	
29	—	2	—	2	4	—	—	—	—	—	—	2	4	—	—	—	
30	—	9	—	—	9	—	1	—	—	—	9	—	—	—	—	—	
31	—	2	1	—	3	—	—	—	—	—	—	—	—	2	1	3	
Total	12	38	39	257	346	—	1	—	—	—	9	9	241	23	73	96	

The persons affected were in the following age groups:—

Age last birthday.	Number of		Total.
	Males.	Females.	
Under 5 years	12	11	23
5—14 years	12	5	17
15—44 „	31	24	55
45—64 „	11	10	21
65 and over	58	166	224
Age not known	1	5	6
Totals	125	221	346



The figures above relate only to cases statutorily notified. In addition, 300 school children in Division 31 developed mild diarrhoea with intestinal pains and, in a few cases, vomiting, after partaking of school dinner, but specimens all proved negative to food poisoning organisms on bacteriological examination. A number of outbreaks of suspected food poisoning among schools and staffs following a meal supplied under the school meals scheme have been investigated by the Divisional Medical Officers concerned, with, in the majority of cases, the co-operation of the County Sanitary Inspectors.

Following the limited investigation carried out in 1949 in co-operation with the Public Health Laboratory and the Education Committee into the bacteriological condition of crockery and utensils used for school meals, which was reported on in my Annual Report for 1949, an experiment on a larger scale was undertaken during the year. 20 schools were selected for the purpose, 10 with modern kitchens, provided with heated rinsing sinks, and 10 with wash-up sinks only. The work was begun on March 1st and continued over a period of four months. The experiment was divided into two parts designed so as to find:— (a) The best possible bacteriological standard which could be expected at the modern canteens with heated rinsing sinks, but without using hypochlorite, and (b) The best results that could be obtained at the single sink schools with and without chemical sterilization.

Methods of washing-up were devised and typewritten instructions, supplemented verbally and by demonstration, were given to all the staffs. Rubber plate scrapers, detergent measures, dish cloth bowls, dip sticks and thermometers were provided. Extra plate racks were supplied where necessary at schools with rinsing sinks and it was ensured that each school had sufficient tea-towels and dish cloths. The chief feature in the methods devised has been the use of hot water as near as possible to 120°F. for washing-up and at 180°F. for rinsing in the heated sinks. Other matters dealt with included the scraping of plates, proper treatment of dish cloths and tea-towels, time of immersion in the rinsing sink, amounts of water and detergents to be used and in the case of the 5 schools using chemical sterilization details of the routine to be followed.

These methods were started in the schools a month before any samples were taken. Visits were then paid to each school approximately once a week and swabs were taken from dinner and pudding plates, forks and spoons. The results of examination of the samples were forwarded to the schools and discussed with the staffs at the next visit. In this way an attempt was made to find out the reasons for any failure to reach the desired standard of not more than 100 colonies per utensil. Altogether the results from 573 samples were considered.

At the 10 schools using heated rinsing sinks 81 per cent. of the samples were satisfactory compared with the previous year's results of only 35 per cent. (Experiment A). At five schools with single sinks without chemical sterilization, 71 per cent. of the samples were satisfactory compared with the previous year's results of 36 per cent., and at the five schools with single sinks using chemical sterilization 95 per cent. were satisfactory compared with the previous 100 per cent. (Experiment B). There was also an improvement during the experiment of 15 per cent. at the schools with rinsing sinks (i.e. from 76 per cent. of satisfactory samples during the first half to 88 per cent. during the second half). At the schools with single sinks not using chemical sterilization the improvement was even more marked, being 36 per cent. (from 59 per cent. to 80 per cent.). In the group using hypochlorite there was no significant difference throughout the experiment.

It became clear during the experiment that with the equipment provided at the schools with heated rinsing sinks it was possible to obtain bacteriologically satisfactory results, provided that a satisfactory routine is devised and the staffs properly supervised and encouraged until that routine is established. It was equally clear that despite the improvement effected by routine methods, satisfactory results could not be expected at the single sink schools without using chemical sterilization. A full report on the experiment has been submitted to the Education Committee and recommendations have been made regarding routine methods of washing-up which it is considered should be adopted. We have tried to make the staffs hygiene-conscious and to help them to understand the significance of bacterial contamination. Canteen staffs at all the schools involved in the investigation must be complimented on the interest they showed and the efforts they made to improve their results; the results obtained have varied with the qualities of the staffs concerned, except at the schools using chemical sterilization.

The prevention of food poisoning and some other illnesses is largely a question of the hygienic handling of food. Dr. J. Lyons, Divisional Medical Officer for Division 19, comprised of Todmorden B., Hebden Royd U.D., Ripponden U.D., Sowerby Bridge U.D. and Hepton R.D. for which Districts he is also Medical Officer of Health, reports as under on health education for the promotion of hygiene in connection with food establishments:—

"In view of the increasing prevalence of food-borne infections throughout the country, I decided to embark upon a campaign in this Division for the promotion of hygiene in all food establishments. Compliance with the relevant sections of the Food and Drugs Act, 1938, although important, does nothing more than provide the minimum facilities for the clean handling of food. There remains the task of ensuring, firstly, that these facilities were fully and properly utilized and, secondly, that all individuals handling food understand the meaning and importance of personal hygiene. The policy adopted was therefore one of education, advice, and encouragement.



As in all educational ventures one had to rely first and foremost on the personal approach. All food establishments were visited by the Sanitary Inspectors of the District Councils or by myself. Problems of food hygiene were openly and freely discussed with all grades of food handlers, from managers and proprietors down to kitchen cleaners. The tradespeople generally co-operated extremely well. Where appropriate, bacteriological techniques were used to assist in investigation and one is extremely grateful for the help and advice so freely given by Dr. Lane of the Wakefield Public Health Laboratory. Samples of dishwater from a number of canteens were sent for examination. The results were at times alarming; at one canteen the bacterial count of a specimen of dishwater was of an order normally expected from a specimen of crude sewage. Further investigation revealed that the washing machine, an excellent up-to-date model, was not being correctly used. The fault was soon corrected and the management were extremely appreciative of our intervention. Bacteriological swabs were also taken from crockery and cutlery at some catering establishments and it was noted that the kitchen staffs took a surprisingly active interest in the results. Although this particular technique is not yet firmly established in this country as scientifically reliable, there can be no doubt that its use had a stimulating effect on the food handlers concerned.

Auxiliary methods of educating food handlers have been employed to the full. These have included pamphlets, films, lectures, etc. Literature published by the Central Council for Health Education and provided by the West Riding County Council as part of the general scheme for health education was distributed to food establishments. In this way the County Council and the District Councils worked side by side, a partnership owing much to the scheme of divisional administration. The lecture audiences included canteen staffs, local organisations (e.g. Co-op. Guilds, Business and Professional Associations, Trades Councils, etc.) and, of course, the general public. The local press have given valuable assistance by liberal reporting of the talks.

A special method of encouraging food handlers was tried with some success in the Hebden Royd district within this Division. The local District Council sponsored the formation of a "Food Traders' Hygiene Guild", probably the first of its kind in the north of England. The voluntary committee organising the Guild consisted of representatives of all local branches of the food industry. Membership certificates were granted only to those traders who could conform with a code of practice drawn up by the committee with the advice of the Sanitary Inspector and myself. The more discerning type of housewife would naturally tend to buy her food at shops which display membership certificates. These certificates therefore represented an economic asset to the shopkeepers concerned and some of them, in order to acquire membership, brought about improvements which otherwise may not have taken place. A disadvantage of food hygiene Guilds in general is that, if a high standard is to be maintained once the food trader has obtained this certificate, frequent inspections have to be made involving a considerable proportion of the time of the Health Department staff. Another disadvantage is that in small communities any new venture of this kind may be greeted with enthusiasm for a time only then to be followed by a period of reaction. This method of dealing with the problem of food hygiene is therefore not applicable in all areas but it is certainly well worth trying where there is sufficient staff and where there is evidence of some interest and enthusiasm in at least a nucleus of food traders.

The model bye-laws made under Section 15 of the Food and Drugs Act, 1938 have been adopted by the Borough of Todmorden and by the Urban District Councils within the Division. The purpose of these bye-laws is to secure the observance of sanitary and cleanly conditions and practices in connection with the handling, wrapping and delivery of food sold or intended for sale for human consumption. Copies of the bye-laws are being circulated to all occupiers of food establishments and a memorandum giving some guidance and advice on the interpretation of the bye-laws is being drawn up."

Communications received from other Divisional Medical Officers indicate that the problem of food hygiene is being attacked with vigour in all areas. Chief emphasis is laid on the value of frequent inspection by Sanitary Inspectors with a view to making a personal approach to those directly concerned with the handling or preparation of food. In a number of areas codes of practice have been drawn up to assist food handlers in putting into practice the general principles of hygiene. Most of the Sanitary Authorities have now adopted the Food and Drugs Bye-laws, although the introduction of this new legislation has not altered the view that the best results can come only from continuous education, advice and guidance.

Where possible and where appropriate the routine work of the Health Departments has been supplemented by special methods. A Hygienic Food Traders' Guild has for example been formed at Skipton, whilst at Keighley and Horsforth "Clean Food Exhibitions" are planned. Lectures supported by films have been given in nearly all areas to food handlers (including school canteen staffs) and to the general public. Posters, pamphlets and display sets designed by the Central Council for Health Education have been found to have considerable propaganda value.

All Divisional Medical Officers report gradual but appreciable improvements not only in the facilities available for securing cleanliness in food establishments but also in the attitude of food handlers in general to the problems of hygiene. The habit of communal feeding in schools, factories and restaurants is still growing and has probably come to stay, and all Medical Officers are aware that the problem of food hygiene will demand an ever increasing vigilance.



## Smallpox

The following table sets out the figures relating to vaccinations performed during 1950:—

	Under 1	1 to 4	5 to 14	15 or over	Total
Vaccinated ... ..	3,259	3,701	4,345	5,763	17,068
Re-vaccinated ... ..	11	178	1,068	6,338	7,595
Totals	3,270	3,879	5,413	12,101	24,663

A marked increase is shown over the number of vaccinations and re-vaccinations performed during 1949, due to the occurrence during May, 1950, of three cases of suspected smallpox, two of which were in the County Borough of Halifax and one in the neighbouring Sowerby Bridge Urban District. This led to a demand by the public for vaccination which was catered for by the setting up of special vaccination sessions. Dr. Lyons, Divisional Medical Officer, Division No. 19, comments "it is noteworthy that since this smallpox scare of May, 1950, there has also been a noticeable increase in the numbers of routine vaccinations of infants." Dr. Appleton, Divisional Medical Officer, Division No. 18, remarks that "the spur given by the scare lasted for a short time after a corrected diagnosis had been made. The scare demonstrated that although the public are loth to have their children vaccinated their belief in the efficacy of vaccination as giving the only reasonable protection against smallpox is unabated." Dr. Payne, Divisional Medical Officer for Division No. 8 (Harrogate, etc.), holds a special vaccination clinic in Harrogate on Friday mornings and in the outer areas of the division, vaccination is carried out at Infant Welfare Clinics. Similar facilities are available in each Division.

One case of post-vaccinal encephalomyelitis was notified in a child aged 2½ years. The illness commenced approximately ten days after vaccination. Two convulsions occurred and there was a slight neck rigidity and a raised temperature. The cerebro-spinal fluid was consistent with the diagnosis of encephalitis. The case was discharged home, well, ten days after onset of the illness.

## Treatment of Scabies

During 1950, 9 men, 22 women and 328 children received treatment for scabies at cleansing centres, school clinics, etc.

## Ophthalmia Neonatorum

39 cases of ophthalmia neonatorum were notified (37 in 1949; 51 in 1948; 82 in 1947), 22 of which were treated at home and 17 in hospital. In none was the vision impaired.

## Library Books

During 1950, 600 books, which had been in contact with infectious disease, were disinfected for the County Library.

## New Claims to Sickness Benefit

It has been suggested that the fluctuations in the weekly figures representing total new claims to sickness benefit may give some index to the general health of the population using each local office of the Ministry of National Insurance, notably, say, in indicating the onset and progress of seasonal or epidemic influenza. Figures of the new claims to sickness benefit compiled in each of the local National Insurance offices in the West Riding Administrative County are received each week from the Regional Controller of the East and West Ridings Region, and those appropriate to each County Public Health Division are sent to the Divisional Medical Officer.

## Tuberculosis

The medical officer of health (and divisional medical officer) is increasingly the "tuberculosis officer" of his area now that the former tuberculosis officers have retreated within hospital as "chest physicians." This means that the medical officer of health must increasingly study the epidemiology of tuberculosis in his area and treat every case as a subject of special investigation. It is lamentable that another year should have passed without finding a solution of the difficulty which prevents joint use of chest physicians by Regional Hospital Boards and Local Health Authorities. With goodwill the services are being maintained but the situation markedly impairs the development of our scheme for the prevention, care and after-care of tuberculosis. Within the limits of the time made available such arrangements should provide for the chest physicians to undertake such duties as the County Council may consider desirable in the furtherance of their scheme (See Appendix on duties of specialists). We already meet with one major obstacle in the X-ray examination of staff (nurses, midwives, teachers, etc.) whose association with groups of the population at abnormal risk makes it essential to eliminate any possible danger of them being a source of infection. This serves again to emphasise (as in last year's report) that the chest physician must be available to tackle any job which may serve to prevent tuberculosis spreading. With the exercise of patience and understanding on both sides we must hope for a final answer to this difficult problem.



## DEATHS FROM TUBERCULOSIS, 1950

There were 471 deaths from tuberculosis representing death rates of 0.25 respiratory and 0.04 non-respiratory (England and Wales 0.32 and 0.04). These figures, the lowest recorded in the West Riding, are a testimony to modern forms of treatment, following early diagnosis, and cannot yet be regarded as an indication of a reduced incidence of the disease. One marked feature is that the younger woman is no longer markedly the victim of this disease. The figures are given below:—

Classification.	AGE AT DEATH																		Grand Total
	0—		1—		5—		15—		25—		45—		65—		75—		Total		
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
Respiratory	—	2	1	—	—	1	10	34	72	64	129	22	48	11	7	3	267	137	404
Non-Respiratory	1	2	8	7	3	10	4	3	11	3	8	6	1	—	—	—	36	31	67
Total	1	4	9	7	3	11	14	37	83	67	137	28	49	11	7	3	303	168	471

## PUBLIC HEALTH (TUBERCULOSIS) REGULATIONS 1930.

1,786 new cases of tuberculosis were notified during the year compared with 1,982 last year, a fall of 10% and an average of 1,767 in the five years 1945-49. There were 1,414 respiratory and 372 non-respiratory cases; details are summarised in the following tables.

	AGE PERIODS													Total (all ages)
	0—	1—	2—	5—	10—	15—	20—	25—	35—	45—	55—	65—	75—	
FORMAL NOTIFICATIONS:—														
Respiratory, Males ...	3	6	29	28	17	59	65	130	114	134	89	50	2	726
Respiratory, Females ...	5	2	19	31	22	70	113	126	61	30	8	9	1	497
Non-Respiratory, Males ...	2	9	30	44	21	11	12	7	7	8	2	1	1	155
Non-Respiratory, Females ...	3	6	18	43	26	17	18	28	8	8	4	2	—	181
SUPPLEMENTAL NOTIFICATIONS:—														1559
Respiratory, Males ...	—	—	—	1	3	5	21	27	8	12	18	14	3	112
Respiratory, Females ...	1	—	—	1	2	7	14	28	8	8	2	4	4	79
Non-Respiratory, Males ...	—	2	1	2	3	2	1	4	1	1	2	—	—	19
Non-Respiratory, Females ...	1	—	2	1	—	1	2	5	2	2	1	—	—	17
														227

The sources of information of the supplemental notifications were:—

Local Registrars (54 respiratory, 4 non-respiratory), transferable deaths from the Registrar General (8 respiratory, 8 non-respiratory); posthumous notifications (12 respiratory); transfers from other areas (105 respiratory, 22 non-respiratory); other sources (12 respiratory, 2 non-respiratory).

After adjustment for removals, recoveries and deaths, the total number of cases on our registers at the end of the year was 9,586, an increase of 262, representing 6 per 1,000 of the population (the rate varies from 4 to 13 per thousand in the different divisional areas). The following table summarises the revision of the registers in the respective divisional areas.

Division No.	Number of cases on register 1/1/50.				Number of cases added to register.				Number of cases removed from register.				Number of cases remaining on register 31/12/50.			
	Respiratory M	Respiratory F	Non-Resp. M	Non-Resp. F	Respiratory M	Respiratory F	Non-Resp. M	Non-Resp. F	Respiratory M	Respiratory F	Non-Resp. M	Non-Resp. F	Respiratory M	Respiratory F	Non-Resp. M	Non-Resp. F
1	179	121	53	69	28	16	9	7	36	22	11	13	171	115	51	63
2	48	23	18	16	7	5	1	4	4	4	6	2	51	24	13	18
3	103	82	41	25	27	15	3	1	8	6	—	—	122	91	44	26
4	176	147	72	71	28	27	3	9	20	14	5	7	184	160	70	73
5	190	134	58	59	43	26	11	6	32	22	16	4	201	138	53	61
6	209	127	78	70	23	10	6	5	37	22	20	7	195	115	64	68
7	36	20	17	16	9	9	3	1	7	5	5	2	38	24	15	15
8	198	161	71	96	46	37	4	11	32	31	10	15	212	167	65	92
9	64	74	45	38	14	8	6	3	20	18	11	12	58	64	40	29
10	106	75	43	40	18	23	8	6	10	10	3	2	114	88	48	44
11	178	145	46	45	41	21	2	5	23	16	2	3	196	150	46	47
12	162	112	53	63	29	22	1	6	17	6	1	1	174	128	53	68
13	62	42	21	16	18	7	3	6	9	9	2	—	71	40	22	22
14	61	42	14	35	15	5	1	4	4	11	1	4	72	36	14	35
15	56	52	36	33	16	11	5	8	13	7	8	8	59	56	33	33
16	117	101	38	32	30	24	5	11	20	11	4	6	127	114	39	37
17	149	93	65	69	24	10	3	3	13	4	2	3	160	99	66	69
18	127	93	55	26	35	12	7	10	18	9	24	7	144	76	38	29
19	136	82	93	83	45	46	12	13	50	45	43	50	131	83	62	46
20	89	75	44	51	33	18	17	19	16	16	7	11	106	77	54	59
21	18	10	8	12	9	6	2	4	4	3	2	1	23	13	8	15
22	191	146	90	54	54	32	8	16	16	10	4	8	229	168	94	62
23	190	134	46	53	43	33	10	4	36	17	17	9	197	150	39	48
24	61	45	20	11	16	16	4	4	12	10	2	2	65	51	22	13
25	117	87	18	29	35	22	8	8	16	5	1	2	136	104	25	35
26	82	47	27	29	25	12	5	5	16	16	5	7	91	43	27	27
27	113	87	57	46	23	15	4	5	22	19	6	7	114	83	55	44
28	117	96	73	67	21	23	10	8	9	13	11	14	129	106	72	61
29	94	78	36	29	22	22	1	3	18	9	12	8	98	91	25	24
30	196	155	42	30	37	27	7	8	45	40	3	8	188	142	46	30
31	158	107	43	34	50	30	18	11	47	40	14	12	161	97	47	33
Total	3783	2773	1421	1347	864	590	187	214	630	470	258	235	4017	2893	1350	1326



Notification is received of tuberculous patients admitted to and discharged from institutional treatment. The table below gives details of such notifications from which it will be seen that 890 cases, of all categories, were admitted for treatment to 95 institutions of various types. Compared with the 1,196 cases afforded treatment under the County Scheme in 1947 it would appear that, although there has been recourse to more improvised accommodation, the accommodation for treatment has not increased. If this is not so the alternative conclusion must be failure to notify under the Regulations.

INSTITUTION	RESPIRATORY								NON-RESPIRATORY							
	Admitted				Discharged				Admitted				Discharged			
	Adults		Children		Adults		Children		Adults		Children		Adults		Children	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Baguley Sanatorium, Wythenshawe ... ..	—	—	—	1	—	—	—	—	—	—	—	—	—	—	—	—
Bierley Hall Hospital, Bradford ... ..	1	6	1	—	1	4	—	—	—	—	—	—	—	—	—	—
Bradford Royal Infirmary ... ..	2	1	—	—	2	1	—	—	1	—	1	—	—	—	1	—
Bradley Wood Sanatorium, Huddersfield ... ..	7	3	4	5	4	1	—	4	2	1	—	—	—	1	1	—
Castle Hill Sanatorium Cottingham ... ..	9	4	—	1	1	—	—	—	—	—	—	—	—	—	—	—
Cheshire Joint Sanatorium, Market Drayton ... ..	—	—	—	—	1	—	—	—	—	—	—	—	—	—	—	—
Commonside Sanatorium, Sheffield ... ..	—	4	—	—	—	3	—	—	—	—	—	—	—	—	—	—
Conisbrough Isolation Hospital ... ..	8	—	—	—	3	—	—	—	—	—	—	—	—	—	—	—
Connaught Hospital, Hindhead, Surrey ... ..	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Cottage Hospital, Beverley ... ..	—	1	—	—	—	1	—	—	—	—	—	—	—	—	—	—
Crimicar Lane Hospital, Sheffield ... ..	2	—	—	—	3	—	—	—	—	—	—	—	—	—	—	—
Crookhill Hall Sanatorium, Conisbrough ... ..	52	—	3	—	53	—	2	—	—	—	—	—	—	—	—	—
Deepdale Isolation Hospital, Preston ... ..	—	—	—	—	1	—	—	—	—	—	—	—	—	—	—	—
Dronfield Hospital, Sheffield ... ..	—	—	—	—	—	1	1	—	—	—	—	—	—	—	—	—
Fairfield Sanatorium, York ... ..	2	2	—	1	—	1	1	—	—	—	1	—	—	—	—	1
Fall Birch Hospital, Bolton ... ..	—	—	—	—	—	1	—	—	—	—	—	—	—	—	—	—
Gateforth Sanatorium, Ambleside, Nr. Selby ... ..	29	2	1	—	11	—	—	—	1	—	—	—	1	—	—	—
Halifax General Hospital ... ..	2	—	—	—	—	—	—	—	1	—	1	—	—	—	—	—
Harefield Hospital, Middlesex ... ..	—	—	—	—	—	1	—	—	—	—	—	—	—	—	—	—
Huddersfield Royal Infirmary ... ..	2	1	—	—	2	1	—	—	4	6	2	—	3	6	2	—
Infectious Diseases Hosp. Leeds Rd., Bradford ... ..	—	16	—	1	—	7	—	1	—	—	—	—	—	—	—	—
Kendray Hospital, Barnsley ... ..	—	—	1	—	—	—	—	—	—	—	1	—	—	—	—	—
Killingbeck Hospital, Leeds ... ..	60	25	2	3	31	9	1	1	1	—	—	—	1	—	—	—
King Edward VII Hospital, Sheffield ... ..	—	—	—	—	—	—	—	—	—	—	1	1	—	—	—	—
King Edward Sanatorium, Eastbourne, Sussex ... ..	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
King George V. Sanatorium, Godalming ... ..	—	—	—	—	1	—	—	—	—	—	—	—	—	—	1	—
Lancaster and District Isolation Hospital ... ..	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Leeds General Infirmary ... ..	2	—	—	—	2	1	—	—	—	1	4	1	—	—	—	4
Liverpool Open-Air Hosp., Leasowe, Cheshire ... ..	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—
Lodge Moor Hospital, Sheffield ... ..	1	—	—	—	3	—	—	—	—	—	—	—	—	—	—	—
Marguerite Hepton Memorial Orth. Hosp., Thorp Arch ... ..	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—
Middlewood Hospital, Bradford ... ..	—	—	—	—	2	—	—	—	—	—	—	—	—	—	—	—
Mill Hill Isolation Hospital, Huddersfield ... ..	7	2	—	1	4	1	—	—	—	—	—	—	—	—	—	—
Montagu Hospital, Mexborough ... ..	—	—	—	—	—	—	—	—	—	—	2	—	—	—	1	—
Moorgate General Hospital, Rotherham ... ..	3	—	—	—	1	—	—	—	—	—	—	—	—	—	—	—
Mount Vernon Sanatorium, Barnsley ... ..	6	6	5	1	4	5	5	1	1	—	—	—	—	—	—	—
Mowbray Grange Hospital, Bedale ... ..	—	6	—	—	—	—	—	—	1	—	—	—	—	1	—	—
National Sanatorium, Benenden, Kent ... ..	1	1	—	—	1	—	—	—	—	—	—	—	—	—	—	—
Nether Edge Hospital, Sheffield ... ..	3	5	—	—	4	6	—	—	—	—	—	—	—	—	—	—
Northfield Sanatorium, Driffield ... ..	—	2	—	—	—	—	—	—	—	—	—	—	—	—	—	—
North Wales Sanatorium, Denby ... ..	—	—	—	1	—	—	—	—	—	—	—	—	—	—	—	—
Oakwood Hall Sanatorium, Moorgate, Rotherham ... ..	—	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Osgodby Hospital, Lincoln ... ..	3	1	—	—	1	1	—	—	—	—	—	—	—	—	—	—
Papworth Hospital, Cambridge ... ..	—	—	—	—	1	—	—	—	1	—	—	—	—	—	—	—
Pinderfields General Hospital, Wakefield ... ..	—	—	—	—	—	—	—	—	1	—	—	1	—	—	—	—
Polish Hosp. (No. 4) Iscody Park, Whitchurch, Salop ... ..	7	2	—	1	—	—	—	—	—	—	—	—	—	—	—	—
Preston Hall Sanatorium, Maidstone, Kent ... ..	2	—	—	—	1	—	—	—	—	—	—	—	—	—	—	—
Ransom Sanatorium, Rainworth, Mansfield, Notts. ... ..	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Robert Jones and Agnes Hunt Orth. Hosp., Oswestry ... ..	—	—	—	—	—	—	—	—	5	8	—	1	6	9	—	1
Royal Lancaster Infirmary ... ..	—	—	—	—	—	1	—	—	—	—	—	—	—	—	—	—
Scotton Banks Sanatorium, Knaresborough ... ..	129	6	17	—	167	5	30	—	2	3	3	—	11	1	6	—
Seacroft Hospital, Leeds ... ..	—	—	—	—	—	—	—	—	—	1	—	—	—	—	1	—
Sheffield Children's Hospital ... ..	—	—	—	1	—	—	—	—	—	1	—	—	—	—	—	—
Sheffield Royal Infirmary ... ..	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Staincliffe General Hospital, Dewsbury ... ..	—	—	—	—	—	—	—	—	—	—	1	—	—	—	—	—
Stanley Royd Hospital, Wakefield ... ..	—	2	—	—	1	1	—	—	—	—	—	—	—	—	—	—
St. George's Hospital, Rothwell ... ..	—	12	—	—	—	3	—	—	—	—	—	—	—	—	—	—
St. Luke's Hospital, Bradford ... ..	—	1	—	—	—	1	—	—	—	—	—	—	—	—	—	—
Storches Hall, Huddersfield ... ..	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
The Hollies Children's Hospital, Leeds ... ..	—	—	—	1	—	—	—	1	—	—	1	—	—	—	1	—
The Hospital, Grassington ... ..	14	9	—	2	5	2	—	2	—	—	—	1	—	—	—	—
The Hospital, Middleton-in-Wharfedale ... ..	137	81	19	13	167	97	12	7	7	2	10	5	11	—	10	4
Thornton Lodge Sanatorium, Aysgarth ... ..	—	—	3	3	—	—	2	1	—	—	—	—	—	—	—	—
Tickhill Isolation Hospital, Doncaster ... ..	10	14	2	1	10	7	1	3	—	—	—	—	—	—	—	—
Wakefield Municipal Hospital, Snapethorpe ... ..	9	6	—	—	4	1	—	—	—	1	—	—	—	1	—	—
Wath Wood Isolation Hospital ... ..	—	—	—	—	—	—	—	—	—	—	1	—	—	—	—	1
Westmorland County Hospital, Kendal ... ..	—	—	—	—	—	1	—	—	—	—	—	—	—	—	—	—
Westmorland Sanatorium, Grange-over-Sands ... ..	—	—	—	—	—	1	—	—	—	—	—	—	1	—	—	—
Whitley Grange Sanatorium, Dewsbury ... ..	9	11	—	—	8	7	—	—	—	—	—	—	—	—	—	—
Winter Street Hospital, Sheffield ... ..	3	3	—	1	3	3	—	2	—	—	—	—	—	—	—	—
Women's Hospital, Leeds ... ..	—	—	—	—	—	—	—	—	—	1	—	—	—	—	1	—
York City General Hospital ... ..	—	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—
York County Hospital ... ..	—	—	—	—	—	—	—	—	1	—	—	—	—	—	—	—
Totals ...	415	374	47	54	348	352	30	54	23	24	25	20	24	31	20	17



**B.C.G. Vaccination**—At the beginning of the year the only chest physicians nominated to undertake B.C.G. vaccination on behalf of the County Council were those formerly employed by the County Council. To meet this situation and to provide similar facilities throughout the whole administrative area, the remaining senior chest physicians were nominated. Nomination in itself does not ensure the full development of the service and much still depends on the successful conclusion of negotiations for the joint appointment of the chest physicians with the Regional Hospital Board and Local Health Authorities.

Vaccinations commenced in 1950 and by the end of the year 143 children (57 boys and 86 girls) had been given this new form of protection against tuberculosis, distributed in Divisions 2(4), 4(12), 6(5), 7(3), 8(21), 9(6), 10(5), 11(4), 12(8), 18(7), 19(16), 21(1), 22(36), 23(10), 25(3), 29(2). This distribution gives a potent illustration of the gaps that are yet to be filled and of the service which still requires a greater impetus. In all cases there was contact with a known case of tuberculosis (114 families and 29 school) for periods of up to 6 years; the children had all remained free from infection as confirmed by an initial tuberculin test. Vaccination was generally followed by slight local reaction which cleared up and the subsequent tuberculin test showed that the vaccination had been successful in all but three cases. The sex and age distribution of the cases dealt with is shown in the following table:—

ANALYSIS OF B.C.G. VACCINATION DURING 1950

	AGE GROUPS.										All Ages.
	Under 1 year Months.				Years.						
	0—	1—	3—	6—	1—	2—	3—	4—	5—	10—15	
Vaccinated :—											
Male ... ..	2	1	3	—	8	4	6	8	16	9	57
Female ... ..	2	1	1	2	12	8	8	3	18	31	86
Total ... ..	4	2	4	2	20	12	14	11	34	40	143
Result of Vaccination											
Successful											
Male ... ..	2	1	2	—	7	8	6	7	15	8	51
Female ... ..	2	—	1	2	10	6	7	2	17	29	76
Total ... ..	4	1	3	2	17	9	13	9	32	37	127
Unsuccessful ... ..	—	1	1	—	—	—	—	1	—	—	3
Not finally ascertained	—	—	—	—	3	3	1	1	2	3	13

It will be noted that Division 22, recording the highest number of vaccinations, includes the Wortley Rural District. Here B.C.G. was a feature of an epidemiological survey, details of which are reported by Dr. Main Russell, the Divisional Medical Officer, as follows:—

“Towards the end of November, I had occasion to put this (B.C.G.) procedure into operation, after consultation with Dr. Midgley Turner, the Chest Physician, of Sheffield. I received information that a child aged 12 years was found by the Chest Physician to be suffering from an extensive bilateral Tubercular infection of the lungs. This child had been attending one of the new Council Schools, and the Chest Physician pointed out to me that there was a possibility of contact spread of infection to other children. I immediately visited the School concerned and enlisted the help of the Head Teacher. I asked him if he could tell me who the contacts might be, and he made enquiries and informed me that over 100 children were known to be fairly close contacts with the infected girl. I suggested to the Head Teacher that the parents of all those children should be notified, and invited to come to School when I would talk to them, and tell them what I proposed to do. The parents responded, and I talked to over 100 mothers and fathers at the school and explained to them the procedure of B.C.G. Vaccination and why I thought it was necessary in this instance. Every parent gave me full approval, and this was obtained in writing.

106 children were submitted to a skin test by a solution of 1-1000 Tuberculin. Two days later the children were seen again, when it was found that 34 cases were negative, 64 cases positive, and 8 cases doubtful. The 8 doubtful cases were re-tested with a solution of 1-100 Tuberculin, and the result showed that 6 were obviously positive and 2 negative. The final figures were, therefore, 36 negative and 70 positive. There were an odd 7 children who had been absentees, and who later sought my advice with regard to protection, and they too were submitted to the skin test. All 7 were positive.



Positive cases needed a further examination, preferably an X-ray examination, to eliminate any possible active focus infection in the lungs. There were 77 positive cases, and being school children, I considered that the best procedure to adopt was to make a special appointment at the Mass Radiography Centre, and have all the children go together by special bus. The County Council approved of my arrangement to convey the children by bus to the Mass Radiography Unit, and meet the transport charges. The 77 children, therefore, attended the Mass Radiography Centre and had an X-ray examination. Of this 77, 13 were asked to go back for a larger picture, and of the total number examined, 5 were considered worthy of having a re-check at the Chest Clinic at a later date. Since this time those 5 cases have been re-checked and everything is found to be satisfactory. Only one case required further investigation, and that was a case which had an unusual heart shadow. There was a satisfactory ending to the investigation into this case when the Paediatrician decided that the condition had no significance.

The 36 negative cases who were submitted to B.C.G. Vaccination were in due course of time seen, and each showed a reaction to the Vaccine, varying in extent. No child suffered any constitutional disturbance. After a period of six weeks those children were re-submitted for skin testing by the injection under the skin of a small drop of 1—1000 Tuberculin. Each child showed a positive reaction, which indicated that each child had been converted from Mantoux negative to Mantoux positive and that an artificial immunity could be expected to develop in consequence.

I think it can be considered a very satisfactory result to this piece of epidemiological work. It is very gratifying to know that there are over 100 children in close contact who have been surveyed from a Tuberculosis point of view. Those who had passed through their primary infection had obviously overcome that infection and there was no active focus to be found. Those who had not passed through their primary infection had been given an artificial infection, and had reacted satisfactorily. This picture of this aspect of the health of these children is a very valuable one indeed.

I must put on record my sincere thanks to Dr. Midgley Turner and his staff at the Chest Clinic, Queen's Road, Sheffield, for their most valuable and kindly help, and I must also thank the Head Master of the School concerned for his most enthusiastic co-operation in all that was done."

**Mass Radiography**—The table below gives details of the examination undertaken in the administrative area by the Mass Radiography Units of the Regional Hospital Board. In the Leeds Region, the ratio of 5 cases of active tuberculosis per thousand examinations has been maintained, a feature of marked consistency since the service first operated. The differing results from the Sheffield area do not disprove these findings but are perhaps significant only of the particular industry, employment in which demands a high standard of constitutional and physical fitness.

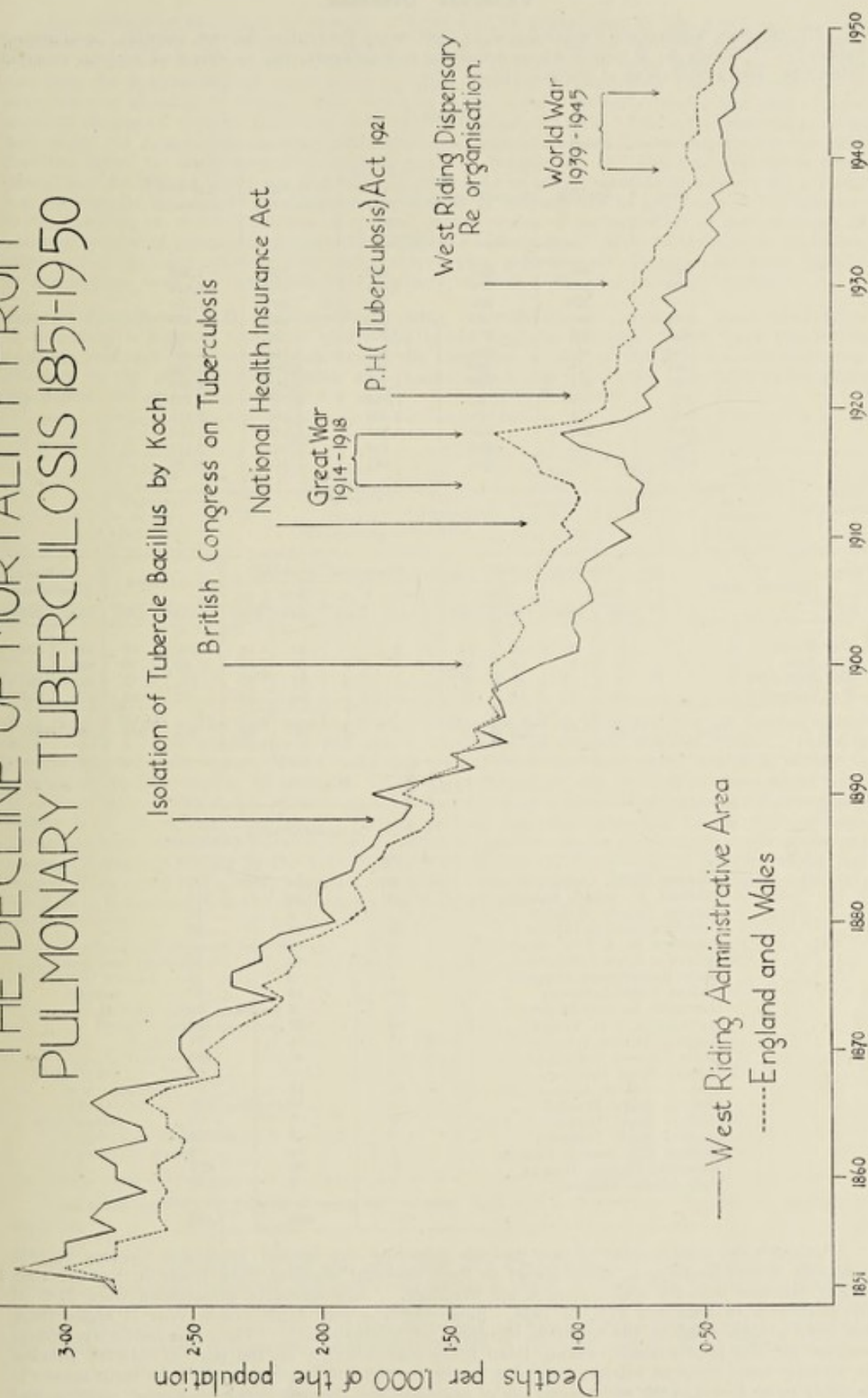
Surveys undertaken at	No. Examined.	Abnormalities Discovered.			Total.
		Tuberculosis.		Others.	
		Active.	Inactive		
<b>A. SHEFFIELD UNIT.</b>					
Samuel Fox & Co. Ltd., Stocksbridge ...	4,729	4	16	70	90
<b>B. LEEDS UNIT.</b>					
Ripon Training College ...	646	—	1	4	5
Barwick-in-Elmet ...	39	—	—	—	—
Boston Spa ...	237	—	3	1	4
Micklefield ...	71	2	—	—	2
Sherburn-in-Elmet ...	212	2	1	3	6
Swillington ...	71	—	—	1	1
Tadcaster ...	1,449	6	7	15	28
Thorp Arch (M.O.S.) ...	344	1	1	5	7
Wetherby ...	466	2	—	5	7
Burton's Factory, Goole ...	423	1	3	1	5
Parish Church and Docks, Goole ...	2,948	1	6	10	17
Shipbuilding Yard, Goole ...	309	1	2	—	3
Standerling Hall, Selby ...	1,516	3	7	6	16
R. S. Depot, Barlow ...	310	2	3	9	14
Cawood ...	36	—	—	—	—
Drax Grammar School ...	116	—	—	—	—
Rawcliffe Hall ...	175	13	—	4	17
Gomersal ...	930	7	3	9	19
Cleckheaton ...	1,192	3	12	15	30
Liversedge ...	954	10	6	14	30
Mirfield ...	1,080	—	8	2	10
Brighouse and Elland ...	3,367	11	21	7	39
Hebden Bridge	17,330	56	71	106	233
Sowerby Bridge					
Todmorden					
North Spring House, Kirkburton ...	2,750	55	46	23	124
Houghton Main Colliery ...	1,147	5	6	41	52
	42,847	185	223	351	759



The 281 non-tuberculous abnormalities revealed by the Leeds Surveys are classified as follows—

Abnormalities of bony thorax and lungs ...	25
Chronic bronchitis and emphysema ...	19
Pneumonia ... ..	1
Consolidation of unknown cause ...	1
Bronchiectasis ... ..	61
Pulmonary fibrosis (e.g. post-pneumonic)	13
Pneumoconiosis (silicosis, asbestosis, etc.)	31
Basal fibrosis ... ..	8
Pleural thickening ... ..	36
Pleural and interlobar effusion ...	3
Intrathoracic new growth ... ..	8
Cardio-vascular lesions—congenital ...	8
Cardio-vascular lesions—acquired ...	40
Abnormalities of diaphragm ... ..	3
Dextrocardia ... ..	2
Mediastinal effusion ... ..	1
Foreign bodies ... ..	2
Enquiries not completed ... ..	21
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	281
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# THE DECLINE OF MORTALITY FROM PULMONARY TUBERCULOSIS 1851-1950





## Venereal Diseases

Dr. Burgess, Consultant Venereologist to the County Preventive Service, submits the following report:— "Tables A, B and C show details of new patients, the incidence of various venereal infections, and attendances at various clinics.

Table A.

Year	Syphilis	Gonorrhoea	Total new cases of Syphilis and Gonorrhoea	Other conditions	Total new patients
1938	346	650	996	503	1,499
1939	403	678	1,081	593	1,674
1940	299	499	798	497	1,295
1941	331	552	883	587	1,470
1942	423	479	902	735	1,637
1943	487	654	1,141	1,344	2,485
1944	413	560	973	1,383	2,356
1945	473	767	1,240	1,419	2,659
1946	723	1,140	1,863	1,859	3,722
1947	573	729	1,302	1,511	2,813
1948	463	550	1,013	1,403	2,416
1949	435	383	818	1,360	2,178
1950	357	304	661	1,447	2,108

Table B.

Quarter ended	Acquired Syphilis				Congenital Syphilis				Gonorrhoea		Other Conditions	
	Early		Late		Under 1 yr.		Over 1 yr.		1949	1950	1949	1950
	1949	1950	1949	1950	1949	1950	1949	1950				
31st March ...	46	20	46	71	4	—	17	15	106	87	364	394
30th June ...	43	17	54	50	3	1	18	19	89	79	366	379
30th September ...	39	17	48	52	—	3	17	12	101	79	322	337
31st December ...	30	22	54	48	—	—	16	10	87	59	308	337
Total ...	158	76	202	221	7	4	68	56	383	304	1360	1447

Table C.

	Syphilis	Gonorrhoea	Other Conditions
Barnsley Clinic, Queen's Road ...	30	14	78
Bradford, St. Luke's Hospital ...	22	20	113
Burnley Victoria Hospital ...	—	2	13
Dewsbury General Infirmary ...	22	20	82
Doncaster M. & C.W. Centre ...	3	—	—
Doncaster Royal Infirmary ...	33	62	58
Goole Bartholomew Hospital ...	1	3	14
Halifax Royal Infirmary ...	25	15	97
Harrogate General Hospital ...	13	8	54
Huddersfield V.D. Centre ...	20	25	101
Keighley Victoria Hospital ...	15	14	81
Leeds General Infirmary ...	31	45	244
Oldham Royal Infirmary ...	—	—	4
Rotherham W.R. Medical Centre ...	20	18	87
Sheffield Jessop Hospital ...	12	12	85
Sheffield Royal Hospital ...	8	6	23
Sheffield Royal Infirmary ...	9	9	24
Sheffield City General Hospital ...	1	—	4
Wakefield Clayton Hospital ...	85	29	262
York County Hospital ...	7	2	23
	357	304	1,447

Although the total number of new patients attending the Special Treatment Centres in 1950 remained almost unchanged, those found to have venereal diseases were fewer in number than in any previous year for which records are available. New cases of gonorrhoea were 27% of the peak year of 1946 and 47% of 1938. Since the first year after World War II ended there has been a steady fall in the apparent incidence of gonorrhoea. There are probably several reasons for this improvement, among them being less reticence on the part of infected persons in seeking early medical advice, and also better methods of treatment. But the main reason is possibly to be found in the widespread use of penicillin for the treatment of a vast number and variety of diseases in general medical and surgical practice. Of all the numerous organisms susceptible to the action of penicillin the germ of gonorrhoea is the most sensitive and frequently killed by a single small dose. This must have resulted in clearing up many unsuspected reservoirs of gonococcal infection.

The number of new cases of syphilis in 1950 was 78 fewer than in the previous year and approximates closely to the pre-war figures. Table B shows that the reduction was mainly in the number of cases of early acquired or infectious syphilis (which fell by more than 50 per cent.), so that from the epidemiological aspect there are good grounds for assuming that the incidence of new cases of syphilis is falling. The reduction in the number of early (under one year of age) cases of congenital syphilis from 7 in 1949 to 4 in 1950 augurs well. This is a preventable disease and given the opportunity to treat all syphilitic expectant mothers Venereologists are confident that the figure for early congenital syphilis could be reduced to nil. Cases of syphilis in pregnancy may be missed if (1) the expectant mother fails to obtain ante-natal advice; (2) a blood test for syphilis is omitted; (3) the expectant mother is infected late in pregnancy. The increase in the number of other conditions diagnosed at the clinics is an indication of the readiness of potentially infected persons to present themselves for examination. Many of these other conditions were in fact diseases acquired venereally, others were non-venereal diseases simulating syphilis or gonorrhoea, and the remainder were contacts of known cases of venereal disease.

**General Practitioner V.D. Service**—Recognising the difficulty of patients in some rural areas in attending a hospital treatment centre the Leeds Regional Hospital Board have decided to continue this service. Patients may attend the surgeries of any of the fifteen authorised practitioners in the administrative county and receive advice and treatment. The table below gives the numbers of cases dealt with in this scheme during 1949 and 1950:—

	1949				1950			
	Cases under treatment at 1st Jan. 1949	New Cases	Cases transferred to the General Practitioner	Total Attendances	Cases under treatment at 1st Jan. 1950	New Cases	Cases transferred to the General Practitioner	Total Attendances
Syphilis ...	88	37	15	1,494	81	15	8	1,272
Gonorrhoea ...	16	12	2	138	2	14	1	101
Other conditions ...	9	88	5	296	21	88	—	313

**V.D. Social Work**—The staff consists of four whole-time Social Workers who are trained nurses with Health Visitors qualifications and special experience in venereal diseases work. There is one confidential clerk typist. The County has been divided into four areas and each worker 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 area. In the control of the spread of venereal diseases Case-finding is of the highest importance. Various methods are used according to the type of case. These methods include (1) Contact slips in which the patient acts as a voluntary unofficial contact tracer; (2) Contact tracing by the V.D. Health Visitor and (3) Follow-up of positive blood test reports from ante-natal clinics, hospitals and general practitioners. The table below gives statistics as to the investigation of contacts by the V.D. Health Visitors:—

Total number of contacts reported ...						187
Located and examined ...					172	
Not infected ...				132		
Infected ...				40		
Already under treatment ...				1		
Brought under treatment ...				39		
Syphilis ...	20					
Gonorrhoea ...	10					
Located ...					7	
Not examined ...					4	
Transferred to other authority ...					3	
Not located ...						8
Insufficient information ...					3	
Unable to locate ...					5	

The total number of re-visits made to contacts was 109 and the total number of ineffective visits 78.

The V.D. Social Workers are also concerned with Case-holding. They interview patients, advise them on their problems and endeavour to assist them in every way to reduce defaulting to the minimum. If a patient defaults, that is, ceases to attend before being cured, the Social Worker finds out the reason for non-attendance and advises and helps the patient to re-attend. The following figures indicate the numbers dealt with in this way and the results obtained:—

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.
373	219	96	15	43	576	538



**The work of Prevention in relation to Positive Blood Tests for Syphilis**—During the year the Pathologists in charge of the laboratories serving the major portion of the County have kindly given me as Consultant Venereologist to your preventive service the names of doctors sending in specimens of blood which on examination have proved to be positive for syphilis. If the specimen has come from a general practitioner or hospital we have written in all cases to the doctor or medical officer concerned offering the services of one of our specially trained V.D. social workers to assist in the socio-medical aspects of the case and the tracing of contacts. Experience has shown that the social workers are often able to help in the difficult and delicate situations which arise, but in no circumstances do they take any action without the authority of the doctor. The type of case in which the assistance of a social worker was most frequently requested was early acquired syphilis, early congenital syphilis and syphilis in pregnancy. In the remainder, mainly patients suffering from late syphilitic manifestations, no socio-medical follow-up was considered necessary or advisable. The following table gives the numbers of cases dealt with and the number of contacts examined:—

No. of positive reports on blood specimens received from Hospitals and General Practitioners.	No. of cases referred to Special Treatment Centres.	No. of contacts examined.	No. of cases not requiring socio-medical follow-up.
105	55	60	50

In the case of positive syphilitic blood reports on specimens from ante-natal clinics a slightly different procedure has been adopted. In order to avoid delay the Social Worker immediately communicated with the Medical Officer in charge of the clinic and offered her assistance in arranging the further examination and, if necessary, the treatment of the patient. The table below gives a statistical summary of the work:—

No. of positive reports on blood specimens received from Ante-Natal Clinics.	No. of cases investigated by Social Worker.	No. of cases referred direct to Special Treatment Centre.	No. found to have syphilis.	No. found not to have syphilis.	No. of contacts examined.
40	35	5	29	11	57

In general I feel confident that the service which we have built up over the years is functioning with increasing efficiency. There are still many improvements possible, particularly in the field of health education. Much of this work will be impossible until the County Health Department has developed a central health education section which can serve the divisions in the difficult tasks of organisation and material preparation. If this were done I am certain that all Consultant Venereologists with attachments to clinics serving different parts of the County would be most willing to help Divisional Medical Officers in such preventive work. I wish to thank our four V.D. health visitors and our clerk typist for their untiring work and all venereologists and laboratories for their collaboration."

## PART III

### MIDWIFERY AND MATERNITY SERVICES

Before July 5th, 1948, approximately 80% of all home confinements in the County were conducted by our midwives. When free medical attention was made available we expected the number of home cases conducted by our midwives to fall. In fact, the total of home confinements has fallen but the proportion undertaken by midwives is no less (79%). Some practitioners continue to misinterpret the motive for the setting up of the maternity services under the Act and insist that once they have contracted to provide the service there is no longer the need of the patient either to seek or be provided with advice from other sources; in two areas of the county this outlook has resulted in the closure of ante-natal clinics. This was never intended; the maternity medical services were looked upon by the Ministry of Health as complementary to those of the local authority. The best maternity service can only be provided under conditions where the general practitioner, midwife, ante-natal clinics, and specialist services act in unison each as members of a team.

The care of the mother during pregnancy has a profound influence upon the baby's chance of survival during the dangerous first month of life. We should now be seeking to extend this ante-natal care by all the means at our disposal if we hope to abolish the remaining loss of infant life. Here again the essential factor for success is team work; the general practitioner must realise that what he has to offer by statute in the way of ante-natal care, namely an examination at the time of booking and again at the 36th week, is insufficient and must be regarded as part, strictly speaking a clinical part only, of a whole. Two important members of the team are the midwife and the ante-natal clinic, which play an educational role in relation to the hygiene of pregnancy and lactation, and a third member is the pathologist whose routine blood tests are wholly preventive in character.

#### Institutional Midwifery

Examination of birth notifications reveals an upward trend of institutional deliveries, 53 per cent, in 1950 compared with 51 in 1949, 46 in 1948, 44 in 1947, 41 in 1946 as shown in the following table:—

Births in ...	1950		1949		1948		1947		1946	
	Total	%	Total	%	Total	%	Total	%	Total	%
Maternity Homes ...	5286	20.1	5199	18.7	11662	39.2	13224	39.3	12590	37.3
Hospitals and Institutions ...	7803	29.6	7724	27.7						
Private Nursing Homes ...	948	3.6	1275	4.6						
	14037	53.3	14198	51.0	13697	46.0	14648	43.6	13854	41.1

Apart from the usual reasons for which applications for lying-in accommodation in hospitals are made, many persons apply on the grounds of economy. It is well known that hospital confinement, where the mother and baby are maintained free, is cheaper for the patient; by a curious anomaly the hospital mother receives the same government grant as her sister who pays for her keep at home. The reduction in the number of births in private nursing homes is probably due to the same economic considerations.

#### Domiciliary Midwifery

In 1950, 488 midwives gave notice of intention to practise (as required by the Central Midwives Board); of these 326 were whole-time County Council midwives, 83 of whom undertook the combined duties of midwifery and home nursing; 125 were employed in institutions and 37 in private practice. Two non-medical supervisors whose duty it is to maintain an efficient midwifery service by the supervision of professional standards made 612 visits for this purpose; special work was undertaken in relation to puerperal pyrexia and pemphigus neonatorum (32); maternal deaths (2); ophthalmia neonatorum (13); tutorials to pupil midwives (20); instructions of new midwives (7); inspection of registered nursing homes (16); consultations with Divisional Medical Officers (132).

Domiciliary midwives attended 12,337 deliveries, of these 10,557 were in the capacity of a midwife and 1,780 as a maternity nurse. They called in the help of a doctor (by issuing a medical aid notice as prescribed by the Central Midwives Board) in 4,972 cases.

The following is a summary of the cases for which medical aid was sought:—

#### PREGNANCY (867)

Abdominal pains ...	20	Chest condition ...	9	Miscarriage ...	68
Ante-natal examination ...	13	Disproportion ...	4	Multiple pregnancy ...	6
Anaemia and debility ...	4	Eclampsia ...	2	Oedema ...	19
Abortion (136)		General condition ...	49	Post maturity ...	6
Threatened (143) ...	279	Hyperemesis ...	8	Renal conditions ...	4
Albuminuria ...	63	Hypertension ...	26	Ruptured membranes ...	15
Ante-partum haemorrhage ...	224	Hydramnios ...	1	Toxaemia ...	26
Blood Test ...	4	Malpresentation ...	10	Varicose veins ...	7



## LABOUR (2898)

Abdominal pain ... ..	2	Eclampsia ... ..	2	Obstructed labour ... ..	35
Abrasion ... ..	4	Foetal distress ... ..	22	Post-partum haemorrhage ...	120
Albuminuria ... ..	1	General condition ... ..	19	Placenta praevia ... ..	10
Blood specimens ... ..	5	Haematoma ... ..	1	Precipitate labour ... ..	94
Chest conditions ... ..	1	Hydramnios ... ..	5	Prolonged labour ... ..	325
Cord presentation ... ..	10	Hysteria ... ..	7	Ruptured perineum ... ..	1655
Delayed labour ... ..	141	Malpresentation ... ..	138	Retained placenta ... ..	134
Disproportion ... ..	6	Multiple pregnancy ... ..	5	Stillbirth ... ..	7
Emergency delivery ... ..	8	Maternal distress ... ..	20	Uterine inertia ... ..	86
Episiotomy ... ..	6	Obstetric shock ... ..	8	Vaginal laceration ... ..	21

## LYING-IN (448)

Abdominal pain ... ..	15	Eclampsia ... ..	2	Pyrexia ... ..	137
Anaemia and debility ... ..	14	Ear discharge ... ..	2	Post-natal examination ...	1
Blood Test ... ..	6	General condition ... ..	69	Shock ... ..	3
Breast conditions—		Haemorrhoids ... ..	4	Secondary P.P.H. ... ..	8
Mastitis ... ..	56	Jaundice ... ..	2	Severe chill ... ..	8
Other ... ..	25	Mental condition ... ..	1	Subinvolution ... ..	3
Chest conditions ... ..	26	Oedema ... ..	6	Skin conditions ... ..	2
Cardiac conditions ... ..	5	Offensive lochia ... ..	2	Thrombosis ... ..	4
Collapse ... ..	2	Phlebitis ... ..	30	Varicose veins ... ..	5
Cystitis ... ..	2	Pyelitis ... ..	1	Vomiting ... ..	7

## THE CHILD (759)

Abscess ... ..	1	Death of infant ... ..	3	Pyloric stenosis ... ..	2
Anencephalus ... ..	2	Deformities ... ..	60	Prematurity ... ..	123
Asphyxia ... ..	32	Discharging eyes ... ..	102	Rash ... ..	8
Atelectasis ... ..	2	Enlarged glands ... ..	4	Septic cyst ... ..	1
Birth injury ... ..	5	General condition ... ..	123	Stillbirth ... ..	7
Born before arrival ... ..	7	Heart condition ... ..	1	Talipes ... ..	11
Chest conditions ... ..	23	Jaundice ... ..	53	Tongue tie ... ..	7
Conjunctivitis ... ..	9	Maelena ... ..	5	Twins ... ..	3
Convulsions ... ..	8	Oedema ... ..	3	Unsatisfactory umbilicus ...	5
Cyanosis ... ..	35	Pemphigus ... ..	13		
Coryza ... ..	10	Phimosis ... ..	1		

Midwives made the following "statutory" notifications:—records of sending for medical aid (4,972); deaths of (a) mother 6 (b) child (125); stillbirths (248); laying out the dead (49); substitution of artificial for breast feeding (733); liability to be a source of infection (159).

**Cost of Domiciliary Midwifery**—At the request of the Ministry of Health a survey was undertaken to determine the average additional cost to the family of a home confinement. The additional cost of £4 9s. was made up as follows:—food and special diet (£1 15s. 6d.); additional laundry (6s. 9d.); additional fuel and lighting (10s. 3d.); additional items of equipment (£1 6s. 6d.); home help (10s.). The total cost of a home confinement (with the possible exception of fees to specialists and general practitioners) was £17 8s. 6d. made up as follows:—midwifery service including administrative cost (£15 9s. 6d.); medical aid fees (15s.); maternity outfit (10s. 6d.); home help £1 3s. 6d. less 10s. recoverable (13s. 6d.).

**Flying Squad**—Arrangements for emergency obstetrical units to give assistance to women on the district in whom grave risk would be entailed in their immediate transfer to hospital are in operation from the following hospitals:—St. Helen Hospital, Barnsley; St. Luke's Maternity Home, Bradford; General Hospital, Halifax; General Hospital, Harrogate; Royal Infirmary, Huddersfield; Maternity Hospital, Leeds; Jessop Hospital, Sheffield; General Hospital, Wakefield. These units are manned by a personnel comprised of an obstetrician, blood transfusion officer and maternity sister with the necessary equipment prepared for immediate operation. In addition negotiations are in progress for the establishment of a similar unit in association with the Montagu Hospital, Mexborough.

**Gas and Air Analgesia**—Generous provision for the relief of pain in childbirth has been made by the County Council; all our midwives have been trained in the administration of gas and air and 296 machines are now available. The response, however, by women over the county as a whole for such alleviation of pain during confinement has not been as popular as anticipated and represents 41% of domiciliary births. Demand varies within the different divisional areas and it is noted that it is greatest in those divisions where concentrated population is the general rule; for example Shipley (79%); Castleford (67%); Colne Valley (66%); Mexborough (59%); Harrogate (58%). Much depends upon our midwives the extent to which women make use of gas and air analgesia, for they are more or less the means by which information on this subject is imparted to the expectant mother. There is still a great deal of fear prevailing in the use of the machine by the patient and every opportunity must be afforded during the late months of pregnancy in teaching the mother by way of practical instruction so that at the time of the confinement there is no apprehension, the mother's only concern being the relief of pain by the intelligent use of the machine. The teaching of analgesia is now recognised as being an essential constituent of a midwife's training and that the relief of pain so far as it can be undertaken without endangering the safe conduct of labour is the duty of the midwife.



**Blood pressure recording apparatus**—There is some disparity in the quality and quantity of ante-natal care throughout the county; in some divisions, for example, attendance at ante-natal clinics is small. This makes it imperative that a high standard of professional care should at all times be exercised by our midwives. An example of new advances in technique is the recording of blood pressure by midwives. For some time now training schools have been teaching pupil midwives in the taking of blood pressure readings and of the significance of departure from the normal. A rise of blood pressure invariably precedes the more obvious signs of toxæmia of pregnancy and it is during this pre-toxæmic stage that treatment is naturally the most effective; we are uncertain how many of the 391 medical aid notices issued in 1950 by our midwives for toxæmia of pregnancy related to cases which might have been detected at an earlier stage had midwives been equipped with the necessary apparatus for taking a blood pressure reading. The period of time which falls between the two statutory examinations by the doctor must be bridged, if it is to be covered at all, by the midwife and ante-natal clinic; in the more rural areas where clinics might not be available, the midwife is the sole safeguard. The County Council appreciated this position by the provision of 200 sphygmomanometers and stethoscopes for issue to midwives who were deemed to be proficient in the recording of blood pressure readings, and the training of those to whom an initial issue could not be made. 170 midwives were making use of this equipment at the end of the year.

**Midwifery teaching**—The course for the training of pupil midwives sponsored by the Central Midwives Board is made up of two parts, the first of which is done wholly in hospital and the second part (6 months) partly on the district under the supervision of domiciliary midwives of standing as midwifery teachers. Two training schemes for the second part are in operation within the county, one in association with the Hazlewood Maternity Home, near Tadcaster, and the second in co-operation with the Nether Edge Hospital, Sheffield. Twenty-three students started training in 1950—it is now learned that 20 passed the examination, one failed and two have not yet taken the examination.

**Post Certificate Instruction**—The rules of the Central Midwives Board require that a practising midwife shall undertake a residential post-certificate course of instruction every seven years. This rule was withdrawn during the war and so far has not been reinstated. The Board has decided, however, that for an initial period of 3 years to encourage local supervising authorities to send midwives voluntarily on refresher courses, particularly those sponsored by the Royal College of Midwives, and 60 midwives attended such courses which were held at Cardiff and Bristol.

### Ante and Post Natal Services

The almost total elimination of deaths in childbirth has been a great encouragement to all of us and it should spur us on to eliminate all disease, mental and physical, associated with the bringing of new life into the world. This is, of course, a tremendous task and one which can only be achieved if we use every scrap of knowledge and through generous support of the personal health services. Team work is essential to ensure that the mother is fitted mentally and physically for childbirth and it is here that the local authority services can play a distinctive role. This distinction is born of the fact that they are the only body which is staffed for the educational side of the operation. Too little emphasis is placed on the value of education in relation to ante-natal work; it is a time consuming occupation and often beyond the reach of a practitioner who is generally overworked in other spheres of medicine. Midwives are able and available to teach hygiene in relation to pregnancy and lactation, to advise the mother in clothing, exercise, diet, sleep, as well as the teaching of mothercraft and relaxation exercises. One of the less satisfactory results of the 1946 Act has been the falling attendances at ante-natal clinics. In our 149 clinics (with 484 sessions per month) 16,769 women attended for a total of 69,463 attendances, compared with 17,846 women and 77,198 attendances last year. Last year I referred to the inadequacy of our arrangements for post-natal care; this continues. Of the 16,769 women who received ante-natal supervision at our clinics only one in seven received post-natal care; one cannot regard those small attendances as being essentially a state of apathy on the part of the mother, who may consider she had had a straight-forward and successful delivery, but probably a combination of this and the relative failure of the educative system. There is scope for great improvement in this sphere. We still have to combine ante and post-natal work in the same clinic excepting at Keighley, Shipley and Tadcaster.

Dr. Paterson (Division II) has given the following account of the combined breast feeding instruction and ultra violet light clinic at Castleford.

"The progressive decline in breast feeding which has taken place during the past two decades has been all too noticeable to anyone interested in this vital subject and the sublime confidence that has been engendered in the minds of the mothers as regards the merits of this or that brand of dried food has become all too well-known. There can be no doubt that one of the main factors contributing to this attitude of mind is the easiness with which proprietary brands of dried milk can be prepared in the home, and indeed it is felt in some quarters that this is an easy way out from the restrictions which motherhood normally imposes whereby a considerable degree of liberty can be obtained by the mother.

Considered Paediatric opinion is overwhelmingly of the opinion that, where possible, all children should be breast fed provided the mother's constitution can stand the strain, but here, fashions for, or against, breast feeding are just as noticeable as in many other walks of life. The ability of a particular mother to secrete a sufficiency of milk successfully, depends on two factors, the one physiological, the other psychological, and of these two factors, the psychological



one is of considerably greater importance. No matter how hard we may try to put the mother's breasts into the best physiological state to sustain the breast feeding of her infant, if the inclination does not exist, or if the confidence of the mother in her ability to do so becomes undermined, then the physiological factor can spell only failure. In none of the body functions can the control of the mind over the body be ignored and certainly on the subject in question, it can be, and frequently is an over-riding factor to be contended with. The fact that breast fed children are on the whole sturdier and less liable to infection than their dried milk fed counterparts has been common knowledge for a long time now, and Dr. Naish, in a recent publication, has emphasised this point by stating emphatically that the sickness rate in artificially fed infants is five times more common than in breast fed ones.

In an industrial area like the one in question, social and environmental conditions often demand that breast feeding should be discontinued by the end of the third week and indeed sometimes much earlier, but in spite of this, I believe that a larger number of women could be persuaded to make an effort to fulfil their natural functional obligations without imposing too great a strain on their physical resources and so breast feed their infants for a considerably longer period of time than is at present the case. In a preliminary effort to tackle this problem, a sunlight plant was installed in Castleford in April, 1945, and it was felt that expectant and breast feeding mothers might reasonably benefit by a course of such treatment and indeed the practical results obtained taken in conjunction with the overwhelming enthusiasm displayed by the mothers justified our most optimistic expectations.

In view of the popularity attained by this clinic it appeared reasonable to assume that a more comprehensive clinic where the principles of breast feeding could be taught and the mothers shown the best methods of putting their breasts into the best physiological condition possible for breast feeding, if run in conjunction with a sunlight clinic, could achieve as great, if not greater degree of popularity than the sunlight clinic alone. Such a clinic was opened on the 1st October, 1949, but it was realised at the very outset that the full co-operation of the doctors was a very necessary factor indeed if it was to be a success, and it was also recognised that the choice of suitable types of nurses to be in charge of, and run this clinic, would require the most careful consideration. All the doctors were therefore circulated with details about this clinic and were invited to send suitable types of patients to it. Originally a health visitor and a midwife were chosen to be in charge, but subsequent experience showed that the service could be most successfully run by the midwives themselves and this arrangement has been in operation for quite a time now.

The following tables show the attendance at this clinic during the period October, 1949, to September, 1950, inclusive and these are divided into two main groups namely those who attend the clinic as expectant mothers and those others who attended as breast feeding mothers. These two groups are further sub-divided into two groups, one for primipara and the other for multipara. To put our findings into a truer perspective it was appreciated that a survey would have to be made of an unselected group to assess the normal extent of breast feeding in this Division, and this survey revealed the fact that only 44% of primipara and 27% of multipara breast fed their infants after the third month.

	Expectant Mothers 46		Breast Feeding Mothers 27	
	Ante-Natal Primipara	Ante-Natal Multipara	Post-Natal Primipara	Post-Natal Multipara
Private Doctor subsequently did not advise				
Breast Feeding ... ..	2	3	—	—
Still births and abortions ... ..	2	1	—	—
Breast fed for a period of up to 1 month ...	5	10	—	2
2 months ...	2	1	3	—
3 months ...	1	2	—	1
4 months ...	—	5	2	4
5 months ...	2	3	2	2
6 months ...	2	5	5	6
	16	30	12	15

# 1. EXPECTANT MOTHERS.

## (a) Ante-Natal Primipara.

16 attended—25% of these continued breast feeding from 3 to 6 months or over.

## (b) Ante-Natal Multipara.

30 attended—43.3% of these continued breast feeding from 3 to 6 months or over.

# 2. BREAST FEEDING MOTHERS.

## (a) Post-Natal Primipara.

12 attended—75% of these continued breast feeding from 3 to 6 months or over.

## (b) Post-Natal Multipara.

15 attended—80% of these continued breast feeding from 3 to 6 months or over.

Whilst it would be impossible at this stage to give any definite conclusion as to the success of this venture or otherwise, it might not be out of place to give one's impressions of the first year's working. It was found that whilst sunlight alone improved the feeling of well-being of the patient, the further treatment of massage and manipulations of the breast stimulated a much



greater flow of breast milk and these two factors combined, with the addition of suitable lactagogue were often most successful. Whilst it is felt that results up-to-date have been most encouraging, it is hoped that as our efforts become more fully known in the division, so will our success become more tangible. It has been found a very necessary adjunct that complete co-operation should exist between the midwife and the health visitor so that when the midwife ceases attendance on a case, the health visitor should immediately follow on her tracks, possessing a full knowledge of all the facts concerning the particular patient. In this way, the continuity of supervision both for the mother and baby becomes much more smooth and uninterrupted. This clinic has, in the first instance, dealt with a small number of mothers, but the interest which has been stimulated amongst the health visitors and midwives of this division as a result of this clinic has given the nursing personnel an added impetus and interest by increasing their endeavour to persuade mothers in this division not attending this clinic to undertake a longer period of breast feeding where such is reasonably possible. In this way it is thought that this venture can have both direct and indirect effects, direct in the sense that a clinic is now in being where the principles of breast feeding, etc., can be taught, and indirect in the sense that a greater interest is taken by the health visitor and midwife of this division in regard to the general breast feeding of infants. It was unfortunate that this clinic had to be carried on in premises not too suitable for the purpose, but by means of improvisation we have been able to ensure continuity of the work reasonably satisfactorily. Alternative accommodation should be available in 1951 at the Divisional Health Office, where this work can be carried out without the hindrances now existing and under more congenial conditions."

Our Ante-Natal Hostel continues to do most excellent work and at last seems to have taken root in the public mind; more applications for admission are being received from a variety of sources including general practitioners, hospitals and obstetricians. The following description of the year's work by Dr. Frank Appleton should be read in conjunction with that of last year. Dr. Appleton has himself taken an intense personal interest in the work of the hostel and its success as a new venture in social medicine must be largely attributed to him.

"There was again an increased use of the Clifton Ante-Natal Hostel during 1950. 102 cases were admitted as compared with 63 in 1949. This is despite the grave disadvantage under which it labours in having no accommodation for the temporary care of the young child, also because it is not regarded as a permanent home. No alternative premises have been found. Personally I am of the opinion that the present premises could be made very suitable and I do not agree with the decision of the Ministry of Health (following a visit in 1949 on a particularly adverse day). Fourteen of the mothers were normal cases and had no complications. They were admitted because they either had no home or were unmarried girls living in grossly overcrowded conditions. Three patients came to us from Institutions. One of the saddest spectacles is that of a woman and her children separated from her husband and their father because of the lack of a home, the husband living in rooms and the wife and children being condemned to Institution life. It is indeed still more unfortunate when the wife becomes pregnant while still living in an Institution. This may appear to be completely irresponsible but the enforced separation of husband and wife with only occasional meetings does not seem to reduce considerably the risk of further pregnancies, and it appears that there is a strong case for the teaching of contraceptive measures to these women who are deprived for a long period of both home and husband.

We were often confronted with the problem of young people who had tried living with each of their parents in turn and who had eventually been rendered homeless because of an inability to live with either. Often these homeless women arrived completely dispirited, with no energy and no interest, and we had many profitable interviews with both husband and wife separately and together. In some instances we were able to persuade the husband into fresh initiative and in a few cases the wife left us with the prospect of a house to which to return. In all these homeless cases without exception the women left us completely different in outlook and appearance. It became more and more apparent that one of the most certain signs of improved mental outlook is the use of cosmetics and other methods of improving and smartening up of the female appearance. Another very significant change is the more determined way in which the woman urges her husband to do something about their position. On admission most of the homeless women had a passive and resigned view of their circumstances. Many of them left us with the determination to alter them. The contact with women from more normal home circumstances is an excellent thing. The trouble with women in Institutions or without a proper home is that their contacts are almost all with women like themselves, and a pre-requisite to improvement is the recognition that such improvement is possible. The only objection to the reception of these women and to the accommodation of unmarried expectant mothers is the effect on the married ones. In only three instances did we have complaints from the other patients of the "class of women" we had in the Hostel, but it is desirable that the rate of unmarried to married mothers should never be more than 1:2.

Several of the lovers of the unmarried expectant mothers were interviewed, and in some cases satisfactory arrangements were made; one girl left the Hostel for a few days to marry her lover who was home on leave. Many other socio-medical problems were encountered. We found very often that bodily fatigue was accompanied by mental lassitude or mental distress. Several women who were completely apathetic on admission later confessed to us their anxious histories and in some cases we were able to help. A few of these histories may be of interest. One woman who had been particularly condemnatory of some of the single pregnant women told a most unhappy story. Her husband deserted the Army while in South Africa. She obtained employment and maintained herself and her infant son. In the factory she met another man who was a widower



with two small children. She eventually became pregnant by this man and took up her life as his wife although the marriage ceremony had not been performed. Just before her confinement her husband returned. He asked her to go back to him and promised to care for the unborn child. As her labour was so near she refused, promising to consider this after the confinement. After the birth of her baby, however, she almost immediately became pregnant again and was again expecting a child when she next saw her husband; she believes that this pregnancy was arranged by her lover to prevent her going away. There was no doubt of her fondness for her second "husband" who was an industrious man of sober habits; she was well known and respected as his wife, and of her real husband who was now "married" to someone else she had no good memories. The proper solution in this case appeared to be for her to remain where she was. Her duty to her children was pointed out to her and a firm opinion given that under her unfortunate circumstances her decision was right. The improvement in this case was remarkable. After she had shared her burden she became brighter and happier and left the Hostel in much better mental health.

Another woman who was admitted in a hysterical condition and suffering from malnutrition gave a history of a husband who attended to his work most irregularly and displayed great irritability. He was a painter and decorator, the business having been left to him; she was not receiving sufficient to live on but went without food rather than reveal this to anyone. This husband of 22 was interviewed. He had been a radio operator in the Navy when he married. He was very childish in his attitude although quite intelligent. In his spare time, and even when he should have been working, he had made several wireless and television sets. He disliked being responsible for other men and put jobs off as long as he could. The business was going down, his employees let him down, and sometimes he had not enough to pay their wages and this made him irritable. He did not like children and had not realised what a responsibility a business and a family were going to be. He liked the Navy and moving about. It was considered that the best solution was for the husband to sell his business and to return to the Navy and his work as a radio operator. This he did, and the relations between husband and wife one year later are now good. He enjoys his leaves and she is happy and healthy and their three children are well. In many other cases I believe that we have been able to help to improve marital relations. There were a few cases of active cruelty by the husband, but very many more where the husband has not taken a sufficient interest in his wife, children, and home. In some instances the very fact of his wife's removal and his practical knowledge of the present-day difficulties of housekeeping have been sufficient to help. In other cases the husband has been interviewed with salutary results. We had a case where the wife, who was a big woman, was being actively cruel to the husband who was a small undersized man and was regularly beaten up. We were able to stiffen his morale and I believe to mitigate to some extent her sadistic tendencies. There was no doubt that she had been desiring more opposition and the lack of this had contributed to her apathy.

It is very obvious what a great advantage one has in advising and dealing with difficulties if one is treating the patient and how great an advantage a Health Visitor has if she visits a patient while she is being treated. It is also apparent how much a general practitioner can do while he is treating patients, in smoothing out difficulties and dealing with the problems of minor mental health. We in the public health department who usually lack intimate clinical contact are not always brought sufficiently early into touch with the family where there is an underground social problem.

I believe that a great deal is now being done by the Health Visitor, along with her colleagues the District Nurse and Midwife, but that there is a vast field still to be covered in the prevention of mental ill-health.

Besides the fourteen cases which were apparently normal, but most of which had their own troubles which were causing them anxiety, the following general complications were found in the other 88 cases:— Heart disease 4, Asthma 3, Bronchitis 3, Enlargement of Thyroid Gland 2, Severe Secondary Anaemia 9, Pernicious Anaemia 1, Splenic Anaemia 1, Malnutrition 3, Post Influenzal Debility 1, Essential Hypertension 1, Marked Constipation 3, Parkinson's Disease 1, Spastic Paraplegia 1, Hysteria 3. Most of the patients had some degree of Anaemia and most of them had substantially higher haemoglobin levels on their discharge from the Hostel, but the above nine cases of secondary Anaemia had a haemoglobin level in the region of 50%. The average haemoglobin level was 70%. The case of Essential Hypertension was a post-natal case admitted after delivery.

Many of the patients complained of varying troubles, some of them due to a pressure syndrome and others being associated with fatigue, but three of the patients were admitted in a most distressed condition and could only be properly classified as cases of Hysteria. One of these patients was having hysterical fits which completely disappeared after admission and reassurance. The history of another one is given above. All three responded well to rest, help and advice and instruction in the technique of relaxation. A very large number of patients complained of habitual constipation aggravated by pregnancy. It was remarkable how well they usually responded to a more rational diet, but in three of the patients the constipation was of very long duration and sufficiently persistent as to be worthy of mention. Of the cases of heart disease, one deserves special mention as this patient who had Rheumatic Endocarditis was suffering from a very serious lesion. While in the Hostel she had an embolic third nerve paralysis and required considerable reassurance. She eventually went to time and was safely delivered. Arrangements were made for her subsequent sterilisation. We also met with the following complications of pregnancy:— Pyelitis 1, Toxaemia 18, Vomiting 6, History of Previous Abortions 6, Threatened Abortion 1, Severe Varicose



Veins of lower limbs 8, Severe haemorrhoids 5, Severe varicose veins of vulva 2, Multiple pregnancy 3, Malpresentation 3. Most of the cases of Toxaemia were early cases with a raised blood pressure. There were only two cases of Albuminuria and both these were immediately transferred to hospital after its presence was found. I consider that many of the cases of very early Toxaemia can be treated in a Hostel with a consequent relief of hospital beds, provided that a constant watch is kept and the cases are sufficiently early. All the cases of persistent vomiting responded almost immediately to treatment by a proper diet and rest. No cases of true Hyperemesis Gravidarum were admitted.

One important part of the work of the Hostel is the relaxation clinic, which is not only important in helping the women during their confinement but also helps the patients to take full advantage of their new opportunities for rest. Many of these women have not for years had the opportunity of complete relaxation, many have never had a holiday at all and many others have never known the opportunity for relaxation a good home and an understanding husband can give. Another important aspect is that of vocational occupational training. Instruction in the preparation of children's clothing and especially in the preparation of clothes for the forthcoming baby is very desirable. This instruction should not be formal; informal talks by the Matron or by a visiting Health Visitor or Midwife can do a great deal. Once the majority of women are so engaged it is unusual that we cannot persuade a newcomer to commence her own preparations for her baby. It is essential that no methods savouring of compulsion are used. We have had several women who could not even knit when admitted but almost all had learnt to do so before discharge.

In terms of human happiness and in its potentialities for the betterment of a future generation the work of the Hostel cannot adequately be measured in economic terms. As with so much public health work it is the intangible and immeasurable benefits that are so important. The extent of improvement in physical wellbeing can be assessed. We can measure the haemoglobin, we can tell precisely by weighing the one aspect of the extent of improvement in cases of malnutrition, and even the untrained eye of the relative or visitor can usually see a vast physical improvement in the patients. But it is impossible to assess so accurately the improvement in mental health, and it is considered that this work of the hostel is at least as important as the more obvious physical improvement. Most patients showed an appreciable gain in weight during their first fortnight's stay but that later their weight increase was in conformity with the usual rise in pregnancy. It was also very interesting to see how much younger patients looked on discharge than on admission. I consider that when a woman begins to look far older than her years she is in need of rest and recuperation. It was remarkable to see how much younger their husbands looked than themselves when most of the patients were admitted and how much more the same age they looked when discharged. The work of the Hostel makes a fascinating study in social medicine and has shown gratifying results. The lack of short stay nursery provision, the reluctance to leave their families and the fact that this is a preventive service and that admission is not an urgent medical necessity has prevented it being used to capacity. Another factor in preventing its full use has been the fact that a form of undertaking to pay has to be signed before admission, whereas admission to hospital is free. The Ante-Natal Hostel has a real service to perform in the community and I hope that its use will continue to grow and that it will prove of real and lasting benefit to the public health of future generations of the West Riding. An Ante-Natal Hostel should be one of the regular services of the Public Health Department, but for its complete success short-stay nursery provision is an essential."

**Maternal Deaths**—Investigations are undertaken into the circumstances attending deaths due to pregnancy or childbirth occurring in the County area, except where the mother's pregnancy and confinement has been the sole concern of the Hospital Authorities; and reports thereon are forwarded to the Ministry of Health. Twelve deaths were investigated during the year, the remainder having occurred either in Hospital or outside the County area. Each death is the subject of a special study by the Divisional Medical Officer of the area in which it occurred.

## The separation of the Maternal Health Service from the Child Health Service

(CIRCULAR 118).

In my reports for the last three years I have discussed the separation of our work in the preventive field as it concerns the child and the pregnant woman. This innovation in maternity and child welfare was advocated in Circular 118/47. A brief account is given in the appendix of the steps taken to bring this about. In last year's report I had to say there had as yet been no final agreement to the scheme owing to the fact that the two Regional Hospitals Boards and the West Riding Executive Council had not agreed. This year I am reporting that the Sheffield Regional Hospital Board have agreed to operate the scheme and that the Council have decided to go forward without the approval of the West Riding Executive Council. In the short time which has elapsed since the Sheffield Regional Hospital Board agreed no further practical steps have been taken but agreement has been reached to make the appointment (when the salary impasse is resolved) of an Assistant Child Health Officer (as the post is at the moment called) within the area of the Rotherham and Mexborough Hospital Management Committee.

In the one instance where such an arrangement came into operation within the field of maternal care before the appointed date, namely, at Mexborough, the scheme has successfully



continued in full operation; I give below a further report by Dr. Leiper upon the scheme for ante-natal care in his division, with particular reference to the fine work of Dr. J. C. A. Renshaw (the second completed year), who holds the joint appointment of Junior Obstetrician, West Riding County Council, and Junior Hospital Officer, Rotherham and Mexborough Hospital Management Committee. He says:—

“As each year's statistics become available, the assessment of the value to the community of this appointment is becoming more apparent, and to show this I set out below a table showing the divisional birth rates, stillbirth rates, infant death rates, and maternal death rates for the two years before and after the appointment.

	1947.	1948.	1949.	1950.
Birth Rate				
per 1,000 estimated population ... ..	24.3	21.1	21.0	20.1
Stillbirth Rate				
per 1,000 live and still births ... ..	21	33	19	25
Infant Mortality Rate				
per 1,000 live births ... ..	57	56	41	31
Neo-natal Mortality Rate				
per 1,000 live births ... ..	26	28	24	20
Maternal Mortality Rate				
per 1,000 live and still births ... ..	1.38	0.77	0.78	3.23

Although the figures relate to a small number of births, I think that they indicate a favourable statistical trend which may become more marked as the scheme progresses and further ground is gained (if allowance is made for the maternal disasters in 1950, see later).

The total number of live and stillbirths in 1950 was 1,238 and as this figure includes 17 sets of twins (3 domiciliary and 14 institutional) a total of 1,221 mothers were confined during the year. There were 31 stillbirths, 37 infant deaths, 25 neo-natal infant deaths and 5 maternal deaths. 1,157 expectant mothers attended the County Council ante-natal clinics during the year, i.e. 94.7% of the expectant mother group, and only 64 expectant mothers did not attend the ante-natal clinics under the direction of the Junior Obstetrician. That this group of 64 mothers not attending ante-natal clinics during the year carried a far higher risk than those who did, can be easily seen from the statement that these 64 mothers represent 5% of the total expectant mother group, and from this 5% of the expectant mothers there were ultimately recorded 75% of the maternal deaths (actual figure 3), 22% of the stillbirths (actual figure 7) and 20% of the neo-natal infant deaths (actual figure 5).

Total attendances at County Council ante-natal clinics here during 1950 were 5,725 giving an average ante-natal attendance per patient of 5 visits. Clinic attendances averaged 475 per month—a slight reduction on the average of 500 per month for 1949. This is probably due to the lower birth rate. A slight reduction was similarly noticed in the attendances of expectant mothers at the ante-natal clinic at the Montagu Hospital from 1,431 visits (432 expectant mothers) in 1949 to 1,292 (388 expectant mothers) in 1950.

Of the 1,221 mothers confined a total of 1,032 were confined within the division, i.e. domiciliary (744), Mexborough Montagu Hospital (288). 288 mothers of the three hundred and sixty one mothers who were confined during the year at the Montagu Hospital live in this division; they gave birth to 381 infants. The remaining 189 mothers were confined in hospitals, nursing homes, and homes outside the divisional area. An analysis of the statistics separating these two groups results as follows:—

	Live Births.	Stillbirths No.	Neonatal Infant Deaths No.
1. Within Divisional Area.			
(a) domiciliary ... ..	737	10	9
(b) institutional ... ..	289	12	10
Total	1,026	22	19
2. Outside Divisional Area.			
(a) domiciliary ... ..	5	—	—
(b) institutional ... ..	176	9	6
Total	181	9	6
Total	1,207	31	25

These figures indicate that the possibility of a difficult confinement is now being detected in the ante-natal period, and the mother booked into the maternity unit at Mexborough and other hospitals. There has been a low stillbirth and neonatal death rate in the domiciliary practice of midwives during the year, and this is expected to improve still further in the future when the normal case only is delivered on the district by the domiciliary midwife.



The infant mortality figure for 1950 is 31 per 1,000 related live births and the stillbirth rate 25.0 for 1,000 (live and still) births. The five-year average rate (1945-1949) for infant mortality was 54 per 1,000 live births and the stillbirth rate for the same 5 years was 25 per 1,000 (live and still) births. It should be pointed out, however, that the greatest improvement has been in the prevention of infant death during the period from 1 month to 1 year. In my opinion, the lowering in this figure is a start of a cumulative response to improved teaching, advice by midwives and health visitors, and medical care of the expectant mother group, and this improvement may reach the neonatal period in the future.

As outlined in my report for 1949, Dr. Renshaw is in charge of the 5 County Council ante-natal clinics in Division 30, and this has undoubtedly resulted in the improved clinic team work which has been evidenced during the year. A health visitor is in charge of the organisation of each of these clinics and is responsible for the group teaching of expectant mothers. The midwives also attend routinely, arrangements being made to ensure that a maximum number of midwives attend the appropriate ante-natal clinic. There has again been a marked increase in the work of the midwives who follow up the attendance of a patient at the clinic by a series of visits to the home, in order that the advice given at the clinic may be implemented. Particular attention is paid with regard to the patient's diet, vitamin take-up, rest and general arrangements for the confinement, whether domiciliary or institutional. During the year the 13 midwives made a total of 9,229 ante-natal home visits to 1,157 expectant mothers.

The influence of this scheme is becoming increasingly evident in the trend of the divisional statistics, as can be seen from the following comparison with the five-year average 1945-1949 and the figures for last year:—

	1950	5 years average 1945-1949.
Live births	1,207	1,288
Still births	31	33
Infant deaths	37	69

The betterment of the figure has been due to the gradual evolution of a clinic team including the health visitor, relief midwife and district midwife, under Dr. Renshaw, thus ensuring better ante-natal care and teaching, and an increase in the number of seeded cases delivered in the Montagu Hospital Maternity Unit, from 200 to approximately 400 in the year. The infant death rate has dropped to the figure of 30 per 1,000 live births in this division. The stillbirth rate has remained fairly constant at slightly above the county figure, and there were a series of nearly 2,000 mothers delivered from March 1949 to December 1950, where the mothers had been attended ante-natally and often during their confinement by Dr. Renshaw, without a maternal death. During the year in the division, however, there were 4 maternal deaths, and as pointed out above only one of these occurred within the County Council's Divisional Scheme for the care of the expectant mother group. The following is a brief resumé of these four deaths:— Case 1: did not attend ante-natal clinic, doctor nor midwife. Died before arrival of doctor. Coroner's inquest. Cause of death—septic abortion and septicaemia. Case 2: did not attend ante-natal clinic. Ante-natal care by own family doctor and domiciliary midwife. Impacted second twin and adherent placenta. Died Jessop Hospital, Sheffield. Case 3: did not attend ante-natal clinic. Unmarried mother. Died of pulmonary embolism six weeks after delivery of still-born child in hospital. Case 4: attended ante-natal clinic regularly. Young primipara. Acute yellow atrophy. Infant alive and well. Again I am glad to report that there has been a slight increase in the proportion of expectant mothers who are attending ante-natal clinics.

During the year the work of Dr. Renshaw has again been most successful. The increase in the number of deliveries in the Montagu Hospital has tended to overshadow all the other work of the Junior Obstetrician, and with the long hours spent there by Dr. Renshaw it is suggested that the status of this office should be raised from that of Junior Hospital Medical Officer. A brief summary of the amount of work carried on during the year in the maternity unit at the Montagu Hospital is appended below, and in addition to this it should be noted that Dr. Renshaw has during the year been associated with Mr. D. H. Lees in the carrying out of gynaecological out-patient clinics and gynaecological operations. The amount of obstetrical work carried out has, for the first time, during the year represented more than one-third of the obstetrician's time spent in the hospital. This has been due to the fact that the number of midwives for the maternity unit has now been brought up to establishment, and thus it has been possible to book and to deliver nearly 400 expectant mothers in the 22-bedded maternity unit. Live births 367; stillbirths 14 (stillbirth rate 35.5); neonatal deaths 9 (neonatal death rate 22.9); forceps extraction 16; Caesarean section 7; malpresentation 27 (14 twins); multiple pregnancies 20; episiotomy 13; ante-partum and post-partum haemorrhage 15; blood transfusion—A.N. 5, P.N. 4; manual removal of placenta 5; expulsion of placenta 4; premature babies 39 (36 living at discharge); surgical induction of premature labour 26; repairs 40.

In conclusion, in my opinion the main change during the year 1950 in this appointment has been the increase in the amount of hospital work carried out to such an extent that it tends to overshadow the preventive work and teaching carried out in the ante-natal clinics. The work during the year has consolidated the value of the ante-natal clinic both as a start of the obstetrico-social sieve for hospitalisation, the clearance of the physical condition of the expectant mother and her child, the teaching of the expectant mother. The vital statistics with the exception of the incidence of maternal mortality show a satisfactory trend. The 5% of expectant mothers who did not attend the hospital and local authority ante-natal clinics carried, during the year,



higher risk to the mother and child than did the 95% of expectant mothers who did attend the ante-natal clinics. It is hoped that the percentage of the expectant mother group attending these ante-natal clinics will still increase. The work of some of the younger midwives in the home, and the care with which they took on cases, not only to be delivered by themselves on the district but also those which were to be confined in hospital, has been pleasing. One factor against success has been the poor nature of some of the clinic premises in the division, and this has been reported upon during the year to you. I am glad to say that during the year there has been an increase in the mutual co-operation with those general practitioners who are on the General Practitioner Obstetrician list. In the broad picture I am very pleased with the progress made during the year, which represents a sound amelioration of the Public Health statistics of this division in relation to the expectant mother group."

I cannot speak too highly of the work in the Mexborough Division of which the above report forms part. To Dr. Leiper, Dr. Renshaw and his health visiting, home nursing, midwifery and other staff (not forgetting the devoted work of the clerical staff in the Divisional Office) the people of this highly industrialised region of South Yorkshire should be profoundly grateful.

## Appendix

### Circular 118

Circular 118, which was issued on the 10th July, 1947, to amplify Part III of the National Health Service Act, contained within its somewhat voluminous sheets one of the most far-reaching statements of policy which has emanated from the Ministry of Health in recent years. It said:—

"Arrangements should be made whereby those of the Local Health Authorities Medical Officers who by experience and choice are best fitted to work in ante and post natal clinics should gradually be assigned to that work and attached to the obstetrical team and thus spend part of their time in midwifery work and in acquiring the necessary experience to enable them to enter full obstetrical practice."

The intention of this was clearly to give effect to the views expressed by Obstetricians and Paediatricians over a number of years, that the standard of work in ante-natal care and in child care in the preventive field could be raised to higher levels if it were to be associated with practical work in the hospital field. In my reports of 1947, 1948 and 1949 I discussed this in detail and explained why it would be impracticable to introduce this new arrangement merely by re-allocating the work of existing staff. To be effective it is clearly necessary to separate the establishment and to appoint new officers, where vacancies arise, with experience and capacity for an entirely new job. The most effective way to produce the change was to create certain appointments in which our officers would engage for part of their time in hospital work. By good fortune one such post was created and filled in South Yorkshire before the appointed day; the wonderful results of this have been outlined from year to year. The possibility of making this arrangement general was outlined in the following letter to the Senior Administrative Medical Officer of the Leeds and Sheffield Regional Hospital Boards in November, 1947:—

"Arising out of the suggestions contained in paragraph 14(a) of the above-mentioned Circular (118/47 Ministry of Health), I am at the present time preparing a report for submission to the Health Committee recommending that they should adopt the suggestions contained in the Circular in regard to the medical staffing of the ante-natal clinics by Medical Officers who would give two-thirds of their time to ante-natal clinic work and one-third as Obstetric Registrar at a maternity home or hospital. With this object in mind consideration has been given to the re-organisation of the number of ante-natal clinics in the County area and linking of such clinics with appropriate maternity homes or hospitals. The work will be arranged in County administrative divisions, generally speaking, there being sufficient work in routine ante-natal clinics to employ two-thirds of the time of a Medical Officer. We have in mind that approximately 23 officers will be required. The County Council's share would amount to approximately 15 and those could be provided out of the present authorised establishment of Assistant County Medical Officers laid down by the County Council. It is proposed to pay salary at the rate of £150 per annum above the Askwith Scale for an Assistant County Medical Officer in view of the higher responsibilities arising out of the hospital work. Experience in practical obstetrics will be required but we do not propose to ask for a D.R.C.O.G. as an essential qualification. I am wondering whether you would let me have your observations on these proposals and whether they would receive the support and co-operation of the Regional Hospital Board after the Appointed Day as, if so, it would be necessary for the Board to take over the payment of one-third of the salaries of these Medical Officers in respect of the time they would devote to their duties as Obstetric Registrars in the various maternity homes and hospitals. If you so wish I should be very glad to discuss this matter with you and perhaps you will let me have your observations in due course."

Following their agreement in general terms I recommended to the Maternity and Child Welfare Committee on 11.2.48 the appointment of 18 officers on the ante-natal side, the cost of which would be apportioned as two-thirds to the County Council and one-third to the Regional Hospital Board, at a total additional cost of £2,400 per annum, assuming that every officer had the D.R.C.O.G. This scheme was deferred pending the resolution of certain doubts about salary scales and the relationship of the new type of medical officer to the newly defined specialist grades. In December, 1948, after it had been determined that the officers would not rank as specialists within the terms of the National Health Service, this scheme, including also provision for six



joint appointments on the children's side (paid at the same rate as the Junior Obstetrician with an additional £50 for the D.C.H.), was approved by the County Council on 19.1.49 subject to agreement by the West Riding Executive Council and by both the Leeds and Sheffield Regional Hospital Boards. It was understood that the medical officers to be appointed for child health would, like those for ante-natal work, continue for the main part of their time to undertake the clinical work within the County Council's services (that is, in schools and child welfare), but the equivalent of one-third of their time, both within the usual hours and outside, would be given to assist the children's specialist in hospitals and elsewhere.

The West Riding Executive Council referred the matter to the Local Medical Committee, which reported that after careful consideration it "strongly disapproved of the scheme for ante-natal supervision outlined by the Medical Officer of Health for the County." The Committee added that "Since the introduction of the National Health Service Act there has been an increasing call by the expectant mother upon her own doctor and the appointment of Obstetric Registrars creates a service for which there is no place and which adds no facility not already provided by the Consultant Service." The West Riding Executive Council then resolved—"That this Committee do concur in the opinions expressed by the Local Medical Committee, it being understood that these observations do not refer to the proposals with regard to the appointment of paediatric registrars which relate primarily to the School Health and Child Welfare Services of the Local Health Authority." The result of this apparent contradiction of the philosophy behind Circular 118 (at least as it concerned maternal care) presented an unexpected setback which, combined with some diffidence on the parts of the Leeds and Sheffield Regional Hospital Boards (who did not reply for two years), caused further delay. On the 9.10.50 the Sheffield Regional Hospital Board finally wrote to express their agreement, as follows:—

"I refer to your letter . . . enclosing a memorandum relating to the integration of the County Council's Health Services with the general medical and the hospital and specialist services and to subsequent correspondence on the subject. The County Council's scheme for the appointment of certain medical staff jointly with the Regional Hospital Board as and when circumstances permit has been submitted to the Board who have approved the proposals in principle. I understand that following the acceptance of the principles of the scheme it is intended to make a detailed study of the individual requirements, and I shall be glad to hear from you again on this matter in due course."

On the 17.1.51, the County Council reaffirmed the resolution of two years before, omitting the requirement that approval of the West Riding Executive Council was necessary. Coincidentally a necessary adjustment was made in the title of the officers to be appointed omitting the use of the word "Registrar," which had come to have a somewhat different meaning in the years since the scheme was first mooted. Thus, with a lapse of almost four years it became possible to operate Circular 118 generally within that part of the County covered by the Sheffield Regional Hospital Board. As a first step the Sheffield Regional Hospital Board have agreed to make the appointment of a medical man to work entirely in the field of children's health, combining school health and child welfare activities with responsibility in one or more of the Rotherham hospitals under the Rotherham and Mexborough Management Committee. Unfortunately this decision coincided with the impasse over salary awards, which has prevented its implementation. This important venture, of a parallel kind to that already operating with this Management Committee for maternity work (as described in my last three annual reports), is thus held up at a crucial stage. The consideration of this and other appointments of the same character in the South of the County will have to wait until the present difficulties have been overcome. At the time of writing (1.8.51) the Leeds Regional Hospital Board have not yet agreed to participate. Our new machinery of administration makes light of five years of office and I must leave to my successor the final stages of this episode.



## PART IV

## CHILD WELFARE

The object of child welfare is to create and maintain a healthy population and when it is regarded that the mother is the environment of her infant it will be realised the responsible position she holds. The Maternity and Child Welfare Act of 1918 showed a full appreciation of the need to educate expectant and nursing mothers and to supervise the health of their infants; not only was the infant mortality rate then very high but there were also many defects and ailments among children of entrant school age which, had the mothers a sufficient knowledge of the simple rules of health, might have been prevented. Thus we saw the setting up of infant welfare centres, primarily intended as educational centres to advise and to teach mothers the care and management of infants and children under the age of five years. Although the treatment of minor ailments in these centres was permissible, the main function was rather to supervise the well child rather than to treat the sick. The educational work today is done mainly in hired premises of similar standard to those of thirty years ago and the success of their teaching owes nothing to the example which these deplorable structures generally present.

The work of the centres has continued on a high plane; many of the divisions, in addition to the usual mothercraft classes and specialised demonstrations, have shown instructional films; the work has been much helped by the purchase on a divisional basis of 31 standardised demonstration outfits for teaching purposes. There were 212 centres operating at the end of the year at which 417,927 attendances were made; of these 280,017 were in respect of infants under the age of one year and 137,910 by children between the ages of one and five years. New centres were opened at Gisburn, Lindholme and Sedbergh whilst the use of the centre at Swinefleet was suspended pending adaptations of the premises following purchase by the County Council; three centres were transferred to more suitable premises; authority was given for the purchase of two mobile clinics to bring maternity and child welfare facilities to those mothers resident in rural areas unserved by static clinics; it will be some time, however, before they are in operation.

**Illegitimate children**—A special scheme for the care of the mother and her illegitimate child came into operation within the divisional scheme. This included a superintendent health visitor at headquarters to give her whole consideration to the details of the work. Miss Mitchell, who first began the work, resigned in 1950. In refilling the vacancy it is intended to combine the work with other superintendent health visitors' duties. There were 1,170 illegitimate live births as compared with 1,323 in 1949. Of these 590 were referred to the department as being in need of special assistance. The source of reference (Table 1), marital status (Table 2), age groups (Table 3), and disposal of these cases (Table 4), are shown below:—

TABLE 1.

	W. Riding cases	Non-County Cases.		
		E.V.W's.	Others.	Total.
(a) Referred by Moral Welfare Organisations	60	5	15	80
(b) Ascertained through own staff (midwives, etc.)	395	7	11	413
(c) Referred by other Services ...	93	3	1	97
Totals ...	548	15	27	590

TABLE 2.

(a) Married.				
(i) with previous illegitimate children ...	46	1	—	47
(ii) without previous illegitimate children ...	69	1	3	73
(b) Single.				
(i) with previous illegitimate children ...	104	—	3	107
(ii) without previous illegitimate children ...	307	13	20	340
(c) Widowed.				
(i) with previous illegitimate children ...	8	—	—	8
(ii) without previous illegitimate children ...	14	—	1	15
Totals ...	548	15	27	590

TABLE 3.

(a) Under 20 ...	121	2	8	131
(b) 20—25 ...	177	7	12	196
(c) 26—30 ...	126	4	4	134
(d) 31—40 ...	114	2	3	119
(e) Over 40 ...	10	—	—	10
Totals ...	548	15	27	590



TABLE 4.

(a) Cases settled				
(i) Marriage ... ..	41	—	2	43
(ii) baby died ... ..	16	—	2	18
(iii) Grandparents take baby home ... ..	57	—	5	62
(iv) baby adopted ... ..	73	2	4	79
(v) baby fostered ... ..	30	2	3	35
(vi) mother keeping baby ... ..	272	5	4	281
(b) Cases referred elsewhere ... ..	29	5	6	40
(c) Cases in which action has been taken but not finally settled ... ..	30	1	1	32
Totals ...	548	15	27	590

### Day Nurseries

Day nurseries were first established in the West Riding as war-time nurseries primarily designed to facilitate the employment in industry of married women with children under school age. They were operated by the County Council on behalf of the Ministry of Health until 31st March, 1946, when the majority were discontinued, the buildings being used for other purposes. On July 5th, 1948, there were seven nurseries in being and seventeen were transferred to the County Council from former Welfare Authorities. The Committee also agreed to re-open Holme House, Brighouse, and to accept responsibility for the Todmorden Corporation's proposal to establish a new nursery at The Glen, Todmorden. This completes the 26 which are now open, providing accommodation for 1,075 children (345 under 2 and 730 for the 2—5 age group). Eight of the present nurseries are on requisitioned sites and it is probable that at least four of these will have to be vacated when requisitioning powers are ended.

In July, 1948, in response to urgent representations from the Ministries of Health and Labour and National Service, the County Council approved a programme for the erection of 16 new nurseries to provide accommodation for the children of women workers then required for the export textile industries. In March, 1950, this programme was reduced to the five new nurseries now in process of erection at Baildon, Barnoldswick, Bingley, Keighley and Shipley, each providing 50 places.

Where there are waiting lists, as at all our nurseries, entrants are taken according to the priority group to which the child belongs, reasons of health being the first priority, as follows: (a) the young child whose mother is ill or having a baby; (b) the illegitimate child whose mother is seeking work; (c) children of parents who cannot find suitable homes and are living in overcrowded and/or insanitary dwellings; (d) the young child of the widow who must educate and support her family unassisted; (e) children of mothers engaged in essential industries. It is only when these categories have been exhausted that consideration is given to the non-priority groups whose admission is desired for social reasons, but it must be understood that one or more of these factors exist in so many thousands of homes today that even when the request is based upon employment, health reasons of varying degree can be found also to justify the provision. An examination of the waiting list during the year showed 1,669 children requiring admission, mainly to allow their mothers to enter into industrial employment but, as previously stated, with many and varying grounds of health. To exhaust this demand it is estimated that there is need for a further 1,000 places, the equivalent of 20 new nurseries, in addition to the places now provided and in course of erection. It is also a striking fact that wherever a nursery is provided the demand generally follows rapidly upon a realisation of its value.

In reply to a question concerning the cost of day nurseries in six large cities, the Minister of Health gave the following information for 1947-48 gross cost per day as compared with 1950: London 9s. 0d. (12s. 3d.); Croydon 8s. 3d. (9s. 7d.); Birmingham 8s. 9d. (11s. 0d.); Liverpool 8s. 11d. (9s. 11d.); Manchester 7s. 8d. (9s. 7d.); Sheffield 5s. 1d. (7s. 1d.). In comparison, the ascertained costs for each child attendance at the County nurseries during the year ended 31st March, 1950, was 9s. 2d. Towards this cost fees are collected for children attending at the rate of 1s. 6d. per attendance, with all meals; 1s. 0d. with two meals only; and 6d. where only one meal is taken. These fees may be remitted in cases of financial necessity, although the occurrence of such cases is fortunately rare.

Lack of trained nursery nurses still remains a problem; in some measure alleviated by the number of students who have qualified under the County Training Scheme. There is no doubt that the low salary scales, especially for the higher grades of nursery staff, are having an adverse effect on recruitment. Several nurseries have been approved for the training of students and suitable nursery nurses approved as Wardens. The number of nurseries now approved for training is 23 but of this number only 12 have approved Wardens on the staff. The duties of the Warden are to organise and supervise child activities for the age group 2 to 5 years.

A number of nurseries were visited by a Ministry of Health Advisory Dietitian, who expressed her satisfaction at the dietary and the high standard of efficiency both in the preparation and serving of meals. The importance of correct diet has been stressed and this has resulted in a diet "awareness" on the part of Matrons leading to increasing efficiency and economic catering.



Generally the health of the children committed to the care of the nurseries has been good, with only limited outbreaks of child infections. Minor outbreaks of Sonne-dysentery have occurred; the circumstances were fully investigated by the Divisional Medical Officers concerned in co-operation with the Pathologist of the Medical Research Council in an attempt to provide more stringent control measures.

**The Training of Nursery Nurses**—Training for the examination of the Nursery Nurses Examination Board continues, with 213 students in training during the year at courses arranged by the County Borough Authorities at Burnley—4, Halifax—9, Huddersfield—8, Oldham—2, Rotherham—16, Sheffield—6; and by the County at Castleford—20, Dewsbury—40, Harrogate—20, Shipley—62, and South Kirkby—26. For various reasons 45 students withdrew from training, 47 sat for the examination with 41 successful, and 121 remained in training at the end of the year. Full use has continued to be made of the Nursery Nurses Training Centre at Ilkley and the following short note of appreciation has been submitted by Miss Brooks:—

"This centre is a valuable part of the nursery training scheme and is happily situated within easy access of a number of day nurseries; it provides a home and also the equivalent of a college life for 20 students. To the majority of the girls admission to the hostel is an awakening to a new corporate life in idyllic surroundings, educational and practical training on the one hand with the development of personal responsibility and social activity on the other fuse to transform the somewhat apprehensive initiates into happy, albeit serious, students with marked mental and social poise. This feature has been the subject of enthusiastic comment by visiting tutors who speak highly of the venture and regard the hostel as an outstanding example comparing more than favourably with many other experiments in collegiate life.

Students remain for one year; during this time they travel on three days a week to the day nurseries for practical training particularly with the young baby (up to 2 years); for the rest of the week the students remain at the Centre and receive the equivalent of two days theoretical training. This consists of further education in vocational and general subjects. The vocational subjects are the health and education of the young child, which are taken by a Health Tutor and a school teacher, who also supervises the students practical training. The general subjects are in four groups; self expression; household arts; The Study of Living Things and Life in the Community. They are intended to develop the resourcefulness of the individual and generally to make the students more capable of meeting the demands of their future work. The tutor for the main portion of the general subjects scheme was chosen for her knowledge of, and interest in, the abounding opportunities to be found in the Ilkley District. She is well able to make this part of Yorkshire come alive for these students who came this year mainly from Normanton, Pontefract and Castleford. She has also made it possible to draw on the experience of a wide selection of speakers, both from the staff of the Health Department and elsewhere, the latter including Mrs. Turner—Matron of Farfield Home for Old People, the Town Clerk, The Water Inspector, The Water Engineer, The Curator of the Museum—an expert on local affairs, The Sanitary Inspector, a local artist, and the Local Librarian.

Of the students at the Hostel 19 sat for the examination of the Nursery Nurses Examination Board and 17 were successful; seven withdrew (illness—2, general hospital training—1, domestic reasons—4) and 15 students remained at the hostel under training at the end of the year. One Oak has also been used for meetings of tutors and nursery matrons."

### Nurseries and Child Minders Regulation Act, 1948

Two further nurseries, established by textile factories, were first registered during the year at Clarence Mills, Cleckheaton (40), and Oakdene, Horsforth Road, Greenfield (14), providing accommodation for 54 children.

### Premature Babies

Table 1 on page 44 shows that the percentage survival rate for premature babies born in the Administrative County in 1950 was 84.5. Tables 2 and 3 on pages 45 and 46 give the survival statistics for premature babies born in the Administrative County, whatever the place of usual residence of the mother (a) in the domiciliary practice of Midwives (Table 2), and (b) in institutions (Table 3). There is a slight improvement on the rates for 1949 (83.8) and 1948 (83.6), and a decided improvement on those for 1947 (77.8), 1946 (75.9), and 1945 (77.1). In 1948 there was an increase of over 10 per cent. in the survival rate in the 4 to 4½ lbs. weight group, an improvement which was more than maintained in 1949 and 1950; the rate in the group in 1950 was 17 per cent. above 1947. In single weight groups, the outstanding improvement is in the 3½ to 4 lbs. group where the increase in the survival rate is approximately 19 per cent. over the rates for the previous five years.

The survival rates for the weight group 3 to 3½ lbs. are based on such small figures that the death or survival of one premature baby may cause a decrease or an increase of approximately 2 per cent. With this in mind compare the three years 1945 to 1947 (38.8 (1945), 35.8 (1946), and 37.0 (1947)) with the three years 1948 to 1950 (55.6 (1948), 60.4 (1949) and 56.0 (1950)). Thus, the higher level of survival in this difficult middle weight group which was attained in 1948, after our scheme of domiciliary care had come into full operation, has been maintained in the past two years. There is an improvement in 1950 in the survival rate in the weight group 2½ to 3 lbs. representing an increase of over 11 per cent. over the rate for 1949 and nearly 16 per cent. over that for 1945. Here again the numbers are too small to be of real significance. 42 live premature babies were born (9 at home, 5 in private nursing homes, 18 in National Health Service maternity homes, and 10 in general hospitals) to mothers not normally resident here.



Figures for the years before 1950 have related solely to premature babies born in the Administrative County. This year we have been able to obtain data of all West Riding premature births, including those where birth took place outside; the total was 1,687; 563 at home (including 6 outside the County), 23 in private nursing homes (including 19 outside the County), 363 in National Health Service maternity homes (including 136 outside the County), and 738 in general hospitals (including 503 outside the County). Table 4 on page 47 shows that 83.3 per cent. of the above-mentioned premature babies were alive at the end of the first 28 days of life; survival rates for babies born in the Administrative County were rather better than for those born outside (see below).

PERCENTAGE SURVIVING AT END OF FIRST 28 DAYS OF LIFE.

Weight group: lbs.	Born in the Administrative County.	Born outside the Administrative County.	Total.
5-5½	97.6	94.4	96.3
4½-5	92.3	94.1	93.0
4-4½	87.8	85.5	87.0
3½-4	78.5	77.3	78.0
3-3½	57.1	52.6	55.2
2½-3	37.2	34.5	36.1
2-2½	10.0	9.5	9.8
1½-2	5.0	7.1	5.9
1½ and under	—	14.3	8.3
Total	84.8	81.2	83.3

The experience of one year is too short to attach any real significance to this higher survival rate in our own services. Of the total of 1,687 premature babies born alive to mothers normally resident within the County, 466 were born in institutions within the County (general hospitals and maternity homes under the National Health Service and private nursing homes) (survival 87.8%), and 658 in similar institutions situate outside the County (survival 81.3%). 75 per cent. of the babies born outside were delivered in general hospitals (compared with 23 per cent. of our own), no doubt in a proportion of cases due to complications; these complications may have an adverse effect on the survival of the baby. On the other hand viability of premature babies weighing 3 lbs. or under at birth is less than in the higher weight groups; 21.6 per cent. of such babies born alive within the County survived over 28 days and 19.7 per cent. of those born outside; 53.4 per cent. of those born within the County and 49.3 per cent. of those born outside, died during the first day of life.

In general our schemes for care of the premature baby have continued to develop along individualist lines in each division. More and more of our health visitors and midwives have received training at Sorrento (56 to date) and every year sees a greater measure of co-operation with general practitioners. In terms of infant life the special care of the premature baby is one of our greatest life saving measures, the difference between a survival rate of 84.5 per cent. (1950) and 75.9 per cent. (1946) is 150 babies a year.

A premature baby, for statistical purposes, is considered to have survived if it is alive one month from birth. Some interest attaches to learning more about survival rates after this date and to determine this we are now following up year by year the premature babies born in 1949. The results so far are shown in Table 5.



THE FATE OF PREMATURE BABIES BORN IN THE YEAR 1950, IN THE WEST RIDING ADMINISTRATIVE COUNTY AREA TABLE 1

Total unadjusted live births—20,496 Number of live premature births—1,065 Percentage of total live births—5.2  
 Number born dead—139

Weight group lbs.	Number of Premature Births					Number Dying (Days of Survival)														Number surviving over 28 days				Percentage Survival in 1950	Percentage Survival in previous years.						
	Born Alive				Born Dead	First Week							Second Week							Over 14 up to 28 days	A	B1	B2		C	Total					
	A	B1	B2	C		Total	1	2	3	4	5	6	7	8	9	10	11	12	13								14				
5-5½	144	2	46	54	246	22	4	2	2	1	1	—	1	1	—	—	—	—	—	—	181	6	129	104	420	97.2	95.2	91.7	94.0	95.8	95.8
4½-5	187	6	131	108	432	17	7	5	3	2	—	—	1	—	—	1	—	—	—	—	132	2	43	50	227	92.3	89.8	87.0	86.2	90.9	91.6
4-4½	82	1	33	35	151	13	8	3	—	2	2	1	1	—	—	1	—	—	1	73	1	29	29	132	87.4	70.6	71.7	70.1	80.6	84.6	
3½-4	63	—	16	16	95	23	8	4	1	1	1	1	1	—	—	—	—	1	—	49	—	14	11	74	77.9	58.9	58.9	54.3	63.1	59.3	
3-3½	27	—	12	11	50	14	7	4	2	2	—	2	—	—	—	—	2	—	1	17	—	5	6	28	56.0	38.8	35.8	37.0	55.6	60.4	
2½-3	32	—	4	8	44	32	16	5	—	1	1	2	1	—	1	—	—	—	—	11	—	1	4	16	36.4	20.7	25.0	12.9	21.7	25.0	
2-2½	14	—	2	5	21	13	15	2	1	—	—	1	—	—	—	—	—	—	—	1	—	—	—	2	9.5	6.7	—	12.9	—	—	
1½-2	15	—	1	5	21	3	12	3	2	3	—	—	—	—	—	—	—	—	—	1	—	—	—	1	4.8	—	—	—	16.7	—	
1½ and under	2	—	—	3	5	2	4	—	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	25.0	—	
	566	9	245	425	1065	139	81	28	12	12	5	7	5	1	1	2	—	2	1	2	465	9	221	205	900	84.5	77.1	75.9	77.8	83.6	83.8

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



TABLE 2

**THE FATE OF PREMATURE BABIES BORN IN THE YEAR 1950, IN THE WEST RIDING ADMINISTRATIVE COUNTY AREA IN THE  
DOMICILIARY PRACTICE OF MIDWIVES**

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, ...	8,223	Live premature births:—born in U.D's	356	Percentage of total live births, 4.3
born in R.D's, ...	3,968	born in R.D's	210	5.3
Admin. County ...	12,191	Admin. County	566	4.6

Weight Group lbs.	No. of Premature Births.			Number dying — days of survival (County)														Number surviving over 28 days.			Percentage Survival 1950			Percentage Survival 1949		
	Born Alive.			First Week.							Second Week.							Over 14 up to 28 days			U.D's.			U.D's.		
	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	U.D's.	R.D's.	County
5-5½	119	68	187	10	1	2	1	1	—	—	—	—	—	—	—	—	—	116	65	181	95.3	93.3	96.8	95.3	93.3	94.7
4½-5	87	57	144	14	5	3	2	1	—	—	—	—	1	—	—	—	—	81	51	132	94.9	90.0	91.7	94.9	90.0	93.5
4-4½	40	33	82	5	2	2	—	1	1	—	—	—	1	—	—	—	1	43	30	73	83.7	82.6	80.0	83.7	82.6	83.3
3½-4	43	20	63	9	5	1	—	1	1	1	—	—	—	—	—	1	—	32	17	49	74.4	50.0	77.8	56.0	50.0	54.3
3-3½	15	12	27	7	2	1	2	—	1	—	—	—	—	—	—	—	—	10	7	17	66.7	58.3	63.0	57.1	33.3	48.5
2½-3	20	12	32	17	12	3	—	1	2	1	—	1	—	—	—	—	—	9	2	11	45.0	16.7	34.4	27.3	33.3	30.0
2-2½	10	4	14	6	10	1	1	—	—	—	—	—	—	—	—	—	—	1	—	1	10.0	—	7.1	—	—	—
1½-2	11	4	15	1	10	3	1	—	—	—	—	—	—	—	—	—	—	1	—	1	9.1	—	6.7	—	—	—
1½ and under	2	—	2	—	2	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
	356	210	566	69	49	16	7	7	3	5	4	—	1	2	—	1	2	293	172	465	82.3	81.9	82.2	84.1	77.0	81.7



THE FATE OF PREMATURE BABIES BORN IN THE YEAR 1950, IN INSTITUTIONS\* SITUATE IN THE WEST RIDING ADMINISTRATIVE COUNTY TABLE 3

Total unadjusted live births—8,305  
 Number of live premature births—499  
 Number born dead—70  
 Percentage of total live births—6.0

Weight Group lbs.	No. of Premature Births.		Number dying (days of survival).														Number Surviving over 28 days.	Percentage Survival in 1950	Percentage Survival in previous years.					
	Born Alive	Born Dead	First Week.							Second Week.									Over 14 up to 28 days					
			1	2	3	4	5	6	7	8	9	10	11	12	13	14								
5-6½	245	7	3	—	1	—	1	—	—	—	—	—	—	—	—	—	—	239	97.6	96.4	91.5	95.0	95.2	96.9
4½-5	102	8	2	2	1	1	—	—	—	—	—	—	—	—	—	—	—	95	93.1	90.5	93.8	92.1	92.0	88.5
4-4½	69	8	6	1	—	1	1	1	—	—	—	—	—	—	—	—	—	59	85.5	70.6	75.6	76.5	86.2	86.2
3½-4	32	14	3	3	1	—	—	—	—	—	—	—	—	—	—	—	—	25	78.1	65.2	64.9	71.4	65.4	66.7
3-3½	23	7	5	3	—	—	—	—	—	—	—	2	—	—	—	—	1	11	47.8	41.2	45.5	52.9	61.1	86.7
2½-3	12	15	4	2	—	—	—	—	—	—	—	—	—	—	—	—	1	5	41.7	37.5	66.7	—	25.0	16.7
2-2½	7	7	5	1	—	—	—	—	—	—	—	—	—	—	—	—	—	1	14.3	25.0	—	—	—	—
1½-2	6	2	2	—	1	3	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
1½ and under	3	2	2	—	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
	499	70	32	12	5	5	2	2	1	1	—	—	2	—	—	—	2	435	87.2	83.4	81.4	84.6	85.3	86.4

\* Hospitals, Maternity Homes and Private Nursing Homes.



THE FATE OF PREMATURE BABIES BORN IN THE YEAR 1950, TO MOTHERS NORMALLY RESIDING IN THE WEST RIDING ADMINISTRATIVE COUNTY  
WHEREVER THE BIRTH TOOK PLACE

Total adjusted live births—25,819      Number of live premature births—1,687      Percentage of total live births—6.5  
Number born dead—214

Weight Group	No. of Premature Births.				Number Dying (Days of Survival)														Number Surviving over 28 days.				Percentage Survival																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																		
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	A	B1	B2	C	Tot.	First Week.							Second Week.											Over 14 up to 28 days																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																	
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A —Born in Domiciliary Practice.  
B1—Born in a Private Nursing Home.  
B2—Born in a Maternity Home.  
C —Born in a General Hospital.



FOLLOW-UP OF PREMATURE BABIES BORN IN 1949 IN THE WEST RIDING ADMINISTRATIVE COUNTY

TABLE 5

Total born ... 976  
 Number who have removed  
 outside Admin. County ... 89  
 887

Weight Group, lbs.	Months of Survival—Number Dying at following periods of life.													Surviving over 12 months
	On 28th day or under	4 weeks to 2 months	2 to 3 months	3 to 4 months	4 to 5 months	5 to 6 months	6 to 7 months	7 to 8 months	8 to 9 months	9 to 10 months	10 to 11 months	11 to 12 months		
5-5½	19	7	—	4	—	3	1	—	—	—	—	—	305	
4½-5	19	1	2	—	1	—	2	—	—	—	—	—	160	
4-4½	20	3	1	—	—	1	—	—	—	—	—	—	97	
3½-4	24	—	1	—	—	—	—	—	—	1	—	—	33	
3-3½	19	—	—	—	1	—	1	—	—	—	—	—	27	
2½-3	24	—	—	1	—	—	—	—	—	—	—	—	7	
2-2½	21	—	—	—	—	—	—	—	—	—	—	—	—	
1½-2	10	—	—	—	—	—	—	—	—	—	—	—	—	
1½ and under	2	—	—	—	—	—	—	—	—	—	—	—	—	
Total	158	11	4	5	2	4	4	—	—	1	—	—	608	
Percentage Survival	82.2	80.9	80.5	79.9	79.7	79.3	78.8	78.8	78.8	78.7	78.7	78.7	78.7	



## PART V

## THE HEALTH OF THE SCHOOL CHILD

*(This, together with the following part VI on the County Dental Service constitutes the report for the year 1950 on the School Health Service, being the 43rd Annual Report of the School Medical Officer).*

## Introduction

The year 1950 has been so far as the School Health Service is concerned a mixture of improvement in some directions and stasis in others. There has as yet been little change in the composition of the medical staff, but recruitment of doctors to preventive medicine is showing a levelling off which is likely to be followed by a decline. The main reason for this lies in the discrepancy in salaries in the hospital and preventive fields. Salaries in the public health field still compare unfavourably with those in the Hospital Service. The number of doctors taking additional qualifications for work in the School Health field, e.g. D.P.H., D.C.H., or other higher medical degrees and diplomas is likely to diminish (an attempt is being made to remedy this in the case of the D.P.H. by the establishment at Leeds University of part-time courses over an extended period). The present position is in many ways alarming. The school doctor must have a full preventive outlook; he must be an expert in the field of nutrition, epidemiology, physical medicine and social and mental hygiene, and have an intimate knowledge of educational matters to enable him to advise what special educational facilities are required for the various types of handicapped child. Such knowledge can only be obtained in the degree that it is needed by prolonged study and much hard won practical experience. If we cannot persuade young keen medical men and women to undertake this then the School Health Service will suffer, but of far greater importance, the health and education of our children will suffer more.

The general situation, since the passage of the National Health Service Act, 1946, is still far from clear. The change brought about by this Act was so drastic that it is singularly difficult to work out all the many side effects. This is particularly true of the School Health Service which in many ways seems to have deteriorated rather than improved. The following few points have been chosen for comment to illustrate some of the exceptional difficulties. During the year further steps have been taken to relate the work of the School Health Service to that of the general practitioner by ensuring that any child who is considered by the school doctor to require a specialised opinion (other than an ophthalmic examination), shall be referred to the specialist through the general practitioner. This arrangement could and should work to the advantage of the child and lead to an increase in the spirit of co-operation between hospitals, health departments and general practitioners. Much more still needs to be done to bind together the work of the School Health Service with that of general practitioners and hospitals. In time it will be unthinkable, e.g. that a hospital should consider its duty discharged until it has taken steps to see that the school health department and the general practitioner are made fully aware of all points relevant to the child's health and education. This spirit of co-operation cannot be brought about by enactments and regulations but can be made to grow if the interest of the child is always the first consideration.

For many years there has been a growth of specialist clinics organised by the school health department situated away from hospitals; this development received great impetus by the Education Act of 1944, which made provision of comprehensive and full treatment for all school children the duty of the Local Authority. The National Health Service Act has, to a large extent, reversed the process, placing specialist children's clinics back in hospitals, often coupling the work with that provided for out-patients of all ages. This must eventually lead to a change from an outlook of prevention, and promotion of health to one of remedy and treatment of disease.

Schools should be much better equipped for medical work. Not only is this essential to an effective School Health Service but also it enables the work of the school to continue uninterrupted during visits of the doctor and auxiliary medical staff. In the drive for economy in school building the provision of medical units (suitable for medical inspections and special examinations) has been much reduced in primary schools. Thus, even in many new schools, medical inspection, which is such an essential part of the work of the service, will not be carried out in rooms specially designed and set apart for the purpose. One of the most unfortunate aspects of this shortsighted economy is to be found in the relationship of the medical and teaching staff for it often results in the presence of the doctor and nurse in the school being unwelcome, just at the time when we have at last come to understand that doctor, nurse and teacher must work together in a team.

During 1950 no special schools were opened for handicapped children by this Authority, but Ingleborough Hall became fully used and progress was made towards increasing accommodation for delicate pupils at Netherside Hall, and for those educationally sub-normal children requiring residential accommodation at Baliol (Sedbergh), Meltham Mills, and Springfield House (Horsforth).

The number of defects in all categories requiring treatment shows a decline when compared with the previous year, although the number of children inspected remained about the same. The nutritional state of the children shows similar improvement. Full employment, the redistribution of income, a gradual improvement of the standard of child care in the home, school and hospital, may all take a share of the credit in this favourable change.



## The Medical Inspection of School Children

The average number of pupils on the registers at the end of the year was as follows:—Nursery (522), Primary (161,256), Secondary Modern (43,271), Secondary Grammar (22,306), Secondary Technical (1,736).

There has been little change since 1949 in the average number of whole-time Assistant County Medical Officers employed during the year and the number of inspections made in the schools has remained approximately the same as for the previous year. There were 61,977 periodic medical inspections and 40,119 special inspections and re-examinations compared with 64,998 and 34,709 for the year 1949.

With the Authority's new Youth Employment Service, the medical examination of school leavers has received particular attention. The Divisional Youth Employment Officers are now visiting the schools and interviewing parents at or near to the child's last term at school; they must know whether there is any physical or mental defect which might, in the opinion of the school medical officer, influence or restrict the choice of employment. Wherever possible, therefore, pupils in their last year at school receive their final periodic medical inspection before entering upon their last term. The greatest care is taken to ensure that information passed by the school medical officer to Youth Employment Officers shall be treated as confidential.

School medical inspections are often carried out under difficult and trying circumstances and a service falling far short of the best is given. In many schools there is no separate room for medical inspection and classes have to be arranged to allow a room to be vacant. In other schools miscellaneous expedients are adopted such as the use of the stage with artificial light only, or a cloakroom, or a kitchen. The least unsatisfactory arrangement is the utilisation of a room normally used for other purposes, such as a staff room, or head teacher's room, but even here the inconvenience caused tends to make the school medical officer's visit unwelcome. In some few instances space in the school is so restricted that premises near by, such as a chapel or church hall, have to be hired at short notice in order to carry out the inspections.

The school medical inspection should be an occasion on which the parent, the doctor and the teacher can meet freely at the school to discuss the training and life of the child, and difficulties such as those outlined above detract greatly from the value which should be gained from the periodic medical inspection. In the planning of new schools the importance of adequate facilities for school medical inspections should be realised and it is shortsighted that this provision be sacrificed in the interests of economy. In spite of the difficulties mentioned, head teachers have been most co-operative and have rendered invaluable help. Without their assistance the work of school medical inspection would have been infinitely more difficult.

The following tables give details of the numbers of medical inspections made in the various age groups and the numbers found to require treatment:—

**Table I**

### Medical Inspection of Pupils Attending Maintained Primary and Secondary Schools (including Special Schools)

#### A. PERIODIC MEDICAL INSPECTIONS

Number of Inspections in the prescribed Groups			
Entrants	...	...	24,496
Second Age Group	...	...	18,701
Third Age Group	...	...	15,135
	Total	...	58,332
Number of other Periodic Inspections	...	...	3,645
	Grand Total	...	61,977

#### B. OTHER INSPECTIONS

Number of Special Inspections	...	...	17,304
Number of Re-Inspections	...	...	22,815
	Total	...	40,119

#### 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	478	3,941	4,077
Second Age Group	1,405	2,658	3,883
Third Age Group	1,209	1,739	2,791
Total (prescribed groups)	3,152	8,338	10,751
Other Periodic Inspections	318	580	834
Grand Total	3,470	8,918	11,585



Table II

## A. DEFECTS FOUND BY MEDICAL INSPECTION IN THE YEAR ENDED 31ST DECEMBER, 1950.

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 or Disease (1)	Periodic Inspections		Special Inspections	
	No. of Defects		No. of Defects	
	Requiring treatment (2)	Requiring to be kept under observation, but not requiring treatment (3)	Requiring treatment (4)	Requiring to be kept under observation, but not requiring treatment (5)
Skin	867	466	832	87
Eyes—				
a. Vision	3,470	1,903	1632	1,684
b. Squint	502	440	203	137
c. Other	272	187	270	92
Ears—				
a. Hearing	179	195	68	66
b. Otitis Media	296	281	144	87
c. Other	218	100	200	82
Nose or Throat	2,288	3,940	979	1,045
Speech	158	244	118	130
Cervical Glands	183	984	100	210
Heart and Circulation	216	685	124	431
Lungs	331	1,044	246	389
Developmental—				
a. Hernia	69	125	15	45
b. Other	68	288	31	81
Orthopaedic—				
a. Posture	416	373	109	89
b. Flat foot	810	616	158	274
c. Other	586	649	179	222
Nervous system—				
a. Epilepsy	34	70	30	37
b. Other	83	278	201	89
Psychological—				
a. Development	70	216	148	142
b. Stability	103	186	82	73
Other	1,188	822	1,269	598

## B. CLASSIFICATION OF THE GENERAL CONDITION OF PUPILS INSPECTED DURING THE YEAR

Age Groups (1)	Number of pupils inspected (2)	A (Good)		B (Fair)		C (Poor)	
		No. (3)	% of Col. 2 (4)	No. (5)	% of Col. 2 (6)	No. (7)	% of Col. 2 (8)
Entrants ...	24,496	10,618	43.35	13,219	53.96	659	2.69
Second Age Group	18,701	7,670	41.01	10,443	55.84	588	3.15
Third Age Group	15,135	6,738	44.52	8,105	53.55	292	1.93
Other periodic Inspections ...	3,645	1,794	49.22	1,761	48.31	90	2.47
Total	61,977	26,820	43.27	33,528	54.10	1,629	2.63

Table III

## Infestation with Vermin

- (i) Total number of examinations in the schools by the school nurses or other authorised persons ... 523,473
- (ii) Total number of individual pupils found to be infested ... 20,214
- (iii) Number of individual pupils in respect of whom cleansing notices were issued (Section 54 (2), Education Act, 1944) ... 704
- (iv) Number of individual pupils in respect of whom cleansing orders were issued (Section 54 (3), Education Act, 1944) ... 23



**Table IV**  
**Treatment Tables**

## NOTES

(a) Treatment provided by the Authority includes all defects treated or under treatment during the year by the Authority's own staff, however brought to the Authority's notice, i.e. whether by periodic inspection, special inspection, or otherwise, during the year in question or previously.

(b) Treatment provided otherwise than by the Authority includes all treatment known by the Authority to have been so provided including treatment undertaken in school clinics by the Regional Hospital Board.

**GROUP 1—DISEASES OF THE SKIN (EXCLUDING UNCLEANLINESS, FOR WHICH SEE TABLE III).**

				Number of cases treated or under treatment during the year	
				By the Authority.	Otherwise.
Ringworm—(i)	Scalp	...	...	52	10
	(ii) Body	...	...	183	7
Scabies	...	...	...	222	21
Impetigo	...	...	...	3,163	32
Other skin diseases	...	...	...	4,711	107
<b>Total</b>				<b>8,331</b>	<b>177</b>

**GROUP 2—EYE DISEASES—DEFECTIVE VISION AND SQUINT.**

				Number of cases dealt with	
				By the Authority.	Otherwise.
External and other, excluding errors of refraction and squint	...	...	...	3,120	145
Errors of refraction (including squint)	...	...	...	—	12,341
<b>Total</b>				<b>3,120</b>	<b>12,486</b>
Number of pupils for whom spectacles were—					
(a)	Prescribed	...	...	243*	7,289
(b)	Obtained	...	...	Not known	Not known

\* Cases dealt with under arrangements with the Supplementary Ophthalmic Services.

**GROUP 3.—DISEASES AND DEFECTS OF EAR, NOSE AND THROAT.**

				Number of cases treated	
				By the Authority.	Otherwise.
Received operative treatment—					
(a)	for diseases of the ear	...	...	—	54
(b)	for adenoids and chronic tonsillitis	...	...	—	2,756
(c)	for other nose and throat conditions	...	...	—	126
Received other forms of treatment				4,111	183
<b>Total</b>				<b>4,111</b>	<b>3,119</b>

**GROUP 4.—ORTHOPAEDIC AND POSTURAL DEFECTS.**

(a)	Number treated as in-patients in hospitals	208			
				By the Authority.	Otherwise.
(b)	Number treated otherwise, e.g. in clinics or out-patient departments	...	...	2,149	354

**GROUP 5.—CHILD GUIDANCE TREATMENT.**

				Number of cases treated	
				In the Authority's Child Guidance Clinics.	Elsewhere.
Number of pupils treated at Child Guidance Clinics				—	302

**GROUP 6.—SPEECH THERAPY.**

				Number of cases treated	
				By the Authority.	Otherwise.
Number of pupils treated by Speech Therapists.				539	26

**GROUP 7.—OTHER TREATMENT GIVEN.**

				Number of cases treated	
				By the Authority.	Otherwise.
(a)	Miscellaneous minor ailments	...	...	51,102	160
(b)	Other				
1.	Ultra Violet Light Treatment	...	...	2,982	—
2.	Chiropody	...	...	570	—
3.	Orthoptic Treatment	...	...	43	—
<b>Total</b>				<b>54,697</b>	<b>160</b>



Table V

## Dental Inspection and Treatment

(1) Number of pupils inspected by the Authority's Dental Officers—	
(a) Periodic age groups ... ..	66,523
(b) Specials ... ..	5,455
(c) TOTAL (Periodic and Specials) ... ..	71,978
(2) Number found to require treatment ... ..	45,555
(3) Number referred for treatment ... ..	41,441
(4) Number actually treated ... ..	38,615
(5) Attendances made by pupils for treatment ... ..	77,909
(6) Half-days devoted to: Inspection ... ..	729
Treatment ... ..	11,114
Total (6) ... ..	11,843
(7) Fillings:—Permanent Teeth ... ..	35,851
Temporary Teeth ... ..	2,904
Total (7) ... ..	38,755
(8) Number of teeth filled:—Permanent Teeth ... ..	31,225
Temporary Teeth ... ..	2,622
Total (8) ... ..	33,847
(9) Extractions:—Permanent Teeth ... ..	8,451
Temporary Teeth ... ..	52,418
Total (9) ... ..	60,869
(10) Administration of general anaesthetics for extraction ... ..	11,114
(11) Other Operations:—Permanent Teeth ... ..	16,648
Temporary Teeth ... ..	6,469
Total (11) ... ..	23,117

## The Care of the Handicapped Child

A large part of the work of the School Health Service has again been concerned with handicapped pupils and the handicapped register has been under continuous review in the closest collaboration with the Education Department. The impending opening of the Authority's three special residential schools for the educationally sub-normal provided the opportunity to review the whole of the cases in this category on the register and the results well justified the labour involved. Increased non-County provision for the partially sighted and physically handicapped also led to a detailed review of the cases on the register in these two categories. Handicapped children are now being brought to the notice of the Assistant County Medical Officers at a much earlier age than formerly, in many cases before they attain compulsory school age. This means that they can be placed on the waiting lists of suitable residential schools and admitted with the least possible delay on reaching school age.

The number of special residential schools in existence for the various types of handicap is still far short of what is required but when so much needs to be done for the many to bring the fabric of our present normal school buildings up to modern requirements, it has not been easy to direct large sums to the erection of special residential schools for the few. There was increasing evidence during 1950 that special efforts are, however, now being made all over the country to establish schools for the delicate, the physically handicapped, the educationally sub-normal, the partially sighted, and the partially deaf; hostels for the maladjusted child are appearing here and there; there are now six residential schools for epileptics (mostly attached to colonies) providing approximately 700 places; and there are one or two special schools for multiple defects. So at last the problem of special residential schools for the handicapped child is being seriously tackled both in the West Riding and elsewhere, but many years and much further study will be needed before a complete answer is found to the whole of this intricate problem.

The total number of new examinations and re-examinations of handicapped pupils made by the school medical officers during the year was as follows:— Educationally Sub-normal 1,031, Physically Handicapped 350, Delicate 715, Diabetic 2, Deaf 35, Partially Deaf 21, Blind 13, Partially Sighted 22, Epileptic 45, Maladjusted 62, Speech Defect (children needing to go to special school) 2, Double Defect 28.

The following table gives details of handicapped pupils and placing in special schools and hostels made during the year, and particulars of the number of children in residence in special schools at the end of the year. In the absence of any reliable figures due to the lack of a complete speech therapy service no figures are given for children with speech defects.



Category	Total No. on register	New Ascertainments	New placings in Special Schools	Total No. attending Special Schools:—		No. Boarded in Homes	No. Attending Assisted Schools	No. awaiting placement in Special Schools	No. receiving Home Tuition
				Day	Boarding				
Blind ... ..	52	7	13	—	42	—	—	9	1
Partially Sighted ... ..	69	14	4	7	20	—	—	41	—
Deaf ... ..	143	20	15	16	102	—	—	25	—
Partially Deaf ... ..	68	8	2	8	42	—	—	13	—
Delicate ... ..	529	311	220	261	111	1	—	153	1
*Physically Handicapped	462	70	29	6	47	—	3	73	39
Educationally Sub-normal	1281	277	12	12	28	—	3	731	1
Maladjusted ... ..	86	48	30	—	3	35	2	46	—
Epileptic ... ..	36	10	4	—	25	—	—	10	1
Diabetic ... ..	6	—	—	—	—	1	—	—	—
Totals ... ..	2732	765	329	310	420	37	8	1101	43

\* Excluding children sent to or awaiting places at Hospital Special Schools.

**The Physically Handicapped Child**—The following table sets out in detail particulars of the physically handicapped children in the West Riding at the time of writing:—

Physical Handicap	No. on register	No. attending ordinary school		No. attending day Special Schools	No. attending Special Residential Schools	Total No. awaiting placement in Special Schools	No. at Home	
		Satisfactorily	Needing placement in Special Schools				Receiving Home Tuition	Not receiving Home Tuition
<i>Disease of the Central Nervous System.</i>								
Spastic Paralysis ... ..	126	25	34	4	25	54	15	23
Infantile Paralysis ... ..	57	36	3	—	7	10	3	8
Encephalitis ... ..	3	—	—	—	2	1	1	—
Disseminated Sclerosis ... ..	1	—	—	—	—	—	—	1
Hydrocephalus ... ..	3	1	—	—	—	—	1	1
<i>Heart Diseases.</i>								
Rheumatic Infections ... ..	57	35	4	2	9	5	1	6
Congenital Defects ... ..	32	16	1	1	3	3	5	6
<i>Congenital Deformities.</i>								
Talipes and Club Foot ... ..	5	3	—	1	1	—	—	—
Other deformities of leg and foot	10	5	3	—	2	3	—	—
Deformities of arms and hands	6	4	—	—	2	—	—	—
Deformities of ribs ... ..	2	2	—	—	—	—	—	—
Spina Bifida ... ..	12	2	1	—	2	3	5	2
Hypospadias and Ectopia Vesicae	2	—	—	—	—	—	2	—
Congenital dislocation Hip ... ..	6	5	—	—	1	—	—	—
Absence of Rectum ... ..	1	—	1	—	—	1	—	—
Pseudo Hermaphrodite ... ..	1	1	—	—	—	—	—	—
Multiple congenital deformities all limbs	2	1	—	—	1	—	—	—
Torticollis ... ..	1	—	1	—	—	1	—	—
<i>Diseases of Bones and Joints.</i>								
Tuberculosis of Spine ... ..	12	9	1	—	1	2	—	1
.. Hip ... ..	13	7	2	—	2	2	—	2
.. Knee ... ..	6	4	—	—	1	—	1	—
Osteomyelitis ... ..	5	2	1	—	1	1	—	1
Achondroplasia ... ..	1	1	—	—	—	—	—	—
Perthe's Disease ... ..	18	13	1	1	1	2	1	1
Still's Disease ... ..	4	1	—	—	2	—	1	—
Kyphosis and Scoliosis ... ..	3	3	—	—	—	—	—	—
Fragilatis Ossium ... ..	2	1	—	—	1	—	—	—
Arthrogryphosis ... ..	1	—	—	—	1	—	—	—
Pseudo Coxalgia ... ..	3	3	—	—	—	—	—	—
Arthritic Knee ... ..	2	2	—	—	—	—	—	—
Polyarthritis ... ..	1	—	1	—	—	1	—	—
Osteogenesis Imperfecta ... ..	1	—	—	—	—	1	—	1
Amputation of Leg ... ..	1	1	—	—	—	—	—	—
<i>Diseases of Muscles.</i>								
Progressive Muscular Dystrophies	14	3	2	—	2	3	3	4
<i>Blood Diseases.</i>								
Haemophilia ... ..	4	1	—	—	—	1	1	2
<i>Accidents.</i>								
Ruptured Spleen ... ..	1	1	—	—	—	—	—	—
Extensive Burns ... ..	2	1	—	—	1	—	—	—
Multiple fracture of legs	1	—	—	—	—	—	1	—
Injury right Shoulder ... ..	1	1	—	—	—	—	—	—
<i>Others.</i>								
Nephritis ... ..	4	1	—	—	—	—	3	—
Coeliac Disease ... ..	2	2	—	—	—	—	—	—
Renal Rickets ... ..	1	—	—	—	—	—	—	1
Epidermolysis Bullosa ... ..	1	—	—	—	—	—	1	—
Dermatomyositis ... ..	1	—	—	—	—	—	1	—
Cirrhosis of Liver ... ..	1	—	—	—	—	—	1	—
Adiposity ... ..	1	1	—	—	—	—	—	—
Totals ... ..	434	194	56	9	68	94	47	60



In addition to the above, there were 9 children with double or triple defects, the major defect being physical, and of these 4 are attending ordinary schools, 2 are in a residential special school and 3 are awaiting admission to residential special schools.

Physically handicapped pupils are pupils, not being pupils suffering solely from a defect of sight or hearing, who, by reason of disease or crippling defect, cannot be satisfactorily educated in an ordinary school or cannot be educated in such a school without detriment to their health or educational development (the School Health Service and Handicapped Pupils Regulations). In such a complicated picture as that provided by handicapped children it is difficult to find any form of words which covers all the needs of the situation. The present definition fails in that it does not adequately recognise the need of the child afflicted with some disorder sufficient to demand the protection of a statutory ascertainment and yet well able to continue to attend an ordinary school. This deficiency is obvious throughout most of the handicapped classes and is particularly evident in the case of the epileptic. The time may have come to seek a re-wording of the Regulations to meet this point. It has been found from experience that many children with some degree of physical handicap are well able to attend the ordinary school with little difficulty and take full advantage of the education provided, apart from their inability to take part in games and physical training. This is true of many children with heart defects and those suffering from some degree of physical handicap as a result of poliomyelitis. Even some of the less severe spastics manage quite well in the ordinary school. This is borne out by the number of children in the foregoing table as being placed quite satisfactorily in ordinary schools. If a child can attend the ordinary school with a minimum of individual attention, it is better to leave him there than to disrupt his home life by placement in a residential school.

Children with heart defects continue to form a large proportion of the total of physically handicapped children; an increasing number of these are being found to be suitable to attend ordinary school with some restriction in physical training after full investigation including advice from our Child Specialist Service. The arrangement with the Rheumatic Research Centre at Harrogate, for the admission and diagnosis of early rheumatic cases has continued during the year and has been of considerable help.

During the year the Central Council for the Care of Cripples opened a new residential school for the physically handicapped at Hesley Hall near Tickhill. The types of cases suitable for admission are chiefly those with severe degrees of physical handicap which are not normally eligible for other physically handicapped schools, such as spina bifida, hydrocephalus, spastics, and cases of pseudo hypertrophic muscular dystrophy. The opening of this school has enabled the Authority to place ten children who must otherwise have spent the remainder of their school life at home without education (except for some limited home tuition).

The number of children receiving home tuition is almost the same as for 1949. My chief Assistant for the School Health Service reviews each case periodically with the officials of the Education Department (on the advice of the local Medical Officer and teacher). Difficulty is still being experienced in obtaining suitable teachers.

**The Spastic Child**—This remains the largest category numerically of physically handicapped children and the provision of adequate facilities for special educational treatment constitutes a major problem. As mentioned in my Report for 1949, the opening of a large residential school with the attendant difficulties of obtaining the necessary highly specialised staff would be a heavy commitment for a single Local Education Authority to undertake. Great as the need is, it is important that we should first provide sufficient special schools for the delicate and other types of physically handicapped children where there would be a much quicker turn-over of cases with lasting results. The special educational treatment of the spastic is still largely unexplored territory and on present knowledge the results are not wholly satisfactory; most of the work must still be done mainly on humanitarian grounds. The problem is now being energetically tackled by The British Council for the Welfare of Spastics established in 1946 and receiving some measure of financial support from many Local Education Authorities. This body is actively engaged in the promotion of facilities, both medical and educational, for the welfare of the spastic. Since the Council was set up, five voluntary special schools (1 day, 4 residential) and five special schools operated by Local Education Authorities (spastic units in existing schools for the physically handicapped) have been established in various parts of the country. Three further schools are either in preparation or under consideration, in the West Riding at Harrogate (to be administered by the Leeds Education Authority), in Northumberland and in Gloucester. There is also a possibility of a School at Huddersfield.

Particulars relating to educable spastics in the County are shown below. The figures include children of pre-school age and many who are not handicapped to such an extent that they need to be placed on the register of physically handicapped children. The figures will not, therefore, agree with those shown for spastics in the table relating to physically handicapped children.

Total No. of Educable Spastics.	No. accommodated in Special Schools	No. attending ordinary schools.		No. receiving Home Tuition	No. receiving no education.
		Satisfactorily	Needing placement in Special Schools		
170	29 *	52	34	15	40



\* Accommodated as follows:— Hesley Hall, Tickhill (6 pupils); Halliwick Cripples Home for Girls, Edmonton (5 pupils); Brighthouse Open Air School, Ian Tetley Memorial Home, Hampsthwaite (2 pupils each); Palace School, Ely, Braithwaite Open Air School, Pinderfields Hospital School, Wakefield, Marguerite Hepton Memorial Hospital, Thorp Arch, Todmorden Open Air School, Chipping Norton Children's Home, W. J. Sanderson Orthopaedic Hospital School, Gosforth, Conover School, Shrewsbury, St. Loyes' Training College, Exeter, Bradstock Lockett Hospital School, Southport, Bamford Memorial Home, Rochdale, Maghull Colony for Epileptics, Liverpool, Adela Shaw Orthopaedic Hospital, Kirbymoorside, Burton Hill House Special School, Malmesbury (1 pupil each).

**The Delicate Child**—Delicate pupils are those who, by reason of impaired physical condition cannot, without risk to their health, be educated under the normal regime of an ordinary school (School Health Service and Handicapped Pupils Regulations, 1945). This category can include children who are temporarily below par in general health and it is not surprising that we tend to accumulate very large numbers of children in this category on the handicapped pupils register. (At the end of 1950 there were over 500 on the register). Although so many delicate children are discovered few can hope for early admission to a residential school; most if not all, however, need to be kept under constant observation by the Assistant County Medical Officers and eventually most are taken off the register without having had the benefit of a stay in a residential school. Many children could have been restored to health and vigour much quicker and have been able to take full part again in the education provided at the ordinary school. For some, it has been found that a short period of rest in the healthy surroundings of convalescent homes has met the need; 214 children were admitted to convalescent homes during the year (under Section 48(3) of the Education Act, 1944), at no cost to the parents.

The shortage of places in residential schools for delicate children does not, of course, mean that we can evade our responsibilities of ascertainment under the Education Act. Every care is of course taken by a full and complete investigation to reach a true assessment. Short of statutory ascertainment much can be done by the family doctor with the backing of a health visitor to remedy conditions at home. In many instances the cause of some minor departures from normal is to be found in the atmosphere at home where preventive measures in the way of guidance to the parents is all that is needed to put the child on its feet again. Typical cases are those of the droopy child, less robust than its brothers and sisters—probably the constant butt of the father and openly called a weakling amongst the family; the child of premature birth who is often undersized or underweight throughout school life, but otherwise perfectly healthy; the child who is absent from school due to minor medical causes and there is pressure from the parents for something to be done; and lastly the peaky child with poor appetite who is classed as suffering from general debility. The guidance of parents is a study in itself but the true cause of failure to progress in children can often be quite simple such as lack of sleep due to domestic noise or fretting because of the loss of one parent or the mildly educationally sub-normal child who, in an effort to keep up with his colleagues becomes frustrated and fatigued. In all such cases wise guidance at the outset undoubtedly prevents many names appearing on the register of delicate pupils. The ascertainment and management of the delicate child is dealt with fully by Dr. Harvey in his Report.

The Authority's special school at Ingleborough Hall, Clapham, opened in 1949, is now well established and the results obtained are most gratifying. During the year, 49 children were admitted and 37 discharged, the majority of the latter being fit to attend ordinary school and their names deleted from the register. This is the Authority's first residential school for the delicate and as might be expected a small proportion of cases admitted have not proved suitable. With fuller experience in diagnosis and a more careful selection of cases only those children most in need of the special educational treatment provided will be admitted. It is hoped to open a second residential school for the delicate accommodating 40 senior boys during 1951 and the experience gained in connection with Ingleborough Hall will prove invaluable.

**The Blind and Partially Sighted Child**—Special educational treatment for the blind and partially sighted child no longer constitutes a problem. At the end of 1949, 10 blind and 47 partially sighted children were awaiting placement. During the year a new residential school for the partially sighted was opened by the Warwickshire Local Education Authority, and by the end of 1950 places were found for practically all outstanding West Riding cases, the children being admitted in January, 1951. There is now only one partially sighted child who has not been found a place and this because the parents have, so far, refused to allow him to go away.

**The Deaf and Partially Deaf Child**—We are no longer able to obtain places in residential schools for children in these categories with the same ease as commented upon in last year's Report but the difficulty in providing for these children cannot be regarded as a major problem. Difficulty is being experienced in finding places for a few girls who, in addition to being deaf or partially deaf, suffer from an additional handicap either physical or of educational sub-normality. Boys with similar double defects are being placed fairly easily in the Authority's special school at Bridge House, Harewood, but there is need for the increased number of places which is planned for this school.

There are at present on the register of handicapped pupils, slightly more than 200 children in the deaf and partially deaf categories. Taking the Ministry's figure of incidence as a guide (this may be a little high) there should be upwards of 400 deaf and partially deaf children in the County. Some children suffer from some defect of hearing which is not readily revealed by the normal



tests for hearing employed at school medical inspections. The defect may be such that a child's degree of hearing is affected by varying distances from a certain sound, or by the reflecting power of the walls in a classroom. The result of a defect of this nature is that the child's educational attainments fall short of the standard expected for its age and in time the child comes to be regarded as educationally sub-normal.

In the Report of the Committee of Inquiry into Problems relating to Children with Defective Hearing (1938) it is stated "Routine Group Testing in ordinary schools with the gramophone audiometer should be the basis of any scheme for the ascertainment and treatment of children with defective hearing." In recent years there has been a great improvement in the construction and effectiveness of gramophone audiometers and in early 1950, the County Council agreed to the purchase of two such audiometers for experimental purposes, and these were allocated to the Mexborough and Spenborough Divisions of the County. A preliminary survey has been carried out in certain schools in the Spenborough Division, and a report by Dr. Douglas, the Divisional Medical Officer for the area, will be found at the end of this Report.

**The Diabetic Child**—Only six diabetic children have been reported to the Authority. Five such children (under the care of their own doctor or attending hospital regularly for investigation and treatment) are able to attend ordinary school without difficulty and have, therefore, no need to be accommodated in any of the Boarding Homes for Diabetics. The remaining child is accommodated in a Home for Diabetics mainly on account of the home circumstances, the mother being most unreliable in the supervision of the child's diet and administration of insulin.

**The Epileptic Child**—The incidence of epilepsy in the population is not completely known although as a social problem epilepsy is of great importance. Since in approximately one half of the cases the convulsions start before school leaving age the ascertainment of these cases, leading to the most appropriate form of education, is the duty of the School Health Service. According to the definition contained in the Handicapped Pupils Regulations epileptic pupils are pupils who by reason of epilepsy cannot be educated in an ordinary school without detriment to the interests of themselves or other pupils and require education in a special school.

Of 255 educable epileptic school children so far known (June, 1951) only 38 (23 boys and 15 girls) fell within this definition; of these 29 (19 boys and 10 girls) attended special residential schools, 7 under school age (4 boys and 3 girls) were at home awaiting admission and 2 girls were at home receiving tuition. Of the 217 not within the definition 211 (124 boys and 87 girls) attended ordinary schools, and 6 under school age (2 boys and 4 girls) were at home.

Most epileptic children are rightly placed in ordinary schools with minor restrictions necessary for their safety; about 1 in 10 (or 0.2 to 0.3 per thousand of the school population), need education in special schools; some in which epilepsy co-exists with a degree of intellectual defect need to go to residential schools for the educationally sub-normal. Of the 211 children attending ordinary school 10 (4 boys and 6 girls) await vacancies in special schools for the educationally sub-normal.

The School Health Service can do much more for the epileptic than to discover his existence. I regard myself as the co-ordinator of all those agencies which exist for the care of these children, thus making their care a scientific exercise in social medicine. The first step is to make certain of adequate continuous treatment by the family doctor. Next to this is the need to see that all epileptic children are seen at appropriate intervals by some person highly skilled in epilepsy—either at a special clinic or by special consultation: this may result in special investigation and advice on treatment which in recent years has become both more effective and more complicated with the introduction of newer remedies. The assessment of the intellectual level of an epileptic child must be attended to most carefully; it is a difficult task and one requiring great patience and care, but it will amply repay the time and effort in the resulting relative ease with which the teacher will be able to tackle the problem. We must be careful to advise sympathetically on school attendance taking into account all factors but having done so we must seek always to impress teachers with the need to admit epileptic children to ordinary classes. The school nurse can help by explaining the simple nature of epilepsy to teachers and children. One of the most important of our tasks is to keep in touch with the parents of epileptic children who are often surprisingly ignorant of what part they should play in the child's welfare. Finally, when the child comes to leave school we must seek to advise Youth Employment Officers, Disablement Resettlement Officers, employers and workpeople to secure that the child finds his right niche in a sympathetic atmosphere.

All handicapped children require substantially more care and supervision from the health authority than do normal children. The divisional organisation in the West Riding provides an almost ideal arrangement for this type of work. An epileptic child becomes a real person to the Divisional Medical Officer and his staff of doctors and health visitors and they are in a key position to advise the Youth Employment Officer and to exercise the necessary follow-up of the children during the difficult phase of school leaving and settlement in useful employment.

Miss Carey (one of the Headquarters Superintendent Health Visitors), has continued her work for the care and aftercare of the epileptic school child. She pays particular attention to the child who leaves the special school or colony for epileptics, under the scheme outlined in the Report for 1949. Her report is given below:—

"During 1950 I continued the follow-up of the epileptic child in close co-operation with the Divisional staff.



The following is a summary of the children seen:—

Children in school having treatment, 23; Children in school not having treatment, 4; Children in school not had a fit for 1—3 years and not on treatment now, 19; Children left school in unsafe work, 2; Left school, no fits from 1—3 years and in steady work, 15; Left school, working as gardeners, still on treatment, 2; Awaiting vacancies in special school, 4; Left school permanently handicapped 2; Children put on special treatment by Professor Craig and referred to County Medical Officer for supervision, 3; Discharged from Epileptic Colonies, 5.

I found the visits to the home most valuable and the parents always ready to discuss the child at great length. Of the 23 children found in school on treatment, the treatment was not given regularly; the mothers, once the major fits were controlled, left off the treatment and only gave it when they thought a fit was coming on. There is a great tendency to keep epilepsy in the child a secret from the neighbours, and still a feeling of "shame" when there is an epileptic in the family. The epileptic child has difficulty in school particularly with his school mates when playing games owing to his frequent "black-outs." In these instances it was found helpful to discuss the child with the Head Teacher who was willing to co-operate and in one special instance, the Head Teacher expressed his appreciation of the interest taken in the child by the Health Authorities. Children who have had residential treatment presented a special problem as the local Medical Officer was not always aware of their discharge. These children find it very difficult after 3—4 or 6 years away to re-settle in the community; also here again seeing the children were so much better on their return the parents did not appreciate the necessity for continuing the treatment. In all the above cases, when necessary, action was taken by the Divisional Medical Officer and satisfactory results obtained. The following are notes on three of these children:—

*Boy*—Discharged Lingfield Special School in July, 1949. When I visited in January, 1950, the boy was still not working, the father had got two jobs for him, neither suitable, the fits returned and he was sent home. The boy was still taking his tablets as recommended by the doctor at the Special School and prescribed by the family doctor. I thought this boy was mentally and physically fit for safe employment and so I had him referred to the Youth Employment Officer through the Divisional Medical Officer. I visited this boy again this year, and was surprised to see how he had deteriorated. The boy was on pheno-barbitone but to me the drug was not being effective; I referred him again to the Divisional Medical Officer who had him, with the consent of the general practitioner, referred to the Neurological Specialist, and a new treatment was presented and the Specialist also recommended the boy for safe employment. The Divisional Medical Officer in conjunction with the Youth Employment Officer secured a job for the boy as a gardener and he is now working steadily.

*Boy*—Discharged Maghull Special School December, 1949. Lived in a rural area and the parents, who were well known in the district, obtained employment for the boy with a farmer who was sympathetic. During the year the boy had three such jobs but was dismissed in each case owing to the attitude of his work mates who found him slow and listless at times. This boy was on treatment but I found the mother was not seeing that he took his tablets regularly as she felt he was now cured. By frequent visiting and getting the mother to see the need for continuing the treatment we managed to get the boy established in safe employment.

*Boy*—This boy, after his discharge from the Maghull Special School had great difficulty in getting established, but here the handicap was due to physical ailments rather than the fits. In this case I worked closely with the Divisional Medical Officer and the Youth Employment Officer and the boy has now been working regularly for several months."

**The Educationally Sub-Normal Child**—By the end of the year the case-files of all children on the register had been reviewed as part of the process of selecting cases for admission to the Authority's three new schools at Sedbergh, Meltham and Horsforth. This Residential accommodation, though limited, has introduced an entirely fresh outlook in our work for the educationally sub-normal pupils. There is still a great need for a large extension of special classes in ordinary schools and for day special schools in suitable areas of population at which children from surrounding areas can attend. This problem is receiving the close attention of the Education Committee.

During the year, 164 children previously ascertained under Section 34 of the Education Act, 1944, as handicapped pupils in the educationally sub-normal category, were examined in their last term at school. In 98 cases reports were issued to the Local Health Authority under Section 57(5) of the Act to the effect that the children were in need of supervision under the Mental Deficiency Acts after leaving school. Arrangements were made for the remaining 66 children to be followed up by the health visiting staff under Section 28 of the National Health Service Act during the period of change-over from school to employment. Much can be done to help the educationally sub-normal child during this difficult period by close co-operation between staff of the Health Department and the Divisional Youth Employment Officers. This follow-up work of the educationally sub-normal child is a comparatively recent measure and no case details are yet available. I hope to report more fully on this aspect of the work in my Report for 1951.

**The Maladjusted Child**—There is little further to report about the problem of maladjusted children in the County and this year's note will deal simply with the Child Guidance Service, with particular reference to the work of our Hostels. For many years the West Riding relied on the Contained County Boroughs for all services relating to child guidance, chiefly Barnsley County Borough where the services of Dr. MacTaggart have been extensively used. In 1948 the Education



Committee appointed Mr. Armstrong as Educational Psychologist, devoting a proportion of his time to the examination of and reporting on maladjusted children. The following tables indicate the extent of the work undertaken by the clinics in Barnsley and Leeds over the past three years.

*Barnsley.* (All cases referred through the School Health Service).

Year	Cases brought forward from previous year	New Cases	Total	Total number of attendances during year
1947/48	25	172	197	867
1948/49	89	174	263	1,016
1949/50	56	178	234	931

*Leeds.*

Year	School Health Service	Own Doctor	Doctors at Leeds General Infirmary	Others	Total	Total Attendances During Year
1947/48	—	8	10	2	20	27
1948/49	2	23	6	—	31	67
1949/50	1	37	—	5	43	117

I wish to thank Professor MacCalman and his staff at Leeds and Dr. MacTaggart at Barnsley for all the valuable help they have given us. The work undertaken is only part of the total needs and, as I have previously reported, the setting up of a fully staffed child guidance team for the West Riding County Council must ultimately be the only satisfactory way of tackling the problem. The function of the hostel for Maladjusted Children in the treatment of the maladjusted child is threefold. Dealing as it does with the more severely handicapped child for whom child guidance as an out-patient, play therapy, etc., will prove inadequate, the hostel is an essential part of the mechanism for the handling of the problem. The first important function of a hostel is a means of full diagnosis. Whilst the child guidance team with its staff of psychiatrist, psychologist and social worker is a highly efficient organism, it suffers from the handicap of not being able to study the child over any but a short period. The simpler cases can be elucidated during one or more interviews, the behaviour of the child during play at the clinic (under observation by the team) may give additional information, and a visit to the actual home by the social worker may give further assistance. However, just as in the case of the sick person when a full solution of the problem can only be achieved by admission to hospital under observation, so in the case of the severely maladjusted child, the removal to a different environment and the observation of its behaviour there may be the only means of securing a true picture of the child's condition and an assessment of future progress made.

The second important function of the hostel is as a therapeutic measure. In many cases the root of the maladjustment lies within the home of the child. Often the overt maladjustment is the result of many years of wrong handling or an adverse environment resulting in the child behaving in an abnormal way to the ordinary problems of life. The removal of such a child from these adverse conditions, and placing in a foster home with sympathetic foster parents may be the best solution, but in many cases the conduct and habits of these children do not make such a placing easy and the hostel may be the only solution. Given suitably trained and understanding staff the child is given a chance to re-adjust itself to the world around him. Child guidance therapy may be necessary as an adjunct during the child's stay. The child would normally attend the local day school and benefit by mixing with normal children. During the period of stay the child may recover sufficiently to return home, albeit an unsatisfactory one, and subsequently weather the storms of life.

The third important factor of the hostel is to allow time for a change in the home. The problem of maladjustment is not, of course, solved by treating the patient alone. The factors in the child's environment which have led to the maladjustment must be tackled at the same time. Hostel placing presents an opportunity for remedying the socio-medical factors which are the cause of the ill; and unless during his stay some attempt is made to remedy the unsatisfactory features of such a home prior to the child's return to it, little benefit will result. This, to my mind, is fundamental, and the whole expensive machinery of child guidance, hostels, etc., may produce no benefit unless this aspect is tackled with efficiency. The problems presented to the socio-medical worker may be difficult of solution, even in some cases well-nigh impossible. Many of these families will be "problem families" and the help of many of the agencies which are required to deal with these families may have to be sought in the home of the maladjusted child. This raises the question whether we ought not to confine activities to those cases where the environment can be remedied, otherwise some provision, catering for long stay cases, will be necessary.

The hostel must, of course, be linked closely with the after-care work of the Divisional Scheme. Immediately following the return of the maladjusted child to its home there is need for frequent and close follow-up to ensure that the benefits of treatment are maintained. The health visitor (or, where necessary, the psychiatric social worker) in her remedial work in the home will continue her visits in this follow-up work, giving continuity and avoiding the visiting of the home by many different people. The signs of any relapse will be noted early and the remedy



applied before any further grave damage results. There will need to be close working between the health visitor, school doctor, general practitioner, and the child's teachers. The Probation Officer may be invaluable where delinquency is a feature of the case. Co-operation of outside bodies such as Youth Clubs may be usefully sought. Such supervision must generally be continued for a long time until the child who has been severely maladjusted at last takes his place as a well-adjusted socially adequate citizen; then the cure of the ill can be said to be complete.

Two hostels for the accommodation of the more severely maladjusted children are now functioning, the children in residence attending the nearby day schools. Hooper House at Wentworth, near Rotherham, was opened in September, 1948, for the accommodation of 24 girls aged from 7 years upwards, who must have an intelligence quotient over 80. Children are selected for admission following the recommendation by the school doctor and by a small committee of the Senior School Medical Officer, Dr. Jeffrey, psychiatrist, Dr. MacTaggart and Mr. Armstrong, psychologists, who also decide on the children to be discharged. A general practitioner is appointed and the hostel visited frequently by Dr. Jeffrey and Mr. Armstrong. The average length of stay for a child is about 18 months, thus allowing for the placement of about 6 children each term. Oakbank Hostel, Keighley, was opened in July, 1949, with accommodation for 15 boys, later to be raised to 19, aged 9 upwards. Since the incidence of maladjustment is greater in boys than in girls, this accommodation is much below that needed, and compares unfavourably with the provision for girls. Children are selected in a similar manner as for Hooper House, except that it has not yet been possible to provide the services of a consultant psychiatrist. The following are typical cases admitted to these hostels:—

*Girl aged 8 years, stayed 16 months.* Mother married twice; 8 brothers and sisters, the eldest in a hostel for maladjusted girls previously. Emotionally retarded; possibly by her immature behaviour she tended to gain more love and attention from her parents. Referred to a child guidance centre for petty pilfering—bought sweets with stolen money to bribe children to be friendly to her. Educationally retarded. Recommended for a short stay in hostel—attempt by mother to withdraw her to act as nursemaid for a further confinement thwarted. Progress report dated 6 months after discharge states:—"Showing improvement, parents more interested in child, good meals served to her. Behaviour satisfactory. The child is being kept under observation by the health visitor."

*Girl aged 9 years, stayed 27 months.* An adopted child subsequently rejected by her parents. Developed filthy habits, became lazy and withdrew into a fantasy world as an escape from her poor environment. During her stay at Hooper House she tried hard at her school work, was a good girl and gave no trouble. The psychiatrist reported 5 months before discharge "appears well now but I feel the slightest stress in her environment would cause a relapse, she may become schizophrenic when protected from such stress." Returned home a changed child but will require careful watching now and the handling of her by her parents carefully guided.

*Girl aged 11 years, stayed 17 months.* Protestant father married a Roman Catholic second wife. Girl had for long had the habit of masturbation about which the mother had strong religious feelings, regarding the habit as a grave sin against the Church. The child was questioned about her behaviour each morning. She was alleged to be a persistent liar. Although on admission to Hooper House the child presented no surface evidence of maladjustment, it was felt a period under observation in the hostel would be of benefit. A report just prior to discharge states she is well adjusted and shows no sign of neurosis. Her behaviour was not an illness but normal for her, the root of the trouble being functional from moralising elders. It is hoped that more sympathetic handling by her parents will avoid further trouble here.

*Girl aged 14 years, stayed 13 months.* In an orphanage until 9 months old when she was adopted by present parents, who are described as "narrow and limited in outlook and bigoted." At the age of 10 years she was told of her adoption and was deeply upset. Her parents were possibly quite unable to understand the problems of adolescence and the handling of an adolescent girl. Child guidance was sought when she was found to be stealing money from her mother, and was believed to be indulging in sex-play with several boys. During her stay she was bright and responsive and showed quite remarkable adaptive powers. The stay enabled her to live through a difficult period in her life in a stable environment. It was hoped she would be able to take up nursing soon after discharge.

*Girl aged 6 years, stayed 9 months.* The mother (a depressed, possibly suicidal psychopath) describes her husband as a rotter who likes to torture her mentally and who has a crafty way with children. She describes her life as "hell." Husband alleged to have child to a neighbour and the resemblance of the child to her husband tortures her. She was an inhibited child, poorly developed, easily fatigued and listless. Admitted to Hooper House to remove her from a home in which quarrelling was incessant but since the home circumstances could not be improved easily the child was discharged and continual supervision at a child guidance clinic is now instituted. The child may eventually come within the care of the Children's Officer.

*Boy aged 12 years, stayed 18 months.* A home in which the boy's stepmother, who has indifferent health, shows no feeling for the boy; on one occasion she told him to "clear out" and he took this literally, staying out in the woods all night. The child was depressed and frightened. Placed in Oakbank in order that he could settle down and later be discharged to either a foster home or to his grandparents. He was eventually placed with his grandparents, but is now with his parents and is liable to be back again where he started.



*Boy aged 11 years, stayed 18 months. I.Q. 107. In 1946 was before a Juvenile Court because of lack of proper care and guardianship and beyond control. An illegitimate child who had been cruelly treated and starved and the subject of N.S.P.C.C. supervision. A misfit in the home—his mother having married and had three children. During his stay improved psychologically and physically, but since his home was not suitable for his return he was placed under the care of the Children's Officer.*

*Boy aged 13 years, stayed 15 months. I.Q. 85. Appeared before the Juvenile Court for truancy. Mother dead. Youngest of a family of seven being cared for by a married sister. Timid, suggestible, and easily led. Admitted to Oakbank in order to allow him to develop and gain self-confidence. Finally discharged much improved but his progress at home will require to be followed up.*

*Boy aged 14 years, stayed 12 months. I.Q. 85. Illegitimate only child, unwanted by his hard-hearted mother. Attended a school for E.S.N. children from 1942 until 1948. In 1949 before the Magistrates on two charges of larceny; placed in the care of the Children's Officer. Placed in a Children's Home but absconded and stole a bicycle. First child admitted to Oakbank, troublesome there also, committing petty thefts in the town. He made little progress educationally and it was decided that little improvement would result unless he was in an environment where more repressive discipline could be maintained and was discharged at the age of 15 to a farm training school.*

*Boy aged 14 years, stayed 9 months. I.Q. 96. Elder of two children of a bigamous marriage. Step-father said to be heavy drinker. Child was taken to a child guidance clinic on account of serious behaviour problems which were seriously affecting the mother's health. Found to be spiteful and sly and appeared to have the ability to get other boys into trouble. It was found after a period of observation that the boy was not severely maladjusted, and the stay enabled the mother to recover from her nervous breakdown.*

In my Report for 1949, I spoke of the anticipated opening in 1951 of three residential schools for the educationally sub-normal and that it was hoped to admit a proportion of maladjusted educationally sub-normal pupils. A system of follow-up of children discharged from these schools similar to that in operation for the children placed in hostels will be needed; as in the case of the hostels, an attempt at relieving adverse factors in the home will be an essential part of the treatment during the child's stay.

**Children with Speech Defects**—1,235 sessions for children with speech defects were held during the year. 267 visits were made to schools and 36 visits to homes. 175 stammerers and 267 with other speech defects were seen as new cases; 22 stammerers and 75 others continued attending from the previous year; 42 stammerers and 78 others were discharged during the year as normal; 2 stammerers and 17 others were unsuitable for treatment; 7 stammerers and 5 others left school; 5 stammerers and 9 others failed to continue attendance. There were 367 cases awaiting treatment at the end of the year.

Little reliance as a complete statement of a handicapped class can be placed on the number of children with speech defects on the existing register. This is due to the absence in many parts of the County of a speech therapy service in consequence of which ascertainment has not been completely carried out. Taking as a guide the figures of surveys carried out in other parts of the country, it is estimated that there may be a maximum of between 6,000 and 7,000 children in the County requiring speech therapy.

In my Report for 1949, I expressed the hope that there would be a comprehensive speech therapy service by September, 1950, when a number of students then completing their training under special awards made by the County Council were expected to take up duty. Unfortunately, some of these failed the examination and our plans must, of necessity, be delayed a little longer. 1950 did see a definite improvement in the number of speech therapists; at the end of the year there were 4 whole-time (one unqualified) and 3 part-time (one unqualified) speech therapists in employment. This improvement was reflected in the number of children dealt with at the clinics, 539 cases being treated during the year compared with 205 in 1949.

So long as it remains impossible to obtain the full complement of staff there must be some selection of children for treatment; the governing principles here are that the more severely handicapped children should be chosen, older children with dysalia rather than young children, and in children with dysalia a younger child who requires a disproportionate amount of care must inevitably be left, as will those very backward children with speech defects. It should be possible to give a fuller account of the incidence of speech defects in the County as a whole in the Report for the Year 1951.

### The School Ophthalmic Service

In January, 1950, the responsibility for the examination of school children and arrangements for the provision of spectacles was transferred to the Regional Hospital Boards but this step did not lead to any great change in the service as a whole. Before that date the majority of children with eye defects were refracted in the Authority's clinics by the Authority's own school oculists and spectacles were provided through the Supplementary Ophthalmic Services administered by the Executive Council. With the change-over to the Regional Hospital Boards, the oculists became



transferred officers but we have continued to arrange their programmes of work and conduct the ophthalmic clinics on the same lines as hitherto. The clinics became affiliated to specific Hospital Management Committees who assumed responsibility for the provision and repair of spectacles, although these were still supplied by the private opticians. The lengthy delay in the provision of spectacles to school children which caused so much concern to Authorities during 1948 and 1949 has rapidly improved during 1950 and by the end of the year, the waiting period after spectacles had been prescribed had been reduced to a few weeks. There have now been two major changes since July, 1948, in the method of supply of spectacles, but in neither instance does the method work as well as that employed by the Authority before the 5th July, 1948, when spectacles were supplied through a central contract which was cheap, efficient and entailed the minimum amount of clerical administration.

In May, 1950, the range of spectacle frames provided wholly free was further limited; and any spectacles outside the standard category are no longer repaired entirely free.

To meet the difficulty that some parents have preferred not to collect broken spectacles sent in for repair (rather than pay their share) the Committee have agreed (under Section 48(3) Education Act, 1944) to pay the fraction originally paid by the Ministry.

In the normal refraction clinics, 12,341 children were examined during the year (including the follow-up examinations) compared with 12,025 in 1949, and 10,755 in 1948. In 7,289 cases spectacles were prescribed but it is still not possible to determine the number of children who were actually supplied with spectacles without laborious follow-up work on the part of the school nurse; a most unsatisfactory state of affairs. Although the school ophthalmic service has now been transferred to the Hospital Boards, the Authority is still responsible for the ascertainment of blind and partially-sighted school children within its borders and this work has continued to be undertaken at the clinics by the former County Oculists within the terms of their contracts with the Boards. 35 examinations of this nature were carried out by the oculists during the year. I have elsewhere reported that arrangements will be needed to employ one or more eye specialists of which this work will form part.

### Medical Treatment at Hospitals and Elsewhere

As part of the Authority's arrangements made under Section 48 of the Education Act, 1944, for the medical treatment of school children, the following clinics were in operation at the 31st December, 1950:—

TYPE OF CLINIC.	NUMBER.	
	Provided directly by the Authority	Under arrangements made with Regional Hospital Boards
Minor Ailment ... ..	164	—
Dental ... ..	18	—
Ophthalmic ... ..	—	89
Speech Therapy ... ..	18	—
Orthopaedic Treatment Centres ... ..	28	—
Ultra Violet Light ... ..	30	—
Paediatric ... ..	14	—
Chiropody ... ..	2	—
Consultant E.N.T. ... ..	—	21
Consultant Orthopaedic ... ..	—	19
Consultant Dermatology ... ..	—	1
Consultant Cardiac ... ..	—	1

The following tables give details of the year's work of the Ear, Nose and Throat, Orthopaedic and Paediatric Services:—

#### Consultant E.N.T. Service

CONSULTANT CLINIC	Number.		
1 No. of sessions held during the year:—	300		
	Pre-school.	School.	Total.
2. No. of individual children referred.	298	3,557	3,855
3. No. of (2) above—			
(a) referred for operative treatment.	196	2,170	2,366
(b) who obtained operative treatment.	155	1,750	1,905
(c) treated at school clinics.	8	1,063	1,071
4. Total number of attendances at consultant clinic	330	4,367	4,697



### Consultant Orthopaedic Service

		Number.		
A. CONSULTANT CLINICS.		310		
1.	No. of Sessions held during the year.	Pre-school.	School.	Total.
2.	No. of individual patients referred.	840	1,603	2,443
3.	No. of (2) above—			
(a)	referred for operative treatment as short-stay cases only.	14	52	66
(b)	who obtained operative treatment.	11	36	47
(c)	recommended long-stay hospital school.	—	7	7
(d)	recommended treatment by orthopaedic nurse or physiotherapist—			
(i)	at treatment centres.	236	494	730
(ii)	domiciliary.	10	19	29
4.	Total number of attendances.	1,208	2,228	3,436
B. TREATMENT CENTRES.				
1.	Total number treated (including cases continuing treatment from previous year).	487	1,912	2,399
2.	Total number of attendances.	3,906	16,415	20,321
C. DOMICILIARY TREATMENT.				
1.	Total number treated.	51	106	157
2.	Total number of visits to patients homes for—			
(a)	treatment.	249	489	738
(b)	supervision only.	213	643	856
D. APPLIANCES.				
1.	Number of appliances recommended.	82	205	287
2.	Number of appliances obtained.	75	198	273

### Paediatric Service

		Number.		
CONSULTANT CLINICS.		129		
1.	No. of Sessions held during the year:—	Pre-school.	School.	Total.
2.	No. of individual children referred.	151	512	663
3.	Total number of attendances.	200	618	818

The following table gives details of the various types of defect or disease for which children were referred for consultant opinion:—

Defect or Disease.	Number of Children.		
	Pre-school	School	Total
Central Nervous System ... ..	12	42	54
Heart ... ..	16	170	186
Respiratory System ... ..	14	108	122
Speech ... ..	3	5	8
Muscles ... ..	1	11	12
Skin ... ..	1	3	4
Psychological ... ..	8	31	39
Ear, Nose and Throat ... ..	2	13	15
Bones, Joints, etc. ... ..	1	6	7
Mental Defect ... ..	6	10	16
Congenital Deformities ... ..	—	1	1
Digestive Diseases ... ..	3	16	19
Epilepsy ... ..	—	5	5
Educational Sub-normality... ..	2	7	9
Generative System ... ..	—	3	3
Genito-urinary ... ..	2	5	7
Blood ... ..	4	6	10
Glands ... ..	4	20	24
Nutritional ... ..	7	4	11
Developmental ... ..	11	9	20
Fainting Attacks ... ..	—	5	5
Delicate ... ..	2	5	7
Weight ... ..	5	5	10
Other ... ..	47	22	69
	151	512	663

### Diphtheria Immunisation

Particulars relating to the numbers of school children immunised during the year and the immunisation state of the population of children of school age will be found in the section of the Report dealing with Epidemiology. The schools have continued to play their essential role in furthering this valuable work and our thanks are again due to all teachers for their collaboration.



## The After-Care of Children Leaving Hospital

The co-operation necessary between the school health service and the hospitals to secure a comprehensive school medical record, and in the interests of the child's future educational progress, is still lacking in our relations with many of the hospitals. The teaching hospitals are an exception and there is now an invaluable link between them and the School Health Service. This is particularly true in the case of the physically handicapped children and paediatricians in general are showing an increasing interest in relating the child's physical condition to its future educational needs. The reports and advice received from them are proving of great assistance in deciding the most appropriate form of special educational treatment for physically handicapped children.

There is still a great need for a closer working relationship with the general practitioners and the agreement reached during the year between the B.M.A. and the Society of Medical Officers of Health regarding the referral of children to specialists and which is dealt with briefly in the introduction to this Report will do much to dispel the suspicion which has existed in the past.

The subject of the social follow-up work in connection with epileptics and educationally sub-normal pupils by the health visitors is dealt with elsewhere in this Report. I hope to see in the near future an extension of these arrangements to embrace all categories of handicapped pupils. The help and advice of the officers of the Health Department in these cases can prove of great value to the Youth Employment Service in choosing and settling children in employment suitable to their physical and educational capabilities.

## Cleanliness

The figures of incidence of infestation by head lice show a slight decline compared with the figures for recent years. There were 20,214 individual cases of infestation compared with 23,457 in 1949, and 27,361 in 1948, the total numbers of examinations made by the school nurses remaining approximately the same. Making arrangements for the cleansing of pupils including visits to the homes and the giving of advice to parents takes up much of the school nurses' time and the very slight improvement shown over the years proves most disheartening. There is a great need for intensive propaganda among the general public, and parents in particular, before any real progress can be made to greatly reduce infestation in the children.

## Nutrition

Figures of the general condition of children examined at periodic medical inspections are given below for 1950 with a comparison of the figures for previous years. It will be noted that there is an appreciable increase in the number of children in the category "Good."

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
1949	64,908	23,467	36.1	39,335	60.5	2,196	3.4
1950	61,977	26,820	43.3	33,528	54.1	1,629	2.6

The average daily number of meals given to school children during 1950 was 120,289. Particulars relating to the supply of milk to school children can be found in the section of the Report dealing with Environmental Hygiene.

## Provision of Specialists for the School Health Service

Some advancement was made during the year towards the implementation of the scheme for the provision of specialist services generally. Our proposals were set out fully in my Annual Report for the year 1949. These proposals have now been examined in detail by both the Ministry of Health and the Regional Hospital Boards. There has been some modification in part, but agreement has now been reached between all parties and awaits ratification by the County Council.

So far as the provision of specialists in the School Health Service is concerned, no change is contemplated in the present arrangements for the Consultant E.N.T. and Orthopaedic Services. In both instances specialists are (with a few exceptions) already undertaking duties in our clinics or in special clinics held in hospitals and look upon such matters as advising the Authority on handicapped children in need of special educational treatment as part of their clinical work. Duties at Local Health Authority clinics are included in the terms of their contracts with the Regional Hospital Boards and this arrangement appears satisfactory. I would mention here the continuing need for additional E.N.T. Services in certain parts of the County, particularly in the south where the long lists of children either waiting to be seen by the specialists or waiting operative treatment, show little improvement. We have again during the year pressed for additional services but without success.



In the matter of the paediatric service, agreement was reached towards the end of the year on the future of the service in that part of the County in the area of the Sheffield Regional Hospital Board. Dr. Harvey, who was appointed by the County Council in 1948 as a child health officer and who by his untiring efforts has been largely responsible for the development of a service in child care with the highest standards of efficiency, has been transferred to the specialist staff of the Sheffield Regional Hospital Board, his appointment being on the basis of 7/11ths for the Board and 4/11ths on behalf of the County Council. Such an arrangement as this will go far to achieve that very necessary close relationship between the hospital, the general practitioner, and the Local Health Authority, working together in the best interests of the child.

It is hoped that similar arrangements for the paediatric service will soon be made in the Leeds area by an agreement with the Leeds University Paediatric Department under the able guidance of Professor Stuart Craig.

Dr. Harvey himself has asked me to put his views on record as expressed in a letter to me as follows:—

"Dear Dr. Brockington,

The change which has recently taken place in my appointment and the imminence of your own departure bring special significance to the preparation of the third annual report, which I submit herewith for your acceptance. In underscoring the salient features of the appointment, I intend a tribute to your imagination in planning such a scheme of work. To me it appeals increasingly for the breadth of contacts and resources which it comprises; and I believe our children stand to gain specifically in these respects. I trust that those on all sides who will have responsibility for future development may share our conviction of the value of these principles, so that this child health service may be facilitated. With renewed appreciation of your plan, and of your continued personal interest and support throughout.

Yours sincerely,

Cedric Harvey."

### Special Investigations

1. **Group Testing of the Hearing of School Children**—Report by Dr. W. M. Douglas, Divisional Medical Officer (17)—"The following table sets out the findings of a survey begun in September, 1950, using an electric gramophone audiometer:—

SPENBOROUGH (No. 17) DIVISION—GROUP TESTING OF THE HEARING OF SCHOOL CHILDREN

Group Testing—Test 1						Test 2—Double Failures									
Age Group	Total No. tested	Failures—Test 1				Total No. tested	Failures (One ear)					Failures (Both Ears)		Total failures for Pure Tone Audiometer Test	
		One Ear	Both Ears	Total (ref'd for Test 2)	% of total No. tested		10db+	15-17db	12-14db	9-11db	Total	% of total No. tested in Test 1	No.	% of total No. tested in Test 1	No.
8 yrs.	58	26	16	42	72.41	42	2	2	3	3	10	17.24	9	15.51	19
11 yrs.	541	88	61	149	27.54	149	14	8	7	15	44	8.13	24	4.43	68
12 yrs.	213	16	7	23	10.79	23	2	—	2	—	4	1.87	2	0.93	6
Totals	812	130	84	214	26.35	214	18	10	12	18	58	7.14	35	4.31	93

I was able to test the hearing, and to estimate the degree of hearing loss in decibels, of 20 children at the same time. From the point of view of ordinary education, I determined the difference in hearing between the two ears, this being the most suitable guide for the teacher. I also carefully measured the loss in one or both ears as a possible guide to future selection for employment as well as an indication of disease. The many commitments of the staff, i.e., doctors and health visitors, and the difficulties in co-ordinating testing into school curricula, together with the difficulty in providing suitable accommodation for testing, have restricted the extent of the work and made it necessary to test all the children in one age group and to carry out as many examinations as possible without regard to the completion of other age groups. I decided to test all the children attending school between the ages of 11 and 12 years at the 31st December, 1950, for the following reasons:— These children are concentrated in a group of schools; secondary school children are quick to grasp the test; recommendations are easier to carry out at the beginning of secondary school life. All children with hearing loss greater than 9 decibels in one ear will in due course be further tested by pure tone audiometer, and, where necessary, referred to an Otologist for further examination and advice.

**CONCLUSIONS.**—Of the 812 children tested, just over one-quarter (214) had some impairment in one or both ears at the first test. In a further test of these 214 the total of failures in either one or both ears was reduced to 11.5 per cent., of whom 4 per cent. had impairment in both ears. These children will be further re-tested by the pure tone audiometer.



Some of the younger children have difficulty in understanding the test and may have failed to do themselves justice. The bright children certainly appear to show better results. Some allowance also has had to be made to meet the interference by background noise, which was fairly general owing to the fact that we could not often find a suitable room of sufficient size with adequate electrical connections.

Although this survey is incomplete in itself, it does show that valuable results might come from widespread application of tests throughout the County. We should also study by these methods to what extent apparent hearing defect is related to backwardness at school or vice versa. There should be throughout the County a sufficient number of ascertained educationally sub-normal children to make such a survey worth while. This would need three audiometric teams."

**2. Tuberculin Survey**—A survey was made during the year by the Todmorden (No. 19) Divisional Medical Officer and his staff into the primary infection rate of tuberculosis in the population between the ages of five and twenty years. This formed part of a wider survey being made by the Medical Research Council and we have been asked to withhold publication of our own area results until such time as the main report of the Medical Research Council is issued.

### **The Work of a Children's Specialist in the School Health and Child Welfare Service**

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

#### **Administrative Report**

This was the third year of the consultant child health service of the West Riding County Council. The uncertainty of policy mentioned in my 1949 report was gradually resolved by negotiation through 1950 into an agreed pattern of contract with Sheffield Regional Hospital Board and the County Council, in which my connections and work with Professor Illingworth's Department of Child Health in the University of Sheffield will be safeguarded. Details are being finally worked out in 1951, but the new programme of hospital work commenced, pending settlement, on 1st January, 1951.

The strength of the triangular framework of my appointment is the envy of some colleagues, who appreciate the degree of far-reaching liaison and the perspective afforded by actual membership of the Public Health team and the University circle, as well as the hospital staffs. Some are mystified by the apparent complexity of the scheme, as it does not fit into conventional concepts. However, Sir Allen Daley pointed out (1949 Proc. Roy. Soc. Med. XLII, 695) that excessive tidiness in administration generally fails to reach greatness. And there is nothing administratively quite so tidy as a tombstone.

**SHEFFIELD UNIVERSITY DEPARTMENT OF CHILD HEALTH.** We have continued to enjoy the advantages of direct access for our clinical problems to Professor Illingworth's Department, and I serve in the Out-patients Department on Friday mornings. Assistant County Medical Officers attend clinical conferences and some out-patient sessions with post graduates. I use the University and Department libraries, and have a small share in Undergraduate teaching. In this New Year I was appointed by the University as Clinical teacher in Child Health. I am keenly indebted to Professor Illingworth for his counsel and help, throughout.

**SHEFFIELD REGIONAL HOSPITAL BOARD.** The programme which became effective at the end of 1950 is as follows:—I handed over to Dr. J. D. Pickup the paediatric consultant work at Wakefield General Hospital, after 2½ years of very cordial and profitable association. I am glad to know that our Public Health Divisions round Wakefield have renewed the former close link, with Dr. Pickup. I have now no hospital responsibility in the Leeds Region, but follow up special old cases through Divisional Clinics.

Dr. A. E. Naish kindly inducted me during the later months of 1950 into his Out-patient and Ward work at Moorgate General Hospital, Rotherham, which at the New Year he handed to me on his retirement. The special emphasis is upon care of the new-born and premature babies, and cubicle treatment of respiratory and alimentary infections. The Rotherham School Medical Officers take a keen interest in the Out-patient Clinics.

At the same time Dr. A. W. D. Leishman transferred to me the medical care of children at Rotherham Hospital; and the newly opened weekly paediatric out-patient session is already active. At both hospitals Health Visitors of Rotherham Borough attend and exchange valuable information and give follow-up supervision.

At Montagu Hospital, Mexborough, the Out-patient session is now held thrice instead of twice monthly. This allows fuller discussion and advice for each case, rather than any shortening of the session.

The triangle of Out-patient facilities in this area (quadrilateral, when Sheffield Children's Hospital is taken into account), affords far greater promptitude of consultation, with prior booking of all appointments, which Divisional Medical Officers and family doctors already appreciate.



I am also able to switch cases for follow-up to Divisional Paediatric Clinics nearer home, when appropriate, or from the latter to hospitals for special treatment. The population served by the Montagu Hospital is entirely in the West Riding County Council administrative area, and that served by the Rotherham hospitals is largely so.

Listerdale and Hallamshire Maternity Homes. It is a special pleasure to renew old links more firmly, not only with emergency calls to ill babies but with a regular weekly visit at which any relevant points may be discussed.

**DIVISIONAL MONTHLY PAEDIATRIC CLINICS.** I hold these in the nine South Yorkshire Health Divisions. As they are the most distinctive element in my County Council appointment I may here review their function over three years. The questions are: In what ways do they differ from hospital out-patient sessions? and, Do the advantages justify the apparent duplication of services?

- (a) These clinics are held on familiar home clinic territory where mothers and children have attended since birth. Travel and waiting time are greatly reduced by comparison with hospitals.
- (b) The Health Visitors in charge know the families and their background, and can often supply essential clues in personal discussion. Infant and Ante-Natal records can often be looked up on the spot. Mothers will listen to advice reinforced by the nurses they trust, who follow up the consultation with home visits.
- (c) Appointments are limited and selected, to ensure adequate time for the detailed tangles of many cases, especially children with lengthy past ill-health and special school procedures.
- (d) The Assistant County Medical Officers commonly share in direct discussion of their cases, and in disposal. Where the Assistant County Medical Officer is not present a significant element is lost from the value of the clinic. At some centres the Divisional Medical Officer himself joins in the clinic, to my keen advantage.
- (e) The simpler laboratory examinations, of urine, haemoglobin and blood sedimentation rate, are made on the spot, yielding results more promptly than is usual in hospitals.
- (f) The paediatric consultation notes are an integral part of the Public Health records of the children, for reference at any time by Medical Officers.
- (g) Through such clinics, surveys of whole populations can be compiled (e.g., for epilepsy, heart conditions, cerebral palsy, asthma) in a way impossible through the hospital approach.

In my judgment this type of clinic provides for the radical solution of tangled problems far more surely than by indirect reference to hospital out-patients. The advising of parents, nurses and doctors justifies the time given to difficult problems. There remain many less tricky cases which can equally well be handled at hospital, and others in which special investigations and treatment at hospital can be foreseen. Selection by Divisional Medical Officers for the Clinics is thus advantageous. This has been a year of more attentive listening to parents. Their discourse in some cases is informative ("An observant parent's evidence may be disproved but should never be ignored."—*The Lancet*). In other cases the parent's story becomes a deflatory device for relaxing tension, preparatory to reassurance. Both in hospital and divisional clinics the work is consultative, all prescribing being referred to family doctors, except in occasional cases during observation of control of epilepsy by toxic drugs.

**DIVISIONAL OFFICES AND CENTRAL OFFICE.** I have continued to attend monthly Conferences of Divisional Medical Officers, taking part in discussions bearing on child health; and I have been in frequent conferences with Medical, nursing and senior clerical staff at County Hall on matters arising from week to week. I meet Divisional Medical Officers frequently at their offices, and have shared in conferences and lectures with Assistant County Medical Officers, and nurses, both in Southern and Northern parts of the County. I look forward this year to sharing in the Infant mortality survey which ought to be of cumulative value over the years, and in the review of children returning from special schools for conditions within the scope of my work.

Towards the end of 1950 the plea of my last Annual Report was met by the seconding of Miss A. Watson to spend the greater part of her time upon my work. I am grateful also to the Divisional Medical Officers of Divisions 26 and 28, who helped to make this possible. We have already been able to offer a much improved, integrated, method of reporting cases to family doctors, Divisional Medical Officers and the County Medical Officer. We are establishing progressive clinical card index record series for cardiac cases, obesity and pink disease, with projects for extension also to include epilepsy and cerebral palsy. We have systematized my abstracting of journals and other studies, into an indexed filing cabinet for immediate reference for consultations and conferences with Medical Officers.

The value of this unified secretarial service has fully come up to my expectations and I believe the clerical staff at County Hall and the Divisions appreciate the readiness of access which now obtains. In the New Year of 1951 a trial extension of the service has been made, in which Miss Watson covers also my out-patient reports at Rotherham Hospital, where a large proportion of the cases are West Riding children. The advantage of this, in consolidation of my note-keeping, has been great; and I believe that a further extension to the Montagu Hospital would also be in the interest of our children and Health Service.



CHILD GUIDANCE. Our indebtedness to Dr. M. M. MacTaggart continued through 1950, for the unravelling of several emotional and psychological problems referred from my clinics. I am accordingly particularly glad that our link with her work is now so much the greater.

SPECIAL SCHOOLS. I visited Ingleborough Hall School twice in the year, and have submitted detailed reports on each occasion. The benefit of such schools would be immensely increased if admission could be secured within a few weeks of the crisis leading to recommendation. After long delay the clinical indications may be blurred, or the prospects weakened by discouragement. It would seem better to cut down acceptances initially, so as to shorten waiting lists. Some cases in my view could have been retained at home at the ordinary school, if the full available out-patient treatment resources had been adopted, in consultation with appropriate specialists. Some children, once admitted, have been held too long, beyond their needs, to the detriment of other children on the waiting list. This is a case for synthesis of policy between Health and Education Departments in the best interests of all the children concerned. In an appendix to this report I consider the problems of diagnosis of "The Delicate Child." In concluding this administrative section of this report, I wish to re-emphasize my confidence that this type of consultant appointment has singular advantages to offer to the Child Health Service as a whole.

### Clinical Paediatric Report

#### A. SOME UNRESOLVED PREVENTIVE PROBLEMS.

(a) *The Premature Baby.* Few premature births are foreseen with any possibility of either prevention or of admission before delivery to a Unit where specialised care can be afforded from the moment of birth. The past year has brought emphasis to the danger of aspiration of stomach contents into the lungs, and the advantage of withholding first feeds until the baby displays hunger. In the later care of premature infants, haemoglobin checks and iron administration (as indicated) should be routine.

(b) *Haemolytic Disease of the New-born.* Ante-natal clinics are not all yet fully geared to the need for Rhesus testing of all mothers. A recurring pit-fall is that multiparae may be overlooked when in fact their former pregnancies were before the days of routine Rhesus testing.

(c) *Breast feeding.* The attitude is significantly improving in some clinic communities where mothers and nurses are discovering that ante-natal breast preparation and neo-natal feeding care really will lead to success. This attitude is coming gradually, by the testimony of experience, as Dr. Harold Waller advised us two years ago. Not all medical and nursing advisers of mothers, however, are yet convinced supporters.

(d) *Child contacts to infective Tuberculosis.* Children continue to die from Tuberculous Meningitis through contact with sputum—positive adults who cannot be admitted or retained in Sanatorium beds. In some of these cases the dangerous source of infection has not even been discovered until the child victim falls ill. There are also adults who refuse to be examined or treated, while one after another of their children succumb to Tuberculosis. While B.C.G. vaccination may afford some protection, placing reliance on this might induce a false sense of security. The general use of Tuberculin skin testing of infants would help in finding sources of infection.

The value of Streptomycin in Tuberculous Meningitis is related to promptitude in diagnosing and commencing treatment. This places an entirely new strain upon our preventive supervision of infants, so that every vague malaise and every slight convulsion call for skilled consideration.

(e) *Institutional Vacancies for Mentally Defective Children.* When parents reach the point of resignation to admission of their children to Institutions, they are caused further anguish through the long delay or impossibility of securing vacancies. Some examples of the noble humanity of parents have been observed in caring for their difficult children. It seems particularly pathetic when parents resolve to dedicate their lives to a defective first-born, abandoning any intention of having further children.

(f) *Poliomyelitis following Inoculations.* The impact of the publicity of such cases upon the Diphtheria Immunisation campaign needs to be balanced by the realisation of the disasters Diphtheria could cause if it were again allowed to become prevalent. Meantime, we may aim to immunise as many infants as possible at seasons when Poliomyelitis is not epidemic.

(g) *Obsessional observance of Infant Welfare Clinic facilities.* Many mothers are seriously disturbed in mind if their baby's weight gain is below expectation, and the disturbance leads often to mistakes such as weaning from the breast. I am coming to think that a perfect unbroken record card of fortnightly weighings, from birth to 18 months, signifies an obsessional apprehensive mother. How can we keep up the attractiveness of clinic attendance with its educative value, if we suggest that a thriving baby is best unweighed?

#### B. CLINICAL COMMENTARY WITH ILLUSTRATIVE JOTTINGS.

(1) *Congenital Malformations.* In the light of advances in surgery, doctors and midwives concerned with the new-born need to review the possibilities of relief in such conditions as simple Meningocele, Tracheo-oesophageal fistula, and bowel obstruction. One baby from our area was operated upon for atresia of small intestine at the age of 4 days, and his return home was carefully prepared by the Divisional Medical Officer and Health Visitor with the Family Doctor. Such liaison with hospitals is especially valuable in very young babies with special feeding requirements.



(2) *Breast feeding.* One baby girl was weaned from the breast at birth by the grandmother in order to put her daughter straight back into her hairdressing business. This child as a toddler became a problem of feeding and bowel habit. A baby boy was weaned from the breast at the age of 3 weeks without skilled advice and he appeared hungry; he went on to require operation for Pyloric Stenosis.

(3) *Possetting.* A record of steady weight gain should relieve mothers, nurses and doctors who are concerned over wiry active babies who regularly vomit after feeds. In one such case the mother admitted her fear at 5 months that her baby girl would need a pyloric operation and would die.

(4) *Anaemia in babyhood.* More frequent recourse to haemoglobin testing seems desirable for pale babies. Without such tests the use of iron is pure guess work. Such testing is specially desirable with premature babies or babies whose mothers were anaemic during pregnancy. One exceptional case was encountered this year: a baby girl whose haemoglobin obstinately failed to rise on the iron and who was found at 4 months of age to have a large spleen and liver. She and her father both showed classical abnormal red cell fragility curves, and father's brother had undergone splenectomy.

(5) *Cretinism and Juvenile Hypo-thyroidism.* Failure of early diagnosis can be serious, and is attributable to not keeping the possibilities in mind. One such child has been erroneously labelled as a "Mongol" until the age of 1½ years. Another, one of twins, was picked out by an alert Health Visitor owing to lagging behind his brother in vigour and growth, and came to positive diagnosis at 4 months. A feeble-minded, dwarf girl of 14 had missed diagnosis and treatment for many years under the label of achondroplasia. She made a specific response to thyroid.

(6) *Pink Disease.* Few cases were encountered this year and the possibility of incriminating Mercury teething powders has not been clinched: "They told me at the clinic to give her the teething powders, doctor . . . Oh! not the nurse—some of the mothers."

(7) *Toddling.* Mothers and clinical advisers too readily suspect abnormality of gait in their infants during the first 3 to 6 months of walking. However, we cannot discourage the reference of such problems, in which we might pick up poliomyelitis, congenital dislocation of hip, and other nervous or orthopaedic disorders.

(8) *Negativism.* Mothers with bright toddlers need much imagination and sometimes advice to avoid building up a conflict over habit training and the wide and earthy interests of the young mind. One mother this year, after overcoming a bowel habit which distressed her, had to face embarrassing presents of handfuls of caterpillars and worms from the garden with what grace she could summon.

(9) *Speech Disorders.* Parents sometimes take it ill to be advised that their child's speech defect is due to mental subnormality and consider we are wilfully withholding speech therapy which they imagine will put everything right. On the other hand a dainty only child, age 2½, was referred from the Clinic recently because her precocious normal speech had broken down into a stammer at the age of 2. The mother was advised to cease making her recite nursery rhymes to adults and was reassured over the outcome.

(10) *Hearing defect.* An instructive case was an only boy, age 4½, referred with temper tantrums and speechlessness. He was found to have a serious degree of hearing defect and was cleared of the suspicion of mental retardation. Facilities for specialised assessment of hearing defect coupled with intelligence estimation will be invaluable if they can be arranged in our territory.

(11) *Disciplinary mis-management.* A boy of 4, the 3rd of 5 children was referred by the Family Doctor as the worst case of behaviour he had encountered. When admitted to hospital for observation his reactions and behaviour were both friendly and intelligent. Both parents gave evidence of being bad disciplinarians.

(12) *Child Guidance.* Apart from numerous cases for which we are indebted to Dr. M. M. MacTaggart, minor problems arise every week; in some the sullenness or obstinacy of the parents prevent readjustment. One normal school girl age 12 with multiple aches and pains and poor stance was found to have a father who publicly ridiculed the notion of wasting time on secondary education. Several problem cases have arisen in broken homes or where father is away in the Services.

(13) *Heart Murmurs.* Repression of normal activity in school children is more often due to heart signs than any other single cause. One boy age 7 had been recommended on Form 4 H.P. for a residential school for "Rheumatic Carditis," without having been referred to any Consultant; he proved to have an innocent murmur. Another very striking rough, innocent murmur in a healthy school leaver age 15, was picked out by the Divisional Medical Officer and promptly confirmed as Innocent by Professor Wayne at Sheffield Royal Infirmary. Our indebtedness to him continues for the invaluable reference and follow-up of selected heart cases.

(14) *Asthma.* Treatment of the whole child is necessary even when there is no associated Eczema. These youngsters often come up with their morale already broken by protracted school absences and by the relative failure of "the little white evergreen tablets, Doctor." Parents sometimes smother their asthmatic children with unhealthy deprecatory remarks. In other cases we have clues to abnormal tension in the household. Such cases seldom break clear with physical treatment. On the other hand we have had many encouraging results with remedial breathing exercises



coupled with the occasional use of anti-spasmodics such as Neo-Epinine mist inhalations. The fact of knowing that the inhalation will cut short an attack often seems to fortify the child's self-confidence so that attacks do not recur. One old friend, now age 11, returned 2 years after successful recommendations, to report a sharp attack of "monkey-nut asthma" one night after consuming a bag full of these delicacies. He was already aware of multiple food sensitivity including chocolate.

(15) *Diabetes scares.* A few cases were referred again this year in which Diabetes was disproved; probably stale chemical reagents had been to blame. No new cases of juvenile diabetes were found during the year.

(16) *Fanconi's Syndrome.* A 6 year old diminutive school boy was referred to a Divisional Paediatric Clinic for severe Rickets with curvature of legs and gross albumin in the urine. He was found to have a brother age 14 who had never attended school owing to rickety deformity and ill-health and inability to walk. Both brothers were admitted by Professor Illingworth for investigation and were found to be suffering from this very rare condition with perverted amino-acid metabolism. Their cases are to be the subject of a forthcoming paper from Professor Illingworth's Department. The elder brother illustrates how the condition could be lost to notice for years under the stress of war time.

### The Delicate Child

(by Dr. C. C. Harvey, Child Health Officer)

A delicate child is one who cannot sustain the circumstances of ordinary school education without risk of breakdown. His condition, therefore, necessitates an exceptional degree of vigilant medical supervision and some form of adaptation of the educational curriculum, commonly the prescription of a special school, either day or residential. The administrative problems facing the doctor include the following:—(a) There are insufficient places in residential schools, to meet the number of recommendations now being made; with the result that selection becomes an anxious problem, and much anxiety and possible hardship may result for those who cannot be placed. (b) In a rural area with scattered population, it is extremely difficult to operate Open Air Day Schools profitably. The situation is different in compact urban communities. The problem of our Open Air Day Schools is that within reasonable travelling distance of any point, we cannot collect sufficient children needing open air education to justify a school large enough to compete educationally with the ordinary school; and hence the education becomes strained with too few teachers covering too wide an age group. (c) If we should misjudge the needs of any child at the age of 9 and commit him to a break in his normal school curriculum, with perhaps some slowing down of the tempo of teaching at a special school, we may prejudice his prospects of securing a scholarship and thus hamper his subsequent career.

Although in my position I have not always access to the full circumstances upon which recommendations are based, yet I have the advantage of seeing the problem from both the central administrative end and also from the local angle of the family and school. Review of cases at special schools and also cases proposed for special schools over the past 3 years leads me to tabulate the following pit-falls in diagnosis and assessment of cases:

(1) Healthy under-size, in which a child is considerably below the average in physique, but this can be explained by prematurity at birth or by considering the diminutive physique of one or both parents.

(2) Healthy, sallow, brunette complexion which is too readily diagnosed as "anaemia" without the precaution of a haemoglobin check. Such children are the despair of their parents and subject to comment by neighbours, yet prove in all respects healthy. It needs merely to be pointed out often that Mother and Father display the identical complexion.

(3) Healthy, normal cycle of energy and exhaustion in which the ordinary child is unfavourably contrasted with excessively bouncy brothers and sisters. It is natural for many children to wilt quite suddenly towards bedtime, but parents are continually making the mistake of thinking this abnormal.

(4) There is the related problem of children exhausted by mismanagement of the sleep routine of the family, youngsters being kept awake by noisy radio programmes and activities of others. The apathy and weariness of these children does not betoken delicateness of constitution, though I agree that if the family cannot be brought to mend its ways, the child may need the respite of removal for a period.

(5) The food-forcing syndrome (maungy diathesis), in which the persistent complaints of the parents about appetite bring unfair pressure to bear upon medical advisers. It is often possible to disprove the suggestion of abnormality by considering the normal physique and nutrition of the child.

(6) Simple recurring faints are seldom a pointer to ill-health, debility or anaemia. They occur in physically robust children and only rarely require more than explanation or reassurance.



(7) Nasal obstruction I find to be commonly overlooked in recommendations for special education. It causes wastage of energy through restless sleep, lassitude by day through the sub-conscious continued strain of mouth breathing, and impaired zest for food with obstinate slowness in eating (again through the need to respire while chewing). I emphasise this factor because so often it is readily curable by surgical treatment of nasal sinuses or adenoids, or by suitable local medication such as Ephedrine in Saline nose drops.

(8) Asthma and bronchitis. This group forms a very large proportion of the children at special schools. Most of the cases which I have reviewed seem not to have had a full trial of the resources available, to keep them fit at home. Amongst these resources I specially refer to skilled remedial breathing exercises which have often given a child confidence that he can overcome expiratory spasm at the outset of an attack. Many children also have only had inadequate trial of anti-histamine drugs and have become disheartened after experiencing side effects with one preparation. We have had considerable encouragement with Neo-Epine mist inhalations not only in school children but also in babies. The clearance of allergic nose obstruction by Ephedrine drops can also be of crucial value.

(9) Emotional wear and tear. Recommendations upon Form 4 H.P. commonly refer only to general debility when in fact the condition is an emotional one which could be prevented if given the understanding and goodwill of the parents. (I appreciate that where this is lacking we may be forced to recommend a special school—but frankly not upon medical grounds). Within this group the following factors have commonly arisen:—

- (a) Educational sub-normality overlooked—in effect being the reason for an apathetic hang-dog expression and faulty stance, together with emotional upsets due to failure to keep up with other children in school. We still have too many such children blocking vacancies in special schools.
- (b) Noisy conflict in the home between parents, shatters the child's sense of security.
- (c) Worry over loss of one parent through death or separation, without adequate explanation.
- (d) Lack of parental interest, e.g., father self-absorbed and will not give time to his growing boys.
- (e) The odium of foolish parental gossip in front of the children, e.g., referring mistakenly to one child as the "weakling" or as the "drooping flower" of the family.
- (f) Illegitimacy seemed in one recent case at Ingleborough Hall to be the only significant abnormality: this acts in various ways, sometimes through a sense of doubt or shame, sometimes merely because the child is in the care of a failing grandmother.

(10) School absenteeism through non-medical reasons seems occasionally to have brought pressure to bear upon doctors to give medical cover to procedure for getting the child away from home.

My misgiving about our approach to the "delicate child" is that the attitude is not so much preventive as defeatist in some senses. It is very easy to label a problem child as delicate; but to do so may brand him for years, and form in him an attitude of "delicateness" which is positively harmful. I would rather that we should always commence by asking "What is it this child needs to make him fit to carry on in his ordinary school?" Thus he may need a haemoglobin check followed by a course of iron. He may need X-Ray of nasal sinuses and appropriate surgical or medical treatment. He may need a recasting of the family discipline regarding sleep and fresh air. His mother may need to cease discouraging him with odious comparisons. He may need the awakening of a father's interest and pride in him. He may merely need the recognition that he is in fact a normal, healthy, lightweight or dark-complexioned type.

Most often "delicateness" which is subjective in the mind of an anxious parent, needs patiently to be reasoned away with careful clinical examination and reassurance.

Discussions at Divisional Offices sometimes end with the formula, "Taking everything into consideration, I still think he ought to go away." This may often be the case but it would be in the child's interest for the real underlying indications to be studied rather than that he be submitted to the indignity of being branded as unhealthy, when in fact he is merely unlucky.

I look forward to sharing actively with Divisional Medical Officers and Assistant County Medical Officers in South Yorkshire, e.g., in seeing children soon after return home from Residential Schools, and also for consultation over any problems they may care to refer before going away. I would, however, emphatically prefer that this be voluntary, without any suggestion that a Paediatric consultation is an essential part of the procedure. In those Divisions where the Assistant County Medical Officers regularly attend and join in the monthly Paediatric Clinic, problems of this sort naturally are discussed at the outset.



## PART VI

## COUNTY DENTAL SERVICE

## Introduction

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

The hope that is said to spring eternal in the human breast is deferred once more so far as the dental service of the West Riding is concerned. The difficulties under which we are working in the matter of staff have not been lightened and although we have held our own, we have not been able to make any progress.

The following figures provide an interesting illustration of dental history during the past seven years. Between 1944 and 1950 the number of sessions of work have fluctuated as follows :— 5954, 7526, 11937, 14212, 18015, 13882, 11843. For the purposes of comparison we have taken as our index the number of sessions devoted to inspection and treatment which gives a more satisfactory and realistic representation of the amount of work being done than does the number of dental officers employed in any one year because the latter figure takes no account of the time of the year at which an officer may commence or terminate his services. The gradual increases from 1944 to 1948 were created by the return of officers from War Service and a certain amount of new recruitment. Then in the midst of 1948 came the lure of private practice under the National Health Scheme and with it disaster to the priority classes which has shown itself in the marked drop in 1949—50.

It was your policy during the war and it has since been reaffirmed that whatever the reduction in staff, no attempt should be made to attenuate and spread the dental service over larger and larger areas which it could not manage at all adequately. This is a wise policy but as it causes some degree of hardship in certain cases it may be well to examine and explain the philosophic foundations upon which it rests.

It has always been an ideal of dentistry for children that the preservation of the permanent teeth should be the main object of its efforts. This has been stressed year after year with almost monotonous regularity in the Reports on the Health of the School Child published by the Board and later the Ministry of Education. If the conservation of children's teeth is to be carried out with any degree of success, certain conditions must be observed :—(1) The teeth must be examined for defects as early as possible after their eruption, (2) The teeth must be re-examined at frequent intervals, (3) The time between these intervals must not be too long. (Twelve months should be the maximum). It is evident that unless a dental officer has a strictly limited number of children under his control these conditions cannot be observed and the more children he has the more impossible it becomes to provide an efficient or even adequate service for the preservation of the teeth.

With what are we left in the way of an alternative? We can turn our clinics into out-patients departments dealing almost entirely with the relief of pain but by doing this we should lose all the hard won ground we have gained during the past half century by our endeavours to educate the general public in the benefits of the preservation of the teeth. If I may be forgiven a personal note, I have been engaged in this work for over thirty years. I have seen the great progress that has been made and I should be very loathe to see it disappear. One dental officer can care for the dental needs of between 2,000 and 3,000 children according to the type of area in which he is working and his individual speed.

If we "spread" our existing staff it would mean that each dental officer would have over 7,000 children under his care. This would manifestly be a direct negation of all our ideals. What we have done is to maintain most of our officers in manageable areas, though far removed from our ideals (an average of one dental officer to 4,000 children) and tried to make some provision for the relief of pain in areas where no routine treatment was being done. We have not been entirely successful in our efforts in this latter direction largely due to geographical difficulties and the absence of any suitable centres to which the children could be drawn, but we can claim roughly that 130,000 children are receiving routine examination and treatment, 67,000 have emergency treatment available within a relatively short distance and 22,000 are outside the scheme. More than this we cannot do.

The amount of emergency work is gradually growing in the areas where routine treatment is not available and is, of course, eating into the time of the officers which would be more profitably employed on routine inspection and treatment, but the hope to which I referred in my opening paragraph stimulates one to think that some way will be found out of that difficulty before it becomes unmanageable.

**The Dental Treatment of Expectant and Nursing Mothers and Pre-School Children—**  
No spectacular developments have been made in this service during the year under review. We have not yet been able to organize a routine service for pre-school children. The following table indicates the work which has been carried out for expectant and nursing mothers by your own dental officers and private practitioners under the County Scheme :—



	County Dental Officers.	Private Practitioners.	Total.
No. of cases examined ... ..	950	605	1550
No. found to require treatment ...	792	577	1369
No. treated ... ..	642	289	931
No. made dentally fit ... ..	580	251	831
No. of extractions ... ..	3987	2020	6007
No. of teeth conserved ... ..	951	528	1479
No. of Local Anaesthetics ... ..	222	168	390
No. of General Anaesthetics ... ..	442	133	575
No. of Scalings ... ..	375	226	601
No. of dentures. { Complete ... ..	315	121	436
Partial ... ..	162	208	370

**Establishment of Dental Clinics**—A new dental clinic has been opened at Goole and we have been fortunate enough to be able to staff it. It is a well appointed clinic of which we may be proud with facilities for the performance of all branches of dentistry. It will serve a very useful purpose in the eastern part of the County.

**Orthodontic Scheme**—The orthodontic scheme continues to flourish and is extremely popular. We have made provision for the performance of this work at Keighley and the scheme there is developing rapidly. There is an increasing appreciation of this service from private medical and dental practitioners, and from Ear, Nose and Throat Surgeons who are realizing the Specialist qualities of the service we are offering. I have had the privilege of demonstrating to the British Society for the Study of Orthodontics some of the work we are doing, and Miss Sclare has been asked to give a similar demonstration at the Annual Meeting of the British Dental Association in London in 1951. During the year 9,388 attendances were made by orthodontic patients and 317 fixed and 733 removable appliances were fitted. As Orthodontic Consultant to the Dental Service of the City of Wakefield we have taken on 16 new cases during the year.

**The Work of the Dental Laboratory**—The following table shows the work carried out in the Dental Laboratory and the considerable increase on last year's figures:—

	Full Dentures	Partial Dentures	Repairs	Appliances Orthodontic	Crowns, Inlays, etc.
1949 ... ..	250	408	57	881	176
1950 ... ..	315	447	58	1,050	113

**Analysis of the Work carried out during the Year**—The information concerning dental treatment provided for in Table V of the Ministry of Education's returns (see Page 53), gives a very limited picture of the actual work done and the following implementations and refinements to the Table may be of interest. **Extractions**:—The total of 52,418 temporary teeth and 8,451 permanent teeth extracted does not represent as might be thought so many teeth which it has been found impossible to save. No less than 8,134 temporary teeth and 2,367 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. Nearly 1 tooth in 6 is extracted with the object of preventing irregularity and ensuring the satisfactory future of the dentition. **Fillings**:—2,622 temporary teeth were conserved by the following means:—1,009 cement fillings, 674 amalgam fillings, 1,221 combined cement and amalgam fillings. 20,119 first permanent molars and 11,106 other teeth; a total of 31,225 permanent teeth were conserved by the following means:— 1,090 cement fillings, 12,025 amalgam fillings, 18,759 combined cement and amalgam fillings, 3,977 silicate (porcelain) fillings. Other treatments of a varied nature include 173 root fillings, 2,962 dressings, 150 crowns, inlays, etc., 5,292 scalings and gum treatments. Dentures were provided in 285 cases to replace teeth lost by accident or disease, 669 attendances being made for the necessary work incurred in the fitting of these dentures.

Once more I must express most sincerely my gratitude to my staff for their loyalty and support; to the Dental Services Committee for their patience and understanding and to Dr. Brockington and other medical colleagues for their willing and helpful co-operation in all matters. This team spirit is a great sustaining factor in these difficult times.



## PART VII

## CARE AND AFTER-CARE

## Care and After-Care of the Hospital Patient

Somewhat tardily we have come to recognise that treatment in hospitals is only half the battle. In the tranquil days before 1946 a hospital was a monastic institution; patients entered its portals into another world to find that there was little concern with what they did outside or how they lived; and when their belongings were once more in their suitcases they said good-bye to the other patients and the staff, returned to the outside world and were generally forgotten by the hospital. 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, was often wasted for want of proper application; but that seemed to have little importance so long as the cost of hospitals was largely borne by voluntary subscriptions.

The year 1946 did, of course, many drastic things to medicine, some of which we have already studied. One of the less well understood side effects of the upheaval has been the altered emphasis upon the importance of social work both in hospitals and outside. Public health will, in fact, experience no greater advance than that which can come from the development of "care and after-care" as an expression mainly of Section 28 of the National Health Service Act, 1946. This section said:—"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, the care of persons suffering from illness or mental defectiveness, or the after-care of such persons, but no such arrangements shall provide for the payment of money to such persons, except in so far as they may provide for the remuneration of such persons engaged in suitable work in accordance with the arrangements." The object is speedy and effective rehabilitation as one of the principle aims of public health. This new branch of the Medical Officer of Health's work is not primarily concerned with treatment but in the solution of socio-medical problems; his interest lies in furnishing the doctor and the hospital with good background reports and in solving difficulties and making adjustments in the patient's life without which there can be no complete response to treatment.

In devising machinery to meet this work the first essential has been to establish convenient methods of transmitting confidential information from hospitals to health departments. An unobtrusive start was made with this under the Education Act, 1944, when, in return for payment for free treatment of children, hospitals agreed to pass on information about admissions and discharges with a confidential report. The experience gained under the Education Act was invaluable to later developments. School health records were seen to be more complete in essential details and the school medical officer for the first time was able to follow up school children and relate hospital findings to the school and the home and eventually was better able to advise on juvenile employment when the time came for the child to leave school and enter industry. Somewhat oddly this first tentative excursion on the ice, like that of Mr. Winkle, if not very spectacular, yet had no ill-effects; it was only when Mr. Pickwick arrived on the scene in the guise of the National Health Service Act that the ice gave way. Nothing, indeed, so far experienced under the new machinery has been so difficult to overcome as the reluctance of the medical profession to operate any scheme which entails the transfer of information to the Medical Officer of Health. This, mistakenly regarded as a breach of confidence, has been only reluctantly and partially accepted following Circular R.H.B.(50)22, which said:—

"It is generally agreed that the family doctor should have early information of the discharge of a patient from Hospital and should make arrangements with the Local Health Authority for services such as home nursing, domestic help, etc. There are, however, cases where direct information including any necessary medical details, should pass from the hospital to the Local Health Authority, in order to avoid a break in the services provided, e.g., in the provision of special nursing requisites for paraplegics, or more simply to arrange for immediate home nursing attention or domestic help. Such arrangements should, of course, only be made with the patient's agreement and the family doctor should be informed that arrangements have been made direct with the Local Health Authority. A form agreed regionally for transmission of this information would be useful."

At first hospital specialists and general practitioners opposed any transfer of information; more recently the opposition has mainly been from the family doctor, who looks upon it as an interference with the doctor-patient relationship. No doubt this opposition will slowly disappear as the benefit to all parties is better understood but the extent of the opposition can be gauged by the recently expressed views of the Leeds Division of the British Medical Association, as follows:—

"The proper procedure should be that the Hospital should report direct to the general practitioner only and he should be responsible for requesting the Local Authority to provide "after-care" where necessary. In exceptional cases where delay might be injurious to the patient, the Hospital might request the Local Health Authority to provide services, informing the general practitioner that this had been done. The strongest objection should be offered to the proposal that Hospital Authority should send reports of cases discharged, to the Medical Officer of Health or School Medical Officer. The Committee considered that the disclosure of details, including the diagnosis of any patient to anyone but the patient's own doctor, was a breach of professional ethics."



With these views before them the West Riding Executive Council decided on the 5th April, 1951, to send the following resolution to Leeds Regional Hospital Board:—

"That this Committee concur in the views of the Leeds Branch of the British Medical Association and the West Riding Local Medical Committee, and that the Leeds Regional Hospital Board be informed accordingly."

Yet much progress has been made in different parts of the County of which the following is a brief account:—

Hospitals throughout the County are increasingly operating Circular (50)22 by informing the Divisional Medical Officer of instances where after-care is considered necessary. Such transfer of information is now much more complete for the premature and weakly baby and for the school child (under arrangements begun following the Education Act, 1944); it is still however only at a beginning for other classes; even for the premature baby the working can be still further improved as shown by the scheme at Leeds (see below). The general arrangements lack precision and definition; it is possible to carry out the work much more fully by detailed arrangements as outlined in my report last year. The work which began at Otley and Mexborough (incorporating the attachment of a Health Visitor at the Hospital) has now been much extended and is working at the following Hospitals (five Management Committees—Doncaster, Harrogate and Ripon, Ilkley and Otley, Pontefract and Castleford, Rotherham and Mexborough—and a teaching Hospital are involved):—

General Hospital, Otley ... ..	Miss Bell
Montagu Hospital, Mexborough ... ..	Miss Bailey
Hallamshire Maternity Home, Ecclesfield ... ..	Miss Rimmer
Listerdale Maternity Home, Wickersley ... ..	Miss Stockwell
Rosehill Hospital, Rawmarsh ... ..	Miss Stockwell
Rotherham Hospital, Doncaster Gate, Rotherham ... ..	Miss Stockwell
Rotherham, Badsley Moor Lane Hospital, Rotherham ... ..	Miss Stockwell
Rotherham General Hospital, Moorgate, Rotherham ... ..	Miss Stockwell
Swallownest Hospital, near Rotherham ... ..	Miss Stockwell
General Infirmary, Pontefract ... ..	Mrs. Schofield
Northgate Lodge, Pontefract ... ..	Mrs. Schofield
The Hospital, Knaresborough ... ..	Miss Smith
Four Gables Maternity Home, Horsforth ... ..	Miss Griffin
Western Hospital, Doncaster ... ..	Miss Humphries
Fullerton Hospital, Denaby Main ... ..	Miss Stowe
The Maternity Hospital, Leeds ... ..	Miss Carey

Arrangements at Otley (despite the resignation of the Medical Superintendent, Dr. J. Norman Hill, to whom the early success of our scheme was largely due) have continued most satisfactorily. Miss Bell replaced Mrs. Wilde in July, 1950. During the year the hospital health visitor had 91 sessions at the hospital and paid 52 additional visits, as a result of which she was able to arrange for the after-care:—midwife (4), home nurse (6), health visitor (343), nursing equipment (12), home help (15), rehabilitation (6), convalescence (34), transfers to other hospitals (20), accommodation in moral welfare homes (4). Many social problems were dealt with involving European Voluntary Workers, reference to Assistance Board, housing, etc. Home visits (68), environmental investigations (28) and follow-up visits were undertaken.

The work at Mexborough has continued in full swing during the year, this was extended (as indicated last year) to all the remaining Hospitals in the Rotherham and Mexborough Hospital Management Committee area. It is impossible to give details of all this but the following summary records the work for the two main Rotherham General Hospitals together and for the Mexborough Hospital:—The work at Rotherham involved Miss Stockwell in 276 sessions at, and 35 additional visits to, the two hospitals. Arrangements for after-care included assistance by:—midwife (14), home nurse (50), health visitor (511), home help (63), rehabilitation (7), convalescence (7), transfer to other hospitals (3). Home visits (132), and environmental investigations (572), were undertaken. At Mexborough Miss Bailey attended 111 sessions at the Hospital. After-care included assistance by:—midwife (3), home nurse (51), health visitor (118), home help (25), rehabilitation (4), convalescence (7), Assistance Board (4). Home visits (101) and environmental investigations (14) were undertaken.

In September, 1950, we received a request from the Doncaster Hospital Management Committee to inaugurate a scheme similar to that in operation for the Rotherham and Mexborough Hospitals including the admission, discharge and social background reports. This scheme included the provision of a Health Visitor for visiting the Western Hospital (former Springfield), Doncaster and operated for only four months in 1950. In the intervening period before the end of the year the hospital health visitor spent 29 sessions at, and paid 3 additional visits to, the hospital. The after-care arrangements included assistance—by midwife (34), home nurse (24), health visitor (10), home help (21). Environmental investigations were undertaken in 134 cases.

A Health Visitor has been attached to the General Infirmary and the Northgate Lodge, both at Pontefract, under the control of the Pontefract and Castleford Hospital Management Committee. She works in close co-operation with a Hospital Welfare Officer (recently appointed for the Hospitals in the Management Committee area). The year's work involved 234 visits to the hospital and the after-care work included assistance by—midwife (1), home nurse (5), health visitor (7), home help (5), convalescence (2). Home visits (191), and follow-up visits (9) were undertaken.



Although this work has been undertaken for such a short time it is already clear that the best results are obtained where there is a definite scheme for transfer of information and particularly if there is a link created by the attachment of a Health Visitor to the Hospital. The following details record in total the work undertaken at Hospitals where such formal arrangements exist:—

Sessions spent in Hospitals 552. Additional visits to Hospitals 400. Patients assisted by midwives 25. Home nurses 170. Health visitors 1,101. Nursing equipment provided for 14 cases. Home help arranged for 152 cases. Rehabilitation arranged for 19 cases, referred to Convalescent Homes 51. Home for Chronic Sick 14. Other Hospitals 45. Residential Nursery 1. Child Guidance 1. Housing 15. Home visits by Liaison Officers 619. Environmental investigations undertaken 855. In contrast the following details record the hospital after-care undertaken throughout the whole of the remaining area of the County where no definite scheme is in operation:—Assisted by midwives 18. Assisted by home nurses 230. Assisted by health visitor 209. Nursing equipment provided 30. Home help arranged 19. Home visits by liaison officers 2. Environmental investigations undertaken 13. Referred to convalescent homes 3. A comparison will readily show that the care and after-care of the hospital patient is implemented far more effectively when the Local Health Department has been brought in as an effective partner.

A new venture took place during 1950 in the "after-care of premature babies." This was designed to improve the link between our domiciliary services and the Leeds Maternity Hospital. By agreement with Professor Craig, Miss Carey was detailed to act as Hospital Health Visitor at the Leeds Maternity Hospital. She thus became the link between the Hospital and the Health Visiting staff in the West Riding for most of whom it was impracticable to travel to Leeds owing to the wide area from which patients are drawn. The link with the General Practitioner is provided from the Hospital and the local Health Visitor. A feature of the scheme is the personal arrangement between Miss Carey and Dr. Kitching, Professor Craig's Paediatric Registrar, which allows Miss Carey to visit whenever necessary and at regular intervals to discuss individual cases. Miss Carey has visited the homes herself whenever possible particularly to study the relationship between the midwives, health visitor and family. There has only been one misunderstanding with a general practitioner; indeed the relationship has been strengthened in most cases and the general practitioners consult with the health visitor over progress of premature infants. Since the scheme started in May, 1950, until the end of the year there were 36 babies discharged and in each case after-care was requested. There were 32 from Leeds Maternity Hospital, 3 from Leeds General Infirmary and 1 from St. James' Hospital, Leeds. The babies discharged from Leeds General Infirmary, and St. James' Hospital were born at home and admitted for treatment a few days after birth. Of the 32 babies discharged from Leeds Maternity Hospital 16 were fully breast fed, 11 part breast and 5 artificially fed. At the end of the year one baby had died, all the others were thriving. The follow-up visits were paid daily by the health visitor where necessary. Miss Carey felt that the continuance of breast feeding was disappointing. In the follow-up reports filled in by the health visitors for Professor Craig it was found that of the 16 breast fed babies discharged only 4 continued for 3 months and 2 for 4 months. This scheme has increased the supervision and the care of the premature baby for the area surrounding the Leeds Maternity Hospital. It is an advance on the arrangements made for formal notification of discharge which are in operation with varying success with most hospitals having maternity beds. The advantage lies in the personal contact which the hospital health visitor provides. The Leeds Maternity Hospital scheme is of course on all fours, so far as it concerns babies, with the arrangements operating in defined schemes described above. It is obvious that we must try to extend the arrangements to all Maternity Hospitals and Homes.

The social work in relation to hospital care of the chronic sick is a valuable new branch of our work; it is everywhere beginning to assume greater importance. In most divisions and in relation to many hospitals, arrangements of different kinds are coming into operation to meet the local needs. The following two kinds of well developed schemes are again an illustration. 1. The Scheme whereby a health visitor has acted as a liaison with the Knaresborough Hospital (former Institution) has grown tremendously during the past year. Miss D. T. Smith, health visitor, who has been in charge of the work from the beginning has dealt during 1950 with 237 cases notified for admission, 482 domiciliary visits, 171 cases admitted to Knaresborough Hospital, 15 cases admitted to other Homes, 126 cases discharged to their own homes or placed in charge of relatives, 15 cases provided with home helps, 30 cases attended by home nurses, 10 cases referred to welfare officer, 15 cases referred to health visitor on discharge, 2 cases admitted to convalescent home, 6 cases that died before admission and 25 cases who refused admission. In her report for the year Miss Smith says:—"Having undertaken this work over a period of many months and having a clear picture of the sordid conditions in which a large percentage of the old people are living, I cannot help but feel it is a great tragedy that there are not more beds available for this type of patient. Many of the relatives who are caring for aged members of their family are unable to give the attention that will satisfactorily ameliorate the condition of the patient and at the same time are undermining their own health. Obviously in the circumstances the more urgent cases have to have priority in being admitted into hospital. Owing to difficulty of obtaining accommodation for these aged sick, several have died before suitable care could be found for them. The success in the development of this scheme has led to the occasional attempt to bring the care of mental defectives into Knaresborough Hospital for which, of course, it is quite unfitted. The experience which has so far been obtained shows without doubt the urgent need there has been for a service of the type under review. The success that has attended this scheme even in its initial stages and with somewhat inadequate accommodation available goes to show the very beneficial results we may hope to achieve with more experience and extended facilities." Dr. Payne, Divisional Medical Officer,



sent in the following report on the details of work done by Miss Smith:—"The work naturally divides itself into two main sections, those cases for whom admission to Knaresborough Hospital is requested, and those cases who are medically fit for discharge from the Hospital and for whom reports on the home care available are required. Knaresborough Hospital has 66 female and 46 male beds. Since January 1st, to the 31st December, 1950, 237 applications of patients for admission were dealt with by Miss Smith. These applications were in the main from general practitioners. Owing to the limited number of beds at Knaresborough Hospital and, in fact, the shortage throughout the country, it is essential that such applications be carefully considered and investigated in order to determine the priority of admission and also to determine whether other arrangements, such as the utilisation of the various social services, may obviate the necessity of admitting certain cases to the Hospital. Miss Smith has a great advantage as an experienced health visitor and having a detailed knowledge of the available Local Authority's services and, as will be seen from her statistical report enclosed, only 171 cases were admitted. In some cases, alternative accommodation was found for those applicants with relatives, in some cases patients were admitted to Nursing Homes or have been looked after at home through the Home Help or Home Nursing Services. By this careful investigation and selection, it has been found possible to reduce the waiting list for admission to a minimum; at the end of the year, there was no waiting list for the admission of male patients and there was a waiting list of only three women patients. During the year 1950, 126 patients were discharged to their homes or were placed in the care of relatives, and there were 102 deaths in Knaresborough Hospital. This, I feel, is a satisfactory state of affairs, I consider I am right in stating that in most Chronic Hospitals there has been a considerable predominance of deaths over discharges. This was certainly the case at the Chronic Sick Hospital at Skipton, where the number of deaths considerably exceeded the number of discharges. I feel that this satisfactory result has been largely due to the arrangements that Miss Smith has made with relatives to care for these old people on discharge to their homes and also, of course, to the provision of home helps and home nursing, etc. Close liaison has also to be maintained with the Welfare Department and a number of cases have been transferred to Part III Accommodation. It has also been found possible to give good warning to the relatives of the patients in hospital, prior to the discharge of the patients to their homes. The consultant, Dr. Curtis Bain, has been very pleased with the scheme and has come to rely very much on the social reports of Miss Smith, and to consider with her the suitability of varied cases before discharge, bearing in mind the care they are likely to obtain in their own homes. Dr. Curtis Bain has emphasized from time to time, the desirability of one health visitor undertaking this work who is in a position to assess priority of admission of cases to the Hospital, a personal knowledge of the cases by one social worker with whom he can discuss the social circumstances prior to their discharge. One of the obvious difficulties that has arisen, is that many of these cases are somewhat urgent when they arise, the doctors who wish the cases to be admitted, not infrequently, do not finish their rounds until the later afternoon and evening, thus Miss Smith receives telephone calls at her own home during the evenings and at the week-ends on Saturdays and Sundays."

2. A scheme on somewhat different lines has been started in Division 19 and Dr. Lyons, Divisional Medical Officer for Todmorden gives the following brief account of the first year's work:—"The Medical Officer of Health has no longer any statutory responsibility in relation to the hospitalisation of the aged and infirm. Yet it is to the Medical Officer of Health that members of the public, voluntary bodies, general practitioners, clergymen and others still turn when difficulty is experienced in the admission of such cases to hospital. Following upon enquiries into these cases one found that the Hospitals Admission Officer rarely knows enough of the social circumstances of the patients to be able to make an accurate, or uniform, assessment of the degree of priority required. It was inevitable, therefore, that less urgent cases were at times selected for admission when very urgent cases were still waiting. It was also observed that there was insufficient appreciation of the fact that where the aged are concerned, social factors are more important than strictly medical considerations in determining urgency of admission. Most of the medical conditions for which old people are hospitalised can be treated at least as effectively in the home. What in fact determines the need for and urgency of admission is, in most cases, the *practicability* of domiciliary treatment in the individual cases. This in turn depends on the conditions in the home and the availability of medical, nursing and domestic assistance. In some cases hospitalisation can be entirely disposed of by the combined efforts of general practitioner, home nurse and home help to the advantage of patient, hospital and tax payer alike. With a view to (a) assisting general practitioners in securing admission for the more urgent cases (b) assisting the hospital authority in making the best use of their limited accommodation and (c) ascertaining those cases which could be dealt with through County services (e.g., Home Nursing, Home Helps, etc.) a scheme was agreed upon whereby a background report was to be completed in respect of each patient resident in this Division whose name appeared on the waiting list for admission to the chronic sick wards. This scheme was put into operation early in 1950. Detailed written reports on uniform lines and supplemented in most cases by a verbal report were completed by the health visitors in respect of each patient referred to them by the Divisional Medical Officer. Consideration was then given to each report by the Divisional Medical Officer and an assessment made on the degree of urgency on social grounds. The written reports, endorsed with the Divisional Medical Officer's personal assessment, were forwarded to the Hospitals Admission Officer. The advisability, in the interests of uniformity, of using one Divisional Health Visitor only for the completion of background reports has been seriously considered. It was felt, however, that this was impracticable for the following reasons:—(a) The geographical nature of Division 19 is such that one Health Visitor covering the entire area would have to spend an inordinate amount of time in travelling—an important consideration when one is short of staff. (b) A Divisional "Investigator" would often not be as intimately acquainted with the patient's social circumstances as



the district health visitor. (c) Reasonable uniformity is assured by the fact that it is the Divisional Medical Officer personally who makes the final assessment in every case, this assessment being based on information received from health visitors (written and oral), general practitioners, and others. (d) The fact that every Health Visitor is given an opportunity of doing this work gives her an added interest and incentive in her duties in relation to the aged. One or two of the older health visitors had previously shown little or no initiative in this aspect of their work. Their duties in the scheme have stimulated them enormously. The effectiveness of the scheme may be judged from the following statistical summary for 1950:—98 background reports were obtained upon which I gave the following assessment—"not urgent on social grounds" 23, "fairly urgent" 22, "urgent" 53; 37 patients were admitted to hospital all of whom were in the category "urgent" and none were admitted when the assessment on social grounds was "fairly urgent" or "not urgent"; average waiting period for those admitted one month; number awaiting admission at end of year 39; number who died before admission 28 (16 "urgent," 9 "fairly urgent" and 3 "not urgent"); a home nurse and/or home help was in attendance on 35 of the 98 patients under consideration. The following conclusions may reasonably be deducted from these statistics:—1. Hospital accommodation for the aged and infirm in this Division is such that only three out of five urgent cases can be admitted within one month. Fairly urgent cases on the waiting list have virtually no hope of admission until their circumstances deteriorate still further. 2. All of the 31 cases admitted in 1950 had been classified as "urgent." This implies that the limited accommodation available is now being utilised more effectively. 3. The difficulties of the waiting period can in a considerable number of cases be alleviated by the fullest possible use of County Council domiciliary services. 4. In some cases hospitalisation is avoided altogether by the use of domiciliary services. Since the inception of the scheme the relationship between the Halifax Hospitals Admission Officer and this Department has been most cordial and co-operative. The Admission Officer is grateful for the assistance given whilst we on our part are glad to have taken the initiative in improving the co-ordination of the three main branches of the National Health Service in this limited field."

### Tuberculosis

Effective measures for the care and after care of the tuberculous patient depend largely on intimate co-operation between the chest clinic and the health department. One major impediment lies in our inability to arrive at any satisfactory agreement for the joint services of the chest physicians, to which reference is made elsewhere in this report. In this situation it is of the utmost importance that a link should be forged through the public health nurse who attends the chest clinic and is the channel of information from that centre to the health department. Formerly it was the practice of the County Council to favour the employment of whole time tuberculosis visitors, wherever practicable, combining clinical duties with domiciliary visiting. The considerations determining such a choice have become largely invalid with the departure of the tuberculosis officers from the County service, combined with the tendency of the Hospital Management Committees to appoint "ad hoc" clinic nurses. It has been decided, therefore, that while present conditions continue further tuberculosis visitors will not be appointed; the work of the local health authority, combined with limited assistance at the chest clinics, being undertaken to an increasing extent by the health visitors of the area.

There is much less caution in recommending issues of extra nourishment (two pints of milk daily), to active cases of tuberculosis and 1,367 received such grants during the year; the limited number of domiciliary open air shelters continue to be used to relieve sleeping accommodation in the homes; beds and bedding are provided for use both in the shelters and in the homes to enable infectious patients to sleep alone; we continue to make use of the institutional training and resettlement establishments for rehabilitative purposes; recourse is made to the West Riding Distress Fund for special grants—for clothing, to pay visitors' travelling expenses, etc.

### Recuperative Homes

518 applications were received, supported by medical certificates, for admission to recuperative homes, generally for periods of two weeks but longer where necessary. In 113 cases (22%) the applications were cancelled, 5 remained on the waiting list at the end of the year and 400 were admitted to—Blackburn and District Convalescent Home, St. Annes-on-Sea; Boarbank Hall, Grange-over-Sands; Brentwood Recuperative Centre, Marple; Children's Convalescent Home, West Kirby; Horncliffe Convalescent Home, Blackpool; Hunstanton Convalescent Home, Norfolk; Men's Convalescent Institution, Rhyl; North Eastern Counties Friendly Society's Convalescent Home, Grange-over-Sands; Ormerod Home, St. Annes-on-Sea; Rechabites Memorial Home, St. Annes-on-Sea; Rockfield Convalescent Home, St. Annes-on-Sea; Sefton Convalescent Home, Birkenhead; Semon Home, Freshfield; Swanscoe House, Macclesfield; Taxal Edge Convalescent Home, Whaley Bridge; The Vicarage, Askham Richard; West Hill Convalescent Home, Southport; Yorkshire Foresters Home, Bridlington.

### Health Visiting

The work of the health visitor has considerably widened during the past year; much additional work has been undertaken in relation to the family as a whole but particularly with regard to the aged and provision of help either by co-operating with voluntary agencies or giving domestic help. More health visitors are linking up with hospital staffs in the care and after care programme for patients discharged from hospitals; this service is greatly appreciated in the areas where it is



working, a separate account is recorded elsewhere. 33,442 visits were paid by health visitors in relation to home helps; 20,602 for the aged; and 2,980 for patients discharged from hospital; giving a total of 63,973 in these new forms of work. The care of the family as a whole in co-operation with the family doctor has been one of the most difficult tasks allotted to the health visitor. This work is developing fast but many general practitioners are still unaware of the help which is now available to them and some are still unaware that a health visitor is a trained nurse with many other qualifications in social medicine. The liaison between general practitioner and health visitor has improved immeasurably during the last year, but there are still large gaps to be filled. One marked difference between the work of a health visitor in 1939 and the present day which arises out of the above lies in the fact that previously the work could be planned to a pattern; home visiting, school medical inspections, clinics, etc; but today the work is more varied and so many calls made upon her time that she cannot plan her programme in the way she would like. This is, however, a small consideration in relation to the excitement, adventure and service which the new work has created.

Staffing problems are still clouding the horizon though there is a gradual improvement. The establishment of public health nurses is 349; health visitors 317; tuberculosis visitors 22; venereal disease social workers 4; orthopaedic nurses 6. The actual staff employed on December 31st, 1950, was—qualified health visitors 208 whole-time (plus 7 part-time); assistant health visitors 50 whole time (plus 15 part-time); tuberculosis visitors 19; venereal disease social workers 4; school nurses 8; home nurses doing part-time health visiting 6, making 289 full-time public health nurses and 28 part-time. The number of qualified health visitors increased from 187 to 208 (students from Leeds University course 27; from other authorities by advertisement, etc., 21; losses 26; retired 5; went abroad 2; to other authorities 8; married 2; went to part-time 2). Of these losses 7 were students from the previous year; (married 1; transferred to other authorities 3; midwifery, Part 2 course 2; senior position in Queen's District Home 1). The number of qualified health visitors is gradually improving; another year the losses should be lessened because the students are under contract for two years' service instead of one year. The establishment of health visitors is made up by the employment of assistant health visitors who are State Registered Nurses with Part I certificates of the Central Midwives Board. They are encouraged to study for the health visitors' examination.

Two Divisional Superintendent Health Visitors were appointed in 1950; Miss Topley to Shipley on 1.10.50, and Miss Corless to Colne Valley on 1.5.50. Miss Topley was promoted from the post of health visitor and Miss Corless came from Twickenham, where she was already employed as a Superintendent Health Visitor. There are now Superintendents in Divisions 4, 5, 8, 20, 28 and 31.

**Week-end Refresher Course—Grantley Hall—**Health visitors attended a successful week-end course at Grantley Hall Adult Education Centre. The subject matter was "Social Medicine" and was effectively dealt with by a team of lecturer from Hull University College—Roger Wilson, M.A., Mrs. Collins, and Miss O'Farrell. Both students and lecturers found they travelled on common ground and the social problems which the social workers dealt with were more often than not the health visitors' problems also. The group discussions were most successful and it was thought that everybody learned more by these than by listening to lecturers. The team left with a feeling they had gained considerable knowledge from the health visitors, this feeling equally reciprocated by the health visitors.

**Post-Graduate Courses—**28 health visitors attended these refresher courses—Women Public Health Officers Association, Oxford, 24th June to 8th July (12); Durham 2nd to 16th September (3); and London 28th December to 11th Jan, 1951, (8); Royal College of Nursing, Leeds, 15th to 29th July (3); London 13th to 27th November (2).

Monthly conferences were arranged for Saturday mornings throughout the year. The lecture programme was as follows: February—National Insurance; Dr. A. Massey, Chief Medical Officer to the Ministry of National Insurance. March—Health Education; Dr. R. Sutherland, Medical Adviser and Secretary, Central Council for Health Education. April—Care of Children Deprived of Parental Control; Mr. R. Stuart, Children's Officer, W.R.C.C. June—Care of Handicapped Children in West Riding County Area; Dr. A. F. Turner, Senior Medical Officer, West Riding County Council. September—The Work of Whitley Council; J. P. Dodds, Esq., Assistant Secretary, Ministry of Health. October—Child Health; Professor W. S. Craig, Department of Paediatrics, Leeds University. November—Early Diagnosis of Cancer; Dr. Nuttall, Chief Radiologist, Leeds General Infirmary and Lecturer for the British Empire Cancer Campaign. The lectures were well attended with an average of 200 health visitors each time.

**Supervisory Staff—**Miss Clarke has continued doing part-time duties with Leeds University in the capacity of Health Visitor Tutor. The training of health visitors entered a new phase with the commencement of a longer training period, that of one academic year replacing the old six months training course. This extension enabled the students to make full use of the facilities offered by the University; they were able to become full members of the Students' Union and so come into contact with other students in the University, thus giving them a wider outlook from that of hospital work which should enrich them for their work in the future. Time for study and lecture, tutorials and informal discussions was extended to three days per week, with two days each week for practice work in the field. Miss O'Brien has been engaged for a good proportion of her time in connection with problem families largely in ascertainment. She feels some measure of frustration to the extent that the cases ascertained are not being followed up by any remedial or rehabilitative measures and this reaction is not uncommon amongst the health visitors in the



area; proposals for further measures of rehabilitation, discussed elsewhere in the report, would go far to remove this. The local action already taken through Miss O'Brien is very encouraging and particularly in those cases where a marked improvement has been demonstrated. The remainder of Miss O'Brien's time has been occupied by surveying the health visiting in five divisions. All the clinics were visited and visits made in the field with 37 health visitors. The work generally was found to be of a high standard and opportunity was found during these visits to give advice and discuss new methods, etc. Miss Carey has for the most part been engaged in forming new contacts with care and after-care, particularly in relation to premature babies (a separate report of the scheme at Leeds Maternity Hospital is given on page 76. The investigation into the care of epileptic patients progressed satisfactorily; a report will be found on page 57. Miss Mitchell, Senior Health Visitor for the Care of the Unmarried Mother and her Child, resigned on April 30th, 1950 (see page 40).

### Home Nursing

Home Nursing has now, after two years, been fully integrated with the Divisional Scheme. The progress of re-organisation has been undertaken as an individual study in each division to give the maximum consideration to local needs. In every case there is now a complete scheme for nursing and relief work based on a divisional unit. There has been a steady growth of appreciation of the new service by general practitioners and the public alike. The decision to separate Home Nursing from Midwifery and Health Visiting has slowly been implemented and is now almost complete. The present staff is 275, 191 (103) on General work; 80 (93) on general and midwifery; 4 (62) on general, midwifery and health visiting. The figures in brackets are those for 1948. There were 668,440 visits to 32,745 patients classified as under:—

#### MEDICAL (22,038)

Acute Abdominal ...	418	Diss. and Art. Sclerosis ...	82	Parkinson's Disease ...	32
Anaemia ...	646	Fractures ...	383	Phlebitis ...	78
Appendicitis ...	35	Gastric and Duodenal Ulcer ...	54	Pneumonia and Pleurisy ...	1,176
Bronchitis and Asthma ...	1,089	General Debility ...	34	Poliomyelitis ...	1
Carcinoma—		Gynaecological ...	1,206	Prolapsed Vert. Disc. ...	11
Breast ...	84	Hernia ...	34	Pyrexia ...	52
Colon and Rectum ...	114	Hypertension ...	90	Rheumatism and Arthritis ...	674
Uterus and Cervix ...	117	Infectious Diseases ...	156	Senility ...	1,563
Other Sites ...	1,013	Influenza ...	205	Shingles ...	34
Cardiac ...	2,165	Intestinal ...	501	Skin Conditions ...	368
Cerebral ...	2,008	Jaundice ...	33	Threadworms ...	377
Cholecystitis ...	46	Kidney and Bladder Cond. ...	317	Tuberculosis ...	216
Constipation ...	1,431	Mental and Nervous Cond. ...	36	X-ray preparation ...	134
Diabetes ...	632	Miscarriage and Abortion ...	24	Miscellaneous ...	4,369

#### SURGICAL (9,449)

Bed Sores ...	21	Gangrene ...	90	Supra Pubic ...	192
Burns and Scalds ...	863	Minor Accidents ...	1,162	Tuberculosis ...	17
Circumcision ...	718	Post Operative ...	1,802	Varicose Veins, Ulcers ...	492
Colotomy ...	172	Septic or Inflam. (Abscesses, Boils, etc.) ...	3,396	Miscellaneous ...	490
Empyema ...	34				

#### EAR, EYE, NOSE AND THROAT CONDITION (1,258)

Eyes ...	151	Ear, nose and throat ...	1,107
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One feature of the service has been the mushroom growth since July 5th, 1948. The case load and consequently the number of visits is much heavier. Little change took place in 1948 itself during early re-adjustment. The number of visits in 1948 was 461,348 in comparison to 604,150 in 1949 and 668,440 in 1950; the case load in 1949 was 29,274 and 32,745 in 1950. Thus for each 100 cases in 1949 there were 112 in 1950; for each 100 visits in 1948 there were 131 in 1949 and 145 in 1950. The visits per case remained stable with an average of 20.4 against 20.6 for 1949. The staff has grown relatively little from an equivalent of 200 in 1948 to 236 in 1950. The average number of visits per nurse is 2838.4 with considerable variation owing to geography and other reasons; this is under constant review. Some of this variation is due to difference in transport arrangements e.g. there are only 70 County cars and 111 privately owned cars in use. In measure as more cars become available the service will improve.

As I mentioned in earlier reports this steady increase in work is due to some extent to the filling of a vacuum, areas of the County not previously served at all have now been covered (see Dr. Leiper's report for Mexborough). Then again the National Health Service Act introduced an entirely new situation in which doctoring and home nursing was made available to all without charge. In this novel situation it was recognised that the doctor would be in a position to practice his work more generously and the nurse would be available to undertake general nursing duties previously either neglected or sometimes done by the doctor himself. This development in the character of home care is particularly important and must have far reaching implications; we cannot in fact suppose that the changes to which it will give rise are more than at a beginning. Any visitor to Mexborough will realise that an increase of 31,000 home visits a year has done little more than touch the fringe of the people's needs. To this we must add the significant fact that many patients still seek attention in hospitals who could be cared for among their own people at home. The Health Authority must be prepared to expand the home nursing service generously and sympathetically to meet this growing need. In time as this vital service comes to fruition we shall see an organisation competing in efficiency and standards with the modern hospital. The present staff in the West Riding is now fully taxed. We have taken up all the slack; a little more, possibly, with more cars, and then the only answer is more home nurses.



To maintain the efficiency of all the work two Supervisors of Home Nurses operate over the County; during 1950 they paid 374 Supervisory Visits, 138 special visits to nurses, and 124 visits to Divisional Medical Officers. Our high standards of nursing is to no small extent due to the untiring efforts and diligence of Miss Jones and Mrs. Taylor; in particular, they have given a great deal of help to newcomers on the areas.

The following three extracts are given in illustration of the progress of work in representative divisions.

Dr. Watt, Division 31, says in his Annual Report for 1950:—

"From the public point of view the biggest improvement in the Divisional Scheme is the new Home Nursing Service. When the County Council took over the Home Nursing, Dinnington, Swallownest and Maltby were without nurses, and in areas where District Nurses were operating the service went upon the principle that if you expect to be attended to you must pay. No attempt was made to deal with districts such as Firbeck, Letwell, Gildingwells, Ulley and Coalbrook Estate, which were inconvenient to reach by the bus service. Today, we have 12 nurses, 6 of whom have cars, and 2 of whom are on full-time relief duties. All these nurses have worked well during the past year. At a conservative estimate, I should say that three times as much work is being done today as was attempted by the Nursing Associations. I believe that there has been a considerable increase in the number of acute cases attended, which in itself is a very good indicator of the efficiency of the service."

Dr. Leiper, Division 30 reports:—

"On the appointed day, 5th July, 1948, the only accommodation for the Divisional Medical Officer was a small office in a corner of the Market Hall in Mexborough. The room was about only ten feet by six feet. The morning was fine, and I asked all the Home Nurses who were already operating in the District to come and see me, and I talked to them as one would expect on such an occasion when their Service was being taken over by the Local Health Authority. There was plenty of room, even in such a small office, to meet them all, as there were only two State Enrolled Assistant Nurses, and one State Registered Nurse. These three Nurses were to carry out the Home Nursing Service in a heavily industrialised and compact Division, of 60,000 inhabitants, where there are nine people to the acre, and about one out of nine people each year attend the Hospitals for treatment. The Dearne District, with 23,000 population, had a Nursing Association, and the sick were being nursed in homes by one State Enrolled Assistant Nurse, and the Mexborough District, with a population of 19,000 which previously had had a Town Nursing Association, had the services of one State Registered Nurse, and also a State Enrolled Assistant Nurse. The third District in the Division, Conisborough, with a population of 16,000 given over completely to deep seam coal mining, had no Home Nursing Service at all, and there had been none for the past 2 or 3 years. Most of those who required nursing attention apparently went to the Fullerton Hospital, Denaby Main, for dressings and other nursing treatment. It was realised quickly by myself and more pertinently by Miss Greenwood and Mrs. Taylor, that this was unsatisfactory. I appreciated that not only was the Home Nursing position bad, but also many other aspects of the Public Health problems here were also bad. It was, thus, not possible to devote as much time to the amelioration of the lack of Home Nursing Staff as I would have liked. The great help that was given by the County, and Area Superintendent, Home Nurse, and the Home Nursing Clerical Department was invaluable. The following Table shows the advance of the Home Nursing Service since the 5th July, 1948. The work has been very strenuous and has taken its toll in the form of illness in several of the Nurses."

As at 31st Dec.	No. of Nurses Employed		No. of Queen's Nurses	No. of Other Nurses, S.R.N., etc.	No. of State Enrolled Assist. Nurses	Mobility.		Total Visits
	Full-time	Part-time				Private Cars	C.C. Cars	
1948	3	—	—	1	2	—	—	2,675
1949	7	—	3	3	1	2	1	19,970
1950	9	1	5	4	1	4	1	33,701

It is expected that the total number of Home Nursing visits here during 1951 will be approximately 50,000. Care is being taken to maintain nursing standards even with this large amount of nursing visits paid. The figures for 1950 show that nurses in my division carried out 51% of the total visits undertaken in 1949 of whole County. The mobility of the Home Nurses has greatly increased their effective nursing capacity.

It is considered that a car adds the equivalent of half a Home Nurse to the number of visits it is possible to carry out. An excellent liaison system has been organised with the General Practitioners in the Division. As a matter of routine all nurses call at, or telephone their respective General Practitioner's surgery each morning and urgent cases in the daytime when the Nurses are normally on the District are telephoned by the General Medical Practitioner to the Divisional Office, and the message sent to the Relief or appropriate District Home Nurse. A meeting at the Montagu Hospital, to which the 18 General Practitioner Principals were invited, was held on June 30th, 1950, to discuss after-care work from the Hospitals. A questionnaire had been sent out previously to these family doctors, asking them if the after-care work of the Home Nurse entailed less visiting or not, and if they were satisfied that the Home Nurses on the staff of this Department, are carrying out their instructions faithfully on their cases. The normal after-care first visits are on my authority and the Home Nurse is instructed to get the General Practitioner's



instructions before her second visit. All 18 General Medical Practitioners expressed satisfaction in the way that the Home Nurses are carrying out their instructions and the following additional observations:— Dr. 'A' "less visiting had resulted in many cases" Dr. 'B' "I have less visiting, especially at night." Dr. 'C' "in my practice the question does not arise as I do not carry out unnecessary visits, but where I consider necessary, I always visit, whether the Nurse is in attendance or not." Dr. 'D' "after-care work of the Home Nurses has made my work much lighter." Dr. 'E' "thanks to the magnificent work of the Home Nurses, their tact, and sound judgment, my work is made much lighter." Dr. 'F' "it has entailed less visiting." Dr. 'G' "I found the work of the Home Nurses very useful and they save me both time and visits."

The amount of Home Nursing of aged, has increased greatly, and this has ensured that aged sick, unless requiring operative or acute medical treatment, can receive adequate medical treatment in their homes. Often the Home Help Service has been linked with the Home Nursing Service and results have been satisfactory. Lastly, the Home Nurse has helped greatly in the domiciliary nursing of sick infants in this Division and has helped thus to minimise Infant Wastage and indeed the necessity to transfer sick children to Hospital. The work of the Home Nurses and their fine loyalty to their work and patients has been outstanding, as has been the difficult work of Miss K. M. A. Billequez, the Relief Home Nurse of this Division."

Dr. Fraser, Division 12, reports:— "The staffing position in July 1948 was as follows. In Pontefract Borough there was one home nurse performing home nursing duties only. In Featherstone Urban District there was no home nursing service whatever. In Knottingley Urban District there was one home nurse performing home nursing duties only. In Osgoldcross Rural District there were two nurses each of whom combined the duties of Home Nurse with those of midwife and school nurse. In the Pontefract Borough a second home nurse was employed forthwith. During 1949 two home nurses were appointed in Featherstone and there was soon a considerable demand for their services. In the same year a complete division of the functions of home nursing, midwifery and school nursing was achieved in the Rural District of Osgoldcross, two whole-time home nurses being appointed. A further appointment at this time was that of a Relief Nurse, of senior status, to serve the whole Division. During the period under consideration the local authorities of Featherstone, Knottingley and Osgoldcross each granted the tenancy of a Council house to a Home Nurse. At the time of writing, all our nurses have a telephone in their houses, and five of them possess cars. Their equipment has been examined and greatly improved.

The service now has a great contribution to make to the after-care of patients discharged from hospital. The rapid growth of the service is shown in the following table:—

	1946-7			1947-8			1949			1950		
	No. of nurses employed.	No. of cases nursed.	No. of visits made.	No. of nurses employed.	No. of cases nursed.	No. of visits made.	No. of nurses employed.	No. of cases nursed.	No. of visits made.	No. of nurses employed.	No. of cases nursed.	No. of visits made.
PONTEFRACT B.	1	88	2864	2	100	3067	2	206	6102	2	212	6971
FEATHERSTONE U.D.	—	—	—	—	—	—	2	194	6524	2	213	7416
KNOTTINGLEY U.D.	1	92	1917	1	87	2139	1	150	3156	1	153	3646
OSGOLDXCROSS R.D.	2 part time	162	3731	2 part time	170	3487	2	146	4368	2	238	7715
TOTAL ...	2 whole time 2 part time	342	8512	3 whole time 2 part time	357	8693	7	696	20150	7	816	25748

### The Home Help Service

On the passing of the Maternity and Child Welfare Act, 1918, the Local Government Board issued Circular M. and C.W. 4 dated 9th August, 1918 drawing the attention of Local Authorities to the widening of their powers in respect of Maternity and Child Welfare. In paragraph 28 of this Circular it was indicated that approval would be given to arrangements for the services of a Home Help to look after the house during a mother's lying-in period whether the confinement was domiciliary or institutional. No action was taken by the County Council at this time. In 1931 the Ministry of Health in Memorandum 156/M.C.W. again commended to Local Authorities the provision of Home Helps to provide domestic assistance during pregnancy and lying-in; action on this matter by the County Council was postponed owing to financial stringency. A third circular from the Ministry of Health No. 1622 (dated 7th May, 1937) recommended the provision



of a Home Help Service as part of the measures necessary to decrease maternal mortality. Following consideration of this Circular a Scheme was approved by the Child Welfare Sub-Committee on 8th December, 1937 and by the County Council in January, 1938. Dr. W. G. Evans, Divisional Medical Officer, Division 13, has made an analysis of the Service throughout the County and submits the following brief statement:—

"Thus before July 5th, 1948, many authorities had for years operated a Home Help Service for domiciliary confinements and a few had expanded this into a comprehensive service during the war. The situation in the West Riding was probably rather behind that in the country generally because of the greater shortage of suitable workers. The County's service had very little to build on when it started on July 5th, 1948. However, the service was established and working well by the end of the year. It was soon obvious that the results varied considerably in different divisions. A number of factors were involved in producing these differences and these are commented on later in this report.

During 1949 the service in most divisions expanded rapidly and great difficulty was experienced in recruiting workers to cope with the increasing demand. Towards the end of the financial year 1949-50 most divisions were operating at a rate above their establishment and when it became obvious that this was not a transitory phenomenon an increase in the establishment was asked for. While this was being considered, Divisional Medical Officers were instructed, on the authority of Council, to reduce their expenditure to within the existing establishment. This reduction was achieved in a variety of ways such as by "transferring" aged people where eligible to the Assistance Board who paid them a grant for domestic assistance. In order to minimise hardship the Divisional Medical Officer often found a suitable person to do the work for the aged person. The number of hours on all cases including maternity cases was reduced below the minimum needed for the job. In some instances where the excess expenditure was considerable the service was suspended altogether for a short time until the excess was cancelled out. The number of Home Helps on the divisional registers was naturally reduced mainly by the withdrawal of women who found they could not earn sufficient at the reduced rate to meet their needs.

In July, 1950 the Council approved an establishment of 500 Home Helps to operate from 1st August. Of these, 41 were to be kept as a reserve pool. Towards the end of the year, however, it was apparent that in most divisions the full establishment was not again being used though generally there was a slow increase towards that figure. There seems to be little doubt from a study of the trend of the figures that full use will be made of the new establishment during the year 1951.

The National Health Service Act lays down (Section 29) that "a local Health Authority may make such arrangements as the Minister may approve for providing domestic help for households when 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 . . . ." This definition of the scope of the service forms the basis of the classification of the work done.

#### ANNUAL RETURN 1950

Table "A"

##### EMPLOYMENT OF HOME HELPS

##### I. Number of Domestic Helps employed at 31st December

(i) Whole-time	...	...	...	...	199
(ii) Part-time	...	...	...	...	577
(iii) Total	...	...	...	...	<u>776</u>

Equivalent whole-time service ... 309.5

##### II. Cases provided with Domestic Helps during the year ended 31st December

	No. of Cases	Hours Employed
(i) Illness (excl. aged) (a) Tuberculosis	76	22,668
(b) Other	1844	203,743
(ii) Lying-in	2359	177,658
(iii) Expectant Mothers	201	19,542
(iv) Mentally defective	18	1,707
(v) Aged		
(a) Illness	1301	159,712
(b) Infirmary	1053	108,543
(vi) Children of School age	82	14,803
Totals	<u>6934</u>	<u>708,376</u>



TABLE 'B'

# HOME HELP SERVICE

## APRIL TO DECEMBER

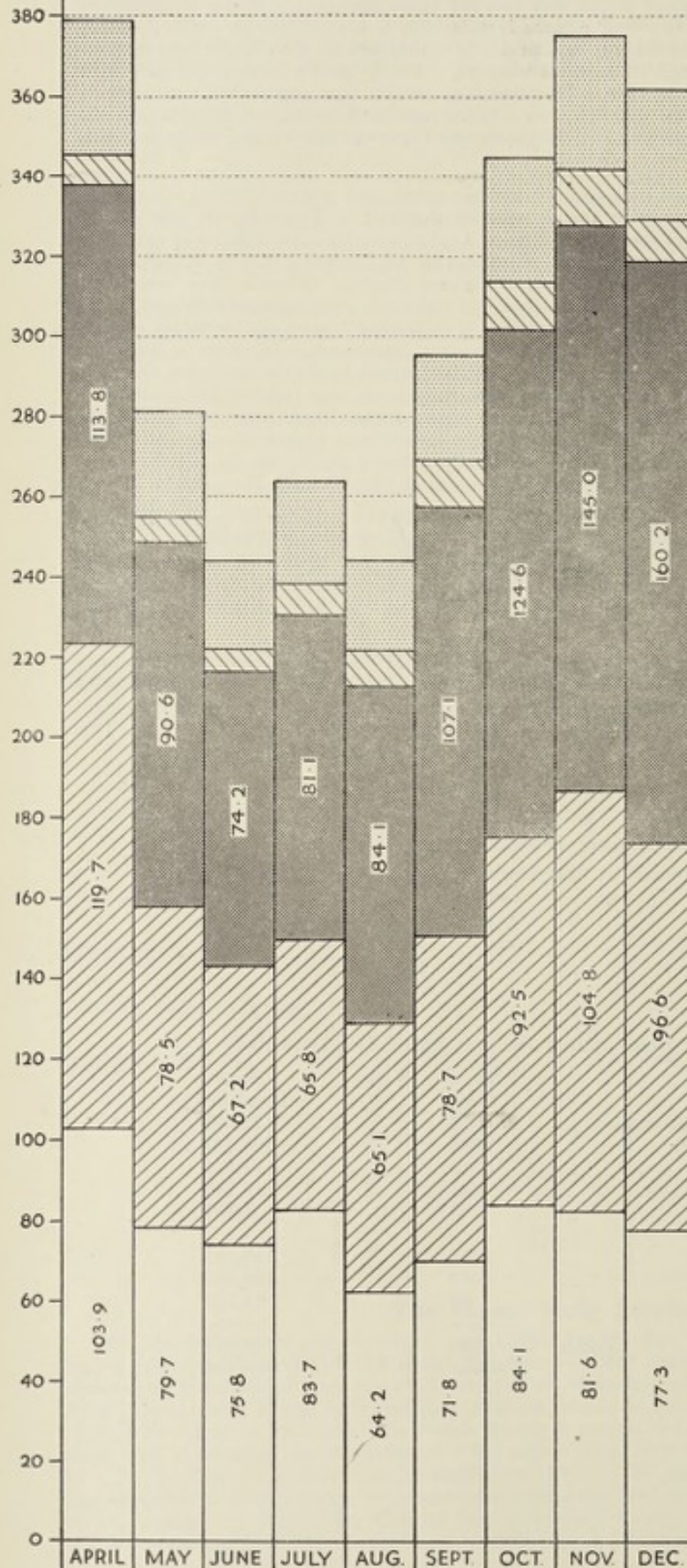
### 1950

## SUMMARY

## CASES

EQUIVALENT  
WHOLE-TIME  
HOME HELPS

APRIL	1604	representing	379.8
MAY	1338	"	281.4
JUNE	1193	"	244.5
JULY	1272	"	263.6
AUG.	1374	"	244.5
SEPT.	1478	"	296.7
OCT.	1497	"	344.8
NOV.	1598	"	374.2
DEC.	1750	"	361.3



N.B. THE NUMBERS INSERTED IN THE THREE MAIN CATEGORIES REPRESENT THE EQUIVALENT WHOLE-TIME HOME HELPS EMPLOYED



Table B shows graphically the relative proportions of the different types of case dealt with. These tables alone clearly demonstrate the importance as well as the volume of the work done by this service. Many of the domiciliary confinements would have had to take place in hospital had a Home Help not been available. Her absence in many cases of illness would mean that some wage earning member of the family would have to stop at home. The Home Help's part in caring for the aged forms a vital part of the services for the aged again helping to maintain at home a person who would, in many cases, otherwise have to be cared for in a hostel or hospital bed.

This aspect of the work of the Home Help, the relief of other more expensive and scarcer services is perhaps the most obvious but by no means the most important from the point of view of social medicine. There is also the educational value of a good Home Help working in a poorly run house and the benefit in health to the housewife or aged persons as a result of lightening her labours or improving her nutrition and that of the family. There is finally the uplift in morale which efficient and practical help brings to a family beset with anxiety and difficulty.

The detailed catalogue of a Home Help's duties is worth examination. It includes, of course, cooking, the day to day cleaning of the home, shopping, laundry and mending; washing and dressing the children and getting them off to school; and (while it is impossible to specify the actual work involved) the comparatively insignificant jobs and apparently unnecessary touches that together help to introduce or maintain the home-like atmosphere. The Home Help's duties do not include spring cleaning, sick nursing, child minding or sitting-in with adults or children.

This is, of course, but a superficial analysis of a Home Help's work, but it does indicate the qualities we require in a woman to do this work well. She must be honest, conscientious and competent. She must be tactful, kind and patient. Above all she should have a tremendous sympathy for her fellows. The wonder is, surely, not that we are short of staff but that we have been able to recruit enough of the right sort to carry out the great work shown in prosaic figures earlier in this report. It should be remembered too that while we do have complaints, they relate to a very small percentage of the work done and many of them do not bear examination. On the other side of the account there are the letters of thanks and appreciation which are a source of gratification to all concerned particularly the Home Help.

**The Recruitment of Home Helps**—This presents problems of widely differing nature and perplexity in different parts of the County and in each division these will be determined ultimately by the availability of other female employment: for employment as a Home Help, in the eyes of the worker, suffers by comparison with almost any other type of job. The most important reasons for this are:— 1. There is no guarantee of continuous employment. 2. The hours worked sometime drop so low that with deductions for insurance etc. it is no longer worth while financially. 3. The jobs involve a good deal of changing or travelling. A Home Help gets used to one house and family. The job is then finished and she is moved to another. Another Home Help may have several jobs to do, each of two or three hours, involving a lot of travelling. Home Helps always prefer the long term or full time jobs. 4. The conditions of work, holiday pay, sickness pay and split duty pay are apparently designed for a full time staff working continuously. It is practically impossible for a Home Help to qualify under present conditions for sickness or accident pay because she seldom has the opportunity to work 44 hours in any consecutive 4 weeks. If this were reduced to 40 hours for 4 weeks several more would qualify but on the whole the fairest method would be to relate the sickness payment to the aggregate hours worked in the previous six months or one year. Split duty pay is another bone of contention. The present regulation allows an extra 2/- to be paid if more than one family is assisted for an aggregate of 8 hours in the day. No travelling time is paid except in special cases determined by the Sub-Committee. In fact it is very rare for a Home Help to be given two cases totalling 8 hours in the day. There are few women who can afford to leave their homes more than 8 hours. On the other hand it frequently happens that a Home Help is asked to deal with two or three short cases, say two or three hours each, and her total expenditure of time working and travelling may well come to more than 8 hours.

I consider it justifiable to offer Home Helps an extra 1/- if they deal with two cases in the day and 2/- extra if they deal with three or more cases in one day, irrespective of the time worked on the cases. These comparatively small adjustments would do much to overcome the lack of attraction which the work has when compared with work in mills and other factories. Since this report was drafted it has been made clear that the Home Helps come within the purview of the National Joint Industrial Council for Local Authorities' Non-Trading Services (Manual Workers). Special terms and conditions of service are being negotiated and their promulgation is awaited with keen interest.

Generally speaking the types of woman applying for this work fall into three categories. First are those to whom the regular weekly wage is economically essential and to whom domestic work is for one reason or another more attractive than other kinds. Secondly there are those for whom a few hours extra work in a week means some useful pocket money. Thirdly, the rarest of all, is the woman who has a vocation for the work and to whom financial considerations are of little consequence. These are jewels of great price not often come by.

The dividing lines between these groups are not clear cut but it can be seen how the first two groups are likely to be influenced by the working conditions. The first group must have a regular wage coming in and the second have little hesitation in giving up the work if it ceases to be "worth-while"; they are nevertheless useful. They do, in fact, provide a source of labour



particularly for short time cases, which otherwise would be unused and for which there is at present no substitute. The recent decision of the Council to allow a proportion of the establishment to be full time salaried Home Helps will do much to ease the problem of recruitment and will reduce appreciably the very high wastage of workers which the service has suffered since its inception.

**The Training of Home Helps**—This question resolves itself between two alternatives. The first is to train selected recruits and the second to appoint applicants after examination of their qualifications and experience, taking the best that is offered. The first method, as carried out by the National Institute of Houseworkers (with a Training Centre at Keighley) does not increase the supply of Home Helps, mainly because the trained worker finds the attractions of private employment irresistible. The second alternative is that at present practised.

The purpose of training recruits is mainly two-fold:— 1. To provide a source of competent and reliable workers for the service. 2. To raise the status of the workers and the work and so attract additional recruits. Both these objects are nullified by the fact that there are already far greater calls on the potential labour force than it can possibly contend with. Under these circumstances, the only way to attract workers to a job is to make it more attractive than other jobs and that, in most instances, means raising the wages above the level of the competing industries. There are many obvious reasons why this is an undesirable method of attracting recruits.

In the absence of a steady and copious stream of trainees any training scheme must involve an uneconomical expenditure of money and of trained staff. We are left, therefore, with the second alternative. It has been suggested that a short course of about three weeks might be useful in improving the efficiency of recruits and making them familiar with the Council's rules and regulations. Few women of the type usually recruited, most of them with some domestic ties, would be prepared to live away from home even for three weeks. The multiplication of centres to cope with trainees locally would be open to the same objections as the longer training scheme. In short then the conclusion must be that whatever the theoretical attractions of training schemes, the state of the labour market and the high cost of the training added to the already high cost of the service make them quite impracticable.

Can we then run the scheme giving adequate service to those who seek help simply by selection of the best of those who offer themselves for recruitment. I believe the record shows that we can. I consider that record to be one of which the Home Helps of this County can justly be proud. Like all work involving personnel selection it requires care and experience and should always include a report on the applicant's own home in addition to the usual interview and reports from referees.

**The Administration of the Service**—It is not proposed to examine this in detail here. Certain aspects of it must, however, be considered if only because of the controversy that has from time to time arisen. In the first place, it should be emphasised that this is essentially a service that must be administered locally. The workers must live in the neighbourhood. The work often arises in the first place as an emergency which must be dealt with immediately and on the spot. The background of all the cases is a compound of human problems which, to be dealt with properly and humanely, must be dealt with individually. That is to say the local executive must have a great deal of latitude and discretion. In fact, this is just the sort of service with which the Divisional Scheme was designed to cope. Divisional administration of this service has, of course, the defects inherent in its virtues but there is no doubt in the minds of those who work in this field that the principle is right. Much has been done to eliminate faults in the organisation and, no doubt, more will be done as experience points the way.

Divisional Medical Officers hold varying views about the method of the immediate supervision of the day to day work. Many argue in favour of a specially appointed supervisor. Others rely upon one Health Visitor to do this work part-time with her other duties and others leave it to the individual nurse (Midwife, Health Visitor or Home Nurse) who is concerned in the case. In all cases the clerical staff are inevitably more or less involved. Experience generally shows that in compact, thickly populated urban areas with populations of 30,000 or more a Home Help supervisor is a good investment. Few West Riding divisions come into this category.

The arguments in favour of supervision by the individual nurses are strong and need emphasis. The most important reason is that this service is a method of treating social disease or disorder. It is a method of treatment that can be applied to a particular case; just as a doctor prescribes penicillin for an infection or thyroid to a cretin. There are well defined indications for this treatment and the "dosage" is also important. For example, many aged persons need relief from all heavy household work, but generally speaking should not be relieved of all necessity for effort. The precise amount of assistance appropriate to the case must be considered, a point of importance also from the financial point of view. Another aged person may be neglecting his or her food and suffering from malnutrition as a consequence. In such a case the daily preparation of meals may be all that is required. A debilitated mother of a large family may require a Home Help simply to relieve her of the family washing or the general housework or to form part of her education in household management. In all these cases it is the nurse on the spot who, collaborating with the family doctor, is best able to determine the needs and specify the amount and type of help required.



A further complication which has arisen in the past and may well arise in the future must be mentioned here. At times when the demand for the service exceeds the establishment not only may cases have to be selected but the jobs that must be done in a particular case may have to be specified so that others less necessary may be omitted and the total hours used kept within the necessary limits. It is also often useful to have an authoritative prognosis. To do all this effectively the person responsible for making a decision must be thoroughly familiar with the case. Once again this points to the fact that the person responsible for supervising the Home Help case should be the midwife who has attended the mother ante-natally and delivered her, the district nurse who is nursing the sick person in the home or the Health Visitor who has known the family since she came to work on that district.

The attitude of the nurse towards her work is also important in this as in other respects. One frequently hears of nurses and others talking of the supervision of Home Help cases as being "extra" work which is apparently considered a separate job and dealt with quite separately. This is the attitude of the "one senior Health Visitor supervisor" school. It ignores the therapeutic and curative value of the service they are handling. Nurses who share this view seem to feel rather disgruntled at having more burdens thrust upon their already overloaded shoulders instead of feeling relieved that at last they have at their personal command a therapeutic weapon of inestimable value. In fairness to those who favour the use of one nurse as supervisor it must be said that the system has many administrative conveniences. It should never be forgotten, however, that in social medicine, no less than in clinical medicine, administrative convenience must never be allowed to transcend therapeutic efficiency.

The financial aspects of the administration of the service are dealt with mainly by the Welfare Department. The question of the scale of assessment for recovery of charges affects directly the volume and nature of the calls for the service; it is, therefore, of great interest to this department. The changes in the scales which were made shortly after the establishment of Home Helps was increased resulted in increased charges. It is the unanimous opinion of Divisional Medical Officers that this increased cost is the most important factor which for so long kept the demand for the service so much below the new establishment. It is difficult to fix a scale of charges at an equitable level. The fixing of the scale must be based on two considerations among others. First, the applicant should pay as much as he can afford and secondly no one in need should be deprived of the service through inability to pay the assessed cost. The general impression among Divisional Medical Officers is that while the original scale of assessment produced charges which were too low, the new scale has produced charges, particularly in the £5 to £12 per week class, which are too high. Certainly applicants have refused assistance on learning the amount of the assessment.

The principle of charging a fixed sum per week (whatever the amount of assistance granted) leads to anomalies. This is apparently a relic of the Public Assistance system, the argument being that if you can afford £1 per week you can afford it whether you are receiving ten hours' assistance per week or twenty. As a result of this, if a man in granted twenty hours per week and charged £1 per week he pays without comment. But later his domestic circumstances change and the hours granted are reduced to ten. He still has to pay £1 per week and not unnaturally feels he is being unfairly treated. Another bad effect of this system is that it encourages abuses of the service. When a man pays a fixed sum whatever the amount of the service given, he has no interest in reducing the amount of service. There have been cases of conspiracy between a householder and a Home Help in which the hours shown on the time sheet were not worked and the wages thus wrongly acquired split between the householder and Home Help. If the amount paid by the householder were related to the hours worked there could be no advantage to be gained in this way.

**Prospect and Conclusions**—The demand for the Home Help Service, having recovered from the set-back it received early in the year, is now re-asserting itself and it seems inevitable that we shall again have to carry out the difficult task of restricting its growth. The amount of assistance required for maternity cases and cases of illness seems remarkably steady while that for the aged is rising. This rise seems to be too rapid to be due to the increasing number of aged. We have probably not yet reached a state of equilibrium for the aged as for other categories; and this is complicated by the need with increasing economic strain for more women to go out to work and leave their aged relatives to the care of the public services.

The future development of this service is bound up closely with that of the other services dealing with the aged. Without digressing too far in this direction, whereas a good Home Help service can save many hospital and hostel beds it is also true that a hospital and hostel service which is not integrated with the home services can impose upon the Home Help service chronic sick who should probably be in an institution. It is in the preventive field that our main hope lies of dealing adequately with the ever increasing numbers of aged people in the population. There seems to be little prospect of immediate relief of this kind from the Regional Hospital Boards.

Home Helps are often working under very unfavourable conditions in poor houses. If these conditions could be improved time and money would be saved. For example the weekly wash for a large family might take six to eight hours using an old fashioned "set-pot" and fire heated irons. The Home Help's wages alone for this work come to 12/3 to 16/4. A public laundry might well charge less than this and where the Local Authority provided any laundry facilities the saving would probably be greater. An arrangement of this kind would also have the advantage of making the work more attractive to workers and potential recruits.



Finally the public should be aware of the policy of the Council, the purpose of the service and their rights, their obligations and their privileges. The service has sometimes been abused and has suffered criticism because of this; the abuse has, in fact, related to only a small fraction of the total work done. I feel certain that whatever the immediate cause of these abuses the fundamental fault which predisposes to such occurrences is a big deficiency if not a total lack of serious effort to educate and to inform the public on the points already mentioned.

The Home Help service has in a relatively short time established itself as an essential public service. It has a great part to play in dealing with emergencies and temporary setbacks but it has also an unexampled opportunity for education in citizenship and for the promotion of stable family life. We have already seen the beginnings of such extended work in that done by the Family Service Units. While these at present confine their attentions to problem families, there would seem to be no reason why the principle upon which their work is based should not be extended to cover less advanced cases of social maladjustment and perhaps, more important, to cover the education of young people in the art of making and running a home."



## PART VIII

### THE CARE OF THE AGED

England has grown old suddenly; when Public Health began a hundred years ago our country died young. English literature of later Georgian and early Victoria days abounds in reference to the death of characters we should now regard as in middle age. Old age has come upon us too suddenly to have been adequately studied as a problem in social medicine. The expectation of life has advanced twenty years during the lifetime of persons living today. The suddenness of the change has been reflected in the attitude of the medical profession. The curative branch of medicine has continued to be absorbed in the problems of acute sickness to the almost total neglect of chronic illness; rarely, for example, has the good general hospital admitted chronic cases. Medical and nursing staff have tended to look down upon the work of dealing with the chronic patient; in consequence he continued into the first half of the twentieth century to find his only succour in the Poor Law, receiving attention more in keeping with the first half of the nineteenth century with, in particular, medical and nursing standards on a much lower level. The preventive branch of medicine has been equally absorbed in other problems such as the environment and the young family; moreover, the health department was for nearly a century virtually excluded from the work of the Poor Law. These attitudes are now rapidly changing under the impact of two big administrative reforms, the unification of the hospital system under one management (National Health Service Act, 1946) coupled with the break up of the Poor Law (National Assistance Act, 1948).

How old is this nation? In the England and Wales census of 1851 (population 12 millions) there were just over three-quarters of a million persons (4.6%) over 65 years of age; the figure for 1950 (population 44 millions) was just under 5 millions (11%). In the next forty years this total of aged people may rise to 8 millions (16%) in a static or declining population. An indication of the rate at which ageing is taking place is given by the following West Riding of Yorkshire figures: in the 1931 census 65 persons in every 1,000 were over 65 years of age; the computed figure for 1947 was 105. Thus, in the last twenty years the number of aged persons has nearly doubled. One in ten, or more, are now aged. It is true that we must revise our ideas of what is "old age" and there are indications that this is already in process; University Professors can in some instances remain in office to 67 years of age and the Chancellor of the Exchequer in his latest budget is operating reliefs to encourage old age pensioners to continue in work. Yet the fact remains that we are old and getting older fast. Down every street one family in two has an old person in its midst; many live alone in great loneliness and discomfort. This is one of the great sociological problems of our history, thrown into sharp relief by the decline in the number of young folk who must bear the burden. In the 1851 census there were just over 6 (35.4 per cent) million children (under 15 years); today there are just under 10 (21.9 per cent) million children in a population nearly three times as great. More than one-third of the men and women of working age in Britain are today over 40 years of age and by the turn of the century this may be as much as half. We have here a problem of considerable extent and complexity. Unless there is a steady and marked improvement in health and physique much of the benefit normally derived from medical progress will be dissipated; instead of increasing output per head we shall succumb to a decline in physical energy.

The promotion of health in the aged is, therefore, of paramount importance in this as in many other countries today. Egeria is a business as well as a moral proposition. It must pay to keep the aged out of hospitals and old folk's homes, which are so costly in money and skilled attention; some (no doubt an increasing number now with the Chancellor of the Exchequer's latest reliefs) will continue to work and so add their quota to the country's wealth; others will play an active part in running the household in which they live, particularly in caring for invalid children, grandchildren and other, often aged, relatives. If community health is looked at as a moral or aesthetic asset then it is well to remember the lasting contributions which many have given in their so-called declining years; Daniel Defoe and Voltaire would, for example, have been unknown men today had they died before the age of sixty years. How different might the world have been had Bernard Shaw died 35 years earlier.

The problem of the aged is fundamentally one of health. The incidence of acute and chronic sickness is much higher among the aged than in the lower age groups and it is this which produces most of the difficulties. One third of all old people fall ill every year and need the services of a doctor and the number of such home visits runs at twice the rate for younger ages. The incidence of degenerative diseases in those over 65 years of age is 84 per 1,000. In the Wolverhampton survey (Sheldon, *The Social Medicine of Old Age*, 1948) nearly a third has some constitutional disturbance; 14 per cent. had difficulty in ascending the stairs and 2.5 per cent. were bed-fast. Scurvy, which has disappeared in the young, has reappeared in the old and some aged now admitted to mental hospitals are suffering from extreme deficiency of vitamin B1; is there any wonder when we see how small is the single ration without the extras to be obtained in canteens and elsewhere and unswollen by the pooling of family resources. The relationship of age and health is so close that an ageing nation is bound to look to the health department for a lead in formulating schemes and for general direction.

What then can medicine offer in the solution of this relatively new problem? What is needed is a combined operation bringing in both the preventive and the curative sides of medicine. The first task of the curative side is to reorganise the treatment of the chronic sick. The strictures upon the character of the chronic sick institutions under the Poor Law have no doubt been exaggerated and in any event it is easy to be wise after the event. McEwan and Lavery (*The Chronic*



Sick and Elderly in Hospital, 1949) say "The 701 patients who have been examined and classified are, nearly all of them, the final result of the hospital system of the past which is now, it is to be hoped, nearly at an end. They are decrepit in mind and body. Their mental activities have decayed and they are dull, listless and apathetic. Their joints are often stiff and painful, and their muscles weak. Everyone, themselves included, has regarded them as hopeless and useless, and that is just what they have become. This group has in actual fact furnished us with many useful lessons of 'what not to do'. Even for these patients, as they are today, much can be done. The old atmosphere of gloom and apathy can be changed and their outlook made brighter and happier, and many can enjoy getting about again, but the cure ratio must be small. The chief aim of a geriatric service must be to keep the elderly in the future from falling into this hopeless state, and it is certain that much can be achieved". This state of affairs is now being remedied by the inclusion of the chronic sick within the general hospitals system and by providing a full range of diagnostic, therapeutic and rehabilitative skill. In some instances as many as half of the patients of chronic sick wards have been improved sufficiently to go home or to hostels. Nevertheless, the Repeal of the Poor Law has not been an unmixed blessing for the increasing numbers of chronic sick, for it has removed the absolute right to admission even when this went hand in hand with overcrowding and a low grade service. The increasing need has also coincided with a tendency to reduce accommodation for the chronic sick as an outcome of improvements in arrangements for the acute sick. This is a subject of concern to the preservation of community health which calls for the closest scrutiny. There is no clear dividing line between infirmity and chronic sickness and many chronic sick are not in need of full hospital care. Among much else consideration should be given to the expedient of making the community health authority responsible for providing accommodation of a hostel character for those chronic sick not in need of full hospital care—a parallel form of institution to the old folks' home.

The admission of sick aged to hospital needs to be done more scientifically as a partnership between the hospital and the health department. Except in the case of acute illness, when immediate admission is necessary, there should be a close study of the background picture to determine the need for hospital care and to establish the obligation of the relatives. This may have the effect of securing adequate home care without admission to hospital and it can secure the admission of cases in order of priority in relation to the home background. The discharge of cases can be organised along the same lines. An instance of such work is the arrangement which has been conducted during the past year in connection with a former poor law institution (112 beds) in the West Riding. A health visitor from the divisional health office of the area in which the hospital lies has been appointed (in agreement with the local hospital management committee) to undertake the work. When a general practitioner asks the hospital to admit a patient the hospital health visitor first undertakes a social enquiry; when the hospital physician considers a patient fit for discharge she again tackles the home to try and bring about the desired result. For details of this work see *Care and After Care of Hospitals*, Section VII page 76. I have gone into this aspect of the care of the aged in some detail because it presents an excellent example of the development of social medicine which this problem so clearly needs.

Nevertheless it is health in the home rather than in the hospital which is the main issue. According to Sheldon all but 2 per cent of aged persons live at home (and only 1 per cent are in hospital); of the sick aged only 5 per cent reach hospital. What is needed to meet this situation is a combination of preventive and therapeutic measures with emphasis upon the former. This, it has been said, "is a typical example of social medicine and requires the administration of doctors who can see all its facets and are sufficiently interested and experienced to persuade others to do their share." As Professor Crew has declared "The Medical Officer of Health must find here one of his greatest opportunities." One of the important functions of health departments should be that of keeping the aged from falling into such a state that they require institutional care either in hospital or in homes for the aged. There must be attention to personal welfare, health education and the treatment of minor disabilities. Some of this calls for visiting at home and some can be done in association with social clubs or community centres. Minor ailments are more irksome to the aged; they reduce an already impaired mobility, prevent participation in community activities and thereby induce loneliness; they can progress more readily to severe disorders because of a diminished power of recuperation. But the work involved requires time and patience; it is often more than can be spared in the overcrowded surgery and in the busy doctor's round; hospitals are often remote and inaccessible and may also be ill-equipped to render special services to the large numbers of aged with minor disabilities and major socio-medical problems.

The suggestion made in the Poor Law Minority Report (1905-09) that health departments should exercise a general guardianship over the aged is fundamentally sound. They should survey their areas and know where there are aged living in bad conditions and likely to need guidance. Some health departments maintain a register of all aged persons in order to be able to give particular attention to those living in difficulty. The social work involved cannot be separated from that in other health fields; it entails the full use of the health visitor, who can give that same admixture of health teaching and concern for social factors which constitutes her work for other priority classes. The aged can provide a valuable extension of health visiting. Their work must, of course, be supplemented by visiting through voluntary organisations (such as those under the National Old People's Welfare Committee) to help with shopping, books, letter writing, mending, etc. "Home visiting of this kind has been shown to be of particular value for it can mitigate the sense of isolation and loneliness often experienced by these old people" (M/H Circular 11/50), and it can draw attention to those in need of other services. It is a duty of local authorities to promote the formation of such local voluntary organisations. Under the guidance of the health visitor the home help can do much to alleviate the lot of the aged who are incapacitated and



without help from relatives. During the past three years home helps schemes have been organised throughout the country with surprising success; there seems indeed to be only one limit to expansion, namely, the ability of the health authority to foot the bill. In the West Riding of Yorkshire last year the aged absorbed 268,255 hours out of a total consumption of 708,376 home help hours; this entailed a cost of £31,300 but it may well have saved many times this sum in hospital charges. Thus, the present service is designed to provide a home nurse for the bedridden, a home help for any who are substantially incapacitated (for housework, laundry and shopping), a health visitor who supervises the case generally and sees to many details including the financial and other benefits to which the aged person is entitled, and voluntary visitors. Add to this the work of the National Assistance Board which visits through officers of its local offices every applicant for financial assistance (812,000 old people are now in receipt of allowances and the Board made five million visits last year). If there is still a gap this is accounted for by the fact that existing services are not in all cases fully and properly used; some of this is due to the need for economy and some to the slow process of reorientation; health visitors have not yet wholly adjusted themselves to the new duties. It may well be argued that the present service is too extravagant in trained personnel and that the staff and finance will never be available on the scale needed in the future. This is an aspect which will need to be carefully watched, particularly to determine how extensively the voluntary unqualified worker can be used. I believe there is an immense scope for them in this field.

The aged present a fine field for experiment by health departments everywhere. One such experiment is the establishment, in conjunction with social clubs or independently, of centres to advise upon health and socio-medical matters. It is surprising how many aged folk have problems, the solution of which can be of immense importance to them and indirectly to the community health. Advice on housing, home helps, home nursing, admission to hospital, old folks' homes and convalescent homes, the problem of work and of occupational therapy. In its simplest form a health visitor can attend for half to one hour at the social centre; this can be supplemented by routine medical inspection from a doctor attending on a sessional basis, and by the occasional visit of a geriatric specialist. The services of a chiropodist are invaluable; a high proportion of aged are in varying degree incapacitated by callosities and not a few eventually find themselves in hospital at the end of a long chain of circumstances which began with an uncared for corn. Physiotherapy can also be a beneficial adjunct but in Britain physiotherapists are in such short supply that they now work almost wholly in relation to hospitals. The occupational therapist can develop the creative element which helps to delay deterioration and provides a personal and social interest so necessary to the ageing; paper, raffia and leather work, working in wool, webbing and felt, bead threading, toys, simple modelling and painting, sewing and weaving, can all find a valuable place, together with the growing of simple things.

The accommodation for the aged and infirm (as distinct from the chronic sick) in the "House" Section of the old workhouses has long been regarded as unsatisfactory. As one of the most persistent attributes of the old poor law this continues as "Part III" accommodation (separated from the sick wards, which have gone to the hospital boards) for which welfare authorities are now responsible. It is, of course, impossible to change the character of this accommodation (or indeed its inmates) overnight. A new type of hostel has, however, come into operation as the old folks' home (under Sec. 21 of the National Assistance Act). Since the war 300 local authority homes have been opened and 300 more are in course of completion (in the West Riding 7 with 141 places) with a standard approximating to a medium class hotel. The inmates pay according to their means and not less than 21s. 0d. out of the 26s. 0d. (raised in the recent budget to 30s. 0d.) pension. Such homes (mainly supported out of public funds) can do little more than touch the fringe of the problem. The total places for the aged in the West Riding is 1,535 in former institutions and 141 in new hostels, or 11 places per 1,000 aged. Like the maternity homes these hostels should be considered as primarily to protect the community health; admission to this accommodation (limited and expensive) should be for cases selected by the Medical Officer of Health on health or socio-logical grounds.

Thus, in the past three years the approach to the problem of the aged has indeed undergone transformation; on the one hand hospital management committees have, as it were, swept through the old poor law institutions, redecorating and equipping; on the other new schemes of care in the community, including many new homes, have grown up with surprising speed. The greatest difficulty to progress lies in the continuing dichotomy between "health" and "welfare." The first circular (70/48) under the National Assistance Act, 1948, discouraged local authorities from placing the new welfare services under the Medical Officer of Health. It is perhaps significant that the Advisory Council for the Welfare of Handicapped Persons (established under the National Assistance Act to advise the Minister of Health) has only one medical man among its 15 members. This is one of the instances of dichotomy to which social medicine has been so cruelly subjected; the socio-medical services under section 28 of the National Health Service Act, 1946, are separated from the welfare services (under section 29 of the National Assistance Act, 1948). Social welfare in the form of social clubs, the teaching of handicrafts, the organisation of meals schemes (generally on wheels), and voluntary home visiting, can contribute much to eugenia. But unless these "welfare" schemes are fully integrated with health visiting and home nursing, arrangements for home helps, centres for advising on minor ailments and schemes for studying the social background of the chronic sick seeking admission to, or awaiting discharge from, hospital, there is certain to be overlap and waste of effort. The real answer must lie in placing the new "welfare" within the department of the Medical Officer of Health with trained welfare officers who can organise the social aspects as a member of the community health team. The Medical Officer of Health should be responsible for a co-ordinated scheme of social medicine and social welfare for the aged as a group of susceptibles whose health and welfare are vital to the health of the community.



Dr. Battersby, Divisional Medical Officer from Division No. 4 (Shipley) has submitted the following short account of his work for the aged during the year.

"This brief survey takes no account of the social work of many voluntary organisations such as Churches, Chapels, Rotary Clubs or Veterans Associations on behalf of the aged. Furthermore, it is appreciated that much work in Hospitals at Shipley, Bingley, Bradford, in private Nursing Homes, Denominational Homes and care in the home by the Medical Practitioner, is directed to their medical care and well being. Without being exhaustive the work for the aged associated with the Health Department may be conveniently considered in six groups. 1. General welfare work. Provision of Part III accommodation under the National Assistance Act and admission to Old Aged Persons Homes and Hostels under the general direction of the County, Divisional and Local Welfare Officers and staff. 2. Provision of Regional Hospital Board accommodation for chronic and occasionally acutely sick aged persons. Almoners' work; Specialist provisions and Out-Department work. 3. Local Voluntary Organisations exclusively for the aged and inaugurated since the passing of the 1948 Act and backed by the Local Health Authority and the Local Authority. 4. Housing provisions through the appropriate Local Authority Committee and Housing Manager. 5. National Assistance Board work. 6. Health Department duties discharged by District Nurses, Health Visitors, Home Helps, Sanitary Inspectors, Medical Officers. Liaison work of the above Officers with the General Practitioners.

To some extent the Department acts as a co-ordinating centre for certain work in each of the Sections 1 to 6.

1. Health Department staff are in day to day contact with the Welfare Officer who is also Duly Authorised Officer for relief of the aged who are mentally ill. Correspondence, meetings and visits to cases are regular. On receipt of applications from relatives, friends, family Doctors or other sources, visits to the home are arranged to determine appropriate action in each case. The Divisional Medical Officer acts in an advisory capacity to Thornton View, Clayton, Bradford, where many aged persons in the area are accommodated. He furthermore supervises a private Nursing Home for the aged in Shipley.

2. REGIONAL HOSPITAL BOARD ACCOMMODATION. Constant representations are made by family doctors to the Department to arrange or expedite admissions to Hospitals for the chronic sick. Opportunity is then afforded to determine what type of accommodation is required and other forms of assistance are provided after social enquiry by the Welfare Officer or Health Visitor (e.g. the visit of a District Nurse and/or Home Help may be a temporary alternative should there be delay). Appreciation must be here expressed of the services of the Secretary of "B" Group, Bradford, his staff and of the Consultant Geriatrician for their unstinted efforts and helpful co-operation. Health Visitors frequently visit Hospital, contacting Almoner, the Matron or Nursing Sister on social problems of in-patients and arranging after-care.

3. VOLUNTARY OLD AGED PERSONS' COMMITTEES.

SHIPLEY. An active organisation under the Chairmanship of Mr. A. E. Roberts and with Mr. A. Hart as Hon. Secretary has the following Committees:—

(a) *Finance and General Purposes.* (b) *Benevolent.* Arranging gifts of clothing, blankets, installation of wireless relay sets, payment of wireless licences. Contact is maintained with National Assistance, Welfare, and Medical Officers.

(c) *Handicapped Sub-Committee.* Clubs for blind and deaf meet at fortnightly and weekly intervals respectively. These are heavily attended and many elderly handicapped persons derive much recreational and social enjoyment.

(d) *Visitation Sub-Committee.* Lists of elderly persons throughout the town were distributed, and it was hoped to undertake regular visitation in the home. Although individual members have rendered good service, this has proved most difficult to organise.

(e) *Social Sub-Committee.* This active Committee is responsible for conducting Havens at Saltaire, Windhill and Wrose, with a combined average weekly attendance of nearly 200 persons. Holidays and outings are arranged and members of the Club go to Blackpool, Cleethorpes and Withernsea at special advertised rates.

Provision of meals, old folks' treats and library services are being explored.

DENHOLME. An organisation has functioned for many years in Denholme, meeting at the Mechanics Institute. Clubs are held for both men and women and trips to Theatres, the seaside and social events promoted. Nearly 500 elderly persons are catered for, and district visitation of the sick is undertaken. Out-season facilities are available at coastal resorts for members who wish to take advantage of such facilities.

BINGLEY. A Club for the aged sponsored by members of the public and the Local Authority was inaugurated during the year in the premises of the British Legion. Weekly meetings are held and about 40 persons attend. It is proposed to open another Centre in 1951 in Bingley adjoining the Library, Main Road.

BAILDON. Plans were complete for establishing a Centre for the aged early in 1951. A well equipped comfortably furnished Centre is available at the Towngate Rooms. Much excellent work has been done by members of the Committee and the Local Authority, and the assistance of the County Committee obtained.



4. In Shipley 18 elderly persons were re-housed, of whom 10 were admitted to new bungalows. Certain work of maintenance is undertaken and an example of useful help is the proposed intention of the Council to arrange to have the gardens scythed.
5. Close contact has been maintained with the Officers of the National Assistance Board. In certain cases financial assistance of from 8/- to 10/- per week is provided to meet the need of domestic help; the total amount of service rendered varied weekly between the equivalent of 6 to 10 full-time Home Helps.
6. Much departmental work is unrecorded, being telephone calls, interviews by Doctors and staff, with relatives, in the Department. It is widely recognised that visits to the aged are often time consuming, and the returns of figures give an inadequate estimate of the total work done. During 1950, however, 1,974 visits to the aged were made by Health Visitors; 135 cases were provided with Home Helps and 14,650 hours domiciliary work rendered. A major part of 16,607 visits by District Nurses was devoted to work for the aged and infirm.

### **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. It is only in those cases where other suitable steps cannot be taken, or have failed, that application for a Court Order is made; 6 men and 3 women were removed under Court Orders to appropriate accommodation.



## PART IX

## THE CARE OF THE INDUSTRIAL WORKER

Not least of the symptoms of the Industrial Revolution was the great surge of population towards the industrial centres, to life in crowded urban areas and to work in confined and dusty atmospheres where individuals were exposed to risks of a nature hitherto unknown. Lord Shaftesbury's recognition of this fact is in his first great Factory Act of 1833, an Act which has not yet reached the maturity enjoyed by other initial measures of social legislation. The majority of the 50 million people in this country go to work in nearly a quarter of a million factories and workshops yet there is no comprehensive industrial health service. The present arrangements include a lay inspectorate, supplemented since 1898 by 15 medical inspectors, and strengthened here and there by new medical departments as in the Coal Board, new research centres such as the Medical Research Council Pneumoconiosis Unit at Cardiff. Some of the large factories have developed their own health services, including whole-time and part-time doctors and nurses, but there is as yet hardly any attempt to promote health in the smaller factories except in isolated instances such as the Slough scheme where 127, mainly small, factories in one area are served by one joint service. The Factory Act of 1833 has been brought up to date, the latest edition in 1937, and gives limited powers to health authorities in matters of factory sanitation and mainly in factories which do not use mechanical power. Nevertheless there are 1,800 "appointed factory doctors," mostly in general practice, carrying out the duty of examining entrants to factory life, and those changing from one job to another, in the same manner and measure as first established in 1833.

In a highly industrial country such as this the absence of care for the worker is a notable gap in our personal health services. We provide for the care of the young mother and her child, for the health of the school child, and now for the care of the aged; for preventive and personal health service from before birth to school leaving age and again after the period of useful employment has ceased. In the intervening years, the span of the normal working man's life, we care only for certain special groups—the expectant mother, the tuberculous, the handicapped, and the person suffering from venereal diseases; or for certain aspects—the protection of his home environment, his food, and in some measure his recreation. We do not provide a preventive and personal health service for the industrial worker. It is fundamentally unsound that the period of working years, the major part of the life span, with its strains and uncertainties should not be completely covered. Apart from the decline in efficiency of the worker which results from his neglect, the nation has to deal with a vast amount of chronic illness which could be prevented. The happiness and health of the whole nation demands that this gap shall be closed.

The need to close this gap is fairly widely recognised and the Minister of Health made it clear that he would consider closely the needs of industry. In 1949 he set up a Committee of enquiry.

"to examine the relationship (including any possibility of overlapping) between the preventive and curative health services provided for the population at large and the industrial health services which make a call on medical manpower (doctors, nurses and auxiliary medical personnel); to consider what measures should be taken by Government and other parties concerned to ensure that such medical manpower is used to the best advantage; and to make recommendations."

Industrial health should be developed as an integral part of the service to protect community health under the general direction of the Medical Officer of Health. The first most important point which needs emphasis is the relatively small number of industrial workers that are employed in large undertakings. The greatest need is to be found in the small factories and workshops and offices. The total number of factories (broadly, places where things are made or mended) in the country is 243,769; only 4,499 had (in May, 1949) any kind of medical service. Four-fifths of these factories employ less than 26 workers and there are, in addition, a great number of small offices, shops and restaurants not covered by the Factories Acts. In general, all these small places of work are totally lacking in any service to prevent illness and promote health; yet it is here that so much harm to health may be done; it is here that the health of our nation is cradled. The chief object of an industrial health service should be to concentrate upon filling up gaps, and it is upon this large number of small undertakings that the service should concentrate.

The second point is how little power the Medical Officer of Health is given by existing statutes to prevent illness and promote health in the places where men and women spend their working hours. The Factories Act, 1937, permits the enforcement of provision as to sanitary conveniences in all factories and as to other environmental factors (cleanliness, overcrowding, temperature, ventilation, drainage of floors) in factories that do not use mechanical power; it also gives power to supervise "outworkers." There are further limited powers over environmental conditions in the Public Health Act, 1936. Within these limited powers the Medical Officer of Health has effected considerable improvements, but he is limited by having inadequate powers over the environment and even more by having no responsibilities at all for personal health.

The third point is that the health of the worker in industry is closely related to his health in other community spheres. The social problems involved will relate to other problems of a like nature. In a divided health service (as can be seen in the outline of a full industrial Health Service below) the balance of advantage must lie in placing such a development (if it can be brought about) under the community health authority. Complete, and indeed convincing, as the case may be, there is a risk that the tendency to split up community health problems will continue to operate.



The broad outlines of an industrial health service can be given under the following seven headings—(a) a comprehensive service for environmental conditions, i.e. factory design, heating, lighting, sanitation and the conditions of work in relation to the nature of the industry; (b) continuous health supervision of a preventive character, intended to detect the first signs of disease (including psychological disorders) and to emphasise the need for positive health; (c) a service to advise on job analysis, including "pre-employment" and "change of employment"; (d) a service for health education with particular reference to the nature of the work; (e) a service for special medical advice and research on hazardous occupations; (f) a service for rehabilitation after illness and accidents; (g) the provision of welfare services.

To protect the environment of the worker, the first essential is to secure that the community health department has powers to control the whole of the environment of industry. Ever since the first great Factory Act (the Shaftesbury Act of 1833), it has been customary to employ a centralised inspectorate. This overlaps with the work of the local sanitary inspector and has the disadvantages of remoteness. It is clearly out of date in the twentieth-century. Local problems can best be solved by local people, who have knowledge gained by long experience on the spot. Factory inspectors employed by the central authority can no doubt be of great value, but the immediate attack on the problem should be local. With the obligation to provide a complete health cover, the community health authority might employ one or more industrial health doctors (with special experience) to exercise an overall supervision of all factories, workshops, offices and restaurants in the area. Under these day-to-day supervision could be undertaken by general practitioners serving the authority part-time and working over defined areas; they could visit the departments of various concerns and see the operatives at work. As the right hand of the industrial health doctors and the general practitioners doing day-to-day supervision, there would be work for sanitary inspectors (and no doubt public-health trained engineers); these sanitary officers would work over the whole environmental field in order to correlate the factory work with other environmental conditions of the area.

To secure continuous health supervision of the workpeople themselves there needs to be routine medical inspection in a service closely allied to what is done in schools. A medical officer (preferably the general practitioners referred to above) should undertake to do this work in a defined area. In this work the general practitioner should have the assistance of the health visitor, and, just as the sanitary inspector exercises a continuous supervision over industrial environment, the health visitor can do the same for personal health in industry. She can bring to the notice of the doctor all departures from normal; promote health discussions with the workers and deal with the management over points of detail; and relate the personal health factors at the place of work with the social and health factors at home. The health visitor, working with the industrial medical officer, should be a member of the community health department and where appropriate engaged in the full range of health visiting duties elsewhere at home and at school. This would not often be possible for the large factories, where whole-time staff would be fully occupied but, as already indicated, it is the very large number of small factories and workshops which present the major hazard to community health. A system of health visiting for these small places could be arranged as an extension of functions for the present health visitors. (An example of this work is given in Appendix 1 to this section.)

Job analysis is largely the question of how best to advise the child leaving school and the adolescent trying, by changing employment, to find his most congenial work; this cannot be wholly effective unless it is integrated with the work of the school health service. The following quotation from "School and Life" is appropriate:—

"In order that the examination of fitness to enter industry should take its proper place in the health service, the statutory examination now carried out by the factory surgeon for certain employments should be transferred to the School Health Service, which will of course be extended to the county colleges as they are established. The school medical officer engaged on such work must have special knowledge of factory work and factory conditions....."

The same general practitioners and health visitors previously described could undertake this work.

A service for health education could conveniently and economically be combined with the health education scheme which every community health authority must develop. Much health education is common to all walks of life, and this could be supplemented where necessary by advice from the medical officers and health visitors working in industry who would know the hazards of particular occupations.

A service for special medical advice and research on hazardous occupations so far as it has been developed has also been centralised, first in the Home Office and now in the Ministry of Labour, with fifteen medical factory inspectors to cover the country. This is, of course, hardly adequate and in a complete industrial health service the community health authority should employ as indicated above, specially trained industrial health officers. It should also be part of the work of every medical officer of health to study the industrial hazards of his area. (An example of research in this field of work (so largely unexplored) is given in Appendix II to this Section).

To secure rehabilitation of the injured and sick workers the community health authority must extend arrangements now being made for care and after-care of all sick and handicapped persons (under section 28 of the National Health Service Act) to cover industry. There should be no great difficulty about this, and the work for industry would gain much from such integration. It would be wrong to establish an independent care and after-care service for industry. The medical officer on the staff of the community health department would be an impartial investigator with



access via the Medical Officer of Health to all departments and could use the close liaison which exists for other forms of care and after-care with hospitals and out-patient clinics. One great benefit of integrating industrial care and after-care with the rest of public health work will result from the advantage to the family doctor. A new route would be open to the general practitioner for solving his patients' medical and social problems via the services of the community health department; this would be facilitated by the employment of the part-time general practitioner with a special interest in industrial health. He could rely upon the ready provision of such services as rehousing overcrowded and tuberculous workers, home helps and home nursing for the sick, domiciliary midwifery, the assistance of health visitors and other social and welfare workers for the ageing and infirm, and the help of the mental health service in solving the many forms of mental ill-health to which the stresses and strains of industrial life contribute—in fact, for every contingency not clearly a hospital problem. The care and after-care made possible under section 28 of the National Health Service Act would thus be extended to the industrial worker.

Finally, the provision of welfare services for the industrial worker is a logical development of social welfare now making advances under the National Assistance Act, 1948. The organisation of social clubs, recreational facilities, canteens and other activities, can contribute greatly to the health of the worker. The Medical Officer of Health should be supported in promoting this side of the work by a welfare officer, who might combine it with other welfare activities. Welfare is, of course, part of social medicine; to be effective it must be closely integrated with preventive medical care in general.

If the above plan could come into effect, the Medical Officer of Health would be placed in a position to promote the health of the worker in industry with the aid of an industrial health team; the specially qualified industrial medical officer, the general practitioner giving part-time service to a defined area, the health visitor, the sanitary inspector, and the welfare officer. The principles governing occupational health are the same as those for preventive and social medicine in other aspects of community life, except in so far as certain occupations have special hazards. The training and qualifications of the Medical Officer of Health and the health visitor and of the sanitary inspector, should therefore be adequate for this work. For the whole-time industrial medical officer a specialist knowledge of industrial hazards must be gained either, preferably, as a selective subject in the normal D.P.H., or by a separate diploma as at present; if the latter, the D.P.H. should be taken as a preliminary. For the general practitioner doing part-time work, who is not able to take a full qualification, short courses lasting six weeks (or the equivalent) should be instituted.

The large firms which now provide an excellent service (there are about 230 doctors employed whole-time in industry), and such other firms as wish to do the same, should be permitted to operate their own services with advice and guidance only from the health department.

Finally, there is an overall need for economy in medical manpower which supports the inclusion of an industrial health service within the community health service. In planning an occupational health service on a national basis, heed must be taken of the number of doctors available to take part in the scheme. There are now, and will be for a long time, too few industrially trained medical officers to provide a full-time service for all industrial establishments in the country, even if several factories combine to employ a full-time doctor. One or two whole-time medical officers could, as a first step, survey the area of the community health authority; medical staff could then be completed by the appointment of part-time general practitioners. Furthermore, it would be an economy to make use of the community health department as a basic administrative machine.

With this brief review of what might be, it is of interest to examine the Dale Report (Command 8170, February 1951). The report is disappointing and it will not lead to anything like the above comprehensive cover. The Committee's main recommendation is for another committee—a standing joint advisory committee of the Ministries of Health, Labour and National Service, and Fuel and Power "to co-ordinate the development of industrial health services fully and effectively." Is this another great opportunity lost to bring together the services vital to the protection of the community health?

## Appendix I

### The Health Visitor and Industrial Health

Mrs. Sheldon, a Health Visitor in Division 31 (Rotherham) quotes the following case histories in illustrating the new work which she and her colleagues are now undertaking in industry.

*Case 1.* A man frequently absented himself from work and said to have an ulcerated stomach. The Divisional Health Department was asked to help. A home visit revealed an accumulation of domestic worries; his wife in sanatorium, children in County Homes, hire purchase payments in arrears, and unable to cope with housekeeping. He was nervous, miserable, and dreaded the future. The initial approach to this problem was to give encouragement for the little the man had achieved, to advise him on matters of domestic finance, and to promise some information about the progress of his family. This involved visits to the Sanatorium where it was found that the wife too was not making satisfactory progress, largely due to concern as to the welfare of her family. Following enquiries at the Children's Home she was assured that they were well and happy. There is little doubt that the personal interest and enquiries have had a beneficial influence, the subject of favourable comment by the matron at the sanatorium, and that the patient is now



making much better progress. One feature which emerged from the visits, both to the home and to the sanatorium, was the fear of the husband and children having contracted tuberculosis. Medical and X-ray examination have eliminated this possibility and resulted in a happier state of mind. As for the man, his social interests have been stimulated, he is having sympathetic treatment by his employer, with a promise of lighter work and additional pay and is now looking forward to resuming his occupation. *Case 2.* The second case was that of a workman at a forge who frequently absented himself from work due to alleged sickness. The Divisional Health Department was asked to help. On visiting the home it was found that when getting ready for work the man complained of diarrhoea and was then encouraged, by a sympathetic wife, to stay at home. Eventually he confessed to his wife that he was afraid of a repetition of an accident at work when his "mate" was killed. Armed with this explanation the health visitor discussed the case with the works personnel officer who then arranged for the workman to be transferred to other work, as a promotion. He is now in good health and working extremely well. *Case 3.* An older man had recently been paying little attention to his own work, was obviously slackening and irritable. The Divisional Health Department was asked to help. The Health Visitor on arriving at his home in the evening was greeted with "Come in, I've not had anyone over that doorstep since she went; what's home now, and my bit of savings I saved for our old age." It was learned that he had lost his wife, had no children, could not cope with housekeeping, and had no social life. The neighbours were a young couple who were out working all day and dancing or visiting the cinemas in the evenings. The health visitor arranged for workmates to visit the man who has now resumed his interests in life, is happy at his work, and is seeking an elderly couple to live with him so as to solve his housekeeping problems; in this search he is again being aided and advised by the health visitor. Mrs. Sheldon concludes her report on this last case with the comment "If we could interest the personnel officer, at all the works, in social medicine and had the opportunity to talk to the men in the canteens, etc., we should get them to be more neighbourly."

## Appendix II

### Investigation into the Evolution of Chronic Bronchitis

The year saw the beginning of a long term study designed to learn more about the evolution of chronic chest diseases with subsequent heart failure. This condition known as "Cor Pulmonale" certainly appears to be prevalent in South Yorkshire and although we know singularly little about its epidemiology may in fact occur more frequently here than in other parts of the country. Professor C. H. Stuart-Harris of Sheffield University approached me with a proposal that his department and the West Riding health department should combine in fundamental research into its cause and incidentally add to our knowledge of bronchitis and emphysema with which it is closely associated. Professor Stuart-Harris discussed his project with myself and the nine Divisional Medical Officers in the part of the County covered by the Sheffield Regional Hospital Board and it was ultimately decided to pursue the study among the workers in Newton Chambers steel works on the borders of Sheffield and in Dr. Main Russell's area. With the goodwill of the Management and the workers it has been possible to obtain sufficient volunteers from this one industry to enable the study to proceed. The general practitioners in the area from which the workers are drawn have agreed to collaborate with Professor Stuart-Harris and Dr. Russell. The County Council have agreed to bear the cost of two whole time health visitors for five years whose duty it will be to make regular visits to study the background of the family, the environment, the infections and all other matters concerning the workers whose progress is being studied. The venture will be watched with interest by all those who are concerned with health in industry.



## PART X

### THE NEGLECTED CHILD

Since the origins of society in our remote past children have been born out of wedlock, and deprived of a natural family life by death or insanity. This did not constitute an urgent problem in the years when we were a predominantly agricultural land with cohesive self-supporting village communities. It was the change in our structure created by the industrial revolution, with its enormous increase in population, which gave rise to difficulties. The shift from country to town, and the increase in vagrancy which accompanied it, during the latter part of the 18th century completely swamped the Elizabethan Poor Law system based on parishes. Indeed, it was the situation of the children in our workhouses which gave rise to the demand for a reform of the Poor Law in the first part of the 19th century. When Chadwick was secretary of the Royal Commission to enquire into the Poor Law, which reported in 1832, there were 50,000 children in the workhouses out of a population of only a quarter of our own today. The Commissioners said in their report that the workhouse was a place in which the young were trained in idleness, ignorance and vice.

The new Poor Law, to which the Act of 1834 gave rise, was a beneficent measure for its time; it was, for example, the first statute to enforce state education (for the pauper child) and the Poor Law schools preceded by nearly half a century the elementary schools for all children. The trouble with the Poor Law was that it outlived its day; what was benevolent in 1834 became almost malevolent a century later. The Poor Law was the natural receptacle for all our "down and outs," the illegitimate children, the paupers, the deserted, the orphans, the blind, deaf and dumb, epileptic and other handicapped children. This treatment, consistent with the views of the times in which it was born, gradually fell behind our growing ideas and was replaced twice by other measures designed to ameliorate the lot of different classes of individual (mental defectives, deaf and blind). The Poor Law itself continued to operate until 1948, when all its power in relation to children deprived of a normal home life were transferred to the new children committees of the counties and county boroughs. Prior to this a good measure of reform was introduced by the Local Government Act, 1929 (which created public assistance committees to replace the boards of guardians) and by the Poor Law Act, 1930 (which included one important feature, section 52, the legal adoption of children by the Authority). After 1929 many enlightened authorities began to introduce reform to abolish the barrack-like premises (so stigmatised later by the Curtis Committee) and to introduce grouped and scattered homes, but on the whole the new public assistance did not differ greatly from the old poor law; both lacked the inspiration of the growing sciences of medicine and education. The poor law really failed on "standards." It was the growing pressure of public opinion fired with knowledge of what could be done, both socio-medically and educationally, that eventually broke down the administrative barriers of a well entrenched service. Voluntary effort early became interested in the homeless child; the founding hospital began in London in 1740. A century later Lord Shaftesbury (who joined with Chadwick to reform the poor law) walked the slums, as he records in his diary, with Dr. Southwood Smith, and we find him poking under the hay and tarpaulins of Covent Garden with Dr. Barnardo. After Barnardo's pioneering effort there was a steady growth of voluntary children's homes, so that the Minister of Health, Mr. Willink, was able in 1943 to report that there were 212 charitable institutions registered as schools and Mr. Morrison, the Home Secretary, said that there were a further 828 charitable institutions not acting as schools—a total of over 1,000.

One of the worst evils of the industrial revolution was its treatment of the illegitimate child, and in the 1850's the mortality of these infants was little short of 100 per cent. Dr. Curgenven conducted a campaign to stir public opinion and when Mrs. Margaret Waters was hung in 1870 for baby farming the first Infant Life Protection Act was passed in 1871. This required a notification to the Town Hall when any person took in two or more children under one year of age for more than 24 hours, and to inform the Coroner within 24 hours of any death; it was largely ignored. In 1896 a second baby farmer, Mrs. Dyer, was hung and a further Infant Life Protection Act, 1897, was passed. The great step forward came with the Children Act, 1908, which provided for infant life protection visitors; this was from the first mainly done by the new health visitors and particularly so when in 1918 the Maternity and Child Welfare Act made infant life protection a function of the new maternity and child welfare committees. This was the first work of this character to come into the professional sphere of medicine—social medicine. Child Life Protection, which had its origins in the hazards of illegitimacy, was developed to cover all infants and children up to nine years who were fostered for gain by their parents. The administration of the service always presented, and still does, difficulties in finding cases and in the question of whether money or its equivalent in kind is passing. By the Children Act of 1948 this work has been removed from the health departments and handed to the new children's departments. The Maternity and Child Welfare Act of 1918 gave health authorities power to make provision for the care of the unmarried mother and her child. Since then most of the health authorities pay particular attention to this problem; advising and guiding from early in pregnancy and seeking to overcome the hazards to life and health by attention to all medical and social problems involved. This is true prevention, or social medicine, designed to build up a biological unit within the family instead of waiting to tackle the end products of disaster.

The unwanted child can fall into undesirable hands by other means, as by the simple expedient of adoption, and be used, for example, for begging and stealing. In 1926 a great new legislative measure introduced a new risk; until the passage of the Adoption Act of 1926 it was impossible for a father voluntarily to deprive himself of his rights and responsibilities in respect of his children (the mother at common law has none except her entitlement to reverence and respect). Legal



adoption has since been possible, subject to certain rigid requirements; for example, that the adopter must be resident in England and Wales and must be at least 25 years of age and 21 years older than the child. The consent of the parent or guardian or person having actual custody of the child must be obtained, together with a formal order of the court. This most proper and helpful measure has gone far to reduce the terrible handicap of illegitimacy and about 50 per cent. of illegitimate babies are now adopted, thus creating a new family unit almost, if not wholly, as complete as the original biological unit. There are, however, accompanying risks and it is necessary to supervise closely the process of adoption to see that the adopters are good sound reliable persons likely to make a happy home and to ensure that the baby is likely to be normal and healthy. It is an equal disaster for good parents to adopt a baby who turns out to be, for example, a mental defective, as it is for a normal baby to find itself in the home of unhappy and selfish parents. The chief danger lies with the third party who seeks to arrange adoptions—this can become an evil equal to that of baby farming; to avoid it section 7 of the Adoption Act of 1939 said that every third party must give notice of his interest and action in any adoption; adoption societies have to be registered and can be inspected.

In more recent time the difficulties facing the young child whose parents fall ill, or for some other temporary reason cannot look after him properly, has been met by the establishment of short-stay residential nurseries (Maternity and Child Welfare Act, 1918, re-enacted Public Health Act, 1936). The short-stay nursery fulfils an important need in the social medical service, relieving as it does the anxiety of the mother for her children whilst she is temporarily unable to care for them at home, due possibly to a further confinement, sudden attack of illness, or surgical emergency. Since these came to be from the first under skilled professional administration they achieved standards of nursery care which were in sharp contrast with those in poor law institutions. The care of children in residential nurseries introduces problems for which medical knowledge is essential. With frequent admissions and discharges these nurseries have a higher medical hazard. Particular care must be taken to guard against the introduction of infections with the new entrants. Frequent medical supervision of the children is required, especially for those under the age of two years. A proper diet must be given and most stringent hygienic measures constantly enforced to prevent the occurrence of epidemics, especially of the enteritis group. The choice and planning of the nursery itself, the provision of sufficient floor space per child, and the proper facilities of washing accommodation and lavatories, and the all important appointment of competent staff, should all fall within the province of the Medical Officer of Health. The Children Act of 1948 has been sufficiently widely drawn to include these children, removed for temporary care, within the purview of the new children committees, although it is at least doubtful whether it is right to call such children "deprived of a normal home life."

Then finally we have the powers given to magistrates (substantially the law today re-enacted in the two Children and Young Persons Acts, 1933 and 1936 and the Children Act, 1948). The Children Act of 1908 has defined "cruelty" widely and given to the magistrates powers to hand children who are the subject of cruel treatment to the custody of a "fit person," i.e., a person or body able to care for the child. The Court can, in fact, do one of four things—(a) make an order requiring the parent to exercise proper care and guardianship; (b) place the child in the supervision of a probation officer; (c) send him to an approved school; or (d) hand him to the care of a "fit person." The "fit person" until 1948 was usually the Education Committee of the Local Education Authority and is now generally the Children Committee. The approved school is the direct descendant of the "ragged school" of the early 19th century, which became the industrial school or reformatory which the Youthful Offenders Act (1854) first recognised officially as a place to which children under 16 years of age might be sent in place of imprisonment or penal servitude. These schools, like much else, have undergone change and improvement, which has tended to lessen the penal aspect and introduce the new outlook which can come from modern studies of the mind. Since the child in an approved school is generally maladjusted and his reformation lies mainly in skilful and sympathetic handling by specially trained teachers, many people regard as anachronistic that responsibility (for both voluntary and authority approved school) should continue with the Home Office—a penal institution; these schools and remand homes (where juveniles can be kept for short periods pending trial), to which the same principles apply, should be integrated with the school system under education authorities.

In these and other ways there has been a steady growth of machinery to deal with the neglected child. What is the philosophy behind this elaborate machinery? What are the modern views about the care of deprived children? Briefly, that every child who has been deprived of a natural home, whether by death or insanity of the parents, or as the result of desertion or neglect or because the magistrates have ordered removal on account of anti-social behaviour, should be provided with a substitute home suitable to its character and attainments. This turns upon psychological issues in the main. Every child requires love and security and the feeling that those about him care. Many doubt whether this desirable state can be secured outside the normal home with father, mother and relatives. Even the child who is away at boarding school or in hospital has a normal family background to his life. It is the severing of the mental thread of connection with his parents rather than the parting of the physical one which determines the state of the child's mind. It rarely happens that any one or two other persons can replace the parents. The young baby can be adopted into a family and come to be absorbed completely but after six months or a year this assimilation becomes increasingly difficult. The term "substitute home" is to this extent a contradiction in terms. The best substitute according to the Curtis Committee is the foster home. That this should have been their considered opinion will strike some as strange, since the committee was set up largely in consequence of the death of Denis O'Neill in a foster home. The foster home must be carefully selected and the foster child carefully



matched against his environment. One of the difficulties in this administrative task is the maladjustment of so many prospective foster children. Few children endure life in a problem family and reach the stage of dissolution of the family, from the will of the magistrates or the action of the authorities, without their psyches being bruised. Their loss of security leads them to take it out of life in other ways and foster parents may have unusual difficulties to encounter; persistent and distressing enuresis; destruction; bullying. Another difficulty is that a large number of such children are educationally subnormal or backward; where this is the case they have little alternative security in their school background. In the West Riding there are 722 children fostered by the authority and 1,022 in children's homes. Of those in children's homes, as an example, approximately 50 to 60 are educationally subnormal. A still further difficulty is the relationship of the foster child with the natural issue of the foster parents; it is almost beyond human powers to accord identical treatment to the natural and the foster child. The foster home—yes; but don't imagine that it is the solution of all our ills.

Despite the Curtis Committee, we are quickly back upon the children's home as the only possible substitute home. Authoritative opinion demands for this the small family group not larger than 12 in number, with a foster mother and father and a gradation of children from the baby to the adolescent. Such a family group may be placed in separate units at different points (the scattered home) or in 10 or 12 units together (the grouped home). This, too, has its problems; one arises from the fact that the local schools may have to accommodate an undue proportion of homeless children, a problem which can be most serious in the case of a large children's home situated in the country, particularly since such homes often contain a high proportion of educationally subnormal and backward. The provision of modern homes is slow and there are still many deprived children housed in the barrack-like premises of the old poor law. One of the evils of the children's home system has been the splitting up of the family, which it so often entails. Here are the details of one family which I studied in Warwickshire:—

Five children, aged 12, 8, 7, 6, and 3, each in a different children's home. Father dead; mother and children bombed out of London. Evacuated to Peterborough under the evacuation scheme, where found too dirty for billeting, the family transferred in September, 1942, to Warwickshire as mother's place of origin. The mother has since been discharged and is out at domestic work but cannot earn enough to establish and maintain a home.

Another of the evils which so easily creeps into the system is the mixing of the more or less normal child with the severely handicapped, with the delinquent, and with the educationally subnormal.

There is a growing belief that the law protecting children is in one respect out of date, as it makes insufficient provision for dealing with the whole family as a unit; we can see now more clearly than in the past that the break up of the family introduces its own difficulties and must be strenuously combated. Our laws have been framed under the belief that a child needing care and protection must be removed from its natural family and placed in entirely different surroundings; section 52 of the Poor Law Act, 1930 (re-enacted in section 2 of the Children Act, 1948) gives power for legal adoption by the authority, and section 61 of the Children and Young Persons Act, 1933, gives power to remove to care and protection. The present system has the merit that it gives control to, and vests parentage in, authorities for so long, up to 18 years of age, as is necessary to secure the desired end for the welfare of the children; and when the home conditions are remedied the process can be reversed. But it overlooks the fact that the disease is a family concern and cannot be cured by forceful disruption. To enable a neglected child to be treated as part of a family, petty sessional courts must have power to place the family on probation and under the legal guardianship of the health authority; this expedient could be applied both for types where the child is now removed from its parents and for other problem families which present the same symptoms in a less aggravated form; a system of family probation offers scope for immediate action and might in many cases be the means of avoiding drastic courses of obtaining a "care and protection" order or adoption by children's committees under section 2 of the Children Act, 1948.

A further measure requires careful consideration—the removal of the family as a unit to the care and protection in a controlled house where more detailed supervision could be given by the health authority, including teaching of family management by a trained social worker; this might give surprisingly good results. The law would have to be amended to make this wholly effective, as authorities could often carry out such a step successfully only where an order of the court enabled them to enforce removal. The existing scarcity of houses would be an immediate difficulty, as would the fact that such houses might come to be regarded as "homes of correction"; yet this course might be justified by the great need to take all possible steps to reconstitute the natural family home and so prevent homelessness. This measure (no more drastic than existing powers to remove children from their parents) would be used only in the last resort. Allied to this is the practice of eviction for non-payment of rent and for misuse of property. A much closer understanding with housing authorities (and with private owners) to prevent indiscriminate eviction of families without full consultation with the rehabilitation authority is also essential to success. There will be a recurring danger of interference with successful rehabilitation unless some agreement on the problem of eviction is reached.

Thus, the study of child neglect has been growing steadily in importance in Britain for some years and the new understanding of its significance (especially to the Welfare State) is one of the most encouraging evidences of progress towards a health community. After a long, piecemeal growth of interest there has been a sudden concentration of responsibility by the Children Act, which we must examine critically. The break up of the poor law and its replacement, in the case



of its obligations towards the neglected child, by the new machinery of the Children Act has in the space of three years produced many improvements. Children committees have striven towards the ideals of the Curtis Report in creating among much else new children's homes and reception centres (to date 9 reception centres have been established) and the Central Council for Training in Child Care has sought to provide trained staff. This makes the Sixth Report on the Work of the Children's Department (H.M. Stationery Office, 1951) of exceptional interest. We learn that out of a total of about 55,000 children in the care of local authorities approximately 19,000 are boarded out and 30,000 in children's homes. There are a further 29,000 in the care of voluntary organisations, of whom 25,000 are in children's homes and 3,500 are boarded out. To this should be added 35,000 children subject to Child Life Protection (including 25,000 in independent schools and 7,500 in private foster homes). The total of deprived children is, therefore, approximately 120,000. Roughly 14,000 boys and girls have been committed to the care of the local authority as a "fit person." The percentage of children who are boarded out has risen slightly since 1946 (from 29 to 35 per cent.). The family group home of not more than 12 children (usually in an ordinary house in an ordinary street) so strongly advocated by the Curtis Committee has made little progress with the opening of 41 new units; the grouped homes, consisting of groups of cottages each with 10 to 20 children in the care of a house-mother (a somewhat less preferable method because "it creates in the aggregate a large community of children in care, who are too numerous to be absorbed readily in the ordinary life of the neighbourhood") does not appear to have been extended. We are, indeed, little nearer the ideal of the small family unit in group or scattered homes, so much so that students leaving training courses are often disappointed to find themselves at work in barrack-like institutions of the old poor law type. The difficulties of building are likely to impede our activities for many years. The numbers of staff trained through the training courses of the Central Council for Training in Child Care (established in 1948), although no doubt valuable additions, cannot be regarded as very great in relation to the total numbers employed; for example, "355 students (300 women and 55 men) have been awarded the Council's certificate for the residential care of children" (as house-mothers and house-fathers) and again "216 students (211 women and 5 men) have qualified for the Council's certificate in child care" (as boarding-out officers).

The disintegration of the family involves problems of adoption, the fostering of children for gain, boarding out, children's homes, residential nurseries—both short-stay and long-stay, remand homes, and approved schools. The children involved may be the result of the illegitimate birth, the destitute and abandoned, those taken to care and protection either by the authority acting on its own initiative or at the order of magistrates, the delinquent child, children whose parents pay others to care for them, and children who need to be removed temporarily owing to illness or other adverse circumstances at home. The integration of the many and varying aspects of one important subject under the Children Officer has been a wise step but the separation from the health department is a grave disadvantage. Community health can be achieved only upon the basis of the happy family; both environmental and personal hygiene have this object at heart and most of the services of the health department are, therefore, concerned ultimately with this one object. It is in this respect that the Children Act has failed most signally. The Home Office report emphasises the "overlapping and division of effort among different government departments and different committees of the local authorities" which existed before the Act came into operation and by inference it suggests that unity has now been produced, including all the problems relating to the deprived child. In fact, the disunity is as great today as it was before the Act, for the real unification must be of the problems which lead to children being deprived of a normal home life with all other health matters relating to the integrity of the family; what we have today is a unity of end results. The work of the Children Act should be re-integrated with the rest of community health matters. The children officer, who has so much to offer in ensuring an individual concern for the details of each child, should be retained but she should work on the staff of the Medical Officer of Health.

This resumé can do little to emphasise the many disadvantages which can arise from the separation of the work of the children department from that of the health department. It can be seen clearly in its conflict with health visiting. The present arrangement of children's departments whereby special boarding-out officers are used for visiting boarded-out and foster children has many disadvantages. In theory this is intended to give more thoughtful consideration for the educational aspects of child development than is considered to be possible from the use of health visitors; in fact, this special visitation creates an illusion of something different just when it is our most earnest desire to present the opposite picture to the unfortunate child who has lost its own home. The visiting of children in foster homes, boarded-out children, the selection of suitable homes, visiting and examination of adopted children and those placed with a view to adoption, would best be done by the normal staff of the health department under the immediate direction of the children officer. It is towards this end that the more thorough training of health visitors at University level, which I have advocated elsewhere, has been aimed. The one-year Leeds University course for health visitor students under the able direction of Professor Davies goes far to equip students for this work.

The disunity which the Children Act has produced within the field of social medicine can also be seen very plainly in our present approach to the problem family. The Home Office report has a chapter on the subject of children neglected or ill-treated in their own homes. This gives the impression that the solution of the problem family, if indeed one can be found, lies within the ambit of the children officer and the children committee. How far this impression has already gone can be seen from the action taken under the recent Joint Circular 157/50 (Home Office), 78/50 (Ministry of Health), 225/50 (Ministry of Education), which was addressed to County and County Borough Councils asking for an officer to be designated who could be responsible for



the co-ordination of the work relating to the child neglected in its own home. We learn "about half of the officers designated so far are children officers; most of the others are Clerks of Councils or Medical Officers of Health, while some others have selected the Chief Education Officer." This increased interest in the child neglected in its own home, which has arisen from public agitation leading to a debate in Parliament, is a refreshing illustration of the steady growth of appreciation of the matters of prevention rather than of cure. A child neglected away from its home has at one time been a child neglected in its own home. There may be as many as 300,000 children living in unsatisfactory conditions in problem families, compared with the total of 55,255 "in the care of local authorities on the 30th November, 1949."

The problem family is one of the great social diseases of modern times; it has far reaching repercussions, not only in its production of the deprived child but in its creation of many other disorders in the community health. The problem family equals in its importance to community health today the high infant mortality of one hundred years ago; but, whereas the remedy of the conditions that led to the high infant mortality has followed well accepted lines of practical application of medical knowledge in the preventive field, the eradication of the problem family presents such a complex of features that we are unable to see yet how to tackle it. It may require many years of painstaking public health work including research, to find an adequate solution (see Appendix I). In 1948 the West Riding collaborated in an experiment by the Eugenics Society to determine how best to find out the existence of the problem family. This pilot investigation, here as elsewhere, showed that the health visitor is the best and most reliable source of information; with a suitable backing and further training she will be able in the future to ascertain all such families in her area. A solution of this problem can only be found by painstaking ascertainment and rehabilitation by an authority that can bring to bear a full range of preventive weapons. Ascertainment must be early and be done by those members of the health department such as the health visitor, who can, in collaboration with the family doctor, in the ordinary course of visiting to advise on the infant and school child, make an early assessment. It should be our object to instil into all health staffs the need to make an early diagnosis and give them a flair for detecting these unfortunate families in an early stage. Rehabilitation will entail the use of such important members of the health team as the sanitary inspector, the school medical officer, the home nurse, home help, mental health social worker and, of course, the health visitor. This is work of the first importance for all health departments. We cannot accept the illusion presented by the Home Office report that the work falls within the ambit of the Home Office.

How far we now are from a general recognition of these fundamental principles can be seen from the reaction of the Ministry of Health to recent proposals by the West Riding County Council. In 1947 with the commencement of the scheme for Divisional Administration of the Preventive Medical Services, the Divisional Medical Officer was given the duty "To maintain a register in accordance with any County Scheme for problem families and operate any arrangements for rehabilitation, with a view to protecting the children in such families and maintaining the family as an effective unit." This was the first practical step to be taken in what amounts to a combined operation in social medicine to deal with a subject of grave importance to the health of the county. One result has been a steady ascertainment of problem families throughout the whole county under the general supervision of a senior and experienced county health visitor, who has seen each family before a final diagnosis has been made. To date there have been at least 700 possible families ascertained. Each problem family is a separate problem in social medicine and where appropriate the family is the subject of case conference of all interested parties. Health visitors, sanitary inspectors, and other workers in the health field have shown a growing interest in this work and much good and unspectacular rehabilitation has already been effected.

During the past four years the members of the Public Health Committee in the West Riding have come to accept the fact that it is a right and proper function of health departments to try to prevent the deterioration of the problem family to the point at which it has to be broken up, with all the consequences in human unhappiness and cost to the tax-payers which this entails. They now know that our children's homes and foster homes are full of children who need never have been removed from their parents if an effective scheme for the rehabilitation of the problem family had been in operation to detect and prevent deterioration at a sufficiently early stage. As a measure of the interest of the Health Committee in the work of the health department in problem family rehabilitation the Divisional Medical Officer has been designated as the officer responsible for the co-ordination of the work to prevent the neglect of the child in its own home (as recommended in the Joint Circular 157/50 (Home Office), 78/50 (Ministry of Health), 225/50 (Ministry of Education)). Much can be done in this field by existing health staffs imbued with the right ideas and ideals but for success in its fullest sense in a task of such complexity we need new and special weapons. What is the precise form that these weapons should take is not yet clear; from the work of Miss Abraham at the Brentwood Recuperative Centre, Marple, Cheshire (see Appendix II), one such is the combination of a convalescent and instruction centre for the mother together with her young children. Another form of attack is through the specially trained social worker, as developed by the Family Service Units, who can combine teaching with practical measures for household reconstruction. The Council resolved (in early 1951) to apply to the Minister of Health for an amendment of the schemes under Part III of the National Health Service Act to include a reference to the rehabilitation of problem families: (1) to include under S.22 (Care of Mothers and Young Children) power to develop arrangements for the rehabilitation of problem families by the use of accommodation in suitable Recuperative Centres; and (2) to include under S.28 (Prevention of Illness, Care and After-Care) power to expand these arrangements to the rehabilitation of the problem family home and environment by the expenditure of money in cleaning, minimum equipment and reconditioning of the home before, during and after the family is at a



recuperative centre including the employment direct, or through a voluntary organisation of officers with special experience in such work. In furtherance of the scheme the West Riding agreed to collaborate with the National Council for Social Service in the establishment of a recuperative centre by paying for six family places at an estimated cost of £3,500 per annum.

Such a recuperative centre could treat 30 or 40 family groups during the year; these to be carefully selected as being capable of benefiting from the convalescence and the sort of practical tuition which can lead to an appreciation of home making and parent-craft. During the time of the absence of such families the divisional health office would be empowered to spend money in the reconstitution of the home so that when the family returned it could return to a better atmosphere and one from which it might be able to maintain the improved standards. Careful supervision would continue in the home, with the help of specially trained social workers where appropriate. It is not suggested that this is all that is required. It is certain that other new untried weapons will have to be used. Many cases would probably never be fully rehabilitated without removal for a greater length of time from the home background; for these some half-way house, as already described, may have to be developed.

There can be little doubt that we are at the beginning of a new chapter in our social services. Fifty years ago, when we began our personal approach to community problems, we tackled such obvious ills as infant mortality and maternal mortality. We evolved the health visitor, the midwife, the infant welfare centre. Over the same period we have evolved the district nurse, the probation officer, the V.D. social worker, and many other special workers in the field of social medicine. Such a personal approach to the eradication of social evils is peculiarly British. All these new movements have had their champion to strive against ignorance and opposition. Just as Dr. Curgenven fought for the child life protection laws that would safeguard the illegitimate child by stopping the evil practice of baby farming, and Dr. Ballantyne fought for ante-natal care. That is what the problem family needs today—a champion to fight its battles and create a new social conscience. There have been enormous improvements in child care. Can you take back your mind to the three years of fierce debate in Parliament when it was proposed to reduce the hours of labour for children in factories from twelve to ten; when all the eloquence and oratory of Macaulay in 1846 failed to convince Parliament, and even he said that perhaps we hazarded too much in reducing from twelve to ten, we might start by reducing to eleven hours. We did finally hazard as much and ever since have striven to remedy all abuses in child care. No child today stands before the factory gate, ill-clad and ill-shod, in the half light of a cold winter's morning. But it is not enough. We must hazard more yet. Three hundred thousand children live in such squalor in problem homes as might defy the descriptive powers of Dickens himself. We must tackle this and quickly. It is urgent. Yet we should not be under any delusion about the difficulty of the problem. It is indeed evident that as each social evil is attacked and remedied, those evils that remain present greater difficulties. We tackled infant mortality by teaching in the home Florence Nightingale's ideal of "household hygiene" when we followed her advice and made health visiting an honourable profession for a nurse, but there is no such easy remedy of the problem family.

It is in these circumstances that we have received the following letter from the Ministry of Health in relation to our proposals:—

"I am directed by the Minister of Health to say that he has given careful consideration to the question whether the rehabilitation of problem families might appropriately be regarded as part of the arrangements of local health authorities under Sections 22 and 28 of the Act. The Minister appreciates that to some extent the scheme submitted by the Council would include the care of neglected or ill-treated children on which a circular to County and County Borough Councils was issued on the 31st July last by the Home Office, and the Ministries of Education and Health, but it is possible for Authorities to proceed, as the Minister would wish, with measures in accordance with that Circular without recourse to their powers under Sections 22 and 28 of the National Health Service Act. In these circumstances and in view of the limits which it has been necessary to set to National Health Service expenditure in present conditions, he regrets he cannot see his way to approve development of these two services in this direction."

The implication is that the Minister is prepared to continue the present vast expenditure upon the results of the problem family without making even a modest contribution towards prevention. This can, however, be no more than a temporary setback.

## Appendix I

### Further Study of Problem Families in the Riding

(Dr. Bryant and Miss O'Brien)

This limited enquiry was held into the circumstances of problem families in the county; It served mainly to provide data for future action and to help in bringing the divisional registers up to date. Divisional Medical Officers were asked to give details of all problem families in their areas based upon a schedule of circumstances filled up by the Health Visitor. No attempt has been made to select from the material submitted because the method of submission is, presumably, that which will be adopted when families are selected for rehabilitation. Results are available for the following Divisions:— 1, 2, 5, 7, 13, 14, 20 and 22. The total population of



these Divisions is 394,193 (an average of the last five years estimated population as supplied by the Registrar-General). The number of problem families submitted was 88, and, therefore, this means that for every 1,000 of the population there were 0.22 problem families. The following is an analysis of the details presented:—

**FATHERS**—(including consorts where no legal marriage exists) Alive 84 (living with family 78, divorced 2, separated 4), Dead 2. No father 2. In permanent employment 72, Casual or Temporary Employment 7, No details of employment 5. Health: (The usual condition of health as expressed by the Health Visitor) Good 57, Poor 27; Intelligence: (Based on the rough assessment by the Health Visitor) Normal 65, Low 21.

**MOTHERS**—Alive 85 (legally married with husband alive 75, Widowed 2, Cohabiting 6, Unmarried and with no male partner 2), Dead 3. In 83 cases the mother was present with the family. In full time employment 7, part-time employment 8. Health: (The usual condition of health as reported by the Health Visitor) Good 58, Poor 27. Intelligence: (Based on the rough assessment by the Health Visitor) Normal 32, Low 53.

**HOUSING**—The circumstances of 83 families were recorded.

Post War municipal houses	15
Pre War municipal houses	18
Houses in reasonable state	14
Insanitary houses	13
Cottages	14
Rooms	2
Huts or sheds	3
Prefabricated bungalows	4

There are no bathrooms available for 27 families.

#### CHILDREN.

Total number of children	406
Average number of children per family	4.6
Commonest occurring number of children in family	5
Total number of children over school age	80
Total families containing a child over school age	35
Total number of pre-school children	109
Total number of families with a pre-school child	55
Total number of school children	217
Total number of families with a school child	77
Number of school children usually verminous	48 (22%)

Educational ability (Based on the rough assessment by the school teacher, when asked by Health Visitor).

Figures are available for	154 children
Above average intelligence	10
Of average intelligence	42
Retarded 1 year	48
Retarded 2 years	35
Retarded 3 years	15
Retarded 4 years	4
% retarded 2 years or more	35
Irregular attenders at school	52
Highly irregular in attendance	21
Total % of school children who are irregular in attendance	47.4
Delinquency admitted—School children	9
Over school age child	10

#### FAMILY FINANCE.

Details were asked for whenever possible. Income included wages, family allowance, unemployment benefit, National Assistance grants, Pensions and income from sub-letting of the house. Essential expenditure was noted including rent, rates, insurance, hire purchase, debts, arrears of rent and maintenance orders. The balance is the available income shown in the details below. No attempt was made to check the accuracy of the figures given. The incomes of 46 families were recorded.

Available income less than £3	2
Available income between £3 and £4	9
Available income between £4 and £5	9
Available income between £5 and £6	12
Available income between £6 and £7	8
Available income between £7 and £8	3
Available income over £8 (including one of £15)	3

The important figure is, of course, the amount of money available for housekeeping. Unfortunately, this was difficult to obtain. Many families have different methods of organisation—in most cases the mother is the treasurer, but in some the father pays the regular bills such



as rent and rates and may even do all the financial transactions. Consequently, it was not possible to get any reasonably accurate figures from the statements about the money available for household expenses. The commonest occurring available income was £5-£7. In order to produce a comparable figure for families of different sizes, available income per person at home was calculated.

Under 15/- per week per person	...	...	...	...	...	16
Under £1 per week per person	...	...	...	...	...	15
Under 25/- per week per person	...	...	...	...	...	3
Under 30/- per week per person	...	...	...	...	...	5
Over 30/- per week per person	...	...	...	...	...	7

**DISCUSSION**—The incidence of problem families was 0.22 per thousand population and approximately one person in every 685 was from a problem family according to the survey. This compares with one person per hundred in complete surveys in other parts of the country, and suggests ascertainment is by no means complete. A large number of fathers are in permanent employment and therefore any rehabilitation of the whole family away from their home district is impracticable. 32% of the fathers are in ill-health and most of these suffer from digestive trouble. 25% of the fathers are of low intellectual capacity as assessed by the Health Visitor.

Discouragement of the mother is commonly given as a cause of problem families, but not much has been said about the part played by the father in causing this. There are many families where the mother and children, if alone, would improve their condition but the presence of a demanding, lazy and feckless father prevents improvement. Although so many fathers are in permanent employment, this does not prevent them from keeping their wives unnecessarily short of money and from playing the petty tyrant at home. It is difficult to assess the importance of this in the production of problem families. Few of the mothers have any employment and 31% of them are in a poor state of health. 63% are of low mental capacity, thus adding weight to the opinion that this is a primary cause of problem families.

There are usually five children in a problem family. This is more than the average in most families and in view of this it is extremely important to mitigate the effects of environment on so large a number of children. The proportion of school children retarded two years or more in their education is 35% and though this cannot strictly be compared with the estimate of the Minister of Education that 10% of all school children are likely to be educationally sub-normal, it does suggest that a much higher proportion of such children occur in problem families and, therefore, in the worst possible environment. The survey shows 47% of the school children are irregular in their attendance at school and this may in itself be responsible for some of the increase amongst the educationally retarded. In addition, these children are not receiving the full benefits of education. 22% of the children were stated to be verminous. It is very probable that these children constitute the reservoir of infestation in our schools. It is from this reservoir that infestation of normal clean children comes.

Details of the housing of these families show that half of them are in good property. It would, therefore, appear that though housing is undoubtedly an important factor, it is not a primary cause of problem families. Family income shows that the majority of these families have a low available income per head. It is unlikely, therefore, that any of the cost of rehabilitation can be recovered from the family. Divisional Medical Officers were asked to comment on each family. They considered that 29 families would have benefited from a stay in a recuperative home, 14 would have been helped by the cleaning of the household and 30 by the provision of household necessities. Such provision of necessities is, of course, useless unless it is made conditional upon a definite effort to reform. Ten families showed some improvement maintained over one year whilst under supervision by the Health Visitor and ten showed slight improvement during supervision for periods, less than one year.

## Appendix II

### The Brentwood Recuperative Centre

An appreciation of the work of the Brentwood centre was given to the Public Health Committee in the following brief note following the visit of the Chairman of the Health Committee, the Chairman of the Care of Mothers and Young Children and Nursing Services Sub-Committee and myself:—

"We visited Brentwood Recuperative Home on Tuesday, November 14th. On our arrival at 11.45 a.m. Miss Abraham, the Warden of the Home, received us. In 2½ hours we were shown over the Home and were able to discuss in detail with Miss Abraham the aims and objects of the work. The Home is a large private house in a good residential area overlooking the hills of Cheshire; it is within easy reach of shops and entertainment on the one hand and picturesque countryside on the other. The Home was given by the next door neighbour for purposes of convalescence and used during the war for evacuees; after the war it continued as a pioneer venture, mainly for problem families, with a certain proportion of other families in need of rest and rehabilitation. The Home takes ten families, including all the children in the family up to 7 years of age. The families come from all over England, mostly from local authorities but some from voluntary organisations. The tendency is increasingly to take from local authorities and to answer the chief demand—the problem family. The Home cannot now take in all the families for whom they are asked to give assistance. The staff,



including Miss Abraham and her deputy, amounted to ten and the running cost is £7 a week per mother and two children. The Home has plans to extend the building considerably and proposes to increase the number of families from 10 to 14. This would make the total of persons, including staff, in the neighbourhood of 70. This might reduce both the overall cost and the present overcrowding.

We were impressed with the happy atmosphere prevailing. Miss Abraham dedicates her whole life to the work, which is clearly of a most arduous character. Every family is given individual care and attention. There is an ordered plan of operation for the Home, carefully devised to avoid any impression of dragooning or teaching. This plan covers the whole of the day and proceeds throughout the week. The mother is relieved of the care of her children for a large part of the day; for example, the children feed and play separately and mother takes over for bathing at bedtime. This gives a chance for the mother to rest (after doing her share of housework) in the morning; the afternoons are occupied by walks, cookery demonstrations, sewing classes, etc. In the evenings there are informal discussions led by Miss Abraham or by well-wishers from the neighbourhood; on two evenings the whole group of mothers visit the cinema together and on another there is a games and social evening to which two men from Marple contribute.

Miss Abraham left us with no doubt that the family improved considerably during the stay (not less than one month); a new sense of well-being and appreciation replaced despondency and abandon. This, as far as she could judge, generally continued afterwards (Miss Abraham had herself just visited 9 "old" families in London and found 8 maintaining an improved status). However, Miss Abraham made it clear that the recuperative home could only be regarded as one part of a much wider picture and that success depended on much else besides; for example, the clearing up and improvement of the home environment while at Brentwood and the continued supervision and guidance after return."



## PART XI

## COUNTY AMBULANCE SERVICE

The Service is under the charge of Mr. V. Whitaker, County Ambulance Officer, who has supplied the following report:—

"It is now almost three years since the "Appointed Day" when the Service first commenced operations under Section 27 of the National Health Service Act, 1946. In the first instance patient demand which the Service would have to meet was one of conjecture and it is only in recent months that the continued rise in patients using the service has stabilised to what may now be considered the future annual demand. No major policy changes have taken place during the year. Concentration has been on consolidating at the present stage of development and improving operational efficiency. To this end discussions are taking place with the various Hospital Management Committees to promote means of reducing patient waiting time and maintain appointment times. One such instance is for the hospitals to allocate specified treatment times to residents in defined catchment districts, and is a system that will eventually reduce the number of ambulance journeys previously undertaken. Gains of this nature will do much to improve the service in general. With the exception of new entrants in the Service, First Aid training of personnel now stands at 100% qualified and additional training is also given in the use of oxygen resuscitation equipment that has been fitted in all ambulances.

Since the last report, six local authority Services have been transferred to direct Control and the areas so arranged that service is now provided from four Depots. Twelve agency services still remain; two operated by private concerns, five by the St. John Ambulance Brigade, one ex-Miners' Welfare Service and four by local authorities. With the exception of the latter and possibly that of the Selby St. John Ambulance Brigade, there are no physical or economic reasons for directly controlling the remaining agencies unless some unforeseen development takes place in the future. During the year 20 Morris Ambulance/Buses and 20 Daimler Ambulances have been taken into service bringing the total fleet strength to 137. Of this total 46 vehicles have been fitted with radio equipment.

County Controlled Depots are now established at Bentley near Doncaster, Birkenshaw, Bramham, Brighouse, Castleford, Garforth, Goole, Guiseley, Harrogate, Hoyland, Huddersfield, Keighley, Maltby, Morley, Pudsey, Settle, Shipley, Skipton, South Kirkby, Todmorden, Wakefield, Wath; (Sub-depots)—Kiveton Park, Penistone, Pontefract, Rossington, Rothwell.

Agency Depots are established at:—Private concerns—Clitheroe, Thorne; St. John Ambulance Brigade—Grassington, Pateley Bridge, Ripon, Sedburgh, Selby; Local Authority—Barnoldswick U.D.C., Cudworth U.D.C., Earby U.D.C., Holmfirth U.D.C.; Ex-Miners' Welfare Service—Royston.

225,606 patients have been carried in County Council or agency vehicles a distance of 2,844,993 miles (agency vehicles 20,532 patients and 326,953 miles). The patient figure is based on the single daily registration of each patient irrespective of one way or return journeys. This work has included 123,613 out-patients, 31,045 admissions to hospital (not including accidents), 27,768 discharges from hospital, 6,439 transfers, 4,597 accidents and 11,612 M.D. children. 157 patients have been conveyed by train."

The point of view of a Divisional Medical Officer on the working of the service is set out in the following statement compiled by Dr. E. Ward., Divisional Medical Officer for Division No. 20 (covering the Urban Districts of Colne Valley, Denby Dale, Holmfirth, Kirkburton and Meltham with an estimated population of 74,225):—

"During the year close co-operation has been maintained with the Superintendent of the Huddersfield Depot and any difficulties of a medical nature arising have been discussed. These have been much fewer than in the previous two years, in fact not more than two or three cases have come to my notice during the year as compared with one or two each week in 1948. The general practitioners and hospital authorities have co-operated more readily than hitherto, and there is now much less chance of improper use of the service than formerly. So far as hospital out-patients are concerned the first journey to hospital is made on the authority of the general practitioner, but transport is only provided for subsequent visits when this is requested by the almoner on the instruction of a hospital medical officer, the authorisation being limited in each case to a period not exceeding one month, subject to renewal. The public generally, the doctors and the hospital authorities now seem to appreciate the practical limitations of the service and complaints regarding delays are now seldom received.

The collection and return of groups of patients by means of the small 12-seater buses now available naturally involves delays and detours, but it is obviously impossible and undesirable to provide a private taxi service for each patient. So far as cases for urgent removal are concerned, these are adequately covered. Two of the ambulances were equipped with wireless control by the end of the year, whilst the drivers of the other vehicles get in touch with the depot whenever they are collecting or delivering patients at the various hospitals. All drivers are required to pass a qualifying examination in first aid within 9 months of joining the service, and must pass a further proficiency examination every 18/24 months. Records of the attendances of drivers at first aid classes are kept by the Depot Superintendent.



During the year the ambulances from the Huddersfield Ambulance Depot made 4,564 journeys involving 122,769 miles and carried 13,323 patients, 2,892 of these being stretcher patients. Included in the 13,323 patients carried were 10,244 hospital out-patients. Particulars of the cases carried are given below:—

Accident ... ..	201
Urgent ... ..	330
Maternity ... ..	176
Infectious ... ..	—
Mental ... ..	25
General ... ..	2,347
Out-Patients ... ..	10,244
	<hr/>
	13,323

In addition to the ambulances stationed at the Huddersfield Depot, an ambulance, the property of the Holmfirth Urban District Council, is operated as part of the County Service. This ambulance is available for accident work in the Holmfirth area, the staff coming on duty when called. During the year the Holmfirth ambulance carried 58 cases and travelled 421 miles.

In addition to the Ambulance Service vehicles there are available a number of private cars in the Voluntary Car Pool. These have proved very useful for the conveyance of sitting patients for long distances and for the removal and transfer of patients to mental hospitals. Cars in the Voluntary Car Pool made 141 journeys, these being principally to Leeds, Bradford, York and Doncaster."



## PART XII

### MENTAL HEALTH

Work in relation to mental health has continued with little change in character and scope during the year. The changes which the National Health Service Act had in mind for the promotion of a community free from mental derangements of all kinds will certainly entail the evolution of new services which time and circumstances have not so far permitted. Through the development, particularly of prevention, care and after-care under Section 28, the work of prevention and rehabilitation falls naturally into three sections, that concerned with mental deficiency, that relating to lunacy and the psycho-neuroses; there is a fourth section, Child Guidance, which, although closely related, is provided under the Education Act, 1944. The battle for mental health, like all other community health problems, is a team operation including the Medical Officer of Health, the psychiatrist, the psychiatric social worker, the mental health worker, the authorised officer and the petitioning officer. Among much else there will need to be established centres, conducted by a Medical Officer or a psychiatric social worker for advising those with mental worries; such centres will succeed best when entirely dissociated from the atmosphere of a hospital or clinic. Advances of this character are hardly possible until more trained staff become available, in particular we have as yet no psychiatric social workers, nor have we appointed to the staff the services of a psychiatrist for preventive work in lunacy and psycho-neurosis. Within these limitations the work has continued satisfactorily particularly in mental deficiency with the able assistance of Dr. H. J. O'Loughlin who gives us part-time service. Subject to the limitations which I stressed in previous reports the mental health social workers are undertaking an increasing amount of care and after-care work for patients who have left Mental Hospitals and they help in the provision of background reports when requested. Much of this work is also done by health visitors who combine it with advantage with other activities. The operation of the service is on a divisional basis. Central meetings have been held with the Medical Superintendents of Mental Hospitals throughout the Riding to discuss the ways and means of linking up the work of the Health Department with that of the Hospital and important progress has been made in this direction.

The year saw the beginning of an important venture by the filling of a few vacancies for whole-time Mental Health Social Workers with Health Visitors and the inauguration of a special course of training for these new members in conjunction with the Leeds Department of Psychiatry and the Leeds Regional Hospital Board. (A brief note of the philosophy behind this step is given in Appendix II).

In the field of mental deficiency one of the most important advances is that of the Hostel in which mental defectives can live and from which they can work. This is an old idea which has been extended by the Ministry of Agriculture to meet the needs of the farmer. Two Agricultural Hostels established in the County by the Ministry of Agriculture and staffed by the National Association for Mental Health (one at Ripon and one at Woolley transferred to Tadcaster) have done extremely valuable work. Life for a mental defective in a Hostel is more attractive than in a hospital or colony. I should like to see the use of these and other types of hostel greatly extended and I believe that they would prove economical since they can be made self-supporting and they meet agricultural and other community needs. It is unfortunate that the duty of developing such hostels has not been placed on the shoulders of the mental health authority where it properly belongs. This is a further example of the disadvantage of separating the work of caring for individuals in institutions from that which covers the care in the community; the disadvantage of the division is nowhere more apparent than in the mental health service. It is for example particularly unfortunate that the colony for the mentally deficient, which is, of course, only supplementary to the general care of the mental deficient in the community, should be organised separately. To overcome this we have worked in the closest relationship with the Regional Hospital Boards and the joint employment of a Mental Deficiency Psychiatrist has been of great benefit. I am most grateful to the work which Dr. O'Loughlin has been able to do in the community health field and for his efforts to integrate this work with that of the colony. We have not been able to extend our arrangements for occupation centres but with the experience of the past 3 years the year saw a more defined plan (as indicated in Appendix I) to give effective cover for the whole County. This awaits the general approval of the Ministry, and with the difficulties of building cannot come fully into operation for some years. An account of the working of the only occupation centre (Castleford) to be opened before the end of 1950 is also given in Appendix III.

Details of the year's work under the Lunacy and Mental Treatment Acts, 1890-1930, is given as follows:—633 patients admitted to mental hospitals; under Section II of the Lunacy Act, 1890—2; under Section 16—415; under Section 20—162; under Section 21—54. The Duly Authorised Officers have also assisted with 189 other admissions; under Section I of the Mental Treatment Act, 1930—176; and under Section 5—13. In 203 cases no action was taken under the Lunacy and Mental Treatment Acts; many of these were elderly senile patients, some of whom were admitted to chronic sick wards; others to Part III accommodation under the National Assistance Act whilst in a number of cases the relatives were persuaded to accept the responsibility and care. The number of elderly people referred by General Medical Practitioners for action under the Lunacy and Mental Treatment Acts is still high, due no doubt to the inability of the doctors to obtain places for these old people in chronic sick accommodation. Many of these unfortunate old men and women were normal chronic sick whose mental condition had deteriorated whilst awaiting admission to chronic sick accommodation. Difficulty is still experienced in obtaining accommodation in mental hospitals and this is shown by the increased use of Section 20 (162 cases during 1950 as against 80 in the previous year) but it is hoped that the new catchment areas for mental hospitals arranged by the Leeds Regional Hospital Board will mitigate this difficulty. Several of



the Duly Authorised Officers have commented on the psychological effect of the use of ambulances for the removal of patients to mental hospitals. They are of opinion that the sight of an ambulance calling for the patient often turns an otherwise docile patient into an obstreperous one and we have made arrangements for the use of cars for this purpose. We have appreciated the ready advice and assistance of the Medical Superintendents and Staffs of the mental hospitals.

Details of the work under the Mental Deficiency Acts during the year, are as follows:—320 alleged mentally defective persons were ascertained or reported to the Local Health Authority during 1950 as follows:—(a) by Local Education Authority (i) under Section 57(3) of the Education Act, 1944—117; (ii) under Section 57(5)—98; (b) by parents, Mental Health Social Workers, Doctors, Police, etc.—105. These patients were disposed of as follows:—(a) admitted to Institutions—38 (b) placed under Guardianship—1 (c) taken to a "place of safety"—3 (d) placed under Statutory Supervision—197 (e) died or removed from area—9 (f) action not completed at 31.12.50—53 (g) placed under Voluntary supervision—2 (h) found not to be mentally defective—14 (i) action unnecessary—3. At the 31st December, 1950, the total number of defectives in the Riding, ascertained to be "subject to be dealt with" or where voluntary action was agreed, was as follows:—in Institutions for defectives, or on licence therefrom—1,525; under Guardianship—148; in Places of Safety—5; under Statutory Supervision—1,738; under Voluntary Supervision—275; action not yet completed—74. Of these 90 were receiving training in occupation centres and 201 were being trained at home by home teachers and social workers. There is a greatly increasing demand for occupation and industry centres for mentally defective persons. Orders under Section 6 of the Mental Deficiency Act, 1913, were made sending 107 patients to institutions; 7 Orders were made by Courts under Section 8; 11 Orders were made by the Secretary of State under Section 9 and Varying Orders were made transferring patients from guardianship to institutions, a total of 134 Orders during the year. Of these patients admitted to institutions, 108 were admitted to institutions in the area of the Leeds Regional Hospital Board; 24 in the area of the Sheffield Regional Hospital Board; 1 in the Newcastle Regional Board area and 1 to the Rampton Hospital.

## Appendix I

### SCHEME FOR THE PROVISION OF OCCUPATION CENTRES AND HOME TRAINING FOR MENTALLY DEFECTIVE PERSONS

Medical Division	Arrangements for Training	Type of Centre recommended
<b>Division 1</b> Population 58,751 Acres 163,666 Barnoldswick Urban, Earby Urban, Silsden Urban, Skipton Urban, Skipton Rural	Children from Skipton and Silsden Urban Districts to attend a Centre in Keighley. A Home Teacher to be provided for some parts of the Division and patients in the more outlying areas to be visited by the Mental Health Social Worker	—
<b>Division 2</b> Population 23,340 Acres 288,088 Sedburgh Rural, Settle Rural, Bowland Rural	Home Teacher to be provided for more populated districts, but patients living in outlying areas to depend on guidance of parents by Mental Health Social Worker	—
<b>Division 3</b> Population 56,570 Acres 23,611 Keighley Borough	A full Centre for all types of patients. Home Teacher may be needed to visit some of the crippled children, etc.	C
<b>Division 4</b> Population 67,384 Acres 18,968 Bailldon Urban, Bingley Urban, Denholme Urban, Shipley Urban	A small Centre to be provided, the higher grade children and adults to go to the Keighley Centre. Home Teacher to be provided for isolated cases.	A
<b>Division 5</b> Population 72,150 Acres 14,885 Aireborough Urban, Horsforth Urban, Pudsey Borough	A Centre to be provided at Guiseley to serve also Ilkley and Otley	A
<b>Division 6</b> Population 34,630 Acres 50,922 Ilkley Urban, Otley Urban, Wharfedale Rural	A Centre at Guiseley in Division 5 to take patients from Ilkley and Otley. A Home Teacher to be provided for remainder of the Division	—
<b>Division 7</b> Population 23,082 Acres 126,673 Ripon City, Ripon and Pateley Bridge Rural	Home Teacher to visit a few patients in the more populous areas, and the Mental Health Social Worker to continue to advise parents in the other cases	—
<b>Division 8</b> Population 74,270 Acres 85,823 Harrogate Borough, Knaresborough Urban, Nidderdale Rural	A Centre to be provided for Harrogate and Knaresborough and a Home Teacher for the rest of the Division	A
<b>Division 9</b> Population 48,250 Acres 140,257 Tadcaster Rural, Wetherby Rural	Children who can attend Centres in Leeds or other Divisions by vehicles otherwise employed to continue to do so. Home Teacher to be provided for most cases in the Division	—



Medical Division	Arrangements for Training	Type of Centre recommended
<b>Division 10</b> Population 45,390 Acres 74,800 Selby Urban, Selby Rural, Goole Borough, Goole Rural	Home Teacher to be provided	—
<b>Division 11</b> Population 62,710 Acres 7,460 Castleford Urban, Normanton Urban	Centre for Castleford, Normanton, and parts of Rothwell. Adult males to attend Oulton Hall for training and possibly a few older females could attend Hatfield Hall.	A
<b>Division 12</b> Population 53,995 Acres 46,078 Featherstone Urban, Knottingley Urban, Pontefract Borough, Osgoldcross Rural	A small Centre for Pontefract and Knottingley and some of the nearer mining villages. Home Teacher to be provided for rest of Division	A
<b>Division 13</b> Population 42,214 Acres 26,448 Horbury Urban, Ossett Borough, Wakefield Rural	A Centre in or near Wakefield to serve parts of this Division and also Stanley and Outwood (Division 16) and parts of Morley (Division 14). If the Wakefield City Authority are prepared to join a large Centre to be provided	C
<b>Division 14</b> Population 39,800 Acres 9,493 Morley Borough	Children from the Division to attend Centres in Wakefield, Leeds, Batley or Cleckheaton	—
<b>Division 15</b> Population 48,815 Acres 5,157 Batley Borough, Heckmondwike Urban	Arrangements to be made for patients from the Division to attend a Centre in Dewsbury and in Cleckheaton	—
<b>Division 16</b> Population 53,170 Acres 19,584 Rothwell Urban, Stanley Urban, Garforth Urban	Most of the patients from this Division to continue to attend the Castleford Centre, but those from Stanley Urban District to attend a Centre in or near Wakefield. Garforth to be served by a Home Teacher	—
<b>Division 17</b> Population 48,700 Acres 11,645 Mirfield Urban, Spenborough Urban	A medium Centre to take also children from parts of Batley and Morley	B
<b>Division 18</b> Population 59,205 Acres 16,614 Brighouse Borough, Elland Urban, Queensbury and Shelf Urban	A small Centre for Brighouse and Elland. Children from Shelf and Queensbury to attend Westwood Hospital daily for training or Centres in Halifax or Bradford	A
<b>Division 19</b> Population 57,467 Acres 60,683 Hebden Royd Urban, Hepton Rural, Ripponden Urban, Sowerby Bridge Urban, Todmorden Borough	Children from Sowerby Bridge to attend a Centre in Halifax and the remainder of Division to be served by Home Teacher	—
<b>Division 20</b> Population 74,252 Acres 63,620 Kirkburton Urban, Meltham Urban, Denby Dale Urban, Holmfirth Urban, Colne Valley Urban	The focal point of the Division is Huddersfield and a Centre to be provided in or near there if arrangements cannot be made for patients to attend Centres opened by Huddersfield Corporation	B
<b>Division 21</b> Population 16,760 Acres 18,485 Saddleworth Urban	Children to attend Centres in Oldham, as more provision is made by that Authority. Other training to be provided by home teaching	—
<b>Division 22</b> Population 82,500 Acres 89,922 Hoyland Nether Urban, Stocksbridge Urban, Wortley Rural, Penistone Urban, Penistone Rural	Centre to be provided for southern part of Division to serve growing population at Parson Cross, Grenoside, etc. Other children to attend a Centre in Barnsley, but a Home Teacher to be provided for much of the Division	B
<b>Division 23</b> Population 61,630 Acres 33,182 Hemsworth Urban, Hemsworth Rural	A small Centre to be provided and outlying districts to be served by Home Teacher	A
<b>Division 24</b> Population 31,023 Acres 7,894 Cudworth Urban, Darton Urban, Royston Urban	A medium Centre to be provided in Barnsley for Division 24 and patients of Divisions 22 and 25	B



Medical Division	Arrangements for Training	Type of Centre recommended
<b>Division 25</b> Population 43,306 Acres 11,133 Darfield Urban, Wombwell Urban, Worsborough Urban, Dodworth Urban	A medium Centre in Barnsley for Division 24 and patients of Divisions 22 and 25	—
<b>Division 26</b> Population 44,240 Acres 6,907 Swinton Urban, Rawmarsh Urban, Wath-upon-Deane Urban	A large Centre to be provided in Wath-upon-Deane for Divisions 26 and 30 and parts of Division 25	C
<b>Division 27</b> Population 39,100 Acres 8,561 Adwick-le-Street Urban, Bentley-with-Arksey Urban	Patients from this Division to attend the Centre in Doncaster. A Home Teacher to be provided	—
<b>Division 28</b> Population 55,376 Acres 81,236 Doncaster Rural, Tickhill Urban	Do. .... Some older patients might attend the St. Catherine's Institution, Doncaster, daily for training	—
<b>Division 29</b> Population 31,910 Acres 38,419 Thorne Rural	Population not adequate to justify a Centre. Training to be done by home teaching	—
<b>Division 30</b> Population 60,120 Acres 6,933 Conisbrough Urban, Mexborough Urban, Dearne Urban	A Centre in Wath-upon-Deane (Division 26) for Divisions 26 and 30	—
<b>Division 31</b> Population 76,840 Acres 53,592 Maltby Urban, Kiveton Park Rural, Rotherham Rural	A Centre to be provided in one of the larger colliery villages	A

The types of Centres referred to above are as follows:—

- A Small Centres serving a restricted area.
- B A somewhat larger Centre which would take boys who have reached puberty and need to be under male supervision.
- C A larger Centre taking brighter children and adult males and females, where provision can be made for more advanced training and industries, such as weaving, boot repairing, simple joinery, laundry work, etc.

County Hall,  
Wakefield,  
January, 1951.

## Appendix II

### A Consideration of the Use of Health Visitors as Mental Health Social Workers

I have, in my last Annual Report, spoken of the important role played by Social Workers in the community; this is ever growing and the public as well as general Medical Practitioners are becoming increasingly aware of the great help that such workers can be. I also referred to the acute shortage, indeed absence, of trained Psychiatric Social Workers. The result is that mental health Social Workers have still to be recruited from the ranks of untrained persons. Great care is required in the selection of untrained persons, for not all candidates are suitable for the work although this service has, so far, been fortunate in its social workers. Because of this dearth of trained workers and the advisability of knowing well the candidates for the position of untrained worker, the thought of using health visitors as mental health social workers presents itself to one's mind; as an experiment it may have several advantages to commend it as follows:—in the first place, only those candidates considered suitable by the supervisors of health visitors would be accepted and it is reasonable to believe that health visitors cannot know less about mental health than any other untrained worker. It is also reasonable to believe that they know more, for their course includes lectures on psychology. There is another tremendous advantage in that the health visitor would be taught to regard the patient as a whole, taught to help the person as well as fight the disease; health of body and mind are indivisible; every sick man is to some extent a worried man; the mother of every sick child is to some extent an anxious woman. How eminently desirable, then, it would seem to have health visitors who possess a knowledge of mental as well as physical health; attendance at the out-patient clinic of any Infirmary would rapidly convince anyone of the importance of good mental health in the treatment of physical diseases.



It has been customary to give untrained workers appointed to the mental health service a period in the central office together with lectures at a Mental Deficiency Colony. This course has been adopted and extended for the health visitors appointed under the above scheme to cover five months as follows:—First month—one week in the central office: instructions in Mental Deficiency and Lunacy and Mental Treatments Acts, Regulations, etc.: lectures at Oulton Hall, a Mental Deficiency Colony, on psychology, anatomy and physiology—2 days each week, and attendance at occupation centres in Leeds, Castleford and Doncaster. 2nd month—at Oulton Hall for further lectures and demonstrations and on the wards. 3rd month—lectures and demonstrations, etc., at the Stanley Royd Mental Hospital and out-patient clinics. 4th month—Child Guidance, attendance with Dr. McTaggart, County Child Guidance Service. 5th month—lectures and demonstrations at Neurological and Child Guidance clinics, arranged by the Departments of Psychiatry of Leeds University. A feature of the arrangement is that each health visitor so appointed may at the end of one year make a choice whether (a) to leave the mental health section and resume the usual duties of the health visitor but now able to do mental health social work more effectively in her general duties, or (b) to continue in whole-time mental health work. In the event of the health visitors returning to general duties the gradual development of the scheme by fresh secondments each year will rapidly extend the number of health visitors with this special experience and hence give a widespread advantage already mentioned that there will be only one instead of two persons visiting the patient in his home. The salary scales fluctuate so frequently today that it is difficult to estimate the relative cost of professional services but, in fact, there is now so little difference in the scales applied to health visiting and other forms of social work that any difference in cost arising out of this new venture must be very slight. There is, of course, some economy in using one basic worker over that incurred in the use of two or more; the saving relates to the time and cost of travel.

### Appendix III

#### CASTLEFORD OCCUPATION CENTRE

Dr. Paterson (Division 11) has given the following account of the Castleford Occupation Centre for the year 1950:—The Centre re-opened on the 9th January, 1950, after the Christmas holidays, with 35 children in attendance of whom 31 attended in 1949 and during the year under review 4 new admissions were made. The children were divided into three classes according to their mental grading, and a supervisor and three unqualified assistants were in charge of them. The lessons taught were in keeping with the mentality of the group, that is, simple sense training, speech exercises and physical exercises (with and without music) for Class I, with a rather more difficult routine for Class II, and a still harder programme for top grade defectives. If a child was found to make progress in one particular group, he or she was moved to the next higher group. As two-thirds of the total children were mongols, dancing, singing and percussion bands proved to be the most suitable and popular types of exercises to their requirements. During the past year, all children who attended regularly appeared to derive benefit from training in general tidiness, personal cleanliness, obedience and good manners.

In general, speech has greatly improved throughout the School, and notably as in the case of two boys. One of these boys received dental treatment and this noticeably assisted his articulation. Diction and tone have been improved by means of simple poems, nursery rhymes and singing. Handwork of a simple nature involving threading, lacing, tying, etc., is done by smaller children and the lower grade types, but sewing, knitting, rug making, simple cane and raffia work was done by the higher grades. Owing to the inability of the children to concentrate for long periods, handwork lessons show very slow progress. Only 7 children were unable to tie their own shoe laces, and 5 could not dress themselves. Two of these 5 children will require further training in this respect after which there appears to be no reason why they should not be physically capable of performing this function. Training in the use of the toilet and washing is very slow, as at home this is nearly always done for them by their parents. Seeing other children who are "clever" and can look after themselves is a great incentive to the "backward" child to be more self-reliant and soon it, in turn, tries hard to reach a higher standard of self efficiency.

During the year, "Mothers' Day" was held at the end of every month, with demonstrations of speech, speech and movement, music and movement, and percussion band exercises. These little concerts with "Mother" for audience encouraged the children to do their best, as all the children are exhibitionists and love to "show off" whenever the opportunity arises. The bi-monthly meetings of the Mental Health Sub-Committee were held at the Centre during the year, when members expressed their pleasure at the good behaviour and general improvement of the children as a whole. All who visit the Centre, be they guests from other Centres, or those who are in daily contact with the children, are impressed by the general air of interest and well being of the pupils. It is common knowledge that, deprived of the benefits of any form of education, such children rapidly lose all contact with their surroundings and the human beings populating them, and they become more dull and apathetic than normally should be the case. They simply degenerate lower and lower and even the kindly ministrations of their parents have little or no effect on them whatsoever. Placed in an occupation centre, these children, properly handled, quite quickly become amenable to discipline and co-operative, showing a lively interest in their surroundings, and it is a joy to watch them make social contacts with mental equals, which not infrequently ripens into friendship, irrespective of their physical age or characteristics. It has not infrequently been said that money spent in educating these children is money wasted, but to such people, I would say "Visit



such a Centre, take an interest in these poor unfortunates, and it will soon be realised that quite a lot can be done to rehabilitate them." By no stretch of imagination can they ever be brought to any accepted standard of normality, but at least their miserable lot can be ameliorated and made more bearable.

Although the need has not so far been pressing, the fact will have to be faced in the near future that suitable provision will have to be made for those in the Centre whose need for expression demands more vigorous outlets than are possible at the Local Centre, and for such, especially in the case of boys, a Centre where woodwork, basket making, cobbling, and even tailoring are taught would be more in keeping with their increasingly advancing needs.



## PART XIII

### ENVIRONMENTAL HYGIENE

#### Milk

The County Council, as a Food and Drugs Authority (Section 64 of the Food and Drugs Act, 1938) has completed its first full year as a Licensing Authority for the Milk (Special Designation) (Pasteurised and Sterilised Milk) Regulations, 1949. At the end of the year there were 32 licences in force for the production of pasteurised milk, widely distributed throughout the county. These licensed establishments were regularly inspected by the County Sanitary Inspectors (516 inspections). Monthly reports on samples are forwarded to the Ministry of Food. The table below shows the action taken regarding breaches of the Regulations:—

Verbal Advice or Cautions	Warning Letters from the County Medical Officer	Warning letters from the Clerk of the County Council	Reference to the Public Health Sub-Committee	Visits regarding unsatisfactory phosphatase and methylene blue tests on samples
88	5	14	2	30

The following conditions apply to milk in relation to which the special designation "Pasteurised" is used:—The milk shall be pasteurised, i.e.:—(a) retained at a temperature of not less than 145°F. and not more than 150°F. for at least thirty minutes and be immediately cooled to a temperature of not more than 50°F., or (b) retained at a temperature of not less than 161°F. for at least fifteen seconds and be immediately cooled to a temperature of not more than 50°F., or (c) retained at such temperature for such period as may be specified by the licensing authority, with the approval of the Minister. Samples of pasteurised milk are subject to the phosphatase and methylene blue tests. The former test is to prove the efficiency of the treatment as to whether or not the milk has been properly pasteurised, or whether any raw milk has been added after treatment. The methylene blue test shows the keeping quality of the milk. The number of samples obtained during the year by the Milk Sampling Officer is as follows:—

Total	Phosphatase Test			Methylene Blue Test		
	Satisfactory	Unsatisfactory	No result	Satisfactory	Unsatisfactory	No result
823	790	25	8	754	36	33

Licences in force at the end of the year are as set out below:—

1. Co-operative Wholesale Society Ltd., Maxwell Street, Morley; 2. Skipton District Dairy Farmers Ltd., Skipton;
3. A. Wild, Prospect Farm, Grotton, Near Oldham; 4. H. A. Button, Mickethwaite Dairy, York Road, Wetherby;
5. Paley's Dairies Ltd., Brandon Nook Farm, Shadwell, Near Leeds; 6. H. J. W. Scarr, Prospect Farm, Bradley, Near Keighley; 7. West Marton Dairies Ltd., West Marton, Near Skipton; 8. J. E. and E. Oates, Thorne Dairies, Thorne, Near Doncaster; 9. J. Mawer and Sons, Glentworth House, Skellow, Near Doncaster; 10. Whittaker's Wholesale Dairies Ltd., Adwick-le-Street; 11. Laurence Bros., Bramhope, Near Leeds; 12. Pontefract Industrial Co-operative Society Ltd., Pontefract; 13. Dobsons' Dairies Ltd., Barnoldswick; 14. Goole Co-operative Society Ltd., Centenary Road, Goole; 15. E. O'Shaughnessy, Benson Lane, Normanton; 16. L. W. Roberts, Eastfield Dairy, Normanton; 17. Kirkby Malzeard Dairy Co., Kirkby Malzeard, Near Ripon; 18. Stocksbridge Co-operative Society Ltd., Stocksbridge; 19. Busfield and Hargreaves, Rawson Dairy, Farsley, Near Leeds; 20. A. Yates, Hightown, Liversedge, Cleckheaton; 21. Doncaster Co-operative Society Ltd., York Road, Doncaster; 22. Wholesale Dairies (Rotherham and District) Ltd., Claypit Lane, Rawmarsh; 23. G. Millington, Denison's Yard, Yeadon; 24. Windhill Co-operative Society Ltd., Shipley; 25. Knowles Bros., Strawberry Avenue, Garforth; 26. West Riding Dairy Farmers (Wholesale) Ltd., Allan Park Dairy, Sowerby Bridge; 27. Miss B. J. Mudd, Aldborough Dairy, Boroughbridge; 28. Wharfedale Creamery Co. Ltd., Bolton Bridge Road, Ilkley; 29. P. Salmon, Orchard House, Littlethorpe, Near Ripon; 30. R. H. Harrison, Manor Farm, Conisbrough; 31. H. D. Peirson, Victoria Road Dairy, Burley-in-Wharfedale; 32. A. E. Maxfield, Ivanhoe Dairy, Conisbrough.

**Hospital Farms**—At the request of the Ministry of Health, samples of milk were obtained from the following farms:—Menston; Middleton Sanatorium; Middlewood; Scalebor Park; Stanley Royd; Stansfield View; Wheathead.

Results of the examinations carried out were as follows:—

	Number	Satisfactory	Unsatisfactory	Positive	Negative
Methylene blue test ... ..	112	85	27	—	—
Tubercle ... ..	30	—	—	2	28
Brucella Abortus ... ..	28	—	—	1	27

Monthly returns were made to the Ministry of Health, also immediate notifications in connection with positive reports regarding examinations for tubercle bacilli or Brucella Abortus were made to the Ministry of Health, the Ministry of Agriculture and Fisheries, and to the Medical Officers of Health for the districts concerned.



**Supply of Milk to School Children**—The Provision of Milk and Meals Regulations dated 6th June, 1945, state:—"1. The source and quality of the milk supplied for drinking shall be approved by the Medical Officer of Health for the County or County Borough concerned, after consultation with the Medical Officer of Health for any County District concerned, and, if the School Medical Officer is a person other than either of the two officers first mentioned, with that officer. 2. If milk which satisfies the requirements (1) of this Regulation is not available, the Minister may approve the substitution therefor of an equivalent quantity of full-cream dried milk suitably prepared for drinking and if he so approves, the Authority shall make that substitution."

Under the existing scheme milk is supplied to school children in one-third pint bottles. The only exceptions to this arrangement are a few isolated schools, which, of necessity, must be supplied with liquid milk in bulk. The amount of milk supplied during the year was 34,483,106 bottles [average number of bottles per day 164,252; total number of schools supplied with milk—(a) in bottles 1,015 (Departments 1,263) (b) in bulk 9]. Approximately 95 per cent. of the above school departments are supplied with pasteurised milk, the remainder with milk produced at Tuberculin Tested Farms, and a small number of ordinary milk farms. 725 samples were obtained during the year and of these 650 were satisfactory and 75 unsatisfactory.

### Food and Drugs Acts, 1938—50

All County Inspectors of Weights and Measures are appointed Sampling Officers for the purposes of the above Acts, 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 given me details for this report. 4,115 samples were procured (Milk 3,125, Milk Products 19, Ice Cream 11, Meat Products 130, Soup and Vegetable Products 8, Sauces and Condiments 158, Beverages 93, Fruits, Preserves and Sugar 164, Oil and Fat Products 29, Cereals and Confectionery 207, Miscellaneous Products 62, Drugs 109).

Of the 131 alleged adulterated samples 109 were in respect of milk which was low in the fat content or milk to which water had been added. 22 prosecutions were taken, and 75 letters of warning were sent to retailers and dealers by the Clerk of the County Council. 6 reports were submitted to the Ministry of Food for their attention. Practically all the sampling of articles other than milk set out in the above summary has been carried out at the time Inspectors have visited shops on Weights and Measures Inspection. A few samples were taken in respect of complaints received by the County Council. In the industrial areas, particularly in South Yorkshire, the pasteurisation of all milk retailed has resulted in producer-retailers transferring the retailing part of their businesses to the Co-operative Societies and the large private distribution firms. In one area with 20 retailers in 1938 only one supplies milk today.

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 1950 was 556 of which 14 were found to be adulterated.

### Sanitary Circumstances

**Housing**—In the Municipal Boroughs and Urban Districts there were 362,224 dwelling houses and in the Rural Districts 119,007. County District Councils have again continued under difficulties their schemes for re-housing, the numbers of new houses provided during the year being as follows:—

<i>Permanent Traditional.</i>	<i>Permanent Non-Traditional</i>	<i>Permanent Aluminium Bungalows.</i>	<i>Total.</i>
3,985	829	116	4,930
By Private Enterprise:—			
<i>Houses.</i>	<i>Police Houses.</i>		
613	17		

It is still evident that many families are living under very unsatisfactory conditions and, during the year, 159 letters were received by the County Medical Officer from tenants and sub-tenants, requesting assistance in obtaining alternative accommodation. 29 personal visits were also made to the Department. In every instance, requests for assistance were referred to the County Districts concerned, particular emphasis being paid to those cases where any members of a family are suffering from the effects of tuberculosis. Overcrowding would appear to be one of the serious problems yet to be dealt with.

The following details have been extracted from the Housing Returns of the County Districts and give the position regarding unfit houses, houses not in all respects fit for habitation, Demolition Orders made, houses demolished, etc.



Total Number of Municipal Boroughs and Urban Districts	Number of Districts for which details were given	Unfit houses	Houses not in all respects reasonably fit for habitation	Demolition Orders Made	Houses demolished or closed following Demolition Orders	Houses overcrowded at year end	Cases of overcrowding abated during the year
68	64	3,271					
	65		13,472				
	67			124	160		
	41					3,629	
	52						1,097
Total number of Rural Districts							
21	20	2,696	7,707	54	31		
	16					1,642	
	15						286

The approximate number of back-to-back houses in the Administrative area of the County is 30,000.

HOUSING (RURAL WORKERS) ACTS, 1926-1942. The number of cottages inspected by the County Sanitary Inspectors during the year was 306. These visits were made to cottages for which grants have been given under the above Acts. The work entails ascertaining the structural conditions of the cottages, tenancies, rents paid, etc., and the compiling of schedules whereby any defective conditions are notified to the owners by the Clerk of the County Council, following reports by the County Medical Officer. This routine work is of an extensive nature and entailed visits in the following Rural Districts:—Selby, Tadcaster, Ripon and Pateley Bridge, Nidderdale, Bowland, Wetherby, Kiveton Park, Hepton, Doncaster, Wakefield, Hemsworth, Rotherham, Wharfedale, Settle, Penistone and Goole. Other cottages are situated in the outlying parts of Todmorden and Bingley.

#### Closet Accommodation

	Municipal Boroughs and Urban Districts	Rural Districts	Total
No. of privies with open middens ... ..	441	4,124	4,565
No. of privies with closed middens ... ..	6,481	7,220	13,701
No. of pail or tub closets ... ..	4,174	7,978	12,152
No. of water closets (including trough closets) ...	322,284	93,255	415,539
No. of waste water closets ... ..	7,501	2,113	9,614
No. of other closets ... ..	354	485	839
Total closets ... ..	341,235	115,175	456,410
Percentage on water carriage system ... ..	96.6	82.8	91.2

**Scavenging and Refuse Disposal**—It can be considered that this work has, on the whole, been satisfactorily carried out. In certain parts of six boroughs and urban districts, refuse collection is not undertaken and in the case of eight rural districts there are some parishes in which there is no collection of refuse. The tables below show the methods of disposal of refuse:—

Municipal Boroughs and Urban Districts	100% Controlled Methods.	Non-Controlled Methods.	Part: Controlled methods and by destruction and disposal to farmers.	Part: Controlled methods along with non-controlled methods.	Controlled methods, separation, salvage and destruction	Controlled methods and destruction	Controlled methods and disposal to farmers.	Controlled methods and Salvage
68	46	1	5	4	1	5	5	1

Rural Districts	100% controlled methods	Non-controlled methods	Part controlled and part non-controlled methods	Partly controlled methods	Controlled methods and disposal to farmers	Non-controlled or part controlled methods and disposal to farmers
21	10	1	1	3	2	4



**Water Supplies**—The approximate percentage of dwelling houses on public water supplies was 97 in Municipal Boroughs and Urban Districts and 90 in Rural Districts.

	Municipal Boroughs and Urban Districts	Rural Districts	Total
No. of dwelling houses ...	362,224	119,007	481,231
No. of above on public supply ...	350,695	106,631	457,326
Percentage on public supply ...	97	90	95

Houses not on public supplies in the Municipal Boroughs and Urban Districts are mainly in the very outlying parts of the districts, and in the Rural Districts, in the isolated areas, away from any public supplies and for which new schemes of supply would either be impracticable or entail considerable cost. Regular sampling of water supplies is carried out by the officials of County Districts and in cases of pollution, etc., action is taken to remedy matters. The number of samples obtained during the year is as follows:—

	Chemical Analysis			Bacteriological Examination		
	Number obtained	Satisfactory	Unsatisfactory	Number obtained	Satisfactory	Unsatisfactory
Municipal Boroughs and Urban Districts	665	616	49	2,947	2,458	489
Rural Districts	102	85	17	1,075	774	301

**PLUMBO-SOLVENT WATER SUPPLIES.** 64 supplies in the County are known, or suspected to be, plumbo-solvent, and in accordance with normal practice, the County Health Department arranged for samples of such supplies to be submitted for examination for the presence of lead, the samples being taken in pairs, one after the water had stood in the lead service pipe for 30 minutes, and the other after the water had stood in the pipe all night. 254 samples from the 64 supplies were collected and examined. In the case of only two supplies was lead found to be present in quantities considered to be injurious to health. The results generally indicate that measures to counteract plumbo-solvency are being effectively maintained.

**Drainage and Sewerage**—The following table shows the number of houses not connected to sewers in 61 of the Municipal Boroughs and Urban Districts, and in 14 of the Rural Districts, no details having been given in the remaining cases:—

	No sewer available	No reasons given	Outlying farms and smallholdings	Houses below sewer level	Total
Municipal Boroughs and Urban Districts ... ..	5,851	2,662	291	71	8,875
Rural Districts ... ..	10,001	2,365	—	—	12,366

#### Nuisance Inspections and Action Taken

	Number of inspections made	Nuisances found in 1950	Nuisances in hand at end of 1949	Total needing abatement	Abated during 1950	Outstanding nuisances at end of 1950	Informal notices served	Statutory notices served
Municipal Boroughs and Urban Districts	96,264	29,474	8,604	38,078	30,784	7,294	30,743	2,386
Rural Districts	9,370	5,120	1,125	6,245	5,173	1,072	4,221	497
Totals	105,634	34,594	9,729	44,323	35,957	8,366	24,964	2,883

The average number of nuisances abated during the year in each of the Municipal Boroughs and Urban Districts was 453, and in each of the Rural Districts 246.

**Prevention of Damage by Pests Act, 1949**—During the year the County Medical Officer was notified by the Chief Education Officer regarding infestations of rats and mice at school canteens and kitchens and inspections were carried out by the County Sanitary Inspectors, in conjunction with the Sanitary Inspectors of the County Districts concerned. 71 inspections were made. Reports were prepared regarding any structural defects at the premises and these were notified to the Chief Education Officer. Disinfestation treatment was carried out by the local Sanitary Inspectors, as well as by the canteen staffs, who used traps supplied by the Education Department at the



request of the County Sanitary Inspectors. A local authority, under the above Act, may serve notice upon the owner or occupier of any land (which includes buildings), requiring action to be taken to rid buildings of rats and mice. The co-operative action outlined has been smoothly operated, both before, and after the Act came into force and, as a result, notices have been unnecessary. The services rendered by the Sanitary Inspectors of the County Districts were much appreciated.

**Rural Water Supplies and Sewerage Act, 1944**—During the year applications were made as follows for grants in aid of schemes:—

Name of Authority	Description of Scheme	Date of Application	Estimated cost of scheme
Colne Valley U.D.C.	Extension of Sewer to Westward Edge, Golcar.	13.3.50	£5,600
Denby Dale U.D.C.	Sewerage and Sewage Disposal Works at High Flatts (Scheme E).	7.2.50	£7,200
ditto.	New Sewer at Riding Wood, Clayton West (Scheme F).	2.1.50	£1,850
Doncaster and Tickhill Joint Water Board	Hooton Pagnell, Brodsworth and Pickburn Water Supply.	4.9.50	£26,000
Doncaster R.D.C.	Barnbrough and Harlington Sewerage and Sewage Disposal.	21.2.50	?
Hemsworth R.D.C.	Kirk Smeaton and Little Smeaton Sewerage and Sewage Disposal.	7.7.50	£28,650
ditto.	Barnsdale Bar Water Supply.	26.5.50	£10,600
Holmfirth U.D.C.	Extension of water mains to Lane and Stand Bank.	16.1.50	£300
Kirkburton, Holmfirth and Denby Dale U.D.C.'s.	Sovereign (Shepley) Water Supply.	11.12.50	£11,355
Nidderdale R.D.C.	Follifoot Parish Water Scheme.	28.8.50	£2,700
Penistone U.D.C.	Hoylandswaine Sewerage and Sewage Disposal.	15.11.50	?
Penistone R.D.C.	Green Moor Water Supply.	4.1.50	£3,715
ditto.	Ingbirchworth, High Hoyland and Crane Moor Sewerage and Sewage Disposal.	31.1.50	£26,800
Ripon and Pateley Bridge R.D.C.	Regional Water Scheme.	5.4.50	£130,580
ditto.	Borehole at Summerbridge.	7.6.50	£15,120
Settle R.D.C.	Horton-in-Ribblesdale Sewerage and Sewage Disposal.	11.10.50	£14,883
ditto.	Sewer at Thickrash Brow, Bentham.	30.11.50	£1,544
Spenborough U.D.C.	Hartshead Sewerage and Sewage Disposal.	12.9.50	£9,200
Tadcaster R.D.C.	Barrowby Lane Water Supply, Austhorpe.	—	£532
ditto.	Great and Little Preston, extension of sewer.	25.10.50	£342
ditto.	Bilbrough Sewerage and Sewage Disposal.	15.11.50	£4,611
ditto.	Little Fenton and Sherburn Water Supply.	3.11.50	£1,790
ditto.	Newton Kyme Water Supply.	23.5.50	£6,032
Thorne R.D.C.	Hatfield Woodhouse Sewerage Scheme.	17.7.50	£6,350
ditto.	Skyhouse Water Supply.	—	£26,500
Wetherby R.D.C.	Sicklinghall Water Scheme	3.4.50	£5,270
Wharfedale R.D.C.	Timble Water Supply.	19.10.50	£7,400
ditto.	Newall-with-Clifton Sewerage.	30.8.50	£3,650
Wortley R.D.C.	Foldings Water Supply (Wharnciffe Side).	4.11.50	£1,215

#### Ministry of Health Inquiries Attended by the County Sanitary Inspectors

Date	Sanitary Authority	Locality	Purpose	Amount
January 31st	Tadcaster R.D.C.	Parishes of Aberford, Lotherton-cum-Aberford, Parlington, Barwick-in-Elmet, Saxton-cum-Scarthingwell, Barkston, Church Fenton, Ledston, Micklefield, Ledsham, Huddleston-with-Newthorpe	Water Supplies.	£51,186
March 3rd.	Wakefield R.D.C.	Parish of West Bretton.	Sewerage and Sewage Disposal.	£1,720
June 2nd	Denholme U.D.C.	Doe Park.	Sewage Disposal Works.	£12,750
June 21st	Aireborough U.D.C.	—	Conservancy of Water "The Aireborough Area."	—
June 29th	Hemsworth R.D.C.	Parishes of Ackworth, Radsworth and Thorpe Audlin.	Sewerage and Sewage Disposal.	£64,000
November 14th	Tadcaster R.D.C.	Parish of Great Preston.	Bowers Row Clearance Order.	—



Summary of Visits and Duties carried out by the County Sanitary Inspectors. Number of visits, investigations, etc., made:—Licensed Pasteurised Milk Establishments 516; inspections in connection with applications for pasteurised milk licences 18; sampling of milk for biological examination 6; school canteen milk supplies 3; school milk contractors' premises 123; unsatisfactory school milk 3; T.B. Glands in a child, farm visit 1; farms visited along with Ministry of Agriculture and Fisheries Veterinary Officer 4; water supplies at a school camp 1; water supplies at County Institutions 9; water supplies in general 4; alleged nuisance from ponds 2; drainage and sewerage 6; refuse tips and refuse disposal 5; sanitary accommodation at schools 7; school canteens regarding rats and mice 71; suspected food poisoning at schools 14; insanitary conditions in the County Districts 11; smoke nuisances 6; smoke observations 29; meetings of the West Riding Regional Smoke Abatement Committee 5; Ministry of Health Inquiries attended 6; enquiries regarding appointment of Sanitary Inspector in the County Districts 3; meetings with County District officials regarding general sanitary conditions, etc., 153; verminous premises 1; Housing (Rural Workers) Acts 306; meetings with owners or agents of cottages in connection with the Housing (Rural Workers) Acts 4; housing complaints personally investigated 12; schools, dishwashing experiments 198; lectures regarding hygiene in kitchens at schools, residential nurseries, etc., 6; school swimming baths, investigations and sampling 3.

### Atmospheric Pollution

The measurement of Atmospheric Pollution is done throughout the county in co-operation with the Department of Scientific and Industrial Research. The deposit gauges and other instruments are of a standard pattern in connection with which analyses are made at monthly intervals. The County Council agreed in January, 1936, to bear the cost of analyses of deposit gauges provided by County District Councils. Only 8 gauges were operating under this arrangement (Colne Valley 1, Horsforth 1, Keighley 4, Otley 1, Skipton 1). In January, 1949, the County Council approved of a scheme for the provision of deposit gauges, lead peroxide instruments and smoke filter equipment in each Public Health Division. The deposit gauge is for measuring the amount of deposited matter polluting the atmosphere, the lead peroxide instrument the amount of sulphur pollution ( $\text{SO}_2$ ) and the smoke filter the amount of suspended impurity. There are now 34 deposit gauges, 35 lead peroxide instruments and 21 smoke filters in operation under this scheme, but not all of these have been in operation during the whole of 1950. The results of the analyses with these instruments are shown in the following table:—



Situation of Instruments	Rainfall in inches		Deposit Gauge		Sulphur Measurements by Lead Peroxide Method 80(3) per 100 sq. cms. per day Average for period	Situation of Daily Smoke Filter	Average Daily Suspended Impurity Milligrammes per cubic metre Average for period
	Monthly Average	Total	Total solids deposited in Tons per sq. mile				
			Monthly Average	Total			
Skipton—Behind Town Hall in industrial and residential area.	3.03	18.16 for 6 months	14.68	88.07 for 6 months	0.59 for 5 months	On top floor of Town Hall, in industrial and residential area.	0.251 for 2 months
Keighley—Abattoir, Hardings Road in mainly open country.	2.57	28.28 for 11 months	11.34	124.69 for 11 months	1.26 for 8 months	First floor of Public Health Dept., in a built-up area in centre of town.	0.231 for 8 months
Keighley—Oldfield, Oakworth in windy, moorland country.	2.60	31.19 for year	10.56	126.73 for year	1.21 for 8 months		
Keighley—Low Bridge, dense industrial area.	2.49	27.37 for 11 months	15.39	169.34 for 11 months	1.36 for 8 months		
Keighley—Library, built-up area in centre of town.	2.92	35.07 for year	21.01	252.16 for year	1.46 for 8 months		
Bingley—St. Ives Research Station in parkland and residential area.	2.97	23.74 for 8 months	9.73	77.84 for 8 months	0.72 for 8 months	In grounds of St. Ives Research Station, in parkland and residential area.	0.099 for 8 months
Bingley—Town Hall in manufacturing and residential area.	2.93	5.87 for 2 months	14.59	29.19 for 2 months	0.86 for 2 months		
Shipley—Somerset House Clinic in manufacturing and semi-residential area.	3.00	12.00 for 4 months	15.58	62.32 for 4 months	1.20 for 4 months		
Horsforth—Broadgate Walk, residential area.	2.53	30.31 for year	14.41	172.96 for year	1.02 for 8 months		
Aireborough—Yeadon Moor, Yeadon Waterworks, Agricultural N.W. to S.E., manufacturing S.E. to W.	—	—	—	—	0.95 for 8 months		
Otley—Nursery Gardens, Westgate. Manufacturing and semi-residential.	2.71	27.10 for 10 months	12.38	123.75 for 10 months	0.82 for 2 months	First floor of Council Offices, in town centre, mainly manufacturing.	0.211 for 1 month
Ripon—Engineer's Depot, residential area.	2.47	4.93 for 2 months	11.02	22.04 for 2 months	1.15 for 1 month	Health Dept., High Skelgate, in centre of country town.	0.245 for 2 months
Wetherby—Council Offices, residential, surrounded by open country from $\frac{1}{4}$ to $\frac{1}{2}$ mile distant.	2.36	26.00 for 11 months	10.17	111.88 for 11 months	0.54 for 11 months	Council Offices, residential, surrounded by open country from $\frac{1}{4}$ to $\frac{1}{2}$ mile distant.	0.198 for 11 months
Goole—Health Centre, Bartholomew Avenue, residential and industrial.	2.37	26.04 for 11 months	10.37	114.08 for 11 months	1.04 for 11 months	Div. Health Office, in residential and industrial area.	0.253 for 10 months
Castleford—Roof of Marks and Spencer's shop, Carlton Street, in centre of industrial town.	1.83	20.11 for 11 months	19.83	218.15 for 11 months	1.45 for 8 months	First floor of Div. Health Office, in residential area.	0.231 for 8 months
Castleford—Roof of Cleansing Station, Cinder Lane. Manufacturing area.	1.74	19.19 for 11 months	13.57	149.22 for 11 months	1.64 for 8 months		
Castleford—U.D.C. Pumping Station, Ings Lane. Manufacturing area.	1.65	18.10 for 11 months	14.88	163.66 for 11 months	0.95 for 8 months		
Castleford—U.D.C. Housing Depot, Redhill Road, Airedale. Industrial and residential area.	2.02	22.21 for 11 months	13.06	143.69 for 11 months	1.18 for 8 months		



Situation of Instruments	Deposit Gauge				Sulphur Measurements by Lead Peroxide Method Milligrammes SO(3) per 100 sq. cms. per day Average for period	Situation of Daily Smoke Filter	Average Daily Suspended Impurity Milligrammes per cubic metre Average for period
	Rainfall in inches		Total solids deposited in Tons per sq. mile				
	Monthly Average	Total	Monthly Average	Total			
Horbury—Carr Lodge Park, residential and manufacturing to north, open country to south.	2.32	25.55 for 11 months	11.36	125.00 for 11 months	1.13 for 11 months	Sewage Works, $\frac{1}{2}$ mile south of town centre, north manufacturing and residential, south open country.	0.162 for 8 months
Morley—Flat roof of Co-operative Society premises, residential, commercial and manufacturing.	2.56	20.46 for 8 months	19.33	154.63 for 8 months	1.12 for 8 months	Ground floor Public Health Dept., in centre of mixed residential, commercial and manufacturing town.	0.221 for 8 months
Batley—Flat roof of one storied building at rear of P. H. Dept., Market Place. Centre of town. Mixed residential, commercial and manufacturing.	2.46	29.55 for year	22.09	265.04 for year	1.46 for year	Public Health Dept., Market Place, in centre of mixed residential, commercial and manufacturing area.	0.212 for 8 months
Rothwell—Central Clinic, Oulton Lane, residential.	2.18	21.80 for 10 months	12.32	123.16 for 10 months	0.93 for 6 months	Div. Health Office, Oulton Lane, in residential district.	0.316 for 2 months
Elland—"Ellen Royd," Public Library in manufacturing area.	—	1.96 for 1 month	—	12.07 for 1 month	1.89 for 1 month		
Hebden Royd—Redacre Sewage Works, Mytholmroyd, residential and manufacturing area.	3.70	25.87 for 7 months	14.79	103.55 for 7 months	0.92 for 7 months	Redacre Sewage Works, Mytholmroyd, residential and manufacturing area.	0.135 for 7 months
Colne Valley—Marsden Park, residential and manufacturing area.	4.00	40.00 for 10 months	16.89	168.89 for 10 months	1.85 for 1 month	Town Hall, Slaithwaite, in mixed residential and textile manufacturing district.	0.196 for 1 month
Colne Valley—Sewage Works, Slaithwaite.	3.32	39.84 for year	12.49	149.85 for year	1.86 for 1 month		
Holmfirth—Sewage Works, Neley, Brockholes, residential and manufacturing.	2.75	19.23 for 7 months	12.15	85.07 for 7 months	0.91 for 1 month		
Wortley—Hallwood Hospital Grounds, Grenoside, open country and woodland.	—	1.03 for 1 month	—	5.01 for 1 month	1.13 for 1 month		
Hemsworth—Vale Head Park, parkland, surrounded by open country.	2.12	23.36 for 11 months	12.72	139.87 for 11 months	0.90 for 9 months		0.179 for 8 months
Darlington—Grounds of Council Offices, semi-residential, colliery district.	2.51	27.66 for 11 months	13.00	143.04 for 11 months	0.83 for 11 months	Council Offices, semi-residential, colliery district.	0.457 for 11 months
Wombwell—Grounds of Divisional Public Health Office, The Gables, semi-residential, colliery district.	2.30	25.29 for 11 months	15.47	170.16 for 11 months	1.01 for 11 months	Div. Health Office, semi-residential, colliery district.	
Rawmarsh—Nursery School, Barbers Avenue, residential and industrial.	1.74	15.63 for 9 months	15.09	135.82 for 9 months	1.18 for 9 months	Sanitary Inspector's Office, in centre of residential and industrial area.	0.178 for 9 months
Bentley-with-Arkey—Bentley Park, Askern Road, semi-residential, colliery district.	2.23	20.03 for 9 months	13.90	125.07 for 9 months	0.74 for 9 months	Council Offices in centre of semi-residential area, colliery district.	0.193 for 9 months
Doncaster—Council's Depot, Kirk Sandall, open country, large glassworks approx. 1 mile to north.	1.92	13.24 for 10 months	10.72	107.23 for 10 months	1.01 for 10 months	Council's Depot, Kirk Sandall, in open country, with large glassworks approx. 1 mile to north.	0.166 for 10 months
Thorne—Grounds of Council Offices, semi-residential, colliery district.	2.01	16.10 for 8 months	12.11	96.90 for 8 months	0.63 for 8 months	Council Offices, town centre in semi-residential and colliery district.	0.151 for 8 months
						Maltby—Council Offices, one mile west of town centre, semi-residential, colliery district.	0.109 for 8 months
					Sulphur Measurements by Volumetric Method		
					SO(2) in parts per million		
					Average for period		
					Situation of Volumetric Sulphur Dioxide Apparatus		
					Hebden Royd—Redacre Sewage Works, Mytholmroyd, residential		
					0.054 for 7 months		



## PART XIV

## OTHER PUBLIC HEALTH SERVICES

## Health Centres

It is sad that any reference to health centres should have to appear in an addendum to the report under the heading "Other Public Health Services." In my report for 1948 I emphasised the tremendous significance of a health centre as a key to the preventive services. Since then many millions of pounds have been spent on the National Health Service but so far as I am aware the expenditure on health centres has not exceeded a few thousand pounds. It is now not uncommon to hear said that the health centre is dead. If this is so then the soul of the service has been destroyed. We must hope that a new impulse towards the fulfilment of this ideal will come from the publication of the deliberations of the Central Health Services Council which is expected shortly. In 1948 so far as concerns the West Riding I said that we must regard the multi-clinic, designed to provide services for the care of mothers and young children and school children, as the nucleus around which to build the main health centres, with a number of satellites. This fundamental concept seems to me to have withstood the test of our thoughts during the last three years and the Committee decided to act upon it in November, 1950, in their proposals for further clinic buildings in the 1951-52 capital building programme. It was decided to erect two multiple clinics at £27,000 each and four satellite clinics at £7,250 each, together with mobile units to operate in scattered rural and semi-industrial areas. The two new multi-clinics would be part of the general plan for a multi-clinic in each of the 31 divisions. They are to be placed in the areas of greatest need and will be sited with a view to development later by the additional facilities for group practice in the full health centres. The areas of greatest need are Pontefract and Morley. In both these cases the ground has been surveyed with care and possible sites have been considered in conjunction with the regional office of the Ministry of Health. The satellite clinics, which can never be developed into full health centres, but which could operate in conjunction with them, will be sited at Barnoldswick, Hemsworth, Holmfirth and Selby. The two mobile units are to operate one in the north and one in the south of the County, the areas at present under consideration being divisions 28 and 31 in the south and divisions 1 and 2 in the north. Ministry of Health approval is still awaited.

## Registration and Inspection of Disabled and Old Persons' Homes

(National Assistance Act, 1948)

In conjunction with the County Welfare Officer inspections of the under-mentioned property were carried out during 1950:—

	Recommended for Registration.	Number of Residents.	Type of Home. (Part I, II or III)*
Stone Bower Fellowship Housing Society Ltd., "Stone Bower," Burton-in-Lonsdale.	Yes	13	III
Congregation of Sisters of Charity of Our Lady of Good and Perpetual Succour, St. Anne's Convent, Burghwallis.	Yes	14 females	I
Mrs. Bessie Fox and Mrs. Dorothy Oldfield, "Moor Lane House," Moor Lane, Gomersal.	Yes	7	I
Harrogate Old Peoples Home, 66-68, Cold Bath Road, Harrogate.	Yes	26	I
Cotterhill Woods Home for Aged Persons, Woodsetts, nr. Worksop.	Yes	4	I
Skelldale Housing Society Ltd., Borlase House, Ripon.	Yes	11	I
Ernest Ayliffe Home for Deaf and Dumb Men, Fulford Grange, Rawdon.	Yes	18 males	II
North Regional Association for the Blind, "Oaklands," Huddersfield Road, Holmfirth.	Yes	20 females	II

\* Part I—Homes for Old Persons.

Part II—Homes for Disabled Persons.

Part III—Homes for Old and Disabled Persons.



## Registration of Nursing Homes

(Public Health Act, 1936, Sections 187—195)

Six Homes were first registered during the year. The number of Homes on the register at the end of the year was 39 providing 54 beds for maternity cases and 268 for other cases.

One application for registration was refused.

## Agencies for the supply of Nurses

The Nurses Acts 1943-45 provide that no person shall carry on, on any premises in the Administrative County, an agency for the supply of nurses, unless he is the holder of a licence from the County Council authorising him to do so on those premises. Licences are granted on conditions regulating the suitability of the premises and the conduct of the agency. Only two agencies are established in the Administrative County and both have been carried on satisfactorily during the year.

## 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. 1,648 medical certificates were submitted for approval and of these, 69 were not approved. In 23 cases, further enquiries were made from the medical practitioner completing the certificate, and 117 cases were referred for a specialist's opinion.

In addition, 76 special medical examinations of staff were arranged at the request of employing departments.

## The Employment of Specialists in Preventive Medical Services

In previous reports I have developed the idea of the full use of various specialists in expanding the work of our preventive services. A statement of our needs for such specialists was prepared following the conference between representatives of the Leeds Regional Hospital Board and Local Health Authorities on the 21st October, 1948, and this scheme was published in full as an appendix to my annual report of 1948. Unfortunately this scheme has only partially come into operation before the end of my term of office. Following consideration by the Policy Sub-Committee of the Public Health Committee it was discussed at a special visit of myself and the County Clerk with Sir William Douglas, then Permanent Secretary of the Ministry of Health. Following this the scheme was studied in detail by one of the Ministry of Health's medical officers in consultation with myself and the Chief Administrative Medical Officers of the Leeds and Sheffield Regional Hospital Boards, and in the result the Ministry of Health communicated with us the extent to which they found themselves in agreement with the scheme; the following statement sets out the comments of the Ministry of Health and consequential adjustment to the original scheme:—

### C.M.O.'s. Report of 4th April, 1949

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

In regard to paediatrics, obstetrics, orthopaedics, oto-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 are 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.

### Dr. Lilico's Report of May, 1950

As schemes go we agree that they conform to good public health, but there appear to be differences of opinion on the division of responsibility, implementation and payment for the services required.

Some of the schemes were in operation before the changeover whereas others were either planned to commence on the changeover or were even less advanced. Plans have broken down or have not been augmented principally on the grounds of availability of staff.

Dr. Brockington strongly supports integration of the Local Health Authority and Regional Hospital Board services and with one or two possible exceptions he is desirous of utilising the part-time services of Regional Hospital Board personnel. Subject to suitable arrangements being possible the Boards are prepared to fall in with this suggestion, the difficulty appears to be the percentage of the work, administrative in character which the Local Health Authority should be asked to meet.

### Observations and Recommendations

It will be noted that the Ministry of Health's representative agrees that the scheme put forward in April, 1949, conforms to good public health, and that being so it must remain as containing my proposals for the greatest good of the community. There is also agreement to my proposals in that they integrate the services of the Regional Hospital Boards with the Local Health Authority. The Boards are prepared to fall in with the proposals subject to suitable arrangements being possible and in these circumstances there should be little difficulty in reaching agreement.

It is, of course, desirable that the proposals as originally submitted in April, 1949, should be implemented in their entirety, but it is possible that owing to shortage of specialists this may not be wholly possible at the outset. The Committee may feel, therefore, that temporary modifications should be agreed. Wherever possible I suggest that payment for the services of specialists should be made to the appropriate Board and not to individual specialists.



## C.M.O.'s Report—(continued)

## 2. Paediatricians (Children's Specialists)

One 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.

*Method of Application:*

To continue (in agreement with the Sheffield Regional Hospital Board) the use of the services of Dr. Harvey for that part of the County south of the Sheffield Regional Hospital Board line, to the extent of half of his time or 24 sessions a month. The remaining sessions to remain in abeyance until the present scheme has developed more fully. To contract with paediatricians for part-time service (in agreement with the Leeds Regional Hospital Board) as follows:—one at York to give 8 sessions a month covering divisions 9 and 10; one at Harrogate to give 10 sessions a month covering divisions 6, 7 and 8; one at Huddersfield to give 20 sessions a month covering divisions 17, 18, 19, 20 and 21; one at Bradford to give 24 sessions a month covering divisions 1, 2, 3, 4 and 5; one at Wakefield to give 24 sessions a month covering divisions 11, 12, 13, 14, 15, 16 and 23.

## 3. Obstetricians

One 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 or 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 childbirth.

*Method of Application:*

To contract with obstetricians for part-time service (after consultation with the Leeds and Sheffield Regional Hospital Boards) as shown in Appendix I.

## 4. Orthopaedic Surgeons

One 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.

## Dr. Lilico's Report—(continued)

The paediatric services are well covered in that part of the West Riding around the Sheffield area. Dr. Harvey, who has hospital commitments plus consultant clinics which occupy more than 50% of his time, should have been transferred to the Regional Hospital Board at the changeover. Arrangements should be made with the Board for this to be rectified and for three-elevenths of his time to be placed at the disposal of the Local Health Authority.

In the Leeds area a sufficient number of paediatricians have not yet been placed to give a satisfactory service, but things are moving and co-operation between the County Medical Officer and the S.A.M.O. should make it possible to reach a solution.

The obstetric scheme prepared by the County Medical Officer has not yet materialised. This should be revised in consultation with officers of the two Boards and should include in the time of the consultants a modicum of work for which the Local Health Authority should be asked to pay.

Unlike the paediatric services the orthopaedic and E.N.T. services are more or less functioning. Most of the consultants look upon Dr. Brockington's "duties and responsibilities" as part of their clinical work. Where this is not accepted the ratio payable by the Local Health Authority should not exceed 1:10.

## Observations, etc.—(continued)

The proposal was, as regards the Sheffield Region, for 50% of the time of Dr. Harvey. This would mean 5½ sessions of the 11 sessions in a week. Dr. Lilico suggests that 3 sessions per week of this officer should be devoted to Local Health Authority work. This latter figure I consider to be insufficient but I agree to 4 sessions per week being arranged on the understanding that it is reviewed in the light of experience.

In regard to the Leeds Region, I would suggest the following solution:—that an arrangement on all-fours with that of Dr. Harvey in the South of the County be entered into with the Leeds University. Using the same ratio approved by Dr. Lilico for the Sheffield Region on a population basis, this would mean the use of 5 sessions of the 11. To put this into operation and to meet the present difficulties of staffing generally the County Medical Officer should be authorised to arrange with the Child Health Department of Leeds University for the use of paediatricians up to the total of 5 sessions a week.

In view of Dr. Lilico's statement I recommend that the scheme drawn up in my report now be revised in consultation with the Senior Administrative Medical Officers of the Boards and that a plan in which specialists cover defined territories (see Appendix I) be agreed on the terms that we pay to the Leeds Board the equivalent of one specialist and to the Sheffield Board half specialist.

In view of Dr. Lilico's statement that the duties and responsibilities as set out are accepted as part of clinical work, it is now only necessary for us to secure an official assurance of this and that these are incorporated in the terms of contract. As the duties cover defined territories the plan of division for the County, as suggested in Appendix II, will need to be agreed with the Boards.



## C.M.O.'s Report—(continued)

- (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.

*Method of Application:*

To contract for part-time service with orthopaedic specialists, as shown in Appendix II.

5. *Oto-Rhino Laryngologists*

One session a week per 40,000 children. Equivalent in whole-time specialists—two-thirds (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.

*Method of Application:*

To contract with part-time ear, nose and throat specialists and to continue and extend the scheme in operation on the 5th July, as shown in Appendix III. There may be changes as a result of re-planning in the areas of the Boards.

6. *Ophthalmologists*

One session a week per 500,000 population. Equivalent in whole-time specialists—three-tenths (80% to Education).

*Duties and Responsibilities*

- (1) To advise on the direction 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.

*Method of Application:*

To contract part-time with a consultant ophthalmologist to give 3 sessions a week or, if desired, one in the Leeds region of the County to give 2 sessions and one in the Sheffield region of the County to give one such session.

7. *Dermatologists*

One session a week per 1,500,000 population. Equivalent in whole-time specialists—one-tenth (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.

*Method of Application:*

To contract for part-time services with a skin specialist for the whole County.

## Dr. Lilico's Report—(continued)

## Observations, etc.—(continued)

Unlike the paediatric services the orthopaedic and E.N.T. services are more or less functioning. Most of the consultants look upon Dr. Brockington's "duties and responsibilities" as part of their clinical work. Where this is not accepted the ratio payable by the Local Health Authority should not exceed 1:10.

In view of Dr. Lilico's statement it is now only necessary for us to secure official acceptance of the duties and responsibilities as set out as part of clinical work. With this assurance we need do no more than see that these are incorporated in the terms of contract.

The ophthalmic scheme in so far as it relates to Blind Persons raises another problem for the County Council, who have about 800 examinations to make outside the free health service. For these the Local Health Authority must pay and it will be necessary to contract with individual ophthalmologists for this work. The total sessions, including advisory work on eyes generally, would amount to five per week.

Dr. Lilico has stressed the obligation of the Authority to make arrangements for the examination of blind persons. His figure of 5 sessions per week is greater than mine of 3 sessions per week. I do not object to the larger amount but think that, although there may be casual sessions depending upon the volume of work, one or two ophthalmologists should have definite appointments on the Authority's staff as advisers.

Dermatologists. The amount of advisory work, etc., required in this subject is infinitesimal and could be ignored.

I remain convinced of the great value of this simple step to the furtherance of community health but this is an appointment which could be left in abeyance temporarily.



## C.M.O.'s Report—(continued)

## 8. Venereologists

One 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 in 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.

## Method of Application:

To continue the employment of Dr. Burgess for 20 sessions monthly to work on the staff of the County Medical Officer in the detailed day to day administration of contact tracing and V.D. health education and for effective liaison with other V.D. specialists of the area. To contract for part-time service as follows:—

LEEDS REGION		
Divisions	Name of V.D. Specialist	No. of sessions per week
1, 2, 3, 4.	Dr. C. P. Heywood	3
5, 6, 7, 8, 9.	Dr. R. Lees	3
10, 11, 12, 13, 14.	Dr. J. A. Burgess	
15, 16, 17, 18.	assisted by	
19, 20, 21, 23.	Dr. E. Campbell	8
SHEFFIELD REGION		
24, 25.	Dr. J. J. Danaher	1
26, 30, 31.	Dr. E. H. Jeanes	2
27, 28, 29.	Dr. L. Dougal Callander	2
22.	Dr. D. O. Stevenson	1

## 9. Psychiatrists

- (a) for Lunacy: 1 session a week per 300,000 population. Equivalent in whole-time specialists— $\frac{1}{2}$  (None to Education).
- (b) for Mental Deficiency: 1 session a week per 300,000 population. Equivalent in whole-time specialists— $\frac{1}{2}$  (50% to Education).
- (c) for Child Guidance: 1 session a week 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.

## Dr. Lilico's Report—(continued)

**Venereologists.** All the V.D. administrative work of the West Riding is dealt with by Burgess in Wakefield. This is almost entirely confined to correspondence with doctors and patients and the work of the social workers. This could be carried out in two sessions per week and these should be charged to the Local Health Authority by the Board.

## Observations, etc.—(continued)

My recommendation was for five-elevenths of the time of Dr. Burgess, together with a smaller amount of the time of other venereologists. I think in the long run more than two-elevenths of Dr. Burgess's time suggested by Dr. Lilico will be required, but I am prepared to recommend that this be accepted for a period. Similarly, for a temporary period I shall not press our financial responsibility for a proportion of the time of the other venereologists. It will suffice to negotiate a division of territory in accordance with the sketch map, which will be available at the meeting, and for duties and responsibilities as outlined in my original report for such territories to be incorporated in their contract of employment by the Board.

**Psychiatrists.** It may be that the easiest method will be for the Local Health Authority to provide one whole-time or two half-time psychiatrists for the children's work, but here again the supply of personnel will hold up any scheme.

In view of Dr. Lilico's statement I now recommend that the scheme to employ Dr. O'Loughlin (Mental Deficiency) for 40 per cent. of his time be formally ratified with the Leeds Board, and that a similar arrangement be sought with a psychiatrist in lunacy.

Dr. Lilico does not specifically mention the psychiatrist for child guidance. This appointment is now greatly needed and I recommend that an arrangement be entered into with the University of Leeds to appoint such a man, two-thirds of whose work would be for the County as indicated in my report, and one-third with the University for the purpose of research and teaching.



*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 Education 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.

*Method of Application:*

- (a) Agreement is being sought to employ the Medical Superintendent of the Wakefield Mental Hospital or the equivalent.
- (b) Agreement has been reached with the Leeds Board for the employment of Dr. O'Loughlin for two-fifths of his time.
- (c) This should be an appointment wholly by the Council. The Council agreed to such an appointment in October, 1947, but no applications were received at the salary offered. I should like approval to advertise again at the specialists scale now approved by the Minister at the Senior Medical Officer level—£1,300–£1,750—which I understand is to be the lowest grade in specialist salaries.

*10. 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.

*Method of Application:*

To contract with part-time geriatric specialists as follows:—

*Leeds Region*—For 6 sessions per week by one or more part-time specialists.

*Sheffield Region*—For 3 sessions per week by one or more part-time specialists.

*11. Consultant Tuberculosis Officers*

One 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 from 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.

*Geriatric Specialists.* These can be left out of the picture at present as they are too much in the air.

I agree that these appointments may be left in abeyance for a temporary period. Careful watch should, however, be kept on the position as, in my view, the need for geriatric specialists will soon become generally accepted.

*Tuberculosis.* The Local Health Authority have decided to have X-ray examinations on a large number of their personnel—some annually, others by appointment only. As they no longer have X-ray apparatus they will either have to pay for the films plus an interpretation or just the films and have the interpretation done by a member of their staff. Dr. Brockington has been informed that this work does not come within the duties of that part of the Chest Physician's services which is paid for by the Local Health Authority.

Since my report the whole picture presented by consultant tuberculosis officers has been so changed by re-organisation that my proposals must be re-considered in their entirety. In place of the six tuberculosis officers originally in the County service and confined to County territory we now have approximately 14, most of whom cover one or more county boroughs in addition to some part of our territory; see sketch map, which will be available at the meeting. On a population basis, assuming that local authority work is allotted 2/11ths of the time of each tuberculosis officer, we should expect to have the following fractions in the Leeds Region:—2/11, 4/33, 1/55, 1/33, 1/55, 1/11, 1/11, 1/8, 2/11, 2/11; the Sheffield Region has submitted proposals for the allocation of the services of two officers only on the basis of 3/11 and 2/11 although, if 3/11ths of the time of each tuberculosis officer is to be allotted to local authority work, the proportion, on a population basis, of the four officers affected would be 3/11, 3/44, 3/22, 1/88. It will be seen that the fraction is in some instances very small.



## C.M.O.'s. Report—(continued)

*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 providing 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.

*Method of Application:*

To use Dr. Johnston 20 sessions a month (exclusive of that given below) on the central staff to supervise the after-care and consolidate the arrangements with Tuberculosis Officers. To use the six Consultant Tuberculosis Officers of the Leeds and Sheffield Regional Boards (as taken over from the County Council on the 5th July, 1948, with such modification of areas as may be agreed). This was as follows:—

Divisions	Population	Consultant Tuberculosis Officers	No. of sessions per week
1, 2, 5 (part), 6, 7, 8, 9, 10 (part), 16 (part), 10 (part), 11 (part), 12, 23.	152,627	Dr. Raeburn	2
26, 27, 28, 29, 30, 11 (part), 13, 14, 15, 16, 17 (part), 22, 24, 25.	161,981	Dr. Ryan	2
3, 4, 5 (part), 17 (part), 18, 19, 20, 21, 31.	179,831	Dr. Johnston	2
	206,457	Dr. Ratner	3
	457,661	Dr. Crowther	6
	364,573	Dr. Mann	5

*Observations, etc.—(continued)*

I want to stress again the grave position in which the County is placed by the continued prevalence of tuberculosis. The disease is rampant and has ceased to decline. In these circumstances the re-organisation mentioned above will, I fear, prove somewhat embarrassing. The situation is further complicated by a recent decision that the preventive work of such tuberculosis officers will not be comprehensive as we expected it to be; the preventive examination of staff and the necessary interpretation of films are, for example, excluded. Nevertheless, I see no satisfactory alternative to agreeing with the Boards for our fraction of the 2/11ths or 3/14ths time of all the tuberculosis officers (say 14) now covering portions of the West Riding territory, subject to the duties and responsibilities outlined in my report being incorporated in their terms of service.

The situation cannot, however, in view of its gravity, be allowed to remain like that and I recommend the appointment at headquarters of a Senior Assistant Medical Officer to co-ordinate and develop measures for the eradication of tuberculosis. This officer should have a good knowledge of the epidemiology of tuberculosis, and may indeed be a recognised specialist in diseases of the chest. Part of his duties will be to interpret the films to which Dr. Lilico refers (this will save half to threequarters of his total salary).



## APPENDIX 1

Obstetricians  
Leeds Region

<i>Division</i>	<i>County Districts</i>	<i>Situation of Consultant Clinic</i>	<i>Consultant</i>	<i>No. of sessions per week</i>
1	Barnoldswick U. Earby U. Silsden U. Skipton U. Skipton R.	Skipton	Mr. A. M. Claye	1
2	Sedbergh R. Settle R. Bowland R.			
3	Keighley B.	Keighley	Mr. H. A. Rippiner or Mr. G. W. Theobald	1
4	Bingley U. Baildon U. Shipley U. Denholme U.	Shipley	Mr. H. A. Rippiner or Mr. G. W. Theobald	1
5	Aireborough U. Horsforth U. Pudsey B.	Pudsey	Mr. D. W. Currie	1
6	Ilkley U. Otley U. Wharfedale R.	Otley	Mr. A. M. Claye	$\frac{1}{2}$
7	Ripon City Ripon and Pateley Bridge R.	Harrogate	Miss G. Kay	1
8	Harrogate B. Knaresborough U. Nidderdale R.			
9	Tadcaster R. Wetherby R.	Tadcaster	Mr. Rutherford Morison	1
10	Selby U. Selby R. Goole B. Goole R.	Goole	Mr. H. Agar	1
11	Castleford U. Normanton U.	Castleford	Mr. B. L. Jeaffreson	1
12	Featherstone U. Knottingley U. Pontefract B. Osgoldcross R.	Pontefract	Mr. B. L. Jeaffreson	1
13	Horbury U. Ossett B. Wakefield R.	Ossett	Mr. D. W. Currie	1
14	Morley B.	Morley	Mr. H. Agar	1
15	Batley B. Heckmondwike U.	Batley	Mr. H. Agar	1
16	Rothwell U. Stanley U. Garforth U.	Rothwell	Mr. B. L. Jeaffreson	1
17	Mirfield U. Spenborough U.	Spenborough	Mr. H. Agar	1
18	Brighouse B. Elland U. Queensbury and Shelf U.	Brighouse	Mr. J. N. I. Emblin	1



## Leeds Region—(continued)

<i>Division</i>	<i>County Districts</i>	<i>Situation of Consultant Clinic</i>	<i>Consultant</i>	<i>No. of sessions per week</i>
19	Hebden Royd U. Hepton R. Ripponden U. Sowerby Bridge U. Todmorden B.	Sowerby or Todmorden, or Hebden Bridge	Mr. J. N. I. Emblin	1
20	Kirkburton U. Meltham U. Denby Dale U. Holmfirth U. Colne Valley U. Saddleworth U.	Slaithwaite	Mr. W. S. Dickson	1
21			Mr. W. S. Dickson	$\frac{1}{2}$
23	Hemsworth R. Hemsworth U.	Hemsworth	Mr. D. W. Currie	1
Sheffield Region				
22	Hoyland Nether U. Stocksbridge U. Wortley R. Penistone U. Penistone R.	Hallamshire Maternity Home	Mr. J. E. Stacey	1
24	Cudworth U. Darton U. Royston U.	Barnsley	Mr. J. E. Stacey	$\frac{1}{2}$
25	Darfield U. Wombwell U. Worsborough U. Dodworth U.	Wombwell	Mr. J. E. Stacey	1
26	Swinton U. Rawmarsh U. Wath-on-Dearne U.	Rawmarsh	Mr. L. B. Patrick	1
27	Adwick-le-St. U. Bentley-with-Arksey U.	Doncaster	Miss C. E. Peaker	1
28	Doncaster R. Tickhill U.			
29	Thorne R.		Miss C. E. Peaker	$\frac{1}{2}$
30	Conisbrough U. Mexborough U. Dearne U.	Mexborough	Mr. L. B. Patrick	1
31	Maltby U. Kiveton Park R. Rotherham R.	Maltby	Mr. J. Chisholm	1



## APPENDIX II

## Orthopaedic Surgeons

## Leeds Region

<i>Division</i>	<i>County Districts</i>	<i>Situation of Consultant Clinic</i>	<i>Consultant</i>	<i>No. of sessions per month</i>
1	Barnoldswick U. Earby U. Silsden U. Skipton U. Skipton R.	Skipton and District Hospital	Mr. A. B. Pain	3
2	Sedbergh R. Settle R. Bowland R.			
6	Ilkley U. Otley U. Wharfedale R.	Otley General Hospital	Mr. A. B. Pain	2
3	Keighley B.	School Clinic, Keighley	Mr. H. L. Crockatt	2
14 17	Morley B. Mirfield U. Spenborough U.	Staincliffe General Hospital, Dewsbury	Mr. H. L. Crockatt	3
15	Batley B. Heckmondwike U.	School Clinic, Batley	Mr. H. L. Crockatt	2
18	Brighouse B. Elland U. Queensbury and Shelf U.	School Clinic, Brighouse	Mr. H. L. Crockatt	2
4	Bingley U. Baildon U. Shipley U. Denholme U.	School Clinic, Shipley	Mr. A. Naylor	2
5	Aireborough U. Horsforth U. Pudsey B.	School Clinic, Pudsey	Mr. A. L. Dick	2
7	Ripon City Ripon and Pateley Bridge R.	C.W. Centre, Ripon	Mr. H. Petty	1
8	Harrogate B. Knaresborough U. Nidderdale R.	C.W. Centre, Harrogate	Mr. H. Petty	2
10	Goole B. Goole R. Selby U. Selby R.	C.W. Centre, Goole	Mr. H. Petty	2
19	Hebden Royd U. Hepton R. Ripponden U. Sowerby Bridge U. Todmorden B.	Halifax Royal Infirmary	Mr. G. Hyman	2
21 20 (part)	Saddleworth U. Meltham U. Colne Valley U.		Not yet arranged	1
9	Tadcaster R. Wetherby R.	C.W. Centre, Tadcaster	Mr. D. H. Russell	1
11	Castleford U. Normanton U.	C.W. Centre, Normanton	Mr. D. H. Russell	2



## Leeds Region—(continued)

<i>Division</i>	<i>County Districts</i>	<i>Situation of Consultant Clinic</i>	<i>Consultant</i>	<i>No. of sessions per month</i>
13	Horbury U. Ossett B. Wakefield R.	Wakefield General Hospital	Mr. D. H. Russell	4
16	Rothwell U. Garforth U. Stanley U.			
12	Featherstone U. Knottingley U. Pontefract B. Osgoldcross R.	The Dispensary, Tanshelf, Pontefract	Mr. D. H. Russell Mr. J. M. P. Clark	4
23	Hemsworth R. Hemsworth U.			

## Sheffield Region

20 (part)	Holmfirth U. Kirkburton U. Denby Dale U.	The Dispensary, Church Street, Barnsley.	Mr. D. H. Russell	6
22	Hoyland Nether U. Stocksbridge U. Wortley R. Penistone U. Penistone R.			
24	Cudworth U. Darton U. Royston U.			
25	Darfield U. Wombwell U. Worsborough U. Dodworth U.			
26	Swinton U. Rawmarsh U. Wath-on-Deane U.	Rawmarsh C.W. Centre	Mr. D. H. Russell	4
31	Maltby U. Kiveton Park R. Rotherham R.			
27	Adwick-le-St. U. Bentley-with-Arksey U.	The Dispensary, Christchurch Rd., Doncaster	Mr. W. H. M. Smith	6
28	Doncaster R. Tickhill U.			
29	Thorne R.			
30	Conisbrough U. Mexborough U. Deane U.			

Some parts have been considered independently and come satisfactorily into operation. This relates in the main to the use of children's specialists covering the work of Dr. Harvey in the south of the County (as detailed elsewhere in the report) and the recent approval to enter into a similar arrangement with the Children's Department of the Leeds University. In its final form the full scheme was approved by the Public Health Committee on the 5th February, 1951, but had not been before the Establishment Committee at the time of writing (27th July, 1951). I very much hope that this scheme, which has received such long and earnest consideration by all those who are concerned with the medical services in the West Riding and by the Ministry of Health will be implemented.



## PART XV

## STAFF

(December, 1950)

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, T.D., M.D., Ch.B., D.P.H.	Deputy County Medical Officer.
J. M. Anderson, M.R.C.S., L.R.C.P.	Senior Medical Officer for Maternity and Child Welfare.
Vacancy	Senior Medical Officer for School Health.
G. S. Johnston, M.D., Ch.B., D.P.H.	Tuberculosis—Prevention and After-Care. (Part-time).
J. A. Burgess, M.D., Ch.B., D.P.H.	Venereologist (Part-time).
C. C. Harvey, B.Sc., M.D., B.S., F.R.C.S., M.R.C.P.	Paediatrician (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.
Vacancy	Area Superintendent Health Visitor.
Vacancy	Senior Health Visitor for Care of Unmarried Mother and her Child.
Miss E. M. Taylor	Supervisor of Midwives.
Vacancy	Supervisor of Midwives.
Miss H. Brooks	Supervisor of Day Nurseries.
Miss C. Bellamy	Supervisor of Day Nurseries.
Vacancy	Superintendent Home Nurse.
Miss G. Jones	Assistant Superintendent Home Nurse.
Mrs. W. Taylor	Assistant Superintendent Home Nurse.
Vacancy	Senior Speech Therapist.
Mrs. M. I. Morrison	Domestic Help Organiser.
L. Butterworth (1), (2), (4), (5), (11)	Acting Chief County Sanitary Inspector.
H. Taylor (1), (2), (6)	County Sanitary Inspector.
R. D. Irving (1), (2), (7), (9), (10)	County Sanitary Inspector.
F. C. Brookes (1), (2)	County Sanitary Inspector.

## CLERICAL STAFF

J. Colman (1), (3), (8)—Chief Clerk

Sectional Senior Clerks—J. W. Beaumont<sup>(1)</sup>, H. Bywater, G. Richardson<sup>(7)</sup>, A. Charlesworth,  
J. H. Milne<sup>(7)</sup>

## 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., Ch.B., D.P.H., D.T.M., D.T.H.	„ No. 2 (Settle).
H. M. Holt, T.D., M.B., B.S. (Lond.), M.B., Ch.B. (Leeds), 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., B.Chir., 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).

(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).

(10) Cert. in Advanced Knowledge of Sanitary Inspectors' Duties, Royal Sanitary Inst.

(11) Building Trades Course Certificate, Lancashire and Cheshire Inst.



## DIVISIONAL MEDICAL OFFICERS—continued

W. G. Evans, M.A., M.B., B.Ch., M.R.C.S., L.R.C.P., D.P.H. ....	Division No. 13 (Ossett).
F. G. E. Hill, D.S.O., M.B., Ch.B., D.P.H. ....	" No. 14 (Morley).
J. F. Caithness, M.B., Ch.B., D.P.H. ....	" No. 15 (Batley).
A. L. Taylor, M.D., Ch.B., D.P.H., L.D.S. ....	" 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. S. Walters, M.B., Ch.B., D.P.H. ....	" No. 23 (Hemsworth).
J. R. Murdock, B.A., M.D., Ch.B., B.A.O., D.P.H. ....	" No. 24 (Cudworth). †
R. S. Hynd, M.B., Ch.B., D.P.H. ....	" No. 25 (Wombwell).
D. J. Cusiter, M.B., Ch.B., D.P.H., D.T.M., D.T.H. (commenced 1.3.51.).	" 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).
G. Higgins, B.Sc., 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)

M. R. Anderson, M.B., B.S., D.P.H., D.C.H. ....	(Division No. 11).
P. A. G. M. Ashmore, M.R.C.S., L.R.C.P. ....	" No. 7).
E. M. R. Bell-Syer, M.B., B.S. ....	" No. 10).
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G. M. Buckle, M.B., B.S. ....	" No. 4).
P. S. R. Burrell, M.B., Ch.B., D.P.H. ....	" No. 8).
F. M. Cox, M.R.C.S., L.R.C.P. ....	" No. 15).
E. E. Cromb, M.B., Ch.B., D.P.H. ....	" No. 23).
B. R. A. Demaine, M.B., Ch.B., D.P.H. ....	" No. 30).
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*H. Gray, M.D., Ch.B., D.P.H. ....	" No. 4).
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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).
A. Kropacz, L.R.C.P., L.R.C.S. ....	" No. 27).
R. B. Laidlaw-Becker, M.D., Ch.B., M.R.C.S., L.R.C.P., D.P.H., D.P.M. ....	" No. 29).
B. M. Leakey, M.B., B.S. ....	" No. 1).
H. F. Lindsay, M.B., Ch.B. ....	" No. 30).
S. Lindsay, M.B., Ch.B. ....	" No. 22).
M. J. Lowe, M.B., B.S., D.C.H., C.P.H. ....	" No. 10).
*A. Marshall, M.B., Ch.B. ....	" No. 18).
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. R. Menzies, M.B., Ch.B. ....	" No. 26).
*H. C. Milligan, M.B., Ch.B., D.P.H. ....	" No. 20).
H. M. Mitchell, M.B., Ch.B. ....	" No. 5).
*J. R. Murdock, B.A., M.D., Ch.B., B.A.O., D.P.H. ....	" No. 5). †
M. M. Neil, M.B., Ch.B. ....	" No. 4).
J. J. Pienkowski, M.B., Ch.B. ....	" No. 23).
A. Seelig, M.D. (Strasbourg). ....	" No. 19).
J. J. Smith, M.B., Ch.B., D.P.H. ....	" No. 23).
D. M. Summers, M.B., Ch.B. ....	" No. 16).
*J. M. Taggart, M.B., Ch.B., B.A.O., D.P.H. ....	" No. 22).
N. M. Whalley, M.B., Ch.B., M.R.C.S., L.R.C.P., D.C.H. ....	" No. 17).
E. M. Whitehead, M.B., Ch.B. ....	" No. 17).
*G. A. Wilthew, B.Sc., M.B., B.S. ....	" No. 19).
M. H. Witt, L.R.C.P., L.R.C.S. ....	" No. 14).

\* Deputy Divisional Medical Officer

† Divisional Medical Officer Division No. 24 as from 1.1.51.



**JUNIOR OBSTETRICIAN (Joint Appointment with Hospital Services).**

J. C. A. Renshaw, M.B., Ch.B., M.R.C.S., L.R.C.P., (Division No. 30 and Rotherham  
D.Obst.R.C.O.G. ... .. and Mexborough Hospital  
Management Committee).

**SCHOOL OCULISTS (100% School Health)**

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

**AREA DENTAL OFFICERS (95% School Health)**

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

**SCHOOL DENTAL OFFICERS (95% School Health)**

W. J. Brown, L.D.S.	E. S. Midgley, L.D.S.
G. H. Bulcock, L.D.S.	S. Mitchinson, L.D.S.
G. C. Burton, L.D.S.	R. T. Mosbery, L.D.S.
F. W. Buzza, L.D.S.	D. B. Owen, L.D.S.
B. C. Clay, L.D.S.	M. H. Platford, L.D.S.
W. H. Dyke, L.D.S.	F. H. Sanderson, L.D.S.
W. H. Etheridge, L.D.S.	B. Sleight, B.Ch.D., L.D.S.
M. M. Gibson, L.D.S.	H. Taylor, L.D.S.
V. F. H. Gollidge, L.D.S.	M. Thom, L.D.S.
J. Haddow, L.D.S.	E. Thornton, L.D.S.
M. Hattan, L.D.S.	P. W. Thornton, L.D.S.
S. Henry, L.D.S.	J. Todd, L.D.S.
A. M. Holburn, L.D.S.	B. Watts.
F. Kershaw, L.D.S.	G. O. Wood, L.D.S.
S. Levinson, L.D.S.	H. M. Yuile, L.D.S.

**HEALTH VISITORS, MIDWIVES, MEDICAL AUXILIARIES, etc.**

- 5 Divisional Superintendent Health Visitors.
  - 283 Health Visitors and School Nurses.
  - 8 Orthopaedic Nurses and Physiotherapists (three part-time).
  - 19 Tuberculosis Visitors.
  - 293 Home Nurses.
  - 244 Midwives.
  - 4 Venereal Diseases Social Workers (Qualified Health Visitors).
  - 7 Speech Therapists (three part-time).
  - 1 Supervisor of Mental Health Home Teachers and Social Workers (vacancy).
  - 4 Mental Health Social Workers (Qualified Health Visitors).
  - 10 Mental Health Social Workers §
  - 4 Mental Health Home Teachers.
  - 4 Psychiatric Social Workers—School Health (to be appointed).
  - 6 Psychiatric Social Workers—Mental Health (to be appointed).
  - 38 Dental Attendants (one part-time).
- § 2 hold Diploma in Social Studies.

**COUNTY ANALYST (Part-time)**

F. W. M. Jaffe, B.Sc., F.R.I.C.  
J. C. Harrel, F.R.I.C. (Deputy).

**DAY NURSERIES**

- 26 Day Nurseries—total nursing staff 214.
- 1 Nursery Nurses Training Hostel, One Oak, Ilkley.

**ANTE-NATAL HOSTEL**

Clifton, Brighouse. Matron Miss E. Walker. Nursing Staff 1.

**MENTAL HEALTH OCCUPATION CENTRE**

Castleford. Staff—1 Supervisor; 1 Assistant Supervisor and 2 Nursery Assistants.



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