

## THE DUTIES OF THE MEDICAL OFFICER OF HEALTH.\*

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IT is usual for the President in his address to avoid enlarging on any special detail of our common work, but rather to deal with some general matter which is of interest to us as a body of medical officers of health, and I propose this afternoon, with your kind indulgence, to make a few observations on the subject of our duties as medical officers of health.

Owing to the constant additions to our duties and their ever-widening scope, we have found, within the last two or three years, that the functions of the medical officer of health have, with increasing frequency, been the subject of debate; opinions as to their limitation have been sometimes dogmatically expressed by various persons or bodies of persons more or less interested. Some of these have been interested in the ordinary sense of the word—I mean that our work is of interest to them; others have been interested in the sense of being affected, or likely to be affected, especially by new duties which are being, or may be, entrusted to us.

Under Section 191 of the Public Health Act, 1875, the Local Government Board was given the power of prescribing the duties of medical officers of health, and the Order of March, 1891, to which so much has been added since, is familiar to us all. Like most other statutory enactments, the actual wording of the list of duties is not altogether definite. The Order contains many such expressions as “as far as practicable,” “by such means as are at his disposal,” “as occasion may require,” etc., which give the whole list a pleasant elasticity; and among the most satisfactory features of the list is the comprehensiveness of the first four sub-sections, in which we are required to inform ourselves respecting “all influences affecting injuriously the public health,” to study the etiology of “diseases within the district,” to keep ourselves informed of the “conditions injurious to health,” and “to advise the Sanitary Authority on all matters affecting the health of the district.” Although it is clear that the idea underlying this original list of duties is that the medical officer of health is concerned with the prevention of disease rather than with its treatment, it is equally clear that there is no limit to his preventive duties over the whole area of

disease. The somewhat general idea of the public that we are specially concerned only with what I may generally term the “infectious diseases” is due, I suppose, partly to the fact that they are the diseases most obviously capable of prevention, and in some quarters ignorantly assumed to be the only diseases capable of prevention by our agency, and partly to the fact that we are mainly associated in people’s minds with disinfection and other details connected with the common infectious diseases. There is no such limitation in the list of duties set forth by the Local Government Board, and year by year the newer duties imposed on medical officers of health, such as the work under the Midwives Act and the Notification of Births Act, and the medical inspection of school children, all tend to show how the medical officer of health’s duties cover the whole range of disease and are limited to no one section only, however important. This progress can never be checked now; whether the medical officer of health is called by the same title as at present, or not, a medical man in a position similar to his is bound in the future to have the direction of these and like matters as the evolution goes on. Except that our duties are so frequently added to—as, for instance, by the Housing and Town Planning Act, 1909, and the circular of September 2nd—without corresponding compensation and without ensuring provision for necessary clerical assistance, I think that, on the whole, the average medical officer of health has nothing to complain about in the list of duties set forth by the Local Government Board. Like the new list recently issued as to the duties of a county medical officer of health, there is an elasticity and broadness which are necessary and important where the agents are capable and thinking men and not mere machines.

Beyond the general principles of our work there is, and must be, a great variation in the duties in any one particular district compared with those in others, and I do not agree with those who would have our duties laid down with great definition. What would be a useful line of work in one district, in another would be of less comparative value. The taking on of elementary bacteriological and analytical work, for instance, would be impossible in some cases and unwise in others, but is extremely useful to some medical officers of health. It would be, I think, a mistaken policy to insist either that medical officers of health should carry on their own routine bacteriology, or, on

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the other hand, that in moderate-sized urban and other districts the medical officer of health should have to send such work away to a distance when he can do it himself quickly and inexpensively, and without doing it at the expense of neglecting more important work.

In my experience the medical officer of health's work is never finished, in that there is always something that can be done. I should say that he must be allowed to be very much of an opportunist, not in the sense of moving in the direction of least resistance, but of moving in that direction where experience has shown him he can get the best results.

The original list of duties to which I have referred apparently limited our work to prevention of disease; almost, if not entirely. The boundary line between prevention and treatment, however, is so indefinite in many cases—such as the sanatorium treatment of consumption or the use of anti-toxin, for instance—that we have for some time included certain treatment within the scope of our duties. To such an extent as this no one can rationally object, but it is, I think, a matter for considerable doubt and debate as to how far the medical officer of health should go in the actual medical and surgical treatment being introduced in the form of school clinics. One man cannot well carry out the work of all branches of our profession, and the most satisfactory line of demarcation for the medical officer of health seems to me to be that line separating duties concerning the public health of the community at large from details connected with the personal health of individual members of the community. When this personal element affects the public health the medical officer of health is entitled to take action involving treatment of the individual, but if the medical officer of health carries out details of treatment rather than insists on treatment being carried out, then there is, in my opinion, a danger of more important duties peculiar to our branch being neglected and of serious collision with other branches of the profession.

While referring to the Local Government Board Order as to the duties of county medical officers of health, one may remark with satisfaction the reference to consultations between the county and district medical officers. We are free from a form of tyranny of trade-unionism which forces individuals on to a plane of dull equality where the standard of work done must be that of the weakest member, and, just as in other branches of the profession,

ability, experience, accident and influence—and especially combinations of these—bring men to the leading positions in our branch of medicine. We are all, however, equal to the extent of being members of the medical profession, and of a very important branch of it, and I should be sorry to see growing up amidst our ranks a feeling that there are grades of medical officers of health—that a district medical officer of health, for instance, is necessarily an inferior officer to a county medical officer of health, or that a “part-timer” is necessarily inferior in his ability to a “whole-timer.” There are experiences special to each variety of appointment, and any joint duties will be best performed by consultation and the observance of strict medical etiquette, as in the other branches of the profession.

The present unequal, and often not quite satisfactory, methods of appointment of medical officers by Sanitary Authorities are at once, amongst other factors, a fatal bar to any arrangement of medical officers of health into a sort of regimental system of seniority, and while the present conditions exist we shall, in my opinion, be better off under a system of medical etiquette and courtesy.

Next to the Local Government Board the bodies chiefly concerned with our duties and the way we carry them out are the Sanitary Authorities who elect us. In accordance with the directions of the Local Government Board, and also with the terms of our appointments, in most cases we have to do practically what the Councils wish us to do, and I suppose that the department of the medical officer of health is the one which receives more fresh duties from year to year than any other department of a Council or Corporation. It is satisfactory to be able to state that in these days the large majority of Councils and Corporations desire the work to be done as effectively as possible, whatever may be the feelings of some individual members of these bodies. I remember in an early public health appointment a member of the Council saying to me after the election and I had been informed that I was the appointed officer: “Now, I hope you understand that as long as you attend our periodical meetings and sign a receipt for your salary that is about all we expect of you, and the less we see of the medical officer of health in the district the better.” This was the only Councillor who directly approached me then with regard to the carrying out of my duties in my first appointment. I soon found, how-

ever, that his wishes were not the wishes of the Council as a whole, but that rather I was expected to attend much more frequently than the salary attached to this "part-time" appointment warranted, for at the other extreme from this gentleman were some who expected me to act as a sort of cat's-paw in various private affairs. Whilst there were these two extremes, I found, as usual, that the majority were men who wished done just that which was right, and, although there have been notable exceptions, in most instances a medical officer of health is able to get on with his work if he works conscientiously pretty much on the lines that he advises his Council that it would be advantageous for him to take.

There is a tendency on the part of some Councils to starve the department of the medical officer of health in the direction of proper clerical assistance. It is necessary for the medical officer of health, especially in small districts, to stop, if possible, the tendency to put on to him too much clerical work. I do not refer in this matter to the preparation of reports. The making of reports to one's Council I look upon as a very important matter, especially the annual report. The annual report and other reports are valuable to the medical officer of health in that they crystallize, as it were, his ideas, and bring into a concrete form his deductions and advice. They also are extremely useful to him in later years as milestones showing the course he has travelled in his work, and are practically the only indication in writing or print as to how the state of his district has altered, both as to the extent of the improvement and as to the directions of the improvement. They also sometimes show that items have remained stationary which might perhaps have been improved.

An important duty of the medical officer of health towards a Sanitary Authority is often to get it to carry out its own duties properly, and to use, or allow to be used, the powers it might if it wished. There is a lot of unused power, as for instance in connection with milk supply. Sanitary Authorities would also find their work better done, I am convinced, if the whole of the sanitary department were always under the medical officer of health. Medical supervision of much of the sanitary inspector's work is very advisable.

After the Local Government Board and Sanitary Authorities, the next important body which has a considerable amount to say with regard to our duties is the medical profession

at large, and recently the British Medical Association in particular. This is perhaps the more natural in that of recent years, I am glad to say, the tendency of our duties has grown to be more strictly medical in proportion to those duties which might be equally well carried out by a sanitary inspector acting under medical supervision. The British Medical Association has recently taken an increased interest apparently in our duties and our doings, and has had resolutions at its meetings as to what we ought to do and what we ought not to do. At the recent annual meeting in London of the British Medical Association, the subject of the address in medicine was "The Dominance of Etiology in Modern Medicine." However debatable the celebrated "Minute 234" and similar resolutions as to the limitations of our duties may be—and they are so controversial that I cannot properly refer to them at length here—it must be interesting to all of us that the subject chosen for the British Medical Association address in medicine should deal with the dominant position in medicine of the doctrine of causation, which is the special field of our particular branch of the profession. With reference to the British Medical Association and our duties, we must all feel that it is important for us to remain in close and comfortable relations with the rest of the medical profession, and when we consider ourselves not altogether well used by such an Association to try to get matters settled amicably, and to get our side of debatable questions understood. The British Medical Association has kindly tried to assist us in such matters as that of security of tenure, and where an occasional article has been written or a resolution has been passed which, in the opinion of some of us, might be injurious to our branch of the profession, it must be remembered that the article or resolution often represents the opinion of but a few, and our course must be to get both sides of the matter before the profession.

Interests are bound to be in conflict at times, but whatever opinions we hold, and whatever the outcome of the resolutions connected with Minute 234, there is no doubt there is no member of this Society but would object to any interference with the privilege of any existing medical officer of health.

While keeping in touch with the great Association of the profession, I look upon the relations of the medical officer of health and the local medical men as of more importance in the carrying out of our duties. The

co-operation of the profession locally makes the duties not only more pleasant but also more efficacious. It is important not to let such matters as school clinics interfere with our friendly relations. Voluntary systems of notification and similar matters are useful or not, according as one has the confidence of the local medical men, and without comfortable co-operation public health work is not going to be so remunerative. The commencement of various useful public health measures, such as notification of disease, particularly of phthisis, and notification of births, has been often possible only by the kind and self-sacrificing voluntary action of the medical profession, and it is a mere truism that the help of the general body of practitioners is necessary to a perfect public health service. It has been assumed in many districts that a duty of the medical officer of health is to come when asked for at any time into consultation with medical men in any case of infectious illness. Where the experience of the medical officer of health is such as to warrant his summons to a consultation—and it usually is—I certainly think that in the case of the well-to-do a proper fee should be paid to the medical officer of health. It is not right that special knowledge, acquired at great expense and trouble, should be at the call of the well-to-do free, but it is difficult to draw a strict line as to where the giving of this special experience for the sake of the public health stops, and, for the special advantage of a patient, begins. In the former instance the consultation is no doubt strictly a duty, in the latter it is simply a matter of gain to the patient. With the exercise of tact I think there are no great difficulties in agreeing with general practitioners as to what our duties are with regard to their patients, and, although it is not possible to set them down definitely, strictest etiquette and respect of the privacy of the patient as far as possible must be primary considerations. Poor Law medical officers seem to have been a little nervous of us since the issuing of the Reports of the Royal Commission on the Poor Law. There is no need to seek for trouble in advance. Although methods may change, the same amount of work or more will remain to be done, and, however the relations of the services are adjusted, one man can only do a certain proportion of the work. Personally I think our interests will not come into conflict much in the future, and if they do the adjustment will be very little, if at all, in our hands. Some of our

duties, such as the medical inspection of school children, have in a few instances thrown additional work on Poor Law medical officers, and their employers, the Boards of Guardians, ought to allow for this. Certainly our Poor Law confrères would hardly have the matter dealt with by curtailing the efforts of the medical officer of health to ensure the healthiness of the community.

Next, and by no means least, the public has a considerable amount to say concerning our duties. The medical officer of health and the health of a particular district figure much more largely in the cheap Press than they used to do. It would take a very long time, even if it were worth while, to attempt to detail what the public expects from the medical officer of health from time to time. We all know from personal experience the absurd matters which are occasionally brought before us and the expectations that the public have of us. No doubt you have noticed recently in the Press, and, I think, even in the Journal of our Society, lists of duties given by school children in reply to a question asking them what the duties of a medical officer were. The answers ranged from "To empty the dustbins" to "Looking after the doctors of a town," and were about as varied as we know the ideas of the general public are. It is a very satisfactory matter and a sign of the increased education of the people that they do take an interest in the work of a medical officer. It is an important part of our duties that the interest in health matters in a community should be kept up, and the more the children are discreetly educated in health matters the better.

It is not possible to deal with all the various bodies which have something to say as to our duties, but besides those to which I have alluded it is necessary nowadays to mention the Poor Law Commission. The Poor Law Commission and the various reports have been pretty fully dealt with during last session in our Society, and I do not propose to go into them at any length; but it must be obvious to anyone who has attended meetings or read reports on the subject that, without taking any particular side in the matter, we can but feel that the attitude of those who support the Minority Report is more flattering to medical officers of health than that of those supporting other reports. The reports and the discussions on them have been extremely interesting to all medical officers of health, and it is much more fascinating to look upon our branch of the

profession as being specially called upon to hold out a helping hand to prevent the fall of people into destitution through illness, than to read, as we have on the other hand, that our duty is simply to attend to the prevention of the spread of infectious disease. Those of us who believe that we should, for instance, continue to deal with the treatment of the tuberculous on the lines of the sanatorium and dispensary, where prevention is intimately bound up with treatment, are bound to disagree with the supporters of the Majority Report, and much more would those who would have the school clinics in our department. The recent circular of the Local Government Board with regard to the use of diphtheria anti-toxin by medical officers of health is an instance showing that in the Board's opinion also prevention cannot be divorced entirely from treatment. The supporters of the Minority Report evidently take a more sympathetic and satisfied view of our past work, and are prepared to trust us with more important work in the future, than the Majority supporters would do. The Majority Report, so far from appreciating the wide scope of our duties over the field of health matters, contains the old narrow view that "the Sanitary Authorities' functions are mainly concerned with the prevention of infectious disease." It is the prevention of all and any disease that I hope we look upon as our privilege and duty. Not merely is this larger idea our aim, but we may, I think, also claim as a right and part of our office to advise on and to use any means of improving the physical possibilities of that portion of the community whose health is entrusted to us. The narrow view as to our office expressed by supporters of the Majority Report make one incline with more pleasure to the much more sympathetic ideas of the supporters of the Minority Report, even if we disagree with them in many points.

As a matter of fact, I presume that we shall go on much as we have done hitherto: that is, as we find new fields of productive and remunerative work—and by remunerative I mean work resulting in improvement of the public health—we shall adopt them as far as we are permitted irrespective of Majority or Minority Reports, or of those who sit on the fence between the two. I suppose that gradually the best points in both reports will be brought into action by authorities such as the Local Government Board, and there will be no great sudden radical change. At the

same time, the evidence given and the reports themselves form a useful guide to medical officers who are studying the problems that come before them in their own districts.

A gratifying recognition in recent years of the value of our branch of the profession, and an addition to the duties of some of us, is our inclusion in the Territorial Army as sanitarians. Gradually the powers that be have come to the very obvious conclusion that the deaths from disease in a campaign are not only disastrous but to a large extent preventable. The Regular Army medical officers nowadays not only include eminent sanitarians, but are all in a sense medical officers of health, and we may, perhaps, modestly think that the Territorial part of the Royal Army Medical Corps is none the worse for including a number of practical civilian medical officers of health.

After this brief mention of some of the most important bodies interested in our particular duties, I come lastly to ourselves. Any conscientiously working medical officer knows, and is studying to know, what is his best line for his own particular district. He will neither be, on the one hand, a mere visionary seeing himself at the head of a large department, including everybody else and acting as a sort of general manager; nor will he, on the other hand, while attending to mere details lose larger opportunities of doing the greatest good. Not that one has the slightest contempt for details; what might seem to be mere details in our work are often important factors for the health and comfort of the community, and, after all, it is the routine work of the medical officer, and the Sanitary Department uniting with him, that has had such a lot to do in increasing the standard of comfort, in lowering the death, disease and infantile mortality rates in the past, and that is continuing to do so in the present. I mentioned just now that a child had stated that one of the duties of the medical officer of health was to empty the dustbins. As an instance of what may be done by attention to such a detail as the dustbin, I may mention a fact from my own district with regard to dustbins and infantile mortality. In connection with some work on infantile mortality I decided that the dustbins of the small houses were not emptied often enough, and were too often unsuitable and unsuitably placed. Hundreds of new dustbins were supplied, and a more frequent summer collection of refuse was made. This was in 1900. The average number of deaths from diarrhoea for the nine years up to 1900

had been just over 30, for the nine years since it has been 12, and for the last seven years—in spite of a large increase of population—not quite 9; showing a reduction of about 70 per cent. Other things remained fairly equal, so that attention to that particular detail evidently had important results, for besides saving so many lives, it must have conduced to the comfort of, and kept off suffering from, a very much larger number. The routine work and details such as these are important, and it is necessary that the medical officer of health should have a sense of the proportionate value of all the branches of his work.

I am one of those who believe that a most important factor in public health is the home life of the people, and one of the latest important additions to our duties—viz., work in connection with the new Housing Act—will, I think, give good results, although discounted by the fact that similar work has been done by most of us with the powers we already had.

For a long time one has known that a most important line of work, and one for which a medical officer of health must find time, is that of a study of the houses of the people in his district. If he can see some of them personally he gets a much better idea as to how to work in directions which should improve the public health; other factors besides mere structural matters require attention. In the Minority Report of the Poor Law Commission a statement occurs somewhat to the effect that four-fifths of the work of the medical officer of health is wrapped up in the casual labourer and his home. I know that the people who signed the reports of the Royal Commission did not do so without much careful investigation, but I am not altogether prepared to agree to this. The complexity of the subject makes it extremely difficult to put into any sort of figures the special need there is for the work of the medical officer of health in any particular direction. In addition to personal and staff inspection, it is a very interesting matter to obtain the opinion of the school nurse, the school attendance officers, the police, or the clergy, as to which are the worst houses, who are the dirtiest people and the most uncared for children they know, and then to personally inquire into the causes of the state in which they are. I have done this to a small extent in my own district, and certainly casual employment was not the cause of four-fifths of the trouble. In some instances a father was in prison, in some more instances drink seemed to

be the origin of the trouble, in other cases consumption had brought the family into the difficulty in which they were; but cause and effect in many instances were difficult to differentiate. Poverty, overcrowding, hopelessness, ignorance, unemployment, consumption, mental defectiveness, crime and alcoholic excess are often so closely intermingled that which of these is cause and which effect is difficult to disentangle. The insanitary house is the constant accompaniment of the conditions mentioned, and from them comes the bulk of the dirty conditions and neglect which lead to personal ill-health. Another accompaniment is the under-fed and the badly-fed child. The medical officer of health is, therefore, bound in his work to be thankful for the help of the individuals who, in various social ways, are trying to cope with the conditions mentioned. An interesting fact from among my small experiences is that mentally defective children are found to be specially connected, in undue proportion, with dirty and unsatisfactory houses. The causes of the special connection are difficult to determine in some cases, but often mentally defective children have mentally defective parents, and the neglect of the home and children is due sometimes to weakmindedness rather than to viciousness or intentional neglect. To this I am referring again later on. Investigations similar to these convinced me long ago that, in addition to the ordinary routine duties of the medical officer of health, he should specially direct his attention to the difficult duty of the improvement of those matters leading to unsatisfactory homes, and should encourage in every way he can the efforts of those who are endeavouring to bring the social condition of the people to a higher level. If the medical officer of health can, through any agency, get his people cleaner and more self-respecting, better housed, sufficiently clad and sufficiently fed, he will save himself a considerable amount of trouble in other directions, especially among children; and to obtain the best results it is the individual who has to be made into a decent member of society. For that reason the advent of the medical officer of health into the schools as superintending school medical officer is, in my opinion, going to be a great blessing to the country. Not only do we through the children get to know the homes and home life as they are, but it is in the schools of to-day that the householders of to-morrow

are. While it is necessary to struggle on with those already in possession of houses, and by encouragement and help, and if necessary by punishment, to do what we can, it is by assisting to get the children coming on to be healthier, to have a greater feeling of self-respect, and to want and demand cleanliness and proper home surroundings that we shall achieve most for the coming generation in this particular direction of public health.

While the public may associate us with the prevention of a few well-known infectious diseases, it is important for the medical officer of health to separate in his mind diseases in the concrete from disease in the abstract, and the prevention of disease is a greater aim than the prevention of diseases. It is true that certain special diseases are special objects of our work, and must always be, particularly when they are prevalent; while diphtheria and cancer, for instance, are on the increase, while diarrhoea, measles, and whooping cough kill thousands annually, and while now and again any special disease threatens our districts, then we have to fight the spread of the individual disease. Without minimizing the importance of this, I may call that part of our work higher and more remunerative that aims at fighting disease rather than specific diseases, and that aims at raising the general standard of health in such various ways as improved housing, improved feeding, improved clothing, improved modes of living, and improvement in the conditions of the life of the masses. The disease diphtheria will serve to illustrate what I mean. Complete knowledge of the methods of dealing with this individual disease is very essential. It is a little humiliating—at all events, I feel it so—that a disease like this, of which we have in recent years learned so much, should still be a cause of death and illness. Thanks to expert bacteriologists we have learned the bacteriology with which the disease is always associated, and in many districts the disease is dealt with in excellent scientific detail and yet still goes on. There is something yet to be learned. The fact is that the specific bacillus is only one, though a very important, factor in the etiology of the disease. Although in my experience a patient cannot have clinical diphtheria without bacteriological diphtheria, yet he may certainly have bacteriological diphtheria without clinical diphtheria. The importance of dealing with the unknown factor or factors is as paramount as that of dealing

with the bacillus. I am not going into a discussion on the etiology of diphtheria, but what one sees again and again has been re-emphasized to me after the trying experience of a recent epidemic—viz., that the clean, the well fed, the well housed, and the healthy do not get the disease in anything like the proportion that the dirty, badly fed, badly clothed, and sickly do; and if the disease did spread to the well-to-do section of the community they easily got over it, and did not have it badly. This is almost merely a truism I know, but it serves to illustrate that a medical officer of health must direct his efforts to such conditions as bad housing and those I have just mentioned and to their causes as strenuously as, or more so than, to the bacilli causing any one disease. In dealing with the Klebs-Loeffler bacillus he does what is right to that extent for diphtheria, but in treating the conditions shortly summarized above affecting public health generally, and particularly the home and home life in his district, the medical officer of health has an even better return in that he strengthens his people so that they form poor soil for any germ, and also become more highly-resisting subjects for any disease, whether associated with germs or not. It was by general sanitation, and not by special measures, for instance, that the severity of tuberculosis in the community commenced to decrease before the specific cause was dealt with or even discovered.

Before closing these necessarily brief remarks on our duties, I wish to allude again to the factor of feeble-minded people in connection with insanitary homes. Experience has shown me that in home conditions, to which I attach such importance, feeble-mindedness is productive of some of the worst results from a public health point of view. Not only are feeble-minded persons producing feeble-minded children, but a feeble-minded parent, whether with a tendency to idiocy or to crime, is more often than is imagined the chief cause of a disgraceful home. Last month, at the Central Criminal Court, a man was charged with manslaughter by neglect of a child of 14½ years, one of a family of six, where, as stated in court, the mother was mentally weak. The home and the children were, of course, disgracefully neglected. These cases are not so uncommon as might be thought; in my own district such a case, though short of manslaughter, has also recently had to be dealt with in the courts. A serious duty of the



medical officer of health who is also school medical officer is his action with regard to such children as are intellectually between the ordinary child and the hopelessly idiot and imbecile. Just as a medical man has to keep life going as long as possible in, say, a hopeless case of cancer or consumption that is bound soon to end fatally, so we have to do our utmost for the health of any child, even if intellectually and morally it is apparently almost hopeless. It is an unfortunate thing that the result of our efforts during its school life sometimes is to bring along such a child to a state when it can merge imperfectly intellectually developed into the marriage market, with disastrous results for another generation. It is noticeable how comparatively frequently the mothers of illegitimate children are of imperfect intellect, and yet not actually idiots or certifiable. We must often wonder if it is worth while to bring them on, but these children are in grades of backwardness, and at the better end of the scale, I suppose, we improve and bring up to a more or less normal condition children who would otherwise drift into the condition of our worst cases and marry and have children all the same. The care of the feeble-minded in this respect is too great a responsibility for a local official to contemplate, and, speaking as a medical officer of health, I am bound to say that the sooner the Government adopts these feeble-minded people altogether and directs their career the better for the public health of the country.

In a short address such as this, over a large subject, condensation leaves one with an unsatisfactory feeling of not having perhaps put one's ideas clearly, or of not having given the various items alluded to their due proportion of importance. The importance I attach to the social condition and the home life of the masses as affecting public health, and the duty of the medical officer of health to study, with a view to remedy, the causes of degraded homes, as well as to merely remedy from time to time their effects, must have been evident. I have wished also to emphasize that among the various duties allotted to him the medical officer of health should have no cramping limit to his efforts in the shape of a stereotyped list of detailed duties; that, broadly, having to do his best for the public health of his particular district, he should best know in what directions his efforts are mostly wanted, and should endeavour to keep a fairly free hand to act in the directions he thinks best.

## THE INFLUENCE OF THE PERIOD OF DETENTION OF SCARLET FEVER CASES IN HOSPITAL UPON THE RETURN-CASE RATE.\*

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IN 1895, fifteen years ago, the Metropolitan Asylums Board appointed a committee to inquire into return cases. In their published report† they state that the average stay in the Board's hospitals was seventy days. They made inquiries of all the large provincial and Scottish fever hospitals and found that the mean stay in hospital was as a rule very much less, ranging from thirty-seven days at Leicester to seventy-two at Birmingham.

The conclusion was come to that return cases were very few, and in some cases at least were due to imperfect disinfection by the sanitary authorities. It was also rather implied than expressed that the detention in the Board's hospitals was already too long. The former conclusion naturally evoked the opposition of the Metropolitan medical officers of health. The latter, perhaps as naturally, failed to convince the Board's own superintendents.

Since that date much has been written upon return cases, and nearly every paper or report gives details as to the period of detention of the originating cases. The Board itself has appointed three special investigators to report upon the subject<sup>1</sup>. Lauder<sup>2</sup>, of Southampton, Matthews<sup>3</sup>, of the Metropolitan Asylums Board, and Moore<sup>4</sup>, of Huddersfield, published papers showing that an intentional reduction of the period of detention has not been accompanied by any increase in return cases. Bond<sup>5</sup>, Millard<sup>6</sup>, Newsholme<sup>7</sup>, Butler<sup>8</sup>, and others have published papers in various journals and transactions, and Niven has dealt at length with it in a series of his official reports<sup>9</sup>. It has become a common practice for medical officers of health

\* Read before the Metropolitan Branch of the Society of Medical Officers of Health, October 13th, 1910.

† Metropolitan Asylums Board Minutes, 1895, p. 523.

1. Simpson, "Return Cases of Scarlet Fever and Diphtheria," 1901. Cameron, "Report re Return Cases of Scarlet Fever and Diphtheria between July, 1901, and July, 1902," 1905; Turner, "Report on Return Cases of Scarlet Fever and Diphtheria notified for the three years 1902, 1903 and 1904," 1906.

2. Lauder, "Source of Scarlatinal Infection and Hospital Treatment, *Lancet*, 1904, Vol. I, p. 712.

3. Matthews, Metropolitan Asylums Board Report for 1905, p. 306.

4. Moore, PUBLIC HEALTH, June, 1908.

5. Bond, PUBLIC HEALTH.

6. Millard, *British Medical Journal*, 1898, Vol. II, p. 614.

7. Newsholme, *Med. Clin. Trans.*, Vol. 87.

8. Butler, *Roy. Soc. Med., Epidem. Section*, 1908, p. 59.

9. Reports, Medical Officer of Health, Manchester, 1901-9.