SMALL-POX IN LONDON.***SUGGESTIONS AS TO EXECUTIVE AND ADMINISTRATIVE MEASURES.**

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SMALL-POX has never within knowledge been entirely eradicated from Great Britain as a whole, but there have been periods during which it has been reduced to very small proportions. In separate parts, counties, or towns, it has been eradicated and absent during varying periods of time.

Dr. Sykes then gave a brief retrospect of the past origins and spread of small-pox in London since the commencement of the notification of infectious diseases at the end of 1889.

Small-pox was prevalent in Paris throughout 1900 in increasing proportion, reaching its maximum towards the end of the year, when it subsided somewhat; and in the spring of this year recommenced to increase, reaching its highest point about the beginning of June.

The influx of travellers from the Continent increases considerably about this time of year, and in June and July a series of remarkable outbreaks occurred independently in different parts of the Metropolis. No person arriving from the Continent was actually notified as suffering from the disease, but there are strong grounds for believing that unrecognised cases were imported. Thus, in Wandsworth a person, at the beginning of June, suffered and died from an obscure illness. A visiting friend who returned to the provinces developed chicken-pox, a relative in the same house developed small-pox; the dirty linen was sent to a particular laundry, and at that laundry small-pox developed in a female sorter and a female fellow-worker.

In Hackney also, in June, a male collector of dirty linen for a particular laundry fell ill with small-pox, a female fellow-worker, the daughter of the collector, the step-son of the collector, a sister of the step-son, another sister, a young male person living in the same house, and the brother of a young woman living next door to three of the young women attacked.

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In St. Pancras, after many inquiries and overcoming persistent reticence, I ultimately ascertained that a girl, seventeen years of age, a sorter of dirty linen at a laundry, receiving from hotels and boarding-houses in the W.C. District, fell ill at work in July, went home, and developed measles two or three days afterwards, and remained at home some three weeks. Her mother *knew* it was chicken-pox, and said a doctor who saw it confirmed her; nevertheless, about a fortnight afterwards, her two sisters were sent from a general hospital to the ships with small-pox. A child next door, that they were seen to fondle, developed "chicken-pox," was nursed at home for a week, and died, and of the members of this child's family no less than six were sent one after the other to hospital suffering from small-pox, in addition to seven other persons from the same house, and about twenty other persons from the same street.

It is a remarkable fact that during the great prevalence in St. Pancras no two patients were found to have received linen from the same laundry, an indication of the fact that laundries did not spread the imported disease to their customers; on the contrary, the process of washing is evidently an effectual disinfectant process, since the sequence of cases comes to a stop at the laundries, and does not pass through with the linen. This is a credit to properly managed laundries in London, where ailing employes are not allowed to remain on duty and do not handle clean linen. But those who handle dirty linen, and especially the sorters, run great risk. This was brought home to me vividly in tracing out the first suspicious case, when I was suddenly confronted with the innocent young girl, weeks ago recovered, standing in the centre of a great circle of dirty linen in heaps, picking up each article, shaking it out, and spreading it to search for the mark whereby it might again be known when it emerged from the wash-tub. The sorters of dirty linen must excite our sympathy in the risks of infection that they run, and, falling ill, carry to their families and acquaintances. The poor do not send their linen to be sorted or shaken out at laundries; it is from the more comfortable classes that the laundries derive their customers.

Thus, it would appear that several of the sources of the disease introduced into London were *unrecognised cases* amongst persons from abroad staying at hotels and boarding-houses, whose linen was sent to laundries where the infection was stopped from being distributed in direct descent to the customers, and was spread laterally to the sorters and other workers, and their families away from the laundries; and, further, again through *unrecognised cases*

in these families, spread amongst the public even lower in the scale, until it has reached the casual class and vagrants.*

The conclusions appear to be :

1. That small-pox is an imported disease, imported (*a*) from abroad, and (*b*) from one town or part to another.

2. That small-pox is imported and spread from person to person (*a*) by unrecognised cases, (*b*) by cases delayed in recognition, and (*c*) by incubating cases probably between falling ill and development of the rash.

3. That small-pox is carried by the dirty linen and clothing (*a*) of unrecognised cases, and (*b*) occasionally of recognised cases.

4. That small-pox is also carried by persons brought into contact with infected cases, probably by the clothing, and that these contacts may also incubate, develop, and spread the disease, and so reiterate the cycle.

PREVENTIVE MEASURES.

As to importation from abroad, quarantine of ships and cordons round towns, with the object of isolating communities *en masse*, have ceased in this country, and are impracticable where trade and intercourse are extensive and rapid. They have been displaced by isolation *in detail* of sick persons, and in the first line of defence are medical officers of ports. But large numbers of travellers arrive in this country by the ferry-boats from the Continent, who pass through without question, whose journeys occupy but a few hours, and some of whom may be incubating the disease, which takes from twelve to fourteen days to develop. It is difficult to devise, and would be still more difficult to carry out, measures to secure these infected persons on their journeys. After arrival, when the disease develops, most of them are recognised as suffering and isolated, but some are so mildly affected as to escape recognition, either temporarily or entirely.

As to importation from one town or part to another, it is equally difficult, in the face of continuous and rapid intercommunication, for an uninfected town or part to protect itself against unseen and unknown invasion. But warnings may be given of any known movements of infected or suspected persons, or of persons brought into contact with infected persons. As a matter of fact, this is the method adopted in this country by medical officers of health, by

* One means of checking the spread amongst the casual and vagrant class should be to make a medical examination every evening of the persons admitted to casual wards, and every night or very early morning of the persons admitted to common lodging-houses and shelters.

whom, after inquiry in each case, any discovered movements are immediately communicated direct to the medical officers of health into whose districts the movements may take place.

If the Local Government Board and Port and County Medical Officers could devise a similar method of international warnings of suspects and contacts, I believe their efforts would be rewarded with practical results. Small-pox is a disease that, on account of its long incubation period, is eminently fitted for the first trial of international notification and warning.

Persons incubating small-pox may introduce the disease from places within a fortnight's journey of this island of Great Britain. The area accessible within a fortnight's journey is immense, and embraces a large portion of the civilized world, in some parts of which small-pox is always present.

International notification could commence with greater probability of success with small-pox than with any other infectious disease. Firstly, because of the long incubation period; secondly, because it would not interfere with maritime commerce, inasmuch as fixed maritime quarantine measures on the Continent are only applied permanently to plague, cholera, and yellow fever; and, thirdly, because there is an alternative in efficient vaccination and re-vaccination.

The first point for consideration is the international notification of small-pox.

As to discovery and diagnosis, in the absence of any knowledge, or of only partial knowledge, of the introduction of the disease, and in the presence of the fact that when introduced it is often overlooked, the early discovery of cases is of the greatest importance.

Before the disease is definitely diagnosed, a patient passes through two series of opinions, the one lay and the other medical.

Persons having the disease very mildly are extremely dangerous in spreading the disease widely. There are three types of such mild cases: firstly, the person who has only a few pains and pimples, and takes no notice of them; secondly, the person who is certain of having chicken-pox only; and, thirdly, the person who declines to obtain a medical opinion on account of the fear of expense, or the dread of having to stop earning, or the dislike of going to hospital. The last is almost confined to foreigners and to outcasts, until they have experienced the kind treatment they receive in hospital.

Through the press or by notices the public may be exhorted to seek medical opinion as to their rashes and ailments, however slight, not only for their own sakes, but also for the protection of

their families and households. Gratuitous medical advice is provided by means of the Poor Law medical officers for the destitute, for the necessitous the charitable public have provided hospitals, and for those who can only afford a small fee there are numerous dispensaries. Therefore, there can be no legitimate reason for not seeking medical advice.

The question presents itself whether persons with eruptions, in times of small-pox prevalence, who wilfully avoid medical opinion, and are found to be suffering from small-pox, and exposing themselves so as to spread the disease, are not almost as culpable as persons who expose themselves wilfully after having been informed that they are suffering from the disease, and whether they should not be liable to some proportionate punishment.

Vaccination officers and their assistants, when notified of small-pox cases, are instructed to visit from room to room, dwelling to dwelling, and house to house, and they should also be instructed, when meeting with any suspicious rash or illness, to advise that medical opinion be sought, or in the case of the necessitous, to report to the relieving officer, district medical officer, or public vaccinator.

The second point for consideration is extension of the instructions to be given to vaccination officials as to suspicious rashes and ailments observed by them in the course of their duties.

As to diagnosis, errors in small-pox have been common. First, groups of cases in recent years have often been traced to small-pox treated at home as chicken-pox, and it must be admitted that in mild and modified cases such errors are likely to occur. The converse is also noticeable; within the last ten years, about one-half of the cases not small-pox sent to the Metropolitan Asylums Board Hospital has been chicken-pox, the other half has been distributed amongst a considerable number of diseases, amongst which syphilis appears fairly frequently. Therefore, chicken-pox is a disease as to which we have to be particularly on guard.

The third point for consideration is the making of chicken-pox a notifiable infectious disease.

Several Borough Councils have made chicken-pox a compulsorily notifiable disease for a period of six months. During the first four weeks that the order has been in force, fifty cases of chicken-pox have been notified, and one was promptly discovered to be a case of small-pox. The notification has evidently led to greater circumspection, and to confirmation by a second medical opinion. Chicken-pox is essentially a disease of children, and in efficiently

vaccinated children under ten years of age we used not to expect to meet with small-pox, but the amount of inefficient vaccination has altered our expectations and misled many practitioners. If only as an aid to diagnosis between chicken-pox and small-pox, the value of thorough and efficient vaccination demonstrates itself, just as partial and insufficient vaccination proclaims itself misleading and therefore dangerous. Unfortunately, it is by the latter only that the value of vaccination is judged by its opponents.

The fourth point, and one to be insisted upon, is that the law should require that in every case of vaccination the operation should be thorough and efficient, and that a description of the result obtained should form part of the certificate.

In this manner those who seek the protection of vaccination would be reassured by more certain safety, and those who do not would realize more distinctly their danger and responsibility.

Passing now to the question of diagnosis in its administrative aspect. It is obviously the duty of medical practitioners to diagnose their cases, or in difficulty to recommend that a second opinion be obtained. The kind of second opinion depends upon the patient's circumstances: if destitute, the case is referred to the relieving officer and district medical officer; if poor, the patient is often advised to go to a general or special hospital, but if unable to leave the sick-room this course cannot be adopted; if of competent means a medical colleague is generally called in as consultant, and if well-to-do an expert consultant is applied to. It is amongst poor patients of incompetent means and unable to leave the sick-room that the great difficulty of obtaining a second opinion presents itself to medical practitioners.

The duty of a medical superintendent of an infectious hospital is to diagnose a case before admission. As the hospital is usually at a distance and the patient may be near, it is often found more convenient in provincial towns for the medical superintendent to diagnose the case at home. The medical superintendent may also happen to be the medical officer of health, and this is where a confusion of ideas as to spheres of responsibility has taken place. A medical officer of health, when asked, has been known to say to two medical men who differ, "I shall be happy to diagnose provided you accept my decision"; but in expressing an opinion in response to one medical attendant alone, he would prejudice the case of the other if subsequently called in again, and would then find himself in a false position.

The duty of a medical attendant, of a consultant, of a medical superintendent of an infectious hospital, and of a medical officer

of health, personally, towards a patient is perfectly clear and distinct.

The long journeys and the great expense that would be incurred in sending with the ambulances a number of medical men for the purpose of confirming the diagnosis before removing small-pox cases to the wharf for admission to hospital has no doubt deterred the Metropolitan Asylums Board from taking such action in London as might be taken with greater facility in a small town. In the largest towns and boroughs it would be physically impossible for the medical officer of health to act compulsorily as consultant at call in infectious cases to hundreds of medical practitioners, even if it were desirable. Wherever there is possibility of danger to the public, there the medical officer of health, whilst displaying every courtesy to the medical profession, must make such inquiries as circumstances require for the public protection, but he must retain his freedom of action and judgment.

On the other hand, to facilitate the statutory notification of infectious diseases, most authorities have adopted bacteriological examination in cases of suspected diphtheria and typhoid fever. Bacteriological examination is not available in suspected small-pox, chicken-pox, or allied symptoms, and only clinical examination is available to assist diagnosis. The St. Pancras Borough Council has, with this view, appointed a medical referee in each ward as clinical examiner for those patients who cannot afford the expense of a consultant, and to encourage medical practitioners to obtain a second opinion in doubtful cases.

The fifth point is the provision of clinical examination in doubtful cases.

The sixth point is that the medical officers of health and medical superintendents of small-pox hospitals should be in direct and continual communication with each other, and furnish each other immediately with any information necessary for the protection of the public.

CONTACTS.

Seventhly, I would ask you to consider the powers and duties of medical officers of health with regard to the exclusion and seclusion of persons in contact with small-pox.

As this raises a number of difficult points, I shall put them in the form of consecutive questions :

(a) Is it advisable for a medical officer of health to notify a laundry of small-pox in the family of a customer ?

(b) Is it advisable for a medical officer of health to notify an

employer that a person in contact with an employé is suffering from small-pox? Is he justified in advising exclusion, and is there any liability for loss of wage upon the employer or the authority?

(c) Is it advisable that the employer should be liable or the authority have power to pay compensation to a person excluded from employment to protect a business?

(d) Is a person excluded from school or employment to be allowed to associate everywhere else with other persons?

(e) Is it advisable that authorities should have power to provide and maintain seclusion or quarantine stations, power to seclude contacts within infected houses or stations, power to enforce cleansing and disinfection of the person and clothing of contacts, and power to pay compensation?

(f) How can old clothes shops, pawnbrokers, and rag and bone shops or marine stores, be best protected?

(g) How far would compulsory vaccination, and *re-vaccination* as an alternative, affect these questions?

The questions raised in this paper, I venture to say, are not only serious to us as executive officers, but are also questions of vital administrative importance for the discussion of local authorities.

DISCUSSION.

Dr. HAMER said the point that Dr. Sykes had raised with regard to the difficulty of ascertaining the names and addresses of persons of the vagrant class had been very much in the mind of the Medical Officer of Health of the London County Council and his assistants during the past few weeks. It was quite impossible to get reliable information from many of the inmates of common lodging-houses, and their experience of the past fortnight was that it was highly desirable that some power should be given by which such information could be demanded.

Dr. CALDWELL SMITH said the first case he had in Wandsworth, and which spread to a laundry, was certainly imported from Paris. The patient had been in Paris nine weeks; he returned home on a Saturday, was taken ill on Sunday, and died on Tuesday from a disease which the medical attendant said he could not diagnose even after death. He could not see any pathological condition except slight congestion of the kidneys. The Medical Officer of Health of Coventry first called his attention to the case in consequence of a lady resident of Coventry, who, several days after, during a visit to Streatham, had slept in the bed occupied by this patient, having been taken ill with small-pox. He at once visited the premises in question, and found that the bed and all the bed-clothing had been sent to a laundry, which he at once visited, and where he found a girl suffering from small-pox. This girl was the one who sorted the clothing referred to, and she subsequently gave the disease to another girl. A second lady, who had also slept in the bed, developed the disease at Loughborough. There could be no question but that unrecognised cases had far more to

do with spreading the disease than most people thought. He agreed with Dr. Sykes that international notification would be very useful. With reference to vaccination, to him (Dr. Smith) the law, with regard to public vaccinators, did not seem to be very clear. Was the public vaccinator bound, on the recommendation of the medical officer of health, to call and offer revaccination at the homes of the people? If the Guardians refused to instruct their public vaccinator, what was the medical officer of health to do? He himself favoured the notification of chicken-pox. As to the medical officer of health acting as a consultant, he was asked every day to visit and see cases, and he was always glad to do so if it did not interfere with his other work. He went when asked, but he always explained to the medical practitioner that it was not part of his duty, and the onus of diagnosing the case was not upon him. He did not take the responsibility of deciding whether it was small-pox or not. He also agreed that the amount of clerical work during the prevalence of small-pox in London was enormous.

Dr. R. DUDFIELD, referring to the question of medical officers of health acting as consultants, said he held the view that it was his duty to go if he were asked to do so: first, because he had charge of the health of the district, and it was his duty to find out all he could of the health in the district; and, secondly, because by so doing he could the more readily secure the co-operation of his medical *confrère* practising in his district; besides which they, as medical officers of health, often had knowledge in their possession which might greatly assist in diagnosis. He remembered a case of great difficulty last year. A woman sickened and died, but of what disease she died her medical attendants could not decide. He recognised the address, and had he been asked he might, with the information at his disposal, have been able to help very much in making a correct diagnosis.

The theory that linen when it left a laundry was properly disinfected was very good up to a certain point, but then it broke down, because the same person at times sorted the clean linen who had previously sorted the dirty linen. If that was so, the laundry might easily become a centre of infection.

Dr. KENWOOD, referring to the necessity for better quarantine for members of the vagrant class, said that, since the history of so many small-pox epidemics was so closely associated with this class of persons, it was high time they had more power to confine their movements. These people should not be allowed to spread the disease. They were at least but parasites on the community, and there ought to be power to restrict their movements when they became a source of danger. He went even further than that: they wanted power to restrict the movements not only of the vagrant class, but to quarantine all "contacts." Probably about 80 per cent. of the cases in London were due to their failure to quarantine "contacts." In his district they had succeeded in quarantining the "contacts" in every case. They had not the power to compel their isolation, but they bribed them. They said to them, "You will have to keep to yourselves for a fortnight. You must not mix with other people. We will feed you and fund you for that fortnight." Generally the "contacts" had agreed, and he had no doubt that the £40 or £50 which they had expended on "contacts" had saved the ratepayers some hundreds of pounds they would otherwise have had to spend on patients. They wanted power for the compulsory quarantine of "contacts" who had run the maximum risks of exposure.

Dr. Sykes had said that washing was an efficient disinfecting process. He (Dr. Kenwood) believed that to be perfectly true, and it was probably the experience of all of them that the spread of small-pox was more by reason of

the susceptibility of the "contact" than the great infectiousness of the disease. As far as its infectiveness was concerned, it could be very rapidly dealt with.

He had a case in Stoke Newington due to visiting a patient on the ship. The practice of the Metropolitan Asylums Board was to invite two persons to visit a patient who was on the "danger" list. These visits ought to be restricted to the very nearest relatives of the patient, and even to them nothing in the shape of an invitation ought to be issued. The notice should state that two visitors would be permitted, but they were strongly requested not to avail themselves of the permission, on account of the great danger they ran of contracting the disease and of carrying it to others.

Dr. H. MEREDITH RICHARDS referred to the intercommunication of information with regard to "contacts." He had a case in his borough (Croydon) recently, where, upon inquiry, he found the patient had come from the north of London, where he had been in contact with a small-pox case. The authority in question had taken no trouble to let him know that the "contact" had moved to Croydon, although they were well aware of that fact. With regard to imported cases, he instanced a traveller who arrived at Dover with the rash well out. No action at all was taken by the port authorities at Dover, and the man was allowed to go, and so spread small-pox.

As to the notification of chicken-pox, he did not know how far the school system of notification would meet this, but they got all the cases notified in Croydon by the school authorities.

After as long experience of nearly 3,000 cases of small-pox, he came to the conclusion that it was better to disregard whether a patient had been vaccinated or not, and diagnose the case on its clinical aspect.

As to a medical officer of health acting as consultant, certainly in provincial towns that duty was undertaken, and he thought with very great advantage. During the epidemic in Birmingham, some years ago, when he was in charge of the isolation hospital there, he visited nearly every doubtful case on behalf of the medical officer of health. There was no hardship to the ordinary consultant in doing this, for, to put it bluntly, consultants in the best practice had the least knowledge of small-pox. In many cases where he visited consultants had already been called in, and generally they were only too glad to shift the responsibility on to him.

As regards the exclusion of "contacts" from work, he was disposed to hold that, provided the name and proper address was taken, and visits to the houses paid after the ninth day up to the sixteenth or seventeenth day, they could detect even a mild case of small-pox in time to prevent the further spread of infection.

With respect to visits to patients in hospital, he said that in large towns in the Midlands this was certainly not allowed. He could only remember one case in which he allowed a friend of a patient to visit the hospital, and then it was only after revaccination, and on the visitor undertaking to remain in the hospital for quarantine.

Dr. ALLAN said that a number of persons living in flats and restaurant-keepers in Westminster used the laundries referred to by Dr. Sykes. No one had contracted small-pox from the linen sent back as far as Westminster was concerned, but in every instance they got the linen and disinfected it, which perhaps showed that he was not of opinion that there was no danger from laundries. Up to a certain point he agreed there was no danger; but if you had the same woman, as Dr. Dudfield had said, who sorted the dirty linen also sorting the clean, there would be some risk. In some cases, too, he understood, not only

the person who sorted the linen had small-pox, but also the carman who delivered it.

He agreed with Dr. Sykes as to the necessity for doing something with common lodging-houses. During the past fortnight they had had a good number under supervision, accommodating something like 300 persons, and it was only with the greatest difficulty that they had, in conjunction with the officers of the London County Council, been able to keep these people under observation. They wanted power to quarantine them completely. The London County Council had taken a house for the purpose of keeping in quarantine people of this class so far as possible ; but they had no actual power to keep them in, and these people, comprising, amongst others, hawkers who sold newspapers and other articles in the main thoroughfares, flower-girls, and others of the same class, were just the ones to spread the disease. As to the diagnosis of cases, his own practice was, so far as he could, consistently with the performance of his other duties, to see cases when asked to do so by the medical man in attendance. He did not think that could lead to very much trouble with the ordinary consultant, as the consultant did not generally know any more about small-pox than the ordinary practitioner. In the only two cases in his district where a consultant had been called in, the disease had been diagnosed as small-pox, when they were, in fact, both chicken-pox. There should, however, be some method by which poorer people could obtain help in this direction. It was quite impossible for the medical officer of health in some districts to see all the doubtful cases, and he admired the idea which had been given effect to in St. Pancras to appoint experts to see such cases. This ought to be done, if for nothing else, to avoid the mental anguish to the patient's relatives, and the putting of extra work on the shoulders of the Metropolitan Asylums Board.

With regard to the visits to the ships, theoretically they might object to visits to patients, but human nature would be stronger than any scientific scruples. The Asylums Board offered to revaccinate such visitors, but it ought to be insisted upon as one of the conditions on which the visit was allowed.

They must, of course, all be agreed that the removal of the duties with regard to vaccination from the Guardians to the Sanitary Authorities was a necessity so far as London was concerned, but that struck at the whole question of the Metropolitan Asylums Board as well. So long as the Asylums Board was representative of Guardians, they looked upon the Guardians as the body to whom they were responsible. Their books were all based on Poor Law areas, and so long as they were so based the Sanitary Authorities would have that trouble. No doubt vaccination would work all right with the Sanitary Authorities in London, but in the country it might be a very different matter, and perhaps in small areas there would be no more facilities for carrying out the Vaccination Acts under the Sanitary Authority than now existed under the Guardians. Without fixity of tenure for the medical officer of health, it would be of little use to transfer these powers.

Dr. MILLSON said in his district all these "contacts" had been provided with board and lodging in a reception-house during the quarantine period. For disinfection they burnt all bedding, sheets, blankets, and infected clothing of every description, replacing it at an average cost of £6 per patient. Up to the present they had only had thirteen cases, so they could bear that cost ; but of, course, if the disease became epidemic in the borough, they might not be able to do this. Was the disease really so very infectious in the first few days ? He had had a good many cases in common lodging-houses where the patients had been two

days with the rash upon them, sleeping in a common dormitory, taking meals in the common kitchen, but he had never had a secondary case.

Dr. W. A. BOND was glad to say the Holborn Council had adopted the notification of chicken-pox. One of the earliest cases of small-pox he had was notified as chicken-pox.

He entirely agreed with Dr. Sykes as to the standard of vaccination. The Local Government Board ought to insist upon an efficient standard of vaccination from *all* medical practitioners. On the general subject of vaccination the following figures which he had got out would perhaps be of interest to the Society.

SMALL-POX AND VACCINATION.

STATISTICS OF THE FOLLOWING LARGE TOWNS:

	Total No. of cases of Small- pox.	UNDER TEN YEARS OF AGE.					
		VACCINATED.			UNVACCINATED.		
		No.	No. of deaths.	Death- rate.	No.	No. of deaths.	Death- rate.
London, 1891-1900 ...	5,166	125	0	Nil.	672	153	22·8
Leicester, 1895-1896 ...	357	2	0	Nil.	107	15	14·0
Sheffield, 1887-1888 ...	4,703	353	6	1·7	228	100	43·9
Dewsbury Union, 1891- 1892 ...	1,029	44	1	2·2	174	56	32·1
Warrington, 1892-1893 ...	867	33	2	6·0	32	12	37·5
Gloucester, 1892-1893 ...	1,979	26	1	3·8	680	279	41·0
Manchester, 1892-1893 ...	805	11	0	Nil.	36	7	19·4
Oldham, 1892-1893 ...	124	3	0	Nil.	15	5	33·3
Leeds, 1892-1893 ...	200	4	0	Nil.	8	3	37·5
Halifax, 1892-1893 ...	330	4	0	Nil.	38	15	39·5
Bradford, 1893 ...	658	17	0	Nil.	57	23	40·3
Totals ...	16,018	622	10	1·6	2,047	668	32·6

NOTE.—The vaccinated include all cases that had *any* evidence of vaccination.

He was very glad to see that Dr. Sykes had arranged for medical referees; he wished the Holborn Council had done the same. He had seen the Chairman of the Metropolitan Asylums Board, and suggested that, as an expert had been appointed to visit doubtful plague cases should any arise, the same might be done with regard to small-pox. Dr. Ricketts was quite willing to come if able, but, of course, in an outbreak of small-pox, when he would be most required, he would be unable to do so. The Metropolitan Asylums Board ought to appoint experts. He had been asked to see a great many cases, and had always been willing to do so. He agreed that the ordinary consultant was useless in small-pox cases.

With regard to direct communication between medical officers of health and medical superintendents, he had recently had a case notified as diphtheria, and sent as such to the South-Western Fever Hospital. It was there diagnosed by Dr. Caiger, within a few days, as a case of small-pox, and transferred to the ships. He (Dr. Bond) received the same day a communication direct from

Dr. Caiger that it was a case of small-pox, and he was thereby able to take the steps usual in small-pox cases.

He was of opinion that the medical officer of health should notify the employer of the patient, and also the keeper of any laundry receiving linen from the infected house.

He agreed with previous speakers on the vagrant question. Three common lodging-houses had been attacked in his district. In one of these houses, which had been taken by the London County Council, the door was now always closed, and the women who occupied the house were staying in and kept under strict observation.

He feared that general quarantine, as suggested by Dr. Kenwood, was ideal, but exceedingly difficult as a matter of practice. In some of the earlier cases in Holborn they were able to enforce this, and in a good many cases they had kept "contacts" in for four or five days, during the disinfecting and cleansing of their rooms, but the cost even of this was very great.

With regard to the destruction of articles, he was afraid most authorities would object to the great cost involved.

Dr. KAYE, speaking with reference to the necessity for efficient vaccination, asked whether the Society could not then frame some resolution which might be sent on to the General Medical Council. It was most unfair that certain medical practitioners vaccinated in one place only, while the public vaccinator was required to make four marks.

Dr. GROVES approved of the suggestions for securing efficient vaccination, but the people would have to be taught. There were many who did not object to one or two spots, but they would strongly object to four. With regard to the relationship of the medical officer of health to the medical practitioner, they ought not to forget that they were all medical men; they could not get away from that, and they had no right to go behind the notification. They might, of course, form their own opinion, but that they should keep to themselves. Indeed, they might themselves make mistakes between chicken-pox and small-pox. He thought, however, they were bound to go to see any case they were asked to see; that was part of their work as health officers.

The PRESIDENT strongly supported Dr. Sykes on the question of international notification. At the time of the Exhibition in Paris last year, he attended a Congress of the Société Française d'Hygiène and Sanitary Institute, and read a paper on the same subject, when a resolution in its favour was passed, and subsequently sent up to the British Government. It was now, no doubt, in one of their pigeon-holes.

He agreed with Dr. Sykes that it was unfortunate there was no more direct communication between the superintendents of the Metropolitan Asylums Board Hospitals and medical officers of health; the communication had to go through the Central Office instead of direct.

With regard to a medical officer of health acting as consultant, his practice was, if a medical man in his district asked him to see a case, as a matter of courtesy, he always went. If he demanded it as part of his duty, or as a matter of right, then he did not go, because, if it was a matter of duty in small-pox, why not in whooping-cough, why not in measles, or, indeed, in any infectious disease? He agreed with Dr. Groves that they ought to accept the diagnosis of a medical man. He recently saw a child certified to be suffering from typhus fever. He formed the conclusion that the child was suffering from flea-bites, but he allowed the child to go to hospital, from whence it was promptly

returned. They were fortunate in London in having an observation-station at South Wharf, where doubtful cases could be sent. He had known cases kept there a week under observation before they could be diagnosed as small-pox or otherwise. He wished that a similar institution existed for other diseases as well as small-pox, and he also wished that a practitioner could notify "suspected" small-pox or "suspected" diphtheria or scarlet-fever.

He admired Dr. Kenwood's action as to quarantine, which, he had no doubt, had really kept the disease from spreading in his (Dr. Kenwood's) district. He laid claim to have done something with the vagrants in St. Marylebone. By the adoption of the Cleansing of Persons Act they were enabled every day to cleanse and disinfect the person and clothing of thirteen to fifteen vagrants of the lowest class. They provided them with a hot bath, and whilst they were taking their bath their clothing was disinfected. They made no inquiry as to where they came from, and he thought this was a good work which might well be adopted by other local authorities.

The idea of small-pox experts was admirable. It would be impossible for a medical officer of health in a large district to see all doubtful cases.

He moved that a hearty vote of thanks be accorded to Dr. Sykes for his paper.

Dr. SYKES, in reply, said, from the discussion, he was more than ever convinced that the question of more power for dealing with vagrants should at once be taken in hand.

One of the most important points touched upon was that of the medical officer of health acting as a consultant. If he acted as a consultant, ultimately the diagnosis of the whole of the notifiable infectious diseases would be cast upon him, and that would be a physical impossibility to carry out in large districts.

With regard to the transfer of the powers relating to vaccination from the Guardians to the Sanitary Authorities, he reminded the Society that two or three years ago they declined to take any action. He was glad to see that the opinion of the Society appeared to be the other way now.

He did not see why Dr. Kenwood's idea of wholesale quarantine could not be enforced, as in small-pox because there was the alternative of vaccination. In America a forcible method of this kind was in practice.

As to chicken-pox notified from schools, that only applied to children up to school age. It was in persons developing the disease before and after that age that the difficulty came. With regard to laundries, he wanted to emphasize that the small-pox got through the dirty linen to the sorter, and there it stopped, and was taken to the home of the laundry worker. Of course, if the same person acted as sorter to the clean linen who had sorted the dirty linen, then the disease was likely to be spread, but he found in the majority of cases the laundry people at once sent home anyone who was ill.

He thought they might pass a resolution that visitors should not be allowed on the Metropolitan Asylums Board hospital ships until they had been re-vaccinated.