COUNTY BOROUGH OF LIMERICK.

ANNUAL REPORT

OF

MEDICAL OFFICER of HEALTH

FOR THE YEAR 1938.

JAMES McPOLIN, M.D., D.P.H., B.Sc.,
Medical Superintendent Officer of Health.

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OFFICERS OF THE PUBLIC HEALTH DEPARTMENT.

Medical Superintendent Officer of Health:
JAMES McPOLIN, M.D., D.P.H., B.Sc.

School Medical Officer: Tuberculosis Officer:
T. W. MORAN, M.B., B.Ch., B.A.O., D.P.H.

Maternity and Child Welfare Officer (part-time):
H. G. ROCHE-KELLY, M.B., B.Ch., B.A.O., D.P.H.

Chief Veterinary Officer:
JOHN J. DUNDON, M.R.C.V.S.

Assistant Veterinary Officer:
FRANK CROWNE, M.R.C.V.S.

Public Health Nurses:
MISS ANGELA NOLAN.
MISS MARGARET FITZGERALD.

Maternity and Child Welfare Nurse:
MISS E. M. FITZGIBBON.
MISS M. LAFFAN.

Inspector of Food and Drugs and Sanitary Inspector:
GEORGE F. BOWLES.

Sanitary Inspectors:
SOLOMON FROST. BENJAMIN FITZGIBBON.

Secretary to Public Health and Water Departments:
M. F. DONNELLAN.

Secretary to Tuberculosis and School Medical Services (part-time).
A. J. O'HALLORAN.

Clerk to the Public Health Department:
MISS NORA PEPPARD.

INTRODUCTION.

"Public Health" has been coming into greater prominence during the past two decades and bids fair to be regarded to-day as an essential factor in the life and organisation of civil society. It will be well in consequence to have a clear notion of its purpose and function. It has obviously to do with health considered in its public aspect, and by public we mean here what has reference to the State as the responsible guardian of the health of the community at large: so that the term "State Medicine," which is sometimes used as an equivalent of Public Health gives a more accurate notion of what we wish to treat of here.

From a study of the services which can be rendered a community there emerge two main divisions:

(a) Services rendered by individuals or voluntarily organised bodies as the result of private contract and personal relationships.

(b) Services organised, directed and financed by the Public Authority.

These latter are known as Public or State Services, which, of course, include our Medical Services, and it is with these that Public Health in its technical sense has to do.

Existing health services in this country have grown up as the result of the pressure of hard facts though until recently they were largely inspired by that outworn erroneous doctrine 19th century Liberalism. Our Poor Law Services were established when this doctrine was rampant; under it those unfortunates who succumbed in the race for existence came to be regarded as inferior beings; they were "paupers" to whom a certain odium was attached, a notion which survives to-day in our errational anxiety to be rid of all the institutions which grew and flourished under this doctrine. A changed outlook is however manifest to-day in the attitude adopted towards more recent schemes, e.g., School Medical Services, T.B. Service, Blind and Old Age Pensions, Unemployment Benefit, as contrasted with services rendered under the title "Out-Door Relief," and even these latter are losing gradually the odium associated with them.

The false outlook referred to above is shown also if we examine the attitude assumed not infrequently towards our Medical Services of the past: it was assumed that the "workhouse" hospital was necessarily inferior in some strange way to all others, despite the fact that its patients were of the same mould as all other humans, its doctors possessed the same human qualities as their colleagues elsewhere, exercised no less skill and care than did the members of the profession working in other branches. The condemnation then of the "workhouse" hospital rested principally on the notion that the casualties in the battle of life treated there were in some way outcasts, or at least inferior specimens of the human genius, an error we believe traceable to a widespread false concept of the destiny and dignity of the human "person,' which was the classical heresy of 19th century Liberalism.

This social heresy has changed its front to-day; it has not disappeared. To-day the place of the human person in society tends to be denied in another form. There is an increasing tendency to consider the person as purely a creature of the "State" or "Nation," whereas the fact is that the State exists to serve the person as the latter possesses a far higher dignity and destiny than the former.

The consideration of Medical Services in light of these ideas is to-day urgently necessary. The function of the State considered as an authority is to serve the community. The very word "Minister," e.g., Minister for Local Government, conveys this idea. In carrying out this function the Public Authority must

(a) provide services that are essential for the "common good" and that cannot be provided by private or voluntary enterprise;

(b) guard against providing services that can be satisfactorily provided by such private and voluntary effort;

(c) direct and co-ordinate the activities of the citizens and services towards the "common good."

Thus we see that the Public Authority are under no obligation to provide Medical Services that are essential where such services can be provided by voluntary enterprise. In providing medical services expenditure must be given very serious consideration because the monies required have to be levied on the public and it could occur that the community would receive more injury in paying for the service than good accruing from the service. This applies also in the designing of the service as it is quite possible the service might be designed in a manner that would put it within the means of the tax payer whereas if designed in another manner it might be beyond his resources.

The local Authorities of Limerick region are embarking on a scheme of medical services which is full of great possibilities and difficulties, and should receive intelligent and dispassionate consideration from the public. They are at present providing large-scale Medical Services, and there are indications that the future will make even higher demands on their resources. There is no doubt that these services require complete re-organisation and further expansion and it would be a great pity if in all this work the best possible were not achieved.

VITAL STATISTICS.

I. Population.—41,395 (Census of 1936).

II. BIRTHS.—There was a total of 1,303 births registered in the city during the year, which is an increase compared with 1,193 for the previous year.

III. DEATHS.—There were 551 deaths registered during the year which compared with 603 for the previous year shows a decrease.

DEATH RATE—10 YEARS ENDING 1938.

1929	1930	1931	1932	1933	1934	1935	1936	1937	1938
16.3	16.1	16.1	15.7	17.9	13.4	16.3	15.0	14.6	13.4

INFANTILE MORTALITY—The number of deaths of infants under the age of one year was 72 which is equivalent to a rate of 71 per 1,000 births.

INFANTILE MORTALITY RATE FOR THE COUNTY BOROUGHS FOR YEAR 1938.

City of Dublin	98
Cork County Borough	76
Limerick County Borough	71
Waterford County Borough	98

CANCER—There were 45 deaths attributed to this disease compared with 57 for the previous year.

PHTHISIS—The number of deaths due to Pulmonary Tuberculosis was 39 compared with 50 for the previous year, and deaths from other forms of the disease were 6 compared with 10 for the previous year.

MATERNAL MORTALITY—There were no deaths due to puerperal sepsis during the year, which is satisfactory.

INFECTIOUS DISEASE RATE—The infectious disease rate for the last year was 1.0 per 1,000 of the population compared with 0.7 for last year.

MEDICAL SERVICES.

Space will not permit of an exhaustive review of all the factors concerning these services. Owing to projected re-organisation of the whole Hospital System in the area analysis of some of the fundamental factors involved is urgently required.

At the outset it should be realised that medical science as such, is a different entity from this same science applied to actual facts. The trained medical man knows the methods of the science, but he has to apply his knowledge to individual cases, each of which is different, e.g., two persons suffering from pneumonia are two separate problems, and correct application of medical knowledge to each requires that the doctor studies and notes the peculiarities of each patient and acts in light of the knowledge thus gained. This aspect can be described as the Art of Medicine. The examination of this simple instance shows us that the practice of medicine requires a knowledge of social facts conditioning the application of scientific medicine to living realities. This can be stated in another way, viz., medical practice is a department of social science and is fundamentally a service. This service is given by doctors as a private enterprise in those cases where the patient is able to pay the doctor. This part of medical practice is termed private practice. There is a large section of the community not able to afford these services and this aspect is met by private charity or by the public authority employing medical men to do this work. When the public authority undertake this practice it is State medicine. It is a direct health activity of the State and strictly speaking is "public health."

Attempts are made to raise distinctions such as curative and preventative medicine, but these distinctions do not stand a practical analysis.

In organising medical services the public authority is applying the results of medical science to the social body—to the public. It can be seen that the doctor has a difficult problem in correlating the facts concerning a single individual, and from this it became clear that the application of the same science to a group of persons considered in their collective aspect presents a far more difficult problem. It is more difficult because the facts are incomparably more complex and hence are more difficult to ascertain and having ascertained them, they are more difficult to analyse.

The problem that presents itself to the public authority is therefore extremely difficult. The modern discoveries of medical and allied sciences have opened a wide field and have made the problem more difficult. This latter phenomenon has made it more necessary for the public authority to provide both general and specialist services and

their corresponding equipment. The dimensions of medical knowledge have rendered it impossible for any one man to be able to apply it all. From this has arisen the two classes of practitioners—the general practitioner and the specialist and from this has arisen corresponding equipment and insitutions.

So far it is clear that our medical services must consist of these two main sections—general and specialist. These sections must be thoroughly co-ordinated. When the specialist services are considered we again are faced with the problem of their organisation. The guiding principle of the problem is again given by the facts.

Amongst the various specialist services we find that some of them must deal with a large volume of work as compared with other specialist branches, e.g., the number of cases occurring in the local community requiring the services of a specialist general surgeon is far greater than those occurring which will require the services of a specialist lung surgeon or brain surgeon. This fact indicates that in a given area there will be less work for the latter kind of specialist and for the extremely expensive equipment required for such work. The solution of this problem as given by the Hospital Commission consists in equipping certain Hospitals in the Country to deal with such cases. A Hospital so equipped would deal with cases of this kind from a wider area than would be served by a hospital not so equipped. In other words, the hospital would be equipped to serve a health district in respect of a specialist service which would have a large number of cases of this kind and it would be further equipped to serve the same health district in regard to the less frequent kind of case. But in order to make full use of this latter service such a hospital would serve several health districts in regard to this special class of case. In other words, it would serve a "region" in this particular field. The Commission designate such a hospital as a Regional Hospital.

The suggested hospital for Limerick would be of this class. It would be euipped and staffed to do all the work now done by the existing local authority Hospitals, and it would be further equipped and staffed to deal with a higher grade specialist work for the Limerick district and for neighbouring districts. The hospitals in the neighbouring districts would deal with the wider specialist field of work for their own area and send the more unusual kind of case to the Limerick Hospital. The Limerick regional service would again be co-ordinated with Hospitals in Dublin, etc. This latter would be staffed and equipped for the still more unusual class of case—this latter Hospital would be classed as "central" or "national."

The general practitioner is the keystone of the whole structure. He fulfils the office of family doctor without which medical service would completely fail. The dispensary system in Ireland pays for the family doctor to the poorer families. The well-to-do families pay

their own family doctor. The work is exactly the same in both classes—it requires the same high moral and scientific equipment. The specialized services again require the same qualities in its personnel, but in addition this aspect of the services requires institutions and equipment which are extremely expensive to set up and equally expensive to maintain.

This latter attribute makes it incumbent upon the local authority to act with great circumspection and especially with respect to the following points:—

(a) A really suitable building must be provided.
(b) It must be fully equipped for specialised work.
(c) It must be staffed by competent medical men in their respective specialist fields and facilities provided for further study.

The provision of this department of service is absolutely necessary for the poor, and it is obvious that the other social classes in this area have not the organisation or financial resources to provide these things for themselves. These other classes are made up of citizens who are entitled to these necessities, and hence it would seem permissable for the public authority to provide these, with the condition that these classes of people would pay for services received. Considered on this basis such an institution would be a community institution.

Further, in organising such an institution the authority must guard against using such an institution to give services that can be provided in the field of general practice by a properly organised system relating to this aspect of medical work. Failure to provide this safeguard will mean that the institutions will require to be much larger than is reasonably necessary and would be providing services at a high rate of cost, but yet would not be any better—if as good—than could be provided under a general practice scheme. This would be the case if such an institution was accessible to the public without having to pass through the hands of the family doctor. The concrete problem that presents itself in the district is as follows.

The public authority is providing the service of specialized institutions and staff in

(a) The Co. Hospital, Croom.
(b) The City Hospital.
(c) The Co. Infirmary.

These institutions require a large capital outlay to modernise and equip them. The minimum estimate for the Co. Hospital would be £40,000 for structural work alone. To provide proper X-ray and Laboratory services in each of these—and each would require same if they wish to be efficient—would cost a large initial sum and a large annual outlay.

The Limerick Co. Board of Health considered that the Hospital Sweepstakes should help and make application accordingly. The Commission then surveyed the position and came to the conclusion that the Co. Hospital, Croom, the City Hospital and the Co. Infirmary should be replaced by one properly constructed and equipped Hospital. The Commission considered this would be much cheaper in the long run. This seems reasonable when we realise that the modernising of the three institutions would require triplication of Laboratory X-ray and instrumental equipment, all of which are to-day extremely costly.

At the same time it appears that the Hospital Commission investigated requests for grants to the voluntary Hospitals in the City. These Hospitals are voluntary and are not in any way subject to the jurisdiction of the local authorities, hence the question of setting up a Regional Hospital by the public authority is entirely separate from any question that arises in connection with the voluntary Hospitals and does not concern the Limerick local authorities in their function of providing Hospital facilities for those persons for whom they must make provision.

While this is so, it appears that the Commission decided that the existing voluntary Hospitals could not be put in position to deal with all the Hospital needs of the area and recommended the voluntary Hospitals to join in a scheme which would meet the needs of all —including the patients for whom the local authority is bound to provide a service and which service is financed out of local taxation.

In putting forward a solution for the Hospitalization of Limerick the Commission was faced with the conclusion that a proper solution must involve amalgamation of all the Hospitals with the formation of one complete unit. In theory this could be done by abolishing the local authority Hospitals and centralising all the work in one large voluntary Hospital, or vice versa, viz., centralising in one large local authority Hospital. One or the other of these courses had to be followed.

As a general principle it is always preferable to encourage and utilize voluntary forces in the community if such can be made sufficiently capable of meeting the essential needs of the community. In this regard it is worth noting that the Commission strongly recommend the expansion of the voluntary system in Dublin, while in Limerick it recommended the expansion of the public authority Hospital system. The reasons for this policy have been set out at length in the reports of the Commission.

Briefly these reasons are:—

The services, equipment and financial resources already available in the voluntary institutions in Dublin are much greater than that availabe from the local authority, and hence the local

authority institutions should be linked to the voluntary system. On the other hand it appears that the services and equipment available from the local authority Hospitals in Limerick are much greater than that available from the voluntary organisations.

It was further concluded that the finance required to hospitalize Limerick would have to be furnished by the Sweepstakes and local taxation.

This question of Sweepstake monies raises an acute question. If an institution is financed by Sweepstake monies is it a voluntary institution? How is a voluntary institution to be defined? The more usual definition is that an institution is voluntary if financed by voluntary subscriptions and a State institution is usually defined as an institution financed by State monies.

These issues require authoritive definition before the atmosphere can be cleared. The further question as to whether the Sweepstake monies are private monies or public monies in the strict sense also requires an authoritative answer. Legistlative enactments contain the definite implication that they are public monies subject to full control of the State authority.

It would appear that this is not fully accepted in certain quarters. If the Sweep monies are State funds the question simplifies itself. The following table shows the details of hospital services rendered to the community by the local authority hospitals and those rendered by the voluntary hospitals.

Patients Treated in Hospitals under the control of the Public Authority in County and City, Limerick Area.

I.

	No of Patients.	Payments from Patients.
A. In Area Hospitals		
Co. Hospital, Croom, 1937	2897	£800
City Home & Hospital, 1937	1591	£500
Co. Infirmary, 1938	1127	£2591
Patient sent to regional and central Hospitals by Local Authorities (Co. and City) :		
B. Regional	114	
C. Central	114	

2. **Patients treated in Hospitals under the control of Voluntary Hospitals during the period January 1st, to December 31st, 1937.**

A. Area Hospital	No. of Patients	Payments from and for Patients.
Barrington's	1827	£3039 and £400 from Corp.
St. John's	1368	£4233 and £450 from Corp.
Totals ...	3195	

Taking the average cost £2 : 2 : 0. per week per patient, these figures indicate that these two institutions provided free intern Hospital services for approximately 1250 patients.

Calculations based on these figures would indicate that County Hospitals and City Hospitals treated 4000 patients at the expense of the ratepayer. The public authorities also provided for patients under regional and central Hospitals by payment to institutions in Dublin and Cork. These patients are very costly in compariosn with area Hospitals. This is because these patients require very long period of treatment—varying from 6 months to 2 years stay at these institutions.

A survey of the Hospital services provided for patients unable to pay indicates the enormous amount of help given by the ratepayer and also enables the public to realise the dimensions of the problem. It will also given an indication of the nature of the considerations that weighed with the Hospitals' Commission in recommending that the whole service be unified under the public authority.

Below are set out extracts from the Policy of the British Medical Association and Hospitalization. The report referred to is extremely valuable, as it sets out the opinion of probably the greatest world experts on Hospital Services.

1. Amongst the social changes of recent years none is more remarkable than that which has taken place in our hospitals. Originally charitable institutions for the general treatment of the very poor they have become centres of highly specialized and complex service to which four-fifths of the population look for help and where the community as a whole claims as a right services which

can only be rendered by a great organisation or its dependent branches.

2. The British Medical Association recognising that hospital accomodation in any given area may be provided by voluntary bodies or by statutory authorities or by any combination of these, believes that the continuance of voluntary hospitals is in the public interest. The Association is concerned especially to see that in all cases certain fundamental conditions are met:—

(i) that the accommodation be utilized for the provision of those medical services which in the best interests of the patient can be given only in an institution;

(ii) that accommodation should be provided in all districts for the treatment of patients by general medical practitioners;

(iii) that the arrangements for the medical staffing of these hospitals be such as meet with the considered approval of the medical profession;

(iv) that the normal method of admission of patients to hospitals should be on the recommendation of a medical practitioner;

(v) that as far as practicable, all hospitals should be available for purposes of medical education;

3. The people's needs cannot be satisfactorily met by delimiting spheres of independent and possibly competitive service, but only by the most intimate co-operation between the public and the voluntary hospitals in any area. Full co-operation will not readily be achieved unless the governing bodies and medical staffs of voluntary hospitals adjust themselves to the altered conditions which must now prevail.

4. There are in this country two types of hospital in which provision is made for the treatment and nursing of the sick, viz., council hospitals and voluntary hospitals. In the opinion of the Association it is necessary to ensure (i) that there shall be no unnecessary duplication of accommodation or wasteful competition with or between these two types of institution, and (ii) that in the development of additional accommodation this development may be related to existing hospital accommodation.

DISPENSARY MEDICAL SERVICES.

Analysis of the facts governing the organisation of Medical Services clearly shows the necessity for "division of labour." The first link between the people and the service is the family doctor. His importance cannot be over-emphasised. He must be skilled in the science of medicine ,and he must be skilled in the application of the science to concrete cases. This is a very big work. It involves a capacity to classify the cases he meets with in two principal groups, viz:—

(a) cases of illness requiring institutional treatment;

(b) cases that can be treated at home.

Having done this he then has the duty of directing and assisting class (a) to their required centre and giving his personal attention to class (b). All this requires that he becomes a very intimate and trusted friend of the afmily. He becomes acquainted with family secrets and troubles and is bound to guard the interest of the family. This shows us that he is a social force of very great importance indeed.

This aspect of medical services must govern all attempts at creating an organised medical service. Its existence will defeat all schemes of organisation that in any way minimises its importance. All these factors must be considered in organising a family doctor service for those families that are unable to pay for such services out of their own resources. This problem is very varied according to the type of community involved. In purely rural areas where the families live very far apart from each other it presents a problem which is very satisfactorily solved by the present part-time dispensary service.

In a community such as is found in Limerick City. the conditions are entirely different. and are of such a kind that a solution is extremely difficult. The existing system was satisfactory at the time of its inception. but habits and needs of the people have undergone great changes in the city since those times. The system as is exists at present is a State service—the provision of a family doctor for this class is a function of the public authority—and apparently must remain so.

In its present state it is found necessary to supplement it by auxiliary schemes such as Maternity and Child Welfare Schemes, T. B. Services, and School Medical Services.

In their present mode of operation these latter services are being treated as if they were intended to replace the family doctor. Difficulties are arising because of a lack of a clear direction as to the place of these services in the scheme of medical organisation. In this regard it can be stated that any scheme which trespasses upon the sphere of the family doctor is doomed to failure, and in

order that these schemes may exert a beneficial effect they must function through and with the trusted co-operation of the family doctor. On this basis these schemes should be organised as specialist services. This is, they should be organised, staffed and equipped to deal with conditions outside the functions of the family doctor. In the case of School Medical Services the special work should be related to the medical aspect of education and should be related to the work of the family doctor. As functioning at present they are doing work which tends to replace the family doctor. Their phenomenon is partly due to the fact that such schemes have been copied from England. In England there is no State provision for the family doctor such as exists in our Dispensary System, and hence it is reasonable that these schemes in England should do the work of the family doctor.

It will be obvious that in order that the Dispensary Doctor in a city like Limerick should carry out all the work required it will be necessary to increase the number of doctors employed as part-time workers or to change over to full-time officers.

The arguments for and against either of these methods are legion, and in making a decision on the point we must consider the administrative difficulties involved as well as the many other factors.

Amongst many criticisms of the full-time medical officers the following have been suggested:—

(a) The full-time official will not be efficient because of lack of competition.

(b) Such a system will segregate these families into a class and such a system is therefore in contradiction with correct social principles.

Space will not permit a full examination of these two assertions, but the following points are worthy of consideration:—

Competition in life is a natural thing, but we are going somewhat far when we assume that men are only moved to activity by the desire for gain of a material nature. A person who will not make him proficient in his profession unless he can see a cash return is hardly likely to place his skill at the service of persons who cannot reward him in cash. Thus, if a doctor develops a proficiency in his work purely in order to gain money he will not place this proficiency at the service of his patients except in proportion to the payment received.Such a man will not make a good part-time officer any more than he will make a good full-time officer. Individual doctors have been known to refuse to place their skill at the service of the sick because of money, but such a case is very uncommon. Consideration of this question has as much force against the part-time official as it has against the full-time official.

As a matter of actual fact very few men make money their only consideration. The majority of men who have amassed money at their profession have amassed it as a consequence of an activity inspired by a love for their work.

The criticism included in (b) is more difficult to discuss. Part of the difficulty arises from the absence of any knowledge of what constitutes a correct social principle in its applied form and from whence we are to take such principles. There is no doubt that during the 19th century the poorer classes were considered inferior beings and the puritan culture contained the implication that the Almighty expressed His love for certain persons by making them rich. From this type of thought grew the idea that persons who worked for these classes were of inferior calibre. This idea still persists but in weakened degree. The suggestion that there is a social error involved in allotting a family doctor exclusively to this class does not seem to be well founded when we remember that the whole organisation of medical services are at the disposal of this class, at least equally with other classes. Under the proposed hospitalization scheme with its highly specialized staff and personnel it is this class that has the first claim to its services. It has first claim because there is a legal obligation involved concerning this class that does not exist in regard to the other classes.

In conclusion, it can be stated that the organisation of the family doctor service in the city requires radical re-organisation, and the proposal to appoint a full-time doctor seems to offer a reasonable hope of providing a system which will integrate the full idea of the family doctor amongst this class, and in so doing help to preserve the family as the social unit in the administrative order. Notwithstanding these considerations there is still the possibility that with serious co-operation of all concerned a service which will reconcile all points of view may be secured.

INFECTIOUS DISEASE.

DIPHTHERIA.

The incidence of this disease has markedly decreased all over the world, since the introduction of immunisation. Not alone has the number of cases become less but the severity of the cases has decreased. Immunisation has a very great value in this respect.

The progress of immunisation of the children in the area is very bad. This is the result of a number of factors. The greatest problem in this matter is the difficulty of convincing parents of its value and desirability. Under present conditions parents will not submit their children to immunisation until the disease breaks out in the district. When this occurs there is a rush for the treatment. It is not clearly understood that in order to secure full benefits this work should be carried out in the absence of the disease in the district. The existence of the disease in the community increases the dangers attendant on the treatment.

The principal factors obstructing progress in the work of educating parents are as follows:—

1. The separation that exists between this work and family doctor service.
2. Publicity of accidents that have occurred during immunisation.
3. The existence of a dispute between the dispensary doctors and the public authority concerning rates of payment.

In order to educate parents on the value of the procedure and to give them courage to face the procedure and its risks it is necessary that they should be educated and encouraged by the family doctor. He alone possesses the sufficient intimate contact and confidence of the family that will ensure the convincing of the parents that the procedure is necessary. In the absence of the influence of the family doctor progress is impossible. If a strange doctor comes along to do the work there is not the same faith in the procedure as will arise if the family doctor takes an active interest in the education of the people and carries out the work himself. This is an instance of the practical impossibility of maintaining the distinction between preventative and curative medicine. It is also an illustration of the difficulties created by out-of-date legislative separation of "Public Health" and other medical services. In this instance the family doctor is an officer under the Medical Charities Act while treating a case of Diphtheria but he becomes a Medical Officer of Health when he is immunising the contacts of a case against the disease.

(2) Publicity of accidents attendant upon the procedure. This is inevitable and cannot—even if it should—be avoided. This factor is at present important as the result of the unfortunate affair in Waterford. This happening convinced the public that the procedure was dangerous. A little careful thought should help the public to realise

that all medical procedures contain an element of danger—in fact being alive is an element in exposing us to danger of death. It is this degree of danger in medical operations that has produced all the legal enactments that surround the medical profession and regulate training and practice. The mere fact that there is an element of risk attached to the procedure should not cloud the issue. If the sum total of injuries inflicted upon persons by immunisation were set out against the enormous amount of deaths and suffering that has already been prevented by the procedure we would realise that the risks are infinitesimal in comparison with the benefits that will accrue.

(3) Dispute between the medical profession and the public authority. This is a sensitive problem. Again we meet a result of confused legistlation. But apart from this factor we are faced with the position of doctors who are engaged in work that is of such a nature that they cannot go on strike. The public have developed an attitude towards doctors that it is considered criminal for the doctors to leave a patient in suffering because of a failure to secure proper remuneration for medical services.

This position of the doctors before the public is of course not the whole story. There are compensations, and the public concede many privileges to the profession But the above fact should be stressed in order that doctors may realise the position and shape their methods of securing redress in light of hard facts.

The question of remuneration for this work is ouside my province and I cannot express an opinion on this aspect, but I would venture to suggest that whatever methods may be used by the profession to secure its claims it should carefully avoid all methods that in any way savours of withholding services that if given might prevent loss of life. It seems a pity that the profession and the Government could not discuss their differences in better terms.

The following is a table showing the number of deaths due to the Principal Epidemic Diseases since 1935:

	Typhoid Fever	Typhus	Small Pox	Measles	Scarlet Fever	Whooping Cough	Diphtheria	Dysentery	Diarrhoea and Enteritis of Children under 2 years	Total
1935	4	—	—	27	—	2	6	—	45	84
1936	2	—	—	—	—	21	10	—	23	56
1937	2	—	—	—	—	1	7	—	21	31
1938	—	—	—	1	—	7	2	—	32	42

There were 7 deaths due to Influenza during the year.

NOTIFICATION OF INFECTIOUS DISEASE.

The following diseases are notifiable in this area:—
Small Pox, Cholera, Diphtheria, Membranous Croup, Erysipelas, Scarlatina, Typhus, Typhoid or Enteric, Relapsing, Continued or Puerperal Fever, Cerebro-Spinal Meningitis, Poliomyelitis, Encephalitis, Lethargica, Acute Primary Pneumonia, Acute Influenzal Pneumonia, Malaria, Dysentery.

The notifications received during the year and during the previous year are as follows:—

Typhoid Fever	16	6
Diphtheria	85	50
Scarlet Fever	40	30
Erysipelas	5	12
Pneumonia	47	33
Puerperal Sepsis	—	1
Para-Typhoid Fever	—	—
Dysentery	2	—
Cerebro-Spinal Fever	1	1
A.A. Poliomyelitis	—	2

The following is a table showing the number of cases and the number of deaths from Diphtheria, 1929-1938:—

Year	Cases Notified	Deaths	Deaths per 100 Cases
1929 ...	28	5	17.8
1930 ...	15	4	26.6
1931 ...	68	7	10.3
1932 ...	342	22	6.4
1933 ...	445	37	8.3
1934 ...	235	16	6.8
1935 ...	87	6	6.9
1936 ...	112	10	8.1
1937 ...	85	7	8.2
1938 ...	50	2	4.0

DIPHTHERIA IMMUNISATION SCHEME—The scheme was continued during the year by Dr. P. Liddy. The immunisation of school children was carried out at fifteen schools, and at clinics in the city, at which 442 children were immunised. This number completes, as far as is practicable to obtain, the immunisation of the school children in the city.

The following is an Age Classification of the immunised children in the city at the close of the year 1938:—

Number of immunised children over 5 years of age	1,351
Number of immunised children under 5 years of age	9,195.
Total	10,546

During the year it was found increasingly difficult to induce parents to have their children immunised.

CANCER INVESTIGATION.

No voluntary notifications were received during the year from the Medical Practitioners of the area.

MATERNITY AND CHILD WELFARE.

Under the Notification of Births Acts, 1907 and 1915, there were 1,303 births notified and those relating to infants whose mothers came from outside areas were notified to those areas.

The two Child Welfare Nurses made the following home visits during the year:—

First Visits	702
Second and Subsequent	4,531
Children over 1 year	4,004
Mothers ante-natal	2,983
Mothers post-natal	448
Total	12,668

The following report is supplied by the Medical Officer to the Child Welfare Committee:—

"The amount of work done at the Clinic at Bedford Row Hospital was somewhat less than last year, owing to the fact that the Clinic was closed for one month while alterations were carried out by the Hospital Authorities.

Following this, the Clinic was transferred to different premises in the Hospital building. These, while not by any means ideal, are the best that can be arranged under present circumstances, and have the advantage of much improved waiting-room accommodation for the patients.

The statistics of the Clinic are as follows:—

Number of Clinics held	88
Total attendances of Infants and Children	2,644
Individual Cases	458
Ante-natal attendances	1,470
Individual Cases	245
Ultra-violet Ray treatment cases	13

The usual visits were paid by the Nurses to infants in their homes on notification of birth, advice given on feeding and care, and cases referred to the Clinic when advisable, or further home visits paid as required.

These activities have certainly caused a steady improvement in the care and methods of feeding of infants in the city, with a marked decrease in such diseases as Infantile Diarrhoea, which was formerly much more prevalent.

The provision of free milk from Government Grant to children of poor families is another very important factor in child welfare. A larger provision under this heading is very desirable, as malnutrition, or partial starvation, is still common among children whose parents are unemployed.

(Signed)—H. G. ROCHE-KELLY, M.B., D.P.H."

SUPERVISION OF MIDWIVES.

Forty-two Midwives notified their intention to Practise in the City during the year. There were 36 inspections made.

The following are the names and addresses of the Midwives who were registered:—

Adam, Julia Mary, 17 Crescent Avenue.
Allen, Hanora, 7 Bedford Row.
Barry, Matilda A., 11 St. Francis Place.
Burns, Christina, 2 St. Mary's Terrace, Island Road.
Burrowes, Mary E., 5 Lower Mallow Street.
Chambers, Frances, 15 Lower Hartstonge Street.
Cleary, Eily, 30 Elm Park, Ennis Road.
Collier, Bridget, 6 Lower Mallow Street.
Costelloe, Ellen, 1 Sonth Circular Road.
Cullen, Ann J., 3 St. John's Square.
Daly-Kelly, Theresa, 9 Edward Street.
Dunbar, Beatrice L., 7 Shelbourne Terrace.
Dunbar-Hennessy, Anne, 7 Shelbourne Terrace.
Frazer, Catherine, Thomond Terrace, Thomondgate.
Gallagher, Mary, 4 Mount Vincent View.
Gilligan, Hanora M., 17 Island Road.
Hazelbeck, Helen M., 77 Wolfe Tone Street.
Hanrahan, Emily, 17 Barrington Street.
Kelly, Margaret, 10 Wolfe Tone Street.
Kennedy, Bridget, 16 Charlotte Quay.
Killington, Annie, 77 Pennywell.
Laffan, Christina, Bedford Row Hospital.
Lynch, Mary C., 5 Rossa Villas.
Laycock, Mary, Shelbourne Road.
Molaney, Mary, 14 Denmark Street.
McAuliffe, Albina, 3 Newenham Street.
McInerney, Aunie, 10 Carey's Road.
McInerney, Bridget, 76 Henry Street.

McInerney, Margaret, 9 Convent Street.
McMahon, Mary, Westfields, N.C.R.
O'Brien, Alice, 3 Newenham Street.
O'Flynn, Kate, 29 Patrick Street.
O'Halloran, Susanna, 10 Little Barrington Street.
Reddan, Mary, 26 William Street.
Ryan-Liddy, Nan, 28 O'Connell Street.
Sammon, Elizabeth, Bedford Row Hospital.
Sexton, Mary, 8 Rossa Villas.
Shanahan, Mary F., 27 O'Curry Street.
Shechy, Margaret, 22 Catherine Street.
Walsh, Bridget M., 42 Cecil Street.
Walsh, Mary, Mrs., 42 Cecil Street.
Walsh, Catherine, Bedford Row Hospital.

REGISTRATION OF MATERNITY HOMES ACT, 1934.

The following are the Maternity Homes in the City registered under the above-mentioned Act:—

Bedford Row Hospital.

City Home and Hospital.

2 Kylemore Villas, Corbally
(Mrs. Bridget Collier)

5 Lower Mallow Street
(Mrs. Elizabeth Burrowes).

Thomond Home, Thomondgate
(Mrs. Catherine Frazer).

7 Shelbourne Terrace, Thomondgate
(Mrs. Anne Dunbar-Hennessy).

St. Anne's, 10 Belfield Park
(Mrs. Mary Walsh)

3 St. John's Square
(Mrs. Anne Jane Cullen).

St. Benedict's Nursing Home, Barrington Street
(Mrs. Winifred Shaw).

St. Joseph's Nursing Home, Newenham Street
(Mrs. Alice O'Brien).

All the Homes were duly inspected during the year.

WELFARE OF THE BLIND.

The Scheme for the Welfare of the Blind which came into operation in the County Borough on the 1st October, 1933, was continued during the year. The names of 165 blind persons remained on the Register. Five of these were maintained in approved Institutions for the Blind.

FREE MILK SCHEME.

The Free Milk Supply Scheme which was adopted by the Corporation under the terms of the National Free Milk Supply Grant was in operation during the year. The amount of the Grant was £2,996 15s. 4d. and £2,985 8s. 11d. was expended—£2,755 14s. 11d. being the cost of the milk supplied and £229 14s. 10d. being the cost of distribution from the several depots. 1,469 necessitous children under 5 years of age received a supply of Free Milk, The total quantity of Grade A Milk supplied was 40,014 gallons.

VETERINARY DEPARTMENT.

The following report was submitted by Mr. J. J. Dundon, Chief Veterinary Officer, and gives full details of the work done by this Department:—

I.—PRIVATE SLAUGHTERHOUSES.

	Inspected	Completely Condemned	Partially Condemned	Tubercular	Other Diseases
Cattle	2556	32	891	720 (28.1%)	171
Sheep	1433	—	9	— —	9
Pigs	1370	7	68	64 (4.7%)	4
Sows	1754	10	651	621 (35.4%)	30

Number of visits by Inspectors to Slaughterhouses, Shops, etc., 3,158.

Weight of Meat and Offal condemned 58,136 lbs.

II.—BACON FACTORIES.

Number of Pigs inspected	105,899
Weight at 150 lbs. per pig dead weight	15,884,850 lbs.
Weight of Pork Offal condemned	233,188 lbs.
Percentage of total weight condemned	1.46%
Number of carcases completely condemned	398
Percentage of carcases completely condemned (nearly 2¼ per 100 pigs)	.375%

Bacon Factory statistics were not available after the 31st July, 1938.

III—DAIRIES, COWSHEDS and MILK SHOPS.

Number of	Cowsheds inspected	97
,,	Cows inspected	310
,,	Notices served	3
,,	Milk Samples, microscopically examined	79
,,	Milk Samples showing Tubercle Bacilli	3
,,	Visits to Graded Milk Farms	6
,,	Graded Milk Samples bacteriologically examined	80
,,	Graded Milk Samples rejected	10
,,	Commercial Milk Samples bacteriologically ,,	13
,,	Milk Shops Inspected	487
,,	Visits to approved Milk Shops	86
,,	Milk Cars Inspected	337
,,	Prosecutions under Milk and Dairies Act, 1935	39
,,	Convictions under Milk and Dairies Act, 1935	30

SLAUGHTER OF ANIMALS ACT, 1935.

The above Act was put into operation in the County Borough during the year. Licences were issued to thirty persons engaged in the slaughter of animals.

FOOD AND DRUGS ACT.

Inspections under the Food and Drugs Act were carried out by Inspector Bowles.

Particulars of the samples taken and forwarded for analysis are as follows:—

New Milk	112
Butter	23
Margarine	3
Cheese	6
Jam	2
Olive Oil	1
Condensed Milk	2
Tea	1
Sago	1
Dripping	1
Sausages	1
Castor Oil	1
Liquid Paraffin	1
Skimmed Milk	1
Syrup of Figs	2
Tawny Wine	1
Iodine	1
Tinned Peas	1
Tinned Fruit	1
	162
Water Samples	23

Defective Samples:—

Jam	2
Butter	6
Syrup of Figs	2
Milk	4

Prosecutions under the Food and Drugs Act 10

SANITARY DEPARTMENT.

The following is a table showing a record of the sanitary work performed during the year and during the three previous years:—

WORK DONE.	YEARS.											
Orders or Notices to abate Nuisances, making connecting Drains or perform other sanitary work served ...	1938 548			£17	1	9	£13	1	5	£7	8	2
										1937	1936	1935
										626	712	573
Prosecutions for Neglect of Orders or Notices ...	2				52			61			45	
Convictions ...	6				42			53			39	
Fines imposed by order of Justices ...	£3	14	6									
Houses, Yards and Premises inspected by S. S. Officers	5179				4116			3584			3625	
Houses, Rooms or Premises limewashed ...	51				—			12			160	
Dwellings Disinfected ...	102				148			161			169	
Disinfecting Chambers used by persons ...	—				—			—			—	
Articles of Clothing Disinfected therein ...	—				—			—			—	
Clothing and Bedding destroyed to value of ...	—				—			—			—	
Orders or Notices complied with ...	302				396			321			281	
Reports sent to Sanitary Authority ...	255				259			260			242	
Reports received from Medical Officers of Health ...	2				3			36			51	
Drains Constructed ...	45				85			17			9	
Water Closets Constructed ...	40				61			33			68	

WATER SUPPLY.

Owing to the increasing demand for water the capacity of the filtration plant requires to be increased. It is found that owing to the variation in quality of the raw water the filter beds are not capable of delivering sufficient quantity of pure water. To meet this situation, temporarily, a chlorination plant has been installed. This measure guarantees a safe water supply pending consideration of the problems involved in expansion of the filtration plant. The amount of chlorine added to the filtrate is one part per million.

HOUSING.

To date, the Corporation has completed the erection of 967 houses under the Housing of the Working Classes Acts. Of these, 670 were completed under the Housing (Financial and Miscellaneous Provisions) Act, 1932. Of the 670 houses, 480 have been let to persons removed from 'slum clearance' areas or individual unfit houses. 152 houses are nearing completion, and a further 120 are in course of erection on the Janesboro' site. These will be used for ordinary housing requirements and will be let at economic rents.

During the year 8 houses showed signs of becoming dangerous to the occupants, who were removed and temporarily accommodated in the Strand Barracks.

Official representations under the Housing of the Working Classes Acts have been made in respect of the Carey's Road area—this comprises 460 dwellings and 2,300 persons, and covers an area of approximately 10 acres. In order to deal with this problem, the Sanitary Authority have acquired land in the Prospect and Lord Edward Street district and are taking steps to commence building operations thereon. Lands have also been acquired at Killeely.

It is proposed to erect 720 houses on the Prospect and Lord Edward Street sites, and 369 houses on the Killeely site. 235 of these houses are to be used for persons to be displaced by operations under the Housing (Financial and Miscellaneous Provisions) Act, 1932, and 134 for ordinary housing requirements.

The Sanitary Inspectors have completed a detailed house-to-house survey of the city. This survey will enable us to submit a complete and accurate report on the housing needs of the city.

The following table is an approximate estimate of the unhealthy houses in the city:—

District	No. of houses
Arthur Mews	6
Barrack Hill and Roden Street	14
Barrington Street Little and Schoolhouse Lane	29
Bishop Street, including Dominick Street, Broad Lane and King's Island	46
Carey's Road North, South, and adjoining lanes	460
Carey's Road Upper and Roxboro' Road	59
Clancy's Strand, including Mass Lane, Clune's Lane and The Green	30
Clare Street, including Chapel Lane, Back Clare Street, and adjoining lanes	104
Clontarf Place Little	6
Crosby Row, including Newgate Lane, Hasting's Lane, Grattan Street, Garvey's Range and Lane, Campbell's Bow, Bell Tavern Lane, Walsh's Lane	100
Davis Street, Back Duggan's Court	25
Dominick Street Upper and Taylor Street, and Griffith's Row	30
Edward Street, Lanes west of Hall's Range and Punch's Cross	101
Francis Abbey and Lanes	80
Garryowen, including O'Halloran's Lane, Ball Alley Lane, Cassidy's Lane, O'Donoghue's Lane, McDonnell's Cottages	61
Gerald Griffin Street Little	20
Gerald Griffin Street Lower, including Kerwick's Lane, William's Lane, Hall's Bow, Bushy Lane, Barrack Lane, Smith's Row, Summer Street, Brennan's Row, Gammel's Yard, Osborne Lane, James' Street, Cathedral Place	80
Gerald Griffin Street Upper (Wide Lane and Narrow Lane)	6
Henry Street Little	5
James' Street, Myles' Street	24
Market Alley and Pillar Lane	35
Mungret Street, including Joss' Lane, Benson's Lane, Blackbull Lane, Taylor's Row, Little John Street	41
Naughton's Lane ...	17
Newenham Lane	11
New Road, Pennywell and Lelia Street	17
Pennywell ...	40
Phayer's Lane	7
Roche's Row	4
Roxborough Road	32
Theatre Lane	6

Thomondgate, including High Road, Farranshone, New Road, Cash's Lane, O'Halloran's Lane, Quarry Road, Barrack Lane, Cross Road, Gloster's Lane	126
Vize's Fields	65
Watergate, including White Wine Lane, Jones' Lane, Rosemary Place, Alley Lane, Margaret's Place, Ryan's Lane, Michael Street, Mardyke	125
Windmill, including Little O'Curry Street, Coogan Street, and Crosby Row	60
Total	1,903

J. McPOLIN, M.S.O.H.

COUNTY BOROUGH OF LIMERICK.

ANNUAL REPORT

OF

TUBERCULOSIS OFFICER

FOR THE YEAR 1938.

T. W. MORAN,
Tuberculosis Officer.

TUBERCULOSIS.

The number of notifications received during the year was 19.

The number of attendances at the Tuberculosis Dispensary was 1,111, and the number of visits paid by the Nurses to the house of patients was 1,326.

The following tables show the number of patients treated in Hospitals and Sanatoria:—

Twelve patients remained in Sanatoria at the beginning of the year and the following were admitted during the year:—

	Males	Females	Total
Insured	15	5	20
Non-Insured	7	9	16
	22	14	36

Patients discharged from Sanatoria during the year:—

	Males	Females	Total
Insured	11	5	16
Non-Insured	8	8	16
	19	13	32

Fourteen patients remained over in the City Home and Hospital at the beginning of the year and the following were admitted during the year:—

	Males	Females	Total
Insured	16	10	26
Non-Insured	24	27	51
	40	37	77

Patients discharged from City Home and Hospital during the year:—

	Males	Females	Total
Insured	18	12	30
Non-Insured	21	27	48
	39	39	78

Patients sent for treatment to Surgical Hospitals:—

Males	Females	Total
18	17	35

Patients sent for X-Ray Examination	28
Patients sent for Pneumothorax Treatment	1
Patients sent for Sanocrysin Treatment	1

Return of number of Patients treated under the Co. Borough Tuberculosis Scheme, during the year ended 31st December, 1938.

	Pulmonary Tuberculosis.			Non-Pulmonary Tuberculosis.			Total
	Children under 15 years	Other Persons		Children under 15 years	Other Persons		
		Males	Females		Males	Females	
I. INSURED PATIENTS:							
(i) No. remaining under treatment							
(a) On 1st Jan., 1938 ...	—	23	17	—	6	2	48
(b) On 31st Dec., 1938 ...	—	33	23	—	1	1	58
(ii) No of new patients treated during 1938 ...	—	13	9	—	—	—	22
(iii) No. of cases under observation at close of year 1938	—	8	7	—	—	—	15
II. OTHER PATIENTS:							
(i) No. remaining under treatment							
(a) On 1st Jan., 1938 ...	3	23	29	39	13	9	116
(b) On 31st Dec., 1938 ...	2	23	40	42	11	13	131
(ii) No. of new patients treated during 1938 ...	1	3	16	12	—	5	38
(iii) No. of cases under observation at close of year 1938		6	19	11	1		37

(Signed)—T. W. MORAN, Tuberculosis Officer.

COUNTY BOROUGH OF LIMERICK.

ANNUAL REPORT

OF

SCHOOL MEDICAL OFFICER

FOR THE YEAR 1938.

T. W. MORAN,
School Medical Officer.

SCHOOL MEDICAL SERVICE.

Facilities for the treatment of Tonsils and Adenoids and for Ophthalmic treatment are available at St. John's Hospital, City Home and Hospital, and Barrington's Hospital, and for Dental treatment at St. John's Hospital.

The numbers of children who received treatment under the Scheme during the year are as follows:—

Eye Defects	431
Tonsils and Adenoids	231
Dental Treatment	710

There is a School Clinic held once a week for the re-examination of children found defective in the schools and also for new cases.

PROVISION OF SCHOOL MEALS.

The average daily number of children receiving school meals was 1,584. The meals are supplied at twelve schools in the city. The meal consists of a half-pint of Grade A Milk supplied in bottle and a 4 oz. bun manufactured of stated quantities of flour, butter, milk, sugar and currants. The milk is supplied by seven contractors, whose premises, dairy herds, and methods of production are under the supervision of the Veterinary Department. The milk is guaranteed to contain less than 200,000 bacteria per c.c. and is examined bacteriologically at least every month. The distribution of the meals is undertaken by the teachers in eight of the schools, whilst in the case of four schools the meals are issued at nearby shops, the owners of which are paid at the rate of 1s. or 1s. 6d. per school day.

The following is a summary of the defects found, tabulated according to the Schedule of the Medical Treatment of Children:—

		Nutrition	Cleanliness and Condition: Skin	Cleanliness and Condition: Head	Cleanliness and Condition: Body	Clothing and Footwear	Nose & Throat: Teeth	Nose & Throat: Tonsils	Nose & Throat: Adenoids	Nose & Throat: Submaxillary and Cervical Glands	External Eye Disease	Vision R	Vision L	Ear Disease	Hearing	Speech	Mental Condition	Heart and Circulation	Lungs	Nervous System	Tuberculosis	Rickets	Deformities, Spinal Disease, etc.	Infectious or Contagious Disease	Other Diseases or Defect
Routine Examination—																									
	Boys 903	8	—	3	1	—	170	117	175	—	5	109	12	4	7	1	—	19	18	1	7	6	6	3	4
	Girls 809	4	2	5	3	—	108	73	105	—	2	84	4	6	—	—	—	10	11	2	2	1	2	2	6
Special Examination—																									
	Boys 511	6	8	—	—	—	247	67	83	—	23	75	6	2	1	—	—	1	3	4	2	4	—	5	29
	Girls 485	7	8	1	—	—	260	63	57	—	30	98	13	2	—	—	—	2	5	2	1	1	2	4	17
	2,708																								

Rheumatic Heart Disease—There were 8 cases of Organic Heart Disease encountered during the year.
There were no cases of Trachoma recorded during the year.

T. W. MORAN,
School Medical Officer.