

# Imperial Social Hygiene Congress

British Empire Exhibition, Wembley.

May 12—16, 1924.

*Proceedings*  
of the  
Imperial Social Hygiene Congress  
at the  
BRITISH EMPIRE EXHIBITION,  
WEMBLEY

May 12th—16th, 1924.

*Organised by the National Council for Combating  
Venereal Diseases.*

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MAY 12TH TO 16TH, 1924

*Organised by The National Council for Combating  
Venereal Diseases (Incorporated),*

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Mr. Leonard Bowden.

## PREFACE

THE Imperial Social Hygiene Congress was organised as a step towards the co-ordination of the social problems of the Empire. The groundwork of the problem of social hygiene has been prepared by the campaign against venereal diseases which has been carried on by the National Council and its affiliated Councils and Branches in the United Kingdom, the Dominions, in India and the Crown Colonies during the past eight years. Its activities have been officially recognised by the British and Canadian Governments, by the Governments of the Crown Colonies, and by certain of the municipal bodies in India. Their various educational campaigns have been supported by financial grants from official bodies supplementing voluntary contributions.

Sufficient progress has now been made in certain parts of the Empire to enable a clear appreciation to be gained of the need of broadening the basis of future advance to include the broader aspects of social hygiene. The discussion of the problem at the present time in its Imperial aspect is calculated to stimulate public interest, to summarise recent experience and to extend the movement to include allied social problems in the existence of which venereal diseases have a share, either as cause or effect.

The Congress was fortunate in securing the Minister of Health as its Hon. President and in attracting the co-operation of a number of distinguished men and women, and its discussions were enriched by the contributions of the representatives of the appropriate Government Departments at home and overseas, as well as of delegates from the various local authorities, the national social welfare organisations and professional bodies.

The Congress was very successful from every point of view—in numbers, in the maintained interest amongst both the papers offered and the discussions which followed, and above all in its primary object of stimulating an Imperial sense of responsibility for moral and physical evils, which are being fought under varying social and climatic conditions throughout the British Empire—therefore the National Council feel justified in reporting its transactions in this volume, in the hope that the experiences here summarised may prove of assistance to those who have to face the problem in its practical forms in all parts of the world.

SYBIL NEVILLE-ROLFE,

*August, 1924.*

*General Secretary.*

# CONTENTS

	PAGE
OPENING ADDRESS. Rt. Hon. J. Wheatley, M.P., Minister of Health . . . . .	1
ADDRESSES . . . . .	3
THE PRESENT POSITION OF GOVERNMENT ACTION IN V.D. (GREAT BRITAIN) . . . . .	7
THE ADMINISTRATIVE CONTROL OF THE VENEREAL DISEASES (SCOTLAND) . . . . .	23
LEAGUE OF NATIONS . . . . .	28
THE RELATIONSHIP BETWEEN V.D. AND THE REGULATION OF PROSTITUTION . . . . .	36
SOME ASPECTS OF SOCIAL HYGIENE . . . . .	55
EDUCATION . . . . .	68
THE PSYCHOLOGY OF ADOLESCENCE . . . . .	70
EDUCATION AND SOCIAL HYGIENE . . . . .	79
ADMINISTRATION.	
PLACE OF LOCAL AUTHORITY IN V.D. CAMPAIGN . . . . .	91
PLACE OF LOCAL AUTHORITY IN V.D. CAMPAIGN (SCOTLAND) . . . . .	93
CONTROL OF V.D. IN NORTHERN IRELAND . . . . .	110
PLACE OF LOCAL AUTHORITY IN V.D. CAMPAIGN (LONDON) . . . . .	111
THE NEED FOR A POLICY . . . . .	114
VENEREAL DISEASES TREATMENT.	
HOW TO SECURE THE MAXIMUM EFFICIENCY OF A V.D. CLINIC . . . . .	127
METHODS OF SECURING THE MAXIMUM EFFICIENCY OF A V.D. CLINIC . . . . .	135
THE PUBLIC HEALTH NURSE IN V.D. CLINICS IN TORONTO (CANADA) . . . . .	147
SOME OF THE DIFFICULTIES EXPERIENCED IN THE ADMINISTRATION OF A COUNTY V.D. SCHEME . . . . .	154
THE VENEREAL CLINIC IN ITS RELATIONSHIP TO THE TREATMENT OF WOMEN AND CHILDREN . . . . .	169
THE MEDICAL PROFESSION.	
THE GENERAL PRACTITIONER AND THE TREATMENT OF V.D. . . . .	179
THE POSITION OF THE GENERAL PRACTITIONER IN ANTI-VENEREAL DISEASE SCHEMES . . . . .	186
EXHIBITION OF FILM.	
"DIAGNOSIS AND TREATMENT OF GONORRHOEA IN THE MALE" . . . . .	209

## CONTENTS

	PAGE
IMPERIAL QUESTIONS . . . . .	210
<i>Canada.</i>	
SOCIAL HYGIENE AND V.D. CONTROL IN CANADA . . . . .	213
<i>Australia.</i>	
THE PREVENTION AND TREATMENT OF V.D. IN AUSTRALIA . . . . .	221
THE CONTROL OF V.D. IN VICTORIA . . . . .	224
<i>U.S.A.</i>	
THE SOCIAL HYGIENE MOVEMENT IN THE U.S.A. . . . .	226
<i>India.</i>	
THE NEED FOR A DEFINITE EDUCATION IN V.D. FOR BOTH MEDICAL PRACTITIONERS AND STUDENTS OF MEDICINE IN INDIA . . . . .	230
INDIAN EXPERIENCES . . . . .	232
V.D. AMONG THE CIVIL POPULATION OF SOUTHERN INDIA . . . . .	234
THE POSITION OF MEDICAL AFFAIRS IN THE GOVERNMENT OF MADRAS . . . . .	237
<i>South Africa.</i>	
SOCIAL HYGIENE IN NATAL . . . . .	241
<i>East Africa.</i>	
V.D. WORK IN THE COLONY AND PROTECTORATE OF KENYA . . . . .	244
<i>Uganda.</i>	
ANTI-VENEREAL DISEASE WORK IN UGANDA . . . . .	249
PROBLEMS OF THE PREVENTION AND TREATMENT OF V.D. IN UGANDA . . . . .	252
<i>West Indies.</i>	
THE V.D. PROBLEM IN BRITISH GUIANA . . . . .	255
<i>West Africa.</i>	
THE V.D. PROBLEM IN NIGERIA . . . . .	257
MEMBERS AND DELEGATES OF THE IMPERIAL HYGIENE CONGRESS ALPHABETICAL LIST OF MEMBERS . . . . .	267

# Imperial Social Hygiene Congress

*President of Congress :*

THE MINISTER OF HEALTH—  
THE RT. HON. J. WHEATLEY, M.P.

## Opening Address.

The Conference which I am to have the honour of opening this morning is one to which I, as Minister of Health, attach very great importance, and I am therefore highly pleased with its very representative character and with the papers to be read and the subjects to be discussed, which have been so wisely chosen.

We have represented here this morning five Government Departments—the Army Council, the Air Ministry, the Admiralty, the India Office, and the Ministry of Health. This representation of the War Services shows how conscious these Departments are of the leakage in fighting force that may be caused by the preventable diseases for the obliteration of which we are all so enthusiastically working, and I am particularly pleased with the Imperial character of the Conference. We have six official representatives of Dominions, and ten delegates of Crown Colonies. I am sure that while I am extending a welcome to you all as delegates that you will pardon me and join with me in extending a special and cordial welcome to the delegates from overseas.

I have very often felt that if the resources of the Empire could be mobilised for schemes on which there is universal agreement that the world would thereby be rapidly enriched.

We have also with us, I am pleased to say, representatives of fifty-eight important local authorities, representatives of ten universities and delegates from thirty-six national organisations. In addition to these, the League of Nations is represented by that lady so well known to all social workers—Dame Rachel Crowley—and we have also representatives from the American Social Hygiene Association.

Now the mere list of representatives is proof of the interest taken in this subject all over the world. It is not a national but an international subject. Disease, as we are so fond of saying, knows no race nor class nor creed nor politics, but in its nature emphasises the fundamental unity of the human family, and so in fighting it we must cordially co-operate. Here is a field in which there is no political difference. The most ardent individualist will not contend that the community should rely for its health on unorganised, unaided, uncontrolled individual action. I think

## SOCIAL HYGIENE

I might venture to go to the length of saying that in the production and distribution of health we are all Socialists now, and—if I might carry the political phraseology one sentence further—it would be to say that we are all opposed to Free Trade in disease.

I find that the first paper is to be read by Sir George Newman, my chief medical officer, and that the title of it is "The Present Position of Government Action in Venereal Disease." I am quite sure that Sir George will characteristically deal minutely and comprehensively with his subject and therefore I hesitate to steal even the slightest morsel from the feast which he has prepared, but perhaps it will not be out of place or an encroachment on his paper if I give you a few notes indicative of the venereal diseases campaign which has been conducted in this country.

The steps taken to deal with the venereal diseases problem have followed the recommendations of the Royal Commission on Venereal Diseases which reported in 1916, and, briefly, they are:—

1. The establishment of treatment centres at which all persons may obtain treatment free of cost and under conditions of secrecy.
2. Facilities for the diagnosis of venereal diseases by laboratory methods available free of cost, not only to the medical officer of treatment centres, but also to medical practitioners in general.
3. A gratuitous supply, subject to proper safeguards, of salvarsan compounds to medical practitioners.
4. Propaganda as to the dangers of venereal diseases and the necessity for treatment.
5. The suppression of treatment of venereal diseases by quacks by the Venereal Diseases Act of 1917, which prohibited treatment of these diseases by other than qualified practitioners.

Schemes for the diagnosis and treatment of these diseases are carried out by the councils of counties and county boroughs with the aid of a Government grant of 75 per cent. of their approved expenditure.

One hundred and ninety-four treatment centres have been provided in England and Wales, and in addition there are fifteen hostels which have been approved for the accommodation of women and girls suffering from these diseases, and ten other special institutions for the treatment of women and children. The annual cost of these schemes is now about £400,000.

Since the inception of the scheme in 1916 approximately 540,000 persons have attended the treatment centres, but it is satisfactory to note that of these 100,000 were found after examination not to be suffering from venereal disease. Approximately 220,000 were found to be suffering from syphilis, and 210,000 from gonorrhœa.

These are startling figures, but the figures show a steady decline in the number of cases since 1920, when the figures were at their highest. In 1923 the number of new cases of syphilis was 23,920 as compared with 42,800 in 1920, a fall of 44 per cent.; and for gonorrhœa 30,908 as compared with 40,284 in 1920, a fall of 23 per cent. Total attendances at the treatment centres now exceed 1½ millions per annum.



## OPENING ADDRESSES

It is also satisfactory to note that the importance of persevering with treatment is being increasingly appreciated, the percentage of those who cease to attend before completion of a course of treatment having fallen from 47 per cent. in 1921 to 33 per cent. in 1923. Many of the cases, however, who failed to continue their treatment or to remain under observation until a cure could be pronounced are rendered non-infective before ceasing attendance at the centres.

This is only, as I said, a very brief and partial and general summary of the work that is being conducted under the Ministry of Health. Time does not allow me, although I should have liked to acknowledge the very valuable services rendered by various organisations in carrying out this work, and I want to assure all those engaged in it that these services are appreciated and recorded by my Department.

Perhaps I may too be pardoned for merely touching upon the results achieved by the Commissions organised by the National Council with the co-operation of the Colonial Office, which visited the West Indies, the Far East, and the Mediterranean to devise a scheme for the protection of our merchant seamen.

I shall only say in conclusion that I will await with great interest the results of this Conference which will be of the greatest assistance to me in settling what modifications of policy are now desirable.

### **The Crown Colonies.**

*Sir Gordon Guggisberg*: Our President has not accurately described me as I do not belong to the Colonial Office, but am merely the Governor of one of His Majesty's Crown Colonies.

I have been asked to read a letter from Mr. Thomas to express his great regret at not being present to-day. Mr. Thomas wishes to be conveyed to the Congress his best wishes for the success of the meetings. He is deeply interested in all that affects the progress of public health and morality in the Colonies, and he would be glad to receive a report of the proceedings of the Congress if one could be sent to him.

On behalf of the British Colonies in West Africa I should like to give a message wishing the greatest success to this Congress and to its proceedings this week.

The question of venereal diseases is one that affects us all very deeply, as all those who have had experience of tropical Africa will understand. We in the Gold Coast, which is a comparatively small country, have fully realised the gravity of the question, and four years ago the Government started its first venereal disease clinic, the first venereal disease clinic, I believe, to be started by a Government of tropical Africa.

We have to steer our way with great caution, much in the same way as you have to at home. Education in hygiene is the matter upon which depends the success of this venereal treatment movement. I am glad to say that the statistics of the past four years have shown a slight increase in the number of people attending and a gradual awakening to the gravity of the situation on the part of the inhabitants of the country itself, but we have a very

## SOCIAL HYGIENE

long way to go, and we shall wait with very great interest to hear the results of these meetings and to take lessons from the printed report of the proceedings.

### **Australia.**

*Major Morris:* I have been asked by the Rt. Hon. Sir Joseph Cook, High Commissioner for the Commonwealth of Australia, to come here this morning to represent him and to ask that you will accept this expression of his apology for not being able to be present, but we desire on behalf of our Government—that is of the Commonwealth of Australia—to associate ourselves in every possible way with this Congress and with all that is being done by the various associations in connection therewith.

Medical colleagues of my own from the various States of Australia will, later on, detail to you what has been done in the way of preventive legislation and compulsory notification and so on with regard to combating venereal disease in Australia. Also it is hoped to be able to compare for your information the results of the legislation and the treatment and the facilities afforded for treatment in comparison with the incidence of the disease in the Colony at the present time as compared with the conditions before the legislation commenced. It will not, I am sorry to say, be quite complete. The Director-General for Health for the Commonwealth of Australia is at the present time engaged for the League of Nations in making a full return and comparison of what has happened with regard to venereal diseases in Australia since the commencement of the Acts, from about 1908 onwards, but unfortunately this will not be ready for publication until July. But my medical colleagues will be able to give you something in the way of enlightenment.

May I say on behalf of my Government that I hope this Congress will be a great success.

### **India.**

*Mr. Montgomery:* Sir Dadiba Dalal has asked me to come here this morning, at practically a moment's notice, to represent him and to express to you his regret at his absence. He had intended, right up to the very last minute, to be here, to show by his personal appearance his interest in the subject which is to be discussed, but has unfortunately had to cancel the arrangement he had made. He has asked me to express in just a few words, on behalf of the great Empire which he represents, his cordial good wishes for the success of this Conference, and his hope that its deliberations and conferences during this week will greatly assist towards the moral uplift of the whole world.

### **Canada.**

*Mr. Donald Armour:* In the unavoidable absence of the Hon. Peter Larkin, High Commissioner for Canada, I have been asked by him to represent the Dominion of Canada. I have been asked to assure the Congress of the very deep interest which the Government of the Dominion of Canada takes in the subject of combating

## OPENING ADDRESSES

venereal disease, and on its behalf to express the hope that practical success may be achieved in the objects for which this Congress has been convened.

A cable was received a few moments ago from Dr. Gordon Bates, Secretary of the Canadian Council for C.V.D., which I have been asked to read to this meeting. It reads as follows :—

“ Urge in view of serious situation here that Imperial Conference pass resolution endorsing Canadian programme urging continuance and if possible increase grants to provinces for control of Venereal Diseases. If this done please cable Canadian Premier and Health Minister also notify Canadian and Associated Press and Reuters terms of resolution. Please discuss with Mr. Cameron.”

### **New Zealand.**

*Dr. Colquhoun* : My duty is a very brief one. It is to express Sir James Allen's extreme regret that owing to his absence from England it is impossible for him to take any part in this Conference, but he desires me to express the opinion of his Government that your problems are our problems, and that a Royal Commission was established two years ago by his Government to inquire into this question, and they arrived at conclusions which do not vary from those which have been arrived at by other Commissions. Generally speaking, there is an enormous amount of preventable disease arising from causes which we are met here to try to find means of eliminating, and Sir James Allen desires me to say that his Government will look with particular care and anxiety to the results of this meeting. They know that there is no royal road to the elimination of these diseases, and that it will be a matter of slow and perhaps painful experience before we can declare a clean bill of health for the two diseases here to be considered, but the Government of New Zealand has adopted the motto which was enunciated many years ago by Lord Beaconsfield : “ Sanitas sanitatum omnia sanitas.”

No population, no country can exist with any degree of safety until preventable diseases are eliminated. I give you therefore the greetings of New Zealand to this Congress and its heartiest hopes that it may be a successful and fruitful one.

### **The Home Office.**

Mrs. Rolfe read the following letter from the Right Hon. Arthur Henderson, M.P., Home Secretary, which he had sent owing to his inability to attend the meeting :—

“ I am very sorry that my official engagements make it impossible for me to be present at the opening ceremony of the Imperial Social Hygiene Conference. It seems to me very appropriate that a Congress like this, which is to consider subjects of vital importance to the welfare of the Empire, should meet at Wembley, and I am glad to think that so excellent an opportunity is being

## SOCIAL HYGIENE

seized for a frank exchange of opinion and experience. I should like to express to the Congress my sincere wishes for its success."

*Mr. E. B. Turner, F.R.C.S. (Vice-President of the N.C.C.V.D. and Chairman of the Medical Committee):* On behalf of the National Council I beg to move an exceedingly hearty vote of thanks to the Minister.

In moving this I wish at the same time to move a hearty vote of thanks to the High Commissioners and Sir Gordon Guggisberg. The National Council has taken the opportunity of the presence in this country of a large number of overseas representatives to call this Conference for consultation and for mutual assistance in the great fight in which we are engaged. The Council has invited ladies and gentlemen of widely differing views on many different subjects which touch this important work, and the papers that are read and the opinions expressed in the speeches will be individual expressions of opinion. The policy of the National Council has been clearly defined at many meetings, and that policy, with very little exception, has not been modified.

As this Conference is one for mutual interchange of ideas, there will be no resolutions or voting.

*Mr. Whyte (Secretary of the Scottish Committee, N.C.C.V.D.):* It is a very real pleasure to me to be asked to second this Resolution. We are all deeply indebted to the Minister of Health for coming here and affording us such an inspiring and encouraging address. It must, I am sure, be a matter of surprise, if not amazement, to the man in the street to understand how it is that the Minister of Health can, so soon after his assumption of office, have assimilated the many details of the duties which he is called upon to discharge and deal with. Apart from the personality of the man—and that must always be the outstanding factor—I venture to suggest that Mr. Wheatley's special success in his new sphere arises in great measure from the fact that he had a very extensive knowledge of Local Government work over a long period of years. The mere fact that he has had this is an excellent augury for success, because he can visualise from the point of view of the Minister of Health what he has learnt and known as a member of a large Local Authority. I have very great pleasure in seconding the Resolution and also in associating with the Minister in that Resolution our sincere thanks to the various Commissioners' representatives who have come here this morning to give such a good send-off to the Congress.

The vote was then put, and carried with acclamation.

Mr. Turner here took the chair in the unavoidable absence of Lord Trevelin, President of the National Council, and called on the readers of the papers.

## GREAT BRITAIN

### THE PRESENT POSITION OF GOVERNMENT ACTION IN VENEREAL DISEASE.

By SIR GEORGE NEWMAN, K.C.B., M.D., F.R.C.P.,  
*Chief Medical Officer, Ministry of Health.*

- I. Treatment of Venereal Disease at end of Nineteenth Century.
- II. Recent advances in knowledge.
- III. Johnstone Report, 1913, and Royal Commission, 1913.
- IV. Legislation arising therefrom.
- V. The Establishment of Schemes :—
  - (a) Provision of facilities for laboratory diagnosis.
  - (b) Organisation of treatment.
  - (c) Provision of approved arseno-benzol compounds free to general practitioners.
  - (d) Public and professional education.
- VI. Results.
- VII. The question of compulsory notification.
- VIII. The question of compulsory treatment.
- IX. Prophylaxis and the principles of prevention.

#### I. TREATMENT OF VENEREAL DISEASE AT END OF NINETEENTH CENTURY.

Speaking generally, it may be said that up to the end of the Nineteenth Century, little or no effective attempt had been made in this country to treat venereal disease by public organisation. Patients suffering from these maladies were treated by private practitioners or in three separate classes of institution, namely, the General Hospitals, the Workhouse Infirmary and the Lock and special hospitals for venereal diseases. During the latter part of the century the voluntary hospitals became more and more reluctant to admit early cases of these diseases, and as a general rule no beds were reserved for such cases, and the governing bodies did not encourage their reception as in-patients. In some cases this attitude apparently had the approval of the medical staff, in several it was contrary to statutes to admit venereal cases, and in others it was deemed unreasonable to expect subscribers to spend their money on rescuing persons from the consequences of their indiscretions. Hence it came about that the residential treatment of syphilis and gonorrhœa was practically confined to Poor Law Institutions and to certain Lock hospitals, where special wards were frequently provided for infective venereal cases, sometimes at the Infirmary, but more often at the workhouse. Cases of late syphilis were accommodated in the general wards.

The only measures of control of venereal disease that had been attempted in this country were the Contagious Diseases Acts which

## SOCIAL HYGIENE

were introduced at certain military stations in 1864. These Acts required prostitutes resident in certain military towns to attend at certified hospitals for examination, and if found to be suffering from venereal disease allowed their detention for a period not exceeding three months. The Acts of 1864 also prescribed penalties for keepers of houses knowingly allowing diseased prostitutes to practise their trade there. It was in force for three years, but was amended by the Contagious Diseases Act, 1866, which made it possible to extend the period of detention in hospital to a maximum of six months, and also empowered the authorities to compel women to attend for periodical examination if required. In common with kindred methods which had been adopted in other countries and which depended upon measures dealing with prostitutes, their registration, medical examination, police supervision and so forth, the Contagious Diseases Acts appear to have had little effect upon the prevalence of venereal disease in general, and aroused considerable opposition. In 1883, therefore, they were suspended and they were finally abolished in 1886.

About 1896 certain public-spirited persons, concerned at the gravity and prevalence of venereal disease, urged the appointment of a Royal Commission to inquire into the whole subject. Such an inquiry was subsequently supported by the Brussels Conferences on Venereal Diseases of 1899 and 1902, and also by the Inter-Departmental Committee on Physical Deterioration, 1904. The project was postponed for a time, partly because in some quarters it was feared that such an inquiry would be made the occasion for an agitation in favour of a revival of the Contagious Diseases Acts, and it was not until 1912 that comprehensive inquiries were instituted.

## II. RECENT ADVANCES IN KNOWLEDGE.

Meanwhile, certain important advances had been made in our knowledge of syphilis. In 1903 Metchnikoff and Roux succeeded in conveying syphilis to the lower animals by the successful inoculation of monkeys. In 1905 Schaudinn and Hoffmann discovered the causative organism of syphilis in a spirochæte, which was named *spiro-chæta pallida*. In 1906 Wassermann introduced a test for syphilis by which the fixation of complement is ascertained by a Bordet-Gengou phenomenon. Above all, in 1910, a new drug—salvarsan or 606—discovered by Ehrlich was made available and rapidly became a most important adjunct in the treatment of syphilis to the drugs hitherto chiefly used, namely, mercury and the iodides.

The specific value of salvarsan treatment is that it rapidly causes the organisms of syphilis to disappear from the blood and secretions of the patient and thus renders him non-infective. There can be little doubt, also, that modern treatment of syphilis is much more effective than the old in eradicating the disease produced by the organism.

These four great steps in our knowledge of the causation of

## GREAT BRITAIN

*Sir George Newman, K.C.B., M.D., F.R.C.P.*

syphilis have transformed the whole position and made possible an organisation of treatment hitherto beyond our reach.

### III. JOHNSTONE REPORT, 1913, AND ROYAL COMMISSION, 1913.

In March, 1912, the Local Government Board, on the advice of Sir Arthur Newsholme, instituted an inquiry into the control over venereal diseases, with reference to the adequacy and general character of the arrangements for their institutional treatment. Dr. R. W. Johnstone, one of the medical inspectors of the Board, was instructed to make this inquiry, and his Report was issued in 1913 (Cd. 7029). In November, 1913, a Royal Commission on Venereal Diseases was appointed and heard a large volume of evidence, their Report being published in February, 1916. The principal recommendations of the Royal Commission were:—

- (a) Confidential registration of causes of death.
- (b) Extension of facilities for diagnosis.
- (c) Organisation by the local authority of means of free treatment for all classes at convenient hours and under suitable conditions.
- (d) Improved professional and public education.
- (e) A grant-in-aid of 75 per cent. of total cost incurred in approved schemes.
- (f) Treatment in Army and Navy, Poor Law Institutions, Prisons, etc.
- (g) Prohibition of all advertisements of remedies and unqualified practice.
- (h) Recognition by the Government of the National Council for Combating Venereal Diseases as an authoritative body for spreading knowledge.\*

The Commission recommended that "no system of notification of venereal diseases should be put in force at the present time," and they condemned "unqualified practice" by chemists, herbalists and others as "disastrous" and "one of the principal hindrances to the eradication of those diseases." The Commissioners stated that "the most urgent requirement is to secure to every patient the freest and earliest possible access to medical assistance when there is suspicion of venereal disease. This implies, *inter alia*, that all temptation for the patient to have resort to an unqualified person shall be removed."

### IV. LEGISLATION ARISING THEREFROM.

Action was taken on the recommendations of the Commission with somewhat unusual rapidity, no doubt largely because the conditions of the war made these diseases a special menace to public health. The Public Health (Venereal Diseases) Regulations, 1916 (made under the Public Health Act, 1875, Section 130), were issued by the Local Government Board on July 12th, 1916, and an

\* Final Report. (Cd. 8,189) pp. 62-64.

## SOCIAL HYGIENE

advisory circular\* was sent to the local authorities concerned.† These Regulations require all Counties and County Boroughs:—

- (i) To make arrangements for enabling any medical practitioner practising in the area of the Council to obtain at the cost of the Council a scientific report on any material which the medical practitioner may submit from a patient suspected to be suffering from venereal disease;
- (ii) To prepare and submit a scheme:—
  - (a) For the treatment at, and in, hospitals or other institutions, of persons suffering from venereal disease, and
  - (b) For supplying medical practitioners with salvarsan, or its substitutes, for the treatment and prevention of venereal diseases.
- (iii) To make such provision as the Council may think necessary or desirable for the giving of instructional lectures and for the publication of information on questions relating to venereal diseases.

It is laid down that all information obtained in regard to any person treated under a public scheme should be regarded as confidential. In order to encourage the establishment of efficient schemes at the earliest possible date, the Local Government Board resolved to repay 75 per cent. of the approved expenditure incurred under the Regulations.

Since the issue of the 1916 Regulations, schemes have been adopted for every County and County Borough in England and Wales (similar arrangements being in force in Scotland). It was not always practicable for each County Council to provide facilities for effective treatment of venereal diseases within their own area, and the schemes of some County Councils involve arrangements with hospitals outside their areas. In order that inhabitants of Rural Districts should not be unduly deterred by their distance from official Treatment Centres, County Councils were permitted to pay the travelling expenses of patients to the nearest approved Centre, which should be available for all comers, irrespective of place of residence or financial means. The names and addresses of patients obtained for the purpose of subsequent communication with them, in order to arrange for continuity of treatment, or to enable the authorities to allocate costs as between different areas, were not to be divulged. It was arranged that the clinics should not be specially designated as for venereal diseases, and that nothing should be done to distinguish the patients who attend for

\* Circulars issued and Regulations made by the Local Government Board, July, 1915, and Memorandum by the Medical Officer. (H.M. Stationery Office. Price one penny.)

† It will be observed that the responsibility for providing a comprehensive scheme for dealing with venereal diseases was entrusted to the larger Local Authorities, namely, County Councils and County Borough Councils. The smaller authorities (Urban and Rural District Councils) have no direct responsibility for this work, but the facilities provided by a County Council are available for the inhabitants of every Urban and Rural District within the county administrative area.



## GREAT BRITAIN

*Sir George Newman, K.C.B., M.D., F.R.C.P.*

treatment of these diseases. The times fixed for holding the clinics were to be such as would meet the convenience of patients.

In 1917 Parliament passed the Venereal Disease Act, 1917,\* making it illegal for anyone except a duly qualified medical practitioner to treat any person for venereal disease, or prescribe any remedy for such diseases, or to give any advice in connection with the treatment. It was also made illegal to issue public notices or announcements offering to treat venereal diseases, or to hold out or to recommend to the public by advertisements, etc., that certain medicaments could be used for the prevention, cure or relief of venereal diseases. This Act was aimed at the suppression of quack treatment of venereal diseases, and according to our information, it has been largely successful in suppressing such forms of treatment.

### V. THE ESTABLISHMENT OF SCHEMES.

The approved schemes include four main services, viz.:

- (a) Provision of facilities for laboratory diagnosis.
- (b) Organisation of treatment.
- (c) Provision of approved arseno-benzol compounds free to general practitioners.
- (d) Public and professional education.

#### (a) *Facilities for laboratory diagnosis.*

In accordance with the recommendations of the Royal Commission and of Report No. 14 of the Medical Research Council dealing with the Wassermann test, it was considered desirable to restrict the pathological work in connection with venereal diseases as far as possible to a small number of laboratories except as regards microscopical examinations for detection of gonococci or spirochætes which can often be carried out conveniently at the clinics. A Committee of the Medical Research Council† recommended that the Wassermann tests should only be performed in laboratories at which it might be expected that an average of not less than 100 tests would be made weekly. Not all the approved laboratories deal with as many specimens as this per week. Considerable care, however, has been exercised in approving laboratories, unless at a university or a large hospital. In every area general practitioners have been informed as to the laboratory to which specimens should be sent from patients suffering, or suspected to be suffering from venereal diseases. Whilst a considerable number of specimens from private medical practitioners are examined every year at approved laboratories, by far the largest part of the laboratory work is concerned with specimens sent from the public treatment centres. The chief specimens are blood for the Wassermann tests, and "smears" for the detection of the gonococcus or the spirochæte. At a considerable number of laboratories, however, other facilities are available, e.g. complement fixation test for

\* Venereal Disease Act, 1917. (H.M. Stationery Office. Price 1d. net.)

† Special Reports Series, No. 14, Medical Research Council.

## SOCIAL HYGIENE

gonorrhœa, and preparation of vaccines for use in gonorrhœa. There are seventy-three approved laboratories and the following return shows the number of examinations made over a series of years :—

### *Pathological Examinations at Approved Laboratories (England and Wales).*

YEAR.	MICROSCOPICAL EXAMINATIONS.		WASSERMANN TEST.
	Spirochaetes.	Gonococci.	
1917		11,697	27,192
1918		22,564	59,379
1919	3,868	48,264	104,336
1920	4,403	63,082	143,892
1921	3,553	64,940	161,814
1922	2,417	63,190	151,146
1923	2,056	69,930	148,331

### *(b) Organisation of Treatment.*

In accordance with the recommendations of the Royal Commission, Local Authorities were asked in the first instance to endeavour to make arrangements for the provision of treatment centres at general hospitals in their areas, and the majority of the approved treatment centres have been established at general hospitals by agreements between the hospital authority and one or more County or County Borough Councils. In these cases the management of the centre has remained almost entirely in the hands of the hospital authorities : so that the Local Authorities concerned exercise control indirectly. The treatment provided at these centres is mainly out-patient treatment, but occasionally, owing to emergencies, or otherwise, a patient may need to be treated in bed for a time, and the agreements with the hospital provide for such in-patient treatment when required.

In some areas suitable arrangements could not be made with general hospitals, and treatment centres have had to be established in other premises, either as entirely *ad hoc* centres provided for the purpose, or in premises already used by the Local Authorities as tuberculosis dispensaries or otherwise. Experience has shown that, notwithstanding the disadvantages of *ad hoc* centres for these diseases, patients attend in considerable numbers, provided that the personality of the medical officer is sympathetic and the treatment effective. Some of the approved centres established at general hospitals have not been successful owing to lack of these qualities, or owing to the hours or conditions of the clinics being arranged for the convenience of the staff rather than the patients. Experience has also shown that it is very desirable that the work of the medical officer of a treatment centre should not be looked at purely from the clinical aspect, but that the officer should be imbued with the preventive and communal outlook and co-ordinate his work with that of the public health administration of the area. In England and Wales, at the close of 1923, there were 193 treatment centres at work (142 at hospitals, 51 *ad hoc*) providing approximately 832 weekly sessions, and staffed by 380 expert medical officers. These schemes are under the supervision of the Ministry of Health, which has established a special department under my

## GREAT BRITAIN

*Sir George Newman, K.C.B., M.D., F.R.C.P.*

colleague Dr. F. J. H. Coutts, C.B., with the assistance of expert medical officers, including Col. L. W. Harrison, D.S.O., who also serves the Ministry as Director of the V.D. Clinic at St. Thomas's Hospital. The Ministry's medical officers advise as to schemes and inspect centres and laboratories.

*General Conditions.*—It has always been recognised in this country that if patients are to be induced to make the fullest use of the facilities provided for diagnosis and treatment, it is necessary to have the most sensitive regard for the natural susceptibilities of the patients, and to study their convenience and comfort in the arrangement of the clinics and in the times of the sessions. Suitable premises and equipment, satisfactory medical, nursing, and orderly staff are necessary to make the clinic both *efficient* and *popular*.

It has been found advantageous to arrange, wherever possible, to have the treatment centres open for as long a period as possible on every day of the week, and particularly to provide that patients can attend for irrigation or other special local applications at any hour convenient to themselves, and be dealt with promptly.\*

In addition to the ordinary treatment centres the authorities of some poor law institutions have brought their treatment of venereal disease up to modern standards, and in these cases special grants are made by the Ministry towards the cost incurred.

The authorities of seaports have made special arrangements for the treatment of seamen, and at all treatment centres seamen† of whatever nationality can be treated free of all expense to themselves.

The provision of effective treatment for venereal disease in rural areas presents great difficulties. Even if suitable hospitals can be found willing to arrange to undertake the work, patients are shy of attending for fear that their condition may become known to their neighbours. Attempts have been made in some areas to overcome these difficulties, e.g. by the establishment of branch clinics (under the supervision of an expert venereal disease medical officer) at cottage hospitals, dispensaries, or premises used jointly for other medical purposes, such as maternity work, school medical service or tuberculosis. Hitherto the difficulties of formulating a practicable scheme of utilising the services of private practitioners have proved insuperable. Apart from the difficulty

\* At St. Thomas's Hospital an all-day clinic has been in operation for some time. Similar arrangements have recently been made at St. Paul's Hospital, and it is expected that one or two other hospitals in London will shortly provide an all-day service. The special Seamen's Dispensary in Liverpool has been inaugurated with a view to providing practically a continuous service for seamen. See also Ministry of Health "Memorandum on Organisation of Work of V.D. Treatment Centres," 1921, and Colonel Harrison's "Public Control of V.D.," 1923.

† As a seaman's call at any particular port is usually brief, a card (Form V 1<sup>b</sup>) has been prepared, which the seaman can take with him and present to the Medical Officer of the next treatment centre to which he resorts. It contains information as to laboratory tests and as to the nature of the treatment given, and thus aids in securing continuity of treatment. A similar card is used for commercial travellers and other itinerating persons.

## SOCIAL HYGIENE

of finding in each area practitioners willing to undertake the work and specially skilled in modern methods of treatment, other obstacles present themselves, concerning finance, possibility of adequate supervision, and delicate questions as to the relation of the selected practitioner to the private patients of other doctors.

*Women and Children.*—It is particularly desirable that special arrangements shall be made, wherever possible, for women and children, and provision for their natural susceptibilities and requirements. For this reason the Ministry have encouraged:—

(1) Separate sessions for women;

(2) The appointment of women doctors on the staff of the clinic; and they have insisted on the necessity for women nurses always to be present when sessions for women and children are in progress. It has further been found possible and advantageous in some cases to hold special sessions for women and children at centres used for maternity and child welfare work, since (a) some women would willingly undergo treatment under such conditions who would hesitate to attend an ordinary centre; (b) it is often inconvenient for a mother to attend on one day at a Maternity and Child Welfare Clinic and on another day at a Venereal Disease Clinic.

There are also fifteen hostels which have been provided by charitable bodies connected with rescue work for the reception of 270 young women suffering from venereal disease. Where these provide skilled treatment, the Ministry have authorised the cost of treatment and maintenance being charged to the Venereal Disease Account with a view to giving the 75 per cent. grant.

In several areas great success has been attained in securing the birth of healthy children by ante-natal treatment of pregnant women, and this most fruitful line of work is being extended. One of the earliest examples of special arrangements for this class of work was the centre established, through the Metropolitan Asylums Board, at Thavies Inn, in London. Pregnant women suffering from syphilis have been admitted, in some cases in a comparatively early stage of pregnancy, and after a course of treatment by arseno-benzol preparations, have been delivered of infants showing no evidence of syphilis at birth and remaining free from this disease. The success attained at this Centre has been largely due to the enthusiasm of the medical officer, Dr. John Adams\* who has succeeded in persuading the mothers to come up regularly for treatment after their confinement, and has been able to follow the after history of the babies.

Another special line of work may be mentioned, viz. the establishment of a residential home in Surrey for young children (mainly from London) suffering from venereal disease. This has been found particularly useful for the treatment of the rather intractable vulvo-vaginitis of young girls.

*Tracing Contacts.*—The scheme should include measures for dealing with related cases which have hitherto escaped treatment and which should be traced and brought under treatment. For

\* "Results of Three Years' Treatment of Syphilitic Mothers and Babies." *Lancet*, November 13th, 1920, p. 990.

## GREAT BRITAIN

*Sir George Newman, K.C.B., M.D., F.R.C.P.*

example, the appearance at a centre of a child with congenital syphilis should lead to some inquiry into the health of the parents. A married woman with venereal disease has in most cases contracted the disease from the husband and he should be induced, if possible, to come under treatment.

For this purpose, as well as to give general advice and assistance, welfare or inquiry officers have been appointed in a few instances whose duty it is, after gaining the confidence of the patient, to endeavour tactfully to take steps to bring up for examination any contact who might reasonably be suspected to be suffering from venereal disease. Similarly the officers of Maternity and Child Welfare centres may make discreet inquiries in connection with women or children showing evidence of venereal disease. The possibility of gaining evidence of the existence of syphilis by studying information as to still-births and miscarriages has not been overlooked, and in some districts special arrangements have been made for examination of foetal tissues for spirochætes, and for the making of Wassermann tests in women who have had miscarriages. Similarly, notification of ophthalmia neonatorum may provide a clue to gonorrhœa in the parents.

*Continuity of Treatment.*—Medical Officers of treatment centres are required to make an annual return to the Ministry of the work of the centre. These returns show that some patients do not continue attendance until they are entirely cured. Carelessness on the part of patients, lack of enthusiasm on the part of the medical officer or removal of patients to other areas, no doubt account to some extent for this failure to complete treatment. But much the most operative factor in increasing the apparent default is the exceptionally high standard of cure recommended by the Ministry of Health for syphilis and gonorrhœa, a standard which is not only a very rigorous one, but implies, in the case of syphilis, attendance over three or four years. It must be remembered that our aim is to make the patient absolutely non-infective and also permanently to cure his disease. It is therefore not surprising that a considerable number of patients are either unable or unwilling to complete the whole course—for in all countries the degree of "default" is to be measured by the standard of treatment required—although no doubt in many cases they have been rendered permanently non-infective and greatly relieved, even if they could not be written off as absolutely cured. It should be mentioned that the treatment of venereal disease at these centres is carried out as far as possible under conditions of secrecy, the names of the patients being kept only in a locked up register, and there is a system of "following up," which in some areas is successful in obtaining re-attendance and continuance of treatment.

(c) *Provision of approved arseno-benzol compounds.*

Local authorities undertaking venereal disease schemes provide (free of cost) for registered medical practitioners, arseno-benzol preparations for the treatment of patients suffering from syphilis, but these drugs are only supplied to those practitioners who have

## SOCIAL HYGIENE

satisfied the medical officer of health that they have had sufficient experience in their administration. Only such arseno-benzol preparations are distributed under this scheme as are approved by the Ministry of Health.\* The Ministry lay down certain conditions with which the vendors of these drugs must comply before receiving approval. Amongst other things the drugs are subjected to tests, carried out by the Medical Research Council, for toxicity and therapeutic potency.†

### (d) *Public and Professional Education.*

In accordance with the recommendation of the Royal Commission the National Council for Combating Venereal Diseases has been recognised as an authoritative body for the purpose of spreading knowledge in regard to venereal diseases. Considerable grants have been given by the Ministry to the Central Council of that body, and in a large number of areas the Local Authorities have made arrangements for their educational work to be carried out through its local branches. The Central National Council, as well as its branches, have done a large amount of very valuable work—by Press advertisements, by the distribution of leaflets, by conferences and lectures to inform the public as to the dangers of venereal disease, and by special lectures at factories and workshops. The National Council have also provided cinematograph films dealing with this question. Local authorities have also independently inaugurated successful educational campaigns. The effect of propaganda work in increasing attendances at the treatment centres in many areas has been very noticeable.

While it is obviously undesirable that particular instruction should be given to elementary school children on this subject, the Board of Education have made arrangements for the guidance of pupils and students in training colleges and in other ways sought to equip the school teacher.

Steps have also been taken to improve and extend the facilities for professional education. Special provision is now made in all the twenty-two Medical Schools of England and Wales for teaching medical students the diagnosis, pathology and treatment of venereal disease, the subject having been included in the new medical curriculum of the General Medical Council. All the venereal disease clinics approved by the Ministry of Health are open for the instruction and assistance of medical practitioners; and the Medical Schools provide opportunities for the special post-graduate study of these diseases and for instruction in the application of

\* The following preparations have been approved by the Ministry of Health: arseno-benzol (Corbière), novarseno-benzol (Corbière), arseno-billon, novarseno-billon, diarsenol, galyol, kharsivan, neokharsivan, salvarsan (Boots), neo-salvarsan (Boots), stabilarisan, sulfarsenol, salvarsan, neo-salvarsan, sodium-salvarsan, silver-salvarsan, novarsan, arseno-argenticum.

† As untoward effects sometimes followed the intravenous injection of arseno-benzol preparations, the Ministry issued, in 1919, a memorandum by the salvarsan Committee of the Medical Research Council on the administration of salvarsan and its substitutes. This indicated the precautions necessary in the use of these remedies.

## GREAT BRITAIN

*Sir George Newman, K.C.B., M.D., F.R.C.P.*

the newer methods of treatment. There can be no question that immense strides have been made in respect of medical education in this matter, the importance of which can scarcely be over-estimated.\*

### VI. RESULTS.

There is every reason to believe that venereal disease is declining in this country. There has been a steady fall in certified mortality of syphilis since 1875, though no doubt the mortality returns stand at a lower figure than the actual deaths thus caused. Many clinical authorities believe the disease to be much less severe than two generations ago. The following returns of the British Army Medical Department give the rates of admission for venereal disease in the British Army in the United Kingdom.

*Admissions for Venereal Diseases per 1,000 per annum  
among Troops in the United Kingdom from 1870-1913.*

	1870 .. 201.0		1892 .. 201.2
	1871 .. 201.5		1893 .. 194.6
	1872 .. 202.2		1894 .. 182.4
	1873 .. 167.6		1895 .. 173.8
Contagious Diseases Acts in force	1874 .. 145.7	} †	1896 .. 158.3
	1875 .. 139.4		1897 .. 139.7
	1876 .. 146.5		1898 .. 132.7
	1877 .. 153.2		1899 .. 122.4
	1878 .. 175.5		1900 .. 93.2
	1879 .. 179.5		1901 .. 105.4
	1880 .. 245.9		1902 .. 122.7
	1881 .. 245.5		1903 .. 125.0
	1882 .. 246.0		1904 .. 107.6
			1906 .. 81.8
Contagious Diseases Acts suspended	1883 .. 260.0		1907 .. 72.0
	1884 .. 270.7		1908 .. 68.0
	1885 .. 275.4		1909 .. 66.0
Contagious Diseases Acts abolished	1886 .. 267.1		1910 .. 65.0
	1887 .. 252.9		1911 .. 60.5
	1888 .. 224.5		1912 .. 56.4
	1889 .. 212.1		1913 .. 50.9
	1890 .. 212.4		
	1891 .. 197.4		

It is probable that this remarkable decline in incidence is due to various factors, including improvements in the soldiers' surroundings, social amenities and means of recreation, and improvements

\* See special report of the Ministry of Health on "Recent Advances in Medical Education in England," 1923.

† From October, 1873, to November, 1879, soldiers forfeited pay whilst under treatment for venereal diseases. The low rates during this period are probably due to concealment of disease.

## SOCIAL HYGIENE

in treatment, particularly continuation treatment and irrigation in gonorrhœa. After 1913 came the European War, and comparative returns are no longer available. The war was the indirect cause of serious increase in incidence, but we seem now to be recovering from those excesses. The table below, relating to England and Wales, provides information as to cases coming to the official treatment centres for the first time during a series of years.

NUMBER OF PERSONS DEALT WITH FOR THE FIRST TIME.

England and Wales.	Syphilis.	Soft Chancre.	Gonorrhœa.	Total V.L.	Other than V.D.	Total new Cases.	Total Number of attendances.	Number of Clinics at end of year.
1917	—	—	—	—	—	29,036	204,692	113
1918	26,912	806	17,635	45,353	6,622	51,975	488,137	134
1919	42,134	2,164	38,499	82,797	15,447	98,244	1,002,791	160
1920	42,805	2,442	40,284	85,531	19,654	105,185	1,488,514	190
1921	32,733	1,654	32,433	66,820	17,459	84,279	1,612,952	194
1922	25,762	1,108	29,477	56,347	16,988	73,335	1,560,568	191
1923	23,927	1,110	30,908	55,945	17,668	73,613	1,605,617	192

The figures both for syphilis and gonorrhœa show a rapid rise from the date of initiation of the scheme, until they reached a maximum in 1920. Since that year the number of new cases of syphilis has fallen, until in 1922 the number was 40 per cent. less than in 1920, and the figures for 1923 indicate a further fall of 4 per cent. of the 1920 figures. These figures seem to confirm the opinion expressed by many experienced Medical Officers of health and Medical Officers of Venereal Disease Centres that there has been a considerable diminution in the number of fresh infections of syphilis, and it is legitimate to believe that the work of the venereal disease centres has contributed to this fall, since it is recognised that modern treatment rapidly renders the syphilitic patient non-infective, and if the treatment is continued this freedom from infectivity remains permanent. It should also be noted that the number of attendances in proportion to the venereal cases at these clinics has steadily increased, indicating more complete treatment.

With regard to gonorrhœa; although the figures show a reduction in new cases from the level of 1920, the percentage reduction is less than in syphilis, and the figures for 1923 show an increase over the record for 1922. There are several points, however, with regard to gonorrhœa which render it more difficult to draw conclusions than in the case of syphilis. The known incidence of gonorrhœa is more than double that of syphilis, yet the new cases of gonorrhœa were fewer than those of syphilis each year until 1922. There is no specific treatment for gonorrhœa comparable to that for syphilis, and probably many doctors who referred their syphilis patients to the clinics carried out treatment themselves for their gonorrhœa cases instead of sending them to the clinics. The improved methods adopted at some clinics for dealing



## GREAT BRITAIN

*Sir George Newman, K.C.B., M.D., F.R.C.P.*

with gonorrhœa probably account for a tendency for a larger number of gonorrhœa cases to attend the clinics, and it is not at all unlikely that this increased use of the clinics may still be associated with an actual decline in the total incidence of gonorrhœa in the community.

It is desirable I should add a few words upon the subjects of notification, compulsory treatment and prophylaxis.

### VII. THE QUESTION OF COMPULSORY NOTIFICATION.

We have not in this country up to the present established by law any system of notification of venereal diseases. Apart from the statistical information obtained, official notification of infective diseases is only of value if it permits of useful action by the State or public authorities on behalf of the patient or the community. Notification was originally introduced in connection with acute infectious diseases, and was primarily intended to give information which would allow the health authorities to take action (early discovery, isolation, disinfection, etc.) to protect the public. These diseases were of short duration and the period of infectivity could be predicted with fair accuracy. Isolation of the patient usually involved only comparatively short absence from his ordinary avocation. When one considers statutory notification in connection with the more chronic communicable diseases, e.g. tuberculosis and venereal diseases, it is clear that quite different considerations arise, and each disease must be dealt with on its nature and according to the mode and degree of its infection. The conveyance of infection in venereal disease usually implies special circumstances, and these diseases are not comparable to the other notifiable diseases.

Then again there is a social stigma in the case of venereal disease which does not apply to the ordinary notifiable diseases, and this necessarily causes reluctance on the part of medical practitioners to notify venereal diseases. It is also only too likely to lead patients (in fear of notification) to conceal their condition as long as possible, and have recourse to quacks who will promise secrecy. Moreover, notification may inflict grave injustice and irreparable social harm on innocent individuals or families.

Thirdly, syphilis is an important example of a condition in which active treatment is the best form of prevention. A single dose of arseno-benzol compound may render the patient temporarily non-infective. Every venereal disease patient rendered non-infective by proper treatment in the early stage of the disease means not only that the prospect of ultimate cure is brighter for the patient but that the spread of the disease to others is prevented. The great object, then, of the public health authorities must be to encourage the sufferer to seek effective treatment at the earliest moment, and to put no obstacle or deterrent in the way of his doing so.

Lastly, notification of syphilis can only be reasonably demanded from medical practitioners, since medical knowledge is required

## SOCIAL HYGIENE

for diagnosis. In some stages or degrees of this disease the diagnosis is not easy to establish even for medical men, and often involves the application of bacteriological or other tests, which the patient may decline if he thinks it may lead to his being branded as affected with venereal disease. In view of the difficulties of the private medical practitioner, it is clear that a system of notification would be only partial in its operation and might indeed turn out to be a class measure, affecting only the poorer section of the community, for practically the only places from which accurate and adequate notification returns could be checked would be the official treatment centres. It would be difficult to conceive a course of action more inequitable or more calculated to damage and restrict the usefulness of the very clinics at which arrangements are made by the State for thorough and complete modern treatment of these diseases. For such reasons, general notification of venereal disease has not up to the present been considered desirable in this country.

### VIII. THE QUESTION OF COMPULSORY TREATMENT.

Similarly, no action has been taken to compel the continuation of treatment when patients suffering from venereal disease cease to attend before they are cured. At present the only means of securing persistence in treatment is by persuasion and by providing efficient treatment. Many medical officers of treatment centres have been successful in inducing a large proportion of their patients to persist in treatment, or in cases of default have succeeded in securing the return to treatment by means of a tactful "follow up" system. There is of course a residue of careless individuals, who once they are free from troublesome symptoms seem to have insufficient concern for their own future health, or the risks to others.

But it is of doubtful expediency and of doubtful equity to compel by statute such persons, or any persons, to submit themselves to a particular form of medical or surgical treatment. The liberty of the subject is rightly protected by English law. We can isolate cases of diphtheria or smallpox, but we cannot compel the acceptance of antitoxin or vaccine; even a soldier cannot be ordered under military law to undergo a surgical operation. And who shall say which patients shall be compelled and at what stage in their malady? Is that a responsibility to impose upon a medical man? Here again the scale would be unduly weighted against official medical treatment centres, since they would be under official supervision and would have to make returns. Considerable variation would also arise through varying standards as to the amount of treatment required. Obviously the only justification for compulsory treatment of the individual would be the fact that he is still infectious and a danger to the community. But the determination of the stage at which a person suffering from venereal disease has ceased to be infectious is often extraordinarily difficult, particularly in women with gonorrhœa, and

## GREAT BRITAIN

*Sir George Newman, K.C.B., M.D., F.R.C.P.*

the standards adopted by doctors would vary widely. Information from our treatment centres indicates that a very large proportion of patients are probably non-infective before they cease to attend the clinic, so that any reasonable regulation which could be laid down would not be applicable to a large number of the clinic patients who do not continue treatment to the stage of cure. Indeed, the effect of having to consider a standard of infectivity instead of, as now, a standard of permanent cure, would probably be to diminish the number of patients who persist in treatment; and the effect of a compulsory system of treatment would likewise be to empty the clinic. But quite apart from its impracticability, it seems to be unjust in principle.

### IX. PROPHYLAXIS AND THE PRINCIPLES OF PREVENTION.

Some controversy has occurred in England over the question of prophylaxis for venereal disease by "self-disinfection." Some people have recommended the use of "packets" of medicaments before, as well as after, exposure to infection, and there has been vigorous advocacy of the advantages of giving information to the public as to disinfectants which can be used by them after exposure to infection, and the Ministry have been pressed to give their official blessing to such proposals. In 1921 the Ministry issued a circular (No. 202) dealing with the question and stating that the Government could not officially support the sale of disinfectants as a policy. It was pointed out that there was general agreement on the following conclusions:—

(1) That the best way to avoid risk of venereal disease is to abstain from promiscuous sexual intercourse, and that a steady and continuous policy of public enlightenment on this point and as to the risks of venereal disease and its resulting consequences on the general health of the community is essential.

(2) That disinfection immediately after exposure to risk of infection is effective only to the extent to which it can be thoroughly and intelligently applied in a particular case.

Medical opinion is divided on the question of the efficacy of self-disinfection for the civilian population and in particular on such questions as whether it is practicable to give such instruction to the population generally as will ensure that the disinfectants are thoroughly and skilfully applied; whether the spreading of the knowledge as to the efficacy of disinfectants would not lead to persons running a risk of infection who would otherwise avoid that risk, and thus increase the spread of the disease; and whether the disinfectants will not be used in some cases for the treatment of developed disease, with the result that the proper treatment will be delayed and cure of the disease rendered more difficult and uncertain.

It is clear that this question is one which cannot be decided solely by reference to medical opinion—moral and social considerations of very great importance are involved in it. A great deal has been published on this matter, but reliable evidence is, in the

## SOCIAL HYGIENE

nature of things, difficult to obtain, and there are no figures on self-disinfection to which any great weight can be attached as proof of its efficacy in ordinary civil life. It is to be noted that most of the statistics collected by advocates of self-disinfection relate to skilled disinfection, as carried out in the British or American Armies, and not to self-disinfection in the civil community. On the other hand, there is considerable evidence, through the appearance of the individuals concerned as patients in venereal disease hospitals, that self-disinfection, even when applied within a few minutes after exposure, has not infrequently failed to protect. On these grounds the Government decided in 1921 against any official advocacy of self-disinfection.

It may be convenient for me briefly to summarise the principles of prevention.

First, the Ministry of Health are in favour of the education of the public, both as to the incidence and danger of venereal diseases and the extreme importance of not contracting them. The only certain way of avoiding them is to avoid all risk of infection. It is equally clear that sexual promiscuity increases these risks and, on that and other grounds, is to be condemned. Obviously this is not only a matter of medical opinion or action, for the social and moral standards of a people bear relation to its health, and such national standards and habits, and not the medical issue only, are the decisive factors in any practical solution. Closely allied with the education of the public are various general conditions which, directly or indirectly, affect the issue. The social and home life of the people, recreation and amusement, and the occupation of leisure are all important. Further, professional education of the medical student and practitioner in regard to these diseases is hardly less important at the present juncture than the general education of the public.

Secondly, we must reduce the sources of infection. The Ministry believe that thorough cleansing or skilled disinfection of the body immediately after risk of infection has been incurred tends substantially to reduce the likelihood of disease. The Ministry, however, are not prepared to recommend a general practice of *self-disinfection* apart from skilled advice and supervision. It is believed that, except under skilled control, attempts at self-disinfection are likely (1) to be ineffective, owing to the inherent difficulties of ensuring that the effective disinfectant is properly applied; (2) to create a false sense of security and thus tend to increase promiscuity; and (3) to lead to postponement of treatment, which thus becomes more difficult and uncertain. It is impracticable to train the general public in effective self-disinfection by means of leaflets of instruction. What is required in all such cases is not general directions for self-manipulation but prompt and skilled advice. The alleged success of certain disinfection work accomplished in the Army, under official powers, military discipline, and competent medical supervision, affords no reliable guidance for dealing with the matter in the civil community. The army authority is single and undivided, but the Local Authorities

## SCOTLAND

*Sir Leslie Mackenzie, M.A., M.D., LL.D.*

concerned in this problem are numerous and are responsible to the ratepayer; moreover, the civil community consists of a vast population, unselected, of all ages and both sexes, without military discipline and without medical supervision or direct control. The two problems are therefore not comparable, though valuable lessons have been learned from the experience of the army. Further, in addition to these insuperable practical objections to self-disinfection, a moment's reflection will make it clear that any particular recommendation of this sort, especially by Government, apart from personal medical diagnosis and advice, is open to grave and far-reaching abuse. It is not practicable for Government or any high contracting party to usurp the position of the private medical man in his relation to his patient.

Thirdly, treatment and prevention should not be separated. A clinic providing facilities for instruction and advice, diagnosis, early and intermediate treatment, is in itself a preventive measure of the first order. The patient here learns the importance of prevention, and in undergoing treatment he himself is prevented from continuing to be an infective agent. To make a patient suffering from infective disease—whether typhoid, tuberculosis or venereal—non-infective is an important step in preventive medicine. The same truth applies to the person who has incurred, or suspects that he has incurred, infection. He also should betake himself immediately to a treatment centre where preventive methods may be properly applied. *Thus every treatment clinic has direct preventive work to do.*

### THE ADMINISTRATIVE CONTROL OF THE VENEREAL DISEASES IN SCOTLAND.

By *Sir LESLIE MACKENZIE, M.A., M.D., LL.D.,*  
*Member of Scottish Board of Health.*

#### I. OLD ATTITUDE AND NEW.

In the short time available to me I propose to pick out some of the chief factors in the transition from the old attitude to the new. On the medical side there were two factors: an increase in our knowledge of the causation of syphilis, and the invention of salvarsan. Formerly, even forty or fifty years ago, the clinical knowledge of syphilis, thanks largely in this country to the work of Jonathan Hutchinson, was extremely detailed, and in my day as a student, the man that did not understand that he was to allow for syphilis as a possible factor in a whole multitude of diseases where it was not obviously present, was simply not doing justice to the thoroughness of the teaching. The teaching as to gonorrhœa was equally thorough; but the changes here have been slightly less dramatic.

On the social side, the discovery of a relatively rapid cure for syphilis stimulated hope for the prevention not merely of the acute disease, but of its many known results—general paralysis,

## SOCIAL HYGIENE

locomotor ataxia, and the many other tertiary derivatives. Long before the war the hopes of prevention were steadily generating new ideas of treatment and administrative control. But the war added an entirely new factor: the need for immediate fitness. The war revealed the necessity of treating venereal diseases as disabling diseases and not as incidents in the ethical behaviour of men and women. This was only doing what had been done generations ago for tuberculosis and small-pox. Even in pneumonia, only a madman would now suggest that pneumonia following drunken exposure, whether accompanied by other forms of debauchery or not, is a good and proper deterrent from drunkenness, and that on moral grounds all drunkards should be kept ignorant of the dangers of excessive drinking. If we are to prevent disease, we must take the way of prevention that will work and find less easy-going methods of safeguarding the ethical position. It is quite certain that, up to date, neither precept nor fear of infection has had a measurable effect in the prevention of venereal diseases. But now, largely as a result of the war, the acute venereal diseases have passed on to the same plane for treatment as other forms of disease. The war revealed to the multitude what has been known to the medical world for centuries, namely, that a sick man is in a place apart and that our first business is neither to scold nor punish him, but to treat him and heal him. If you find a man dying, you don't first ask his creed or his ethical history; you do what you can to save his life. If you don't, you are in spirit a murderer and you had better look after your own soul. And so, through every lesser grade of sickness, the first medical commandment is: Heal the sick. This attitude is now, I think, frankly maintained all over this country.

### 2. ROYAL COMMISSION.

The next great landmark was the Royal Commission. Their report gave form to the growing views on prevention. But it was the work in the army that cut open the new paths and I for one shall never cease to praise the experts of the army and navy for the gift of organisation they have made to civil life. They, it is true, were dealing with a relatively manageable population; but their difficulties nevertheless were enormous. It was out of the conflict of ideas generated in the army that much of the Commission's material grew and the Trevethin Report, which we are discussing to-day, may fairly be looked upon as one of the typical products of sane British sense. The formulations, both of the Commission and of the Trevethin Report, are formulations after the fact; but they are essential steps in the evolution of the administrative control of the venereal diseases.

### 3. FACTS FOR SCOTLAND.

The immense change in Scotland can perhaps be best expressed in a few figures. In the eight years since the Venereal Diseases Regulations were issued in Scotland, probably more cases have been treated than in the previous thirty or forty years. It is impossible to say precisely, but there is

## SCOTLAND

*Sir Leslie Mackenzie, M.A., M.D., LL.D.*

no doubt that the old in-door and out-door provisions for treatment were found to be ludicrously inadequate the moment the local authorities were put under an obligation to provide diagnosis, treatment and education. Here are a few of the recent figures: In the calendar year 1920, there were 20,418 cases treated. Of these, 13,311 were new cases. The total attendances were 207,968. In 1921, there were 18,648 cases treated. Of these 13,724 were new; total attendances, 260,018. For the year ending May 15th, 1922, the total cases treated were 22,898, of which 12,542 were new; total attendances, 262,643. For the year ending May 15th, 1923, the total cases treated were 22,844, of which 12,398 were new; total attendances, 289,945. If we take the years 1920 and 1923, we may say that, roughly, the total cases in 1920 were 20,400 with 208,000 attendances; the total cases in 1923 were 22,800 with 290,000 attendances. In 1920, the new cases were, roughly, 13,300; in 1923, they were 12,400. These figures justify us in saying that under the old system of higger-mugger, at least hundreds, probably thousands, failed to find treatment and the treatment provided whether by private practitioners or by the hospitals was far from adequate. And it should be remembered that the vast mass of the work implied in those figures has been done in intimate official association with the large hospitals, whose resources were not of themselves equal to the burden. It would be difficult to name any official order either in England or in Scotland that has been more fully justified by the results. The hospitals have been thus enabled with rate and state assistance to develop their medical work, and the local authorities have been enabled to secure reasonably adequate service. Incidentally, it may be said that, in Scotland as in England, the policy has been to keep the work of the venereal disease clinics as far as practicable in close association with the great hospitals and medical schools.

But large as those numbers are, they cannot be regarded as covering all cases needing treatment. There are no data to let us even conjecture how many cases are treated in private; but the numbers must be very large. At all the clinics, however, the view is expressed that the new cases show a slight falling off, but the attendances show an increase. The falling off is more marked in syphilis. In 1922-23 there were 66 fewer new cases of syphilis, but 327 more new cases of gonorrhoea as compared with 1921-22. The inference is not necessarily that the gonorrhoeal cases are really more, but that more of them come forward for treatment. One general inference is reasonable: the cases have not yet reached a constant level. When we consider all the social factors involved, it is marvellous that the clinics should have succeeded so well. That they have done so is itself proof that the old attitude is gone and the new attitude better understood.

### 4. DEFAULTERS.

These, however, are the gross figures. It is true that the average attendances per case in syphilis have gone up from

## SOCIAL HYGIENE

9.1 for men in 1921-22 to 10.9 in 1922-23; the figures for women being 6.8 and 7.3. Also the attendances for gonorrhœa have risen in those years from 20.2 to 22.7 for men, and from 12.2 to 15.7 for women. Clearly, therefore, those that do attend are getting more adequate treatment. But what of the defaulters? This is not so gratifying. Of 10,294 cases treated in 1922-23, some 4,054 (39 per cent.) were discharged cured; but 2,378 (23 per cent.) left after completing a course, but before cure, and 3,042 (30 per cent.) left before completing a course. As the Trevethin Report states, many of those partially treated cases are not directly and readily infectious and to that extent the injury to other members of the community is lessened; but large numbers remain infectious or again become so and continue to spread the diseases. It is this disconcerting fact that constantly stirs the clinical officers to ask for powers of compulsory treatment just as the certainty that the voluntary system does not bring forward all the cases induces the administrative officers to ask for obligatory notification. And here we have the two main problems that are now calling for solution. In the old days the hospitals, when they treated venereal diseases as such at all, were content to take what came, knowing that only a fraction of the cases appeared and that nothing effective could be done either to complete the treatment or to prevent the occurrence of fresh cases. Notification was often suggested, but it was never pressed, largely because the means of treatment were undeveloped. But all that is changed and the question of obligatory notification and obligatory continuation of treatment are ripe for discussion.

### 5. TWO SPECIAL PROBLEMS: COMPULSORY NOTIFICATION AND COMPULSORY TREATMENT.

These two are now waiting for an answer. The Scottish Board of Health, like the Ministry of Health, is quite familiar with the arguments for and against, and at this moment the greatest of Scottish local authorities definitely suggests that the time has now come for compulsory notification. The Board's answer has not yet been given and we shall have some further conversation with the authority before any conclusion is formulated. Up to the present the official attitude in Scotland has been that expressed in the Royal Commission's Report and in the Trevethin Report. But both these renderings are based on the view that compulsory notification would tend to reduce rather than to increase the number of persons coming forward for treatment. The implication is that, if notification really increased the numbers, it would be a justifiable addition to the methods of administrative discovery. One factor in the case is that notification and confidentiality are difficult to reconcile, and that loss of confidentiality would result in diminished numbers. Perhaps it would; perhaps it would not. Whoever says more is out-running the evidence. So far as I am aware, no local authority in Great Britain has tested or been in a position to test the effects of compulsory notification. Personally,



## SCOTLAND

*Sir Leslie Mackenzie, M.A., M.D., LL.D.*

I am disposed to rely on education and social propaganda, and in the Venereal Diseases Order local authorities have the widest conceivable powers to educate their people by any method adapted to the various types of audience. Further, the Treasury has given generously for propaganda on a national scale, and much good use has been made of the money voted. There is, no doubt, room for a much more intensive campaign of teaching. Until every adult and adolescent in the community has the chance of obtaining knowledge as definite about the venereal diseases as he has of obtaining knowledge about tuberculosis, all, of course, in ways appropriate to his age, stage and acquisitions, it cannot be said that the resources of education have been adequately used. And let me say, in passing, that the knowledge I am thinking of is the knowledge that only a scientifically competent teacher can give and I assume that it is given in the same clean and cold light as the physiology of respiration or digestion would be. Done so, teaching is fruitful. It may at once be said that the effects of the education already organised have been enormous. But when the best that can be said for education is said, the question—Is there a case for compulsory notification?—remains unanswered. For we must remember that every fresh infection, whether knowingly conveyed or not, seriously affects the social rights of the person infected. Here we are at once face to face not with a theory, but with an act. The question then is: Are we taking the right method to stop injurious acts of this kind? It may very well be that notification will end in repression of cases. That was said twenty years ago about the notification of tuberculosis. But so far from ending in repression, notification resulted in such a crowd of cases that the numbers are more than the local authorities can handle. My mind is open; but I own to a feeling akin to blood-guiltiness when I contemplate the horror that so often marks the occurrence of the venereal diseases. An infant in the course of its birth gets gonorrhoeal ophthalmia and in a few days is blinded for life. How are you to deal with the mother or the father? Ophthalmia neonatorum is a notifiable disease; many cases are notified and many eyes are saved. By humane persuasion some local authorities succeed in getting at least the mother to undergo curative treatment, but the father is often a difficulty. Similarly, with the less immediate, but ultimately greater horror of congenital syphilis. Are we justified in leaving the father and mother alone? I say no; but what is the best way of acting?

Similarly, we might argue as to compulsory treatment or continuation of treatment. The Congress, I trust, will thrash out all aspects of these two questions. To the disputants the official authorities may fairly look for a factually well-grounded "lead." It is not enough to set prejudice against prejudice and fear against fear. We expect a reasoned answer to the questions: Will notification increase the numbers coming forward or diminish them? Is confidentiality consistent with notification, or can it be made so? If notification is rejected, are the current alternatives

## SOCIAL HYGIENE

adequate? Is there a case for experiment? If a sufficient local authority wishes to enforce notification for a period, is there adequate reason for refusing their proposal? Again is it just to require a known case to continue treatment when the unknown goes free?

Incidentally, I should like to see the question discussed whether, as in tuberculosis in Scotland, the venereal diseases should be kept within the highly adaptable powers of the Public Health (Scotland) Act, 1897, amended in a few details, or whether special legislation is called for. My own preference would be for keeping the venereal diseases on the same general lines as the other infections, with, perhaps, some amendment of the exposure clauses. But on this matter the Scottish Board of Health have issued no decision and I am not stating any policy, but only a point for discussion.

### 6. ETHICAL ASPECTS.

With the ethical aspects of the various problems that have emerged I have dealt more or less in a document circulated by the Scottish Committee of the National Council. There I have tried to state the ethical groundwork of all action in this field, and to disentangle the primary problems. I shall not resume the discussion here.

### 7. CONCLUSION.

It seems to me as in part responsible for the formulation and administration of official regulations that when I reflect on the social commandments lying at the basis of preventive medicine, I find that the primary commandment is: Thou shalt not kill. It has many corollaries, and one of them is: Thou shalt not spread disease.

## THE LEAGUE OF NATIONS: INTERNATIONAL POSITION WITH REGARD TO PROSTITUTION AND THE SUPPRES- SION OF THE TRAFFIC IN WOMEN AND CHILDREN.

By Dame RACHEL CROWDY, D.B.E.,  
*Director Social Section, League of Nations.*

### PREAMBLE.

I should like to explain at the outset the position of the League of Nations with regard to traffic in women and children in order to remove any possible misunderstandings which may exist and to define more clearly what part, in my view, the League of Nations is called upon to play in solving the problems which are before you.

The League of Nations, as everyone knows, depends for its existence upon the Covenant. Its duties are defined by the Covenant; its fields of action are stated in the Covenant, and it cannot for one moment go outside the Covenant except by the universal consent of its members. Now, by Article 23 of the Covenant, the members of the League have entrusted it "with the general supervision and the execution of the agreements with regard to traffic in women and children and traffic in opium and other dangerous drugs." The League then is primarily and

## LEAGUE OF NATIONS

*Dame Rachel Crowley, D.B.E.*

officially concerned only with traffic in women and children. It cannot concern itself with prostitution, which is a domestic problem—and one by which every one of its members is faced—except in so far as prostitution concerns the international traffic in women and children, which it is its duty to combat by every possible means. I am therefore at pains to make the League's position clear at the outset, so that you may know at once its limitations and its strength. The League works through Governments and is in a certain sense the servant of Governments. It can tap sources of official information often not available, except by chance, to unofficial bodies, but it has an equally close bond with the voluntary organisations which are combating this traffic.

This much by way of explaining the functions and position of the League.

### PREVIOUS HISTORY.

I will now briefly recapitulate what has been done in recent years to combat the international traffic.

Towards the end of the last century various voluntary organisations were formed in Europe with this object. In 1899 these organisations held a congress which resulted in the establishment of the International Bureau for the Suppression of Traffic in Women and Children.

The years 1899 to 1904 saw much private activity throughout Europe, partly as a consequence of the formation of this bureau, with the result that in the latter year the French Government convened a diplomatic conference, which drew up the agreement of 1904. This agreement, however, to which but few States adhered, was neither of so drastic nor of so comprehensive a nature as could have been wished, and accordingly, in 1910, the French Government convened a second conference. The resulting convention, which went somewhat further than the 1904 agreement, had been adhered to by sixteen States when the League was established in 1920. It is the agreement of 1904 and the convention of 1910 to which Article 23 of the Covenant refers and of which the supervision of the execution were entrusted to the League.

It was soon felt, however, that both these instruments were inadequate to deal with the problem, with the result that the first assembly of the League of Nations dispatched a questionnaire to all Governments asking them for details of the measures taken to suppress the traffic in their respective countries and of the various problems directly connected with that traffic.

A third international conference, which was attended by thirty-four States, was held in Geneva in June, 1921, again under the auspices of the French Government. The conference examined the replies to the questionnaire and also considered the evidence furnished it by the representatives of various voluntary organisations. It embodied its conclusions in a final Act, which was later converted into a Convention by the second Assembly. This Convention has been signed by thirty-three States, eighteen of

## SOCIAL HYGIENE

which have up to the moment ratified and three States which have not signed the Convention have adhered to it. The new Convention is intended to supplement rather than to replace the earlier international acts relating to the traffic. More than one delegate to the conference bore witness to the remarkable effect of both the international Agreement of 1904 and the Convention of 1910, which, in those countries where they had been applied, had rendered the traffic difficult, dangerous and unremunerative. The first article of the new Convention therefore prescribes that the High Contracting Parties, if not already parties to the Agreement of 1904 and the Agreement of 1910, shall ratify or adhere to them without delay. Of the new provisions in the Convention of 1921 the first is that the punishments prescribed by the Convention of 1910 for traffickers in women and girls are also made applicable to those who engage in the traffic of children of both sexes.

The Convention of 1921 requires the punishment of those guilty not only of the offences committed, but of attempts to commit, and, within legal limits, of acts preparatory to the commission of such offences.

The new Convention raised to 21 the age limit, which in the earlier Convention had been fixed at 20.

Its provisions relating to extradition also went further than those of the Convention of 1910, for the High Contracting Parties have agreed that in cases where no extradition conventions are in force between them they will take all measures within their power to extradite or provide for the extradition of persons accused or convicted of the offences specified in Articles 1 and 2 of the Convention of 1910.

Further, the High Contracting Parties agreed to provide regulations for the supervision of employers' agencies and offices, in order to protect women and children seeking employment in other countries.

In addition, an article dealing with the protection of emigrants was embodied in the new Convention.

The next step taken by the League was the constitution of a permanent committee, formed with the object of advising the Council on all matters relating to the traffic. This Committee has now held three sessions, in June, 1922, March, 1923, and April, 1924. It consists of ten Government representatives and five assessors or advisory experts appointed by the five principal international voluntary organisations for combating the traffic. Among the Governments represented on the Committee are France, Great Britain, Italy, Japan and the United States, which, though not a member of the League, has none the less felt the Committee's work to be of such importance as to make it necessary for its Government to be represented upon it.

This is to date a short statement as to the international machinery which has been set up by the League to deal with the problem.

### GROWTH OF INTERNATIONAL FEELING AGAINST THE TRAFFIC.

A brief consideration of the official action which I have just described will, I think, show the gradual growth of an international

## LEAGUE OF NATIONS

*Dame Rachel Crowdy, D.B.E.*

conviction—that white slave traffic should at all costs be suppressed, but that that conviction is growing stronger and stronger in the minds of Governments is more clearly shown by what I may term the inner working of the League's Advisory Committee. That Committee, as I have already said, is composed of Government representatives assisted by representatives of voluntary organisations in the capacity of expert advisers. Among those advisers or assessors as they are called, are to be found no less than four women, and I think it is a striking fact that Governments (two of whom have also appointed women to represent them) have not only consented, but welcomed, the co-operation of private bodies. The assessors are entirely free in the Committee to speak and to put forward whatever views they like, though they have not the right to vote. I do not think I am indiscreet when I say that the co-operation between the representatives of voluntary organisations and the official Government representatives on the Committee has invariably been of the closest and most cordial kind. It is inevitable that they should view the problem from different angles, but that has stimulated rather than prevented the search for a solution.

Further, the natural antipathy of the official mind to publicity has very rapidly given way to a recognition of the obvious need that any steps taken to combat this social evil must be made as widely known as possible. This is shown by the manner in which the Committee has held its meetings. During its first session in June, 1922, it sat in secret and the only account which appeared of its doings was its report to the Council, which was published together with the minutes of the Council, many months after the Committee had met. At its second session in March, 1923, the Committee still elected to sit in secret, but the report of its work which it furnished at the end of its session to the Council was read and discussed in public. At its third session last month it held all its meetings in public, although many very controversial matters were discussed.

### CONNECTION BETWEEN THE TRAFFIC AND STATE REGULATION.

As I have pointed out at the outset, it is not possible for the League to concern itself directly with the problem of prostitution, but only with that problem in so far as it is connected with the white slave traffic. Prostitution is a domestic problem as well as an international one, and States have so far dealt with it as a matter of domestic policy. There are, roughly speaking, two schools of thought with regard to prostitution: those who are in favour of its regulation, that is to say, of the segregation of prostitutes into a given area or into specified houses, their periodical medical examination or the police registration of prostitutes; and those who regard this system as ineffective, therefore useless, and against all the principles of civilisation and humanity.

At the first session of the Advisory Committee only a small minority of the members desired that State regulation should be

## SOCIAL HYGIENE

discussed since the general opinion of the Committee was that the regulation of prostitution had perhaps no direct connection with the traffic. At its second session, however, a marked change was evident. The majority of the Committee came to the conclusion that certain aspects of State regulation were within the Committee's terms of reference since the licensed house was said to provide a constant market for the traffic. The question was therefore discussed in private and the majority of the Committee adopted two resolutions:—the first recommending that a questionnaire should be sent to all members of the League, asking those States which have a system of regulation for a full report of its workings and results, together with a statement of the grounds on which it is advocated, and those States which previously had a system of regulation but have abandoned it, for a report of the reasons that led them to take this course and of the results which have followed their action; and the second that a general study of the conditions under which the traffic in women and children is carried on should be made on the spot.

At its last session in April the answers to the questionnaire were before the Committee. They were discussed at a public meeting, and the most important of them included textually in the committee's report to the Council. The replies to the questionnaire are by no means complete and I shall not attempt to draw any conclusions from them. I think, however, it is a matter of interest that I should lay before you a short summary of the more important of these replies in order that you may see the views of countries as far apart as Holland and Panama. I accordingly quote certain relevant passages.

*Denmark.*—This country abolished the licensed house system in 1901 and State regulation system in 1906, but this action was not taken as a result of experience or of observations connected with the traffic in women and children.

*Hungary.*—A system of State regulation and of licensed houses exists, but the Government is of opinion that the severe measures taken to punish procuration prevents the possibility of licensed houses becoming a source of traffic. Hungary has prevented the registration of foreign women as prostitutes and is preparing a scheme for the uniform regulation of prostitution and the suppression of licensed houses.

*Sweden.*—No licensed house system has ever existed, but a system of regulating prostitution which was in force in some of the principal towns was abandoned in 1919.

*Panama.*—This State regards the system of regulation as essential to public health. "In our view," the answer states, "the greatest objection to regulation is the obvious contradiction which exists between the system of tolerance and the highest ends of the State, which from the ethical standpoint cannot but condemn prostitution and the traffic in women. But these considerations of a purely theoretical nature are not sufficiently cogent to prevent the recognition that prostitution is inevitable, and that its regulation in the interests of public health is a necessity."

## LEAGUE OF NATIONS

*Dame Rachel Crowdy, D.B.E.*

*Latvia.*—This State abandoned the system of licensed houses for the following reasons: "As experience has shown everywhere, the number of prostitutes who can be placed in licensed houses is relatively insignificant. Consequently, prostitution in general can only be supervised in a very imperfect manner. Efforts to establish general regulations for the supervision of prostitution have thus proved of little use and the system of licensed houses, quite apart from the evils which the system engenders, has not justified expectations. This general failure of the system was taken into consideration when abolishing it."

*Belgium.*—The Department of Justice states, quoting the opinion of specialists, that "the system of State regulation, originally established as a measure for the protection of public health and as a guarantee of decency in large towns, has in no wise fulfilled, in these two respects, the expectations of its originators. . . ." "Alleging that licensed houses are recognised by the State—a claim which is in some sort borne out by the system of regulation—the proprietors of these houses constantly renew and change the inmates by admitting younger members, and by this fact alone they are a permanent factor in the traffic in women. Houses of this nature apply to special agents engaged in this type of recruiting. In addition, the inmates of licensed houses rapidly lose all will power and moral sense; having fallen to the last stage of abjectness, they are the constant victims of traffickers to a far greater extent than clandestine prostitutes."

*Netherlands.*—The memorandum of the Netherlands Government explains the reason why the system of police regulation has been abandoned. It was realised, the report states, that the system of supervision in force did more harm than good, a view which has been confirmed by several international medical congresses. "As regards the connection between the abolition of licensed brothels and the international traffic in women, Dutch experience has shown that the traffic depended on the existence of licensed brothels, and that their abolition has almost killed it. The agents of the proprietors of such houses could always count on licensed brothels taking the women and girls procured. Even in 1901 (two years before the actual closing of licensed brothels in Amsterdam) in the course of the inquiry held by the National White Slave Traffic Committee, it was proved that in fifteen months seventy-nine women had been engaged for and had been given employment in the three chief brothels in that city. Further investigations showed that many of these women were under age, and were entered in the civil registers under the names of women of full age, from whom the necessary papers had been obtained by the Paris agents of the brothel proprietors."

*Poland.*—Poland gives succinctly the reasons for which licensed houses were abolished in 1922: "(1) Licensed houses constituted centres for the international traffic in women; (2) It was impossible to give assistance to prostitutes, owing to the fact that the inmates of licensed houses were materially dependent on the proprietors;

## SOCIAL HYGIENE

- (3) Large quantities of alcohol were consumed in those houses, thus contributing to the number of cases of venereal diseases;
- (4) The bringing together of large numbers of prostitutes also tended to disseminate these diseases."

*Czecho-Slovakia.*—Czecho-Slovakia replied to the effect that the professional prostitute and the traffic in women were rendered possible by the existence of licensed houses. The clients of these houses constantly demanded fresh blood. In consequence, the dispatch of prostitutes from house to house is very frequent and the exchange of prostitutes is continuous. If licensed houses did not exist, traffic in women would be reduced to a minimum. The demand for fresh blood is above all active in countries where a system of State regulation exists. The Czecho-Slovakian Government further states that prostitutes in licensed houses contract venereal disease far more frequently than prostitutes living independently and are more susceptible to contagion.

Statistics prepared by Dr. Sprk of Petrograd show that on an average a prostitute in a licensed house contracts syphilis after three years, whereas an independent prostitute usually escapes for five years. As a result of the higher degree of promiscuity in licensed houses the danger of venereal contagion is greatly increased. According to the Czecho-Slovak Government the argument that it is easier to regulate health supervision if a system of licensed brothels and State regulations is in force falls to the ground, because it has been proved by statistics that all prostitutes suffer from chronic gonorrhœa and at least one-third of them from latent syphilis. The morbidity of prostitutes as the result of venereal diseases is higher among those living in licensed brothels than among independent prostitutes.

With regard to the economic condition of the inmates of these houses, the Czecho-Slovak Government states that experience has shown that the inmate is a down-trodden creature, without rights of any kind, entirely at the mercy of the keeper of the house. Everything given to her is placed against her account so that she is always in the keeper's debt, and it is thus impossible, or very difficult, for her to abandon her position should she wish to do so. She may be described as an example of modern slavery.

With regard to the effects of licensed houses on the general public, the Czecho-Slovak Government states that it is well known that licensed brothels are for the most part frequented by youths of 20 years of age or even younger. They encourage depravity and cynicism among young people, and "it is an established fact that venereal diseases are found among pupils in secondary schools in the sixth form and upwards."

I quote these replies because it seems to me that they are of great interest, but I beg leave to draw no conclusion from them. The evidence which the League has so far been able to collect regarding the system of State regulation is very far from complete. Important countries where the system of State regulation exists, such as France and Spain, and the majority of the South American States, have not yet replied. The only conclusion which it does



## LEAGUE OF NATIONS

*Mr. S. W. Harris (Home Office).*

seem at the moment to draw is the fact that evidence regarding the effects of the system is fairly easily obtainable and, with the co-operation and goodwill of the Governments, it should not be difficult within a comparatively short time to arrive at a definite conclusion regarding the problem.

In passing, I might perhaps bring to your notice the interesting fact that it is especially the newly formed States such as Czecho-Slovakia, Poland, Hungary and Latvia who appear to be concerned with the problem of prostitution.

*Mr. S. W. Harris (Home Office):* I am afraid I did not come here to address this conference, but to listen to the paper which has been read by Dame Rachel Crowdy, who frequently has the opportunity at Geneva of listening to members of the Advisory Committee. I thought I should like to have the opportunity of hearing what she had to say regarding our work, and I was very well rewarded by coming, though unfortunately I did not hear the beginning of her paper. Judging, however, from the part of it which I heard I think she has covered the ground so completely that it is almost impossible for me to add anything as regards the scope of the work which is being done by the League of Nations. Unfortunately I am in the position of having to attend another meeting at 4 o'clock, but I should like to add one or two words as to the general aspects of the question which you are considering during this Congress. You are discussing a question which is of vital importance to the world and to the British Empire in particular. It has, if I may say so, two sides to it—the medical and the social side, and it is very difficult to separate one from another. You cannot deal with the medical side adequately without considering the social questions involved, nor the social side without its medical aspects. A great deal of progress, I think everyone will agree, has been made in the last few years on the medical side, largely owing to the fact that the question of venereal disease has been brought more into the light of day. This question is now discussed much more openly than used to be the practice, with the consequence that far more progress has been made than was possible when the facts were largely concealed from the public. The same principle applies and is likely to be applied still more in the future to the social side, and a great deal of credit is due to the League of Nations for having brought the social side more into the light of day and for having invited much more general discussion of these questions.

As you have heard from Dame Rachel Crowdy, the Advisory Committee started with a rather limited field. It was first of all entrusted only to deal with the white slave traffic in its narrowest aspect. That has been the subject of international consideration and international conventions for many years, and a great deal has been done to meet the evils which used to exist years ago. But, as a Committee, we soon found that we could not restrict our attention to the white slave traffic in this narrow form, and we soon began to discuss such questions as the abolition of the system

## SOCIAL HYGIENE

of the State Regulation of Vice, and we began also to deal with subjects which may be included in the term "commercialised prostitution." No doubt before very long we may still further have to extend our work to prostitution generally. I think that a good deal of harm has been done on the social side by the attitude which many States and many private persons have shown towards the question of prostitution. Dame Rachel Crowdy quoted one reply—I think from the Government of Panama—in which the phrase occurred that "prostitution is inevitable." Well, that is the sort of sentiment which is held not only by Governments but by a great many individuals, and it appears to me to make it very difficult to find a solution if you start with that theory. We must start with a more hopeful idea than that if we are ever going to find a remedy for the serious social evils which arise from this particular problem. Dame Rachel Crowdy in her account of what the Advisory Committee is doing, has told us enough to show that very definite progress has been made in the small number of years the Committee has been at work, and, speaking as a member of the Committee, I think the prospect is hopeful, and that in the course of a few more years we shall have made a great deal more progress than has been possible in the past.

### THE RELATIONSHIP BETWEEN VENEREAL DISEASE AND THE REGULATION OF PROSTITUTION.

By S. NEVILLE-ROLFE, O.B.E.,  
*General Secretary N.C.C.V.D.*

THROUGHOUT modern historical times, and especially since the great outbreak of syphilis in the Middle Ages, attempts have been made by Governments and municipal authorities to reduce the spread of these diseases through the "Regulation"\* of prostitution.

It was believed that by segregating professional prostitutes into known areas, and by compelling them to submit to medical supervision, it would be possible to withdraw infected women from the practice of their profession and so reduce the spread of disease.

Of the two venereal diseases—syphilis and gonorrhœa—the latter has been in the past, and is still in some of the Latin countries, regarded as a comparatively slight ailment. Medical science still lacks any specific cure and the accepted forms of treatment are long. Syphilis, owing to its destruction of life during the most productive ages (25-50) and to its disabling and obvious consequences, has always been considered the more serious disease. Racially, both are serious—gonorrhœa by causing sterility and,

\* "Regulation" as used in this paper means the system by which prostitutes are registered by the police and are subject to various regulations including a periodical medical examination, either under national law, municipal bye-laws, or tolerated by the Government on conditions that such regulations are voluntarily adhered to.

## REGULATION OF PROSTITUTION

*S. Neville-Rolfe, O.B.E.*

in children, blindness, and syphilis owing to its congenital effects which may result in blindness, deafness and mental deficiency in the offspring, as well as causing miscarriages and stillbirths.

Until early in the present century the results of treatment were unsatisfactory and left the patient infective over a long period of time. With the discoveries of Mechnikoff, Schaudin, Bordet, Wassermann, Ehrlich and others, the whole situation changed and it became possible not only to treat syphilis effectively by a method which greatly reduced the infective period but also to recognise this disease as the cause of many serious conditions whose origin had hitherto been unknown. The treatment of gonorrhoea has also within the same period been greatly improved.

On the preventive aspect in 1910, with the collaboration of various Governments and municipalities in Europe, a scientific inquiry was undertaken by Professor Abram Flexner of the Rockefeller Institute into the systems for the regulation of prostitution then in force. The report of this inquiry, published under the title "Prostitution in Europe," presented a clear picture of the then existing position and provided striking evidence of the methods by which the regulation system lent itself to the dissemination of disease.

The Report of the Royal Commission on Venereal Diseases, which sat from 1913-15 under the chairmanship of Lord Sydenham, demonstrated that these diseases were spread throughout the community as a whole and not confined to the prostitute group. In Great Britain the regulation of prostitution has been abolished for generations. The Contagious Diseases Acts applied only to certain military areas. They were introduced in 1864, amended in 1867, and abolished in 1886. Regulation is still in force in France, Italy and other Latin countries. If the regulation of prostitution reduced the incidence of venereal diseases, these countries should logically show a lower ratio of disease than Great Britain where no regulation has obtained. It is impossible to give any actual figures as to the incidence of these diseases in countries that have no system of notification and no system by which adequate facilities for the treatment of these diseases are provided; but in the case of syphilis there are certain sequelæ, such as general paralysis of the insane, from which a rough comparison is possible. It is a direct sequelæ of syphilis, but it is one of the few wherein the cause of death is registered with approximate accuracy in all countries having reliable vital statistics. If we compare the number of deaths from general paralysis of the insane in Italy and in this country, we find that the incidence in this country is certainly no higher than in Italy; in fact the published statistics would make it appear to be definitely lower. It would appear that even if some allowance is made for a higher tendency in the Italian syphilitic to develop general paralysis of the insane, which may be possible, the incidence of syphilis in Great Britain compares favourably with that in Italy. Evidence of a high incidence of disease is also available from other "regulated" countries, and

## SOCIAL HYGIENE

it is clear that the practice of the regulation of prostitution over a long period of years has not protected those countries enforcing such legislation from the spread of disease.

On the other hand, the recent medical discoveries have provided a method of diagnosis and treatment of syphilis, and to a lesser degree for gonorrhœa, and those countries having an active public health service have from 1916 onwards endeavoured to apply recent knowledge and to make the facilities for diagnosis and treatment under the modern methods available to their population as a whole.

It is significant that in the Scandanavian countries where regulation was in existence that this system has been found to be a barrier to obtaining the best results on public health lines. In every country in Northern Europe the endeavour to secure the elimination of venereal disease from the population as a whole has been immediately followed by the abolition of the regulation of prostitution, for the reason that the weekly or bi-weekly medical examination of the small proportion of professional prostitutes that are registered in any community is, on the one hand, useless as a method of assuring that the examinees are not diseased, and on the other tends to give a false sense of security to persons visiting the brothels, thereby attracting larger numbers and concentrating exposure to infection on a small, highly infected group.

Again, the average number of visitors received by a woman in a brothel may be put at 20 per diem, or 140 per week. Supposing, as must frequently happen, that a woman is infected shortly after being medically examined, before her next examination she will expose over 100 men to infection, of whom at least a considerable percentage will develop acute symptoms. Even if medical examination could afford an assurance of absence of disease, unless it were carried out after every visit it must fail. Inquiries have shown that at least 40 per cent. of venereal disease is spread by prostitutes.

As an indication of the change in medical opinion on the subject of regulation may be cited the resolutions passed at Regional Conferences held under the ægis of the League of Red Cross Societies in Europe to consider how the problem of venereal disease could best be dealt with from the public health standpoint. To these Conferences were invited delegates from the Governments concerned and from the official venereal disease organisations recognised either by the Governments or by the Red Cross Societies, and in every case the personnel of the Conference was mainly medical.

Resolution passed by the International Regional Red Cross Conference, Copenhagen, May 20th to 25th, 1921 (including Denmark, England, Finland, Germany, Holland, Norway and Sweden):—

“That the regulation and official toleration of professional prostitution has been found to be medically useless as a check

## REGULATION OF PROSTITUTION

*S. Neville-Rolfe, O.B.E.*

on the spread of venereal diseases and may even prove positively harmful, tending as they do to give official sanction to a vicious traffic."

Resolution adopted by the Conference of Countries of Western Europe for the prophylaxis of venereal diseases (including France, Spain, Portugal and Italy), Paris, December, 1921 :—

"La réglementation de la prostitution ne jouant pas le rôle prophylactique que l'on a cru pouvoir lui attribuer, les moyens prophylactiques modernes éducatifs et thérapeutiques, peuvent la remplacer avantageusement."

Resolution adopted by the Conference of Societies of the Red Cross of Eastern Europe for the prophylaxis of venereal disease, Prague, December, 1921 :—

"La réglementation actuelle de la prostitution doit être remplacé par :

- (a) Une loi relative aux maladies vénériennes dans laquelle hommes et femmes seraient placés sur un pied d'égalité absolue.
- (b) Des mesures visant les clauses fondamentales de la prostitution :
  - (1) Des mesures sociales et économiques.
  - (2) L'explication au public et à la jeunesse des dangers sociaux de la prostitution.
  - (3) Des mesures en vue de la protection efficace de la jeunesse.
  - (4) La lutte efficace contre l'alcoolisme.
  - (5) Des mesures contre le proxénétisme.
  - (6) Des mesures servant à élever la moralité.
  - (7) La création d'établissements d'éducation pour les jeunes gens en danger au point de vue morale.
  - (8) Des mesures concernant la protection de la femme et de la jeune fille (protection des filles-mères et des enfants illégitimes)."

The policy of abolishing the Red Light Districts in the United States having already been adopted and put in force during the war, the resolutions at the corresponding All-America Conference on Venereal Diseases held in 1920 dealt mainly with methods of enforcing the law in order to obtain the effective suppression of known centres of prostitution and to procure the continuous treatment of all known infective persons in the community.

In Paris in May, 1923, the resolution passed at the Congrès Internationale d'Hygiène Sociale et d'Education Prophylactique Sanitaire et Morale, attended by many French venereal specialists and heads of the Paris and provincial municipal clinics is interesting :—

"That in the opinion of the Congress regulation of prostitution of women is useless in effect, iniquitous in law, and ought to be abolished and should be replaced by a régime based on

## SOCIAL HYGIENE

common justice of forbidding the knowing transmission of disease and, if necessary, by the isolation of infected persons of either sex in curative institutions."

As this paper only purports to deal with the public health aspect of the question it is proposed to give but little space to the difficulties arising from the regulation system in relationship to police corruption. It must, however, be noted that its effect on the police system is never beneficial; the temptations to which they are put when attempting to carry out their duties in this connection generally prove too strong to resist, and gradually they tend to become more or less completely corrupted by the clandestine members of the profession; they are told that it is better to let a dozen women go free than to accuse one decent woman of being a prostitute, with the result that many women purchase immunity from police control—in fact experience goes to show it is only the feebler and less energetic prostitutes that get on to the police registers or into the controlled brothels. Those with energy and a little intelligence have never found much difficulty in carrying on their trade unmolested.

In a district with a miscellaneous population and a native police force the risks of police corruption would be manifestly increased, and it is safe to assume that large numbers of prostitutes would contrive to exist with complete freedom even if their presence were known to the police, by the payment of tribute.

Among many who have not had the opportunity of studying the question it is often suggested that the abolition of regulation tends to increase clandestine prostitution. Evidence, however, does not bear this out. In all countries where prostitution is regulated the number of women registered varies from one-fifth to one-twentieth of the known clandestine prostitutes.

To take two examples. In Japan, in the provinces where the Yoshiwara were abolished some thirty-seven years ago there are proportionately fewer geishas and waitresses practising prostitution, while the numbers of such clandestine prostitutes is higher in those Japanese provinces having the largest provision of Yoshiwara in proportion to the population.

In the United States of America it was also found, contrary to expectation, that the abolition of regulation and the enforcement of the law prohibiting brothels resulted in a reduction of the number of clandestine prostitutes. This point is important as many police officials only support the regulation system because they are of opinion that its suppression would lead to scattering the centres of infection.

To take an example from our own Empire. The brothels in Colombo were abolished in 1913. A special Committee of Inquiry, consisting of the Chief of Police, the Attorney-General and others, was appointed to examine the position in 1918. Though the Report of this Commission has not yet been published we are aware that it was emphatically maintained that dissemination had not resulted and that conditions had generally improved. The statement often made in the East that the suppression of brothels

## REGULATION OF PROSTITUTION

*S. Neville-Rolfe, O.B.E.*

in Colombo had led to an outbreak of unnatural vice in that Colony has been completely disposed of by the findings of this Commission;—that the practice alluded to existed quite independently of the ordinary prostitution—it obtained prior to the abolition of the brothels and existed subsequently to it.

It was also clear from the incidence of the sequelaë to venereal disease among the inmates of the various institutions in Colombo that venereal disease was far less prevalent in that port than either in Singapore or in Hong Kong.

It is recommended that the problem of venereal disease should be considered from its public health aspect; that all schemes adopted should be applicable to the population as a whole and should make adequate provision for diagnosis and treatment of all sections of the community. The best results have, so far, been obtained by offering such facilities free of charge at hospitals or at poly-clinics, while supplying the necessary drugs either free or at cost price to private practitioners duly qualified to administer the modern treatment.

Most legislation with reference to venereal disease in countries other than Great Britain imposes certain compulsory clauses in order to retain under treatment persons in an infective condition, and to enforce the treatment of persons known to be infective. But an analysis of the results obtained under these methods and under the voluntary system obtaining in Great Britain shows that a slightly larger proportion of the infected population comes within the sphere of medical treatment in this country and that the majority remain under treatment for as long a period as they are required to do by law in other countries, although it is true a small minority discontinue treatment while in an infective condition and no means exist in this country of controlling their subsequent action in spreading the disease.

It appears that there is less disadvantage in introducing certain legal measures to secure treatment if adequate enlightenment of the general population as to the dangers of these diseases when untreated has previously been carried into effect. If compulsory measures for treatment are immediately introduced there is a serious tendency on the part of the public to conceal disease and avoid treatment, especially in the communities where a moral stigma attaches to the disease.

### Statistics and Reports from Various Countries.

*Austria.*—Regulation still exists.

In Vienna in—1900 there were 1,780 registered prostitutes.

1910	"	1,441	"	"
1912	"	1,689*	"	"

When war broke out in 1914 the 551 controlled brothels in Austria contained 6,797 prostitutes. The prostitutes in Vienna

\**Prostitution in Europe*, by Flexner, p. 145.

## SOCIAL HYGIENE

alone were computed at 40,000. Of the 6,000,000 population of German Austria 500,000 were infected with venereal disease; 70 per cent. of the youths under 20 years of age had been to a brothel.\*

During the period 1909-14 the population of Austria and particularly Vienna, had considerably increased. The ratio of inscribed to non-inscribed women generally in Europe has been reckoned as anything from one-fifth to one-twentieth.

In Vienna in 1916, 6,666 women were examined, 25.4 per cent. were infected; in 1918, out of 5,540 women examined, 27 per cent. were infected; in 1920, out of 7,240 women examined, 29 per cent. were infected;† in 1922 there were 5,541 women arrested for plying as prostitutes without having registered, of whom 1,163 were suffering from venereal diseases.

In November, 1918, the Public Health Department was formed, and a Committee of the Department recommended :

- (a) Universal Compulsory Treatment with penalties for default.
- (b) Compulsory examination of suspects.
- (c) Conditional notification by medical practitioners.
- (d) Installation of clinics for diagnosis and treatment.

The Ministry issued regulations embodying the recommendation in November, 1918. Attention has since been directed mainly to the establishment of free clinics. By 1920, 40 had been established, of which 19 were in Vienna. By 1922 the Ministry announced a fall in the incidence of the disease, and closed 16 of the clinics.

Since 1919 active propoganda has been carried out.

Regulation of Prostitution still exists, but public opinion is very divided on the subject, the majority of political and social opinion seems to support abolition, but a section of the medical faculty including some strong protagonists, favour regulation. The Ministry of Health subsidises eight voluntary organisations for educational purposes to the extent of 250,000 kronen a year; these support the medical policy of the Ministry and advocate the abolition of regulated prostitution. ‡

Dr. Weinberger, Director of Public Morals, in control of the regulation of prostitution at the International Congress of Police in Vienna, 1923, stated :—

"Prostitution itself cannot be fought by the law, it can only be looked on as the *source* of evils which the law can and must suppress. *Logically, therefore, the State Control of Prostitution must cease and the hardest fight be against V.D.* An effective law against V.D. is the surest protection against the consequences of prostitution, and the surest road to the solution of the problem presented by prostitution."

*Belgium.*—Regulation is maintained somewhat on the lines of the

\* *Völkerwacht*, January, 1922.

† *Lancet*, 26th March, 1921.

‡ Ministry of Health pub., Vienna. *Völkerwacht*, Jan. to September, 1922.



## REGULATION OF PROSTITUTION

*S. Neville-Rolfe, O.B.E.*

French system of police regulation: recognised houses, morals, police and registration. Almost a year ago an active anti-venereal disease campaign was instituted, and the modern policy of popular enlightenment and universal facilities for treatment pressed forward. There is now an active movement on foot to suppress regulated prostitution. In May, 1924, at the instigation of the Mayor the Municipal Council abolished the regulation system in Brussels for a year. The present system, it is urged, is not as effective as it might be because regulation reacts unfavourably on the treatment centres.

In Brussels about 10 per cent. of the population has, or has had, syphilis; of those under 25 years of age the figure is given as 15 per cent. This means that in Brussels there are between 70,000 to 80,000 persons who have, or have had, syphilis.\* In the whole of Belgium between 300,000 to 400,000 persons have, or have had, syphilis; these figures, be it noted, do not include those suffering from gonorrhœa, which is more prevalent than syphilis in Europe.

A provisional estimate puts the annual mortality from syphilis at 8,000, and from hereditary syphilis at 4,000, a total of 12,000.†

This indicates that under the regulation system venereal diseases were extremely prevalent. A year ago the modern system of general facilities for treatment and enlightenment were adopted and already considerable improvement is reported.

*Czecho-Slovakia.*—Czecho-Slovakia borrowed from Old Austria the system, under which prostitution was forbidden under the Civil Act of 1885, par. 5, though the police could, under certain conditions, tolerate it and issue regulations. In 1922 the system of regulation was abolished, brothel keeping became a penal offence, and a Public Health Act was passed at the same time making provision for facilities for treatment for the population as a whole—free to the poor. The treatment was provided under confidential conditions, anonymous notification only being required under certain conditions. The wilful exposure of others to infection is dealt with by quarantining the infected person who refused to carry out medical instructions.

*Denmark.*—Since 1788 facilities for the free treatment for venereal diseases have been provided to the poor at hospitals. Modern medical progress emphasised the need for early treatment, therefore out-patient treatment, both at hospitals and at private clinics is now provided.

The regulation of prostitution was abolished in 1906.

It is believed in Denmark that all who are infected have for some years received treatment, thanks to the admirable Jersild system of anonymous notification; therefore the figures given of persons under treatment coincide more accurately than elsewhere with the incidence of disease.

As evidence that the system is efficient, very few late cases of

\* *Bruxelles-Médical, La Lutte Antivénérienne en Belgique*, Professor Bayet, 1922.

† *Ibid.*

## SOCIAL HYGIENE

syphilis now come for the first time for treatment. The hospital figures of Copenhagen show since 1910 a decrease of syphilis from 6.1 per cent. to 2.9 per cent. among males, and in gonorrhœa from 32.5 per cent. to 26.9 per cent. Among women syphilis decreased from 2 per cent. to 1 per cent., and gonorrhœa from 6 per cent. to 4 per cent. The decrease in cases of syphilis is attributed to the introduction of salvarsan treatment.

The latest figures are, with a population of 3,300,000 for Denmark, and 665,000 for Copenhagen, for syphilis—

		Copenhagen.	Provinces.	Total.
1921	..	1,093	849	1,942
1922	..	885	693	1,578

*France.*—Prostitution is recognised and regulated, the latter rests on a law of 1790 by which the preservation of public order was given to the administrative authorities: in Paris the Prefect, in other Communes the Mayors. The decrees of various Prefects are largely responsible for the present system of—

- (1) Regulation, voluntary or compulsory.
- (2) Recognised brothels and houses of assignation.
- (3) Medical examination.
- (4) Hospital treatment.
- (5) Control over the activities of prostitutes.

For certain reasons a name can be taken off the register. Prostitutes do not come before the Courts, but are dealt with by the police.

The numbers of inscribed prostitutes in Paris in—

1830	were	4,519
1873	„	4,603
1883	„	2,816
1903	„	6,418
1910	„	6,000*

During this time Paris had increased enormously in size, and the ratio of inscribed to non-registered women is from one-fifth to one-twentieth.

It was estimated that in 1904 there were more than 60,000 prostitutes in Paris, and it was stated in evidence before a Commission: "The influence of regulation may be compared to a drop of water in the ocean. Are all of them arrested? The segregated women who can secure no influence and those who have not 5 francs in their pockets are arrested."†

France, during the war, gave serious attention to the question of venereal disease in the civil population and from 1914-17 a number of memoranda were issued by the Ministry of the Interior to the Municipal Authorities (Prefects): increased facilities for treatment were provided at hospitals; by the end of 1917 there were sixty-

\* *Prostitution in Europe*, by Flexner, p. 144.

† Mons. Gaucher before the Commission of *Régime des Mœurs*, 18th March, 1904.

## REGULATION OF PROSTITUTION

*S. Neville-Rolfe, O.B.E.*

five free clinics. A special Anti-Venereal Disease Commission was started in 1916 and transferred to the Ministry of Health when that department was created. There are now 166 free clinics. In none of the official circulars on the matter issued by the Ministry of Health is regulation alluded to, and a distinct movement is apparent among the venereal disease specialists in the provinces to secure its abolition and the recognition of venereal disease as a public health question affecting the population as a whole.

At a Western European Regional Medical Conference held under the auspices of the League of Red Cross Societies in Paris in December, 1921, at which the French Red Cross was represented by medical specialists, the following Resolution was passed unanimously:—

“That regulation of prostitution does not play the prophylactic rôle that has been attributed to it—the modern methods of prophylactics of an educational and therapeutic nature can replace it with advantage.”

At the Congrès Internationale d'Hygiène Sociale et d'Education prophylactique Sanitaire et Morale held in Paris, in May, 1923, medical and administrative sections were attended by a number of the most prominent venereologists in France. Those cities which had made most effective progress in providing accessible facilities for the modern methods of treatment were the most insistent on the need for abolishing the regulation of prostitution.

The following Resolutions were passed:—

“That in the opinion of the Congress the regulation of prostitution of women is useless in effect, iniquitous in law, and ought to be abolished, and should be replaced by a régime based on a common justice of forbidding the knowing transmission of disease and, if necessary, the isolation of infected persons of either sex in curative institutions.”

“The Congress believes that the law ought to be the same for all under its protection, and that it ought not to be applicable for any particular section of the nation, nor should any individual have any privilege that interferes with the rights of the community.”

Thus showing that the trend of medical opinion in France is towards the abolition of regulation of prostitution and the substitution for it of adequate facilities for free treatment. It is now recognised that venereal disease is a public health measure, and can only be adequately dealt with if treatment is secured to all infected persons.

*Germany.*—Up to date regulation has existed in Germany. The system under the Imperial Code provided that prostitution was not forbidden, it was an offence, however, to carry it on not under police control, or to break their regulations. The regulations included, as in France, registration and compulsory medical examination. Brothels are illegal but exist.

## SOCIAL HYGIENE

From 1886-1896 the number of inscribed women in Berlin averaged 3,006; in 1905 there were 3,115, and in 1910 there were 3,559.\*

It is estimated that for about the years 1908-12, of the clerks and merchants between the ages of 18-28 in Berlin, 45 per cent. had had syphilis, 120 per cent. gonorrhœa; 77 per cent. had had syphilis, 200 per cent. gonorrhœa in Breslau.† This does not show regulation as an efficient preventive of venereal disease.

A census taken by the Prussian Government on April 30th, 1900, showed with incomplete returns that in Berlin only 18.46 per 10,000 of the population were under medical treatment for venereal diseases.

In an investigation made in 1913 in the large cities in Germany there were 64 per 10,000 inhabitants under treatment, and in spite of the inclusion of venereal disease under the Government Health Insurance scheme and the opening of 164 dispensaries for advice, the incidence of disease remains very high as a similar inquiry through the large towns in Germany in 1919 showed 61 per 10,000 of the population under treatment.

However, in the latter inquiry, owing to post-war conditions, fewer medical men responded to the questionnaire, and on a closer analysis of the figures Dr. Berger, of the German National Board of Health, estimates the number under treatment as 80 per 10,000.

In 1903 an Amending Act to the Health Insurance Act did away with the special disabilities of the venereally diseased. A year before this the German Society for Combating Venereal Diseases had been formed. As the result a system of dispensaries for the insured venereally infected has sprung up throughout Germany. By 1921 there were 164 such centres, and the number of patients under treatment rose from 4,839 in 1916 to 107,985 in 1920.

As the result of a more general understanding of the problem on the part of the medical profession and the public, Bills were introduced in 1918 and 1922 at the instigation of the German Society for Combating Venereal Diseases. The Bill for 1922 has passed through all its stages and only awaits ratification. Under this the regulation of prostitution is altogether abolished and sanitary measures are taken. The whole of the administration with reference to venereal disease becomes a matter for the Public Health Service, and among other measures the knowing transmission of disease is penalised.

It is clear that under regulation the incidence of venereal disease, as shown by the inquiries made in the large towns, was extremely high, while with the institution of facilities for free treatment for the whole population very large numbers were brought under treatment, and the medical opinion in the country has been convinced that the persistence of the regulation system is a barrier to the complete success of their present scheme.

\* *Prostitution in Europe*, by Flexner, p. 144-5.

† *Prostitution in Europe*, by Flexner, quoting Blaschko.

## REGULATION OF PROSTITUTION

*S. Neville-Rolfe, O.B.E.*

*Great Britain.*—There has been no form of regulation of prostitution in this country since the repeal of the C.D. Acts in 1886, and this only applied to certain areas occupied by the fighting forces. It was claimed by the advocates of the C.D. Acts and by many military authorities, the health of the troops were protected by this form of the regulation of prostitution. The following table showing the fall in the incidence of venereal disease among the troops since the repeal of the Acts gives the facts :—

Year.	United Kingdom.	Aldershot.	London.
1885	275.4	321.7	339.4
1886	237.2	301.1	259.8
1897	127.5	130.0	165.2
1898	121.3	115.2	160.5
1899	111.2	96.2	150.2
1900	85.9	84.4	132.2
1901	95.6	69.8	151.1
1902	110.1	86.0	179.1
1903	109.1	119.7	165.4
1904	107.6	79.1	165.2
1905	90.5	79.9	176.5
1906	81.8	69.0	186.0
1907	72.0	60.0	162.0
1908	68.0	52.0	99.0
1909	66.0	48.0	160.0
1910	65.0	50.0	137.0
1911	60.5	44.1	93.2
1912	56.4	37.1	107.1
1913	50.9	29.8	95.6

This fall in incidence is attributable to the improved social conditions provided for the soldier, increased recreation, better social conditions for the civil population, the suppression of known centres of prostitution and the improvements due to the introduction of the modern methods of diagnosis and treatment.

The Royal Commission was appointed in 1913 and reported in 1915. The estimates given by witnesses before that Commission placed the incidence of disease in this country as 10 per cent. of the whole population in the large cities that were, or had been, infected with syphilis. This was the estimate given by Sir Frederick Mott. As there was no system of notification and no provision of facilities for treatment, it was impossible to test the accuracy of these figures.

Since 1916 the Government have made provision, with the co-operation of the local authorities, for facilities for free treatment to be provided for the whole population, and at the present moment there are 191 free clinics in existence. In addition to this a steady campaign of popular enlightenment directed to the general public

## SOCIAL HYGIENE

is supplementary to the educational efforts in the same direction made during the war for the men in the Services. This has had the beneficial result of securing that in 1920, 105,000 persons presented themselves for treatment at the free clinics; in 1921, 84,000; in 1922, 73,000, thus showing a steady decrease. The figures of 1922 show a decrease of 39 per cent. in the case of syphilis since 1920; cases of gonorrhœa show a decrease of 26 per cent.

The present estimate, based on the information obtained from the clinics and elsewhere, is that there are not more than 200,000 fresh infections annually.

In Great Britain, treatment of the venereal diseases is organised on an entirely voluntary basis; there is no system of notification, but even under these conditions it is believed that a larger proportion of the infected population are attracted to the treatment centres or to their private practitioners, and with the growing standard of public enlightenment the numbers discontinuing treatment while still infective are falling. Though not satisfied that all infected people are yet under treatment, or that the machinery is adequate for securing that those who begin treatment should continue until non-infective, there is ground for belief that not only is the incidence of venereal disease in this country falling materially, but that under the system of no regulation it has not been as high among the British population as among the Continental populations, especially in the Latin countries, within the last two generations, a period over which figures are available.

As an indication of this the figures relative to general paralysis of the insane may be cited. Between 2 and 3 per cent. of all cases of syphilis, if untreated or inadequately treated, develop general paralysis of the insane, and in these cases the true cause of death is returned to the Registrar-General. The number of cases of general paralysis of the insane in this country ranges between 2,000 and 1,500 per annum with a population that averages from 35 to 37 millions, while in Italy, with a slightly smaller population, the annual number of deaths from the same cause are quoted by the Registrar General as ranging between 4,000 and 4,900 per annum.\*

As an illustration of the uselessness of regulation in reducing the incidence of venereal disease, the ratio of venereal disease in the British Army for four years in regulated and in non-regulated countries may be cited:—

Area.	Annual Ratio per 1,000 strength.		
	1920	1921	1922
United Kingdom (non-regulated)	48.30	40.26	33.66
Army of Rhine (regulated) ...	188.64	212.34	213.53
Army in Constantinople (regulated) ... ..	213.73	228.48	83.41

\* Since writing the above, enquiries from the Italian Registrar General elicit the information that the classification of G.P.I. cases may not be strictly comparable with the British classification, and for the current year a uniform scheme is to be adopted.

## REGULATION OF PROSTITUTION

*S. Neville-Rolfe, O.B.E.*

*India.*—The following figures give the incidence of venereal disease among the British troops in India. Until 1895 regulation, segregation and periodical examination of prostitutes were in vogue; it is felt that the figures speak for themselves. The decline in the last twenty years is due to increased recreational and educational facilities and above all to improved methods of medical treatment. In 1868 the Contagious Diseases Acts were introduced into India and were in force till 1889, when they were replaced by the Cantonment Acts; tolerated houses in British Cantonments were closed under the Defence of the Realm Act in 1918. At the present time in the industrial centres of India there are large tolerated areas and an extremely high incidence of venereal disease throughout the whole population.

*European Army in India.*—Admissions into Hospital per 1,000.

369 in the year 1861	58.9 in the year 1910
192 " " " 1870	118.2 " " " 1920
249.7 " " " 1880	110.4 " " " 1921
503.5 " " " 1890	85.9 " " " 1922
298.1 " " " 1900	72.0 " " " 1923 (estimated)*

The following extracts from the Report made by the Committee held to report on prostitution in Bombay in 1921 indicates the trend of feeling :—

“ . . . regulation was until recently in closely confined cantonment areas enforced in India. . . . We see no reason to expect that medical examination which has in no regulated country been effective as a security against disease could be made efficient in Bombay. . . . The failure of regulation under the Contagious Diseases Acts all over India points to the unsuitability of the soil to such a system.”

The Committee went on to recommend that the keeping of brothels, the procuring of women and the letting of houses for purposes of prostitution be made illegal.

In 1923 a Bill was passed through the Bombay Legislature embodying many of the recommendations of the Committee, including clauses it is hoped will eliminate procuration. A Vigilance Committee supports the authorities in enforcing the new law and propaganda for the suppression of brothels is proceeding and is expected to follow as soon as public opinion is sufficiently enlightened.

*Italy.*—Regulation still exists, though, as elsewhere, it is admittedly powerless to check or control either prostitution or venereal disease. Italy has recently fallen into line with the rest of Europe and initiated a strong campaign against venereal disease on the modern lines of universal free treatment, clinics and education. At Rome in 1912 225 women were registered, whilst the police were endeavouring to keep 5,000 women under observation.†

\* Reports of Public Health Commissioner with the Government of India.

† *Prostitution in Europe*, by Flexner. p. 173.

## SOCIAL HYGIENE

A new Act was passed in 1923 which, although it does not abolish the regulation of prostitution, does away with all police control and places the matter entirely in the hands of the local sanitary authorities. This in several other cases, notably in Finland and Germany, was the prelude to total abolition.

That regulation in Italy up to date has not succeeded in preventing the spread of disease is indicated by the figures for deaths from general paralysis of the insane, a consequence of syphilis (untreated or inadequately treated) that develops in a known proportion of cases.

*Japan.*—When the National Council Commission visited Japan in 1920 the Chairman of the Sanitary Board and the Venereal Disease Director of the Sanitary Department both expressed themselves as opposed to the Yoshiwara on public health grounds, but stated that it would need time to educate the Japanese population in order to persuade them to give up such an old-established custom. An attempt, however, was being made by the authorities to reduce the evil by strictly limiting the number of licences given to fresh inmates of the brothels and by reducing the licences issued permitting new Yoshiwara to be established. The Sanitary Committee had come to this conclusion largely owing to the results of an analysis of the figures taken from the different provinces.

Thirty-five years previously, when the Province of Guma had abolished the Yoshiwara system, it was with great misgivings that the Central Authority had endorsed this municipal reform. It was now found, however, that the incidence of disease in Guma and its adjacent provinces was lower than any other Japanese province.

Provinces in which the Yoshiwara had been abolished showed an incidence of 15.35 per 1,000 as compared with figures ranging from 26 to 47 per 1,000 in the other parts of Japan. This convinced the health authorities that, in spite of all medical measures taken to reduce the amount of venereal disease among the inmates of the Yoshiwara, known centres of prostitution inevitably led to the dissemination of disease. All centres of prostitution tend to concentrate the exposures to infection on a known highly infected group. Japanese experience appears of practical value in that the problem of venereal disease in that country is not confused by any prejudice, but is purely a matter of public health interest.

On December 22nd, 1923, in the House of Representatives in Japan, representations against the reconstruction of the licensed quarters destroyed in the recent earthquake was raised, and the whole matter was referred to a special committee of the House.

*Norway.*—Until 1884 the same conditions existed as in Germany. Prostitution was prohibited by law but tolerated under police supervision. The brothels were then closed. In 1887 all regulation was abolished. At the present date the only laws remaining are those penalising procuration, brothel keeping and solicitation.





## SOCIAL HYGIENE

questionnaire issued. Among much other interesting information elicited was the outstanding fact that the population of Geneva, the one town in which regulation existed, shewed the highest incidence of disease, and this in spite of the fact that 80 per cent. of the medical practitioners in Bâle, while only 55 per cent. of those in Geneva replied to the questionnaire.

The following table gives the number of persons under treatment per 10,000 of population during the period October, 1920 to September, 1921—

Geneva	...	...	106	Zürich	...	...	60
Bâle	...	...	95	Lucerne	...	...	24*

The following gives the number of infections in the various cantons for the same period—

	Total No. of Infections.	Infections due to Prostitutes.
Geneva	1,079	514
Bâle	508	183
Zürich	989	428†

The general incidence of venereal disease for the country for the period in question was 17.3 per 10,000; the proportion varied from 63.3 per 10,000 in Geneva to 3 per cent. per 10,000 in Schwyz; 40 per cent. was attributable to prostitution.‡

*United States of America.*—Regulation is contrary to law, and though for a time Red Light Districts were tolerated in some States they have now been abolished everywhere.

In 1916, of the 320 brothel women in San Francisco only 3 per cent. failed to show signs of syphilis infection.§

In Baltimore out of 289 brothel women examined, 62.3 per cent. had syphilis, 92.1 per cent. gonorrhœa, 45 per cent. had both, whilst only 3.39 per cent. were free from infection.¶

In 1919 in Pottsville, Pa., there were three brothels with twenty girls, each of whom was certified medically free from disease. An inquiry established the fact that eighteen were infected. In one of the houses with three girls in it a hole was punched in a card for each customer; the number of punches in one day on the three cards were 49, 37 and 28 punches respectively. All three girls were syphilitic.¶

In Panama in June, 1918, a survey showed there were 231 registered women in the segregated district, 175 outside it, and

\* *Les Maladies Vénéériennes en Suisse d'après les resultants de l'enquête* (1st October, 1920–30th September, 1921), by Dr. H. Jaeger, Premier Asst. de la Clinique dermato-vénérologique de l'Université de Zurich.

† *Ibid.*

‡ *Ibid.*

§ *V.D. among Prostitutes*, by Dr. G. Bates. *Social Hygiene*, Vol. III, No. 4, 1917.

¶ Winthrop D. Lane, *The Survey*, March 25, 1916.

¶ *V.D. among Prostitutes*, by Dr. Gordon Bates. *Social Hygiene*, Vol. III, No. 4, 1917.

## REGULATION OF PROSTITUTION

*S. Neville-Rolfe, O.B.E.*

302 unregistered clandestines; 91 per cent. of the 231, 95 per cent. of the 175, and 98.5 per cent. of the 302 had venereal disease.\*

The following experience was gained by Dr. Goodman, Officer in Charge of the Venereal Disease Control Work, Panama Department, U.S. Army, 1913-18.

The following table shows the effect on the venereal disease rate of the abolition of the brothel system:—

Date.	Venereal Disease Infections per 1,000 were	Remarks.
1913	... 196	Military medical measures, including prophylaxis.
1914	... 135	Prohibition of liquor sales in dance halls. Red Light Abatement Law.
1915	... 136	
1916	... 119	
1917	... 123	Special Anti-Venereal Disease Military Campaign.
1918 (1st 6 mths.)	78	Abolition of regulated and tolerated prostitution and enforcement of Brothel Closing Law, etc.
1918 (2nd 6 mths.)	6.09	

A further example can be given as to the effect of a known brothel area in encouraging promiscuity, from the Report of the Army Corps stationed in the San Francisco area in 1917. This report shows the direct relationship between the facilities for exposure and infection rate and the effect of active suppression of brothel areas in reducing the Army venereal disease rate.

Date.	Remarks.	Prophylactic Treatments per 1,000 men.	V.D. Infec- tions per 1,000 men.
Oct., 1917	Medical examination and regulation of prostitutes in force.	826.18	167.67
Nov. "	Change of Municipal Administration followed by Red Light Abatement Law.	497.46	75.11
Dec. "	Ditto	426.42	84.87
Jan. 1918		251.02	40.51
Feb. "	Temporary resumption of old régime owing to Municipal changes.	331.13	45.74

\* *Urologic and Cutaneous Review*, May, 1920.

## SOCIAL HYGIENE

Date.	Remarks.	Prophylactic Treatments per 1,000 men.	V.D. Infec- tions per 1,000 men.
Mar. 1918	Ditto.	264.77	53.14
April "	Law enforcement revised	218.03	37.73
May "	"	162.19	19.15
June "	"	155.69	17.77
July "	"	165.90	18.39
Aug. "	"	151.48	6.84
Sept. "	"	124.34	6.99
Oct. "	"	39.65	6.61
Nov. "	"	47.74	8.59
Dec. "	"	53.29	5.42

(These figures were authorised for publication by the Surgeon-General, U.S. Army, Washington, D/C, March, 1920.)

The following extract from the U.S. Naval Medical Bulletin, June, 1923 (p. 748), is another indication of the high incidence of the venereal diseases in those places in which prostitution is regulated:—

“In Constantinople, prostitution is practised probably to as great, or perhaps a greater, extent than in any city of its size in the world, clandestinely as well as in houses of prostitution. The Turkish laws requiring registration of those who practise prostitution are excellent, but are not enforced. The records show that there are about 2,600 registered prostitutes, but the number practising prostitution will probably reach 20,000 or more. It is interesting to note that during 1922 there were 3,500 cases of venereal disease treated in the venereal disease hospital in Constantinople, representing eleven nationalities, none of whom were Turks. In view of these conditions and in view of the great number of cases of venereal disease which developed within the first month after our arrival it was necessary to apply more stringent measures regarding prophylactic treatment.”

In a Fleet Circular issued by the Chief of Staff of the U.S. Asiatic Fleet on May 4th, 1923, he indicated that the incidence of venereal disease among the American crews of the Asiatic Station is higher than elsewhere. In all the ports of this Station there is tolerated or regulated prostitution, and the incidence of venereal disease has risen, in spite of medical measures taken by the Fleet, as follows:—

Date.	Per cent of total admissions.	Annual rate per 1,000.
1919	26.49	187.87
1920	37.88	295.256
1921	46.01	314.195
1922	44.06	368.916

(Figures taken from U.S. Naval Medical Bulletin, July, 1923, p. 87.)

## SOME ASPECTS OF SOCIAL HYGIENE

*Sir Arthur Newsholme, K.C.B., M.D.*

The following are extracts from the U.S. Naval Medical Bulletin, April, 1923 :—

"From experience gained on the Pacific Coast, it is believed that the lowering of venereal disease rates on board ship depends principally upon the activities of public health officials, the police and social hygiene workers of the community in which liberty is granted.

"In the campaign waged in Southern California, the officials broke up the Red Light districts, closed the so-called coffee houses, and arrested, examined and treated every infected prostitute. The venereal disease rates immediately dropped off at San Diego, San Pedro, and in the Pacific Fleet."

"... The venereal disease rate has been high, owing to the fact that this vessel has been in Chinese, Japanese and Siberian ports a great part of the time. However, the percentage of the crew infected has been at a minimum during the latter part of the year, whilst stationed in Philippine waters. This is due to the fact that houses of prostitution in the Philippine Islands have been closed."

## SOME ASPECTS OF SOCIAL HYGIENE.

By *SIR ARTHUR NEWSHOLME, K.C.B., M.D.,*

*Vice-President N.C.C.V.D. Late Medical Officer Local Government Board.*

IN the last half century the public health, however measured, has enormously improved. The death-rate at each age-period right up to old age has decreased, and average life has been lengthened by some eleven or twelve years. Not only so, but the balance of evidence favours the conclusion that the average standard of health has been raised, for while many lives have been saved which would formerly have been sacrificed, many others—almost certainly a much larger number—have been saved from the malnutrition, defective hygiene and actual disease which cause deterioration of health. Furthermore, the greatest saving has been in young lives, and the years of life saved are being lived chiefly at ages 15 to 65, when economically and socially they have the highest value.

Of communicable diseases in this country, we know that tuberculosis only claims half its former number of victims, that typhus fever has been almost extinguished, and that typhoid fever is but a shadow of its former self.

So far as these and other communicable diseases are concerned, success has been achieved by inhibition of the action of the vectors of infection, as in the spectacular reduction of typhoid fever in this and of yellow fever and malaria in other countries; and by specific immunisation, as in smallpox; (prospectively also in diphtheria). Increased resistance to disease has also occurred in some instances and has played its part in the reduction of tuberculosis,

## SOCIAL HYGIENE

though it baffles all wishful to make an accurate statement to say how far the reduction of tuberculosis is ascribable to increased resistance to infection and how far to diminished opportunities for frequent or massive doses of tubercle bacilli. The wise administrator neglects neither item whether he is undertaking preventive or curative measures.

In syphilis and gonorrhœa, the social diseases *par excellence*, no question of relative resistance to infection arises. We are concerned only with preventing infection, though there is evidence that alcoholic indulgence may increase the severity of disease when acquired.

But although for these diseases the avoidance of infection is the one essential problem, for them even more than for tuberculosis we are faced with an intricate network of factors which favour the action of the essential cause, and impede the necessary measures of prevention.

In the prevention of venereal diseases—a most important branch of social hygiene—consideration of these factors acquires extreme importance, for reasons which are not far to seek. Syphilis and gonorrhœa are infectious diseases which would rapidly disappear from our midst if one could prevent promiscuity, or if one could ensure, when there is sexual contact between two persons one of whom is diseased, the carrying out by both of certain precautionary measures at the time of or immediately after exposure to infection.

In fact, such exactitude of preventive action commonly cannot be secured, owing to carelessness or intoxication, or for other reasons which are sufficiently obvious. That persons individually asking for it should be given information as to disinfectants and be able easily to obtain the materials themselves is generally agreed, and few physicians, I think, would withhold information as to the procedure necessary to minimise the risk of acquiring disease. To an adult set upon sexual irregularity, repulsive though the task would be. The physician would doubtless in most instances supplement this information by giving the warning embodied in the policy of the N.C.C.V.D. as to—

- (a) The possible failure of the precautionary measures;
- (b) The resultant danger of illicit sexual intercourse;
- (c) The great risk to future wife and children; and
- (d) The gross injustice done to the associate in promiscuity;

and it will be agreed by most of us that in addresses on the subject of venereal disease and in any printed circulars of advice, earnest counsel as to the importance of avoiding promiscuity as a social offence of the greatest gravity should be associated with the giving of information on disinfection.

This is the medical aspect of the case; but, as already indicated, treatment of the problem on these lines does not meet the social requirements of the family, nor of the larger family formed by the community.

In the evolution of civilisation the outstanding feature is the gradual realisation of the fundamental importance and sacredness

## SOME ASPECTS OF SOCIAL HYGIENE

*Sir Arthur Newsholme, K.C.B., M.D.*

of the family; and quite apart from any religious teaching—though this gives important support to the same conclusion—we are learning the lesson that the guardianship of the germ plasm of the future, the passing on untainted and if possible improved of the inherent qualities of the family group, is an essential and fundamental duty of family life. One of the greatest enemies to this is the occurrence of venereal diseases, but in “the endeavour to lift the standard of our sexual life out of the mire of barbarism” (Dr. D. Hooker) we need to remember that the eradication of these diseases is but an incident in the wider battle that is being waged. This wider battle is that of the sexual morality required to ensure the permanent success of family life; and, although it has many collateral efforts, the main struggle, unceasing and relentless, must be against promiscuity, which even in the absence of venereal disease is the great enemy of family life.

No subject can be adequately understood apart from the study of its historical development; and in the light of Bishop Westcott’s dictum that “history is the best cordial for drooping spirits,” we can take courage in respect of the control of promiscuity.

Gradually the two great passions of mankind, food hunger and sex hunger, have emerged in the course of the ages from “the mire of barbarism.” Monogamy has replaced polygamy, and although promiscuity—in the sense of casual sex relations—is still seriously prevalent, there is evident a more wholesome public opinion in this respect, as shown by the general discredit now attaching to vice regulation, and by the increasing legislative and administrative efforts to suppress commercialised vice.

The former mischievous silence as to the avoidable diseases caused by promiscuity and the unwillingness to face the problem disappeared with the publication of the report of the Royal Commission on Venereal Diseases in February, 1916, and this was followed by the organisation, with the aid of official money and as part of public health administration throughout the country, of gratuitous means of diagnosis and treatment of these diseases and educational propaganda in regard to them. This fundamentally valuable line of action is now in operation throughout the country; it is capable of still further extension by the use of existent machinery; and already there is reason for concluding that a material reduction of disease has been secured.

But even if all possible medical and hygienic measures, including the searching out of sources of infection, were to be adopted to the maximum extent and if personal disinfection were to be practised to the extent which can reasonably be expected, we cannot reasonably anticipate that by these means alone venereal diseases can be annihilated or even reduced to insignificance. I do not propose to argue this contention, but the great natural urge to sexual indulgence and the conditions of secrecy and shame associated with promiscuity justify me in starting from the assumption that this is true.

There will remain, when the vast amount of good practicable

## SOCIAL HYGIENE

by extension of our present medical, hygienic and educational work has been secured, a large portion of the wider question of promiscuity and its prevention. Sexual vice is a serious enemy of family life, whether associated with venereal disease or not; and we cannot succeed in our complete aim until a public opinion is formed which will hold fornication as a sin against the community and as an insanitary act, at least as serious in its results for the community as drunkenness, cruelty to children, or adultery. *The aim of social hygiene*, so far as it is concerned with sex hunger, is to bring about this improved social attitude towards fornication.

To review the whole of the social activities which can conduce to this end is impracticable here. One of these, viz. the energetic pursuit of medical and hygienic measures has already been reviewed. It is useful to consider the three chief branches of anti-venereal work in relation to each other. They are :

- (a) Medical and hygienic measures ;
- (b) Legal enactments and the police action following on them ;
- (c) Character building.

So far our chief progress in officially organised effort has been under the first of these headings, valuable and far-reaching work having been accomplished. This work will need to be continued and indeed vastly extended until venereal diseases have ceased to be an important cause of disease and death. It is inevitable, however, as Dr. W. H. Snow has pointed out, that as B and C extend the scope of their success, the sphere of operations of A will shrink, that furthermore as the possibilities under C are increasingly realised, B becomes unnecessary; and it is for this happy result that we struggle.

A careful review of legal powers shows serious hiatus in our possible action; and notwithstanding the proper jealousy of those who object to restrictive measures likely to operate chiefly against women, while leaving their male associates untouched, it is certain that much more could be done than is now being done to restrain commercialised prostitution. Even success in the complete fulfilment of present law cannot be achieved unless the police in their efforts to suppress vice receive the constant support of the public. Is there not need for the formation of Law Enforcement Leagues in each great centre of population to give the necessary assistance in this direction? It is practicable, given adequate effort, to eliminate the organised commercial forms of prostitution, leaving only the problem of the clandestine dealings of men and women who seek each other directly; and this would mean a long step forwards in reform, which is only waiting for co-operation of the general public for its accomplishment.

Direct clandestine prostitution and still more non-commercial fornication obviously cannot thus be reduced; and we must resort to more general social measures, consisting of a number of converging factors, none of which can advisedly be neglected.

Of these one thinks first of the motive of fear of disease; and although this is a lower motive than the love of good for its own sake, it can claim some partial success. But apart from other



## SOME ASPECTS OF SOCIAL HYGIENE

*Sir Arthur Newsholme, K.C.B., M.D.*

motives operating at the same time, the fear of disease has not proved effective when passion is aroused.

The influence of rightly directed public opinion is almost immeasurably great. Cannot this be brought more effectively to bear? In the past vast social reforms have been secured by its aid. The abolition of slavery, the steady reduction in alcoholic indulgence, the change in public opinion and legislative enforcements as regards cruelty to children, cruelty to animals, compulsory school attendance, the wages in sweated industries, etc., are illustrations of what can be effected by public opinion.

This influence can be brought to bear in various directions. Thus it can be made to encourage early marriages and to favour them by careful graduated taxation; and by liberalisation of some of the present hardships of our present marriage laws the risk of promiscuity can be further diminished.

Even more important will be rebellion against the tacitly accepted unequal standard of sex morality for men and women. This is essential if, in addition to an attack on prostitution, we are to face the much more important task of stopping the masculine demand which alone maintains the supply of prostitutes.

There is needed a determined attitude to the sexually immoral man as an enemy of society, who cannot be tolerated; and until this is secured—and public obloquy would help enormously—rescue work for women is a poor substitute for a stopping of the demand for them. Current social opinion is a most important part of our environment, and it can be given far-reaching effect by the repudiation by all women of repute of dissolute men, by the discouragement of sensual literature, and by working for a higher standard of kinema and other entertainments.

The teaching of sex hygiene is important. Knowledge is not necessarily safety, though it supplies the basis for the adoption of a moral standard by deliberate voluntary choice. We need to steer clear of injudicious teaching which may even imply the psychological risk that the prominence given to the subject may act as an incitement to immorality.

But although the judicious teaching of sex hygiene enters into the programme of prevention, it must take a subordinate place in the training of the adolescent for a normal sex-life, the chief rôle in this training being taken by what may very broadly be described as character-building. The essential element in this is the training of the child from the cradle onwards to adolescence, in the practice of self-control in all respects, and without any definite regard to sex-life.

The call for self-control is a necessary element in civilised life. This becomes impracticable if individual freedom, i.e. licence, is conceded in every direction. In respect of sex-life self-control is compatible, and is only satisfactorily secured when the subject is robbed of its assumed nastiness; when love is idealised; and when restraint means not the deprivation but the postponement of satisfaction within the limits which successful family life, as the

## SOCIAL HYGIENE

fundamental institution of civilisation, demands. Osler's advice to medical students to "put their passions into cold storage" hits the need.

How is this self-restraint to be made generally acceptable? The fear of disease is a relatively ineffective motive, as we have already seen. And public opinion, a potent influence, only works good in so far as it levels the moral standard of the two sexes up and not down.

Much good may be done by appeal to moral motives. A man, especially a young man, prepared to run risks for himself is influenced if he is made to realise (a) the mischief which he is doing to his associate, (b) the injury to his present or future family life, moral as well as physical, and (c) the betrayal of the next generation which probably is involved in his lapse from virtue.

In another contribution to the National Council's publications I have stated my personal views on "The Moral Aspects of Social Hygiene," and indicated what appears to me the main line of hopeful action. This consists in parental action in the cradle and toddler's stages of life in the development of the powers of self-restraint of the instincts which entirely govern uncontrolled infantile activities; and in corresponding sympathetic guidance which will convert the self-centred toddler into a socially tolerable character. It is at this time of life that trails are being blazed and the initial direction is being given to the motive forces of adult character; and as the child learns to practise self-control in childish life he is making straight his adult path of chastity and sobriety. It is by the power acquired through persistent practice in minor matters that temptation can be resisted when it comes as a whirlwind.

To develop this aspect of social hygiene a special paper is needed, embodying the wisdom of the educational psychologist and the ideally successful parent, but perhaps I have sufficiently indicated the lines on which action can fruitfully be taken.

We have to remember the special demands especially as puberty approaches of each individual child, which vary with its health, vigour and temperament, in short, its innate characteristics. More than we realise depends on the establishment between parent or some other adult and the child and boy of a judiciously frank relation, completely non-repressive in character. It is of immense advantage to a boy, especially when home life is ceasing to hold, to have someone to whom he can turn as an equal, who has knowledge and experience in human values. One chief aim of the parent and the teacher should be to establish a feeling of comradeship which is produced by lifting the boy as soon as possible to one's level, at which level helpful discussion of difficulties becomes practicable.

The giving of information in any form which encourages introspection and morbid brooding is bad. Under the influence of parental example, of healthy physical habits formed in early life, of outdoor games, of interest in athletic achievements, and of a chivalrous outlook, one can look forward with confidence to a normal adolescence, a continent and chaste bachelorhood, and to

## SOME ASPECTS OF SOCIAL HYGIENE

*Sir Arthur Newsholme, K.C.B., M.D.*

the abolition of fornication which is one of the chief enemies of civilisation.

### DISCUSSION.

*Professor Winifred Cullis:* The National Council has always urged the importance of the educational side in its campaign against venereal disease. Some aspects of its educational work are the education of the general public as to the seriousness of these diseases and the ravages produced by them, the formation of a sound public opinion without which legislation in such matters would be useless, and even the provision of facilities for treatment robbed of much of its value, and education as to the necessity for women to take their share in all the measures taken to combat these diseases. In this latter aspect a magnificent lead was given by the two women Dr. Mary Scharlieb and Mrs. Creighton who sat on the Commission and whose high motives in doing so could not be called in question.

But the form of education that will be of most avail will be one which will prevent these diseases altogether by the development of a standard of conduct and an attitude of mind that would prevent actions leading to them. This will necessitate amongst other things training in self-control in very early years, which in turn demands self-control in those in charge of children. Spread of schools for mothers, infant welfare centres, courses of lectures on the care of the child all are helping to a realisation of the value of habits of self-control even in the infant.

But an aspect of fundamental importance in this educational campaign is one which though at first sight may be considered as only remotely bearing upon, but which has an intimate connection, and that is a spread of biological knowledge. The teaching of biology in our schools lags sadly behind even in those which have developed excellent science departments and good teaching in physics and chemistry, and the recent action of the General Medical Council in separating biology from physics and chemistry in the pre-medical examination will, it is feared, have an unfavourable effect on the development of this biological teaching. It is a subject which, taken either in its more general aspect or in its more specialised one of physiology, has a great appeal and may be made the vehicle for the teaching of the responsibility of the individual and of the community towards the achievement of public health, and is of great importance in this particular campaign. When the public demands the teaching of biology as an integral part of the curriculum of all schools, elementary and secondary, it will be put there, but not before. Also biology, and arising from it sex hygiene, should be taught in every training college. The Board of Education has shown itself most willing to co-operate in the provision of this teaching, and it only remains for public opinion to demand that it shall be compulsory for all those who are going to take over the charge of the children of the nation to have this knowledge, not necessarily for teaching it but as a part of their

## SOCIAL HYGIENE

own educational equipment. The actual teaching will probably always be best dealt with by those who specialised in biological subjects and who have a special aptitude for this particular teaching.

But the general public can help greatly in this work of the Council by urging the introduction of adequate and suitable biological and sociological teaching into all the educational institutions of the country.

*Miss Alison Neilans (Association for Moral and Social Hygiene) :*  
There is really only one point that I want to bring before you this afternoon. It is that, as the result of nearly eleven years study of prostitution I, at any rate, have come to the conclusion, and many who have worked with me have moved far towards the same conclusion, that we can do very little on this subject by law or police, and that if we put our hopes on suppressing vice by compulsion, we are not going to get very far. Every speaker this afternoon has referred to public opinion and it seems to me that the really one important thing in this problem is to change public opinion. But how is this to be done? I hesitate to speak on this very definitely, because it is easy to give the impression that one is really carrying on a sort of sex war and chiefly anxious to stress the feminist attitude. I am very anxious not to do that. One result of my own work has been that I have come to the conclusion that in dealing with sex matters it is almost impossible to judge another person in regard to them, and it is best not to judge at all, and therefore in anything I may say I am not presuming to judge any other person. The difficulty about public opinion is that when we get together in groups like this we all more or less say the same thing, and we get into the habit of thinking that public opinion as expressed here is the opinion of the world in general, and it is not. Really, the public opinion, broadly speaking, of the world in general in regard to prostitution, is that it is inevitable; and that is what we have got to fight. If public opinion were the same as the opinion expressed at these meetings we should have little difficulty. I want to put it in this way—we do not altogether realise in this problem how much public expectation does count, although we realise it in other things. If any of us is working with a man or a woman who thinks one a fool, doesn't one do just the silly things one wants to avoid? And when one works with somebody who has a high opinion of one's ability and organising powers, one naturally rises up to the level expected. We know something to-day of the psychology of suggestion. Look at this Exhibition and its advertisements! The trouble with our public opinion is that outside these Conferences public opinion is *expecting* prostitution, and that is the thing we have to fight. It is no good passing laws to persecute prostitutes because they are immoral, or to lock up men because they say "good evening" to a woman in the streets. What we have got to get people to accept is the fundamental idea that prostitution is a dirty, bad habit and thoroughly bad form, and unsocial and

## SOME ASPECTS OF SOCIAL HYGIENE : DISCUSSION

cruel. It is more effective to get people to think of it as bad form than as wicked, as wicked things are extraordinarily attractive; you can do more by branding it as low-down bad form.

There are one or two lines I want to suggest to change public opinion. First of all to challenge everything that is based on the double standard of morals. If women are to be chaste, and if a great number of men are not expected to be so, then we must have a class of women to meet the irregularities of that class of men. That means prostitution. Directly you admit that the double standard is wrong you get a reduction in this sort of thing. By challenge I don't mean expressing pious opinions that you hope that men will be moral but, when you come up against any law or custom which upholds the double standard, to challenge it there and then; that will do more to drive home the single standard than anything else. It is that which has made the change in public opinion so far. Read Fielding's "Tom Jones," and see the enormous change in public opinion in the last fifty years or so; it was the challenge by women to the prevailing moral standards that brought it about. We have to-day this extraordinary and encouraging spectacle of a rising moral standard amongst men, and yet we are all going about, off the platform, thinking it impossible to expect long-continued self-control from men. We shall help it to come about by expecting it.

Secondly, when you challenge the double standard, do not harshly condemn people who do not act up to your ideal. We have made women chaste by the pressure of public opinion, but we have also made the prostitute by the obloquy cast on the woman who falls. Do not let us do this to men; let us be merciful not to women only but also to men. Thirdly, there is the need for a re-statement of the basis of sex morals. Now, at quite a number of meetings one would think that the only argument for morality is that you might get venereal disease if you were not moral. That is not a real argument for morality. That kind of argument makes people selfish, not moral. If you have the fear of exposure, it merely makes you deceitful, not moral. I am anxious that you and I who are working for this cause, should sit down and try and work out how to present our case for good morals on an intelligible and simpler basis. It is not because we might get venereal disease; there are other reasons for good citizenship than the reasons we generally give, and I believe these are very much based on social and biological considerations. But what I do lay emphasis on is this: Do not meet this generation, which, like all generations is showing contempt for authority—this generation more than others because of the war—do not let us meet the demands of the young men and women of to-day with mere prohibitions and Mrs. Grundy. Let us see how to re-state the basis of the sex ethic, so that the question "Why should I be moral?" can be answered in a way which will appeal to the intelligence, to the loyalty, and to the spirituality of our young people.

*Dr. F. J. H. Coultts (Ministry of Health): It was not my intention*

## SOCIAL HYGIENE

to have intervened in the discussion this afternoon, but the Chairman was kind enough to wish me to say a few words. I fear I have nothing new to say, but I should like to emphasise one or two points already made in the discussion this afternoon.

I was interested in what Dr. Winifred Cullis said about the teaching of biology to children. I am a great believer in it; in fact, I do not think it is fair to allow a boy or girl to grow up to adolescence without teaching them what is surely one of the most important elements in education, that is a knowledge of the physiological and anatomical concerns of the human body, and their bearing on the health and welfare of the individual and of the community. I think the teaching of biology is a most important matter. The more one deals with public matters, the more, I think, one realises the importance of education. It has already been said that you cannot legislate or advance beyond public opinion and it is necessary to educate public opinion. I think that the experience of several nations has shown what an enormous variation in the psychology of the community or in the attitude of the nation to certain matters can be made by organised, systematic attempts at education. I believe that the system in Japan called "Bushido" was very largely developed by attention to the education of the young, and I think there is much room in this country for the organised teaching of patriotism, and by the organised teaching of patriotism I do not mean merely the glorification of our own country but organised teaching of the individual's responsibility to the community. If our whole education had the object of letting every person feel—or had the tendency to make people feel—that they are members of a community, that they derive advantages from that community and have a responsibility to it, we should have a different outlook on social questions and a great many of our difficulties would be done away with in a generation. If we once cultivate that social consciousness that the individual is responsible to the community, and that his actions have an effect upon it, he will carefully avoid any anti-social action.

*Mrs. Falconer (American Social Hygiene Association):* I am very sorry that our General Secretary, Dr. William Snow, could not himself be here, especially in view of his active interest in the work which Dame Rachel Crowdy mentioned. He was in England a few weeks ago but was obliged to return to America. I am very glad, however, to be here to represent the American Social Hygiene Association and to listen to the discussions at this conference. I quite agree with what Sir Arthur Newsholme said, that the fear of infection alone is not going to get us anywhere, and I speak as one who has had years of experience in running an institution, of which I am Superintendent, where we had 600 girls who were committed by the Court, and about 500 more out on parole. What was the source of supply? What was the matter with Pennsylvania, with the church, with the schools, and with the home that these girls needed to come to us? I congratulate you that in your country, as mentioned this morning, you have made it incumbent

## SOME ASPECTS OF SOCIAL HYGIENE: DISCUSSION,

in your medical schools to train and teach your future doctors. Will you not go a step further and influence your theological schools in the training of future ministers, because they have a wonderful opportunity of leadership and of coming into close contact with families?

It was my privilege some years ago to serve on the Vice-Commission of Philadelphia. Seventeen men and five women worked for a year, with many differences of opinion, but only one in the end, and we were ready to submit our Majority Report with only one dissent, and that was on the subject of the teaching of sex hygiene. People are so apt to say that of course it must be taught in the home, young people must learn that from their parents. That is true if they had intelligent and sympathetic parents. Then there would be no need for a good deal of the work, but until then you must go on, I think, educating communities. My work has been with those who have fallen. I do not agree with Miss Neilans. The fact that you can have such conferences as these and that men and women can discuss these matters frankly is, to me, a great gain in public opinion, and it would be a great shock to people in our country to learn to-day how much there was of venereal disease and how many men were unfit for service because of it—in every walk of life and in every State in the Union. We felt that the time for the conspiracy of silence was past and that we must get back to the causes rather than establish more rescue homes. So we are pushing our educational work. We want more education for marriage and that is one reason why we want to get the future ministers of religion, if not the present, interested in the preparation which we think ought to come for marriage, not alone for parenthood, not alone for the woman, but for the man too, and for the adjustments which have to be made for happy marriage. Professor Cullis touched upon the question of policewomen. We now have one of your women, Commandant Allen, who is visiting in our country, and we were very happy indeed to arrange for her to meet various groups both at dinners and luncheons. She has spoken at the League of Women Voters in Buffalo; she came and told us about the work which is of such interest to her—the work of the policewomen. Through the co-operation of the American Social Hygiene Association, the New York School has established courses of training and lectures to the women of the Women's Bureau of the Police Department because we believe that policewomen can be of very great help in looking after women and children in parks and other places of public amusement, and that policewomen when they are trained and when they are intelligent can do a very great deal.

We are doing a great deal to urge communities to ask about the right use of leisure time, and recommend the philosophy and creed of the Boy Scouts and the Girl Guides. Slowly a demand is being created in schools and colleges to have this subject of sex hygiene presented to them. Prejudice is breaking down and people are becoming more and more willing to discuss sex hygiene openly and to face facts.

## SOCIAL HYGIENE

What are we going to do to preserve home life? We feel it must be a matter of education and perhaps of legislative action. I do not quite agree with Miss Neilans, because there are those who are degraded and an immense number of the community themselves need protection. But let us have more organised recreation, more organisations of policewomen, more of all those things which come first, and then there will be less need for committing men or women to any kind of an institution.

*Mrs. Neville-Rolfe*: We want the outcome of this conference to be the formulation of a social hygiene programme for the British Empire. We have undertaken public enlightenment, treatment facilities have been provided, and progress has been made along those lines. We now want to broaden the whole basis of our advance and to give positive teaching as to the possibilities of educating the sex instinct along lines of control, to give positive teaching on scientific lines as to the advantages of a stable family life, and to apply the knowledge we now have as to the need of furnishing adequate counter-attractions to sex indulgence. We hope the result of this conference will be to outline this broader programme.

Opinion in this country and in the Empire will not only affect our rate of scientific and ethical progress in Great Britain and the British Empire, but it must inevitably react on international standards. The British Empire is so scattered throughout the world that its inhabitants come in contact with many and divergent peoples and have a special responsibility in forming international public opinion. We are therefore anxious during this Congress to arrive at a co-ordinated programme for the British Empire. We realise how different the problems are, for example, which face West Africa and our Eastern Colonies, but we feel that the principles which have been successfully applied in other parts of the world can be applied there, and it would be a real tragedy if Great Britain, which has taken such a prominent part in raising standards of conduct and in pressing, through the League of Nations, for measures to suppress vice and the traffic in women and children, should in any of her colonies take a retrograde step now, and suggest the re-introduction of any system of the regulation of prostitution; and yet there is a feeling among those who are responsible for the administration of certain colonies that it would be a good thing. We are convinced that such opinions are only due to a lack of facilities for following the experiences of other countries and other parts of the Empire. Therefore we look to this conference to give us an opportunity of exchanging experiences, to save us from the possibility of any part of the Empire going back to an old and retrograde system. We trust all parts of the Empire will combine in a united effort to secure the practical recognition of a high moral standard, which strengthened by the application of medical knowledge, adapted to the needs of the various peoples, should result in a rapid and lasting reduction in the incidence of V.D. throughout the world.



## SOME ASPECTS OF SOCIAL HYGIENE: DISCUSSION

*Dr. Scurfield:* There are only two points I want to make.

I wish to express my agreement with Miss Neilans when she said that in public opinion prostitution is inevitable; that is undoubtedly public opinion and that must be altered. Do all doctors teach that continence for men is consistent with good health? I ask you that because I think that we have got to get a stronger expression from the leaders of the medical profession on that subject.

The other point is that when I was a young man it was a common thing to say that it was all the better for a man to sow his "wild oats," and even quite nice women said that they liked men who were "fast," and who, in fact, were sowing their "wild oats." It may be different now, but that is another way in which public opinion requires to be educated, and if public education has not gone far enough to remove that abominable idea that a man must "sow his wild oats" before marriage, then I think that that is one of the ways in which we must get to work to alter public opinion.

*Sir Arthur Newsholme:* We are indebted to Miss Neilans for opening this discussion from a fresh and novel point of view, and for raising many points with which most of us are in agreement. But I cannot agree with her that there is no need for legislative action. In the evolution of civilisation the policeman preceded the schoolmaster, and I think we may say with perfect confidence that he has been one of the best of schoolmasters; at any rate, the scholastic work of the policeman must go along with the psychological work of the parent and teacher.

I am sorry that in the discussion which has taken place—which is obviously only preliminary—more stress has not been laid on the point that the best kind of education is that which is concerned with the development of right habits in young people and that we cannot get sexual morality by teaching biology alone. It must be in the main a question of the cultivation of character from earliest infancy until adolescence. The most important part of education is not the intellectual part, but the evolution of the individual until his instincts and emotions are brought into control and made subservient to a normal adolescent life. Papers bearing on these points will arise in the subsequent days' proceedings. I am sorry not to be able to call upon more members of the audience to contribute to the discussion this afternoon.

## Education.

*President of Section :*

The Right Hon. VISCOUNT ASTOR in the Chair.

The CHAIRMAN on opening the proceedings stated that of the many difficult problems which are before the world that of social hygiene occupies a foremost position. Ordinary disease can be admitted by individuals without any sense of shame—can be contracted without endangering family relations—can be publicly discussed without sense of embarrassment. With V.D. it is different.

The causes of immorality are diverse, varying from primitive animal instinct to the social environment and habits of our so-called civilisation with its industrialised and urbanised population.

Then too one of the most difficult tasks before parents, teachers and medical persons is the amount and nature of instruction which they can and should give on sexual matters to young persons reaching the age of adolescence.

Hard though it is to know exactly what to teach about sex, when to teach it and how to teach it, it is infinitely more difficult obviously when one has to go beyond the questions of mere sex relations and consider the imparting of any instruction on V.D. to the young. Personally I feel strongly that as it is amazingly difficult for the young to visualise what disease of any sort really means, on the whole the less they know about sexual promiscuity and venereal disease the better. After 18, young men and women—on the threshold of adult life—should probably be taught more definitely about the physiology and pathology of sex. But here again it is easy to go too far.

As regards medical students I should say (but I speak only as a layman) that students should be taught more fully the physiology and pathology of V.D. and that there should be more post-graduate education in these matters in order that doctors in practice should learn the newer methods of treatment.

Lastly comes what we call "the public." Every recent official inquiry is agreed that education is vital for the reduction and elimination of this problem. The public should be warned of the personal and national dangers of V.D. and of immorality—of the pain, suffering, death and infinitude of social unhappiness and misery—of the cost to the State in money, of the loss of capacity and of life itself.

Now when we consider the public and the world, let us frankly recognise that we are too apt to feel that we must explain and defend the forces and customs of the day rather than that we should boldly try to alter them. Let us drop our too prevalent

## • EDUCATION

spirit of complacent pessimism about human nature. The world as it is may not be as bad as the world as it was, but it is assuredly not as good as the world as it might be but isn't yet. In the eternal conflict between what we call good and evil, do not let us so readily admit evil into a position of prominence and permanence.

Then take another aspect. Without a high spiritual and moral sense man must approximate to the animal. I believe that one reason why the Anglo-Saxon race occupies such a leading world position to-day is because it has refused to look on man as being of necessity a lustful animal, because it has (not yet with sufficient success I grant) led the way in developing the idea of a single moral standard for the sexes and that this single standard should be a high one.

The position given to woman and demanded by her in a country is to my mind a fairly accurate index to the outlook and spiritual development of any nation. British girls during the war showed comradeship, courage, endurance, initiative, without loss of modesty or position. There was probably less sex appeal in the close daily intimate contact of the sexes overseas during the war than is often the case now at home in the aloofness or segregation of peace conditions. Men and women have hitherto been too reconciled to a comparatively low male moral standard, to the sowing of wild oats, to the young men about town. If mothers of daughters and fathers of sons were not so ready to defend the tradition that "boys must be boys" then boys would still be boys, but they would be cleaner boys.

Go into the countryside now in May—see the lambs frisking, the birds singing and ask yourselves whether in our large cities we give to our children, to our adolescents, to our young men and women an adequacy of recreational facilities. At all times idleness and curiosity have tempted the young (and the old) to go to hell to try and discover what was there. Open spaces, organised games, clean theatres and cinemas, interesting literature, proper facilities for companionship of the sexes are essential to a high moral tone, but are woefully deficient.

But finally don't let us deceive ourselves. This is an age of challenge. There is probably not an institution or convention which is not being challenged and challenged searchingly by the young. On our ability to give intelligent answers and logical reasons as well as on the fundamental spiritual and religious outlook which we succeed in imparting to the rising generation, will depend much of that family and social stability on which the progress of a people so largely depends.

## SOCIAL HYGIENE

### THE PSYCHOLOGY OF ADOLESCENCE.

By SIR FREDERICK MOTT, K.B.E., F.R.S., M.D., LL.D.

THE period of childhood which precedes puberty and lasts about three years is one in which growth, both physical and mental, is slower than at any time until near complete maturity. The child has reached a point of stability and of almost complete adaptation to its environment. The dawn to the full development of the function of reproduction occupies four to five years, and during this period and coincident with the formation of the secondary bodily sexual characters there is a complete mental revolution peculiar to each sex.

A new and potent source of psycho-physical energy comes into being; consequently circumstances and influences which promote or antagonise the normal evolution of pubertal development will exert a profound influence on the mind, the effects of which will leave a lasting impress upon the conduct and character of the individual.

The period of adolescence has been the inspiration of the poet, the dramatist and the novelist. An investigation of Shakespeare's characters has shown that he centred his attention on this period of life, and that his adolescents are by far the most interesting of his characters. Undoubtedly men delighted Shakespeare, and women also, but as Mr. Gosse says, the chief problems of life seem "to lurk for Shakespeare in the souls and lives of men, and therefore he was more profoundly interested in the natures of men than in those of women. Shakespeare's men have a history, a moral growth or moral decay; his women act and are acted upon, but seldom grow and are transformed." We get from Shakespeare no histories of a woman's soul like that given by George Eliot in the history of Romola, or of Maggie Tulliver ("Mill on the Floss"). The diary of Marie Bashkirtscheff throws a flood of light on the development of character in adolescence. In some of the novels of Hardy the psychology of the central female characters is extraordinarily well-developed, especially in relation to the sexual instinct, e.g. "Tess," in which is depicted a conflict between the sexual and moral instincts. Her tragic downfall is brought about by conditions and circumstances over which she had no control overweighing the balance. Again, in Flaubert's "Madame Bovary," the Abbé Prevost's "Manon Lescaut," and in the Sidonia of Daudet's novel "Fromont Junior and Rissler Senior," is graphically described a type of adolescent women of humble origin failing to realise their true position in life, but possessed of unbounded egoism, vanity and craving for social position, which, united with feminine charms and a sensuous sexuality, enabled them to captivate the hearts of men. Each of these women from early adolescence onwards is depicted by the authors of these novels in such a realistic way that it can only be surmised that in their fundamental characters these authors were describing their mistresses. Guy de Maupassant in the preface to "Manon Lescaut" contrasts these types of adolescent women:—

## THE PSYCHOLOGY OF ADOLESCENCE

Sir Frederick Mott, K.B.E., F.R.S., M.D., LL.D.

"The youthful Juliet, the young girl in whose bosom love awakens, love already burning, chaste still, which bruises and kills. Then there is Virginia, more candid, more naive, divinely pure, in the green island yonder, she dreams, she weeps. She never evokes any sexual desire. She is virgin and martyr of poetic love. Then here is Manon Lescaut, more truly feminine than all the others, frankly rouée, perfidious, loving, distracting, spirituelle." In this figure the Abbé Prevost seems to have embodied all that is most pleasing, the most tempting, of the creature woman. Her young lover, Des Grieux, as soon as he met this irresistible girl, became without knowing it, without understanding why, by the simple contagion of a feminine soul, a cheat, a blackguard, a conscienceless partner of a conscienceless woman, sincere in her deception and frank in her infamy.

Having thus called attention to some of the great dramas and novels dealing with adolescence, I will pass on to a consideration of some of the psycho-physiological points in connection with the period of adolescence. Undoubtedly motives and conduct originate in the early periods of puberty from a biological source connected with the evolution of the primal instinct of reproduction. The bio-chemical stimuli originating in the sex organs not only stimulate and energise all the cells and tissues of the body, affecting especially the endocrine glands directly or indirectly through the autonomic nervous system, but they also arouse in the brain the inborn tendencies and dispositions peculiar to each sex and their mutual attraction for the supreme biological end of reproduction and the preservation of the species.

The evolution of the sex instinct in relation to human character and its biological foundation is of interest and will next be considered. At puberty the mentality of the boy and girl at first presents no very notable difference, but soon a vague mental disturbance of which they do not know the cause arrives, and with it an awareness that something new has entered into their lives. Ideas and desires, at first indefinite, are experienced, leading to impulses and aspirations of which they are unable to appreciate the cause, and many impressions which previously only interested the perceptual and ideational faculties are now associated with vaso-motor and visceral disturbances, e.g. blushing, respiratory changes (such as sighing) and conscious alteration of the normal action of the heart. A biological phase of sexual evolution common to men and animals is shown by a desire for display, in the nature of self-adornment, love of jewels, ornaments, and dress, especially in girls. This is the dawn of the sentiments of pride and vanity. In boys pride of adornment is shown by the desire of wearing military uniform or any other dress suggestive of combat or prowess in sport; combined with this desire for display is a love of praise and of being noticed by others. Self-assertiveness or self-abasement in the presence of the opposite sex, and an *amour propre* or self-regarding sentiment, which is easily wounded and followed by

## SOCIAL HYGIENE

resentment, is observable. Jealousy is a sentiment which arises in adolescence ; it is as Eliot, in his very interesting work on " Human Character," says, one of the most important motive forces in the development of human character. Novelists, dramatists and poets have depicted love turned to jealousy, and the involuntary emotive response to love turned to those of hate and revenge, although the outward voluntary expression of this passion by voluntary word or action may be repressed. But the mute involuntary expression of love's tender spring cannot be simulated when carry-tale dissentious jealousy is in possession of the involuntary emotional mechanism. This is depicted by Shakespeare in " Venus and Adonis " :—

" This sour informer, this bate breeding spy,  
This canker that eats up love's tender spring,  
This carry-tale dissentious jealousy  
That sometimes true news, sometimes false doth bring."

Jealousy may occur before adolescence by the boy for his mother's love and by the girl for the father's ; it may arise even in early childhood. I do not, however, accept all the fantastic statements of the Freudian School regarding this biological fact. Again, it must not be supposed that jealousy is concerned only with the love instinct. This passion may arise from a wounding of the egoistic or social instinct.

At puberty or in adolescence a loosening of the ties of old affections may gradually arise. The change in conduct and character which occurs in consequence is ill understood. The adolescent often feels, he knows not why, that parental and family affections are insufficient, and there is a need of the affections of others which, not knowing how to seek and obtain, causes brooding and depression. He may thus become uncommunicative to the family, even about daily affairs, and develop a " shut in " personality, which should be a signal to the friends that all was not well in the mental evolution of the youth or maid. It may be indeed the precursor of insanity or suicide. Such a change of character has its roots in the instinctive desire found in animals to shift for themselves and find a mate. The biological sexual instinct of attraction to the opposite sex, if unsatisfied, often causes young people, and in particular girls, to devote themselves to religious observances, mysticism, or fanaticism, or the urge of the sex instinct may be sublimated along more healthy lines of intellectual or æsthetic culture, industrial occupations, or outdoor sports, which are to be desired and encouraged. Parents are not sufficiently aware of these psycho-physiological facts and their biological significance.

At puberty fancy is awakened and fantastic ideas and daydreams arise in which the youth desires to play a romantic rôle of captor or hero, while the girl has thoughts in which she imagines herself the object of the desires of a prince *charmant*. This romantic building of castles in the air is an exaggerated expression of the sentiment of love, and its instinctive sexual source in the sub-

## THE PSYCHOLOGY OF ADOLESCENCE

*Sir Frederick Mott, K.B.E., F.R.S., M.D., LL.D.*

conscious mind is revealed by dreams. This is a critical period of the evolution of the mind; for sooner or later there may be such an exaggeration or regression to these daydreams and fantastic imaginings as to dominate the mental personality, giving rise to hallucinations and delusions, which owing to a functional failure of the highest evolutionary level of control, leads to brooding melancholic introversion, apathy and emotional indifference, or to outbursts of irrational and impulsive disorders of conduct. The moral sense of the normal adolescent controls the sex instinct, but there are many preventable causes whereby this control may be weakened or destroyed, e.g. auto-eroticism may arise in consequence of anatomical or pathological conditions of the genital organs, causing a local irritation which, leading to their manipulation, arouses a sexual excitation and a pleasurable feeling. Onanistic habits may thus be accidentally acquired. Again, the moral sense may be despoiled by the bad influence of suggestion, or imitation of others. Sexual pleasures having once been tasted, young people of both sexes, but more particularly the male may abandon themselves without shame and without restraint to onanistic practices, or even sexual perversion. Sexual desire in the uncontaminated youth is at first obscure, consisting of vague longings without fixation upon a particular object. Sooner or later, however, in the evolution of normal adolescence, the desired object arrives and the sexual impulse materialises and bursts forth in a flood of passion. There is a linking up of the old primitive instinctive and involuntary nervous systems with the conscious voluntary system peculiar to each sex. This is well exemplified in the following lines of Cowper's translation of Milton's "May Day," written by the poet in 1628, when he was nineteen.

"Then it was that Cupid drew his bow at a venture and smote the unsuspecting youth and pierced his unguarded heart."

"(with . . . quiver at his side)

Now to her lips he clung, her eyelids now,  
Then settled on her cheeks, or on her brow,  
And with a thousand wounds from every part  
Pierced and transfixed my undefended heart.  
A fever, new to me, of fierce desire,  
Now seized my soul, and I was all on fire."

This spontaneous welling up from the unconscious of the love instinct is picturesquely described by Stacpoole in "The Blue Lagoon."

"A marriage according to nature. So happy in their ignorance were they, that they only knew that suddenly their life had changed, that the skies and the seas were bluer, and that they had become in some magical way one a part of the other. Dick had lost his restlessness, his wish to wander had vanished. He had no reason to wander; perhaps that was the reason why. In all the wide world he could not have found anything more desirable than what he did. He would look at her for a long

## SOCIAL HYGIENE

time absorbed in thought, admiring her. He breathed her as one does the perfume of a rose. Dick had suddenly stumbled upon her. His courtship had lasted only some twenty minutes; it was being gone over again and extended."

The first effect upon the imagination of the youth of the woman he first falls in love with is that she is something divine and an object to be adored. "Not my five wits nor my five senses can dissuade one foolish heart from serving thee." Things which belong to her may even be sacred and constitute for him true fetishes, whilst in her actual presence he may be timid and abashed.

The maiden is more at ease with boys in the early period of pubertal development, and her early aspirations are that she should be admired and preferred. The desire to be loved and cherished comes later. In the second stage of adolescence the essential differences which characterise the two sexes are more clearly manifested.

All the differences of character dependent upon racial and familial ancestry now begin to show themselves in the conduct of the individual.

The crisis of adolescence is expressed in the involuntary emotional system by vaso-motor disturbances such as blushing, alterations of respiration such as sighing, and conscious increase or slowing of the heart's action, when meeting the opposite sex. Conscious impressions connected with the opposite sex arouse new and more elevated feelings in a youth, resulting in an egoism that regards at first serenely all obstacles to the pursuit of his dreams of ambitions and desires. Frustration disturbs his peace of mind and may make him recalcitrant and cause him to regard all limitations to his liberty as insupportable. As the normal sex instinct of adolescent youth matures, an increase of psycho-physical energy is displayed by boldness in desires and thoughts and courage in actions.

The sentiments peculiar to the individual personality may now commence clearly and forcibly to assert themselves, not infrequently by opposition to parental obedience, familial and social usages, customs and traditions, and tutelary authority. Reproaches are not readily tolerated, and irregularities of conduct which occur as much in the well-to-do as in the poorer classes are not infrequent. By virtue of better nutrition in the well-to-do classes, the sexual instinct develops earlier and behaviouristic delinquencies consequently may occur at an earlier age. The mind of the adolescent has not yet crystallised the dogmas, traditions and customs of the herd; in consequence he may be a potential reformer able to strike out with new ideas and ideals. In the great majority of cases, and almost universally in the field of art, inborn greatness is clearly foreshadowed before the twenties; an exceptional case is that of music, and to a less degree mathematics, where evidence of unusual ability generally appears before puberty.

### THE DEVELOPMENT OF ADOLESCENCE IN THE MALE.

The psycho-physical energy of the sex impulse (*libido*) is manifested by an elated feeling of the personality. This is well expressed by Shakespeare when Romeo says:—



## THE PSYCHOLOGY OF ADOLESCENCE

*Sir Frederick Mott, K.B.E., F.R.S., M.D., LL.D.*

"My bosom's lord sits tightly on his throne, and all day long an unaccustomed spirit lifts me above the ground with cheerful thought." This elation renders a young man sensitive to flattery and very susceptible to suggestion by the conduct of others, which excites his admiration and stimulates him to action. Moreover, the *libido* arouses in him aspirations for a new life, and he may become thus the subject of numerous ambitious projects. Their fruition coming to naught, he readily passes from elated confidence to discouragement, and a natural healthy sublimation of the sexual urge may be transmuted into hypochondriacal mental preoccupations connected with the sex instinct; perversions, mysticism, eccentric conduct, or a spurious form of socialism may result. It may be truly said that an unforeseen psychic state may arise at this period of life, for the individual receives from the unconscious sphere impulses that reflexion and judgment have not yet acquired the capacity to control and regulate. At first there is often an abyss between his aspirations and their realisation, between what he desires and proposes, and his powers of accomplishment, and his hopes are often later dashed by disillusionment. In the development of character some people do not advance beyond this stage, and remain permanently unable to grasp the realities of life. The normal individual as a result of his experiences and his aptitudes gradually develops his virtues and his vices, and the differences of types due to the multiform inborn racial and ancestral dispositions become more and more clearly pronounced and accentuated. We may take as examples of racial dispositions Hamlet, the philosophical intellectual man of meditation, but lacking will power and resolution, and Romeo, the man of passion. Gosse, in his "Heart and Mind of Shakespeare," contrasts these two forms, the Romeo form and the Hamlet form, abandonment to passion and abandonment to brooding thought, two diseases of youth, each fatal in its own way. "Hamlet is steeped in meditation, and we may contrast the hero of the one play, the man of the south, with the chief figure of the other, the man of the north. Contrast Hamlet's friend and comforter, Horatio, possessed of great strength, self-government, and balance of character, with Romeo's friend, Mercutio, of brilliant intellect; wit, and effervescent animal spirits. Contrast the perfect love of Juliet and her Romeo with the piteous foiled desire for love in Hamlet and Ophelia. Contrast the passionate seizure upon death as her immediate and highest need of the Italian wife, with the misadventure of the crazed Ophelia, so pitiful, so accidental, so unheroic, ending in muddy death." Yet with all these points of contrast due to race, there is, Mr. Gosse affirms, one central point of affinity between the plays. Hamlet resembles Romeo in his inability to maintain the will and the fruitful relation with facts and with the real world. Neither were able to grasp and control realities. Luck is for ever against Romeo, the stars are inauspicious to him, and to such men the stars will always be inauspicious. As for Henry V, they will always prove auxiliary, because he was able to see and control realities.

## SOCIAL HYGIENE

We see here the influence of race upon the development of adolescence clearly portrayed. In "Romeo and Juliet" not only the substance but the forms of the language come from the south. Italy was the inventor of the tale; she drew it from her national memorials, her old family feuds, her annals filled with amorous and bloody intrigues. In its accent, its blindness of passion, its blossoming and abundant vitality, in the brilliant imagery, in the bold composition, no one can fail to recognise Italy. Contrast the character of both of these with Henry V., *the man of action*, who in his youth sowed his wild oats and preferred the wisdom and folly, the humorous wit and coarse vulgarity, the good nature and vices of Falstaff to the intrigues, flattery, hypocrisy, and vices of the Court. He saw the realities of life. So that when he came to the throne he was able to grasp and control them, become a king to his people, and consolidate his throne by marriage with a French princess.

### THE DEVELOPMENT OF ADOLESCENCE IN THE FEMALE.

In the female the course of development of adolescence presents notable differences to the male. Although she may be as sensitive as the male to impulses arising from the sex instinct, they exercise less effect on the intellectual side of her nature, but more on the affective, and motor reaction is inhibited rather than excited. Such is in accordance with the passive rôle of the female in the operation of the sex instinct. Whilst the adolescent male reveals his sexual tendencies to action by what he does, the adolescent female seeks to make obvious what she is.

The differences between the nature of young women and young men reveals itself in their delinquencies, and a comparison of causes of punishment in reformatory schools show that boys and youths are punished more frequently for active faults, quarrels and theft, or attempted theft, whilst girls are more often punished on account of passive or negative delinquencies, such as laziness, negligence, or faults of propriety. There is one active fault which occurs in both males and females, and that is lying.

The passiveness of the adolescent female is only apparent; it is the passivity of the magnet in its apparent immobility which attracts the iron which approaches it. The sex instinct of the female is in two forms, viz:—

- (1) Amiability, which in an exaggerated form is coquetry; by this means she makes herself more noticed by men, and attracts them.
- (2) Modesty, by which she ensures courtship.

Whilst the young man tends to rid himself of his rival by force, the young woman seeks to eclipse her rival by attractiveness. All that can serve to satisfy this disposition of making herself attractive is a natural feminine characteristic, and that is why in the most humble to the most elevated conditions of life at all times and among all peoples, young women do not recoil before any means, and will submit to any form of physical discomfort or suffering to increase

## THE PSYCHOLOGY OF ADOLESCENCE

*Sir Frederick Mott, K.B.E., F.R.S., M.D., LL.D.*

their attractiveness or supposed attractiveness. She pinches her feet in tight shoes, wears short dresses and thin stockings in winter, pierces the ears, and even the lips and nose in order to attach ornaments, and she brings to her aid besides jewels, ornaments and physical attractions, emotional reactions which make her more interesting and attractive.

Her emotivity, revealed by her blushes, her tears, her cries, rapid transition from joy to grief, all provide her with powerful means of enlisting sympathy. Either the air of timidity or of caprice may be practised in a refined way to attract the attention of the opposite sex. The young woman has a keener intuition of danger and quicker perception than the youth. She trusts more to these qualities than reason. She is more open to suggestion. Her sympathy is stronger; her altruism is more disinterested. Her love more readily develops into devotion. The desire of the young woman to feel herself in harmony with society is more imperative than in the youth who loves to fight and brave it through.

She desires admiration, and in her deportment, in her dress, in her work, in her amusements, never forgets to consider the effect she will produce upon others who are looking on, even her own sex.

Another mental characteristic of female disposition is modesty, which is represented by shame in the moral order, and by virginity in the physical. It is by these two innate moral qualities that courtship is ensured, and the maternal mission of begetting children by a man who will share with her the responsibilities of caring for them is thus effected.

The amiability and attractiveness of woman has served to favour the primal instinct of propagation, her modesty has served to assure it. The development of the disposition of modesty of the female, and the conditions which favour it, has been a great factor in sexual selection, in social evolution, and the progress of civilisation. The weakening of this instinctive female disposition of modesty and of the maternal instinct is of national importance at the present time.

The tender emotion connected with the maternal instinct, so beautifully and divinely symbolised by the Madonna and Child, owing to the progressive development in all grades of society of the self-regarding sentiment is greatly weakened. This is shown by promiscuous sexual intercourse and spread of venereal disease, late marriages, and the universal practice, except among the poorer Roman Catholic population, of contraceptive methods, one obvious remedy for which is the encouragement of early marriage of people healthy in mind and body endowed with the three attributes of civic worth obtainable in all grades of society, viz. courage, honesty and commonsense. This can be effected by all such being able to obtain a living wage and a decent home to live in, whereby a contented healthy couple can bring up a healthy and contented family.

### THE SOCIAL INSTINCT.

The three primal instincts common to men and animals, of

## SOCIAL HYGIENE

self-preservation, propagation, and the instinct of the herd, are the springs from which the streams and rivers of mental activity have their source. The bond of union of the herd is based upon the willingness of each member to sacrifice self-interest and even life for the common good, and by thus doing directly to ensure the preservation of the species and indirectly that of the individual. The herd instinct has played a most important part in peace and war, in fact the history of nations has depended upon it. This gregarious instinct has been the great stabilising force in the fixation of traditions, customs, and social usages of successive civilisations in the world's history. "Thou art a blessed fellow to think as all men think ; never a mind in the world keeps the roadway better than thine " (Prince Henry to Poins).

Patriotism, morale, and discipline have their roots in this instinct, yet every successive age has shown that progress in religions, ethics, the arts and sciences has originated in men and women with such a strong belief in their individual mentality that they were willing to court death, torture, or exile in their endeavour to overthrow traditional dogma and superstition, or to incur disapprobation by not conforming to the customs and social usages of the herd. Patriots, preachers, prophets, philosophers, artists, and scientists have in all ages and all civilisations, at one time or another, been regarded by the herd either as bad men or mad men, when, inspired by imagination and courage of conviction they have refused to admit the accepted doctrines of the society in which they lived. What an inestimable benefit such men have conferred upon mankind ; for they have made the world's history and averted a petrified civilisation. A just balance between the influence of the independent, original and imaginative mind of the few, and the stabilising influence of the collective mind of the many is the secret of social progress. Mental hygiene should, then, be largely concerned in ensuring this just balance by encouraging all those factors and conditions in education which support morale, discipline, self-sacrifice, and *esprit de corps* in schools, in universities, in the Services, and in industries ; but it must be effected without repressing or destroying that independent imagination and originality in thought and purposive action which is essential for mental success or welfare. All games of skill in which the individual plays not for himself or herself but the side, such as cricket, hockey and football, foster the right spirit and tend to an establishment of a code of honour in which the *amour propre* is centred not in the individual but in the school or university. The same applies to the regiment or the ship, and the great value of *esprit de corps* and morale was strikingly shown in the retreat from Mons of the Expeditionary Force. Again it was shown by the fact that the proportion of cases of shell shock and war neurosis in great measure directly depended upon the morale, discipline and *esprit de corps* of the regiment. The stabilising force of the collective mind of a regiment with high morale was always operating against individual fear and preventing it from being contagious.

## EDUCATION AND SOCIAL HYGIENE.

By PROF. J. ARTHUR THOMSON, M.A., LL.D., Aberdeen University.

### I

THE problem is how education may help social hygiene, and what strikes one first is that the solution must be found by experiment. It cannot be thought out in any armchair, it must be put to the proof, and that takes time. But reflection and discussion may suggest lines of experiment and may indicate the probable pitfalls along various lines. There has already been some experimenting, but positive experimenting has been individual and sporadic, and the results have not been pooled. The biggest experiment has been "DOING NOTHING," and its results are not encouraging.

### II

What is wrong that we wish to help to put right? Many women live miserable and degraded lives as instruments of man's irregular sexual indulgence. Many men are abnormally sensual. There is much venereal disease. Numbers of both sexes sink into the captivity of bad sexual habits. In many fine types the disharmony of the sex-urge is very marked. Too many men remain in selfish nominal celibacy and in some countries too many women are left unmarried. The greater the numerical preponderance of women over men, the lower the standard of sex-selection tends to sink. Various social conditions operate against reasonably early marriage. The influences of family, society and religion that work towards clean living and high control have been weakened.

What we have just stated appear to be verifiable facts; the uncertainty is in regard to numbers. But when we pass to the psychological background, we are apt to find ourselves among unverified opinions. It is probable that "love" has suffered considerable materialisation; it is probable that the ideals of chastity, faithfulness, control and clean-mindedness have been weakened, and that men in particular, even in a country with our traditions, like pleasure more and enduring hardness less than their forefathers did. It is probable that the poetic chivalrous outlook has been not a little dimmed. But it is not easy to prove these statements.

It is difficult to arrange either the objective or the subjective evils in their proper order; and it is difficult to say when the bodily aspect of the organism leads and when the mental.

### III

In many simple peoples there are adolescent ceremonies and attempts at sex instruction for both sexes. It is not known whether these are beneficial or not; they occur in tribes with very different moral habits; in any case they are too remote from modern life to be of any service except as a hint that our contemporary ancestors have found the need of such measures. In modern civilised nationalities sex instruction has dwindled to a vanishing-point, except that there is generalised ethical education in many

## SOCIAL HYGIENE

families and schools, as well as in churches and in literature. The value of ethical education is recognised by all, but there are many wise people who do not favour direct sex instruction.

The arguments against direct sex instruction may be illustrated : it is difficult to instruct wisely ; parents are next to useless, and it is asking too much of ordinary school teachers to lay the responsibility on them ; the school physician, who, if willing, could probably do it best, has not always the educational sense ; there is great risk of anticipating organic interests and promptings ; it is better to let sleeping dogs lie, *if* they are sleeping.

The arguments in favour of some sex instruction may be illustrated : the experiment should get a fair trial, for we surely need to do something ; many young people stumble into bad habits through ignorance ; the ignoring of the subject leads them to get information all discoloured or it engenders morbid curiosity ; it is perilous to trust to "instinctive guidance," for sex promptings in man are blunt-pointed and generalised, they cannot be relied on when there is any difficulty in the path.

### IV

Using the wider word education instead of instruction, we may say that there are four lines that promise well.

(a) There is the plan of giving sound lessons in physiology—in a physiology that does not ignore the reproductive system and yet does not isolate sex. Let in light and face the facts. Speaking of jesting about sex, Sir William Bayliss writes : "I feel compelled to state my belief that much mischief is done by the habit of looking at anything related to sex as, in itself, a matter for jesting, apart from any real humour. Perhaps the excessive secrecy and reticence maintained on the question are much to blame, and there is no doubt that the wider teaching of a proper physiology in schools will have a good effect in this direction." This hygienic physiology would be confined to the older pupils, and it would be modified differentially by teachers of discretion. Thus it might not be always appropriate to go into details about sex hormones ; but it could never be inappropriate to explain, so far as we can, what is meant by a habit.

(b) Many teachers have recognised the value of biological nature study in clearing away the clouds that gather round sex. Without spoiling good botany and zoology, much may be done to let open air and sunshine into the whole subject of sex and reproduction. They can be studied in their natural and evolutionary setting, apart from any direct human and personal reference. As Thoreau wisely said : "For him to whom sex is impure, there are no flowers in Nature" ; and in birds, for instance, one can illustrate how love may transcend the sex urge.

(c) The attainment of wholesome adolescence may be aided by developing external interests, preoccupations, responsibilities and services ; by opening up paths of legitimate excitement—in music and pageant, drama and celebration ; by discipline in self-control and in enduring hardness. Above all, as Stanley Hall says, develop

## EDUCATION AND SOCIAL HYGIENE

Prof. J. Arthur Thomson, M.A., LL.D.

motor activities ; but, one must hasten to add, develop emotional activities as well. In our own generation the idea of the biological and psychological control of life is being seized and applied with a new hope and a new understanding. No one knows what may not be done in the way of influencing hereditary characters by appropriate nurture. Vigour or "fitness" is an ideal of normal youth—an ideal to be appealed to ; it may be nipped in the bud or it may be made to blossom. Of course, there is no use pretending that healthfulness will necessarily lessen the imperiousness of the sex urge, but it may help in its control and it will work strongly against its debasement.

(d) Finally there is the pre-occupation of the mind with things that are comely, noble, and of good report. It is the empty chamber that the devils enter. We must hitch our waggon to a star. We must link the sex-impulses, regarded as the physical basis of love, to the chivalrous, the poetic, and the romantic. It will not spoil school studies in history and biography that they should show what a powerful lever the noble love of man and woman has been in the world's history. It is a historical and biographical fact that "control and chastity make marriages happy and nations strong, while the *corruptio optimi* is already hell." Much may be done to crowd foul pictures out of our gallery.

### V.

These then are the four educational methods which commend themselves : more and better physiological hygiene, more and better nature study, a discipline in control, and a preoccupation with nobility. There is hope in all these four lines of education, and we must have them all. But the question rises whether we have not reversed the order of their power. We have tended to biologism. We have put physiology and nature study in the foreground—we can teach these more directly. But perhaps the most effective appeal is the most indirect ; perhaps we should begin with the mind, trying the expulsive power of new affections.

Let us indicate several reasons which suggest that we should trust as much to poetry as to physiology. (1) Clear ideas based on facts are always powerful ; as Hegel said, they have hands and feet. But much of our activity is swayed by emotion, and the culture of the emotions is a possibility. Children should be brought up in familiarity with noble lives, great deeds, wise sayings, beautiful pictures. (2) Repression leads to a disunion of life ; bodily disharmonies tend to split up the self ; hence the great value of any centralising idea or emotion, whether it be religious, or æsthetic, or social. Keep the heart with all diligence, for out of it are the issues of life. (3) Not necessarily, yet very often, the suggestions of physiological and biological studies are "don'ts." Don't become unhealthy, don't lose control, don't get disease, and so on. But from experience and from theory alike, we know that "don'ts" are apt to defeat themselves. The powerful lever is a *positive* ideal of health of body and mind, of living at a high level of thought, feeling and action.

## SOCIAL HYGIENE

Perhaps our position may seem reactionary, especially for a biologist. But in emphasising the need for more education of the inner life we do not cease advocating physiological and biological teaching. On the contrary we have a definite suggestion to make. The adolescence of many fine natures is like the coming of spring, but for many others it means stormy weather—and there is sometimes shipwreck. It seems congruent with our modern mood of letting in daylight, that those who wish it should have available all that well-established science has to say. We agree with Mr. Wells that it is very undesirable that “the cardinal thing in life” should “sneak in to us darkly and shamefully like a thief in the night.” We agree with Samuel Butler that there has been far too much reticence. “Get all,” he said, “the best opinion of our best medical men, and let us have it out.” But our point is that to this there should be added the best opinion of our best biologists, psychologists and moralists. Sex at its best is like religion at its best, a reaction of the whole organism—heart, hand and head. We distrust its treatment solely in terms of metabolism and hormones; we distrust its treatment solely in terms of the Freudian Unconscious; we distrust its treatment solely in terms of society and race. Our suggestion is that direct verbal sex instruction is so extremely difficult, that the National Council should undertake the preparation of a co-operatively produced book of guidance embodying all the wisdom we have from all sides, and readily available to all who wish it.

### VI.

As joint author, with Prof. Patrick Geddes, of “The Evolution of Sex,” published in 1889, I have made a long study of sex, especially from the biological side, and I may be allowed to submit for your consideration three general convictions.

(1) There is a time to embrace, we are told, but there is also a time to refrain from embracing; and both are normal parts of our life. Passion is often imperious, the reproductive hormones are powerful accelerators; but a steady brain is also part of the normal inheritance. It has not been proved that extreme variations in the reproductive endocrinal glands are very common. We do not share the view that sex is such a distinct and dominant factor in ordinary life as some specialists maintain. “Sex” is often made a scapegoat for empty heads, lazy selfishness and general lack of control. The organism is a unity, and the sex life is inextricably mixed up with the rest of our life. We should not tolerate its isolation—that is the way to disaster. Some people are born with a greater capacity for loving than for fondness, with others it is the other way. Others, again, inherit a sex strand that is peculiarly liable to kink or knot. But in all cases we should refrain from isolating or analysing apart the sex life, as if it were not an integral part of a unity, as if for instance it might be indulged without peril to the rest, or as if on the other hand it were not linked to the best that is in us. Our inheritance is more than a bundle of discrete factors (as even the extreme Mendelians now



## EDUCATION AND SOCIAL HYGIENE

*Prof. J. Arthur Thomson, M.A., LL.D.*

admit); it is an organism—a life. One of the safeguards is trying to refuse to allow the isolation of the sex life. We strongly suspect that some devotees of psycho-analysis are doing harm by bringing into every-day life and conversation a method appropriate to the laboratory and hospital. Ordinary people should be bigger than their endocrinal glands. It is man's prerogative to cultivate his personality—the integration of the organism.

(2) Much that is said about man's sex instincts seems very shaky. Among some humble creatures, such as insects, there are often very definite and complicated reproductive instincts in the true sense. They sweep their possessors through an intricate routine of courtship, mating and preparation for the young—often never seen. But man is at the opposite pole, for his reproductive and sexual promptings are very generalised. We have, in regard to sex functions, very little instinctive knowledge of what the various phenomena mean, or of what is normal or of what is to be carefully avoided. Thus, one may slide into bad habits without being at first well aware of what is happening, or, on the other hand, one may make oneself miserable without good reason. It follows that we cannot trust our so-called sex instincts; we must try to command our course. Hence the need of available advice, which in our opinion is in most cases to be got from a wise co-operative guide-book—not yet written. It does not seem to be contradictory to say, on the other hand, that it is not part of normal experience to have the deep under-currents forced to the surface; the ideal is that they should operate *through* the upper currents of controlled life. And are we not apt to forget the evolutionary aspect of *the unconscious*, that it represents a relegation of the anachronistic to the low zones of our life current?

(3) Those who see large numbers of young people to-day must be impressed with the wholesomeness of the great majority. Most of the exceptions are among those handicapped by a vitiated inheritance or by a blighting environment, or by a low-down tradition in the family circle. Perhaps the last factor is most within our hands for amelioration, and everything that helps towards thinking nobly of love is to the good. The deepest thing that is wrong with us is a materialisation of outlook. Love is the flower of which sex is the root, and what is most needed is a deeper appreciation of the flowers. Then we need not bother so much about the roots. The sublimation of fondness into love is the outstanding psycho-biological fact emerging from the study of the evolution of sex in the animal kingdom, and it is for man to continue the evolution on a higher turn of the spiral. Health and wealth are indispensables, but they are the pre-conditions of progress on higher levels, in the quest of the higher values. To have men free from venereal disease would mean an enormous increase of power and happiness to the nation, but it would only be a particulate progressive step if these men were more sex indulgent than ever, if the bulk of them were incapable of looking at a woman with eyes of clean admiration. A lifetime is not too

## SOCIAL HYGIENE

long, Comte said, for a man and a woman to get to know one another well and to learn to love one another worthily. That is the way of progress—a heightened tradition of loving. We do not mean that we should think of eugenics less; we mean that we should think of eupsychics more.

### VII

What practical suggestions have we to make? While there should be a continuance of education in hygienic physiology and in thinking biologically, there must be a change of tactics in various directions. The needs of the inner subjective life are to be recognised as supreme, though the needs of the body are fundamental. A positive ideal is much more potent than a negative prohibition. In proportion to the subtlety of the desired end should be the indirectness of the appeal. More inquiry should be made into the way in which young people regard sex; it is dangerous to be guided by the reminiscences of people over sixty. No teacher should ever be asked to do what one would not gladly do oneself. The percentage of parents who can be trusted with the education of their children, except by their daily walk and conversation, is negligible. Partial views of sex, however true, are likely to do as much harm as good. No one man or woman is competent to write a thoroughly satisfactory guide to the adolescent; the only hope is to extract it from a critical committee who care more for the race than for one another. In all modes of sex instruction care must be taken not to anticipate interest; not to excite; not to say what is untrue; not to teach what will have to be unlearned afterwards; not to make false mysteries, which a short stay at a farm might dispel; never to deal with the pathological or with sewers; not to frighten; not to pretend that men and women are angels; and above all, not to say too much.

### DISCUSSION.

*Mr. A. Reid (Natal Training College)* said that in Natal the problem of sexual hygiene is aggravated by peculiar local conditions.

- (1) The presence of an unsegregated native race, the Zulus, with morals lower than those constituting the European standard.
- (2) The presence of low caste Indian coolies who largely retain their national habits and ideals.
- (3) The presence of a medley of coloured people, some of whom succeed in maintaining a European standard of morals, but most of whom from economic circumstances are compelled to live socially low. These people live in close social contact with Europeans and by example set a degraded standard of character. They are largely employed as nurses for European children, and are utterly unhygienic in all their ways. And further, many native women especially in the towns and villages suffer from sexual disease and constitute a reservoir for the infection of Europeans—a reservoir which constantly leaks since

## EDUCATION : DISCUSSION

the problem of the treatment of native women at clinics and kraals seems utterly hopeless.

Other local conditions aggravating the problem are :—

- (1) The warm climate that accelerates the onset of puberty and intensifies desire, and the consequent wearing of scanty dress often of a suggestive kind.
- (2) The lack of houses that forces respectable parents to live congregated in boarding houses—a condition that leads to young people knowing little or nothing of home life, and having of necessity to find, for a somewhat abundant leisure, recreation in picture houses and the streets where the onset of darkness is rapid and early, there being no long twilight in summer.

But these social conditions are realised by public authorities, and a free V.D. clinic is attached to the Government hospitals, there are earnest and successful social workers, and the Education Department have drawn up syllabuses of hygiene instruction for the elementary schools and all teachers in the training college.

In my opinion further help and instruction might be secured in the following ways :—

- (1) By an earnest appeal to parents either to enlighten their children on sex problems, or to seek them to encourage their children to go where wisely-presented enlightenment might be obtained from doctors, the school medical officer, from nurses, and from such teachers and others who by personality and knowledge have the gift of commanding a respectful hearing, and classes should be small.
- (2) By the teaching of "biological nature study" in the elementary schools, and by the teaching of physiology, hygiene and biology in the adolescent classes.
- (3) By special lectures by competent persons (preferably doctors) to adolescents in evening schools, in bible-classes associated with churches, in factories, in workshops, etc.
- (4) By the provision of the best available literature, and by the frank, honest answering of questions put by those desiring to know the facts.

Finally, sex-teaching is a matter requiring handling of the most delicate kind and whilst care should be taken not to raise morbid fears in the sensitive and impressionable, it is desirable that the elements of happiness, wonder and mystery associated with healthy love and marriage should receive due emphasis.

*Mr. Z. F. Willis, M.A., Educational Secretary, Y.M.C.A.*, questioned the wisdom of formal group instruction in matters specifically relating to sex in the case of industrial adolescents. Experience had tended to show that the most effective results were often obtained when the teacher or social worker sought to give such guidance and instruction to individuals as the need and opportunity to do so might arise in the course of their general

## SOCIAL HYGIENE

contact. Such individual and incidental methods of approach had also been found successful with young adults, amongst whom dangerous ignorance existed. In very many cases information of the wrong kind was being obtained from undesirable and often merely commercialised sources under extremely unhealthy conditions. The inspiration of ideals and habits of service and responsibility was of the utmost importance, and much was to be gained by the provision of right opportunities for the mingling of the sexes in the activities of ordinary life.

In order to prepare them for their responsibilities in the matter of sex education, as many as possible of those who would occupy positions of close contact with the young should receive special training in social hygiene and psychology. Much might also be done by increased co-operation between those engaged in social and welfare work and members of the medical profession. One of the greatest needs was the provision of literature dealing with sex for the personal use of teachers and social workers, and suitable for recommendation by them to adolescents and adults.

The conception of life as a unity was a necessary basis of any adequate approach to the problem, and attempts to treat sex, as it were, in isolation tended to produce over emphasis, and an attitude to the normal too much influenced by experience of the abnormal. Sex instruction and sex education should be recognised as an integral part of the general social and educational problem. The promotion of research by properly qualified persons was extremely necessary, and everything would be gained by the partnership in this of workers from the moral and scientific fields. Too often in the past the approach to such questions from the moral and scientific standpoints has been made on parallel if not indeed on actually conflicting lines.

*Miss K. L. Johnston* said she had taken the occasion offered by the invitation to speak as an opportunity of stating the attitude taken by the training colleges on this question of sex instruction. The training colleges are most emphatically taking note of the need of a sane educated outlook on these topics in all those who pass through their courses. Evidence of what is being done in women's colleges was offered by the practice at the Maria Grey. Here much that is offered to the students comes indirectly through observation of what is done for the girls in the large demonstration school attached to the training college. The students are present at the lectures delivered by women doctors to the girls on cleanliness. Such addresses, combined with the curriculum in games and gymnastics and the periodic medical inspections, lay stress on what the college regards as the foundation for a healthy and hygienic outlook—the possession of a clean, healthy, well-disciplined body.

From the mental side help is offered—

(1) By the attitude taken to children's questions on these topics.

They are answered as far as possible by the simple truth simply stated.

## EDUCATION : DISCUSSION

- (2) By the treatment of questions that the students raise in connection with their lectures.
- (3) By lectures sometimes to teachers and students alone, at other times to the mothers of the pupils in the school at which the students are present.

In organising such courses of lectures the speaker had had much help from the Tavistock Clinic, 51, Tavistock Square.

The speaker urged that sex instruction should be given to *individuals* by the *parents* and begged of those competent by personality and spiritual insight to communicate spiritual values, their interest in the problems of early womanhood and manhood, when the prospect of biological incompleteness can only be faced on the plane of the spiritual life.

*Mr. Wansey Bayly*, representing the Society for the Prevention of Venereal Disease, said that the question of education was one in which his society was particularly interested, as they believed that the great prevalence of venereal disease was largely the direct result of a lack of education, and consequent ignorance, regarding the nature of such diseases and the means and methods of medical prevention. They claimed that it had been clearly established that where the life-giving light of knowledge had dissipated this disease-encouraging ignorance, that venereal disease had been very markedly reduced. Mr. Bayly thought that mediæval intolerance with other people's point of view was now, as in the past, the chief obstacle to education and progress, and that it was the clear duty of those responsible for the people's education to encourage the spread of knowledge in regard to simple scientific facts having a direct bearing on national health. He claimed that if immediate self-disinfection was efficacious if promptly and properly applied, as everyone now acknowledged, that it deserved enthusiastic and wholehearted support, and should not be relegated to an unimportant position amongst our anti-venereal weapons.

Whilst endorsing all the previous speakers had said regarding the very great importance to the nation as a whole and to the individual in particular of maintaining, cultivating and developing the national and individual conscience towards ever higher ideals of sexual morality, Mr. Bayly considered that such ideals would be more likely to flourish under the sun of knowledge than if kept in the darkness of ignorance for fear of scorching. He believed that moral exhortation and training alone would not suffice any more in the future than in the past to exterminate venereal disease, and that male adolescents going out into the world should be trusted with the full panoply of knowledge.

As regards venereal disease, this education should comprise the dissemination of knowledge regarding :—

- (1) The existence of venereal disease.
- (2) The medical as well as the moral importance of chastity.
- (3) The means of medical prevention should a moral lapse occur.

## SOCIAL HYGIENE

- (4) The importance of efficient treatment should disease have been acquired.

Mr. Bayly then gave the published policy of his society regarding education in immediate self-disinfection, and stated that the preamble to this policy had been written by Bishop Welldon, who had also helped in the framing of the policy itself.

Mr. Bayly concluded by drawing the attention of the Congress to the support given to the policy of his Society in the Report of Lord Trevethin's Committee, and said that the National Council for Combating Venereal Diseases were joining with them in asking the Minister of Health to give effect to the recommendation contained in this Report that the law should be altered so as to permit properly qualified chemists to sell *ad hoc* disinfectants, provided such disinfectants are sold in a form approved and with instructions for use approved by some competent authority.

*The Rev. Lionel Ford (Headmaster of Harrow)* said he was relieved to think that the responsibility of writing the Preface to the Report mentioned by the last speaker, had been laid upon one of his predecessors at Harrow and not upon himself. It was perhaps only natural that the representative of the Society for the Prevention of Venereal Diseases should have made a somewhat combative speech; but he himself was there as a non-combatant, and desired his own contribution to be mildly educative and sapiential. Professor Thomson had rightly deprecated isolation of the sex question from other moral problems of which it was only one aspect; there was a like protest to be made against narrowing down the sex question itself into mere prevention of disease. The general teaching of physical hygiene, he thought the Conference would be interested to know, had been recently under discussion among the English schools of the class which he represented, and already at Harrow, and he believed at other schools, under the title of physiology boys were being given a fairly general commonsense knowledge of the laws of practical health—the proper care of the body, fresh air, exercise, food and drink, dangers of bacteria, etc. Such teaching was, he thought, likely to become part of the staple teaching in the schools, and would naturally be given by the teachers of biology there. Boys were interested in it too, as was amazingly evidenced by sundry protests against their being nourished on nervous stimulants like tea and coffee instead of more wholesome milk. But the proper teacher of moral hygiene, as distinct from physical, was surely not the science master but the person who stood to the boy in the relation of "guide, philosopher and friend"—at home the parent, at school the housemaster or tutor, or it might be the headmaster or sometimes the school doctor. A wise teacher of morals would be careful not to treat sex questions independently of advice about honesty, truthfulness, language, unselfishness, helping of others, and the like. But with that proviso he thought that a fairly adequate, if not complete, instruction on sex questions could be provided during a boy's school career on some such lines

## EDUCATION : DISCUSSION

as the following. At the outset a general talk by the headmaster on a right attitude towards school discipline, loyalty and cleanness of speech and action, this to be supplemented soon afterwards by a personal talk, best from the boy's tutor or housemaster, based upon the boy's observed dangers or idiosyncrasies, later on, as suitable occasions offer, more intimate instruction on the phenomena of adolescence, and the right and wrong methods of facing these, and finally, when the boys leave school, a collective talk from the headmaster, possibly reinforced by the school doctor, on the relations of the sexes, inculcating chivalry to women, respect to oneself, and the ideal of future married love—and incidentally giving some information as to the danger of venereal diseases from sexual irregularities, and while counselling continence urging any who may unfortunately run amok in spite of warning not to be deterred afterwards by false shame from taking expert medical advice. He hoped that the "wise co-operation guidebook" which Professor Thomson indicated might yet be written, but thought that even when written he would rather put it into the hands of the teacher than the taught.

*Miss Meliscent Shephard* emphasised the importance of realising that venereal disease is the symptom, not the disease itself. The disease lies far deeper and is the wrong way of thinking about—

(a) Human beings.

(b) Social relationships.

(a) Human beings are so often regarded as means to an end instead of ends in themselves. Each of infinite equal value, each a living sacrament, an outward and visible physical sign of an inward and spiritual life. As such, each must recognise the sanctity of personality of every other and the unity of the three-fold nature. The physical must be controlled by the mental, the mental directed by the spiritual, and the spiritual must be in contact with God, the author and giver of life.

(b) In social relationships the speaker pleaded for a higher social expectation of men, and for a recognition of the fact that the traditional standard of expected purity surrounding womanhood has itself helped to maintain that standard. She asked women to be chivalrous, and (if it be true that chivalry is the service of strength to weakness), to create by their influence, behaviour and dress, the same standard of expected purity for men.

Turning to points raised in a previous speaker's address and whilst recognising the invaluable contribution that science could make and had made, Miss Shephard begged that no steps to promote ablution centres, or the teaching of self-disinfection, might go forth as the considered policy of any body of people seeking to promote social and moral hygiene. Having had personal knowledge in the Manchester area of the disastrous effects of such centres, she spoke from experience of the false sense of security created by such provision. She pleaded that to the minds of both sexes

## SOCIAL HYGIENE

the existence of the centres indicated that those in authority considered immoral practices inevitable, and any appeal to self-control therefore fell on ears already deafened.

Miss Shephard asked the Congress to consider this great question in its relationship to the whole life of the people. Any Society seeking to combat venereal disease must take into account the current cheap literature, postcards, newspapers, housing, films, recreation and methods of acquiring knowledge on sex matters. Constant insistence on the fear of consequences in many anti-V.D. films was deprecated, as such methods do not deter but appeal to the spirit of adventure and risk.

Great as is the task before medical, mental and moral welfare workers, Miss Shephard urged that by joining forces, spiritual, medical and mental, it can be accomplished. This task of leavening the minds of the race is the joint responsibility of men and women together. By using every opportunity (whether by popular medical articles in the cheaper press, by wise teaching, by the insistence on a high ideal of permanent marriage, and by provision of the wages and housing conditions necessary to ensure the attainment of this ideal), the vision of life as it might and can be will be pressed home.

Facts, ugly facts, distortions of truth, must be faced and conquered. It is not enough for men and women to climb just high enough for beauty, but too low for desolation. Not so will they attain to the heights of the creative purpose or know the ultimate austerities and joys of love.

It is enough to know without any shadow of doubt that whatever is right must be possible, and in that knowledge men and women together can go forward.



# Administration.

*President of Section :*

Mr. JAMES STEWART, M.P., *Under-Secretary of State for Scotland,*  
in the Chair.

Dr. JOHN C. MACVAIL, *late Member of the Scottish Board of Health.*

Dr. MACVAIL, on having been requested to take the chair, conveyed to the Congress the regrets of Mr. James Stewart, M.P., Under-Secretary of Health for Scotland, whose parliamentary duties prevented his presiding over the deliberations of the section

## PLACE OF THE LOCAL AUTHORITY IN THE V.D CAMPAIGN.

By A. MEARNS FRASER, M.D.,  
*Medical Officer of Health, Portsmouth.*

IN discussing the place of English local authorities in relation to venereal disease it is somewhat surprising, in view of the terrible and far-reaching effects of this disease upon the health of the community, that so few attempts have in the past been made by the legislature to secure its control. Parliament has practically ignored the subject; the only serious attempt to deal with it was the Contagious Disease Prevention Act, 1864, and this applied not to the whole country but only to certain garrison towns. This Act made provision for the compulsory examination of prostitutes in special hospitals, and for their detention for a period not exceeding three months if found to be suffering from venereal disease; so much opposition, however, did the Act arouse that it had to be amended in 1866, it was suspended in 1883, and finally repealed in 1886. For many years, possibly because public sentiment in the Victorian age was opposed to the discussion of so unsavoury a subject, or possibly because no government would again face the difficulties of a problem so involved with social considerations, no further attempt at legislative control was made, and what we are suffering to-day is the result of allowing this scourge to burrow, unchecked and unheeded, into the life of the nation.

Towards the end of the last century, however, a number of public-spirited men and women, determinedly breaking through the conspiracy of silence, made repeated efforts to force the Government to realise the urgent necessity for some action being taken to further the object, and, to secure an authoritative basis upon which legislation could be founded, they strenuously urged the appointment of a Royal Commission. For many years these efforts were in vain, but eventually, after many disappointments, a Royal Commission was finally set up; it held its first meeting in November, 1913, and published its final Report in February, 1916.

The evidence given before this Commission, and the conclusions

## SOCIAL HYGIENE

arrived at by the Commissioners, revealed a state of affairs which could not fail to make a deep impression, added to which the publicity which some of the London papers, notably *The Times* and the *Morning Post*, gave to the Report had the much desired effect of tearing down the veil of obscurity in which a false sense of delicacy had hitherto enveloped the whole subject.

The publication of the Report was singularly opportune in that it appeared shortly after the announcement of most important advances which had been effected by medical science in respect of the etiology and methods of treatment of syphilis, and its effect was further intensified by the fact that at this time the excessive prevalence of venereal disease amongst our soldiers was seriously affecting the strength of our armies in the Great War.

Under such circumstances it was inevitable that legislative action for the control of venereal disease should be instituted, and accordingly the Local Government Board (now replaced by the Ministry of Health), taking advantage of its powers under Section 130 of the Public Health Act, 1875, issued in July, 1916, "The Public Health (Venereal Diseases) Regulations," the principal effect of which was to throw upon county and county borough councils the duty of making, free of charge, adequate arrangements in their districts for the diagnosis and treatment of venereal disease. In order that local authorities might not be deterred on the ground of expense from efficiently carrying out their duties, the Government undertook to reimburse them to the extent of 75 per cent. of all approved expenditure incurred in carrying out the Regulations. As a result every county council and every borough council in the country has now completed arrangements for the treatment and diagnosis of venereal disease, and, by the end of last year, there were, in addition to approved hostels and facilities for treatment provided by boards of guardians, no fewer than 183 approved treatment centres in active operation in England.

The effect of these Regulations has been that now for the first time local authorities are in the position to take action in regard to a dangerous disease which had for too long been neglected and ignored. The duty is thrown upon them of arranging for the provision, at hospitals and other institutions, of free treatment for all persons suffering from venereal disease; of making arrangements so that any medical practitioner may obtain, free of cost, a scientific report upon any material which he may submit from a person suspected to be suffering from venereal disease; and of supplying to medical practitioners, free of cost, certain drugs for the treatment of venereal disease. In addition to the above duties which are obligatory, local authorities are also empowered to undertake propaganda work in connection with the prevention and treatment of venereal disease, and to make provision for the giving of instructional lectures and for the publication of information on questions relating to the subject.

It will be seen then that the powers of local authorities in regard to the prevention and treatment of venereal disease are very comprehensive and give authority for practically any measure which is

## LOCAL AUTHORITY IN V.D. CAMPAIGN

*A. Mearns Fraser, M.D. (Portsmouth).*

likely to prove of service; the only restriction on the activities of local authorities is that, in order to obtain from the Government the grant of 75 per cent. of their expenditure in connection with venereal disease, they must obtain the approval of the Ministry of Health to their proposed course of action.

But, although arrangements are now completed so that any person in the country can, free of all charge, secure skilled medical treatment, more has yet to be done. The provision of free treatment is of little avail if those for whom it is intended do not take advantage of it, and I doubt if sufficient attention is being paid by local authorities to the important point of keeping the public constantly informed of the facilities which have thus been provided. The success of the treatment centres depends on their being resorted to by patients as soon as the first symptoms of disease make their appearance; to secure this end greater publicity should be given to the situation of the treatment centre; and to the hours at which it is open; it is not sufficient for a centre to be advertised when first opened, it is also essential that its existence, and the arrangements made for treatment should be brought constantly before the notice of the public, thus any person who contracts venereal disease will know at once where to go for proper treatment, will be impressed with the necessity of obtaining skilled treatment, and will not lose his best chance of being cured by first resorting to quacks and herbalists. It is of the utmost importance that local authorities should realise that the money expended on the provision of treatment centres will be money wasted unless at the same time they adopt adequate measures to secure the attendance of those suffering from the disease. Amongst such measures may be mentioned the fixing of notices in places of public convenience, a weekly advertisement in the local press, the supply to chemists of small printed cards giving particulars of the centre, the keeping in touch with men's clubs, etc.; the methods adopted will necessarily vary to some extent with local conditions. If only local authorities will take full and intelligent advantage of their powers under "The Public Health (Venereal Diseases) Regulations, 1916," for the treatment of this disease, such action cannot fail to achieve, both now and in the future, an enormous improvement in the health of the nation.

In the campaign against venereal disease, after local authorities have satisfactorily completed their arrangements for the provision of treatment, there is a further important matter for their consideration. I submit that the duties of local authorities extend beyond the provision of treatment: the prime duty of a local authority is not the treatment, but rather the prevention of disease. Methods of treatment, although they may reduce disability and loss of life, can never exercise a great effect upon the prevalence of disease; the prevalence of cholera, typhus fever and smallpox, for example, has been reduced to a minimum in this country, but this has been effected, not by improved methods of treatment, but by the adoption in each case of suitable sanitary measures. Similarly, although improved methods of treatment may modify the ill-effects of venereal

## SOCIAL HYGIENE

disease in the individual, and may, indeed, assist in preventing the spread of infection, yet they cannot be relied upon to bring about that control of the disease which is the object of the present campaign. And I believe, if the same measure of success is to be secured in the reduction of the prevalence of venereal disease, as that which has been secured in respect of the other diseases to which I have just referred, it can only be accomplished by the adoption of certain sanitary measures specially adapted to securing that end.

Now, I think no one can doubt that, owing to the great advances of medical science, we are in a better position in this year, 1924, to secure the control of venereal disease than we have ever been before, indeed, we are in a far better position than in respect of most other infectious diseases. In no other disease is our knowledge more complete of the organisms causing the disease, or of the mode in which infection is spread. I believe, also, that the methods which may be employed to prevent the spread of infection are simpler, more easily understood by the lay public, and more easily applicable, than is the case in most other diseases.

Sir George Newman has well said that "The practice of preventive medicine in its modern meaning rests upon the growth of medical science and the application of that knowledge to the problems of disease." The "growth of medical science" has established beyond doubt the fact that venereal disease (and in this paper by venereal disease is meant "syphilis" and "gonorrhœa") is caused by one of two micro-organisms, the *spirochæta pallida* or the gonococcus (or both, if both syphilis and gonorrhœa are present), and that without the presence in the body of one or other of these organisms no venereal disease can arise. We know further that the organisms causing venereal disease are usually transferred directly from person to person during sexual intercourse, and for the most part during promiscuous or extra-marital intercourse. Added to which we know that the micro-organisms of venereal disease are readily destroyed by germicidal or disinfectant substances.

In the light of this knowledge it is evident that if effective action were taken in one of two directions venereal disease could be very largely prevented; one would be to effect such a change in social and moral conditions that promiscuous sexual intercourse should no longer be indulged in; the other is the general adoption of such methods as shall prove effectual when the germs of venereal disease are transferred from an infected to a healthy individual, in destroying the germs before they have had time to set up the disease.

If these are the only two alternatives, and I do not know a third, it must be conceded by every thinking person that the latter is the one which under present conditions offers the best chance of success, and I submit therefore that it is the duty of local health authorities to take the necessary steps to acquaint the inhabitants in their districts with those methods of destroying the organisms of venereal disease which medical science has shown to be most likely to prove effectual. It is common knowledge that the germs of disease can be destroyed by germicides or disinfectants; such

## LOCAL AUTHORITY IN V.D. CAMPAIGN

*A. Mearns Fraser, M.D. (Portsmouth).*

methods are successfully employed every day by medical men with respect to other infectious diseases, they are seen in the application of carbolic acid to a bite from a dog to prevent rabies, in the application of iodine to a wound to prevent tetanus, and in similar treatment of a scratch during an operation, or post mortem, to prevent blood poisoning; the principle in every case is the same, and, applied to venereal disease, it means the immediate application of a suitable disinfectant to those parts which have been in contact with a person who may have been suffering from venereal disease, a practice now commonly known as "self-disinfection."

It must be admitted that nothing in connection with the prevention of venereal disease has excited keener controversy than the proposal that the general public should be afforded information on methods of self-disinfection. Although such information is systematically given to soldiers and sailors without arousing adverse comment, the suggestion that it should be given to the civilian public is met in some quarters with the argument that the latter could not successfully carry out the methods, that the practice would give rise to a feeling of false security and so increase disease, and, lastly, that by removing the fear of disease it would act as an inducement to immorality. I have not the time at my disposal to-day to enter fully into a discussion of these controversial points; in my opinion they have all been adequately answered and there is considerable evidence to-day of a strengthening of the opinion that the public should not be kept in ignorance of a method which promises some reduction in the prevalence of so dire a scourge as venereal disease. It must be admitted at once that self-disinfection will not always be so efficiently carried out as to prevent disease, but if the practice were generally adopted, and if it proved successful only in fifty, or even twenty-five per cent. of cases, there would at once be a very great reduction in the prevalence of venereal disease.

The confusion of thought around the subject of self-disinfection has to a certain extent been cleared by the publication of two valuable reports by two Committees which have devoted special attention to this subject. I refer to the report of the Committee under the chairmanship of the Bishop of Birmingham which was appointed by the Birth-rate Commission, and that issued by the "Committee of Enquiry on Venereal Disease," of which Lord Trevethin was chairman. Although it cannot be claimed that either Committee has gone so far in its report as directly to advocate the policy of instructing the public in methods of self-disinfection, yet both reports serve the useful purpose of exposing the fallacy of a number of the arguments which had hitherto been advanced against this policy. Moreover both reports admit that if self-disinfection be skilfully carried out it is a valuable preventive measure, and both reports urge further that the law should be so amended that no difficulty should be placed in the way of members of the public who desire to obtain from chemists suitable substances for the purpose of self-disinfection.

## SOCIAL HYGIENE

In view of the known facts about venereal disease it is not surprising that both reports should agree as to the effectiveness of self-disinfection in preventing venereal disease if skilfully carried out. Such a view is in keeping with all the facts which are known to medical science in regard to germ diseases. Where a difference of opinion occurs is as to whether it is possible to convey such adequate information on the subject to the public generally as would enable them effectively to practise self-disinfection. Bearing upon this point I would quote two extracts from the Trevethin Report; in paragraph 9 it is stated: "... we think a man who after exposure is thoroughly and promptly disinfected by disinfectants of appropriate nature and strength runs little risk of infection," and in paragraph 11: "Obviously the chances in favour of success are greater in the case of skilled disinfection (i.e. disinfection at the hands of a trained person) than in the case of self-disinfection, but we see no reason to doubt that an intelligent man, if furnished with reasonable instructions, could in favourable conditions effectively disinfect himself." Another opinion expressed by the Trevethin Committee should be of interest to local authorities as discounting the argument constantly brought forward that any system of self-disinfection would tend to increase the number of exposures and so raise the disease rate. The Committee state (paragraph 14): "We have received no evidence of facts in support of this view, and we are inclined to think that those who hold it attach too much importance to the deterrent effect of the fear of disease."

The policy of instructing the public in what is, at any rate, the principle of self-disinfection, finds approval in Circular 202 on "The Prevention and Treatment of Venereal Diseases," which was issued by the Ministry of Health in May, 1921, to all local authorities. In this circular, among other things, there is suggested to local authorities the advisability of the widespread issue of leaflets warning the public of the dangers of venereal disease and containing advice on the following lines: "It is the duty of all individuals who have incurred, or think they have incurred, the risk of contracting disease, to cleanse themselves thoroughly and immediately, and thereby diminish the risk." The fact of this advice being issued shows definitely that the Ministry of Health regards cleansing (and thorough cleansing is simply a mild form of self-disinfection) as a valuable preventive measure against disease. And it will occur to anyone that if thorough cleansing, presumably by soap and water, is a prevention, then thorough cleansing by means of a germicide must be a more efficacious preventive. The publication of the above advice by such a body as the Ministry of Health should go far to allay the fears of those who are afraid that the practice of self-disinfection may lead to an increase of immorality.

I have dwelt at some length on the question of the instruction of the public in methods of self-disinfection because I have felt for some years that if knowledge on this subject could be spread amongst men it would do more than anything else to reduce the prevalence of venereal disease. It is a policy which to a certain

## LOCAL AUTHORITY IN V.D. CAMPAIGN

*A. Mearns Fraser, M.D. (Portsmouth).*

extent, but not so extensively as I could have wished, has been adopted in Portsmouth, and, so far as evidence is available, has not been without effect in the reduction of disease. Statistics as to the results of the policy are for obvious reasons impossible to obtain, the weak point being that one can only secure information with regard to the failures; no facts can be ascertained in regard to successes. One thing cannot be disputed, that is, the practice of immediate self-disinfection is based on definite scientific knowledge, and, if it be efficiently carried out, is almost certain to prevent infection. Medical opinion to-day is practically unanimous that the efficient application of a germicide is the most reliable means of preventing disease after exposure to infection; if failure occurs it is almost certainly due to faulty technique. It is a matter of some historical interest to note that nearly 150 years ago the great John Hunter, the outstanding medical genius of the 18th Century, specially directed attention to the value of immediate disinfection and suggested the use of a solution of corrosive sublimate for the purpose.

The success of the campaign waged by local authorities against venereal disease depends upon many factors—if one were to try and sum these up in one word it would be "education." Where there is ignorance there is almost certain to be disease, and owing to the past policy of silence the ignorance in regard to venereal disease is gross. It is necessary to make the public realise more than they do at present how far-reaching are the effects of venereal disease on the health of the community. Because the word venereal disease does not as a rule appear on certificates as the cause of disability or death, the wide extent of the disease is not apparent, except to members of the medical profession, and the general public are apt to regard venereal disease as something which after all only affects those who lead a loose life, and many, indeed, still largely associate it in their minds as a divine-sent punishment for immorality.

It is an essential part of the campaign against venereal disease to make the public familiar with all the aspects of venereal disease, and these include other matters beside scientific methods of treatment and prevention. Local authorities may do much indirectly to assist the campaign. One important matter is to improve the conditions under which many of the poorer classes are at present forced to live, conditions which render decent family life almost impossible; they may endeavour to promote a healthier tone in their districts by the provision of open air recreation grounds and the fostering of wholesome games and amusements, they may exercise supervision over the display of posters, advertisements, public performances, printed publications, and in many other directions use their powers to promote a higher and better social standard.

I would only say in conclusion it has been impossible, in the time allotted to this paper, to do more than touch upon some of the outstanding points in connection with venereal disease. I have

## SOCIAL HYGIENE

endeavoured to indicate, I fear only in an imperfect manner, some of what appear to me to be the more important measures which might with advantage be undertaken by local authorities. I believe that the campaign against venereal disease, if conducted along scientific and intelligent lines, offers great hopes of success. Signs that the efforts of local authorities are proving successful are already to be seen in the reduction in the number of new cases of infection which apply at the centres for treatment. I trust that the effect of this Congress may be to stimulate and hearten local authorities to further efforts so that at no distant date the control of venereal disease may be added to those triumphs which sanitary administration has already secured in this country.

### PLACE OF THE LOCAL AUTHORITY IN THE V.D. CAMPAIGN (SCOTLAND).

By W. E. WHYTE, O.B.E., *Clerk to the District Committee of the Middle Ward of Lanarkshire.*

It will be at once conceded that, apart from the individual interest and responsibility in such a matter, it is the local authority, i.e. the public health authority, that we must look to to deal with venereal diseases in the wide and practical sense; in other words, that those diseases being infectious and inimical to the public health, it is the duty of the local authority to see that adequate measures are applied to their control, treatment and prevention.

In virtue of the powers contained in the Public Health (Scotland) Act, 1897, the Local Government Board for Scotland (now the Scottish Board of Health) made an Order known as "The Public Health (Venereal Diseases) Regulations (Scotland), 1916, dated 26th October, 1916."

That Order proceeded on the following terms:—

"Whereas Venereal Diseases are endemic and infectious diseases and it is expedient that Regulations should forthwith be made with a view to the treatment of persons affected with these diseases and for preventing the spread of these diseases:

Now, therefore, We the Local Government Board for Scotland, Do by this Our Order, and in the exercise of the powers conferred on Us by the Public Health (Scotland) Act, 1897 and every other power enabling Us in that behalf, make the following Regulations, that is to say—

Article I. (1) Every Local Authority shall prepare and submit for our approval a scheme—

- (a) for enabling any medical practitioner, practising in the area of the Local Authority, to obtain, at the cost of the Local Authority, a scientific Report on any material which the medical practitioner may submit from a patient suspected to be suffering from Venereal Diseases;



## LOCAL AUTHORITY IN V.D. CAMPAIGN

*W. E. Whyte, O.B.E. (Scotland).*

- (b) For the treatment at and in hospitals or other institutions or in their homes of persons suffering from Venereal Diseases ;
  - (c) For placing at the disposal of medical practitioners such skilled assistance in the treatment of Venereal Diseases as may be required ; and
  - (d) For supplying medical practitioners with salvarsan or its substitutes or other drugs, for the treatment and prevention of Venereal Diseases.
- (2) When we have approved the scheme, the Local Authority shall make arrangements for carrying it into effect at the cost of the Local Authority.
- (3) All information obtained in regard to any persons treated under a scheme approved in pursuance of this Article shall be regarded as confidential.

Article II. Any Local Authority may make such provision for the giving of instructional lectures and for the publication of information on questions relating to Venereal Diseases as the Local Authority may think necessary or desirable.

Article III. (1) Expressions used in these Regulations shall (unless such meaning is inconsistent with the context) have the meanings assigned to them in the Public Health (Scotland) Act, 1897.

(2) The expression 'Medical Practitioner' means 'registered medical practitioner.'

(3) 'Venereal Diseases' mean syphilis, gonorrhœa, and soft chancre.

Article IV. These regulations shall come into operation on the date of this Order, and shall then and thereafter apply and have effect throughout Scotland, and shall be executed by every Local Authority."

The foregoing Regulations enable local authorities to make special arrangements for the three main problems in the control of venereal diseases, namely diagnosis, treatment and prevention. It will be noted that it is obligatory upon every local authority to prepare and submit, for the Board's approval, a scheme in terms of the Order.

Venereal diseases being declared infectious diseases, they at once come within the purview and jurisdiction of the public health local authority, and all the public health enactments and provisions which are referable to infectious diseases are applicable accordingly to venereal diseases.

Venereal diseases, however, are not for the purposes of notification, infectious diseases to which the Infectious Disease (Notification) Act, 1889, applies without extension, and before they could be brought within the scope of the Act and have applied to them all the powers and provisions referable to infectious diseases in that category, a local authority would require to exercise the powers contained in Section 7 of the Act of 1889, namely, to pass a special

## SOCIAL HYGIENE

resolution that the Act was to apply to venereal diseases, which resolution would require to be approved by the Board of Health. No such action has so far been taken, and venereal diseases therefore are not notifiable infectious diseases. For various reasons it would be more appropriate if it were decided that those diseases should become notifiable, that this should be effected by an Act extending the statutory definition rather than by the procedure by individual local authorities. The question of notification is referred to later in some detail.

It may be of interest to note shortly what has been done in Scotland by the local authorities since the central authority made their Order in 1916.

The number of public health local authorities who have prepared schemes and had these approved by the Scottish Board of Health is 281 out of a total of 307 authorities. A pleasing feature in this connection has been the spirit of co-operation that has been evinced among local authorities. There are no fewer than twenty-three joint V.D. Committees in Scotland representing 230 local authorities.

Thirty-nine clinics have been established throughout the country.

On the opposite page is a summary of returns relating to all persons\* treated at venereal diseases treatment centres in Scotland during the year ended May 15th, 1922.

For the financial year ending May 15th, 1923, there were 12,398 *new* cases treated at the V.D. centres. Adding cases carried forward from 1921-22, the total number of cases dealt with has been 22,844. In the year 1922-23 patients made 289,945 attendances at V.D. centres.

But there can be no question that much remains to be done to secure adequate treatment of the diseases. In Poor Law institutions, for example, there is a considerable amount of venereal disease, yet generally speaking no similar effort is being carried out for this part of the community to what is being done for persons who attend the clinics. The same remarks might be made as regards the prison authorities who, in many cases, have not in operation schemes of treatment necessary to the circumstances. The public health local authorities should obviously press for something more effective being done in the directions mentioned.

As is universally recognised, propaganda and educative work must form an important part of the campaign against venereal diseases, and this aspect of the question has received especial attention in Scotland. A Scottish Committee under the auspices of the National Council for Combating Venereal Diseases was set up in 1921, and it has carried through an extensive programme of propaganda work. Its first effort was to secure the goodwill and support of the local authorities of Scotland, recognising that it must be essentially through the local authorities that all progress

\* The word "persons" includes all persons examined or treated at centres either as out-patients or as in-patients. It also includes persons treated in their own homes, where the treatment was conducted by a member of the staff of a centre.

SUMMARY OF RETURNS.

	Syphilis.		Gonorrhoea.		Soft Chancres.		Mixed Infections.†		Conditions other than Venereal.		TOTAL.	
	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.
1. Number of persons who, at the commencement of the year, were under treatment or observation for ... ..	3,788	2,276	2,056	589	142	48	651	660	107	39	6,744	3,612
2. Cases in which treatment or observation was commenced during the year for ... ..	2,956	2,286	3,194	1,000	549	27	465	677	853	535	8,017	4,525
TOTALS OF ITEMS 1 & 2 ...	6,744	4,562	5,250	1,589	691	75	1,116	1,337	960	574	14,761	8,137
3. Number of persons who ceased to attend—												
(a) Before completing a course of treatment for‡ ... ..	1,082	705	661	199	36	7	97	54	—	—	1,876	965
(b) After completing a course but before final tests as to cure of‡ ... ..	810	525	438	192	110	10	52	148	—	—	1,410	875
4. Persons transferred to other centres after treatment for§ ...	224	187	121	195	2	—	28	34	—	—	375	416
5. Persons discharged from centres after completion of treatment and observation for ... ..	800	490	2,067	531	308	56	102	405	—	—	3,277	1,482
6. Persons who, at the end of the year, were under treatment or observation for ... ..	3,828	2,655	1,963	472	235	2	837	695	—	—	6,863	3,825
TOTALS OF ITEMS 3, 4, 5 & 6 ...	6,744	4,562	5,250	1,589	691	75	1,116	1,337	—	—	13,801	7,563

(Continued on next page.)

SUMMARY OF RETURNS—continued.

7. Total attendances of all persons at out-patient departments who were suffering from   ... ..	61,552	31,175	106,292	19,421	8,582	1,145	16,538	12,475	4,145	1,318	197,109	65,534
8. Aggregate number of "in-patient days" of treatment given to persons suffering from ... ..	6,392	16,445	6,515	14,311	674	63	1,814	9,926	318	48	15,713	40,793
9. Number of doses of Salvarsan substitutes given ... ..												52,992
10. Number of cases of Congenital Syphilis included in total of items 1 & 2 above ... ..												1,297
11. Number of cases of Syphilis that showed evidence of extra-genital infection ... ..												86
12. Classification of persons treated according as age of patients was												
(a) Under 1 year ... ..	217	367	14	43	—	—	—	5	—	—	231	415
(b) 1 and under 5 years ... ..	46	186	—	68	—	—	—	4	—	—	46	258
(c) 5 " 15 " ... ..	139	269	12	88	6	2	—	4	—	—	157	303
(d) 15 " 25 " ... ..	1,117	664	1,531	477	335	13	217	379	—	—	3,200	1,533
(e) 25 years and upwards ... ..	1,991	1,138	1,770	305	214	12	417	301	—	—	4,392	1,816
TOTALS ... ..	3,510	2,624	3,327	1,041	555	27	634	693	—	—	8,026	4,385

† Persons suffering from two or more venereal diseases are entered only under the heading "Mixed Infections."

‡ Patients were not marked off as having ceased to attend until after efforts had been made by letter or otherwise to induce them to continue attendance. Patients who did not return to the clinic within two months of the last of such efforts were regarded as having ceased attendance, and were entered under heading 3 (a) or 3 (b).

§ These persons are not included under items 3 (a) or 3 (b).

|| These figures cover all attendances made by out-patients, including those made for irrigation, local applications, etc., under general medical supervision, during the intervals between the ordinary out-patient clinics.

These totals do not agree with the figures under items 1 or 2, because some of the centres supplied an age-classification of new cases only, while others classified all the patients treated.

## LOCAL AUTHORITY IN V.D.' CAMPAIGN

*W. E. Whyte, O.B.E. (Scotland).*

and development could be secured. In this effort the Scottish Committee have been strikingly successful. Every step of consequence that has been taken has been in consultation with the local authorities who are represented on the Committee along with co-opted members especially qualified in venereal diseases and allied social work.

The aims of the Committee have been to develop interest in this phase of public work among local authorities; to secure and maintain local effort; to spread knowledge and information through the agency of the local authorities and branch councils; to consider difficulties and defects in the law and practice and to formulate proposals for improvement and alteration of same; to enlist the interest and co-operation of social organisations, including women's organisations, and generally to carry on in Scotland the excellent work—publicity and educational—being performed by the National Council in England and Wales. The Scottish Committee carry on their work with the approval of the Scottish Board of Health who approve of their programme of activities and make an annual grant of money towards the cost of same. Mention might be made of the great advance that has taken place in the attitude not only of members of local authorities and the public but of medical officers of health and medical practitioners towards propaganda work. There have been instances, for example, of hostility in certain quarters to proposals to educative films being shown, but after an exhibition had been given the objections not only disappeared but requests were made for further showings. Again, in several districts the medical practitioners when they have been made acquainted with the experiences and difficulties of local authorities in controlling and treating the diseases, have become strong advocates of the methods and courses proposed by the authorities. These are referred to later.

As an illustration of the effect of propaganda and educative work, it may be mentioned that in Scotland there are now several *ad hoc* clinics which are just as well attended as clinics and centres attached to institutions and public buildings. This is due entirely to an enlightenment of the public mind and understanding. It may be said with every assurance that the scheme of propaganda work carried on has met with very great success.

Venereal diseases being infectious, it may be asked why do local authorities not deal with them at once in the same way as they deal with other infectious diseases, namely, to require notification. One does not wish to open up a field of controversy at this Conference bearing on the question of notification, but a survey of the place and position of the local authority in the V.D. campaign would be quite incomplete if some reference were not made to the question of the adequacy of the powers and machinery of the local authority to efficiently discharge their duty. The local authority must look upon V.D. from at least two stand-points: (1) the standpoint of the effectiveness of the methods they are employing, and in relation thereto (2) the expenditure

## SOCIAL HYGIENE

being incurred in applying those methods. It is said by some that to refuse to recognise venereal disease in the same way as other infectious diseases and to deal with it accordingly is unwarranted, foolish and sentimental, and that if we had the necessary courage to adopt their view venereal disease as we know it now—uncontrolled, disastrous—would soon be effectively controlled and kept within proper bounds. But a careful consideration of the various factors associated with the question—social, domestic, public—all tend, it is suggested, to the conviction that this disease is of so special a character and importance that it must be dealt with along special lines.

It is unquestionable that the experience generally in securing complete and adequate treatment of persons affected has been discouraging and disappointing. Patients attending clinics do so of their own good will; they cease to attend when the immediate symptoms and inconvenience are relieved or removed and while they are still in an infectious state, and no moral, or personal, or communal appeal to many of such persons is of any avail.

Such a situation is undoubtedly serious, not only from the point of view of the danger which such persons are to their families and to the public generally but the financial aspect is equally a matter of concern. The effort and expenditure of the local authorities, designed to secure the treatment and cure of infected persons, are in great measure lost if that effort and that expenditure do not result in the rendering of the great majority of such persons non-infective.

In many quarters the experience referred to has led to a demand for the introduction of compulsory notification of venereal diseases. That demand is fairly widespread, and strong efforts have been made to have it brought home to the Government.

The Convention of Royal Burghs at their Annual Meeting in 1921 unanimously adopted a Resolution in the following terms:—

“That, in the opinion of this Convention, the expenditure incurred by the State and Public Health Authorities in dealing with Venereal Disease cannot be fully effective and therefore economical until the disease is made compulsorily notifiable and adequate provision is made for dealing with failure to notify, and that the matter be remitted to the Annual Committee.”

It is argued by those who support notification that because notification was found to be necessary, and has proved to be successful in the case of other infectious diseases—smallpox, scarlet fever, tuberculosis—there can be no good reason for absolving venereal diseases from its application. It is urged that the first consideration must be the protection of the community. And there is undoubtedly much plausibility in the view. But we must never forget that infections such as smallpox and scarlet fever are very different in the public estimation from venereal diseases. Even tuberculosis, on account of the attitude of certain members of the public, has had to be regarded with more laxity from the

## LOCAL AUTHORITY IN V.D. CAMPAIGN

*W. E. Whyte, O.B.E. (Scotland).*

public health standpoint than certain other infectious diseases. Much greater is the social stigma attached to venereal diseases, which at once marks it out for special consideration and special treatment. In other words, notification may be feasible and expedient as regards ordinary infectious diseases, but it may be impracticable and not only not yield successful results in the realm of venereal diseases, but be positively harmful.

What does notification precisely mean?

If the same procedure were followed as in the case of notification of other infectious diseases, then it would mean that every case of venereal disease which was notified to the medical officer of health would require to be dealt with in such a way as to prevent the spread of the disease. In a word, there would require to be compulsory treatment. It has to be kept in view that the medical officer is a preventive officer, and it is his duty to see that all cases of infectious disease which are compulsorily notifiable are properly dealt with. In each case the medical officer of health would, on notification being made, cause inquiries to be made to ascertain if the patient was being treated; if the recognised methods of treatment were being followed, and if the conditions under which the treatment was being carried on were such as to prevent the spread of the disease. If the medical officer of health as a result of his inquiries was of opinion that proper methods of treatment were not being applied, and that there was serious risk of the spread of infection, then he would have power to cause the patient to be removed to a hospital to be there treated.

Section 3 of the Infectious Disease (Notification) Act, 1889 makes it obligatory on every medical practitioner attending a patient suffering from infectious disease to which the Act applies, to notify the medical officer of health of the infectious disease. There is a similar duty imposed on the head of the family to which the patient belongs, or in default of such person, on the person in attendance on the patient.

In considering the foregoing procedure under notification it will, it is believed, be conceded that there is at least very great danger that, if it were applied to venereal diseases it would not effect its purpose. The disease would be concealed; quack methods would be employed; and more damage would result in consequence. It is said by some that public opinion is not ripe for introducing notification, but, apart from that view, it is suggested that on the practical aspect, the danger of complete failure is so great that modified methods should be attempted in the first instance in order to deal with the situation.

That something must be done is evident. As already mentioned, the local authority's efforts are in great measure nullified under the present conditions and the expenditure incurred is not justified, or at all events not fully justified, by the results obtained. In view of these facts and considerations the whole subject received special consideration at a Conference of the local authorities of Scotland

## SOCIAL HYGIENE

held in Glasgow on March 8th, 1923, when after a full discussion the following resolutions were adopted:—

“ Resolution 1. That in the opinion of this Conference the present law and machinery are inadequate to secure the proper control and treatment of venereal diseases.

Resolution 2. That in order to secure adequate control of venereal diseases (both acquired and congenital) it is essential that a system of notification should be introduced.

Resolution 3. That it is essential every person suffering from venereal disease should be required by law to place himself or herself under treatment by a qualified medical practitioner and to continue under such treatment until pronounced free of infection.

Resolution 4. This Conference resolves that a deputation be appointed to submit the foregoing Resolutions to the Scottish Board of Health and to urge upon the Board the desirability of their taking such steps as may be necessary to have same carried into effect with the least possible delay.”

Under such a system as is proposed by the foregoing resolutions, namely, (1) that all persons knowingly affected must put themselves under medical treatment, and (2) that all persons undergoing medical treatment must continue such treatment until certified to be non-infective; failure to observe these requirements would entail a heavy penalty with the option of imprisonment.

Under such a scheme everything that is essential is fairly met. The direct procedure is confined to the person affected, and that is of the essence of any machinery that may be set up. It would, of course, apply to the innocent as well as to the others, but the object and end being to secure that everyone affected will be treated, that is inevitable under any scheme that seeks to deal with the problem. It may be said that these proposals are not far removed from compulsory notification, but they are substantially different and distinctive. Apart from their specific application to the person affected, there would be no statutory duty put upon the local authority to deal with the matter further, and the strict enforcement of the requirements with the dread of the penalties behind them would, it is believed, have beneficial results. It may be said that affected persons would not present themselves for treatment and that, if that were so, they could never be traced, but that argument would apply to any scheme that might be conceived.

It is undoubted that there is a very strong opinion held among the local authorities of Scotland that some step in the direction of securing improved control must be taken in the very near future, and no doubt the question will again, and very soon, be brought home strongly to the Central Department in Scotland. It is in view of the very great importance which the local authorities attach to this aspect of the problem that the matter has been referred to in some detail—mainly for the purpose of showing the



## LOCAL AUTHORITY IN V.D. CAMPAIGN

*W. E. Whyte, O.B.E. (Scotland).*

trend of things in Scotland—and that the question will undoubtedly be forced to the forefront in the near future.

The concentration at the instance of the National Council, the Scottish Committee and the local authorities on venereal diseases work has unquestionably accomplished an immense amount of good, but one may inquire if we have not now reached the stage that a broader basis of work might be thought of. In a word, can the efforts at present being directed *solely* in connection with V.D. not be associated with greater advantage with efforts in connection with certain other work which is undoubtedly allied in some form or another with V.D.? There has been a tendency ever since V.D. became an active phase of local authority work to treat it as something separate and distinct from the other public health work administered by the local authority. The diseases, of course, call for treatment in a special manner, but they cannot, I suggest, be successfully or satisfactorily divorced from the general public health administration of the local authority. We have the educational aspect as regards tuition in sex hygiene which has not so far been successfully co-related to the other spheres of V.D. activity. We have the housing question which is undoubtedly closely concerned with V.D. work. We have the recreation aspect which all are agreed may and can fill a very important part in V.D. preventive work. We have the mental deficiency aspect. We have tuberculosis schemes and the maternity and child welfare service, in connection with which much good can be accomplished if there is close co-operation with V.D. efforts.

It is of interest to note the larger view of the subject that is expressed in the Trevethin Report, where the following paragraphs, for instance, occur:—

\* \* \* \* \*

“The extension of knowledge as to the nature of venereal disease and its consequences is of the first importance; the community should, as far as possible, be made to appreciate . . . that the presence of these diseases in the community is a menace to the maintenance and advancement of the physical and intellectual standard of the race. Again, in addition to the spread of knowledge, it is necessary that measures should be pursued which will diminish those conditions of life which tend to foster promiscuous intercourse and the spread of disease.”

“It has been shown that if syphilis is detected in the pregnant woman, treatment during pregnancy is remarkably successful in securing healthy offspring, and gonorrhoeal infection of the infant at birth may generally be prevented if the danger is known. Increased facilities for medical supervision of women during pregnancy are desirable, and may in part be obtained by an extension of the system of ante-natal clinics, and by the instruction of midwives who would refer

## SOCIAL HYGIENE

suspicious cases to a doctor. In this connection we would also call attention to the importance of including instruction on venereal diseases in the general training of midwives and nurses."

\* \* \* \* \*

It scarcely requires to be argued that closer co-operation is called for. Its advantages are obvious: both patient and practitioner will benefit by it. Looking at the question in a general way, where is it that the patient not actually bed-ridden gets the most up-to-date and most efficient treatment? Is it not at the out-patient clinics of our large general hospitals, where various medical departments are working side by side, and where consultation and co-operation between professional colleagues is most readily obtained? Patients suffering from tuberculosis, from venereal diseases, from skin diseases; patients requiring treatment for trouble of the eyes, the ears, the teeth; young infants and expectant mothers in need of advice, all can be seen and referred without delay to the proper department. Some symptoms of tuberculosis resemble syphilis; some forms of syphilis are mistaken for comparatively harmless skin eruptions. An infant with a so-called "teething" rash has been found to be suffering from a contagious form of syphilis in urgent need of proper treatment. Those who know will tell you that there are overcrowded sanatoria with beds occupied by supposedly tuberculous patients, really cases of unrecognised syphilis. There have been cases of cancer mistaken for syphilis and invaluable time wasted at a clinic when the case should have passed at once into the surgeon's hands. One knows of mothers with congenitally infected syphilitic infants ceasing to attend a clinic because it was labelled "V.D." It is urged in many quarters that ante-natal and congenital syphilis ought to be treated at child welfare centres. It is no uncommon experience to find expectant mothers refuse—either through a sense of modesty or of repugnance—to attend a V.D. clinic, and there ought to be at every ante-natal clinic and every maternity hospital adequate facilities for the skilled treatment of such cases, the patients being treated as part of the ordinary routine of the centre or hospital and not specifically associated with anything suggestive of a V.D. department. The many maternity and child welfare centres which exist might in addition play a most valuable part in the propaganda work connected with sex hygiene and venereal disease. The educational possibilities of the centres are very wide indeed and can reach a section of the public most intimately interested.

The local authority have just as important, if not a more important, field than treatment to operate in, namely, the field of prevention. This side of their work ought to be concentrated upon more and more, for prevention is not only better than cure, it is also cheaper. Preventive measures as these may be applied and secured at maternity centres and otherwise should play a larger part in the work of the local authority.

Colonies are being set up for the treatment of early cases of

## LOCAL AUTHORITY IN V.D. CAMPAIGN

*W. E. Whyte, O.B.E. (Scotland).*

tuberculosis; the patient, besides being educated in a trade which he is likely to be able to follow without risk of breakdown in health, is made physically fit, by means of fresh air and good feeding, to overcome the tubercle bacilli. The chronic gonorrhœa patient, unable to overcome the microbe of gonorrhœa on account of his low state of health, would benefit enormously by residence for a period in some sort of convalescent home; and he need not be there a source of infection to others. To prevent further ill-health due to lowered resistance, children convalescent from diphtheria, scarlet fever, broncho-pneumonia, etc., ought all to be sent to a home to recuperate. One might go on multiplying cases indefinitely, but these should suffice to prove the need for greater co-operation and for conjoint effort as well as for strong and bold preventive measures. And lastly, but not of least importance, the general practitioners must be made to regard public health services as in no way professional rivals, but rather as consultative clinics, where they may obtain expert advice and assistance. In consequence, the medical personnel of health services must be highly experienced and well trained, if the confidence of the profession is to be won and maintained.

Larger reforms—e.g. the introduction into every town of one or several health institutes at which panel practitioners would have their surgeries, at which radiologist, dentist, aurist, consultant surgeon and physician, gynæcologist, obstetrician, tuberculosis and venereal diseases officers would attend—may be too distant to contemplate with profit at the present time.

If it is a fact that all those phases of public work are inter-related—in a word, that all disease is related to public health and sanitary measures generally—it is fairly obvious that the best results cannot be secured unless there is the fullest co-ordination of policy and effort. It may not be feasible at present to obtain co-ordinated measures of treatment and practice, but it should be certainly kept in view. This at all events could be accomplished now, namely, co-ordinated educative and propaganda work. The possibilities are immense. We have separate efforts being made in all the different phases of public health work that have been mentioned; they have all their foundation in the common need for the instruction and education of the public in the knowledge of diseases, how these may be prevented, and if acquired how they may be treated. In short, what is being done through separate agencies and by different methods is public health education in its widest sense. By a co-operative effort we would secure these things: (1) a less total expenditure than obtains at present; (2) a combination of the best personal elements of each sphere; (3) variety and therefore added interest in educational work on the part of the public; and (4) the machinery for securing a single aim and object.

The illustration of the National Council carrying out on behalf of the local authorities of the country the educative and propaganda side of venereal diseases is an excellent example of how the other

## SOCIAL HYGIENE

phases of public work might be dealt with. Some such machinery and work which more properly belongs to and can be better executed by a composite body substantially representative always of the local authorities but untrammelled with the reservations, procedure and formalities attaching to the local authorities themselves, is obviously the best medium for carrying on a publicity campaign. This agency might also with advantage become a bureau for the collection and dissemination of useful information, statistics and advice to the local authorities of the country. The creation and development of this means of disseminating information would result in great profit and advantage not only to clinicians and members of local authorities but to the public generally. Local authorities, with the assistance of the Central Department, could combine in setting up a first-class organisation designed to collect, collate and classify the available extensive data of common interest to all local authorities.

The proposition mentioned is one involving many considerations, but the idea has been gradually taking shape in the minds of many of those concerned with the development of our public services. It has been felt that some of the strength and effect of the work being done is dissipated by reason of the fact that it is not a unified effort that is being made in the realm of public health. It is suggested, therefore, that if the local authorities, in conjunction with the Central Authority, were to set up a Consultative or Advisory Committee to go into the whole proposal in detail and endeavour to lay down general principles and a line of policy, there would undoubtedly be every prospect of a sound scheme being evolved which would immeasurably help on the whole future public health work of our country.

### CONTROL OF V.D. IN NORTHERN IRELAND.

COLONEL DAWSON, *Government of Northern Ireland.*

In the first place I wish to convey the thanks of the Government of Northern Ireland to the National Council for their kindness in inviting that Government to send a representative to the Congress. I think that the chief object of my Government in sending me here was to gain information and report to them, because as we are going through a transition period in Northern Ireland now, I have not very much of interest to tell you about our organisation against venereal disease, especially as, being still part of the United Kingdom of Great Britain and Ireland, our methods are much the same as those in force here.

There are, however, a few points regarding venereal diseases in Ireland which I may briefly touch upon. In the first place, in Ireland (before the war and to a considerable extent still) there is practically no venereal disease question outside the few large towns, the country districts being almost entirely free. It has long been my view that the occurrence of general paralysis may be regarded as an index of the prevalence of venereal disease. In my official

## LOCAL AUTHORITY IN V.D. CAMPAIGN

*Letitia D. Fairfield, C.B.E., M.D., D.P.H. (London).*

capacity I formerly had occasion to visit all the Irish asylums, and in the country asylums it was the rarest thing to find a case of general paralysis. In the few large towns however the conditions are very much the same as in the large towns over here: since the war there has been an increase in the number of cases of general paralysis in these towns—in some of them, at any rate; but one rather hopes this is simply due to the larger number of cases of syphilis which occurred in the Army, and that gradually the increase in general paralysis will diminish again as this cause ceases to act.

In Ireland the commencement of a serious campaign against venereal diseases dates from the year 1917. In that year an Act was passed for Ireland only, extending some of the provisions of our Public Health Act of 1878, and enabling the Local Government Board to give the County Councils and the County Borough Councils power to undertake the carrying out of regulations devised by the Board for the treatment of venereal disease. It was not made compulsory upon the County Council, but I am glad to say that all the County Councils and County Borough Councils of Northern Ireland have now established schemes—six County Councils and two County Borough Councils—and all but two have full-fledged schemes on the English model. There are in full working order about fifteen different centres in Northern Ireland at the present time to deal with a population of somewhere about one and a quarter million people, but, as I said before, in the country districts there is practically no venereal disease at all. Perhaps I might add that the total expenditure for the year ending March, 1922, in Northern Ireland upon venereal disease treatment was £7,434.

At the present moment, however, the medical reorganisation of Northern Ireland is to be taken in hand. The Minister of Home Affairs has just appointed a Commission to inquire with a view to reorganising as far as may be necessary the whole of the medical services, attendance on the sick, and public health work in Northern Ireland, as part of a general revision of Local Government, and it is therefore unnecessary for me to say anything more seeing that we are in this transition stage, and that whatever is being done is of a temporary character. I hope on some future occasion to be able to inform you that we have achieved the most perfect system of medical service in the British Isles, but on this occasion my object in coming really was to learn rather than to teach, and I feel that I have not only acquired a great deal of information myself, but am in a position to place before my Government a report which will I hope, be of assistance to them in the inquiry which they are undertaking.

### THE PLACE OF THE LOCAL AUTHORITY IN THE V.D. CAMPAIGN (LONDON).

By LETITIA D. FAIRFIELD, C.B.E., M.D., D.P.H.

THE great scheme for the treatment of venereal disease in which London and the Home Counties combined in 1917 was one of the

## SOCIAL HYGIENE

first to be inaugurated in this country, and it has remained the largest. The provision for treatment now includes 28 clinics, 7 hostels for women and 1 home for children. The attendances made to this year are shown in the appended table.

The London figures show a slight total increase over those of last year, as opposed to a decrease in the figures for England and Wales generally. In the initial stages of a new campaign it is always difficult to know whether a rise is a matter for regret or congratulation. Is this London increase an indication of (a) failure to control disease, or (b) of increased popularity of our clinics?

A direct answer to this question is in the nature of things impossible, but it is at least clear that we are casting our nets wider and investigating more possible cases. The number of non-venereal cases applying at the clinics is slowly but steadily rising and the number of pathological examinations made shows a marked increase, those performed for private practitioners being nearly seven times as great as in 1917, and 4,600 more than last year.

It is interesting to note that the male syphilis cases in London are now practically the same as in 1917, when however the male population at risk was far smaller, but syphilis in women is declining. In the case of gonorrhœa there has been a marked increase in men in the same period (3,830 to 9,043) and a lesser increase in women (1,207 to 2,520).

One admittedly unsatisfactory feature of the returns thus still remains; i.e. the figures for gonorrhœa in women. The number of new cases of gonorrhœa has always been less than those of syphilis, the disparity being 2,000 in 1917, 1,000 in 1921, and 100 last year. From all that is known of the incidence of these diseases it is inconceivable that this can represent the true state of affairs. No other inference can be drawn than that much gonorrhœa in women still escapes our notice. This is confirmed by the persistence of ophthalmia neonatorum and other secondary effects.

The number of attendances continued to rise steadily, though for two years previous to 1923 there had been a steady and rapid fall in the number of new cases. The number of persons ceasing to attend before cure is (when all possible fallacies have been eliminated) still too high.

The above record shows reason for satisfaction, but not for complacency. In dealing with such a disastrous matter as venereal disease it is not enough merely to hold our own, we want to go ahead and be able to show evidence of substantial reduction.

In London the policy has been to maintain clinics run by existing charitable institutions, and the local authority has in no case direct control over the clinic. Certain items of expenditure are, however, definitely encouraged with the view of correcting obvious gaps in the scheme.

In the first place, the local authority has done its utmost to secure a wide range of hours for attendance. It is recognised that in these diseases (especially gonorrhœa) the stupendous demands made by the doctor on the patient's patience and faith are unique in the whole range of medical practice, and the least one can reason-

## LOCAL AUTHORITY IN V.D. CAMPAIGN

*Letitia D. Fairfield, C.B.E., M.D., D.P.H. (London).*

ably do is to diminish the burden as much as possible. We are still far from having secured ideal arrangements for busy men and women, but the number of all-day clinics has been increased, and we will shortly have four of these invaluable establishments for men and women open in different parts of London.

For *women* patients, the lady almoner has been found to be a boon which a local authority will do well to encourage. One finds that at two of the largest and most successful of all London women's clinics the lady almoners are most active and prominent, indeed it might be said that a women's clinic has not reached its maximum usefulness until the help of a trained social worker has been enlisted. To be of any use the worker must be a well-trained, experienced woman of sympathetic and balanced temperament. Moreover, her relationship with patients must be tactfully managed. It is often found convenient for the lady almoner to act as booking clerk and have the charge of records and "following-up" of defaulters. She can then approach patients without any breach of the obligation of secrecy and without appearing inquisitorial. A few simple practical questions concerning, say, the patient's capacity to attend as often as the doctor wants, and an offer of help to remove any obstacle will often open the floodgates of confidence. A sensible reassuring word at the right time may avert a family tragedy and help the patient to the wise decision on a vital point. A friendly relation of this sort once established makes the difficult work of securing the examination of contacts far easier. Sometimes it is found that payment of fares, arranging help with young children, sending in the district nurse for a time, will keep up a chain of attendance which would otherwise be broken and never resumed.

For dealing with unmarried girls the almoner's patience must be great and her resources many. An experienced almoner told me recently that she had never known any social work in which money was so frequently and urgently required. To save a girl from a fatal false step, it may be necessary to arrange for admission to a hostel or "boarding-out" at once and without delaying for inquiries.

In the matter of hostel accommodation London is fortunate, as we have seven hostels (five being for maternity cases), and they are all popular and constantly full. The maintenance is very expensive, for the 200 cases dealt with therein during 1923 cost London £3,950 in grant, but when one remembers that the patients dealt with are the most dangerous type of infecting agent, it may be considered well worth while from the material side alone. The results obtained in the after-care of mothers and babies have been most gratifying.

The fear is sometimes expressed that if the social worker is admitted the clinics will be used for a kind of compulsory rescue work. There must of course be a frank recognition that a woman's affairs are her own concern—be she married or single. No one can help her if she does not want to be helped, and often the almoner

## SOCIAL HYGIENE

can only say: "I am here as your friend when you want me," and wait for a change of heart. This attitude appeals to the woman's self-respect and yields the fullest results in the long run.

Apart from the special difficulties of the unmarried girl, it is recognised that the weakest part of the scheme is the discovery and treatment of women with gonorrhœa. The matter will be dealt with fully in other papers, and I will only point out here that our fundamental difficulty lies not so much in ignorance or prejudice, but in the very nature of the disease, which is very hard to distinguish *prima facie* from other common gynæcological ailments. It is surely both unfair and unwise to urge every woman with discharge and other symptoms of pelvic infection to go to a V.D. clinic. Only a small minority of such cases are actually suffering from V.D., and the majority who are not will be justifiably offended at the suggestion. Moreover, all such cases need treatment of some sort, and if they are merely referred to a V.D. clinic for diagnosis they are likely to drift away altogether if they are pronounced "not infected." There is a strong case, therefore, for the closer co-operation between V.D. schemes and the maternity and child welfare movement, and existing agencies for the treatment of women's ailments, such as the special departments of general hospitals. If we could raise the standard of well-being among working-class women as we have raised it during the last twenty years for the working-class child, and if we can make ample provision for the diagnosis and treatment of her ailments without stigma, there will be some real prospect of ascertaining and treating the mass of gonorrhœa which goes unrecognised to-day. Incidentally the equally important problems of the early diagnosis of cancer, the prevention of sepsis in childbirth, the elimination of ophthalmia neonatorum would be brought nearer solution at the same time.

### THE NEED FOR A POLICY.

By A. K. CHALMERS, M.D.,

*Medical Officer of Health, Glasgow.*

WHEN the Royal Commission on Venereal Diseases reported in 1916, it recommended the formation of treatment centres throughout the country for the double purpose of extending facilities for the early diagnosis of these diseases by laboratory methods and their adequate treatment. For this purpose schemes were to be organised by the local authorities and financed to the extent of 75 per cent. by the Treasury.

Within a comparatively few years preceding the appointment of the Commission, new methods of clinical research had thrown a wide net round many diseases not formerly regarded as syphilitic in origin, and new therapeutic agents offered results with a precision unknown to earlier methods.

Moreover the circumstances of the period in which the Report was issued were exceptional. There was a rising tide of venereal disease associated with war conditions, and a mixing of strains which added virulence to the infections.



VENEREAL DISEASES.

Summary of the work done at the London Clinics for all areas from 1917.

Year.	New cases.						Total Venereal cases.		Total Non-Venereal cases.		Total Attendances.		In-patient days.		Pathological Examinations for	
	Syphilis		S. Chan.		Gonorrhœa.		M.	F.	M.	F.	M.	F.	M.	F.	Clinic.	Practitioners.
	M.	F.	M.	F.	M.	F.										
1917 ...	4,427	3,351	199	11	3,830	1,207	8,456	4,569	1,192	1,168	120,659		63,923		3,988	3,649
1918 ...	3,764	3,002	116	13	4,844	1,940	8,724	4,955	1,345	1,348	169,485		66,095		25,973	6,380
1919 ...	6,394	3,391	463	18	10,441	2,440	17,298	5,849	3,418	1,700	201,626	106,096	24,025	49,186	51,554	10,464
1920 ...	6,988	3,579	766	25	10,669	2,427	18,423	6,031	4,403	2,189	329,940	134,093	29,430	52,182	58,920	14,027
1921 ...	5,088	3,100	458	13	8,573	2,136	14,119	5,249	3,696	2,354	357,503	138,706	30,272	49,420	66,134	18,472
1922 ...	4,207	2,600	309	12	8,233	2,402	12,749	5,014	3,759	2,191	387,631	141,372	28,809	83,755	74,022	19,836
1923 ...	4,497	2,631	311	4	9,043	2,520	13,851	5,155	4,167	2,477	412,915	142,594	29,661	77,001	69,784	24,403

## SOCIAL HYGIENE

In the urgency thus arising the obvious course was to utilise whatever centres of medical treatment existed, and equip them for their new purpose. Hospitals and dispensaries everywhere co-operated with local authorities, and the value of their combined action is illustrated by the growing volume of attendance which falls to be recorded year by year, but more especially, I think, by the growing ratio of attendance to cases. In England it is 21; in Glasgow it was 10 in 1919, but 20 in 1923.

In 1922—the last year for which complete returns are available—there would appear to have been 185 treatment centres in England and Wales, and 36 in Scotland—a provision roughly of one centre for every 190,000 of the population.

In the same year 68,600 cases presented themselves for treatment for the first time in England and Wales, and 12,542 in Scotland, which together might be taken to represent an attack rate of almost 2 cases (1.9) per 1,000 of the population per annum. This cannot be an accurate reflex of the actual number occurring, if only for the reason that syphilis and gonorrhœa are represented in about equal numbers and we know from other sources that the ratio of syphilis to gonorrhœa is about 1 to 3 or 4.

For the year ending March 31st, 1923, the grant to England and Wales would appear to have been £326,634, and to Scotland for the calendar year 1922, £65,783; together £392,417, and if we add one-third to this to represent local authority contribution, we have a total cost of well over half a million (£523,223) pounds annually.

As the total attendances for the period we are considering numbered 1,832,231, this works out at 5/8.5 per attendance and £5 14s. 2d. per case on an average of twenty attendances per case. The ratio of attendances to cases, however, in Scotland was only eleven.

These facts, however, lie on the surface, although I think they support the impression that no inconsiderable use is being made of the facilities provided.

But there are many other aspects of the problem which you as representing authorities responsible for the success of treatment schemes desire to know, some of which by a succession of question and answer I shall endeavour to submit to you as they appear to myself.

1. Do the figures for successive years show a progressive reduction in the number of persons presenting themselves for the first time, or is any reduction which can be shown simply a return to what may be regarded as a normal prevalence in this country in time of peace?

The difficulty here is that we have no pre-war data with which to compare present experience. In our local experience the cases attending outdoor centres for the first time were approximately equal in number in the years 1922 and 1923, but both were lower by about 700 (in a yearly number of between 5,000 and 6,000) than in 1920 and 1921.

This coincides with what would appear to be a common experience

## THE NEED FOR A POLICY

*A. K. Chalmers, M.D. (Glasgow).*

in this country and abroad, but it does not answer the question whether the reduction is a recession from post-war prevalence or is to be ascribed to the operation of the treatment centres.

2. Is the ratio of syphilis to gonorrhœa as seen at treatment centres a true index of their relative prevalence?

Australian, American and Swiss reports coincide with the experience of our own Navy and Army that the usual ratio is 1 to 3 instead of an equal distribution as our local figures at least suggest.

The reason would seem to lie in the lack of appreciation of the gravity of gonorrhœal affections and failure to seek treatment unless the symptoms are urgent.

3. What proportion of persons discontinue treatment without approval of the clinical officer?

Experience here is by no means uniform. For all the Glasgow centres 43 per cent. of the total were still under treatment at the end of the year 1922. Of the remainder who ceased attending during the year, 55 per cent. were discharged medically, 45 per cent. ceased attendance without consent of the clinical officer.

In a special survey of 367 cases of syphilis by the clinical officer of the Broomielaw Centre (which is under municipal direction), 59 per cent. ceased attendance after the first course of treatment, and 15 per cent. at the end of the second course. These are not reassuring figures.

4. Is the type of infection undergoing attenuation to a greater degree, that is, than was observed before the war? If decreasing virulence is observed, how far is it to be explained by the lessened opportunity of mixing several strains of infection which war conditions presented?

The impression of those who have been treating these diseases for some years would appear to be that the cases are not now so severe clinically. Phagedenic cases are seldom seen, and at the Glasgow centres it is said that a really rampant case of syphilis is rare.

Such results might follow reduced potency of the organism, alteration in the strain, or earlier recourse to treatment.

5. Has evidence been collected to indicate the social conditions under which the courtesan lives or the economic strain of underpaid female labour?

The centres afford no answer.

6. Is the country getting a return in reduced prevalence of venereal diseases, or in decreased virulence of the infection, commensurate with the cost?

There is, I think, a growing volume of opinion to the contrary.

7. Is there any evidence or has sufficient time elapsed to show whether the late sequelæ of both diseases are being reduced? Is congenital syphilis less prevalent, or ophthalmia neonatorum, or stricture? Is the admission rate of general paralysis of the insane reduced? Is there a reduced demand on the beds in hospitals for diseases of women? Are cases of specific bone affections or syphilitic affections of the heart lessening in frequency?

## SOCIAL HYGIENE

The returns from treatment centres afford no answer to any of these questions, and yet an answer is essential if we are to understand the true position of venereal diseases.

Congenital syphilis was reported from all the centres in Glasgow in 652 instances in 1922, and in 818 in 1923.

Ophthalmia neonatorum as notified has risen from 15 to 20 per 1,000 births between 1914 and 1923, having reached 30 in 1917 and 31 in 1921. Much of this, however, I think is to be regarded as due to an increasing compliance with the requirements of the Order and not as a true reflex of the prevalence of gonorrhoeal ophthalmia. Round about the years 1917, 1918 and 1919, the proportion of swabs found positive to the number examined was fully a third. This has fallen to less than a fifth now, namely 19 and 15 per cent. in 1922 and 1923, but the compulsory use by midwives of nitrate of silver as an eye lotion at birth may be regarded as vitiating any comparison with preceding years.

8. Last of all, but not least in importance, is the question—what effect is the treatment centre having on the social habits of its clientele?

Each clinical officer could throw some light on this from his own experience, but published returns are silent on the question.

I am able through the courtesy of Dr. Brown, the Clinical Officer of the Municipal Treatment Centre in Glasgow, to submit some figures which are, I think, of considerable if not grave significance.

It is a distribution of cases presenting themselves during a recent year according to the number of times they had formerly undergone a course of treatment followed by cessation of symptoms. It is not necessary here to inquire whether the reappearance of symptoms arose from *de facto* re-infections or were merely recrudescences. The point rather is that so large a proportion of them—after an interval of freedom from symptoms—had again exposed themselves to infection and reappeared for treatment with all the symptoms of a primary attack. The patients were all males, 745 in number; 359—or rather less than half of them—had no earlier record of symptoms, i.e. they were without doubt primary attacks. But 311 after an interval of freedom from symptoms had recently exposed themselves to infection for a second time and suffered a recurrence of symptoms—61 for a third time, 12 for a fourth time, and 2 for more than four times. In other words, more than half the total number were habitual libertines.

If this is a fair sample of the habits of patients attending male clinics elsewhere, then we must frankly recognise that the treatment centres are being put to a use foreign to the intention for which they were created and that a corresponding proportion of their annual cost is being diverted to the furtherance of promiscuity.

The ablution centre failed to gain acceptance because of the conviction that it would lend itself to this very purpose, and if the experience of the centre I have submitted is a fair reflex of the experience of other male centres, then I submit that the time has come to draw up the veil of secrecy which was devised to replace the veil of ignorance of former times.

## THE NEED FOR A POLICY

*A. K. Chalmers, M.D. (Glasgow).*

It is, I think, a fair description of the position since treatment centres were established to say that while valuable clinical knowledge has been acquired and much suffering relieved, local authorities have learned little of the distribution of venereal disease and even less of what may be called its social epidemiology—if one may apply this term to the setting in which much of it occurs—the underpaid female labour, the inadequate housing and other conditions which are recognisably associated, I think, with some at least of its phases. They adopted without question and as in a sense an "emergency measure" in a time of national trial the duty of arranging schemes for treatment which in the larger towns, at least, necessitated much "farming out" of their responsibilities to existing institutions.

These are not the lines on which they have endeavoured to cope with other diseases. Nor would the position be improved, so far as I can see, by passing over to them for disciplinary purposes those who fail to continue treatment.

The proposal to compel a patient to continue treatment is based on a complete misapprehension of the powers of local authorities. They may prevent him from spreading infection and for this purpose remove him to hospital, but they cannot enforce a specific method of treatment. This, I understand, is common law.

If notification is to be considered, it must be approached, I think, on much wider lines. To those who regard social evolution as a completed movement it may be useful to suggest the contrast between present day customs and what we believe to have been those of the period of phallic worship.

The Royal Commission considered the question of notification and expressed the opinion that better results might be obtained by a policy of education and the provision of increased facilities for prompt diagnosis and adequate early treatment (Venereal Disease Report, para. 167). But they said further "that the situation may be modified when the facilities have been in operation for some time, and that the question of notification should then be further considered." They thought it also possible that when the general public became alive to the grave dangers arising from venereal disease, notification in some form would be demanded, and that the measures which may be required in the future must depend on experience gained after existing deficiencies have been remedied (para. 168).

I submit to you that the time for further consideration has arrived.

Until quite recently I was inclined to regard congenital syphilis in quite young children, and ophthalmia neonatorum of gonococcal origin—constituting as they do unimpeachable evidence of physical injury to third parties—as offering means of dealing directly with infectious parents and preventing a like injury to later children.

The record of the male treatment centres suggests a much wider need. It is that local authorities should themselves undertake responsibility for treatment and prepare for a comprehensive

## SOCIAL HYGIENE

study of the whole problem of the distribution of venereal diseases. Towards this end notification by name and address is the first step in the programme. But to be effective notification would, I think, require to be applied simultaneously to large areas which would include, it might be, many contiguous local authorities. Sectional notification by local authority districts would, I believe, defeat the object.

Para. 162 of the Venereal Disease Report strikes, I think, a false note in suggesting that the value of notification is to be assessed rather by its power of ensuring continued treatment of the individual than of aiding in the provision of general preventive measures. Both are required, and they are of equal importance.

### DISCUSSION.

*Dr. Daley, Medical Officer of Health, Blackburn.*

(1) **Notification.**—There has been constant discussion on this matter for over five years. All the arguments *pro* and *contra* are threadbare and are well known to all who take an interest in the subject. The history of sanitary legislation in this country shows that it is the result of trial and error. Notification of infectious diseases was first tried in Bolton. The appointment of the first medical officer of health was at Liverpool as a result of powers obtained in a Local Act. Notification of tuberculosis was tried in several towns before it became generally compulsory. Notification of births was tried in Huddersfield. Many of the arguments against the notification of V.D. were used in opposing the notification of the acute infectious diseases, but in practice it was found that the difficulties disappeared. The notification of V.D. is a much more complex problem than any other notification problem, but at the same time there is no reason why it should not be tried, preferably in a town where there are other towns containing clinics within easy distance. After two years one would know whether or not notification had decreased or increased the attendances in the notification town and whether or not patients from the notification town were attending centres in the surrounding non-notification towns in greater numbers.

(2) **Education.**—The speakers up to now have alleged that fear has no deterrent effect, yet there must be many to whom an appeal based on character-building would fall on barren soil. It appears to me that fear is a real deterrent, both fear of the physical consequences and fear of public opinion if it should be known that a patient has acquired V.D. Reference was made in this connection to an anatomical museum in which the results of V.D. are set out somewhat luridly. After an intensive V.D. campaign much good can be done by referring incidentally in general health propaganda work to the ravages of V.D.

(3) **Treatment of Women and Children.**—Stress was laid on the advantage of treating respectable married women and young children at a maternity and child welfare centre and of appointing the same woman doctor to treat women at the treatment centre

## LOCAL AUTHORITIES AND NOTIFICATION : DISCUSSION

at the general hospital and to attend to the general maternity and child welfare work in a town.

*Dr. R. M. F. Picken, Medical Officer of Health, Cardiff*, said that in Cardiff, if not in the rest of Wales, they were coming to the view that the local authority, which was the agency through which the campaigns were supposed to be carried out, should be more "in the thing" than was the case now. Unfortunately the local authority had contracted out its responsibilities regarding venereal disease, with the result that it was not very much interested in the subject. If the local authority realised what a serious problem this was, they would carry into their activities this knowledge when providing recreation for the people in their parks, in selecting suitable recreations, and in the training of teachers and the teaching of children.

He suggested that too much stress had all along been laid on secrecy in connection with the treatment and prevention of venereal disease, and stated that it would be difficult to make real progress so long as the likelihood of exposure to these diseases was not recognised by the public.

In connection with prophylaxis, he agreed that instruction would most successfully be given through the clinics rather than by the handing out of pamphlets, bills, etc., and expressed the view that this aspect of the subject, and indeed the whole problem of prevention, would be advanced if the clinics were under the direct administration of the local authority.

Some form of notification, in his opinion, was going to come, and when it did he did not think it would be efficient until they were working their own schemes.

*Baillie Fraser, Dundee*: For a V.D. scheme efficiency is essential. This remark applies, of course, to any public health activity, but it applies particularly to the venereal diseases campaign. Yet the fact is that it is a most difficult scheme to make efficient for reasons which we all know. There is first of all the difficulty of getting information regarding persons who are infected. Many people who know they are infected will not go to a doctor or to a public clinic for treatment, but prefer to treat themselves or to accept the advice of unqualified persons. There are many others who are infected with the disease, but who are quite unaware of the fact, in all probability the infection having been contracted innocently. Then again, when infected persons do seek the advice of a private doctor or of the medical officials of a venereal diseases scheme, a large number cease treatment long before they can be certified free from infection, and indeed it must be a comparatively small percentage of those commencing treatment who continue to carry out the advice until they are cured. The general result is that the venereal diseases scheme, as it stands, only eradicates a comparatively small proportion of the enormous number of the sources of infection from which the disease may radiate. This brings to one's mind the advisability of making the venereal infections notifiable all over the country, and I feel satisfied that if notification were made compulsory the efficiency of the campaign

## SOCIAL HYGIENE

would be greatly increased. The system of notification may have to be rather different from that which has been applied to the other infectious diseases, and to be satisfactory it would be essential to combine notification with compulsory treatment. Further, before notification could be made compulsory all over the country, facilities for free treatment of the disease must be available to every member of the population, no matter where he resides. I must admit that there are many difficulties in the way, and that many arguments, and good ones too, can be used against notification, but careful and prolonged study of the problem has convinced me that it should be given a trial. Even if it is granted that there would be only a trifling increase in the number of new cases presenting themselves for treatment, or no increase at all, or even a reduction, there would, I am sure, be a larger number of patients treated to a termination and thereby a reduction secured in the incidence of, for example, syphilitic diseases of the nervous system and heart.

*Judge Harvey, Convener Edinburgh Public Health Committee:* Before discussing the main plea in Mr. Whyte's paper, there were three matters which had been incidentally mentioned to which he would like to refer. Mention had been made of the treatment of venereal disease in prisons. While regulations did exist issued from the relative department, their interpretation was at the mercy of the respective prison commissioners, or it may be the prison governor or prison medical officer. The result was very unsatisfactory, and in some cases led to a system of treatment which was not up to the standard of the local authority, or was not conveniently amenable to the local authority's scheme. He thought the regulations ought to be more specific, and where the local authority desired, clinics as well as treatment should exist within the prison walls.

The Order issued in 1916 by the Board of Health rendered it obligatory on all local authorities to submit schemes of their own or become part of the scheme of some larger local authority. Notwithstanding that, Mr. Whyte's figures showed that there was a considerable proportion of local authorities in Scotland who had not complied in either of these ways with the Order.

With regard to the proposal for a consultative committee, this was a desirable development in the campaign. It should, however, be made clear that the Ministry of Health would be represented on any such committee, and look upon it as part of the departmental machinery.

With regard to the main part of Mr. Whyte's paper discussing notification, it might be said that the outstanding success of the Edinburgh scheme would suggest that notification was not necessary. We had *prima facie* a slight reduction in the number of positive cases of venereal disease, but when the figures were critically examined we did not find much reason for satisfaction. It is true that we have the unparalleled achievement of 85 per cent. of completed cures. On the other hand, last year we had to deal with 356 cases of congenital syphilis. There was also a



## LOCAL AUTHORITIES AND NOTIFICATION: DISCUSSION

considerable number of cases of ophthalmia neonatorum. Until there was some power given to the local authority to trace the source of child infection with consequent compulsory treatment for guilty parents and other infected members of the family, there was little room for satisfaction in the achievement recorded. As regards notification generally, we were not so much impressed in Scotland with interference with the liberty of the subject. There was also to be considered the extension of licence to the libertine. Balancing these two factors, there was a feeling in Scotland that some system of notification was more than justifiable. It was desirable if the local authority was to be able to carry out its prime function in public health, namely, preventive administration.

*Mr. Councillor Armstrong, Glasgow Corporation:* The Corporation of Glasgow passed a resolution recently almost unanimously in favour of notification. I happened to be absent on the occasion through illness, otherwise my support would have been added to the minority. I am quite prepared to accept the principle of notification if anyone can satisfy me that the results will be beneficial or an improvement on our present methods, but I have not met such a person, and the fact that the results of our own private voluntary treatment are as good, if not better, than those of almost any other place where compulsion has been adopted strengthens my belief in our present methods. I am not a believer in coercion. Notification without some means of detention is useless. What good purpose can be served, though we have all the correct names and addresses of the victims, when we allow them to go free and spread the disease at will? We cannot guard them morning, noon and night. Venereal diseases cannot be classed with other diseases such as smallpox or tuberculosis. There is a moral stigma in the one and not in the other. The average man does not want his sins paraded, and without detention any attempt at notification would be unavailing. It simply penalises the man who honestly comes forward and allows the man to go free who attends quacks or undergoes other treatment. In any case it tends to make for concealment. I had occasion recently to visit our various clinics, from one of which I selected what I considered the most intelligent man who had come for treatment that night. He was a faithful attendant and seemed anxious for cure. I spoke to him in a friendly way, telling him of the scheme of notification proposed by the Corporation. His answer was that if such a measure was put into practice he would go elsewhere. This, I think, is the general feeling amongst this class. What we really want is to give our present scheme, which has only been in existence for five years, a proper chance. The results are good but can be improved.

I am a believer in propaganda and education. Teachers can do much with their scholars, parents with sons and daughters. There need be no timidity. Boys and girls know. We can warn the public by leaflets and posters and give instruction by lecture

## SOCIAL HYGIENE

and film. If this fails, then other ways and means can be adopted ; but I consider it best for the good of our cause to walk warily and on safe ground.

*Provost Sir Henry Keith, Convention of Royal Burghs*, urged that all possible steps should be taken to secure the introduction of compulsory notification. He supported the references to this aspect of the question in Mr. Whyte's paper pointing out that the Convention of Royal Burghs in Scotland which represented all the Burghs in Scotland had declared unanimously in favour of it. He confessed that he did not see, in principle, any difference between venereal disease and other diseases that were notifiable, and emphasised the waste of public money so long as compulsory notification was delayed.

*Mrs. Somerville, Scottish N.C.C.V.D. Committee*: After sixteen years' experience in child welfare work and from close observation of its most difficult problems, I should like to place before the Conference certain types of situation which would seem to demand in the name of the child a certain measure of control of known sources of infection. The four situations described have come under my personal notice.

(1) In a V.D. hospital a woman, in the infectious stage of her illness, was visited by her husband, a man home on holiday from the Navy. The doctor in charge offered to make all arrangements for frequent visits to the hospital by the husband, but earnestly begged both husband and wife not to spend the fortnight at home together. No pleading was of any avail. The patient went home, lived with her husband, and entertained and was entertained by friends. What chance had that husband of escaping infection? What chance had any child, conceived in such circumstances, of being born healthy? No authority had power to detain that woman to prevent almost certain infection, or to intervene so that the possibility of a diseased child might be avoided.

(2) A mother, visited fortnightly by me, had a badly nourished child. Under persuasion she attended a child welfare centre, where the child was treated for some weeks for malnutrition. As no improvement followed mother and child were sent for observation to the V.D. ward of a hospital. Both were found to be suffering from venereal disease. In spite of skill and care the baby died. The mother remained for a short time in hospital and then returned home to her family, still far from cured. She is now the mother of another small, feeble and badly nourished child. No authority had power to make the mother remain under treatment until she was free from infection and fit to return home to become the parent of another child. No authority had power to say to her: "You have brought into the world one diseased child; if you are again an expectant mother you owe it to the next child to be treated throughout your pregnancy to prevent a second catastrophe."

(3) I spent a month in a Poor Law hospital so that I might

## LOCAL AUTHORITIES AND NOTIFICATION: DISCUSSION

compare the child life there with the child life in the homes of the congested areas so well known to me. During that month ten infants out of twenty-six died; two more died a few days after I left. Some of these deaths were due to venereal disease, others, as no evident cause of death could be attributed, were presumably suffering from hereditary poisoning in some form. The children either gradually assumed the expression of the aged who have lived beyond their years, their faces lined and sad, bones showing through transparent skin, red feet and excoriations. They took a little food; it made no difference. After a time they quietly went out. In other cases, without any reason, they suddenly collapsed. The mothers of these children were known, in some cases the fathers were known. To the mothers who were in the poorhouse a certain measure of treatment was given. But no authority had power, in the interests of the future, to compel these parents to remain until free from infection. They returned to their homes or to the streets free to repeat the tragedy of the diseased child.

(4) Some months ago a man assaulted a little girl of four. The case was tried and guilt was acknowledged. A plea of feeble-mindedness was put forward and accepted by the judge. The little girl, suffering from shock, was taken to a hospital. She was found to be suffering from venereal disease. No authority had power to compel that man to be examined nor, having been examined, had power to treat him until he was free from infection. Two months later the man married. What chance had his wife of escaping infection? What chance had any child born of that union of escaping infection?

With those four types of situation before you—and they are only specimens of many others which might be presented—I submit that in the interests of the child some measure of control is essential. The life and health of children is in danger. The medical officer of health can place his finger accurately on the source of danger; it is essential for him to be able to do this and to be able to control it, otherwise what does the prevention of disease mean?

*Colonel Harrison, Ministry of Health:* I came in so late that I am afraid I am not competent to discuss the various points which have been raised this afternoon. My only reason for taking any part in this discussion is that I have gathered from the remarks I have heard that the Scottish delegates are seeing red when they contemplate the returns showing the percentage of patients at V.D. treatment centres who cease treatment before completion, and that they propose to achieve the millennium by the method of notification with its natural sequence, compulsory treatment. I see many difficulties in such a measure and fear that it may have an undesired effect in some directions. As to difficulties, if anyone will take the trouble to study the working of a system of compulsory treatment in countries where this is law, they will find that in congested areas the difficulties are very great. Assuming that notification and

## SOCIAL HYGIENE

compulsory treatment were established in this country, it is easy to understand the fear in the mind of the prospective patient that his disease would be disclosed if he were to report at a treatment centre. It is easy to understand that he would certainly be longer in screwing up his courage to report for treatment and that he would do so under a false name and address. Do you propose to keep an army of detectives to check this? In any case I believe that fear of disclosure such as would be entailed by compulsory proceedings would cause many patients to wait until the last moment before attending. It is well known that one of the great essentials to success in the treatment of V.D. is that it should commence at the earliest possible moment. It does not matter what would really happen; what matters is the impression the general public gains of the effect of such a measure of notification and compulsory treatment as that which has been so strongly advocated this afternoon. Again I would ask if the defaulting is so very serious as to require such a drastic procedure. The records of defaulting put the case really in its blackest light, because, as many medical officers of clinics will agree, many of the patients who are returned as having ceased to attend before completion of treatment were non-infective when they first attended the centre, so that their defaulting does not make them a danger to the public. Also there are many included amongst defaulters who, under treatment, had long ago become non-infective. They have to be returned as having ceased to attend before completion of treatment because there is no other category in the annual return in which they can be placed, but as far as my own experience is concerned, at any rate, it is quite certain that a large number of patients are kept under treatment long after they have become non-infective. Again, how is it possible to make a law of compulsory treatment effect the purpose we desire when a patient can go to any practitioner, however ignorant of the standards of cure of venereal disease, and obtain from him a certificate that he is non-infective? Shortly, then, I fear that notification and compulsory treatment would not have the effect desired; it would involve considerably increased labour and it would have the disastrous effect of deterring many patients from seeking treatment at the earliest possible stage of their disease. I would rather, for the present at any rate, concentrate on perfecting the treatment facilities in the country, because I believe that, as these improve, defaulting will become less and less.

# Veneral Diseases Treatment.

*President of Section :*

DR. F. N. KAY MENZIES

*(Late Assistant Principal Medical Officer to the London County Council)*  
in the Chair.

The chairman stated he would reserve his remarks until the opening of the discussion.

## HOW TO SECURE THE MAXIMUM EFFICIENCY OF A V.D. CLINIC.

By Col. L. W. HARRISON, D.S.O., R.A.M.C. (Ret.)

At the outset of a discussion on the best means of securing the maximum efficiency of a V.D. clinic, it seems desirable to state its functions. These are :—

- (a) To render non-infective those infected persons who apply to it for treatment in response to outside influences.
- (b) To assist the propagandist work of the public health scheme by attracting for treatment the greatest possible number of the infected population who would not otherwise come under medical care.

According to the perfection with which it carries out these functions, should its efficiency be judged in the first instance, and according to the financial economy with which it accomplishes its purpose should it be judged in the second. In short, a clinic succeeds in proportion to the percentage of its patients who are rendered non-infective and also in proportion to the use which it makes of its opportunities of attracting more patients who would not otherwise come under efficient medical care. It must not only keep its patients attending until they are cured, but it must seize every opportunity of bringing under treatment those who have been infected by, or have infected, its patients.

In the pursuit of these objects the clinic is faced by certain obstacles which must be clearly understood before measures can be taken to overcome them. The chief factors opposing success in retaining the patient under treatment until no longer infective are as follows :—

- (1) The failure of many patients to realise the seriousness of their diseases to themselves and others, and their tendency to believe that, when outward signs have disappeared, the disease has been eradicated.
- (2) All forces which increase a patient's disinclination to attend such as fear of discovery, the loss of time involved with

## SOCIAL HYGIENE

perhaps loss of work, or, what is almost equally important in the eyes of many patients, loss of amusement during hours of leisure.

It is clear, then, that the treatment centre must educate the patient in the seriousness of his disease and the importance of insuring its eradication. It must treat its patients with such skill as will insure recovery as soon as possible, so that the period of treatment may not be lengthened unduly. Further, it must study the convenience of its patients so as to make the attendance as little irksome as possible.

The measures to be taken to secure these objects may be considered under the following headings:—

- (1) The situation and arrangement of the premises in which the work is conducted.
- (2) The composition of the staff.
- (3) The routine of work.

I would place the situation and arrangement of the premises first in the list of requirements because bad situation and bad internal arrangements are, I believe, at the root of much of the inefficiency of centres at the present moment.

There is not much to be said on the situation of the centre. It is generally agreed that it should be reasonably convenient of access and that it is a great advantage when the approach can be such that the object of the patient in using it is not disclosed. For these reasons we try, wherever possible, to place the centre at a general hospital, but it is, to me, rather surprising that, in some of the places where this has been done, the authorities have made a point of providing a special entrance, thereby nullifying the great advantage of the hospital cover. I have particularly in mind one such centre where the neighbouring inhabitants assemble nightly to watch the arrival of the unfortunate V.D. patients at the special entrance so carefully provided by the hospital authorities. With all respect to hospital authorities, a V.D. patient does not contaminate the ground on which he walks, nor the air he breathes. As to convenience of arrangements, I hold very strongly that the premises should be designed specially for the requirements of the treatment of venereal diseases and that they should be available for the purpose any hour of the day they may be required. The special design and the constant availability are required particularly for the management of gonorrhœa. For syphilis very simple arrangements suffice, as will easily be understood. But syphilis is not the only venereal disease, though many people seem to have that impression. The problem of syphilis is simple in comparison with that of gonorrhœa. Its solution is helped by the fact that the patient takes a much more serious view of it than he does of gonorrhœa; its treatment is easy, and it is not a disease which requires frequent examinations of a particularly private nature. Gonorrhœa, on the other hand, bristles with difficulties. The patient, whether male or female, regards it much less seriously, while its cure demands frequent painstaking examinations which occupy much of the surgeon's time and involve exposure of the

## MAXIMUM EFFICIENCY OF A V.D. CLINIC

*Col. L. W. Harrison, D.S.O., R.A.M.C. (Ret.).*

person to a degree which must be repulsive to the patient, even under good conditions. If the arrangements are not convenient, these systematic examinations to determine the locality of the residuum of infection cannot be carried out to nearly the required extent. The medical officer is then forced into a line of treatment which may be summed up in repetition of medicines and irrigations or injections, under which the infection remains uncured until the patient, seeing that he is getting no more from his attendance that he could do for himself at home, becomes tired and disgusted and ceases attendance before he has been rendered non-infective. It is easy to cover bad work in gonorrhœa, and it is easy for the medical officer to slip along the line of least resistance which is summed up in repetition of medicine and irrigation *ad nauseam*, especially when it is so difficult to make hospital authorities appreciate the special difficulties of treating large numbers of gonorrhœa cases and the prime necessity for arrangements which are as convenient as possible. Too often medical officers of centres fail to voice their requirements. They put up with such arrangements as are made for them by hospital authorities, who cannot be expected to know what is necessary. Such medical officers forget that it is for them, as the experts, to state their needs.

In designing the V.D. treatment centre at St. Thomas's Hospital, I tried to trace out in imagination the movements of each type of patient from the beginning to the end of the treatment, as also the movements of the staff in its various functions, and aimed to secure for the patient the maximum degree of privacy, and for the staff the smallest amount of unnecessary movement. The result is a centre in which the patients take a route on the perimeter, and the staff moves on internal lines, so that each journey is as short as possible. In order further to reduce unnecessary movement on the part of the staff, the patients are examined in cubicles opening on to a space which is sacred to the staff so that traffic of patients and staff is not confused. The cubicles are themselves almost completely self-contained so that a medical officer can carry out his examination without, either himself or an attendant, having to run about for necessary implements.

I think I can fairly claim that the design has proved convenient to the staff and satisfactory to patients. The convenience of the arrangement is further demonstrated by the fact that the centre is far more economical than the average, as judged by the cost per attendance, and it is in fact almost the cheapest in the country. The centre deals with more than one-fifth of the attendances at all the London centres, and one-twelfth of all the English centres. A slightly abbreviated form of the Ministry's plan, which is on the same principle, can be seen at Hastings, where I believe that Dr. Huckle is eminently pleased with his arrangements.

### STAFF.

As regards the staff of medical officers, it is sometimes contended that venereal diseases can best be dealt with by relegating syphilis

## SOCIAL HYGIENE

to the care of the dermatologist; gonorrhœa in males to that of the genito-urinary surgeon; and gonorrhœa in women to the gynæcologist. Such a contention assumes that syphilis is only a skin disease, and that, for the treatment of gonorrhœa, it is necessary to possess all the knowledge and skill of the genito-urinary surgeon, or all the knowledge and skill of the gynæcologist, according to the sex of the patient. I hold that it is unnecessary to possess all these great attainments in order to treat gonorrhœa successfully, or to avoid diagnosing as syphilitic, simple dermatoses. I would even go further, perhaps from a prejudice resulting from my own training, and prefer for the management of venereal diseases someone who had first received a thorough laboratory training and had learnt the fractions of the dermatologist's art to enable him to say what was syphilitic and what non-syphilitic; the fraction of the genito-urinary surgeon's knowledge to enable him to treat the urethra, and the very little of the gynæcologist's art to enable him to detect enlarged, inflamed uterus, tubes and ovaries. These diseases are bacterial in origin, and I feel confident that progress in their treatment will continue, as in the past, to emanate from the laboratory rather than the surgery. But that only by the way. A greater consideration in the selection of the medical staff for the management of venereal diseases under the V.D. scheme is this.

The V.D. treatment centre is a unit of the public health service, and, unless it is thoroughly imbued with the public health spirit, it will not attain its maximum efficiency. More is required than the mere treatment of patients, as I hope to show, and it militates against the efficiency of the unit if its direction is divided up. Apart, therefore, from the fact that venereal diseases are grouped together naturally by the circumstances attending their contraction, just as are tropical diseases, there are strong reasons for grouping them in a V.D. centre under one direction. As to the choice of director, he should be one who is not only skilled in treatment and imbued with the public health spirit, but should have some organising ability. He should be able to co-ordinate the efforts of his staff so that there is as little as possible waste of energy, and he should be one who will even condescend to study the prevention of waste in the matter of the materials and implements he uses. This question of prevention of waste is one to which I have given some attention, on the principle that there is a limit to the amount which the public can be expected to pay, and the less money is wasted on unnecessary the more there will be for drugs and implements which are essential to the centre's efficiency. Many medical officers in charge of centres consider that it is not within their function to concern themselves with what seem to them such petty details as the comparative prices of remedies which are equal in therapeutic activity, or with the necessity of using such remedies at all, and I have no doubt that my request that some attention should be paid to this side of the question has called forth some criticism on the score of pettiness. In reply to such criticism, I can say only that, if I were as extravagant in the matter of drugs, other than salvarsan, and in dressings as a



## MAXIMUM EFFICIENCY OF A V.D. CLINIC

*Col. L. W. Harrison, D.S.O., R.A.M.C. (Ret.).*

number of medical officers in charge of centres, these items would cost my hospital no less than £8,000 a year, instead of about £700.

Naturally the staff working under the director depends on the turnover of the centre. The medical officers must of course be skilled in treatment, but they must be more than this. They must be doctors in the best sense of the word, able to sympathise with their patients and consider their difficulties. I know some very skilled medical men who would never be appointed assistants in my clinic because their censorious, unsympathetic attitude would cause many patients very quickly to cease attendance. As regards other staff, besides the necessary trained attendants and clerks, in clinics of any size I would always include a trained lady almoner, whose duties are to inquire tactfully into the social circumstances of female patients, so as to be able to give a helping hand where required. For instance, to obtain hostel accommodation for a girl who is wavering between the streets and respectability, or to arrange for the payment of fares for a woman who finds it difficult to attend on account of the expenses of travelling. Also, for many other purposes to which I shall refer in speaking of the routine of duties.

### ROUTINE OF WORK.

The routine of work of a V.D. treatment centre may be considered under the following heads:

- (a) Hours of work.
- (b) The examination and treatment of patients.
- (c) The following up of patients who have ceased attendance before receipt of a clean bill of health.
- (d) The tracing of contacts.

As to the hours of work, I think that the most efficient centre must be open at all hours of the day and evening, so that patients who require such daily treatment as can be applied by, or under the supervision of, the trained attendants, can attend at any time which is most convenient to themselves. Daily attendance makes a large demand on the patient, and the best which can be done is to arrange that the patient can come at any time and lose as little time in the clinic as possible. Attendance by arrangement with a nurse or attendant does not meet the case throughout the long period the patient often has to attend.

It is also a great advantage if the turnover of the centre is large enough to justify the presence of a medical officer at all hours of every day and evening, as for instance at St. Thomas's Hospital and St. Paul's, where the centres are open from 8 a.m. to 10 p.m. daily. When a continuous service of medical officers cannot be arranged, the hours at which they can attend should be selected with some regard to the patient. Naturally if a patient has always to attend at some hour when he would otherwise be at work, or at some particular amusement, the forces influencing him to discontinue are stronger than if he can attend at some time when he would be doing nothing in particular. As an example, I will

## SOCIAL HYGIENE

instance two centres both serving an equally congested industrial population, within a few miles of one another, and equally staffed by medical officers who are in every way excellent for this work. One centre is open every week-day and evening until 10 p.m., the other is open on one evening only and on Wednesday and Saturday afternoons. The ratio of cases to attendances during 1923 in the all and every day clinic was 1 to 11.8 syphilis and 1 to 33 gonorrhœa, while that in the clinic which was open during comparatively restricted hours was 1 to 4.6 syphilis and 1 to 17.2 gonorrhœa, that is less than a half in the case of syphilis and only just over a half in that of gonorrhœa. The syphilitic patients who ceased attendance before completion of treatment in the all-day centre were 12.3 per cent. of the whole of the syphilitic cases and the gonorrhœa patients who ceased were 14.6 per cent. of the gonorrhœa cases. On the other hand, in the restricted hours clinic the syphilitic patients who ceased attendance before completion of treatment were 33.2 per cent. of the syphilitic cases and the similar gonorrhœa patients were 32.4 per cent. of the gonorrhœa cases, i.e. the defaulter ratio in the clinic with restricted and inconvenient hours was more than twice that of the all-day clinic. I may add that the system of book-keeping in the all-day clinic favours a higher record of defaulters. The anti-syphilitic treatment also is longer, and naturally, other things being equal, the longer the course the greater the number who fail to complete it. A very large proportion of the work in the restricted hour clinic is done on Saturday. In the all-day clinic the average proportion of patients who attend for medical advice on Saturdays is no more than one-sixth of the average number who attend to see medical officers on any other week-day. I think it fair to infer from this that, although a patient will attend on Saturday afternoon if he cannot attend at any other time without loss of work, he will do so only so long as his disabilities appear to him to require medical attention urgently. His dislike of Saturday afternoon is shown in the experience of the all-day clinic which is only sparsely attended on that day, while the effect of the constant lure of Saturday afternoon entertainments is shown in the fact that the clinic which offers to the man in employment only Saturday afternoon has a much larger proportion of defaulting. I would urge therefore that, in choosing the hours during which a clinic is open, regard should be paid not only to the hours of labour but to those during which the adult patient has become accustomed to look upon as for his special enjoyment.

The examination and treatment of patients must be carried out as decently and expeditiously as possible. In the ordinary routine it is easily possible to arrange that patients for arsenobenzol injections are first examined rapidly one after the other for their fitness to receive the next doses of the selected remedies and can then be passed on in small batches for injection. Only a slight amount of organisation is necessary to insure that no patient is injected without a previous examination for his fitness for the dose.

The routine of gonorrhœa in men is simple enough in acute cases,

## MAXIMUM EFFICIENCY OF A V.D. CLINIC

*Col. L. W. Harrison, D.S.O., R.A.M.C. (Ret.).*

but it is in cases which hang fire that the organisation often fails. Without a numerous staff it is quite impossible to examine such cases in detail during hours when large numbers of patients attend. An attempt is often made to carry out such an examination, but it is usually restricted to the prostate, or only the urethroscope is passed, and in the scramble of work in some centres it is very apt to happen that no patient receives any systematic examination at all. The medical officer will exclaim that such a systematic examination is quite impossible owing to the number of cases. I suggest that it would be possible if he were to make a list of his chronic cases, set aside a fraction of his available time for the special examinations and, in the course of successive sessions, work systematically through the list. The mistake which is so often made is neglect to review the case records when the patients are not there and to mark down those which require more special attention than can be given in the course of a routine session. It does not matter greatly how, or at what hours, it is arranged so long as the hours are not such as to keep other patients waiting unduly long at ordinary sessions, and I may say that the Ministry of Health is always sympathetic to the desire of a medical officer for a special session for the examination of these chronic cases. The great thing is to recognise that they exist; that their examination consumes more time than that of the ordinary routine case; and that in the arrangements of every centre provision must be made for them.

For the rest, I would add only that the relation between the patient and the doctor should always be friendly and sympathetic. There is a great difference between medical officers in this respect. One gives the patient the impression of being considered a great nuisance and the other that his only ambition in life is to see the patient restored to complete health, so that, if the patient were not to attend at the appointed time, the doctor would be broken-hearted. I wish to convey the truth that a very great deal to maintain attendance can be done by the medical officer during the examination and treatment of the patient, and I can usually forecast the percentage of defaulting in a centre simply by watching the manner in which the patients are handled, the amount of sympathy displayed by the medical officer and the amount of interest which he takes in the work.

### FOLLOWING UP.

In the best of centres a certain proportion of patients are certain to cease attendance before they have been pronounced cured, and there is some difference of opinion as to the course which should be taken in these cases. Some medical officers hold that it does harm to send letters requesting re-attendance and urge, in support of their argument, that many letters are returned through the dead-letter office, while some are opened by others and give rise to family trouble. Those who have adopted the method of sending letters to patients who have ceased attendance

## SOCIAL HYGIENE

and have studied the most ingenious methods of doing so are convinced that follow-up letters are very successful in securing re-attendance. It is true that many letters come back through the dead-letter office. A few are opened by others, and complications threaten which require a little tact for their settlement, but altogether I am convinced that it is well worth the trouble to write to patients who default. I would urge, also, that the letter should follow quickly on the default; in my own centre I have experience of the difference between giving a patient three months' rope and writing to him after only one month's absence. If the delay is too great, the success is small, but if the patient receives a letter within a month, it is much more likely to bring him back. It is a good plan to let patients know they will be written to if they cease attendance, and on the back of the identification card given to my patients, as well as on a notice displayed in the waiting-room, I request them to write and let us know if they cannot attend for any reason, *in order that we may not have the trouble of writing to them.* At St. Thomas's we have two letters for patients who cease attendance. The first is very non-committal. The second is printed in red and very much to the point. I argue that a patient who has ignored the notice on the back of his identification card, the notice displayed in the waiting-room, and my very mild first letter, deserves the red letter, even with all the trouble it may bring him from falling into wrong hands. In the following up of female patients I would pay a special tribute to my lady almoners, who have been particularly successful in restoring attendance.

### TRACING OF CONTACTS.

In an early part of this address I mentioned that one of the functions of a V.D. clinic is to secure the treatment of others who would not otherwise come under medical care. Part of this is accomplished by the manner in which the work is carried out. Just as a good doctor secures a large practice, so the turnover of a clinic depends on the value it gives to its patients. But, besides this, there is another side of the question, namely the securing of persons who have been infected by, or have infected, patients already attending the clinic. This is a side which is often forgotten by medical officers, who are content merely to get through the work which presents itself, and many opportunities of securing the treatment of contacts are missed. A woman who attends with an infected child should be persuaded to undergo examination and treatment if this, as is often the case, proves to be necessary. Very often the woman can be induced to persuade her husband to attend, and so whole families are secured; the miserable chain of congenital children in the family is broken, and the clue of one patient leads to the restoration to health of numbers who would never have attended but for the little extra effort made on the clue afforded by one case.

To sum up what I have put in so many words, to secure the maximum efficiency of a clinic requires, besides skill in diagnosis

## MAXIMUM EFFICIENCY OF A V.D. CLINIC

*David Lees, D.S.O., F.R.C.S. (Edinburgh).*

and treatment, first a clear idea of the public health object of the clinic; a little imagination; some organising ability; a few grains of commonsense; and last but not least, a measure of charity—not the smug, self-satisfied travesty which masquerades so commonly as charity, but the kind which is described in the thirteenth chapter of St. Paul's epistle to the Corinthians.

## METHODS OF SECURING THE MAXIMUM EFFICIENCY OF A VENEREAL DISEASES CLINIC.

By DAVID LEES, D.S.O., F.R.C.S., Royal Infirmary, Edinburgh,  
*Lecturer on Venereal Diseases, University of Edinburgh.*

THE conditions which exist in different parts of the country and in the various clinics throughout it are so entirely dissimilar that it is impossible to lay down methods which would be universally applicable in the management of every clinic. My remarks throughout apply more particularly to Scotland in which there are one or more clinics in each of the four larger centres of population. There are also several smaller hospital and *ad hoc* clinics in densely populated areas and in the provincial towns to which they are applicable. The problem of running a successful department differs in the hospital and in the *ad hoc* clinics. It is much more difficult in the latter. In both, however, there are several points which are of importance in attaining the maximum of efficiency. The question must be studied from two points of view (1) the administrative and (2) the clinical aspect.

### ADMINISTRATIVE.

Any state aided scheme of medical services seems to call for a large amount of administrative work. Estimates of expenditure, statistical returns of treatment, records of attendance, and many other returns are called for. For such work the average medical man has no training, he finds it irksome and often considers it a waste of time. From the economic standpoint it is unsound to employ a highly trained medical man at such statistical work. In every clinic handling more than 500 new patients per year a trained clerk to carry out such work is essential. It is advisable that this clerical worker should be one of the permanent staff of the Medical Officer of Health and thus the necessary close touch with the Public Health Department is obtained. In smaller clinics the part-time services of such a person should be similarly available. In addition to being responsible for all statistical returns this person would be available for typing the correspondence between the Clinical Officer and practitioners who send cases. He should be the means of keeping the clinic officer posted from day to day in the essential administrative medical details which require attention.

When a clinic is established in a general hospital the accommodation provided must be adequate. An office separate from the clinic, but in close proximity and with a separate entrance, is essential for the chief and the full or part-time secretary. Such

## SOCIAL HYGIENE

accommodation provides a suitable place in which to interview patients who are suspected of having, but do not know they have venereal disease; the wife, for example, of a known infected husband, or the husband of an infected wife, or the parents of known congenital children. Until one is certain that these people have disease the interviewing of them in the actual clinic is difficult and often gives rise to domestic troubles. A private office for such and other confidential interviews between the head of the clinic and his patients is, I think, essential in any follow-up system.

The treatment centre itself should if possible be situated in an existing medical institution. It should not be relegated to some badly lit and badly ventilated underground rooms or to some shoddy reconstructed and badly fitted hut. Rather should it be in a department fitted and furnished on the same principles and with the same attractive setting as the other special departments of the hospital. On what grounds can one justify the treatment of a patient with primary syphilis in such bad surroundings as are often allocated to venereal disease with his transfer ten years later to the comparatively palatial conditions of a medical ward when the same patient returns with tabes?

While the situation of the clinic and its fittings are important, it is also of the utmost importance that it should be centrally situated for the population which it proposes to serve. This is easy in the larger towns, it is difficult in the case of the suburban population and in rural areas. The clinic of which I have charge serves the population from Berwick to the Firth of Forth on the East of Scotland, and also serves a large area of the South of Fife and the eastern counties. The treatment centre thus is not within easy travelling distance of the whole area. Quite a number of the provincial towns in this area have Cottage Hospitals, and it should be possible for routine daily treatment to be carried out in these, the patient reporting once or twice weekly to the main centre for observation and control of treatment. This is more essential in cases of gonorrhœa than in syphilis and especially in female gonorrhœa. It would, of course, entail special training and special remuneration for the staff of these smaller hospitals with their sub-centres.

In my experience there are few male patients who can do posterior irrigation efficiently without teaching, and still fewer who have the means of carrying it out in their own home without divulging their complaint. The female patient with gonorrhœa cannot efficiently carry out any part of the necessary local treatment. A system of visiting nurses might help, but economically it would be cheaper to treat cases in small sub-centres than to provide visiting nurses and the facilities for carrying out such treatment do not exist in many homes. In men there is the objection to home treatment that once the patient begins to do so he often automatically ceases to attend the clinic and so is never with any certainty cured. These sub-centres must necessarily remain in close touch with the large central clinic at which the patient should attend periodically and at a minimum once weekly.

## MAXIMUM EFFICIENCY OF A V.D. CLINIC

*David Lees, D.S.O., F.R.C.S. (Edinburgh).*

This system of decentralisation of the work would, I think, bring within the reach of the patients in rural areas and in small provincial towns the same facilities for treatment as are obtainable by patients who live in large towns. It would be to the advantage of the Health Authorities in areas where there was not a sufficient number of cases to justify the setting up of a separate clinic. If such sub-centres could be established in association with cottage hospitals or small provincial hospitals, they would go far to solve the difficulty of attaining continuity of treatment in many of the cases from the smaller towns and country districts. It would not be necessary to have any beds in association with these small sub-centres as any case requiring in-patient treatment could at once be transferred to the main centre. There is no reason why such sub-centres should not be utilised also by general practitioners in the area which they serve, for the local treatment of any cases who are under their immediate observation and care. The administration of such small centres would be under the Medical Officer of Health of the area. The work of the orderly in charge or of the nurse in charge would be under the clinical officer, who could visit them from time to time and satisfy himself that the treatment was being carried out satisfactorily.

In any centre of population where the attendance rate at these subsidiary centres rapidly increased it would be possible at any time to extend the scope of the work by appointing either a part-time medical man in the district or one of the public health staff to hold sessions once or twice weekly, or better still the staff might be provided from among the assistants in the main central hospital clinic in the nearest large town.

In any area where there was no hospital such subsidiary centre might be established in an unobtrusive way in a quiet side street.

One may be met with the statement that such a scheme of linking up subsidiary centres with the main clinic does not give the general practitioner his proper place in the scheme. The general practitioner up to now has not shown himself sufficiently interested in the work and, with few exceptions, has not taken steps to make himself competent to take part in the scheme for the diagnosis and treatment of venereal disease. This will be and should be remedied through time when every graduate of medicine is required to show himself proficient in the diagnosis and treatment of venereal diseases. Until this is compulsory for every university graduate I cannot see any possibility of successfully linking up the venereal services throughout the country with the general body of practising physicians and surgeons.

Granted that the administrative side of the work, the hospital accommodation and a central situation are provided for, no clinic can secure the maximum efficiency unless it has a competent and well trained medical and nursing staff. The junior appointments in the clinics are not at present sufficiently well paid to enable the medical staff to continue at this work long enough to gain the essential experience. After six months to a year of the work the

## SOCIAL HYGIENE

young graduates are anxious to earn their living and the number of higher and well paid appointments in venereal work is not at present sufficient to attract the best medical brains to continue at the work. If for example a graduate after qualifying takes his Diploma in Public Health and applies himself conscientiously to the study of venereal disease he cannot hope by excelling in this to attain to the higher appointments in Public Health, certainly not in the same way as graduates who undertake an administrative appointment or who specialise in Tuberculosis or Child Welfare. The remedying of this side tracking would materially assist in obtaining better service and more efficient clinics.

### MEDICAL ASPECTS.

Granted that one has a competent staff the attainment of efficiency in the treatment of the infected patient must be considered separately in the case of

- (a) The adult male.
- (b) The adult female.
- (c) Children of both sexes with acquired or congenital disease.

Acquired syphilis in the adult male and female, at least during the contagious period, is an easy matter to handle with an efficient staff and good hospital surroundings. A visit to hospital is rarely required more than once weekly and the greatest difficulty in such cases is the attainment of continuity of treatment. There is nothing which tends so much to secure this in both male and female patients suffering from syphilis as the giving of practically all treatment inside the clinic. This applies more particularly to the time when a patient has no surface symptoms of disease, feels well, and is apt to think that there is nothing wrong with him or her. When patients, who have reached this stage of apparent cure, are given oral medication, say with Mercury, apart from the fact that the treatment may be forgotten, there is a strong tendency on the part of the patients to treat themselves and to cease attending. If in such cases the Mercury or other medicament is given intramuscularly or intravenously there is no doubt that the mental impression is conveyed to the patient that all is not well and that they must continue to attend. I have no doubt that the method which has been adopted in Edinburgh of asking the patients to report once weekly or fortnightly and giving them all treatment in the hospital clinic until they are considered cured has been one of the main factors in enabling one to lessen the number of those failing to continue at treatment from 40 per cent. to 14.5 per cent. within the last four years.

This system in addition has the very great advantage in that the patient is under close medical observation and can be watched more closely for signs of intolerance during the periods he is receiving potent drugs like Mercury, Arsenic and Iodides.

There is another aspect of the treatment of syphilis which is all important in attaining the best results. We know that syphilis may for long periods show no symptoms both in the early and late stages. A patient may have the virus of syphilis circulating in his blood and yet have no obvious signs of disease on the surface



## MAXIMUM EFFICIENCY OF A V.D. CLINIC

*David Lees, D.S.O., F.R.C.S. (Edinburgh).*

of his body. Similarly the virus of syphilis may be present in the nervous system and yet no clinical sign or symptom of any note may be present. In the blood Wassermann test we have the means of finding out asymptomatic syphilis in the systemic tissues. It gives us no assistance in diagnosing infections of the central nervous system. There are no doubt cases of early syphilis which suggest possible central nervous system involvement because of the headache and other associated symptoms. There are some who show pupillary changes or slight aberrations from the normal in their reflexes. All cases with the slightest suggestion of any involvement of the central nervous system should in addition to the clinical picture and the blood Wassermann test, have a complete examination of their cerebro-spinal fluid. A case which shows no sign or symptom initially should have the cerebro-spinal fluid examined at the latest by the end of the first year of treatment and a repetition of the examination in every case at the end of the second or third year of treatment prior to discharge should be the invariable rule.

I have been driven to this conclusion by the rather unfortunate experience of having treated consistently for two years patients who at the end of the first or second course showed neither clinical sign nor symptom and no evidence in their blood of any syphilitic taint. On examination of the cerebro-spinal fluid at the end of the second year one was surprised to find gross signs of syphilitic disease of the central nervous system with an apparently negative clinical picture.

The routine which one has mentioned above would eliminate this and enable one to apply much more intensive treatment than one would otherwise do at a very much earlier and more hopeful stage of the central nervous system involvement. There are some who argue that examination of the spinal fluid cannot be carried out without hospitalising the patient, but this is not one's experience. With careful technique and by resting the patient in the recumbent position for one or two hours subsequent to lumbar puncture very few require to be kept in hospital. It is very noticeable that the patient with disease has fewer symptoms of discomfort after lumbar puncture than the patient with a normal spinal fluid. There is no method that I know of which is of so much value in enabling one to prevent by early and intensive treatment the development of late neuro-syphilis and its disastrous end results. The performance of this test should be made a matter of routine in every clinic handling syphilitic patients.

While still on the subject of syphilis there is one other point which would be helpful in increasing the efficiency of any clinic. Late and latent syphilis may affect any organ in the body and for the effective treatment of some of the late manifestations it is at times essential to have the opinion of and co-operation with specialists in other subjects. Cardiovascular syphilis, for example, is very prevalent. Congenital syphilitic infections of the eye are numerous, and in handling these and similar cases the clinical officer should have the advantage of consultation with the physician

## SOCIAL HYGIENE

or the ophthalmologist from the point of view of diagnosis. From the point of view of treatment the physician or the ophthalmologist or other specialist would benefit from the experience of the syphilologist. This interchange of thought between the various departments of a general hospital and the venereal clinic is lacking in many centres, and if attained generally would greatly enhance the value of the work done. It is one of the great advantages in having the clinic inside a general hospital as opposed to the *ad hoc* clinic. If I might quote one example of the value of this interchange between two specialised departments of medicine I would draw attention to the fact that the number of congenital cases treated in Edinburgh increased from under 100 in 1920 to 356 in 1923. The larger majority of these were treated intensively as the result of the close co-operation between the ophthalmologists and the venereal department, and were chiefly cases of interstitial keratitis.

The attainment of efficient treatment in acquired gonorrhœa in the adult is much more difficult. It is so in the male and much more so in the female. The main difficulty in the treatment of the male in the early acute stages is the inability of the patient to come frequently enough for treatment. The majority of patients can attend once daily, a certain number can come twice daily, very few, except the unemployed, can attend more often in the acute stages. There are many cases who benefit by local treatment every four hours or even more frequently. Rarely if ever in my experience is it advisable for the patient to carry out much of his treatment at home. If a syringe and antiseptic are supplied the chances are that the patient does not return again, and ends up by overtreating himself or ceasing treatment before cured. With few exceptions, it is, I think, preferable to have all the treatment carried out in the clinic, making certain thus that it is done efficiently and under accurate observation and changed from week to week as occasion arises. Home treatment is carried out under considerable difficulties; privacy cannot be obtained; the work is usually hurriedly done and as a result badly. It often leads to complications in the home and complications in the individual case.

By having the clinic open for routine treatment at all hours of the day until late in the evening those within a radius of ten miles of the centre may possibly obtain sufficient treatment. For those at any greater distance and in the provinces subsidiary irrigation centres, such as I have mentioned previously, are essential for carrying out the routine treatment.

As in the treatment of syphilis one's experience is that the more contact the patient infected with gonorrhœa has with the medical staff the more likely is it that the patient will continue under treatment until completely cured, and in the acute stages they should be seen twice weekly, later once a week will suffice.

While the difficulties of treatment in the male can be overcome, those which surround the treatment of gonococcal infection of the female are innumerable, and there are few clinics in which the treatment of this condition is as satisfactory as it should be. Infected females may be divided into three groups:—

## MAXIMUM EFFICIENCY OF A V.D. CLINIC

*David Lees, D.S.O., F.R.C.S. (Edinburgh).*

- (1) The married woman who has been infected and who often has no knowledge of her condition, the disease being discovered when the patient is under treatment for some other condition or through the husband having reported for treatment.
- (2) Single girls who are in service or other employment.
- (3) Prostitutes.

1. A purely venereal clinic is not the proper place to treat the first group of patients. They suffer from disease which in many cases is not acquired venereally, and the only place in which to treat them thoroughly and without undue hardship to the patient is in the gynæcological wards of a general hospital. It should not be difficult to organise this work in association with a gynæcological out-patient department, and the attachment of a person who has specialised in venereal diseases to the gynæcological staff of any hospital would be of great advantage to both specialities. When the married woman is pregnant treatment should be carried out in the gynæcological wards up to a certain time, and the patient subsequently transferred to the ante-natal department of a lying-in hospital. In all such lying-in hospitals there should be facilities for the treatment of both gonorrhœa and syphilis in the pregnant woman. The conditions there for keeping in touch with the patient are ideal, and the end results of treatment under such conditions cannot but be good if the treatment is carried out efficiently. There should be close co-operation between the ante-natal department and the clinic in the gynæcological department, and the patient after the puerperium should be transferred to the gynæcological centre. This method is carried out with success in some of the Colonial and Continental hospitals. It is in my opinion the soundest method of enabling one to keep in touch with and to continue in touch with until cured many of the married women who suffer from gonococcal infection.

There are some who argue that Child Welfare Centres are better adapted for treating this type of case. The latter however are not equipped for minor surgical treatment and do not appeal to the childless woman or the woman with a grown up family. Apart from this latter objection there are quite an appreciable number of these cases who benefit from operative gynæcological treatment. In the gynæcological department they would have the advantage of being in a department where the operative part of the work and the special therapy could be carried out efficiently.

2. The treatment of the girl who is in employment bristles with difficulties. If she is in service it is almost impossible for her to attend hospital more than once weekly if she is not to lose her employment. If she is admitted to hospital during the acute stages it is almost impossible for her to obtain employment when she leaves. The end result is that these young girls cease attending when they are free from acute pain and discomfort.

The ideal method would be to hospitalise all such cases and thus attain a more rapid cure. This period of hospital life might

## SOCIAL HYGIENE

be considerably lessened if one could accommodate the convalescent cases in a hostel and provide them with a variety of occupations to enable them to earn their board. The ideal would be to have small hostels scattered on the outskirts of a large town so that the girls could be moved from one to the other according as they conducted themselves. It would be essential in addition to have enrolled a body of influential persons who were willing to employ these girls again when they were guaranteed a cure. Doubtless such hostels would be difficult to manage and would require careful and tactful control. Something along such lines will be essential and would be more easily managed if and when control of venereal infection is obtained by the Health Authorities. Admission to hospital followed by hostel treatment is the only possible method of attaining the necessary daily treatment in an appreciable percentage of the single girls who become infected.

3. The third group, the prostitute, would not call for any special treatment apart from that mentioned above. In the majority of cases, however, it might be advisable to keep the patient continuously in hospital until one was certain of cure.

Congenital syphilis, vulvo vaginitis and ophthalmia neonatorum are three conditions which demand long periods of treatment. The treatment of such patients in a department for the treatment of venereal diseases is obviously unfair to the patient. One naturally thinks of Children's Hospitals as the place in which to treat these cases. Such institutions however could not and perhaps would not care to handle the parents of the congenitally infected child. In Edinburgh we have to a great extent solved this problem by establishing in one of the corporation hospitals a department for the treatment of diseases of women and children. This department has twenty beds and six cots, and the number of cots and beds respectively can be increased or decreased as occasion demands. The patients are not treated under the concrete term venereal diseases, but under the inclusive generic one of diseases of women and children.

Instituted in 1923 this new departure in Edinburgh has been a complete success and the beds are always fully occupied. It has been especially valuable in treating ophthalmia neonatorum in that both mother and child are hospitalised until cured. It has provided means of hospitalising the syphilitic pregnant woman and enables her to have hospital accommodation for a longer period in the puerperium than the average maternity hospital can keep their patients. It is invaluable in the treatment of Interstitial Keratitis and other congenital conditions without attaching a stigma to the patient, and we have had the advantage of the close co-operation of an expert ophthalmologist and an expert pediatrician in the work. Not the least important factor in association with these beds is that there has been little if any difficulty in keeping in touch with patients after they are discharged from hospital because of the close interchange between this department and the various Child Welfare Centres throughout the city, whose nurses can follow up the cases effectually. It provides as it were in-patient

## MAXIMUM EFFICIENCY OF A V.D. CLINIC

*David Lees, D.S.O., F.R.C.S. (Edinburgh).*

accommodation for the Child Welfare Centres and at the same time provides accommodation for the patients' mothers when the disease is in any way of hereditary origin.

Even if a community is served by a good general hospital in which special departments are set up for handling venereal diseases and one attains the objects previously mentioned; a clinic open all day for the treatment of male patients, and a clinic open daily for the routine treatment of female patients; a sufficiency of hospital beds for acute cases in the male and for a large proportion of the female patients; an annexe in the gynæcological department for the treatment of married women, an ante-natal department in association with the existing maternity hospital for the treatment of pregnant women, and beds set apart for the treatment of diseases of women and children, all of which departments were in close co-operation with other departments such as those of general medicine and surgery, eye departments, ear and throat departments, etc., even then I am doubtful if the maximum efficiency of the clinic system can be obtained without some control over the diseased person.

The lack of control is obvious in :—

- (1) The type of patient who reports for treatment and is partially treated and subsequently fails to continue at treatment; the patient who thinks the disappearance of symptoms and the cure of the disease to be synonymous. The patient on whom, no matter how skilled one's persuasive powers are, all efforts to obtain continuity of treatment are of no avail.
- (2) Suspected cases which are almost certain to be cases of acquired disease; in other words, the source of infection in the patient either male or female who has reported with disease. In this latter group I would include cases resulting from illicit intercourse and those which result from marital intercourse.
- (3) Known sources and known cases of hereditary disease, the fathers and mothers, the brothers and sisters of congenital children, and the fathers and mothers of cases of ophthalmia neonatorum.

As things at present exist it is impossible in many cases to get into contact with any of these classes. It is particularly difficult when seeing a boy of 12 with interstitial keratitis to impress his father and mother that both may require treatment. In many cases one succeeds with the one and not with the other. It is difficult to get the other children examined, and one could quote endless cases where preventive medicine could be applied with ideal results if only one had the opportunity and the power to apply it.

I had an excellent example some weeks ago. A mother brought her child, aged two years, to see me, the child having a syphilitic rash and condylomata. Both mother and child were examined and advised to come into hospital. The mother was three months

## SOCIAL HYGIENE

pregnant, she refused treatment in hospital and left the child with us. Correspondence with her doctor induced her to come to hospital, and fourteen days subsequently she had a miscarriage in the maternity hospital. Arrangements were made to transfer her beside her child subsequent to the puerperium, but both she and her husband refused to consent to her remaining in hospital, and both declined to have any treatment. Both undoubtedly had syphilis and the progeny will undoubtedly be syphilitic, yet the Public Health Authority knowing this, had no power to step in and safeguard the parents and the future children.

As an example from the second group I might quote another case. A single female was admitted to the maternity hospital with a syphilitic rash and subsequently aborted about the fourth or fifth month. She had some three or four weeks' treatment and was discharged from the maternity hospital with instructions to report at the hospital clinic for further treatment. Letters, visits from nurses, and all efforts to get this patient to have treatment have up to now failed, and one has been able to trace five or six different contacts who have been infected with syphilis since then.

As an example of the first group I might quote the case of a patient who in 1919 had three injections in the early stage of his syphilis and then ceased attending for treatment; he married subsequently and at the end of last year was brought into hospital suffering from a hemiplegia, the result of syphilitic infection of the central nervous system. His wife has been infected, she had had two miscarriages, and two living children were infected.

These three cases and there are many not dissimilar, show forcibly the necessity of the health authority having some control of known cases and known sources of venereal disease, whether acquired or congenital.

I have accumulated in Edinburgh a bureau of such cases, and I think a knowledge of its contents would convince the most obdurate opponent that some measure of control is essential if the clinic system is to attain its maximum efficiency.

Whether it be complete notification or confidential notification, or simply some measure to ensure continuity of treatment that is aimed at, the main difficulty I think is created by labelling under the name venereal disease conditions which, although they are due to syphilis or gonorrhoea, are not venereally acquired. The name venereal disease has attained in the lay mind a very definite stigma, and I have no doubt medical men and women would make more progress in controlling the venereal diseases if in the future they decided to deal with the conditions met with as affections of the organs involved rather than under the generic term venereal disease. Cervicitis, salpingitis and bartholinitis do not convey to the lay mind the same stigma as the words venereal disease and the more names used in any measure of control the less likely would the general public be to associate any stigma with the condition for which the patient was under control.

Even if all medical practitioners aimed at the ideal of impressing on their patient that the disappearance of symptoms did not mean

## MAXIMUM EFFICIENCY OF A V.D. CLINIC

*David Lees, D.S.O., F.R.C.S. (Edinburgh).*

the cure of the disease and made every effort to convince the patient of the absolute necessity of continuing at treatment for a long time after the surface symptoms had disappeared, there are still a considerable number of individuals suffering from latent gonorrhœa and syphilis who care nothing of the future in regard to themselves and still less of the safety of other people.

If the maximum of good is to be obtained from the clinic system some method must be devised for dealing with this type of patient and the only method which, I think, is likely to be successful is one in which there is vested in the Medical Officer of Health power to compel such patients to continue at treatment until they are considered non-infective.

This does not necessarily mean the notification of every case of venereal disease. It simply means power to control known cases of disease, known causes of disease and known sources of disease who do not see fit to carry out the necessary treatment.

As the clinic system is at present constituted the medical officer in charge of it has notified to him the name and address of each infected patient. This information is in reality accessible to the Medical Officer of Health and nothing more would be required than at present exists in the cases of patients who carried out their treatment to the end. In all others the medical officer of the clinic should have at his discretion power to notify the Medical Officer of Health of any patient who failed to do so. The very fact that the clinic officer had power to do so would enable him to handle his patients much more thoroughly. The knowledge would gradually filter among the patients that he had such power and would make the necessity of using this power comparatively rare.

There are, I know, opponents to this line of action and the chief arguments against it are, first, that it would lead to concealment of disease and increase of treatment by quacks. The latter difficulty could be easily overcome by tightening up the existing legislation of the 1917 Act and suppressing the advertisement of quack remedies. With regard to concealment I am very doubtful after studying the mentality of these patients for a considerable time if there would be much of it; certainly not in the male sex and in the female sex treatment in a gynæcological department would ultimately overcome any great tendency to concealment. Even if there were some cases of concealment the control which one would have over known cases of virulent infection would enable one to deal more effectively with the disease. It would more than compensate for any hardship on the individual and would give a better economic return for the money spent than is at present obtainable by partial treatment.

The second objection used by opponents to any system of control is that it would lead to sex discrimination. I see no reason why this fear should exist. The infected wife or husband who has transgressed the moral law would be treated on the same footing as the prostitute or as the unfaithful wife. Legislation would and must be the same for both sexes.

## SOCIAL HYGIENE

Another objection is that it would interfere with the liberty of the subject and would cause domestic strife. The former cannot be considered in face of the danger to communal health and with control of venereal diseases one would be able to obtain permanent cure which would be the best means of restoring domestic happiness. One has no power at present either to cure or to ensure domestic happiness and health.

Another argument against control is that medical men would not be willing to take their place in any such system of control. It would not necessarily interfere with the confidential relations between the patient and doctor so long as the patient kept faith with his doctor and carried out treatment to the bitter end. If a patient does not carry out his doctor's instructions the doctor is absolved from confidence and must consider the needs of the community in preference to that of the individual.

There is perhaps a greater objection in that it would put in the hands of the medical profession power which some of them are not competent to wield. While this may have been so, and was the finding of the Trevethin Committee, it is rapidly being remedied by the compulsory teaching of the subject of venereal disease in the medical curriculum.

These are I think the main objections, and when the advantages of control of the disease are placed against them they far outweigh the disadvantages.

A system of confidential notification and compulsory continuous treatment, such as that which is in force in Canada, would enable medical men to treat efficiently until cured a large number of cases of venereal disease. It would bring the knowledge of these diseases before the public at large and would assist those engaged in both moral and social propaganda in their present efforts to combat the disease.

It would bring under treatment a large number of cases of known venereal disease and of known sources of infection, whether male or female. It would enable us to handle known sources of and cases of hereditary disease and known causes of ophthalmia neonatorum.

There is no doubt that the carrying out any such scheme of confidential notification would mean an immediate increase in expenditure and an immediate increase in the number of beds required especially for female patients.

The increased expenditure would, to my mind, be sound economy in that one would be enabled to handle disease in the early and curable stages, and less money in the long run would be required to treat and support the end results of these infections in homes for the blind, in schools for mentally defective children, in poor law institutions, in surgical and medical wards of our large hospitals, in asylums and in prisons.

The expenditure incurred in increasing the beds required would, I am sure, be more than compensated for by the rapidity of cure and the certainty of cure, and certainly would be a more economic way of handling venereal disease in single girls and others than the



## PUBLIC HEALTH NURSE IN V.D. CLINICS

*Frances Brown (Canada).*

partial treatment at present given with such unsatisfactory results.

Legislation to this effect would be of very great educational value in the country and would bring venereal diseases into their proper perspective both in the lay and medical mind. Although primarily any such measure would be difficult to enforce and might possibly inflict a certain amount of hardship on some individuals, this would be more than compensated for by the gain in health to the individual concerned and to the state.

Such notification with resulting compulsory continuity of treatment would only be resorted to in extreme cases and only when milder methods of persuasion had failed to influence the careless but infected individual. The medical man attending the patient, whether he be the clinic officer or private practitioner, would be the person to advise the Medical Officer of Health in which cases it was essential to act, as he would be the person best fitted and best situated to understand the mentality of the patient and to advise him how to act.

If the powers conferred on the health officer were handled delicately and with the purpose in view of dealing with known disease rather than of punishing the sufferer from disease these powers would, I think, materially assist the medical profession in reducing the incidence of venereal disease without appreciably lessening the willingness of the infected person to come for treatment. They would certainly go a long way in stamping out ophthalmia neonatorum and congenital syphilis.

Such powers would be still more valuable if and when the general body of practising physicians and surgeons have had in their undergraduate career a training in the diagnosis and treatment of venereal diseases, and have had brought home to them in this early stage of their medical work the immense importance of syphilis and gonorrhoea as factors in militating against communal health.

## THE PUBLIC HEALTH NURSE IN VENEREAL DISEASE CLINICS IN TORONTO, CANADA.

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### HISTORY.

THE entry of the public health nurse into the field of venereal disease prevention, in Toronto, dates from the war. For some years before that time workers with public health and social service training had been employed in venereal disease clinics in certain hospitals in Canada and the United States. Since 1920 the public health nurse has been an integral part of the Canadian Government scheme for the control of venereal disease.

## SOCIAL HYGIENE

### THE CANADIAN GOVERNMENT SCHEME FOR THE CONTROL OF VENEREAL DISEASE.

The war brought forcibly to the attention of the public the fact that the venereal diseases constitute a menace to national health and life, and the Government in Canada was persuaded to appropriate funds and outline programs for their control. In 1920 the Canadian Parliament voted \$200,000.00 for this purpose and the grant has been continued annually until this year, when a campaign for national economy carried away \$50,000.00 of that sum. The money was divided among the provinces on a *per capita* basis, and was granted on condition that the provincial governments furnish an equal amount of money, and fulfil certain conditions laid down by the Federal Department of Health. The provinces, with one exception, have accepted the grant and are carrying on more or less extensive programs of venereal disease control.

#### ONTARIO PROGRAM OF VENEREAL DISEASE CONTROL.

The activities of the Ontario Provincial Board of Health in the matter of venereal disease control include the establishment of free clinics, the examination and treatment of persons in penal institutions, the establishment of laboratories, the manufacture and free distribution, for use in clinics, of phenarsenamine and mercurial preparations, and an educational campaign. Eighteen clinics have been established in thirteen cities in Ontario. During 1923, 56,357 treatments were given in these clinics. The clinics, with five exceptions, are located in hospitals and are carried on under an agreement with the Provincial Board of Health by which, when the hospital has fulfilled certain conditions in regard to equipment, staff, hours, etc., the Board agrees to pay \$1,000.00 toward the purchase of clinic equipment, \$500.00 annually toward the salary of a physician, the same amount toward the salary of a nurse, and 50 cents per treatment given.

#### NURSES IN VENEREAL DISEASE CLINICS.

The regulations of the Provisional Board of Health in regard to nurses read as follows: "All venereal disease clinics receiving government grants shall employ a full time social worker, who shall be a nurse, a graduate of a recognised training school." This requirement called forth, at first, some opposition from certain clinicians who contended that social service work had no place in the treatment of venereal disease. The Board, however, stood firm, and the opposition has rapidly disappeared as the public health nurse has demonstrated to the physician that she is his greatest ally in securing and maintaining an efficient clinic.

There has been some controversy over the question as to whether the graduate nurse or the trained social worker is better qualified to do hospital social service work. In my own mind there is no doubt but that the nurse has the advantage in this particular branch of hospital work. She has the medical and technical knowledge without which it is difficult to understand all the factors

## PUBLIC HEALTH NURSE IN V.D. CLINICS

*Frances Brown (Canada).*

involved in handling a venereal disease case; her training has made it easier for her to separate, in her own mind, the moral from the physical side of the question, and what is perhaps most important of all has taught her the importance and absolute necessity of professional secrecy.

### VENEREAL DISEASE CLINICS IN TORONTO.

In Toronto there are six centres for the treatment of venereal disease located in six hospitals. In each hospital three clinics are held weekly, one of which is an evening clinic. Men and women are treated, as far as possible, on different days or at different hours. Only children are treated at the Hospital for Sick Children, two clinics a week for the treatment of congenital syphilis and two for the treatment of gonorrhoea in children.

During 1923 1,367 new patients were admitted to the Toronto clinics and 33,584 treatments were given in these clinics.

The nurses employed in these clinics, with the exception of those in one hospital, are furnished by the Department of Public Health, City of Toronto, the Provincial Board paying \$500.00 toward the salary of each nurse, the City paying the remainder and reserving the right of supervision of the work done by her.

### DUTIES OF PUBLIC HEALTH NURSES IN VENEREAL DISEASE CLINICS.

The duties of the public health nurses in venereal disease clinics may be dealt with under the following heads:—

1. Duties in the clinic.
2. Duties in the homes of the patients.
3. Duties in relation to the community.

#### DUTIES IN THE CLINIC.

The public health nurse is present at all clinics for the purpose of interviewing patients, keeping records, instructing patients in regard to treatment, and in fact to do anything which will contribute to the smooth running and efficiency of the clinic. In each of the hospital clinics a pupil nurse is detailed to assist the physicians in giving treatment and to be responsible for clinic management and supplies. The public health nurse is thus free to attend to the duties which more particularly belong to her.

#### INTERVIEWING PATIENTS.

Each new patient, upon admission to a venereal disease clinic, is seen by a physician or the public health nurse, and a medical and social history made out for him. The record forms used are provided by the Provincial Board of Health, and are used in the clinics throughout the province. The social case sheet contains, in addition to the usual questions regarding age, nationality, religion, occupation, etc., inquiries which aim to bring out information concerning the underlying causes of the moral delinquency

## SOCIAL HYGIENE

which led to infection with a venereal disease. These questions include: amount of education received, sex instruction received, kind, from whom, age at which first immoral sex conduct occurred, etc. When a mental examination has been made the result of that is recorded also. Such information, when carefully gathered and tabulated, should be very valuable for use in determining the underlying causes of sexual immorality and resulting venereal disease in any locality among any group of people. Unfortunately, the pressure of work in the clinics has, up to date, made it impossible for the workers to tabulate the information gathered and formulate conclusions in regard to it.

The information gathered from social case histories, which has proved of very practical value, is that regarding sources of infection and contacts. Each patient is carefully questioned as to the name of the persons from whom he believes he has acquired his infection, the place where the act occurred which led to infection, and his sex contacts since that time. If the patient is unwilling to give names, etc., it is explained that the information will be considered confidential, that his name will not be divulged, and that for the sake of others who may be exposed later it is his duty to co-operate with the health authorities in this matter. Of course there are many patients from whom it is impossible to obtain any reliable information regarding their contacts or sources of infection, but there are others from whom it is possible to obtain information which leads to the discovery of very infectious cases of disease in the community. The importance of making inquiry into the source of infection and the contacts of each venereal case is demonstrated repeatedly by cases coming to the clinic. Recently a girl of seventeen came to one of the clinics, complaining of a rash which she said she believed to have been caused by "eating tomatoes." She was referred to the venereal disease clinic. Examination made there showed that she was infected with gonorrhœa and syphilis, and was five months pregnant. Upon being questioned by the public health nurse she gave the name of the man responsible for her condition and stated that he was married. The man was sent for, examined and found to have syphilis and gonorrhœa also. His wife was located after some difficulty and persuaded to come in for examination, when it was found that she had a secondary syphilis: she had recently given birth to a still-born child. Her two children were examined, but they were negative, the infection of the father evidently having been acquired following their birth. The three were then placed under treatment for a disease which they did not suspect they had and which would, in all probability, not have been discovered had inquiries not been made in regard to the source of the girl's infection. She was treated during the remainder of her pregnancy, and her child was non-syphilitic.

During 1923 in the Toronto clinics, 657 persons, the contacts and alleged sources of infection of patients attending the venereal disease clinics, were examined, and of these 164 persons were found to have syphilis and 44 to have gonorrhœa.

In taking social histories inquiry is made in regard to the place

## PUBLIC HEALTH NURSE IN V.D. CLINICS

*Frances Brown (Canada).*

where the act occurred which led to the infection. In this way it is possible to secure the location of bawdy-houses, the names of men who use taxi-cabs for immoral purposes, the names and location of dance halls and other places where prostitutes congregate, etc. This information, when secured, is referred to the authorities organised to deal with it. During the past year a number of houses of prostitution have been raided and their keepers brought into court as a result of information secured through the venereal disease clinics.

The nurse in the venereal disease clinics makes every effort to gain the confidence of her patients, and make them feel that she is interested in their welfare and that of their families. Since clinics have grown so large there is little time for the personal touch between physician and patient, and the patient is apt to be looked upon as a case rather than a human being. The personal interest is very necessary in these clinics, since many of the patients are very sensitive about their condition, and feel that they cannot talk about it even to their best friend. The nurse by gaining their confidence and explaining any difficulties and misunderstandings that arise, is the most important factor in keeping up clinic attendance, and keeps the patient coming to a clinic long after he has lost interest or hope in his own cure.

While there is no attempt made by the nurse to moralise, there is no doubt that the presence in the clinic of one whom these patients regard as a "good woman" has a good and refining influence upon the patients and raises the moral tone of the clinic.

### DUTIES IN THE HOMES OF PATIENTS.

During 1923 the public health nurses in the venereal disease clinics in Toronto made 3,405 visits to the homes of the patients attending these clinics. These visits were made for the purpose of:—

1. Securing the regular attendance of patients at clinic.
2. Securing the examination of other members of the family.
3. Instructing the family as to home treatment.

### SECURING REGULAR ATTENDANCE.

Before the advent of the public health nurse in venereal disease clinics a great deal of time and energy was wasted in treating patients who attended clinic for a few times and did not return. This has been largely done away with by a follow-up system now in use in the clinics. A card, known as the Tickler, is made out for each new patient upon his admission to clinic. Upon this card is recorded the date of attendance and the date expected to return. These cards are filed behind the date of the clinic day on which the patients are told to report. If he fails to return on this day

## SOCIAL HYGIENE

a card is sent out reminding him that he has failed to keep his appointment and requesting him to come in on the next clinic day. When this fails the nurse visits the home. Occasionally she finds that the patient has moved leaving no address behind. She does not discharge him before making every effort to locate him through neighbours, relatives, place of work, the school, etc. If necessary the nurse makes several visits to the patient's home, explaining very carefully the need of regular treatment and the danger to himself and others of neglecting treatment. If in spite of this he still refuses to return the case is usually reported to the Medical Officer of Health, who may compel treatment under the authority of the Venereal Diseases Prevention Act. There is no doubt that these visits are very important in keeping up the clinic attendance and keeping the patients under treatment until cured. The treatment, especially in syphilis, is long and tedious, the patients become discouraged and would not return were they not urged to do so by the nurse. As one woman said recently: "I had made up my mind a hundred times not to go back to that hospital but the nurse was so nice I couldn't refuse her."

### SECURING THE EXAMINATION OF OTHER MEMBERS OF THE FAMILY.

Unless the clinic physician for a very good reason decides to the contrary, all known contacts of the patients under treatment in the venereal disease clinics must be examined. It is the duty of the public health nurse to accomplish this task, which is perhaps the most difficult part of her work and the one which requires all the tact and good judgment which she possesses. This task is especially difficult of accomplishment in the case of families where the husband or the wife may not know that the other is infected. Unless great care is exercised the results in domestic unhappiness may be actually worse than the disease. There is no set rule to be followed in dealing with these cases, each patient being dealt with according to the circumstances of the case. When the wife is beyond the child-bearing age it may be decided that it is wiser not to insist upon examination of the other partner. In the case of young couples, especially if the disease is syphilis, it is usually thought better to run the risk of a domestic upheaval than the bringing into the world of syphilitic infants. It usually requires much persuasion to bring these examinations about, and this can usually be done best in the quiet of the patient's home. The absolute necessity for the examination of the other members of the family in the cases of familial syphilis is shown repeatedly through cases attending the clinics. Two families coming to the attention of the Hospital for Sick Children show what may be done when this disease is discovered early and the results of its late discovery.

Case number one was that of a family discovered through a seven-year-old child referred to the hospital with a diagnosis of cancer of the throat. The child upon examination was found to have congenital syphilis and the other members of the family,

## PUBLIC HEALTH NURSE IN V.D. CLINICS

*Frances Brown (Canada).*

three children fifteen, twelve and ten years respectively, and the parents were brought in for examination. All five were found to have syphilis and were placed under treatment, but already much damage had been done. The father, aged 42, developed general paresis and is now in a hospital for the insane, the mother is a chronic invalid and is also showing nervous symptoms, three of the children are mentally defective and the youngest, the original patient, has developed juvenile tabes. In the opinion of the psychiatrist who examined them, the entire family will have to be supported by the State as long as they live.

Case number two was discovered through a baby of seven months brought to the hospital with paralysis of the arm. The case was diagnosed as congenital syphilis, the child placed under treatment and later discharged as cured. The parents were both found positive for syphilis, and when questioned the man admitted having been treated during the war, but stated that he believed himself cured. The parents were placed under treatment and a baby born a year later has given repeated negative Wassermann reactions. The woman is now expecting her third child, and we trust it also will be free from disease. The history of the first case would likely have been repeated in the case of the second had no examination been made of the parents.

In securing the examination of contacts and sources of infection, and also in securing the attendance of patients for treatment, the public health nurse is frequently confronted with the problem of persons who refuse to co-operate in any way. In dealing with such as these the law in regard to compelling examination and treatment is an effective weapon and the only one which is of avail in some of these cases, many of which are the most dangerous to public health. The law is only used as a last resort, but is effective with those who fail to respond to any appeal but that of fear.

### INSTRUCTION IN REGARD TO HOME TREATMENT.

In visiting the homes of the patients attending the venereal disease clinics, the public health nurse instructs the patients as to the proper method of carrying out the treatment ordered by the clinic physician—douches, mercurial rubs, etc. In the case of little girls under treatment for gonorrhoeal vaginitis it is usually necessary to demonstrate the method of giving treatment and to instruct the family as to the procedure to be followed in order to prevent the spread of infection to other children of the family and the neighbourhood.

### DUTIES OF THE PUBLIC HEALTH NURSE IN RELATION TO THE COMMUNITY.

While the first interests of the public health nurse is in the cure of the patients attending the clinic, it is inevitable that her interest will finally extend to the conditions outside the clinic which are

## SOCIAL HYGIENE

responsible for a never ending supply of new venereal cases. The public health nurse is in a strategic position to gather statistics and formulate conclusions regarding the relation between venereal disease and such social conditions as professional prostitution, the lack of custodial care for the mentally defective, lack of education and lack of wholesome recreation. The nurse, who is doing good work, will not rest until she has brought this information to the attention of the agencies organised to deal with it.

The nurse in venereal disease clinics is an important factor in the education of those with whom she comes in contact—other nurses, social workers, teachers, etc.—in regard to the nature of the venereal diseases and the methods for their prevention.

### CONCLUSIONS.

In the newest field of public health nursing in Toronto, that of venereal disease, the public health nurse has already proven her value. Her presence in the venereal disease clinics has resulted in raising the moral tone of the clinics and increasing the efficiency of the work done by them. Through her efforts many cases of venereal disease have been discovered in the community outside, as well as bad social conditions which would eventually lead to venereal disease. The public health nurse's opportunity for service in this field is wide. To fully profit by this opportunity, she should be a person of unusual qualifications, which include a sound technical training, a wide experience of life; if possible, additional public health or social service training; and, perhaps most important of all, a personality which includes a fund of sympathy and a love of human beings. Given all this she can only do her work well when she receives the support and co-operation of all the agencies for social betterment in the city in which she works.

### SOME OF THE DIFFICULTIES EXPERIENCED IN THE ADMINISTRATION OF A COUNTY V.D. SCHEME.

By J. J. BUTTERWORTH, M.D., D.P.H., *Medical Officer of Health Lancashire County Council.*

#### THE PROBLEM IN LANCASHIRE.

The county of Lancashire presents every kind of problem from the administrative point of view with regard to venereal diseases.

The north is almost entirely rural, devoted to dairy farming and grazing, thinly populated, and broken up in its northernmost part by hills and mountains into remote valleys to which access is difficult. In the west are the flat and level areas of the rich agricultural lands of the Fylde and West Lancashire. In the east, south, and south-west are the densely populated areas of industrial Lancashire.

The extreme length of the county measured in a straight line on a map is 76 miles, and its extreme breadth is 45 miles, but by



## MAXIMUM EFFICIENCY OF A V.D. CLINIC

*J. J. Butterworth, M.D., D.P.H. (Lancashire).*

existing means of transport its actual length is about 120 miles and its breadth about 60 miles.

		Area.	Population.
GEOGRAPHICAL COUNTY ADMINISTRATIVE COUNTY IS AREA UNDER ADMINISTRATION OF COUNTY COUNCIL FOR VENEREAL DISEASES PURPOSES	Geographical County ...	1,194,555	4,927,484
	17 County Boroughs...	140,047	3,181,693
	<hr/>		
	19 Municipal Boroughs ...	86,426	580,924
	83 Urban Districts ...	255,458	922,749
	19 Rural Districts ...	712,624	242,218
	<hr/>		
Total Administrative County	1,054,508	1,745,891	
<hr/>			
Rateable value, £11,228,326.	1d. in the £ produces about £43,500.		

The predominantly industrial character of the county is shown in the following Table:—

Occupations of Persons. (Geographical County.)	(Census 1921.)	
	Males.	Females.
Total population ...	2,332,931	2,594,553
Number of persons not engaged in occupations ...	189,522	1,233,336
Number of persons 12 years' of age and upwards engaged in occupations ...	1,614,243	833,717
Approximate number of persons occupied:—		
Metal workers ...	218,000	8,000
Transport ...	213,000	9,000
Textile workers ...	183,000	317,000
Commercial occupations ...	140,000	72,000
Clothing and textile goods ...	33,000	79,000
Mining and quarrying ...	110,000	2,000
Building and allied trades ...	77,000	—
Clerks and draughtsmen ...	81,000	50,000
Wood, furniture, etc. ...	64,000	4,000
Warehousemen, storekeepers, etc....	48,000	24,000
Professional occupations ...	31,000	38,000
Agricultural ...	48,000	5,000
Public administration and defence	31,000	6,000
Food, drinks, etc. ...	22,000	20,000
Paper, books, etc. ...	21,000	16,000

### *Cotton Trade.*

Over 1,000 spinning mills employing 200,000 persons; 250,000 persons engaged in weaving and finishing cotton goods. Total population engaged in textile work, 500,000.

### *Coal Mining.*

25,000,000 tons mined annually in Lancashire. Estimated amount of coal still available in the county 4,000,000,000 tons.

## SOCIAL HYGIENE

### *Stone and Ore Mining.*

Stone or rock or metallic ores mined annually in the county, 3,750,000 tons. Persons engaged in mines and quarries, 112,000.

### *Agriculture.*

Total area of county, 1,200,000 (approx.) statute acres. Area cultivated, 800,000 acres. Persons employed in agriculture, 53,000. Area of Lancashire farms, average 36.5 acres.

### SYNOPSIS OF COUNTY SCHEME.

#### (a) *Treatment Centres.*

Arrangements for the treatment of venereal diseases have been made by the County Council with twenty-two hospitals and three *ad hoc* clinics in the geographical county. These treatment centres, with one exception, are situated in the county boroughs and are not evenly distributed geographically, being mainly in the thickly populated areas of south-east Lancashire. The residents in many of the rural and smaller urban districts have to travel considerable distances for treatment. There are several other hospitals in the administrative county which might be used for the treatment of venereal disease, but it has not been possible, for various reasons, to make suitable arrangements.

The following Table I is a synopsis of the work carried out in the treatment of residents in the administrative county at the centres since the beginning of the scheme in 1918 :—

(It might be well to repeat that the term "administrative county" means the whole of the geographical county, excluding the seventeen county boroughs.)

TABLE I.  
No. of Persons resident in the *Administrative County* who have attended the Treatment Centres.

YEAR.	Number of Residents in the Administrative County area attending Treatment Centres for the first time and found to be suffering from :				Total.	Total No. of attendances of County Residents at Out-patient Clinic.	Aggregate No. of In-patient days.
	Syphilis.	Soft Chancre.	Gonorrhœa	Conditions other than Venereal.			
1918	674	12	173	104	963	9,010	950
1919	1,510	94	729	408	2,741	22,732	2,838
1920	1,433	85	802	496	2,816	31,096	2,490
1921	1,104	33	622	414	2,173	32,739	2,367
1922	701	17	573	399	1,690	29,420	1,490

It will be observed that the number of patients is tending to decrease, and the average number of attendances to increase.

It has been found by experience that very few children or babies are presented at these clinics.

## MAXIMUM EFFICIENCY OF A V.D. CLINIC

*J. J. Butterworth, M.D., D.P.H. (Lancashire).*

*Period of attendance for treatment at the venereal diseases clinics.*

From the Returns made to the County Public Health Department from certain of the venereal diseases treatment centres in Lancashire during the six years 1918-1923, the following statistical details have been collated.

It should be stated that it has not been found possible from the information available to include in these statistics the large treatment centres in Liverpool and Manchester; and from certain other institutions the Returns do not cover the whole period of six years. In most instances the "agreements" with the treatment centres are between the management of the institution and the County Borough Council, and the County Council has to rely for statistical details on Returns, often incomplete, supplied by the County Borough Health Departments.

I have endeavoured to ascertain, from the data available, the proportion of the total persons attending the clinics who *complete* the full course of treatment, or who cease to attend *before* completion of the course.

The statistics here quoted refer to 23,270 persons—males 17,164, and females 6,106—who attended certain Lancashire treatment centres, for which complete Returns have been received, between the date of the commencement of the County Scheme (1918) and December 31st last year.

The following tabular statement shows, as far as the data available permit, the gross percentage of persons who actually completed the course and attended the final tests, contrasted with those who ceased to attend at various stages of treatment.

Years 1918-1923:—

	Syphilis.		Soft Chancre.		Gonorrhoea.	
	M.	F.	M.	F.	M.	F.
Persons who ceased to attend the Clinic at various stages of treatment and before the final tests as to cure ...	%	%	%	%	%	%
	79.3*	80.5*	57.5*	71.9*	60.7*	61.0*
Persons transferred to other Treatment Centres after treatment ...	6.4	4.7	3.6	2.2	8.9	10.4
Persons discharged from the Clinic after completion of treatment and observation ...	14.2	14.7	38.8	25.8	30.3	28.5

\* Includes a large percentage (in the case of syphilis 35 to 40 per cent.) who completed the course of treatment, but did not attend for the final tests.

## SOCIAL HYGIENE

The following yearly percentages may be of interest. Year 1918 :—

	Syphilis.		Soft Chancre.		Gonorrhœa.	
	M.	F.	M.	F.	M.	F.
	%	%	%	%	%	%
Persons who ceased to attend the Clinic at various stages of treatment and before the <i>final</i> tests as to cure ...	80.3*	78.6*	90.9*	—	68.0*	66.6*
Persons transferred to other Treatment Centres after treatment ...	—	—	—	—	—	—
Persons discharged from the Clinic after completion of treatment and observation ...	19.3	21.3	9.1	—	32.0	33.3

\* Includes a large percentage (in the case of syphilis 35 to 40 per cent.) who completed the course of treatment, but did not attend for the final tests.

For the years 1919 and 1920 :—

	Syphilis.		Soft Chancre.		Gonorrhœa.	
	M.	F.	M.	F.	M.	F.
	%	%	%	%	%	%
Persons ceasing to attend Clinic before completing a course of treatment ...	45.7	46.3	23.4	41.3	45.0	52.1
Persons ceasing to attend after completion of a course of treatment, but before <i>final</i> tests as to cure ...	36.6	38.1	36.8	35.6	21.7	23.7
Persons transferred to other Treatment Centres after treatment ...	5.4	2.7	2.5	—	6.1	4.8
Persons discharged from the Clinic after completion of treatment and observation ...	12.1	12.7	37.2	23.0	27.0	19.4

## MAXIMUM EFFICIENCY OF A V.D. CLINIC

*J. J. Butterworth, M.D., D.P.H. (Lancashire).*

For the years 1921, 1922, and 1923 :—

	Syphilis.		Soft Chancre.		Gonorrhœa.	
	M.	F.	M.	F.	M.	F.
	%	%	%	%	%	%
Persons ceasing to attend the Clinic before completing the first course of treatment ... ..	24.4	24.5	25.6	40.0	33.2	32.1
Persons ceasing to attend after one or more courses but before completion of Treatment ... ..	30.1	30.5	—	—	1.8	1.4
Persons ceasing to attend after completion of treatment, but before final tests as to cure... ..	22.4	22.5	25.1	20.0	21.2	19.7
Persons transferred to other Treatment Centres after treatment ... ..	7.8	6.7	6.4	20.0	10.7	13.3
Persons discharged from the Clinic after completion of treatment and observation ... ..	15.2	15.5	42.7	20.0	32.9	33.3

### CONCLUSIONS FROM THE ABOVE TABLES.

As regards syphilis approximately 50 per cent. of both sexes cease to attend at the treatment centre *before* completing the full course of treatment.

During the last three years (1921-1923), as compared with 1919 and 1920, there was an increase in the percentage of persons discharged from the clinics *after* completion of treatment and observation, the percentage of the sexes being equal.

In gonorrhœa cases the percentage of completed attendances is higher than in syphilis.

#### (b) *Arrangements for General Practitioners.*

The Lancashire County Council have made arrangements by which medical practitioners practising in the Administrative County area can be supplied gratuitously with the necessary outfits for collecting materials for examination from persons suspected to be suffering from venereal disease, and scientific reports upon the materials submitted are furnished to them direct by the pathologist.

The laboratories available for such examinations are :—

LIVERPOOL... .. The University of Liverpool, City Laboratory and School of Hygiene, Mount Pleasant.  
(Prof. Beattie.)

## SOCIAL HYGIENE

- MANCHESTER ... The University of Manchester, Public Health Laboratory, York Place, Oxford Road, Manchester. (Prof. Topley, Director.)
- BURNLEY ... The Borough Health Department Laboratory.

In addition to these laboratories, several of the hospitals carry out portions of the bacteriological work.

It is not possible to state the number of patients treated by general practitioners either privately with their own drugs or with arseno-benzol compounds supplied by the County Council. It would be interesting to receive from practitioners an annual return of the number of persons treated by them.

The County Council supply free of charge arseno-benzol compounds to approved medical practitioners, and the following Table II shows the amount of work carried out.

The addresses of the "approved" practitioners show that they are grouped for the most part around the large towns in the vicinity of the venereal disease treatment centres. The greater number of the "approved" practitioners received their training during military service.

Practitioners who did not receive training in venereal disease work during the war have not as a rule taken up this work, as it is difficult under present conditions to spare the necessary time and money for post-graduate work. Some of these continue to treat syphilis with mercury only.

In the course of my work I meet a large number of general practitioners, and those in practice in rural areas and in the smaller urban districts state that they rarely see cases of obvious venereal disease.

## EDUCATIONAL WORK.

The County Public Health Department began educational work to combat venereal disease in the year 1917 by the appointment of two organisers—one male and one female—and since 1920 has continued the work mainly by the services of a lady organiser and a panel of about a dozen medical lecturers. The propaganda and educational arrangements have comprised lantern and film lectures in theatres, picture houses, public halls, etc., talks to mothers in child welfare centres, and lectures to men and women in clubs, works, institutes, etc. Special courses of lectures in biology have been given by a medical woman to teachers.

The following Table III sets out the amount of work carried out in these directions.

I think it can be argued that the campaign inaugurated against venereal diseases during the last few years has already gained a great measure of success in certain directions. In my own county a considerable section of the population, by means of propaganda, has been made to realise the contagiousness and serious results of venereal disease. Table III shows that we have brought the subject before more than a quarter of a million people during the last five years. The attitude that even the innocent sufferer

ADMINISTRATIVE COUNTY OF LANCASTER.

TABLE II.

Number of Outfits and the number of Doses of Arseno-benzol Compounds issued by County Council to Medical Practitioners.

Year.	No. of Outfits issued by County Council to Medical Practitioners.				Result of Examination of Specimens forwarded to the Manchester Laboratory.		Supply of Arseno-benzol Compounds	
	Wassermann Test.	Detection of Spirochæte.	Detection of Gonococci.	Total.	Positive.	Negative.	Total No. of Practitioners "Approved."	Total No. of Doses supplied.
1918 ... (portion)	195	10	51	256	% 40.14	% 59.86	27	269
1919 ...	405	43	62	510	43.33	56.67	65	881
1920 ...	602	18	39	659	34.01	65.99	96	944
1921 ...	951	6	64	1,021	27.25	72.75	109	796
1922 ...	580	13	37	630	38.73	61.27	116	517
1923 ...	900	5	61	966	38.97	61.03	123	845

LANCASHIRE COUNTY COUNCIL.

TABLE III.

Approximate Audiences reached by Propaganda Work carried out by the County Council Public Health Department.

Year.	Lectures and Addresses by Organising Lecturers, etc.			Medical Lectures.			Lectures to Teachers.	Lectures to Mothers.	Lantern Lectures.	Film Lectures.	Works Meetings.		TOTAL.
	Men.	Women.	Mixed.	Men.	Women.	Mixed.					Men.	Women.	
1919	310	910	8,450	2,827	4,010	500	390	1,275	1,890	2,300	2,160	2,630	27,652
1920	1,914	2,605	1,840	1,350	1,470	—	710	2,004	6,215	3,900	8,210	5,906	36,124
1921	2,914	3,773	1,875	1,290	725	60	350	1,318	2,100	122,500	—	66	136,971
1922	—	2,725	360	750	50	200	94	805	1,450	10,820	—	—	17,254
1923	—	3,125	360	1,340	—	60	540	—	520	13,400	—	100	19,445
	5,138	13,138	12,885	7,557	6,255	820	2,084	5,402	12,175	152,920	10,370	8,702	237,446



## MAXIMUM EFFICIENCY OF A V.D. CLINIC

*J. J. Butterworth, M.D., D.P.H. (Lancashire).*

should be treated as a social outcast has been broken down. Many of the infected persons, by treatment have been rendered non-infective. The governing bodies of hospitals are beginning to realise that these diseases can no longer be neglected and that treatment must be provided. The best results have been achieved in the treatment of syphilis, particularly in the male.

The facilities in this county for treatment of infected persons are, with more or less difficulty, within the reach of all. The County Council has issued, free of charge, over 800 railway vouchers to enable persons to travel from their homes to treatment centres. The campaign against the disease, however, requires development in certain directions.

The greatest defects in a number of the present schemes are (a) the lack of proper provision for the treatment of infected children, (b) the lack of proper provision for the discovery and treatment of gonorrhœa in the female, and (c) the difficulty of providing treatment with sufficient privacy for the respectable woman who objects to have to wait her turn in company which is often very mixed and undesirable. It is mainly with the first two defects that I shall deal for a few minutes to-day, as, in a large number of cases, the sufferers are innocent victims and therefore most worthy of treatment and consideration.

Before discussing any administrative action it is necessary to know something of the extent of the problem.

(a) *Children suffering from venereal diseases.*

These children can be divided into two classes: (1) Children of school age, and (2) Children under school age.

(1) Children of school age:—

About two years ago, I instructed the medical men on my staff working in the Lancashire County Schools and Child Welfare Centres to carry out an investigation into the incidence of the signs of congenital syphilis in children attending the elementary schools. It was impracticable to use the Wassermann test in the investigation.

As the result of the clinical examination of several thousands of children, I formed the following conclusions:—

- (a) That the gross manifestations of congenital syphilis in school children resident in the rural districts of the county are very rarely seen.
- (b) That the gross manifestations of congenital syphilis are occasionally seen in the routine examination of school children in the smaller towns (less than 0.15%).
- (c) There was some evidence that congenital syphilis, which had remained latent, was lighted up by inter-current disease. Thus, one child developed signs of congenital syphilis after measles, and another after the removal of tonsils and adenoids; and

## SOCIAL HYGIENE

(d) There were certain cases, but few in number, in which the medical officers thought a Wassermann test necessary before a definite opinion could be expressed.

### (2) Children under school age:—

The medical officers working in the County Child Welfare Centres are unanimous in stating that they see and suspect the existence of syphilis more frequently in the babies attending the centres than in school children, but that it is by no means a common disease in these children. They think, however, from the evidence supplied by their Health Visitors, that the disease has its greatest incidence in the premature and ailing infants which die in the first months of life or remain too feeble and ill to attend the centres. In other words the infected children die off and do not survive till school age.

Several of the medical officers express the opinion that syphilis is frequently a cause of still-births.

The following statement shows the number of still-births, etc. reported by midwives practising in the Administrative County Area:—

Year.	Total Births in County Area.	No. of Births attended by Certified Midwives practising in County Area.	No. of Still-births reported by Certified Midwives.	Percentage of Still-births reported by Midwives to total Births attended by them.
1914 ...	38,507	21,880	498	2.27
1915 ...	34,595	20,941	392	1.87
1916 ...	32,695	17,069	397	2.32
1917 ...	28,420	15,592	361	2.31
1918 ...	27,736	14,966	305	2.03
1919 ...	28,799	16,240	381	2.34
1920 ...	39,767	21,843	479	2.19
1921 ...	36,558	19,566	443	2.26
1922 ...	32,011	17,046	401	2.35
1923 ...	30,672	15,763	359	2.27

There is a strict supervision of the work of certified midwives practising in the Administrative County area, and the record of still-births stated above may be taken as approximately correct. "Still-births" include all infants born dead after the twenty-eighth week of pregnancy.

Table IV shows that in spite of the great reduction which has taken place in the post-natal causes of infant mortality during recent years, the causes of ante-natal death remain as potent as ever.

## MAXIMUM EFFICIENCY OF A V.D. CLINIC

J. J. Butterworth, M.D., D.P.H. (Lancashire).

Dr. Cruickshank,\* working at the Glasgow Royal Maternity and Women's Hospital, in a recent report to the Medical Research Council reaches certain conclusions which appear to be very apposite to the matter under discussion.

(1) "The Wassermann reaction in the child at birth is in close agreement with that of the mother, but during the first few weeks of life the great majority of children born with a positive reaction lose that reaction and not only remain negative to the Wassermann test, but fail to develop clinical signs of syphilis during the first two years of life."

He concludes from this that:—

- (a) "A positive Wassermann reaction in the blood of a new-born infant is due at least in the majority of cases to a transference of reacting substances from the mother."
  - (b) "A positive Wassermann reaction in the new-born infant is of no value in diagnosis."
  - (c) "The incidence of congenital syphilis is very much less than purely serological data would indicate."
- (2) "The effects of syphilis in the mother are seen chiefly in the later months of pregnancy, at which time the disease leads to premature birth and, more particularly, to premature still-birth. As a cause of interruptions of pregnancy in the earlier months, syphilis does not appear to be of predominating importance."

(3) "Many of the signs supposed to be characteristic of congenital syphilis in the new-born are quite inconstant in their presence in definitely syphilitic cases, and others, e.g. splenomegaly, are not confined to syphilitic infants."

"The diagnosis of syphilis in the new-born can be made definitely only after a careful review of the clinical serological and pathological findings."

Syphilis in the child is, of course, the result of syphilis in one or both of the parents in almost every case, and it is necessary therefore in any administrative scheme to make provision for securing the examination and treatment of the parents and other members of the family where the child is found to be infected. The work of Findlay in Glasgow, and Adams in London, demonstrates the superiority of pre-natal over post-natal treatment of the congenitally syphilitic infant. If this work is correct, then the pre-natal treatment of pregnant syphilitic women is administratively economic.

(b) *The discovery of gonorrhœa in the female.*

In the rural and small urban districts of under 20,000 population in a large county like Lancashire the discovery and treatment of

\* Cruickshank, John Norman. "Child Life Investigations." "Maternal Syphilis as a Cause of Death of the Fœtus and of the New-born Child." (Medical Research Council, 1924).

## SOCIAL HYGIENE

gonorrhœa in the female is a very difficult administrative problem. One of the greatest difficulties is our lack of knowledge of the incidence of the disease. The sources of information are meagre. I obtain a certain amount of information as to the occurrence of gonorrhœa in women through the administration of the Midwives' Acts.

The following statement shows the number of notifications of ophthalmia neonatorum received since the year 1914 in connection with the work of the County Public Health Department under the Midwives' Acts :—

Year.	Number of Notified Cases of Ophthalmia Neonatorum.	Total Births Registered.	Percentage of Cases of Ophthalmia Neonatorum notified to total Births.
1914 ...	273	38,507	0.70
1915 ...	234	34,595	0.67
1916 ...	255	32,695	0.81
1917 ...	233	28,420	0.81
1918 ...	231	27,736	0.83
1919 ...	323	28,799	1.12
1920 ...	464	39,757	1.16
1921 ...	265	36,558	0.72
1922 ...	235	32,011	0.73
1923 ...	208	30,672	0.67

It will be noted that the greatest incidence of ophthalmia neonatorum occurred in the years 1919 and 1920, the period of the demobilisation of troops.

The Table IV shows, for three years, the condition of the eyes after ophthalmia neonatorum, as obtained by re-visits by the County Staff after a lapse of from 2 to 26 months from the date of the first report. It is our practice in the County of Lancashire to follow up these cases.

On examination of the details obtained in the inquiries into ophthalmia cases the following facts were ascertained :—

Extending over a period of  $6\frac{1}{2}$  years :

The average interval of time between the birth of the child and the onset of the disease (ophthalmia neonatorum) was 6.05 days.

The interval between onset of disease and the date on the record sent by the midwife to the medical practitioner was 1.36 days.

The interval between onset of the disease and the date of notification of the case, under the Ophthalmia Neonatorum Regulations, was 4.29 days.

## MAXIMUM EFFICIENCY OF A V.D. CLINIC

*J. J. Butterworth, M.D., D.P.H. (Lancashire).*

TABLE IV.

	YEAR 1919.		YEAR 1920.		YEAR 1921.	
	All "Eye Cases."	Notified as Oph. Neon.	All "Eye Cases."	Notified as Oph. Neon.	All "Eye Cases."	Notified as Oph. Neon:
Total No. of "Eye Cases" reported to the Local Supervising Authority under the Midwives Act... ..	447	—	665	—	436	—
Total No. of "Cases" notified as Ophthalmia Neonatorum...	—	323	—	464	—	265
Information regarding condition of eyes after a lapse of from 2 to 26 months from date of first report:—						
Totally Blind ... ..	2	2	3	3	2	1
One Eye Blind ... ..	1	1	—	—	—	—
R. Blind—L. Keratitis ... ..	—	—	1	1	—	—
R. Blind—L. Nebula ... ..	1	1	1	1	—	—
L. Blind—R. Nebula ... ..	1	1	—	—	—	—
R. Blind—L. Normal ... ..	2	2	—	—	1	1
L. Blind—R. Normal ... ..	—	—	2	2	1	1
R. Nebula—L. Normal ... ..	1	1	3	3	1	1
L. Nebula—R. Normal ... ..	2	2	4	4	3	3
L. Large Opacity—R. Normal	1	1	—	—	—	—
R. Squint—L. Normal ... ..	—	—	2	2	—	—
L. Squint—R. Normal ... ..	—	—	3	1	—	—
R. Weak—L. Normal ... ..	—	—	1	1	1	1
L. Weak—R. Normal ... ..	—	—	1	1	—	—
Both Eyes—Weak ... ..	5	4	10	9	3	2
Adherent Iris ... ..	—	—	1	1	—	—
Occasional Conjunctivitis ...	1	1	—	—	—	—
Marked Internal Squint ... ..	1	1	—	—	—	—
Slight Opacity (one eye) ... ..	3	1	1	1	—	—
Left Eye Defective ... ..	1	1	—	—	—	—
Miosis ... ..	1	—	—	—	—	—
Vision Unsatisfactory ... ..	1	1	1	—	—	—
Eye Discharging ... ..	5	3	1	—	—	—
Eyelids Inflamed ... ..	2	2	3	3	1	—
R. Squint, Eyes Discharging ...	—	—	1	1	—	—
R. Blind—L. Myopia ... ..	—	—	1	1	—	—
Corneal Opacity (both eyes) ...	—	—	1	1	—	—
L. Blind—R. Defective ... ..	—	—	1	—	1	1
L. Blepharitis—R. Normal ... ..	—	—	—	—	1	1
Blepharitis (both eyes) ... ..	—	—	—	—	1	—
R. Defective ... ..	—	—	—	—	1	—
Eyes—Normal ... ..	345	240	533	362	355	205
Children Deceased ... ..	31	26	67	51	50	37
Left District—No information, or still under treatment ...	40	32	23	15	14	11
	447	323	665	464	436	265

## SOCIAL HYGIENE

The length of time between the date on the Medical Help Record (first report of the case) and the date a doctor first saw the child (commencement of treatment) was 1.25 days.

The investigations carried out by the inspector of midwives, health visitors, and assistant county medical officers show that many of the severe cases of ophthalmia neonatorum are due to gonorrhœa in the mother, but the data are insufficient to express as a percentage the incidence of gonorrhœa in notified cases of ophthalmia.

I also receive certain information from certified midwives. It is their duty under the rules to call in a medical man in cases where they discover purulent discharge in pregnant women. There are 663 midwives practising in the county area at the present time, and the number of records received from midwives in respect of these conditions in the year 1922 for "purulent discharge" was twenty. It is unlikely that these figures represent the true incidence of gonorrhœa in pregnant and parturient women attended by certified midwives, but medical practitioners inform me that they also see very few cases in pregnant and parturient women in the rural and small urban districts, and they further state that they see very few cases either in adult males or females.

The assistant medical officers and health visitors report to me very few cases of gonorrhœa in females either at the infant welfare centres or during their home visits. It is my experience, therefore, that it is very difficult to estimate, with any approach to accuracy, the amount of gonorrhœa existing in women in the rural and urban districts of Lancashire.

### THE TREATMENT OF WOMEN AND CHILDREN.

The provision of treatment for women and children suffering from venereal disease in a large county with 121 separate urban and rural districts is a difficult administrative problem.

The problem in a large town is comparatively easy where there is a well equipped hospital containing special departments for women, children and persons suffering from venereal disease such as are seen in the large London hospitals. The gynæcologist seeing a case of venereal disease, or the physician in the children's department seeing a syphilitic child, can co-operate with the Director of the Venereal Diseases Department and through the lady almoner knowledge is gained of contacts to be followed up.

In the smaller districts of Lancashire there are either no hospitals, or they are not suitably equipped. The respectable married women generally will not attend the treatment centres provided in the large towns nor will they take their children.

In the textile towns a large number of the women are engaged in industry, and the wife of the coal miner is a hard worker. The provision and cooking of meals for perhaps several workers on different shifts, the care of their working clothing and the bringing up of a family leave very little spare time for the coal miner's wife.

## MAXIMUM EFFICIENCY OF A V.D. CLINIC

*Margaret Rorke, M.B.*

I think provision for the treatment of syphilis in women and children might be made in certain of the existing child welfare, ante-natal, and school clinics where it is possible to make proper arrangements.

In one of the combined child welfare and school clinics in a small urban district in Lancashire, I was able for a time to arrange for the treatment of syphilis in children. The final results were good.

The numbers would not be large in any particular district, and the patients could be seen regularly by appointment. There could by this method be a close co-operation between school medical and child welfare medical officers, inspector of midwives, health visitors, school nurses, midwives, etc., and the venereal diseases medical officers treating the cases. Ophthalmic cases of syphilis in children, such as keratitis and choroiditis, should be treated by ophthalmologists.

The treatment of gonorrhœa in women in county districts is a much more difficult problem for the following reasons:—

- (a) Gonorrhœa requires daily treatment.
- (b) It is not advisable from a surgical standpoint to treat gonorrhœa in the same department at which young children and babies attend.
- (c) There would be a danger of bringing the centre under the label "venereal."

The discovery of a specific treatment for gonorrhœa would simplify the administrative problem in county districts. It is the exacting nature of the present mode of treatment which creates the main difficulty.

## THE VENEREAL CLINIC IN ITS RELATIONSHIP TO THE TREATMENT OF WOMEN AND CHILDREN.

By MARGARET RORKE, M.B., *of the Royal Free Hospital V.D. Clinic for Women.*

THE treatment of venereal diseases in women and children is admittedly beset with special problems—some relatively easy to overcome and others almost insuperable.

The lives of married women of the working and lower middle class are made up of such infinite detail and endless duties that it is only when persistent illness forces them to do so that they seek medical advice, and frequently such advice as they are able to afford, includes as a result of its cheapness such perfunctory examination or lack of examination by the overworked practitioner, that the condition goes unrecognised or is diagnosed as something necessarily a sequel of motherhood, and in this way further time is apt to be

## SOCIAL HYGIENE

lost before the patient makes her way to hospital. Even then she goes to Casualty or to the wrong Out-patient Department, and thus there is further delay while she is referred to the V.D. Clinic. Some cases cannot afford another few hours that week to attend at the clinic and journey to and from it, and so delay again; while others on getting there are sometimes waylaid while undressing by some of the old and tough habitués and told gloatingly of the nature of the clinic, and so flee in horror without ever being seen by a doctor.

These statements may seem far-fetched, but are founded on fact and observation. By the time the patient is seen in many cases her disease is sub-acute or well-established, and in consequence the length of time required before cure can be obtained is frequently great and discouraging to the patient.

With regard to unmarried women the position is in many cases little less difficult. Should she be at business and living at home, she is consumed with dread lest her mother, sisters or friends should get to know of her illness; if the patient is a strong-minded girl whose lapse was an exceptional thing and who is determined to "make good," she will *make* the opportunity to attend the clinic daily, either before or after business hours, for irrigation treatment, or weekly for her injections as the case may be. But should she be of poor moral fibre there are only too many possible excuses for evading treatment, or for attending so irregularly as to be worthless from the point of view of cure.

The shop-assistant and the domestic servant in a private house are more difficult problems; even with the best will in the world they cannot get out to hospital often, and one can only sympathise with their natural desire to do something a little more amusing than come to hospital on at least one of their infrequent nights off duty.

As to the unmarried woman who is infected with venereal disease and also pregnant, this is a mighty problem. In the majority of cases she conceals her pregnancy as long as possible, and in her ignorance ascribes all or any of her symptoms to that condition. She remains at work from dire necessity as long as her employer will keep her, and when at the seventh month of pregnancy, or often later, she attends the ante-natal department of a hospital to seek admission for delivery, and her infected condition is recognised, where has she to go? The homes for pregnant unmarried mothers that will admit venereal cases are few in number, and till more are founded many of the girls have to go to a big venereal hospital or to the poor-law institutions. Against both of these there are objections for this special type of case; no matter how admirable the medical treatment may be, these patients come in contact very frequently with a coarse and vicious type of woman, who is often a patient there, and the girl who has made one false step sometimes through her very womanliness and affection, instead of being given a chance to "make good" by associating with refined women of high moral tone as the best type of rescue sister is, is encouraged by depraved associates to regard herself as



## MAXIMUM EFFICIENCY OF A V.D. CLINIC

*Margaret Rorke, M.B.*

definitely "done for," her outlook is anti-social and she becomes a parasite on society. We are careful nowadays not to let the first offender and the "old lag" congregate together when the law of the land has been transgressed. Should we give a poorer chance to the girl who has transgressed the laws of morality?

My last problem is the children of school age who have become infected, in only too many cases from the poverty or carelessness of parents living in overcrowded rooms, with a gonorrhœal infection. The treatment required is tedious, and if not meticulously carried out the case will become chronic. Daily douching is required and attendance also to the doctor once or twice weekly. This takes time, and unless the mother is an enthusiastic co-operator, results are disappointing. Unless also every other infected member of the family is having treatment there will be a constant re-infection of the child from the original source—bedclothes, towels, or sanitary chambers.

How should we meet these difficulties?

Well, some of them have been met and the rest can be dealt with if there is only goodwill and enthusiasm on the part of those in authority, be they public health officials or clinic M.O.'s.

One liaison officer of immense help in dealing with all these types of patient is the trained social service worker. The hospital almoner can be of tremendous value both to doctor and patient—explaining the point of view of the one to the other, allaying the fears of the timid patient, writing to or calling on the recalcitrant one, placating employers; being in close touch with every charitable agency in the country she knows just what special committee can deal with this special difficulty; she will obtain extra insurance money for a hostel in connection with a hospital, will arrange for convalescence when the patient is fit for it, and for employment of the right kind, and will be an after-care worker too. I have been fortunate beyond telling in the magnificent help I have obtained for my patients and myself from the Almoners' Department of the Royal Free Hospital. But there are not enough almoners, and other social workers have to be pressed in to help. An admirable social worker is the trained nurse of the right type. There are some nurses who possess to a high degree the mothering instinct, and these make the best V.D. clinic nurses. The nurse who is inclined to the work only on its technical side is of little real use in the clinic; but the one keen on the work itself and filled with a great pity for the poor infected children and women will by reason of the combination of her training and personality be an immense power for good with the patients. They respect the nurse's professional ability, and without realising it listen to her unobtrusive advice and are helped and guided by her opinion. The rescue worker too, attached to various homes and missions, can be most helpful with certain types of cases; but one wants to deal in a kind but common-sense way, and a few rescue workers I have met have tended to be too insistent on the lurid side of V.D. to be altogether ideal co-operators. The calmly religious woman with common-sense, who knows about V.D., preferably from having helped in

## SOCIAL HYGIENE

the V.D. wards of a hospital or workhouse, can be a great power for good; and she is particularly useful as an after-care worker who can follow the case after it leaves hospital.

The outstanding needs to my mind at the moment to secure the maximum efficiency of the V.D. clinic on the female side are:—

1. Better facilities for married women's treatment. There might well be one or two afternoon sessions a week set apart for married women only. This could easily be done without in any way depriving unmarried women of chances of treatment. These married women bitterly resent having to mix with the semi-prostitute type at the clinics, and though there are only a very few of that type usually present, yet by their make-up, dress, and idle and often boastful chatter they can be a great offence to the decent married woman, who in several cases to my knowledge has given that as her reason for non-attendance. I think also that the time has come for a V.D. session a week to be attached to each large maternity and child welfare centre or group of smaller centres, or perhaps for each borough. All cases attending the centre which seemed to need investigation could be referred there for that purpose, and if treatment was found to be needed the patient could be referred with a short note and the pathological reports to the appropriate clinic. I myself attend weekly two ante-natal clinics attached to welfare centres in far distant parts of London—supposedly for ante-natal work only—and am constantly finding cases of syphilis and gonorrhœa among them. It is not possible, I think, nor is it desirable, to attempt *treatment* of V.D. in such centres, but one would meet with no difficulty in getting mothers to attend or bring their children for tests to a special session of the centre they are accustomed to attend, and then it would be part of the duty of the health visitor in her visiting to make certain that cases needing treatment are attending hospital, i.e. we would be extending our after-care and follow-up facilities.

2. For unmarried girls clinics open all day are necessary so that they may obtain treatment while going to work, for however much we feel that many of these cases should stop work and have a considerable amount of rest, both for her own sake and to remove a potential source of infection from the community during the first few weeks of her treatment, it is in many cases a practical impossibility. The girl tells you she must earn, and daren't hand in a sick certificate for two or three weeks running, lest in these times of poor trade she should lose her work. Considering all this it is not only fairest to the girl but cheapest to the public in the long run, to provide every facility for adequate intensive treatment.

3. For unmarried pregnant girls suffering from V.D. more hostels are required. I should like to see every female V.D. clinic with its hostel for such cases—a dozen girls and their babies should be the maximum number in any single hostel, thus ensuring the personal attention of the matron for each case. They want the intermediate treatment properly carried out, good food, airy rooms, sufficient housework to keep them occupied and to ensure the hostel's

## MAXIMUM EFFICIENCY OF A V.D. CLINIC

*Margaret Rorke, M.B.*

being kept clean by the girls' own efforts, while other more amusing occupations such as the making of their own and their children's clothes, reading, and music fill up the evenings. We have in connection with the Royal Free Hospital a hostel for such cases run on these lines, and I believe that in nearly every case when a girl leaves us when she is well enough after the birth of her baby, she leaves not only in better health, but with a quickened moral sense and a new ideal of citizenship.

4. For the children of school age, where home conditions are discovered to be genuinely bad, e.g. severe overcrowding, drunkenness or bad character of the parents, or in those outlying districts where the child lives at a long distance from the nearest clinic, the child should be drafted to a V.D. children's home. The ideal home is one where the children are thoroughly treated for the disease from which they are suffering, and where part of the day is also given up to lessons and such games as the child is fit to engage in; thus preventing her from losing education, and at the same time having her mix with her equals. The V.D. child at home, kept from school by reason of infectivity, is apt to become a rather self-centred and neurotic little person.

Finally I would plead as an aid to both prevention and treatment of V.D. amongst women and children, for more persistence in completing treatment by men patients, and above all for the need for better understanding of their responsibility by men patients. Admittedly most cases of V.D. infection in respectable women are got by contagion from apparently cured men. By no means do I believe that all these men are bad, and that women infected by them are necessarily their innocent victims, but I do feel that there is a great lack of appreciation on the part of nearly all these men of the inevitable outcome of their marriage while in a diseased state, or of their continuing to live with their wives while suffering from a post-marital infection. It may be Utopian, but one feels that absolute frankness is the thing to aim at when such cases occur—the man should be encouraged to tell his wife that he is ill and to get her to be examined lest he have infected her before he was aware of his own infection; naturally he dreads doing so, but in only too many cases the confession is forced from him some time later when his wife discovers the cause of her own sufferings. There are "Schools for Mothers" eagerly attended by working class women; I appeal to our public health leaders to teach men how to live as citizens and husbands. Without a very different outlook on sex and marriage by the majority of men, we can never hope to rid our homes of the scourge of venereal disease.

### DISCUSSION.

The CHAIRMAN, in opening the discussion, expressed the hope that as many medical officers as possible who had had practical experience of the management of V.D. clinics would participate in the discussion. He desired to draw the attention of the

## SOCIAL HYGIENE

conference to six items which in his experience had played a very prominent part in connection with the efficiency of the V.D. clinic.

1. The first point was the question of the premises in which the work was carried on. It had been his experience that in many of the voluntary hospitals, where clinics were provided, the medical and nursing staff were considerably handicapped by their unsuitability, inconvenient arrangements and overcrowding, and he submitted that no clinic could be expected to attain a high standard of efficiency unless the arrangements for carrying on the work were so planned as to provide every possible facility for the doctors, nurses and patients. It was very well known that the principal difficulty which faced the voluntary hospitals in providing suitable premises was the large capital expenditure which frequently would be involved in the building or re-construction of such premises, and in view of the financial difficulties of the voluntary hospitals, with which everyone was quite familiar, it seemed to him that it would be quite a reasonable step on the part of the Ministry of Health to offer to make capital grants to the voluntary hospitals which undertook, on behalf of the local authority, the diagnosis and treatment of venereal diseases. This principle had long been in operation in the case of tuberculosis, and there did not seem to him to be any reasonable grounds for not extending similar facilities in the case of venereal diseases. The Chairman went on to remark that Colonel Harrison had quite rightly emphasised that maximum efficiency could only be expected where the conditions under which the medical and nursing staff carried on their work were specially designed for the purposes of a V.D. clinic, and any person who was really interested in this problem would find that a visit to the model V.D. clinic at St. Thomas's Hospital would very well repay the time occupied in inspecting the premises there.

2. Another question which seemed to him to require careful consideration was the position or status of the medical staff of the V.D. clinics in relation to the honorary medical and surgical staff of the voluntary hospitals. In his experience there had been far too great a tendency on the part of the voluntary hospitals to look down, as it were, upon the medical staff engaged in V.D. work, and to refuse to give them the same status on the honorary staff of the hospital as the other members of the medical staff of the hospital. The Chairman was of opinion that the time was drawing near when this question would certainly become a subject for serious consideration by the public authorities which subsidise these clinics, as it was felt by many who were interested in the maintenance of the highest possible standard of medical staff engaged in V.D. work, that the attitude of their medical colleagues could not have anything but a detrimental effect upon the class of medical officers who would be willing to undertake this work in future. After all, it seemed absurd to suppose that there should be any professional distinction, so far as the medical staff of the hospitals was concerned, between those who specialised in the diagnosis and treatment of venereal diseases and those who were engaged in any other special

## MAXIMUM EFFICIENCY : DISCUSSION

branch of medical and surgical work in other departments of the hospital.

3. The third point to which the Chairman wished to draw attention was the value of the establishment wherever possible of V.D. clinics which were open all day for the treatment of patients. Experience in London had gone to show that where such clinics were provided many of the worst features of part-time clinics were entirely avoided. For example, there was no overcrowding. There was ample time for the medical officer of the clinic not only to examine each patient thoroughly, but, in addition, to impress where necessary upon the patient the importance of continuity of treatment. Moreover, such clinics were an immense convenience to the patients themselves as it was possible for them to visit the clinic at any time of the day between 8 a.m. and 10 p.m. It was also possible to provide ample facilities for special examinations of a more prolonged nature, where necessary, and another important advantage was the elimination of the complaint frequently heard in part-time clinics, namely, that it avoided the herding together for prolonged periods in the waiting-room of different classes of patients who in some cases it was undesirable to mix up together. The Chairman said that in London there were at the present time V.D. clinics provided at twenty-eight different hospitals, but that if it was possible, after the experience of the last seven years, to start a V.D. scheme with a clean slate, there would be no doubt whatever that it would be very much more satisfactory to concentrate the work into half or even less that number of clinics and to make it a condition of grant that they should be open all day long. Such an arrangement in his judgment did more than any other individual item towards attaining the maximum efficiency of the work of the clinic.

4. The fourth point to which he wished to refer was the importance of endeavouring to keep a much closer watch over the costs of maintaining the clinics, and in this connection referred to some interesting experiences which he had had in conjunction with Colonel Harrison in investigating the different costs of such items as drugs, dressings, etc. in the various London clinics. Close investigation had shown that in many instances it was possible to reduce costs which amounted to 9*d.* per out-patient attendance to a figure varying from 3*d.* to 6*d.* per out-patient attendance, and when one bore in mind that out-patient attendances in the large clinics represented over 100,000 attendances per annum, it would be obvious that there was great scope for economical management by attention to such items as those referred to.

5. The fifth point was that experience in London enabled him to testify to the immense value of what might be called ancillary institutions in connection with V.D. clinics. He referred to such examples as those of hostels for young girls in domestic service, etc., who were undergoing treatment at the clinics; also to special institutions for the treatment of ophthalmia neonatorum and vulvovaginitis. These institutions had been referred to more particularly by Dr Rorke, and he did not think it was necessary to do anything

## SOCIAL HYGIENE

more than confirm the remarks which she had made in regard to the value of these institutions in connection with V.D. clinics.

6. The sixth and last point to which he wished to refer was the subject of compulsory notification and treatment, which had been dealt with by Dr. Lees in some detail. While it is true that Dr. Lees had only advocated what he called conditional notification, he desired to remind the audience that the whole of this question had been most exhaustively inquired into quite recently by the Trevethin Committee, of which he was a member. They had taken evidence from a large number of witnesses and after very careful consideration had found it impossible to make any recommendation advocating the adoption of compulsory notification and treatment in any shape or form, not even in the form recommended by Dr. Lees. It was impossible in the short time at his disposal to go into the reasons which induced the Trevethin Committee to come to this conclusion. The subject was one which would require the whole of a session for its proper discussion, but he would like to remind the audience of one significant fact which had always carried great weight in his mind in considering the desirability or otherwise of adopting compulsory notification and treatment in connection with venereal diseases. The point to which he referred was this: That although compulsory notification of tuberculosis had been general throughout England and Wales for some years past, there was ample evidence to show that in actual practice from 30 to 50 per cent. of the notifications were not received by the medical officer of health until within three months of the death of the patient. Moreover in those urban areas in this country to which Parliament had given special powers for the compulsory treatment of cases of infective tuberculosis—and there were more than twenty urban areas in this country which possess this power—experience had again gone to show that in actual practice it had been found impossible to put the powers into operation. If this was the experience in tuberculosis, it seemed to him to be perfectly hopeless to expect any satisfactory result in diseases like those which they were now considering, where the stigma of having contracted the disease was much more a factor than it was in the case of tuberculosis.

*Dr. H. M. Hanschell, D.S.C., of the Seamen's Hospital, Royal Albert Dock:* The very great majority of men who attend our venereal disease clinic are seafarers. Seafarers attend readily. They often request certificates to show the mate in order that they may be paid off and so be able to attend for treatment. They can rarely afford to remain on shore for longer than five or six weeks. This means that they receive treatment just long enough to enable them "to get past the doctor" who examines them before they are signed on another ship, but barely long enough to render them safe from the public health point of view. This state of affairs could be remedied by having more beds at one's disposal. Most of them, especially boys and apprentices, would stay in hospital until declared fit for discharge by the medical officer.

## MAXIMUM EFFICIENCY : DISCUSSION

As to non-European races. The African attends as readily as the European. The Chinaman and Indian attends once or twice only. The treatment of these different races all together in the same clinic has certain difficulties.

The non-European would plainly prefer not to be stabled with the European. The latter as a seafarer frequently acquires his venereal disease from a non-European, yet nevertheless resents finding himself next to a "native" in waiting or irrigation room of a venereal disease clinic and even in a hospital ward. The proper clinic for a seaport such as London should provide separate apartments and separate wards for European and non-European.

*Dr. A. H. Headley Huckle, Sussex Branch B.M.A.*, pointed out the extreme importance of suitable and adequate premises and said that he was in charge of a clinic which had been opened in January last, built by a grant to the Royal East Sussex Hospital, on the lines shown by Col. Harrison.

Attendances have at once gone up in the proportion of from four to seven. It is necessary to be at a hospital in order to work in connection with the routine hospital cases.

Under the Prevention of Cruelty to Children Act it is legal cruelty to withhold necessary medical treatment in the case of children suffering from any disease, and under this clause a parent can be compelled to send or bring a child suffering with congenital syphilis for proper treatment.

*Dr. F. H. Lawson* stated in regard to the question of married women and children that an arrangement had been made that this class of case was taken before the ordinary turn at the clinic established at the Royal Sussex County Hospital, Brighton.

*Sir Francis Champneys, East Sussex County Council*: I came to learn and not to speak, but at the Chairman's request I say a few words.

*Dr. Lees* said that in the gynæcological department visual examination of the cervix and vagina was made. This is not true of the gynæcological department over which I presided. In this what I taught and practised was that, in cases of discharge the spectrum should be used before the finger.

The other point is that we still have a good deal of benighted obstruction to contend with. In a County Council with which I am connected there has been great opposition to propaganda on venereal diseases, and a grant has been opposed, on the ground that the subject was unpleasant and disgusting and should not be mentioned. On the first occasion I gave the County Council a lecture on venereal disease lasting ten minutes and beat the opposition by three to two; the next year I beat it (after another lecture) by three to one, and this last year there was no opposition. But there is still a good deal of opposition to contend with. It is dying, but it is not yet dead.

*Rev. G. Bell-Doughty, British and Foreign Sailors' Society*: Though a parson, one feels that one is in this discussion a

## SOCIAL HYGIENE

layman among clerics, and one realises that "fools step in where angels fear to tread," but one wants to comment on one point in the able paper read by the last speaker (Dr. Rorke). She seemed to imply that in certain Poor Law Institutions the women especially felt the reflection of moral reprobation on the part of some of the staff which was unnecessarily painful. My own experience does not bear out this comment. I am speaking as representing the British and Foreign Sailors' Society, but my experience is derived from a long seventeen years' membership of the Metropolitan Asylums Board, and I am sure that in the three institutions I am acquainted with—Thavies Inn, Sheffield Street and St. Margaret's Home, Kentish Town, one has been struck by the atmosphere of consideration and complete absence of anything like moral stigma. I think it only fair and right to say this.

*Dr. Mary Douie*: Though not exactly relevant to the discussion this afternoon I ask leave to say one word in defence of the Poor Law Institutions. There may be, and no doubt are, some infirmaries which maintain the somewhat antiquated attitude of reprobation to which one speaker has referred—but as Chairman of the Hospital Committee in a Poor Law infirmary, and having knowledge of others, I can say that in none of those which have come under my notice has such an attitude been present, among either doctors or nurses.

*Provost Sir Henry Keith, Convention of Royal Burghs*, remarked that the last speaker had said he opposed notification twelve years ago, but a man could grow sensible in twelve years and it would be quite possible for him to change his mind even on that subject.

He urged the necessity of some form of compulsion. Unless we had compulsion how were we going to deal with these diseases which we had now come to recognise as of the most fatal, insidious and destructive character? The conscience of this country was awakening to this question in a way that it had never awakened before. Public opinion had grown since the Chairman (Dr. Menzies) was "sick of the question" of notification, and it was up to men like the Chairman to say how they were going to deal with the problems raised; such, for instance, of the wife cured after two years' treatment, and reinfected by her husband on his return after a prolonged absence at sea. Sending letters to the defaulters, as some doctors did, requesting them to attend, was a form of moral compulsion. Was a medical officer not entitled to get some further power than the mere sending of a postcard in order that they should make the treatment efficient?

The Chairman should try to get "healthy" regarding this question. We would never reach within sight of national efficiency and a cure of these diseases until some form of notification and compulsory treatment had been organised. Neither sex nor class should be exceptionally dealt with. There should be no discrimination between rich and poor. When this was fully recognised the work now being done would become "efficient."



# The Medical Profession.

*President of Section :*

Mr. E. B. TURNER, F.R.C.S., V.P. of N.C.C.V.D.,  
in the Chair.

THE CHAIRMAN : The problem of the place the general practitioner should occupy in the campaign against venereal diseases is one of the utmost importance. The general practitioner is the first line of defence against disease, and it is only through his co-operation that the early diagnosis and treatment of the whole population, especially the rural population, can be secured. The National Council have been working on this matter for some years, and the Medical Committee elaborated a scheme and scale of fees for carrying out treatment which was approved by the British Medical Association and submitted to the Ministry of Health. Should it be found possible administratively to do something of the sort, a very great advance would have been made towards a greater success in the treatment and cure of venereal disease by attacking it at its origin.

## THE GENERAL PRACTITIONER AND THE TREATMENT OF VENEREAL DISEASE.

By CHAS. E. S. FLEMMING, M.R.C.S., L.R.C.P.

The success of the national scheme for dealing with venereal disease has, owing to the foresight and statesmanship of its authors and promoters, been so great that we might be tempted to leave it as it is, were it not that this very success encourages us to strive for still greater results than at one time we thought it reasonable to expect. In attempting this we ask :—

Is there any need for an improved service for the treatment of venereal disease, and if so do rural districts require special consideration ?

Is the co-operation of the general practitioner required ?

What are the difficulties in the way of utilising the services of the general practitioner ? and

What can be done by Government to overcome these difficulties ?

The total number of cases treated through the service has been steadily decreasing since 1920, and this decrease may fairly be considered as due to the improved health brought about by the work done at the clinics. Individual attendance is better, the average attendances for each case in 1918 were 10.8, in 1922 they were 28 ; this better persistence in treatment points to a growing appreciation of the value of the service, as also does the fact that clinics are in an increasing degree resorted to by those in doubt as to their condition ; in 1918 those found not to be infected were as 1 to 8.9 that were infected, in 1922 the proportion was 1 to 4.3.

But on the whole, attendance is by no means as satisfactory as it should be, so far as figures are available (and I would like here to express my thanks to the Medical Officers of Health and Directors of Clinics for the information they have so kindly given me), the numbers failing to complete more than one course, though they vary greatly at different clinics, may be said to average from 20 per cent. to 30 per cent. ; and it is interesting to note that, so

## SOCIAL HYGIENE

far as completion of treatment is concerned, the patients suffering from syphilis attend better than those with gonorrhœa, although a much longer period is required. On the other hand we may fairly assume that quite a large proportion of the gonorrhœa cases that fail to carry out the entire course do get well naturally.

As to the working of the scheme in rural districts, I found that in about 80 per cent. of the areas from which I received information the attendance of patients from the country was on the whole as good as, and in some cases, even better than that of patients from the towns. In these areas distance was found to be no bar to treatment, this being largely due to the fact that the cost of travelling was defrayed by the public authority, though it was stated that in spite of this, in some instances, the loss of a day's or half a day's work prevented attendance. But there was no doubt that in some parts of the country distance seriously interfered with continued attendance. So far as can be estimated from attendances at clinics, the incidence of venereal disease per 1,000 of population was in rural districts less than a third of that in urban districts. This may be interpreted to mean that only a small proportion of affected persons in rural areas attend the clinics, but in view of the proved good attendance of the country patients, I am inclined to think that it means that the actual incidence of disease in the country and small towns is less than in large towns.

This is supported by the fact that men practising in the country seem to be agreed that there is not there, generally speaking, much venereal disease; there is unfortunately no means of getting anything like exact figures of the actual amount in town or country. However in view of the above statements it appears that it is only a small proportion of country districts that can claim special consideration in any contemplated reform of the service.

The fact remains that in rural as in urban districts there are quite a considerable number of cases that fail to complete treatment, and some no doubt that have no treatment at all, and if our object is to stamp out this disease there is no hope of doing so while these foci of infection remain, so that from the public health point of view there is need for a better service both for prevention, diagnosis and treatment, which cannot in fact be properly separated.

For this purpose the active co-operation of the general practitioner is required; he alone can insure continuity of treatment, detect those innocent victims of disease, chiefly wives and children, who, not suspecting, do not go to any clinic; find out the position of possible contacts and secure their treatment; discover those latent cases which only become evident at times, but which it is equally essential should receive effective treatment. What is the good from a public health point of view of treating the husband or the wife if the other is infected and not treated, and how are the facts to be found out in time for useful action, except through the patient's private doctor who, under the present system, is generally ignorant of the existence of a possible source of infection; how important to him and his patient is this knowledge in the case of those all too common pelvic affections of women which are gonorrhœal in origin.

## THE GENERAL PRACTITIONER

*Chas. E. S. Flemming, M.R.C.S., L.R.C.P.*

Under the present system there is little to keep the practitioner interested in the questions of diagnosis, treatment or prevention, and unless he is so interested he is not likely to play his proper part in instructing his patients as to the value of treatment and the danger of neglecting it or stopping it too soon. The failure of the patient to continue treatment is due generally to ignorance of its importance, and the necessary knowledge will not be imparted by a doctor who has but a casual acquaintance with the disease, yet the doctor feels that he should have a good knowledge of the disease and skill to deal with it, because problems of diagnosis, especially of atypical cases, and of treatment must every now and then present themselves, and may, if not solved, be disastrous for his patient and for himself. In his care of the family there is no disease the knowledge of the existence of which it is more important for him to have; unless he has this information and appreciates its value, even if the patients have to go away for special treatment, his value as a family medical attendant must be much depreciated.

It is very important for patients that they should have at hand at any time a medical attendant with experience and knowledge of the clinical history and treatment of these diseases, knowledge of their various manifestations in the skin, in every organ of the body, in the whole nervous and circulatory system, in pregnant women, in babies before and after birth, in children, youths and adults affected mentally or physically.

Not only has the immediate infective condition to be got rid of, but the individual has to be watched throughout his life, and it is the general practitioner only who can have the patient under observation during the whole of this time.

To no medical man is this knowledge and the power to control and destroy these diseases more important than to the insurance practitioner, to whom inadequate and tardy treatment means greatly increased anxiety and work.

As more harm than good may be done if the treatment provided is not carried out by those who are expert, and if the whole technique and apparatus used are not what they should be, the easily controlled clinic has been adopted by those responsible for this service.

Can these clinics be usefully increased in number? If so, it must naturally be by adding smaller ones, and although the more doors that are open for cure the better, it is no good opening clinics that are too small to be effective. Their good points are equipment, supervision and convenient administration, but if they are in special premises they are not likely to be used by many of the patients in a small town because of the publicity involved; they might be used by patients from other districts, but these patients from outside if they have to travel may just as well attend the larger or central clinic, provided the distance is not unreasonable.

The ideal plan for small clinics would be to provide them at selected cottage hospitals; there are unfortunately at present not many of these that have accommodation available for the special arrangements necessary, one hopes that the time will soon

## SOCIAL HYGIENE

come when every cottage hospital will have a department set aside for this and other communal services, which would as a matter of course be undertaken by the general practitioners in the district. Thus would be formed a link with the public medical service.

In any event the central clinics must be maintained, if only for the treatment of special and difficult cases and for consultations. Special diagnosis will probably have to be left to a considerable extent to the expert, although there must be an increasing number of medical men quite capable of demonstrating the spirochæte from a primary sore or gonococci in a purulent discharge.

But we may look forward to the time not far distant when the general practitioner will undertake the greater part of the work, either as part time medical officer at a clinic, or in his own surgery or the patient's home.

So far as the patients are concerned, there is no doubt that many who now fail to get treatment at all, or to complete their treatment, would act differently if they could get it carried out by a doctor in the privacy of his consulting room or in their own homes and, as at the clinic, free of cost, for cost is a much greater bar to treatment than distance.

There must be quite a considerable number of men now in practice who would be competent to undertake this work, and it is in every way desirable that this transference of work should take place generally as soon as enough medical men become fitted to undertake it, but they must be quite competent; and now that the importance of the education of the medical student in the diagnosis and treatment of these diseases and the elements of preventive medicine has been officially recognised, the time must be near when every general practitioner will be, not only so competent, but will look upon the care of these cases as part of the ordinary routine of his work.

The success of any general practitioner treatment must, of course, depend on the capacity of the medical man; now that is steadily increasing, and it must be considerable where the conditions of practice are such that his function is to diagnose and treat on his own all sorts of cases under all sorts of conditions, and it is well to encourage and to help him by education and by opportunity to neglect none and to keep all in the sphere of his practice.

Education is essential, the whole question revolves on the efficient education of the general practitioner, but his education does not end when he gets his qualification, it must be continued year by year afterwards, not only by study and attendance at post graduate lectures, but by actual practice, and this he can only obtain if he has a sufficient number of patients.

It is not every medical man that will want to undertake this work, but endeavour should be made to make its practice so worth the while at medical men that there will be found at least one competent and willing in the area of every practice.

Is it possible and practicable for the competent practitioner to undertake this work as part of his daily practice?

The service at present is certainly unsatisfactory so far as the doctor himself is concerned, the technique of treatment is difficult

## THE GENERAL PRACTITIONER

*Chas. E. S. Flemming, M.R.C.S., L.R.C.P.*

to carry out in the ordinary surgery or consulting room, that and diagnosis require considerable time and trouble, and yet the number of cases that he sees is so small that it is not worth his while to obtain the necessary knowledge, technical skill and equipment. If all the new cases that attended clinics in 1922, that is 56,000, were divided among the practitioners who might possibly attend them—say 20,000—there would be an average of less than three a year for each, but the number of medical men who would actually undertake this work would no doubt be considerably smaller; so that with the cases that now go to clinics, and the old cases, and those that do not now go to clinics at all, or get treatment of any sort, they would have quite a sufficient number to make it worth their while to look after them.

It is probably in the treatment of gonorrhœa that the private practitioner will mostly be needed. Yet this is, if one may judge from the expressed opinion of a large number of general practitioners, that which they least desire, largely no doubt because they realise that effective treatment is so tiresome. "Thank goodness, nowadays I seldom see and hardly ever have to treat a case," is a common answer to the question, how many cases of gonorrhœa do you see in a year?

The present day treatment of gonorrhœa with its somewhat elaborate technique, the accommodation and the frequent attendances necessary, make it in practice the most troublesome for the general practitioner to conduct. One looks forward with some hope to a more simple cure; when it arrives the difficulty of getting this disease treated will be easily overcome. Gonorrhœa patients are those for whom apparently an alteration in service is most urgently required. They do not attend as well as the syphilitics; it may be that the latter, though their disease and discomforts are frequently less obvious, have a better knowledge of its serious consequences if neglected. The campaign of education in venereal disease may be said to have produced a sort of public syphilophobia.

Gonorrhœa patients fail more frequently than others to complete their treatment, though the proportion of these to cases of syphilis attending clinics is steadily increasing. In 1918 there were 64 to every 100 of syphilis; in 1922 the proportion was 110 to 100, and according to such figures as are available the proportion for the year 1923 is still greater.

I would like here to put a question that can only be answered by collective opinion, it may be too early for any answer at all. Are we sure that the present method of treating an uncomplicated case of gonorrhœa is in fact in its ultimate result much superior to the older methods, except in so far as, owing to the arrangements made, it is more thoroughly and generally carried out? I am incited to ask this question because several practitioners have said to me that, judging from what they have seen of patients after clinic treatment, they are doubtful as to whether it is worth the trouble and expense incurred. This question and that of the actual incidence of venereal disease to which I have already referred,

## SOCIAL HYGIENE

might usefully be made the subject of an inquiry in the area of a branch of the British Medical Association or of an Insurance Committee.

With regard to syphilis, the increasing use of intra-muscular injection of the arseno-benzole compounds makes this treatment more easy to practise, and in the use of these drugs there is less risk now that dosage is better understood, and the possible, the probable, introduction of other compounds equally effective and less dangerous bring the treatment of this disease more nearly within the sphere of the ordinary practitioner.

The provision of clinics at cottage hospitals, and the enrolling of general practitioners in this service, should meet the claims of districts in which distance is now found to interfere with proper treatment, and would provide what would be in effect a never-stop clinic.

The reasons given above for putting this work into the hands of the general practitioner apply equally to town and country.

It will, of course, be necessary for the State to pay the doctor who undertakes the treatment of these diseases, as it already does in midwifery cases; in estimating the fee allowance must be made for the special education and experience required, for the equipment and accommodation provided, and for the length of time taken and the special hours that would have to be appointed. The practitioner on his part would have to undertake to provide any records required by the service.

The work is, of course, easier and quicker and in so far cheaper in a clinic, but against this we must put the maintenance and equipment of the clinic, the time lost by the patient in getting there, the cost of his transport, and the insufficient attendance with consequent loss of the value of the treatment, that is, waste of money spent on the service.

Is the panel practitioner required to attend these patients?

It is generally accepted that the treatment of both syphilis and gonorrhœa involve the application of special skill and experience of a degree or kind which general practitioners as a class cannot reasonably be expected to possess.

The Minister of Health issued instructions to local authorities that arseno-benzole compounds were only to be supplied free to medical men with special qualifications; and when a panel doctor has been notified by the Insurance Committee that any special medical service, such as a venereal clinic, is provided by a public authority, he is required to take such steps "as may be reasonably necessary" to ensure that the patient may derive full advantage from the provision of such service.

Although apparently there has been no finding on the point, it may fairly be inferred from the above and from the fact that special education is now required, that all medical men are not considered as yet to be competent to deal effectively with these diseases, and that there is no obligation on the insurance practitioner to undertake the treatment of these patients; that being so he should, at present, be paid as any private practitioner would be.

If there is anyone to whom the early and effective treatment

## THE GENERAL PRACTITIONER

*Chas. E. S. Flemming, M.R.C.S., L.R.C.P.*

of venereal disease is important, it is to the practitioner who takes the Health Insurance risk—it is important to him individually and to the whole Insurance Medical Service. Think what one case of syphilis undiagnosed or not properly treated may mean in attendance required later.

So important to all members of the service is prompt and efficient treatment of these patients that we may fairly ask whether, when the newly adopted scheme of education in these diseases has had time to take effect, it would not be well worth their while to undertake the care of these cases as part of their contract.

Not long since I saw a patient who had for months required the constant attendance of his doctor for supposed gastritis and was told that he would probably require an operation. He came home to his family to be nursed, a Wassermann was + + +, in a few days under specific treatment the vomiting stopped, and in a few weeks he was convalescent from his syphilitic cerebral disease. When one thinks of the amount of work done by his medical attendant, the money paid as sickness benefit, the wages lost, the distress and anxiety incurred, all of which might have been saved by a Wassermann done earlier, one realises the importance of a knowledge and appreciation of this disease.

Such cases as these, and of course there are large numbers in various forms, only the patient's ordinary medical attendant has the opportunity of detecting, and when we consider the invalidity, the disability and the deaths that they account for, the costly charge that they are to the Insurance Service or the local authority, we realise how important it is that the State should do everything possible to acquire the help of the competent family doctor, whether or not a panel practitioner, to treat them promptly and effectively. If this is important in the late phases of these diseases, of how much greater consequence must it not be in the earliest stages, when also treatment is easier and more effective.

The Government can help in the building up of a service of men of ample capacity if it will not only realise the importance of the special training in this work of all students and practitioners, by every means available, but see that it is done. It can to-day assist in the training of men in practice by means of post-graduate courses, by appointing those who wish it assistants at clinics and by making arrangements for the treatment of patients at the surgeries of those practitioners competent to undertake it, and willing to work in consultation with the V.D. Officer, whole time or otherwise.

An officer, who might with advantage be appointed in each county or county borough, having much the same position as the tuberculosis officer, would be in charge of the central clinic, would act as controller of the service, as consultant and adviser; he would be able gradually to transfer much of the work from the clinics to the general practitioner, and still have some hand in controlling it. A practitioner might resent the interference of a junior or part time official, but would welcome the assistance of such an officer, whom he would look upon as a consultant.

## SOCIAL HYGIENE

I would like here to suggest that there should at once be provided some means by which information would as a matter of routine be sent from the clinic to the general practitioner about any case which attended there at his request, and also by which the practitioner could get information about any patient from the clinic at which he had been treated, assuming of course the patient to be willing ; also he should be informed when cases that he had sent stopped treatment too soon ; limited in this way there would be no question of any breach of confidence. Such procedure would have the added advantage of keeping the medical man interested in his cases ; under present conditions when he sees a case and has sent it to the clinic, he is naturally apt to think that he has done his whole duty by it.

A general practitioner service will only be built up by degrees, and as it comes to be understood that private practitioners are, in this respect at any rate, allies of the Public Health Medical Service, for there can be no doubt that for the conquest of this plague all concerned must work together and with one accord.

### THE POSITION OF THE GENERAL PRACTITIONER IN ANTI-VEREAL DISEASE SCHEMES.

By MADELINE ARCHIBALD, L.R.C.P., L.R.C.S.Edin., L.R.F.P.S.Glas.  
(Glasgow)

THE general practitioner's attitude to any disease reflects the attitude of the general public to that disease. This is apparent in the case of gonorrhœa and syphilis. Until the outbreak of war, when the clamant problem of wastage, physical and economic, resulting from venereal diseases, was brought home with vivid point to the national mind, it must be admitted that the general practitioner showed but little interest in their prevention and treatment. His lack of interest merely reflected the public apathy to the problem. Without dwelling on that apathy, which many of us deplored, it might be explained as the outward aspect of an attempt to repress an ugly and distasteful aberration. It is true that the undoubted existence of public apathy did not excuse the practitioner's lack of interest, but a medical qualification affords but little protection from the operation of the herd instinct.

Prior to the war it was not an uncommon experience to hear an intelligent layman discuss gonorrhœa or syphilis as appropriate and necessary punishments for acts of disobedience to the moral code, and the logical outcome of that attitude was further expressed in the common statement that the treatment of these diseases tended to lessen the punishment, alleviating as it were pains and penalties richly deserved. I have noted a kindred mental attitude in many practitioners, so that it was more common to find gonorrhœa treated with contempt than otherwise. But the persistent spade work of a section of the medical profession and the public spirited efforts of an enthusiastic body of laymen, fully alive to the venereal



## THE GENERAL PRACTITIONER

*Madeline Archibald L.R.C.P., L.R.C.S.Edin. (Glasgow).*

diseases problem, did much to convince the public that ignoring venereal diseases, or condemning the sufferers from them, was foolish and criminal. When the public realised the appalling effects, immediate and remote, of untreated venereal diseases a demand for investigation and knowledge made itself felt, and the pressure of that demand was gradually extended until the practitioner was no longer able to maintain his aloof attitude.

The outposts of medicine are held by the general practitioner. It is to his notice that disease is brought in the first instance, and it may be said that 90 per cent. of all treatment, medical and surgical, is rendered by him from first to last. It is consequently clear that the view point from which he regards any disease must have wide-spread social effects, effects which assume national importance where venereal diseases are concerned.

At present much is left in the practitioner's hands. The Ministry of Health can offer the public some measure of protection from smallpox or scarlet fever. A person suffering from either of these diseases is isolated, and the measure of his isolation is judged by definite standards. It is laid down with precision when the infected person can be said to be free from infection, and at liberty to participate once more in the social round. Unfortunately venereal diseases come within a different category. Their ætiology and pathology, and the causes which underlie their spread, social and economic, are still too much obscured by hush and secrecy. Yet the plain truth is that the public deserve to enjoy the same protection from gonorrhœa or syphilis as they do from scarlet fever, smallpox, or other contagious disease. This protection will be afforded when the public asks for it, and it is no uncertain sign of an awakened public conscience that already steps are being taken to secure some measure of protection. When the Corporation of Glasgow agrees, by a majority, that there is no essential difference between the notification of smallpox and that of venereal diseases it is obvious that there is a desire abroad to bring venereal diseases within administrative action and control.

The practitioner's lack of interest in venereal diseases has been to some extent the result of his training, for it was not till 1922 that a course of instruction in these diseases was made compulsory in medical schools; even in Glasgow, with an enthusiastic teacher like Dr. David Watson, whose text-book on gonorrhœa is one of the medical classics, there were students who did not avail themselves of the excellent opportunities which his clinics presented. At the risk of repetition, it might be stated that the medical schools, in not insisting upon compulsory instruction in venereal diseases, were, like the general practitioner, reflecting the pre-war attitude of the public to these diseases.

It must be stated at once that the later manifestations of gonorrhœa and syphilis which swell the country's list of invalidism cannot all be laid at the door of the general practitioner who has failed to deal adequately with their initial stages. Syphilis may be seen in the average consulting room in the secondary stage, more

## SOCIAL HYGIENE

commonly in its later stages, while gonorrhœa is complained of when the discharge has already persisted for days or even weeks. While this statement is true of the male it applies, I think, with greater force to the female whose delay in seeking relief, even from a doctor of her own sex, contributes largely to the seriousness of her condition when treatment is at last sought.

I can give statistical expression to the foregoing paragraph. In the practice with which I am associated it has been estimated that our daily examinations of patients average 170. In the year 1922, 200 cases of syphilis and gonorrhœa were under treatment, while in the course of five years our case records show only 11 instances of primary chancre. To put it another way, in 1922 a diagnosis of syphilis, latent or tertiary, was made in 83 patients presenting themselves for the first time, while in that year only 2 chancres were noted. The difficulty of the adequate treatment of syphilis is plainly apparent in face of these figures: in 85 cases presented for treatment there were only 2 where therapy could be prosecuted to the issue of cure.

Sir James Mackenzie rightly insists on the importance of early symptoms, and he looks forward to the day when an educated public will present symptoms for investigation long before signs of disease or actual alterations in structure have declared themselves. But I am convinced that the average sufferer from syphilis or gonorrhœa places but little importance on early symptoms and just as little on early signs. This is strikingly true in the case of syphilis.

Far from presenting himself when there is but a little itching of the glans, which he must in most cases associate with recent exposure to infection, the patient generally fails to seek relief when the presence of a chancre demonstrates alteration in structure and blood infection. Reasons for delay are many. The chancre is often a trivial lesion, a mere patch of discoloration or little more formidable in appearance than a small wart. The full blown Hunterian chancre of the text-books is not, I think, of such common occurrence as many believe. Gonorrhœa is often regarded, as Luys puts it, "as a cold in the pipe," and in districts of Scotland where I have worked the discharge has been considered a good thing for the patient, "running off," in some mysterious way, disordered or unhealthy blood. I think too much has been made of the view that patients are ashamed to seek relief for venereal diseases. I cannot recall any case where great embarrassment followed the declaration of a positive Wassermann, and I think that the real reason for delay lies in the apparent triviality of the early signs.

A primary chancre may escape the notice of a patient, a circumstance, I believe, of frequent occurrence: and I know that gonorrhœa often exists in the female unknown to and unsuspected by her. I have considerable experience of gonorrhœa in young and recently married women, infected by husbands who believed that they were wholly cured. The disease was generally discovered during a routine examination in the course of pregnancy and careful inquiry

## THE GENERAL PRACTITIONER

*Madeline Archibald, L.R.C.P., L.R.C.S.Edin. (Glasgow).*

showed that the women were entirely ignorant of the presence of any infection. Where a history of local heat, itching, or frequency of micturition was obtained it was generally found that these were regarded as the normal accompaniments of sexual intercourse. When opportunity occurred for questioning the husbands the existence of gonorrhœa was rarely denied, but the declaration was invariably made that freedom from symptoms had existed for months or even years prior to marriage, and that there was reason to believe, supported in many instances by medical opinion, that the disease had been cured.

I think the problem of gonorrhœa, from the viewpoint of early discovery and adequate treatment, is much greater than that of syphilis. In the mild forms of gonorrhœa, where secondary infection is slight, the gross manifestations disappear early, and the patient believes that the cure of the disease coincides with their disappearance. Even when he is under treatment it is difficult to get him to realise that the cessation of the discharge is not the end of the matter; and as the treatment is apt to be long and irksome for patient and doctor alike, it is a difficult matter, in the absence of dramatic symptoms, to make the patient realise that the mucous membrane of his urethra is still the hunting ground of the gonococcus. Where the gross manifestations of a gonorrhœal urethritis have disappeared before the patient has thought it worth his while to seek medical aid it frequently happens that the serious sequelæ of the disease which ultimately declare themselves in the patient, or his innocent wife, surprise the man with their startling unexpectedness, as the mild discharge which disturbed him for a day or two so many years ago has been entirely forgotten.

In the treatment of syphilis the Wassermann test can be used with effect: the result of the test is an objective fact the importance of which can be easily impressed on the lay mind, and none but the mentally deficient will persistently disregard treatment in face of a positive reaction.

I have considerable experience in the treatment of venereal diseases in the ordinary course of private practice, an experience extended by long periods of asylum work: I have the charge of a venereal clinic associated with the Victoria Infirmity and the Corporation of Glasgow; I assist Dr. Watson in the clinical work of the Glasgow Lock Hospital, and I would say, coldly and deliberately, that the problem of venereal diseases will not be tackled with sufficient adequacy until every case of syphilis and gonorrhœa is brought within the notice of the Public Health Authority so that the individual patient, male or female, will be made to realise once and for all the steps and time necessary for the eradication of his or her particular disease: not only the question of eradication, but the period of time during which his or her disease is communicable to others.

The general practitioner can and will play a very important part in the prevention and treatment of venereal diseases, but that part will be lacking in adequacy failing (1) the education of the

## SOCIAL HYGIENE

general public in the early manifestations of venereal diseases, and (2) what is perhaps just as essential, notification of syphilis and gonorrhœa. If the average member of the general public remains, as he now is, ignorant of the first symptoms and signs of gonorrhœa and syphilis, it is indeed difficult to see how he will report to the general practitioner when his condition is most accessible to the effects of modern scientific therapy. The education of the general public is not a forlorn hope. My own experience in addressing large audiences in industrial areas has proved to me beyond all doubt that men and women are anxious for information regarding venereal diseases, their transmission, natural history and economics. Talking to members of the audiences after the lectures, I have been surprised to realise not only their ignorance of the nature and dangers of venereal diseases, but their eager desire to acquaint themselves and their children with the paramount necessity of surmounting that ignorance. Within the last few weeks I have had the opportunity of addressing two large audiences when excellent cinematograph films provided by the National Council for Combating Venereal Diseases (Incorporated) were shown illustrating methods of reproduction in the animal kingdom and the ravages, physical and social, which followed the contraction of venereal diseases. The moving pictures made a telling impression and members of the audience left the hall armed with a knowledge they had not previously possessed and which they meant to use in safeguarding younger relatives from the results of incontinence. The exhibition of such films could well be included in the activities of every Public Health Authority, and the information so disseminated would in time result in a considerable curtailment of public expenditure. So far as the general practitioner is concerned cases are usually seen too late for the reasonable promise of cure, and in view of the ready educability of the general public it seems desirable and right that steps should be taken to place before it clearly, attractively and interestingly all the information necessary.

I am aware that notification is a thorny question, and because my support of it has always been deliberate and unswerving, I realise how difficult it is for me to view coolly and dispassionately the other side of the question. Experience in the treatment of venereal diseases is not long begun before the wish for some measure of notification arises. The wish does not spring from any vindictiveness or any desire to enforce medical authority with the greater authority of the State, but simply and solely, I think, to give scientific treatment the efficiency and force which it deserves.

I know that it requires much self-control to see a patient give up treatment in mid-course, and to find that patient unresponsive to all the arguments and persuasion which can be used, and when that patient, as so often happens, is a young married woman with the greater part of her child bearing period before her it is felt that, if she is foolish enough to place the restrictions which treatment entails before her duty to her yet unborn children, measures of some sort should be available to bring that duty home to her with plainness and decision. The young man with the neglected gonor-

## THE GENERAL PRACTITIONER

*Madeline Archibald, L.R.C.P., L.R.C.S.Edin. (Glasgow).*

rhœal urethritis is a similar source of trouble, and his duty to his future wife must be laid down equally clearly. Notification would be a valuable asset to the public health in the treatment of young prostitutes or "free lances" where mental deficiency prevents them from continuing the treatment essential for their own safety and that of their clientele. Young girls of this class usually stop treatment as soon as the gross manifestations of the disease have disappeared, manifestations interfering with their personal comfort or their market value.

The pros and cons of notification do not properly come within the scope of this paper, but I must confess that in my opinion the utility of the general practitioner in any scheme for the prevention and adequate treatment of venereal diseases will be severely hampered if notification remains in abeyance. At the risk of repetition I would say that the general practitioner's part in the general campaign against venereal diseases will certainly be an important one, and that the measure of that importance will depend entirely on the circumstances in which he works. Notification and public knowledge of early symptoms would give him an increasingly wide scope for the recognition of gonorrhœa or syphilis in their first stages, but I must confess that it is difficult to say whether he would be able to contribute much to the actual treatment of these diseases. The specialist who can dress for dinner and add a chapter to his thesis between dinner and the first act of the opera has little knowledge of the harassing work, hard and unceasing, which besets the average panel practitioner. When morning consultations extend from 10 to 1, and evening consultations from 6 to 9, with the afternoon occupied by scattered visits and the hours of sleep broken two or three nights each week by late calls or "midders," it will be realised that freshness of mind, let alone freshness of body, is no easy achievement for the panel practitioner. If he sees forty patients during the morning consultation hours and a similar number in the evening it will, I think, be apparent that he will have but little time for the use of the urethroscope, and much less for the performance of those tests which cannot be neglected in the treatment of outdoor syphilitics. The treatment of gonorrhœa in such circumstances would be farcical were it not for the tragic fact that the patient believes that by such treatment, daily doses of medicine, personal urethral injections—uncontrolled except for the occasional inspection of his urine, cure can be obtained. And what applies to the treatment of venereal diseases applies to other therapeutic measures. It will be a good day for medicine when the practitioner's list is halved and his remuneration doubled, allowing him to cultivate medicine as a science and practise it as an art.

Within certain limits the treatment of syphilis can be carried out by the average practitioner. I know many busy men who do it efficiently and well, and certainly the administration of modern products like Neo-Kharsivan is not a time consuming process. The treatment of syphilis can be controlled to some extent by the Wassermann reaction and the drug treatment presents no special

## SOCIAL HYGIENE

difficulties. When the patient is intelligent and alive to the necessity for treatment he appears with regularity, and a little ordering of the daily routine makes it possible not to disappoint him when time for an intravenous injection arrives. Even a short experience teaches one the necessity for having everything in order for an injection—Neo-Kharsivan, steriliser, syringe, needles, etc.; for regular visits to a well-filled waiting-room are irksome enough in themselves without making them occasions for disappointment because the supply of needles has failed or the consignment of Neo-Kharsivan has not arrived from the Public Health Authority.

If it were possible for the general practitioner to carry out treatment adequately I think the patient would prefer that treatment. I know that when I give my panel patients the choice of treatment in my own consulting rooms or at one of the clinics at which I am employed the former course is usually selected. And while several small venereal clinics are certainly more costly than one large centre the comparative privacy of the small clinic recommends itself to many patients. I have under my care one small ward, associated with an outdoor department, accommodating four beds to which I admit outdoor patients requiring indoor treatment, and thanks to the care and consideration of the nursing staff I have found that patients admitted to that ward generally look back on their residence with pleasure, contrasting its quiet and seclusion with the more or less public character of large hospital wards. In many respects the practitioner's consulting room is comparable with the small clinic. The patient is aware that those sitting with him in the waiting-room are suffering from various diseases and that his particular secret cannot be guessed at or surprised.

But the advantages which the patient finds in attending his own doctor for treatment are insignificant if the treatment rendered falls below the present scientific standard. The treatment of gonorrhœa which consists in the prescription of some urinary antiseptic and the recommendation of some particular type of urethral syringe which the patient is taught to use cannot be said to be treatment at all. If the patient does not acquire a secondary infection in the process he will most certainly acquire a sense of false security, and it is doubtful whether it is not better to have an untreated urethritis which he knows to be so, than to have him lulled into the belief that his infected mucous membrane is free from disease.

It is to be remembered of course that I am speaking of the practitioner who received little or no clinical instruction in venereal diseases during his medical training, and who did not avail himself of the opportunity for post-graduate instruction in the work. But I am afraid a well-trained man, or woman, with a high degree of efficiency in the treatment of venereal diseases would experience little but exasperation and sorrow if the attempt was made to treat venereal diseases, as they should be treated, in the average consulting room of an industrial district; and the sorrow and exasperation would be proportional to the degree of efficiency which the doctor had attained.

## THE GENERAL PRACTITIONER

*Madeline Archibald, L.R.C.P., L.R.C.S.Edin. (Glasgow).*

In the practice with which I am associated my colleagues and I have put the "team work" system into practice thereby securing an advantage not within the reach of the individual practitioner. I do not know however that we would care to undertake the thorough treatment of gonorrhoea in more than a few cases. About 200 cases of syphilis are treated each year. A thorough clinical investigation of the patient is made before treatment, including blood counts, blood pressure estimations, and urea concentration tests if albumin is found in the urine. In cases where many injections have been given, or where complaint of malaise is made during or after treatment, the estimation of the bilirubin content of the blood is made by Van den Bergh's quantitative method (recently discussed by me in a paper read before the Medical Society for the Study of Venereal Diseases) the discovery of latent jaundice leading, of course, to modifications in treatment. An excess of bilirubin may appear without the later occurrence of jaundice, but it is my practice to discontinue Neo-Kharsivan therapy for a period when the amount of bilirubin present oversteps the normal limit. The estimation of the blood sugar after a dose of laevulose is also employed in certain cases where there is clinical reason to suspect liver inefficiency.

While the spinal fluid has not been examined as often as I should have liked, largely because of the difficulty of carrying it out in the ordinary consulting room and the extra time involved in visiting the patient when headache or discomfort follows the puncture, I have decided that in view of the importance of such examination time and provision must be made for it.

The work just outlined has been carried out in private practice, and the time consumed by it would at once put it without the scope of the private practitioner. But for the opportunities which "team work," even on a limited scale, presents, the scheme discussed would have been impossible of achievement. It must be said that the work adds interest and variety to the ordinary routine of general practice, and while a certain amount of leisure is necessarily sacrificed the interest and light accruing make such sacrifice worth while. It would be only fair to add, by way of acknowledgment, that I have found great help in the enthusiasm of two or three senior students of medicine who were glad to amplify their medical training by taking part in the laboratory work which the scheme entailed.

If venereal diseases are to be treated by the general practitioner some system of "team work" will need to be instituted. The diseases which bulk largely in the work of general practice may be classified roughly as (a) respiratory, (b) digestive, (c) myalgia and rheumatism, (d) cardio-vascular, (e) skin and venereal diseases or their effects. The type of "team work" I have in mind in a district served by five or six doctors would apportion to each doctor the treatment, or the bulk of the treatment, of that group of diseases to which he happened to be attracted by interest and training. Where the doctors are more numerous, as in an industrial district, each doctor should be asked on making application for service under his local Insurance Committee to state any special qualifications

## SOCIAL HYGIENE

he may possess in any department of surgery or medicine: and if a doctor already on the list of an Insurance Committee has, during the period of his general practice, developed an interest in any particular disease or group of diseases and undergone post-graduate training in that particular group he should be invited to inform the Committee of the fact. Insurance Committees would then be in possession of information which would be of assistance if a system of "team work" was contemplated, and I believe that such a scheme would ultimately work for the benefit of all insured persons. It is a fact that in large provincial cities many doctors working under the National Health Insurance Committee are junior members of the various hospital staffs maintaining themselves by panel practice while prosecuting their studies and training in some department of surgery or medicine. A hæmatologist is not necessarily wasting his time in the examination of chest conditions, and a budding bio-chemist may be broadening his mental horizon in the treatment of myalgia and rheumatism, but it is, I think, reasonable to say that Insurance Committees are misdirecting the energies of these men while failing to reap the undoubted advantage of their employment in the work which they are best qualified to perform. From the financial viewpoint the distribution of the insurance medical work under a team system might be more expensive than it is at present, but the patient would be benefited, and the energies of the doctor would be directed into channels where the driving force of keen interest would give them a value not now in evidence. Failing such a scheme I cannot see that the treatment of venereal diseases can be left to the general practitioner, and while the centralisation of treatment in several big centres possesses the advantage that patients are examined and treated by experts, I think the "team work" scheme would operate just as well and just as cheaply, clinics being reserved for special examinations.

There is much to be said for the principle of "team work." Panel practice, as it promises to evolve, will sooner or later be comparable with repetition work in industry, a soul destroying business in which the spirit of the craftsman and the artist is overwhelmed by sheer automatism. "Team work" offers an escape from this, allowing the natural interest of the doctor that freedom from restraint which its full development demands. The benefit which would result to the patient is obvious.

Men, women, and children come within my scope in the treatment of venereal diseases in private practice. The men are usually seen in the first instance by my male colleagues, while the women and children generally consult myself or my woman assistant. When a diagnosis of syphilis or gonorrhœa is made in patients seeking relief for the first time inquiry is always made as to whether they are married or single. In the case of a married man he is asked to send his wife to my consulting room while the married women are encouraged to send their husbands to my male colleagues.

In this way whole families suffering from venereal diseases or their effects have been brought under our care, and I can record but



## THE GENERAL PRACTITIONER

*Madeline Archibald, L.R.C.P., L.R.C.S.Edin. (Glasgow).*

few instances where a man or woman refused to inform his or her partner of the need for special medical examination. No difficulty was ever raised about the children, and if husband or wife had the slightest suspicion that any disease contracted by them was influencing their children's welfare any desire to conceal that disease was at once suppressed in the children's interests. I must say that I was largely aided in the work by the fact that I was known by the people in the district. I had frequently lectured to them on venereal diseases, their effects, and their causes, social and economic, and I rarely found any hesitation on the part of patients, male or female, to bring those involved with them under my care or that of my colleagues.

The foregoing paragraph reveals, I think, the valuable place which the general practitioner must hold in any great scheme for dealing with venereal diseases. His outpost is planted in the very midst of the people. He is the husband's doctor, he attends the wife in her confinements, and the children are brought to him when they fall sick. It is true that panel practice, poverty, and the establishment of various clinics have circumscribed the scope of the practitioner as the family doctor; but in spite of these, even families who cannot afford to pay him for his services, and who seek relief where it can be obtained free, nevertheless continue to regard him as the family doctor, adviser and friend.

When all is said and done the venereal clinic deals with units, while the general practitioner deals with families. Social workers may be employed by venereal clinics quietly investigating the home circumstances of the various patients, and determining the directions in which disease is likely to be spread by the persons under observation, but the information which they acquire, more or less laboriously, is within easy access of the general practitioner whose contact with the patient and his relatives is direct and personal and whose position as family doctor gives him an ascendancy which the social worker cannot reach. It is plain that the general practitioner cannot be displaced in any scheme against venereal diseases, and it is the duty of all those concerned with the public weal to extend his scope in the directions which I have outlined.

Some practical points fall to be discussed, but in view of the fact that instruction in venereal diseases is now compulsory for the student of medicine their importance need not be stressed. There are still many doctors who have never done veno-puncture, and in consequence many cases of latent syphilis go untreated and unrecognised. In spite of the fact that public health laboratories are available for the sero-diagnosis of syphilis it is nevertheless true that many practitioners in large industrial cities go from year to year without submitting a single specimen of blood for examination. The diagnosis of gonorrhoea in the female is often badly performed, and a negative report by the public health bacteriologist seems to me to point in many cases to faulty swabbing rather than to the absence of the gonococcus. These faults will be remedied when men and women properly instructed in the diagnosis and treatment of venereal diseases begin to take part in general practice.

## SOCIAL HYGIENE

As things are at present, the part which the general practitioner can play in combating venereal diseases, valuable as it is, is strictly limited. These limitations have been imposed on him from without. It is admitted that he has been inadequately trained in the diagnosis of syphilis and gonorrhœa and in many cases unable to avail himself of modern methods of diagnosis. When he recognises the disease the best he can do is to offer the patient some perfunctory treatment or recommend him to the services of a venereal clinic. If the patient declines to continue treatment at the hands of the practitioner or to present himself at any of the venereal clinics the matter ends so far as the practitioner is concerned, but the propagation of the disease continues. The general practitioner can render invaluable service by bringing the family of the diseased person under observation, but, because of the limitation of his time and the narrow scope of his treatment, the value of his service in this direction is considerably minimised. He stands as it were with his hands tied, owing his bonds to defective training, public apathy, and a social system which seeks to enmesh him in an inglorious and deadening industrialism.

I think it is fairly well established that certain conditions are essential before the general practitioner can serve with anything like full efficiency in the campaign against venereal diseases.

1. He must be fairly well trained in the diagnosis and treatment of venereal diseases. This has already been provided for, and with the advent of compulsory instruction it is probable that diagnosis and treatment will reach a much higher standard than they do at present.

2. Steps must be taken to educate the general public in the importance of the early signs and symptoms of venereal diseases so that patients will present themselves to the general practitioner when these diseases are most amenable to modern therapy.

3. Notification is advisable in the interests of patients and public alike. As things are at present the prosecution of treatment depends very largely on the good will of the patient, and, unfortunately, venereal diseases are frequent in those whose social activities are limited by the satisfaction of their appetites. The infection of innocent persons is plainly a matter for public concern. The usefulness of the general practitioner would be enhanced by a measure of notification, as it is reasonable to expect that he would in time be able to impose limits to the spread of gonorrhœa and syphilis much as he can circumscribe, at present, the propagation of diseases like scarlet and enteric fever.

4. A measure of "team work" must be instituted if the treatment of gonorrhœa or syphilis is to become part of the daily routine of the general practitioner.

### THE POSITION OF THE GENERAL PRACTITIONER IN ANTI-VENEREAL DISEASE SCHEMES.

By ALFRED COX, O.B.E., M.B., *Medical Secretary, B.M.A.*

I COMMENCE with the axiom that the position of the general practitioner as regards venereal diseases should be as nearly as

## THE GENERAL PRACTITIONER

*Alfred Cox, O.B.E., M.B.*

possible the same as it is in regard to all other diseases. It is his duty towards every patient who consults him, either to treat the case himself or to get it treated; and to get it treated in preference to treating it himself if he knows it can be done better by others than by himself, provided that this better treatment is available for his patient. Our attitude to this question depends upon our ideal of what the general practitioner should be. If we are content that he should be a mere "Cook's guide" to the nearest specialist, then our demands on him will be trivial. But if we believe that he should be a competent, self-reliant person able and willing to use his hands and brains he will be a prime factor in any V.D. scheme, as he should be in all schemes for the betterment of the public health.

It is not sound economy to use a special institution like the V.D. centre, with specialised officers, for treatment which can and therefore ought to be done by general practitioners. Everything which lowers the capacity of the general practitioner to treat common diseases or lessens his willingness to do so, diminishes his professional self-respect and his usefulness to the public. Moreover, the centre tends to take away from him experience which should assist him by treating those people who are quite able to pay for treatment without public assistance and therefore should not be encouraged to go to the centre. And the more competent the general practitioner is the more likely will he be to send to a specialist the cases which really require special advice or treatment.

I am not prepared to admit that the men and women who are being turned out of our medical schools nowadays are incompetent to apply modern methods, capable of being administered at the doctor's surgery or at home, either as regards venereal or any other diseases.

Inquiries that I have made seem to point to the probability that within a short time the treatment of ordinary cases of syphilis will be within the reach of every competent general practitioner; whether it be done by intravenous injection or, as seems likely, by sub-cutaneous medication. The V.D. officer should then take his proper place as the consultant to be called in for help in diagnosis, or in the treatment of complications and particularly obstinate cases, exactly as the tuberculosis officer is or should be in cases of tuberculosis.

So far as gonorrhœa is concerned the matter is not so simple. I have seen reports of discussions in which the superiority of the modern methods of treatment as compared with the old has been seriously questioned, and it is within the bounds of possibility that in a few years we may have a complete revulsion of medical opinion (these things have been known) and the present frequent irrigations may be replaced by something more compatible with home or surgery treatment. But the best authorities seem to be agreed that the method of frequent irrigation, combined often with vaccine treatment, is superior to anything else at present available, and accepting that, one is bound to admit that many

## SOCIAL HYGIENE

sufferers from this disease will, in their own interest, as well as in the interest of the community, be best treated at a centre.

As Dr. Flemming has pointed out, under present arrangements there is a real danger of the general practitioner losing his interest in the treatment of these diseases and saying: "Thank goodness I hardly ever see a case"—a dangerous and short-sighted attitude. There are two kinds of knowledge—to know how to do a thing yourself, and to know how to get somebody else to do it for you; but the former is far and away the better, and all of us who will have to come sooner or later and for one disease or another into the hands of the general practitioner, should deprecate and resist any schemes which will encourage him to drop his interest in the manifestations of any diseases and thereby diminish his general skill and manual dexterity.

One of the claims for the V.D. centre is that it caters for a large number of people who are ashamed to go to their own family practitioner. As an old general practitioner I have always had my doubts as to the truth of this theory even in pre-V.D. centre days, and I am glad to see that Dr. Archibald in her paper does not seem to take much stock in it.

But nowadays, in the new atmosphere created largely by the work of the National Council for Combating Venereal Diseases, in which we are more and more emphasising the word "disease" and less and less the word "venereal," and in which much of the furtiveness which used to surround this subject has been dissipated, I am of opinion that if the public had good reason to believe that their family doctor was thoroughly educated in the more modern methods of treatment there would be very little reluctance to go to him, and still less if it were as easy and as cheap to go to him as it is to go to the centre. So far as being ashamed is concerned, what about those country districts from which people have to travel to the centres and consequently have to claim their expenses from the local authority? I should imagine that they would be much more ashamed of disclosing their disease to these officials than in telling their own doctor.

I want to encourage and even compel the general practitioner to make himself a very active factor in all public health (including V.D.) schemes. He exists for the benefit of the public and must be made as efficient and as helpful as possible. Some 15 million people at the present time are entitled under our National Health Insurance system to "all proper and necessary medical services other than those involving the application of special skill and experience of a degree or kind which general practitioners as a class cannot reasonably be expected to possess." Insured persons can claim from their insurance practitioner the treatment of venereal and any other diseases, but as it is his duty as a conscientious doctor to see that his patient gets the best treatment available, so when, as often now occurs, he is not able to give that treatment himself, it is his duty not only to his conscience and his patient but under the regulations of the Insurance Act to recommend the patient to any public provision which has been made for it. At the present time

## THE GENERAL PRACTITIONER

*Alfred Cox, O.B.E., M.B.*

he naturally refers all his V.D. cases to the centre, and there will always be a certain proportion of these cases which he should and will continue to refer to the centre. But surely the normal modern method of treatment, at any rate of syphilis, should soon be within the competence of the average general practitioner, in which case he would give this treatment as a matter of course.

If the modern methods of treatment of venereal diseases (in so far as it is compatible with home treatment) were regarded as within the competence of the average general practitioner, those insurance practitioners who did not feel themselves competent to carry out these methods would have a strong inducement to make themselves familiar with them, because their patients suffering from these diseases would tend to transfer themselves to those doctors who were known to be competent, a thing they can do without notice and without ceremony and would be likely to induce their families and friends to adopt the more competent doctor as their family doctor.

As a first step I would suggest that some of the money which would be saved when the venereal disease centres became mainly consultative, should be added to the local pool from which Insurance practitioners are paid, but earmarked for the treatment of venereal diseases. Practitioners treating these diseases could be paid an agreed fee out of this pool on condition that they kept proper records and did work of a standard satisfactory to the venereal diseases officer.

The venereal diseases officer under such a scheme would refer all cases capable of being treated at home to the insurance practitioner responsible for them and would, of course, follow the case up and see that the patient was getting adequate treatment. This proposal seems to me to be practical; the machinery for it already exists and could easily be co-ordinated with that of the centre; it would not be costly; it would encourage and, indeed, enforce the interest of the general practitioner in the treatment of these diseases; and there is no reason why it should be confined to insured persons or only to those practitioners at present doing National Health Insurance work—the scheme could readily be extended to the dependants of insured persons and so would cover the great majority of those people now provided for by the centres. To sum up:—

(1) In any anti-venereal diseases scheme adopted the general practitioner should not be allowed to assume that it is his business to get rid of V.D. cases.

(2) The stimulus to the general practitioner should be supplied in the first place by his medical school which should teach him that it is absurd and deplorable that a practitioner supposed to be competent to deal with acute diseases and emergencies of all kinds should be regarded as not competent to treat by modern methods routine cases of diseases so common as the venereal diseases.

(3) The V.D. centre should gradually be regarded more and more as an educational and consultation centre for cases sent for diagnosis,

## SOCIAL HYGIENE

and for treatment by methods not suitable for home use. It should be the duty of the V.D. officer to keep the practitioner who sends any case to the centre informed of its progress from time to time and particularly to let him know when the treatment is finished and what the state of the case is. The V.D. officer should, of course, be supplied with an adequate clerical staff for this work. It should equally be the duty of the practitioner to acknowledge these communications, and thus to let the V.D. officer know that interest in the case is being taken by both parties concerned.

(4) The general practitioner should regard himself as an essential part of a scheme for discovering and treating every case of venereal disease with as much promptitude and despatch as is now exercised in regard to the infectious fevers. He and the V.D. officer should work into each other's hands just as the general practitioner and the medical officer of health do about infectious fevers, and as he and the tuberculosis officer are learning to do about tuberculosis.

(5) The education of the public in the recognition of the seriousness of these diseases and the early signs of their existence should be zealously pursued. The public should be taught that on the first suspicious signs they should at once go to their own doctor, whose duty it would be either to treat them or send them where they can be treated.

Finally, full use should be made of the access which the practitioner has to the home and his knowledge of the family for detecting contacts and inducing them to seek treatment. As Dr. Archibald very pertinently remarked, the general practitioner deals with the family, the V.D. centre with the individual. If insured persons and their dependants were provided for as I have suggested, the early detection and treatment of these diseases would not only appeal to the insurance practitioner's professional conscience but in two ways to his pecuniary interest. First, it would pay him better to do such treatment as could properly be carried out by him than to pack the patient off to the centre and lose sight of him; and, secondly, as Dr. Flemming pointed out, the prompt cure of venereal diseases would lessen very materially the attendances he would otherwise have to give to the patients for the later manifestations of these diseases, for, being paid on a capitation basis for undertaking the risk of any medical attendance required by all those on his insurance list, the more he inculcates preventive medicine and practises early treatment of this and all other diseases the better his remuneration works out in the long run.

## DISCUSSION.

*Dr. Lees:* Speaking from experience of general practice for five years and from conversations with practitioners I should like to mention the reasons why the general practitioner does not handle venereal disease. Firstly, he does not like it, and many think that it spoils their practice; secondly, he has not the time available; and thirdly, he is not always trained in the methods of diagnosis and treatment.

## THE MEDICAL PROFESSION : DISCUSSION

It will be difficult to overcome the idea among the profession that the handling of venereal patients spoils a practice. With regard to time I am certain that the busy general practitioner cannot see many venereal patients in his consulting hour. He would require to take such cases at a special time and receive special remuneration for them.

In Edinburgh last year the Scottish Board of Health paid the expenses of four competent medical practitioners to attend a general post-graduate course including venereal disease. This system is a good one and if extended would gradually educate the keener men in the profession in the methods of diagnosis and treatment.

The education of the student must be attended to. The General Medical Council have advised all University Authorities to give tuition in venereal diseases. Advice is not enough, and they should insist, rather than advise, that it is done. In Scotland, Edinburgh excepted, the classes are optional and in none of them is an examination compulsory. I would strongly advocate the teaching of the subject and insist on examination at the end of the course of teaching. The clinic officer should be on the lecturing staff and also on the examining board. This is the most practical way of disseminating among medical men a knowledge of venereal diseases.

Personally I think any general practitioner can treat syphilis. One cannot say the same of gonorrhœa. He could treat acute or sub-acute gonorrhœa in the male ; I am doubtful if he can or will carry out much of the therapy necessary to establish a cure in gonorrhœa. He cannot carry out, except under difficulty, the treatment of female gonorrhœa. It is interesting that practitioners in general attempt to treat more gonorrhœa than they do syphilis. The present day methods of treatment are essential for rapid cure and certain cure. Sandalwood oil no more cures gonorrhœa than black wash does syphilis.

I agree with Dr. Cox that the practitioner's help is desirable. He can and ought to do part of the work. If he is prepared to treat it thoroughly by all means let him do so, but if not, he must send it at once to someone who will see that it is thoroughly treated. This advice is more essential in regard to high class than it is with insured patients. Colonel Harrison's figures of the amount of salvarsan given per patient by private doctors as compared to the amount given by the clinic officer are very enlightening. One's experience is that patients treated by their private doctor rarely complete their treatment and are practically never tested for cure.

I can with Dr. Cox visualise the potentialities for good of the practitioner in the venereal diseases scheme. He could help, as Dr. Flemming says, but will he do so ? The education of the under-graduate will help him to do so, but there will always be many cases where expert opinion is essential, such as cure of syphilis and the treatment and cure of gonorrhœa.

The practitioner must avail himself of the facilities for diagnosis, especially those for examining serum for *spirochæta pallida*. It is more valuable in early syphilis than the Wassermann test.

## SOCIAL HYGIENE

I would like to throw out a suggestion to the authorities with regard to laboratory facilities. A great deal of the work done is lost in that a report goes out to the practitioner who in many cases does not understand its import. The practitioners should send particulars of their cases to the serologist. The serologist should consult the clinical worker and jointly send out to the practitioner a report on the material examined and suggestions for treatment.

I mentioned previously the desirability of decentralising the work of the clinics in rural areas. This would help the general practitioner to take his place in the scheme. He could have his private patients handled there while he still observed them in his consulting room. He could undertake the supervision of the work in those sub-centres and would have the necessary accommodation and equipment to treat any case. The opinion of a consultant could always be had at the nearest clinic.

Whether he can help or how he can help is dependent on education. This must be compulsory and thorough. If this is attained within the next few years there should then exist a body of young medical men competent to handle cases of venereal disease. When this is attained it might be advisable and necessary for the State to subsidise those who undertake this work, and the funds might be obtained, as Dr. Cox suggested, out of the surplus panel fund. Practitioners, however, who undertake this work and are paid for it must be prepared to keep the work up to certain standards and to have their work subject to a measure of supervision as to its efficiency. If the practitioner will do so and take his place in the handling of these cases it will be a great step forward in dealing with the problem, more especially in rural areas.

*Dr. Dain, Birmingham*, said that his difficulty in dealing with the relation of the general practitioner to schemes for treatment of venereal disease was due to two causes. First, that V.D. was so unevenly distributed that many practitioners rarely saw cases to treat, and that with a diminishing incidence they were going to be still fewer. In his own practice cases were very far between, and such cases as cropped up were most often strangers who were avoiding consulting their own doctors. It was not economical to train a practitioner in the technique of the modern treatment of V.D. if he did not have the opportunity to use it say more than once or twice a year, and when in perhaps five years or less he would be again out of date in his methods and equipment.

*Mr. Bishop Harman, Ophthalmic Surgeon to the London County Council*: Your Chairman has asked me if there are any lessons learned in the treatment of ophthalmia neonatorum which have a bearing on the problem under discussion. First, let me premise my statement with the observation that the notification of ophthalmia neonatorum has no bearing on the notification of venereal disease. Ophthalmia neonatorum is truly in the majority of cases due to the carrying of the contagion of maternal gonorrhœa to the eyes of the new born child, but there are not a few cases of the disease which are not due to the specific organism



## THE MEDICAL PROFESSION : DISCUSSION

of gonorrhœa, and the indubitable existence of cases due to other organisms, such as the bacillus coli or the streptococcus, removes the notification of ophthalmia neonatorum from any relationship to propositions for the notification of venereal disease. That must always be kept in mind. Some speakers and writers are apt to forget it on occasions. To forget this fact is to endanger the efficiency of the notification of the eye disease, and therefore to risk the sight of new born infants.

The main lesson we have learned in the last few years in the treatment of ophthalmia neonatorum relates to the effects of institutional treatment. Strenuous efforts have been made to secure institutional treatment for affected infants and mothers. Both were to be taken into hospital. In Liverpool arrangements were made to do this in the local voluntary eye hospital; the hospital was well known and the arrangement has worked admirably. In London institutional treatment has been also arranged for. But in this vast city it was arranged for in one hospital only, and that a special hospital maintained by a public authority. The hospital deals only with these cases and no other. The energy of the local medical officers of health has secured the diversion of all cases of ophthalmia neonatorum from the voluntary hospitals, so that none are seen there now unless perchance a rare case come into London from outside territory. For the last two years I have not had a single case at my eye clinic at the West London Hospital, so that teaching for the post-graduate students attending the practice of that hospital is confined to theoretical talk without the chance of demonstrating the actual disease to them, and making them familiar with a disease which may confront them in practice at any time and which demands instant recognition and energetic treatment. The segregation of these cases in a special institution separate from the teaching hospitals is therefore likely to prove disastrous, for the general practitioner will not have had experience of it in his student days. If in London arrangements for institutional disease of ophthalmia neonatorum had been planned upon the lines followed in Liverpool these untoward effects would not have resulted. We, in London, should have these cases sent for treatment to several of the teaching hospitals by some special arrangement.

A very important lesson for us in the treatment of venereal disease arises from the experience I have narrated to you. The devotion of those who are the doctors of venereal disease clinics has led to the intensive treatment of venereal disease, to the great advantage of the patients, and without doubt to the reduction of disease, and the shortening of the length of contagiousness. That is all to the good. But with that natural tendency of human nature to magnify an office without necessary care for general effects, there is seen a tendency on the part of many doctors of clinics to desire that these clinics should be separated from the general hospitals. They would if they could reverse the recommendation of the Royal Commission on Venereal Disease that the treatment wherever possible should be undertaken in the voluntary

## SOCIAL HYGIENE

hospitals. If these strenuous advocates of separate clinics have their way, what has happened with regard to ophthalmia neonatorum in London may very well happen to venereal disease. A few men will be experts in the treatment of the disease, but the general knowledge of these diseases and their treatment will decline amongst private doctors generally. That would be disastrous. For without a constant succession of private practitioners prompt in the recognition of these diseases disaster may overtake the population.

That is not a picturesque speculation on possibilities that can never happen. It has happened with regard to other diseases. Trachoma, a severe contagious and most dangerous eye affection used to be rife in Europe, just as it is to-day in the East. Recently an outbreak of this disease has occurred in a port of this country, almost certainly brought in from abroad. From the evidence I have it would appear to have been spreading through the ranks of the children for many months before it was recognised. It had become so rare that doctors did not recognise the full nature of the outbreak of "sort eye." Such an occurrence is bad enough, it would be far worse if doctors had not the opportunity of keeping in touch with venereal disease clinics as part of their ordinary medical education. The severance of these clinics from the general hospitals would involve a serious risk of this danger occurring.

*Dr. Coultts, Ministry of Health*, said that he had devoted a considerable amount of time to the study of the question of the possibility of arranging for the co-operation, under official schemes, of general practitioners in the treatment at their own surgeries of patients suffering from venereal diseases.

Particularly in rural areas, in which it was impracticable to establish sufficient venereal disease clinics, it appeared at first sight that it would be convenient and effective to utilise general practitioners for this purpose.

But hitherto no scheme had been evolved which seemed likely to provide efficient treatment under suitable conditions and at a reasonable cost. The evidence showed that in rural areas the amount of venereal disease was comparatively small and few practitioners saw enough cases per annum to make it worth their while to provide the necessary equipment, etc., for dealing with venereal disease cases, and particularly as regards the prolonged irrigation treatment of gonorrhœa and the instrumental investigation and treatment of chronic gonorrhœa.

The Local Government Board had indicated their desire to facilitate the treatment of syphilis by private practitioners by arranging for the free supply of arseno-benzol preparations to those who had experience in their administration.

With regard to the suggestion that the Ministry of Health should approve certain practitioners in each area as competent to treat venereal disease and to pay them for this work, he feared that if the Local Government Board had put forward proposals on these lines there would have been active protests from the organisations representing the medical profession against such a scheme under

## THE MEDICAL PROFESSION: DISCUSSION

which the Government would pay fees to a practitioner for treating patients who were ordinarily attended by some other doctor.

*Colonel Harrison, Ministry of Health*, said that the ground had been so well covered by other speakers that he need only touch on two points. First, he would like to refer to the point which had been raised by Dr. Flemming as to whether the modern treatment of gonorrhœa achieved any better results than the older, simpler methods. He would do so because he thought that the doubt which had been voiced by Dr. Flemming might give rise to impressions which would seriously affect the attitude of the medical profession towards the requirements in the treatment of gonorrhœa. It was not the first time that he had heard this doubt expressed. During the time that he was in the army he had frequently been told by his superior officers that they, in the old days, had been able to get their patients out of hospital just as quickly by the use of a squirt as he had with all his new-fangled methods. Needless to say, such an expression of opinion from those to whom he might reasonably have looked for encouragement had not been particularly inspiring, and it was not surprising that sometimes he had been goaded into a retort asking the officers in question how soon the patient had returned to hospital with a relapse. He was quite certain that under the old methods of treatment the relapses had been enormous, and he had been able to prove in his hospital in France that the relapse rate varied inversely with the thoroughness with which the treatment had been carried out. Naturally in this hospital the quality of officers varied. He had made a practice when a patient returned to hospital with a relapse of sending him back to the medical officer who had originally treated him, and he found that the greatest proportion of these patients returned to officers who had regarded treatment and the tests of cure in a lighter spirit than did the better officers. One effect which he was sure that the modern treatment of gonorrhœa would have would be the reduction of stricture. He had a strong impression that stricture resulting from gonorrhœa was already becoming much less frequent, as he had hardly seen any severe cases for a considerable time. He regarded stricture resulting from gonorrhœa as a reproach on the doctor who originally treated the case, always provided that the patient had faithfully continued with the treatment.

On the question of the practitioner's relation to the treatment of venereal diseases, he considered that the root of the whole business lay in education, and he referred to a lecture which he gave in Edinburgh some years previously, in which he expressed the opinion that if the practitioner was vague on the requirements of treatment in venereal disease there was little hope of the patient continuing with such treatment. It was not necessary for him to say anything to prove his keen interest in the education of practitioners. He had worked incessantly in that cause and had taught many post-graduate classes. But he was bound to say that he was disappointed with the result, and he could only conclude that he must be a most indifferent teacher.

## SOCIAL HYGIENE

*Dr. Edward Gregg, London Panel Committee:* As representing the London Panel Committee I am pleased to have an opportunity of assuring Col. Harrison how much the post-graduate lectures have been appreciated by those practitioners who attended the courses he conducted under the ægis of that Committee. The London Panel Committee is, as far as I know, the only Panel Committee which has consistently, for many years past, organised post-graduate courses of instruction for practitioners giving service under the National Health Insurance Act. I have good reason to believe that none of these courses have been of greater assistance to the doctors attending them than have Col. Harrison's lectures and demonstration work. I know of a considerable number of practitioners in London to-day carrying out the treatment of venereal diseases on modern lines as a result of an interest first aroused by these post-graduate lectures.

It has been claimed during to-day's conference that the general practitioner does not and cannot carry out proper venereal disease treatment because of lack of three things:—

- (1) Necessary knowledge and skill.
- (2) Time.
- (3) Equipment.

I think the National Council for Combating Venereal Diseases might well give some attention to the problem as to how best to associate the general practitioner not only with post-graduate lectures but with the regular work of the clinics. This will require very great patience and some overcoming of the practitioners' unwillingness to leave his own groove, but it is worth the effort necessary to accomplish it. I hold most strongly that the general practitioner must be associated with the practical work of hospital clinics as part of his ordinary regular professional work if he is to be as efficient as he might or ought to be. The efficiency of the general practitioner is a matter in which every agency working in the interest of the public health is vitally concerned. I unhesitatingly affirm that to get the highest possible efficiency he must have a place in the routine work of hospitals and clinics. Here it is that most readily he can acquire not only the knowledge and skill required but also that spirit of enthusiasm which must be the mainspring of his effort. The isolation of the general practitioner from these things is the great weakness of our present medical system.

As regards equipment in private practice, I do not think it is a matter, as one speaker has said, of apparatus and instruments. That is not beyond the purse of most general practitioners. It is a question of suitable consulting-room accommodation and assistance so as to enable this kind of work to be done with the minimum loss of time on preliminary preparation of patients and after the patients' dressings, etc. This requires an assistant trained by the doctor for this purpose and a room adjoining his regular consulting-room. With such an arrangement the doctor can, having the patient prepared first by his assistant, carry out the essential part of the treatment and afterwards leave the patient

## THE MEDICAL PROFESSION : DISCUSSION

to his assistant and continue in his ordinary consulting-room with other patients.

The provision of such extra accommodation and assistance costs money. I am satisfied that if there were a higher standard of remuneration for the general practitioners' service these things would in a short time follow. We are again faced with a weakness in our medical systems, viz. that the general practitioner is obliged to undertake a great volume of professional work, the various portions of which are poorly or at least very indifferently paid, in order to earn a sufficient income for himself and his family. To be able to provide adequate accommodation for the easy handling of patients, and the necessary assistance to carry out the non-medical duties of practice, would not only mitigate but in a great measure remove these difficulties. It would also make general medical practice a more attractive career and lead to the best types of men and women taking it up.

*The Chairman :* We have listened this afternoon to two papers and a discussion, both of a very high order of excellence, and the whole subject has been very adequately treated from every point of view. There have been refreshing differences of opinion. For my own part I consider this all to the good, because far often better results eventuate after discussion between those who widely differ than if all went along the broad easy road of perfect unanimity.

The matters which seem to me particularly to emerge from the papers and speeches we have heard this afternoon are firstly that it is necessary for the general practitioner to be so educated as to be able to treat these diseases employing the latest modern scientific methods. The new regulations of the General Medical Council, in which it is enacted that every student must attend a venereal disease clinic before presenting himself for examination, will ensure in future years a constant and ever-increasing supply of newly qualified practitioners who will both know what should be done and be able to do it in the treatment of these illnesses.

Some fear has been expressed that a great number of doctors do not like to treat venereal disease and avoid doing so if they possibly can. With regard to this I am encouraged by remembering what Colonel Harrison said shortly after the war—that when men were detailed to work with him in the venereal disease hospitals in the Army, at first they were very reluctant to do so, but after a short experience they became quite keen and wishful to continue the work. It is to be hoped that we shall have the same experience in civilian life. We must recognise the fact that general practitioners are the first line of defence against disease, more especially in the sparsely populated districts. The ideal would be that every private practitioner coming across a case of gonorrhœa or syphilis should be able to make an accurate diagnosis, confirm that diagnosis by catching the elusive spirochæte or gonococcus and then at once commence the treatment for gonorrhœa, or give the first injection of salvarsan or of one of its substitutes in a case of syphilis even though he did not intend to carry on the treatment

## SOCIAL HYGIENE

himself. By so doing much precious time would be saved and the patient referred to the clinic or hospital would go there already fortified by the commencement of his treatment.

I think it would be a very good thing if it were possible for more private practitioners to treat these cases until cured, more especially with regard to women patients. We have heard during this Congress a great deal of the unwillingness and disinclination of the respectable woman to be herded in waiting-rooms with the prostitute, and I think that if such women could go to their own or some other private doctor—a woman practitioner for those who preferred one of their own sex or a man for those who preferred the other—a great many more would come under treatment, and there would not be that great discrepancy between numbers of those who we know are being treated for gonorrhœa and those who are infected and escaping treatment altogether. I think that if it were possible to arrange in all districts for a supply of practitioners who would undertake and carry through the treatment of venereal disease it would be an exceedingly good thing. It is physically impossible for a busy insurance practitioner to treat cases of gonorrhœa in the male in the way which was so beautifully shown in the film exhibited by Col. Harrison this morning, and though the treatment of this disease is supposed to be included in the contract of the insurance practitioner, he does wisely in seeing that his patients obtain their treatment at a clinic or hospital. It might be easier for him to treat syphilis, but owing to the fact that not all practitioners are considered capable of administering salvarsan, and are not all eligible for free supplies of that drug according to the regulations of the late Local Government Board, that disease is outside the contract of the insurance doctor. If, however, practitioners in all districts who, either from their experience in the Army or by taking up and satisfactorily completing post-graduate courses in the study of these diseases, have made themselves fit to treat both syphilis and gonorrhœa in the modern way, could be organised and be paid adequately by the State for the work which they might do, I think a very great step in advance would have been made. I was very pleased to hear Dr. Cox in his admirable paper suggest that it might be possible to use some of the pooled money for this purpose.

The vexed question of notification came in for considerable mention. It is universally admitted that general notification on the lines of the Infectious Diseases Act would be both mischievous and ineffective. With regard to what is known as modified or conditional notification and compulsory continuous treatment there was a very wide difference of opinion, some of the speakers being absolutely in favour of it, others absolutely opposed. It must be remembered that those who claim to speak with authority on this matter in so far as the United Kingdom is concerned are simply voicing their own opinions without any foundation of fact whatever on which to build their conclusions.

Let us hope that to-morrow, when we shall have the advantage of hearing the representatives of our overseas Dominions and

## THE MEDICAL PROFESSION: DISCUSSION

Colonies, that we may have such up to date facts and figures given to us, that it may be possible for those who hold either opinion to come to a conclusion based on experience and results. Perhaps, acting on one of the recommendations in the Report of Lord Trevethin's Committee, it may be possible to launch an experiment locally in some part of these islands which may be exceedingly instructive to those of us who wish to form a correct opinion on the question. One thing, however, must be remembered, and that is that it is absolutely impossible to institute any form of notification or compulsory treatment, until there is a large mass of public opinion behind it and the medical profession is prepared to carry out whatever may be enacted.

### EXHIBITION OF FILM:

#### "DIAGNOSIS AND TREATMENT OF GONORRHOEA IN THE MALE."

In the morning Colonel Harrison showed to medical practitioners a film, prepared by himself in association with the Community Service, Ltd., on the diagnosis and treatment of gonorrhœa in the male. In introducing the film Colonel Harrison said that he wished publicly to acknowledge his great indebtedness to Mr. Hodges and his staff of the Community Service, Ltd., for the excellent way in which they had interpreted his ideas in the production of this film. The audience would readily realise how difficult it must be for a layman to understand the intricate processes taking place during a gonococcal invasion of the male urethra, and they would appreciate those difficulties still more when they saw the first section of the film, in which are portrayed the histological changes. This section would above all convince them of the success with which the Community Service, Ltd., had carried out their part of the work.

The film was received with considerable enthusiasm and afterwards there were many expressions of opinion that it would prove of very great value in the education of medical practitioners and students.

## Imperial Questions.

*President of Section :*

The Right Hon. L. S. AMERY, M.P., *late Parliamentary Secretary for the Colonies*, in the Chair.

THE CHAIRMAN : I do not suppose that at a gathering like this the Chairman is expected to make a long address. We have a very full and interesting programme for to-day, and all I need say about it is that it falls more or less into two parts.

For a considerable part of the day we shall be discussing the problem of social hygiene in the Dominions. That is a problem more or less of the same character as the problem which the Conference has been discussing with regard to this country for the last few days : the problem of securing the concentration of an intelligent and outspoken public interest on the great social and health problems connected with these diseases. It is also a problem of securing the right social conditions which prevent their spread and multiplication and, lastly—and this is perhaps one of the most important matters with which the papers are concerned—the question of securing effective, adequate and easily accessible methods of curing the spread and diffusion of these diseases.

But in all these matters the problem in the Dominions is not essentially different from the problem in this country, and I imagine that the main object of the Conference, as far as they are concerned, is an interchange of ideas and experiences so that whatever may have been learnt in different parts of the Empire may be available to add to the common stock of knowledge and to increase the efficiency of our methods.

When we come to the Colonies and Dependencies we are dealing with a different problem in this sense, we are there confronted in this matter, as in all other matters, with a great responsibility. The spread of the white races and of their authority over other peoples may have begun merely in the desire for an expansion of their own economic interests, but it has brought with it—at any rate we have long recognised this—a great responsibility. In the earlier stages of public opinion in this country we looked upon that responsibility mainly as a question of preserving law and order, of preventing such devastating evils as the slave trade, the prevention of mutual warfare and of an endeavour to get rid of those grosser superstitions—witchcraft and other forms of sacrifice—which appear repugnant to our Western sentiment. But I think we are gradually coming to see that our responsibility goes much further, that our trusteeship is not merely a negative one, but has its very positive aspects and obligations, and that



## IMPERIAL QUESTIONS

*The Right Hon. L. S. Amery, M.P.*

we are concerned not merely in keeping the peace but in endeavouring to make the very most out of the populations for whom we have assumed responsibility. We have long recognised, in that sense, that we have a duty of political education. Sometimes, I think, the importance of this has been over-estimated as compared with the duty which we owe to the actual training of those for whom we are responsible in industry and, even more, in the very foundations of social life, in health and in moral conduct. And I think in this particular matter of health we have got to recognise not only our responsibility for the future, but our responsibility for the past. If we have been deserving of praise for what we have done to stamp out many mischiefs in Africa and elsewhere, we have been unconsciously guilty of some mischief the full extent of which we are only now beginning to understand. The contact of civilisation with primitive races has often meant a very serious moral breakdown—a lower morality has not been replaced by a higher—and very often this contact has been accompanied by a very disastrous physical breakdown due to the introduction of diseases into a primitive community which has been entirely unprepared and unable to cope with them. We know the stories of South Sea Islands practically exterminated by a disease like measles, and this is true of other diseases, particularly of the diseases which we are discussing at these Conferences.

My own personal impression dates back to a visit paid some sixteen years ago to Uganda when, in conversation with missionaries and with medical men, and not least perhaps the man who was a great pioneer in this particular subject, the late Colonel Lambkin, it was brought home to me what an immense amount of disease had in a few years come over an intelligent and, within its own limitations, a civilised people by its first contact with European civilisation. From the West, Stanley's porters had brought in sleeping sickness, and the whole lake-side population of Uganda was not only desolated but in large areas exterminated by this disease. I remember looking at the beautiful Sesse Islands, opposite Entebbe, which a few years before had been inhabited by an active population of some thirty thousand souls—and the last two or three of them were dying while I was there. And in exactly the same way the Indian workers on the railway had brought syphilis and other venereal diseases into Uganda, and they, over a wider area, were effecting a devastation hardly less immediately deadly, and perhaps even more serious in its consequences, than the devastation of sleeping sickness.

Ever since then I have watched with interest the progress of health work in Uganda, very admirable work which has been done in dealing with these problems. I have seen the thing from the point of view of the Colonial administration concerned. The extent to which the work can be carried out right through the dependent regions of the British Empire is, of course, always limited by the difficult financial position of the Colonies. But, real though that difficulty is, it is always a relative difficulty—I

## SQICAL HYGIENE

mean in the sense that it is relative to the strength of public opinion both in the administrative services out there and in this country. What one hopes is that the result of Conferences like these, of the interchange of opinion and of growing public opinion both at home and in the services, will bring about the realisation of the need of apportioning a steadily increasing part of the revenues of the various Governments, and of the attention of the various Governments, and again, behind them, of the understanding sympathy of the Colonial Office, to the importance of these problems.

When one talks in general terms of the immense possibilities of a continent like Africa, and its immense resources, and of all that might be done there, the moment you begin to look into actual problems of development you are up against the inadequacy of population to meet the demands. These can only be met, not by trying to force the pace by measures of compulsion, they can only be met by the steady creation of a healthy population, and therefore, if we want to develop our great Dependencies, the foundation of such development must be the increase of a healthy population multiplying naturally as opportunities on the material side develop. Consequently, even through the purely material side, and apart from any moral responsibilities which we bear towards these populations, it is in our own interest, as well as in theirs, that we should concentrate attention on this great problem as one of the foundation problems in creating a healthy, progressive population. It has always struck me, from what I have seen in the tropical parts of the world, that their reputed unhealthiness is far less a matter of mere climate as of the fact that disease of every kind has been allowed to run riot and has never been seriously tackled. When you tackle disease, as we have tackled tuberculosis at home and as malaria has been tackled in many places—and no other disease can be so effectively tackled as venereal disease—then one will see an entirely new point of view developed about vast areas of the world which are supposed to be unhealthy, especially for our race, and where the unhealthiness for our race is only the reflex of the unhealthiness for the race belonging to the country.

Well, as I said just now, this is not an occasion when much is expected from a Chairman, in view of the fact that a large number of papers are waiting to be read by those who really know the subject at first hand, and so I will now call upon the first of our speakers.

## CANADA.

### SOCIAL HYGIENE AND V.D. CONTROL IN CANADA.

By Dr. GORDON BATES, *General Secretary Canadian Social Hygiene Council*, transmitted by Professor I. H. CAMERON, LL.D., F.R.C.S.

#### HISTORY OF MOVEMENT.

The plan for the control of venereal diseases in the Dominion of Canada developed to a large extent because of the war. The first steps for the control of venereal diseases were made in the Army. It was realised by Army authorities, however, that essentially the problem was of a civil character, and as a result efforts were made to stimulate the civil authorities to organise definite machinery of their own.

The first result of the stimulus from the Army was an agitation for legislation. In 1918, an Order in Council dealing with the reporting of venereal diseases was passed in the Province of Saskatchewan, and shortly afterwards, as the result of the appointment of a Royal Commissioner, Hon. Mr. Justice Hodgins, the Province of Ontario brought into being the Ontario Act for the Prevention of Venereal Diseases. Since that time legislation making venereal diseases reportable, either by number or by name, and giving the public health authorities wide powers, has come into effect in all of the provinces of Canada.

#### LEGISLATION.

Some of the provisions of the Ontario Act, which is a fairly typical example of Canadian legislation, may well be given here with some details as to its machinery.

Persons reported to the medical officer of health for action under the Venereal Diseases Prevention Act of Ontario may be either suspect cases of disease or those on whom a diagnosis has already been made. The names of suspected persons may come from two sources, the courts and jails or through credible information. Sub-section 1, Section 3, reads as follows:—

“Whenever any person is under arrest or in custody charged with an offence against the Criminal Code of Canada or against any statute of Ontario or any by-law, regulation or order made under the authority thereof, or has been committed to a gaol, reformatory or other place of detention upon conviction of such offence, and the medical officer of health for the municipality or district believes that such person is or may be infected with, or has been exposed to, infection from venereal disease, the medical officer of health may cause such person to undergo such physical examination as may be necessary, or as may be prescribed by the regulations, in order to ascertain whether or not such person is infected with venereal disease.”

In Toronto a representative of the Health Department is in daily attendance at the men's and women's police court and interviews persons who come up charged with sex offences, or others

## SOCIAL HYGIENE

where it appears in the course of the evidence that the individual is sexually promiscuous. Such persons are served with a Form I, which is an order to report within twenty-four hours following receipt of the notice to a physician for examination for venereal disease, and twenty-four hours following examination to furnish the Medical Officer of Health with a certificate stating whether he is or is not infected with a venereal disease.

The second class of persons is dealt with under Section 4, Sub-section 1, of the Venereal Diseases Prevention Act, which reads as follows:—

“ Subject to the regulations, where the medical officer of health is credibly informed that a person resident in the municipality or district for which the medical officer of health is appointed is infected with venereal disease and has infected or is liable to infect other persons, the Medical Officer of Health may give notice in writing to such person requiring him to consult a legally qualified medical practitioner and to procure and produce to the Medical Officer of Health within a time to be specified in the notice, a report or certificate of such medical practitioner that the person so notified is or is not suffering from venereal disease.”

The credible information concerning suspected persons comes to the Medical Officer of Health from such sources as physicians, nurses, social agencies, clinics, hospitals, etc., and the persons reported are usually the contacts of infected persons or others, who because they are known to be sexually promiscuous, may reasonably be suspected of being infected with disease. If the Medical Officer of Health believes the information to be “ credible,” he orders the examination of the person, in the same way as in the case of persons coming through the courts.

When a person who has been served with a Form I fails to produce a certificate within a week's time, a summons is issued, charging him with a breach of the Venereal Diseases Prevention Act. The penalty upon conviction in these cases is a fine of \$25.00 to \$100.00 or three months' imprisonment.

When an individual who has been ordered to be examined produces a certificate showing that he is infected with a venereal disease, or upon receipt of a certificate from a qualified medical practitioner that a venereally diseased person has discontinued treatment, the Medical Officer of Health may order such a person to place himself under treatment and may outline the course of conduct to be followed by him. This is done by serving a Form IV, which states that the infected person must place himself under treatment and report to the Medical Officer of Health once a month with a certificate stating that he is under satisfactory treatment. While under treatment and until non-infective, he is ordered to abstain from marriage, sexual intercourse or any conduct likely to infect another. The penalty for failing to continue treatment is \$25.00 to \$100.00 or three months' imprisonment, and for exposing others to infection \$500.00 or twelve months' imprisonment.

## IMPERIAL QUESTIONS: CANADA

*Dr. Gordon Bates.*

### PERSONS EXAMINED, TREATED AND DETAINED IN CUSTODY.

All persons in custody at the provincial reformatories of Ontario, as well as the municipal farms of Toronto, are on admission examined for venereal disease. If found to be diseased they receive treatment during the time of their sentence. It is important that the time spent by such persons in custody be utilised in giving them intensive treatment, so that they may be, as far as is possible, non-infective on their discharge. The Medical Officer of Health is given authority under the Act to order the detention of any person who may, on account of venereal disease, be considered a menace to public health. Of the 1,880 persons who were examined while in custody during 1922 at the municipal farms of Toronto, 151 were ordered to be detained for treatment for varying periods of time. No person was detained after the time when he was pronounced non-infective by the physician of the institution.

Other sections of this Act make provision for the examination and treatment of cases of venereal diseases in all hospitals receiving aid in the Province of Ontario, provided that no person other than a legally qualified medical practitioner shall attend upon or shall prescribe for or supply or offer to supply any drug, medical appliance or treatment to or for a person suffering from venereal disease for the purpose of alleviation or cure of such disease. There is an exception, of course, in the case of a pharmaceutical chemist dispensing to the patient of a legally qualified physician a prescription of such practitioner.

Physicians are required to report cases of venereal diseases to local officers of health by number, and the name of the patient is not revealed unless the patient discontinues treatment without the permission of his physician.

### CONFERENCE OF MAY, 1919.

It was realised early that much more than legislation was necessary if we were to elaborate a really effective scheme. In the year 1919 two conferences were called by the Dominion Government, the first consisting of Chief Officers of Health, the second of the Chief Officers of Health of the Provinces, with many representatives of organisations and interested citizens. Shortly after the second Conference, which was held in May, 1919, the Federal Department of Health was established, and the Government as a result of the recommendations of the second conference decided to appropriate the sum of \$200,000.00 a year, this sum to be spent in a specified way by the provinces on condition that each Province raised an amount equal to that given by the Dominion Government. Since that time approximately \$400,000.00 a year has been spent by the Dominion and the Provinces.

It was realised that to make treatment machinery effective, public education was essential. At the conference of May, 1919, therefore, an organisation known as the Canadian National Council for Combating Venereal Diseases came into being. This organisation has carried on educational work in the various provinces

## SOCIAL HYGIENE

since that date, latterly under the name "Canadian Social Hygiene Council." This name was adopted in 1922 because of the ever broadening character of the work which was found to be necessary.

### CASES BROUGHT UNDER TREATMENT.

The first immediate result of the decision arrived at in 1919 was the springing up of a number of clinics established under the direction and supervision of the provincial Boards of Health in various parts of Canada. As far as is known, previous to the establishment of a definite scheme there were only two venereal disease clinics in Canada. Since that time approximately seventy clinics have been organised and thousands of patients have come under treatment. Exact figures dealing with the number of cases brought under treatment are as follows:—

#### DOMINION DEPARTMENT OF HEALTH.

##### *Venereal Diseases Report for 1921, 1922 and 1923.*

	1921	1922	1923
Total number new cases admitted to clinics and institutions .. ..	10,267	12,252	12,526
Total number cases reported by physicians .. ..	15,189	16,220	15,477
Total number new cases for the year .. ..	25,456	28,472	28,003
Total number new cases admitted to clinics and institutions:			
Syphilis .. .. .	4,953	5,171	5,421
Gonorrhœa .. .. .	5,070	6,680	6,865
Chancroid .. .. .	244	401	240
	10,267	12,252	12,526
Totals for 1922 and 1923:			
Total number of treatments .. .. .		280,433	328,963
Total number of Wassermanns .. .. .		22,624	20,932
Total number of injections of arsphonamine .. .. .		41,951	51,133
Total number of laboratory examinations .. .. .		77,579.	36,334

It will be noted that the number of cases in clinics and institutions were 12,526 in 1923 as compared with 12,252 in 1922, that in the last three years 38,045 new cases have been admitted to institutions and clinics and that 46,886 cases have been reported by physicians, or nearly 85,000 individuals altogether either treated by physicians or in clinics.

### VALUE OF LEGISLATION.

On the whole it has been found that the matter of reporting by physicians in private practice has been largely confined to reporting by number, its principal value being in arriving at an idea of the number of cases actually under treatment. Reporting by physicians is as yet not the success which it might be in at least some of the provinces. Reporting by physicians serving in clinics, however, is quite satisfactory.

## IMPERIAL QUESTIONS: CANADA

*Dr. Gordon Bates.*

Venereal disease legislation, however, has been of very great value in connection with the clinics; and in cities such as Toronto, scarcely a day goes past in which some part of the Venereal Disease Prevention Act is not utilised to bring patients under treatment who would otherwise be quite intractable. Repeatedly individuals, for example, who are the parents of syphilitic children, have refused to even bring their children to the clinics for examination until compelled to do so. Patients who have not been convinced of the seriousness of venereal diseases by all of the educational methods available, will also frequently try to avoid treatment. In these cases the provisions of the Venereal Diseases Prevention Act have proved to be of value.

### THE WORK OF THE CANADIAN SOCIAL HYGIENE COUNCIL.

The Canadian National Council for Combating Venereal Diseases, or as it is now known, the Canadian Social Hygiene Council, has functioned since the commencement of the Dominion scheme. This Council has established branches in all of the provinces except Prince Edward Island, which has not come into the general scheme adopted by the Dominion Government and the provinces. With these branches some form of educational work has been undertaken.

The first big piece of propaganda undertaken by the Council was the utilisation of the moving picture entitled "The End of the Road." This picture during 1920 and 1921 was shown to approximately 500,000 people. Its utilisation was an excellent example of the type of work which can be done by a voluntary organisation but is impossible for official bodies such as the Dominion or Provincial Boards of Health.

The Council entered into an arrangement with a large moving-picture company for the circulation of this picture in various parts of the Dominion. An admission fee was charged, the greater part of the money raised going to the commercial firm and not to the Council, although the Council did share to a small extent in the proceeds. In each town or city where the picture was shown, as far as possible it was arranged for the local committee of the Council to back the showings of the picture. Speakers at each showing of the picture were arranged for, literature was distributed, etc., while following each showing of the picture there was a statement screened as to the policy of the Government in the matter of controlling venereal diseases.

The showing of this picture had an immediate effect on clinic attendance in all parts of the country, and in addition it had an effect on public opinion which made it much easier for the Council to organise.

Other types of propaganda have, of course, been utilised by the Council. For example, newspaper articles dealing with various phases of the question have been distributed to newspapers in all parts of the Dominion, and from this method alone a tremendous amount of publicity has resulted.

Propaganda meetings have been held in most of the provinces.

## SOCIAL HYGIENE

In the province of New Brunswick last winter a series of meetings was arranged by the Honourable Dr. Roberts, Minister of Health. These meetings were addressed by Dr. J. J. Heagerty, Chief of the Division of Venereal Diseases, Federal Department of Health; Dr. J. A. M'Carthy, Chief of the Venereal Division of the New Brunswick Board of Health; Mrs. Emmeline Pankhurst; and Dr. Gordon Bates, General Secretary of the Canadian Social Hygiene Council. One should state in passing that Mrs. Pankhurst, with her eloquence and forceful personality, has been a power of strength in the movement.

These meetings in New Brunswick are said to have been the most successful series of public health meetings ever arranged in the Dominion of Canada. The final meeting of the series was held in the Imperial Theatre in the City of St. John. The Honourable Wm. Pugsley, Lieutenant-Governor of the Province, who was in the chair, stated that the meeting was the largest he had ever addressed in the province of New Brunswick. Similar meetings were put on later in the year in the provinces of Saskatchewan and Alberta; the services of three of the same speakers were utilised. The Saskatchewan series was arranged by Dr. M. M. Seymour, Deputy Minister of Health for the province, and in Alberta by Dr. Laidlaw, who occupies the same position in Alberta. Meetings of this character provide an opportunity for organising, and as a result of such work approximately fifty branches of the Social Hygiene Council have been brought into being in Canada.

Other interesting pieces of propaganda work have been the utilisation of certain moving pictures other than "The End of the Road," and the organisation of exhibits. Recently in the city of Ottawa certain moving pictures, not of a story character, loaned by the American Social Hygiene Association, have been shown to audiences of men and women separately. A speaker representing the Dominion Health Department has addressed the gathering in each case. In the city of Ottawa there is a very strong Social Hygiene Council, under the Presidency of Right Honourable Sir George Foster, and these meetings were so organised that they were extremely successful. On more occasions than one the interest aroused has been so great that the streets in front of the large moving picture theatre used have been blocked on the occasion of the showing of the moving picture in question. It is felt that meetings of this type have done a great deal of good, and it is now planned to work out a programme whereby meetings of this type can be arranged for in different parts of the country.

Both in Ottawa and Toronto the social hygiene exhibit idea has proved to be successful. A series of wax models dealing with the ravages of syphilis have been procured by the Provincial Board of Health in Ontario. These models, with about two hundred posters dealing with various phases of social hygiene, and literature on social hygiene subjects, have constituted the social hygiene exhibit. At the same time moving pictures are shown and addresses given on appropriate topics. It has been found possible by judicious advertising to get thousands of people to visit these exhibits, and



## IMPERIAL QUESTIONS: CANADA

*Dr. Gordon Bates.*

there is no doubt that the educational result has been very good. Subjects taken up by speakers have been of a varied character, as the following partial programme will show: "The Meaning of Social Hygiene," "Preparing the Child for Life," "The Woman Physician's Point of View," "An Educational Creed," "Relation of a Social Settlement to Community Life," "Society and the Delinquent Woman," "Who is to Blame," "The Church and Social Hygiene," "Personal Hygiene," "Marriage and Syphilis," "Some International and National Aspects of Social Hygiene," "The Need of Public Education," "Books Boys ought to Read," "What this Government is Doing," "The Attitude of Labour to Social Hygiene," "Play in the Life of the Child," "The School as a Community Centre," etc.

Another interesting development in Canada has been an arrangement with the University of Toronto whereby intra and extra mural courses of social hygiene are given by the University. Local Social Hygiene Councils request the University to provide speakers, and the University has responded by arranging specific courses dealing not only with the subject of venereal diseases, but with the methods whereby the social factors must be dealt with if we are ultimately to control the venereal disease scourge. These courses are now better arranged than were the early ones. The following programme was given in the city of Hamilton before the Hamilton Social Hygiene Council and is fairly typical: "Introduction to the Study of Social Hygiene," "Mental Defect and Social Hygiene," "The School Programme and Sex Education," "Law and Morality," "Life Problems of Social Hygiene," "How Life Begins," "Problems of Girlhood and Motherhood," "The Venereal Disease Problem," "Teaching Boys to Guard and Direct their Minds."

### COMMITTEES.

Various committees of the Social Hygiene Council have been at work and one or two specific achievements have been of value. The Medical Committee, consisting of approximately thirty-five physicians, recently brought in a report on the diagnosis and treatment of venereal diseases which was considered to be of such value by the Dominion Department of Health that it should be generally distributed. Recently a copy of the report has been forwarded by the Dominion Government to each physician in the Dominion of Canada.

A committee on nurses' education has also brought in a report in the form of six standard lectures of a type suitable for delivery in Nurses' Training Schools. This report will be printed shortly and will then receive general distribution among the training schools of the dominion.

### LITERATURE.

The Dominion Department of Health and the Provinces have both issued literature of an educational type dealing with various phases of venereal disease control. Literature issued by the Dominion Government includes the following titles: "To-day's

## SOCIAL HYGIENE

World Problem in Disease Prevention," "General Circular of Information Concerning Venereal Diseases," "Venereal Diseases—Diagnosis and Treatment," "Information for Men—Syphilis and Gonorrhœa," "Information for Young Women about Sex Hygiene," "Information for Parents—Teaching of Sexual Hygiene to Children," "Prevention of Blindness in Babies."

The Canadian Social Hygiene Council has issued literature of their own which is either given away or sold at a nominal price. Titles of literature prepared by the Social Hygiene Council are as follows: "She Might Have Been Your Daughter," "Fighting Disease," "The Scapegoat" by Edith H. Hooker, "Canadian Social Hygiene Council," "Essential Factors in a Campaign Against Venereal Diseases," "Introductory Studies in Social Hygiene," "A Special Investigation—Summary of 165 Social Histories taken of Venereal Diseases Patients" by Mildred Kensit, "Brochure for Clergymen" by Rev. Archdeacon Ingles, "The Power and Responsibility of Womanhood" by Miss Violet Trench, "How to Teach Little Children" by Miss Violet Trench, "Healthy, Happy Womanhood," "An Open Letter to Young Men" by Dr. Douglas White, "How to Fight Venereal Diseases," "Sex Education" by Louise Bulley, "A Woman's Honour" and "What Makes a Man" by Rev. Ben Spence, "Conquering an Old Enemy" by Will Irwin, "The Strength of Ten" by Dr. Winfield Scott Hall, "Life's Story" by Jeanette Winter Hall, "The Responsibility of Religious Leaders in Sex Education" by Thos. Galloway, etc. Some of this literature has originated in Canada. Other literature has been adapted. At a recent social hygiene exhibit held in the city of Toronto no less than 100,000 copies of literature of various types were disposed of.

It is felt that during the last four or five years the general programme in Canada for the control of venereal diseases has progressed in a very satisfactory way.

It has been fully realised that for a health programme of this character to succeed it is not only necessary to pass laws, appropriate money and establish clinics, but that the solution of the problem of venereal diseases depends very largely upon the solving of many social and educational problems. This being true, every effort must be made to keep the public interested in the problem as a whole, in order that those organised units in the community whose services must be utilised for the solution of these problems may be kept informed and at work. Therefore definite recognition of the function of such organisations as the National Council for Combating Venereal Diseases in Great Britain, the American Social Hygiene Association in the United States, the Canadian Social Hygiene Council in Canada and similar organisations is essential. No plan can succeed which does not recognise the function of such organisations in insuring the stability of work undertaken by Governments and in stimulating the difficult pioneer work which must be carried on at the same time.

In Canada we believe that the functions of the purely Governmental part of the organisation and those of the voluntary organisa-

## IMPERIAL QUESTIONS: AUSTRALIA

*Dr. W. T. Hayward, C.M.G., LL.D.(Hon.).*

tion have been clearly defined and recognised. This implies a co-operative effort upon the part of the Government and citizens generally which should mean the keeping up of public opinion, proper undertaking of the obviously necessary work and the initiating and carrying on of this work. Success in all three fields is essential both for the control of venereal diseases and for the solving of the more difficult problems which exist in the field of "social hygiene."

### AUSTRALIA.

#### THE PREVENTION AND TREATMENT OF VENEREAL DISEASE IN AUSTRALIA.

By Dr. W. T. HAYWARD, C.M.G., LL.D.(Hon.).

WHEN I was asked by the High Commissioner for Australia to represent the Commonwealth at this Congress I accepted the position somewhat unwillingly inasmuch as for very many years I have practically only had to deal with the after results of venereal disease and had only a general information of the working of the Contagious Diseases Legislation. I mention this as I do not wish to pose as an authority on the subject.

The prevention and treatment of venereal disease in Australia may be best introduced by bringing before you the main features of the Venereal Diseases Act of 1920, South Australia, which I believe is generally considered to be best of such Acts that have been passed by the six States of Australia.

Only medical practitioners can attend or prescribe for cases of venereal disease.

Every individual suffering from, or suspected to be suffering from, venereal disease must consult a medical practitioner within three days of becoming aware of his condition—shall attend some hospital or place himself under treatment. He must give his full name, occupation and address and must notify any change of address.

If he wishes to change his medical practitioner for any reason he must inform his fresh attendant of name, etc., of his former one.

Any person who has placed himself under treatment must, until he has received a certificate that he is free from venereal disease, attend as directed by his medical attendant. Should he fail to do so the medical attendant must inform the Inspector-General of Hospitals.

Having ceased to be liable to carry infection, but not cured, does not exempt him from complying with the provisions of the Act, e.g. continued treatment, notices, etc.

A medical practitioner becoming aware that a patient is suffering from venereal disease must give notice to the Inspector-General of Hospitals in prescribed form and period. He must give a written notice to the patient directing attention to the infectious

## SOCIAL HYGIENE

nature of the disease and legal consequences of infecting others and warn him against contracting marriage, also printed information *re* duties of persons infected. If the medical practitioner has reason to believe the patient intends to marry he shall inform Inspector-General, who shall inform the other party, or parent or guardian. All such communications made in good faith shall be privileged.

Any person who married while suffering from venereal disease shall be liable to £500 penalty or imprisonment.

A medical practitioner may give a certificate as to cure of venereal disease or that the liability to convey it has ceased. Any person using such certificates for purposes of prostitution is liable to a penalty of £20.

The parent or guardian of a child suffering from venereal disease is responsible for the child being treated in accordance with the provisions of the Act.

No person suffering from venereal disease in the infectious stage shall work in any capacity requiring him to handle food, liable to heavy penalty.

Similar obligation to employer.

Any medical practitioner who gives a false certificate in any material particulars (e.g. that patient is cured, not liable to convey infection) is liable to imprisonment for six months.

Any proceedings held by special magistrates on matters pertaining to venereal disease shall be heard *in camera*. Absolute secrecy imperative.

A special magistrate may authorise a warrant to search any home, other than that of a medical practitioner or pharmaceutical chemist, shop, room, etc., and seize any medicines, appliances, etc., that may be used in connection with cases of venereal disease.

No person shall publish any statement, advertisement or otherwise, to promote sale of any article used as a cure of venereal disease or in connection with the generative organs or sexual life or of female or menstrual irregularities. Minister may arrange with public hospitals for reception and treatment of cases of venereal disease free of charge.

If Inspector-General of Hospitals has reason to believe that any person is suffering from venereal disease, that he is not under treatment, he may issue an order requiring such person to place himself under treatment. The Governor may appoint any public hospital or any ward as a place in which cases may be detained for treatment.

Any medical practitioner who, otherwise than in accordance with the provisions of the Act, communicates to any person or in any other way makes known any name or address furnished to him in connection with this Act, shall be liable to a penalty of £100 and shall be deemed guilty of professionally infamous conduct.

I think it must be admitted that the provisions of this Act are very drastic; but does it not frequently happen that in measures of this kind the very drasticity has the effect of rendering them in a measure nugatory? I believe this to be so in this case. For instance, the power of compulsory notification has never been enforced in some of the States and in others it has become per-

## IMPERIAL QUESTIONS : AUSTRALIA

*Dr. W. T. Hayward, C.M.G., LL.D.(Hon.).*

functory. I do not mean that notification is absolutely neglected, for such is not the case, but it becomes obligatory, not compulsory.

Since the first year after the termination of the war no hospital or ward in any hospital has been compelled to receive cases of venereal disease. The cases of disdemeanours declared by the Act that have come before the Courts are practically negligible—the reason being that it would be very difficult to secure such evidence that would secure a conviction. There is, however, one feature in the Act that I believe will be of great service to the community—I mean the creation of venereal disease clinics, and I think it is the only one. These clinics are staffed by male and female medical practitioners; they are carried out in fairly central localities in some unobtrusive position and they are furnished with up-to-date suitable appliances; they are available after sunset, or I should say in the evenings. These are being more and more availed of, and the result must be of benefit to the community sooner or later. Though there is a difficulty in securing that the treatment is continuous or patients shall not cease treatment till a cure is effected, still these cases are in a minority. I am not sanguine enough to believe that venereal disease will ever be stamped out, but I do think that it will be considerably controlled. Time alone will show if this surmise will prove correct, and a considerable time must elapse before we shall be justified in drawing conclusions.

Dr. Littlejohn will probably give you certain statistics that may be of interest, but there is one table that I should like to direct your attention to: "Cases treated at the Melbourne Clinic for 4 years ending June, 1923." Sources of infection in males:—

Disease acquired from professionals	..	..	4,009
Disease acquired from amateur prostitutes	..	..	4,057

These figures give rise to thought. Think for a minute what they imply. The enormous amount of promiscuous irregular intercourse that must prevail. In Adelaide practically one never sees a prostitute in the streets, but there is no decrease in the number of attendances at the clinics. What is the cause? A lax morality equally amongst males and females. Both young men and young women have more money to spend than those of earlier days; it is spent recklessly—in men alcohol to a certain extent, in girls finery, in both second-rate cinema shows and exotic trashy books. The natural sexual desire is intensified, the opportunities of expressing it increased.

During the past week we have heard addresses, speeches that have tended to leading us to a higher plane—I might almost say celestial; it takes a lot of climbing to reach those heights—we must get clear of the terrestrial atmosphere first. It is a very difficult problem. An increased knowledge of botany and biology in our education system has been advised with a view to alter the aspect of sexual relations; this may possibly have some beneficial effect, but I confess I have not noticed any excess of morality in students versed in this knowledge, neither have I

## SOCIAL HYGIENE

found that knowing the dangers of immorality has proved a great deterrent. I place more reliance on the advice so ably given that children should be trained from their earliest days to exercise self-control over *all* their passions, to learn to think less of themselves; the service to others should be encouraged, then when adolescence arrives they will be more fitted to meet the dangers they will have to contend against.

### THE CONTROL OF V.D. IN VICTORIA.

By Dr. LITTLEJOHN (*University of Melbourne*).

Dr. Hayward has already given you a summary of the main points in the legislation on this subject in Australia, and there is not much left for me to say.

I consider that the important points are:—

(1) Compulsory application for treatment. Anyone who is aware that he is suffering from venereal disease is compelled to apply for treatment within three days.

(2) Notification.

(3) Provision of free treatment.

(4) Penalties for failure to continue under treatment.

(5) Protection of the medical practitioner in connection with legal action.

(6) Prohibition of advertisements of cure.

With regard to the protection of the medical practitioner from legal action, this is important from our standpoint rather than from the standpoint of the patient. As you know, the practitioner is compelled to give a certificate of cure, and in certain circumstances, for instance, if the uncured patient contemplates marriage, the practitioner is supposed to notify the Inspector-General of Hospitals who has powers to prevent such marriage. Under these circumstances it is extremely important that the practitioner should be protected against legal action, and this is provided for in the Act.

The sixth point—the prohibition of advertisements for the cure of venereal disease—has certainly done some good, though not much, because in the majority of cases information as regards non-professional treatment is handed on from one patient to another.

Regarding special points on which information is desired, I find myself in the main in agreement with Dr. Hayward.

The experience in Victoria is that notification is not generally carried out by the private practitioner unless he is engaged in treating large numbers of these cases. The ordinary private practitioner who gets one, two or three cases a week does not always carry out notification. Where the patient refuses to continue treatment notification is resorted to as a means of compulsion. If a patient does not return, what the doctor generally does is to report the case to the health authorities, or perhaps simply to say he will report the case, and of course the man nearly always does turn up again.

The provisions of the Act are enforced by the Board of Health

## IMPERIAL QUESTIONS : AUSTRALIA

*Dr. Littlejohn (Melbourne).*

which acts through the Police Department. We have no social workers.

In the absence, then, of reliable figures from private practitioners, statistics are useless and I cannot attempt to say whether there has been an increase in incidence or not. In Western Australia in 1916 the rate was 463 per 100,000; in 1922, six years later, the figure had dropped to 269 per 100,000, a drop of 40 per cent. In Victoria in 1910 there was an incidence of 265 per 100,000, and in 1922 of 355. Queensland showed a decrease of 50 per cent. But in 1916 there were factors which are non-operative at present—the Acts were new; notification was more strictly carried out; the glamour of the uniform was over the land with its attendant increase in opportunity and heedlessness of consequences; in addition to that, the military cases, which were included in the above figures, were all notified; so I think one should hesitate to say from these figures that venereal disease is on the wane.

Another question—does the Act weigh more heavily upon women than upon men? As to weighing more, I do not quite understand the question—certainly it applies more to men. In New South Wales in 1924 there were 5,574 men notified as against 724 women. But here again the fallacies are obvious. A man generally knows when he has contracted venereal disease, and he is only too anxious to be cured, whereas very often a woman remains in ignorance of her complaint, and the discharge or leucorrhœa in infected cases is generally diagnosed by the patient herself as due to cold or catarrh; even syphilitic infections may give rise to remarkably little trouble in women. Even when she knows her condition, a woman, if she is a prostitute, is often unable to earn her living otherwise and is therefore heedless of consequences to others. I should say that in the case of children—and at the Children's Hospital in Melbourne we have a large number of congenital syphilitics—the Act does weigh more heavily upon women. The majority of these are the children of women of poor circumstances, and it is very hard for these women to bring them up perhaps twice a week and spend a whole morning or afternoon in the clinic. For these children I think perhaps something more might be done, but the time for that is not yet ripe.

As regards the regulation of prostitution, there has been for a good many years compulsory regulation and examination of prostitutes in Queensland. The failure of such regulations, not only in Queensland but in other countries, has discouraged the enthusiasm of people who favour regulation, and at present there is no outcry for such legislation.

In the main I believe that this is a good Act because it has provided:—

- (1) Free and efficient treatment—and that is a most important point.
- (2) The possibility of enforcing the continuation of treatment until cured or non-infective.
- (3) The prevention of quack remedies and quack doctors and—
- (4) Occasionally the provision of prophylaxis.

## SOCIAL HYGIENE

That is a very delicate point, but one which I believe to be of considerable importance.

The strong point of our legislation, I have heard Dr. Cumpston say, is that the diseases are treated as diseases and not as moral crimes. The weak point is that there is not a great amount of infection due to prostitution; it is general promiscuity which spreads the disease. Of all births notified in Australia during 1909 to 1920, 54 per cent. were illegitimate or occurred within nine months of marriage.

The education of the adolescent is the key to the problem, but there will always be prostitution and promiscuous intercourse. The conditions are becoming worse instead of better. Boys are the same the world over. You cannot frighten them; you may do much worse by arousing their curiosity. My father is the principal of the largest public school in Australia, and we have many talks on subjects such as these. The procedure for boys is to explain stage by stage, as the boy grows up, the sexual relationship between men and women. You can do it best by the analogy of plants and animals. For girls I cannot speak with any authority, but I do not believe that in this particular stage there is any great degree of difference. I consider that the change in female psychology comes later, and for that reason I do not believe in co-education at the curiosity period. Later, after puberty, I believe that elementary instruction should be given as to venereal diseases. I believe, too, that instruction in prophylaxis should be given. I do not believe that the fear of disease keeps young men straight, and if they are to fall they are better to fall lightly. All we can hope for is the ultimate good of the greatest number.

### THE SOCIAL HYGIENE MOVEMENT IN THE U.S.A.

By Mrs. FALCONER, *American Social Hygiene Association.*

AT our conference yesterday the question of the treatment of prisoners was discussed, and I would like to emphasise the point made by Mrs. Rolfe in suggesting that examination should be a routine matter. It was brought out yesterday how well this is being done in certain prisons where there are large numbers of prisoners and where there is an adequate medical staff, but with us, as with you, the asylum breaks down over the smaller prisons, our city work-houses or the county gaols. I hold no brief for those places which often detain their prisoners awaiting trial without classification. Those who are serving short sentences are often all kept together in idleness, and usually without any medical work being done for them.

In some of our larger cities we are stressing the point of trying to have houses of detention for women, just as we have them for our juveniles—both boys and girls—where there is a laboratory where children can be sent to have a very careful examination, mental and physical, and their social history taken, so that all information may be given to the magistrate or judge when the child is brought before him. If this is good for the children, we are beginning to urge the same thing for adults. We are making progress slowly, but we are making progress, and we are having some houses of



*Mrs. Falconer.*

detention organised for adults where women particularly may have this careful examination—both physical and also mental, which we think is very important. Should the magistrate have that information before him? Is the person suffering from venereal disease? And in this connection we feel very strongly that no person should be committed on his medical record. No woman, because she is a prostitute, must be held against her will and examined and committed on that medical record. We are trying to establish the fact that the medical record is one thing and the police record another, and that if a woman or man has venereal disease of course they need treatment, but that the commitment ought to be made on the record that she has been soliciting, that she has been an inmate of a "sporting house," or has kept a "sporting house," not because she has venereal disease. Too often in some of our communities it has been very easy to pass information over to the Medical Department of the Board of Health and to ask what is the record of that woman, and if it is found that she has got venereal disease she must be committed.

We made great strides during the war and aroused interest in the question of prostitution. No decent city now will ever stand for a segregated district. We are preaching that prostitution is not necessary, and to do that we must have an all-round community programme. It is not enough to work for the establishment of clinics and hospitals and then not have follow-up work or social workers. It is not enough because of the low mentality of many of the people, and therefore there must be a law enforcement programme too. The need of probation was mentioned in connection with some of the discussions yesterday. We are pushing this very much because the juvenile courts cannot function properly without trained probation officers for children, and we are now urging the same thing for adults. Probation and prohibition both are helping tremendously in this question of prostitution, because they are very apt to go together. We want less and less friction between the Commissioners of Health or the State Boards of Health and the Police Department. It must be a question of co-operation.

The question of better marriage laws is occupying the attention of many of our States and some progress has been made. Some of the State Boards of Health are taking an active interest and trying to get the law passed—but that can only be done by creating an enlightened public opinion—to have a medical examination with the marriage license. Action has been taken in a few of the States to have the marriage license taken out forty-eight hours in advance, and that we feel is a gain when it requires witnesses or proof of age. The next step is to have a medical certificate, not only for venereal diseases, but for any communicable disease, and we must get the co-operation of the women's organisations for this. The best work is being done in communities; we are getting groups of men and women to work together. In a certain city it was found that a house of bad repute had been frequented mostly by boys of school age. The community was tremendously aroused,

## SOCIAL HYGIENE

and out of that efforts were made, and police associations were formed. But why wait for serious situations such as this to arise? What was the matter with the police that they were not "on their job?" What was wrong with the parents that boys of sixteen, and younger, could be away from home all night without anybody knowing it? We want communities to realise that they must have law enforcement, to know about their resources for the right use of leisure time, and to hold up the hands of the police department and to make possible the extension of the work of the clinics because it takes money; to have not only the clinics but follow-up work as well done by social workers in connection with every clinic, otherwise the work cannot be as well done as it should be. An expenditure of money is involved and groups of people working in co-operation, and I think we may feel that perhaps our greatest gain has been in the sex education of groups. I disagree with the speaker who thought that this should always be done by personal work. It was suggested yesterday by one of the speakers that there is very much less consciousness in talking to small groups and encouraging them to ask questions afterwards. I agree that sex education cannot come in one lecture, but must be given in a series by a person trained for it—but do it in small groups.

Therefore we come again to the problems of the community worker, of law enforcement, of co-operation with State Boards of Health in securing proper places of detention, seeing that our courts for adults function in the same humane way as those for the juvenile courts. We must do our work so well that there will be fewer and fewer men or women going astray because we are going to make it less easy for prostitution to flourish.

### DISCUSSION.

*Mrs. Neville-Rolfe*: One thing which has interested us in hearing of the progress which has been made in Australia has been the discrepancy in numbers between the men and the women coming up for treatment, and we should like to know what form of public enlightenment has been attempted that would especially reach the women in Australia.

*The Rev. Mr. Berry (Hull)*: Is there any penalty laid upon the medical officer for not carrying out notifications?

*Dr. Patin (Norwich)*: I understood Dr. Littlejohn to be speaking for Victoria. Is there any legislation applicable to the whole Commonwealth, or is it only applicable to the constituent States, and how far does this legislation differ? It would really be very interesting to know how far this legislation is applied to the whole of the Colony or to what limited portion?

*Mrs. Somerville (Edinburgh)*: May I ask if Dr. Littlejohn expressed the opinion of the whole of Australia when he said that illicit intercourse was inevitable?

*Dr. Colquhoun (New Zealand)*: We have no information as to the cost of those Acts. Dr. Chalmers told us the other day that the cost of treatment in Scotland was 5s. 8d. each treatment, and he raised the important question, was it worth while? Can

## DOMINIONS: DISCUSSION

Dr. Littlejohn give us any idea of the cost of working these Acts in Australia?

*Mr. Armstrong (Glasgow)*: May I ask if it is true in the Australian system of notification many people give false names and addresses? We find in Glasgow that we seem to get better results without notification than you do in Australia with notification. I also want to know if notification in Australia does not make for concealment and for quack remedies? That is the feeling we have in Glasgow.

*Dr. Littlejohn*: I wish I could answer these questions, but I only arrived in England the night before last, and so have not many good data.

In reply to Mrs. Rolfe, who asked if there was any explanation of the difference in numbers of men and women who are notified, please understand the difficulties one has in dealing with a subject like this. We know nothing whatever of the unnotified cases dealt with by the private practitioner; we can only deal with the cases notified, and they are almost entirely cases treated at public clinics, at the public hospitals and by specialists in venereal diseases. I still hold to my previous statement that, as far as Victoria and New South Wales are concerned, the ordinary practitioner who treats these cases occasionally does not always notify them.

I do not know definitely how to account for the difference in numbers between men and women treated, except in so far as whereas a man knows that he is infected, and has no chance of not knowing, the majority of women do not know. I think it is an accepted medical fact that only a very small proportion of women infected with gonorrhœa actually develop any complication which will cause them to seek treatment. A little urinary disturbance, the sort of thing which only too many of these women are accustomed to regard as being due to cold, is often the only symptom in such cases.

What form of public enlightenment do the women receive? None, except in so far as that in the public lavatories there are various notices posted up, and these notices, I think, are read by certain people who want to get a little gratuitous excitement perhaps—but not enlightenment. I am sorry I cannot give any more definite information, but really there is no propaganda to reach women.

In reply to Mr. Berry, as to the penalties for not notifying the disease, the penalty for the first misdemeanour is £20, and, for the second, up to £500.

*Dr. Hayward* gave you a résumé of the Act passed in Southern Australia in 1920. The present Acts are in force throughout the whole of the six States of the Commonwealth, and differ only in very minor points. The points which *Dr. Hayward* made, and which I also summarised, are the same in all the States. Up to 1923 I do not think that New Zealand had any legislation, but I understand that the legislation differs in no important particular all over the whole of the Commonwealth.

*Mrs. Somerville* asked if my opinion as regards the inevitability

## SOCIAL HYGIENE

of promiscuous sexual intercourse is held by the majority of people in Australia. This is a difficult question, but I should say, if you rule out the fanatics, it is held by practically everybody.

Dr. Colquhoun asked a question with regard to the cost of treatment. There is a grant from the Commonwealth Government of £15,000 per year, which is given to subsidised hospitals. That is no answer to the question. Nobody knows what it costs so far. Every State-subsidised hospital is obliged to treat venereal cases free, and in the majority of cases the actual amount expended by the clinics is not definitely laid down. I think it is probably more than the 5s. 8d. per treatment mentioned in regard to Scotland.

Dr. Armstrong asks if it is true that only half the patients give their correct name and address. That is just about true of the patients treated at the special clinics, but not of private practitioners' patients. On the other hand, the number of patients who go away without being fully treated is remarkably small. Of those who go away, disappear and do not continue treatment, about one-third to one-half are found to have given the wrong names and addresses. I think that the man who gives the wrong name and address probably means to disappear any way, but, provided they continue treatment, that does not matter. I do not think that in Victoria notification has led to increase of concealment or of the use of quack remedies. However, I can produce no figures to support this belief.

One weak point of our legislation is that it does not cover the transit of the patient from one State to another. A patient who contracts venereal disease in Victoria and is notified in Victoria, can get his treatment and go to New South Wales, and you cannot bring him back to Victoria for treatment nor make him seek it in New South Wales.

## INDIA.

### THE NEED FOR DEFINITE EDUCATION IN VENEREAL DISEASES FOR BOTH MEDICAL PRACTITIONERS AND STUDENTS OF MEDICINE IN INDIA.

By Major A. T. FROST, R.A.M.C.,  
*Late Consultant Dermatologist in India.*

My interest in this subject is my only excuse for making a few remarks on this question. The experience gained of conditions in India is the result of three years as a cantonment medical officer at a large station and three years teaching venereal diseases, diagnosis and treatment while Consultant Dermatologist to the British and Indian Armies in India. During this period post-graduate classes were held at the venereal diseases military centres at Poona and Doolali for medical officers, assistant surgeons and sub-assistant surgeons, and also for lady doctors of the Women's

## IMPERIAL QUESTIONS: INDIA

Major A. T. Frost, R.A.M.C.

Medical Service of India. Discussion with members of the latter service helped me to realise some of the problems which handicap medical work in India.

An essential condition which must be present if propaganda against venereal diseases is to become a success is a medical profession ready to carry out treatment of those diseases on effective up-to-date lines. It is no reflection on the medical profession in India to say that this condition is not present in the country yet. The spread of accurate knowledge of the diagnosis and treatment of venereal diseases dates in all the countries of Europe and elsewhere from the time when the State has taken notice of the diseases as a social and political problem.

The study of venereal disease has become a specialism during recent years, especially syphilis, and we have gained in knowledge by it becoming practically a special branch of medicine, as it has only emerged eighteen years ago out of the obscurity of those diseases due to unknown causative organisms. But now that we are getting to stability in diagnosis and treatment, I believe that the aim of medical teaching should be to make the knowledge of venereal diseases as compulsory as of fevers or heart diseases.

Two interdependent conditions must be brought into being before the teaching of the treatment of venereal diseases in India can become efficient. One is that clinical material must be collected in one or two departments of teaching hospitals in cities with medical schools. The general system of venereal diseases clinics as worked in England could be modified to suit Indian conditions and customs. The *ad hoc* clinic is not suitable for India. It would only affect one class and prevent the more respectable classes from availing themselves of the opportunities of treatment and also restrict the scope of the work intended to spread throughout the country. Even as part of a general hospital the stigma of the name of a venereal clinic should be hidden under the cloak of dermatology and urology more carefully than in this country. Already in a few cities the clinic system has been instituted, but this is only comparatively a drop in the ocean when one remembers that India is a country of over 300 millions of inhabitants, who are probably more heavily infected with these diseases than European states. One such clinic at each of the medical school hospitals would be the nucleus for the spread of information amongst medical practitioners. Here post-graduate courses for teaching the practical essentials of diagnosis and treatment of these diseases could be held at intervals of a few months. The second condition, one which must be faced sooner or later by every country which has awakened to the economic importance of venereal diseases, is the adding of the study of venereal diseases as a compulsory subject to the medical curriculum. Before this can become a practical proposition the clinic must be in working order with an assured attendance, otherwise the teaching cannot be systematised and adequate value for the increased expense will not be forthcoming.

Officers of the Indian Medical Service in civil employ, members

## SOCIAL HYGIENE

of the Women's Medical Service and private practitioners have given me some idea of the high incidence of both syphilis and gonorrhœa in India and the urgent need of medical attention and of trained medical practitioners to deal with them. Under the conditions just mentioned no great headway can be expected until the teaching hospitals are empowered to arrange for clinics. When they are in existence the first need, and one which would give the earliest results, is the post-graduate course.

Owing to the difficulties of medical men being away from their districts for long, a short intensive course of fourteen days would bear fruit, more than commensurate with the cost of the course. Those who have been engaged in teaching the practical diagnosis and treatment of venereal diseases will bear me out when I say that, once it is stimulated, the interest taken in this subject is rarely lost. This is just as true in India as in England.

I have not touched on the financial side of this question, on which it all depends. I only wish to emphasise that the Indian medical profession must have some system of education in up-to-date methods of both diagnosis and treatment before propaganda against venereal diseases can accomplish anything.

A good workman sees that his tools are sharp, which is a corollary to the principle that, in venereal diseases, the most efficient form of prevention is treatment.

### INDIAN EXPERIENCES.

By Dr. MARGARET BALFOUR, *the Countess of Dufferin's Fund Council.*

AFTER over thirty years' experience of medical work in India there were three facts that impress themselves on me:—

- (1) The prevalence of venereal diseases among all classes of women in India;
- (2) The great lack of knowledge among the people of the serious and far-reaching consequences of these diseases;
- (3) The lack of what one might call the moral sense about them.

At home, when a medical student, one had to be very careful how one even hinted that a person might be suffering from venereal disease, and had to use all sorts of round-about words in referring to it. In India one found this was not necessary.

My attention was seriously drawn to the state of affairs about 1918 when a lady came up to Simla to try and arouse the sympathy of the Government officials with regard to the Cantonments Act. Several meetings of persons interested were held, and I think what impressed me most was the very fragmentary and chaotic state of our knowledge of these matters. Everybody was agreed that the first thing to do was to form an All-India League for Social Purity or Prevention of Venereal Diseases, but, after a good deal of talking, the matter ended—as I believe it had done before—because no one could be found to organise it. At that time I was the secretary

## IMPERIAL QUESTIONS : INDIA

*Dr. Margaret Balfour.*

of the Dufferin Fund, and I was able to secure the services of one of the members of the women's medical service to make an inquiry into the whole question of venereal disease among the women of India. It was only an elementary sort of an inquiry, but a Report was written which contained a great deal of confidential matter and which was printed for private circulation. From this it was found that the opinions of a great many representative medical men and women in India agree with what I had always felt, that there is an immense amount of venereal disease among the women and that this is responsible for many of the gynæcological diseases which fill the women's hospitals; also for a great deal of the very high infant mortality and for any amount of the miscarriages and stillbirths which occur. We also found that practically nothing was being done in the way of modern treatment. For one thing, many of the doctors did not know the recent methods and the cost of appliances was so great that the hospitals could not meet the expense.

The next thing we did was to make an application to the Government of India for a grant in aid to enable us to get up post-graduate courses for medical women. We also asked that the women who attended these courses should get drugs and appliances at cheap rates from the Government medical stores, and have their pathological examinations done free of charge in Government laboratories, and we asked for some alteration in the returns from Government hospitals to enable us to get more light on the subject. The Government of India agreed to all these proposals and in 1919 gave a grant of 24,000 rupees—about £1,600—which has been used during the last four years in organising post-graduate instruction for medical women at Poonah, and Doolali in the Central Dermatological Laboratory. We also had courses of instruction for women assistant surgeons at Madras, Agra and Calcutta. I am sorry to say that this grant is now exhausted, and we have been told that it is no use applying for more money, because, under the new reformed Government, medicine and public health are transferred subjects which must be dealt with by the provincial Governments and not by the Government of India.

A large number of medical women have attended these post-graduate courses, and I have had the opportunity of discussion with a good many of them. These have mostly informed me that the courses were excellent and of great professional value, but their usefulness was to some extent discounted owing to the fact that it is very difficult to get Indian women to attend for any length of time for treatment. They attended for a few days or a few weeks, but as soon as benefit began to appear, they would leave off before they were nearly properly cured. I have heard the same thing said by many Indian private practitioners, and I believe that in this way a great deal of money is being wasted.

Well, in this way we come back to the second point I mentioned, and that is the great ignorance throughout India among both men and women of the serious consequences of these diseases, and that

## SOCIAL HYGIENE

is where I think we have to begin by an energetic and far-reaching course of propaganda. I think this is the first step without which nothing can be hoped for. I believe there is a possibility of a Commission going out from this country to deal with the question, and, if that is so, I think it would be of the greatest possible use as regards the more educated members of the community. We want propaganda among Government officials, among the members of the Legislative Assembly, the Legislative Councils and the Municipal Committees, the University students, the medical profession—in fact, all the educated classes.

As regards the illiterate population, who, of course, in India are far the greater part, I think what is needed is an All-India League, perhaps affiliated to some league in this country, which would have branches in all the different provinces and would prepare literature, magic lantern slides, etc. which would be available for the provincial and local committees. Such a League would endeavour to press the work in every possible way, not so much, I think, by great expenditure or by forming new organisations, but by trying to interest the existing organisations and the existing workers—of whom there are many. There are, of course, many health officers, assistant surgeons, health visitors, nurses, midwives, and teachers of all kinds in India who are thoroughly agreed as to the necessity for checking venereal diseases and who would gladly take some share in the campaign if they knew exactly what to do. It seems to me that propaganda is not so much a question of expenditure and is not so difficult to carry out, but it requires organisation and energy, and I think this is the first thing to tackle. That is we must alter the present state of public opinion in India and we must advertise widely the need for sympathetic action in the present state of affairs.

## VENEREAL DISEASE AMONG THE CIVIL POPULATION OF SOUTHERN INDIA.

By COLONEL F. ELWES, *I.M.S., Government of Madras.*

As one of the delegates from the Government of Madras, I wish to express the thanks of my Government for the invitation to attend this meeting and also to express their wish for the success of the Conference.

I notice that on the programme I am put down as reading a report from the Government of Madras. This is not quite correct. It was only immediately before the opening of the Conference that I received a cable asking me to represent the Madras Government, and it was only last night that I heard I was to address the Conference. I have therefore had no access whatever to official records.

Also I notice that in the paper by Sir Gerald Giffard, which is to follow, he has dealt with the position of venereal diseases in the civil population and the position of the Government in relation to it in Southern India, and therefore, instead of attempting



## IMPERIAL QUESTIONS: INDIA

*Colonel F. Elwes, I.M.S.*

to give any sort of report, I merely wish to say a few words in connection with this disease among the civil population of Southern India.

The first question to consider is whether or not venereal diseases are very prevalent in the civil population of India. You have just heard expressed the opinions of Dr. Balfour and Major Frost that it is very prevalent. Sir Gerald Giffard states in his paper, from his vast experience, that he believes the incidence is from 20 to 25 per cent. This seems to me very low, as I have heard other estimates which vary between the extremely high figures of 60 per cent. to 80 per cent. Now I do not believe there are any reliable figures whatever, but, more or less by accident, I happened to obtain some figures in connection with other work which at all events indicates a high percentage of syphilis amongst all sections of the community. Last year I was doing some work with a view to proving the adequacy or otherwise in Kalu Azar of a certain blood test which gives a closely allied though not identical reaction in syphilitic subjects. Therefore, to obviate any error, I sent the blood of each of these cases—numbering in all 100—to be examined. Not any one of them showed any discernible signs of active syphilis, yet not less than 13 per cent. showed a marked positive Wassermann reaction. In addition to this, there is local evidence to be gained from the fact that the indigenous practitioners of India in the majority of their prescriptions include some form or other of mercury, and they are well aware of the fact that mercury has a marked effect upon syphilis. With all due deference to Sir Gerald Giffard, who has had vast experience in this matter, I am inclined to think that his estimate is considerably below the mark. Especially as, in an experience of over twenty years, though I have seen a very considerable amount of syphilis, I think gonorrhœa is far more common.

It must be allowed, therefore, that with a population of 350 millions in India the necessity for venereal disease work is both very urgent and difficult. The chief difficulties in the way of a venereal disease campaign can, to my mind, be summarised under three headings:—

(1) The mental attitude of the people. Dr. Balfour has just explained the mental attitude of the people, and I agree with her in every respect. As a whole, the people of India look upon venereal diseases and prostitution as no sort of moral degradation whatever and, apart from this, they have no fear nor dread of venereal diseases as such; they look upon them as an inconvenience rather than a disease. So remarkable is this that I am frequently asked to give anti-syphilis injections as the person evidently thinks he must have got the disease.

(2) The poverty of the population, the vast distances they have to travel to obtain help, and the difficulties of transport.

(3) The lack of funds. The Government of Madras, just as other Governments in India, have been extremely short of funds

## SOCIAL HYGIENE

in recent years, and when it is remembered that in India, with the exception of a few missionary hospitals, there are no voluntary hospitals at all—the hospitals are maintained by State aid or by local bodies—the serious obstacle which this is in the way of carrying on extensive venereal disease work can be understood.

As regards the position of venereal disease work amongst the civil population in India at the present time, I am afraid it can be summarised by saying that there is little or no work being done at present. Certainly there is no legislation, and, to my knowledge, very little or no propaganda. There did exist a voluntary Venereal Disease Hospital in Madras, but that was closed some years ago as it was recognised as being by no means efficient and it was probably a source of spread of the disease as those who resorted to it were able to leave it at any time. Subsequently to that, venereal departments have been attached to some of the Government hospitals, but these in themselves are quite inadequate to deal with the subject. Apart from other factors, they are very sparsely supplied with funds and have only small staffs who have additional duties to perform, and therefore these departments are only able to remain open for a short number of hours each day, and consequently cannot be very successful in dealing with the problem.

Having allowed as established facts that there is a considerable amount of the disease in the country and that the difficulties to be overcome are great, one must consider what are the means to be adopted to deal with the matter. It seems to me that, as Dr. Balfour has already told you, the only method at present of commencing to deal with this subject is by education, and by education I mean two forms of education, primarily the education of the medical practitioners on the subject of venereal diseases and their treatment, and secondly the education of the more enlightened classes of Indians with regard to the seriousness of venereal diseases and their consequences. I thoroughly endorse what Major Frost said about the compulsory study of venereal diseases by medical students, but I do not endorse his statement that it is necessary to cloak the venereal disease departments under another name, for one of the astonishing things is the attitude of the people of India towards these diseases; the majority of the people in India have no shame about them, and their attitude to them in Madras is not one which leads me to think that concealment is necessary. Every year the Medical College in Madras turns out from 60 to 80 students who obtain University degrees in medicine and surgery, and in addition to this there are some 120 to 150 additional students who undergo a four years' course of training, and at the end of their training, if they pass their examinations satisfactorily, are granted by the Government a diploma which qualifies them to practise medicine and surgery in India. These conditions, or very similar ones, exist in all the University towns of India, and, with the clinical material available at these centres, aided by the use of such excellent films as were shown by Col. Harrison yesterday, if a venereal disease course was made

## IMPERIAL QUESTIONS: INDIA

*Major-General Sir Gerald Giffard, K.C.I.E., C.S.I., K.H.S., I.M.S.*

compulsory I am sure a great deal could be done to teach the future medical practitioners of India the necessity for interest in this subject. In addition, post-graduate courses are now held at medical colleges, and it would be very easy to include a satisfactory course in venereal diseases for the existing medical practitioners. It seems to me that to begin with this is the only way of dealing with the subject. We should then have a body of men and women scattered throughout India well qualified to deal with these diseases. But apart from this they would be useful in other ways—they would tend to educate in their districts the Indians and to open their eyes as to the effects and seriousness of venereal diseases in India. In fact, one of the great obstacles is the attitude and present outlook in India, and I think such a body of men would exercise great influence in the future by educating the masses in this way, and only by so doing can we hope to deal with the subject in India.

One other point. In Madras at all events there has recently been formed an Association of Social Service Workers, and it is quite possible that propaganda amongst these Social Service Workers might enable them to do something to deal with the problem.

I do not think at the present time much more can be done in India, at all events, to deal with this problem.

### THE POSITION OF MEDICAL AFFAIRS IN THE GOVERNMENT OF MADRAS.

By Major-General SIR GERALD GIFFARD, K.C.I.E., C.S.I.,  
K.H.S., I.M.S. (Retd.)

HAVING been asked to write a short paper on my experiences of V.D. in the Madras Presidency and the position of medical affairs in the Government of Madras I begin by stating that my remarks refer only to the civil population.

Writing as I do without access to reports and State documents I feel that I can only say that venereal diseases are very widely spread throughout all ranks, castes, and classes of the population of Southern India, which I believe does not differ in this way from other parts of India. Speaking without access to statistics and only from my experience I estimate that some 20 to 25 per cent. of the adult population is suffering or has during some part of their lives, suffered from some form of V.D. I have served on the staff of a 500 bed general hospital for fourteen years and was surgeon superintendent of a maternity and gynaecological hospital (200 beds) for ten years. I have also had an extensive private practice amongst the more well-to-do members of the population, mostly the women. The two late superintendents of the Madras Ophthalmic Hospital have both informed me that they consider that 70 per cent. of the blindness in Madras is due to venereal diseases. I know from long experience that chronic salpyngitis

## SOCIAL HYGIENE

is by far the most common cause of laparotomy in women in South India. I also know that the great majority of the cases of abortion and foetal death are due to syphilis.

Thousands of respectable and married women come to hospital every year suffering from erosion of the cervix and endometritis nearly always due to gonorrhoea. The museum of the Madras Medical College has a very fine collection of specimens of V.D. There can be no doubt that the venereal diseases are very prevalent throughout South India. Facilities for treatment exist in a scattered, and not very efficient, way throughout the Madras Presidency.

For many years a 100 bed hospital named the "Voluntary Venereal Hospital" was maintained by Government for the prostitutes of Madras, but this was closed about seven years ago and the cases are now treated at the Government General Hospital and at the Government Maternity Hospital, and to some extent at the two other large general hospitals in that city. A special V.D. department, with a few beds, has been started at the Government General Hospital, but everyone recognises that it is inadequate and might be greatly improved if funds were available. There are Government Headquarter hospitals in each of the twenty-five districts of the Presidency where venereal diseases are treated, but there are no special facilities for early diagnosis and treatment either at the Port of Madras or at any of the ports of the Madras Presidency.

When I left India in May, 1923, there was no national anti-V.D. organisation, nor was there any special V.D. educational propaganda. The Government have been for the past few years very short of money; forced economy and financial stringency have been very prominent and the Government have turned their attention, very naturally, to the enormous problem of combating diseases that produce a more obvious mortality such as cholera, plague, malaria, tuberculosis and hookworm.

All medical men and women, whether Government servants, private practitioners or medical missionaries recognise the serious ravages of V.D., but their time, energy and funds, at present, are insufficient for an anti-V.D. campaign on a grand scale such as is being done in India for hookworm by the Rockefeller grants.

The originators and draftsmen of the Government of India Act considered Medicine and Sanitation to be fit subjects for popular control in India. These subjects form therefore, at the present day, part of the portfolio of a popularly elected *Minister* in each of the Provincial Governments in India. The Government of India (Imperial, i.e. Federal Government) still retain an I.M.S. officer as Director of Public Health but Medicine and Sanitation are not controlled by the Imperial Government except in matters connected with foreign Governments, ports, quarantine and such affairs: the ordinary medical and health affairs of each province being entirely the business of each Provincial Minister who holds the portfolio.

## IMPERIAL QUESTIONS: INDIA

*Major-General Sir Gerald Giffard, K.C.I.E., C.S.I., K.H.S., I.M.S.*

Before the passing of the Government of India Act (i.e. the Reforms) the Executive Government of each Province or Presidency was carried on by the Governor and two senior officers of the I.C.S. assisted by one Indian gentleman appointed by H.M. the King. These four men divided up the various portfolios between themselves. They were, in executive matters, practically independent of the Legislative Council and entirely uncontrolled by popular votes. The budget could be passed without the consent of the elected members of the Legislative Council. The present constitution of a Provincial Government is different. There are now four (two I.C.S. and two Indians) Executive Councillors and three Ministers. The Executive Councillors are irremovable and deal with *reserved* subjects. The Ministers are removable and depend on existence in the Legislative Council of a majority party. Medicine and Sanitation are *transferred* subjects, and so their control is subject to the vote of the majority of the Legislative Council and the Minister (this system is so-called Diarchy.) It is, as yet, rather too soon to see the effect on medicine and sanitation of these changes but it is already obvious that it is a more cumbrous system than the old system and that persuasion, propaganda and convincing argument are much more needed at present to stimulate executive action than in the past, when the Professional Head of a Department (the Surgeon-General or Director of Public Health) could translate his ideas into action by the order of the *one* Executive Councillor whilst nowadays, not only must the Minister act but he must feel sure that his action will be accepted by the majority of the Local Legislative Council and the money supplied by this same body.

The responsibility is largely sliding off our shoulders and being taken up by the India Ministers themselves, but I think we may say that this ought not to make it less important that we should take a hand in this business, because the Ministers in India do not at all appreciate the necessity for work in connection with venereal diseases. Previous speakers have told you that the people of India do not realise the prevalence of disease and do not understand the need for doing anything; they must be stirred from their apathetic contentment.

We cannot stress too often the Chairman's statement that a tropical climate, by itself, does practically no harm to Europeans, except after many generations of the people who live in it. All the diseases in the tropics, of which we are so afraid and which produce such a large mortality, are preventable diseases. Then why not prevent them? It will take a lot of time and money, but it can be done. As I said before, it cannot be done by compulsion, but must be done by education. Our experience of plague and cholera work makes this plain. In old days, before the medical profession knew much about plague, attempts were made, and seriously made, to try and stamp out plague by compulsion. The result was a complete failure. What we want is slow, quiet and continuous education.

## SOCIAL HYGIENE

The position seems almost hopeless; the diseases are so widespread, the distances so immense, and the people do not appreciate the need for any action. Also there is the rapidly diminishing number of Europeans in the medical services, and the women of the country are highly infected and resigned to it. Can anything be done? Well, in India one is inclined to become hopelessly pessimistic, but that is the wrong spirit, because we have managed to do, quite lately, some very important things in India which before looked hopeless.

First of all, women's education has begun to come along wonderfully during the past fifteen years. Now, in Southern India you cannot provide colleges quickly enough—women's education is going like hot cakes, and if there was money enough I believe you could have twenty times the amount of women's education that you have at present.

The next single experience which I would recount to you, in order to do away with pessimism, is that we used to take no notice of hookworm. The Americans have taken a great interest in hookworm, and they said to us, "Do you think your population has got hookworm—would you like to look into it?" So two men came from the Rockefeller Institute. The first man who came began, quite rightly, searching to find out, and got astonishing results—he found an infection of approximately 79 to 80 per cent. of the population. He very soon got the people themselves to recognise the need for trained assistance, and I believe that if the people of Southern India were educated as to venereal disease they would shout for help in the same way that the people suffering from hookworm are beginning to do. When they do that they will press their rights in the Legislative Assembly which will pass the money that will enable much good to be done in the next few years. Although the problem is large and seems hopeless, I am far from being one who believes it hopeless, and I hope the National Council will be able to help us as soon as possible.

*Mrs. Neville-Rolfe:* With regard to the National Council's negotiations with the Government of India and with the Provincial and State Governments of India, the position of affairs at the present moment is that an official letter has been sent out with the knowledge of the Government of India, in fact to the Government of India, for them to transmit to the Provincial and State Governments asking them if they would welcome the visit of a Commission such as was sent out to the Far East, the West Indies, and the Mediterranean under the ægis of the Colonial Office when our Chairman held office there, to confer with the Government and municipal and social organisations in the various Provinces and States in India, with a view to stimulating public opinion on this subject on the lines we have been advised to-day would be useful. The present High Commissioner, Sir Dadiba Dalal, who is interested in this question, is also doing what he can to raise funds to finance this suggested Commission from certain voluntary charitable sources in India. The financial

## IMPERIAL QUESTIONS : SOUTH AFRICA

*Mr. A. Reid, M.A.*

question is one which will probably adjust itself. One thing is quite clear—we are not going unless we are invited, we are not going to force ourselves on the authorities, as such work is much more effective if those visited wish to be visited. We hope those representatives here from India to-day will do what they can to stimulate the issue of such invitations. We have already received two invitations : one from Bombay, and a long-standing invitation from the State of Baroda. We hope Madras will follow, also Bengal. I had a very cordial letter from the Governor there quite recently, and when it is realised that we are not trying to do anything by force, that all we want to do is to take out to them such information and experience as we have been able to gain on the subject of the enlightenment of public opinion in other parts of the Empire, then I think the invitations will be forthcoming.

### SOUTH AFRICA.

#### SOCIAL HYGIENE IN NATAL.

By MR. A. REID, M.A. (*Government Training College and Natal University College*).

I feel that in the absence of Dr. Dunston I can do nothing to take his place. Besides, the problem under discussion is one which would be better treated by a medical man than by myself, and especially by one such as Dr. Dunston, who is conversant with all its aspects in the Union of South Africa. I can speak of Natal only, a comparatively small province, and from the point of view of one employed in the education service.

The need for a social hygiene propaganda in Natal is, of course, exceedingly great, and so far little of value has been done. I will try, therefore, to confine my remarks to the outlook of one whose interests are purely educational and in no sense administrative or medical.

We have in Natal a complexity of communities. In the first place there is the European population associated with a great native population, Indian coolies—particularly on the coast—and a concourse of coloured people of mixed descent. Now, all these communities are in very great need of enlightenment, and how that enlightenment to be of value is to be secured is difficult to say. The Europeans themselves, as in Great Britain, present a difficult problem for solution, and there is no doubt that much venereal disease amongst them is due to close proximity to native and coloured communities. How propaganda work is to be effective seems to be the problem. Undoubtedly education will do more than it has done in the past. The Education Department has provided facilities for all teachers in training being taught the elements of sex hygiene under the best conditions available, but

## SOCIAL HYGIENE

there is the rank and file of the community seeking guidance. Nevertheless, the parents at least of that community need enlightenment, and also some conviction of the need of enlightening their children in turn. There is need also for the parents to know something about the psychology of the adolescent, since at present most have nothing more to guide them than their own past experience which is a dangerous thing from which to generalise to young people. If the parent cannot bring himself to teach his children he should encourage them to seek enlightenment through suitable literature, or other means. The white population at the present moment is not in close enough touch with the medical services of the Colony, and something should be done to enlighten all as to the extent of the prevalence of venereal disease, and secondly, something needs to be taught of its nature, for without knowledge little can be done to get a real grasp of the situation. Another point on which enlightenment is needed is the nature of the possibilities by which venereal diseases can be transmitted to the innocent. Much could be done by securing the co-operation of the medical officers of health in the various provinces, and particularly of the medical inspector of school children and his staff. It seems to me that the breach between the medical and educational services is a great obstacle in the way of successful propaganda.

But the greatest problem of all is the prevention and check of venereal diseases amongst the natives. That such disease is very prevalent is well known. No statistics can be got, and it would be very difficult to procure any statistics of value on account of the peculiar way in which the natives live. But there is a great deal of illicit intercourse between the ignorant and degraded European and the native women. These natives drift into the cities and drift out again, so that venereal diseases spread apace.

Another very discouraging circumstance is that the native races have no moral standard equivalent to that of Europeans. A native does not think it a disgrace to be contaminated with venereal disease, and in the industrial districts of cities the same idea is prevalent amongst many Europeans themselves. They are apt to regard such disease more as a matter for jest than for serious consideration.

Still, there is hope. It is curious that the native in his desire for knowledge and uplift, is seeking a European standard of education. An effort has been made to provide the native with an education which will meet his peculiar needs, but he does not wish this exclusively because he is afraid of being always a native with a native standard of education and not a native with a European standard of education. The demand is for a type of education the same as that provided for Europeans, and herein lies some hope for action.

I have been associated with Dr. Loram, late Chief Inspector of Native Education in Natal, and now a member of the Native Commission for the Union of South Africa. Dr. Loram would like to see introduced, in connection with the treatment of invalid



## IMPERIAL QUESTIONS: SOUTH AFRICA

*Mrs. Neville-Rolfe.*

natives, not only European but native nurses, specially trained for work amongst their own people. It is almost hopeless for European doctors and nurses to manage natives, because they have peculiar superstitions which they seldom divulge, you can never really get at the back of the black man's mind. But native nurses might do much to lessen this difficulty.

The Indian community is one which keeps strongly to itself. I am sure there is very little inter-communication sexually between European and Indian, but that venereal diseases are prevalent amongst them is only too well known. They live a very low type of life, even when earning good wages.

Then again, there is the coloured population which is a great lure to the irregular European, coloured women are often handsome and prepossessing, and this is not a helpful factor in any sense. Again, they live more on the standard of European civilisation, and so become more closely associated with Europeans and many Europeans marry coloured wives. Now I have said all I need say. May I summarise my ideas?

I think hope for the future lies through education, biology in the elementary schools, enlightenment of the adolescent as to the mystery of sex, knowledge of the prevalence of venereal diseases, and of the menace these diseases present to the innocent. Then again, propaganda work should be carried on in the evening schools, through various bodies such as the Y.M.C.A., church societies, and so on. But when all this is done, there is a residue of the population which cannot be reached by any easy means, and this residue includes those most in need of enlightenment and uplift. I regret I cannot say more and I am exceedingly sorry that Dr. Dunston is not here to enlighten you further and with some authority upon the situation in South Africa.

*Mrs. Neville-Rolfe:* As Mrs. Shennan is not here might I make a few supplementary remarks on what is being done from our point of view in South Africa?

There is a Union of South Africa Council for Combating Venereal Diseases. It has hardly penetrated as far as Natal, but has a branch in Cape Town and a branch in the Transvaal. There are free treatment facilities in Cape Town and they have been increased recently to meet the needs of the Mercantile Marine in the port. Also the educational films of the Council have been sent out to the South African Council for use in an educational campaign which has the financial support of the Government. The Councils of South Africa, the Cape Town and Transvaal Councils are on the same footing as our own Council here, in that their educational programmes are approved and subsidised by the respective Governments.

## SOCIAL HYGIENE

### EAST AFRICA.

#### V.D. WORK IN THE COLONY AND PROTECTORATE OF KENYA.

By Dr. A. L. PATERSON, *Chief Sanitation Officer.*

I WAS asked to attend this Conference by the Principal Medical Officer of the Colony and Protectorate of Kenya firstly and chiefly in order that we might obtain information with regard to the methods which are being adopted to advance and improve conditions both at home and in the Dominions and Crown Colonies, and secondly that I might put before you, should you desire it, such information as I can with regard to conditions in our own Colony and with regard to what is being done there.

I note from to-day's programme that the Overseas members of the Conference are asked to speak on "existing conditions." I am not sure what exactly that may mean, whether you desire to be informed as to the extent to which propaganda is being carried out, or should be carried out, as to details of the curative services provided, or as to the incidence of venereal disease in Kenya, but if I may, I should like shortly to review certain conditions which pertain in Kenya and appear to govern the incidence of venereal disease which should not be lost sight of, if the real import of these diseases among the natives of that part of Africa is to be recognised and their incidence ultimately diminished.

First of all with regard to the present incidence: The Colony and Protectorate of Kenya—formerly the East Africa Protectorate—has an area of about 240,000 square miles, and a native population of about 2½ millions. It is to the native population alone that I shall refer. Roughly this population may be divided into two classes for the purposes of the present discussion, a large and comparatively unsophisticated rural class in which the basis of organisation is still the tribe and a much smaller urban class. The urban class can again be divided. In the coast towns the population is to some extent literate and has for many years been accustomed to urban conditions, while in the up-country towns the population is composed for the most part of Africans who have but recently come in from the Native Reserves. In the coast towns the incidence of venereal disease is, I think, considerable, and it is probable that the presence of the disease there is no new thing. In the up-country towns the incidence is probably much less though even here it could not be said that venereal disease is uncommon.

Of the rural populations of the large and extensive Native Reserves from which the populations of both the up-country and the coastal towns are now recruited fortunately another story can be told. The incidence of the venereal diseases in these Reserves is for the most part small, in some cases it may be said that to all intents these diseases are even yet unknown, and in support of this contention reliable figures can be advanced. It is true that in the earlier medical reports of the Colony statements are quoted to the effect that syphilis was then spreading rapidly; there is no evidence in support of these statements, such evidence as we have is to the

## IMPERIAL QUESTIONS: EAST AFRICA

*Dr. A. L. Paterson.*

contrary effect. About two years ago a medical survey was made in one of the Native Reserves near the Victoria Nyanza when some eight thousand Kavirondo natives were carefully examined by a medical officer as to their physical condition. Only 1 per cent. of the number examined showed any evidence of syphilitic infection. This survey is of particular interest in that it was made among the members of a tribe which provides a very large amount of the labour employed in towns, on larger works, and in the European farming districts. That there has been some spread of the venereal diseases is undoubtedly true and it is practically certain that such a spread is going on to-day—the venereal diseases are continually being carried back into the Reserves by natives returning from the towns—but that the alarming reports of the earlier years of the century are incorrect is fortunately still the case.

Now with regard to the attitude of the people towards the venereal diseases: in the towns and particularly in the coast towns their attitude is undoubtedly one of apathy; in the Reserves on the other hand, at least in the large and important Kavirondo Reserves the presence of these diseases is regarded—certainly by some of the chiefs—with alarm, while the attitude of the people themselves towards an infected person is by no means always apathetic. Now why is the attitude adopted in the towns different from that taken in the Reserves? The answer would appear to be that in the Reserves children are still of importance, economically they are an asset, not a liability—and as it is not so long ago since it was of the utmost importance that the tribe should be numerically strong the social sense has not yet weakened; the foundation of the organisation of the tribe is still the family, for a woman to be childless is little short of disgrace, and the venereal diseases inasmuch as they are recognised as interfering with the production of children are looked on as unsocial.

In the old coast towns on the other hand the cost of living has of late years increased, the education, clothing and feeding of children has become a serious matter, economically the child is undoubtedly a liability, while there is also the fact that the size of the community has ceased to be recognised as a matter of practical importance or interest, and the social sense for the production and preservation of children has therefore weakened. In consequence diseases which interfere with procreation are no longer on that account regarded as unsocial or of importance.

In the up-country towns the case is slightly different. There children would still be valued and are desired, but the difficulties in the way of family life are considerable since, as is apt to be the case in pioneering towns, the supply of suitable housing is inadequate and the new inhabitant though anxious to marry and settle down has little opportunity to do so: he is not on his arrival sufficiently a capitalist to build himself a house under urban conditions, and he has therefore to content himself with living as a lodger in the house of some longer established inhabitant. Sooner or later he may become infected, and if he returns to his Reserve he will tend to spread the infection among his tribe.

## SOCIAL HYGIENE

Now with regard to prevention what are we doing? Of *ad hoc* propaganda there is practically none. In the towns where for the reasons specified above venereal disease is not regarded as unsocial, where little importance is attached to it and where the diseases themselves give rise apparently to but little physical discomfort, *ad hoc* propaganda would at the present time be of little or no service. In the Reserves where the venereal diseases are as yet unknown propaganda is obviously not required, while in those Reserves where the diseases are incident to some degree their import is already recognised by the people, and though many of the old tribal customs are such as to render the presence of such diseases especially dangerous, these customs are not such as can be readily altered, or such as should lightly be interfered with, before by careful investigation we have assured ourselves that their alteration or abrogation will not be accompanied by untoward as well as by beneficial results. In these Reserves as in the towns, of much greater importance than propaganda is the provision of adequate facilities for treatment, and the establishment of such confidence in European methods as will ensure that the fullest advantage is taken of them.

At present throughout Kenya free treatment is provided wherever an officer of the medical department is stationed and, thanks largely to the great success which has attended the treatment of another—but not venereal—disease, the disease known as yaws, by intramuscular injections of novarsenobillon and latterly of a preparation of bismuth, a very considerable amount of confidence has been established, and this confidence has been reflected in the increased number of patients who are attending also for the treatment of syphilis and gonorrhœa. As is usual, of course in the case of uneducated folk there is great difficulty in securing attendance after the more distressing symptoms of these diseases have disappeared, and particularly is this the case with regard to gonorrhœa. Nevertheless it is probable that an increasingly large proportion of patients is at least being rendered less actively infective than was previously the case. While speaking of propaganda and treatment mention must also be made of the exceedingly useful work which is being done in Mombasa and Nairobi by the two trained European nursing sisters who are attached to the Health Offices in these towns in the capacity of health visitors. This work is still in its infancy with us, but the ladies engaged on it have already been instrumental in bringing forward women who would not otherwise have received treatment, while as an educational factor their influence in quarters not readily open to such influence in tropical towns has been very considerable.

But even if every infected native in Kenya could be persuaded to undergo a full course of treatment, and supposing we could make adequate arrangements at every point in the Colony for providing that treatment and we were doing nothing more, then, though a most useful work would have been done, the case of social hygiene would not have been very greatly advanced and the vital significance of the present incidence of these diseases

## IMPERIAL QUESTIONS: EAST AFRICA

*Dr. A. L. Paterson.*

and of the attitude of the people towards them could hardly have been fully recognised. It is the fact that by the town dwellers these diseases are not felt to be unsocial that is of importance, and it is to the alteration of the conditions which have brought about this attitude in a folk who elsewhere looked on these diseases as unsocial that our energies should be directed. Insanitary, unhygienic and unsocial conditions must be removed or altered, and of primary importance is the provision of such housing accommodation as will make family life more easy of achievement. This necessity for improved housing is very fully recognised in Kenya, not only by the Medical Department but by the public, by the Municipal Council of Nairobi and by the Government, and the whole question is at present receiving consideration; a certain amount of actual work has recently been accomplished, and a further scheme of some magnitude is in course of preparation.

Even the provision of good housing, however, is not everything; of equal importance is the provision of facilities for education and for economic development, so that an alteration may be brought about in the outlook on life of the African who has come to dwell under urban conditions. In the old days the social sense was to a large extent preserved by the necessity for numerical strength as a protection in inter-tribal war. Team work was understood. That interest has now gone, and it must be replaced. The African must be educated to a sense of the worthiness of things other than war and to a fuller appreciation of the possibilities of life, and to take sufficient pride in his work to desire to see it carried on by his children. That, I think, is the whole question. At present we are providing treatment wherever we can, and we shall go on doing so; but of more importance is the improvement of social and sanitary conditions. For that, however, funds are required, and again we come back to economic development and the education on which such development always depends, and these, as you know, are both matters which are receiving a very great deal of attention in Kenya to-day.

There is only one other point which I should like to mention, a point with regard to the finance of a curative campaign which may be of interest to members of this Conference. It happens that in Kenya we were required to supply treatment on a very large scale for another disease, yaws. It was the existence of this disease which, though not venereal in origin, is in many respects not unlike syphilis which had led to the earlier reports as to a great incidence of the latter disease. Now the arsenical preparations which are used in the treatment of syphilis are equally if not more efficacious in the treatment of yaws, and in 1921 we were spending over £4,000 per annum on their purchase. The treatment became so popular that the natives were ultimately coming in at the rate of several thousand new cases per month, and it was rapidly becoming impossible to finance the campaign. About this time, however, our attention was directed to the possibilities of bismuth. A trial was made and ultimately a satisfactory preparation was

## SOCIAL HYGIENE

produced by the Chemical Research Department of the Colony. From the financial point of view this result was of the greatest importance, the cost per dose of the bismuth preparation being about one-tenth of a penny as against three shillings in the case of the arsenical preparations previously used. That is to say, where £4,000 was previously required for the purchase of drugs less than £15 now sufficed. The latter figure is of course for the purchase of materials only; preparation is not included, but the latter, though it depends on facilities, is not a large item. A large balance became at once available for the increase of staff and the improvement of transport and accommodation. Now not only has the successful treatment of yaws resulted in every sufferer from that disease who can coming up for treatment, but the syphilitics have come as well, and for over a year now we have been relying on bismuth in the treatment of that disease and another economy has been effected. Of course, it will be some time before the exact place of bismuth in the treatment of syphilis and the limitations to its use are as well known as are the place and the limitations of the arsenical preparations. That some success has attended the use of bismuth in syphilis is, however, of interest, while the relative cheapness of the preparation is a point which must deserve consideration wherever cost is of importance and the number of patients in need of treatment is large. I have mentioned this matter because it emphasises somewhat vividly a point which is apt to be lost sight of in curative campaigns—the large amount of money which can be swallowed up in the purchase of drugs and the saving which can sometimes be secured by the substitution of cheaper therapeutic agents. In this case by the mere substitution of bismuth for the arsenicals there was accomplished a saving which more than covered the salaries of two additional medical officers, an entomologist, a sanitary inspector and some clerks, and enabled a great extension of the campaign to be carried into effect.

*The Chairman*: I hope the members of the Conference will excuse me if I leave now, but I am due in another place, and I will ask Mr. Turner to take the Chair.

*Mr. Turner*—Before I attempt to replace your present Chairman I should like you to give him a very hearty vote of thanks for presiding over us and giving up the real working part of a day to this work. When the whole of this subject comes up in the future, among the men who have done much to help in this great fight the name of Mr. Amery will be exceedingly prominent. He was at the Colonial Office when the Commissions from this Council which went round the world were sent out to stimulate the interest in the fight against these diseases. He also sent out more men in the Colonial Service who were skilled in the treatment of venereal diseases and did what he could to increase the Colonial Medical Service in this respect. These things show what a good friend we have in our present Chairman to-day, and we are sure that in whatever condition he may remain—whether as a shadow, as at

## IMPERIAL QUESTIONS: UGANDA

*Dr. J. H. Cook.*

present, or the substance he may become—he will help us in any way he can in this great fight.

I beg to move a very hearty vote of thanks to Mr. Amery.

The vote was put to the meeting and carried with acclamation.

Mr. Amery here left the meeting and Mr. Turner took the Chair.

### UGANDA.

#### ANTI-VENEREAL DISEASE WORK IN UGANDA.

By *Dr. J. H. Cook, Church Missionary Society.*

FOR twenty-one years I have been engaged in active anti-venereal disease work in Uganda, that is from the period 1899 to 1920. I am speaking as the representative and delegate of the Church Missionary Society, and I suppose missionaries approach this subject from a somewhat different angle from the Government, but from a medical point of view the methods are very much the same, and I would like to bear testimony to the very close co-operation that has always existed between the Government and missions in this and in every other matter that concerns the welfare of the people of Uganda.

The Church Missionary Society has four mission hospitals in Uganda, and a fair amount of clinical material on which to base statistics. The largest of these hospitals is at Namirembe (Kampala); it has 232 beds with 3,400 in-patients in the year and 75,000 out-patient attendances. In connection with it are four branch dispensaries in different parts of the country and (in 1924) nineteen infant welfare centres scattered throughout the Provinces which have originated in this hospital.

Since the time when I left Uganda in 1920 I have been in close contact with the work done by the Government and also with the work our men have been accomplishing. When one arrived in Uganda one was struck by the prevalence of venereal disease which was unpleasantly thrust upon one's notice, and we set to work from the first to compile statistics of the attendances of sufferers in an infectious state, and I analysed 30,000 consecutive attendances at our Kampala Mission Hospital Dispensary and 10,000 that attended during the period of nine months when I was at our hospital in Toro (Fort Portal), and in both these places I found exactly the same percentage, namely 22 per cent. of active and infectious venereal disease out of the total number of patients attending. That was a conclusion that made one very seriously reflect. Then, again, one realised that there were parts of the country where the percentage of syphilis was very much higher than it was actually around Kampala or Fort Portal, but it is quite intelligible how one could get such a percentage in the country of Bunyoro or Nkole, because the Bunyoro and Banyankole and the people allied to them have the singularly bad custom that they consider it a mere act of hospitality that any visitor to the house

## SOCIAL HYGIENE

of the Chief should be given one of the Chief's wives for the occasion of his visit.

The next point that came home to one was the ignorant view that obtained as to the origin of venereal diseases. With regard to gonorrhœa, one might say there is not only an attitude of apathy but one of sympathy with that disease. For instance, it was considered a disgrace to any young man in Uganda if he had not suffered from gonorrhœa in his youth. And with regard to syphilis, the ordinary native word for it is "munyo," a word that means "salt," and their explanation is that congenital syphilis is due to the fact that the mother has eaten too much salt!

The third thing brought home to one was the astonishing effect upon the birth-rate, and incidentally upon the death-rate, of the Protectorate by the prevalence of venereal disease. After carefully compiling statistics in our hospitals—and I may say that we have a very large number of maternity cases attending—there were 1,163 admitted last year, and over 18,000 attendances of maternity out-patients from surrounding districts—we found that the chief cause of the infantile mortality was venereal disease. The proportion of infantile deaths reached the astonishing figure of 60 to 70 per cent., according to our calculations. That wants explanation. I do not mean the proportion of infantile deaths per 1,000 of the population, but the proportion of babes that are born dead or die within the first week of life, to the total number of births. Seventy per cent. of the children were either stillborn, or prematurely born and died immediately afterwards, or else failed to attain one week of life. The infant mortality in London is 8 per cent., and that will show that in Uganda for one child that survives two or more die, whereas in England for one child that dies eleven survive.

What was the cause of this tremendous infant mortality? We have seen that the prevalence of venereal disease and the high infant mortality were connected. A second cause was native medicines. I collected fourteen different kinds of native drugs and when the report on these came back from the Government analyst it was found that the majority of them contained alkaloids, and the very high percentage of cases that die in bearing children die simply from the toxic effects of these drugs, or from their oxytoxic effect, as they are given by untrained native women in unmeasured doses—*ante partum!*

The third great cause is the ignorance of the people of how to attend parturient cases.

When things came to this pass I thought it was time to draw the attention of the Government to it, and so wrote a paper drawing their attention to the extraordinary prevalence of venereal disease and the other facts that had come to our notice, and again, as a representative of the Mission, I would like to pay warm testimony to the promptness and efficiency with which the matter dealt with in my paper was investigated. Investigation was followed by the arrival of Colonel Lambkin and a Commission of experts.

What rendered treatment difficult was that we had not then got salvarsan, and the Baganda are extraordinarily susceptible to



## IMPERIAL QUESTIONS : UGANDA

*Dr. J. H. Cook.*

mercury. Major Keane remained on in the country from 1907 to the present time and has built up a magnificent anti-venereal disease work that might make Uganda an object lesson to a good many places.

The next date I will bring before you is July 30th, 1912, when a special Conference was held at Entebbe, at which I had the honour to be present, to consider how, by legislative measures, some influence might be produced upon the widespread diffusion of these diseases. This involved, first of all, compulsory notification, compulsory treatment and, of course, free treatment centres to be established throughout the country. These were well established in two centres before the war. Major Keane issued a report—a copy of which I have here—in which he drew the attention to the widespread existence of these diseases. He corroborated our figures fairly closely and showed that the infant mortality was 500 per thousand of the population, as compared with 80 per thousand in England, and in the Government Blue Book we have the five Provinces of Uganda detailed, and the percentage of still-births to the total births in two of those Provinces is  $33\frac{1}{3}$  per cent. When we add to that the earlier numbers already given of the children that die within the first week of life, we arrive at the figures given before.

With regard to the percentage of infective cases attending the clinics, it is very interesting to read that the same figure I had got in 1900 in Toro of 22 per cent. was also found by the Government investigation. The Government, of course, had access to statistics on a far greater scale than the Mission could attempt, and they showed the birth-rate and death-rate in the different Provinces of the Protectorate, and I think you will be interested to learn that in 1919, in the five different Provinces of the Uganda Protectorate, there were 12,951 more deaths than births in the Protectorate—but there was a very widespread epidemic of influenza during that year. But the amazing fact remains that in 1917-18-19 there were more deaths than births in the Protectorate. That is very, very significant and a sad fact to consider at this Conference. I think since then more recent figures have shown the effect of the more active anti-venereal disease campaign, and once again the population is, I am thankful to say, increasing.

I would like to say a word or two in regard to the remedies that have been attempted. You have heard of the Government measures and of their treatment centres. First, with regard to propaganda, we have in use pamphlets in the vernacular upon infant mortality and upon the causes of these venereal diseases. We have addressed the Native Parliament; we have preached in the churches; we have visited all the schools; we have visited the colleges of the country and in the homes of the people, and have tried in every way to open the eyes of the people to the seriousness of the problem.

Secondly, in 1922 my brother, Dr. A. R. Cook, at the request of the Government, backed up by the synod of the Native Church and by the Local Governing Body of the Mission, made a social hygiene propaganda campaign throughout Uganda, visiting all

## SOCIAL HYGIENE

the different principal centres in the Protectorate; the troops were paraded in the various military camps, the Native Anglican Mission and the Roman Catholics gave free entry into their schools, and there were no less than fifty-four mass meetings held at which considerably over 11,000 people were addressed. Literature had been prepared by my brother in conjunction with the Principal Medical Officer of the Protectorate, and preparations were made for establishing infant welfare centres at the main centres of population, and, as you have heard, there are now nineteen of them.

Thirdly, there is the work of the Maternity Training School, under the superintendence of Mrs. A. R. Cook, at Namirembe [the speaker here showed a diagram of the Training School], where the young women of the country are being trained to attend native confinements and to carry out active anti-venereal disease propaganda in the various States, and where they can obtain a diploma in midwifery which involves equivalent training to that for the C.M.B. certificate in this country. [The speaker here showed diagrams and plans of the infant welfare centres.]

The last word I have to say is with regard to character building, which was alluded to on the first day of our Conference here. It seems to me there has been one aspect of the subject which has been in the background of all our minds, and that is the very great importance of really influencing the country in the best spiritual and moral methods. I believe it is an aphorism that you cannot make a country pure by legislation; it must be made by spiritual and moral methods.

### PROBLEMS IN THE PREVENTION AND TREATMENT OF V.D. IN UGANDA.

By E. A. C. LANGTON, M.R.C.S., L.R.C.P., Capt. R.A.M.C.,  
*Uganda Medical Service.*

I HAVE been asked by the Government of Uganda to give a brief account of the way in which the problem of venereal disease has been dealt with in that country.

Even before 1914, some effort was made to combat the ravages of syphilis, but this obviously had to be dropped during the war. In 1920, Major Keane, R.A.M.C., the present deputy Principal Medical Officer, commenced operations afresh by establishing a centre for the treatment of venereal diseases at Mulago, some two and a half miles from Kampala, the native capital of Buganda, and rapid progress was made. It was at first exceedingly difficult to persuade the people to come in for treatment, and every opportunity was taken of addressing meetings of Chiefs on the subject. As the population of the country was rapidly decreasing, largely owing to the prevalence of syphilis among their people, many of the better educated Chiefs were enthusiastically in favour of the movement, and gave great assistance in the matter of persuading their people to attend for treatment. I joined the staff at Mulago

## IMPERIAL QUESTIONS: UGANDA

*E. A. C. Langton, M.R.C.S., L.R.C.P., Capt. R.A.M.C.*

in February, 1922, and at that time there were four male and two female wards, capable of accommodating 150 in-patients, in addition to a large well-equipped out-patient department. The European staff consisted of four medical officers and one nursing sister. At the beginning of that year the attendances averaged daily about 200, and the proportion of males to females was about 4 to 1. These numbers grew rapidly during 1922, and by the end of the year the daily attendance was over 300. During this year, also, four subsidiary centres in charge of natives trained at Mulago were opened at distances varying from fifteen to twenty miles from Kampala. These centres were visited by the European staff as frequently as possible.

For some six months of 1922 I was in charge of the women's and children's department, and the attendance which at the beginning of the year was under 50 daily, increased to about 100. I am informed by Miss Stringer, who was in charge of this department during the whole of 1923 and up to the middle of March, 1924, that the attendance is now about 130 daily. Every endeavour has been made to encourage women to come for ante-natal treatment, which is now very popular. The results have been very satisfactory. The attendance in the male department has increased in approximately the same proportion. These results were obtained by sympathetic treatment of patients, and by losing no opportunity of addressing meetings of Chiefs.

At the present day there is accommodation for over 200 in-patients at Mulago, and it is estimated that during 1924 the number of attendances at this and the subsidiary centres—which now number six—will reach 500,000.

In the case of syphilis, the objectives of treatment must clearly be one of the following:—

1. Complete cure.
2. Rendering the patient incapable of infecting his offspring.
3. Rendering the patient non-contagious to his associates.
4. Removing signs and symptoms of the disease.

For many reasons, No. 3—rendering the patient non-contagious—is the one on which we are compelled to concentrate. Complete cure is almost out of the question. It is exceedingly difficult—if not impossible—to persuade a native that two years' treatment is required. The possibility of No. 2—rendering him incapable of infecting his offspring—is, however, not lost sight of. Unfortunately, the only point that the native takes any interest in is the removal of signs and symptoms of the disease.

The work I have hitherto described is confined to Kampala and the population round it, and, while unquestionably much has been done there, it is obvious that only the fringe of the question has been touched until the other three provinces have been dealt with. With this in view, in June, 1923, a medical officer and staff from Mulago, opened up at Hoima in Bunyoro, some 120 miles north of Kampala, where I believe excellent progress has been made. I believe I may claim to have been, if not the first,

## SOCIAL HYGIENE

one of the first, to commence operations in the outside districts. In November, 1922, I was posted to Mbarara, the administrative centre of Ankole, 180 miles south-west of Kampala. In this district of about a quarter of a million people no attempt had ever been made to deal with venereal disease, and I quickly found that syphilis was as prevalent in Ankole as in Buganda. With the invaluable assistance of Captain Place, the district commissioner, I commenced systematic venereal treatment in January, 1923. I had the opportunity of addressing a meeting of the principal Chiefs in December, 1922, and they promised loyal co-operation.

I started in a small way—the Banyankole are not noted for their intelligence—but the number of attendances grew with encouraging rapidity, and I soon had a flourishing little V.D. clinic. Here again, I was faced with the problem of reaching the outside districts, which could not be touched from Mbarara itself. Two courses were open to me: to improve existing machinery, or create fresh. The existing machinery consisted of three dispensaries in charge of natives, each some fifty miles from Mbarara. I soon found that two of these natives were not of sufficient intelligence to be quickly trained to carry out systematic V.D. treatment. Of the third, however, I had more hope, and I brought him in to Mbarara for training. In June, I was able to start him in venereal treatment, in addition to general work, at his dispensary. Though his results were not very brilliant, a start had at all events been made.

In May, 1923, I opened a subsidiary centre sixteen miles out of Mbarara, and this had an immediate success. There were, at first, many who attended a few times and then when their symptoms were relieved did not return, but this number gradually diminished during the year. In September, I opened a second centre sixteen miles out, and this was very successful as in the course of a month or two I was dealing with 350 patients. In the absence of a trained boy whom I could leave in charge, these centres were only open once a week each, and the whole treatment was carried out by myself and a native assistant, whom I obtained from Mulago in August.

There are many disadvantages, and few advantages, about this method of opening outside centres which can only deal with patients once a week, and which are worked by the medical officer from the station. The only advantage is that one becomes known in the district, and the people begin to realise the necessity of treatment. The great disadvantage is that it throws too great a strain on the medical officer. It is scarcely necessary to mention that to ride out twenty-two miles in a motor-bicycle and sidecar over an indifferent road, deal with 350 patients, and return to the station in the evening, is no easy day's work. Unquestionably, the better way is to open centres with well-trained native assistants who can be trusted to carry on properly, giving them as much supervision as possible. These assistants should be available in increasing numbers. Given a suitable intelligent boy, these assistants are readily trained, and, provided they are properly supervised, are quite satisfactory. They quickly become exceedingly good at giving intravenous injections. My own boy would

## IMPERIAL QUESTIONS: WEST INDIES

*Dr. J. F. C. Haslam.*

give 300 a day without showing undue fatigue, and, out of the many hundreds he gave, I saw very few bad arms.

Many of these boys are now being given a thorough training at Mulago, and in a short time most districts should have one or more capable of running a V.D. clinic, and I feel convinced that much real benefit to Uganda will result.

### WEST INDIES.

#### THE V.D. PROBLEM IN BRITISH GUIANA.

By Dr. J. F. C. HASLAM, *Government Medical Officer of Health for British Guiana.*

I REGRET that indifferent mail facilities made it impossible for my few remarks to be available in print in advance.

Had such been possible I had no need to explain that what I have to say is rather upon the venereal disease problem in British Guiana than upon any movement for its prevention or restriction.

It cannot truly be said that there is any such movement, although efforts towards its initiation have been made by medical men and many of the well informed lay public are alive to the importance of checking the ravages of venereal disease.

There is in British Guiana no special organisation, no special medical department, and no special medical officer whose particular concern is with venereal disease.

Accurate statistics therefore are lacking, but sufficient evidence is available to show that the small colony I represent is riddled with the diseases we are studying. Local conditions, as I shall show later, are such as to facilitate the wide propagation of these maladies.

Whether or no the gonorrhœa of British Guiana is less virulent than that of other places it is certain that many a case has the early and obvious symptoms cleared up by native remedies or treatment at a "doctor shop," and that degree of education is yet lacking which might prompt thorough early treatment to prevent delayed disaster.

It is very noticeable too that nerve syphilis is uncommon and general paralysis may be said to be rare. Possibly there is more connection between the scarcity of general paralysis of the insane and infection by malaria.

Certainly it is that the lightness with which many British Guiana sufferers from venereal disease regard their maladies is a factor which will hinder any campaign for their eradication.

I have said that local conditions favour the spread of these diseases. Irregular sex relationship is general. Among East Indians the disproportion of the sexes among immigrants for long made marriage almost impossible. This matter is however becoming gradually adjusted.

I am indebted to the careful observations of Dr. Delgado, formerly of the Colony's Medical Service, for the following figures: 75 per

## SOCIAL HYGIENE

cent. of all male medical patients under treatment in the Georgetown Public Hospital for other complaints were found to be suffering from venereal disease.

About 60 per cent. of the policemen attending hospital for other diseases were found to be venereally infected, and over a period of several months all female prisoners in the Georgetown Gaol suffered from one form of venereal disease or another.

The Registrar-General of the Colony gives the deaths directly due to venereal disease as nearly 100 per annum exclusive of deaths due to heart or nerve and other affections which take their origin in venereal disease. The Registrar-General's figures show a small increase of deaths during the decennium 1913-22 :—

	Syphilis.	Other V.D.
1913 .. ..	70	5
1914 .. ..	99	4
1915 .. ..	131	—
1916 .. ..	96	1
1917 .. ..	96	2
1918 .. ..	73	1
1919 .. ..	66	1
1920 .. ..	68	1
1921 .. ..	89	1
1922 .. ..	93	2

The records of cases treated at the public hospitals form no true index of the real incidence, for only a small proportion of cases seek medical aid as is shown by the large numbers under treatment for other complaints who make no mention of their venereal troubles.

Among the young black women there is little, if any, stigma attaching to unmarried motherhood, while the reproach of barrenness is hardly to be borne. Annually the illegitimate births exceed 50 per cent. of the total.

Georgetown, the capital, contains a very large proportion of young women for whom, in the city, there is insufficient employment. As might be expected in a seaport town the number who turn to whole or part time prostitution is considerable. There has come to notice recently a very special danger.

The diamond industry has boomed, and in 1923 over 20,000 men visited the diggings, many of them more than once. All this human traffic, both going and coming, passes through the village of Bartica, when several days are spent awaiting transport. The miners live in primitive dormitories called logies, and in obedience to the laws of supply and demand prostitutes from Georgetown have flocked to Bartica.

An alarming incidence of venereal disease occurred among the miners who on return to their own villages too often acted as distributors of disease from the centre at Bartica.

I understand that special legislation is being undertaken to limit this evil. What then has been done to combat venereal disease in British Guiana? Little indeed I regret and financial stringency,

## IMPERIAL QUESTIONS: WEST AFRICA

*Sir Hugh Clifford, G.C.M.G.*

shortage of medical staff, and no small amount of indifference and prejudice still make progress difficult.

I understand that a Commission from England visited the Colony some years ago, but that from a variety of causes nothing resulted. Recently the local branch of the B.M.A. made representations to the Colonial Government advocating the appointment of a special officer for venereal work. The effort yielded no results.

Modern drugs and appliances have been made available at the public hospital but it is impossible to deal successfully with venereal disease in time spared from other duties or as a sort of side show.

Education, propaganda, organisation and enthusiasm are required before any anti-venereal disease movement in British Guiana can progress. These cannot be given by an already overburdened medical service, nor is the constitution of the population such that either these or the money to make them effective can be expected from that source.

If it can go forth from this Conference that the tackling of venereal disease is of vital colonial importance then a step will have been taken towards the initiation of an effective campaign.

### WEST AFRICA.

#### THE V.D. PROBLEM IN NIGERIA.

By SIR HUGH CLIFFORD, G.C.M.G., *Governor of Nigeria.*

BEFORE I speak on Nigeria I should like to congratulate Dr. Haslam on a very interesting paper of which, unfortunately, I only heard a portion. One point I should like to elaborate for the information of those who have no personal acquaintance with the West Indies. Dr. Haslam told you of the enormous percentage of illegitimate births in British Guiana, placing them at 50 per cent. My recollection of Trinidad, Barbadoes and British Guiana, which, however, dates back to 1907 and is therefore not up to date, would have led me to place the percentage higher than that, but in explanation of it I think you should realise that the opposition to marriage among the negro population of the West Indies almost invariably comes from the woman. So long as there is no binding and lasting tie the woman can feel moderately certain that the man with whom she has thrown in her lot will do his fair share of the common work of the household. The day that marriage takes place the husband believes himself to be emancipated from those obligations. Missionaries in different parts of the West Indies have frequently discussed the situation with me and have explained the extraordinary difficulty which they feel in persuading the woman to accept marriage when they know that the penalty attached to it is practical slavery. As long as there is no such binding tie the woman feels herself in a position of considerable independence, and I think it only right that you should appreciate the real reason for the high percentage of illegitimacy

## SOCIAL HYGIENE

in the West Indies. Do not put it down to the depravity of the negroes of the West Indies. Put it down to the hatred of labour which has largely been engendered in the rank and file of the negro population by the fact it has only been in comparatively recent times that the badge of slavery has been removed, labour itself having thus become in some form an indignity in the eyes of the average West Indian negro. He is inclined, therefore, to turn his wife into a drudge in preference to doing his fair share of their joint work, and he is only restrained by the fact that the woman who is only living with him can walk out at the door at any time. When she is married to him he feels he is in a position to compel her.

I would like to say a very few words to you on the subject which is being discussed this afternoon with special reference to Nigeria for which I and my colleagues in the public services of that great Dependency are responsible. I see that Dr. Foy, the Director of Sanitary Services in Nigeria, who is far more capable of presenting this subject to you than I am, is present here, and I could have wished that he, rather than I, had been invited to address you. You, of course, are very well instructed people with more than ordinary knowledge and intelligence, and therefore you of course know on which side of Africa Nigeria is situated. That is a secret which is closely hid from the bulk of the British public. The fact that its name begins with the initial N seems to relate it in their minds to Nairobi, and I am constantly being asked about the people who live in that town, which is something like asking people in Iceland whether they are acquainted with folk in Western Siberia.

Nigeria has an area equivalent to post-war Germany, Holland, Belgium, and two-thirds of France. It covers, therefore, a very considerable area, five times as large as the Gold Coast, and the single Province of Kano has a population of 3,500,000 as against the Gold Coast's total population of 2,200,000—that is, there are practically 1,300,000 more people in that single Province alone. I tell you these facts because they are pertinent to this afternoon's discussion. The population of the whole of Nigeria is very nearly 19,000,000 souls, that is, 3,000,000 souls and more in excess of the total white population of all the great self-governing Dominions of the Empire put together. Of that population, roughly 8,000,000 are Muhammadans who are governed by their own native rulers, their Emirs, acting on the advice of British Residents with their political staffs, but carrying on the system precisely as it was before our coming, except that the Muhammadan law has in some instances been softened. For instance, the amputation of the hand as a punishment for theft is no longer carried out and the flogging of women is very strongly discouraged. But the difference that our presence has made is this—that the people before we came, although the law was theoretically in operation, found that those who were sufficiently strong and powerful among them were able to set it at naught when it suited their convenience. To-day, from the Emir and the great Chiefs downward to the meanest



## IMPERIAL QUESTIONS : WEST AFRICA

*Sir Hugh Clifford, G.C.M.G.*

peasant, everybody is compelled by the presence of the European officers to obey faithfully the law to which they always owed traditional allegiance. Farther south you have a much more difficult proposition. There you have some nine or ten millions of Fetish worshippers whose religious convictions find their manifestations in many barbarous customs which conflict so abruptly with the white man's idea of right and wrong that we have constantly to punish men who believe themselves to have performed righteous acts. In January last I and my Executive Council were compelled to confirm the death penalty passed upon two men who, being dissatisfied with the funeral celebrations which had taken place on the decease of their mother to whom they were much attached, procured a boy from a neighbouring village and offered him up as a human sacrifice. They dug open their mother's grave and secreted the boy in the grave to serve as her slave in the next world. There is not the slightest doubt that these men believed themselves to be acting rightly and to be performing an act of the highest filial piety; there is not the slightest doubt that the inhabitants of the neighbourhood regarded them as men of great virtue; but we have made ourselves responsible for life, for peace, for justice and for security throughout the country. The men who committed that crime knew the risks they were running, and it is not possible for a European Government to tolerate an action of that description. We consider it our bounden duty to prevent such barbarisms, and the only prevention is by example which will force people to act as they do to-day in the Gold Coast, where contact with Europeans is much older.

What I am telling you these facts for is that, taking it altogether throughout the country, I have an average of one European political officer to over 81,000 of the indigenous population in the North, and in the southern Provinces I have one European to over 62,000 of the native population. I have altogether, among these nearly 19,000,000 human beings, a very attenuated European staff, and I have at my disposal of African troops, voluntarily enlisted from the native population and trained and officered and led by Europeans, numbering in all some 2,500 men. Now I put it to you that we are ruling that immense population with their consent and approval, or government of them in such circumstances would be an impossibility; but when we come to talking lightly of controlling such things as venereal disease we are stepping into an arena into which at the present moment a Government such as mine is in no sense equipped to enter. You cannot attempt anything in the nature of an inquisitorial inspection of either men or women—least of all of women—among such a population. Many years, possibly many decades, must elapse before we win the confidence of these people who are at once suspicious and shy and who vary enormously in the stage of their culture and education, their religion, their traditions and their history in one part of the country and another. Many years, many decades must elapse before we shall hope to have won their

## SOCIAL HYGIENE

confidence to the extent of weaning them from their own remedies and medicines and familiarising them with European medical science. A great deal has been done in that direction in some of the French Colonies, to the credit of the French West Africa Government, be it said, and there are many men of light and leading in the West African Medical Staff who are doing all they can to-day to spread the knowledge of the assistance which medical science can afford among the native population. But all that I would suggest to you this afternoon is that it is not possible, with the machinery at our disposal to-day, to *control* such things as venereal diseases among the 19,000,000 people of Nigeria. What we have to do is very slowly to win the confidence of the people and gradually to build up upon that sure foundation a faith in medical assistance from European science without which they will never voluntarily submit themselves to the cures which we have ready to offer them.

*Dr. Foy (Chief Sanitation Officer, Nigeria):* His Excellency, Sir Hugh Clifford, has referred to me in his speech, and I feel compelled to say a few words.

He has told us that the immense area and population to be dealt with and the paucity of the staff only just enable us to touch on the health conditions of the very fringe of this vast population. The areas under control are the urban and the rural—the urban situated on the coast along railway lines, along trade routes and rivers. At various centres we have medical officers whose duties are many. These duties comprise the treatment not only of venereal disease but also of all other numerous ailments to which the population is subject, and they also supervise, organise and carry out the sanitary work connected with these stations. The influence of medical officers from these centres can only extend out very gradually to the districts round about by means of lectures to the chiefs and by means of education of the people. The prevalence of venereal disease is very considerable. We have heard much with regard to the prevalence of venereal diseases in other parts of Africa, such as Uganda and Kenya, and in the same way we also have to contend with a population which is very highly infected. We also have not got the statistics that would enable us to say the exact proportions that are infected, but there is no doubt that the danger exists in the spread of infection from these urban centres into the more rural districts where the population has been known to be free from infection in the past. The two points that strike me forcibly with regard to improving the situation are in providing greater facility for treatment. The cost of treatment in the use of salvarsan is expensive, but with the introduction of cheaper drugs, of which we have heard this afternoon, the proportion of those who can benefit by treatment at our disposal will be increased, and if the treatment is given freely it will help much to eradicate the disease from the bigger centres. At the same time, education in these bigger centres is essential, and the point in my mind is largely the

## IMPERIAL QUESTIONS : DISCUSSION

necessity of education beginning in the schools where the more senior boys and those capable and fit for such tuition should be educated, so that the knowledge of need for prevention and of the avoidance of such dangers may grow up with the younger element, who will then also help to impart such information in their own countries and their own towns from which they come.

### DISCUSSION.

*Mrs. Neville-Rolfe* : In several of the reports to-day we have heard that education has been carried out by word of mouth to the native chiefs. I know that in certain parts of Africa the film and picture illustration are practically useless for the natives because such a form of presentation does not convey anything to them. Is there any material that would assist those who educate the chiefs by word of mouth that we could supply to them?

*Dr. Cook* : I think with regard to the Uganda chiefs you can say at once that the bulk of them are educated, but the difficulty comes in the chiefs' conveying these truths to their people by means of propaganda literature, films and slides. I feel quite certain that any of the Baganda who have been educated in any of the schools would thoroughly grasp either a diagram or a film or lantern slides—that is the visual representation—but, when you come to the uneducated peasant, I heartily agree with those who say that pictures are perfectly useless ; I do not think they would understand transferring the two dimension plane into three dimensions ; therefore you must get an intermediary, but you have a very good intermediary in the educated Muganda, either man or woman, and it is in this that hope lies. The educated Uganda native can be trained to do almost anything, and once the educated native has grasped the need for propaganda, he will find ways of explaining it to the people.

*Dr. Paterson* : My point was that the serious matter in Kenya is the fact that venereal diseases are looked on so lightly, and I do not think we are going to alter that fact by displaying films ; we have to alter the conditions which make the people look lightly on these diseases, and that is the only way in which we can do anything. Certainly at present I should consider it inadvisable to display films.

*Mr. Reid (Natal)* : I can endorse what Dr. Cook said, but, as Dr. Haslam pointed out, it is through the educated natives that propaganda can be done, but they are just as great offenders as the others.

*Mrs. Neville-Rolfe* : With regard to what the representatives from Kenya Colony said, I have heard that there is some trouble in the way of venereal diseases among the natives who are in the European houses as servants. What one had in mind in regard to education was whether something could not be done to enlighten our own people out there—especially the young married woman who might be apt to leave her children in charge of infected natives. This

## SOCIAL HYGIENE

is a question—quite apart from the native question—as to whether something could not be done for the European people to give them an enlightened view of the whole question, and to secure their co-operation in any scheme the Government might have for the protection of the European as well as the native.

*Dr. Paterson:* That particular matter of the question of servants and of pointing out the difficulties of European ladies with families is one which receives some attention I think from the East Africa Women's League.

*Dr. Letitia Fairfield:* May I ask whether there has been any work done to find out any difference in kind between venereal diseases as found in tropical regions and those found at home? I ask because, as one of the Commissioners to the West Indies, my medical colleague and I were struck by certain facts with regard to the percentage of gonorrhœa among the population of the West Indies. We were informed that in many sections of the West Indies about 80 per cent. of the population had gonorrhœa; on the other hand, ophthalmia neonatorum was practically unknown, for gonorrhœa as a whole did seem to be a milder disease than in Europe, and again syphilis, which had very serious primary and secondary manifestations—the tertiary stage was seldom seen and general paralysis of the insane and tabes were practically unknown. We visited every asylum in the West Indies and only saw one case of general paralysis of the insane.

*Dr. Haslam (British Guiana):* I am not able to say what work has been done in regard to the difference in virulence of diseases found in parts of the West Indies, but I have formed the impression that certainly gonorrhœa in British Guiana is of a milder type than in Europe. I may be wrong about that, because I took the opportunity of discussing that point with Dr. Craigen, our resident surgeon, and I learned that stricture as the result of gonorrhœa is very common indeed, but that the natives do seem to be able to clear up the early acute symptoms with native remedies. As far as syphilis is concerned, it is undoubtedly the fact that general paralysis of the insane and tabes are very rare.

*The Chairman* said he had received a question in writing from a member of the conference asking what measures were taken to guarantee the health of the natives working in the sugar refineries who were known to work standing in the syrup.

*Dr. Haslam:* I know of no measures taken.

*Mr. Reid:* The same conditions prevail along the coast, but I do not know of anything that is done to prevent them.

*Dr. Letitia Fairfield (re West Indies):* As far as the coolies who work in the factories are concerned they have a very effective medical service.

*Mrs. Somerville:* Can a medical officer of health or anybody else say if there is any part of the world in which venereal diseases are not found?

*Dr. Cook:* Dr. Livingstone said that venereal diseases were never found in the pure-blooded native races. How far that is true I am not in a position to say, but I think venereal diseases

## IMPERIAL QUESTIONS : DISCUSSION

are less frequent among those races than where there is an admixture of elements. The first records we could find of syphilis in Uganda were after the arrival of the Arabs, and then there was a great epidemic when the railway came up and brought a large number of Indian traders from Bombay, and I think it is a matter quite worthy of investigation as to whether in pioneer districts where no other races have penetrated, you would find venereal diseases.

*Dr. Chalmers :* Much has been done in America showing that the presence of syphilis seems to hold tuberculosis in restraint. Is there any information available as to the prevalence of both syphilis and tuberculosis in Uganda ?

*Dr. Cook :* I cannot say in which place syphilis shows the highest incidence, but it is amongst the Bahima that you find most tuberculosis.

*Dr. Chalmers :* Does syphilis restrain the growth of tuberculosis ?

*Dr. Cook :* I do not know that you can argue from the association of two diseases together that they are favourable to one another or otherwise. You get syphilis abundantly in the one province of Uganda where tuberculosis is most prevalent. I think it is quite a possibility that the lower stage of organisation of the nervous system of the African may have something to do with the absence of the nervous manifestations of tertiary syphilis in certain races of Africa. I mean to say that the nervous systems in the educated and civilised races are subject to much more strain and therefore would be more liable to fall a victim to epidemic disease.

*Mrs. Neville-Rolfe :* I want to extend on behalf of Admiral Sir Reginald Tupper, Chairman of our Imperial Questions Committee, an invitation to the overseas delegates here to-day to attend the next meeting of our Imperial Questions Committee, which will take place on Tuesday next, at 3.30 p.m., at 102, Dean Street.

In connection with that will you note that negotiations are going on at the moment with the Colonial Office, and I understand that in all probability an Imperial Social Hygiene Advisory Committee to the Colonial Office is about to be established on which we understand this Council is to have the privilege of being represented. Therefore, we are particularly anxious, while the overseas representatives are here, to have the opportunity of discussing with them the possible developments along social hygiene lines which they would advise.

*The Chairman :* The conference has now come to an end and I think, and I hope you will agree, that it has been worth while, and that it has been successful and will be productive of good. This conference may even be the stepping-stone to a really great progress, not only in this country but in all the Dominions and overseas parts of the world with which we are so particularly in touch and where we so particularly wish to progress on the right, proper, safe and sound lines with regard to the treatment and management of these maladies.

## SOCIAL HYGIENE

Looking back on the conference as a whole, it seems to me that various things come out of it. First, that the really important and great thing is education and enlightenment of the public and the peoples, and the enlightenment and education of my profession in this matter; and, in addition to this, the next great thing is the absolutely essential necessity of the proper provision of treatment, treatment of which sufferers can avail themselves as early as possible in the disease. You will agree with me that these two facts have stood out very prominently during the whole of this conference.

There have been at the different meetings refreshing differences of opinion—various controversial subjects looked upon from one side or another with a great gulf fixed between them. But that makes no difference. Even in the Council itself differences of opinion exist. It is better to have differences of opinion than to go on in one rigid line of dull unanimity, because then you do not do so much good as when you have differences of opinion—get them well ventilated, get them out and reap the good which may come from them.

I met a gentleman the other day who has had a large experience of attending conferences such as this and also of scientific meetings, and he said: "I have never known a conference at which the papers have been of such a high standard of excellence, where the speaking has been so good and the interest so well maintained." Now, I take this, coming from this particular gentleman, as a great compliment to this conference. I have listened and learned a great deal—an enormous amount—and have been extremely proud and pleased at the very high level of the proceedings from the beginning to the end.

The last thing of all—you probably all know that the Council has been during the last year run on lines of the strictest economy. The staff has been cut down until it is only just sufficient to carry on the routine work of the Council, but during the greater part of the last year during which this Congress has been in preparation we have not had one single additional member on the staff, and all the work has been done by the staff of the office in addition to the routine work of the Council. I want you to give them all a very hearty vote of thanks for the self-sacrificing work they have put in which has made this great success.

The proceedings then terminated.

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