THE ROYAL SANITARY INSTITUTE HEALTH CONGRESS, 1951

BY

Lieut.-Colonel C. L. DAY
Royal Army Medical Corps
Department of Army Health, R.A.M. College

The annual congress of the Royal Sanitary Institute was held at Southport from April 23–27, 1951. The President of the Congress, the Right Hon. the Lord Hesketh, D.L., was installed by Dr. J. Greenwood Wilson (M.O.H. Cardiff), chairman of the council of the Institute.

The variety of interests is shown by the number and title of sections—Preventive Medicine, Engineering and Architecture, Maternal and Child Health, Veterinary Hygiene, Food and Nutrition, Housing and Planning, Tropical Hygiene and Hygiene in industry. In addition there were conferences for Medical Officers of Health, Engineers and Surveyors, Sanitary Inspectors and Health Visitors.

A total of some 2,300 attended of whom 1,800 were delegates, many of them from overseas.

Sir John Charles, C.M.O. Ministry of Health, chose “John Simon and some contemporaries—a Brief Retrospect” as the subject of his Presidential Address in the Section of Preventive Medicine. In his introductory remarks Sir John mentioned the far-reaching changes in medical education now taking place. Medicine was becoming more comprehensive, dealing with the individual man an an entity. As a result of this the old antithesis between “prevention” and “cure” will be banished. It was noted that the term “preservative” medicine was used in place of “curative” medicine.

The opening paper in this section was on “Rheumatic Diseases” by Sir Henry Cohen, Professor of Medicine, University of Liverpool. He pointed out the vast size of the problem. In 1937 a planned community survey in Aberdeenshire showed that 11.4 per cent of all doctor attendances during an average winter were for rheumatic diseases. In the U.S.A. in 1935–36 with a population of 127 millions, 3 millions had arthritis. It is certain that there are at least 250,000 arthritics in Great Britain. It is important to remember, in considering the economic and social implications of arthritis, that 70 per cent of the victims are under 55 years of age. Sir Henry warned his listeners against too much enthusiasm for the use of “Cortisone.” It is well to remember that at 35 dollars
a gramme it would cost £112 millions a year to treat the 250,000 patients in this country—assuming that such large amounts of the drug were available. Much controlled investigation on the influence of such factors as humidity, temperature, draughts and conditions of work on the chronic rheumatic diseases are required. The answers to these fundamental problems must be forthcoming before there can be "Prevention."

In the Sanitary Inspectors Conference much interest was taken in the paper on the topical subject of "Food Hygiene, Theory and Practice" by the chief sanitary inspector of Guildford—Mr. H. A. Perry.

After detailing the various legal powers, the importance of voluntary cooperation and education (particularly in school children) was stressed. Some 65 clean food organizations have been set up—the majority sponsored by local authorities but some by trade associations with the guidance of Public Health Officers. In general the codes of practice, to which these organizations work, are based on existing laws; but requirements are more clearly defined and, in some cases, demand a standard higher than that which can legally be enforced.

Professor Pippard, in his Address to the Section of Engineering and Architecture, stressed the few facilities which exist in this country for post-graduate studies in Public Health Engineering—a lack emphasized if the position here is contrasted with that in the United States of America. Opportunities for using specialized education in Public Health Engineering are numerous—in the municipal field, in the prevention of river pollution and in water supply and in many countries abroad, in the control or extermination of insect and other disease carriers. It is essential that if the medical scientist and the engineer are to co-operate to the best advantage each should know something of the other's work. Useful instruction in this connexion is being done in the University of London in the organization of post-graduate courses jointly by the Imperial College of Science and Technology and the London School of Tropical Medicine and Hygiene, both of which are Colleges of the University. "Young engineers and young physicians will work together and it is hoped learn something at least of each other's outlook and approach."

Dr. A. Massey, Chief Medical Officer, Ministry of National Insurance, gave the Presidential Address to the Section of Hygiene in Industry. He said that the extent to which the industrial health services should or can be related to the National Health Service has been much under discussion and has recently engaged the attention of the Dale committee whose report was published in February last.

As background to the council's deliberations was the need to avoid overlapping services and to use all resources to the best national advantage.

"The main recommendation is for the setting up of a representative standing
joint advisory committee in England and Wales (with an equivalent committee for Scotland) with consultative functions and their co-ordination with the general health service. The committee saw the desirability of some eventual comprehensive provision for occupational health, but thought that much more experience and experiment were first necessary.”

A point mentioned by Dr. Massey was the “veritable hunger” for morbidity information in all branches of social medicine. The death certificate had played its pioneer part; sickness statistics from social surveys and hospital records are valuable, but it seemed that in the medical certificate of incapacity in connexion with insurance claims there may be a new and major source of information.

Professor Fred Grundy, Mansel-Talbot Professor of Preventive Medicine, University of Wales, read the opening paper at the conference of Medical Officers of Health. His subject was “Basic Research and the Medical Officer of Health.”

He classified the various investigations commonly included under the heading, “Social—medical research” into two groups; the first dealing with those factors which are primarily administrative such as the medical care—needs, and the second being Basic research—anthropometric and epidemiological. He concentrated on the sub-group—“epidemiological,” the word being used to mean “the orderly study of incidence of disease, both communicable and non-communicable, for the purpose of elucidating aetiologies.”

In discussing the problem of organization of research Professor Grundy was of the opinion that central design and collation with local collection and scrutiny is the right line to pursue. The isolated local survey is necessarily local in its application. Conclusions from local data have local validity only. The speaker realized that this advocacy of more centralization of research was likely to be viewed with some misgiving. “It is a question of sustaining the individual’s sense of the importance of his particular part in a big undertaking—a question of ensuring that he does not feel himself to be a mere cog in the machine.”

Personal prestige has to be subordinated—“Satisfaction must derive from applying skill to the tedious and difficult task of compiling accurate records which others will process; and with suitable acknowledgments, will ultimately publish.”

He suggested that the more active the interest of the Society of Medical Officers of Health in research the more likely are its members to regard themselves as real participants in these projects and he urged that basic research should not play second part to other interests of the society.

The meeting of the Tropical Hygiene Section was of particular interest to Army Medical Officers. The Presidential Address, “The Function of Medical Services in the Tropics,” was given by Professor T. H. Davey, Professor of Tropical Hygiene, Liverpool School of Tropical Medicine.
He pointed out that the chief diseases of the backward areas of the tropics were fundamentally due to an unhealthy environment and many faulty habits of life. He instanced the main causes of mortality and morbidity in such areas as malaria, yaws, schistosomiasis (community wide endemic diseases) and cerebrospinal meningitis, typhoid and louse-borne relapsing fever, sleeping sickness, smallpox and malaria (community wide epidemic diseases).

The present hospital organization which is a heavy financial burden on the country plays no significant part in the reduction of epidemic or endemic disease. "We must adopt the greatest good for the greatest number. On this reckoning the introduction or elaboration of the hospital services in primitive areas stands condemned."

The greatest benefit for the greatest number will be found along the lines of disease prevention and in the early stages of development, effort and expenditure should be concentrated in this direction.

Professor Davey went on to say that history shows that even in the absence of specific medical measures, endemic disease tends to recede as social and economic conditions advance and the doctor should realize, in this connexion, the importance of the work of the agriculturist and the educationalist.

Professor Davey's Address was followed by a paper by Dr. D. W. Horn, M.O.H. Colonial Medical Service, Nigeria, on "The Epidemic of Cerebrospinal Fever in the Northern Province of Nigeria, 1949-50."

Dr. Horn stated that the greatest scourge of all epidemic disease in Nigeria was cerebrospinal fever due to Neisseria meningitidis, and gave a summary of previous epidemics. This certainly was a surprise to many of us, accustomed to think in terms of smallpox or plague. In the epidemic 1949-50 the enormous total of 92,964 cases with 14,273 deaths (case mortality rate 15.4 per cent) was reported. Some idea of the size of the problem may be gauged when it is realized that the epidemic was spread over an area four times the size of England and Wales—with a sparse population and poor communications.

Control measures consisted in making available to all who needed it a rapid and effective treatment. This was done by setting up temporary treatment centres and at the height of the epidemic treatment was available in eleven hospitals, 80 native administration dispensaries, 350 temporary treatment centres and 41 mission dispensaries. These centres were made possible by mobilizing the Medical Field Units of the Sleeping Sickness Service and sending them to the worst affected areas.

Each centre was put in charge of a trained African attendant who was made responsible for giving all treatments and keeping records. The centres were visited regularly by a Medical Officer of Health or a Health Superintendent.

The standard treatment consisted of intramuscular injections of a watery suspension of sulphathiazole in a strength of 1.5 grammes in 10 c.c. Dosage for an adult case was:
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First day: 2 injections of 10 c.c. suspension with a soluble sulphonamide preparation as an adjuvant.
Second day: 10 c.c. of suspension morning and evening.
Third and subsequent days: 10 c.c. suspension once daily.
Five days' treatment usually sufficed to cure.

The results obtained were comparable with those obtained in the United Kingdom using sulphonamides.

The administration of this vast organization was in the hands of the Senior Medical Officer in charge of the Medical Field Units, who kept all epidemic supplies of drugs and equipment with mobile teams of reserve staff ready to proceed by lorry to wherever their services were required.

Little is known about the epidemiology of cerebrospinal fever under tropical conditions. Notification of cases and deaths increased rapidly week by week from the end of December 1949 and reached a climax in the first week of April 1950.

It is essentially a "dry season" epidemic. "In January and February, it is usually very cold at night compared to the day; the natives sleep huddled together for warmth in small ill-ventilated huts." In one province an investigation showed the carrier rate to be 20 per cent for December to March—during the rainy season it varied from 0-2·5 per cent.

In suggestions for the future, Dr. Horn discussed mass prophylaxis but considered prophylactic administration of sulphonamides to be unsound in view of the danger of producing drug-resisting strains of organisms; and in any case it would be administratively quite impossible in Nigeria. It was hoped to undertake some experiments next year using a Todd insecticidal fog applicator (TIFA) to "fog" a community with a mild antiseptic in the hope of reducing the carrier rate.

Dr. H. N. Davies, Tuberculosis Specialist, Tanganyika, gave an account of the work of the tuberculosis unit on Kilimanjaro and its effect on general tuberculosis policy in Tanganyika Territory.

Based on a hospital sanatorium started in 1927 at Kibongoto on the South-West corner of the mountain, the unit has gradually worked up until it has feelers in every habitable area of the district. In an endeavour to examine and treat contacts, a chain of dispensaries has been formed round the mountain. The "dispensaries" are really points of contact without patients. Although it is now drawing Asians and Africans from all over East Africa (mainly because there is nowhere else for them to go), its main concern is with local tribes.

Dr. Davies pointed out the efficacy of the "local" scheme compared with the abortive attempt at becoming a territorial or inter-territorial scheme when tracing of contacts is of course impracticable.

The original 12 in-patients in 1927 has increased year by year until the
daily average in 1950 is about 250 (of whom about half are from the local tribe).

Although the Hospital was started in 1927 it is only now that the whole place is being properly rebuilt. "During all these years patients have had to live in anything that we could beg, borrow or steal; mud and wattle bandas with thatched or corrugated-iron roofs, corrugated-iron frame buildings, mud brick buildings with thatched roofs, lean-to's of thatching or corrugated-iron—any old thing we could lay our hands on. Home from Home: bottles under the bed; chickens all over the place; bananas and firewood suspended from the eaves—until we got a matron."

The scheme shows what useful work can be done by enthusiasts even when financial help is very limited and elaborate hospital buildings lacking.

Many other papers were read leading to useful discussions.

Visits to various factories and places of interest were arranged for the afternoons.

The social side was not neglected. Civic Receptions were held by the invitation of the Mayor and Corporation of Southport.

A well-attended Congress dinner was held and there was also a successful dinner of the Services Group of the Society of Medical Officers of Health, attended by 24 members.

The 3 official War Office Medical Delegates were Major General T. Young, D. of A.H., Colonel H. E. Knott, Commandant of the Army School of Health, and Lieut.-Colonel C. L. Day, Reader in Army Health, R.A.M. College.
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