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THE ORIGINS AND DEVELOPMENT OF
THE SCHOOL MEDICAL SERVICE
1870 - 1919

A THESIS SUBMITTED FOR THE DEGREE
OF PHILOSOPHIAE DOCTOR
OF THE UNIVERSITY OF WALES

by

David Hirst

Department of Social Theory & Institutions
University College of North Wales.

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SUMMARY

This thesis attempts to provide a detailed account of the process by which medical supervision of the health of school children became established in England and Wales. The analysis focuses primarily on the foundation of the School Medical Service in 1907 and its subsequent history. Although the School Medical Service itself is sometimes regarded as a consequence of the fears about the national condition aroused by the South African War, evidence suggests that the earliest attempts to monitor the physical condition of school children occurred during the school board era, when the links between health and nutrition and educational performance became apparent. A consequence of the ad hoc development of work in the field of school hygiene during this period was the emergence of a number of political, professional and even personal disputes following the establishment of the School Medical Service nationally. These meant that uniformity of standards and of administration had not been achieved by the outbreak of the First World War. Particular difficulties were encountered in London, which is the subject of a special study. Despite these, there was a gradual growth in medical treatment and other non-mandatory services, resulting in the creation of an entirely new agency of treatment; the school clinic. The demands for doctors for military duties in the First World War curtailed some of the work of the School Medical Service, but treatment facilities continued to expand. After the war, the passage of legislation affecting all aspects of the Service marked the end of the first phase in the creation of a national system of health care for school children. The study concludes by attempting to assess the significance of the establishment of the School Medical Service, and its impact during the first stage of its development.

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David Hirst
February 1983.

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ABBREVIATIONS

The following abbreviations are used in the text and citations:

Addison MSS :	Addison Papers, Bodleian Library.
Gainford MSS :	Papers of J.A. Pease, Nuffield College Library.
Newman Diaries : (D.H.S.S.)	Diaries of Sir George Newman, Department of Health and Social Security.
Newman MSS : (Hereford)	Papers of the Newman Family, Hereford and Worcester Record Office, Hereford.
Newman MSS : (Wellcome)	Letters of Sir George Newman, Wellcome Institute for the History of Medicine.
Passfield MSS :	Papers of Sidney and Beatrice Webb, British Library of Political and Economic Science.
Runciman MSS :	Papers of Walter Runciman, Newcastle University Library.
SMOH, Oxford :	Records of the Society of Medical Officers of Health, Wellcome Unit for the History of Medicine, Oxford.
BPP :	British Parliamentary Papers
R.O. :	Record Office.
GLRO :	Greater London Record Office.
PRO :	Public Record Office
M.O.H. :	Medical Officer of Health
C.C. :	County Council
L.C.C. :	London County Council
C.B.C. :	County Borough Council
M.B.C. :	Municipal Borough Council
U.D.C. :	Urban District Council
R.D.C. :	Rural District Council

INTRODUCTION

The period 1906 to 1914 stands out in the history of social policy in England as being one of the major periods of reform.⁽¹⁾ Some historians have identified in the earliest period of reform, 1906 to 1907, the origins of the post World War II "welfare state". In The Evolution of National Insurance in Great Britain, Bentley B. Gilbert asserts:

The passage of the Education (Provision of Meals) Act of 1906 and the Education (Administrative Provisions) Act of 1907, establishing medical inspection in state schools, marked the beginning of the construction of the welfare state.⁽²⁾

Similar views have been advanced by other commentators.⁽³⁾ The passage of these two Acts has also been indentified by Titmuss⁽⁴⁾ as being an early example of the relationship between war, in this instance, the Boer War, and the advancement of social policy.

It is thus surprising that despite the significance attached to these two Acts, the services thereby established have received relatively little detailed attention from the historian of social policy. The 1906 Act, which allowed the provision of free school meals for necessitous

(1) J.R. Hay, The Origins of the Liberal Welfare Reforms, 1906-1914, Economic History Society Studies in Economic and Social History, (London: Macmillan, 1975), p.11.

(2) Bentley B. Gilbert, The Evolution of National Insurance in Great Britain, (London: Michael Joseph, 1966), p.102.

(3) See e.g. Karl de Schweinitz, Englands Road to Social Security, (London: Oxford University Press, 1943), p.202.

(4) R. M. Titmuss, Essays on the Welfare State, 2nd. ed., (London: Allen & Unwin, 1963), p.81.

school children, has been the subject of an unpublished M.A. thesis,⁽⁵⁾ part of which has subsequently been published as a short article,⁽⁶⁾ while a privately circulated typescript monograph by Frederick le Gros Clark also deals with the 1906 Act.⁽⁷⁾ Otherwise, the establishment of this service has been dealt with extensively only by Gilbert.⁽⁸⁾ The establishment of the School Medical Service under the 1907 Act has received even less attention. Other than the chapter in Gilbert's book which gives, it will be suggested, a somewhat flawed account of the development of school health care, the only substantial studies are the general histories of the School Medical Service produced by the Leffs,⁽⁹⁾ and by the Department of Education.⁽¹⁰⁾ Neither of these, however, attempts seriously to examine the political aspects of the establishment of medical inspection in any detail. Although Huw W.S. Francis has made some useful contributions to study of the medical aspects of the service,⁽¹¹⁾ it is suggested that a need remains for a detailed study of the origins, establishment and subsequent development of an allegedly historically significant welfare service.

(5) L.I. Andrews, "The Education (Provision of Meals) Act, 1906", (M.A. thesis, University of London, 1968).

(6) L.I. Andrews, "The School Meals Service", British Journal of Educational Studies, 20(1972), 70-75.

(7) Frederick le Gros Clark, A Social History of the School Meals Service, (Unpublished typescript, 1964).

(8) Gilbert, op.cit., pp. 117-58

(9) Samuel and Vera Leff, The School Health Service, (London: H.K. Lewis, 1959)

(10) Department of Education and Science, The School Health Service, 1908-1974, (London: H.M.S.O., 1975).

(11) Huw W.S. Francis, "Education and Health: the English Tradition", Public Health, 89 (1975), 129-35; 181-90; 273-78.

This thesis represents an attempt to remedy this deficiency, and in so doing, to present an analysis of the growth of a social welfare service based on such contemporary documents and publications as remain extant. Some limitations to the scope of this thesis have been necessary.

First it is fundamentally concerned with the functions conferred on local education authorities by clause 13(i)(b) of the 1907 Act.⁽¹²⁾ That is, the duty placed on education authorities to provide for the medical inspection of school children according to the directions given by the Board of Education, and the optional power also given to "make such arrangements....for attending to the health and physical condition of the children" as were approved by the Board. It also examines the administrative structures and procedures adopted both by the Board and by the local authorities for procuring the performance of these functions. As the Annual Reports of the Chief Medical Officer of the Board of Education testify the School Medical Service at both central and local government level soon embraced a much wider range of activities. This expansion derived either from the transfer of existing work to the Medical Department or the local school medical officer, such as the supervision of special schools, or from natural growth in the activities of the school doctors themselves, as with the promotion of the "open air" schools. Some of these additional functions have already been the subject of historical examination, both at central⁽¹³⁾ and at local government⁽¹⁴⁾ level. In the context of this thesis, however, such developments receive

(12) Education (Administrative Provisions) Act, 1907, 7 Edw.VII, ch. 43.

(13) See e.g. P.W. Musgrave, "Morality and the Medical Department: 1907-1974", British Journal of Educational Studies, 25(1977), 136-54.

(14) See e.g. D.A. Turner, "The Open Air School Movement in Sheffield", History of Education, 1(1972), 58-80.

attention only when they are relevant to the main areas of study.

The second limitation relates to the period to be covered. Although an attempt is made to provide a chronological analysis of the development of interest in the health of the school child from the earliest attempts to link the fields of education and health, the period covered here terminates in 1919, when, during a period of two years, all the major areas of interest to this study: the medical inspection and treatment of school children, and the administration of services at both central and local level, were subject to major legislative changes.⁽¹⁵⁾ The reforms introduced during this period prompted Sir George Newman, the Chief Medical Officer of the Board, to declare that the School Medical Service had then "reached the end of the pioneering period."⁽¹⁶⁾

This thesis, then, is an attempt to analyse and explain the emergence and development in its "pioneering period" of a state welfare service the study of which has been seriously neglected, despite the considerable significance attributed by historians of social policy to its establishment.

(15) By the Education Act, 1918, 8 & 9 Geo. V, ch.39
and the Ministry of Health Act, 1919, 9 & 10 Geo.V, ch.21.

(16) BPP 1919/XXI:149, Board of Education, Annual Report of the Chief Medical Officer for 1919, Cmd. 995, p.88

CHAPTER ONETHE EMERGENCE OF INTERESTIN THE HEALTH OF THE SCHOOL CHILD1870-1884

Sir George Newman, the first Chief Medical Officer to the Board of Education, traced interest in the health of children at school back to Richard Mulcaster, Head Master of the Merchant Taylor's School, who in the sixteenth century made a plea for mind and body to be given equal consideration in education.⁽¹⁾ State intervention to ensure such a link was established came only at a much later date. On the Continent, one of the earliest examples of the medical inspection of schools was the French law of 28 June, 1833, which empowered a Committee to keep the schools of the Commune in a sanitary condition.⁽²⁾

The Sanitary Influence

Sanitary concern also motivated the earliest British interest in school hygiene for:

By the first general Board of Health it was provided, as part of the duties of the medical officer of health, that there should be a regular inspection of the school children; and on the detection of a case of incipient infectious or contagious disease, he was directed to see to the removal of the sick child, to follow it home, to watch its treatment there, and to attend to

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- (1) Sir George Newman, "The Evolution and Policy of the School Medical Service", in The Year Book of Education, 1933, ed. Lord Eustace Percy (London: Evans Bros., 1933), pp.398-410.
- (2) John Priestley, "The Past, Present and Future of School Medical Inspection", in The Child Welfare Annual, 1916, ed. T.N. Kelynack (London: Bale & Danielsson, 1916), p.66.

the sanitary condition of the home and its amendment.Had it been carried out, it would have stopped the greater number of those epidemics which occasion the closing of schools.(3)

The implementation of these proposals was abandoned in the face of the administrative and political difficulties encountered by the first General Board of Health which led to the retirement of its motivating force, Edwin Chadwick, in 1854.⁽⁴⁾ Dr. Huw Francis has suggested that Chadwick's retirement and the departure of other figures connected with the first General Board of Health, including Lord Shaftesbury and Dr. Thomas Southwood Smith, removed those interested in bringing the schools under sanitary supervision from public health administration. Sir John Simon, Chadwick's successor, was a man of narrower interests who attached little importance to this aspect of public health work.⁽⁵⁾

Although Chadwick had now withdrawn from sanitary administration he continued to press for greater sanitary control over schools. In an address to the Society of Medical Officers of Health in 1860 he argued:

That as school-houses are commonly constructed and as schools are usually conducted without regard to sanitary science, they are frequent sources of disease and of permanent bodily and mental infirmity, and tend, together with over-sedentary constraint, to augment the excessive amount of infantile and juvenile mortality. [and]

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- (3) Benjamin Ward Richardson, The Health of Nations: a Review of the Works of Edwin Chadwick, 2 vols. (London: Longmans Green, 1887), vol.1, p.242. The reference is to the Board's circular on "The Duties of the Medical Officer of Health", issued 2 February, 1851.
- (4) For a discussion of the work of the General Board of Health see e.g. R.A. Lewis, Edwin Chadwick and the Public Health Movement, 1832-1854. (London: Longmans, 1952), pp.181-375.
- (5) Huw W.S. Francis, "Hesitant Beginnings", Public Health, 89 (1975), pp. 129-35. For an account of Simon's career see Royston Lambert. Sir John Simon and the Public Health Movement, (London:MacGibbon & Kee, 1963).

That, for the prevention of these evils, special applications of sanitary science and superintendence are required.(6)

Chadwick restated his views in his letter to the Newcastle Commission on the State of Popular Education.⁽⁷⁾ The public schools also frequently showed only a cursory interest in sanitary or individual health, though some improvement from earlier conditions had occurred.⁽⁸⁾

A more general debate on the sanitary implications of education came only with the passage of the Elementary Education Act 1870⁽⁹⁾ and the stimulus it gave to elementary school construction. This gave Chadwick a further opportunity to stress the importance of the sanitary supervision of schools. Addressing the Social Science Association, he argued:

If the schools that were about to rise in every district in England, were built on a bad principle; if they were of unhealthy construction; if they were so constructed as to be unsightly inside and outside, they would miss half their national usefulness.(10)

Beyond identifying defects in the construction of the schools, Chadwick claimed that as then "constructed and conducted" the schools constituted

(6) Reginald Dudfield, "History of the Society of Medical Officers of Health", Public Health, Jubilee edition, (July, 1906), 31.

(7) BPP 1862/XLIII:1, Two Papers submitted to the Royal Commission on Popular Education by Mr. Chadwick, H.C.120.

(8) BPP 1864/XX:1, Royal Commission on the Revenues and Management of Certain Colleges and Schools, vol.1, Report, C.3288, pp. 49-50; Medical Research Council (School Epidemics Committee), Evidence on School Epidemics, M.R.C. Special Report Series no.227, (London: H.M.S.O., 1938), pp.18-29.

(9) Elementary Education Act, 1870, (33 & 34 Vict. ch.75).

(10) Richardson, op.cit., p.306

centres from which infectious disease might spread. (11)

It was this concept of the school as a centre for the spread of infectious disease which was to lead increasingly to demands by public health officials for a greater degree of influence or control over educational institutions. Infectious diseases accounted for most of the deaths occurring among children aged from five to fourteen years old. Between 1848 and 1872, the mean annual death rate among five to fourteen year old males was 6,683 per million living, of which 4,128 were attributed to infectious diseases, including tuberculosis. Among females, an even higher proportion of deaths was attributable to infectious disease. (12) Although infectious disease subsequently accounted for a diminishing proportion of a declining absolute death rate among this age group, it remained the largest single cause of deaths until after the Second World War. Tuberculosis, scarlet fever, diphtheria and measles were the major agents of deaths from infectious disease. (13)

Following Chadwick's pioneering interest, the more progressive and better informed members of the sanitary profession continued to debate the relationship between school conditions and health, particularly the extent to which school attendance facilitated the transmission of infectious disease. (14) In 1870 the Society of Medical Officers of

(11) Ibid., p.307

(12) B.R. Mitchell and Phyllis Deane, Abstract of British Historical Statistics, (Cambridge: Cambridge University Press, 1962), pp.38-39.

(13) W.P.D. Logan, "Mortality in England and Wales from 1848 to 1947", Population Studies, 4(1950-51),132-78. See also F.B. Smith, The People's Health, 1830-1910. (London: Croom Helm, 1979),pp.136-94.

(14) A combination of low salaries and part-time appointments meant that many of the early Medical Officers of Health were neither progressive nor well-informed about sanitary principles. Jeanne L. Brand, Doctors and the State, (Baltimore: John Hopkins Press, 1965), pp.108-11.

Health heard a paper read by its President, Dr. Robert Druitt, on the "Physical Education of Children in Elementary Schools" in which he emphasised the poor physical condition of many of the pupils.⁽¹⁵⁾

In 1872 a Prussian surgeon then working in London, Dr. Richard Liebreich, read a paper entitled "A Contribution to School Hygiene."⁽¹⁶⁾

In 1876 a paper by Dr. T. W. Crosse on an outbreak of scarlet fever at Norwich concluded with a call for legislation "for preventing infected persons from going into public places, and especially children from attending schools".⁽¹⁷⁾

The view that the school was a prime factor in the transmission of infectious disease was given further support by the work of the medical staff of the Local Government Board. In 1876 Dr. W. H. Power's report on an outbreak of diphtheria in the village of Brailes, in Warwickshire, suggested that the spread of the disease might have been facilitated by school attendance.⁽¹⁸⁾ This argument was explored more thoroughly the following year, when Dr. Richard Thorne Thorne investigated another outbreak of diphtheria, this time at Coggeshall in Essex. As attendance at school was not at this time compulsory in all cases Thorne Thorne was able to compare the incidence of diphtheria among children attending school with that among a group of non-attenders, as the table below illustrates:

(15) SMOH, Oxford, Box A59, Annual Reports, Annual Report for 1870-71 p.3.

(16) SMOH, Oxford, Box A59 Annual Reports, Annual Report for 1872-73, p.9. See also Richard Liebreich, A Contribution to School Hygiene, (London: J. & A. Churchill, 1873). Friedrich Richard Liebreich (1870-1917), qualified in Berlin, but was ophthalmic surgeon and lecturer at St. Thomas's Hospital, London, between 1872 and 1886.

(17) SMOH, Oxford, Box A59, Annual Reports, Annual Report for 1876-77, p.10.

(18) Richard Thorne Thorne, Diphtheria, its Natural History and Prevention, Royal College of Physicians Milroy Lectures, 1891 (London: Macmillan, 1891), p.107.

DIPHTHERIA AMONG CHILDREN IN COGGESHALL, ESSEX⁽¹⁹⁾

	ALL CHILDREN IN COGGESHALL				CHILDREN WITH DIPHTHERIA			
	AGE				AGE			
	0-3	3-12	12-15	Total	0-3	3-12	12-15	Total
Known to be at school	18	620	49	687	1 (5.5)	59 (9.5)	5 (10.2)	65 (9.4)
Remainder	254	308	161	723	10 (3.9)	19 (6.2)	5 (3.1)	34 (4.7)
Total	272	928	210	1410	11 (4.0)	78 (8.4)	10 (4.8)	99 (7.1)

(Figures in brackets represent percentage of all children in category contracting diphtheria)

Thorne Thorne observed, from an analysis of these figures, that:

the incidence of disease upon children from three to twelve years was not far from 50 per cent greater upon those who are known to have attended school than it was upon the remainder. (20)

Also in 1877 W.H. Power identified school attendance as an important factor in an outbreak of diphtheria at Radwinter, Essex.⁽²¹⁾ In 1883 he compared the incidence of diphtheria in Pirbright, Surrey, during periods when the school was alternatively opened and closed for periods during the epidemic.⁽²²⁾ Thorne Thorne used these studies to argue

(19) Thorne Thorne, op.cit., pp.108-10.

(20) Ibid., p.110.

(21) Ibid., p.111

(22) Ibid., pp.115-19

that school influence was a potent factor in the transmission of infectious disease. He thought this was due to a combination of reasons, including the susceptibility of the school-age group to infection, their aggregation together for long hours, the unsatisfactory sanitary conditions of the schools, and insanitary customs among the children such as the sharing of cups and the exchange of kisses in greeting.⁽²³⁾ These investigations led to discussions with the Education Department about the provisions for closing schools during an epidemic.⁽²⁴⁾

Although interest was thus focussed on the school as a possible centre for the spread of infectious disease, the desire of the sanitary profession for a greater involvement in the supervision or management of schools was to be frustrated. One contributory factor was the administrative separation of education and sanitary powers. Until 1902, public health and education functions devolved on different authorities at both local and national government level. For most of the period relevant to the present discussion, local public health administration was governed by the provisions of the Public Health Act, 1872, which established sanitary authorities, consisting of town councils or local boards in urban areas, and Boards of Guardians in rural areas. Each sanitary authority had to appoint a medical officer of health, though often these were part-time posts.⁽²⁵⁾ The Local Government Act 1888 gave some sanitary powers to the newly created County Councils, although they were given the option of appointing a County M.O.H.⁽²⁶⁾

(23) Ibid., pp.136-38.

(24) Brand, op.cit., p.56.

(25) Public Health Act, 1872, 35 & 36 Vict. ch.79, The Local Government Act, 1894, 56 & 57 Vict. ch.73 transferred these duties to Urban and Rural District Councils

(26) Local Government Act, 1888, 51 & 52 Vict. ch.41.

Many county councils chose not to exercise this power.⁽²⁷⁾

The system of educational administration established by W.E. Forster's Elementary Education Act of 1870 was both divorced from other local government organisation and extremely fragmented in character. Voluntary schools, mostly established by the different religious denominations, were run by independent committees of managers. These numbered some 14,000 by 1902, with each of which the central authority had to correspond individually.⁽²⁸⁾ Only in areas where there was a demonstrable need for further educational provision were elected school boards to be established, "ad hoc" bodies whose powers related wholly to education, and whose expenditure was financed both from Exchequer grants and from local rates. By 1902, 2,560 school boards had been established, varying in size from small rural boards with one school and ten pupils to the London School Board with some 500 board schools and 535,000 pupils on the register.⁽²⁹⁾

Two features of this pattern of provision were to influence the development of school hygiene in England and Wales. First, almost throughout the nineteenth century most children were being educated within the voluntary sector. In 1880, only 28 per cent of the school population was attending board schools.⁽³⁰⁾ Even by 1900 the proportion

(27) In 1904, 35 out of 62 county councils in England and Wales had no Medical Officer of Health. BPP 1904/LXXXII:735, Return showing the Names of County Councils in England and Wales who have Medical Officers of Health, H.C.316

(28) P.H.J.H. Gosden, The Development of Educational Administration in England and Wales, (Oxford: Basil Blackwell, 1966), p.180.

(29) C.H. Wyatt, Wyatt's Companion to the Education Acts, 1870-1902, (Manchester: Thos. Wyatt, 1903), p.171; BPP 1902/XXIV:1, Board of Education, General Report for 1901-2, Cd.1275, p.11

(30) Gillian Sutherland, Policy-making in Elementary Education 1870-1895, (London: Oxford University Press, 1973), p.350.

had reached only 54 per cent.⁽³¹⁾ Second, most units of educational administration were responsible for only a relatively small number of children. Apart from the 14,000 committees of managers, 25 per cent of school board districts had a total population of less than 500 in 1886.⁽³²⁾ Thus most children were being educated by boards or committees that were under-resourced and too small to provide other than basic elementary education.

The separation of administrative responsibility was mirrored at central government level, where public health was administered by the Local Government Board, established under the Local Government Board Act of 1871,⁽³³⁾ while education was administered by the Education Department of the Privy Council, until responsibility was transferred to the Board of Education in 1899.⁽³⁴⁾ Thus at no level of administration did the public health officer have any formal links with educational administration, or even find himself an officer of a body with education responsibilities.

One consequence of this divorce between sanitary and educational administration was that education authorities formulated and implemented policies without reference to sanitary principles, and attempts by sanitarians to secure amendments were then resisted as being contradictory to educational objectives. This can be illustrated by reference to the method of financing the elementary education system.

Prior to 1870, the steady increase in the Exchequer grant in aid to the existing voluntary schools, from £150,000 in 1851 to £541,233 in 1857, had prompted the appointment of the Newcastle

(31) Derek Fraser, The Evolution of the British Welfare State, (London: Macmillan, 1973), p.79.

(32) Sutherland, op.cit., p.105

(33) Local Government Board Act, 1871, 34 & 35 Vict. ch.70

(34) Board of Education Act, 1899, 62 & 63 Vict. ch.33

Commission to enquire into the state of popular education.

In 1861 the Report of the Commission recommended an extension of "sound and cheap elementary instruction". This led Robert Lowe, the Vice-President of the Education Department, to introduce the "Revised Code" of 1862, which embodied new regulations for the payment of Exchequer grants. These provided for a payment for each child in regular attendance, and further grants for those children who passed examinations at one of six standards. The original examination subjects were reading, writing and arithmetic - the three 'R's.⁽³⁵⁾ Thus a school's grant depended both on the numbers attending and on the children's performance in the annual examination of the standards. The objectives underlying the Code were explained by Lowe in a well-known passage from his speech in the House of Commons introducing the Revised Code proposals:

I cannot promise the House that this system will be an economical one and I cannot promise that it will be an efficient one but I can promise that it shall be either one or the other. If it is not cheap it shall be efficient, if it is not efficient it shall be cheap. (36)

The principle underlying the Revised Code system, that of "payment by results", was taken a stage further by many boards and committees of managers who linked the salaries of the teachers they employed to their pupils' performance in the annual inspection.⁽³⁷⁾

(35) S.J. Curtis, History of Education in Great Britain, 7th ed. (London: University Tutorial Press, 1967), pp.230-71.

(36) Parl. Deb., 3rd series, 165(13 February, 1862), 229.

(37) Fraser, op.cit., p.79; M.A. Fenton, "The Elementary Education Act as a Factor of Disease", Public Health, 1(1888-89), 198.

Even such a large and progressive school board as the London School Board did not abolish the practice until 1883.⁽³⁸⁾ Thus under this system both managers and teachers had a financial incentive to maintain the highest possible attendance, with particular efforts being made to ensure the presence of all children capable of passing a standard at the time of the annual examination. The consequences of this system for the sanitary profession were detailed to the Society of Medical Officers of Health in 1876, when a paper by Dr. Thursfield:

pointed out, that attendance being one basis of payment to the masters, and the amount of education another, it is in the interest of the master to ensure as large an attendance as possible both at the daily classes and at examinations. (39)

This consideration led to the concealment by teachers of the presence of epidemic disease in their schools,⁽⁴⁰⁾ and to experiences such as that of Dr. Fenton, the Medical Officer of Health for Coventry, who:

was investigating an outbreak of measles in a home when a message arrived from the school stating that the examination was in progress, and the teacher would give the children a penny each to attend, so as to pass, and thus earn the grant.(41)

W.E. Fletcher, the Medical Officer of Health for Ormskirk, in Lancashire, found the local school attendance officers so reluctant to provide him with information about children, whom they had found

(38) David Rubinstein, School Attendance in London, 1870-1904, University of Hull Occasional Papers in Economic and Social History, no.1 (Hull: University of Hull, 1969), p.38

(39) SMOH, Oxford, Box A59, Annual Reports, Annual Report for 1876-77, p.11.

(40) Fenton, op.cit., p.201

(41) Ibid., p.198; see also W.N. Thursfield, "School Attendance and Infectious Disease", Public Health 6(1893-94),411.

to have infectious disease that he persuaded the local School Attendance Committee to pass a resolution requiring them to do so. He then found his intentions frustrated by the teachers, who failed to notify the attendance officers of such absences. Fletcher believed:

that teachers are unwilling to inform the attendance officers of absentees whom they themselves know to be suffering from infectious disease, knowing they would report to me, and fearing that I would keep away from school many children who, though themselves quite healthy, might be living in infected dwellings; whereas so long as I was kept ignorant of the cases, they could compel these children to attend school by threatening the parents if they persisted in keeping them at home.

He then threatened the teachers with prosecution under the Public Health Act 1875.⁽⁴²⁾

In 1874 the Education Code for the first time included a provision intended to reduce opposition to intervention by public health officials, a footnote saying:

if a school has been closed during the year, under medical authority, on account of a local epidemic, a proportionate reduction is made from the number of meetings (400) and attendances (250) required by this article.⁽⁴³⁾

This was intended to protect a school from loss of grant if closure was ordered by the medical officer of health during an epidemic of infectious disease. But financial loss could still occur if scholars were excluded, rather than the school closed, while

(42) Quoted in Thorne Thorne, op.cit., p.144. In areas where no School Board existed, enforcement of school attendance byelaws and regulations was the responsibility of a School Attendance Committee established by the Elementary Education Acts of 1876 (39 & 40 Vict. ch.79) and 1880 (43 & 44 Vict. ch.23). At least half the membership of the School Attendance Committee had to be members of the appointing authority, which might be the Poor Law Guardians, Borough Council or urban sanitary authority according to the status of the local government area. School Attendance Committees were thus not directly affected by the loss of grant caused by closure of schools or exclusion of scholars due to infectious disease. See Sutherland, op.cit., pp.87-88.

(43) BPP 1874/LI:241, Code of Regulations...for 1874, C.931, p.6

exclusion or closure near the date of the annual examination might prejudice that part of the grant given for children passing their standards. In some areas there was a further concern:

If the medical officer closed the school for a long time teachers would have doubts whether they might not have done better had the school been kept open. If the rural school were in the neighbourhood of a town, the children went off to a town school, and the rural teacher would be afraid that he might not get them back when his school re-opened.(44)

Such considerations could be important, given the link between grant and salary, and led to a continuing reluctance to obey the instructions of the sanitary authority. To combat this, in the 1882 Code a new clause was inserted requiring managers to:

comply with any notice of the sanitary authority of the district in which the school is situated, requiring them for a specified time, with a view to preventing the spread of disease, either to close the school or to exclude any scholars from attendance, subject to an appeal to the Department if the managers consider the notice to be unreasonable.(45)

With the advent of the 1882 Code therefore, a school could be closed, or scholars excluded, even if the managers or the board opposed the medical officer of health's decision.

The inclusion of the new clause was given an immediate welcome by the Society of Medical Officers of Health,⁽⁴⁶⁾ but subsequent changes to the relevant sections of the Code, discussed in the next

(44) Reginald Dudfield, "Sanitary Supervision of Schools", Public Health, 10(1897-98),265.

(45) BPP 1882/L:511, Code of Regulations...for 1882, C.3152, art.98

(46) SMOH, Oxford, Transactions of the Society of Medical Officers of Health for 1881-82, p.3

chapter, indicate that the power of the sanitary authority remained incomplete.

Other aspects of educational administration were subjected to criticism in the literature of the sanitary profession during this period. In Sheffield the Medical Officer of Health complained in 1883 that children were being sent from school to the homes of absentees with forms on which the parent was requested to explain the cause of absence. Dismissing his fears about the risk of infection, the local school board voted to continue the practice.

The same system was still being operated in 1900.⁽⁴⁷⁾ A similar rebuff was given to the Medical Officer of Health for South Shields, who complained:

while I was obtaining information concerning a case of scarlet fever in a one roomed house, a child sent from the school came into the room where the patient was lying, saying that he had been sent by the teacher to enquire why children of the family were not at school. I at once pointed out to the School Board the danger of allowing such a practice to continue; but, in reply, I obtained a letter from the clerk stating that the practice was as old as the schools themselves, and allowed, within "reasonable limits", by the Board.(48)

The major educational concern of the public health officer after infectious disease, however, was the condition of the school building. To a limited extent, the importance of a satisfactory environment for the school building had been recognised since the first involvement of the state in the financing of elementary education, for in its first

(47) J.H. Bingham, Education in the Period of the Sheffield School Board, 1870-1903, (Sheffield: J.W. Northend, 1949), p.233.

(48) Annual Report of the Medical Officer of Health for South Shields, quoted in Public Health 4 (1891-92), 284.

Circular in 1839, the Committee of Council on Education instructed architects of new schools to state whether there were "any vitriol works, tanneries, size manufactories, slaughter houses or other noxious trades" situated near the school, and also whether it was "in the neighbourhood of any undrained marsh or swampy ground, any large uncovered drain, or large stagnant pool".(49)

The sanitary standard of the school itself attracted little attention, and Chadwick's earlier concern about this has already been noted.⁽⁵⁰⁾ The guidelines issued by the Education Department in 1871, Rules to be observed in planning and fitting up schools, contained no advice on the desired standard of heating, ventilation, natural and artificial lighting to be adopted. Sanitation was discussed, but the only minimum standard specified in the document was that one child should be allowed twenty two inches of desk.⁽⁵¹⁾ The relevant clauses of the Education Code provided further guidance. Article 17(c) of the 1872 Code allowed grant to be paid only if the school premises were:

healthy, well lighted, drained and ventilated, properly furnished, supplied with suitable offices, and contain in the principal school room at least 80 cubic feet of internal space, and in the school room and class rooms at least 8 square feet of area, for each child in average attendance.(52)

(49) Malcolm Seaborne, The English School:its Architecture and Organisation, 1370-1870, (London: Routledge & Kegan Paul,1971),p.228.

(50) See also SMOH, Oxford, Box A59 Annual Reports, Presidential Address by Dr. Robert Druitt in Annual Report for 1870-71,p.3

(51) Committee of Council on Education, Rules to be observed in planning and fitting up schools, 1871.

(52) BPP 1872/XLVI:291, Code of Regulations....for 1872, C.483, art.17(c)

Only in the 1873 Code was it provided that the school premises should be "well lighted, warmed, drained and ventilated",⁽⁵³⁾ while in some sections of the Education Department, extreme economy in expenditure on school buildings continued to be applauded. Seaborne and Lowe note H.F. Codd, the H.M.I. for Devon and Cornwall, referring with approval in his 1876 Annual Report to the savings to be made when a school was built without a professional architect being employed.⁽⁵⁴⁾

Standards for school buildings were thus vaguely defined and minimal even where definite guidance was given. In the rapid expansion that followed the 1870 Act there was a temptation, particularly with the voluntary schools and in the smaller boards, for these minimal standards to be adopted as the norm. The growing impoverishment of the voluntary societies during the school board era made later maintenance and improvement of school premises difficult.

The existence of schools of poor quality and unsatisfactory sanitary standards concerned the sanitary profession. Led by Chadwick, they called for standards to be improved.⁽⁵⁵⁾ But in this period, little practical work was done, though the 1880's saw the publication by public health officers of texts on school sanitation and health that were among the earliest attempts to codify and disseminate knowledge about the relationship between health and school life.⁽⁵⁶⁾

(53) BPP 1873/LII:75, Code of Regulations...for 1873, C.722, art.17(c)

(54) Malcolm Seaborne and Roy Lowe, The English School: its Architecture and Organisation, 1870-1970 (London: Routledge & Kegan Paul, 1977), p.3

(55) See e.g. Edwin Chadwick, "Norms of Sanitation in the School Stages of Life", Sanitary Review, n.s.1(1880), 176-78, and A. Downes, "Hygiene of Village Schools", Sanitary Review, n.s.3(1881-82), 92.

(56) Arthur Newsholme, School Hygiene (London: Swan Sonnenschein, Lowrey, 1887); Charles E. Paget, Healthy Schools, 1884 International Health Exhibition Handbook (London: William Clowes, 1884)

The foregoing discussion indicates how the sanitarians, both from a general interest in the health of the people and a specific adherence to the view that schools constituted centres for the spread of infection, campaigned for some form of sanitary supervision over the public education system.

The analysis also indicates, however, that the separation of functions at both central and local government level weakened the sanitarians' ability to exercise influence over even the board schools, while the system of educational finance, combined with the ignorance of hygiene and suspicion of sanitary bureaucracy displayed by some board members and managers, reduced the incentive to accept the advice proffered by public health officials. The analysis suggests, therefore, that concern about the sanitary implications of elementary education, important though it was in developing and sustaining the interest of a group of medical men in the health of school children, did not in itself produce action by the education authorities. For this, it was necessary for education authorities in both the private and the public sector to be persuaded that it was in their own best interests to devote more attention to the health of their pupils.

The "Over-Pressure of Work" Concern

In this respect, it may be suggested that it was the "over-pressure" scare of the early 1880's, and the consequential growth of interest in means of maximising returns from expenditure on education, that first persuaded educational interests in both the public and private sectors to consider the potential advantages of

paying greater attention to the health of school children.

Until the 1850's and 1860's, British education had not been especially concerned with maximising educational achievement or with securing efficiency or economy of provision. In those decades and after, however, a series of changes had taken place which made the identification and reward of merit a much more significant objective. In the public schools, the introduction of reforms involving competitive entrance examinations for many of the main career outlets of the public schools, in combination with internal pressure to introduce examinations and prizes both as a means of raising academic standards and as a preparation for the entrance examinations for the various professional careers, led to a greater emphasis on academic competition during the 1860's and 1870's. The trend was further accentuated by the demands of the new middle class influx into the public schools for more 'modern' subjects to be taught.⁽⁵⁷⁾

In the elementary schools, the 1860's and 1870's saw an increase in the element of competition embodied in the education system through the introduction of the Revised Code and its attendant system of grant payments. The unimaginative and mechanistic approach to teaching engendered by the introduction of the Code was described by Mathew Arnold in his reports as an H.M.I.⁽⁵⁸⁾ Although the Revised Code was not actually a system of individualized competition, a major effect of

(57) Edward C. Mack, Public Schools and British Opinion since 1860 (New York: Columbia University Press, 1941), pp.3-133.

(58) See J.S. Maclure, Educational Documents, England and Wales: 1816-1963, (London: Chapman and Hall, 1965), pp.81-82.

its introduction was to increase the competitive pressure on pupils and teachers alike. The pressure exerted on the children by the system of learning by rote was magnified by revisions of the Code which increased the number of examinable subjects. Managers and board members tried to maximise the grant obtained, and the teachers sought to protect their salaries and career prospects, by attempting to ensure as many passes as possible in examinable subjects.

The teaching profession opposed the Revised Code system for its destruction of worthwhile teaching methods and the professional insecurity it created, but opposition to the introduction of the Code sapped both the strength and the financial resources of the existing teachers organisations, so it was not until after the formation of the National Union of Elementary Teachers in 1870 that it gained a united, and increasingly powerful voice with which to attack both the Code and its results.⁽⁵⁹⁾

By the 1870's, therefore, competition had assumed a central role in both the elementary and public education systems, whereas twenty, or even ten years before, it had been of much less significance. In the elementary sector, the instrument by which this competitive element had been introduced, the Revised Code, was strongly opposed by the main teaching union, which therefore had a standing interest in any evidence which seemed to discredit the Revised Code system. It is against this background that the development of concern about the "over-pressure of work" on school children, the first debate about the health of school children to reach any other than a purely professional audience, must be considered.

(59) Asher Tropp, The School Teachers (London: Heinemann, 1957), p.97.

The first suggestion that the pressure of school work had adverse, long-term effects on children's health came from Prussia. In Britain at this time there was considerable interest in the social and educational provisions thought to underpin the successful Prussian military machine.⁽⁶⁰⁾ This led to an awareness of the difficulties, as well as the achievements, of those services. In Prussia, medical concern about the effect of the education system on the health of school children had first been expressed in the work of Dr. Herman Cohn of Breslau, whose study of the eyesight of over 10,000 school children in Leipzig, with a discussion on the apparent effects of school life on eyesight, had first been published in 1867.⁽⁶¹⁾ Cohn's work quickly became known to interested ophthalmologists in England, and a translation of one of his later books was published in 1886 by W.P. Turnbull, an H.M.I.⁽⁶²⁾ Cohn's work led to further research and investigation by other Prussian doctors on the effects of schooling on health, and British interest in the question was first generally aroused by the publication in the Times of a paper by a Prussian physiologist named Treichler. He claimed that over one third of all children in the Prussian equivalent

(60) W.H.G. Armytage, The German Influence on English Education (London: Routledge, Kegan Paul, 1969), pp.58-72.

(61) Herman(n) Cohn, Untersuchungen der Augen van 10,060 Scholkindern (Leipzig:1867).

(62) Hermann Cohn, The Hygiene of the Eye in Schools, trans.by W.P. Turnbull (London: Simpkin, Marshall, 1886). According to G.A.N. Lowndes, this earned Turnbull the accolade of "father of the school medical service". G.A.N. Lowndes, The Silent Social Revolution, 2nd ed. (London: Oxford University Press, 1969),p.174.

of the elementary schools suffered from "habitual headache" caused by excessive homework and the number of subjects studied at school.⁽⁶³⁾ Although there had been earlier warnings in the medical press about the dangers of over-pressure on school children, including an article in the first number of the neurological journal Brain,⁽⁶⁴⁾ Treichler's article brought the debate to a wider audience. It prompted a considerable number of letters to the Times,⁽⁶⁵⁾ many of which supported his allegations, and suggested that similar problems existed in both the public and the elementary schools. The Times itself declared in a leading article that there was no problem in the public schools, but in the elementary schools "it must be admitted...that a certain number of children suffer from the consequences of over-study".⁽⁶⁶⁾

Academic discussion followed Treichler's article. At the Annual Meeting of the British Medical Association in August 1880, Dr. James Crichton-Browne⁽⁶⁷⁾ discussed Treichler's paper in an address to the

(63) Times, 8 April 1880, p.7. For analysis of the over-pressure debate see A.B. Robertson, "Children, Teachers and Society: the Over-Pressure Controversy, 1880-1886", British Journal of Educational Studies 20(1972), 315-23, and Sutherland, op.cit., pp.24-25. For a comprehensive, but not exhaustive bibliography of the contemporary literature about the over-pressure issue see A.B. Robertson, "State Education and the Welfare of School Children". Education Libraries Bulletin 44(Summer 1972), 20-29.

(64) T. Clifford Allbutt, "On Brain Forcing". Brain 1(1878-79), 60-78.

(65) See e.g. Times, 13 April 1880, p.11, and 15 April 1880, p.11.

(66) Ibid., 21 April 1880, p.9.

(67) Sir James Crichton-Browne MRCS(Edin.) MD, FRS(Edin), FRS (1840-1938). Born in Dumfries, where his father was the Medical Superintendent of the Crichton Royal Institution, Crichton-Browne thus enjoyed the rare distinction of being named after a lunatic asylum. Educated at Dumfries Academy, Trinity College Glenalmond and Edinburgh University. After various junior posts in mental hospitals, became Medical Superintendent of the West Riding Asylum, Wakefield, in 1866. In 1875, he was appointed Lord Chancellor's Visitor in Lunacy, a post he retained until 1922. Co-founder and co-editor of Brain. Kt.(1886).

Psychological section of the meeting. Although Crichton-Browne thought Treichler had seriously exaggerated the problem, he believed the incidence of mental illness amongst school children was increasing, and that one of the causes was the extension of the education system. In view of the fact that education could produce such "pernicious consequences", he called for the education system to be placed under the general supervision of physiologists and psychologists.⁽⁶⁸⁾

Thus during 1880 the possibility that the health of school children, particularly in the elementary schools, was being directly affected by the work load imposed on them was being widely debated. The correspondence in the Times quickly linked the problem to the Revised Code controversy,⁽⁶⁹⁾ and this alleged link was to dominate the subsequent history of the over-pressure debate.

As already indicated the National Union of Elementary Teachers had long opposed the Revised Code system. In the decade after the passage of the 1870 Act, its desire to secure a reform was strengthened not only by the growth in membership of the Union but also by developing trends in school attendance. The 1870 Education Act by no means ensured universal attendance at school, and it was not until after the passage of two further Acts in 1876 and 1880 that the legal basis for this was achieved.⁽⁷⁰⁾ In the decade after the 1870 Education Act, numbers on the school registers and average school attendance increased substantially, as the following table

(68) British Medical Journal i (1880), 265

(69) See e.g. Times, 21 April 1880, p.6.

(70) See Sutherland, op.cit., pp.115-62.

indicates:

CHILDREN IN ELEMENTARY SCHOOLS 1870 - 1880⁽⁷¹⁾

Year	Number on Registers	Average Attendance
1870	1,693,000	1,152,000
1874	2,497,000	1,679,000
1879	3,710,000	2,595,000

It was estimated that a further 400,000 to 500,000 children remained to be registered in 1879. Thus in the first ten years of the elementary education system the numbers on the registers and attending school both increased by nearly 250 per cent.

Only as time went on therefore did many children of the poorest, most destitute families enter the elementary schools. When they did so, the effects of their presence were profound. First, they gave many teachers an insight into the poverty affecting the lives of many children of school age. T.J. Macnamara, President of the National Union of Teachers, an M.P. and Minister, recalled seeing children at his school in Bristol eating raw turnips for lunch.⁽⁷²⁾ But apart from this, the presence of such children made the teacher's task harder. Under-nourished, often unhealthy, their ability to acquire the knowledge needed to "pass their standards" was impaired. Coupled with claims that the requirements of the Revised Code were being progressively upgraded, the difficulty of teaching these children increased the anxieties of both individual teachers and the N.U.E.T.

(71) Parl. Deb., 3rd series, 254 (2 August 1880), 1966-67

(72) Parl. Deb., 4th series, 152 (2 March 1906), 1421.

Thus the emergence of the over-pressure concern provided a good opportunity for the teachers to claim that the root of the problem was the Revised Code system, and to demand its reform. At first, it appeared that their demands would be dealt with quickly and sympathetically, for on 27th April 1880 Gladstone appointed A.J. Mundella to be Vice-President of the Committee of Council on Education.⁽⁷³⁾ Mundella was thought to be sympathetic to many of the views of the N.U.E.T., and to be willing to listen to their complaints. His subsequent announcement, on 2nd August 1880, of his intention to reform the system of grants paid under the Revised Code system⁽⁷⁴⁾ was therefore welcomed by the N.U.E.T., which then concentrated its immediate energies on preparing a memorandum for Mundella on the reforms they wanted to see embodied in any new Code. The N.U.E.T.'s views were forwarded to the Education Department in December 1880.⁽⁷⁵⁾

With the Revised Code seemingly about to undergo substantial revision, relatively little prominence was given to discussion about over-pressure, or about the medical problems relating to elementary education, during the next few months. But following the announcement on 8th August 1881 of Mundella's proposals for a new system of grant payments⁽⁷⁶⁾ which, although reducing the importance of individual examination of scholars in the calculation of the grant, did not fully meet the suggestions of the N.U.E.T., and the subsequent

(73) Rt Hon. Anthony John Mundella FRS (1825-1897). Apprenticed to a hosiery manufacturer in Leicester, he became an industrialist in Nottingham. Liberal MP for Sheffield 1868-85, Sheffield Brightside 1885-97. Vice-President, Committee of Council on Education, 1880-85; President, Board of Trade, 1886, 1892-94.

(74) Parl. Deb., 3rd series, 254(2 August 1880), 1979-80.

(75) National Union of Elementary Teachers, The New Code and Over-Pressure in Elementary Schools (London: N.U.E.T., 1884), p.8

(76) Parl. Deb., 3rd series, 264 (8 August 1881), 1210ff.

implementation of substantially the same proposals in the 1882 Education Code, renewed opposition to the Code system developed.⁽⁷⁷⁾ Further allegations about the existence of over-pressure among school children were also made.

Essentially, it was the operation of the new Code system with which the teachers were most concerned. While the former Code had effectively required that all children should be presented for examination in order to obtain the maximum grant, under the 1882 system much of the grant was dependent on the percentage of pupils passing their standards. The higher the percentage of failures in the examination, the lower the average grant per child. An increased grant would thus result if the weaker pupils were withheld from the examination. To guard against this possibility, however, the Instructions to H.M.I.'s issued with the new Code stressed the need to ensure the maximum attendance:

Hitherto, since part of the grant was based on the individual payment for the successful examination of all scholars who had attended 250 times in the course of the year, managers were interested in getting together all such scholars on the day of examination. As the grant is now based on the average attendance of all the scholars, and will be adversely affected by the failure in examination of backward scholars, it will be your duty to see that every child who is liable to be presented for examination, is present unless there is reasonable excuse. (78)

(77) BPP 1882/L:511, op.cit.

(78) BPP 1882/L:547, New Code of 1882: Instructions to H.M.I.'s, C.3335.

The N.U.E.T. alleged that this instruction was rigorously applied by the H.M.I.'s,⁽⁷⁹⁾ and suggested the Code be amended to require examination of only 90 per cent of the average number of children in attendance.⁽⁸⁰⁾ This was held to be in the interests of the weaker pupils, but was also, no doubt coincidentally, favourable to the interests of the teachers themselves. The refusal of the Education Department to accede to these proposals stimulated a revival of

(79) The suggestion that this instruction was being stringently applied was vigorously denied by H.M.I.'s and critics of the over-pressure hypothesis. Sydney Buxton, quoting H.M.I.'s in evidence, claimed that teachers were in fact allowed to withdraw children from the examination freely, and that 146,000 out of 153,000 withdrawals had been sanctioned as reasonable. Sydney Buxton, "Over-Pressure" and Elementary Education (London: Swan Sonnenschein, 1885) p.69. But, as T.J. Macnamara explains, the teachers did have grounds for their grievance:

"When an Inspector paid his annual visit of examination to a school, the teacher was permitted to enter upon an 'Exemption' list the names of such children as might reasonably be excused the ordeal of examination on the ground of physical or mental unfitness, and so on. Some Inspectors objected most strongly to this list if it contained more than one or two names per hundred of the pupils....Another of the charming ways of the system was this: that once a child's name was put on the Exemption Schedule he could not then, under any power in Heaven or earth, be examined. If the reason for his presence on the 'Exemption' list was a good one, the Inspector wrote 'E' upon the Schedule, and all was well. If, however, the reason was, in his opinion, not a good one, then he wrote 'N.E.' upon the form, and the child was counted, to the teacher's professional detriment, a failure in all the subjects of examination".

T.J. Macnamara, Schoolmaster Sketches (London: Cassell & Co., 1896), p.32.

(80) N.U.E.T., Annual Report for 1883, p.lviii

opposition to the Code system and renewed allegations of "over-pressure" resulting from its application. This renewal of the debate about over-pressure of work among school children was, in the view of a senior member of the Inspectorate, expressly designed to justify these proposals to exempt some children from examination.⁽⁸¹⁾

Certainly the N.U.E.T. played a leading role in the renewed agitation over the alleged existence of over-pressure, although a further stimulus was given by the publication of the Registrar-General's Annual Report for 1882, which noted a relative increase in the mortality from nervous diseases among children of school age since 1870.⁽⁸²⁾ Although the N.U.E.T. Executive was at first in favour of giving Mundella's new Code a trial,⁽⁸³⁾ the Union's 1882 Annual Conference, meeting in Mundella's constituency of Sheffield resolved:

That this Conference is of the opinion that great injury has been inflicted on teachers and scholars by the over-pressure of work under the Education Code....and that little relief is offered by the new Code just issued. (84)

The N.U.E.T. then embarked on a prolonged correspondence with the

(81) BPP 1888/XXXV:1, Royal Commission on the Elementary Education Acts, Final Report, C.5485, evidence of J.G. Fitch, p.178.

(82) The Report noted that while there had been a general decline in mortality at the ages 5 to 15 between the decade 1861-70 and that of 1871-80, which had continued in 1881 and 1882, the death rate at those ages from diseases of the nervous system had remained unchanged during this period. This failure of the death rate from nervous diseases to decline proportionately to overall mortality was held to support the view that school work was adversely affecting the brain and nervous system of some children. BPP 1884/XX:1, Registrar-General, Annual Report for 1882, C.4009 pp.xv-xvi.

(83) Tropp, op.cit., p.127

(84) N.U.E.T., The New Code....., p.10

Education Department, and ensured maximum publicity for the controversy by publishing the correspondence in the Times. The general public, academic and medical debate about the existence of over-pressure was also revived.

In the face of this pressure, the Education Department maintained its stance that further changes in the Code were not required. Mundella rejected approaches by teachers from his own constituency, causing the Sheffield Daily Telegraph to comment:

Social Science congresses, medical experts, thousands of teachers, may shriek themselves hoarse, children may die, little heads may ache, unknown harm may be done to hundreds of delicate children, but there is no over-pressure. Mr. Mundella has said it. (85)

The officials of the Education Department also denied that the Code itself was responsible for any over-pressure, putting forward the ingenious argument that:

In fine, my Lords believe that over-pressure is caused, not by the Code itself, but by the inconsiderate manner in which its provisions are used for the purposes of obtaining high grants. (86)

The continuing correspondence in the press produced numerous letters condemning the effects of the new Code, and some defending it, including one from a school attendance officer who had:

ever found the children looking anxiously and joyously forward to the day of examination, so much so that it would be nothing short of absolute cruelty to deprive any of those dear little souls of their long-hoped-for privilege. (87)

(85) Ibid., p.22

(86) Ibid., p.14

(87) Nature 31 (1884-85), 73.

Eventually, though, the continuing criticisms forced Mundella to act. He invited Dr. James Crichton-Browne to an interview on 16 February, 1884, and asked him to conduct an inquiry into the allegations of over-pressure.⁽⁸⁸⁾ He announced this to the House of Commons on 19 February.⁽⁸⁹⁾ Later, presumably after officials in the Education Department had expressed their concern about the nature of the inquiry, Crichton-Browne was notified that an H.M.I., J.G. Fitch, was to accompany him during his investigations.⁽⁹⁰⁾

The news of Crichton-Browne's inquiry did little to quell the outcry against over-pressure. The N.U.E.T. held a large protest meeting at the Exeter Hall, at which Lord Shaftesbury presided,⁽⁹¹⁾ while three thousand people demonstrated at Bradford.⁽⁹²⁾ Dr. Rabagliati, a surgeon at the Bradford Infirmary, later gave a paper on the subject to the N.U.E.T.'s 1884 Annual Conference.⁽⁹³⁾ The Birmingham, Leeds, Bradford and London School Boards decided to establish their own inquiries into the question,⁽⁹⁴⁾ while the N.U.E.T. persuaded over fifty M.P.'s to meet their representatives and discuss the problem.⁽⁹⁵⁾

The continuing agitation now developed in new directions. A proportion of the reports about cases of over-pressure now related to alleged over-pressure on teachers at the time of examination or

(88) Times, 8 October 1884, p.3.

(89) Parl. Deb., 3rd series, 284 (19 February 1884), 1331-32.

(90) Times, 8 October 1884, p.3.

(91) Ibid., 27 March 1884, p.5.

(92) British Medical Journal, i(1884), 278.

(93) N.U.E.T., Annual Report for 1884, pp. lvi-lxiv.

(94) Times, 3 April 1884, p.6; 11 April 1884, p.4; A.J. Evans, "A History of Education in Bradford during the period of the Bradford School Board", (M.A. thesis, University of Leeds, 1947).p.80. GLRO, London School Board Files SBL/430, Special Sub-Committee on Over-Pressure.

(95) British Medical Journal, i(1884), 783.

during preparation for it.⁽⁹⁶⁾ Doctors, influenced by the topicality of the question, diagnosed and published in the medical press instances of serious illness or death of children of school age allegedly caused by over-pressure of work.⁽⁹⁷⁾ Against this background, Crichton-Browne's Report gave little comfort to Mundella. On 9 June 1884 he told the Commons, in response to a question, that he had received a "voluminous and highly controversial" letter from Crichton-Browne, but felt that because of the nature of the document he felt unable to publish it "in extenso".⁽⁹⁸⁾ This not surprisingly failed to quell calls for publication of the letter, and on 13 June 1884 Mundella was forced to promise publication of a resume of Crichton-Browne's Report.⁽⁹⁹⁾

On 15 September 1884 Crichton-Browne's Report was finally published, although a critical memorandum by J.G. Fitch was attached. This strategem did little to reduce the immediate public impact of the Report, interest in which had, if anything, been increased by Mundella's delaying tactics. Fitch's dry, official style was no match for the "glowing periods"⁽¹⁰⁰⁾ of Dr. Crichton-Browne, whose highly emotional and dramatic descriptions of the symptoms and effects of over-pressure were used to reinforce his conclusion:

that educational over-pressure does exist to some extent in elementary schools, that it is even now exerting appreciable evil effects, and that, if

(96) Times, 3 March 1884, p.7.

(97) See e.g. Medical Times & Gazette i(1884), 370. A number of such cases are collated in N.U.E.T., The New Code... p.30ff. A subsequent investigation by the Education Department rejected over-pressure as a contributory factor to most such cases, probably with justification. BPP 1884-85/LXI:143, Education Department, Return of cases which have been Reported to the Department in which over-pressure has been Alleged as the Cause of Illness, C.4268.

(98) Parl. Deb., 3rd series, 288 (9 June 1884), 1772-73.

(99) Ibid., 289(13 June 1884), 240-41.

(100) Medical Times & Gazette ii (1884), 405.

unchecked it is likely to entail very serious consequences on future generations.(101)

Fitch's criticisms of Crichton-Browne's methods and objectivity were more influential in political and administrative circles, justifying Gillian Sutherland's suggestion that Crichton-Browne was effectively demolished by Fitch.⁽¹⁰²⁾ But the immediate public reaction, reflected in the correspondence columns of the national and the professional press, was to support Crichton-Browne's conclusions. Many correspondents related their own experiences of children allegedly suffering the effects of over-pressure.⁽¹⁰³⁾

The N.U.E.T. Executive subsequently endorsed "the general conclusions arrived at in Dr. Crichton-Browne's Report....and thanks him for the masterly way in which he has presented the facts of the case".⁽¹⁰⁴⁾

Nevertheless, little real action followed publication of the Crichton-Browne Report. Fitch's criticisms proved more influential than the initial public reaction suggested, and Crichton-Browne became involved in an acrimonious public argument with Fitch over personal matters connected with the enquiry. The over-pressure issue eventually became subsumed into more general educational issues in the 1885 general election, although the protagonists debated the issue whenever

(101) BPP 1884/LXI:259, Report of Dr. Crichton-Browne on the Alleged Over-Pressure of Work in Elementary Schools, H.C. 293.

(102) Sutherland, op.cit., p.255. For a critical review of the Report, see the Times, 16 September 1884, p.9.

(103) See e.g. Medical Times & Gazette ii (1884), 451-54, 484-87.

(104) Lancet, ii(1884), 659.

(105) Times, 18 September 1884, p.10; 20 September 1884, p.6; 8 October 1884, pp.2-3, and subsequent correspondence.

a suitable opportunity arose.⁽¹⁰⁶⁾ The appointment of the Royal Commission on the Elementary Education Acts in 1885 appeared to satisfy the immediate grievances of the teaching profession, for at the 1885 Annual Conference of the N.U.E.T. a resolution had been passed calling for the appointment of a Royal Commission "to enquire into the existence, causes and extent of over-pressure in elementary schools".⁽¹⁰⁷⁾ Much of the evidence submitted to the Commission alleged the existence of over-pressure among both pupils and teachers,⁽¹⁰⁸⁾ but the Final Report of the Royal Commission was not issued until 1888, by which time the immediate heat had been removed from the controversy.

Because of the apparent lack of tangible results from the Crichton-Browne Report, its significance in the history of school hygiene in Britain has perhaps been undervalued. James Kerr, perhaps the most influential of the early practitioners of school hygiene,⁽¹⁰⁹⁾ thought the over-pressure outcry, although marking the first signs of a general public interest in school health, was "not derived from scientific or medical observation", and that Sir Joshua Fitch, as he

(106) See e.g. T.C. Horsfall, ed., Proceedings of the Conference on Education under Healthy Conditions (Manchester: John Heywood, 1885).

(107) N.U.E.T., Annual Report for 1886, p.cxxxvi.

(108) BPP 1888/XXXV:1, op.cit., pp.177-78.

(109) James Kerr, MA,MD,DPH, (1862-1941). Born in Glasgow, the son of a warehouseman, he was educated at Manchester Grammar School, St. John's College Cambridge and St. Barts Hospital. A member of the medical staff of two hospitals in Bradford, his interest in the welfare of school children led him to work with Margaret McMillan and thus into a career which made him one of the most prominent and influential figures of the early days of the school health movement. Appointed full-time Medical Officer to the Bradford School Board, 1893. In 1902, he took up a similar position with the London School Board and continued as Medical Officer (Education) under its successor, the London County Council until 1911. Re-organisation of responsibilities led to his becoming successively Medical Research Officer and Consulting Medical Officer. Sometime member of the Executive Committee of the Fabian Society.

later became, had "distinguished himself in laying the bogey".⁽¹¹⁰⁾

Such a view neglects the role of the Crichton-Browne Report in shifting the over-pressure debate away from an essentially self-interested campaign by the teaching profession to permit the exclusion of less academically able pupils from the annual examination, thus raising the percentage pass rate and hence the grant paid under the 1882 Code method of calculation, towards other important, indeed, potentially more important, causes of over-pressure. Many children in the schools visited were underfed, and for Crichton-Browne:

liberal and regular feeding is necessary in order that a child may be prepared to profit by education, and medical men will be unanimous in declaring that it is futile and dangerous to force the half-starved children in London schools through examinations. (111)

Certainly dull, unintelligent children might be subject to pressure if they faced the examination, but:

A larger question than dullness, however, in connection with educational over-pressure in elementary schools, perhaps the largest and most important of all, is that of starvation.(112)

Deriving from this came the recommendation that a physical examination of the children should be conducted to determine their fitness to be educated. Crichton-Browne had made this suggestion for public school boys in his contribution to Sir Malcolm Morris's Book of Health, published in 1883.⁽¹¹³⁾ This was quoted extensively by Fitch in his attack on Crichton-Browne's ideas. In his Report

(110) BPP 1906/XLVII:157, Inter-Departmental Committee on the Medical Inspection and Feeding of Children Attending Public Elementary Schools, vol.2, Evidence and Appendices, Cd.2784, evidence of Dr. James Kerr, p.235.

(111) BPP 1884/LXI:259, op.cit., p.10.

(112) Ibid., p.8.

(113) James Crichton-Browne, "Education and the Nervous System" in The Book of Health, ed.Sir Malcolm Morris (London:Cassell & Co.,1883),pp.269-380.

to the Education Department Crichton-Browne suggested elementary school children should be similarly examined. He specified the physiological measurements, and background information on the family, to be obtained. Many of the measurements, such as those for height, weight, "circumference of head", and strength of eyesight were to be re-measured every two months. (114)

In making these suggestions for medical intervention, and also for the modification of children's nutrition by the provision of school meals, Crichton-Browne was challenging the traditional view of the school as being wholly and exclusively a pedagogic institution, a view reflected in J.G. Fitch's criticism of Crichton-Browne's suggestion that educational performance could be improved by the provision of fresh milk for the children:

The answer to this is that a school is established for the purposes of instruction, and not for the purpose of dispensing new milk, and I trust that the statesmen and philanthropists who are now considering this difficult and anxious question will think twice before complicating the problem of national education by mixing it up with the administration of food and medicine to the children of the poor. (115)

Fitch feared such proposals would lead to an erosion of parental responsibility, while Crichton-Browne's proposals for a medical inspection of children were questioned dismissively: "whether it is the office of an elementary school to become a mine of wealth to statisticians and anthropologists I do not pretend to discuss." (116)

(114) BPP 1884/LXI:259, op.cit., p.77. Others, including some sceptical of the general tenor of Crichton-Browne's Report, accepted that a case had been made for the provision of medical advice to school boards. See Robert Farquharson, School Hygiene and Diseases Incidental to School Life (London: Smith, Elder & Co., 1885), pp.120, 125-26. A Liberal MP, Farquharson had previously been Medical Officer to Rugby School.

(115) BPP 1884/LXI:259, op.cit., p.77.

(116) Ibid., p.78.

The publication of the Crichton-Browne Report, however, marks the point at which this traditional view started to weaken. Ever since the introduction of the Revised Code, managers, boards and teachers had been concerned to provide efficient instruction, efficient in the sense that it maximised the grant obtained from the Education Department. In the original perception of the over-pressure question, it was this attempt to maximise grant which created mental stress, and hence mental and physical ailments, for some children. After Crichton-Browne, the problem was increasingly seen in a different light. It was the presence of disease and malnutrition which, by reducing the ability of children to attend to their work, prevented education from being as efficient, in terms of grant maximisation. (117)

Thus one of Mundella's responses to the publication of the Crichton-Browne Report was to give his support for the expansion of the penny school dinner movement. Although he was promptly attacked by the Lancet for avoiding the main issue, (118) Mundella's suggestion was in fact a reflection of one of the earlier manifestations of the new concern about the physical well-being of school children, a rapid and considerable expansion in the number of both free and penny school dinners provided by voluntary groups. This was coupled with moves toward the provision of such meals on a daily basis, rather than the more infrequent provision formerly characteristic of this kind of charity. (119)

(117) The importance of Crichton-Browne's identification of malnutrition and ill-health as underlying causes of "over-pressure" was recognised even by his critics. See Buxton, op.cit., p.84.

(118) Lancet ii (1884), 1113.

(119) See Mildred E. Bulkley, The Feeding of School Children, Ratan Tata Foundation (London: G. Bell & Sons, 1914), p.12.

Apart from the obvious humanitarian impulses behind such provision, considerations of financial efficiency also played a role for, in the words of a rural vicar's wife as reported to a government inquiry some years later, providing meals "is not charity; this is far-sighted self-interest; because our children get better grants if they are fed than if they are underfed, and we feed them for the purpose of getting more money out of the government". (120)

It may be suggested, therefore, that the Crichton-Browne Report, by identifying the benefits to be gained by ensuring that school children were in a fit condition to be educated, marked the beginning of real interest in the health of the school child, an interest which derived not only from the humanitarian response to the revelations of Crichton-Browne and other social investigations of this period, but also to the realisation of the gains in terms of educational efficiency that might be obtained. After Crichton-Browne, it was increasingly accepted that both the sanitary conditions of the school and the state of health and nutrition of the school child might affect educational performance, and in so doing jeopardise the income of the school or the professional careers of its teachers. From 1885 onwards, therefore, albeit hesitantly, the doctor becomes involved to a greater and greater degree with educational administration.

Those developments of interest in the health of the school child which did occur prior to the publication of the Crichton-Browne Report were essentially manifestations of a wider professional interest in sanitary health. Political interest in school health was almost

(120) BPP 1904/XXXII:145, Inter-Departmental Committee on Physical Deterioration, vol.2, Minutes of Evidence, Cd.2210, evidence of Sir John Gorst, p.434, q.11849. See also Emmeline Pankhurst, My Own Story (London: Eveleigh & Nash, 1914), p.34.

completely absent although the Social Democratic Federation, at its inception in 1884, adopted a programme including "free compulsory education for all classes, together with the provision of at least one wholesome meal a day in every school".⁽¹²¹⁾ But the small membership of the various socialist parties meant that their influence in this early period was negligible.

Summary

The sanitarians were the first professional group to become interested in the health of the school child. They did so primarily because of a concern that the aggregation of children in schools contributed to the spread of infectious disease. As such, they were interested in the collective health of the children, rather than the health of individual pupils. The influence of the sanitarians was, however, limited by their separation from educational administration, and by the way in which the desire of school board members, school managers and teachers alike to maximise grant prevented a sympathetic reception for the advice of the sanitarians, which often was considered to threaten grant income.

This disinterest in the health of the school child shown by education authorities was first challenged by the over-pressure concern, and the subsequent linking, during the investigations engendered by the scare, of the condition and nutrition of school children and their educational performance. The period between the publication of

(121) Justice, 9 August 1884, quoted in Brian Simon, Education and the Labour Movement, 1870-1920 (London: Lawrence and Wishart, 1965), p.133. The continuing interest of the avowedly revolutionary S.D.F. in palliative measures to promote the health of school children owed much to its founder, H.M. Hyndman. See W.P. McCann, "Trade Unionist, Co-operative and Socialist Organisations in Relation to Popular Education, 1870-1902", (Ph.D. thesis, University of Manchester, 1960), pp.200-202.

Dr. Crichton-Browne's Report and the 1902 reform of educational administration was to see the first results of this realization, though structural and other factors were to reduce the rate at which progress was made.

CHAPTER TWOINITIATIVES IN SCHOOL HYGIENEIN THE LATER SCHOOL BOARD PERIOD1885-1902Progress in School Health after Crichton-Browne

It was in the residential schools, both those catering for the sons of the middle and upper classes, and those preparing boys for eventual entry into the navy or army, that the first manifestations of the new concern about the fitness of the child for the education he received were found, rather than in the elementary day schools on which Dr. Crichton-Browne reported. Although few of those connected with these schools went so far as the headmaster of Foyle College, Londonderry, Dr. Hime, who suggested "that not merely ought schoolmasters to be laymen, but that they ought to be medical doctors",⁽¹⁾ an effect of the over-pressure controversy was to secure a position of greater prominence for the doctors connected with them. In 1884 a letter appeared in both the Lancet and the British Medical Journal, signed by two medical officers to residential schools, suggesting the formation of an association to discuss the medical problems common to residential schools, such as:

School hours, periods of study, recesses, the feeding and lodgement of pupils, the isolation of infectious diseases and quarantine; the questions of the structure of classrooms and sport equipment, gymnastic training and field

(1) M.C. Hime, A Schoolmaster's Retrospect (London: Simpkin, Marshall & Co. 1885), p.65.

sports, over-pressure and cramming.(2)

The response to this letter resulted in the formation of the Medical Officers of Schools Association in April 1884, with an initial membership of thirty five medical officers to schools and residential institutions, and some other interested medical men.(3)

As the letter suggests, sanitary matters, predominantly the prevention and control of epidemics of infectious disease in boarding schools, were among the primary concerns of the new association, and many of the early meetings of M.O.S.A. were dominated by discussion of this subject. M.O.S.A.'s first publication, in 1885, was a Code of Rules for the Prevention of Infectious and Contagious Diseases in Schools.(4) Other subjects discussed during the 1880's, however, related to non-sanitary aspects of the health of the school child, including eyesight and physical training. The true range of interests embraced at this time by the medical officers of the residential schools is accurately reflected in the textbook written by Dr. Clement Dukes,(5)

(2) Quoted in Medical Officers of Schools Association, A Record of Fifty Years Work, 1884-1934 (Hertford: G.Creasey & Sons, 1934), p.9.

(3) Ibid., pp.10-11. Although some M.O.S.A. members were medical officers to Poor Law residential schools, medical supervision in some of these institutions was sometimes deficient due to financial restraints and other factors. In 1890, 334 of the 993 children in the Hanwell poor law schools were suffering from purulent ophthalmia. British Medical Journal i(1890),89. So frequently did outbreaks of this eye disease recur that it was claimed "ophthalmia at Hanwell" was "a standing and attractive headline for the evening papers", Lancet i(1890), 768-71.

(4) Medical Officers of Schools Association, op.cit., p.14. A revised edition of this pamphlet is still in print.

(5) Clement Dukes MD,FRCP,FRCS (1845-1925). Educated at St. Thomas's Hospital. Resident Medical Officer and House Surgeon, Gt.Ormond St. Hospital, then Physician to Rugby School 1871-1908. See R. Smith, "Great School Doctors and the Evolution of Adolescent Medicine", Practitioner 206(1971),183-86.

the Medical Officer of Rugby School, whose Health at School; Considered in its Mental, Moral and Physical Aspects⁽⁶⁾ was to become the standard textbook for the medical officer of a residential school, although it was by no means the only text aimed at this emergent market during the mid 1880's.⁽⁷⁾ The publication of texts by and for medical officers of residential schools thus paralleled the more sanitary orientated texts being produced at this time by medical officers of health. Duke's book ranged over a number of aspects of the school curriculum, and recommended a medical examination "as searching as a thorough examination for life assurance"⁽⁸⁾ on entering school. This recommendation also appeared in the Code of Rules issued by M.O.S.A.⁽⁹⁾

The establishment and subsequent growth of M.O.S.A. and the publication of the texts by Dukes and others are indicative of the greater degree of interest in the health of the pupils that was being displayed in many of the residential schools by the mid 1880's. This was stimulated both by the fear of epidemic disease and by the over-

(6) Clement Dukes, Health at School; Considered in its Mental, Moral and Physical Aspects, 2nd ed. (London: Cassell & Co., 1887). This was first published in Sir Malcolm Morris, ed., The Book of Health (London: Cassell & Co., 1883), pp.677-726.

(7) The market for which these publications were designed may be seen from the following comments on the qualifications of a school doctor:

"In the first place he must be a gentleman, as he has to deal largely with gentlemen, and it is well, if possible, that he should himself have passed through the curriculum of a public school and University, so as to bring him into sympathetic relations with those among whom his lot in life is to be passed".

Robert Farquharson, School Hygiene and Diseases Incidental to School Life (London: Smith, Elder & Co., 1885), p.217.

(8) Dukes, op.cit., p.58.

(9) Medical Officers of Schools Association, op.cit., p.15. A survey by M.O.S.A. in 1909 showed, however, that only 11 out of 38 schools questioned did in fact have a medical examination on entry. Journal of Education 31 (1909),457.

pressure debate, as the early proceedings of M.O.S.A. demonstrate.

Such manifestations of this new interest in the health of the school child were slower to emerge in the elementary school sector. This delay must be attributed to the structural, financial and legal influences bearing on the elementary education system. In the last chapter, brief reference was made to the structure of educational provision in England and Wales. With the majority of children being educated in voluntary schools until almost the end of the school board period, and the existence of a number of boards catering for small numbers of children, there was a considerable fragmentation of educational administration. Only the larger urban boards were responsible for sufficient numbers of children to make the provision of specialized facilities feasible. Only these boards had the relative wealth of resources required. But before these resources could be deployed to help ameliorate the health of school children the legal obstacles of the district audit system had to be surmounted.

The school boards, as with all British local government bodies, operated under the general principle of "ultra vires". That is, they were not legally empowered to incur expenditure for purposes for which no sanction had been given in the statutes defining their powers and duties. If such expenditure were incurred, it could be disallowed by the district auditor, who had been given power to examine the accounts of the school boards under the 1870 Act.⁽¹⁰⁾ Such a disallowance could result in the board members paying the cost from their own pockets. Because the powers and duties of the district auditor were tightly defined and rigidly enforced, a considerable number of instances of disallowance arose. In 1885 district auditors made

(10) L.M. Helmore, The District Auditor (London: Macdonald & Evans, 1961) p.48.

2,832 disallowances of expenditure in all local government bodies. These were referred to the Local Government Board, which could reverse the surcharge on a point of law or, if the legality of the surcharge was confirmed, allow the remission of the charge as an act of administrative policy. A significant proportion of surcharges by auditors, 298 in 1885-6, related to school boards. Although the Local Government (Expenses) Act was passed in 1887 in an attempt to reduce the number of disallowances, they remained at a high level. There were 2,371 in 1898, of which 220 related to school boards.⁽¹¹⁾ For those school boards contemplating expenditure on medical care of children in their schools, the possibility that the members of the board might be surcharged for any such expenditure was obviously an important consideration.

A board's ability to obtain medical assistance was limited by section 35 of the 1870 Elementary Education Act which provided:

A school board may appoint a clerk and a treasurer and other necessary officers, including the teachers required for any school provided by such board.⁽¹²⁾

Thus, except for certain specific instances for which sanction was given in legislation passed in the 1890's, discussed below, the power of a school board to obtain paid medical advice rested on a liberal interpretation of this power to appoint "necessary officers". Unless the board was a very large one, like London, or a radical board such

(11) This compares with an average of 69 disallowances of expenditure per year during the 1923-1930 period. E.J.D. Eaglesham, "Controlling Educational Expenditure Eighty Years Ago", British Journal of Educational Studies 5(1956-57), 121-22.

(12) Elementary Education Act, 1870, 33 & 34 Vict. ch.75. See also James Murphy, The Education Act 1870: Text and Commentary (Newton Abbot: David & Charles, 1972).

as Bradford, which was prepared to make such a consistently liberal interpretation of its statutory powers that it was in frequent conflict with the district auditor, and was therefore permanently in "bad odour" with the Education Department,⁽¹³⁾ then full time medical advice was unobtainable, the payment of a salary for a medical officer being in the Local Government Board's view illegal.⁽¹⁴⁾ As late as 1905, it was unwilling to sanction payment by an education authority, even on a fee or capitation basis, for a medical officer to test the eyesight of school children. Discussing:

the power of a local education authority to employ a medical practitioner to test the eyesight of children attending the public elementary schools, the Local Government Board stated that the legality of any expenditure for this purpose would in the first instance be a matter to be dealt with by the district auditor at the audit of the authorities accounts; but that it did not appear to the Board that the local education authority have any general power of incurring expenditure in the employment of a medical practitioner to examine school children with a view to reporting on the occurrence of defects of the eyes and prescribing medical treatment therefore.⁽¹⁵⁾

Arguably the fear of the district auditor, in combination with the Local Government Board's unwillingness, as the quotation above indicates, to express a definite opinion of the legality of an action in advance of a decision by the auditor, was a more potent inducement to financial probity and conservatism in policy than the

(13) David G. Pritchard, Education and the Handicapped, 1760-1960 (London: Routledge, Kegan Paul, 1963), p.128; Bradford Corporation, Educational Services Committee, Education in Bradford since 1870 (Bradford: Bradford Corporation, 1970), p.31.

(14) Local Government Chronicle (1902), 614.

(15) Ibid., (1905), 223.

actual use of the power or surcharge. A significant proportion of the surcharges imposed were remitted by the Local Government Board, and Eric Eaglesham argues that from 1885 onwards the Board was increasingly prepared to listen to the advice of the Education Department on cases of surcharge. He presents evidence to suggest that from 1890 onwards the Department was trying to influence the Board "in the direction of what was, in the Department's view, expedient".⁽¹⁶⁾ Nevertheless, the above example of advice given by the Board at a much later date, and reproduced for the information of local authorities in the Local Government Chronicle, indicates how restrictive the operation of "ultra vires" could be to boards wishing to obtain medical advice about their scholars. Other remedial work was also hindered, for in 1905, again, the Local Government Board was warning:

in the case of ordinary public elementary schools it does not appear to them that it would be competent for the local education authority to provide spectacles for the use of the children.⁽¹⁷⁾

It is suggested therefore that there were structural and legal hindrances slowing the development of health work in elementary schools during the period under discussion in this chapter. The continuing reliance on an expanded voluntary system of school meals provision at this time serves to illustrate that the problems of health and nutrition in relation to education, though now more widely recognised and better understood, still of necessity had to be dealt with through means other than direct provision by the boards.⁽¹⁸⁾ During this period,

(16) E.J.D. Eaglesham, From School Board to Local Authority (London: Routledge, Kegan Paul, 1956), p.86.

(17) Local Government Chronicle (1905), 735.

(18) Mildred E. Bulkley, The Feeding of School Children, Ratan Tata Foundation (London: G.Bell & Sons, 1914), p.12.

however, an increasing amount of health related work did begin in the elementary sector, particularly in the larger board areas and especially in relation to two main areas of activity. First, there was the increasing interest in the eyesight of children; second, the growth of specialised education necessitating selection procedures which were deemed, or which were required to have a medical input. There was also more widespread use of medical advice for other administrative purposes.

The Eyesight of School Children

Of these, it is the concern about eyesight which can be most directly related, both in its origins and in its objectives, to the over-pressure concern, for discussion about the effects of education on the eyesight of children derived from the same Prussian sources that had triggered the debate about over-pressure in Britain.⁽¹⁹⁾

Dr. Cohn's original investigation, briefly discussed in chapter one, found that the proportion of myopes, that is, children who were short-sighted, increased steadily from only 1.4 per cent of children in village elementary schools to 55.8 per cent of pupils in the highest classes of the gymnasia. By 1885, Cohn's work had stimulated at least forty investigations in a number of different countries,

(19) One of the earliest English publications on the eyesight of school children, Simeon Snell, Influences of School Life on Eyesight (London: Wyman & Sons, 1884) was derived from a lecture given to the Sheffield Certificated Teachers Association on 12 January 1884 at the height of the N.U.E.T.'s dispute with the Education Department and its political head, Sheffield's M.P. A.J. Mundella, about the over-pressure question.

including Britain,⁽²⁰⁾ although the first English publication to discuss the eyesight of school children in any detail was the work of another German doctor, Dr. Richard Liebreich.⁽²¹⁾

The first British replication of Cohn's study was undertaken by Joseph Priestley Smith,⁽²²⁾ a Birmingham ophthalmic surgeon and a close friend of Joseph Chamberlain, whose position and connections enabled him to gain access to three Birmingham Board schools. Here he examined 1,636 children aged from seven to thirteen years of age, and found about 5 per cent to be shortsighted in one eye or both. At a teacher training college, Priestley Smith found about 20 per cent of the students to be myopic.⁽²³⁾ A later study by W. Adams Frost, assistant ophthalmic surgeon at St. George's Hospital, London, found 27.3 per cent of the children to have "sub-normal vision".⁽²⁴⁾

In 1882, the potential links between eyesight and the efficiency of educational provision were raised, in a rather specialised case, by the Report of the Committee to Inquire into the Greenwich Hospital School. This school's main function was to educate and train boys for

(20) Robert Brudenell Carter, "Eyesight in Schools", Medical Times & Gazette i (1885), 535-39, 569-75.

(21) Richard Liebreich, School Life and its Influence on Sight (London: J. & A. Churchill, 1872). Of the eleven references listed under "Schools and Eyesight" in the British Museum subject catalogue for the period 1881-1900, five are by German-born authors.

(22) Joseph Priestley Smith MSc.FRCS (1845-1933). Born Edgbaston, son of Brooke Smith, an active member of Birmingham Town Council. Apprenticed as a mechanical engineer, but changed to medicine. Educated at Queen's College Birmingham and the London Hospital. From 1874, Ophthalmic Surgeon, Queen's Hospital Birmingham. Appointed Professor of Ophthalmology at Birmingham University in 1900. A Unitarian, he was related through his mother to the Chamberlain family. Joseph Chamberlain was one of his patients.

(23) Joseph Priestley Smith, Short Sight in Relation to Education, Address to the Birmingham Teacher's Association 2 November 1880 (Birmingham: Midland Educational Co., 1880).

(24) Brudenell Carter, op.cit., p.570. Normal vision refers here to the ability to read all the lines on a Snellen's test type.

eventual entry into the Royal Navy, and concern had arisen when it was found that nearly 40 per cent of the boys were rejected as physically unfit to serve, frequently because of poor eyesight, even though they had been acceptable to the school's medical examiners when seen two years earlier. The wastefulness of expenditure on the education of boys who were subsequently to be rejected for Navy service led to the establishment of the Committee of Inquiry.⁽²⁵⁾

Although the presence of defective vision and its implications for educational objectives were thus recognised by the early 1880's, action was slow in coming. At this juncture, the over-pressure question dominated all discussions of school health, while the remedies proposed when defective vision was actually discussed were firmly rooted in the medical concepts of the mid-Victorian period. Both Priestley Smith and the Committee on the Greenwich Hospital School placed most emphasis on improvements to lighting, and to the design of the desks, along with some reduction in the hours of work. The main bias of the proposals was therefore toward environmental improvements to the school, and the reduction of the school work required, rather than individual physical amelioration.⁽²⁶⁾ This approach, the preservation of sound eyesight by the provision of satisfactory environmental conditions at school continued to have its adherents even after a more individualised approach began to gain popularity. In 1889, for example, one writer's solution to the problem of educating short-sighted children was the provision of:

(25) BPP 1882/XVI:39, Departmental Committee...to Inquire into the Greenwich Hospital School, Report, C.3187.

(26) Ibid., Priestley Smith, op.cit., p.21.

schools which should be in the country, in healthy, high and bracing situations...lessons should be broken frequently by runs in the fresh air....books would be banished and replaced by viva voce instruction. (27)

Even in 1895, the bulk of a text on the eyesight of school children was devoted to a discussion of the environmental influences prejudicial to the preservation of good eyesight.⁽²⁸⁾

Gradually, however, the years after 1885 saw a movement toward a greater emphasis on remedial or at least ameliorative measures with individual school children. In this respect the public schools played a pioneering role. The appointment of medical officers to some of these schools led to the introduction of individual medical examinations of pupils on entry. These examinations led to a rise in the number of spectacles prescribed and worn and this, coupled with the interest in the over-pressure question, led to comment in the medical press by the early 1880's.⁽²⁹⁾ The discussions of M.O.S.A. publicised the trend towards the testing of sight. In 1885, Robert Brudenell Carter,⁽³⁰⁾ an ophthalmic surgeon at St. George's Hospital, read a paper before M.O.S.A. at which he concluded that "the considerable functional use of the eyes involved in education is liable to render pre-existing myopia actively progressive." He recommended that all children should have their eyes examined before

(27) Ernest E. Maddox, A Suggestion for the Special Instruction of Short and Weak Sighted Children (n.p., n.d.), p.10.

(28) Simeon Snell, Eyesight and School Life (Bristol: John Wright & Co., 1895)

(29) See e.g. British Medical Journal i(1881), 568.

(30) Robert Brudenell Carter FRCS(1828-1918). Educated at the London Hospital. Volunteered for service as a staff surgeon in the Crimean War, and while in the Crimea began to contribute articles to the Times. Became ophthalmic surgeon to St. George's Hospital in 1870. A member of the editorial staff of both the Times and the Lancet, he was a member of the first London County Council, and was a member of the General Medical Council 1887-1900.

they began their studies.⁽³¹⁾

Brundenell Carter continued to investigate and discuss the vision of children at school,⁽³²⁾ as also did Priestley Smith, who devoted his address, as President of the Ophthalmological Section of the 1890 Annual Meeting of the B.M.A. to a discussion of the possibility of preventing the development of myopia by the regular ophthalmic examination of school children.⁽³³⁾ This led to a request from the headmistress of the King Edward's High School for Girls, Birmingham, Edith Creak, for Priestley Smith to examine the eyes of all her students.⁽³⁴⁾ By the mid 1890's, a number of day secondary schools for girls had introduced medical examinations of their pupils.⁽³⁵⁾

In the elementary schools, progress on the individual identification and amelioration of eye defects was slower due in part to suspicion of medical interference. When Doctors Edward Bronner and John Henry Bell, two Bradford surgeons who had become interested in the allegedly detrimental effect of over-pressure on children's sight, attempted to enter the local schools to see if there was evidence to support this hypothesis, they were denied entry to every board school in Bradford. Eventually the Rev. C.W.N. Hyne allowed them in to Bierley Church School, where they found seventy children with defective

(31) Brudenell Carter, op.cit., p.575.

(32) Medical Officers of Schools Association, op.cit., p.19.

(33) British Medical Journal, ii(1890), 723-28.

(34) Ibid., i(1894), 438.

(35) See BPP 1895/XLVII:1, Royal Commission on Secondary Education, vol.5, Memoranda and Answers to Questions, C.7862, Memorandum by Miss Julia Cock MD, pp.375-78; A.E. Ridley, Frances Mary Buss and her Work for Education (London: Longmans Green, 1895), pp.222-23. The growth of medical examinations in girls day secondary schools is probably attributable to the development of games and physical exercises, and to concern about the effect of needlework and embroidery lessons on the eyesight of the girls.

eyesight. (36)

Even where such attitudes were not present, the difficulties facing any board that was interested in rectifying the sight of individual school children were formidable. The parents of many children attending elementary schools, if not either antagonistic or apathetic towards equipping their children with spectacles which were widely held to prejudice their chances of employment, were unable to afford the cost of them. The onus to take any remedial action thus fell on the school boards and managers who, for reasons discussed earlier, were unable or unwilling to act.

At least one school board did seek at this time to make the education it provided more efficient. The Sheffield School Board resolved to provide short-sighted children with spectacles, for use during school hours only, due to the "real disadvantages suffered in the prosecution of school work by children whose eyesight was defective". (37)

Although Bingham provides no further details, it is unlikely that this decision was implemented, for as indicated earlier in this chapter, even twenty years later the Local Government Board held such expenditure to be "ultra vires". When the Pontypridd Education Committee did pay for spectacles to be provided just before the passage of the 1907 Act it was surcharged £25 by the District Auditor, although the surcharge was remitted on appeal to the Local Government Board. (38)

(36) City of Bradford School Health Service; School Health Service Jubilee 1908-1958 (Bradford: Bradford Corporation, 1958), p.6.

(37) J. H. Bingham, Education in the Period of the Sheffield School Board 1870-1903 (Sheffield: J.W. Northend, 1949), p.227.

(38) Lancet ii (1907), 1731.

Nevertheless, in the 1890's developments did occur in this field, due not only to the recognition by some school boards that ameliorative action aided educational achievement, but also to public concern about the increasing number of children, particularly in the public schools, who were wearing spectacles, and the reformist inclinations of A.H.D. Acland, Vice President of the Committee of Council on Education from 1892 to 1895.⁽³⁹⁾ The earliest identifiable example of action by a board is the publication in February 1890 of a pamphlet by William Abel, Secretary of the Nottingham School Board, reproducing instructions the Board had ordered to be given to the teachers. A short chapter on eyesight contained a set of test-types which the teachers were recommended to use to test the sight of their pupils.⁽⁴⁰⁾

Early in 1893 press comment suggesting education was increasing the numbers of short-sighted children led to a question in the House of Commons, in response to which Acland announced that, with the assistance of "competent persons", he would order an investigation into the question of defective vision in schools.⁽⁴¹⁾

As Ernest Hart, the Editor of the British Medical Journal, was later to point out, the alleged increase in myopia was really an increase in the number of myopes whose sight was being corrected through the prescription of spectacles. This was due both to

(39) Rt.Hon. Arthur Herbert Dyke Acland (1847-1926). Educated at Rugby School and Christ Church College Oxford. Lecturer, Keble College 1871-72. Later became Bursar of Balliol College through his friendship with Benjamin Jowett. Liberal MP for Rotherham 1885-99. Vice-President, Committee of Council on Education, 1892-95.

(40) William Jenkinson Abel, School Hygiene (London: Longmans, Green, 1890).

(41) Parl. Deb., 4th series, 9(10 March 1893), 1601-2.

increasing knowledge of refractive errors and their correction, and the vigour with which the public schools, where the increase in spectacle wearers had been particularly noticeable, were tackling the problem.⁽⁴²⁾ Nevertheless, Acland asked Brudenell Carter to investigate the question on his behalf, and after obtaining permission from the London School Board, which seemed unworried by the issue,⁽⁴³⁾ Brudenell Carter visited twenty five board schools in London, and arranged for the eyesight of the 8,125 children in attendance to be examined by their teachers. Any thought to have defective vision were referred to Brudenell Carter for further examination. The results, published as a Parliamentary Paper in 1896, showed that only 39.15 per cent of the children had "normal" vision in both eyes.⁽⁴⁴⁾ Commenting on his results, Brudenell Carter indicated that his opinions had changed since his early work in 1885, when he broadly subscribed to the view that school life did in fact make a significant contribution to deterioration in eyesight.⁽⁴⁵⁾ By now, he believed that deterioration in "visual acuity" was due to the more general influence of urban life.⁽⁴⁶⁾ This being the case, improvement of school conditions alone would not prevent the development of myopia, and Brudenell Carter suggested other methods by which the deterioration

(42) Ernest Hart, "Spectacled Schoolboys", Atlantic Monthly 72 (July-December 1893), 681-84.

(43) London School Board, Minutes 39 (31 July 1893), 1071-73.

(44) BPP 1896/LXIV:543, Report on the Vision of Children Attending Elementary Schools in London, by R. Brudenell Carter, C.8151.

(45) Brudenell Carter, op.cit., p.575.

(46) BPP 1896/LXIV:543, op.cit., p.14.

of sight might be minimised or corrected, including the holding of "seeing competitions" and, more significantly, individual testing of the eyesight of the children.⁽⁴⁷⁾ A further study of some 2,000 children in eight London schools was also carried out at the Education Department's request. Conducted by Arnold Lawson, an eye surgeon at Paddington Green Children's Hospital, it broadly confirmed Brudenell Carter's results, and supported his suggestion that regular testing of the children's eyesight should be carried out. Lawson thought that this could be done by the teachers themselves.⁽⁴⁸⁾

The publication of Brudenell Carter's Report marks the point at which simple methods to supervise some aspects of the pupils' health and physique to secure greater efficiency of educational provision became widespread in the elementary schools. In the years after the issue of the Report, many of the larger school boards followed the earlier example of Nottingham and issued Snellen's test types to their teaching staff, directing them to test their pupils eyesight periodically.⁽⁴⁹⁾ Bradford had already started in September 1894, following Kerr's appointment as Medical Officer.⁽⁵⁰⁾ Liverpool began testing pupils' sight "after [a] report in 1896".⁽⁵¹⁾ Sheffield began in

(47) Ibid., p.16ff.

(48) Arnold Lawson "Eyesight of London School Children", British Medical Journal i(1898), 1614-17.

(49) Usually only the test-type for the correction of myopia, or short-sightedness, was used. That for hermetropia, or long-sightedness, was thought too complex for use with children, while little attempt was made to identify cases of astigmatism.

(50) James Kerr, "School Hygiene: its Mental, Moral and Physical Aspects", Journal of the Royal Statistical Society, 60(1897), 613-80.

(51) BPP 1906/XLVII:157, Inter-Departmental Committee on the Medical Inspection and Feeding of Children Attending Public Elementary Schools, vol.2. Evidence and Appendices, Cd.2784, evidence of F.J.Leslie, p.37, q.1083.

1897⁽⁵²⁾ and the London School Board in December 1899.⁽⁵³⁾ Other urban boards, and some of the rural boards also, followed suit when the practice of vision testing was officially recommended by the Board of Education in 1901. In Circular 456, on The Eyesight of Scholars Schools in Large Towns, vision testing, and any other ameliorative work which could be undertaken without expenditure of public funds, was recommended to school boards.⁽⁵⁴⁾ With such official support, vision testing became the most widespread aspect of school hygiene prior to 1907, other than infectious disease notification.⁽⁵⁵⁾

The spread of vision testing illustrates a major rationale for the growth of medical work in schools prior to 1907: "the increase of school efficiency".⁽⁵⁶⁾ Vision testing was introduced for practical, educational purposes, and was intended to maximise the ability of the pupils to respond to the education provided for them. As the London School Board was told:

the object of this test was not to obtain statistical information or to satisfy scientific curiosity but to achieve the practical end that children whose distant vision is defective should be placed in the front benches in the classroom where they are required to see what is written or drawn on the blackboard.⁽⁵⁷⁾

Vision testing was thus an aid to educational achievement, and an

(52) Bingham, op.cit., p.228.

(53) GLRO, London School Board, File SBL/1465, Report of the School Management Committee on Vision Testing.

(54) Board of Education, "Eyesight of Scholars in Schools in Large Towns", Circular 456/1901, issued 1 October 1901. Reproduced in British Medical Journal, ii (1901), 1119-20.

(55) BPP 1906/XLVII:1, Inter-Departmental Committee on the Medical Inspection and Feeding of Children Attending Public Elementary Schools, vol.1, Report, Cd.2779, p.27.

(56) W. Leslie Mackenzie, The Medical Inspection of School Children (Edinburgh: William Hodge, 1904), p.76.

(57) GLRO, File SBL/1465, op.cit.

attempt to maximise the return from money invested in education. These objectives were being cited elsewhere, by the mid 1890's, as reasons for the employment of medical staff to supervise schools and their pupils. One memorandum to the Royal Commission on Secondary Education argued:

In order to understand the need which exists for the sanitary supervision of schools and scholars it is desirable to put aside all sentimental considerations and look on the education of children as a national industry.

The memorandum continued with a discussion on the "capital value" of education.⁽⁵⁸⁾

Actual applications of this concept were generally limited to the vision testing programme. Identification of deaf children was less frequently undertaken due to the less widespread interest in the problem and the unsatisfactory means of identification. Usually, a watch was held behind the ears of the child.⁽⁵⁹⁾ Other activities were also restricted by doubts about the legality of the work. Vision testing itself was almost always performed by the teachers to avoid accusations of illegal expenditure, even after the 1902 reform of educational administration, and little actual remedial work was attempted.

Such restrictions, occasioned by the doubtful legal status of remedial activities by school boards, served only to illustrate

(58) BPP 1895/XLVII:1, op.cit., pp.352-55.

(59) See R. Brudenell Carter and Arthur H. Cheatle, Sight and Hearing in Childhood (London: Scientific Press, 1903), pp.79-112.

the inadequacies and weaknesses of the existing system. With vision testing by the teachers regarded as the limit of legal activity by the boards, children whose needs could not be met simply by seating them at the front of the classroom were directed to other agencies, particularly the voluntary hospitals. The many disadvantages of these institutions in relation to the treatment of the ailments of school children, discussed at greater length in chapter eight, were first highlighted by the arrival of droves of parents bringing children to the ophthalmic outpatient departments after vision testing had taken place at school. Malcolm MacHardy, a surgeon at the Royal Eye Hospital, Southwark, complained that the London School Board's initiation of vision testing meant:

that during the Christmas holidays, without notice to the ophthalmic surgeons concerned, thousands of children with radically defective eyesight were brought to the various ophthalmic outpatient charities of the metropolis. The outpatient machinery and staff, thus inundated, were over-whelmed, and the difficulties of the position were increased by the shortness of the daylight at that season of the year.⁽⁶⁰⁾

MacHardy went on to describe how:

working early and late, the staff and appliances as they existed could not master the conditions safely and satisfactorily. This may be judged when it is known that, at this hospital alone, in one week, upwards of 800 such School Board referred, picked, defective sighted children were counted among the new attendances, who included doubtless many more such children whose origin was not detected. By extending the staff's hours of attendance until as late as 7,8 or even 9 p.m., by precluding them for the time from scientific and patient investigation

(60) Lancet i(1900), 1022.

and study of rare cases, by abstaining from all attempt at clinical instruction, it was possible to see every new case and, after ascertaining that serious harm would not result from the delay, to refer the time taking Board School children's spectacle-needing eyes for future investigation, when the days would be longer, the light better, and the appliances and assistants reinforced.(61)

MacHardy's complaints illustrate the problems ensuing both from the point of view of the patients and their parents, and from that of the medical staff. For the parents attendance at an outpatients department might entail loss of earnings (the hospitals would not treat unaccompanied children) and travelling expenses. They might be interviewed and investigated by the almoners appointed in many hospitals to ensure that the facilities were not abused by those able to pay for their own treatment.⁽⁶²⁾ The over-crowded waiting rooms made it uncertain whether a consultation would be obtained at all. When it was, it was sometimes of a cursory nature only. Obtaining a prescription for spectacles needed two visits⁽⁶³⁾ and the hospitals sometimes prescribed needlessly elaborate and expensive bifocal lenses, costing 15/- or more, which parents were unable to afford.⁽⁶⁴⁾

The hospital outpatient departments were originally intended to provide a pool of patients from whom those with interesting or unusual conditions could be passed to consultants for study or for teaching purposes.⁽⁶⁵⁾ The vision test cases, though numerous, required only routine work of the most uninteresting kind, and provided little

(61) British Medical Journal i(1900), 851.

(62) Brian Abel-Smith, The Hospitals, 1800-1948 (London: Heinemann, 1964) pp.174-76.

(63) British Medical Journal i(1903), 616.

(64) BPP 1906/XLVII:157, op.cit., evidence of Dr. James Kerr, p.129, question 3833.

(65) Abel-Smith, op.cit., p.118.

income for the hospital.⁽⁶⁶⁾ The staff showed their frustration:

An exasperated senior surgeon at one of the great eye hospitals, after pushing his way through hordes of children and their parents each morning, is said to have chalked up regularly on his consulting room wall - "God damn the LCC".⁽⁶⁷⁾

Under pressure from their medical staff, many of the voluntary hospitals reacted by refusing, or becoming increasingly reluctant to treat, children referred by the education authority.⁽⁶⁸⁾

Experiences such as these served not only to illustrate the need which existed for adequate provision for the medical treatment of school children, but also influenced the kind of provision made when local authorities became empowered to provide it. By demonstrating the inability of the existing institutions to provide effective treatment through their normal procedures, they stimulated the search for alternative means of treatment. By giving the staff of the voluntary hospitals an unpalatable taste of the kind of demands which might be made upon them they turned the hospital staff, and through them the B.M.A., into firm supporters of the concept of the school clinic.⁽⁶⁹⁾

A further problem with the use of untrained teachers to test vision was that some children sent to the hospitals were then claimed by the hospital staff not to require treatment at all. As a result the London School Board resolved to employ "oculists" to check the teachers diagnoses.⁽⁷⁰⁾ This could be said to be the first example

(66) L.C.C., Education Committee, Minutes, 26 June 1907.

(67) Sir Gwilym Gibbon & R.W. Bell, History of the London County Council, 1889-1939 (London: Macmillan, 1939), p.301.

(68) BPP 1906/XLVII:157, op.cit., evidence of Dr. Price, p.163, question 4570.

(69) British Medical Journal ii(1908), supplement, 42.

(70) Ibid., ii(1901), 1553.

of individualized medical attention being given to groups of elementary school children, but it had to some extent been preceded by the introduction by school boards of medical supervision for the individual "special" child, and the use of medical opinions in administrative decisions on other individual pupils.

Special Education

Identification of children requiring special education, and supervision of the educational regime, were activities which brought the doctor into closer contact with educational administration. Eventually, it was in this area that the employment of doctors by school boards was first given specific legal sanction.

Special educational provision was slow to develop due in part, as Pritchard shows in his Education and the Handicapped, 1760-1960, to fears about its legality.⁽⁷¹⁾

The 1870 Education Act had neither specifically excluded nor specifically included handicapped children from its provisions, but generally the attendance of such children was not required, nor actually encouraged, by the school boards.

Special educational provision in the early part of the school board era was therefore dependent in large measure on personal initiatives by members of the larger boards. In London it was the personal interest of the London School Board chairman, Sir Charles Reed, who by investigating the possibility of educating children who were deaf or blind ensured the appointment of a superintendent

(71) Pritchard, op.cit., p.80. Much of the following narrative draws heavily on Pritchard's study.

to control the teaching of deaf pupils, and the establishment of special classes within the ordinary elementary schools where such children could be taught.⁽⁷²⁾

Even where these classes were provided, only rarely did the children concerned spend all their time being taught in the special classes. Blind children in London spent half a day in a special class, being educated, as far as possible, in the ordinary school for the remainder of the time.⁽⁷³⁾ For children in areas where the school board was either unwilling to provide special facilities, or was not large enough to generate sufficient demand, education in the ordinary school, or no education at all, were the only alternatives to institutional education.⁽⁷⁴⁾ The doubts about the legality of special education retarded its development, and some boards with special classes chose to forgo grant aid rather than submit the classes to inspection, and so draw attention to possibly illegal expenditure.⁽⁷⁵⁾

The appointment in 1885 of the Royal Commission on the Blind, whose terms of reference were later extended to include the deaf, was to change these attitudes. It gave consideration to the education of the blind and deaf to determine how far educational provision could prevent later dependence on the state. For blind children, the Royal Commission proposed that they should be allowed to attend the local school and be educated in the normal classes, unless there were

(72) Ibid., p.76

(73) Ibid., pp.79-80.

(74) Ibid., pp.24-44.

(75) Ibid., p.80.

sufficient children to allow a part-time centre to be established. For the deaf, it recommended education in separate schools or classes.⁽⁷⁶⁾

A personal initiative by the newly appointed Secretary to the Education Department, Sir George Kekewich,⁽⁷⁷⁾ stiffened the original Bill drafted to implement these recommendations of the Commission, and ensured that compulsory attendance at school was required for blind and deaf children, and that the board or school attendance committee responsible should make suitable provision for them.⁽⁷⁸⁾ Although delayed by religious and financial controversies, these provisions were eventually embodied in the Elementary Education (Blind and Deaf Children) Act of 1893.⁽⁷⁹⁾ Pritchard argues that despite some problems this Act was on the whole a success. After 1894 almost all blind and deaf children were being sent to school, with specialised provision being made for an increasing proportion of them. Some of the smaller boards and attendance committees did attempt to evade their new responsibilities and in these areas only the 1902 re-organisation finally ensured a satisfactory pattern of provision.⁽⁸⁰⁾

(76) BPP 1889/XIX:1, Royal Commission on the Blind, Deaf and Dumb, vol.1, Report, C.5781, pp.xvii-xviii, lvi-lviii.

(77) Sir George William Kekewich (1841-1921). Educated at Eton and Balliol College Oxford. After being wrongly credited with First Class Honours in his classics tripos, entered the Education Department as an Examiner in 1867. Secretary to the Education Department, 1899-1900, and to the Board of Education 1900-1903, when he was pressed to retire. Liberal MP for Exeter 1906-10. KCB (1895). See Sir George Kekewich, The Education Department and After (London: Constable, 1920).

(78) Pritchard, op.cit., pp.107-110.

(79) Elementary Education (Blind and Deaf Children) Act, 1893, 56 & 57 Vict. ch.42.

(80) Pritchard, op.cit., p.112.

This expansion of special provision for handicapped children left the boards with administrative problems - how to identify the children in need of special education, and how to ensure the education they received was commensurate with their needs. The 1893 Act offered no real guidance on this point, other than to define the terms "blind" and "deaf". Many authorities decided, however, that selection of the children for special education required medical advice.

The next steps in the development of special education emphasised this trend. Provision for the special needs of physically and mentally handicapped children and epileptics by the boards came later than that for the blind and the deaf. This meant that in the early years of the elementary school system such children, although they attended the elementary schools, tended not to "pass their standards", but to remain in the lower forms. In 1897, nearly every board school in London had at least seventy children in the lowest standard I. Sometimes the problem was resolved by the creation of a standard O.⁽⁸¹⁾

The scale of the problem was revealed in the early 1890's when Dr. Francis Warner conducted a survey of some 50,000 children on behalf of a joint committee of the B.M.A. and the Charity Organisation Society. His basic conclusion was that at least one per cent of the 50,000 children studied had physical or nervous defects, or were considered by their teachers to be of low intelligence.

(81) Ibid., pp.116-17.

(82) Francis Warner MD, FRCS, FRCP (1847-1926). Educated at Kings College Hospital. Physician, then Consulting Physician to the London Hospital. Lecturer on the neuroses and psychoses of children. Numerous publications on defects in children.

Warner recommended that these children should receive their education in special units or schools.⁽⁸³⁾ The Royal Commission on the Blind and Deaf, taking advantage of an extension of its terms of reference, also recommended that feeble-minded children should receive separate instruction.⁽⁸⁴⁾

These recommendations led eventually to the establishment of special units for handicapped children and others with learning difficulties. The first such units were in Leicester and London, and by 1897 some 1,300 children were being educated in thirty-one special schools and units.⁽⁸⁵⁾ From this work stemmed the establishment of the Departmental Committee on Defective and Epileptic Children. When this reported in 1898 it not only recommended that special education should be provided for defective children, who were defined as those who were unable due to their disability to profit from ordinary education,⁽⁸⁶⁾ but also discussed how such children were to be identified. Two main options were considered by the Committee: either selection could be by the teachers, on the basis of performance at school, or it could be undertaken by medical staff. The medical profession gave evidence to the Committee that weak-minded children could be identified by a physiological examination. This

(83) See Charity Organisation Society, The Feeble-Minded Child and Adult (London: C.O.S., 1893); idem, The Epileptic and Crippled Child and Adult (London: C.O.S., 1893).

(84) BPP 1889/XIX:1, op.cit., pp.civ-cvi.

(85) Pritchard, op.cit., pp.121-31.

(86) BPP 1898/XXVI:1, Departmental Committee on Defective and Epileptic Children, vol., Report, C.8746, p.3.

evidence so impressed the Committee that it recommended a doctor should ultimately be responsible for the selection of children for special education.⁽⁸⁷⁾

This recommendation was incorporated into the Elementary Education (Defective and Epileptic Children) Act of 1899, which thus became the first educational legislation specifically to allow, and indeed to require, a school board to obtain medical advice about children attending its schools.⁽⁸⁸⁾ In contrast to the 1893 Act, however, the 1899 Act was permissive rather than mandatory legislation, and a decade later only 133 of the 328 local education authorities who inherited this power in 1902 had elected to exercise it,⁽⁸⁹⁾ while parents who wished to avoid the stipulation that children receiving special education should remain in school until the age of fourteen could, until 1902, avoid the application of the Act in those school boards exercising their powers by sending their child to a voluntary school. When the medical staff of the London County Council Education Department were finally able to enter the voluntary schools in London after 1903 to seek out any children in need of special education, the numbers in the L.C.C.'s special schools rose rapidly from 7,056 children to 8,892.⁽⁹⁰⁾ Nevertheless the 1899 Act and the powers it bestowed

(87) Ibid., p.9. See also BPP 1898/XXVI:49, Departmental Committee on Defective and Epileptic Children, vol.2, Evidence and Appendices, C.8747, evidence of Dr. Shuttleworth, pp.1-6, Pritchard, op.cit., p.139.

(88) Elementary Education (Defective and Epileptic Children) Act, 1899, 62 & 63 Vict. ch.32.

(89) Pritchard, op.cit., p.150.

(90) BPP 1910/XXIII:1, Board of Education, Annual Report of the Chief Medical Officer for 1908, Cd. 4986, p.23. In London the LCC did not assume responsibility for education until the passage of the Education (London) Act, 1903, 3 Edw. VII, ch.24.

stimulated some of the urban boards to appoint a medical officer, and then use his services for purposes additional to the operation of the 1899 Act.⁽⁹¹⁾

Although the 1899 Act was the only instance where specific legal sanction was given to school boards to obtain medical advice about individual children, other educational and administrative developments also led to an increasing use of doctors by boards. They were used to examine children allegedly unfit to attend school, whose absence represented a financial loss to the board or education authority, although in deference to the attitude of the Local Government Board, few boards paid their medical officer a salary for doing so.⁽⁹²⁾ Similarly the development of higher grade education, and the increasing provision of scholarships for further educational opportunities, prompted some boards to require medical examinations of candidates for these awards, in order to ensure the award would not go to a child suffering from tuberculosis or other incapacitating disease. Teachers and other potential employees were also required to undergo a medical examination before being offered contracts.

A growing awareness of the need to provide the most efficient means of education, both for normal children and for those with special needs, was thus linking the medical profession more closely to educational administration, though legal considerations restricted the development of this trend. Public health officers were not the only members of the medical profession to benefit, although the

(91) See BPP 1906/XLVII:157, op.cit., Appendix 5, pp.235 ff.

(92) An investigation by the B.M.A. in 1904 showed that of 88 County and County Borough authorities replying to questions, six had a salaried medical officer to examine children allegedly unfit for school, twenty-two paid capitation fees, while the remainder had made no fixed arrangement. B.M.A., Medico-Political Committee, Minutes, 1904-5, p.7.

sanitary interest in the schools continued to evolve after 1885.

The Sanitary Influence: Infectious Disease

The continuing desire of the sanitary profession for a greater influence over the administration of the elementary education system derived in part from the wide acceptance of the concept of the school as a centre from which infectious disease might spread. This stemmed from the work of the L.G.B. medical staff detailed in chapter one. Following this line of analysis, by the early 1890's it was commonplace for school attendance to be considered the major, and in some cases almost the only, factor in the spread of all the common infectious diseases among children in rural districts. In 1893 the Medical Officer of Health for Shropshire thought:

As regards scarlet fever and diphtheria in their epidemic form, it is my experience that in the case of fully 90 per cent of the houses infected with these two diseases in rural districts, infection has been introduced by school agency.(93)

The work of the Local Government Board inspectors had been exclusively related to the rural districts so far as the question of school attendance as an influence on the spread of infectious disease was concerned, but it naturally served to stimulate interest in the extent to which the apparently crucial role played by the school was replicated in more urban districts. In the 1890's some evidence suggested that the role of the school was significant in

(93) W.N. Thursfield, "School Attendance and Infectious Disease", Public Health 6(1893-94),410.

urban areas also. A leading figure in this debate was Sir Shirley Murphy,⁽⁹⁴⁾ the Medical Officer of Health to the London Council, who in a series of Annual Reports drew attention to an alleged relationship between school attendance in London and the incidence of infectious disease, citing the reduction in the number of cases reported during the school holidays as evidence of a correlation.⁽⁹⁵⁾ The work of medical officers of health in other urban areas supplemented and supported Murphy's work,⁽⁹⁶⁾ but the importance of the role the school played in the dissemination of infectious disease in the urban areas remained a matter of controversy. At one extreme there were those who believed the rise in the incidence of diphtheria to have "taken place not only synchronously with, but consequent on, the increased aggregation of children at the most susceptible age for diphtheria in our elementary schools".⁽⁹⁷⁾ This was a stronger view of the relationship than Murphy himself suggested. But even Murphy's more limited hypothesis of a positive correlation between school attendance and infectious disease in urban areas attracted strong criticism. W. R. Smith,⁽⁹⁸⁾ the London School Board's

(94) Sir Shirley Forster Murphy, FRCS (1848-1923). Educated at University College School and Guys Hospital. Medical Officer of Health for St. Pancras and then, from 1889 to 1911, for the London County Council. Kt. (1904), KBE (1919).

(95) LCC. Annual Report of the Medical Officer of Health for 1893, pp. 25,29; Annual Report of the Medical Officer of Health for 1894, pp.30-32; Annual Report of the Medical Officer of Health for 1897, Appendix 1.

(96) See e.g. Lancet i(1895), 1140.

(97) Ibid., ii(1897), 1677.

(98) Sir William R. Smith MD (1850-1932). Educated at Aberdeen and Edinburgh Universities, St. Barts and University College Hospitals. Medical Officer, London School Board, 1890-1902. Medical Officer of Health, Woolwich Borough Council. Professor of Forensic Medicine and Toxicology at Kings College London. Mayor of Holborn 1905-6. Contested 1906 Election as a Free Trade candidate. Editor, Journal of State Medicine Kt. (1919).

own Medical Officer, wrote a sceptical review.⁽⁹⁹⁾ James Kerr, his eventual successor and then Medical Officer to the Bradford School Board, similarly argued in his important article in the Journal of the Royal Statistical Society that there were weaknesses in the theory. One criticism was that the apparent fall in notifications during school holidays could be explained by the departure of children and their parents for holidays or hop picking. Another was that closure of the schools reduced the efficiency of the notification system, while Kerr also argued that in urban areas, if children could not catch the disease at school, they would catch it while playing in the street.⁽¹⁰⁰⁾ Such criticisms did not come only from those outside the sanitary profession. Arthur Newsholme,⁽¹⁰¹⁾ later to become Chief Medical Officer to the Local Government Board, also expressed reservations, regarding:

school infection as forming only a minor cause of the spread of diphtheria, as forming, in other words, but one incident in a battle, which by no means determines the issue of the entire campaign.⁽¹⁰²⁾

(99) W. R. Smith "Report to the London School Board", Journal of State Medicine 4(1896), 169-227. A copy is also filed in the Public Record Office (hereafter cited as PRO), Ed. 14/20, London School Board, General File.

(100) Kerr, op.cit., pp.626-30.

(101) Sir Arthur Newsholme MD FRCP (1857-1943). Born Haworth, where his father was churchwarden to the Rev. Patrick Bronte. Educated at Grammar School, then became assistant to a Bradford doctor before entering St. Thomas's Hospital in 1875. G.P. and also part-time Medical Officer of Health in Clapham. Medical Officer of Health for Brighton 1888-1908. Principal Medical Officer, Local Government Board, 1908-1919. KCB (1917).

(102) Arthur Newsholme, "A Discussion on the Means of Preventing the Spread of Infection in Elementary Schools", British Medical Journal ii(1899), 589.

Newsholme acknowledged elsewhere that transmission through school contact could be an important factor in the spread of diphtheria, but enforcement of compulsory school attendance could not, he thought, be described as the chief mode of transmission.⁽¹⁰³⁾

After such criticisms, adherence to the view that school attendance was the sole or predominant cause of the spread of infectious disease among school children in urban areas diminished after 1900. By 1906, a medical officer of health could say: "I think it will be generally agreed that the school exerts but little influence in the spread of scarlet fever",⁽¹⁰⁴⁾ and find only a rural sanitary officer in disagreement. But during the 1880's and 1890's, a belief that the impact of infectious diseases could be curbed if schools were under closer medical supervision was common among sanitarians, and led to the publication of numerous articles in the professional journals, calling for greater powers of direction to be given to the medical officers of health over the schools.⁽¹⁰⁵⁾ The introduction, in the 1882 Code, of a new clause requiring managers to close schools at the behest of the sanitary authorities has already been noted. It is significant, and indicative of the continuing difficulties experienced by many medical officers of health, that this clause required further strengthening in subsequent issues of the Education Code. In 1889, managers were instructed to comply "at once" with any notice from

(103) Arthur Newsholme, Epidemic Diphtheria (London: Swan, Sonnenschein 1900), p.136.

(104) William Wright, "The Influence of School Closure on the Spread of Infectious Disease", Public Health 19(1906-7), 24.

(105) See e.g. M.A. Fenton, "The Elementary Education Acts as a Factor of Disease", Public Health 1(1888-89), 197-206.

the sanitary authority, and were allowed to appeal to the Education Department only after the closure of the school,⁽¹⁰⁶⁾ while the Code for 1893 removed the loophole which allowed managers to wait until the sanitary authority met to confirm the notice by requiring compliance with:

any notice of the sanitary authority of the district in which the school is situated, or any two members thereof acting on the advice of the Medical Officer of Health.....(107)

Although these changes in the Code increased the coercive authority of the medical officer of health, they gave no positive incentive for managers or board to co-operate with the sanitary authority. Such an incentive emerged gradually after the introduction of the Code for 1890, which contained further changes in the regulations for payment of grant, reducing further the influence of individual or collective examination performance in determining the amount received by introducing a system in which a relatively high principal grant was paid for each child in average attendance.⁽¹⁰⁸⁾

Although this change marked a movement towards achieving the educationists objective of eliminating "payment by results", the immediate effect of the change was to create a further incentive for the education authorities to conceal the presence of infectious disease. Exclusion of individual infected scholars or their contacts might, under the new regulations, have a more serious

(106) BPP 1889/LIX:399, Code of Regulations...for 1889, C.5663,art.87.

(107) BPP 1893-94/LXVIII:1 Code of Regulations...for 1893, C.6923, art.88.

(108) BPP 1890/LV:423, Code of Regulations...for 1890, C.5966.

effect on grant because of the greater importance now attached to average attendance. As a response to this difficulty, the Code for 1892 introduced a new article, numbered 101*, which provided that:

where the Department are satisfied that by reason of a notice of the Sanitary Authority under Article 88 requiring the exclusion of certain children, the average attendance has been seriously diminished and that consequently a loss of annual grant would, but for this Article, be incurred, the Department have power to make a special grant not exceeding the amount of such loss in addition to the ordinary grants. (109)

The importance of the introduction of Article 101* is that most of the actions a medical officer of health could take in excluding pupils or closing schools need not now lead to a loss of grant by the managers or board responsible. Indeed, as the regulations under which the grant for Article 101* was paid specifically required the absence to be certified by a qualified medical practitioner, a positive incentive existed for a board or committee of managers to co-operate with the local sanitary officer.

Although some teachers alleged that Article 101* was so stringently interpreted as to be almost useless, requiring a lot of administrative work but providing only one or two pounds of grant in return,⁽¹¹⁰⁾ the evidence of the Annual Reports of the Committee of Council on Education and its successor, the Board of Education, indicate that increasing use was made of this provision during the 1890's. At first, amounts paid in Article 101* grant were modest.

(109) BPP 1892/LX:1, Code of Regulations...for 1892, C.6607, art. 101*. An anomaly of this and subsequent Codes was the presence of two clauses numbered 101, so that dealing with the "Epidemic Grant", as the provision became known, was distinguished by the asterisk.

(110) Reginald Dudfield, "Sanitary Supervision of Schools", Public Health, 10(1897-98), 265.

In 1893 ninety-two schools received payments of grant totalling £377.⁽¹¹¹⁾ By 1897 Article 101* grant was being paid to 1,756 separate school departments, almost twice as many as the previous year.⁽¹¹²⁾ In 1902, the grant was given to 10,123 departments, and total payments amounted to almost £50,000.⁽¹¹³⁾

In some cases, boards and managers obtained Article 101* grant on an ad hoc basis, calling in the medical officer of health as and when necessary, sometimes only when an epidemic had reduced attendances so severely that service of retrospective or predated exclusion notices was the only means by which a school's grant could be restored. Such abuses, along with the increased size of education authorities under the 1902 Education Act, were used to justify the Board of Education's decision to discontinue Article 101* grant in 1903.⁽¹¹⁴⁾ But the increase in the use of the Article 101* provision in the 1890's also indicates that a much closer relationship between education authority and sanitary officer was being established in many areas. The need for medical certification of excluded scholars in the administration of Article 101* grant claims led to the emergence of formal systems of referral between

(111) BPP 1894/XXIX:1, Committee of Council on Education, Report for the Year 1893-94, C. 7437, p.xxvi.

(112) BPP 1898/XXII:65, Committee of Council on Education, Report for the Year 1897-98, C.8987, p.xli.

(113) BPP 1903/XX:349, Board of Education, General Report for the Year 1902-3, Cd. 1763, p.28.

(114) Dudfield, op.cit., p.265, J. Middleton Martin, "Schools and Infectious Disease", Public Health 14(1901-2),609.

authorities. An efficiently run system like that operated by Arthur Newsholme in Brighton could bring significant financial benefits for the local board and voluntary school managers.⁽¹¹⁵⁾

The growth in the use made of Article 101* grant thus indicates the establishment of a closer, though by no means universally cordial relationship between many educational and sanitary authorities in the 1890's. Other developments also served to subdue the adversarial attitudes that had sometimes prevailed in former years.

The changes in the financial provisions of the Code reduced the desire of the education authority to embark on a "whip-up" of children at the time of the annual examination, the area where the compensation principle had least effect. The passage of the Infectious Diseases (Notification) Act of 1889 improved the quantity and quality of information available to the medical officer of health, and thus his ability to act on cases of infection among school children irrespective of the co-operation or otherwise of the board or managers.⁽¹¹⁶⁾ Although this Act required notification of specified infectious diseases only in London, it was gradually adopted by many other authorities, and in 1899 compulsory notification was extended to the whole of England and Wales.⁽¹¹⁷⁾

(115) Newsholme (1899), op.cit., p.590; John J. Boyd, "School Notification of Infectious Disease", Public Health 16(1903-4),95.

(116) Infectious Diseases (Notification) Act, 1899, 52 & 53 Vict. ch.72. Under section 6 of the Act, smallpox, cholera, diphtheria, membranous croup, erysipelas, scarlatina or scarlet fever, typhus, typhoid, enteric fever, relapsing fever, continued fever and puerperal fever were to be notified. Not until 1916 were measles and german measles added to the list of notifiable diseases.

(117) By the Infectious Disease (Notification) Extension Act, 1899, 62 & 63 Vict. ch.8.

Furthermore, knowledge about infectious disease became more widespread among teachers, managers, and members of school boards. As early as 1877, the London School Board had instructed its Visitors, as the school attendance officers were then known, not to force the attendance of children from infected homes.⁽¹¹⁸⁾ The London School Board was, however, a very exceptional authority, with sanitarians such as Professor Gladstone and Benjamin Ward Richardson among its members, and only many years later did some other boards and school attendance committees follow London's example.

As the goodwill of the education authorities was by no means universal, calls for an increase in the powers of the medical officer of health over elementary education continued.⁽¹¹⁹⁾ The M.O.H. for Eccles considered it necessary to obtain powers of entry into the local schools under a local Act of Parliament, and other authorities followed suit.⁽¹²⁰⁾ In this respect the 1902 Education Act, although not directly concerned with the position of the medical officer of health, made a significant contribution through its abolition of the school boards. This resulted in both the board and the voluntary schools being placed under the general administration of local authorities. The significance of this administrative reform is discussed subsequently in more detail.

(118) Reginald Dudfield, "History of the Society of Medical Officers of Health", Public Health, Jubilee edition (July 1906), 94.

(119) H. Meredith Richards, "The Sanitary Control of Schools, with Special Reference to the Education Bill", Public Health 15 (1902-3), 136.

(120) Eccles Corporation Act, 1901. Local and Personal Acts, 1 Edw. VII, ch.cxxii, cl.130-32. Stockport obtained similar powers through a local Act.

The Sanitary Influence : School Design

Reference was made in chapter one to the sanitarians dissatisfaction with the standard of school buildings. Under the earlier Education Codes, the standard laid down was for eighty cubic feet per child in the principal school room, but only eight square feet per child in the class rooms.⁽¹²¹⁾ Only in 1875 did the Code require eighty cubic feet per child in the class rooms also.⁽¹²²⁾

Despite unfavourable comparisons being made in the medical press between this standard and those laid down in the regulations governing common lodging houses, prisons, and even stables for Army horses,⁽¹²³⁾ these regulations remained unaltered until after the issue of the final Report of the Cross Commission on the Working of the Elementary Education Acts, in 1888. The Report suggested the existing building regulations governing school construction did not eliminate the possibility of unsatisfactory school premises being provided, and recommended that the existing standards should be upgraded.⁽¹²⁴⁾ In response, the Education Department declared its intention in the 1889 Code to endeavour to secure one hundred cubic feet of space and ten square feet of area for each child.⁽¹²⁵⁾ For

(121) BPP 1872/XLVI:291, Code of Regulations....for 1872, C.483, art. 17(c).

(122) BPP 1875/LVIII:1, Code of Regulations...for 1875, C.1170, art. 17(c).

(123) Sir Henry E. Roscoe, On the Ventilation of Schools (London: T.W. Danks & Co., 1889), p.9. Budgett suggests that "six foot square [i.e. thirty six square feet] and ten to twelve feet high is the minimum space allotted by the authorities on the Continent". J.B. Budgett, The Hygiene of Schools (London: H.K. Lewis, 1874), p.31.

(124) BPP 1888/XXXV:1, Royal Commission on the Elementary Education Acts, Final Report, C.5485, pp.61-65.

(125) BPP 1889/LIX:399, op.cit., art.85. For an extended account of this episode see Gillian Sutherland, Policy-making in Elementary Education, 1870-1895, (London: Oxford University Press, 1973), pp. 263-82.

the voluntary societies such an increase represented a threat to denominational education, and protests were made to the Conservative administration.⁽¹²⁶⁾ As a result of these representations from their natural allies, the Government announced the withdrawal of the 1889 Code on 11 July 1889,⁽¹²⁷⁾ and the Code for 1890 effectively reverted to the previous standard.⁽¹²⁸⁾

With the return of the Liberals in 1892 however, the campaign to improve the basic standards of school buildings was revived. Acland, the Minister responsible, issued Circular 321 in January 1893. This called on H.M.I.'s to provide a return of the condition of all school buildings inspected.⁽¹²⁹⁾ The 1894 Instructions to H.M.I.'s extended the inquiry to the conditions of instruction, as well as the "structure and material equipment" of the school rooms.⁽¹³⁰⁾ Between April 1894 and October 1895 over 150 schools were threatened by the Education Department with the loss of their grant unless the condition of the school was improved. This was again attacked by the voluntary societies, assisted by the Tory peers, and allegedly stimulated the Anglicans' desire for a revision of the Education Act. The Education Department, however, claimed that a substantial improvement in school conditions was effected.⁽¹³¹⁾ Poor conditions

(126) Ibid., pp.270ff.

(127) Parl. Deb., 3rd series, 338(11July 1889),137.

(128) BPP 1890/LV:423, op.cit., art.85.

(129) Malcolm Seaborne and Roy Lowe, The English School: its Architecture and Organisation, 1870-1970 (London: Routledge, Kegan Paul, 1977), p.11.

(130) BPP 1894/LXVI:103, Instructions to H.M.I.'s, C. 7321, pp.17-18.

(131) Seaborne and Lowe, op.cit., pp.11-12.

remained, however, not only in the voluntary schools,⁽¹³²⁾ but in some of the board schools also.⁽¹³³⁾ Apart from the purely spatial dimension, the medical officers of health were also concerned about the heating, lighting and, especially, the ventilation of the schools. In contrast to the voluntary societies, many of the school boards built schools which in size, architectural design and equipment represented an expression of civic pride, well funded by the rate revenue of the boards. Arnold Bennett's comment from Clayhanger aptly reflects the public perception of the new board schools: "the world had been whizzing ceaselessly from one miracle into another. Board schools had been opened in Bursley, wondrous affairs, with ventilation; indeed ventilation had been discovered".⁽¹³⁴⁾ Unfortunately, the discovery and perfection of systems of mechanical ventilation were separated by a period of experimentation with and modification of the various systems. During this period, the public health profession took a continuing interest in the question of school ventilation and other aspects of design, particularly after the publication of research showing the foul condition of the air inside many classrooms in both ventilated and unventilated schools. Such investigations were

(132) See British Medical Journal i(1904), 104.

(133) See H.M.I. Sneyd-Kynnersley's description of Hewitt Street Council School, Manchester, in 1905:

"One hundred and forty three boys in four classes were being taught in a large hall: the windows were shut to keep out the fog, and from eighty to a hundred gas jets were adding pollution to the poisoned air. Thirty two more boys were struggling for existence in a small and vilely lighted classroom....there was not a foot of playground; the boys played in the street".

E.M. Sneyd-Kynnersley, H.M.I. (London: Macmillan, 1908)pp.332-33.

(134) Arnold Bennett, Clayhanger (London: Penguin, 1970), p.156.

commonplace during the 1880's.⁽¹³⁵⁾ By the 1890's, the condition of the atmosphere in school rooms, the inadequacies of the existing school building regulations which contributed to these conditions, and the merits and demerits of the various systems of ventilation were regularly discussed in the medical journals.⁽¹³⁶⁾ Many medical officers of health thought this another question on which they ought to offer advice to the school boards and voluntary school managers.⁽¹³⁷⁾

At this juncture, however, there was no general agreement on the most appropriate form of ventilation for schools. Sydney Barwise, Medical Officer of Health for Derbyshire, acknowledged that mechanical ventilation of schools had been a failure in some cases, but only, he argued, in instances where the vacuum method of ventilation had been used. He favoured mechanical ventilation

(135) See e.g. N.F. Lupton, "The Sanitary Condition of Air in Public Schools", Chemical News 39(1879),180; R. Beveridge, "Ventilation of Schools", Sanitary Journal of Glasgow, n.s. 9(1885-86),253-57; Sir Henry E. Roscoe, op.cit., pp.4-8.

(136) See e.g. Sydney Barwise, "Presidential Address", Public Health 8(1895-96), 76-82; H. Scurfield, "The Ventilation of Schools", Public Health 10(1897-98), 192-97.

(137) James Wheatley, "Extract from Report of the Medical Officer of Health for Blackburn", Public Health 7(1894-95), 373.

on the "plenum" or forced-air method,⁽¹³⁸⁾ though he ridiculed the Education Department's regulations covering the installation of such systems.⁽¹³⁹⁾ The fact that some advocates of the plenum system argued that it could work efficiently only when all windows were permanently closed led other public health officials, like Francis Vacher of Cheshire, to oppose the plenum system in favour

(138) Three main systems of ventilation were applied in school design: natural ventilation, which used the difference in weight between equal volumes of warm and cold air to ensure that warm air was dispersed through a flue in the ceiling of the classroom; the pressure or plenum system of ventilation, in which warmed air was forced under slight pressure into the classroom through vents above head height, and then escaped through outlets in the base of the classroom walls; and the vacuum method, in which a fan in a central flue extracted the warm air from the classroom. See Sir Felix Clay, Modern School Buildings (London: Batsford, 1902), pp.383-413. The debate was partly concerned with the technical efficiency of the various systems, with the use of the vacuum method for educational buildings being particularly criticised due to the sensitivity of the system to the opening of windows and other disturbances. A further factor, however, was the legacy of the miasmatic theory of disease transmission, which had led to the postulation of ideal standards for ventilation, expressed in cubic feet of air per person per hour, which were much higher than modern standards. Greater or lesser adherence to these standards meant that estimates of the air required by children varied from 500 to 2000 cubic feet per hour. See Roscoe, op.cit., pp.9-10. Such variation in views led to some public health officials condemning natural ventilation as being incapable of supplying the required amount of air, while others held it to be the only reliable system for use in schools. Such divergencies of view also led to a protracted debate about the adequacy of the Education Department's building regulations. For a general overview of the subject, see Robert Bruegmann, "Central Heating and Forced Ventilation: Origins and Effects on Architectural Design", Journal of the Society of Architectural Historians, no. 37 (October 1978), 143-60.

(139) Barwise, op.cit., pp.76-77.

of natural ventilation.⁽¹⁴⁰⁾

Dissatisfaction with the adequacy of the Education Department's, and later the Board of Education's regulations led some medical officers of health to negotiate local arrangements with the school board to examine and advise on school building plans,⁽¹⁴¹⁾ while controversy about the most suitable form of ventilation continued. Some sanitarians began to put their faith in as much natural ventilation as possible. Alfred Greenwood, Wheatley's successor at Blackburn, ordered "every door, window and other ventilation opening must be opened widely during playtime" to let in fresh air.⁽¹⁴²⁾ Others, noting the resistance shown by many teachers to such instructions, argued for artificial ventilation of various kinds as the only workable solution.⁽¹⁴³⁾

In this context the development by George Reid, Medical Officer of Health for Staffordshire, of a new approach to the problem involving a re-appraisal of traditional school design, rather than mere tinkering with different forms of ventilation, is of particular significance. The school design followed at the time was the central hall school, with classrooms, often fitted with moveable partitions enabling the whole interior to be opened up, ranged round the sides of the building. This design, Reid argued, demanded the use of mechanical ventilation if the

(140) James Wheatley, "School Ventilation", Public Health 10 (1897-98), 274.

(141) C. H. Tattersall, "The Medical Inspection of Schools", Public Health 19 (1906-7), 655.

(142) Alfred Greenwood, "School Sanitation and the Duties of Medical Officers", Public Health 17 (1904-5), 645-46.

(143) E. Walford, "School Hygiene in its Relation to the Education Authorities", Journal of the Royal Sanitary Institute 25 (1904-5), 164-67.

atmosphere inside was to be kept satisfactory.⁽¹⁴⁴⁾ To avoid this problem Reid persuaded the County Architect, Education Committee, and, eventually, the Board of Education, to experiment with a new "pavilion and verandah" concept designed to allow efficient natural ventilation.⁽¹⁴⁵⁾ The building of the first schools to this experimental design provided Reid with a model with which he could continue his campaign to persuade the Board to adopt his new ideas, and abandon the stereotyped and unsatisfactory concepts which continued to be embodied in its building regulations. Even after the establishment of a medical department at the Board, this reform was slow in coming, and it was not until 1914 that a major change in the building regulations was implemented.⁽¹⁴⁶⁾ By this time Reid and other medical officers of health who came to agree and collaborate with him had instigated a major revision of ideas about school design which, by linking concepts of school and hospital design closely, served to emphasise the growth of interest in the relationship between education and the health of children.⁽¹⁴⁷⁾

Although infectious disease and building standards were the main foci of the sanitarians interest in the schools, they were also critical of other aspects of educational administration, such

(144) See George Reid, "The Planning of Schools", Public Health 20(1907-8), 84-97; Idem, "Ventilation and Warming of Schools", Local Government Review 2 (1910), 122-26.

(145) Idem, "The Staffordshire Type of Elementary School", Journal of the Royal Sanitary Institute 17(1906-7), 206-10.

(146) Seaborne and Lowe, op.cit., pp.75-76.

(147) Ibid.

as the attendance prize system. With regular attendance paying a dividend in increased Exchequer grants many school boards adopted a policy of offering book prizes, award cards or medals to children who achieved an unbroken, or almost unbroken, record of attendance during a school year. Although in London at least such awards allegedly had no identifiable effect on the average attendance, for some children the pursuit of an attendance prize became obsessional. In 1903 the London School Board was told of a child who broke her arm en route to school, but who waited until the lunch hour to have it set, so as to be marked present and punctual both morning and afternoon.⁽¹⁴⁸⁾ Attendance prizes, seen by the education authority as a means of maximising the numbers in school, were seen by sanitarians as an inducement to ignore symptoms of disease, and pleas for the abandonment or reform of the prize system were made in the medical press.⁽¹⁴⁹⁾

Progress in School Health 1885-1902: some issues

The evidence thus far presented in this chapter suggests that a greater appreciation of the educational value of good health among scholars was leading some school boards to pay more attention to possible methods of alleviating ailments and handicaps. Their approach was to some degree conditioned by the restraints imposed

(148) David Rubinstein, School Attendance in London, 1870-1904, University of Hull Occasional Papers in Economic and Social History, No.1(Hull: University of Hull, 1969), p.42.

(149) In Sheffield the School Medical Officer persuaded the Education Committee to change to a "progress and efficiency" prize system. Ralph P. Williams, "The Attendance Prize System", British Medical Journal i(1908), 864.

by the doctrine of "ultra vires", although the larger or more radical boards were able to set important precedents during the early 1890's by making full-time appointments of medical officers. The first such appointment, of W. R. Smith, was made by the London School Board in 1890, for reasons variously reported as the prevention of infectious disease,⁽¹⁵⁰⁾ or the inspection of candidates for office under the Board.⁽¹⁵¹⁾

The size of the London School Board meant that such requirements, intermittent in most boards, represented a constant demand on the services of the medical officer. By 1903, 2,738 examinations of candidates for appointment were being made,⁽¹⁵²⁾ and additional duties had resulted in the appointment of three part time assistants to the medical officer.⁽¹⁵³⁾ Smith, however, was only nominally a full-time officer, and until his resignation in 1901 he continued to hold a number of other appointments.⁽¹⁵⁴⁾

The appointment of James Kerr as Medical Officer to the Bradford School Board in 1893, as well as being a more radical interpretation of the Board's legal powers, was also a more extensive application of the principles of school hygiene, for Kerr's original duties were not restricted to general sanitary supervision of schools. He also had to determine:

(150) BPP 1906/XLVII:157, op.cit., p.235.

(151) BPP 1910/XXIII:1, op.cit., p.22.

(152) London School Board, Annual Report of the Medical Officer for 1902-3, p.1.

(153) BPP 1910/XXIII:1, op.cit., p.22.

(154) GLRO, London School Board File SBL/287, Sub-Committee on the Medical Officer's Department, Minutes, 2 May 1901.

whether certain children mentioned by the head teacher are physically capable of proceeding to a higher standard or class; to examine and test the eyesight, hearing and other physical condition of any scholars to whom attention may be called by the head teacher.

and had other duties.⁽¹⁵⁵⁾ Kerr's appointment as a full-time officer and his personal dynamism resulted in substantial advances being made in the understanding of child health being made, including seminal work on dyslexia.⁽¹⁵⁶⁾ His Howard medal winning essay on school hygiene, published in the Journal of the Royal Statistical Society in 1897, indicates the breadth of his activities in Bradford.⁽¹⁵⁷⁾

These appointments have been noted as landmarks in the history of school hygiene in England.⁽¹⁵⁸⁾ Much less is known, however, about the subsequent development of medical work in other board areas prior to 1902. Undoubtedly many boards were using medical men, if only on an ad hoc basis, for administrative purposes such as the examination of candidates for appointment, children allegedly unfit for school, or those being assessed for special education under the 1893 Act. The absence of further full-time appointments prior to 1902 is perhaps indicative of the degree to which concern about the legality of these appointments influenced school boards actions in the area of school hygiene. Even formal appointments of part-time medical officers seem to have been delayed until the

(155) Huw W. S. Francis et. al., "The Doctor as Educationalist: James Kerr, 1861-1941", Medical Officer 123(1970), 303.

(156) Ibid.

(157) Kerr, op.cit.

(158) BPP 1910/XXIII:1, op.cit., p.4.

impending passage of the 1899 Act gave boards the legal sanction to employ a medical officer. This was reportedly the stimulus for appointments at Salford, Burnley and Halifax. Other boards such as Rochdale and Keighley also appointed a medical officer at this time.⁽¹⁵⁹⁾ Thus the legal right to appoint a medical officer conferred under the 1899 Act appears to have had a significant effect, and boards used this provision to appoint officers whose duties ranged well beyond that of superintending the school for defective and epileptic children. By 1902, the Congress of the Sanitary Institute, held in Manchester, could attract seven school board medical officers from Lancashire and Yorkshire, in addition to Kerr, by then Medical Officer to the London School Board.⁽¹⁶⁰⁾

By 1902 therefore, it could be argued that appointments of medical officers on at least a part-time basis by the larger, urban and especially the Northern school boards was becoming more frequent. Administrative needs and, following the 1899 Act, legal requirements, seem to have been the main motivation for such appointments, with political commitment stimulating action in only a small number of instances. This was not due to a lack of commitment, for by the 1890's the Independent Labour Party, as well as the Social Democratic Federation, was calling for "free state maintenance of children",⁽¹⁶¹⁾ while its candidates in the 1897

(159) BPP 1906/XLVII: 157, op.cit., Appendix 5, pp.235ff.

(160) Sanitary Institute, "Congress Report", Journal of the Sanitary Institute 23(1902-3), supplement, 119.

(161) Brian Simon, Education and the Labour Movement, 1870-1920 (London: Lawrence and Wishart, 1965), p.140.

board elections called for medical officers to be appointed to examine children at the request of the board.⁽¹⁶²⁾ It was a function of the minority role such socialist, or indeed working class representatives played on the school boards.⁽¹⁶³⁾ Apart from Bradford, and the work of Margaret McMillan and other I.L.P. councillors,⁽¹⁶⁴⁾ the achievements of the socialist groups were limited. Annie Besant did some work in London,⁽¹⁶⁵⁾ while S.D.F. councillors in Reading eventually secured the appointment of a medical officer.⁽¹⁶⁶⁾ Elsewhere, individual councillors secured some minor reforms.⁽¹⁶⁷⁾ In general, however, the achievements of the socialist groups were limited, due partly to the intricacies of the school board election system which, though it to some degree helped to secure the representation of socialist and labour organisations on the urban boards, ensured also that they would form only a minority of the board membership.

(162) Ibid., p.153.

(163) Ibid., p.154.

(164) See Albert Mansbridge, Margaret McMillan: Prophet and Pioneer (London: J.M. Dent, 1932); Miriam Lord, Margaret McMillan in Bradford, 4th Margaret McMillan Lecture (London: University of London Press, 1957); G.A.N. Lowndes, Margaret McMillan, the Children's Champion (London: Museum Press, 1960).

(165) A. H. Nethercot, The First Five Lives of Annie Besant (London: Rupert Hart-Davis, 1961), pp.276-86.

(166) Simon, op.cit., p.157.

(167) W. P. McCann, "Trade Unionist, Co-operative and Socialist Organisations in Relation to Popular Education, 1870-1902", (Ph.D. thesis, University of Manchester, 1960), pp.267-75.

If, however, the boards were increasingly seeking medical advice on a formal basis, they were not necessarily eager to appoint representatives of that branch of the medical profession which had been most consistently interested in school hygiene. Of the eight medical officers to school boards recorded as attending the R.S.I. Conference, none held office as the local M.O.H.⁽¹⁶⁸⁾ Continuing suspicion of the sanitarians objectives, the independence traditional in some of the larger urban boards and their successors, and the workload which might be imposed on the M.O.H. all contributed to this trend. In some areas, however, especially where the M.O.H. had a particular interest in school health work, formal links with the school board were forged. Both James Wheatley and his successor Alfred Greenwood were formally appointed as medical officer to the Blackburn School Board,⁽¹⁶⁹⁾ and Meredith Richards held an identical position at Croydon.⁽¹⁷⁰⁾ This led to a continuation of the calls from the sanitarians for control over the medical aspects of the education system. By 1900, the literature of the sanitary profession carried an increasing number of articles which not only reiterated the long-standing demands for unrestricted access to, and sanitary control over, schools, but argued for a more extensive provision of medical services under the direction of the medical officer of health. Thus in 1902 Meredith Richards, while acknowledging the basic sanitary interests of the medical officer of health, also stressed

(168) Sanitary Institute, op.cit.

(169) BPP 1906/XLVII:157, op.cit., p.242.

(170) Meredith Richards, op.cit., p.121.

that:

Difficulties from defective sight, deafness and the presence of adenoids often arise, while in other instances the question of transferring a defective child to a special school requires consideration. (171)

Criticising School Boards who "neglected the pedagogic aspects of school life entirely", Meredith Richards insisted:

the problems of school hygiene should occupy a very conspicuous place in the field of applied preventive medicine, and conversely that school managers and teachers are constantly in need of skilled medical advice in dealing with the practical health problems that daily require solution. (172)

Following Meredith Richards' address, the meeting resolved:

1. That the hygienic control of public elementary and of other public schools should devolve on the Medical Officer of Health of the district.
2. The Medical Officer of Health, or a medical practitioner under him, should be given power of entry and power to examine scholars on the lines of the Eccles Corporation Act.

Among the other resolutions, which were concerned mainly with sanitary conditions in schools and other longstanding concerns of the public health profession, was a call for the Board of Education to appoint its own medical adviser.⁽¹⁷³⁾ The resolutions were forwarded to the Parliamentary Committee of the Society of Medical Officers of Health with a request to raise the subject with the Board of Education. However, the Board made a non-committal response to the Society's approach.⁽¹⁷⁴⁾

(171) Ibid., p.122.

(172) Ibid., pp.123, 121.

(173) Ibid., p.136.

(174) Public Health 15(1902-3), 367.

Summary

The years between the publication of Dr. Crichton-Browne's Report and the end of the school board system of educational administration saw the beginning of many kinds of medical work in schools. In this, a concern for the efficient use of educational provision played a part. Concern about "ultra vires" and its consequences precluded formal appointments of medical staff by most boards, although some increase in appointments came after the 1899 Education (Defective and Epileptic Children) Act had given boards adopting the Act the power and the duty to pay for medical advice. Despite the long term interest of the sanitarians in school health, they found other branches of the medical profession becoming actively engaged in school health work as these appointments were made. Differences of view about the character and orientation of school medical work began to emerge.

In view of the importance attached in this chapter not only to legal hindrances, but also to the structure of educational administration as a factor in retarding the development of medical work in schools, the passage of the Education Act 1902 and the administrative reforms it imposed on the education system in England and Wales, must be regarded as of considerable importance.⁽¹⁷⁵⁾

Deriving as it did from the increasing difficulties faced

(175) Education Act, 1902, 2 Edw. VII, ch.42. George Auden, the School Medical Officer for Birmingham, thought:

"This unity of administrative control prepared the way for a general scheme of medical inspection which otherwise would have been impossible, though it was being strongly urged in many quarters".

George A. Auden, "School Medical Inspection in England", Child Health Bulletin 10(1934), 153.

by the voluntary schools in competing on a financially unequal basis with the board schools, at least in the urban areas,⁽¹⁷⁶⁾ the main administrative reform instituted by the 1902 Act was the abolition of the school boards, and the placing of virtually all former board and voluntary schools under the control of the education committees of the responsible local authorities. All County and County Borough councils became education authorities, while Municipal Boroughs with a population of 10,000 or more, and Urban District councils with a population greater than 20,000 could elect to become responsible for the provision of elementary education.⁽¹⁷⁷⁾

This meant that in place of the 2,560 school boards formerly existing, and the 14,000 management committees of voluntary schools with which the Board of Education was required to correspond directly and individually,⁽¹⁷⁸⁾ elementary education was now the responsibility of some 330 education committees.⁽¹⁷⁹⁾ This reform had two important implications for the development of school hygiene. First, all elementary school children were now the responsibility

(176) See P.H.J. Gosden, The Development of Educational Administration in England and Wales (Oxford: Basil Blackwell, 1966), pp.166-84, and P.L.P. Clarke, "The Education Act of 1902", (Ph.D. thesis, University of London, 1964).

(177) 2 Edw. VII, ch.42, clause 1.

(178) Gosden, op.cit., p.180; C.H. Wyatt, Wyatt's Companion to the Education Acts, 1870-1902, (Manchester: Thos. Wyatt, 1903), p.171.

(179) The total number of local authorities required by the 1902 Act to form an education committee was 333, to which the London County Council was added by the Education (London) Act, 1903, 3 Edw.VII, ch.24. This total was, however, reduced through authorities amalgamating or transferring their responsibilities. BPP 1903/XX:349, Board of Education, General Report for 1902-3, Cd. 1763, p.7.

of a local authority of significant, if not always substantial, population size. Second, with the exception of some County Councils which had chosen not to exercise the optional sanitary powers conferred on them by the 1888 Local Government Act, all education authorities were sanitary authorities also. Thus although the 1902 Act did not make any specific changes in the law relating to the appointment of medical staff by education authorities, the Act for the first time joined schools and sanitary officers under the same authority.

CHAPTER THREESCHOOL HEALTH:NATIONAL DEBATE ANDLOCAL ACTION, 1902-1906.

Whatever contribution the 1902 re-organisation of educational administration made to the further expansion of school hygiene at local authority level, the establishment of the School Medical Service on a national basis by the Education (Administrative Provisions) Act of 1907⁽¹⁾ has often been attributed to concern about the condition of the British people generated as a result of the South African War of 1899 to 1902.⁽²⁾

The Concern for "National Efficiency"

In The Heart of the Empire, published in 1901, C.F.G. Masterman contrasted the contemporary mood with that of the 1880's. That decade had seen the development of popular protest movements, demonstrations against unemployment and the growth of a new style of trade unionism. These trends had been matched by an active middle class response reflected in the growth of the settlement movement, the emergence of the literature of social inquiry such as The Bitter Cry of Outcast London, and government investigations into the housing of the working classes and other problems.

(1) Education (Administrative Provisions) Act, 1907, 7 Edw. VII, ch.43

(2) See J. Roy Hay, The Origins of the Liberal Welfare Reforms, 1906-1914, E.H.S. Studies in Economic and Social History (London: Macmillan, 1975), p.18.

Discussion was dominated by the problem of poverty and the possibilities of social reform.⁽³⁾ But, said Masterman:

One who had gone to sleep in the midst of that stirring time and suddenly awakened at the commencement of the twentieth century, might be pardoned if on rubbing his eyes and gazing on the present ideals and conditions of society he maintained that he was still dreaming. For a wave of 'Imperialism' had swept over the country, and all these efforts, hopes, and visions have vanished as if wiped out by a sponge.⁽⁴⁾

Masterman attributed the decline of interest in social reform to the improved conditions of trade, and the consequent improvement in the rate of employment: "with all busy working for subsistence, none have leisure to cry out or demonstrate in favour of change".⁽⁵⁾ The middle class he considered disillusioned with the results of their attempts at reform. In contrast, a series of Imperial successes, including the annexation of the Transvaal and the Zulu and Afghan Wars, saw the growth of popular support for Imperial expansionism, particularly in the conurbations:

Imperialism, indeed, was a peculiarly urban, though hardly urbane phenomenon. Something in the gathering of large conglomerations of individuals in the big cities, for the very reason that it destroyed the traditional social groupings, seemed to create a need for newer and more artificial stimuli.⁽⁶⁾

(3) See Helen M. Lynd, England in the Eighteen Eighties (London: Oxford University Press, 1945).

(4) C. F. G. Masterman, ed., The Heart of the Empire (London: Fisher Unwin, 1901), p.3.

(5) Ibid., p.5.

(6) Alfred Cobban, "The Idea of Empire", in Ideas and Beliefs of the Victorians, ed. Harman Grisewood (London: Sylvan Press, 1949), p.330. See also Herman Ausubel, In Hard Times, Reformers among the Late Victorians (New York: Columbia University Press, 1960), pp.250-64.

Imperialism and its attendant cult of jingoism was considered to have reached a peak in the "Khaki Election" of October 1900, in which the Conservatives achieved a majority of 134 over the combined Liberal and Irish parties.⁽⁷⁾ Later historical discussion has questioned the extent to which the Khaki Election was, in fact, a reflection of real working class support for Imperial expansionism. Purely local issues, and the disarray and lack of preparation in the ranks of the Liberal Party are also considered to have contributed to the Conservative victory.⁽⁸⁾

Even before the Khaki Election, however, events in South Africa were bringing about a questioning of the assumptions upon which the ascendancy of the Imperialist sentiment were based. The British army had suffered a number of reverses, due in the main to incompetence and ill-considered actions by some of the field commanders. These culminated in the events of "black week" in December 1899. Further setbacks were to follow. Although a recovery of sorts was subsequently made, and the Khaki Election itself was designed to capitalise on the mood of relief after Lord Roberts had entered Pretoria,⁽⁹⁾ the earlier failures had already induced a more intro-

(7) R.C.K. Ensor, England, 1870-1914, Oxford History of England, vol. 14 (Oxford: Clarendon Press, 1966), p.267.

(8) See e.g. Henry Pelling, Popular Politics and Society in Late Victorian Britain, 2nd ed. (London: Macmillan, 1979), pp.82-100; Richard Price, An Imperial War and the British Working Class (London: Routledge, Kegan Paul, 1972), esp.pp. 97-131; T. Boyle, "The Liberal Imperialists, 1892-1906", Bulletin of the Institute of Historical Research, 52 (1979), 48-82.

(9) G. R. Searle, The Quest for National Efficiency (Oxford: Basil Blackwell, 1971), pp.35-36.

spective mood, and had:

transmuted the complacent arrogance and contempt of other nations begotten of long years of peace and prosperity to a truer consciousness both of our strength and of our defects, and has awakened an earnest desire to make those defects good.(10)

This change of mood was reinforced by the prolongation of the War by the Boer guerillas, and the army's failure to crush this resistance swiftly. This led to concern that Imperial power was no longer being "efficiently" organised. Arnold White's Efficiency and Empire, a book devoted like that of Masterman to this theme, took up this point, complaining:

What should have been an affair of police, to be taken in the stride of Empire, has been expanded by the incompetence of our rulers to the dimensions of a great war....the whole strength of the Empire has been mobilised to destroy two peasant communities.(11)

Failure to achieve a swift victory suggested shortcomings in the way the Empire was administered, and "when efficiency goes out of the door, it is inevitable that Empire will fly out at the window."(12)

The Civil Service (and the Foreign Office particularly), the Parliamentary system and political institutions, and the lack of leadership by the Church were all criticised by White and Masterman.

(10) L. S. Amery, quoted ibid., p.39.

(11) Arnold White, Efficiency and Empire (London: Methuen, 1901), p.17.

(12) Ibid., p.23.

But both also emphasised the role of social conditions and changes in reducing efficiency. White was concerned about rural depopulation:

The harvests of recent years have been reaped in many countries by bronzed veterans of fifty or more and by boys of fifteen. Country-born labourers in the prime of life are now white-faced workmen living in courts and alleys.(13)

Premature marriages, and the lack of controls on the "unfit" were also criticised. Masterman similarly commented on:

The physical change [that] is the result of the city up-bringing in twice breathed air in the crowded quarters of the labouring classes. This as a substitute for the spacious places of the old, silent life of England; close to the ground, vibrating to the lengthy, unhurried processes of "Nature".(14)

The prolongation of the South African War had thus introduced a critical note to basic beliefs about British institutions, character and health. This contrasted sharply with Joseph Chamberlain's assertion in the 1880's that:

I believe in this race, the greatest governing race the world has ever seen; in this Anglo-Saxon race, so proud, tenacious, self-confident and determined, this race which neither climate nor change can degenerate, which will infallibly be the predominant force of future history and universal civilisation.(15)

In hinting at the possibility of national "inefficiency", the War also emphasised the developing consciousness of Imperial rivalries. The diplomatic repercussions of the Boer War meant that: "during

(13) Ibid., p.96

(14) Masterman, op.cit., p.10.

(15) Cobban, op.cit., pp.329-30.

the South African War Great Britain felt her isolation acutely. She had no ally and scarcely a friend".⁽¹⁶⁾ Thus isolated internationally, and apparently under threat from structural inefficiencies, calls for a greater emphasis on policies relating to "the heart of the Empire" rather than just its peripheries became increasingly popular. For a model, such policies looked to Germany itself, whose military power was thought to be derived from, or based on, a pattern of social legislation emphasising a common national interest transcending class interests.⁽¹⁷⁾

Among the politicians to argue that a new synthesis between Imperialism and social reform was now required if the Empire was to be maintained was Lord Rosebery. Rosebery had briefly been Prime Minister between 1894 and 1895. A committed Imperialist, he had voted with the Government in July 1900 during a censure debate on Unionist policy on South Africa which served only to formalise the split in Liberal opinion. He was subsequently urged by R. B. Haldane to seize the Liberal leadership from Campbell-Bannerman, but he desisted.⁽¹⁸⁾ After the Khaki Election, however, he began to argue that social reforms were needed to secure the maintenance of the Empire. A speech on 16 November 1900, on his installation as Rector of Glasgow University, became a rhetorical debate about the

(16) Ensor, op.cit., p.256.

(17) See William Harbutt Dawson, Bismarck and State Socialism (London: Sonnenschein, 1890).

(18) Robert James Scally, The Origins of the Lloyd George Coalition (New Jersey: Princeton University Press, 1975), p.32. For an account of this period of Liberal Imperialism see Henry C.G. Matthew, The Liberal Imperialists (London: Oxford University Press, 1973), esp. pp.37-121; Bernard Semmel, Imperialism and Social Reform (London: George Allen & Unwin, 1960), pp.54ff.

future of the British Empire: "Are we worthy of this prodigious inheritance? Is the race which holds it capable of maintaining and developing it?"⁽¹⁹⁾

A survey of the condition of the British people, he suggested, would find that:

the general result would probably be satisfactory; but it may be predicted with much more certainty that weaknesses and abuses and stagnation would be discovered; an ill-condition which is apt when neglected to be contagious and dangerous.⁽²⁰⁾

In particular, Rosebery said:

An Empire such as ours requires, as its first condition an Imperial race - a race vigorous and intrepid and industrious. Are we rearing such a race? In the rural districts I trust that we are. I meet the children near Edinburgh returning from school, and I will match them against any children in the world. But in the great cities - in the rookeries and slums which still survive - an Imperial race cannot be reared. You can scarcely produce anything in those foul nests of crime and disease but a progeny doomed from its birth to misery and ignominy.⁽²¹⁾

Rosebery's ideas had many similarities to those of Sidney and Beatrice Webb. The Webbs were Fabian socialists but like a majority of those who remained in membership after a schism precipitated by a speech by Bernard Shaw defending Imperialism, they were committed to the concept of Empire.⁽²²⁾ This conjunction of views led Rosebery to establish contacts with the Webbs through Haldane, a mutual friend.⁽²³⁾ Rosebery's apparent interest in leading a party committed to both Imperialism and social reform, further indicated by a speech at the Central Liberal Club in July

(19) Times, 17 November 1900, p.12.

(20) Ibid.

(21) Ibid.

(22) See Margaret Cole, The Story of Fabian Socialism (London: Heinemann, 1961), pp.95-102.

(23) Scally, op.cit., p.36

1901,⁽²⁴⁾ led to a response by Sidney Webb. Entitled "Lord Rosebery's Escape from Houndsditch" and first published in the Nineteenth Century and After for September 1901, this was later published as Fabian Tract 108, Twentieth Century Politics: a Policy of National Efficiency. In this, Webb gave his support to Rosebery, and listed a series of social reforms he thought should form the social programme of a party of national efficiency. Such a policy, according to Webb, would start with the condition of the people. This would necessitate action to deal with sweated labour, to improve housing conditions and to reform the Poor Law. The improvement of educational standards was also needed.⁽²⁵⁾ For Webb, the essential question was, "can we allow the submerged fifth to be housed, washed, watered worse than horses".⁽²⁶⁾ In spite of being provided by Webb with a draft social manifesto for a new party, Rosebery proved temperamentally incapable of exercising the political thrust required to force himself back into the highest spheres of politics, and often "displayed a marked tendency to be hard to reach at the critical moment",⁽²⁷⁾ although in his speeches he continued to press the case for greater efficiency to match Imperial needs. His speech at Chesterfield in December 1901 was

(24) Times, 17 July 1901, p.7; 20 July 1901, p.15.

(25) Sidney Webb, Twentieth Century Politics: a Policy of National Efficiency, Fabian Tract no. 108 (London: Fabian Society, 1901), p.7.

(26) Ibid., p.9.

(27) Scally, op.cit., p.33. See also Matthew, op.cit., p.37.

an apparent endorsement of Webb's proposed social programme,⁽²⁸⁾ and his campaign resulted in the formation of the Liberal League.⁽²⁹⁾ The Webbs, however, tiring of Rosebery's vacillations, developed instead contacts with younger Liberal Imperialist politicians. In November 1902 they founded the "Co-efficients", a dining club including Haldane, Grey, Maxse, Masterman and Milner, dedicated to discussion about the needs of the Empire.⁽³⁰⁾ Discussion remained the limit of the Co-efficients' activities.

Britain's poor military performance in the South African War thus created a political climate favourable to ideas stressing social reform as a precondition for the continuation of Imperial power. The discussion generated by the debate about national efficiency also raised more specific fears about the existing condition of the British people, including the alarming possibility that an actual deterioration of the national physique was contributing to the shortcomings typified in the conduct of the Boer War. This suggestion was the more alarming for its apparent verification by two independent and apparently irreproachable sources.

Allegations of Physical Deterioration

Of these, the first, and most directly linked to the concern over the Boer War, was the journalism of General Sir Frederick Maurice. Son of the Rev. Frederick Denison Maurice, the Christian

(28) Times, 17 December 1901, p.10. Scally, op.cit., p.54.

(29) Ibid., p.59.

(30) Ibid., pp.73-95.

Socialist leader, and a professional soldier of some distinction, Maurice picked up and gave wider publicity to a point first made by Arnold White. Following the outbreak of the War, only a small proportion of the men volunteering for service with the forces in South Africa who presented themselves at the Manchester recruiting office were found to be physically fit for service. White alleged that only 1,200 of 11,000 volunteers were capable of immediately achieving the moderate standard required.⁽³¹⁾ In the Contemporary Review for January 1902 Maurice, writing under the pseudonym "Miles", expanded this point into a national survey of the recruitment figures. Ostensibly, Maurice observed, it appeared that the percentage of volunteers who were rejected on medical grounds had actually diminished during the War. In fact this apparent improvement was due only to an increase in unrecorded rejections occurring at an earlier stage in the recruitment process, for officers had been instructed not to pass on to the medical board any potential recruits who would clearly fail the medical examination. So:

taking into account those whom the officers did not think it worthwhile to bring before the doctors, those whom the doctors reject, and those who are rejected after trial in the Army, sixty per cent are rejected, and that, to put it in its simplest terms, out of every five men who are willing to enlist only two are fit to become effective soldiers.⁽³²⁾

(31) White, op.cit., pp.102-3.

(32) "Miles" (Maj. Gen. Sir Frederick Maurice). "Where to Get Men" Contemporary Review 81(January-June 1902),79.

In this paragraph, Maurice includes the original version of the "two out of five" phrase which was later to be used freely during debates on the allegations of physical deterioration. For the actual causes of the apparent disability, Maurice blamed social customs and changes, including, "early marriages or.... less happy connections between the sexes. The small accommodation in the houses, the close neighbourhood, the early association at Board schools..."(33) In a second article in the Contemporary Review a year later, Maurice, by now writing under his own name, returned to the problem of recruitment. Now, he considered the evidence on the effect of early marriages inconclusive, but he was prepared to speculate on the contribution which rural depopulation made to the problem. His January 1903 article concluded with a call for further investigation of the question, asking the medical profession:

for assistance in getting at the truth on the tremendous question which has been raised by the investigations of Mr. Rowntree. "Is it or is it not true that the whole labouring population of the land are at present living under conditions which make it impossible that they should rear the next generation to be sufficiently virile to supply more than two out of five men effective for the purposes of either peace or war". We want the truth.(34)

Maurice's use of the actual term "physical deterioration" was, so far as his article went, indirect. He linked low physical standards to low incomes, referring to:

(33) Ibid., p.82.

(34) Frederick Maurice, "National Health: a Soldier's Study", Contemporary Review 83(January-June 1903), 55.

the fact - to which Mr. Booth so strongly testifies, that it is capacity or skill alone which in some form or another commands or ever can command an adequate wage in the towns; and therefore the enormously strong presumption that neither the unskilled labourer who has been tempted into the towns, nor the hereditary townsman who after two or three generations, has deteriorated in physical vigour, will be able to rear a healthy family.(35)

In this sense, physical deterioration was a presenting symptom of the wider problems of poverty. However, Maurice's article was followed by the issue of government publications which apparently confirmed independently that physical deterioration was a reality, rather than just speculation.

The Royal Commission on Physical Training in Scotland had been established at the end of March, 1902, to:

inquire into the opportunities for physical training now available in the state-aided schools and other educational institutions of Scotland; and to suggest means by which such training may be made to conduce to the welfare of the pupils.(36)

The members of the Commission interpreted this uncontroversial remit so flexibly that its Report, when issued in 1903, considerably extended the debate on the presence of "physical deterioration". Considering that physical training could not be considered in isolation from the physical condition of the subjects of the training, the Commission:

felt it to be our duty to take medical evidence with regard to the general physical condition of

(35) Ibid., p.49.

(36) BPP 1903/XXX:1, Royal Commission on Physical Training in Scotland, vol.1, Report and Appendix, Cd. 1507, p.4.

the youth of the country, to ascertain the data which were available for guidance, and whether any conclusions might safely be formed with regard to its tendency to advance or decline.(37)

The Commission was thus preoccupied from the outset of its enquiry with the possibility of a deterioration of the physique of Scottish children. It found the existing data to be fragmentary and containing little directly relevant. Apart from an investigation by the Anthropological Committee of the British Association for the Advancement of Science dating from 1883, the Commission was given data relating to an English girls school, children in Industrial and Reformatory Schools in Britain, and children in Boston, Massachusetts. This was supplied by Francis Warner, along with details of his own investigations.⁽³⁸⁾ As little of this information referred to Scottish children, the Commission decided to conduct its own investigation, a comparative study of children in schools in Aberdeen and Edinburgh. The Aberdeen children were examined by Mathew Hay, a Professor at Aberdeen University and Medical Officer of Health for the city, while Dr. W. Leslie Mackenzie, a former pupil teacher and Medical Officer to the Local Government Board for Scotland examined the children in Edinburgh. The results of their study, which covered 1,200 children in all, and the relationship of their study to the other data possessed by the Commission, were discussed at length.⁽³⁹⁾

The Aberdeen child (and both sexes and all ages from six to fifteen are included in all these

(37) Ibid., p.8.

(38) Ibid., pp.21-22.

(39) Ibid., pp.24-25.

comparisons) is 0.07 inches taller than the average British child, but weighs 0.63 pounds less. The British child stands 0.86 inches less, and scales 2.3 pounds less, than the American child. The Edinburgh child is the worst of all four, being 1.28 inches shorter and 5.61 pounds lighter than the British standard. The facts may be given, in slightly greater detail, in the following table:-

Height (")	Brit. Ass.	Boston	Aberdeen	Edinburgh	Lon.Col.
male 6-9	45.67	46.15	46.0	44.52	
female 6-9	44.64	45.89	45.4	44.51	
male 9-12	51.68	52.10	51.2	50.20	53.66
female 9-12	50.96	51.72	50.9	49.93	
male 12-15	57.07	58.34	57.3	55.26	60.61
female 12-15	57.74	58.74	57.4	55.65	
Weight (lb.)					
male 6-9	49.6	49.68	51.1	46.60	
female 6-9	47.1	48.25	47.9	45.62	
male 9-12	66.6	66.32	64.0	59.53	N/A
female 9-12	61.8	63.95	60.9	57.76	
male 12-15	83.7	89.12	84.5	74.02	
female 12-15	86.7	90.95	83.3	78.36	

The Commission insisted that the validity of the data could not be challenged, and concluded:

we find, by comparing the statistics of Aberdeen and Edinburgh, and quite as much by comparing the better with the poorer schools in Edinburgh itself, evidence that whatever may be the case with the population as a whole, there exists in Scotland an undeniable degeneration of individuals of the classes where food and

and environment are defective.(40)

The Commission's discovery of "undeniable degeneration" was given further emphasis by the issue of the 1902 Annual Report of the Army Inspector-General of Recruiting in March 1903, which referred, obviously with Maurice's articles in mind, to:

The one subject [that] causes anxiety in the future as regards recruiting [which] is the gradual deterioration of the physique of the working classes from whom the bulk of recruits must always be drawn.(41)

By a process of mutual reinforcement, the issue of these Reports created the impression that the existence of physical deterioration was not a question to be resolved but a fact to be discussed. The qualifications and uncertainties discernable in Maurice's earlier comments were gradually deleted from the later publications.

Apart from its significance as a stimulus to social policy initiatives, a major feature of the concern about the possible "physical deterioration" of the British people is the way it illustrates how a misinterpretation or misuse of statistical material can lead to questionable conclusions. The case for the presence of physical deterioration effectively rested on two sets of data. . First, the number of recruits rejected during the Boer War. This tended to be given added significance by the losses from disease among soldiers who were actually considered fit to go to South Africa. During the War, the British Army lost more

(40) Ibid., p.25.

(41) BPP 1903/XI:1, Army and Militia, Report of the Inspector-General of Recruiting for 1902, Cd. 1417, p.30.

men through ill health than it did during action.⁽⁴²⁾ Second, the studies by Mackenzie and Hay of 1,200 school children in Edinburgh and Aberdeen and their interpretation by the Royal Commission. Of these, the former was of questionable significance, being statistics of a self-selecting group whose composition tended to vary according to the state of the economy, while the use made by the Royal Commission of Mackenzie's and Hay's data serves as an almost classical illustration of the way data could be misused. It must be said that at this juncture statistical methodology, sampling techniques and tests of significance were very much in their infancy, and non-specialists could not be expected to have knowledge of techniques which were even then only just being published in the specialist journals.⁽⁴³⁾ Nevertheless, the way in which the Royal Commission chose to disregard the qualifications expressed by its own investigators in its eagerness to argue for the existence of degeneration is noteworthy.

An examination of the way the basic data were assembled, and of the way they were interpreted, illustrates the basic weaknesses in the physical deterioration hypothesis. The Edinburgh children examined by Mackenzie had lower average height and weight measurements for all age groups and both sexes than those examined by Hay in Aberdeen, but it was among the highest age group, the twelve to fifteen year olds, that the difference was greatest, and it was this disparity which the Commission

(42) L. S. Amery, ed., The Times History of the War in South Africa, 7 vols. (London: S. Low Marston & Co., 1900-9) 7 (1909), Appendix 3, p.25.

(43) See Charles Singer and E. Ashworth Underwood, A Short History of Medicine, 2nd ed. (Oxford: Clarendon Press, 1962), p.726.

emphasised. It was in this group also that the investigators experienced the greater difficulty. In Mackenzie's report of the examination of children in Edinburgh, he observed that:

the only point in the selection of the children that might possibly give rise to the wrong inferences was the impossibility of obtaining a full number of children of ages fourteen to fifteen. Only in one school was there sufficient children to make a ballot possible for the full number. Consequently I had to make up the group of twelve to fifteen from a larger number of those at the lower of the three years of age.(44)

According to the arrangements he had made with Hay, therefore, at each of the four schools he visited Mackenzie should have made a random selection of eight or nine boys, and a similar number of girls, in the fourteen to fifteen age group. Because he found this to be impossible, he examined instead a greater number of the younger children. Mackenzie stressed that this procedure would lead to problems in making a comparison between the Edinburgh schools, and was perhaps unaware that the Commission would make a comparison between his Edinburgh results and those of Hay in Aberdeen, where a similar difficulty had been resolved in a different manner. Hay, as arranged, also visited four Board schools, "and two advanced schools. The latter were included mainly to obtain the necessary number of children at the higher ages".(45) Hay's sample thus contained the correct number of fourteen to fifteen year olds, but many of these were children from a different and higher social class than would

(44) BPP 1903/XXX:1, op.cit., Appendix 9, p.76

(45) Ibid., p.101.

normally be found in Board schools. Such class differences in the samples, the significance of which were already known to social investigators,⁽⁴⁶⁾ were ignored by the Commission, which claimed:

The more Doctors' Hay's and Mackenzie's reports are studied, the more they are found to present a harmonious mass of diverse observations of the most varied nature, all pointing in the same direction.⁽⁴⁷⁾

So convinced was the Commission of the existence of physical deterioration that, as one critic of the Report correctly pointed out, authors critical of the hypothesis were so misquoted in the Report as to suggest they in fact concurred in the view that deterioration existed.⁽⁴⁸⁾ Such criticisms, however, went largely unheard in the debate stimulated by the publication of the Report. A more typical reaction was to accept as fact that there was "undoubtedly a progressive deterioration in physique, a vast amount of 'unrecognised disease', and various 'lesser ailments'".⁽⁴⁹⁾ The fear of deterioration immediately became a subject of debate in the popular press, and in Parliament, where the Earl of Meath among others pursued the matter energetically.⁽⁵⁰⁾

A question arises as to why the existence of physical deterior-

(46) Frances Barrymore Smith, The People's Health, 1830-1910 (London: Croom Helm, 1979), p.176.

(47) BPP 1903/XXX:1, op.cit., p.25.

(48) J. H. Vines, "The Physique of Scottish Children: Some Fallacies of a Royal Commission", Westminster Review 160 (July-December 1903), 319-20.

(49) H. Rippon Seymour, "The Royal Commission on Physical Training (Scotland)", Westminster Review 160 (July-December 1903), 306.

(50) See e.g. Parl. Deb., 4th series, 124(6 July 1903), 1324 ff.

ation was so readily accepted by a large segment of opinion during this period. The apparent discovery of evidence for the existence of physical deterioration was consistent with, and was an apparent confirmation of, theories of urban degeneration current since the 1880's. The idea that residence in large towns, and particularly the more over-crowded sections of those towns, had a progressively deleterious effect on health had been given some credence in 1885 when the Royal Commission on the Housing of the Working Classes remarked on the subject in its Report.⁽⁵¹⁾ The writings of Dr. James Cantlie illustrate the most extreme form of this argument. He claimed in a lecture in January 1885, subsequently published in pamphlet form, that he had never encountered a third generation Londoner, whom he defined as a person all of whose parents and grandparents had been born and had lived continuously in London.⁽⁵²⁾ Significantly Cantlie, who attributed the absence of such thoroughbred Londoners to the absence of ozone in the London air, published a further pamphlet on the subject in 1906. In this he claimed that events and discoveries subsequent to his earlier publication had vindicated his original contention, and suggested a package of measures including the banning of dummies for babies, the use of disused gas mains to pump ozonised seaside air into the centre of major cities, and the introduction of regulations "that only

(51) BPP 1884-85/XXX:1, Royal Commission on the Housing of the Working Classes, First Report, C.4402, p.19.

(52) James Cantlie, Degeneration amongst Londoners (London: Field & Tuer, 1885).

healthy persons should be allowed to marry, [and] that female candidates for matrimony should have to pass an examination in cookery".⁽⁵³⁾

Although Cantlie's ideas represented the wilder realms of the theory of urban degeneration, as Gareth Stedman Jones has demonstrated in his study of Outcast London the 1880's and 1890's saw the theory gaining support from a variety of respectable intellectual sources, including Charles Booth, the economist Alfred Marshall, and Herbert Llewellyn Smith.⁽⁵⁴⁾

By the early 1900's, both Masterman and White, writing before either Maurice or the Royal Commission had reported, referred almost routinely to the problems of urban degeneration. Similarly the Earl of Meath, in his response to the Royal Commission's Report, linked the apparent degeneration with the movement from an agricultural to an industrial, urbanised, society.⁽⁵⁵⁾

In this respect it should be noted that the seminal social surveys of this period, however influential they were in providing a greater depth of information about the condition of the people, did little to combat the notion that progressive deterioration existed. Indeed, as Stedman Jones notes,⁽⁵⁶⁾ Booth's survey, and especially Llewellyn Smith's contribution on "The Influx of Population", tended to support the hypothesis, postulating a model

(53) Idem, Physical Efficiency (London: Putnam's, 1906). See also Everard Digby, "The Extinction of the Londoner", Contemporary Review 86 (July-December 1904), 115-26.

(54) Gareth Stedman Jones, Outcast London (Oxford: Clarendon Press, 1971), pp.127-51.

(55) Earl of Meath, "The Deterioration of the British Health and Physique", Public Health, 16(1903-4), 287-92.

(56) Stedman Jones, op.cit., p.130.

of labour movement in which the newly arrived country incomer obtained the pick of the posts available, whilst it was the Londoners who formed the bulk of the unemployed:

who are, in the main, the sediment deposited at the bottom of the scale, as the physique and power of application of a town population tends to deteriorate. The movement from the country is thus a movement downwards from above.(57)

Booth's survey, along with that of Rowntree, who called for an anthropological survey of the condition of the people,⁽⁵⁸⁾ thus served by their very publication to add sustenance to claims that deterioration existed. As Philip Abrams points out:

One unintended consequence of the flood of statistics of poverty, crime, intemperance and mental disorder in the 1890's and after was to lend colour to those projections of deterioration. Figures created a more cogent sense of the extent of these social ills, the numbers of the socially dependent, than most middle class Victorians had had before. And this easily produced the illusion of the growth of dependence.(59)

Apart from the concept of urban degeneration, a further and allegedly more scientific application of ideas about human development and deterioration also served to act as a basis of support for the physical deterioration hypothesis, the study of Eugenics. Since the publication of Charles Darwin's Origin of Species, interest had grown in the possibility that "natural selection" could be applied, in theoretical and practical terms, to human development. In Social Darwinism, such ideas

(57) Charles Booth, Life and Labour of the People of London, 10 vols. (London: Macmillan, 1892-97), 3(1894), 121.

(58) Seebohm Rowntree, Poverty, a Study of Town Life (London: Macmillan, 1901), p.209.

(59) P. Abrams, The Origins of British Sociology, 1884-1914 (Chicago: University of Chicago Press, 1968), p.124.

were applied to explain personal economic or moral success or failure in society as the outcome of individualised competition resulting in the highest material awards and achievements for those with the most satisfactory social, intellectual, or physical attributes. Under Sir Francis Galton and Karl Pearson, the idea of competition was extended to focus on competition between races or societies through the development of the study of Eugenics.

Prior to the Boer War, the essentially competitive philosophy of the Social Darwinist school had been reflected in a basic antipathy to social reforms or even to many methods of individual treatment or amelioration. Among the early proponents of school hygiene, Brudenell Carter was attacked by the Darwinists during his research on the eyesight of children when he had claimed that the eyes of "savages" were, on the whole, superior to those of the civilised races.⁽⁶⁰⁾ The controversy culminated in a debate at the Anthropological Institute, during which one of Brudenell Carter's critics argued that:

if he [Brudenell Carter] and his brother specialists, instead of encouraging the use, would decree the entire abolition of spectacles, there would be some chance of the law of evolution taking place. Every time he recommends a pair of spectacles he interferes with the survival of the fittest by placing an imperfectly sighted patient on a level with the normal sighted, and it is in this direction, more than any other - that is, by the transmission of hereditary or imperfect organs - that civilisation has done the greatest harm to our eyesight.⁽⁶¹⁾

(60) Medical Times & Gazette i (1885), 174.

(61) Ibid., p.186.

Although the logic of the discoveries of the Boer War prompted a change in attitude among some of the Eugenists, others continued to oppose basic social reforms. In 1910 Beatrice Webb recorded:

The "Eugenists" have always been our bitter opponents on the ground that all attempts to alter environment are not only futile, but positively mischievous as such improvements in environment diminish the struggle for existence and retard the elimination of the unfit. (62)

The idea that whole nations as well as individuals could grow or decline in stature was obviously influential in a country in the process of questioning the basis of its Imperial power, and concerned about apparent evidence of inefficiency in its institutions and deterioration of its national physique. G. R. Searle suggests that the post Boer War concern about national efficiency and degeneration provided a fertile soil for the Eugenics movement to flourish.⁽⁶³⁾ Arguably, however, the opening of a public debate on the ideas of Eugenics after Galton's lecture to the Anthropological Institute in October 1901 helped to enhance concern when the allegations of physical deterioration were later made by Maurice and the Royal Commission.⁽⁶⁴⁾

(62) Passfield MSS, Diary of Beatrice Webb, Vol. 27, p.77, 4 September 1910.

(63) G.R. Searle, Eugenics and Politics in Britain, 1900-1914 (Leyden: Noordhof, 1976), pp.9ff.

(64) The concepts underlying the urban degeneration and physical deterioration theories differed, and therefore the remedies also varied. Urban degeneration had inherently Lamarckian overtones, was concerned with the general decline in fertility in the urban environment, and supported welfare reforms as a remedy among others. Physical deterioration as propounded by the Eugenists was essentially Darwinian in orientation, concerned with class differentials in fertility rates, and frequently favoured authoritarian remedies such as stirpiculture (selective breeding) rather than social reform. Ibid., p.24.

The existence of these differing fears of degeneration or deterioration, some of long standing, perhaps ensured both a less critical examination of the evidence on which the claims of Maurice and the Royal Commission were based, and a more urgent debate on the remedial action to be taken.

By the nature of its terms of reference, the remedial measures recommended by the Commission were mainly concerned with children and youths in the educational system. As might be expected, the bulk of the recommendations related to systems of physical education, with a call for more exercise and better provision for physical training in all sectors of the education system up to university level, combined with the establishment of co-ordinating committees, and physical training qualifications for all teachers. Auxiliary agencies such as Cadet Corps and the Boys Brigade were also to be encouraged, recommendations reflecting the presence of the President of the Boys Brigade on the Commission.⁽⁶⁵⁾

The Commission also referred:

to a very serious defect in our school organisation to which we desire to call special attention. This consists in the absence of any general or adequate system of medical inspection. Such a system is urgently demanded mainly for remedial objects, but also in order to make available information of the highest value both for ascertaining the facts of national physique and the means that may be adopted for its improvement or for retarding such degeneration as may be in progress.⁽⁶⁶⁾

Much of the supervisory work, the Commission suggested, could be performed by the public health officials already appointed to the

(65) BPP 1903/XXX:1, op.cit., pp.36-38.

(66) Ibid., p.28.

burghs and counties of Scotland.⁽⁶⁷⁾

The Inter-Departmental Committee on Physical Deterioration

The Government's concern at the potential public impact of the Royal Commission's Report and recommendations is reflected in its decision, made only a month after publication of the Commission's Report, to establish an Inter-Departmental Committee charged with making a preliminary enquiry into the allegations of physical deterioration as a preparation for a future Royal Commission on the subject.⁽⁶⁸⁾ The Physical Deterioration Committee was essentially an attempt by the Balfour administration to deflect pressure for action on the allegations of physical deterioration.⁽⁶⁹⁾ The Chairman of the new Committee was Sir Almeric Fitzroy, Clerk to the Privy Council, and the membership consisted of officials from various government departments: likely to be affected by a future enquiry.

As originally constituted, the Committee was intended simply as a preliminary to a larger and, in membership, more prestigious inquiry into the allegations of physical deterioration, but Fitzroy succeeded in enlarging the terms of the Committee's mandate to allow it to make its own recommendations. The Committee examined sixty eight witnesses, including Sir Frederick Maurice

(67) Ibid., p.29.

(68) BPP, 1904/XXXII:1, Inter-Departmental Committee on Physical Deterioration, vol.1, Report and Appendix, Cd.2175, pp.v,1.

(69) Bentley B. Gilbert, "Health and Politics: the British Physical Deterioration Report of 1904", Bulletin of the History of Medicine 39(1965), 143-53.

and others who alleged the existence of physical deterioration.

Fitzroy found Maurice to be an unimpressive witness whose evidence "was tainted by his tendency to generalise from single instances within his own experience, and to develop hearsay gossip into an elaborate indictment of the physical condition of the masses".⁽⁷⁰⁾

The other witnesses from the Army retreated from making a general accusation of physical deterioration. Sir William Taylor, the Director General of the Army Medical Service, emphatically disclaimed any responsibility for the statements made by the Inspector-General of Recruitment, and in Fitzroy's view, had difficulty in avoiding an admission that the Army's problems stemmed directly from its recruitment "from the wastrels and wreckage of society".⁽⁷¹⁾

In contrast, the witnesses who presented more optimistic interpretations of the situation, such as Alfred Eichholz,⁽⁷²⁾ a medically qualified H.M.I. at the Board of Education, made a favourable impression on the Committee. Eichholz provided "a wealth of

(70) Sir Almeric Fitzroy, Memoirs, 2 vols. 2nd ed. (London: Hutchinson & Co., 1925), 1, 175.

(71) Ibid.

(72) Alfred Eichholz, MA, MD(1869-1933). Educated at Manchester Grammar School, Emmanuel College, Cambridge and St. Barts. Hospital. Became the first Jew to be elected a Fellow of a Cambridge College in 1893. Became an H.M.I. in 1898, and transferred to the Medical Department of the Board of Education on its establishment in 1907. Chief Medical Inspector 1919-30. Research Officer, Ministry of Health, 1930-32.

information, conveyed with a resolute air of self-assured confidence that carried great weight"⁽⁷³⁾ to the effect that physical deficiencies were quickly remediable by the provision of satisfactory environmental conditions. Similarly, Professor Cunningham, Chairman of the Anthropological Committee of the British Association, rejected the alarmist suggestions of the Eugenists and asserted that, far from degeneration being progressive, a physical mean existed to which each generation strove to return as soon as healthier conditions prevailed.⁽⁷⁴⁾

After receiving such evidence, the Committee's Report, when issued at the end of July 1904, offered no support to allegations of progressive physical deterioration, and rejected the idea of a Royal Commission to consider the matter.⁽⁷⁵⁾ The Committee did, however, acknowledge that social and environmental conditions existed which might "arrest and depress development", and proceeded to make a wide-ranging review of influences alleged to have such effects, including urbanisation, alcoholism, and a number of conditions relating to childhood and adolescence. The influence of eugenically linked "problems", such as differential birth rates and "hereditary taint" was viewed with scepticism.⁽⁷⁶⁾

To deal with adverse social and economic conditions, the Committee made a total of fifty three recommendations.⁽⁷⁷⁾ Because of the nature of its mandate, the recommendations of the Committee

(73) Fitzroy, op.cit., 1. p.175.

(74) Ibid., p.182.

(75) BPP 1904/XXXII:1, op.cit., p.7.

(76) Ibid., pp.13-83.

(77) Ibid., pp.84-92.

were not confined to childhood only, but suggestions for physical training and medical inspection featured prominently. The Committee considered that "a systematised medical inspection of school children should be imposed as a public duty on every school authority"⁽⁷⁸⁾.

Although inspection would help to detect defects, it could also serve a further purpose. The Committee was sceptical about the alleged presence of irreversible physical deterioration, but it was concerned that very little was actually known about the condition of the people. In European countries, the examination of conscripts served to provide a continuing record of the condition of the male population at least, but "in a country without compulsory military service the period of school life offers the state its only opportunity for taking stock of the whole population"⁽⁷⁹⁾. Thus the Committee supported the idea of the medical inspection also serving as an anthropometric survey, first suggested by the Royal Commission, and recommended "that two ages be selected at which every child in school should be measured by a teacher or other officer selected by the Education Authority for that purpose"⁽⁸⁰⁾. Although weighing and measuring would be general, the Committee suggested that any further remedial measures should operate on what would now be termed a "positive discrimination" basis, concentrating on the schools and the children deemed to be most in need. In concluding the Report the Committee expressed the hope:

(78) Ibid., p.65.

(79) Ibid., p.59.

(80) Ibid., p.11.

that the facts and opinions they collected will have some effect in allaying the apprehensions of those who, as it appears on insufficient grounds, have made up their minds that progressive deterioration is to be found among the people generally.(81)

Although the Committee attempted to dispel the notion of progressive physical deterioration, the publication of its Report placed the Government in a dilemma, for what the Report did do was to provide evidence of the existence of poor physical conditions, and to discuss the ways in which these might potentially be remedied or alleviated. Indeed, the Report magnified the Government's problems by suggesting that remedial action would produce swift results, whereas, had the hypothesis of physical deterioration been accepted, immediate reforms would have had only a limited effect. The reforms suggested by the Committee would, however, cost money, and in keeping with its approach to other social issues of the period, the Government chose to move cautiously.

Although the Government was quickly pressed to take swift action by its former Parliamentary Secretary at the Board of Education, Sir John Gorst,⁽⁸²⁾ who had resigned from the party in 1903 over its attitude to tariff reform,⁽⁸³⁾ the financial

(81) Ibid., p.92.

(82) Rt. Hon. Sir John Eldon Gorst, FRS(1835-1916). Educated at Preston Grammar School and St. John's College Cambridge. Fellow of St. John's. Conservative MP for Cambridge 1866-68, Chatham, 1875-92, Cambridge University 1892-1906, Solicitor-General 1885-86; Parliamentary Secretary, India Office 1886-91; Financial Secretary, Treasury, 1891-92; Vice-President, Committee of Council on Education, 1895-1902. Had links with Toynbee Hall. Kt. (1885).

(83) See Bentley B. Gilbert, "Sir John Gorst and the Children of the Nation", Bulletin of the History of Medicine 28 (1954), 243-51.

implications of the package of reforms proposed by the Committee delayed action. By December 1904 however, Gorst's successor at the Education Board, Sir William Anson,⁽⁸⁴⁾ was presiding over a meeting to discuss what action could be taken on the Committee's Report, insofar as it related to the functions of the Board of Education. Although the desirability of medical inspection was agreed, the financial implications of the suggestion caused some concern. Anson noted in particular that:

if the recommendation of the Committee be adopted and medical inspection be made compulsory, shall we not be also very strongly urged to adopt their other proposal that the Government should make some grant towards the cost? Any grant must involve a large charge on the Treasury.....(85)

Anson suggested an alternative might be to issue a Circular to encourage some authorities to adopt, on a voluntary basis, an inexpensive system of medical inspection. This would give the Government an argument with which to persuade other authorities of the value of introducing a system of inspection.⁽⁸⁶⁾ Anson had already been told by Balfour that he could "be as sympathetic as he liked, but there would be no increase in rates".⁽⁸⁷⁾ When discussion reached the Cabinet in February 1905 Anson suggested

(84) Rt. Hon. Sir William Reynell Anson (1843-1914). Educated at Eton and Balliol College Oxford. Fellow of All Souls College. Vinerian Reader in Civil and English Law, Oxford, 1874-81. Warden of All Souls from 1881. Vice-Chancellor of the University, 1898. Unionist MP for Oxford University 1899-1914. Parliamentary Secretary, Board of Education, 1902-5.

(85) PRO, Ed.24/590, Anson Papers, typed notes on a conference on the educational recommendations of the Physiscal Deterioration Committee 7 December 1904.

(86) Ibid.

(87) Gilbert (1965), op.cit., p.150. This was Lord Londonderry's recollection of Balfour's view. Balfour Papers, British Museum Add. MSS 49787, f.123. Morant to Balfour, 3 December 1904.

that although medical inspection might be sanctioned by the administrative action of the Local Government Board and the Board of Education, to make it compulsory would not only add to the burden on the rates, but also lead to new suspicions that the Government wanted to enforce vaccination regulations.⁽⁸⁸⁾ To avoid making a decision on the issue, or on the related question of free school meals, the Cabinet decided to set up a further Inter-Departmental Committee, which was to "consist of civil servants, so as to avoid the difficulty of having outside persons pressed upon us, who might approach the subject with pre-conceived conclusions".⁽⁸⁹⁾ In advocating this course of action Lord Londonderry stressed it was:

obvious that the terms of reference to this Committee will be a matter of no little importance and difficulty. We have on the one hand to arrange so that the Committee shall not be at liberty to make far-reaching proposals or recommendations upon lines, or in directions, which the Unionist party would decline to support - e.g. such as would result in, or tend towards, universal provision from the rates, of free meals for school children generally. And, on the other hand, if the terms of reference are too narrowly restricted, the Government would be accused of burking discussion while taking no really effective steps to discover or bring about any practical remedies for evils now generally admitted to exist.⁽⁹⁰⁾

Although alternative draft terms of reference were circulated with his paper, Londonderry later reported these had:

been redrafted to make it unmistakably plain that no

(88) PRO Cab 37/74/24, Memorandum by W.R. Anson, introduced by Lord Londonderry, 3 February 1905.

(89) PRO Cab 37/74/28, "Underfed children", memorandum by Lord Londonderry, 10 February 1905.

(90) Ibid.

question is to be raised of conferring new powers by legislation, and that the Committee are to make no recommendations which would involve expenditure out of public funds.(91)

The announcement on 14 March 1905 of the appointment of this second committee, the Inter-Departmental Committee on the Medical Inspection and Feeding of School Children, was quickly attacked by Gorst, who:

could not understand why the Board of Education delayed matters by appointing a committee of junior officials to revise the recommendations of the senior officials. It was a matter for grave regret that the question should be so hung up by an enquiry so futile and so obviously for the purpose of delay.(92)

Anson, responding to the criticism, could only claim the local education authorities had power to appoint medical inspectors.⁽⁹³⁾

Despite the appointment of the new Committee, the debate about the Report of the Physical Deterioration Committee continued.

In April 1905 a Commons debate on the question again saw Gorst demanding action from his former colleagues,⁽⁹⁴⁾ and Anson once more counselling caution on the ground of economy. In the next few months, Gorst made further attempts to open up the issue both in Parliament⁽⁹⁵⁾ and in the country, engaging in an extensive journalistic campaign in which he claimed that the Parliamentary discussions:

(91) PRO Ed.24/106. Copy of Cabinet memorandum by Lord Londonderry, 3 March 1905. This is not present in the Cab. 37 series.

(92) Parl. Deb., 4th series 143(27 March 1905), 1250.

(93) Ibid., col.1269.

(94) Ibid., 145(18 April 1905), 557ff.

(95) Ibid., 147 (1 June 1905), 535ff; 150(1 August 1905), 1222ff.

proved that the only people who had paid no attention to it [the Physical Deterioration Committee's Report] were the Government. All Departments disclaimed having taken any step to consider or carry out its recommendations and the Board of Education, when hard pressed, appointed another committee of junior officials to subvert, if they could, some of its conclusions.(96)

Gorst was by now something of a maverick figure, and no longer had influence on the governing party. But other, more substantial figures were also taking an interest. On 1 July 1905 Almeric Fitzroy visited the Duke of Devonshire, who had resigned from the Government during the Cabinet crisis over tariff reform in 1903 not because Chamberlain required him to do so but because he felt he had no other option.⁽⁹⁷⁾ Devonshire, who had been responsible for Fitzroy's appointment as Chairman of the Physical Deterioration Committee, told him of his continued interest in the Report, and of his intention to urge action on its proposals, particularly with regard to the anthropometric survey.⁽⁹⁸⁾ Along with the Bishop of Ripon, he raised this and other issues from the Report in a debate in the House of Lords during July.⁽⁹⁹⁾ According to Fitzroy, the debate was preceded by an attempt by Home Office and Local Government Board officials to discredit a Report they either regarded as a covert attack upon them, or as one which damaged their interests as against those of the Board of Education.⁽¹⁰⁰⁾

(96) Sir John Gorst, "Physical Deterioration in Great Britain" North American Review 181(1905), 3.

(97) Ensor, op.cit., p.374. For more detailed accounts of this crisis see Alfred Gollin, Balfour's Burden (London: Anthony Blond, 1965), esp. pp.115-88, and Richard E. Rempel, Unionists Divided (Newton Abbot: David & Charles, 1972), esp.pp.49-63.

(98) Fitzroy, op.cit., 1,257.

(99) Parl. Deb., 4th series, 149(20 July 1905), 1312-19.

(100)Fitzroy, op.cit., 1, 257-60.

This challenge evaporated, and Lord Lansdowne promised that the proposals of the Report would continue to receive the earnest attention of the Government.⁽¹⁰¹⁾ By this juncture, however, the Chamberlain administration had only four months of office to run, and apart from gestures such as the issue of the Relief (School Children) Order, 1905, giving the Poor Law Guardians the authority to provide free meals for children,⁽¹⁰²⁾ action on any of the points made in the Report of the Physical Deterioration Committee was not forthcoming until after the election and the assumption of office of Campbell-Bannerman's Liberal administration.

Nevertheless the impact, first of the fear of "physical deterioration" and then, even after this hypothesis had been discredited, of the continuing revelations about unsatisfactory social conditions, served to emphasise the importance of provision for child health in any social imperialist policy. The various inquiries provided a number of arguments to support the introduction of medical inspection in schools; not only to protect educational or national investment in the future, but also to provide anthropometric data to indicate trends in the national physique.

So strong was the concern about the health of the people that it stimulated the formation of pressure groups specifically to campaign on issues related to this area. An example of particular significance in the history of the School Medical Service was the formation of the National League for Physical

(101) Parl. Deb., 4th series, 149(20 July 1905), 1350-51.

(102) Bentley B. Gilbert, The Evolution of National Insurance in Great Britain, (London: Michael Joseph, 1966), pp.99-101, 108-9.

Education and Improvement, an organisation founded in the immediate aftermath of the Royal Commission's Report,⁽¹⁰³⁾ which was largely the inspiration of Sir Thomas Lauder Brunton,⁽¹⁰⁴⁾ a physician forced into early retirement for health reasons. This group argued that action to improve the health of the people was necessary in order to meet the future threat from Germany. It envisaged itself as a co-ordinating body in the main, and was actually based at Denison House, the headquarters of its model, the Charity Organisation Society, but it attracted a large number of distinguished, if rather inactive, supporters,⁽¹⁰⁵⁾ and was later to be engaged in the campaign to establish the School Medical Service.

The Inter-Departmental Committee on Medical Inspection and Feeding

As shown earlier, the Inter-Departmental Committee on the Medical Inspection and Feeding of School Children attending Public Elementary Schools was envisaged by the government as a delaying tactic to stave off the need for financially expensive decisions. The membership of the Committee consisted in its entirety of relatively junior members of the staff of the Board of Education

(103) Sir Thomas Lauder Brunton, "The National League for Physical Education and Improvement", National Review 26(1904),489-98.

(104) Sir Thomas Lauder Brunton MD FRCP FRS (1844-1916). Educated at Melrose Academy, Edinburgh Institute and the Universities of Edinburgh, Vienna, Berlin, Amsterdam and Leipzig. Spent his whole career as a physician at St. Barts Hospital. When forced into early retirement by an attack of blood poisoning he devoted himself to social imperialist causes such as the N.L.P.E.I.

(105) National League for Physical Education and Improvement, Report of Inaugural Meeting at the Guildhall 28 June 1905 (London: National League for Physical Education and Improvement, 1905).

and other departments, and the anodyne terms of reference, which in relation to medical inspection were to "ascertain and report on what is now being done and with what result in respect of Medical Inspection of Children in Public Elementary Schools",⁽¹⁰⁶⁾ were designed to exclude the Committee from actually recommending any course of action to the Government, a restriction acknowledged by the Committee in its Report: "We are confined by our terms of reference to noting results; we are not bidden to make recommendations for improvements".⁽¹⁰⁷⁾

Despite this obviously calculated restriction, the Report of the Committee, when ultimately published in November 1905, a fortnight before the Unionist Government's resignation, provides a useful basis for an analysis of the extent, character and origins of medical work in schools prior to the 1907 Act. As such, it serves to indicate not only the relative impact of the various pressures leading to the development of medical services in schools, but also as a means of identifying the variety of administrative procedures that had as a consequence developed, and which would be required, under the 1907 Act, to adopt some more homogeneous form. The bulk of the Committee's Report dealt with the provisions for the feeding of necessitous school children, reflecting both the greater spread of activity in this field, and the amount of voluntary activity taking place. On medical inspection, however, the Committee provided a relatively comprehensive survey of the

(106) BPP 1906/XLVII:1, Inter-Departmental Committee on the Medical Inspection and Feeding of Children Attending Public Elementary Schools, vol.1., Report, Cd. 2779, p.vii.

(107) Ibid., p.31.

existing provision, obtaining information, in response to an initial enquiry, from 293 of the 327 local education authorities in England and Wales, and then obtaining further information, either as oral evidence before the Committee or as a detailed written submission, from those authorities having the most active systems of medical supervision.

Although only a minority of the authorities responding to the questionnaire undertook no medical work at all, it was also a minority that attempted to provide a systematic scheme of medical inspection incorporating a comprehensive series of objectives. The Committee found that forty nine authorities, three of them County Councils, including the L.C.C., twenty five County Boroughs, ten Municipal Boroughs, and eleven Urban District Councils, had what it called a "definite system of medical inspection". Eighteen other authorities had undertaken some substantial effort in this field.⁽¹⁰⁸⁾ Other areas had begun to consider the possibility of introducing medical supervision in schools, but had not actually commenced such work at the time of the Committee's enquiry.⁽¹⁰⁹⁾

In most instances, any examination of the children undertaken by an authority was in relation to selected children only. Only in the smaller towns, such as Kidderminster or Keighley, was an attempt made to scrutinise all the children attending school. In other areas, the general practice was for the visiting doctor to examine cases selected for examination by the teachers, combined

(108) Ibid., p.2.

(109) Ibid., p.3.

with a "march past" of the remaining pupils, from whom the doctor would select any additional children requiring examination.⁽¹¹⁰⁾ Apart from this work in the smaller towns, two other exceptions to the general rule of selective examination may be identified; the testing of eyesight, usually by the teachers using Snellen's test types, and the systematic inspection of all children in areas where an outbreak of infectious disease had occurred. This latter, however, was not a regular occurrence for any one group of children. The Committee noted that the medical officer of an education authority might be asked to perform a range of duties, including the inspection of schools in relation to their sanitary conditions, the examination of individual children, or of teachers and other candidates for appointment to offices under the authority. Duties which required a more systematic examination of children on either a regular or an ad hoc basis included the prevention of the spread of infectious disease, the making of an anthropological survey, or making "periodic visits to schools and examination of the eyes, ears, teeth and general physical conditions of the children".⁽¹¹¹⁾ With some appointments, a general advisory or consultative relationship with the education committee was sometimes stipulated. Potentially, therefore, a medical officer appointed to an education authority could, even before the 1907 Act, be engaged in a wide range of activities. In practice, however, the full range of activities identified above were undertaken in only

(110) Ibid., p.8.

(111) Ibid., p.4.

a relatively small number of authorities, principally those with a full time medical officer, or those whose school population was so small that a part-time official could perform the tasks effectively. In most other authorities, only a selection of the whole range of duties was performed. The functions chosen reflected the professional interests of the responsible medical officer, or the priorities of the education committee. As such, the differing patterns of activity between authorities are an indication of the varying origins of medical work in schools.

Thus in many of the authorities where the medical officer of health to the local authority had been specifically appointed medical officer to the education committee, and where less formal arrangements with the M.O.H. existed, inspection of the sanitary condition of the schools, or prevention of the spread of infectious disease, or both, frequently formed the only duties assigned to the medical officer and might be the only form of medical supervision actually in operation in the schools of the authority. As an example of this arrangement, the only duty of the School Medical Officer of Warrington, where the M.O.H. had been appointed to this post, was to visit schools to detect the presence of infectious disease.⁽¹¹²⁾ At York, where no formal appointment had been made, the M.O.H. visited the schools at times of epidemic sickness.⁽¹¹³⁾ Among the Borough and Urban District Councils also such limited forms of supervision by the M.O.H. were common. At Accrington, an informal arrangement similar to that at York was in operation,⁽¹¹⁴⁾ while at Aston Manor, the M.O.H.

(112) Ibid., p.94.

(113) Ibid.

(114) Ibid.

was paid £47.5s. to examine the sanitary condition of the school premises, and to take action on cases of infectious disease notified to him by the school attendance officers.⁽¹¹⁵⁾

Many similar cases can be found in the data presented in the Committee's Report. Where the M.O.H., acting as school medical officer, did undertake some other duties, these were often of a most limited character, such as the occasional examination of children allegedly unfit for school. Smethwick serves as a case in point.⁽¹¹⁶⁾

Very few authorities where supervision was limited to sanitary questions used medical officers other than the local M.O.H. to deal with the matter, although at Winchester an independent officer had been appointed to examine children suffering from infectious disease, the only medical work undertaken by the education authority.⁽¹¹⁷⁾ There is an obvious rationale for the use of the M.O.H. for this work, as the public health department would have become involved with cases of infectious disease at some point anyway. What is significant, however, is the number of cases in which an M.O.H., having been appointed to a position under the education committee, had not succeeded, or was not interested, in extending his work beyond the basic area of sanitary supervision.

Evidence suggests, therefore, that in a significant number of cases where the M.O.H. was the medical officer to the education authority before the 1907 Act, the medical supervision provided

(115) Ibid.

(116) Ibid., p.96.

(117) Ibid., p.97.

did not extend far beyond basic sanitary supervision. In a few cases, however, the M.O.H. as school medical officer, was undertaking a wider range of functions, either at the request of the education committee or through his own initiative. In Keighley the M.O.H., in addition to the usual sanitary duties and examination of children allegedly unfit for school, visited each school at least once a year, and examined children selected by their teachers for examination.⁽¹¹⁸⁾ Blackburn, Rotherham, Southport and Weymouth are other instances of areas where the M.O.H. was undertaking a wider range of duties, while at Salford the M.O.H. was also involved in undertaking an anthropometric survey, although here he had inherited the position of an independent medical officer on local government re-organisation.⁽¹¹⁹⁾

Examination of many of these cases reveals the extent to which the control of infectious disease formed the original impulse for the M.O.H.'s appointment as medical officer, or continued, even where a range of duties were performed, to be accorded a relatively high priority by the officer concerned. Thus at Keighley, although every school was to be visited at least once a year, and Dr. Scatterty, the M.O.H., was helping to test the eyesight and hearing of every child, his work ultimately devolved on the prevention of infectious disease, meaning that "a school may be visited daily for weeks, or may be visited only once in many weeks according to the presence or absence of sickness among the scholars".⁽¹²⁰⁾ Similarly at Blackburn, where Alfred Greenwood, one of the most persistent advocates of the

(118) Ibid., p.95.

(119) Ibid., pp.91-97.

(120) BPP 1906/XLVII:157, Inter-Departmental Committee on the Medical Inspection and Feeding of Children Attending Public Elementary Schools, vol.2, Evidence and Appendices, Cd.2784, p.265.

involvement of the M.O.H. in school hygiene, was the town's M.O.H. most of the potential activities of the medical officer other than the anthropometric survey were operative, but the main thrust of Greenwood's work is revealed in the titles of the two reports he presented to the education committee in 1904. One discussed "The sanitary conditions of the fifty two public elementary schools of Blackburn" and the other "Infectious diseases in Blackburn schools".⁽¹²¹⁾ In Brighton, where Arthur Newsholme was the M.O.H., infectious disease regulation also formed the most significant part of the supervision, though a range of activities was undertaken.⁽¹²²⁾

In areas where the M.O.H. was medical officer for educational purposes, the predominant pattern was therefore for sanitary duties to form the foundation for medical activities in the schools, with the addition of other functions being dependent on the demands of the education committee, or the interest and enthusiasm of the M.O.H. concerned. Whether the initial appointment of the M.O.H. dictated, or was dictated by, an emphasis on sanitary questions cannot now be resolved by the historian. The Committee considered the implications of the system of the local M.O.H. also acting as medical officer to the education committee, and commented that:

There are distinct advantages in the School Medical Officer being also the Medical Officer of Health. The duties of the two offices naturally overlap or may do so. The inspection of children and the prevention of the spread of infectious disease and the sanitary inspection of the premises are examples of this. The union of the two offices tends to prevent duplication of work...⁽¹²³⁾

However, the Committee went on to warn that the "chief danger of the arrangement is that the work for the prevention of

(121) Ibid., p.242.

(122) Ibid., p.244.

(123) BPP 1906/XLVII:1, op.cit., p.5.

infectious disease may tend to swamp the work in other directions".⁽¹²⁴⁾ In general, the Committee were more favourably disposed to the work being supervised by the M.O.H. than by a practitioner in private practice, but in consistency with their terms of reference they did not firmly recommend either course.

The data collected by the Committee also indicates that a considerable number of education authorities were employing staff other than Public Health officials to supervise the children in their schools. The likelihood that non-sanitarians would be involved varied according to the priority given to medical activities other than the prevention of infectious disease, to the total range of activities undertaken, and to the size of the local authority concerned.

Where the work of the education committee was limited to the determination of issues such as whether children were unfit to attend school, or were suitable candidates for special education, local general practitioners, rather than the local M.O.H., would often be used. At Luton three local G.P.'s were paid £/- each time they examined a child allegedly unfit to attend school.⁽¹²⁵⁾ South Shields, Wolverhampton and Bridlington had similar arrangements.⁽¹²⁶⁾ In such instances, it appears to have been purely a matter of choice or convenience whether the M.O.H. or some other practitioner was used for these purposes.

Where the authority was engaged in a more extensive programme

(124) Ibid.

(125) Ibid., p.96.

(126) Ibid., pp.93-94.

emphasising educational aspects of medical supervision, which required the retention of a medical advisor on a regular part-time or even full time basis, a similar divergence of appointments occurred. In some instances, particularly in the smaller towns, the medical officer of health would perform a range of duties on behalf of the education authority. In other cases, an independent medical officer would be appointed, particularly where the control of infectious disease was relatively low in the education committee's priorities, and where educational work, particularly in the vision testing field, was given precedence. Thus at Chesterfield, a medical officer was appointed at £40 per annum to visit each school quarterly and examine cases of suspected defective vision, children allegedly unfit to attend school, and also to perform some sanitary duties. At Kidderminster and Wimbledon, independent medical officers performed a similar range of duties for comparable remuneration.⁽¹²⁷⁾

One aspect of the pattern of provision before 1907 is an apparent tendency, where local authorities were engaged in a variety of forms of medical activity, for the larger local authorities to appoint an independent medical officer in preference to the local M.O.H. Of the total of eighty two local authorities which from the data contained in the Report can be identified as having made a formal appointment of a medical advisor, forty six had appointed the local M.O.H., thirty six an independent doctor. Of the twenty seven such authorities which according to the 1906 Municipal Yearbook had a total population of more than 70,000,

(127) Ibid., pp.91-97. At Kidderminster the duties of the independent medical officer to the Education Committee contain no reference to the prevention of the spread of infectious disease, and in practice his work was "largely devoted to the children who appear to have defective sight". Kidderminster B.C. Education Committee, Minutes, 22 September 1903; 29 August 1905.

only six had the local M.O.H. as medical officer to the education committee. Furthermore, in at least two of these six cases, it is arguable that the appointment made owed much to the personal interest in school hygiene possessed by the incumbent M.O.H. At Blackburn, with a population of 129,000, both Dr. James Wheatley and his successor, Dr. Alfred Greenwood, had written extensively on the relationship between education and public health, while at Croydon, with a population of 147,000, Dr. Meredith Richards was a leading advocate of the medical officer of health exercising sanitary control over the education system.

It would thus appear that the larger the authority the more likely it was that an independent medical officer would be appointed. For this trend, several possible explanations may be advanced. First, the larger the authority, the greater the potential burden of work on both the public health and education departments. This increased burden might render the M.O.H. less able to spare time from the affairs of his own department to deal with educational matters, or make him unable to deal with all the matters the education committee wanted its advisor to examine, particularly as at this time the advisor was usually expected to do the work unaided. The larger the size of the school population of an authority, the more time that even the most basic administrative functions such as the examination of children allegedly unfit for school, or of candidates for appointment, consumed. Second, the larger, more urbanised authorities may have laid greater stress on the development of the more educational aspects of school hygiene. The vision testing programme, for example, as the title of the Board of Education's

Circular 456 testifies, was to some degree linked to fears for the eyesight of children in the larger urban areas. Conversely, the concern of the sanitarians about the role of the school in the spread of infectious disease was, as already discussed, less acute in the towns, where other avenues of infection were plentiful, than it was in the less urban areas, where the concept of the school as a centre for the spread of infection was still popular. A third explanation may lie in the greater independence and, sometimes, vision displayed by the larger urban education authorities. These sometimes retained the vestiges of civic pride displayed by the old school boards, which had frequently attracted a high calibre of membership in the larger towns, and also continued the independent tradition of the former board. Some of the earliest appointments of full time, or salaried part-time medical officers were made prior to 1902 by the larger urban boards, and the continuation of these appointments with an independent medical officer reflected the original separation of educational and sanitary functions prior to 1902. Fourth, the additional resources available to the larger urban education committee through its rate income might have acted as an encouragement for the appointment of its own medical officer, rather than rely on the officials of the public health department.

Whatever the explanation, or combination of explanations involved, the resulting pattern of medical supervision in schools prior to 1907 may be clearly distinguished. Numerically, medical officers of health formed the largest distinguishable group of medical staff appointed to posts as school medical officer, but

many, indeed most, of the largest education authorities, including the majority of those most active in the field of school hygiene, judged by the range of activities operated, were headed by an independent full or part-time officer. Thus Birmingham, Bradford, Halifax, Leicester, Manchester, Newcastle, London, Plymouth, Reading, Rochdale and a number of other large urban authorities had all appointed a medical officer independent of the public health department to administer their medical activities in the schools.⁽¹²⁸⁾

Divergent Concepts of School Hygiene prior to 1907.

An effect of this division in the professional interests of the early appointees to positions relating to school hygiene was the development of differing concepts of school hygiene, one of which emphasised the distinctly educational aspects of the work, and in so doing, implicitly or explicitly rejected the sanitarians' arguments for incorporating school hygiene into the main structure of public health administration. The most important figure in the development of this concept was Dr. James Kerr, who was the full time medical officer to the Bradford School Board from 1893, and who then became full time Medical Officer to the London School Board after W.R. Smith's resignation, and then to its successor, the London County Council Education Committee. With no responsibilities other than his educational work, Kerr was able to develop a wide ranging system of school hygiene in Bradford, as the brief description of his work in chapter two illustrates. In the process,

(128) BPP 1906/XLVII:1, op.cit., pp.91-97.

he made important contributions to the recognition of problems such as dyslexia.⁽¹²⁹⁾ On his translation to London, Kerr developed and expanded the medical activities then taking place in the London schools, and secured a progressive expansion of the medical staff working under his direction. By the end of 1908, as a result of decisions taken prior to the passage of the 1907 Act, the staff of the medical department numbered fifty two, although most of these were part-time officials, usually junior hospital doctors, employed in Kerr's system of medical supervision.⁽¹³⁰⁾

The L.C.C., by virtue of its size and progressive reputation for much of the period since its foundation in 1888, enjoyed a considerable influence over the smaller authorities, and thus appointment to a position with the L.C.C. conferred opportunities to lead and influence professional opinion. Kerr seized these opportunities, and quickly became the best known figure in educational medicine. He gave evidence to both the Royal Commission on Physical Training and to the Committee on Medical Inspection and Feeding. His indirect influence is reflected in the instructions given to the medical officer to the Kidderminster Borough Council, quoted by the Committee on Medical Inspection and Feeding as an example of what could be achieved by an enlightened authority:

the function of the Medical Officer in relation to the children in the schools is preventative and in individual cases only applies in matters involving educational questions. The conditions of the special senses, the avenues of knowledge, are of great

(129) See Huw W.S. Francis et al., "The Doctor as Educationalist: James Kerr, 1861-1941", Medical Officer 123(1970), 303-5.

(130) BPP 1910/XXIII:1, Board of Education, Annual Report of the Chief Medical Officer for 1908, Cd.4986, p.24.

importance with regard to educational success. The officer can call attention to the need of glasses, but has nothing to do with prescribing them. He may notice the presence of adenoids, but takes no part in their removal. On the other hand his work should extend far beyond mere investigations of the sanitary state of buildings or the excluding of unhealthy or diseased children. The methods of education, requirements of physical exercise, avoidance, particularly in the young, of overstrain from prolonged fatigue or from improper tasks are all matters in which improvement can only be obtained by the Medical Officer acting, not as an authority to shut or close, to disturb or interrupt the proper work of the school, but as a counsellor and adviser with a knowledge of school routine and of the requirements of health, to assist and collaborate with the Committee, and it is with this in mind that he should enter the school.(131)

These instructions were in fact taken almost verbatim from one of Kerr's Annual Reports to the School Board.⁽¹³²⁾ Clearly, therefore, Kerr was an influential figure with a long list of personal achievements in the field, and had tenure of a position which enabled him to demonstrate what could be done in the field of school hygiene.

As is hinted in parts of the passage quoted above, Kerr's views were fundamentally opposed to those of the sanitarians such as Meredith Richards and Arthur Newsholme, who argued that school hygiene was a part of sanitary medicine in general. For Kerr, the purpose of school hygiene was to advance the educational work of the school. Under Kerr's system, the doctor was an aid towards

(131) BPP 1906/XLVII:1, op.cit., p.4.

(132) London School Board, Annual Report of the Medical Officer for 1902-3, p.25. This was adopted by Kidderminster, after substituting "Committee" for the "teacher" which appeared in the penultimate line of Kerr's original, on 22 September 1903. Kidderminster B.C. Education Committee, Minutes, 22 September 1903.

achieving the school's educational purpose, and the school doctor was enjoined to bear this in mind during his visits to the schools: "he should regard the teachers as colleagues who can give valuable service, and be prepared to act reasonably at all times, remembering that the school is chiefly for educational purposes".⁽¹³³⁾ For Kerr, the consequence of this educational orientation was a rejection of any attempt to subordinate the work of the schools to the public health department. He refused to allow the London borough M.O.H.'s to become members of his team of part-time medical inspectors, and refused to co-operate with the public health officials except to fulfil the statutory requirements of the Education Code. For Kerr, therefore, school hygiene was:

a highly specialised branch of Public Health, which the ordinary sanitarian cannot be expected to follow in its fulness, and which requires officers experienced in the technique and specially trained to do justice to the children and to the public interests.⁽¹³⁴⁾

This argument for a school medical service based within the education system and independent of the local public health department was in strong contrast to the views of many leading public health officials. Although many sanitary officials limited their links with the schools, if they had any, to basic issues of infectious disease prevention and the maintenance of sanitary standards, for a minority of the most active and influential

(133) London School Board, Annual Report of the Medical Officer for 1903-4, p.42.

(134) L.C.C., Annual Report of the Medical Officer (Education) for 1906-7, p.3.

officials this was merely a base from which preventative and curative work of a more individualised kind could develop.

As a result of this continuing interest by many sanitarians a number of issues of Public Health contained articles urging that the medical officer of health should be given the widest possible role in the local schools,⁽¹³⁵⁾ before Meredith Richards, in his Presidential address, returned to the argument he had advanced prior to the 1902 Act. Again putting forward the case for the medical supervision of schools by the medical officer of health, he stressed the wide range of activities which such supervision would entail:

They include not only a complete organisation for the control of notifiable diseases, but advice to communicable skin diseases and verminous conditions, from which quite half the children attending elementary schools are found to suffer. Apart from communicable diseases, advice has to be given respecting byelaws as to employment, underfeeding, defective sight, defective hearing, nasal obstruction and mental capacity.⁽¹³⁶⁾

This was effectively a litany of the duties of medical officers under the 1907 Act. Meredith Richards, and those who supported him, were in part arguing defensively against the claims of independent medical officers to education committees,⁽¹³⁷⁾ but in part also reflected a movement on the part of the more progressive medical officers of health away from an interpretation of their role within a purely sanitary framework towards one which offered

(135) See e.g. James B. Wilkinson, "Medical Inspection in Day Schools", Public Health 17 (1904-5), 225-36.

(136) H. Meredith Richards, "Organised Medical Inspection of Schools", Public Health 19 (1906-7), 87-96.

(137) See e.g. W. Leslie Mackenzie, "Methods for the First and Subsequent Medical Examinations of School Children", in Transactions of the Second International Congress on School Hygiene 1907, eds. James Kerr and E. White Wallace, 3 vols. (London: Royal Sanitary Institute, 1908), 2, pp.437-48.

a wider concept of preventive medicine, involving a greater emphasis on the individual. Arthur Newsholme's School Hygiene, a standard text which was frequently reprinted, written by a man who became a leading figure among public health officers, symbolizes this change in the alterations and amendments made to its layout. The first edition in 1887 laid most emphasis on the school buildings, which were discussed in the first part of the book, while the subsequent discussion of scholars, eighty out of one hundred and forty pages, avoided recommending individual examination except when infectious disease was suspected.⁽¹³⁸⁾ By the second revised edition, published in 1904, the first and most substantial section of the book, one hundred and ninety out of two hundred and ninety pages, dealt with the health of the children, and discussion of individual treatment was frequent.⁽¹³⁹⁾

By 1906, therefore, some medical officers of health were both practicing and advocating a system of medical supervision of schools which gave control over its administration to the medical officer of health, and went beyond the purely sanitary concerns which had first attracted their interest. By 1906 opinion within the sanitary profession as a whole, as expressed through the resolutions accepted by the Council of the Society of Medical Officers of Health after submission by the regional branches, broadly supported this policy.⁽¹⁴⁰⁾

Thus the ad hoc development of medical supervision in schools was leading to the emergence of two distinct and largely ir-

(138) Arthur Newsholme, School Hygiene (London: Swan, Sonnenschein, 1887).

(139) Idem, with Walter C.C. Pakes, School Hygiene, 2nd ed. (London: Swan Sonnenschein, 1904).

(140) SMOH, Oxford, Box A9, Council Minute Book, 11 January 1907.

reconciliable views on the relationship which should be established between school health work and the existing sanitary service, with rival claims being made for the supremacy of the medical officer of health, and independent medical officers directly employed by the education committees. So entrenched did these two models become that attempts by other interest groups to promote alternative modes of safeguarding the health of schoolchildren were to fail almost completely. The B.M.A., seeing the establishment of a national School Medical Service as inevitable after the election of the Liberal Government, sought to protect the interests of G.P.'s by proposing that schools should have a local G.P. or other doctor attached to them as "school doctor".⁽¹⁴¹⁾ Despite the potential influence of the B.M.A. opinion within the Association was divided⁽¹⁴²⁾ and although attempts were made by the B.M.A. to modify its plans to meet the objections of supporters of the existing models of school health, the Association could not command unanimity of support for its proposals.⁽¹⁴³⁾ As a result, the "school doctor" system was tried in only one area after the 1907 Act. In Willesden, thirty six doctors were attached to the twenty nine schools in the urban district area as medical inspectors.⁽¹⁴⁴⁾

(141) B.M.A. Medical-Political Committee, Minutes, 27 March 1906.

(142) See British Medical Journal i(1907), supplement, 74, 107, 137-39.

(143) Ibid., 191.

(144) Public Health Service Directory and Yearbook, 1911 (London: Hodgetts, 1911), p.158.

The developing local authority activity appears to have occurred with no overt or covert encouragement from the Board of Education, which seems to have formulated policy only reactively, in response to external pressures. One branch of the sanitary profession, the Council of the Royal Institute of Public Health, wrote to Lord Londonderry, the President of the Board of Education, on 4 February 1903, urging:

upon your Lordship's notice the great necessity which, in their opinion, exists for the Board of Education having at its disposal the services of a skilled and experienced medical officer as one of its permanent staff.(145)

The Board had not at first replied to the letter, and only after a reminder had been sent did the Board consider internally what response should be made. The Permanent Secretary, Sir Robert Morant,⁽¹⁴⁶⁾ thought the letter "rather a cool interference with our administration, and it hardly deserves to be seriously argued with at length"⁽¹⁴⁷⁾ but approved a draft reply to be sent. This argued that the Local Government Board was the government department responsible for medical matters, and that it was undesirable for any element of dual jurisdiction to be introduced.⁽¹⁴⁸⁾ This

(145) PRO Ed.23/198, Royal Institute of Public Health to Lord Londonderry, 4 February 1903.

(146) Sir Robert Laurie Morant (1863-1920). Educated at Winchester and New College Oxford. After a period as tutor to the children of the Royal family of Siam, became Assistant Director, Office of Special Enquiries and Reports at the Education Department in 1895. Resident of Toynbee Hall. After a period as Private Secretary to Sir John Gorst, eventually became Permanent Secretary to the Board of Education in 1903. Chairman, National Insurance Commission, 1912-19; Permanent Secretary, Ministry of Health, 1919-20, KCB (1907). See B.M. Allen, Sir Robert Morant (London: Macmillan, 1934) and E.J.D. Eaglesham, "The Centenary of Sir Robert Morant", British Journal of Educational Studies, 12 (1963), 5-18.

(147) PRO Ed 23/198, note by Morant, 1 July 1903.

(148) Ibid., draft letter by W.S. Davies undated.

was a recurring theme in Morant's arguments, and will be examined further in the next chapter.

Similarly, the advances made by the local authorities on matters of school hygiene were made without any direct encouragement from the Board until a late stage. At times, the Board seemed in ignorance of such developments until the question of ultra vires arose. Thus when Cambridge proposed to appoint a school nurse in 1905, it first asked for a ruling on the legality of such an appointment with the Local Government Board, which considered such an appointment would be illegal, but invited the Board of Education's comments before replying. Such nurses had, of course, already been employed in London for more than two years; news that astonished the Board of Education officials dealing with the Cambridge case, who wondered how the L.C.C. had "got away with it". Eventually, it was decided to ask the L.G.B. to take no action on the matter.⁽¹⁴⁹⁾ Only later did Anson, partly in order to reduce the criticism of the Government's apparent inaction over the physical deterioration question, announce in the House that local authorities were permitted to employ doctors in the schools.⁽¹⁵⁰⁾

With encouragement from the central department apparently lacking, therefore, did the physical deterioration debate itself act as a direct stimulus to the growth of local authority activity in the schools? This appears unlikely, for the two aspects of school health that were most widespread at the time the Committee on Medical Inspection and Feeding reported were the prevention

(149) PRO Ed 111/13, file on proposed appointment of a school nurse at Cambridge, 7 February 1905.

(150) Parl. Deb., 4th series, 145 (18 April 1905), 564-65. Anson was suggesting that Public Health staff which local authorities were legally empowered to employ could be used in the schools.

of infectious disease and vision testing. From the analysis in the foregoing chapters it is clear that the primary impetus for the introduction of work of this nature was derived from sources other than the fears of racial deterioration. In contrast, the Committee found in relation to one of the main proposals of the Committee on Physical Deterioration that:

Very little has so far been attempted in the direction of an anthropometric survey; in fact, Salford and Willesden are almost the only places where anything systematic has actually been carried through, though a survey was made during the last summer at Torquay...(151)

Of these surveys, the work at Salford appears to have been derived from the study by Hay and Mackenzie for the Committee on Physical Deterioration, while the Willesden survey, dating from 1903, was a record of heights and weights in two selected schools, and was an independent attempt to verify the "urban deterioration" hypothesis. At a local level therefore, education authorities do not appear to have been actively concerned about ascertaining the truth or otherwise of the hypothesis of degeneration, and whatever the national impact the physical deterioration question aroused, its effect on the policies of local education authorities, at least in relation to medical activities, seems to have been minimal.

Summary

This chapter has indicated that the fears about physical deterioration expressed after the Boer War led to a period of

(151) BPP 1906/XLVII:1, op.cit., p.64.

national self-examination, during which the idea of establishing a system of medical supervision in schools began to receive national attention. The prevarications of the Unionist administration meant, however, that no real action was taken during its period of office.

Nevertheless, as the evidence derived from the Inter-Departmental Committee on the Medical Inspection and Feeding of School Children indicates, a considerable number of local authorities were undertaking medical work of various kinds in their schools in the years following the 1902 Education Act. The inspiration for this work would appear most probably to be not the national concern about physical deterioration, but the opportunities presented by a re-organised education system concentrated into a smaller number of administrative units and linked for the first time directly to the sanitary administration. Certainly, most of the new medical activity in the schools seems to have been related to the traditional educational and sanitary concerns explored in the first two chapters, rather than to the new fears about physical deterioration.

A consequence of this ad hoc development of local authority activity, without direction from the central government, was the emergence of at least two divergent concepts of school medicine; the sanitary model, espoused by the leading public health officials, and the educational model, identified most closely with Dr. James Kerr and his staff at the L.C.C. This divergence of views was an obvious potential source of difficulty during the establishment of any national system of school hygiene, explored in the next chapter.

CHAPTER FOUR
THE ESTABLISHMENT OF THE
NATIONAL SCHOOL MEDICAL SERVICE:
1906-1907

As the last chapter has indicated, there was a reluctance both by the Unionist Government and by Morant and his staff at the Board of Education to take any definite steps to establish a national system of school medical inspection. As a result, school hygiene developed through local initiatives, and this produced a number of differing, and to some degree competing, administrative models for school health work. Only with the 1906 Liberal Government was progress made toward a national School Medical Service. This chapter examines the process by which the School Medical Service was established.

1906: the First Session of the new Liberal Government

After the resignation of the Balfour administration, and the formation of a Liberal Government under Sir Henry Campbell-Bannerman, the subsequent election of December 1905 confirmed the Liberal revival by giving the new Government a substantial majority. With the support of the Nationalist members, and the group of Labour M.P.'s elected, the new administration had a majority of 358 over the Unionists.⁽¹⁾

A. K. Russell's analysis of the election addresses of the candidates, and of other material published during the campaign,

(1) A.K. Russell, Liberal Landslide: the General Election of 1906 (Newton Abbot: David & Charles, 1973), pp.145-71.

shows that child health and welfare did not feature very prominently in the election campaign. In social policy the most widely debated subjects were unemployment, retirement pensions and the reform of the Poor Law, with only Socialist candidates giving the provision of free school meals, sometimes linked with the school health debate, any priority. These were, however, all over-shadowed by the controversies about fiscal reform and Chinese Labour.⁽²⁾

Nevertheless the Liberal and non-conformist grievances about the 1902 Education Act meant that educational reform was one of the priorities for legislation after the Liberals return to power. One of the key questions was the ultimate control of the voluntary, denominational schools. The arrangement made under the 1902 Act whereby a majority of the managers of the voluntary schools continued to be denominational nominees, although the schools were receiving rate aid, was disliked by the Liberals and their supporters. Lloyd George denounced the system as "Rome on the Rates".⁽³⁾

As the Cabinet were reminded early in 1906 by the newly appointed President of the Board of Education, Augustine Birrell,⁽⁴⁾

(2) Ibid., pp.64-94.

(3) See R. Pattison, "The Birrell Education Bill of 1906", Journal of Educational Administration and History 5(1973), 34-41.

(4) Rt.Hon. Augustine Birrell (1850-1933). Educated at Amersham Hall School and Trinity College Cambridge. A barrister, and Quain Professor of Law at University College London 1896-99. Liberal MP for Fife West 1889-1900, Bristol North 1906-18. President, Board of Education, December 1905-February 1907; Chief Secretary for Ireland, 1907-16.

these grievances had led to the Liberals giving two pledges to the electorate about reform of the education system. First, all elementary schools, including the voluntary schools, were to be placed under effective public control; second, no teaching appointment was to be subject to a test of the religious affiliations or views of the candidate.⁽⁵⁾ These pledges led to the formation of a Cabinet Committee to prepare draft legislation for introduction during the first session of the new Parliament. The Earl of Crewe was the Chairman of the Committee, and the other members Birrell, Lloyd George, Richard Burdon Haldane, Sydney Buxton, and Sir Henry Fowler. The Secretary to the Committee was Sir Robert Morant, Permanent Secretary to the Board of Education.

At the Committee's first meeting it was agreed, with only Sir Henry Fowler dissenting, to make the main Education Bill for the 1906 session a wide-ranging measure, so that the denominational controversies which had prompted the legislation could be presented as being only a part of the whole Bill.⁽⁶⁾ This decision gave Morant, to whom responsibility for the drafting of the Bill had been delegated, the opportunity to suggest that the non-denominational content of the Bill should consist of a number of clauses extending the powers of the Board over educational trusts, legacies and endowments. When the Board had been established in 1899 it had inherited from the Charity Commissioners functions relating to

(5) PRO Cab 37/82/28, memorandum concerning the Education Bill, 17 February 1906.

(6) PRO Ed 24/116, Cabinet Committee on the Education Bill, Minutes, 3 January 1906.

the Charitable Trusts and Endowed Schools Acts. Morant thought these powers to be inadequate and unduly restrictive. Coupled with the denominational clauses, inclusion of these reforms would make a fourteen or fifteen clause Education Bill.

Morant went on to argue, however, that further educational legislation would then be necessary. He suggested that a consolidating Bill was desirable, explaining that the:

Education Acts at present in force are 22 in number, running to 170 closely printed octavo pages. The Schools Sites Acts are nearly 20 pages more, while there are some 12 or more Acts relating to Charitable Trusts and Endowments for Educational purposes, which run to upwards of 260 octavo pages.

The whole of these could, on the passing of the new Bill in regard to Elementary Schools and on the passing of the proposed new clauses in regard to the Board's jurisdiction over Educational Endowments, be compressed into one Act, reducing the 450 pages to, probably, something like 40 or 50 pages, which would obviously be an immense advantage.(7)

To derive the maximum benefit from this proposed consolidation of the statutes, Morant proposed also the introduction of a third Bill containing:

some 9 or 10 clauses making amendments of a comparatively unimportant character in various administrative directions in Elementary and Higher Education, in School Attendance, etc. These would be matters of very modified controversy, not raising the Religious issue, but points of somewhat unimportant educational bearing.

Both this and the main Bill dealing with the denominational issue and with educational trusts were, after passing through all their Parliamentary stages, to be subsumed into the Consolidation Bill

(7) PRO Ed 24/118, memorandum by Morant, 23 February 1906.

prior to Royal Assent.⁽⁸⁾

Morant's passion for administrative simplicity and efficiency, reflected also in his re-organisations of the Board's administration and the Inspectorate,⁽⁹⁾ are illustrated by this analysis of his legislative proposals for the 1906 session of Parliament. This also indicates where, if at all, any legislation contemplated by the Board respecting the powers and duties of local education authorities in relation to school health would have been located within this programme. Logically the third of the three Bills proposed by Morant, that containing the miscellaneous administrative reforms, would have been the Bill referring to this subject.

Only two Bills were actually published, however. The 1906 Education (England and Wales) Bill, incorporating the denominational clauses, was given a First Reading on 9 April 1906.⁽¹⁰⁾ The Education (Consolidation) Bill, a substantial Bill of over 100 clauses claiming to summarise the existing laws relating to education in England and Wales, was given a First Reading on 14 May 1906.⁽¹¹⁾ When the main Education Bill encountered difficulties, the Education (Consolidation) Bill was withdrawn on its Second Reading on 10 December 1906.⁽¹²⁾

(8) Ibid.

(9) See E.J.D. Eaglesham, "The Centenary of Sir Robert Morant", British Journal of Educational Studies 12(1963), 5-18.

(10) BPP 1906/1:895, Education (England and Wales) Bill, as Introduced, Bill 160; Parl. Deb., 4th series, 155(9 April 1906), 1017ff.

(11) BPP 1906/1:999, Education (Consolidation) Bill, Bill 206.

(12) Parl. Deb., 4th series, 166(10 December 1906), 1694.

Examination of the extant drafts of the Education (England and Wales) Bill suggests that the third piece of legislation proposed by Morant, that dealing with miscellaneous administrative matters, was in fact incorporated into this Bill less than a month before it was given its First Reading. Sixteen printed drafts of the 1906 Education Bill have survived, dated between 26 February and 10 April 1906. These drafts are numbered 100/3 to 100/12, and 100/14 to 100/19, indicating that at least nineteen such drafts were in fact prepared.⁽¹³⁾ Up to draft 100/9, the Bill contained fourteen or fifteen clauses in two sections, one dealing with denominational issues, the other with educational endowments. The early drafts thus follow faithfully Morant's suggested pattern for the first, controversial piece of legislation.

With draft 100/10, dated 19 March 1906, the Bill was substantially amended. To the two original sections a third had been added, containing clauses dealing with miscellaneous matters of educational administration. The third section in draft 100/10 contained no reference to medical supervision of schools.⁽¹⁴⁾ Despite this, the new, more radical composition of the House of Commons meant that the health and welfare of school children was becoming a more prominent issue both in Parliament, and in professional and public debate. In Parliament, the Labour and radical Liberal representatives quickly indicated their demand

(13) PRO Ed 24/117, drafts of Education (England and Wales) Bill, 1906.

(14) Ibid., draft 100/10, 19 March 1906.

for legislation in this field. The Education (Provision of Meals) Bill was introduced in the 1906 session by a Labour member, W.T. Wilson,⁽¹⁵⁾ and on 2 April Will Thorne, another Labour M.P., presented his Elementary Education Bill which included among other powers the introduction of medical inspection in schools and the appointment of medical officers by local education authorities.⁽¹⁶⁾

A further indication of the importance of the issue was publicity given to the preliminary arrangements being made for the proposed Second International Congress on School Hygiene, which it was intended to hold in London during August 1907. A preliminary meeting of the British organising committee was held at the Royal Sanitary Institute in February, 1906,⁽¹⁷⁾ after which the organising committee asked, through the leading medical journals, for:

the formation of a local committee for each particular town or district, which committee should approach the authorities of the Education Department and the Treasury, the leaders of educational movements in towns or country...

and other groups, asking for support for the Congress, and action on school health.⁽¹⁸⁾ When the Congress had been invited to London by British delegates to the First Congress at Nuremburg in 1904, it had been partly with the intention of highlighting the paucity

(15) Parl. Deb., 4th series, 152 (22 February 1906), 525.

(16) BPP 1906/11:199, Elementary Education Bill, Bill 143; Parl. Deb., 4th series, 155 (2 April 1906), 191.

(17) James Kerr and E. White Wallis, eds. Transactions of the Second International Congress on School Hygiene 1907, 3 vols. (London: Royal Sanitary Institute, 1908), 2, xi.

(18) Lancet i (1906), 777.

of British provision for school hygiene, and thereby to stimulate official action.

One of the leading figures in the British committee organising the Congress was Sir Thomas Lauder Brunton, later to be the President of the Congress itself, whose initiative in establishing the National League for Physical Education and Improvement has been referred to in chapter three. On 3 February 1906 the N.L.P.E.I. wrote to the Board of Education saying it was "strongly of the opinion that the medical inspection of children in all schools and colleges should be compulsory and under the control of the central authority" and asking the Board to receive a deputation from the League.⁽¹⁹⁾

The Board's permanent staff was unenthusiastic in its reaction to this request. A memorandum to Birrell complained of the vagueness of the resolution, and suggested that the Board itself could do little in respect of medical inspection. This could be done only by the local authorities, possibly under the general supervision of the Board. But the local authorities had no legal power to inspect children, and if this was given, there might be many parental objections. Moreover, while inspection could be performed cheaply, this might lead to calls for treatment, and:

The cost would, of course, be a very serious matter if treatment were also to be undertaken, and it would involve not only provision of medicines, etc., but also spectacles, crutches

(19) PRO Ed 24/279, letter from National League for Physical Education and Improvement, 3 February 1906.

and similar apparatus at the expense of the Local Authority. There would probably be strong objection to such treatment from many quarters on social grounds. (20)

The memorandum concluded by arguing that there had been no general expression of opinion in favour of medical inspection, and suggested that the Board's policy should be to await developments.

Although the memorandum emanated from the lower ranks of the Board's administrative hierarchy, it is clear that the officials concerned had no plans, and knew of no plans, for the Board itself actively to promote medical inspection.⁽²¹⁾ In considering the apparent disinterest of the Board of Education some examination of Sir Robert Morant's ideas and actions is appropriate. A figure of some controversy both among his contemporaries and among historians of the welfare state, Morant's claim to be "one of the greatest of civil servants" has prompted a number of studies of his work or aspects of it.⁽²²⁾ His role in precipitating the Cockerton Judgement and his subsequent drafting of the 1902 Education Act⁽²³⁾ had led to some suspicions

(20) Ibid., memorandum to Birrell, 23 February 1906.

(21) The Board did, however, later publish W.H. Dawson, School Doctors in Germany, Educational Pamphlets, no.4 (London: H.M.S.O., 1908), which was based on a study visit undertaken in February 1906.

(22) Eaglesham, op.cit., p.5. See also B.M. Allen, Sir Robert Morant (London: Macmillan, 1934), and Violet Markham, "Sir Robert Morant: a Personal Memoir", Public Administration 28 (1950), 249-60.

(23) See Eaglesham, op.cit., Allen, op.cit., Blanche Dugdale, "A.J. Balfour and Sir Robert Morant", Quarterly Review 260 (January-June 1933), 152-68; P.L.P. Clarke, "The Education Act of 1902" (Ph.D. thesis, University of London, 1964).

in Liberal circles that he was essentially a conservative influence, opposed to educational progress. However unjustified this view might have been, it was reflected in the way in which external interest groups portrayed the Board's attitude towards the establishment of a school medical service. Welcoming the final emergence of the national School Medical Service under the 1907 Act, the British Medical Journal claimed that it had had to be forced on an unwilling Board of Education.⁽²⁴⁾ Sir Victor Horsley,⁽²⁵⁾ one of the leading members of the British Medical Association, and a man with close radical links, ascribed the Board's alleged reluctance to the "influence of the permanent officials".⁽²⁶⁾ Justice, published by the Social Democratic Federation, described Morant's attitude towards the School Medical Service as representing "reaction of the most

(24) British Medical Journal ii(1907), 760-61.

(25) Sir Victor Haden Horsley MD FRCS FRS (1857-1916). Educated at Cranbrook School and University College Hospital. Professor of Pathology, then Professor of Clinical Surgery and Consulting Surgeon, University College Hospital. First Chairman of the B.M.A. Representative Meeting. Vice-Chairman of L.C.C. Sub-Committee on Medical Treatment, of which he was a co-opted member. Liberal candidate for University of London, and was subsequently prospective candidate for Market Harborough until his support for women's suffrage led constituency officials to withdraw their support.

(26) Justice, 11 May 1907, report of a speech by Sir Victor Horsley in Canning Town.

virulently astute kind".⁽²⁷⁾

Although the evidence thus far presented might be interpreted as lending support to these opinions of Morant's attitude, this would be to misunderstand him. Morant was a close friend and associate of Sidney and Beatrice Webb, and shared with them many views on the reforms of administration and policy required to make Britain more "efficient". Years later, in 1918, Morant and Beatrice Webb were, as members of the Haldane Committee on the Machinery of Government, to advance these views under the guise of the concept of administrative functionalism. This suggested that government administration should pursue the "Ideal of Homogeneity", with functions being distributed between government departments according to the class of service performed.⁽²⁸⁾ The Haldane Report's recommendations reflected Morant's and the Webbs' support for the idea of a Ministry of Health.

In 1906 Beatrice Webb was attempting to secure the adoption of the concept of administrative functionalism in a more limited context, that of a reform of the Poor Law. In 1905, she had been appointed as a member of the Royal Commission on the Poor Laws, and by 1906 was trying to persuade the Commission to adopt her solution to the problems of the Poor Law. This entailed dismantling the existing structure of the Poor Law and distributing

(27) Justice, 28 August 1907.

(28) BPP 1918/XII:1, Machinery of Government Committee of the Ministry of Reconstruction, Report, Cd. 9230.

its functions between other central and local government departments on principles similar to those later enunciated in the Haldane Committee Report. Failing in this objective, she was later to be the prime mover of a dissenting Minority Report issued alongside the Majority Report of the Commission in 1909.⁽²⁹⁾ Part of her strategy for reform was the unification of all Poor Law medical services under the local authority medical officer of health, as a preliminary to the eventual creation of a Ministry of Health with oversight of all public health services. On her own initiative, she secured the presentation to the Royal Commission of a substantial body of evidence from the medical officers of health and other public health officials which was generally, but not unanimously, in favour of a reform on these lines.⁽³⁰⁾

Against this background, the cause of Morant's apparent

(29) BPP 1909/XXXVII:1, Royal Commission on the Poor Laws, vol.1, Report, Cd. 4499, Minority Report by Beatrice Webb and three others, pp. 719-1238.

(30) The material gathered by Mrs. Webb was selectively presented by her to the other Commission members to give the impression that Public Health officials were more united in favour of her proposals to hand over the Poor Law medical services to the local authority Public Health Service than was actually the case. When Mrs. Bosanquet of the Charity Organisation Society subsequently challenged her to place all the material collected before the Commission, Mrs. Webb "looked through the correspondence, took away all letters that were at all compromising to the authors (I had to remember Provis and Downes) and a due proportion of the stupid conservative ones, and bundled the letters and reports off to the Commission". Beatrice Webb, Our Partnership, ed. Barbara Drake and Margaret I. Cole, with an introduction by George Feaver (London: London School of Economics and Political Science/Cambridge University Press, 1975), pp.316-421, esp. pp.392-93.

reluctance to allow the Board of Education to establish a medical service in the schools seems clear. Sympathetic to the aims of the Webbs, he was unwilling to prejudice the eventual creation of a unified public health service under a Ministry of Health by allowing independent medical services to develop under the Board. Even Morant, however, could not resist concerted pressures from interest groups, and the Webbs were unable to bring much influence to bear on Birrell, who was not one of their intimates among the new government. Beatrice Webb's diary records their sense of impotence during the progress of the 1906 Education Bill through Parliament:

Sidney thinks the Education Bill a harsh measure, but takes no part in the agitation against it: does not care to discuss it since it is clear he cannot influence the result. We have no kind of influence either on Birrell or those behind him, or on any of the Parliamentary groups that are likely to carry amendments in committee. (31)

The Board's prevarication over the letter from the N.L.P.E.I. may thus be a reflection of Morant's opposition to independent action by the Board of Education on medical inspection. Birrell did eventually meet a deputation from the N.L.P.E.I., for whom Lauder Brunton did most of the talking. He wanted the introduction of local medical inspection, a regulatory staff of medically qualified inspectors employed by the Board, and a medical advisory committee to assist the Board. Birrell's response

(31) Passfield MSS, Diary of Beatrice Webb, vol.25, p.89, 15 April 1906.

was non-committal. (32)

This meeting indicates, however, that representations were being made to the Board of Education during the early part of 1906 in an attempt to persuade the Board to take some action on medical inspection. The first indication that these representations were having an effect comes in draft 100/12 of the Education (England and Wales) Bill, dated 26 March 1906. This contained a new sub-clause giving education authorities:

b. Power to make such arrangements as may be sanctioned by the Board of Education for the inspection of public elementary schools with a view to acquiring information as to the health and physical condition of the children attending the school. (33)

This was a permissive clause, not one which required local education authorities to undertake medical inspection. Moreover, as drafted, it seemed to envisage only a medical inspection to assess the overall standard of health of school children, rather than one to ascertain the health of individual children.

Draft 100/13 is missing, but draft 100/14, dated 30 March, contained alterations to the clause which, while recognisably retaining elements of the original phraseology, had the effect of widening the power given to education authorities, now granted:

b. Power to make such arrangements as may be sanctioned by the Board of Education for attending to the health and physical condition

(32) PRO Ed 24/279, report of a meeting with a delegation from the N.L.P.E.I., 27 February 1906.

(33) PRO Ed 24/117, Education (England and Wales) Bill, draft 100/12, cl.15(b), 26 March 1906.

of the children in public elementary schools.⁽³⁴⁾

Giving local education authorities this power for "attending to the health and physical condition of the children" was a substantial expansion of their original suggested power of "acquiring information as to the health and physical condition of the children". In view of the machiavellian significance with which the phrase "attending to the health and physical condition of the children" has subsequently been vested,⁽³⁵⁾ its first appearance in a redraft of the 1906 Bill, at a time when there is no evidence that the Board had any overt, or identifiable covert policy of encouraging the development of medical care in schools, is noteworthy. It suggests that the phrase may have occurred as a drafting amendment only, widening the powers of the education authorities to include not only medical inspection (which was not distinguished from the power of "attending to the health and physical condition of the children" as it was to be in subsequent versions of this clause) but also to allow other activities they were already undertaking, and the legality of which were, as has been seen in chapter three, already under discussion by the Board.⁽³⁶⁾

(34) Ibid., draft 100/14, cl.15(b), 30 March 1906.

(35) e.g. by Gilbert: "on the words 'arrangements....for attending to the health', borrowed from Mr. Tennants amendment, hung the establishment of the School Medical Service". Bentley B. Gilbert, The Evolution of National Insurance in Great Britain (London: Michael Joseph, 1966), p.130.

(36) In October 1906 a similar query arose over a proposal by Torquay to pay a surgeon at Torbay Hospital to examine children with defective eyesight. PRO Ed 111/28.

Further drafts of the Bill prior to publication show little change in the sub-clause itself, other than an apparent desire to confine the operation of any arrangements made to bona-fide school children and to the school premises.⁽³⁷⁾ When the 1906 Bill was first published, the relevant sub-clause, by now clause 35(b), gave local education authorities:

b. Power to make such arrangements as may be sanctioned by the Board of Education for attending to the health and physical condition of the children educated in public elementary schools. (38)

For advocates of medical inspection, the clause proposed by the Board was inadequate in two respects. First, it was permissive, allowing each local education authority to decide for itself whether or not it wanted to introduce a programme of inspection. Second, no promise was made that the Board would appoint its own medical staff to guide and supervise the medical work of the local authorities.

Before clause 35 was debated, Birrell was pressed on both these points by Labour members. A call from Keir Hardie for a central medical staff was rejected, with Birrell arguing that the Board already had one medical inspector of schools, and was considering the appointment of another. Until the Board saw

(37) Thus draft 100/15 reads "...for attending, in the school-house, to...". PRO Ed 24/117, Education (England and Wales) Bill, draft 100/15, 2 April 1906.

(38) BPP 1906/1:895, op.cit., cl.35(b).

what the local authorities decided to do under clause 35 (b), additions to the medical establishment were not being contemplated.⁽³⁹⁾ On 9 July, Will Thorne was told that the Board had no intention of forcing local authorities to inspect children.⁽⁴⁰⁾

Despite Birrell's unwillingness to strengthen clause 35(b), the proponents of medical inspection had been organising an attempt to make medical inspection compulsory. In May 1906 the Medico-Political Committee of the B.M.A. had resolved "that steps be taken to obtain an amendment to the Education Bill which should give effect to the already declared policy of the Association as to the compulsory Medical Inspection of School Children".⁽⁴¹⁾ Following approaches from the B.M.A. and other interested parties, Harold Tennant, the Liberal M.P. for Whitby, a member of Rosebery's Liberal Imperialist group and an acquaintance of Sidney and Beatrice Webb, agreed to put forward an amendment to clause 35(b), providing:

b. It shall be the duty of every local education authority to make arrangements, in accordance with a scheme to be made by the Board of Education, for attending to the health and physical condition of the children in public elementary schools.⁽⁴²⁾

(39) Parl. Deb., 4th series, 158(14 June 1906), 1144-45.

(40) Ibid.; 160 (9 July 1906), 524.

(41) B.M.A., Medical-Political Committee, Minutes, 16 May 1906. See also British Medical Journal ii(1906), supplement, 30.

(42) PRO Ed 24/117, memorandum on proposed amendments to clause 35 of the 1906 Education (England and Wales) Bill, undated, unsigned, but probably by Claude Schuster, then the Board's legal assistant.

The proposal to strengthen the provisions of the clause was again unenthusiastically received by the permanent officials of the Board of Education. An internal memorandum advised Birrell that:

The effect of Mr. Tennant's amendment would be to make the clause mandatory instead of permissive so far as subsection (b) is concerned. From every point of view this seems inadvisable. It is a new departure for Local Education Authorities to supervise systematically the health and physical condition of the children in the Public Elementary Schools, and it is much better therefore at the outset to be content with enabling authorities to do it without requiring them to do it. No doubt at some future time what is now a power may be made a duty.

Moreover, it is to be remembered that the amendment making it compulsory would apply to all Village Schools in rural areas where it must be admitted the need is not yet grievous; and this would involve an enormous burden on the Rates without any proportional advantage.

As against the compulsory scheme it must also be urged that the Board of Education have not yet had sufficient experience to devise good schemes for the purpose in view. The whole matter is at present strictly in the experimental stage, and few things would damage this good movement so seriously as the unpopularity that would occur upon any mistaken experiments on a large scale. Those who most earnestly desire medical inspection to be developed should be the most anxious to prevent the likelihood of unwise methods being adopted, and should deprecate the initiation of schemes in any places where they would in fact be carried out with great unwillingness and therefore with the least efficiency. This is just the sort of thing that would bring the whole movement into contempt and throw it back in a manner that could never be recovered. (43)

(43) Ibid.

It was after receiving advice of this nature that Birrell was visited by a joint deputation from the B.M.A. and the Manchester and Salford Sanitary Association on the morning of 16 January 1906, the day that Tennant's amendment was to be considered at the Committee stage of the 1906 Bill. Leading the deputation, Sir Victor Horsley emphasised their desire for medical inspection and for a medical department to be established at the Board, stressing:

We are merely asking for a medical officer, with perhaps one or two assistants, who shall collate the reports that would come into your Department from the local authorities, but who would also collate the information received from other countries.(44)

Birrell, who was accompanied by Morant and Thomas Lough, his Parliamentary Secretary, gave what the Lancet described as "the stereotyped form of reply on such occasions",⁽⁴⁵⁾ appearing sympathetic but arguing that he was under contrary pressures from ratepayer and local authority interests. He was not prepared to concede compulsory medical inspection, but would agree to the formation of a central medical department.⁽⁴⁶⁾

In the debate on Tennant's amendment which followed Birrell's reception of the deputation from the B.M.A. and M.S.S.A. Birrell found himself isolated in his insistence on a voluntary system of inspection. Moving his amendment, Tennant based his arguments

(44) PRO Ed 24/279, minutes of a meeting with a B.M.A./M.S.S.A. delegation, 16 July 1906.

(45) Lancet ii (1906), 178.

(46) PRO Ed 24/279, meeting with B.M.A./M.S.S.A. delegation

for compulsory medical inspection on two grounds. First, educational efficiency:

there were ailments which impaired general health and made it difficult for children to profit by instruction, but defects of the ear and eye made it impossible. If a child did not hear or see a blackboard, how was it possible for it to gain instruction? (47)

Tennant's second argument was the Imperial need revealed by the Army recruitment figures.⁽⁴⁸⁾ Tennant's arguments for compulsion were supported not only by Socialists and Liberal radicals, but also by Tory backbenchers such as Sir Gilbert Parker, who claimed "this Amendment was asked for by both sides of the House....the Party behind him [Birrell] would permit him to make this sub-section compulsory and the Opposition would support him".⁽⁴⁹⁾ Even members of the previous Conservative administration, including the former Prime Minister, A.J. Balfour, and Sir William Anson, who thought the amendment "worth more than the rest of the Bill", now declared themselves in favour of compulsory medical inspection.⁽⁵⁰⁾

Finding himself isolated, Birrell recognised that acceptance of the amendment requiring compulsory medical inspection was inevitable and conceded defeat, although not before expressing

(47) Parl. Deb., 4th series, 160(16 July 1906), 1377.

(48) Ibid., col.1378.

(49) Ibid., col.1380.

(50) Ibid., cols. 1394, 1383.

opinions about the role of the education system reminiscent of J.G. Fitch's response to the Crichton-Browne Report twenty years earlier:

Ever since he had been at the Board of Education he had been pursued by deputations of learned men and women, who looked upon schools as places where not merely reading, writing and arithmetic were more or less badly taught, but as places where they were to consider the health, the future happiness, and what he might call the breed of the English speaking race. Well, those were new ideas to the Board of Education, they were extensive ideas, and they sought to impose on the Board duties which he did not know that the Board was the best body to carry out.(51)

Nevertheless he was prepared to accept "the guidance of the House" on the question of compulsion, and announced that the Board was also "willing to receive inspiration from the House in the direction of strengthening its medical staff at Headquarters", not to inspect children, but to ensure that the local authorities were performing their functions satisfactorily.(52) He undertook to table an amendment to the Bill on Report making medical inspection a duty, rather than simply a power, of local education authorities.(53) This pledge resulted in the Bill, as amended on Report, including a provision in what was now sub-clause 24(b) imposing on local education authorities:

(51) Ibid., col. 1395.

(52) Ibid., col. 1397.

(53) Ibid., col. 1398.

b. The duty to provide for the medical inspection of children before or at the time of their admission to a public elementary school, and on such other occasions as the Board of Education may direct, and the power to make such arrangements as may be sanctioned by the Board of Education for attending to the health and physical condition of the children educated in public elementary schools.(54)

In this draft for the first time the duty of medical inspection became distinguished from the power of "attending to the health and physical condition of the children". In former drafts, medical inspection was assumed to be included in, and in much of the attendant discussion had been held to be synonymous with, the power of "attending to the health and physical condition of the children." This change appears to have attracted little or no comment at the time.

The continued progress of the medical inspection clause was almost unopposed, although in the House of Lords Lord Belper, acting on behalf of the County Councils Association of which he was himself a prominent member, proposed a reversion to a permissive power to inspect, on the ground of cost. He was, however, anxious to emphasise he "had never said a single word in opposition to inspection so long as it was carried out in a reasonable way and with due regard to economy".⁽⁵⁵⁾ After the Bishop of Ripon (a member of the N.L.P.E.I. deputation to Birrell on 27 February) had accused Lord Belper of grossly exaggerating the cost of medical

(54) BPP 1906/1:949, Education (England and Wales) Bill as Amended in Committee and on Report, Bill 327, cl.24(b).

(55) Parl. Deb., 4th series, 165 (21 November 1906), 751.

inspection, the amendment was withdrawn without a vote being taken.⁽⁵⁶⁾ The Liberal Government's inability to resolve the impasse ensuing from the wrecking amendments which the House of Lords inserted into other clauses of the 1906 Bill led to its withdrawal on 20 December 1906. The medical inspection provisions lapsed with the rest of the Bill.⁽⁵⁷⁾

The evidence presented in the foregoing analysis of the medical inspection provisions of the 1906 Education Bill suggests that Parliamentary opinion was strongly in favour both of compelling local education authorities to introduce medical inspection of school children, and of the Board of Education possessing its own medical department. But from an examination of the debates in 1906, and of much of the extra-Parliamentary discussion about medical inspection, it appears there was a general vagueness about the actual details of the system of medical inspection desired.

Examples of this vagueness over details may be found in discussion about the proposed central medical department. Birrell was forced by pressure of public opinion to concede that such a department would be established, but even among those pressing most strongly for the formation of such a department, opinions about the required status, strength and duties were diverse.

(56) Ibid., col. 745.

(57) Peter G. Rowland, The Last Liberal Governments, 2 vols. vol.1 "The Promised Land 1905-1910", (London: Barrie and Rockliff, 1968), p.85.

Tennant thought such:

a small medical department of the Board of Education....would not exceed £1500 or £2000, or at the outside £3000 a year. The department need not be as large as that of the Local Government Board (58)

The deputations received by Birrell talked of a regulatory staff of inspectors, along with an advisory committee,⁽⁵⁹⁾ or of one official, possibly with assistants, to collate statistics and study the policies of other countries.⁽⁶⁰⁾ Birrell offered the latter suggestion almost verbatim to the House on the day it was made to him, perhaps indicating that the Board at that time had developed no internal policy on the matter.⁽⁶¹⁾

Similarly relatively little was said during Parliamentary discussion about how the local service should be organised. The use of medical officers of health was suggested by some Tory M.P.'s, but apparently on the ground of cheapness, rather than of positive preference for any particular branch of the medical profession.⁽⁶²⁾ Although other speakers implied the use of independent officers,⁽⁶³⁾ this was not in a context suggesting opposition to other forms of administration. Finally, the scope

(58) Parl. Deb., 4th series, 160(16 July 1906), 1378.

(59) PRO Ed 24/279, report of a meeting with a delegation from the N.L.P.E.I., 27 February 1906.

(60) Ibid., minutes of a meeting with a B.M.A./M.S.S.A. delegation, 16 July 1906.

(61) Parl. Deb., 4th series, 160(16 July 1906), 1397.

(62) Ibid., col.1381.

(63) Ibid., col.1382.

of the service also attracted little discussion. When conceding the principle of compulsory medical inspection, Birrell emphasised that he did not intend to provide treatment.⁽⁶⁴⁾ But two days later, on 18 July 1906, his response to a question from G.N. Barnes as to whether local authorities would now be able to provide glasses for short-sighted children was to say:

The Amendment which the Government inserted in the clause dealt only with medical inspection, which was made compulsory. The point referred to in the honourable member's question would therefore not fall within it, but would come, if at all, within the remainder of clause 35. On this I have to say that I am not prepared to give a general interpretation beforehand.⁽⁶⁵⁾

Yet despite this obvious vagueness the prospect of ameliorative action being allowed stimulated little debate, and certainly none of the passionate arguments about the danger of undermining parental responsibility which characterised some of the debates on the Education (Provision of Meals) Bill during the 1906 session of Parliament.⁽⁶⁶⁾ Perhaps this was due to tacit agreement that the activities permitted would not extend to a general treatment system, as the Earl of Crewe implied when responding to a suggestion that the word "supervising" should be substituted for the phrase "attending to" the health of the children:

(64) Ibid., col. 1398.

(65) Ibid., 161 (18 July 1906), 170.

(66) See e.g. speeches by Sir Harold Cox, Sir Frederick Banbury and W.C. Bridgeman in the debate during the Committee stage of the Education (Provision of Meals) Bill. Ibid., 166 (7 December 1906), 1377ff; 1392; 1403.

The words "attending to" are perhaps rather wider in their application than the word "supervising", but medical treatment is not included in the term as ordinarily understood. We prefer the words as they stand, and therefore cannot accept the amendment.(67)

No further elaboration of this point was given by either Crewe or, elsewhere, by Birrell.

The 1906 Parliamentary session thus saw general agreement that compulsory medical inspection was desirable, but little debate on more specific details.

School Health in the 1907 Parliamentary Session

At the start of the 1907 Parliamentary session there was a change of political leadership at the Board of Education. The death of James Bryce resulted in Augustine Birrell becoming Secretary of State for Ireland. His successor as President of the Board of Education was Reginald McKenna,⁽⁶⁸⁾ appointed to this post on 11 February 1907.

The medical inspection question quickly demanded McKenna's attention. On 15 February the Education Acts Amendment Bill, a Private Members Bill introduced by Walter Russell Rea, a back-bench Liberal M.P., was given its First Reading. This was a short Bill, with only two operative clauses, intended "to make provision for vacation schools, and for the medical inspection

(67) Ibid., 165 (21 November 1906), 755.

(68) Rt. Hon. Reginald McKenna (1863-1943). Educated at Trinity Hall, Cambridge. Liberal MP North Monmouthshire then Pontypool, 1895-1918. Financial Secretary, Treasury, 1905-7; President, Board of Education, 1907-8; First Lord of the Admiralty, 1908-11; Home Secretary, 1911-15; Chancellor of the Exchequer, 1915-16.

and treatment of school children",⁽⁶⁹⁾ and was considered by Rea to be "an absolutely non-contentious measure".⁽⁷⁰⁾ The Government subsequently introduced its own Education (Administrative Provisions) Bill, a rather longer Bill containing clauses duplicating those contained in Rea's. This was given a First Reading on 28 February.⁽⁷¹⁾ The Government's legislation then made no further progress while Rea's Bill, which was not "starred", that is, given priority, proceeded through its Parliamentary stages. Rea's Bill received a Second Reading on 1 March,⁽⁷²⁾ reached the Report stage on 18 March,⁽⁷³⁾ and was then withdrawn after the Consideration debate on 14 June.⁽⁷⁴⁾ In contrast, the Education (Administrative Provisions) Bill was not given its Second Reading until 31 July, six weeks after the withdrawal of Rea's Bill and more than five months after its own First Reading,⁽⁷⁵⁾ but then passed through the remainder of its House of Commons stages by 12 August,⁽⁷⁶⁾ quickly passed through

(69) Parl. Deb., 4th series, 169(15 February 1907), 419; BPP 1907/1:793, Education Acts Amendment Bill, as Introduced, Bill 22.

(70) Parl. Deb., 4th series, 170 (1 March, 1907), 426.

(71) Ibid., 170(28 February 1907), 269.

(72) Ibid., 170(1 March 1907), 425ff.

(73) Ibid., 171 (18 March 1907), 488.

(74) Ibid., 176(14 June 1907), 33ff.

(75) Ibid., 179(31 July 1907), 1097ff.

(76) Report, ibid., 179(6 August 1907), 1849; Consideration and Third Reading, ibid., 180(12 August 1907), 899-927.

the House of Lords,⁽⁷⁷⁾ and received the Royal Assent on 28 August.⁽⁷⁸⁾

An interpretation of this sequence of events has been offered by Professor Bentley B. Gilbert, in The Evolution of National Insurance in Great Britain, where he refers to Morant's concern at:

the appearance on March 1st of a Private Member's Bill to require school playgrounds and medical inspection introduced by Walter Russell Rea, Liberal of Scarborough. Rea simply used the inspection clause of the 1906 Bill which would have excluded any provision for treatment. His Bill caused considerable anxiety among Liberals of all shades of opinion. It disturbed the radicals by being more limited in scope than they intended inspection to be and the rest of the party because as a Private Member's Bill it was non-political and so offered the Unionists the opportunity to retrieve their reputation as reformers. Both Balfour and Anson supported it, and as a result the measure quickly passed through the second reading, committee and report stages.

Hence, for the second time the government was in the awkward position of having to provide a substitute of its own for the initiative of a private member on medical inspection. Bearing the Unionist jeers as well as he could, McKenna asked Rea to withdraw his bill and on July 31st 1907, Morant's proposal, the Education (Administrative Provisions) Bill received its second reading. Clause 13 of the measure combined the wording of Birrell's and Tennant's amendments on medical inspection of the previous year. The clause specified that the local education authorities were to 'provide for the medical inspection of children' at appropriate times during their school career, and also to make 'such arrangements as may be sanctioned by the Board of Education for attending to the health and physical condition of the children educated in public elementary schools....'. On the

(77) First Reading, ibid., 180 (13 August 1907), 948; Second Reading, ibid., 181 (21 August 1907), 724ff; Committee, ibid., 181 (22 August 1907), 1066; Third Reading, ibid., 181 (23 August 1907), 1371.

(78) Ibid., 182 (28 August 1907), 425.

words 'arrangements....for attending to the health', borrowed from Mr. Tennant's amendment, hung the establishment of the school medical service .(79)

Professor Gilbert therefore sees the unexpected appearance of Rea's Private Member's Bill, containing restricted powers of medical inspection only, as a threat to Morant's strategy. This was to persuade Parliament, through what Gilbert describes as "politico-administrative trickery", to pass legislation which by deliberately vague wording of the relevant clause gave the Board significantly greater scope for developing medical services in schools than Parliament had intended.⁽⁸⁰⁾

This interpretation must be regarded as unsatisfactory. Rea's Bill specifically declared itself to be one providing for the "medical inspection and treatment" of school children,⁽⁸¹⁾ and the wording of clause I(b) of Rea's Bill on introduction, imposing on every local education authority:

b. The duty to provide for the medical inspection of children before or at the time of their admission to a public elementary school, and on such other occasions as the Board of Education direct, and the power to make such arrangements as may be sanctioned by the Board of Education for attending to the health and physical condition of the children educated in public elementary schools.⁽⁸²⁾

was identical to clause 10(b) of the Government's own Education

(79) Gilbert, op.cit., pp.129-30.

(80) Ibid., p.117.

(81) BPP 1907/1:793, op.cit.

(82) Ibid., cl.1(b).

(Administrative Provisions) Bill as first introduced.⁽⁸³⁾ As Rea stressed, the wording of his (and therefore of the Government's) Bill was taken verbatim from the final draft of the corresponding clause of the 1906 Education Bill.⁽⁸⁴⁾ The powers and duties conferred by the two Bills were therefore identical. Similarly, amendments made to Rea's Bill during its passage through Parliament were incorporated into the Government Bill once it, too, was given its Second Reading, so that the final wording of the Education (Administrative Provisions) Act 1907, making it:

b. The duty to provide for the medical inspection of children immediately before or at the time of or as soon as possible after their admission to a public elementary school, and on such other occasions as the Board of Education direct, and the power to make such arrangements as may be sanctioned by the Board of Education for attending to the health and physical condition of the children educated in public elementary schools.⁽⁸⁵⁾

was identical to the final wording of Rea's Bill after Consideration by the House of Commons.⁽⁸⁶⁾ Thus the actual wording of the two Bills, and the legal powers they conferred, were in all respects identical, and it cannot be argued that one allowed, and the other excluded, the provision of treatment. The extent to which Parliament actually acknowledged that treatment would

(83) BPP 1907/1:801, Education (Administrative Provisions) Bill, as Introduced, Bill 83, cl.10(b).

(84) Parl. Deb., 4th series, 170(1 March 1907), 426.

(85) Education (Administrative Provisions) Act 1907, 7 Edw. VII, ch. 43, cl.13(i)(b).

(86) BPP 1907/1:797, Education Acts Amendment Bill, as Amended in Committee, Bill 108.

in fact occur is discussed below.

If any difference between the two Bills can be identified, the subsequent history of the School Medical Service made it a theoretical one only. Parliamentary convention requires that a Private Members Bill cannot directly commit the central government to increased expenditure from the Exchequer.⁽⁸⁷⁾ Rea's Bill could not therefore promise any grant-in-aid of the cost of medical inspection from government funds, a point taken up by A.J. Balfour when, after announcing that the Opposition did not intend to contest the Second Reading of Rea's Bill, he added that: "he ought, however, to throw out the warning that under the Bill a burden would be thrown on the rates, and the suggestion that the Government should provide for that in their own measure".⁽⁸⁸⁾

This convention excepted, however, there were no differences in the powers conferred by Rea's Bill and the Government's own measure. In fact, the Board of Education appears to have been planning the introduction of legislation on medical inspection almost simultaneously with Rea's introduction of his Private Member's Bill. Certainly, such plans had been formulated before 19 February, when Morant wrote to T.J. Macnamara, then Parliamentary Secretary to the Local Government Board:

As I wrote to you the other day, we are very anxious on many grounds, to introduce at once

(87) See Thomas Erskine May, A Treatise on the Law, Privileges, Proceedings and Usage of Parliament, 11th ed. (London: William Clowes & Sons, 1906), pp.545ff.

(88) Parl. Deb., 4th series 170(1 March 1907), 428.

and to pass quickly into law, what was part II [sic] of last year's Education Bill. In particular it will bring about the medical inspection of children in Elementary Schools.

It is more than probable that we shall get the Opposition to consent to its being passed practically without debate.

McKenna is going to speak to the Cabinet tomorrow (Wednesday) about it, and I have had a print of the Bill set up for this purpose, and I enclose you copy herewith. (89)

No copy of Morant's earlier correspondence with Macnamara, or report of McKenna's discussions with the Cabinet, has survived, but it is clear from this letter that by 19 February, four days after the introduction of Rea's Bill, the Board was already well advanced with preparations for the introduction of its own legislation. Given the inevitable delays occasioned by the departure of Birrell and the appointment of McKenna as his successor, it is possible that such preparations were in hand before Rea's intention to introduce his own Private Member's Bill became known.

The subsequent delay in the publication of the Government's Bill was due in part to the negotiations that took place with the Unionist leadership in an attempt to ensure the unopposed passage of the proposed legislation. Negotiations seem first to have been conducted with Sir William Anson, who as a former Parliamentary Secretary to the Board of Education would have been well known to Morant. After examining a copy of the draft Bill

(89) PRO Ed 24/128, Morant to T.J. Macnamara, 19 February 1907. Morant was actually referring to Part III of the 1906 Education Bill.

Anson wrote to A.J. Balfour on 27 February 1907, recommending that it be agreed to treat the Bill as a non-controversial one. He did, however, draw Balfour's attention to:

Clause 10(b) which throws on the Local Authorities the duty of providing medical inspection of school children which was generally, and cordially, accepted last summer, and I suppose that our zeal for 'social reform' has not cooled since. But medical inspection will cost money, and the Bill of 1906 provided a million for the assistance of the Local Authorities in the general purposes of the Bill.

Ought we not to enter a protest against the burdening of the ratepayers with the whole cost of medical inspection?(90)

The Bill was given a formal First Reading the following day. Afterwards Morant went through the Bill with Balfour, who presumably agreed not to offer concerted opposition to the provisions, for on 1 March Morant wrote to Anson defining the limits within which it had been tacitly agreed that the Opposition's criticisms should be confined:

As regards the burden which Medical Inspection will throw on the Rates, we should of course expect the Front Opposition to raise a protest; but this would not go as far as dividing against the Bill or against the Clause.

The Government certainly will not insert any Exchequer Grant in Aid of the cost of medical inspection. (91)

Delays in introducing the Government's Bill were thus at least partly due to negotiations with the Unionist Opposition to secure agreement on the essentially non-political nature of the Bill.

(90) Ibid., Anson to Balfour, 27 February 1907.

(91) Ibid., Morant to Anson, 1 March 1907.

The introduction of two Bills dealing with medical inspection and treatment during the 1907 session should thus be attributed, not to the Government's need to respond to an embarrassing initiative from a private member, but to Rea's impatience with, and possibly ignorance of, the Government's plans in this direction. Reluctant though Morant himself was for the Board to undertake medical inspection, the events of the 1906 session had shown such action to be unavoidable.

But, given that two such Bills were introduced, questions arise about the course of events in Parliament during the 1907 session, with Rea's Bill proceeding through almost all its stages in the Commons, while the Government's Bill was held back. One possible explanation lies in the suggestion made by the eccentric Sir Frederick Banbury, one of the few M.P.'s to express reservations about the medical inspection provisions of the Bill. He alleged the Government was "running two horses", using Rea's Bill to sound out the opinion of the House before bringing forward its own Bill, and curtailing discussion on this on the ground that its provisions had already been discussed during the debates on Rea's Bill.⁽⁹²⁾

(92) Parl. Deb., 4th series, 170 (1 March 1907), 429. Sir Frederick Banbury was a constant objector to and obstructionist of reformist legislation, for reasons he later explained to Dr. Christopher Addison after he had objected to an apparently innocuous Private Member's Bill Addison had sponsored: "Addison, you are a Radical. It is therefore ten to one that your proposal is a bad one and ought to be objected to. If by any wonderful chance it is a good one, it is a bad thing that any Radical should get credit, and on that ground it should still be objected to". C.R. Addison, Politics from Within, 2 vols. (London: Herbert Jenkins, 1924), 1,19.

Given the support the medical inspection clause of the 1906 Bill had received, and the negotiations taking place with the Unionist leadership over their attitude to the Government's Bill of 1907, this suggestion appears unfounded. Yet in some respects this may be a plausible explanation. In the 1906 session Parliament had been vague about many details of the scope and character of the medical service it wanted to see established, and on these the debates on Rea's Bill could be used to test the opinions of the House.

In this respect it is significant that the debates in the 1907 session contained more detailed discussion of the question of what forms of treatment, if any, were to be provided, and on what terms, than had the debates on the 1906 Bill. In the debate on Consideration of Rea's Bill, Lord Robert Cecil raised this very issue and, rather than oppose the provision of treatment in toto, wondered only "whether some provision should not be made with reference to recovering the expense of medical attention from those parents who could afford to pay".⁽⁹³⁾ Other speakers in the debate also indicated that ameliorative action itself was acceptable, with parental contributions being the key issue. Sir William Anson, again referring to the potential charge on the rates, thought medical inspection itself would not cost much, but:

if they were to add medical attendance for children then the matter became more serious, and the question arose whether the parents might not be called upon to contribute towards the cost incurred. (94)

(93) Parl. Deb., 4th series, 176 (14 June 1907), 41.

(94) Ibid., col.45.

Nevertheless, when an M.P. proposed an amendment to Rea's Bill making the cost of "attending to the health and physical condition of the children" recoverable from parents in "a court of summary jurisdiction", the amendment was defeated by 229 votes to 39, after Thomas Lough, the Parliamentary Secretary to the Board of Education, had reassured the House that with schemes having to be approved by the Board of Education extravagant or unrealistic proposals would not be permitted.⁽⁹⁵⁾

This acceptance of limited systems of treatment, and a rejection of the minority adherence to levying charges for treatment given, continued during the debates on the Education (Administrative Provisions) Bill itself. In the Committee stage of the Bill, the provisions for treatment were discussed by Thomas Lough, who explained that medical treatment for such things as minor ailments, in what he described as "a small hospital outside the school" would be included among the powers conferred by the clause.⁽⁹⁶⁾ Again, the only serious opposition came from those who wanted to see the cost of any treatment charged to, and recovered from, the parents of the children receiving treatment. One opponent of free treatment, Col. George Lane-Fox, the M.P. for Barking Ash, proposed an amendment making a charge compulsory. Even Lane-Fox, however, felt compelled to qualify his amendment:

(95) Ibid., col.57.

(96) Ibid., 180 (12 August 1907), 916, 920. As only formal minutes of the Committee stage were published, Lough's comments are taken from quotations included in speeches by Anson and Henry Butcher.

There was no doubt that a large number of the ailments from which children suffered, and which it was hoped to remedy by this clause, were the small ailments. He did not wish to prevent these being dealt with, and if dealt with on the spot they need not do harm. Therefore, if the amendment he was moving could be improved by the addition of such words as "conducted outside the precincts of the school" he would be happy to accept it. Of course, under this system what they would hope to see were village nurses employed to deal with small matters such as children arriving with dirty heads which could be dealt with quickly. (97)

Despite this attempt to rally greater support, Lane-Fox's amendment was defeated by 149 votes to 39.⁽⁹⁸⁾ In the House of Lords also the clause had an uneventful passage, even though the Earl of Crewe in his introductory speech emphasised that:

Provision is made for the medical care of the minor ailments to which children are subject, and the manner in which it is thought that this can best be carried out is by visits of nurses employed by the local authority to the homes of the children, where they are able to deal with small ailments very often caused quite as much by the ignorance of the parents as by anything which could properly be called neglect or want of care. (99)

Evidence suggests, therefore, that the 1907 debates on the medical inspection clause provided clear statements that medical treatment of a limited kind, in respect of certain ailments of school children, would be permitted under the provisions of the clause, and that this intention was generally acceptable to most

(97) Ibid., col. 918.

(98) Ibid., col. 926.

(99) Ibid., 181 (21 August 1907), 726.

members of the House. This must cast some doubt on Gilbert's assertion that treatment came about largely through "politico-administrative trickery" on the part of Morant,⁽¹⁰⁰⁾ and on Morant's own assertion, made to Sir Lawrence Brock years after the Act, that he:

knew, ...but did not tell his Minister, that medical inspection would reveal such a mass of disease and defects that no government subsequently would be able to resist the demand of Local Education Authorities to provide treatment. Morant told me himself that he foresaw what would happen and meant it to happen because without these horrifying results of inspection there was no chance for a Bill authorising treatment.⁽¹⁰¹⁾

Nevertheless, there is some evidence that, at least in the early part of 1907 Morant remained cautious about discussing openly how extensive the arrangements for treatment might be, even after there had been a general acceptance of the principle of treatment during the debates on Rea's Bill. When, the Birmingham Education Committee wrote to the Board in April 1907, requesting confirmation: "that it is intended that Local Education Authorities should have full power to take whatever steps may be necessary in dealing with children medically after they have been medically inspected",⁽¹⁰²⁾ Morant's response was a cautious one, advising McKenna:

My own opinion, with experience behind it, is that it is usually wiser to avoid attempting, in correspondence, any interpretation of a Bill which is before the House of Commons - the proper place

(100) Gilbert, op.cit., p.117.

(101) Quoted in Violet Markham, Friendship's Harvest (London: Reinhardt, 1956), pp.200-1.

(102) PRO Ed 31/151, Birmingham Education Committee to Board of Education, 24 April 1907.

for this is on the floor of the House. This letter from Birmingham draws attention to what may prove to be an acutely controversial point, viz., the amount of medical treatment (as distinct from mere inspection) of Elementary School children which the Local Authority will be empowered by the Bill to provide gratis out of the Education Rate..[it is]probably wiser to say that the Board are not prepared to offer, in advance, legal interpretations of points arising under clauses of a Bill not yet discussed in Committee in the House.(103)

Morant was thus clearly wary of discussing the details of treatment too openly at this juncture and the 1907 Parliamentary timetable may thus be explainable as an attempt to test the opinion of Parliamentarians about such issues prior to bringing forward the Government's own Bill.

It is possible, however, that Morant had other reasons for delay. Reference was made earlier to Morant's support for the Webbian concept of administrative functionalism, and it was suggested that this was an explanation for his apparent lack of enthusiasm for the establishment of a medical department at the Board of Education. There is some evidence to suggest that by August 1906 the political pressure on the Board to establish such a department had resulted in internal discussion on who should be appointed to head such a department, if established.⁽¹⁰⁴⁾

(103) Ibid., Morant to McKenna, 30 April 1907, Note, however, that it is not treatment itself, but treatment "gratis", or free of charge, which is the potentially controversial issue.

(104) "You have probably realised, probably indeed so long ago as August last year when the matter was first mooted, that political and other considerations necessitated that the first Chief of whatever Medical Bureau might be started by this Board should have to be appointed from outside".

PRO Ed 24/280, Morant to Alfred Eichholz, 28 August 1907.

It was alleged that Birrell had offered James Kerr "the refusal of the post of medical officer to the Board" in July 1906, only to be told by Morant in January 1907, after the withdrawal of the 1906 Education Bill, that the question of a medical department at the Board had been dropped entirely.⁽¹⁰⁵⁾

If this latter allegation is true, and although there is no supporting evidence it was never publicly or privately denied, then Morant in the last few months of 1906 was faced with a serious challenge to his hopes of seeing all health services, including school health services, unified under a Ministry of Health. As chapter three has shown, Kerr was a leading proponent of the view that the school medical service required an independent orientation outside the mainstream of the Public Health service. With his forceful personality he could be relied upon to oppose any attempt by Morant to impose his own views. The withdrawal of the 1906 Education Bill, which allowed Morant to tell Kerr that the idea of a medical department had been dropped, and Birrell's departure for the Irish Office were thus, from Morant's standpoint, fortuitous events which gave him the opportunity to recover his position. McKenna was closer to the Webbs and was also:

neither large, nor wise, nor imaginative, but essentially Treasury, financial, statistical, mechanical....He has no interest whatever in education, nor in educational organisation and development. I fancy his only real interest

(105) British Medical Journal ii (1907), 772-73. Letter from A.H. Hogarth.

is to become Chancellor of the Exchequer as quickly as possible, and certainly to get quit of Education as speedily as he can.(106)

This made him liable to lean on Morant for guidance.

McKenna's early responses to Parliamentary probing on the intentions of the Board of Education over the establishment of a medical department were evasive, and avoided making any definite commitments about the size or composition of any such department.⁽¹⁰⁷⁾ But this masked moves by Morant and the Webbs to secure his support for their own views on the policy to be followed over the Board's proposed medical department; moves which could only be aided by any delays occasioned by the slow passage of the legislation through Parliament. Although Morant was now convinced that the Board would have to establish its own medical department the Webbs were less sure of the inevitability of such action, and were concerned about the possible implications for any future moves toward a Ministry of Health, as Beatrice Webb indicates in her diary entry for 27 April 1907:

Dined alone with Morant....He says he will be forced to start a Medical Department because of the incapacity of the LGB to do the necessary work. But we pressed on him the desirability of placing the new medical officers under the MOH in each locality, and if possible doing likewise with the central inspectors and the LGB. (108)

A few days later Morant wrote saying:

I fancy all I can do at present in the directions we talked over is to try to prevent mistaken

(106) Passfield MSS, II, 4,c,82. Morant to Beatrice Webb, 1 May 1907.

(107) Parl. Deb., 4th series, 171 (18 March 1907), 421-22; 173 (6 May 1907), 1310; 174 (9 May 1907), 363-64; 174 (16 May 1907), 1101-2.

(108) Passfield MSS, Diary of Beatrice Webb, vol.26, p.57, 27 April 1907.

things being done in a hurry in my own department which would set up wrong trends and be difficult to reverse or modify later.

He added that it was better McKenna should not be aware of his discussions with the Webbs.⁽¹⁰⁹⁾

The delay in implementing school medical inspection allowed the Webbs to embark on a characteristic intrigue with two main objectives. First, to gain McKenna's general support for the integrated health system envisaged in their concept of administrative functionalism; second, given the apparent inevitability of a medical department being established at the Board of Education, to identify and secure the appointment of a candidate who would be sympathetic to the need to co-operate with, and ultimately integrate with, the established public health service. On 30 April she wrote to McKenna enclosing some of the evidence submitted to the Royal Commission on the Poor Law favourable to her ideas, and saying:

The evidence from all parts of the Kingdom [to the Royal Commission] is becoming so overwhelming that I believe there is already a clear majority in favour of the consolidation of all medical assistance under the Public Health Authority. Incidentally this means, I think, a similar consolidation in the Central Authority and finally the creation of a Ministry of Health.[therefore]I think it would be a grave misfortune if each local education authority were now to appoint its own medical officer - more especially as he would probably be a private practitioner who would regard the matter merely as a fee paying business unconnected with the

(109) Passfield MSS, II, 4,c,82, Morant to Beatrice Webb, 1 May, 1907.

discovery and prevention and cure of all diseases within the district. (110)

That Morant and the Webbs were gradually successful in persuading McKenna of the desirability of linking the Board's medical initiatives with the public health service is reflected in the increasingly anxious comments and questions from those opposed to this approach. The preparations for the International Congress on School Hygiene served to some degree as a vehicle through which such opposition could be articulated, for James Kerr was acting as Joint Secretary to the Congress, and many prominent members of the medical establishment were closely linked with the preparations. On 18 June the Times carried an unsigned article on medicine in schools which, after referring to the forthcoming Congress, and to the Bills before Parliament, noted that:

There have lately been rumours of an intention on the part of the Government to treat the medical inspection of schools as a single portion of the general sanitary administration of the country, and to transfer the control of it to the medical department of the Local Government Board. Such a course would be highly objectionable, even if a special sub-department of the Board were created for the purpose of dealing with the questions which would arise, because it would involve a divided authority in every school; but without the creation of such a sub-department it would be fatal....(111)

This article, written by Kerr himself or by someone closely allied to him, reflects the increasing fears of those committed

(110) Passfield MSS II, 4,c,81, Beatrice Webb to McKenna, 30 April 1907.

(111) Times, 18 June 1907, p.14.

to the educational concept of school hygiene that the Board was now moving away from the adoption of their ideas as policy. This anxiety was later translated into allegations that the Board was trying to minimise the impact of the International Congress on School Hygiene by placing obstacles in the path of its organisers. Closely questioned in Parliament, McKenna rejected these charges.⁽¹¹²⁾

During this period, in a classical exercise in "permeation", the Webbs had introduced a candidate sympathetic to their aims to Morant and had, by the end of July, almost secured his appointment by McKenna, with the help of some additional testimonials from some of their influential acquaintances.

The candidate was Dr. George Newman,⁽¹¹³⁾ a member of a Herefordshire Quaker family who, after studying medicine at Edinburgh, moved to London. By 1894, he was studying for his Diploma in Public Health at King's College Hospital, and acting as Warden of the Quaker settlement in London, Chalfont House, a post he retained until his marriage in 1898.⁽¹¹⁴⁾ By 1900,

(112) Parl. Deb., 4th series, 178 (15 July 1907), 335-36; 179 (25 July 1907), 140-41; 179 (6 August 1907), 1835-36.

(113) Sir George Newman MD FRCP (1870-1948). Son of a Leominster grocer. A Quaker. Educated at Bootham School, York, Edinburgh University and Kings College London. Medical Officer of Health for Bedfordshire and for Finsbury M.B., 1900-7. Chief Medical Officer, Board of Education, 1907-35. Chief Medical Officer, Ministry of Health, 1919-35. Warden of the Quaker Chalfont House Settlement, 1894-98. Editor of the Friends Quarterly Examiner for 40 years. Kt. (1911) KCB (1918) GBE (1935)

(114) Newman MSS (Hereford) M4 /159, notes by Sir George Newman for his proposed autobiography.

he had been appointed Medical Officer of Health to Finsbury Metropolitan Borough, and had had his first encounter with Beatrice Webb when she called at his home in Bloomsbury.⁽¹¹⁵⁾ After publication of his study on Infant Mortality in 1906⁽¹¹⁶⁾ he was drawn more firmly into the Webbs' circle, having dinner with the Webbs, Charles Booth and Josiah Wedgwood in the second half of 1906,⁽¹¹⁷⁾ and then advising Beatrice Webb during her campaign to unify the Poor Law medical services under the medical officer of health.⁽¹¹⁸⁾ Newman was one of those asked to give evidence to the Royal Commission by Mrs. Webb.⁽¹¹⁹⁾

In 1907 the Webbs sought to introduce Newman to contacts whose influence would be important when an appointment to the medical department at the Board of Education was made. On 12 March, Newman dined with the Webbs and A.J. Balfour and then, on 13 May, he met Morant at the Webbs house, apparently for

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- (115) Passfield MSS, II, 4,n,263, Newman to Sidney Webb, 1 June 1943.
- (116) George Newman, Infant Mortality: a Social Problem (London: Methuen, 1906).
- (117) Newman MSS (Hereford), M4/159.
- (118) Passfield MSS, Diary of Beatrice Webb, vol.25, p.113, 17 July 1906.
- (119) BPP 1910/XLIX:1, Royal Commission on the Poor Laws Appendix vol.ix, Cd.5069, evidence of Dr. George Newman, pp. 262-88. Newman recorded that at lunch afterward the Chairman of the Commission, Lord George Hamilton "advocated compulsory military service as a means of improving physically and morally the rising generation. I urged medical inspection and physical training". Newman Diaries (D.H.S.S.), vol.1, 25 February 1908.

the first time.⁽¹²⁰⁾ These meetings had the desired effect for on 30 July Newman was approached by Morant, and subsequently had interviews with Morant and McKenna on 2 and 7 August. At the second interview he was formally offered the appointment by McKenna, though a public announcement was delayed.⁽¹²¹⁾ Newman's interviews with McKenna were in many respects a formality, for McKenna, pressured by personal recommendations from A.J. Balfour and others, had already confided to Beatrice Webb that he intended to appoint Newman as he had heard "nothing but good of him".⁽¹²²⁾

Clearly, Newman's appointment was a triumph for permeation, and Newman himself was well aware of the debt he owed to the Webbs work on his behalf, for on 19 September he wrote to Beatrice Webb:

Somehow or other I connect you with this post - the offer of which to me has come as a very great surprise. I have often wondered how much you had to do with it. I do not forget a pleasant little dinner party where I first set eyes on Sir Robert Morant. Since then he and I have had something to do with each other and several very plain conversations!⁽¹²³⁾

Years later, after further reminiscences, Mrs. Webb was to write to Newman, not, perhaps, altogether truthfully:

I have a vague remembrance of that little dinner and the deep impression which you made

(120) Newman MSS (Hereford), M4/160, notes on Newman's medical career; Passfield MSS, II,4,c,99. Newman to Beatrice Webb, 19 September 1907.

(121) Newman MSS (Hereford), M4/160.

(122) Passfield MSS, Diary of Beatrice Webb, vol.26, p.69, 18 July 1907.

(123) Passfield MSS, II,4,c,99, Newman to Beatrice Webb, 19 September 1907.

on Arthur Balfour, but I had no notion that it had anything to do with your appointment some weeks afterwards....(124)

With his appointment thus imminent but yet unannounced, Newman was able to attend the meeting of the International Congress on School Hygiene as an independent delegate. Meeting from 6 to 8 August, this coincided with his final interview by McKenna. The proceedings of the Congress saw further debate on the controversy over control over the school medical service,⁽¹²⁵⁾ and gave Newman an indication of the reaction which could be anticipated when his appointment became public knowledge.

When the announcement was made on 13 September,⁽¹²⁶⁾ there was an immediate and sometimes critical response from the medical press. The British Medical Journal, which had been most closely linked to James Kerr and his views, ran a leading article attacking Morant's alleged views on school medical inspection, and gave space in the same issue to a vitriolic letter from Archibald Hogarth,⁽¹²⁷⁾ one of Kerr's subordinates, alleging that Kerr had originally been offered the post by Birrell.⁽¹²⁸⁾ The Lancet,

(124) Newman MSS (Wellcome), no.57, Beatrice Webb to Newman, 12 March 1935.

(125) See Kerr and White Wallis, eds. op.cit., 2, 431-45.

(126) Times, 13 September 1907, p.5.

(127) Archibald Henry Hogarth MD MRCS LRCP (1877-1919). Educated at Westminster School, Christ Church College Oxford and St. Barts Hospital. Served in the Boer War while an undergraduate. Resident of Toynbee Hall 1907-9. Assistant Medical Officer, Education Department, L.C.C., and Medical Officer, Mansion House Council Dwellings for the Poor. Later became Medical Officer of Health for Buckinghamshire.

(128) British Medical Journal ii (1907), 760-61, 772-73.

though more restrained in its criticism, still thought "Dr. Newman's excellent public work has not necessarily given him much first hand experience of the kind he will require in the discharge of his important and delicate duties." (129)

These personal attacks, particularly the correspondence in the British Medical Journal, appear to have upset Newman considerably, and much of the correspondence he pursued with Morant at this time was devoted to self-defensive justifications of his appointment.⁽¹³⁰⁾ To Beatrice Webb, however, he revealed a more confident face:

I am aware that I am going to have some enemies, and many critics; but if I have the sympathy and goodwill and support of persons like yourself I can face a good deal. I am much more aware of my deficiencies than are my critics - but I will try to be worthy of you. (131)

Nevertheless, the criticisms reflect the divisions of opinion which Newman's appointment accentuated, and which were to contribute to some of the problems of the newly established School Medical Service. These are discussed in later chapters. It created particular difficulties in respect of the London County Council and Kerr, for whom the personal disappointment was such that, as Newman told Morant: "I wrote to Kerr. He is annoyed, apparently, and though I wrote a very friendly and conciliatory

(129) Lancet ii (1907), 844.

(130) See e.g. PRO Ed 24/280, Newman to Morant, 20 September 1907.

(131) Passfield MSS, II, 4,c,99, Newman to Beatrice Webb, 19 September 1907.

letter he replied in a nasty way"⁽¹³²⁾ This tension reflects the professional divisions within the School Medical Service as it commenced its operations. The way in which Newman and Morant sought to direct the service and manage the professional and other conflicts, and the political and financial context within which the School Medical Service operated, are examined in the next chapter.

Summary

This chapter has sought to examine the Parliamentary and extra-Parliamentary processes by which the School Medical Service became established on a national basis. It has suggested that the more reformist attitude of the 1906 Parliament overcame Morant's initial reluctance to include provision for medical inspection in drafts of the 1906 Education Act. This reluctance, it is suggested, was due not to indifference to the cause of school hygiene, but to a commitment to the administrative reforms advocated by the Webbs.

Examination of the process by which the School Medical Service was eventually established under the 1907 Education (Administrative Provisions) Act throws some doubt upon Professor Gilbert's account of the episode, and also suggests that the eventual provision of treatment through the School Medical Service, rather than being a result of "politico-administrative trickery"

(132) PRO Ed 24/280, Newman to Morant, 20 September 1907.

by Morant, was accepted widely by Parliamentarians during the debates on the Bill. The debates did, however, indicate a vagueness about the administrative details of the service, and this, and his Minister's weakness, enabled Morant to shape the School Medical Service to fit his own preferred public health model. This caused some anger among supporters of the rival system advocated by Kerr and his colleagues in London.

With Newman's appointment, the first task of the new Medical Department of the Board of Education was to provide guidance and directions to the local authorities as to how and under whose authority the School Medical Service should be operated at local level. The extent to which Newman and Morant sought to smooth over the existing professional differences, and to cope with the other problems to emerge in the early years of the School Medical Service, will be discussed in the next chapter.

CHAPTER FIVETHE CENTRAL MEDICAL DEPARTMENT:
POLICY FORMULATION AND
ITS CONTEXTThe Role and Policy of the Treasury

Apart from the potential difficulties with Kerr and his followers, a further problem facing Morant, Newman and the Board was the financing of the new service. Warnings about the financial implications of the introduction of medical inspection, especially for local government, had been voiced by Unionists and representatives of the local authority associations ever since Tennant's amendment had first provided for compulsory inspection.⁽¹⁾

The actions and attitudes of the Board of Education in relation to both these areas of difficulty were to some degree constrained, directly or indirectly, by the policies of another department; the Treasury. Treasury consent was required before any additions to departmental establishments were made, and the Treasury's attitude on this question would influence the size and structure of the Board's Medical Department, and hence its ability to exercise the inspectorial functions expected of it. The extent to which the local authorities willingly performed their mandatory duties and optional powers under the 1907 Act would be influenced by the degree to which the central government helped to meet the cost of

(1) Parl. Deb., 4th series, 165 (21 November 1906), 741.

the School Medical Service through Exchequer grants-in-aid.

The classical image of the Treasury, at least until the late Victorian period, was one of a department seeking extreme economy in expenditure to the extent of attempting to save candle ends.⁽²⁾ Such a view is also reflected in Roy Macleod's study of Treasury Control and Social Administration, 1871-1905, where he concludes that the restrictive and indeed obstructive influence of the Treasury was a major factor in determining the conservative approach to administration adopted by the Local Government Board.⁽³⁾

The Treasury itself held a different view. In evidence given to the Royal Commission on Civil Establishments in 1887, Sir Reginald Welby, then Permanent Secretary to the Treasury, argued that the Treasury's powers of control over expenditure, although complete in theory, were in practice inadequate and ineffective. He suggested the Treasury could only exercise power negatively. It could refuse to sanction proposals for an increase in a department's budget, but it could not order or even request a department to make economies in its existing expenditure, or to be more efficient in its administration. Even the control over new expenditure was imperfect, for a refusal of sanction by the Treasury's permanent officials could be reversed through political channels.⁽⁴⁾

(2) Maurice Wright, "The Treasury 1850-1914", in Studies in the Growth of Nineteenth Century Government, ed. Gillian Sutherland (London: Oxford University Press, 1973), p.195.

(3) Roy Macleod, Treasury Control and Social Administration, Occasional Papers in Social Administration, no.23 (London: G. Bell & Sons, 1968), p.52.

(4) BPP 1887/XIX:1, Royal Commission on Civil Establishments, First Report, C.5226, evidence of Sir Reginald Welby, pp.1-9; BPP 1887/XXVII:1, Royal Commission on Civil Establishments, Second Report, C.5545, evidence of Sir Reginald Welby, pp.10-22.

An analysis of case studies of departmental relations with the Treasury by Maurice Wright finds evidence to support Welby's hypothesis that requests for increases in a department's budget could not ultimately be refused by the Treasury. Wright argues that even Roy Macleod's study of the Local Government Board shows the department got everything it asked for in the end.⁽⁵⁾

The Treasury's ultimate powerlessness led it to develop strategies for restricting the growth of departmental budgets. Unless fully satisfied with a department's application for an increase in funds, the Treasury could "demur", deferring consideration of the request until the department resubmitted the application with further supporting arguments. If the Treasury remained unconvinced, further cycles of demur and re-submission would follow. As Maurice Wright explains, the use of repeated demurs might only partly be concerned with scrutinising the application under consideration. The expectation of a demur by the Treasury ensured that departments would submit only the applications having the greatest merit, while the departmental resources devoted to justifying a submission to the Treasury ensured that departments restricted the number of concurrent requests made.⁽⁶⁾

The Treasury allegedly experienced greatest difficulty in controlling "policy oriented" expenditure,⁽⁷⁾ a difficulty at its greatest when dealing with a policy enjoying such widespread support as the School Medical Service. The first test of the Treasury's attitude toward spending on the Service came in discussions over

(5) Wright, op.cit., p.216.

(6) Ibid., pp.221-24.

(7) Ibid., pp.201-5, 218.

the establishment of the Medical Department.

The Treasury and the Medical Department's establishment

When, in the final days before the announcement of the establishment of the central Medical Department, McKenna repeatedly announced in the House that he was in negotiation with the Treasury on the matter,⁽⁸⁾ he was not simply deflecting Parliamentary queries, for the Board's discussions with the Treasury were protracted. The first contact with the Treasury on the School Medical Service came shortly after Newman's interviews with McKenna and acceptance of the post of Chief Medical Officer, during the final Parliamentary stages of the Education (Administrative Provisions) Bill. On 14 August 1907 Morant wrote to the Treasury seeking permission to appoint a "medical adviser" at a salary of £1,200 per annum. Morant suggested this salary should be regarded as personal to the first incumbent of the post, rather than as the normal remuneration for the office. This was in his view justifiable as the first medical adviser would have to plan the initial development of the service.⁽⁹⁾

This piece of special pleading by Morant indicates that he anticipated some difficulty in persuading the Treasury to agree to his proposal, but in order for Newman to be appointed, the Treasury had to consent to the salary suggested. From his existing appointments, Newman was receiving a total of £1,500 per annum, and although he was prepared to accept some reduction in his income in order to become Chief Medical Officer, he could not agree to take less than

(8) Parl. Deb., 4th series, 179 (25 July 1907), 140-41; 180 (15 August 1907), 1607.

(9) PRO Ed.23/221, Board of Education to Treasury, 14 August 1907.

£1,200..⁽¹⁰⁾

Unaware that the position had already been offered to Newman at £1,200 per annum, the Treasury demurred, arguing that the proposed salary was excessive in comparison with established posts with allegedly similar duties. As examples the Treasury suggested the position of Medical Inspector of Factories at the Home Office, which had a salary scale of £600 to £800 per annum, and that of Superintendent of Statistics at the General Register Office, then on a scale of £800 to £900 per annum. For this reason, the Treasury thought a scale of £800 to £1,000 per annum was appropriate to the new post, although as a concession it was prepared to allow the first incumbent to be appointed at the maximum point on the scale.⁽¹¹⁾

Morant's response to this rebuff was to write a further letter to the Treasury challenging the basis for comparison, and arguing that the duties attached to the new post were in fact analogous to those of the Chief Medical Officer to the Local Government Board, whose salary scale was £1,200 to £1,500 per annum.⁽¹²⁾ To avoid prolonged negotiations, Morant sought to arrange a meeting with Treasury Ministers and officials, and after "an hours wrangle with the very highest authorities" the Treasury agreed to allow the first incumbent of the new post to be paid £1,200 per annum salary.⁽¹³⁾

(10) PRO Ed.24/280, Newman to Morant, 22 August 1907.

(11) PRO T.9/36, Treasury to Board of Education, 15 August 1907. At this time Kerr's salary at the L.C.C. was on a scale £800-£1,000. J.S. Maclure, One Hundred Years of London Education, 1870-1970, (London: Allen Lane, 1970), p.97.

(12) PRO Ed. 23/221, Board of Education to Treasury, 21 August 1907.

(13) PRO Ed. 24/280, Morant to Newman, 28 August 1907.

In exchange for this concession, the Treasury extracted from Morant the promise that the Medical Department as a whole would be small in numbers, and therefore inexpensive. Apart from Alfred Eichholz, who was already on the staff of the Board and thus did not represent additional expenditure, the only other medical staff appointed to the Department were to be a lady doctor and "a fourth person, presumably an efficient medical man young enough not to need a high salary at the start".⁽¹⁴⁾ Although Newman's appointment was thus secured, negotiations with the Treasury over his attributed pension rights were to continue for some months to come.⁽¹⁵⁾

There are arguments for suggesting that this initial exchange between the Board of Education and the Treasury does not fit the classical pattern of demur and delay outlined by Wright. Not only was the negotiation on the substantive issue of Newman's salary resolved relatively quickly, but also the Treasury's initial query of Morant's suggested salary may be explained in terms of a legitimate objective of ensuring uniformity of salary and conditions with existing posts of comparable responsibility. Indeed, Wright suggests that the establishment of greater uniformity within the Civil Service was one of the main policy developments at the Treasury in the period before the First World War.⁽¹⁶⁾ In this respect, it is noteworthy that the post of head of the new Medical

(14) Ibid.

(15) PRO Ed. 23/221, correspondence between Board of Education and Treasury, October 1907 to January 1908. Terms acceptable to Newman were finally agreed by the Treasury in a letter to the Board of Education, 29 January 1908.

(16) Wright, op.cit., pp.224-25.

Department at the Board had usually been referred to as that of Chief Medical Inspector in preceding discussions,⁽¹⁷⁾ with the change of title to Chief Medical Officer coming only after 8 August, when Newman suggested in a letter to Morant that the latter title would "convey things better".⁽¹⁸⁾

Nevertheless, whatever the legitimate objectives pursued by the Treasury, the guarantees it extracted from Morant in exchange for a swift end to the negotiations on Newman's salary were clearly an attempt to exercise some control over the future establishment of the Board's Medical Department. In this respect, as future negotiations were to show, it was to be largely successful in the medium term. It is instructive to compare the establishment agreed by the Treasury with Newman's own desire for at least "two good men",⁽¹⁹⁾ and a number of medical inspectors in addition,⁽²⁰⁾ or with Archibald Hogarth's view, in his text on the Medical Inspection of Schools, that the "immediate needs" of the Medical Department were a Chief Medical Officer, eight assistants, and supporting ancillary staff.⁽²¹⁾ The Treasury's guidelines meant that Newman was unable to employ at least two people whom he wished to appoint to posts in the Medical Department.⁽²²⁾

In practice, as the first few months of Newman's tenure of office were mainly concerned with the drafting of the guidelines for the future administration of the School Medical Service, to

(17) PRO Ed. 23/199, memorandum by Morant, 11 December 1907.

(18) PRO Ed. 24/280, Newman to Morant, 8 August 1907.

(19) Ibid., Newman to Morant, 6 September 1907.

(20) Ibid., Newman to Morant, 8 August 1907.

(21) Archibald H. Hogarth, Medical Inspection of Schools (London: H. Frcude, 1909), p.108.

(22) PRO Ed. 24/280, Newman to Morant, 7 October 1907 and 11 October 1907.

be issued as Circulars 576 and 582, the immediate need to appoint additional staff was not urgent. Most of Newman's own time appears to have been devoted to the preparation of these circulars, the issues underlying which are discussed later in this chapter, while Eichholz remained at his former duty of inspecting special schools. Only with the issue of the circulars, the commencement of the work of medical inspection by the local authorities and the forthcoming issue of the 1908 Education Code did the issue of additional staff for the Medical Department become more pressing. On 8 May 1908 Newman discussed the staffing of the Department with the new President of the Board of Education, Walter Runciman,⁽²³⁾ who had been appointed on 16 April following McKenna's appointment as First Lord of the Admiralty. Runciman had formerly been Financial Secretary to the Treasury, and had left that post with the friendship, respect and good wishes of his permanent officials.⁽²⁴⁾ At the interview, Runciman told Newman that before leaving the Treasury he had promised the Treasury officials to allow submission of an application for one only of the two outstanding posts in the Medical Department.⁽²⁵⁾

This came as a surprise to Newman, who had previously regarded the application as a formality. Nevertheless Runciman was

(23) Rt.Hon. Walter Runciman (1870-1949). Educated at Trinity Hall, Cambridge. Managing Director of the Moor Line Shipping Company. Liberal M.P. for Oldham, 1899-1900, Dewsbury, 1902-18, Swansea West, 1924, St. Ives, 1929. National Liberal M.P. for St. Ives, 1931-37. Cr. Baron Runciman of Doxford, 1937. Parliamentary Secretary, Local Government Board, 1905-7; Financial Secretary, Treasury, 1907-8; President, Board of Education, 1908-11; President, Board of Agriculture, 1911-14; President, Board of Trade, 1914-16 and 1931-37.

(24) Henry Roseveare, The Treasury (London: Allen Lane, 1969), p.199.

(25) Newman Diaries (D.H.S.S.), vol.1, 8 May 1908.

reluctant to break his promise, and Newman could expect little help from the usually persuasive Morant at this time. The weeks following Runciman's appointment had seen little contact between him and his Permanent Secretary. Subsequently, on 22 May, Morant was to write to Runciman complaining:

I have been very much distressed at the way in which a whole month has passed since you became my chief without my seeing you for more than a few minutes, on odd days, and not more than five or six times in the whole month.....(26)

Morant thought this was due to accusations by his enemies, Winston Churchill particularly, that he was prejudiced against the Liberals, and pleaded to Runciman "Please believe that I am not a blind upholder of [the] 1902 Education Act ."(27) Morant's arguments with Runciman in his former capacity as a Treasury Minister, including the "vehement" disagreement discussed by Eaglesham in his article on Morant's career at the Board also probably did little to ensure friendly relations at the outset, (28) although they later improved. (29) In these circumstances, Runciman could not be persuaded to change his mind, and Morant's letter to the Treasury on 14 May 1908 asked only for permission to appoint a female doctor. After sanction for the appointment was given

(26) Runciman MSS, Box WR 21, Morant to Runciman, 22 May 1908.

(27) Ibid.

(28) E.J.D. Eaglesham, "The Centenary of Sir Robert Morant", British Journal of Educational Studies 12 (1963), 5-18, esp. pp.10-11.

(29) Runciman MSS, Box WR 29, Postcard, Morant to Runciman, 25 April 1909.

without demur, Dr. Janet Campbell⁽³⁰⁾ was appointed.⁽³¹⁾

Securing further appointments to the medical staff, even within the limits initially agreed with the Treasury, proved a frustrating experience for Morant and Newman. In December 1908, after what was presumably thought to be a decent interval, Morant decided to make a further application to the Treasury, asking his deputy, L.A. Selby-Bigge,⁽³²⁾ and Newman to:

jot down....the most salient points likely to be useful in squeezing the Treasury to give us:-

- a. A Medical Officer £700 to £900.
- b. Permission for Eichholz to be put on same scale.
- c. Senior Examinership. (33)

With Runciman's approval, a request on these lines was sent to the Treasury on 30 December 1908. As part of the supporting evidence, it was argued that Eichholz was fully occupied with his work examining the special schools, and was thus unable to offer any real assistance to Newman. The Treasury, in what was described by Morant as a "curt" letter, refused the Board's request.⁽³⁴⁾ A

(30) Dame Janet Mary Campbell MD MS (1877-1954). Educated at Brighton High School and the London School of Medicine for Women. Senior Resident Medical Officer, Belgrave Hospital for Children, and Assistant Medical Inspector, L.C.C. Medical Officer, then Senior Medical Officer, Board of Education. Senior Medical Officer (Maternity and Child Welfare) Ministry of Health. Forced to resign in 1934 due to Civil Service rules on her marriage to Michael Heseltine, Registrar of the General Medical Council. DBE (1924).

(31) PRO Ed 23/221, Board of Education to Treasury, 14 May 1908, and T9/37, Treasury to Board of Education, 19 May 1908.

(32) Sir Lewis Amherst Selby-Bigge (1860-1951). Educated at Winchester and Christ Church College, Oxford. Fellow of University College Oxford and Lecturer in Philosophy 1883. Author of several books on David Hume and the Scottish moralists. Assistant Charity Commissioner, 1894. Principal Assistant Secretary, Board of Education, 1908-11; Permanent Secretary to the Board, 1911-25. KCB (1913) Bt. (1919).

(33) PRO Ed 23/201, memorandum, Morant to Selby-Bigge, December 1908.

(34) PRO Ed 23/221, Board of Education to Treasury, 30 December 1908, and T. 9137, Treasury to Board of Education, 11 January 1909.

further attempt to secure another appointment the following month met with a similar refusal.⁽³⁵⁾

This prompted a third letter to the Treasury on 23 April 1909, arguing that the work of the Medical Department had increased so greatly that sanction for two new appointments was now required, an assistant medical officer and a second female doctor to be appointed pending Dr. Campbell's intended departure. This time, the Treasury agreed, though some details of the intended salary were modified.⁽³⁶⁾ When the Board later claimed this agreement entitled them to appoint two women medical officers, sanction for the second appointment was withdrawn,⁽³⁷⁾ and in fact Dr. Campbell remained as one of Newman's subordinates until 1934, when her marriage forced her retirement under the civil service rules applying. The fourth member of the Board's Medical Department, Dr. Ralph Crowley,⁽³⁸⁾ formerly the School Medical Officer at Bradford, was not therefore appointed until October 1909.

In respect of the subordinate posts at the Medical Department, therefore, the Treasury's role falls into the classical pattern of demur and delay identified by Wright, with procrastinations by the Treasury leading to a delay of some eighteen months in filling a post already informally agreed. In the detailed history of the

(35) PRO Ed 23/221, Board of Education to Treasury, 9 February 1909, and T9/38, Treasury to Board of Education, 6 March 1909.

(36) PRO Ed 23/221, Board of Education to Treasury, 23 April 1909, and T 9/38, Treasury to Board of Education, 13 May 1909.

(37) PRO Ed 23/221, Board of Education to Treasury 27 May 1909, and T 9/38, Treasury to Board of Education, 20 July 1909.

(38) Ralph Crowley MD MRCS FRCP (1869-1953). A Quaker. Educated at Brighton Grammar School, Oliver's Mount School, Scarborough, and St. Barts Hospital. School Medical Officer for Bradford, 1902-9; Medical Officer, then Senior Medical Officer, Board of Education, 1909-33. A friend of Newman's since 1895.

negotiations outlined above, there is nothing to support Roy Macleod's suggestion that the expansion of the School Medical Service reflected a new approach to public expenditure on behalf of the Treasury.⁽³⁹⁾

As studies of other departments affected by Treasury control have indicated,⁽⁴⁰⁾ parsimonious Treasury attitudes resulted in departments being unable to embark on innovative or even evolutionary changes in policy. The restrictions placed on the number of professional staff in the Medical Department of the Board of Education put considerable pressure on Newman and his subordinates. As a measure of the volume of work impinging on the Medical Department, the table below indicates how the simple administrative work of the Department progressively expanded in the first years of the School Medical Service.

MEDICAL DEPARTMENT ADMINISTRATIVE WORK⁽⁴¹⁾

	1908	1909	1910	1911
Number of papers registered in Department	1667	2796	2597	4635
Number of letters issued from Department	746	1512	1128	1938

Even with administrative help, this volume of work put Newman under stress, particularly in the early years, as Morant indicated in a memorandum to Runciman:

(39) Macleod, op.cit., p.49.

(40) Ibid.; Wright, op.cit., pp.205-17.

(41) PRO Ed 23/227, Board of Education to Treasury, 19 April 1912.

Dr. Newman was very seriously undermining his health in the last three months of 1908 by his ceaseless endeavours to keep pace with his work; yet he was always, and still is, in hopeless arrears. Since he was appointed in December 1907 he has not, except during his brief holidays, been able to accept a single invitation to dine out or anything of that sort; he has not spent a single evening free from work: he always carries work home with him and works on Sundays and yet he is a rapid worker and regularly puts in long days at the Office. Not only is he unable to keep pace with his office work, but, for this very reason, he is prevented from getting about the country as he should, and cannot find time for any of those more prolonged investigations which would be of service to the Board, or for any considerable work of constructive re-organisation. I think you will agree that the Board cannot any longer take the responsibility for allowing one of their servants to be "sweated" like this; and let me repeat that he is only doing the barely necessary work and is in arrears with that. (42)

Newman's private diary, in which he meticulously itemised his engagements, provides positive confirmation of Morant's assertions, with few of the social engagements frequently recorded in later years appearing in the pages covering 1908. (43)

Among the effects of this over-work, as Morant points out, was a severe limitation on the ability of the Medical Department to exercise a supervisory and inspectorial function over the activities of the local education authorities. Newman's diary again shows virtually no visits to local authorities during 1908, compared with a gradually increasing number in later years. (44)

(42) PRO Ed 23/201, memorandum, Morant to Runciman, 9 February 1909. In the light of these pressures it is no surprise to find that Newman was claimed to work "like ten men and twenty women". Albert Mansbridge, Margaret McMillan: Prophet and Pioneer (London: J.M. Dent, 1932), p.67.

(43) Newman Diaries (D.H.S.S.), vol.1, entries for 1908.

(44) Ibid.

The reduction in the effective size of the Medical Department meant that an essential pre-condition for an effective system of central government inspection and control remained unfulfilled in the early period of the School Medical Service,⁽⁴⁵⁾ for Eichholz, when he was not undertaking the inspection of special schools, and Dr. Campbell were also largely occupied with the mass of administrative work which had been thrown up by the introduction of medical inspection during this period.⁽⁴⁶⁾

Apart from the difficulties created by the inability to spend time performing inspectorial duties, the restrictions on the size of the Department in the early years meant that there was little opportunity for the staff of the Medical Department to engage in research and the pursuit of interests relevant to the School Medical Service, though Newman and Eichholz did manage to make a fortnight's visit to Germany in 1909,⁽⁴⁷⁾ while after Dr. Crowley's appointment, the encouragement of open-air schools and improvement of the physical education syllabus were undertaken.

Before making a final assessment of the Treasury's attitude to the Medical Department of the Board of Education in its formative years, it should be noted that the Treasury appears subsequently to have adopted a more relaxed attitude to the needs of the Medical Department, a change coincident with, although not necessarily consequential to, Morant's departure to the National Insurance

(45) See John S. Harris, British Government Inspection (London: Stevens & Sons, 1955), pp.182-89.

(46) PRO Ed 23/201, Memorandum, Selby-Bigge to Morant, 22 December 1908.

(47) PRO Ed 50/4, report on visit to Germany, 10 to 24 March 1909.

Commission after the affair of the Holmes Circular, and his eventual replacement as Permanent Secretary to the Board of Education by Sir Lewis Selby-Bigge. (48)

An example of this change in attitude came in 1912, when Selby-Bigge suggested to Newman that the time had come for a further approach to be made to the Treasury about the staffing of the Medical Department. He proposed that the Board should indicate to the Treasury not only the immediate need for additional staff, but also the likely future growth required over a three to five year period. (49) Newman's reply revealed that the Medical Department continued to work under stress. Indeed, the expansion of local authority provisions had increased the burden on the existing staff. Even the basic inspection was so much in arrears that more than forty authorities had yet to receive their first visit from a member of the Medical Department. The Department needed at least two more medically qualified staff and, on the administrative side, an additional Junior Examiner. Improvements to the salary and conditions of the medical staff were also required. (50)

(48) Asquith and J.A. Pease, then President of the Board of Education, had some difficulty in finding a successor to Morant as there "was jealousy inside [the Board] and no man really head and shoulders above his colleagues". Gainford MSS, Box 39, Diary of J.A. Pease, 28 November 1911. Among possible candidates suggested before Selby-Bigge's eventual appointment were Robert Blair of the L.C.C., Greham Wallas, and W. Pember Reeves. See Ibid., Box 89, C.P. Trevelyan to J.A. Pease, 4 December 1911.

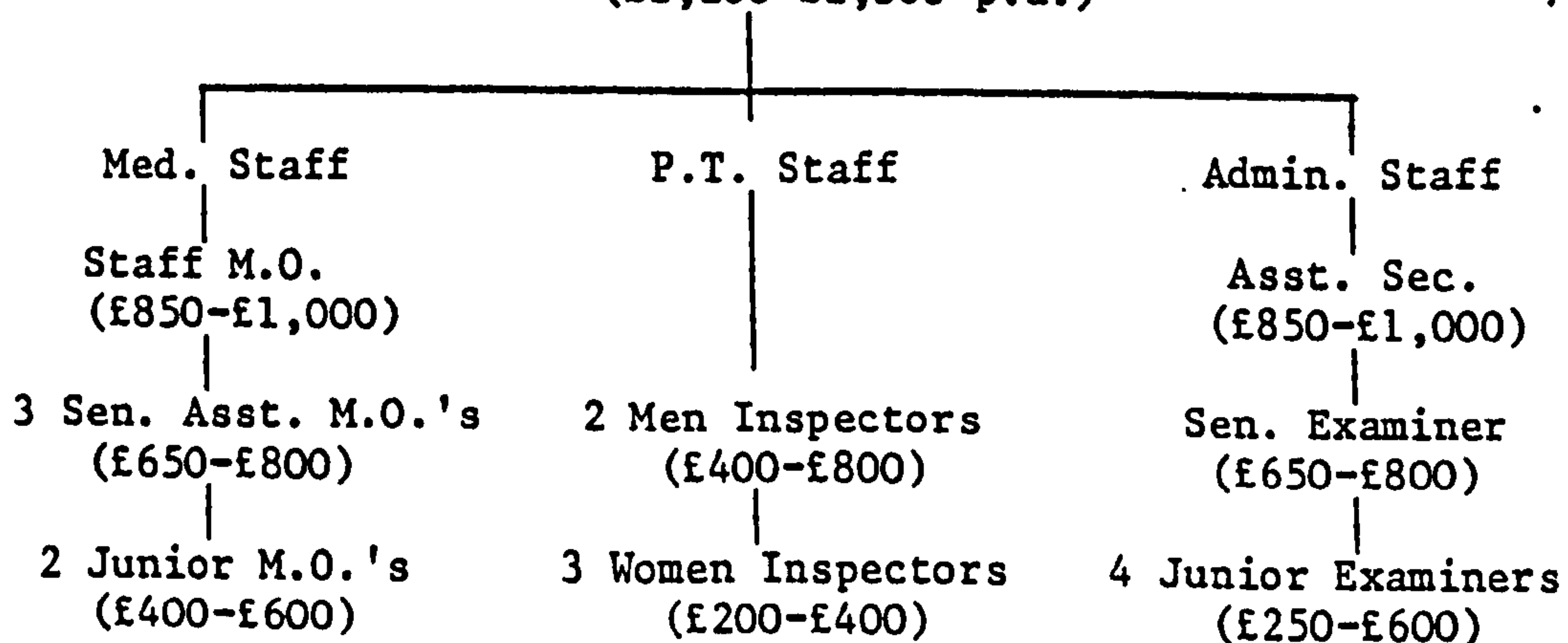
(49) PRO Ed 23/203, memorandum, Selby-Bigge to Newman, 12 June 1912.

(50) Ibid., memorandum, Newman to Selby-Bigge, 15 July 1912.

Following these internal consultations, an approach was made to the Treasury in July 1912 asking for sanction for the immediate appointment of two Junior Medical Officers, one Junior Examiner for the administrative side of the Medical Department, and a female Inspector of Physical Training to join the existing physical training staff transferred to the Medical Department. In addition, the salaries of the various grades needed to be standardised. The submission also went on to indicate the future growth of the Medical Department thought to be required by the Board. In the medium term, it was anticipated the Medical Department would grow to the position indicated below:

PROPOSED ESTABLISHMENT FOR MEDICAL
DEPARTMENT (51)

Principal Assistant Secretary and Chief Medical Officer
(£1,200-£1,500 p.a.)



(51) PRO Ed 23/227, Board of Education to Treasury, 30 July 1912.

This represented a further increase in establishment of a Staff Medical Officer and an Assistant Secretary. If any additional growth was needed, it was to be concentrated on junior appointments, with a possible need for two more Junior Medical Officers and a Junior Examiner.⁽⁵²⁾ The Treasury was thus given not only the Board's justifications for the immediate increases in the Medical Department's establishment proposed, but also an indication of what further requests for an increase in staff the Board might be making in the future. This marked a considerable contrast from the previous negotiations under Morant.

The application was largely successful. The Treasury gave, without demur, approval for all the posts for which immediate sanction was requested, although some of the ancillary requests over salary scales were refused. Consideration of the other posts was deferred until the appropriate time.⁽⁵³⁾ When the Board approached the Treasury in 1914 seeking to increase the medical staff further, the agreement made in 1912 formed the basis of negotiations, although the Board sought to replace the post of Staff Medical Officer with two additional Senior Assistant Medical Officer appointments.⁽⁵⁴⁾ The Treasury responded, agreeing to the Board's proposals, without demur.⁽⁵⁵⁾

In these negotiations, therefore, the Treasury took a significantly more relaxed attitude to the establishment needs of the Medical Department than had been the case earlier. It is

(52) Ibid.

(53) PRO T. 9/40, Treasury to Board of Education, 6 September 1912. The salary scale for the Junior Medical Officers was, however, reduced to £400-20-500.

(54) PRO Ed 23/205, Board of Education to Treasury, 7 May 1914.

(55) Ibid., Treasury to Board of Education, 25 May 1914.

possible to suggest several explanations for this change. First, there is Selby-Bigge's succession to the post of Permanent Secretary. His preference was for disclosure of intentions during the negotiations with the Treasury, in comparison with the secretiveness with which Morant guarded his future plans, and he was willing to concur with a subordinate's suggestion that requests for an increase in establishment "would not have much chance of a favourable reception at the Treasury unless it was preceded by informal communication with Sir R. Chalmers or Mr. Masterman".⁽⁵⁶⁾ This approach, contrasting with Morant's combative, even aggressive relationship with Treasury ministers and officials,⁽⁵⁷⁾ might have smoothed his path. The change of leadership at the Treasury, where Sir Robert Chalmers was now in charge of negotiations, may also have contributed.

Beyond these changes in personnel, the Treasury's enhanced powers of control over establishments and conditions of service, particularly through the increasing use of Orders in Council,⁽⁵⁸⁾ its increasing willingness to do "its duty to a united government with an overwhelming mandate"⁽⁵⁹⁾ to pursue policies necessitating substantial increases in public expenditure, or simply a greater understanding of the powers and duties performed by the Board's Medical Department, may all have influenced the apparent relaxation of controls on appointments to the establishment of the Medical

(56) PRO Ed 23/202, Carr to Selby-Bigge, 3 April 1912.

(57) See Eaglesham, op.cit.

(58) Thus when Newman suggests in his memorandum to Selby-Bigge that all medical staff should receive at least 48 days annual leave, Selby-Bigge's pencilled comment is "O in C". [Order in Council]. PRO Ed 23/203, Newman to Selby-Bigge, 15 July 1912.

(59) Roseveare, op.cit., p.224.

Department.

Despite this later relaxation of Treasury attitudes, it is clear that the work of the School Medical Service in its earliest years was to some degree hampered by Treasury imposed restrictions on the size of the central Medical Department. In this sense, the distinction between "policy-oriented" and other expenditure is an artificial one. By a largely unremarked restriction on the establishment required to administer the new service the Treasury, consciously or unconsciously, restricted the Board's ability to work actively for a high standard of performance within the School Medical Service. It is thus clear that the early attitude adopted by the Treasury to the needs of the Medical Department created difficulties in the performance of its duties, the consequences of which will be examined in a later chapter.

Grants to the Local Authorities

Departmental establishment was an area where the Treasury's control over new expenditure was reasonably strong. Grant-in-aid to local authorities was a more "policy-oriented" question, where political considerations had a more direct influence. The question of financial aid to the local authorities for educational services was at this time a politically sensitive question. Prior to the passage of the 1902 Education Act, about 60 per cent of the cost of elementary education had been borne by the central government, with the local authority rates paying the remainder of the cost.⁽⁶⁰⁾ With the passage of the 1902 Act however, the balance of funding

(60) GLRO, L.C.C. file E0/GEN/5/33, "Increased Exchequer Grants for Education", 18 March 1909, p.2.

began to change, and local education authorities started to bear a greater proportion of the cost, as the table below illustrates:

EXPENDITURE ON ELEMENTARY EDUCATION (61)

Year	Total Expenditure on Elementary Education	Grants	Rates	Proportion borne by	
				Grants	Rates
1904-5	£19,326,548	£10,669,352	£ 8,657,196	55.2	44.8
1905-6	£20,207,017	£10,829,396	£ 9,377,621	53.5	46.5
1906-7	£20,972,446	£11,248,380	£ 9,724,066	53.6	46.4
1907-8	£21,303,291	£11,023,118	£10,280,173	51.7	48.3
1908-9	£21,947,360	£11,040,100	£10,907,260	50.3	49.7

The role of the School Medical Service in contributing to this change in the relationship between central and local government funding of education, and the extent to which the Government attempted to mitigate the financial impact of the School Medical Service on local authority rates by the provision of grant aid, were thus matters of some political importance.

The 1906 Education Bill had included a provision for the payment of an additional £1,000,000 in education grant on its passage into law. After the passage of Tennant's amendment to make medical inspection compulsory, the Government attitude was that a proportion of this additional grant would now effectively become a contribution to the cost of medical inspection, although the original intention of the extra grant was simply to compensate the local education authorities

(61) PRO Ed 23/223, Board of Education to Treasury, 26 January 1909.

for the costs involved in taking over and maintaining schools then in the voluntary sector.⁽⁶²⁾ The cost of the School Medical Service was thus to be met by additional payments contained in the general education grant, rather than from an earmarked grant specifically to meet the cost of medical inspection. Although this remained the Government's position during the remaining debates on the 1906 Bill, there was some opposition expressed in the Lords, where it was pointed out that although the obligations imposed on local authorities during the passage of the Bill had been increased, the amount of additional grant promised remained the same. Lord Belper, the spokesman for the County Councils Association, was particularly vocal in his criticisms.⁽⁶³⁾ When the 1906 Education Bill was eventually withdrawn, the promised additional grant was withdrawn also, for its payment had been made conditional on the passage of the 1906 Bill.

Thus when preparations for the implementation of the 1907 Education (Administrative Provisions) Act were being made, one of the policy issues to be determined was whether, and if so in what manner, the cost of medical inspection to local authorities was to be defrayed by the central government. There is some evidence that the permanent officials concerned were in favour of giving a specific grant. Newman suggested a grant of two thirds of the cost of medical inspection, or alternatively, one of £25 per thousand children inspected, should be made.⁽⁶⁴⁾ Morant claimed in a letter

(62) Parl. Deb., 4th series, 155 (9 April 1906), 1042.

(63) Ibid., 165 (19 November 1906), 336-37.

(64) PRO Ed 50/5, draft of Circular 576.

to an influential County Councillor that he had always maintained a proper grant for medical inspection was necessary, but he had "pleaded without effect".⁽⁶⁵⁾

Morant's failure to persuade his political leaders must be explained in the context of the existing system of education grants, and the desire of the Liberal Party to introduce an effective reform. The structure of the grants paid in 1907 owed much to an ad hoc development over the preceding four decades, so that by 1907 there were at least nine distinct kinds of education grant payable. While many of these were paid for specific purposes, and amounted to relatively small sums, the bulk of the money paid in education grant was divided between three main grants: the Annual Grant, paid under the Education Code, and calculated on the average attendance at a school; the Fee Grant, payable as a consequence of the 1891 Education Act, and based on the average attendance of pupils under the age of fifteen which, like the Annual Grant, was paid in respect of the school year; and the Aid Grant, payable under the 1902 Education Act, which was based on both the average attendance, and the local authorities deficiency, if any, from a standard rateable value per scholar. This was paid in respect of the financial year ending 31st March each year. These differences meant that:

(65) PRO Ed 24/280, Morant to Henry Hobhouse, 20 December 1907. Rt. Hon. Henry Hobhouse (1854-1937). Educated at Eton and Balliol College, Oxford. Liberal, then Liberal Unionist MP for East Somerset, 1885-1906. Played a leading part in the formation of the County Councils Association, and was its Chairman, 1914-20. Chairman of Somerset County Council, 1904-24. Member of the Royal Commission on Secondary Education. A brother-in-law of Beatrice Webb.

the average attendance on which Aid grant is paid during any financial year is generally different from the average attendance on which Annual Grant is paid during the same year, and if there are scholars above the age of fifteen, the average attendance on which the Fee Grant is calculated is different from either of them. (66)

With the minor grants also to be distributed, the net effect was an administratively costly system:

although there are only some 20,000 schools and institutions to be paid for, and only 327 Local Education Authorities to be dealt with, the Grants in Aid now involve, it is said, the issue of something approaching 100,000 separate "credits" or advices, addressed to the Paymaster-General, but sent to the Local Education Authorities, employing, in their preparation, a huge staff of experienced clerks at great expense. Down to three or four years ago, a separate cheque was actually issued in each case! Some of these advices are now grouped together in one cheque, but even now the payment of the 327 Local Education Authorities of their 327 annual subventions involves literally tens of thousands of separate cheques, which arrive in a stream every few days or weeks throughout the year, at irregular intervals, and not exactly coinciding in dates year by year. (67)

Despite its complexity, the grant system took little account of the variation in rate products, relative to needs, between local authority areas. The product of a penny rate per pupil was 9/8d in Hove and 7/2d in Bournemouth, but only 1/2d in Rowley Regis or Tunstall. Nor were variations in maintenance and loan charges for school premises, ranging from 135/11d per pupil in Hornsey to 43/3d per child in Pontefract, adequately compensated by the grant

(66) Sidney Webb, Grants-in-Aid: a Criticism and a Proposal (London: Longmans, Green, 1911), p.69.

(67) Ibid., p.76.

system.⁽⁶⁸⁾ These inequalities had resulted in the introduction of a Special Aid Grant in 1906-7, for "the temporary relief of highly rated areas",⁽⁶⁹⁾ but the Liberal Party's view was that a fundamental reform of the whole grant system was necessary if these disparities were to be minimised. The Government also believed that if a reform was to be politically acceptable, additional grant would have to be made available as a simple redistribution of the existing grant would leave many areas aggrieved at the loss of grant income. As Runciman argued:

without more money we can make no progress. At the top of the scale the Necessitous Areas Grant establishes a standard which it is difficult to reduce; at the other end we must keep within reasonable limits the number of rich areas who would be penalised. (70)

A linkage between reform of the education grant system and an increase in the Exchequer subvention was thus a consistent feature of the Liberal Government's policy.

In this context, the problems of providing a specific grant for the School Medical Service are clear; it would have added to the complexity of the existing grant system, and at the same time would have pre-empted financial resources that could otherwise have been used to finance an acceptable reform of the general system of education grants. Rather than prejudice the reform of a system designed to deal with the problems of education bodies of school board, rather than local education authority size, the 1907 Bill

(68) PRO Cab 37/101/158, "The Need for an Increase of Exchequer Grants-in-Aid of Elementary Education", Cabinet memorandum by Walter Runciman, 12 December 1909.

(69) Webb, op.cit., p.71.

(70) PRO Cab 37/101/158, op.cit.

contained no specific proposal for a grant to help meet the cost of its provisions. This prompted some pointed questioning of the Government, and in the House of Lords, under pressure from members of the County Councils Association, the Earl of Crewe was forced to discuss:

how the expenses under this clause [13] will be met. It is not considered possible and I think for very obvious reasons, to make specific grants to local authorities, buta very considerable addition will be made to the grants in connection with the elementary schools in the next Estimates. That fact is to be taken into consideration in dealing with the possible, or, indeed, the probable extra cost which may be placed on local authorities by this new provision. (71)

In February 1908 Reginald McKenna promised, in introducing the Elementary Education (England and Wales) Bill (a further attempt by the Liberals to reform the education system and resolve the denominational issue) that an additional £1,400,000 in education grant would be made available on the passage of the Bill. (72) Such conditional promises of an increase in grant aid meant that local authorities had to introduce school medical inspection without knowing whether the Government would eventually defray part of the cost of the new service.

This unusual situation led to considerable pressure on McKenna and his successor as President from April 1908, Walter Runciman. The County Councils Association sent a large deputation to meet McKenna on 11 February 1908, at which the Minister was pressed for a specific grant in aid of the cost of medical inspection, (73) and

(71) Parl. Deb., 4th series, 181 (21 August 1907), 727.

(72) BPP 1908/XXXII:27, Memorandum of the Financial Proposals in Connection with the Education Bill, 1908, Cd. 3945.

(73) County Councils Association, Official Circular, March 1908, p.24-25.

the following month, a deputation from the Association of Municipal Corporations made the same plea.⁽⁷⁴⁾ In May 1908 the County Councils Association were back, this time meeting Runciman in a discussion about the general cost of education, including medical inspection,⁽⁷⁵⁾ and in June the London County Council, where Exchequer grants met only 30.3 per cent of the cost of elementary education in 1908-9, against the national average of 49.7 per cent,⁽⁷⁶⁾ also called on the Minister asking for aid to meet the costs of medical inspection.⁽⁷⁷⁾ Protests also continued in the House of Lords, with a debate during July 1908 on the provisions of the Education Code, during which an attempt was made to remove the newly inserted article 25 (c) which made the performance of satisfactory medical inspection a precondition for the payment of education grant.⁽⁷⁸⁾

The Government's response to this lobbying was to insist that the cost of medical inspection would be adequately covered when its reform of the grant system, incorporated in the Elementary Education

(74) Times, 20 March 1908, pp.16ff.

(75) County Councils Association, Official Circular, May 1909, p.62.

(76) GLRO, L.C.C. file EO/GEN/1/19, "Conference of Local Education Authorities on Education Grants, 11 December 1908".

(77) Times, 19 June 1908, p.14.

(78) Parl. Deb., 4th series, 192 (16 July 1908), 1048ff.

(England and Wales) Bill 1908, took effect. After the introduction of this Bill, however, its progress through Parliament was delayed while negotiations took place between the Board of Education and the Church of England in an attempt to resolve the impasse over denominational questions also included in the Bill. (79)

The reformed grant system proposed under the 1908 Bill envisaged a single basic grant, with the exceptions of grants for special schools and for special or additional subjects. The main grant would have two, or in certain cases three, elements, the standard payment, a payment for buildings, and in some cases, a payment for areas with high education rates. (80) There was therefore no specific provision in the new grant system for the payment of the costs of medical inspection. The new grant was provisionally scheduled to come into effect in April 1909, and would result in the payment of an additional £1,400,000 in education grant. (81)

After the negotiations with the church representatives seemed to open the way for a compromise on the sectarian issue, Runciman introduced the Elementary Education (England and Wales) (No. 2) Bill, incorporating some concessions to the views of the established church. Subsequently, however, the Archbishop of Canterbury objected to some of the financial provisions of the Bill, and hopes of a

(79) See Peter G. Rowland, The Last Liberal Governments, 2 vols., vol. 1 "The Promised Land 1905-1910", (London: Barrie and Rockliff, 1968), pp.165-66.

(80) BPP 1908/XXXII:27, op.cit.

(81) Parl. Deb., 4th series, 192 (16 July 1908), 1054.

settlement were finally destroyed on 2 December 1908 when the Church Assembly voted against acceptance. The Bill was then withdrawn on 7 December.⁽⁸²⁾

While the Bill was passing through Parliament, the demands for aid to meet part of the cost of medical inspection were muted, but on 2 December, the day on which the vote in the Church Assembly had effectively killed the Bill, the matter was again raised in the House of Lords. In response to questions, the Earl of Crewe would say only that the Bill was still due for discussion on 7 December.⁽⁸³⁾ Members of the House of Lords went as a deputation to Runciman to raise again the question of the cost of medical inspection,⁽⁸⁴⁾ but the following day the Government's position remained that the 1908 Bill provided the remedy for the difficulty.⁽⁸⁵⁾

The withdrawal of the 1908 Bill signalled a renewal of the lobbying by the municipal and county government associations. On 11 December the L.C.C. played host to a conference, attended by some 210 education authorities, to discuss the question of education grants.⁽⁸⁶⁾ This resulted in a deputation of 340 representatives of education authorities and 167 M.P.'s⁽⁸⁷⁾ meeting Asquith, Lloyd George, Runciman, Morant and others on 18 March 1909. Again, protests about the education rates and about the cost of medical

(82) Rowland, op.cit., pp. 165-66.

(83) Parl. Deb., 4th series, 197 (2 December 1908), 1394ff.

(84) Newman Diaries (D.H.S.S.), vol. 1, 2 December 1908.

(85) Parl. Deb., 4th series, 197 (3 December 1908), 1627-29.

(86) GLRO, EO/GEN/1/19, op.cit.

(87) P.H. Andrews, "The Organisation, Development and Administration of Public Education in the Area of the London County Council, 1903-1922", (Ph.D. thesis, University of London, 1963), p.363.

inspection were made, but were rejected by Asquith, who argued that a settlement of the question was impossible:

until you have got a complete redistribution in the grants, unifying them, making them equitable, placing them on a solid uniform basis, which will do justice as between the various educational wants of the different districts of the country and which will combine above all these two factors - the factor of ability to pay and of local necessity. (88)

Asquith also claimed that the real cost of medical inspection was being exaggerated by the local authority associations. Although minor concessions were promised, none of which related to the School Medical Service, Sir Melville Beachcroft, M.P., who closed the proceedings on behalf of the delegation, summed up their feelings by suggesting they had "asked for bread and received a stone". (89)

The Board of Education had in fact approached the Treasury in January 1909 suggesting that an additional £1,000,000 be put in the Education Estimates for the augmentation of the grant to local authorities. In the absence of reform of the grant system, it was suggested that the amount paid under the existing grants be increased. The letter proposing this course of action stressed that the local authorities had been making a number of representations about the cost of medical inspection and the need for an Exchequer grant, which the Board felt to be justified:

both because Medical Inspection is essentially a National service and because effective Inspection

(88) GLRO, EO/GEN/5/33, op.cit.

(89) Ibid.

will lead and indeed ought to lead to the exclusion of a considerable number of children who have been attending, but are in fact physically unfit to attend, Public Elementary Schools and will thus result in a reduction of the ordinary grant payable to the Authority. (90)

This request was refused by the Treasury.⁽⁹¹⁾ Apart from the general policy of making an increase in the education grant conditional on a reform of the whole grant system, the difficulties of providing aid for medical inspection were increased by the rejection in the House of Lords of Lloyd George's 1909 Finance Bill.⁽⁹²⁾ Perhaps for this reason it was not until December 1909, against a background of renewed criticism in Parliament,⁽⁹³⁾ that the issue was once again discussed. A Cabinet paper was circulated by Runciman arguing once again for a reform of the grant system, coupled with an increase of £1,000,000 in the amount payable, for "with less than this, the number of districts which would lose would be rather disturbing, and the bonus to London would become insignificant".⁽⁹⁴⁾ Apparently Runciman's plea was rejected, and a final appeal to Lloyd George before the Education Estimates were submitted produced no improvement on the position, with Lloyd George replying "that in view of the present financial situation it is quite impossible for me to make the further financial provision which you think is necessary for elementary education".⁽⁹⁵⁾

(90) PRO Ed 23/223, Board of Education to Treasury, 26 January 1909.

(91) Ibid., Treasury to Board of Education, 3 March 1909.

(92) For a discussion of this see Bruce K. Murray, The People's Budget, 1909-1910 (London:Oxford University Press, 1980).

(93) Parl. Deb. (Commons), 5th series, 13(1 December 1909), 517.

(94) PRO Cab 37/101/158, op.cit.

(95) Runciman MSS, Box WR 35, Lloyd George to Runciman, 23 February 1910.

With this refusal, moves to provide a grant for the School Medical Service ended until late in 1911, when Lloyd George's role in establishing health insurance through the 1911 National Insurance Act provided an opportunity for the subject to be re-examined. Lloyd George publicly committed himself to helping the treatment of school children, and promised M.P.'s privately to make money available.⁽⁹⁶⁾ He made a further commitment during the Third Reading of the 1911 National Insurance Bill, after discussing the issue with Morant.⁽⁹⁷⁾

Although finance was now available, problems remained over Lloyd George's insistence that the grant should cover treatment costs only, as he regarded medical inspection as one of the "ordinary burdens of educational administration". This restricted the amount of money which the Board could dispense even at a generous level of grant.⁽⁹⁸⁾ Nevertheless proposals from the Board were sent to the Chancellor at Criccieth "rather than to the Treasury, where some petty official will capture it and hang it up".⁽⁹⁹⁾ After some delay following the Christmas holidays, during which the staff at the Board had "no means of knowing whether or not the Memorandum is in the possession of the Treasury, or whether it lies at the bottom of a Golf Club bag at Criccieth",⁽¹⁰⁰⁾ Newman finally learnt of the Chancellor's agreement to the Board's proposals, and of the availability of a Treasury grant for the

(96)PRO Ed 24/271, J.A. Pease to Lloyd George, 6 December 1911.

(97)Ibid., See Parl. Deb. (Commons), 5th series, 32 (6 December 1911), 1460-61.

(98)PRO Ed 24/271, Selby-Bigge to Pease, 20 December 1911.

(99)Ibid., Newman to Selby-Bigge, 20 December 1911. See also Gainford MSS, Box 89, Newman to Pease, 27 December 1911.

(100)PRO Ed 24/1312, memorandum by Newman, 18 January 1912.

costs of treatment schemes, through a conversation with Dr. Addison, the M.P. for Hoxton, at a medical dinner.⁽¹⁰¹⁾ Following this, the Board issued Circular 792 on 9 April 1912, announcing the availability of a grant-in-aid of medical treatment costs during the 1912-13 financial year.⁽¹⁰²⁾ The circular contained two significant features. First, it emphasised that while the grant would be in aid of treatment costs, payment would be dependent on satisfactory provision for medical inspection: "The Board are indeed precluded under the regulations from making any grant whatsoever unless they are satisfied with the Authority's provision for medical inspection".⁽¹⁰³⁾ The Board thus took the opportunity to remind local authorities that satisfactory arrangements for medical inspection demanded a full inspection of all prescribed groups, on school premises in school hours; and that the inspection should be carried out in "intimate conjunction with" the Public Health authority.⁽¹⁰⁴⁾ This effectively meant, as the L.C.C. was told by its Treasurer, H.E. Haward: "that the Board of Education is using the grants for medical treatment as a lever for raising the standard of administration in respect of medical inspection".⁽¹⁰⁵⁾ The second feature of the circular gave even greater power to the Board. The regulations gave absolute discretion as to how the grant was to be distributed,

(101) Ibid., undated memorandum by Newman.

(102) Board of Education, Circular 792/1912, issued 9 April 1912.

(103) Ibid.

(104) Ibid.

(105) GLRO, L.C.C. file PH/SHS/1/15, memorandum by H.E. Haward.

a feature justified by the Chancellor of the Exchequer on the ground that it was impossible to estimate the number of authorities applying for treatment grants.⁽¹⁰⁶⁾ Despite the L.C.C.'s suspicions, it received fairly generous treatment under the new grant regulations, receiving £12,958 out of the £60,000 available for distribution. This represented about 58 per cent of the L.C.C.'s expenditure on treatment.⁽¹⁰⁷⁾

The rather artificial distinction between inspection and treatment costs posed some difficulties for the Board in administering the new grant, and at least one education authority, Finchley U.D.C., was rebuked for including a "preposterous" proportion of the salary of its School Medical Officer in its claim for treatment expenses.⁽¹⁰⁸⁾ Local authority interests also continued to press the case for an "encouragement" grant for services not covered by the existing grant system.⁽¹⁰⁹⁾

The issue thus became part of a more general debate about

(106) Parl. Deb. (Commons), 5th series, 38 (6 May 1912), 175-76. Out of 317 local education authorities, 229 received a grant during the 1912-13 year. No grant was paid to 88 areas, but only 10 of these submitted applications. See PRO Ed 24/625, "Some Notes on the Physical Basis of National Education", memorandum by George Newman.

(107) L.C.C., Annual Report for 1912, vol. 3, Public Health, p.121. The choice of this percentage level of grant was the result of a desire of the Board to avoid accusations of support for either the Moderate or Progressive faction on the L.C.C., rather than of an objective assessment of the Council's performance of medical inspection and treatment in the previous year. See PRO Ed 24/1312.

(108) PRO Ed 125/15, memorandum by Newman, undated.

(109) See e.g. PRO Ed 24/626, minutes of a meeting with the Committee of the Association of Directors and Secretaries of Education, 12 December 1912.

educational reforms, and changes to the system of educational finance, exemplified by plans for the introduction of a new Education Bill.⁽¹¹⁰⁾ These plans were eventually aborted by the outbreak of the First World War, but not before considerable discussion had taken place within the Government over the best way of proceeding with the proposals. The Board argued that rather than risk plans to aid the School Medical Service out of a general grant being once again defeated by the failure of the substantive Education Bill, the local authorities should be given aid in advance of a general revision of the grant system.⁽¹¹¹⁾ This argument was accepted by the Cabinet,⁽¹¹²⁾ and the Board subsequently issued Circular 823 giving details of a general grant for medical inspection and treatment for the 1913-14 financial year.⁽¹¹³⁾ The effect of the provision of this grant on both central administration and the local authorities is discussed in subsequent chapters.

From the discussion above, however, two points of relevance in examining the local development of the School Medical Service may be identified. First, Treasury control of grant-in-aid to the local authorities does appear to have been relatively weak, in that little difficulty seems to have been encountered in obtaining the promise of additional grant for educational purposes subject to the passage of legislation reforming the existing grant system.

(110) See Geoffrey E. Sherington, English Education, Social Change and War, 1911-1920, (Manchester: Manchester University Press, 1982), pp. 18-43.

(111) PRO Cab 37/115/41, "Education Bill", memorandum by J.A. Pease, 23 June 1913.

(112) PRO Cab 41/34/23, report by H.H. Asquith to the King, 26 June 1913.

(113) Board of Education, Circular 823/1913, issued 18 August 1913.

Second, despite this, for the first four or five years of its existence, the School Medical Service was effectively a duty imposed by the central government on the local authorities without a compensating increase in the grant paid. Given the evidence of the local authorities displeasure at this policy, and the restrictions on the Board's ability to inspect the local authorities due to the curtailment of the size of the Medical Department through the Treasury's actions discussed earlier, a question arises as to the extent to which the local authorities willingly carried out the requirements of the 1907 Act. This will be discussed in a subsequent chapter. A further question is the way in which the staff of the central Medical Department attempted to persuade or direct the local authorities, in the face both of criticism over the absence of grant, and the presence of established medical officers with differing professional views over the ideal orientation of the School Medical Service, to adopt the administrative structure and practices preferred by the Board. This requires a study of the formulation of, and reaction to, the guidance issued by the Board to the local education authorities after the establishment of the Medical Department at the Board.

Circular 576

Newman believed it was essential from the outset to exert a clear leadership on behalf of the Board of Education, saying it was necessary to "have men who will lead. This is just why the Local Government Board is such a huge failure".⁽¹¹⁴⁾ From the

(114) PRO Ed 24/280, Newman to Morant, 18 August 1907.

Board's standpoint, such leadership had to be applied in two important areas from the outset. First, the local authorities had to be urged to adopt the Public Health orientated system of administration favoured by Morant and Newman. Second, a standardised basis for medical inspection had to be formulated, not only to provide a consistent, nation-wide framework within which to develop the collation and comparison of data, but also to provide a standard against which the performance of the statutory duty of medical inspection by a local authority might be judged.

Morant was particularly anxious about issuing early guidance to the local authorities on the administration of the School Medical Service before they took unilateral action, and reminded Newman about the need for such guidance as soon as the agreement with the Treasury on his salary had ensured his appointment.⁽¹¹⁵⁾ Newman, agreeing this was "a most important matter",⁽¹¹⁶⁾ immediately began working on a draft circular.

A considerable amount of material relating to Circular 576, as this became, is preserved in the Public Record Office. This includes not only successive drafts of the circular, but also a substantial volume of correspondence between Newman and Morant. While working on the circular, Newman was working out his notice as Finsbury's Medical Officer of Health, and he was unable to take up office at the Board until 9 December 1907.⁽¹¹⁷⁾ Newman drafted

(115) Ibid., Morant to Newman, 28 August 1907.

(116) Ibid., Newman to Morant, 6 September 1907.

(117) Newman Diaries (D.H.S.S.), vol. 1, 9 December 1907.

Circular 576 entirely during his absence from the Board, the circular being issued over Morant's signature on 22 November 1907.⁽¹¹⁸⁾ This material allows examination of the influences and objectives behind this seminal statement of the principles underlying the School Medical Service. Circular 576 is reproduced in its entirety as Appendix A to this thesis.

By 20 September, Newman had completed his initial consideration of the contents of the circular, and wrote to Morant seeking confirmation of its general structure.⁽¹¹⁹⁾ The rough notes which Newman drew up about his proposals, which formed the basis of his letter to Morant, have been preserved in the Board's administrative file dealing with the preparation of Circular 576.⁽¹²⁰⁾ From these, it is clear that the basic structure of Circular 576 was largely the work of Newman, rather than Morant. It is interesting to discover that even at this very early stage, several of the features that were to be longstanding attributes of the School Medical Service were present. The view that all children should be inspected three times during their school life, a continuing, and ultimately controversial, aspect of the School Medical Service, was present in these preliminary notes. The inspiration for this presumably came from the existing German structure of medical care in schools, for in his book The Health of the State, published in May 1907, Newman had recommended:

First and foremost regular medical inspection.
In Germany every child is submitted to medical

(118) Board of Education, Circular 576/1907, issued 22 November 1907.

(119) PRO Ed 24/280, Newman to Morant, 20 September 1907.

(120) PRO Ed 50/5.

inspection in its first, third and fifth years of school life, and those requiring it are kept under more frequent observation. (121)

Newman relied heavily on the published work of many public health officials, particularly Meredith Richards, during the preparation of Circular 576. (122) Nevertheless, although the circular was intended to emphasise the public health orientation of the service, Newman hoped to avoid unnecessary conflicts with other interests. During October he told Morant:

I have just received a private copy of the proof of Kerr's Report for 1906 and I will see that our memo meets his latest grumblings. I think the Circular will be out before Kerr's Report. I should like it to be as it would reduce the wind in his sails. (123)

After preparation of the rough draft notes, Newman developed his proposals for Circular 576 first into a broader sketch plan, and then into a full first draft of the circular. Extensive consultations then followed, largely with Newman's fellow medical officers of health, before an amended circular was finally issued under Morant's signature. Examination of the various drafts of the circular shows that some themes remain constant during the course of preparation, although the degree of emphasis would change. Other aspects of the circular undergo substantial alterations, indicating the continuing formulation and development of policies by the Board.

(121) George Newman, The Health of the State, Social Service Handbooks, no. 2, (London: Headley Bros., 1907), p.148.

(122) H. Meredith Richards, "Organised Medical Inspection of Schools", Public Health, 19 (1906-7), 87-96.

(123) PRO Ed 24/280, Newman to Morant, 27 October 1907. Kerr's office was administratively a sub-department of the L.C.C.'s

The most consistent feature of the drafts of the circular, as might be anticipated, was the stress laid on the need for an integrated system of administration in which the medical officer of health held ultimate responsibility for the School Medical Service. Even here, a change of emphasis occurred during the drafting process to meet a difficulty arising. County Councils were not required to appoint a medical officer of health. This would not become compulsory until the passage of the Housing, Town Planning, etc. Act of 1909.⁽¹²⁴⁾ As a result, most counties had no medical officer of health, and many of those that did had made only a part-time appointment.⁽¹²⁵⁾ Newman came under pressure to use the establishment of the School Medical Service as a lever to secure appointment of county medical officers of health. A meeting with existing county medical officers in October discussed ways in which counties could be urged to make appointments.⁽¹²⁶⁾

Public Health department. Although Kerr was to all practical purposes autonomous, this meant that his Annual Report had to be submitted to the Council by the L.C.C.'s Medical Officer of Health, Sir Shirley Murphy, a confidante of Newman, and it is probable that Newman obtained his copy of Kerr's Report from this source. Kerr's Annual Report was published prior to 2 November 1907, when the Lancet carried a leading article referring to it. Lancet ii (1907), 1256-57.

(124) Housing, Town Planning, etc. Act, 1909, 9 Edw. VII, ch.44

(125) See Lancet, i (1908), 170-71; and BPP 1904/LXXXII:735, Return Showing the Names of County Councils in England and Wales who have Medical Officers of Health, H.C. 316.

(126) PRO Ed 50/5, memorandum outlining points for a meeting of County Medical Officers, 11 October 1907.

The influence of these pressures may be seen in successive drafts of Circular 576. The first full draft read:

In those Counties which have not at present a County Medical Officer of Health, the Chief Medical Officer appointed by the County Education Authority must work in close co-operation with the Sanitary Authorities in the County. (127)

Before publication, this passage was amended to read:

Where no County Medical Officer has been appointed under the Local Government Act 1888, it will be necessary for the County Council either to appoint one forthwith or to appoint an executive Medical Officer for the purposes of this Act. (128)

When Circular 576 was issued, this passage had been again amended to emphasise further the desirability of appointing a county M.O.H., while references to possible alternative appointments were removed:

Where no County Medical Officer has yet been appointed under the Local Government Act 1888, it would seem that the new duties in regard to medical inspection of children now imposed on the county council will render it inadvisable any longer to postpone such an appointment, since in no other way will the council be able effectually to secure adequate control, economy and efficiency in carrying out their new work, which must obviously be guided from the central county organisation. (129)

Uncommitted authorities were thus urged in increasingly strong terms to appoint a medical officer of health to take charge of the School Medical Service. Newman recognised that in other cases, where independent staff were already in post, compromise

(127) Ibid., Circular 576, written first draft.

(128) Ibid., Circular 576, typescript insertion in written first draft.

(129) Board of Education, Circular 576/1907, para. 7(a).

would be necessary:

where appointments of school medical officers already exist, the Board do not suggest that they should be disturbed, provided always that the officers are competent and sufficient for the new duties and that the arrangements for supervision by the Medical Officer of Health are satisfactory. (130)

Nevertheless, the general tenor of the circular was to stress continually the need to integrate school hygiene with the existing public health administration:

it is manifestly of the highest importance that the administration of this Act should rest upon a broad basis of public health, and should not only secure for the Local Education Authorities as much freedom as is consistent with adequate uniformity in the presentation of results for comparative purposes, but should also use to the utmost extent the existing machinery of Medical and Sanitary administration, developing and supplementing it as required, rather than by supplanting it by bringing into existence new agencies partially redundant and possibly competing.

The Board view the entire subject of school hygiene not as a speciality or as a group of specialities existing by and of themselves but as an integral factor in the health of the nation. The application of this principle requires that the work of medical inspection should be carried out in intimate conjunction with the Public Health Authorities and under the direct supervision of the Medical Officer of Health. (131)

Although the degree of emphasis changed, advocacy of a public health orientation was a consistent objective throughout the preparation of the circular. In contrast, the circular's discussion of treatment betrays a debate about policy even as preparation of

(130) Ibid., para. 7(b)

(131) Ibid., para. 5.

the circular progressed. The obvious sensitivity of the subject to the Board is indicated by the decision to change the title of the section from "treatment" to "amelioration and physical improvement". Much of Newman's correspondence came from friends and acquaintances anxious he should not include controversial material in this section. (132)

Yet, paradoxically, the actual advice given on the subject of the local authorities ability to undertake treatment became more liberal as successive drafts of Circular 576 were prepared. In Newman's first rough notes, the content of the section on treatment was envisaged to be:

Treatment:

(a) General advice on this point: not to be undertaken by Local Authority except [for] minor [ailments].

(b) 1893 and 1899 Acts. (133)

This rather conservative approach to the question of treatment continued to dominate in the preliminary draft of Circular 576, where the relevant section read:

The Board is of [the] opinion that speaking generally Local Education Authorities should not undertake direct medical treatment. There can be no doubt that a system of medical treatment, or as it would soon become, medical relief administered by the Education Committee might tend to pauperize the patient. And there are other objections. If children were to be treated as well as examined, the cost of medical inspection would be very seriously increased; and secondly, such action would almost inevitably lead to complaints from private medical practitioners.

(132) See e.g. PRO Ed 50/5, Newsholme to Newman, 17 November 1907.

(133) Ibid., Circular 576, rough preliminary notes.

The Board look to the existing agencies of the medical profession for treatment of the defects revealed by inspection under this Act. Such agencies will include both treatment by private medical practitioners, or through the means of dispensaries and hospitals. (134)

At this juncture, therefore, Newman's approach to the question of the provision of medical treatment by the local education authorities seems to have been a conservative one. Indeed, in parts the paragraph just quoted is reminiscent of the publications of the Charity Organisation Society. There is little to suggest that this was Newman's personal view, it is perhaps more probably an indication of the way in which those parts of the circular not regarded as being of immediate strategic importance were drafted to obtain an assumed consensus, rather than to invite controversy. On this question, however, the draft was subsequently amended. The draft was sent to Morant, who wrote back to Newman on 15 November, saying he had been through the draft "line by line" with McKenna the previous day. McKenna had approved the first fourteen paragraphs of the circular with only minor alterations, before coming to the section dealing with treatment:

We then come to paragraphs 15 and 16. He [McKenna] likes these, but very much wants (a) to put more peremptorily the duty to treat the minor ailments, e.g. ringworm, dirty heads, etc., without delay, as being a course obviously desired by the country generally; and (b) to speak of other and more comprehensive treatment as a matter for which proposals will be submitted to us by Local Authorities later on. (135)

It would thus appear that there was political support, indeed on this

(134) Ibid., Circular 576, full preliminary draft.

(135) PRO Ed 24/280, Morant to Newman, 15 November 1907.

evidence arguably a political initiative, in favour of a more extensive provision of treatment facilities by local authorities than had first been thought possible by Newman, and, as a consequence of this, the relevant paragraphs of the final circular specifically referred both to the possible establishment of school clinics and to the need for urgent action on minor ailments:

14 The aim of the Act is practical and it is important that Local Education Authorities should keep in view the desirability of ultimately formulating and submitting to the Board, for their approval under section 13(i)(b) of the Act, schemes for the amelioration of the evils revealed by medical inspection, including, in centres where it appears desirable, the establishment of school surgeries or clinics, such as exist in some cities of Europe, for further medical examination, or the specialised treatment of ringworm, dental caries, or diseases of the eye, the ear, or the skin.... The subject of specific medical treatment is, however, one which will require subsequent consideration in the light of the findings of medical inspection and the collateral issues raised thereby, and it is clear that, speaking generally....Local Education Authorities will be unable to formulate....any comprehensive scheme for the furtherance of this object until they have considered the results of their medical inspection in various directions.

15 In the meantime, the authorities should take measures without delay, for dealing through such agencies as are conveniently available, with what are commonly, though in a sense erroneously, regarded as minor ailments. (136)

Newman's desire to avoid unnecessary conflicts with his opponents also influenced sections of the circular. Much of paragraph 16, for example, is taken almost verbatim from Kerr's Annual Report.⁽¹³⁷⁾

(136) Circular 576/1907, paras. 14 and 15.

(137) Compare ibid., para. 16, with L.C.C. Annual Report of the Medical Officer (Education) for 1906.

Public and professional reaction to the circular varied, but was less critical than might have been anticipated. The Lancet thought the circular:

on the whole a statesmanlike and elastic document which should be well received by local education authorities throughout the country. But it decides in a very determined manner a question upon which there must, for a time at least, remain two opinions, viz., whether the inspection should be placed completely under the jurisdiction of the sanitary authorities or not. (138)

The British Medical Journal adopted a more critical attitude,⁽¹³⁹⁾ but even Hogarth was forced to concede:

the general tenor of the memorandum is admirable, and in details it is deserving of the careful study, faithful interpretation and loyal support of all education authorities. (140)

He was of course critical of the recommendation that the medical officer of health should assume overall control of the service. The B.M.A. could suggest only very minor amendments.⁽¹⁴¹⁾

Circular 582

With overtly hostile reaction to Circular 576 muted, Newman, now actually working at the Board of Education, could turn to the second of the initial series of circulars issued by the Board. Circular 582, reproduced as Appendix B, was a short document

(138) Lancet ii (1907), 1541.

(139) British Medical Journal ii (1907), 1604-5.

(140) Times, 27 November 1907, p.18.

(141) B.M.A., Medico-Political Committee, Special Sub-Committee on the Duties of the Medical Inspector, Minutes, 25 November 1907.

incorporating a schedule of medical inspection proposed as a standard by the Board. Again, however, the circular aimed to persuade the local authorities to adopt the required standard, while leaving some latitude to meet local requirements or conditions. Thus although the circular was issued in response to requests from local education authorities not only for guidance about the standard of medical inspection to be adopted, but also for the issue of a set of standard forms for the purpose, Circular 582 announced that:

for the present the Board think it expedient to leave considerable latitude, subject to the considerations hereinafter set out, in regard to the particular Forms or Schedules to be used in different cases or circumstances. (142)

The circular, issued on 23 January 1908, required much less preparation than the politically contentious Circular 576. Apart from examining a series of existing medical inspection schedules, used for purposes such as the notification of phthisis (pulmonary tuberculosis) and the inspection of defective children under consideration for special education, along with some schedules from established systems of medical inspection such as those at Croydon and Leicester,⁽¹⁴³⁾ Newman relied on the advice and comments of virtually the same group of public health service staff who had advised him on the previous circular; Newsholme, Meredith Richards, C.J. Thomas, and, this time, Ralph Crowley, the Bradford School Medical Officer.⁽¹⁴⁴⁾

(142) Board of Education, Circular 582/1908, issued 23 January 1908.

(143) PRO Ed 50/6, samples of inspection schedules.

(144) Ibid., correspondence.

The only potential difficulties arising over the preparation of Circular 582 came over the question of who should see the proof copy of the circular for criticism before issue. On 10 January Newman wrote to Morant suggesting a mixture of senior public health officials, such as Sir Shirley Murphy and J.R. Kaye, medical staff of other government departments, such as W. Leslie Mackenzie, W.H. Power and Sir Alfred Keogh of the War Office, and then:

Eichholz? I think this would be best.

Dr. Kerr - if you approve. This is not a question so much of policy and administration as of technique and though I can anticipate Kerr's criticisms it may save subsequent trouble to let him see it in proof. (145)

Morant replied the same day:

I agree to all the foregoing but if it is sent to Dr. Kerr the covering letter must be very carefully done, not implying that we are anxious for, or are seeking for, his imprimatur on the schedule, of his concurrence, but simply that we are proposing in a few days to issue it, and if he has any observations that he would like to offer upon it or suggestions as to modifications which would in his view make it more effective or more suitable for its purpose.... [we] will consider carefully. (146)

The Ed 50/6 file contains responses from almost all the potential recipients listed by Newman, but no reply from James Kerr. (147)

It is not known whether Kerr was finally sent a copy of the proof.

As will be seen in a later chapter, the L.C.C. was to abandon the Board's schedule after a limited experiment, in favour of a

(145) Ibid., Newman to Morant, 3 January 1908. Newman was at home recovering from influenza at the time.

(146) Ibid., Morant to Newman, 3 January 1908.

(147) Ibid., correspondence.

simpler inspection schedule proposed by Kerr, who recorded his views on the Board's schedule in one of his Annual Reports:

The records of detailed [i.e. according to the schedule of Circular 582] medical inspection showed the wastefulness of applying minute routine examination to all children. (148)

At a much later date, however, when the passage of years had detached Kerr from the intensity of the argument, he could comment that the twenty four headings of the official schedule "could hardly be reduced advantageously"⁽¹⁴⁹⁾ adding that the absence of a record of vaccination was the only notable omission, probably for political reasons. This was in fact the case, for the Board "purposely omitted vaccination or non-vaccination from our schedule of medical inspection because its inclusion might have given rise to controversy".⁽¹⁵⁰⁾ Again, this cautious approach adopted by the Board paid dividends, with little opposition or criticism of the schedule of inspection. In March, Newman went to a Fabian Society meeting to hear Sir Victor Horsley, a prominent and influential member of the B.M.A. Council, discuss school hygiene, and found: "He was very kind in supporting the Board and me and the memorandum and schedule. We expected he was going to be the opposite".⁽¹⁵¹⁾ With support coming from such potential sources of dangerous opposition, it is no surprise to find Morant writing to Newman: "The memorandum has justified all the labour and forethought put into it. No vulnerable point has yet been shown."⁽¹⁵²⁾

(148) L.C.C., Annual Report of the Medical Officer (Education) for 1909, p.3.

(149) James Kerr, The Fundamentals of School Health (London: George Allen & Unwin, 1926), p.633.

(150) PRO Ed 125/12, memorandum, Selby-Bigge to Morant, 24 June 1908.

(151) Newman Diaries (D.H.S.S.), vol.1, 4 March 1908.

(152) Ibid., 19 March 1908.

These two circulars, later to be joined by Circular 596, discussed in subsequent chapters, formed the guidance given by the Board to the local authorities as to the desired standard and direction for the School Medical Service. In 1908, the Board also took powers to allow it to impose sanctions if local authorities disregarded its instructions. These were contained in the 1908 Education Code, which was not published until 30 June 1908, six months after the provisions of the 1907 Act came into operation. The 1908 Code contained several new conditions. Article 25(c) provided that the effectiveness of the medical inspection carried out would in future be one of the elements to be considered in determining the efficiency of a school for grant purposes.⁽¹⁵³⁾ This meant that if the Board was dissatisfied with the standard of a local authorities conduct of medical inspection, it now had the power to refuse to pay grant in respect of a school. Article 44(g) referred to the School Medical Officer as "a medical officer named by the local education authority and recognised as such by the Board",⁽¹⁵⁴⁾ without whom some medical inspection functions could not operate on an official basis. Significantly, the preamble to the Code stressed: "it is very desirable that he [the School Medical Officer] should either be the same person as the Medical Officer of Health or be under his supervision or control."⁽¹⁵⁵⁾ The Board's ability to recognise,

(153) BPP 1908/LXXXII:303, Board of Education, Code of Regulations.. for 1908, Cd. 4158, art. 25(c)

(154) Ibid., art. 44(g)

(155) Ibid., preface by Morant

or to withhold recognition from, a medical officer nominated by a local education authority gave it the ability, if it so chose, to directly influence the kind of administration adopted by the authority.

Again, however, the Code showed the Board's willingness to proceed pragmatically and flexibly in the first years of the School Medical Service. Article 58 of the Code required only two inspections in 1908, of "entrants" and "leavers", as against the three groups referred to in Circular 576.⁽¹⁵⁶⁾ The preamble to the Code stressed this was not a retreat by the Board, but that:

The Board appreciate the efforts which have been made by many local education authorities to cope with the new duties imposed upon them and they recognise that in many cases very satisfactory arrangements have been or are being made for the purpose. On the other hand, they are aware that considerable difficulties have been experienced by certain authorities in appointing the necessary officers and making the other arrangements required for the initiation of the work, and they have felt justified in making some concession to meet the difficulties experienced in these cases. (157)

Summary

The account of the Board of Education's dealings with the Treasury about the financial needs of the School Medical Service suggests that Macleod's view that the expansion of the service reflected a new approach to public expenditure on the part of the Treasury⁽¹⁵⁸⁾ is misleading. The School Medical Service did not have funds readily available during the early years, and although

(156) Ibid., art. 58.

(157) Ibid., preface by Morant.

(158) Macleod, op.cit., p.49.

in respect of aid grant this was arguably due to political factors rather than Treasury influence, nevertheless this compounded the problems the Medical Department faced in persuading councils to implement medical inspection satisfactorily, while the Treasury's reluctance to agree to an early expansion of the staff of the Medical Department led to a weakening of the Board's ability to control the activities of the local authorities. Although the circulars issued by the Board reflect the desire not to conflict openly with opposing professional factions, the absence of a satisfactory financial basis for the new service added to the range of problems faced by Newman and Morant. The resulting tensions, and the way in which the Board sought to resolve them, will be explored in the next chapters.

CHAPTER SIXTHE LOCAL EDUCATION AUTHORITIES:MEDICAL INSPECTIONAND ADMINISTRATION, 1908-1914First Responses

Officially, medical inspection of school children became a local authority duty from 1 January 1908, four months after the 1907 Act received the Royal Assent. Effectively the Board of Education required the commencement of medical inspection after publication of the 1908 Education Code on 30 June 1908. But in many cases, medical inspection did not begin until 1909. Stockport began inspection in January 1909, after the School Medical Officer had been appointed in September 1908.⁽¹⁾ Dorset, Gateshead and Manchester all commenced in February 1909.⁽²⁾ The School Medical Officer for South Shields was appointed only in May 1909,⁽³⁾ while inspection in Berwick-upon-Tweed started in September 1909.⁽⁴⁾

In some cases, delays were caused by disagreements about the best way to carry out inspection, or by difficulties with the local medical profession seeking a role for local G.P.'s consistent with the B.M.A.'s abortive "school doctor" proposal.⁽⁵⁾ But in West

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- (1) Stockport C.B.C., Interim Report by the School Medical Officer on Medical Inspection, 1 January to 31 July 1909, p.3.
- (2) Dorset C.C., Annual Report of the School Medical Officer for 1909, p.3; Gateshead C.B.C., Annual Report of the School Medical Officer for 1909, p.3; Lancet ii (1909), 1623.
- (3) South Shields C.B.C., Annual Report of the School Medical Officer for 1909, p.3.
- (4) Berwick-upon-Tweed B.C., Annual Report of the School Medical Officer for 1909, p.1.
- (5) Lancet i (1910), 1295; Medical Officer 1 (1908-9), 701.

Suffolk, and almost certainly in some other areas also, the start of medical inspection was delayed because the council refused at first to initiate medical inspection until a grant was forthcoming from the Government.⁽⁶⁾ This suggests that the difficulties with grant-in-aid discussed in the last chapter did have some influence on the attitude of at least some local authorities to the new duties imposed upon them by the 1907 Act.

It is, however, difficult to determine the extent to which local authorities failed to implement the suggestions of Circular 576, or why they did so, although evidence exists relating to some individual cases. There are a number of reasons for this. First, there is the discretion exercised by Newman and his political superiors at the Board. Only one or two exceptional cases of default were referred to by Newman in his Annual Reports, and even in these instances, the authority involved sometimes remained anonymous. London, one of the exceptions, is discussed in the next chapter. Publicly, the Board maintained that the great majority of local authorities were operating efficient systems of medical inspection.⁽⁷⁾ Privately, it was admitted there were "many examples" of authorities which diverged at least temporarily from the Board's requirements.⁽⁸⁾ Some failed to inspect the required number of children for several years after the passage of the 1907 Act, usually because they were

(6) County Councils Association, Official Circular, May 1908, p.50.

(7) Parl. Deb., 4th series, 191 (6 July 1908), 1252; Parl. Deb. (Commons), 5th series, 14 (9 March 1910), 1459-60.

(8) PRO Ed 125/11, Precedent Cover: Salford, note from Selby-Bigge, November 1911.

unwilling to appoint the number of medical inspectors needed. These included East Ham and Newcastle,⁽⁹⁾ and Salford, which could only inspect 4709 of its 9,000 "entrants" and "leavers" in 1910.⁽¹⁰⁾ By the end of 1911, the Board was threatening to withhold Salford's grant unless additional medical inspectors were appointed.⁽¹¹⁾

A second difficulty in identifying unsatisfactory performance of medical inspection by local authorities is the variety of ways in which an inadequate investment of resources could be manifested. Apart from postponement of inspection or a shortfall in the numbers inspected, deviations from or abbreviations of the Board's schedule of inspection could occur or, more subtly, other duties might be performed inadequately where the school medical officer was appointed to several posts under the local authority. Thus in Cheshire, the system of inspection was not the comprehensive schedule recommended by the Board.⁽¹²⁾ Several councils, including Denbighshire, Glamorgan and Lancashire, chose not to include the recording of heights and weights of the children in their schedules of

(9) East Ham B.C., Annual Report of the School Medical Officer for 1911, p.72; Tyne and Wear R.O., Newcastle, Newcastle-upon-Tyne C.B.C., Education Department, Medical Correspondence File, letter from Board of Education, 5 December 1910.

(10) Salford C.B.C., Annual Report of the School Medical Officer for 1910, p.87.

(11) PRO Ed 125/11, Precedent Cover: Salford, November 1911. This file also names Ilford as an authority reluctant to employ an adequate number of medical inspectors.

(12) Francis Vacher, The Medical Inspection of School Children (n.p., n.d. [1908?]).

inspection.⁽¹³⁾ Parsimony over appointments and overall expenditure also occurred. It is significant that in just over half the local education authority areas, only one medical officer was initially appointed to deal with questions of medical inspection.⁽¹⁴⁾ Sometimes, the one officer was also expected to perform a range of other duties. In the case of a medium sized town like Shrewsbury, with an average attendance of 4,000 school children, the appointment of a whole time officer to be M.O.H., Police Surgeon and Medical Inspector of Schools was not making unreasonable demands,⁽¹⁵⁾ but in the Rhondda:

a proposal has been made by a committee that an assistant medical officer of health shall be appointed who shall reside at the isolation hospital and devote part of his or her time to the medical inspection of school children. As

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- (13) Clwyd R.O., Denbigh, Denbighshire C.C., Medical Inspection of School Children Sub-Committee, Minutes, 20 April 1910; Medical Officer 1 (1908-9), 549; Lancashire C.C., Annual Report of the Medical Superintendent of Schools for 1909, p.1. Some other councils were unable at first to include these statistics, not as a result of deliberate acts of policy, but because the beginning of medical inspection created a shortage of weighing machines. Berkshire C.C., Annual Report of the School Medical Officer for 1908, p.8, and Chester C.B.C., Annual Report of the School Medical Officer for 1908, p.21.
- (14) BPP 1910/XXIII:1, Board of Education, Annual Report of the Chief Medical Officer for 1908, Cd. 4986, p.18.
- (15) Lancet i (1908), 192. In Carlisle, where the School Medical Officer also held the positions of Medical Officer of Health and Police Surgeon, he reported to the Education Committee that "the labour which I am able to give [to the School Medical Service] is restricted by the fact that my work as Medical Officer of Health demands the greater part of my time and attention". Carlisle C.B.C., Annual Report of the School Medical Officer for 1908, p.3. Carlisle's average attendance was 8,000 school children.

the population of the district is considerably over 130,000 it is obvious that the whole of the medical inspections cannot be done by one officer in addition to the duties attached to the hospital, where there are now 36 beds and will very shortly be 52. (16)

Whether the Rhondda ever attempted medical inspection on this basis cannot be determined, but by 1911 the Borough had two full time medical inspectors, in addition to the school medical officer. (17)

A similar case arose at Hereford, where the County Council lacked a full time medical officer of health. The Council considered the introduction of medical inspection to be an opportune moment to appoint a full time M.O.H., whose duties, in addition to the normal public health functions, were also to include the inspection, unaided, of the County's school children. The Lancet commented:

The County Council has, we understand, no objection to the provision of assistants to the county medical officer provided that he defrays the expenses out of his own pocket, but it does not seem to us that a proposal such as this is at all statesmanlike or even businesslike on the part of the county council. There are in the administrative county 179 schools containing about 16,000 children, and to expect a county medical officer of health to undertake detailed inspection of these numbers and at the same time to perform the duties more particularly attaching to the post of county medical officer is, we think, rather a misconception of the whole position of this officer. (18)

Nevertheless, in 1911 Herefordshire is recorded as having only one school medical officer. (19) Similar penny pinching was evident

(16) Lancet ii (1908), 502.

(17) Public Health Service Directory and Year Book, 1911 (hereafter cited as P.H.S. Directory) (London: Hodgetts, 1911), p.155.

(18) Lancet ii (1908), 1155.

(19) P.H.S. Directory, p.148.

in Carmarthenshire, where the medical inspection was initially carried out by general practitioners on a capitation fee basis. A request from a Sub-Committee for an increase in the capitation fee from 1/- to 2/6d per head was rejected by the Education Committee who offered only 1/6d per head. Similarly, when the Sub-Committee suggested paying one of the G.P.'s £25 to prepare the Annual Report, the Education Committee reduced the amount to be offered to £10. (20)

The third difficulty in assessing the local authorities response to Circular 576 and its successors is the attitude of the Board of Education itself. In the early days of the Service, the Board was in a relatively weak position to take action against defaulters. The small staff of the Medical Department made it difficult to exercise the inspectorial function, while the absence of a grant-in-aid made it morally difficult for the Board to insist on the rectification of all but the most obvious faults. In these circumstances, the attitude of the Board seems to have been to take action gradually, and to seek to persuade authorities to make improvements rather than to threaten them, except in the most serious cases of default, with sanctions through the Education Code. Breaches of the guidelines contained in the circulars were thus overlooked in the short term, in the hope that the authority would respond to exhortations by the Board. Thus Denbighshire's scheme of medical inspection was declared satisfactory for Education Code

(20) Lancet i (1909), 724. The B.M.A. recommended a minimum fee of 2/6d per head where payment was made according to numbers inspected though this form of payment was generally discouraged, British Medical Journal i (1909), supplement, 245.

purposes, despite the absence of records of height and weight. The Board hoped the County Council would include these as soon as possible. (21)

It is thus difficult to assess the local authorities overall response to the introduction of medical inspection. The most likely picture at the outset is one of a small number of progressive education authorities implementing medical inspection fully, and then seeking to develop beyond the basic requirements into the field of "following up" and treatment at an early stage, with a further, probably much larger group of middle range authorities who met the basic requirements of the Code and circulars, but who, through the reluctance of the Education Committee to undertake extra work in the absence of a grant, or lack of interest or time on the part of the local medical officer of health, made no effort to implement the permissive powers of the 1907 Act. This was identified as a particular problem in small towns with less than 10,000 children at school, where:

if the local authorities have been parsimonious, and have saddled the medical officer of health with the new work, without any substantial addition to his salary, and without professional help, little good has resulted beyond the carrying out of the statutory requirements. (22)

In such cases, probably in a majority in the first years of medical inspection, the School Medical Service effectively started and ended with the statutory medical inspection. Finally, a relatively

(21) Clwyd R.O., Denbigh, Denbighshire C.C., Medical Inspection of School Children Sub-Committee, Minutes, 20 April 1910.

(22) "School Hygiene in Small Towns", School Hygiene i (1910), 605-11.

small, and probably diminishing number of authorities existed whose provision for the basic medical inspection was unsatisfactory. No overall assessment of the number of authorities in this category can be made, although individual cases, such as those detailed above, can be identified. In 1913, when the payment of grants for the School Medical Service had commenced, one condition of payment was that the system of medical inspection had to be approved by the Board. In that year, 22 out of 317 areas did not receive approval.⁽²³⁾ However, it is possible that in some or all of these cases, the withholding of approval stemmed not from the Board's dissatisfaction with the system of inspection, but through other deviations from the conditions laid down for the receipt of grant in Circular 792, the circular governing the payment of the grants. One stipulation was that medical inspection should be carried out "in intimate conjunction with" the Public Health authority.⁽²⁴⁾

Administrative Responsibility

This stipulation in Circular 792 is an indication of the Board's commitment to a public health orientation for the School Medical Service. It also indicates that the Board needed more than the purely persuasive recommendations of Circular 576 to ensure this objective was attained.

(23) BPP 1914-16/XVIII:277, Board of Education Annual Report of the Chief Medical Officer for 1913, Cd. 7730, p.3.

(24) Board of Education, Circular 792/1912, issued 9 April 1912.

Privately, the Board acknowledged that it had relatively weak powers if a local education authority was determined to appoint someone other than the medical officer of health as school medical officer. When Edmonton Urban District Council informed the Board that it has appointed an independent medical officer as its School Medical Officer, Newman admitted:

if a Local Education Authority appoint a properly qualified medical man as ad hoc officer to do medical inspection (ignoring the Medical Officer of Health) and ask us to recognise him as School Medical Officer for Code purposes I do not think we can resist very long. If there is an organised system of medical inspection under the control of a single qualified man we have got as much as articles 44, 45 and 53 of the Code enable us to insist upon. (25)

Despite the Board's sense of its ultimate powerlessness, most local education authorities did in fact adopt from the outset schemes of administration which gave ultimate responsibility to the medical officer of health. Of the 307 school medical officers recognised by the Board at the time Newman's first Annual Report was issued, 224 were the local medical officer of health, while in 76 of the remaining 83 cases the school medical officer was to be under the supervision of the medical officer of health or was "directly to co-operate" with him. (26)

That such a high proportion of authorities did adopt a public health orientation owed much to the Board's persuasive powers. Authorities which enquired whether they could appoint independent officers were told that the Board attached great

(25) PRO Ed 125/9, Precedent Cover: Edmonton, note by Newman, 14 July 1908.

(26) BPP 1910/XXIII:1, op.cit., p.17.

importance to the principle that medical inspection should be under the supervision of the M.O.H., though Bolton was informed that:

if the Local Education Authority appoint additional medical officers to carry out medical inspection under the supervision of the Medical Officer of Health, this would seem in complete accord with the memorandum. (27)

Much Wenlock, which appointed three local G.P.'s as medical inspectors, was persuaded to appoint the local M.O.H. to supervise them after the Board queried the original arrangements.⁽²⁸⁾ Other councils which appointed an independent school medical officer received letters from the Board asking how they proposed to secure co-ordination between the School Medical Service and the public health service.⁽²⁹⁾

The adoption by so many councils of a system in which the medical officer of health was ultimately responsible for the School Medical Service also indicates the importance of the 1902 reform in bringing together responsibility for education and public health. Where the medical officer of health did not become school medical officer also this was sometimes due to imperfections in the system of public health administration, or to the legacies of

(27) PRO Ed.125/8: Precedent Covers: Bolton, 11 December 1907, and Cheltenham, 31 January 1908.

(28) PRO Ed 125/11, Precedent Cover: Much Wenlock, 1908.

(29) Tyne and Wear, R.O., Newcastle, Hebburn U.D.C., School Management Sub-Committee, Minutes, 22 March 1908; Clwyd R.O., Hawarden, Flintshire C.C., Medical Inspection Sub-Committee, Minutes, 13 May 1909.

appointment as school medical officer in certain instances.

First, the independent tradition maintained by some of the larger borough education committees, a legacy of the former school board; second, the existence of arrangements for medical supervision made prior to the 1907 Act. The former attitude was typical of many of the larger county borough authorities. At Bristol the M.O.H. outlined to the Education Committee a scheme in which he would become school medical officer, with a whole time assistant working under him. But, as he complained to Newman:

This did not suit them, they knocked the stuffing out of this scheme and prepared an alternative one in which the school medical officer was entirely under the control of the Education Committee. (35)

In practice, Bristol decided to appoint five part time medical officers to do the actual medical inspection, and kept its independence from the M.O.H. by appointing one of the five to act as supervisor and co-ordinator.⁽³⁶⁾ This independence was maintained until at least 1922, when Bristol was named as one of the 36 education authorities in England and Wales where the M.O.H. was not the school medical officer. Significantly, 20 of these authorities were large County Borough Councils, including also Hull, Leeds, Sheffield, Leicester Manchester, Newcastle-upon-Tyne and Plymouth.⁽³⁷⁾

A further factor in explaining the existence of non-conformist systems of administration was the reluctance of authorities that had

(35) PRO Ed 50/5, W.S. Davies to Newman, 30 October 1907.

(36) Lancet i (1908), 1373.

(37) PRO Ed 50/35, memorandum by "J.R.W." to A.H. Wood, 14 August 1922.

the former separation between the systems. The absence of any requirement for County Councils to appoint a medical officer of health meant that in 1904 only 26 counties in England, and one in Wales, Glamorgan, had appointed a medical officer of health.⁽³⁰⁾ As indicated in the previous chapter, Newman in Circular 576 attempted to persuade the remaining councils that the introduction of medical inspection made such full time appointments desirable.⁽³¹⁾ Although some County Councils, such as Gloucestershire, Hertfordshire and Berkshire⁽³²⁾ followed this advice and appointed a full time M.O.H. whose duties were to include the supervision of the School Medical Service, other counties decided either to appoint full time independent officers, as in Buckinghamshire,⁽³³⁾ or used a number of part time inspectors, one of whom acted as co-ordinator, as in Carmarthenshire.⁽³⁴⁾

Even where a medical officer of health was already in post, in both County and other local authority areas, two influences sometimes operated, singly or in combination, to prevent his

(30) BPP 1904/LXXXII:735, Return showing the Names of County Councils in England and Wales who have Medical Officers of Health, H.C. 316. Further appointments had been made by 1908. Lancet i (1908), 170-71.

(31) Board of Education, Circular 576/1907, cl. 7(a).

(32) Lancet i (1908), 1308; County Councils Association, Official Circular, June 1908, p.73; Berkshire C.C., Annual Report of the School Medical Officer for 1908, p.2.

(33) County Councils Association, Official Circular, April 1908, p.43.

(34) Lancet i (1909), 724.

instituted some form of supervision of school health prior to the passage of the 1907 Act to alter their arrangements in cases where an independent medical officer was already in post. Even in 1922, some of these positions were still held by the original appointee, as was the case in Manchester and Sheffield.⁽³⁸⁾ Less frequently, the local M.O.H. had declined to be appointed as school medical officer, was only a part time officer, or, in one case, was adjudged incompetent for office by the Board of Education.⁽³⁹⁾

As the 1922 memorandum suggests, there was a gradual decline, over time, in the number of authorities not having the M.O.H. in overall control of the School Medical Service. By 1922, only two County Councils, Northamptonshire and Carmarthenshire, had an independent school medical officer, an indication not only of the persuasive power of the Board, but also of the duty imposed on County Councils to appoint a county M.O.H. under the 1909 Housing, Town Planning, etc., Act.⁽⁴⁰⁾ Such changes in the system of administration most commonly occurred when the existing appointee left the service of the council. Thus when the independent school medical officer first appointed by the South Shields Borough Council found another post, it was agreed, though not without opposition from some councillors, that the M.O.H. should be school medical officer, with a full time assistant to help him.⁽⁴¹⁾

(38) Ibid.

(39) Ibid.

(40) Ibid.

(41) Tyne and Wear R.O., Newcastle, South Shields B.C., Medical Inspection of School Children Sub-Committee Minutes, 21 May 1913; Lancet i (1913), 1628.

The period under review in this chapter therefore saw the gradual but incomplete adoption of a uniform system of administration giving the local M.O.H. ultimate responsibility for the School Medical Service. The efficiency of this system of administration will be discussed subsequently. In many, indeed eventually most authorities, however, responsibility for, and the actual performance of, medical inspection itself was, of logistical necessity, the task of subordinate medical officers in addition to, or on behalf of, the school medical officer.

Subordinate Appointments

In Circular 576, the Board gave only general advice on the appointment of subordinate officers to perform the medical inspection, suggesting:

preference should be given to medical men and women who (1) have had adequate training in State Medicine or hold a Diploma in Public Health, (2) have had some definite experience of school hygiene, and (3) have enjoyed special opportunities for the study of diseases of children. (42)

This was more an expression of an ideal, rather than a practical reality at the outset. It did, however, stress once again the Board's desire for some professional orientation towards public health. In practice, appointments tended to take one of three main forms. First, a number of part-time inspectors could be recruited from local medical practitioners; second, the district

(42) Circular 576/1907, cl.7.

medical officers of health were employed in some counties to act as medical inspectors in their areas; or third, a small staff of full time medical inspectors could be employed. In some areas, necessity forced the use of two or more of these methods in combination.

The use of part time inspectors was particularly favoured by some rural counties, where it was considered that the travelling involved made the use of whole time officials impracticable or uneconomic. Carmarthenshire used a team of G.P.'s,⁽⁴³⁾ while other counties which used local medical staff other than the district medical officers of health were Denbighshire, Huntingdonshire, Leicestershire, Merionethshire, Montgomeryshire and Oxfordshire.⁽⁴⁴⁾ In London, the largest user of part time staff, junior hospital doctors were preferred.⁽⁴⁵⁾ This was not normally an option available to a rural county. The only overt policy adopted by the Board on the employment of part time staff was to suggest that no area should appoint a staff consisting entirely of Poor Law medical officers or public vaccinators.⁽⁴⁶⁾

Although the part time system commended itself mainly to county areas, some of the larger urban authorities also adopted it at the

(43) Lancet i (1909), 724.

(44) P.H.S. Directory, pp. 141-59.

(45) BPP 1906/XLVII: 157, Inter-Departmental Committee on the Medical Inspection and Feeding of Children Attending Public Elementary Schools, vol.2, Evidence and Appendices, Cd. 2784, evidence of Dr. James Kerr, p.236. This policy continued after the 1907 Act.

(46) BPP 1910/XXIII:1, op.cit., p.25.

outset at least. In London, Kerr advocated the part time system on the ground that it attracted a better quality of applicant, and avoided the boredom of full time inspection.⁽⁴⁷⁾ In Leeds, inspection was initially performed by a team of 20 part time medical examiners, all local practitioners.⁽⁴⁸⁾ In these cases, the inspectors had several schools allocated to them, the only authority to adhere to the pure concept of the "school doctor" being Willesden, where Dr. Butler, the Medical Officer of Health, had a staff of 36 part time inspectors for the 29 schools in the area. Each inspector was paid £15 to £30 per annum.⁽⁴⁹⁾ Elsewhere, remuneration depended on the amount of work involved.

The use of part time inspectors had some support within the B.M.A., anxious to give G.P.'s opportunities to share in the work (and the financial rewards) of school hygiene. The Board was less enthusiastic, believing such appointments limited the work to basic medical inspection only, especially when payment was made on a capitation fee basis. It expressed this view both privately and publicly,⁽⁵⁰⁾ and tried to persuade a number of authorities

(47) BPP 1906/XLVII:157, op.cit., p.125.

(48) School Hygiene 1 (1910), 671.

(49) P.H.S. Directory, p.158. Dr. Butler had advocated use of a full time staff of inspectors from the outset. Medical Officer 10(1913), 298.

(50) "Even a well carried out part time scheme [of inspection] is necessarily inferior to a whole time scheme". Board of Education to Yorkshire (North Riding) Education Committee, quoted in Local Government Chronicle, (1911), 939. See also BPP 1914/XXV:401, Board of Education, Annual Report of the Chief Medical Officer for 1912, Cd. 7184, p.8.

to change to a system using full time inspectors.⁽⁵¹⁾

Practicalities and the views of the B.M.A. meant that part time systems persisted in many areas, however.

The second approach used in many county areas was to appoint the district medical officers of health to do the inspection, a move which sometimes resulted in the creation of full time district M.O.H. posts where part time appointments had previously sufficed. Among counties adopting this system were Cardiganshire, the North Riding of Yorkshire, and Hertfordshire.⁽⁵²⁾ Other counties adopted a similar system using part time medical staff in those areas of the county where the district M.O.H. was unable or unwilling to undertake the work, as in Kent,⁽⁵³⁾ or supplemented the district M.O.H. with some full time inspectors, as in Derbyshire.⁽⁵⁴⁾

F.E. Fremantle, the Medical Officer of Health of Hertfordshire, was a strong advocate of the system of using the district M.O.H.'s, arguing that the use of "this compact body of chosen men" was the best way of ensuring the integration of medical inspection with the

(51) See e.g. the case of Smethwick, reported in Public Health 22 (1908-9), 226; and those of Wednesbury, Leeds, Swansea, Yorkshire (North Riding) and Willesden, reported in the Medical Officer 1 (1908-9), 614, 701; 5(1911), 48, 58; 7(1912), 130; 9(1913), 100; 10(1913), 298.

(52) Lancet i (1908), 112; County Councils Association, Official Circular, June 1908, p.73.

(53) P.H.S. Directory, p.149.

(54) County Councils Association, Official Circular, May 1908, p.59.

Public Health system.⁽⁵⁵⁾ Where use was made of district officials, payment was often on a capitation fee basis, and was open to the same objections as for other part time officials. Again, however, the disadvantages of using a number of part time officials, and opposition from the Board, reduced the number of Counties using this system of operation. Wiltshire, which began by using the district medical officers of health, changed to a full time system of medical inspection at the end of 1908.⁽⁵⁶⁾ In most non-county areas where assistance was required for the school medical officer, however, the most popular option was to employ full time medical staff. This system was also used by some counties, including Cheshire, Shropshire, Staffordshire and Worcestershire.⁽⁵⁷⁾ The gradual increase in the already substantial number of authorities using this system as some of those which had initially adopted a part time system altered their policy meant that by 1909 there was thus:

a distinct tendency on the part of the education authorities to procure the inspection in question by the instrumentality of young medical men who are required to devote their whole time to the duties of their office. (58)

The emergence, as a result of the system of medical inspection most commonly adopted, of a group of qualified medical staff engaged almost wholly, in most instances, in the routine medical inspection of school children had a number of consequences. The first of these

(55) See e.g. Lancet ii (1909), 185; ii (1911), 347-49.

(56) Ibid., ii (1908), 1638.

(57) County Councils Association, Official Circular, April 1908, p.43.

(58) Lancet i (1909), 1839.

was to increase the importance of the policy adopted by the B.M.A. on the payment of medical inspectors. Part time staff were paid on a variety of bases, few of which matched the B.M.A.'s initial recommendation that the remuneration should approximate to a yearly payment of £50 for each half day devoted to medical inspection. With full time staff, the B.M.A. initially suggested £500 per annum, the full time equivalent of the suggested salary for part timers, but later made a more realistic recommendation that no full time inspector should be paid less than £250 per annum, and that no medical practitioner should apply for positions where the salary offered was less than this amount.⁽⁵⁹⁾

Although the B.M.A.'s recommendations were advisory only, they were frequently effective, particularly in relation to the appointment of full time staff. In Newcastle, the Education Committee advertised for an "Assistant School Medical Officer" at a salary of £200 per annum. Although "a few" applications were received, all short listed candidates were rejected as unsuitable, forcing the Education Committee to re-advertise the position at the B.M.A. approved salary.⁽⁶⁰⁾ The effectiveness of the B.M.A. policy owed much to the refusal of the leading medical journals to carry advertisements offering salaries lower than those recommended by it, but moral pressure also played a part. When the B.M.A. Annual Meeting at Belfast in 1909 re-affirmed the policy of a £250 minimum salary, the School Medical Officer at Colchester threatened to resign if her salary was not raised to the minimum. This caused the local

(59) British Medical Journal ii(1907), supplement, 342-43; i(1908), supplement, 243.

(60) Lancet ii(1908), 1042.

authority to protest to the Board of Education, resulting in a lengthy internal discussion about the Board's views on the matter.⁽⁶¹⁾ Publicly, the Board preferred not to express an opinion as to what salary was to be regarded as adequate, and this stance was maintained when Colchester approached the Board.⁽⁶²⁾

Privately, however, Newman and his colleagues sympathised with the policy of the B.M.A., but were concerned at the implications of the insistence on a £250 minimum salary. With some 1,700 children to be inspected annually in Colchester, an inspector paid on a capitation fee of 1/-d per child could do all the work required by the Board for less than £100,⁽⁶³⁾ and it was feared that the B.M.A. policy would lead authorities to adopt the less satisfactory capitation fee system of inspection rather than the more expensive use of full time medical inspectors. By and large, it would appear that this fear was not realised, and the Board did not need to take action.

An unintended consequence of the B.M.A. policy, however, was to increase the number of appointments to "Assistant Medical Officer of Health and School Medical Officer" posts. The establishment of some of these posts was not due so much to an acceptance of Newman's ideal of an integration of the School Medical Service and the general machinery of public health, but to the fact that as the B.M.A. had no set policy on the remuneration for appointments as

(61) PRO Ed 125/8, Precedent Cover: Colchester, 9 October 1909.

(62) Parl. Deb., 4th series, 191 (6 July 1908), 1252.

(63) PRO Ed 125/8, Precedent Cover: Colchester, note by Newman. The Colchester Education Committee eventually resolved to raise the salary of the School Medical Officer, Dr. Ada MacLaren, to £250. Medical Officer 2(1909), 306.

medical officers of health and subordinate positions, advertisements for such posts offering less than the £250 minimum would be accepted. (64)

The evidence suggests, therefore, that on the part of both the Board of Education and of most local education authorities there was a predisposition in favour of employing full time medical staff to conduct the medical inspection of school children, If the full potential of the full time system was to be exploited, however, not only were local authorities required to make more generous provision for the School Medical Service, but problems over the job satisfaction, career prospects, remuneration and calibre of the full time staff needed to be satisfactorily resolved. By the end of the period under review, some dissatisfaction with the position of the full time school medical inspector was being expressed by those employed in such posts. A letter in the Lancet in 1913 suggested:

There has been a feeling of discontent for some time past among the majority of those actually engaged in the work of medical inspection of school children. In the greater number of areas an undue proportion of the work of these officers consists in the routine inspection of a large number of children, a considerable proportion of whom present no feature of especial interest to a medical man. The salary offered for the work is usually inadequate; the initial salary is in most cases too low; rarely is the increased value of the services of the officer acknowledged by an adequate increase in his or her salary. (65)

(64) SMOH, Oxford, Box A17, Committee Minute Book, General Purposes, Legal and Parliamentary Committee, Minutes, 17 June 1909. For an example of such advertisements, see the Medical Officer 3(1910), 15 January 1910, p.vii.

(65) Lancet ii(1913), 1504. The difficulty was partly one of a de-valuation of the standard £250 minimum salary in the five years from the inception of the School Medical Service. By December 1913 the School Medical Service Group of the Society of Medical Officers of Health was pressing for a £350 minimum. The 1914 B.M.A. meeting resolved to recommend a £300 minimum, and by 1914 most advertisements did in fact specify a £300 minimum salary. See Medical Officer, 10(1913), 288.

Although the complaints about the salary scales are necessarily subjective, the complaints about the actual work of many full time inspectors reflect a particular problem. Medical inspection involved the identification of a minority of children with certain kinds of defect from among a majority of examinees who were perfectly healthy. Even the defects were in most cases commonplace, and the routine medical inspection allowed no time for the prolonged examination of the few cases of genuine medical interest. Routine examination was therefore a tedious and monotonous activity for a medical man, but in many cases, full time medical inspectors were expected to devote almost all of their time to this task, the remainder being taken up with administrative functions. In many local authorities, the low percentage of defective children obtaining treatment after medical inspection, and the consequent suggestion that medical inspection alone was futile, must have reduced still further the satisfaction obtained from such posts.

Of course there were exceptions to this approach. In Bradford, during the school year full time inspectors spent only two out of five and a half working days each week on routine inspection, devoting the rest of their time to treatment and to other duties.⁽⁶⁶⁾ Such diversity was to be encouraged by the Board of Education when the boredom and resulting lack of enthusiasm produced by full time inspection became apparent. In 1913 it wrote to the London

(66) Austin Priestman, The Work of the School Medical Officer (London: Political Quarterly Papers, 1916), p.7.

County Council, which by then had adopted a system of full time medical inspectors, stressing the importance of providing such staff with a variety of tasks. Suitable additional work for the inspectors to perform would include:

for example the further examination of visual defects, public health work, including investigations of infectious diseases in schools, the medical inspection of children in secondary schools, scholarship candidates, etc., work in connection with the special schools, research and laboratory work, and some share in the working of the administrative arrangements. (67)

In many authorities, however, it remained the case that poor staffing levels prevented the release of full time medical inspectors for other duties.

Beyond the monotony of the work, the second problem for the full time inspection staff was the lack of career prospects in the School Medical Service. Although many were appointed as "Assistant Medical Officer of Health and School Medical Officer", in practice their experience would be limited to the requirements of educational medicine, and they were thus at a disadvantage if they sought promotion within the wider field of community health. Because of this, the view developed that the creation of the School Medical Service as a self contained part of the public health system had resulted in "the creation of a large number of subordinate officials for whom there is but little outlook".⁽⁶⁸⁾ Other developments in the field of community medicine, including the appointment of a number of Tuberculosis Officers under the National

(67) Lancet ii (1913), 339.

(68) Ibid., p.1504.

Health Insurance scheme, further increased the number of junior public health staff seeking a limited number of senior posts, and led to complaints of disparities in the pay and conditions received by the different groups of junior staff.⁽⁶⁹⁾

A result of this dissatisfaction was a move to establish an Association of School Medical Officers. Although nominally contained within the Society of Medical Officers of Health, opinions within the group varied as to how the lack of career prospects could be resolved. Some favoured closer integration with the public health service, so that school medical inspectors would do a variety of general public health functions, while others favoured an independent service with its own career structure.⁽⁷⁰⁾ This problem had not been satisfactorily resolved by the outbreak of war in 1914.

The monotony of the job in many authorities, and the lack of opportunities for promotion, allegedly raised problems about the calibre of many of the staff recruited. It was suggested that some of the full time staff were either "juniors content to remain juniors" or "seniors who have dropped out of the fight of general practice to seek something with less strenuous demands on energy".⁽⁷¹⁾ Such allegations are not easy to investigate with the passage of time, but the salaries normally attached to full time inspection posts often meant that those with ambitions would quickly seek another appointment, leading to difficulties of staff turnover, and the consequent loss

(69) The starting salary for a Tuberculosis Officer could be £500 p.a.

(70) Lancet ii(1913), 1504.

(71) Quoted in Huw W.S. Francis, "The Rise and Fall of Routine Medical Inspections", Public Health 89 (1975), 185.

of continuity in medical inspection.⁽⁷²⁾

Apart from the doctors, the introduction of the School Medical Service created a considerable demand for school nurses. By 1914, 1237 school nurses were employed by the various education authorities.⁽⁷³⁾ The duties of the school nurses were often concerned only in part with the routine medical inspection of the children. Frequently, they were also required to make separate, and independent, inspections of the children for the presence of ringworm or vermin. In these cases children, especially the girls, whose longer hair was considered more likely to harbour nits and lice, were given a careful examination by the school nurse.⁽⁷⁴⁾ These visits, being unannounced, were more likely to discover cases of verminous children than was the visit of the school medical inspector, for whom the children were often specially cleaned. They were unpopular with parents whose children were declared to be dirty, and in the earlier years of the School Medical Service at least, nurses were sometimes physically threatened by irate parents.⁽⁷⁵⁾ As nurses were then required to visit the homes of the children whom they had declared to be dirty in order to ensure that correct treatment was being applied by the mothers, an appointment as a school nurse was by no

(72) Berkshire, where inspection was performed by two full-time School Medical Officers, had eight incumbents of these two posts between 1908 and 1913. Berkshire C.C., Annual Reports of the School Medical Officer, 1908-1913.

(73) BPP 1914-16/XVIII:665, Board of Education, Annual Report of the Chief Medical Officer for 1914, Cd.8055, p.269. 855 of the nurses were full-time local authority staff, 382 were part-timers

(74) S.C. McCall Knipe, Duties of the School Nurse (London: Scientific Press, 1910), p.9.

(75) See the Sanitary Officer 1(1909), 18; Sir Gwilym Gibbon and R.W. Bell, History of the London County Council, 1889-1939 (London: Macmillan, 1939), p.300.

means a sinecure. (76)

In most authorities where school nurses were employed, however, an important part of their function was to assist the school medical inspector to conduct the medical inspection of the children. In such cases, it was the nurse who was responsible for much of the preliminary preparation of the children, and sometimes also for parts of the inspection itself, such as the weighing and measuring of the children, as well. Form-filling was also frequently delegated to the nurses. (77)

The Conduct of Medical Inspection

Although some authorities tried to abbreviate the schedule of inspection recommended in Circular 582, the nature of the medical inspection process was such that relatively little variation of practice occurred. In its later circular governing the payment of grants for the School Medical Service, Circular 792, the Board laid down three requirements for a satisfactory performance of medical inspection. These were that all children required to be inspected by the Code, meaning, in this period, "entrants" and "leavers", should be inspected; that the inspection should take place during school hours and on school premises, and that all points in the schedule to Circular 582 should be covered. (78)

The first of these created some difficulties. The Code and Circular 596 originally specified inspection of "entrants" and

(76) McCall Knipe, op.cit., pp.15-17.

(77) See "A Late School Doctor", "A Few Details as to the Work Required of an Assistant School Doctor in London", School Hygiene i(1910), 391-95; C. Louis Leipoldt, The School Nurse: her Duties and Responsibilities (London: Scientific Press, 1912), pp.20-31.

(78) Board of Education, Circular 792/1912.

"leavers" only, with the third group of seven to eight year olds specified in Circular 576 being omitted. Not until the issue of Circular 823 in 1912 did the Board formally suggest the inspection of the third group, and inspection of this group was not to become compulsory until April 1915.⁽⁷⁹⁾ With the first two groups, however, problems were encountered in achieving a consistent definition of who were the "entrants" and "leavers". Some councils took the term literally, and assumed an entrant to be any child entering school. Where councils allowed the attendance of children under the age of five, this meant that in some authorities all "entrants" would be three and four year olds, while in other areas with a different admissions policy, five year olds made up the bulk of those inspected. Some councils included those transferring from other schools or authorities, so that in extreme cases an "entrant" could previously have been attending a secondary school. Other areas defined an entrant in terms of an age range, but even these differed, some using an age range of three to six, others five to six. Similar difficulties surrounded the definition of "leaver".⁽⁸⁰⁾ The importance of these differing definitions will be seen when the comparability of the local authorities statistical material is discussed subsequently. Some officers, James Kerr in particular, criticised the whole idea of inspecting these two groups, arguing that "entrants" were too young for satisfactory medical work to take place, while defects detected in "leavers" would not be remedied before their education was completed.⁽⁸¹⁾

(79) Board of Education, Circular 823/1912.

(80) Francis E. Larkins, "The Selection of Groups for Medical Inspection", School Hygiene, 2(1911), 210-13.

(81) LCC, Day Schools Sub-Committee, Agenda, 17 November 1908.

The requirement that inspection be completed on school premises in school hours had two purposes. First, it ensured there was no loss of attendance for Code purposes; second, it avoided the possibility of conflicts if inspection took place on less neutral ground. In special cases, the Board would give permission for inspection to take place elsewhere, but it refused to allow inspection at Faversham to take place in a doctor's surgery due to the obvious potential opposition from other G.P.'s.⁽⁸²⁾ In the first years of medical inspection, meeting this requirement posed some difficulties for many schools. In some cases all children not being inspected had to be sent home⁽⁸³⁾ or the inspection had to be carried out in unsuitable locations, including, in one Chelmsford school, a landing between floors.⁽⁸⁴⁾

The final requirement, that all points in the schedule to Circular 582 be covered, was designed to establish a minimum standard for medical inspection, and to act as a deterrent to schemes such as Kerr's simplified schedule in London, discussed in

(82) PRO Ed 125/9, Precedent Cover: Faversham. A request from Kidderminster for centralized medical inspection was also refused. Kidderminster B.C., Education Committee, Minutes, 28 January 1908. Leamington Spa was reported to have arranged for inspection to be undertaken at the local Provident Medical Dispensary at a fee of 1/6d per head, Schoolmaster 72(1908), 924. It is unlikely that this was sanctioned by the Board, and by 1911, medical inspection in Leamington was being conducted by the School Medical Officer in the schools, Leamington Spa B.C., Annual Report of the School Medical Officer for 1911, p.72.

(83) Shropshire C.C., Annual Report of the School Medical Officer for 1909, p.16. This applied particularly to small, one-roomed schools.

(84) Lancet i(1909), 437.

the next chapter. It was stressed in Circular 582 that this schedule represented only the minimum required for efficient inspection, and authorities were free to adopt a more detailed system if desired. However, certain additional points of detail created difficulties for councils which tried to obtain more information than on the schedule accompanying Circular 582. Questions about the medical history or family circumstances of the child's family, or attempts to obtain information about vaccinations, sometimes led to controversy.⁽⁸⁵⁾ The latter led to questions from the ranks of anti-vaccinationists in Parliament, and led to the Board confirming that its own policy was that medical inspection should not be used as a means of enforcing vaccination.⁽⁸⁶⁾

The actual equipment needed for medical inspection was minimal, the only significant items of capital expenditure required being a steel-yard weighing machine and measuring standard. Some authorities bought one for every school, but elsewhere, at least at the outset, the equipment might be taken from school to school, often in the school medical officer's car, if he had one.⁽⁸⁷⁾ Sometimes this was thought a luxury; in Cheshire it was considered that the school medical inspector "will be all the better for being a good cyclist",⁽⁸⁸⁾ while another council devised portable equipment, including a weighing machine, claimed to be suitable for carriage

(85) PRO Ed 50/3, unsigned memorandum, 2 June 1909.

(86) See e.g. Parl. Deb. (Commons), 5th series, 14(9March 1910), 1457. Such information continued to be collected and published, however. See e.g. Walsall C.B.C., Annual Report of the School Medical Officer for 1911, p.74.

(87) School Hygiene, 2(1911), 12.

(88) Vacher, op.cit., p.7.

on the back of a motor cycle.⁽⁸⁹⁾ Frequently the weighing and measuring was done beforehand by the school staff or school nurses.⁽⁹⁰⁾ The actual inspection was straightforward, and usually conducted on the lines of the following description by James Kerr:

each child comes in separately and should be undressed to the waist by the nurse or teacher, and its boots removed before coming to the doctor's table. The cards must not get mixed. The child has therefore to be recognised from the card "Is this Johnny Smith?" Meanwhile there is a rapid general survey of the tout ensemble of both child and mother.

Nutrition is judged by shadows on the chest, and by a gentle grasp of the forearm; tongue and teeth are quickly examined; tonsils and pharynx noted. A wooden tongue depressor used, is then thrown into the waste basket. Each ear is looked at for obvious discharge, and the fingertips swept round the sub-maxillary regions. The eyes are inspected, the lower lid being depressed if necessary. The chest is auscultated, and then the child stands up, and turns round, its posture, spine and feet being noticed.

When any condition suggests detailed examination - for instance, by eye, ear or nasal specula - the best method is to put the child on the list for an inspection clinic later, and see it at leisure and free from the rush of routine inspection. (91)

This description by Kerr, although of a somewhat later period, succinctly reflects the descriptions of the ideal inspection process given in a number of contemporary accounts,⁽⁹²⁾ and highlights

(89) K. Fraser, "Problems of School Medical Inspection in a Rural Area", School Hygiene, 6(1915), 32-42, esp. 34-35.

(90) See "A Late School Doctor", op.cit.

(91) James Kerr, The Fundamentals of School Health (London: George Allen & Unwin, 1926), pp.633-34.

(92) See e.g. "A Late School Doctor", op.cit.; A.E. Edwards in Lancet ii(1908), 92-93; Ralph H. Crowley, The Hygiene of School Life (London: Methuen, 1910), pp.70-81.

some of the issues arising from the actual medical inspection itself, namely the depth of the medical investigation, parental interest and attendance, and the role and participation of staff other than the school medical officer.

Kerr's description emphasises that the basic medical inspection was only an inspection, and not a thorough medical examination. Although it was stressed that the inspection should be a thorough one, to satisfy the expectations of child and mother,⁽⁹³⁾ the basic pressure of work on the medical officer usually prevented a complete clinical examination. In any case, the very limitations of the medical inspection helped to make it more acceptable to parents. The Board had feared "a considerable number of cases in which the intervention of the Board is necessary to prevent scandals from want of tact or over-zeal on the part of local School Medical Officers"⁽⁹⁴⁾ but relatively few such cases did in fact arise. One well publicised instance was the work of Dr. George Carpenter, an unusual school medical officer in that he was also an eminent hospital physician, who attempted to perform his normal thorough medical examinations on the children presented for medical inspection. He required the children to be completely undressed and wrapped in blankets before giving them a complete clinical examination. Adenoids were tested for by digital examination, which involved the insertion of a finger into the mouth, and thence into the rear of the nasal passage, then a standard

(93) Ibid., p.76.

(94) PRO Ed 23/201, memorandum, Selby-Bigge to Morant, 22 December 1908.

procedure in clinical examination, but distressing to young children, especially after they had witnessed the struggles and heard the screams of former examinees. This brought many parental complaints, and the local authority referred Carpenter's methods to the Board of Education, which suggested that a less rigorous approach would be quite satisfactory. Although Carpenter alleged betrayal by the Board and his authority, his audience was unsympathetic, arguing that the Board wanted inspection, not examination, and, in the words of one speaker, suggesting that:

Dr. Carpenter's misdirected energy was due to the fact that he had spent a good deal of his life in the wards and outpatient departments of a children's hospital, where the children were necessarily diseased, and that fact of disease had become an obsession. (95)

Inspection, rather than examination, was thus the desired aim.

Parental attendance at medical inspection varied widely, with Newman noting in his Annual Report for 1909 a variation in parental attendance ranging from 90 per cent to 13 per cent of parents. (96) In general parents were anxious to attend, particularly in the case of the "entrant" examinees, and where low attendance were reported this would be due either to the inefficiency or absence of arrangements to inform the parents of pending medical inspections, or to social factors, as at Blackburn, where the low attendance at inspection was "mainly due to the circumstance that a large number of the parents are working at the cotton mills during

(95) The thoroughness, and also the practical uselessness, of Carpenter's examination is indicated by his report that of the 552 children he examined, more than 200 had "rickety deformities in varying degrees", Lancet i (1909), 914. See also Medical Officer 1 (1909), 851-56, 892, 945, 984.

(96) BPP 1910/XXIII:175, Board of Education, Annual Report of the Chief Medical Officer for 1909, Cd. 5426, p.75.

the daytime".⁽⁹⁷⁾

One issue to arise was the question of who, apart from the school medical officer, should be present during the medical inspection. The use of nurses, already noted, was sometimes resisted by doctors because it was thought their work might encroach on the preserve of medically qualified staff,⁽⁹⁸⁾ but their participation was generally, and quickly, accepted.

More controversial was the participation of teachers. Some councils relied extensively on the teachers performing duties which might elsewhere be performed by the school medical officer or school nurse. Thus in Hull "the head teachers not only weigh and measure the children, but they also test their sight with glasses".⁽⁹⁹⁾ In Hampshire, the teachers were also requested to record cleanliness and the condition of children's teeth.⁽¹⁰⁰⁾ Concern was expressed, both in individual areas, and by the national teachers union, at certain aspects of the role teachers were sometimes being asked to fulfil.⁽¹⁰¹⁾ Some councils found resistance from teachers⁽¹⁰²⁾

(97) Lancet ii(1910), 428.

(98) See e.g. PRO Ed 50/7, Sir Victor Horsley to Newman, 27 July 1908.

(99) Lancet ii(1909), 410.

(100) R.A. Lyster Text Book of Hygiene for Teachers (London: W.B. Clive, 1912), p.398.

(101) The N.U.T. issued a circular on the subject in 1908, warning teachers that they were not obliged to perform some of the duties related to medical inspection that were required by some education authorities. Schoolmaster 73(1908), 1252.

(102) See e.g. Carlisle C.B.C., Annual Report of the School Medical Officer for 1910, p.19.

particularly when they were asked to do more than their colleagues in neighbouring education authority areas,⁽¹⁰³⁾ while at the 1909 Annual Conference of the N.U.T. it was reported:

In a few instances the committee have been compelled to take action to combat requirements of an unreasonable character, such as the examination by teachers of children's teeth and heads. In certain districts it was suggested that the teachers should be required to give the use of a room in their private houses for the purposes of medical inspection, and the committee found it necessary to inform each member of the union in the areas concerned that such a requirements could not be legally enforced. (104)

As a result, the N.U.T. later issued another circular to its members setting out its policy on what teachers ought and ought not to be asked to do during school medical inspection. Although this advised that teachers should not undertake any role during the actual medical inspection, many councils continued to assume that the teachers would undertake a substantial part of the administrative and other work of medical inspection.⁽¹⁰⁵⁾ Some medical staff were also concerned about the presence of the teachers at inspection, and in 1914 a joint meeting of the B.M.A. and the N.U.T. attempted to agree on a code defining the respective

(103) Lancet ii (1910), 1582.

(104) Times, 12 April 1909, p. 8f. The presence of numbers of verminous children among those to be inspected would deter many teachers from volunteering their houses for medical inspection purposes, even if otherwise willing. Berwick-upon-Tweed B.C., Correspondence File: Medical Inspection, letter from the School Medical Officer for Northumberland, Northumberland R.O., Berwick branch, file L.12/9.

(105) PRO Ed 50/3, circular from N.U.T., 2 June 1909.

roles of the two professions. (106)

Although the Board of Education had no objection to teachers participating in the medical inspection, problems did arise over other groups who wanted to be present, or who wished to see the records of the children inspected. When school managers, or members of school care committees, made requests of this nature, the Board's policy was to advise against their presence, arguing that the need for confidentiality required it.⁽¹⁰⁷⁾ With the growing facilities for treatment, and the attendant bureaucracies for "following-up" and charging for treatment, care committee members or organisers were often present at the time inspection took place, if not actually at the place of inspection. In James

(106) The text of this agreement is reproduced in the Schoolmaster 88(1915), 290. The objects of the agreement were to define the respective responsibilities of teacher and School Medical Officer, and to discourage trespass into what the other profession regarded as its own territory. The Schoolmaster later quoted the Annual Report of the School Medical Officer for Hendon as one example of the difficulty:

"I still notice a good deal of slovenliness of speech and expression, and amongst a fair number of children, even in those of the senior department, I found there was frequently an inability to enunciate the vowel sounds and to pronounce the 'th' sound properly"

Ibid., p.372.

(107) See PRO Ed 125/8, Precedent Cover: Brighouse, 7 May 1908. Some School Medical Officers claimed the real problem with the presence of school managers was that their children were sometimes the dirtiest and most neglected in the school. School Hygiene i (1910), 607.

Kerr's view, such people were "excrescences on the system, and when charges are abolished [they] should be swept out".⁽¹⁰⁸⁾

Generally inspection itself gave rise to few major problems, although one which concerned many education authorities was the question of parents who refused to allow their children to be inspected by the school medical officer. From the outset the Board maintained that medical inspection could not be compulsory,⁽¹⁰⁹⁾ although when preparing Circular 576 Newman did not regard the question as having been finally resolved.⁽¹¹⁰⁾ Many local authorities wanted compulsion to be introduced in case increasing numbers of parents objected to the inspections.⁽¹¹¹⁾ The Board maintained however that the introduction of compulsory inspection would lead to unnecessary prejudice against the School Medical Service, and in 1909 the passage of the Local Education Authorities (Medical Treatment) Act resolved the question, as a clause was inserted during its passage through Parliament to the effect that parents were not required to submit their children to medical inspection.⁽¹¹²⁾ This, not surprisingly, was considered to have made it "very difficult" to support the contention that inspection was compulsory,⁽¹¹³⁾ although some authorities used sections of the 1908 Children's Act to carry out part of the medical inspection, on the pretext of examining

(108) Kerr, op.cit., 635; see also Leipoldt, op.cit., pp.22-23.

(109) See e.g. Parl.Deb., 4th series, 181(23 August 1907), 1397ff.

(110) PRO Ed 24/280, Newman to Morant, 3 October 1907.

(111) See e.g. PRO Ed 125/9, Precedent Cover: Gt. Yarmouth; Lancet ii(1909), 1104.

(112) Local Education Authorities (Medical Treatment) Act, 1909, 9 Edw.VII, ch. 13,cl.3.

(113) PRO Ed 50/3, memorandum on Local Education Authorities (Medical Treatment) Act, 1909.

the children for the presence of vermin. (114)

In practice, objectors to medical inspection were few, in most areas less than 5 per cent of parents. Some areas, Lewes among them, did experience consistently high rates of refusal during the first cycles of medical inspection, when suspicion about the new system was at its greatest. (115) The parental protests provided good copy for the medical journals:

Several indignant mothers have written to the headmistress of one of the schools [in Devon] claiming exemption from the operations of the Act. Perhaps the most emphatic protest is enshrined in the following epistolary masterpiece: "Dear Madam, I objects to my child being overorled by a doctor. I clears his blood vessels reglar with brimstone and treacle, and he don't want no more doctrine." (116)

Once the real purpose of medical inspection became apparent, such collective protests diminished in their incidence. Afterwards, protests tended to be by individual parents and were, on the whole, few in number.

Four main groups appear to have provided the bulk of such protestors as remained. First, middle class or skilled working class parents with their own general practitioner, who saw the School Medical Service as being intended primarily for those without

(114) BPP 1910/XXIII:175, op.cit., pp.198-202; BPP 1911/XVII:449, Board of Education, Annual Report of the Chief Medical Officer for 1910, Cd.5925, pp.270-76; BPP 1912-13/XXI:439, Board of Education, Annual Report of the Chief Medical Officer for 1911, Cd.6530, pp.299-301.

(115) Many objectors in Lewes were anti-vaccinationists. The Education Committee had to issue a circular rebutting allegations that the objective of medical inspection was to encourage vaccination. Medical Officer 1(1909), 674. Even in 1912, 10.9 per cent of parents in Lewes, much higher than the national average, objected to medical inspection, though this percentage was a reduction of the level formerly applying in the Lewes area. Lancet i(1912),904

(116) Ibid., ii(1908), 208.

their own doctor; second, parents of neglected children, who feared the consequences of medical inspection; third, anti-vaccinationists who feared that medical inspection would be used to aid the public vaccinator in his work,⁽¹¹⁷⁾ while the fourth group, particularly noticeable among the parents of older girls, and sometimes including the older girls themselves, were those who objected to medical inspection on the grounds of "decency". In Cambridge "I won't have my children stripped" [was] the most frequent objection" and in one school the elder girls themselves collectively refused to be inspected.⁽¹¹⁸⁾ This group was prominent among 'passive' rather than 'active' objectors. That is, rather than attending the school in person, or sending a note to refuse to allow inspection, the child was absented from school on the day of the school medical officer's visit. Thus at Hull, thirty seven active objectors refused to allow their children to be examined, but:

There is, however, a form of passive resistance to inspection, which is made possible by the fact that the parents are notified of the date of inspection of their children - viz:-that they simply keep their children at home on the day of inspection.

Sixteen male and sixty six female leavers were absent on the day of inspection.⁽¹¹⁹⁾ At Chester, out of forty four active objectors, twelve were the parents of infants, five of male leavers, and twenty seven of female leavers.⁽¹²⁰⁾

(117) School Hygiene 1 (1910), 667.

(118) Cambridge C.B.C., Annual Report of the School Medical Officer for 1913, p.11.

(119) Hull C.B.C., Annual Report of the School Medical Officer for 1912, p.131.

(120) Chester C.B.C., Annual Report of the School Medical Officer for 1908, p.24.

Active objectors are the only definite indication of adverse reactions to or experiences of medical inspection. Yet, at a time when Seebohm Rowntree's survey had only recently indicated more than a quarter of the population were living below the poverty line,⁽¹²¹⁾ stigmatisation of many children must have taken place during the inspection. Not all school medical officers were as sensitive as Dr. Sanders, the School Medical Officer for West Ham, who arranged for all children to be weighed and measured separately and privately, as:

It is very evident that the children, in many cases, would feel ashamed to take of their boots in front of their school fellows. The privacy, here adopted, has regard to the possible sensitiveness of the child and avoids needless comment which might arise if it were carried out in front of others. (122)

The Board considered no action was required in view of the small proportion of objectors. Later, it was suggested that information should be collected on the number of objections, as a relatively high proportion of objections might be an indicator of problems in an area's system of medical inspection.⁽¹²³⁾

(121) B. Seebohm Rowntree, Poverty: a Study of Town Life (London: Macmillan, 1901).

(122) West Ham C.B.C., Annual Report of the School Medical Officer for 1908, p.14.

(123) PRO Ed 125/20, Todmorden file, 1912.

The Results of Medical Inspection: Some Issues

The first reports of the local school medical officers showed that fears of "physical deterioration" were wildly exaggerated, but showed also that many children had defects which required attention. Difficulties occurred, however, in deriving from the reports reliable information on the extent of these defects, or their relative distribution between areas. This was because of the lack of consistency or uniformity apparent even in those areas inspecting according to the Board's schedule, a problem that was to persist throughout the pre-war period.

This was a problem with both an inter- and intra- authority dimension, and was acknowledged by Newman in his Annual Report for 1909 when he compared the reported prevalence of ringworm for different, but in many characteristics similar, local authority areas. Derby diagnosed one child in every sixty seven as having ringworm, Bradford one in eightytwo, Merthyr Tydfil one in one hundred and one; but in West Ham the proportion was one in six hundred, in Smethwick one in eight hundred and seventy five, and in Swansea one in nine hundred.⁽¹²⁴⁾ The issue of comparability of data was causing concern by the middle of 1909, when a conference at the Institute of Hygiene received comparative figures from twenty town and county school medical officers reports. The distribution of results from these reports is shown below:

(124) BPP 1910/XXIII:175, op.cit., p.36.

VARIATION IN DEFECTS REPORTED AMONG SCHOOL CHILDREN (125)

Defects Reported	Percentage		
	Lowest	Highest	Average
Tuberculosis	0.015	4.3	0.8
Bodily deformity	0.04	6.0	2.4
Defective nutrition	0.3	19.0	8.0
Unclean head and body	1.0	60.0	18.0
Decayed teeth	0.7	25.0	8.0
Enlarged tonsils	2.0	23.0	13.0
Adenoids	1.5	21.0	8.0
External ear disease	0.8	3.5	1.8
Eye disease	0.4	8.7	3.0
Defective vision	4.1	39.0	13.0
Mentally defective	0.3	4.2	1.3
Heart disease	0.4	5.0	1.5
Lung affection [sic]	0.1	2.4	1.4
Skin diseases	0.9	2.1	1.9

The conference called on the Board to issue further guidelines to ensure greater uniformity. However, as mentioned, there was an intra, as well as an inter authority dimension to the problem. In Staffordshire, the Annual Report of the School Medical Officer for 1911 compared the results obtained by the County's four full time

(125) Lancet i(1909), 1851.

medical inspectors in respect of eight to nine year old children in the urban areas of the County:

VARIATION IN DEFECTS REPORTED BETWEEN INSPECTORS⁽¹²⁶⁾

Inspector	A	B	C	D
Number examined	930.	759	1,251	1,030
Verminous heads	18.0	37.0	46.0	29.0
Ringworm	0.1	1.4	0.1	0.1
Defective sight	55.0	31.0	34.0	31.0
Sound dentures [sic]	12.0	9.0	13.0	10.0
Heart/func.dis.	1.3	8.8	10.0	2.6
Anaemia, slight.	9.0	3.0	27.0	10.0
Mouth breathers	11.0	13.0	20.0	8.0

These variations had occurred even though the county school medical officer was aware of the problem of consistency, and had attempted, with his colleagues, to achieve greater consistency "by discussions together, by fixing attention on definitions, to some extent by working together, and by occasional study of each others findings."⁽¹²⁷⁾

It is interesting to compare the way in which dentition is recorded in this and in the previous table. Such intra authority variations

(126) Staffordshire C.C., Annual Report of the School Medical Officer for 1911, p.8. All results expressed as percentages.

(127) Ibid., p.9.

were sometimes the cause of difficulty for the School Medical Service, as in Worcestershire where a proposal to increase the salaries of the medical inspectors aroused opposition because:

some of the members of the [education] committee were no doubt irritated by what must have seemed to them the strangely contradictory reports of the medical inspectors concerning the presence of pulmonary tuberculosis; one inspector reporting under the head of phthisis 0.8 per cent of defective children, and another 15.5 per cent, whilst no proof was furnished that either the lower or the higher estimate was correct. (128)

Because of the problem of consistency on an inter authority basis, Newman was urged not to include tabular compilations of the results of local school medical officers in his Annual Reports. (129) Indeed, prior to the First World War, the inclusion of such tables would have been grossly misleading for a number of methodological reasons, of which the differing definition of defect apparent in the tables above was only one. Although in 1913 Arthur Greenwood published a study of The Health and Physique of School Children based on an analysis of local school medical officers reports, he had to reject the material available in many of the reports as being insufficiently accurate or reliable. Although the usual practice was to take heights with the children's boots removed, and weights in ordinary indoor clothing, this was not invariably the case, and some doubtful material had thus to be excluded, (130) while:

(128) Lancet i (1909), 1637-38.

(129) PRO Ed 50/7, undated memorandum by Alfred Eichholz.

(130) Arthur Greenwood, The Health and Physique of School Children, Ratan Tata Foundation (London: P.S. King, 1913), p.4.

In some reports the average height and weight at each age was given, but not the number of children at each age. Such figures could not be included in determining the final average, although they were admissible for comparison with those of other areas. In certain cases the tables given in the reports were useless for the purpose, as, for example, where the average height and weight of all children under five, or between five and eight, are stated without any indication as to the average at each year of age; and also where boys and girls are not distinguished. (131)

An examination of a selection of local school medical officers reports indicates that Greenwood had by no means exhausted the number of possible difficulties in the use of these statistics. Even in the definition of an age group for statistical purposes, such as children aged five, could lead to the publication of tables referring to those "aged five",⁽¹³²⁾ "aged five last birthday",⁽¹³³⁾ "aged four to five and five to six",⁽¹³⁴⁾ "five in 1912",⁽¹³⁵⁾ or "children in their sixth and seventh years".⁽¹³⁶⁾ This could mean that cumulated tables ostensibly relating to the same year of age could include children with birth dates spanning almost two calendar years. It was to remove basic problems of data collection and

(131) Ibid., p.5. An example of unsatisfactory presentation of statistical tables can be found in Enfield U.D.C., Annual Report of the School Medical Officer for 1912, p.8., where the heights and weights of "infants" are presented undifferentiated for age or sex.

(132) Edmonton U.D.C., Annual Report of the School Medical Officer for 1912, p.128.

(133) Tottenham U.D.C., Annual Report of the School Medical Officer for 1912, p.50.

(134) Ilford U.D.C., Annual Report of the School Medical Officer for 1912, p.124.

(135) Kent C.C., Annual Report of the School Medical Officer for 1912, p.32.

(136) York C.B.C., Annual Report of the School Medical Officer for 1912, p.10.

and collation that Newman, in his Annual Report for 1912, published in November 1913, issued a set of standard tables in an attempt to attain a degree of uniformity in the presentation of local school medical officers annual reports.⁽¹³⁷⁾ It is clear, however, that much as concern about the lack of reliable data on the condition of the people may have motivated the establishment of the School Medical Service, prior to the First World War it was unable to provide consistent data when considered on a national basis.

The problem of consistency was emphasised by two further factors. First, many of the reports gave much time to discussions which were subjective appraisals of aspects of children's health on which it was difficult to apply qualitative standards. Discussion of nutrition, or about the presence of "slight anaemia" represented only the clinical judgements of the officers concerned. Second, the standards varied both between districts, and, within any area, over time. Thus in some areas, children were recorded as having defective teeth only if four or more teeth had caries,⁽¹³⁸⁾ in others, all children with bad teeth were recorded as having defective dentition,⁽¹³⁹⁾ whilst in Devonshire:

Teeth: 10 per cent were defective. About 80 or 90 per cent had disease of the teeth, but only those cases were included as defective when the teeth were causing harm either by indigestion or blood poisoning. (140)

(137) BPP 1914-16/XVIII:277, op.cit., pp.25, 396-408.

(138) E.g. Carnarvonshire C.C., Annual Report of the School Medical Officer for 1910, p.15.

(139) E.g. Southport C.B.C., Annual Report of the School Medical Officer for 1909, p.23.

(140) Lancet i (1910), 682.

Similarly, the true extent of a problem, and the progress made in dealing with it, were to some degree concealed by changes in the procedure adopted for recording of defects. Initially, a problem such as the presence of nits in hair might be so prevalent that only the worst cases would be recorded. When the incidence of the problem diminished over time, the recording of the remaining cases became more complete, meaning that the progress made was concealed.⁽¹⁴¹⁾

The evidence presented here indicates some of the difficulties encountered in the development of a service where no work had formerly been pursued in a number of areas, but where existing, and varying, systems were already in operation in others. Although most local education authorities were to adopt the system of administration favoured by the Board of Education, even this was to lead to difficulties in some areas. Coming as it did almost simultaneously with the acquisition of other new duties under, for example, the 1909 Housing, Town Planning, etc., Act, the School Medical Service sometimes led to serious pressures on the medical officers of health, particularly in the counties. Indeed, by the end of 1910 Newman was already re-examining his policy, for in the case of a number of county officials, the pressures were so great that "they are either undertaking their school work at the cost and to the detriment of their county work or they are likely at an early date to find themselves in that predicament".⁽¹⁴²⁾

(141) See e.g. Jennie R. Riddell, "A Study of the History and Development of the School Medical Service in Liverpool from 1908 to 1939", (M.A.thesis, University of Liverpool, 1947), p.44.

(142) PRO Ed 50/1, memorandum on "Duties of County Medical Officers of Health" by Newman, 14 November 1910.

This led to discussions with the Local Government Board about how the difficulties might be resolved.

Summary

Despite the resentment felt by many authorities at the absence of a central government grant in aid of the cost of the School Medical Service, the basic minimum medical inspection was eventually established on a nationwide basis. In some instances, particularly that of London, discussed in the next chapter, the intervention of the Board was required before a satisfactory system was established, while in other cases the satisfactoriness of the systems used rested on a generous interpretation of its regulations by the Board. The introduction of a grant, and the growth in the staff of the Medical Department, were eventually to produce a more rigorous approach which will be discussed in chapter nine. It is clear, however, that in the absence of any financial aid, many authorities sought to make the minimum arrangements necessary for the fulfillment of their legal obligations. Administratively, most authorities placed the medical officer of health in the position of ultimate responsibility for the service, but a significant minority, particularly among the larger authorities, preferred to appoint, or to retain, an independent school medical officer. Where subordinate officers were appointed, these positions were staffed increasingly on a full-time basis. By 1914 concern was expressed about the monotony of full-time medical inspection and the difficulty of

establishing a suitable career structure for such personnel.

Medical inspection itself raised relatively few difficulties, but the way in which the results were presented meant that, prior to the First World War, the desire of the Inter-Departmental Committee on Physical Deterioration for the compilation of nationally comparable statistics revealing the physical condition of the people was not to be realized. Fundamentally, however, the revelations of defect contained in the reports of the local school medical officers raised the question of what further action was now to be taken. This will be discussed in chapter eight.

CHAPTER SEVENTHE CONFLICT WITH THELONDON COUNTY COUNCIL1908-1912The Context of Disagreement

The most serious problem facing the Board of Education in the early years of the School Medical Service was the refusal of the London County Council to conform to the instructions of the Board's circulars and Education Code. The Council's prolonged defiance of the Board eventually led Newman to abandon his customary discretion and comment in his Annual Report for 1909 that "the degree to which this authority [the L.C.C.] have fallen short of accomplishing the work which it was their duty, under the Act, to perform, is without parallel".⁽¹⁾ For the largest education authority in the country, containing almost one in eight of the school population,⁽²⁾ to defy the Board was serious enough in itself for the unity and integrity of the School Medical Service, but the L.C.C.'s size and location made its affairs almost a national issue. Council debates were widely reported in the national press, and the policies adopted by the L.C.C. often served as examples to lesser authorities. The Board thus viewed the Council's departure from its recommendations

(1) BPP 1910/XXIII:175, Board of Education, Annual Report of the Chief Medical Officer for 1909, Cd.5426, p.6.

(2) In the year 1907-8 the average daily attendance at school for the whole of England and Wales was 5,282,455. The average attendance at the 913 schools in the L.C.C. area totalled 649,561, or 12.29 per cent of the total. BPP 1909/LXVIII:171, Board of Education, Educational Statistics, 1907-8, Cd.4885.

with some concern.

One of the roots of the conflict has been referred to earlier; the presence of James Kerr as head of the L.C.C.'s existing educational medical service. The vigorous and innovative approach to school hygiene that made Kerr probably the best-known medical man in the field, and an obvious candidate for the post of Chief Medical Officer at the Board, has been discussed in chapter three. Chapter four has indicated the disappointment he felt when Newman, a man he considered to have few qualifications in comparison, was eventually offered the post at the Board.

By nature, Kerr was a forceful personality. Sir Cyril Burt remembered him as:

a burly man with a bluff manner and a rich accent... [who]seemed the most unconventional member of the L.C.C. staff. Dressed apparently for a country outing, talking in a racy, down to earth idiom,he was ready to ride roughshod over any traditional custom, and had a dogged tenacity of his own. (3)

Although nominally a subordinate of Sir Shirley Murphy since the London School Board's assimilation into the L.C.C., Kerr had successfully maintained a separate office and an independent policy, straining and breaking relationships with Murphy and

(3) Huw W.S. Francis et al., "The Doctor as Educationalist: James Kerr, 1361-1941", Medical Officer 123(1970), 303.

his staff at the Public Health Department in the process. (4)

From this position, he could continue his campaign for a School Medical Service independent of the medical officer of health.

There was, however, also a political dimension to the clash between Board and Council: the change in the political composition of the L.C.C. which took place in 1907. The 1907 L.C.C. elections had seen the defeat of the Progressive Party which had dominated London politics for a considerable time, and its replacement as majority party by the Municipal Reform or Moderate group which was allied politically to the Conservative Party. Many of the Moderate Councillors were also Unionist M.P.'s, just as leading

(4) In 1911 members of the L.C.C. were assumed by Sir Laurence Gomme, the Clerk to the Council, to be familiar with "the relations, or rather, perhaps I should say the lack of relations, which exist between the Medical Officer of Health and the Education Branch of the Public Health department". L.C.C., Children's Care (Central) Sub-Committee, Agenda, 6 February 1911. Some indication of the reasons for the breakdown in relationships can be found in earlier discussions about the L.C.C.'s system of educational administration, following the transfer of responsibility from the L.S.B. In these Kerr claims that during the transfer he was guaranteed independence with the promise "that I should not be called assistant to anyone; that I should be solely responsible and report directly to committees on the medical work of my department and that I should publish an independent annual report". Against this, Murphy blamed Kerr for obstructing the capital's Public Health officials in the days of the L.S.B.'s independence by refusing to agree to the closure of schools during epidemics: "I have no hesitation in saying that there would be a number of people living now if it had not been for the separation of the two departments". GLRC, L.C.C. file EC/GEN/5/25, Special Sub-Committee of the General Purposes Committee on Educational Administration, 1908, Minutes and Appendices. See esp. Appendices 5 and 6, and oral evidence by Kerr and Murphy.

Progressive Councillors held high office in the Liberal Party.⁽⁵⁾

The Moderate campaign of 1907 had centred on the growth of the County Council rate precept during the years of Progressive political control, a growth emphasised and exaggerated by the inclusion of the education rate within the general precept after the L.C.C. had assumed responsibility for education in 1904. Expenditure on education was rising significantly, partly due to improvements in teachers salaries and conditions of service, partly through provision for post-elementary education, but partly, indeed mainly, due to increases in costs caused by the funding of voluntary schools under the 1902 Education Act. This growth in educational expenditure was taking place within a budget that was increasing generally due to expenditure on municipal tramways and other activities.

The new Moderate administration at County Hall quickly aligned itself with the general body of County Councils in calling for a specific Exchequer grant-in-aid to cover the cost of the School Medical Service, participating in the action described in chapter five, but it also took independent action, lobbying Runciman in June 1908,⁽⁶⁾ and sponsoring a conference on the question in

(5) Thirty one of the L.C.C.'s Progressive Councillors were elected to Parliament in the 1906 election. Pall Mall Gazette, The New House of Commons, 1906 (London: Pall Mall Gazette, 1906). Although many of these M.P.'s subsequently retired from the L.C.C., or lost their Council seats in the 1907 Council elections, their replacements among the Municipal Reformers on the L.C.C. included a number of Conservative M.P.'s For an account of the 1907 L.C.C. election, written from a Progressive viewpoint, see A.G. Gardiner, John Benn and the Progressive Movement (London: Ernest Benn, 1925), pp.329-62.

(6) Times, 19 June 1908, p.14

December,⁽⁷⁾ which led to a mass lobby of Asquith, Lloyd George, and Runciman in March 1909.⁽⁸⁾ Individual Moderate Councillors who were also Unionist M.P.'s raised the matter in the House.⁽⁹⁾ For the L.C.C. the problem was felt particularly acutely; London for historical reasons received a smaller than average proportion of its education expenditure back in Exchequer grant.⁽¹⁰⁾

The new administration was also faced by continuing complaints from the voluntary hospitals in the capital about the effects of the Council's vision testing programme. Although the L.C.C. had introduced a number of administrative reforms in an attempt to reduce the impact on the out-patients departments described in chapter two, protests continued to be received. In June 1907 a number of complaints were laid before the Education Committee, now dominated by the Moderates. After deliberation,

(7) GLRO, L.C.C. file EO/GEN/1/19, "Conference of Local Education Authorities on Education Grants, 11 December 1908."

(8) GLRO, L.C.C. file EO/GEN/5/33, "Increased Exchequer Grants for Education, 18 March 1909".

(9) Parl. Deb. (Commons), 5th series, 21(13 February 1911), 708ff.

(10) Exchequer grants met only 31.0 per cent of the cost of elementary education in London in 1906-7, compared with a national average of 53.6 per cent grant support. GLRO, EO/GEN/1/19, op.cit.

the Committee declared:

We think the whole question of vision testing and correction is only a part of the larger question of the treatment of school children by the public charities.

As regards vision testing, the difficulties which are constantly being experienced appears to arise from the fact that the work that ought to be done is very much greater than the hospitals can possibly perform. The work itself is considered uninteresting, and it is said to bring no reward, either from practice or experience, to the doctors, and no additional subscriptions to the hospitals.

We are advised, and our experience goes to show, that the provision for this work is very inadequate, and that further hindrances arise from the various bye-laws and regulations, the chief of which are - the necessity for a subscribers letter, the restriction of patients to a wholly inadequate number on the day on which the oculist attends, and the frequent necessity of paying a high price for needlessly accurate and highly finished glasses.(11)

It is resolved to set up a Sub-Committee to examine the question in detail. The Moderates were not, therefore, opposed in principle to the treatment of children found to be defective on inspection. Discussion on the composition of the Sub-Committee continued for some time, during which the passage of the 1907 Act, giving the Council for the first time the power to finance arrangements for treatment, gave added significance to the proposed inquiry.

(11) L.C.C. Education Committee, Minutes, 26 June 1907.

The Development of Policy

The passage of the 1907 Act also led the Council to discuss the effect of the legislation on its existing arrangements. A Medical Section (a Sub-Committee) of the Day Schools Sub-Committee discussed the matter in the interval between the passage of the Act and the issue of Circular 576, and in the absence of information obviously expected minimal demands to be made by the Board:

No definition of what is "medical inspection" or what "attending to the health and physical condition of the children" may mean is to be gathered from the Act. These no doubt will be defined later, but as there is no grant, the Board of Education cannot expect much at present. (12)

The Medical Section went on to discuss how the Council ought to respond to the passage of the 1907 Act, given that some expansion of the staff of part time medical inspectors had already been agreed:

The question of the medical staff required for the work of medical inspection under the new Education (Administrative Provisions) Act, 1907 depends on whether it is decided to adopt a complete organisation providing for the medical inspection of every child, the recording of all details, and the following up of the child with oversight throughout its school life, or whether the present work is continued and gradually developed pari-passu with other measures. There are at present reasons for rejecting the first plan. The work could not be done without at least 100 quarter time doctors being added to the staff, and neither teachers, ratepayers nor hospitals are prepared for the consequences.

Until, therefore, the Council shall have decided how the inspection is to be utilized and completed by treatment, nine-tenths of the expenditure would be wasted money as far as the children were concerned.

(12) L.C.C., Day Schools Sub-Committee, Agenda, 21 January 1908.

We therefore submit a modified scheme for establishing during the course of two and a half to three years a fairly complete system of "inspection" as far as our present experience justifies the expenditure. The staff may seem ridiculously inadequate but it is the minimum to satisfy the requirements made by the Act. (13)

A gradual increase in the staff of part-time school doctors to one hundred over a three year period was therefore proposed.

This passage illustrates the policy adopted by the Moderate majority. They were not opposed to inspection, or indeed to treatment, for the experience of vision testing had demonstrated the need. But, where expenditure had to be undertaken, the L.C.C. adopted a minimalist position that was contrasted with what was presented as the extravagant and ultimately wasteful demands of the Board of Education. The clear implication was that if the Board wanted a more rigorous system of provision, it would have to pay for it in Exchequer grant.

The political leadership of the L.C.C. was therefore reluctant to accept any proposals from the Board that could be regarded as premature or extravagant. After Circular 576 was issued, Kerr thus found a receptive audience for his arguments that other methods of administration and inspection would be both cheaper and more effective. When the Day Schools Sub-Committee met to discuss the report of the Medical Section, the agenda also included both a copy of Circular 576 and a long commentary by Kerr attacking the circular in trenchant terms. He noted that:

The first eleven sections of this memorandum are of a general nature. It is important to note, however, that these sections are not regulations under the Act,

(13) Ibid.

but merely expressions of opinion which anyone is at liberty to adopt or refuse. (14)

Having thus attempted to establish the non-mandatory nature of the Circular, Kerr then proceeded to review it clause by clause, trying at all times to stress that the Board's powers were limited, and that their suggestions ought not to be adopted.

Thus:

Section 2 - recites the wording of the Act. It is to be noted in the Act that the provision of arrangements for inspection is a matter for the local education authorities and not for the Board of Education except so far as the times of inspection are concerned ...

Section 7 - several of the topics suggested are, if they were requirements, quite ultra vires. There is no compulsion on any county council to appoint a county medical officer of health, and similarly the rest of the paragraph imposes no actual requirement to place medical inspection under the medical officer of health, although at first reading it does so....(15)

Kerr concluded his comments by arguing:

The requirements of this memorandum do not necessitate or suggest any need for alteration in our procedure in London. Most of it is mere expression of opinion as to matters with which the London County Council, as a result of their real experience, is more competent than the Board of Education to decide....the Council are the authority to decide on all details of the organisation of the medical service in the schools, and the Board of Education's opinions need not be further considered as in any way constituting a mandate for change. (16)

Kerr was thus arguing that the powers of the Board to compel the adoption of a particular system of administration and inspection were limited, and that rather than adopt the Board's suggestions, the

(14) Ibid.

(15) Ibid.

(16) Ibid.

Council ought to continue with its existing system of routine inspection, devised by Kerr himself. Prompted by Kerr the Sub-Committee resolved to increase the number of part-time doctors gradually, along the lines suggested by its Medical Section. This meant Kerr could claim publicly, if rather indiscreetly, that the Council was prepared to ignore the Board of Education. (17)

To understand fully the nature of the Council's rebellion, an understanding of the L.C.C.'s existing system of "routine" medical inspection (a term which, confusingly, was also used to refer to the Board's recommended system), is necessary. This had evolved from the vision testing system, and prior to the 1907 Act the L.C.C. had employed a staff of twenty four quarter-time school doctors, mainly junior hospital staff, to visit schools in the L.C.C. area. This staff was insufficient to visit each school every year, but it was intended that every school would be visited in rotation. (18)

The L.C.C.'s routine examination was not a systematic inspection of all children in a school, nor even of all children in one class or standard. Instead, prior to the visit of the school doctor, the head teacher pre-selected the children he or she wanted to be given a detailed examination, and those remaining were then given a brief screening by the doctor on his arrival. The method, and rationale, for this approach were explained by Kerr:

(17) Times, 19 June 1908, p.14

(18) BPP 1910/XXIII:1, Board of Education, Annual Report of the Chief Medical Officer for 1908, Cd.4986, pp.23-24.

If all the cases known to the teacher are placed on one side, and then all the other children passed before the doctor, he can select any obvious cases for further examination, and at once dispose of the 60 or 70 per cent of practically normal children without further waste of time in weighing, measuring or filling in cards with needless family histories, or records of hair, clothes, boots and shoes, all futile as far as practical purposes of medical treatment are concerned. (19)

Thus the routine examination was aimed at concentrating the time of the medical officer on the defective child, with the implied objective of effecting treatment, within the legal restrictions imposed, for as high a proportion as possible of the children identified as defective. Kerr believed the objective of medical inspection was the facilitation of treatment. Inspection without treatment was valueless. (20)

Despite Kerr's claim that the L.C.C. was prepared to defy the Board, the Council spent some time discussing the question of the requirements for inspection with the Board of Education. A deputation went to the Board on 18 June 1908, where they were met by McKenna, his deputy Thomas McKinnon Wood, and Morant. In addition to discussing the issue of the grant for medical inspection, the L.C.C. raised the question of the standard of examination required. The L.C.C. argued that under its existing system of routine inspection:

all children who were in any way defective were examined by the Council's medical officers, that this medical examination was sufficient for statistical purposes, and that if all children in elementary schools were to be examined three

(19) L.C.C., Children's Care (Central) Sub-Committee, Agenda, 10 June 1910.

(20) L.C.C., Day Schools Sub-Committee, Agenda, 17 November 1908.

or four times in each child's school career, i.e. about once every three years, a very great burden would be thrown on the council. (21)

These arguments were rejected, but the L.C.C. continued to probe the Board on its intentions, particularly after the publication of the 1903 Education Code in July enhanced the powers of the central department. After publication of the Code, the L.C.C. resolved to ask the Board formally whether all children had to be inspected, and whether the whole inspection had to be performed by a doctor. (22)

Selby-Bigge, replying to this letter of enquiry from the Council, was emphatic on the question of whether all children had to be inspected, and whether Kerr's system of selective examination and a march-past was acceptable. He said:

The Board do not consider that it was the intention of Parliament that medical inspection should be confined to children selected for obvious defects... the Board have therefore, in their memoranda and Code, proceeded on the principle that the provision made by local education authorities should include arrangements (a) for bringing under inspection each child attending a public elementary school at particular stages in his life, and also (b) for bringing under inspection on each particular occasion when an inspection is held in the school all the children who have reached a specified stage in their school life. It does not appear to the Board that the memoranda which they have issued on the subject leaves any room for doubt on this point. (23)

On the second issue the Board were prepared to be more flexible:

it is obvious that the responsibility for the work of medical inspection must rest with a qualified medical man; but within certain wide limits the Board have no doubt that it will be quite consistent with such responsibility that a considerable amount of assistance should be rendered by school nurses and persons not medically qualified. (24)

(21) Ibid., 30 June 1908.

(22) Ibid., 7 July 1908.

(23) Ibid., 13 October 1908.

(24) Ibid.

Although the Board thus gave the L.C.C. the opportunity of devising a compromise system relying heavily on the work of school nurses and teachers, this possibility was not mentioned in the internal discussions of the Board's letter, which provoked varying reactions from the L.C.C.'s professional staff. Robert Blair,⁽²⁵⁾ the Education Officer, thought it was now "clear that the Board of Education will not be satisfied with what is now being done by the local education authority as satisfying clause 58(b) [of the Code]"⁽²⁶⁾ He also noted that the appointment of the additional staff of school medical officers had still not begun, six months after their scheduled date of appointment, as the Chairman of the Education Committee had moved that no action be taken on the appointments as a protest about the lack of grant for school medical inspection.

In Kerr's comments on the Board's letter, however, he both criticised the policy of the Board of Education and argued again, even in the face of Selby-Bigge's comments, that the Board's requirements were not binding. The groups of children the Board wanted to be inspected were, he said, among the least satisfactory from the school doctor's standpoint, entrants being too young to yield consistent results, and leavers moving out of the jurisdiction of the education committee before it was possible to ensure treatment. Again, he argued that the Board's regulations

(25) Sir Robert Blair B.Sc. MA (1859-1935). Eldest of ten children of a cobbler from Wigtown. Apprenticed as a pupil teacher, but later educated at Edinburgh University. Worked as a teacher in Kelso and London before becoming an Inspector in the Scottish Education Department in 1894. 1901-4, Chief Inspector, Technical Education, then Assistant Secretary, Technical Instruction, Irish Agriculture Department. Education Officer, L.C.C., 1904-24. Kt. [1914].

(26) L.C.C., Day Schools Sub-Committee, Agenda, 13 October 1908.

need not be interpreted rigidly:

obviously, so long as the children entering school after 1 August 1908, and children leaving school before 1 July 1909, are examined, the details of all the examinations need not be comprehensive...As regards the second question, from the answer given by the Board it may be taken that the cases to be seen by the medical man may be selected by nurses and teachers so long as the medical officer takes responsibility. (27)

This misreading of the Board's letter, deliberate or otherwise, allowed Kerr to argue that the Council could continue to operate in the same manner as before, with only a minority of children being subjected to a detailed examination by doctors. Admitting that the proposed increase in the staff of school doctors would be insufficient to provide for the medical inspection of all children in the groups specified by the Board to the standard it required, he suggested an alternative approach. In sixteen schools, one in each educational district of London, the Board's schedule of inspection would be followed rigorously. In a further sixteen schools, an examination of all Code group children on a simpler schedule of inspection devised by Kerr would be followed:

which, I think, will take about a quarter of the time and probably attain nearly equal results. For the rest of the schools, we must carry out the present method, somewhat slightly extended, of examining all the children selected by the teachers according to instructions, and also sampling classes. (28)

This, Kerr argued, would give a guide to the utility of the Board of Education's proposals. Thus Kerr effectively proposed to proceed

(27) Ibid., 17 November 1908.

(28) Ibid.

as before, experimenting with the Board of Education's schedule of inspection in only sixteen out of the nine hundred schools for which the L.C.C. was responsible. For the Moderate majority, part of the attraction of Kerr's proposals was that they were presented as being cheaper than, but at least as effective as, the Board's suggestions. This allowed Kerr to proceed with his plan. The L.C.C. submitted to the Board for approval a scheme for inspection following the suggestions of Kerr, though with inspection according to the Board's schedule in forty schools, rather than the sixteen originally suggested, as each school doctor and assistant school doctor by then employed would inspect one school in accordance with the Board's requirements. A simplified schedule devised by Kerr would be used in a further forty schools, and the remaining schools, or those the school doctors managed to visit during the course of the year, would remain subject only to the "routine" system of pre-selection and march-past. A statement of the proposed increase in the number of school doctors and assistants was also sent to the Board. Thus the bulk of the schools in the L.C.C. area would be subject, at most, to the "routine" inspection.

Nevertheless the Board, with "great hesitation" approved the L.C.C.'s scheme as satisfying its 1908 Code requirements. As the last chapter has indicated, circumstances dictated that the Board had to adopt a flexible approach in the first years of medical inspection, and with some councils yet to begin inspection, the Board could not penalize the L.C.C. without taking action

against many other councils also. The Board did question the adequacy of the L.C.C.'s staffing level for the work proposed, and warned that future proposals would be carefully scrutinized:

it must not be assumed that, in considering the adequacy of such proposals, the Board will adopt the same standard of efficiency as they feel justified in applying to a scheme of an initiatory character. (29)

This was to be the last time the L.C.C.'s arrangements were given formal approval by the Board during Kerr's period as head of the Council's School Medical Service. Even as the Board's letter was delivered, Kerr was telling the Day Schools Sub-Committee that his school doctors had not yet begun the detailed examinations according to the Board's schedule, as he felt it advisable that they first gained some experience in the schools. Only at the beginning of March, 1909, did detailed inspection in the selected schools begin. (30)

While this argument between the Board and the L.C.C. continued, the question of the treatment of children found to be defective on inspection was causing a protracted discussion within the Council. Following the decision to set up a Sub-Committee specifically to enquire into the matter, a debate ensued as to its composition. Eventually, it was agreed it should consist of members of the Education Committee and a number of co-opted members representing the medical and dental professions, the voluntary hospitals and various charitable bodies. (31) After a delay

(29) L.C.C., Education Committee, Minutes, 24 March 1909.

(30) L.C.C., Day Schools Sub-Committee, Agenda, 16 February 1909.

(31) L.C.C., Education Committee, Minutes, 24 July 1907.

necessitated by the solicitation of nominations from the various interests concerned, the Sub-Committee on Medical Treatment began its work in February 1908, by which time, with the passage of the 1907 Act, the Education Committee had asked it to discuss:

- i. What is the existing provision for medical treatment of school children?
- ii. To what extent can this provision be rendered more available by the action of (a) the hospitals and (b) the Council?
- iii. What additional provision, if any, is desirable?
- iv. How should this provision be supplied? (32)

The Sub-Committee's proceedings lasted nine months, during which the members received both written and oral evidence, before the draft report was discussed. Much of the evidence given before the Sub-Committee related to the Council's unsatisfactory experience of trying to obtain treatment for defective school-children under its existing arrangements. A typical parent's letter to a teacher, presented to the Sub-Committee, illustrated the frustrations of the existing system of referral to an out-patients department:

Madam, I took Lily to the Hospital twice last week and had my journey for nothing, because the doctor will not see more than six in one week, so that anyone stands a very poor chance of being seen to. I cannot keep going week after week and then the doctor won't see you. They sent quite thirty away last Thursday and would not attend to them. (33)

(32) Ibid., 13 November 1908.

(33) L.C.C., Education Committee, Agenda, 9 December 1908.

Quite apart from such illustrations of operational difficulties with the existing system of indiscriminate referral to the voluntary hospitals, the evidence given also dealt with the practical problems that would arise if the treatment schemes were to be extended to other diseases and conditions affecting school life. It was suggested that existing dental treatment facilities would be overwhelmed by the demand if a comprehensive treatment scheme for London school children were to be attempted for:

they estimate among themselves [dental surgeons] that they can deal with 187 patients a week; calling this 200, and 50 weeks yearly, we get 10,000 yearly as the present provision for the minimum of 100,000 requiring it [treatment]. (34)

Ringworm, requiring prolonged treatment or expensive specialised facilities "seems to be beyond the capacity of the hospitals out-patient rooms; it is quite beyond the means of the ordinary family doctor". (35)

The Sub-Committee heard a number of proposals for dealing with the question of treatment. Enthusiastic supporters of voluntary, self-help groups suggested, through T. Hancock Nunn, that the remedy lay in the formation of Junior Provident Societies, with children paying between 2d. and 6d. a month for full benefit cover. Hancock Nunn claimed, probably with some exaggeration, that 50 per cent of the child population of Hampstead were "Junior Foresters", adding that "neither Jews nor aliens were excluded" from membership. (36) The Provident Medical Societies

(34) Ibid.

(35) Ibid

(36) Ibid.

were also willing to help, in exchange for funds from the L.C.C. This was no doubt attributable to the financial problems some of these societies were encountering. However, they admitted that they themselves were not equipped to treat children on an extensive scale, and they referred many of their existing cases to the voluntary hospitals for treatment. (37)

The Moderate Councillors, elected on a platform of opposition to the expansion of municipal undertakings and expenditure, were sympathetic to suggestions that the medical needs of the capital's school-children could be met through voluntary agencies. Though Hancock Nunn's proposals were evidently impracticable, it was thought possible that a formal bargain with the voluntary hospitals could be made, paying them to act as the Council's agents for the treatment of a fixed number of children, rather than forcing them to be unpaid attendants to unregulated hordes of pupils. The L.C.C. despatched questionnaires to the hospitals to sound out their opinion of this proposal.

Bentley B. Gilbert's account of the development of the School Medical Service implies that this was a proposal with which Kerr had some sympathy. He suggests that Kerr's anger at failing to secure the appointment as Chief Medical Officer was not only directed at the Board of Education, but also vented on the children of London, in that he refused to establish school clinics, or to aid those such as Margaret McMillan who were trying to establish privately funded clinics. Instead, he sent children "whose need

(37) Ibid.

for care was too apparent to be ignored" to the voluntary hospitals. (38)

This misrepresents Kerr's views and, indeed, his responsibilities. Since his appointment as Medical Officer to the London School Board, Kerr had been grappling with the problem of obtaining treatment for the vision test cases. His experiences were to lead him to argue with growing emphasis that a satisfactory solution to the problem would not be found until the L.C.C. itself intervened to provide treatment facilities. In his early years with the L.S.B., he was content to assume that the hospitals would eventually adjust to the new demands placed on them. In 1903, after complaints had been received from some hospitals, Kerr commented:

it will probably be some time before the hospitals adapt themselves to the increased work resulting indirectly from medical oversight of schools which may now be regarded as permanent, and which can only be met by an increase of staff. These adjustments will no doubt be met in time, or the whole matter of such work may....have to be undertaken at the expense of the rates by the Public Authorities. (39)

By 1906, as the hospitals failed to make any adjustments other than to continue their complaints to the Council, Kerr was pressing for more consideration to be given to the alternative of Council intervention:

a point has now been reached where the question of rigid adherence to the policy of completely

(38) Bentley B. Gilbert, The Evolution of National Insurance in Great Britain (London: Michael Joseph, 1966), p.140.

(39) GLRO, L.S.B. file SBL/287, Sub-Committee on the Medical Officer's Department, Minutes, 18 February 1903.

excluding any medical treatment from the work of the education branch of the Public Health department may have to be very seriously reconsidered. (40)

The following year, he was emphatic that the Council should take action itself:

the next step forward in Public Health will be the provision of treatment for all such common defects as are a nuisance or a risk to the public without being an actual danger to life. Vermin, for instance, defects of vision remediable by glasses, the treatment of chronic aural discharge (a condition, popularly regarded as trifling, but presenting an unfavourable and fatal outlook if left unrelieved), and such general non-fatal but troublesome and offensive diseases due to vermin and parasites. These are likely to need consideration as to whether they should be prevented at the public cost. (41)

By 1909, an Australian visitor to the L.C.C.'s School Medical Service could observe that Kerr:

has expressed the opinion that the only efficient method of getting treatment in large towns is by school clinics. All other methods are cumbrous, ineffective and costly in time to parents, and in superintendence and actual cost for the children. (42)

Kerr's support for the concept of the school clinic is reflected in his evidence to the Sub-Committee on Medical Treatment.

Discussing how best various conditions might be treated, Kerr argued:

Probably dentistry would be best practiced as part of the work of the school clinics which

(40) L.C.C., Annual Report of the Medical Officer (Education) for 1905-6, p.3.

(41) James Kerr, "On the Medical Inspection of Schools", Journal of the Royal Sanitary Institute 27(1906-7), 778.

(42) Edward M. Steven, Medical Supervision in Schools (London: Bailliere Tindall, 1910), p.12.

are suggested....The cases of defective vision could be treated at very much less expense to the whole community in school clinics than in any other ways.... [Ringworm] is almost an ideal subject for treatment in a school clinic. (43)

Other professional witnesses, including the British Dental Association, also argued for the establishment of a school clinic system.

The reaction of the voluntary hospitals to the Council's questionnaire asking if they were prepared to treat children on a contractual basis was at best lukewarm. Some stressed the pressure on their facilities, others mentioned their rules for admission, which often restricted treatment to the "indigent" poor, specified free treatment, relied on investigations by hospital almoners, or had other potential difficulties. While some of those hospitals willing to provide treatment said they were able to treat more than they did at present, others wanted numbers reduced. Many simply refused to treat school-children. (44)

Excluding the impracticable proposals for children's health insurance and self-help schemes, the Sub-Committee was thus faced with a choice between two main options. Either it could support the continued use of the existing voluntary institutions, aiding them with council funds if they formally agreed to treat children on behalf of the Council, or they could recommend the establishment of a separate system of school clinics. Despite the weight of professional evidence in favour of the latter option, the Moderate

(43) L.C.C., Education Committee, Agenda, 9 December 1908.

(44) Ibid.

members of the Sub-Committee favoured making arrangements with the voluntary hospitals. In the Sub-Committee debates on the draft report, however, they were opposed, and to their consternation frequently outvoted, by an alliance of the Progressive members of the Sub-Committee and the majority of the medical representatives. The leader of this alliance was Sir Victor Horsley, the representative of the British Medical Association, who was not only a distinguished surgeon and a leading figure in the B.M.A., but also a Radical Liberal Parliamentary candidate until his constituency party disagreed with his support for female suffrage. Horsley managed to carry the other medical men on the Sub-Committee, most of whom had no identifiable political allegiance, with him, for Norman Bennett, the British Dental Association representative, proposed the establishment of a series of school dental clinics,⁽⁴⁵⁾ while Mr. Angus Owen, a consultant surgeon at the London Hospital, moved a number of resolutions affirming the inability of the voluntary hospitals to provide adequate treatment facilities.⁽⁴⁶⁾

The medical representatives' support for school clinics was not explicitly political in its motivation, but neither could it be said to be wholly a disinterested concern for the best interests of the children. The desire for a reduction in the

(45) L.C.C., Special Sub-Committee on Medical Treatment, Minutes, 21 February 1908.

(46) Ibid., 10 April 1908.

workload of the hospital outpatients departments was also influential.

Whatever the motives of the alliance, it proved effective within the Sub-Committee. When the Moderate Chairman of the Sub-Committee, Henry Gooch, moved that their main recommendation be that:

In spite of the attractiveness at first sight of the system of school clinics, we think it would be unwise, (by setting up, at the cost to the education rate and under the immediate management of the local education authority a number of what would in fact be children's hospitals) to add another type of institution providing medical treatment to those already existing....(47)

an amendment was moved by Horsley which, after a long preamble repeating almost verbatim the B.M.A. policy on medical treatment in the School Medical Service which he and Kerr had helped to formulate, firmly recommended establishing a network of school clinics for treatment purposes. Horsley's amendment was agreed by ten votes to nine. (48)

The Sub-Committee thus recommended to the full Education Committee that a system of school clinics should be established to treat the capital's school-children. However, a "minority report" signed by eleven of the twenty-one members of the Sub-Committee was also submitted, recommending that treatment should be performed by the voluntary hospitals. The eleven included two co-opted allies of the Moderates, one the representative of the Charity

(47) Ibid., 20 November 1908.

(48) Ibid.

Organisation Society, who had been absent when the crucial vote was taken . Only one of the six medical men on the Sub-Committee had signed this minority report, which was accepted by the Moderate majority on the Education Committee by twenty-four votes to twelve.⁽⁴⁹⁾

The L.C.C.'s decision to use hospitals rather than school clinics for the treatment of school-children was thus a political decision, rather than an initiative by Kerr. As the evidence shows, Kerr himself supported the clinic concept, and opposed the use of the hospitals. In fact, Kerr had little direct connection with the L.C.C.'s treatment scheme, for on the somewhat dubious ground that arranging the medical treatment of school-children was a purely educational and administrative function, responsibility for the operation of the treatment scheme was vested in Robert Blair, the L.C.C.'s Education Officer.⁽⁵⁰⁾ This arrangement meant that "London had the unique and Gilbertian situation of its medical officer directing medical inspection in schools while the education officer directed medical treatment in hospitals".⁽⁵¹⁾ It was thus Blair who had the task of persuading the voluntary hospitals to participate in the Council's treatment scheme.

(49) L.C.C., Education Committee, Minutes, 16 December 1908.

(50) L.C.C., Children's Care (Central) Sub-Committee, Agenda, 6 February 1911.

(51) Sir Gwilym Gibbon and R.W. Bell, History of the London County Council, 1889-1939 (London: Macmillan, 1939), p.301.

Hospital Treatment and its Effects

In June 1909 Blair and Cyril Jackson, the Moderate Chairman of the Education Committee (and, until 1906, Chief Inspector at the Board of Education) met representatives of the voluntary hospitals at Charing Cross Hospital.⁽⁵²⁾ The hospitals, or at least some of them, showed a greater readiness than before to reach an agreement to treat London school children on an agency basis, but as Blair later explained to the Day Schools Sub-Committee, they were still concerned about a number of aspects of any such agreement. They wanted a limitation on the number of children who would attend for treatment, and were worried that accepting money from the L.C.C. might entail Council representation on their governing bodies, or interference from the L.C.C.'s own medical staff. Despite these reservations, Blair was optimistic that satisfactory arrangements with the hospitals could be concluded.⁽⁵³⁾

Kerr estimated some 44,000 school-children would need treatment each year.⁽⁵⁴⁾ After hearing that some hospitals would continue to treat children from L.C.C. schools free of charge, the Day Schools Sub-Committee decided it would be necessary to make arrangements for some 28,000 children. However, it argued that a quarter of these would seek private treatment, and decided to

(52) GLRO, L.C.C. file PH/SHS/2/4, notes on an interview at Charing Cross Hospital, 9 June 1909.

(53) L.C.C., Day Schools Sub-Committee, Agenda, 6 July 1909.

(54) 14,782 were estimated to require treatment for ear discharges; 25,950 for defective vision, and 3,014 for ringworm. Other conditions were not mentioned. L.C.C., Education Committee Minutes, 14 July 1909.

negotiate terms with eight hospitals for the treatment of those remaining. Apart from the optimistic assessment of the numbers who would seek private treatment, the Sub-Committee also appears to have assumed, when making its calculations, that each child would need to make only one attendance for treatment. (55)

After some of the hospitals originally promising to continue free treatment had decided instead to press for payment, further negotiations were necessary to bring more hospitals into the treatment scheme. Most of the reservations previously expressed by the hospitals were overcome, and by December 1909, the L.C.C. approached the Board of Education asking for sanction, as was required by the 1907 Act, to implement a treatment scheme involving, initially, eight voluntary hospitals who would receive a payment in return for treating children referred by the Council. Although these proposals were the subject of an intense political and professional controversy, Newman recommended approval. (56) He envisaged that the arrangements would encounter considerable administrative and practical difficulties, but argued that only experience of the scheme would verify this point. The Board therefore gave its approval for a period of twelve months. (57)

By May 1910, the L.C.C. had made agreements with the hospitals for the treatment of a total of 21,590 cases annually.

(55) Ibid., 3 November 1909.

(56) See e.g. Lancet i (1909), 1484.

(57) PRO Ed 125/9, Precedent cover: London, 1 December 1909.

Under the terms of agreements the L.C.C. was committed to paying the hospitals all the additional costs incurred in employing staff to treat the children, irrespective of whether any did in fact attend for treatment. The Council also paid a capitation fee for those children who did receive treatment at a hospital. (58)

This arrangement posed a logistical problem, for as Kerr had pointed out to the Special Sub-Committee on Medical Treatment "practically the whole of the chief hospitals were in the central districts of London, whilst the child population was frequently at considerable distances from any hospitals". (59) It was thus pointless in referring children from many schools in the London area to the hospitals. The repercussions of the introduction of the hospital treatment scheme for the medical inspection system, given the relative distribution of hospitals and children and the financial arrangements made, were subsequently explained by Kerr:

In June 1909 the Council entered into an agreement with the Great Ormond St. Hospital for the Treatment of Children, and I was instructed to select cases from schools in the vicinity of the Hospital.

In July 1909 the Council entered into an agreement with five hospitals to treat 360 cases per week. This work commenced after the summer holidays and it was necessary to take a considerable portion of the inspecting staff out of their districts and place them in schools adjacent to these hospitals.

(58) L.C.C., Children's Care (Central) Sub-Committee, Agenda, 24 November 1910.

(59) L.C.C., Education Committee, Agenda, 9 December 1908.

Between January and May 1910 arrangements were made with 14 hospitals to treat 21,590 cases per annum. In order to make the scheme a success it was necessary to find sufficient cases within a reasonable distance of the institutions at which the arrangements had been made, and for this reason the medical staff was placed in the most convenient schools. (60)

Thus Kerr was instructed to concentrate his staff of school doctors in the vicinity of the hospitals where arrangements for treatment had been made, although it is unlikely that he had any strenuous objection to this instruction, given the close link thereby created between inspection and treatment. Indeed, in another discussion, he was prepared both to justify and to associate himself with such a policy, asking:

whether it is not wiser to examine children in areas where there is a possibility of treatment rather than a smaller number from each school throughout the metropolis. Our action [in concentrating the school doctors in a small number of schools] has been purely to avoid wasteful work. (61)

These arrangements resulted in radical departures being made from the system Kerr had outlined to the Day Schools Sub-Committee in February 1909. In May 1910, the Children's Care (Central) Sub-Committee learned the extent of these changes when it received a memorandum from Kerr. This showed that inspection of a limited number of schools using the Board of Education

(60) These calculations include renewals of existing agreements. L.C.C. Children's Care (Central) Sub-Committee, Agenda, 24 November 1910.

(61) Ibid., 16 June 1910.

inspection schedule or Kerr's own, simplified version continued. In these cases, entrants and leavers were examined along with other children presented for inspection by the teachers. Kerr presented the statistics relating to these schools to the Sub-Committee:

CHILDREN INSPECTED TO 31 DECEMBER 1909⁽⁶²⁾

No. of Schools	Schedule used	No. on roll	Number Entrants	Number Leavers	Teacher refers	Parental Att. (%)	Treatmt. Advised	Time taken
39	B.ofE.	25,632	2,539	1,042	971	71.8	30.5	8'58"
31	Kerr	33,363	4,565	960	349	68.5	31.4	6'43"

The third element of Kerr's initial proposal, the continuation of the "routine" medical inspection of all schools not subject to examination according to the two schedules, had been abandoned completely. Most schools in the L.C.C. area had received no visit from a school doctor, for they concentrated on a limited number of schools in the immediate vicinity of hospitals participating in the L.C.C.'s treatment scheme. In these schools:

The mode of procedure is much the same as that adopted in the detailed examination, except that every child in the school is examined instead of those entering or leaving as prescribed

(62) Ibid., 5 May 1910, The "Time taken" column refers to the average time in minutes and seconds taken to inspect each child.

by the Board of Education Code and memoranda. The work has been carried out on the "simpler plan". Up to 28th December 28 schools have been examined, with the following results:(63)

No. of Schools	No. on rolls	Number Examined	Parental Att. (%)	Treatment Advised	Time taken
28	22,883	22,231	59.1	35.7	4'52"

This remarkable report reveals both the extent to which the L.C.C. had failed to satisfy the requirements of the Board of Education Code, and the reasons for this failure. According to the L.C.C.'s own estimates, there were some 148,000 children in its schools at this time who fell either into the entrant or leaver category, yet by the end of 1909 only 3,531 such children had been inspected in accordance with the requirements of the Board of Education. This represented only 2.4 per cent of the inspections required. Even if those inspected in accordance with Kerr's simplified schedule are included, only 9,106 children, or 6.2 per cent of the group, had been inspected, to which total must be added those children in the twenty-eight schools inspected for treatment purposes who fell into these two categories. Although the L.C.C. had thus managed to inspect only a small number of the children the Board required it to inspect, it had also examined

(63) Ibid.

a considerable number of children it was not required to inspect at all, but who were inspected to satisfy the needs of the hospital treatment scheme. It should also be noted that even if inspection had concentrated on Code group children only, the staff of school doctors then employed was plainly inadequate to inspect the required number of children. In the nine months covered by Kerr's report 32,657 children had been subjected to a medical inspection, in the majority of cases one of a rather less comprehensive nature than that specified by the Board. This was equivalent to approximately 44,000 inspections in a full year, rather than the 148,000 required.

These and other faults were noted by the Board in a letter to the L.C.C. in May 1910. The Board complained that the L.C.C. had not nominated a medical officer for recognition as school medical officer for the area, a requirement of the Code potentially prejudicial to Kerr's position, or at least his independence, that entrants and leavers were not being examined in all schools; and that the inspection staff was inadequate in numbers.⁽⁶⁴⁾ Although this letter did not appear before the Children's Care (Central) Sub-Committee until June 1910, its contents had been the subject of discussions between the Board and officers of the L.C.C. (other than Kerr) since the previous November, when Kerr had had to supply the Board with information about the Council's medical inspection scheme in accordance with the system of

(64) Ibid., 16 June 1910.

administrative supervision of all local education authorities which was being evolved by the Medical Department.

From this date onward, the Board had been engaged in discussion about the Council's operations with Blair, the Education Officer. Kerr seems to have been excluded from the discussion. From the correspondence which has survived, it is clear the main thrust of the Board's argument was that the L.C.C. staff of medical inspectors was proportionately much smaller than that of other large towns. Blair's response to this was to ask for details of the staff employed by Liverpool, Manchester and Birmingham, and then to reply to the Board claiming:

when the scheme is in full operation, i.e. from 1st. September 1910, the inspection staff will be 72 "quarter-time" school doctors - equivalent to 21.6 full-time doctors. On an average roll of 730,500 this works out at 33,800 children per full time school doctor.

Birmingham.....	32,000
Liverpool	33,750
Manchester.....	24,000 (65)

Although this letter is preserved in the administrative files of the L.C.C., it had evidently been to the Board at some stage, as comment from Selby-Bigge to Newman is pencilled in the margin. (66)

Unfortunately for the L.C.C., its schismatic administration helped to undermine its own position, for as one of Blair's assistants later discovered:

(65) GLRO, L.C.C. file PH/SHS/1/14, Medical Inspection: general enquiries file.

(66) Ibid.

Our previous calculations have been based on the total number of children on the role [sic] and the number of school doctors authorized from 1st. September 1910. The Board's figures refer to "entrants" and "leavers" and the doctors working at present.

There is one point of which I was not previously aware, viz., that Dr. Kerr stated on form 9 MI that the quarter time doctors devoted 5 hours a week to medical inspection and the other 2½ to ventilation, infectious disease etc. This reduces our 21.3 full-time doctors to 14.2. 14.2 doctors to 146,000 children is about 10,000 per doctor, the figure the Board arrive at. (67)

Thus the Board's letter to the Council was sent only after the Board had had consultations with Blair and his staff. Despite this, and the threat of a withdrawal of Education Grant that the Board's letter implied, Kerr continued to advocate a system of inspection which would not meet the Board's requirements. He suggested the staff of part-time doctors should be increased to 100 which, in addition to maintaining the supervisory work on which Kerr laid great stress, would allow the inspection of entrants and leavers in every school once every three years. (68)

Blair's comment on this latest proposal by Kerr was:

It is claimed by the Medical Officer (Education) that under his scheme more ailing children would be discovered, and information of greater value

(67) Ibid. This correspondence implies that Blair had been engaged in consultations with the Board about its criticisms of the L.C.C.'s policies without the knowledge or consent of elected members or other responsible officers. A study of Blair's administrative career suggests, however, that he was not above "distributing information to the Board of Education which could then be used to exert pressure on the Council" in order to achieve his own ends. D.W. Thoms, Policy Making in Education: Robert Blair and the London County Council, 1904-1924. Educational Administration and History Monograph no. 10 (Leeds: Museum of the History of Education, 1980), p.10.

(68) L.C.C., Children's Care (Central) Sub-Committee, Agenda 13 June 1910.

in the advancement of knowledge of educational and hygienic conditions would be acquired. There may be some difficulty in obtaining the consent of the Board of Education to a scheme at variance with the system in force throughout the country....(69)

The issue was remitted to a Section of the Sub-Committee. This resolved to recommend a system based largely on Kerr's proposals, although the interval between inspections of entrants and leavers was now reduced. Kerr's modified inspection schedule, rather than that of the Board of Education, was to be used, and the staff of quarter-time school doctors was to be increased to 100. However, this staff was not only to inspect entrants and leavers, but also seven to eight year olds and others selected by the teachers.⁽⁷⁰⁾ Kerr argued that the staff would be sufficient to inspect all these groups.⁽⁷¹⁾

Resolution of the Conflict

By this time, the Board had resolved to curb the independence of the L.C.C. In April 1910 Runciman was telling Newman of his determination to fight the L.C.C. until it carried out the provisions of the 1907 Act,⁽⁷²⁾ and with the increase in the staff of the Medical Department Newman and his subordinate officers were able to spend more time away from the office carrying out inspection and observation of local school medical officers. From

(69) Ibid.

(70) L.C.C., Sections of the Children's Care (Central) Sub-Committee, Minutes, 24 June 1910.

(71) L.C.C. Children's Care (Central) Sub-Committee, Agenda, 27 June 1910.

(72) Newman MSS. (Hereford), M4/159, notes by Sir George Newman for his proposed autobiography.

the middle of 1910, with Runciman's backing, the opportunity was taken to observe and record the deficiencies of the L.C.C.'s inspection and treatment provision. The Board's next letter to the L.C.C., in October 1910, noted that the:

Board's medical department have had opportunities since [the] last letter (of May) was written of observing the actual working of medical inspection in the London schools, and have seen the work of 24 of the 56 doctors and assistant school doctors named.

Although the actual inspection was, perhaps surprisingly, said to be generally satisfactory and thorough, the organisation and supervision of the L.C.C. inspection system was criticised as inadequate. The Board could not accept that the Council's arrangements, taken as a whole, complied with the 1907 Act or the Code for the 1909-10 year, and asked the L.C.C. for an early response to its criticisms.⁽⁷³⁾

Again, Kerr attempted to dismiss the Board's criticisms, claiming that it was chiefly a critique of the "temporary" arrangements made during the summer for supplying cases for hospital treatment. With the extra staff it had been agreed to appoint earlier in the year, he believed the L.C.C. would carry out all the inspections required by the Board's schedule, though the third group of eight to nine year olds might not be inspected.⁽⁷⁴⁾

The matter was once again remitted to a Section of the Sub-Committee.

(73) L.C.C., Children's Care (Central), Sub-Committee, Agenda, 20 October 1910.

(74) Ibid.

By this time, the L.C.C.'s inspection system was attracting considerable public criticism, (75) and Kerr's previously unquestioned authority was coming under attack. When discussion about the proposed increase in staff took place, Kerr's calculations about the work they could do were attacked in detail by one member of the L.C.C., who claimed the staff were expected to inspect far more children than the Board of Education thought possible. However, the Chairman of the Education Committee, Cyril Jackson "asked the Council to rely on the opinion of Dr. Kerr, who was the pioneer of medical inspection in this country, that the proposed staff was adequate". (76)

It is clear that by this time, October 1910, the "inspection for treatment" system, concentrating school doctors in selected schools near to the hospitals, had ended, and the L.C.C.'s system of medical inspection had entered its third phase since the passage of the 1907 Act. Kerr told the Sub-Committee that:

Since I.ix.10 arrangements have been made for children between the ages of eight and nine and twelve and thirteen to be examined, and "entrants" to be inspected, but these last are not at present scheduled. (77)

These new arrangements at least ensured that every school was now visited by a school doctor at more or less frequent intervals, but as Kerr's announcement above indicates, and as the subsequent deliberations of the Medical Section confirm, the system was not

(75) Times, 28 October 1910, p.6.

(76) Lancet ii (1910), 1364-65.

(77) L.C.C., Children's Care (Central) Sub-Committee, Agenda, 20 October 1910.

yet identical to that required by the Board of Education. In his anxiety to include medical inspection of eight to nine year olds, Kerr was prepared to compromise over the inspection of the statutory groups, and persuaded the Children's Care (Central) Sub-Committee to agree to the recommendation put forward by its Medical Section:

That as from 1st January 1911, a card be prepared by the head teacher, in respect of every 'entrant',....that this card be initialled by the school doctor, and that the school doctor shall examine the children individually only when he considers a detailed examination necessary. (78)

According to investigations subsequently made by the B.M.A. this regulation meant that, under this third phase of the L.C.C.'s medical inspection system, only about 25 per cent of the entrants were actually given a detailed medical inspection using an abbreviated inspection schedule. These were the children selected from among those paraded in front of the visiting school doctor, and those pre-selected by the head teacher.⁽⁷⁹⁾ Although the school doctors then returned statistics of entrants according to whether they had been "seen" or whether they had actually been examined, the L.C.C. amalgamated these lists for publication, implying that all such children had been inspected individually.⁽⁸⁰⁾

Thus, although subsequent reports to the Education Committee and its Sub-Committee appeared to justify Kerr's optimism about

(78) L.C.C., Sections of the Children's Care (Central) Sub-Committee, Minutes, 25 October 1910.

(79) PRO Ed 24/282, minutes of a meeting with a deputation from the B.M.A., 27 June 1911.

(80) Ibid.

the ability of his enlarged staff of inspectors both to satisfy the requirements of the Board and to inspect non-statutory groups,⁽⁸¹⁾ this transformation of the Council's system of inspection was more apparent than real. The statutory group of entrants was still not being inspected in accordance with the regulations of the Board. Had the Council chosen to do so its staff of school doctors, or their full time equivalents, was now broadly comparable in strength with that of other large authorities, and fulfillment of the statutory obligations of medical inspection would not have been hindered by inadequate staffing levels.⁽⁸²⁾

Although there was thus a continuing failure to conform with the requirements of the Code and Circulars as far as the L.C.C.'s system of medical inspection was concerned, the administrative reform that finally removed Kerr from his position of conflict with Newman was precipitated by the Board's criticisms of weaknesses of administration and co-ordination within and between the inspection and treatment systems. The Board's letter in October had suggested that the co-ordination and supervision of the growing number of quarter time school doctors was by no means satisfactory.⁽⁸³⁾ From published accounts, it is clear that the school doctors, after some brief initial training, were given a considerable independence in deciding when to fulfil their duties,

(81) Lancet i(1911), 394.

(82) GLRO, PH/SHS/1/14, op.cit.

(83) L.C.C., Children's Care (Central) Sub-Committee, Agenda, 20 October 1910.

including great flexibility as to when to perform their hours of inspection.⁽⁸⁴⁾ When the L.C.C., as a result of the Board's criticisms, attempted to press the staff of school doctors to agree to fixed days of attendance at schools, a number of the part-time doctors found considerable difficulty in complying.⁽⁸⁵⁾

While the L.C.C. attempted to rationalise the work of the part-time school doctors, the Board continued to press its criticisms of the administration and supervision of the inspecting staff. Postponing for the time discussion about the adequacy of the increased inspection staff for the amount of work Kerr proposed to perform, Morant wrote to the L.C.C. in December saying that:

the Board's investigations have disclosed a great lack of that organisation, direction and control of the medical staff which is essential in dealing with the enormous area and numbers involved in the case of London schools, and particularly when the work is attempted by means of a number of part-time doctors. The Board cannot find....any clear indication of the means by which the Council are remedying, or are proposing to remedy, these defects. (86)

With the administration of the inspection system thus under attack from the Board, the operation of the hospital treatment scheme provided the final stimulus for a re-organisation of the L.C.C. system of medical supervision in schools, and resulted in a removal of Kerr from his position of responsibility for

(84) See "A Late School Doctor", "A Few Details as to the Work Required of an Assistant School Doctor in London", School Hygiene 1(1910), 391-95.

(85) L.C.C., Children's Care (Central) Sub-Committee, Agenda, 27 October 1910.

(86) Ibid., 8 December 1910.

medical inspection. When the Board had allowed the Council to proceed with its scheme of hospital treatment, a condition of approval was that the L.C.C. would furnish a report on the operation of the system during the twelve months for which sanction for the scheme had been given.⁽⁸⁷⁾ In fact the L.C.C. neglected to apply for an extension of sanction for the scheme until 20 December 1910, eleven days before the existing approval expired, and did not furnish any detailed report on the operation of the scheme.⁽⁸⁸⁾

The Council's reluctance to provide a report to the Board may have been due at least in part to the embarrassing details this would have revealed. As already explained, the establishment of the hospital treatment system had resulted in considerable disruption of the medical inspection system as Kerr concentrated his school doctors in schools close to hospitals with which the council had made an agreement. But although Kerr had furnished Blair with the names of 56,054 children considered to need treatment, most of whom lived in the immediate vicinity of a hospital within the treatment scheme, it had proved impossible from this list to find the 21,590 cases for whom the council had made arrangements.⁽⁸⁹⁾ The Throat Hospital, which had undertaken to treat 1,000 children in 1910, had received only 131 cases.⁽⁹⁰⁾

(87) PRO Ed 125/9, Precedent cover: London, 1 December 1909.

(88) L.C.C., Children's Care (Central) Sub-Committee, Agenda, 27 January 1911.

(89) Ibid., 24 November 1910.

(90) PRO Ed 24/282, minutes of a meeting with a deputation from the B.M.A., 27 June 1911.

The bureaucracy established by Blair to administer this system was cumbersome, and sometimes made elementary mistakes such as asking children to attend on days when the hospital clinics were not open.⁽⁹¹⁾ As a result, Moderate support for the hospital treatment system was becoming noticeably more muted.⁽⁹²⁾

Whatever the reason for the Council's failure to supply a report on the progress of the treatment scheme, it could not conceal its shortcomings from the Board. In January 1911 the Board wrote to the Council not only expressing its "surprise and regret" at the Council's failure to supply a report, but also revealing that the Board had in any case carried out its own investigation, and that the criticisms of the treatment scheme contained in the Board's letter were the result of personal observation by Newman and his associates. The Board considered that the failings of the treatment scheme were such that:

unless the Council's administration is to be gravely discredited it is essential that the machinery for the selection, admission, registration and following up of children coming within the scope of the treatment scheme should be reformed without any delay. (93)

(91) GLRO, L.C.C. file PH/SHS/2/10, medical treatment at the London Hospital.

(92) Lancet ii(1910), 1437. The L.C.C.'s willingness to oppose the Board's demands may also have been weakened by the Board's action in withholding £10,000 of grant from the L.C.C. in a parallel dispute with the Council over article 14 of the Education Code, which restricted the maximum number of children in any class to 60. One in every seven classes in the L.C.C. area exceeded this number. Thoms, op.cit., pp. 18-26.

(93) L.C.C., Children's Care (Central) Sub-Committee, Agenda, 27 January 1911.

Specific criticism was made of the divorce between the administration of medical inspection and medical treatment; the failure of the L.C.C. staff to visit and liaise with the hospitals, and the inability of the scheme to make effective provision for children in areas beyond the immediate catchment areas of the hospitals. The letter stressed that "had the Board not already received assurances that the Council's serious attention was being directed to this problem, they would not have entertained any proposal for a continuance of the existing scheme". In the light of assurances given by the Council, permission was given for the hospital treatment scheme to continue for a further six months only. (94)

The Council's re-assessment began with an instruction from Sir Laurence Gomme, the Clerk to the Council, to the various officers having responsibility for, or an interest in, the medical inspection and treatment of school-children to report on the modifications in administration that might be made. When the Children's Care (Central) Sub-Committee met to discuss the matter in February 1911 they were told by Gomme that:

The instruction to report was given to the education officer on 3 November 1910 and to the medical officer (education) on 17 November 1910. The education officer's report reached me on 19 January 1911 and that of the medical officer (education) on 23 January 1911.

I mention these dates to show that if, as I believe, the matter is urgent as well as important, the responsibility for delay must

(94) Ibid.

rest on other shoulders than my own. (95)

The prolonged period of gestation did not enhance the objectivity of the officers' proposals. Blair recommended amalgamation of responsibility for inspection and treatment under his control, while Kerr suggested:

The most immediate and working solution, then, of any difficulties in combining medical inspection and medical treatment would be to transfer treatment to the branch of the medical officer (education) placing this branch as an independent department, with the school medical officer at its head. (96)

He would thus receive chief officer status, rather than being theoretically a subordinate of the Medical Officer of Health. The latter officer, Sir Shirley Murphy, submitted a third proposal recommending that his department should acquire both functions, in accordance with the expressed wishes of the Board in its various Circulars. Although Sir Laurence Gomme supported Murphy's argument as being that most consistent with the historical allocation of administrative responsibilities within the L.C.C., the Sub-Committee resolved to place the work under Blair, the Education Officer.⁽⁹⁷⁾ At the same time, leading members of both Moderate and Progressive Parties were in contact with Newman and Selby-Bigge at the Board to discuss details of the proposed re-organisation of medical services. The Board pressed the L.C.C. deputation, which consisted only of councillors, to appoint full-

(95) Ibid., 6 February 1911.

(96) Ibid.

(97) Ibid. There was "personal animosity" between Blair and Gomme due to earlier clashes over responsibility for educational administration. Thoms, op.cit. ., pp.5,10.

time staff to carry out medical inspection when the administrative re-organisation had been completed.⁽⁹⁸⁾ The Board was again attacked for interference in the House of Commons by Hayes Fisher,⁽⁹⁹⁾ but the majority of councillors, of both parties, did not resist the Board's suggestions. Interestingly, both Anderton, one of the leading councillors on the L.C.C., in his letters to Selby-Bigge, and Gomme, in his report to the Sub-Committee, seem to have assumed that the Board's preference was for the School Medical Service in London to be placed under the control of the Education Officer, Blair.⁽¹⁰⁰⁾ Such a departure from the Board's policy is hard to understand, if indeed this was the case. However, the bad blood existing between Kerr and Sir Shirley Murphy was well known. The Board may thus have feared that to place both inspection and treatment under the nominal control of Murphy might have led to a continuation of Kerr's independent line, only on a broader front of both inspection and treatment. In the event, Kerr was really unable to accept subordination to any other officer of the Council. When Blair wrote to him after the decision by the Sub-Committee to place both inspection and treatment under the control of the Education Officer, asking if Kerr had anything he wished to discuss in relation to the proposed transfer of functions, Kerr's response

(98) PRO Ed 24/282, Selby-Bigge to Anderton, 17 February 1911.

(99) Parl. Deb. (Commons), 5th series, 21(13 February 1911), 708.

(100) PRO Ed 24/282, Anderton to Selby-Bigge, 3 February 1911.
L.C.C., Children's Care (Central) Sub-Committee, Agenda,
6 February 1911.

was to write "I am sorry that I cannot suggest any limitations to the absolute independence which I regard as essential to the position of the School Medical Officer".⁽¹⁰¹⁾

The proposed re-organisation had to be discussed by several of the L.C.C.'s committees, and it was not until July 1911 that the full Council met to take the final decision. The extent to which the failings of the systems of inspection and treatment had by this time alienated many influential sectors of opinion is reflected in the deputation from the B.M.A. which protested to Runciman in June 1911 about the conduct of the L.C.C.'s School Medical Service. Appropriately including Horsley among its members, the deputation protested about both the conduct of inspection and the method of providing treatment. Runciman was able to assure them of his agreement with their views.⁽¹⁰²⁾

At its meeting in July, the L.C.C. heard from its General Purposes Committee that two other committees, Education and Establishments, had disagreed on how the proposed re-organisation should proceed. Although the Education Committee had followed its Sub-Committee in resolving that Blair should be given control of both inspection and treatment, the General Purposes Committee favoured the Establishments Committee's view that medical inspection and treatment should be placed under the control of the Medical

(101) GLRO, L.C.C. file EO/WEL/1/1, Blair to Kerr, and Kerr to Blair, both 8 February 1911.

(102) PRO Ed 24/282, minutes of a meeting with a deputation from the B.M.A., 27 June 1911.

Officer of Health, and it was this policy which was adopted by the Council.⁽¹⁰³⁾ The re-organisation was to take place from January 1912, when Murphy retired, to be succeeded by Dr. Hamer. The inevitable consequence is recorded later, when it was recommended that Kerr, who had thus been relieved of his executive responsibility for medical inspection, should receive the title of "Medical Research Officer".⁽¹⁰⁴⁾ Under the re-organisation of the Public Health Department of the Council which then took place under Hamer, he was removed from any position of responsibility for medical inspection or treatment. The system of medical inspection also underwent rapid reformation. By August 1912, the part-time school doctors had been replaced by a staff of thirty-four full-time medical inspectors, and the Board was sufficiently satisfied by the progress made by the Council to give the L.C.C. almost £13,000 of the newly introduced Grant for medical inspection costs.⁽¹⁰⁵⁾ The treatment system also underwent a more gradual reform with the Council, partly due to some prompting from the Board, moving closer to an organisation based on school clinics, or treatment centres, than the original reliance on the hospital outpatient departments.⁽¹⁰⁶⁾

(103) L.C.C., Council Minutes, 25 July 1911.

(104) Ibid., 14 May 1912.

(105) L.C.C., Annual Report for 1912, vol.3, Public Health, p.121.

(106) Ibid., pp. 137-38. See also the printed copy of correspondence between the L.C.C. and Board of Education in PRO Ed 50/45

James Kerr's Role in the Dispute: a Re-assessment

Professor Gilbert's analysis of the dispute between Board and Council sees Kerr as a man embittered by his failure to secure the post of Chief Medical Officer to the Board, who as a result sought to obstruct the activities of the Board wherever possible, supported, at first, Gilbert says, by a "Radical Non-conformist N.U.T." group who effectively controlled the L.C.C.⁽¹⁰⁷⁾ Gilbert considers the overall:

result of the ill-feeling between the London Education Committee and the Board of Education was that until the removal of Dr. Kerr in 1911 London school children received no benefit from the pioneering works of Morant and Newman. After 1907 Kerr virtually disappeared from medical circles concerned with Public Health, and school children's welfare. Particularly, he avoided all public appearances with medical men around the Board of Education, nor did he respond, except in the most cursory way, to medical department circulars. He refused to establish school clinics and, of course, declined to support Margaret MacMillan's work in any way. Children whose need for care was too apparent to be ignored were sent to the voluntary hospitals, with which, fortunately, London was well provided. (108)

It was this continued commitment to the use of the voluntary hospitals which, according to Gilbert, ultimately led to Kerr's downfall by alienating his former allies.⁽¹⁰⁹⁾

Nearly all aspects of this account must be challenged. The Moderate majority on the L.C.C. after the 1907 election continued to back Kerr though in no way Radical Non-conformist N.U.T. in its

(107) Gilbert, op.cit., p.134.

(108) Ibid., p.140.

(109) Ibid., p.142.

orientation. Gilbert records the 1907 election which swept the Progressives, the real Radical Non-conformists, out of office, but attaches no further significance to it. Kerr also continued to address conferences of school medical officers, even when it meant listening to Newman, ever the conciliator, praising his work.⁽¹¹⁰⁾ Although undoubtedly disappointed at Newman's preferment, he was prepared to rebuke some of his subordinates for their unrestrained attacks on Newman, though he did this privately rather than publicly.⁽¹¹¹⁾ But above all, Kerr cannot be accused of refusing to establish school clinics. The foregoing analysis shows the preference for hospitals was a political decision by the Moderate majority, and that Kerr was not, in any case, responsible for the L.C.C.'s treatment provision. He himself clearly favoured clinics, and had in fact helped to formulate the B.M.A. policy statement supporting clinics which Sir Victor Horsley had used while on the L.C.C.'s Special Sub-Committee on Medical Treatment.⁽¹¹²⁾

(110) See Public Health 22(1908-9), 160-61.

(111) "I hear from a private source that Dr. Kerr has expressed himself as not agreeing with Dr. Hogarth, and as surprised when he read Hogarth's letter in the B.M.J. Any disclaimer, however, should have been sent to the B.M.J."

PRO Ed 24/280, Newman to Morant, 27 September 1907. See also GLRO, EO/GEN/5/25, op.cit., oral evidence of Dr. James Kerr, questions 2474-86, 2510-13.

(112) B.M.A., Medico-Political Committee, Medical Inspection Sub-Committee, Minutes, 8 July 1908.

Insofar as Kerr precipitated a dispute with the Board, it was not over the question of the method of treatment to adopt, but over what form of administration was best, and how medical inspection should be conducted. Not only did Kerr continue to advocate a School Medical Service independent of the medical officer of health, but also, at a time when the Board was discreetly pressing for the adoption of a staff of full time medical inspectors, Kerr fervently supported the part-time system, arguing that this made it easier to get "first class men" and that it avoided the boredom involved in the full time examination of normally healthy children.⁽¹¹³⁾ He also opposed the Board's system of medical inspection of "entrants" and "leavers", believing this to be a mere mechanical collection of statistics, which could be more simply performed by the adoption of sampling methods.⁽¹¹⁴⁾ Kerr, who was "keen on the new advances in statistics developed by Karl Pearson", who had himself been awarded the Howard Medal of the Royal Statistical Society,⁽¹¹⁵⁾ and who included analysis of data using correlation co-efficients into his Annual Reports to the L.C.C.,⁽¹¹⁶⁾ had a far more advanced

(113) BPP 1906/XLVII:157, Inter-Departmental Committee on the Medical Inspection and Feeding of Children Attending Public Elementary Schools, vol.2, Evidence and Appendices, Cd.2784, oral evidence of Dr. James Kerr, pp.125ff, See also Steven, op.cit., p.11.

(114) L.C.C., Day Schools Sub-Committee, Agenda, 17 November 1908.

(115) Francis et al, op.cit., p.304.

(116) See e.g. L.C.C., Annual Report of the Medical Officer (Education) for 1906-7.

knowledge of statistical sampling techniques than most of his medical contemporaries. (117)

Kerr must not, therefore, be seen simply as an embittered obstructionist seeking only to frustrate the good intentions of Newman and the Board, but as a man who to some degree "aimed at something more thorough than the Board of Education had in mind," (118) and who can claim some posthumous justification from the more recent criticisms levelled at the routine medical inspection conducted in the School Health Service. (119)

Summary

The dispute between the Board and the L.C.C. encompassed a number of the issues to arise in the early days of the School Medical Service: the professional rivalry between the "school doctors" and the public health officials; the debate about the balance of funding for local services between central government and local authority, coloured in this instance by political differences between Liberal Government and Conservative Council; and the question of how best the defects identified by inspection could be remedied. An eventual result of the L.C.C.'s conflict with the Board was the downfall of arguably the most innovative and effective school doctor in the country, James Kerr. Kerr's fall was not due to the hospital treatment

(117) See Charles Singer and E. Ashworth Underwood, A Short History of Medicine, 2nd ed. (Oxford: Clarendon Press, 1962), p.726.

(118) Gibbon & Bell, op.cit., p.302.

(119) Huw W.S. Francis, "The Rise and Fall of Routine Medical Inspections", Public Health 89(1975), 181-90.

system, which he opposed, though the L.C.C.'s need to re-organise the treatment scheme precipitated the administrative changes that deprived him of responsibility for the Council's School Medical Service. It owed more to his persistent advocacy and practice of a system of medical inspection differing in nature and intent to that advocated by the Board.

The existence of the dispute with the L.C.C. indicates that a consistent pattern of basic school medical inspection was not established on a national basis until almost the beginning of the First World War.

CHAPTER EIGHT
THE DEVELOPMENT OF
MEDICAL TREATMENT, 1908-1914

The first annual reports of many local school medical officers expressed disappointment at the proportion of children obtaining treatment after their parents had been informed of defects discovered during medical inspection. In Kings Norton, Birmingham:

the difficulties of the work were greatly exceeded by the trouble which was incurred in attempting to get the defects remedied, for it was found that only 11 per cent of the parents communicated with had provided the necessary spectacles after a reasonable lapse of time. (1)

Other areas were also reported as having a poor response by parents to the school medical officer's advice.⁽²⁾ Local authorities which took no steps to make their own arrangements for treatment continued to hear similar complaints from their school medical officers for many years.⁽³⁾

Differences of definition and terminology make assessment of overall parental reactions to the school medical officers advice difficult. Newman noted the problem in his first Annual

(1) Lancet ii(1908), 1560.

(2) Ibid., 191; i(1909), 437; i(1910), 1513; Public Health 22 (1908-9), 463.

(3) Lancet ii(1912), 120, 1172.

Report for 1908. To be told that in Derbyshire 63.6 per cent of cases "sought medical advice", or that in the Lindsey division of Lincolnshire 24.8 per cent of cases were "taken to a doctor"⁽⁴⁾ gives little indication of the numbers satisfactorily completing a course of treatment. In Staffordshire, at a somewhat later period, it was estimated that some kind of treatment was obtained in 90 per cent of cases, but "re-inspection of the children noted for treatment shows that the cured and improved cases together are under 50 per cent".⁽⁵⁾

Differing expectations also confused the issue. West Sussex claimed a satisfactory percentage of children were obtaining treatment, due to its use of "special correspondents", these being "influential ladies and gentlemen [who] interest themselves in the local cases".⁽⁶⁾ But in 1908 only 639 of the 1804 children in West Sussex considered to need medical treatment received any treatment at all. This proportion was only marginally higher than the "unsatisfactory" percentage obtaining treatment in Surrey.⁽⁷⁾

Some school medical officers explained the low percentages obtaining treatment exclusively in terms of parental ignorance or indifference. More frequently the disadvantages or inadequacies of existing avenues of treatment were blamed. In some

(4) BPP 1910/XXIII:1, Board of Education, Annual Report of the Chief Medical Officer for 1908, Cd. 4986, p.34.

(5) Lancet ii(1912), 906.

(6) Times, 14 April 1909, p.11.

(7) Lancet i(1909), 662.

areas, self-medication was allegedly widespread. In Guildford "it is the practice of the parents to seek relief from the druggists, or to use some domestic nostrum which is valueless".⁽⁸⁾ Ink was used to treat ringworm, and goose-grease for lung complaints.⁽⁹⁾

Opinion among school medical officers varied as to the extent to which general practitioners were consulted by the parents of children found defective on inspection. In Derbyshire, it was claimed the family doctor was used in most cases where treatment was obtained.⁽¹⁰⁾ This might be an indication that the wealthier parents were more likely to obtain treatment for their children, or a reflection of the conjectures sometimes included in the annual reports of the time. In Shropshire, it was claimed two thirds of all those obtaining treatment (43 per cent of those referred) went to a G.P., but "where information is not quite definite it has been assumed that treatment has been by private practitioners".⁽¹¹⁾ In West Sussex a much smaller percentage was said to obtain treatment from this source.⁽¹²⁾

For many parents, the difficulty in using the G.P. was his fee. Although it was allegedly not uncommon for this to be waived in urgent cases, for routine matters arising from medical

(8) Ibid., p.1203.

(9) School Hygiene 4(1913), 189. See also Pamela Horn, The Victorian Country Child (Kington: Roundwood Press, 1974), pp.170-73.

(10) Lancet ii(1909), 487.

(11) Shropshire C.C., Annual Report of the School Medical Officer for 1909, p.42

(12) Lancet i(1909), 662.

inspection only the better off parents were likely to have a family doctor. Even in these cases treatment depended on the medical problem involved. For short or acute illnesses, parents would be able and willing to pay the practitioners fee, but where prolonged or operative treatment was required, the cost would be beyond even the better off parents of elementary school children.⁽¹³⁾

Apart from the basic question of cost, there were logistical difficulties in using general practitioners for treatment. The recommended treatment for discharging ears was frequent syringing, ideally three times daily, and some eye and skin infections needed similar regular or prolonged medical care. Other conditions frequently affecting school children, such as decayed teeth, were not normally dealt with by general practitioners.⁽¹⁴⁾ Newman, in his Annual Report for 1909, further argued that the experience of many G.P.'s was insufficient to deal with many children's diseases, especially the most common ones affecting ears, eyes, nose, teeth and skin, where palliative treatment only was usual.⁽¹⁵⁾ Although the following year he conceded that some G.P.'s were often "specially experienced in dealing with the complaints of children" he continued to maintain that the

(13) Ibid., i(1910), 1294.

(14) Lewis D. Cruickshank, School Clinics: at Home and Abroad (London: National League for Physical Education and Improvement, 1913), pp.38-39.

(15) BPP 1910/XXIII:175, Board of Education, Annual Report of the Chief Medical Officer for 1909, Cd. 5426, pp.96-97.

cost of using a G.P., and the inexperience of some G.P.'s in dealing with the health of school children, posed continuing problems in relation to this mode of treatment. (16)

For those unable to afford a general practitioner alternative avenues of treatment were not always both accessible and acceptable. It was possible for a child to be given domiciliary treatment under the Poor Law, but evidence suggests that in general this facility experienced, at most, moderate demand from parents of school children. The Royal Commission on the Poor Law received evidence linking high mortality in childhood, and medical complications among surviving children, with the reluctance of parents to call in the district medical officer of the Poor Law guardians. (17) This meant that:

defects of the eyes, the ears, the throat, and the nose, imperfections of the teeth, incipient spinal curvature and malformations of all kinds, which could be successfully dealt with in infancy or childhood, remain entirely untreated. (18)

The stigma of receiving assistance, the necessity of applying to the relieving officer before being able to obtain medical aid, and sometimes the system of administering relief, which could involve long journeys or inconvenience, (19) combined to minimise the use of domiciliary treatment under the Poor Law for the treatment of school children after medical inspection.

(16) BPP 1911/XVII:449, Board of Education, Annual Report of the Chief Medical Officer for 1910, Cd.5925, p.121.

(17) See Sidney Webb and Beatrice Webb, The State and the Doctor (London: Longmans, Green, 1910), pp.72-78.

(18) Ibid., p.66.

(19) Ibid., pp.25-27.

In some Unions, however, the "destitution" condition for receipt of benefit was relaxed, and medical relief was given as a form of loan; in these cases, some increase in the use of Poor Law facilities by school children was noted.⁽²⁰⁾

Not all guardians were eager to provide medical treatment, even where application was made by parents, and sometimes treatment was refused,⁽²¹⁾ or the guardians postponed a decision on the application.⁽²²⁾ Such delays sometimes occurred because the guardians were unwilling to give treatment unless and until they had been given specific permission to do so by the Local Government Board, due to fears of a possible surcharge by the district auditor for illegal expenditure.⁽²³⁾ Although use of the Poor Law to treat school children had the support of a number of influential medical officers of health, such as the future Conservative M.P., F.E. Fremantle of Hertfordshire,⁽²⁴⁾ it tended to be used only as a last resort, when other facilities had proved unsatisfactory,⁽²⁵⁾ or were denied to school children. Thus when the voluntary hospitals near the Hambleton district

(20) Lancet i(1910), 1294.

(21) Cruickshank, op.cit., p.56.

(22) Lancet i(1909), 284.

(23) Ibid., ii(1909), 729; ii(1912), 165.

(24) Ibid., ii(1911), 347-49.

(25) Webb and Webb, op.cit., p.65.

of Surrey refused, in concert, to treat medical inspection cases any more, the district medical officer was asked to operate on tonsil and adenoid cases,⁽²⁶⁾ though parents in Surrey had previously been reported as making no use of Poor Law facilities for treatment of their children.⁽²⁷⁾

Parents unable to afford a G.P. and unwilling to approach the Poor Law turned in the first instance to the outpatient departments of the voluntary hospitals, if one was accessible.

After the passage of the 1907 Act:

in Wiltshire, Worcestershire, Warwickshire, London, Birmingham, Dudley, Weymouth, Wandsworth, Batley, Felling and a large number of other places, evidence has been forthcoming of the greatly increased tax made upon medical charities by parents of children who have been found defective or ailing on medical inspection. (28)

Sometimes, the parents were specifically advised to use the outpatient departments by the local education authorities.⁽²⁹⁾

(26) Lancet ii(1912), 165.

(27) Ibid., i(1909), 1633.

(28) BPP 1910/XXIII:1, op.cit., p.34.

(29) "in all cases where the parents were absent [from the inspection] letters were written informing them of the defect and advising them to take the child either to the Ophthalmic Department of the Royal Infirmary or the Eye Infirmary, Newcastle-on-Tyne....."

Felling U.D.C., Annual Report of the School Medical Officer for 1908, p.4.

Voluntary hospitals throughout the country thus experienced the difficulties the hospitals in London had been facing since vision testing was first instituted by the L.S.B. They reacted in similar fashion. Newcastle-upon-Tyne Education Committee was pressed by the local hospitals to take action about the large number of children attending the local outpatient departments after medical inspection,⁽³⁰⁾ while other voluntary hospitals decided not to treat school children at all. This was the case at Guildford, Brighton,⁽³¹⁾ and Hereford, where the management of the Herefordshire General Hospital refused to treat even those school children who were able to present a subscribers letter for treatment, this normally being a guarantee that the hospital would accept the holder as a patient. The hospital pointed out that a similar exclusion already applied to "parturient women, consumptive patients, infectious cases, cases for dental treatment (except for extraction), and lunatics".⁽³²⁾

The use of outpatients departments to treat school-children was considered by some to be an abuse of their intended function

(30) Lancet i(1912), 1499.

(31) Cruickshank, op.cit., p.40; Iona Davey, School Clinics as a Means of Providing Medical Aid for Elementary School Children (Guildford: n.p., 1913), p.7; Arthur Newsholme, International Studies on the Relation between the Private and the Official Practice of Medicine, 3 vols. (London: George Allen & Unwin, 1931), 3, 367-76.

(32) Lancet ii(1910), 1728-29.

of treating the "necessitous poor" only.⁽³³⁾ General practitioners also disapproved because of suspicions that increased usage of the hospitals occurred only at the expense of the practice and income of the family doctor.⁽³⁴⁾

Not all children could use an outpatient department for treatment, for many areas lay outside easy travelling distance of the nearest voluntary hospital. At Abertillery, a visit to the voluntary hospital in Newport involved a seventeen mile train journey.⁽³⁵⁾ But even for those with easier access, the outpatient departments were an imperfect solution. The charitable basis of treatment frequently required the investigation of family background and income by a hospital almoner, or production of a subscriber's letter, before treatment could be obtained. Unless the parents had subscribed to a hospital subscription scheme based on the workplace, such as the Hospital Saturday Fund, these were hard to obtain in the poorest areas, although more plentiful in better-off districts.⁽³⁶⁾ The search for a subscriber's letter meant "a great deal of begging and tramping is too often the necessary preliminary to treatment".⁽³⁷⁾

For those unable to afford a G.P., unwilling to be

(33) L.C.C., Education Committee, Minutes, 26 June 1907.

(34) Lancet ii(1911), 347-49.

(35) A.E. Remmett Weaver, "The Abertillery School Clinic", School Hygiene 2(1911), 522.

(36) School Hygiene 2(1911), 10.

(37) M. Cecile Matheson, The Medical Inspection of School Children and After (Birmingham: Cornish Bros., 1910), p.8.

stigmatised by the Poor Law, and without a voluntary hospital willing to treat school children within easy travelling distance, finding alternative facilities for the treatment of their children was not an easy task. Medical Clubs and Friendly Societies, on the one hand, and Provident Medical Associations on the other, provided potential avenues for treatment. Indeed, they were willing, on appropriate terms, to cater for child subscribers.⁽³⁸⁾ These organisations, however, provided benefits only to subscribers, and for many ailments simply referred the case to the nearest voluntary hospital, so that they did not form self-sufficient systems of treatment.⁽³⁹⁾ Thus the problems of treatment by G.P.'s or hospital outpatient departments applied also, in some measure, to treatment through the various subscription schemes.

Charitable provision was attempted in isolated instances only. In Yeovil a member of the local authority paid for dental treatment.⁽⁴⁰⁾ At Cambridge, a private dental clinic was opened in 1907.⁽⁴¹⁾ A clinic organised by Margaret McMillan, and financed by Joseph Fels, the Naptha soap philanthropist, operated at

(38) Times, 25 January 1909, p.4.

(39) L.C.C., Special Sub-Committee on Medical Treatment, Minutes, 21 February 1908.

(40) Lancet ii(1909), 1476.

(41) School Hygiene 1(1910), 247.

Devons Road school, Bow. (42)

Existing provision for the after treatment of school children, therefore, had two main defects. First, to obtain access to treatment, a number of barriers had to be surmounted. These might be financial, such as a requirement to pay fees, or pre-payment of subscriptions; they might be overtly deterrent, as with the provision made under the Poor Law, or they might be administrative, geographical or structural barriers, such as the travelling distance to the treatment centre, the need to obtain a "subscriber's letter" for hospital treatment, or the difficulties of obtaining a consultation in a crowded hospital outpatient department. Second, many of the most common conditions requiring treatment in school children were unsuitable for treatment at the existing institutions as then organised and administered. They were conditions needing continual attention, of a fairly mundane nature or, as with the provision of spectacles, requiring simple but effective remedial action, rather than the sophisticated approach sometimes taken by the voluntary hospitals. (43)

(42) Margaret McMillan, New Life in Our Schools (London: Women's Co-operative Guild, [1909]), pp.6-7.

(43) Kerr cites as an example the practice of prescribing expensive bifocal lenses, costing 15/- or more, by the ophthalmic out-patients departments. These were more sophisticated than required by most school-children and too expensive for many parents. BPP 1906/XLVII:157, Inter-Departmental Committee on the Medical Inspection and Feeding of Children Attending Public Elementary Schools, vol.2, Evidence and Appendices, Cd. 2784, evidence of Dr. James Kerr, p.129, q.3833.

Medical Treatment by the Local Authorities

No obligation to provide treatment was placed on the local authorities by the 1907 Act. But increasingly, local education committees began to make their own arrangements for medical treatment. Some radical councils were quick to make use of the new powers they had been given. Where political orientation was not an influence, other factors combined to induce action by local authorities. The sheer numbers of children found to be defective produced anxiety about the needs to be met. When it became clear that the existing institutions were not meeting these needs, increasing pressure mounted on the local authorities to take action if medical inspection was not to be wasted.

Medical inspection also created other problems for the councils. It identified children who should not have been at school because they were suffering from infectious or contagious diseases. Exclusion of these children lost education grant income to the local authority and this, indirectly, increased the cost of medical inspection. In the case of a disease like ringworm, exclusion of even one child could lose a significant amount of grant for the authority, for the usual treatment by ointments was often unsatisfactory, and as a result the disease could be persistent. In Shropshire, the School Medical Officer's Annual Report for 1915 recorded that "three children have been absent from school off and on for more than six years, five for five years, ten for four years, seventeen for three years, and thirty

two for two years, on account of ringworm".⁽⁴⁴⁾ The resulting loss of grant led to a suggestion that it would pay the authority to arrange for treatment of affected children by X-rays, which could produce a cure within weeks.⁽⁴⁵⁾

Local authorities reacting to these pressures and adopting a more interventionist attitude to the question of treatment could adopt one or more of three strategies. They could attempt to force parents to obtain treatment for their children, they could try, by persuasion and discussion with the parents, to convince more of them to try to obtain treatment, or they could consider using their optional power of "attending to the health and physical condition of the children" to ensure the provision of treatment facilities more directly related to the needs of school children.

Coercive action by the education authority was almost exclusively confined to cases of vermin and, less frequently, ringworm.

(44) Shropshire C.C., Annual Report of the School Medical Officer for 1915, p.11.

(45) Ibid. A description of the method of treating ringworm by X-ray is contained in BPP 1914/XXV:401, Board of Education, Annual Report of the Chief Medical Officer for 1912, Cd. 7184, pp. 158-59. An article on the method admitted that at first "a number of regrettable incidents took place" as it was difficult to estimate the correct dosage, although "if a dose 10 per cent too great is given the hair never grows again". Not surprisingly, some parents were said to be opposed to X-ray treatment. See Haldin Davis, "X-Ray Treatment of Ringworm", The Child 2(1911-12), 511-12.

One method was to take action under the School Attendance Acts, excluding children from school until they were sent back free from the affliction. Parents who failed to deal with the problem were then summonsed for failing to send their children to school.⁽⁴⁶⁾ Sheffield, exceptionally, used a more vigorous approach, removing children whose parents failed to remedy the problem into council care under a "place of safety" order.⁽⁴⁷⁾ Vigorous application of an exclusion policy reduced average attendance and lost grant aid for the authority. This sometimes produced conflicts between the school medical officer and the members and officers of the education committee reminiscent of the problems experienced by some medical officers of health during the school board days. In Carmarthenshire, the financial and political repercussions of the school medical officer's action in excluding a number of allegedly verminous children from school prompted one councillor to complain that "for hundreds of years the children had been taught in a dirty condition, and if they were going to take drastic measures to change the habits of the people they would only bring the education authority into disrepute".⁽⁴⁸⁾ Other authorities adopted an alternative approach of using powers conferred under sections 12 and 122 of the Childrens

(46) See BPP 1910/XXIII:175, op.cit., pp.198-202; BPP 1911/XVII:449, op.cit., pp.270-76; BPP 1912-13/XXI:439, Board of Education, Annual Report of the Chief Medical Officer for 1911, Cd.6530, pp.290-301.

(47) Lancet i(1909), 692.

(48) Ibid., i(1912), 59.

Act 1908. This allowed proceedings to be taken against the parents for neglect.⁽⁴⁹⁾ Again, most of the summonses related to allegedly verminous children, but Somerset County Council used its powers to prosecute parents, successfully, for failing to obtain glasses for their children.⁽⁵⁰⁾ Coercive action, when used extensively, was sometimes the catalyst for the most serious opposition to the operation of the School Medical Service. Crowds of angry parents were reported to have gathered outside schools in Willesden following rumours that action was planned against verminous children,⁽⁵¹⁾ while mass exclusions of such children prompted demonstrations at Stroud⁽⁵²⁾ and Tring. In the latter case, police had to be called to disperse the angry crowd.⁽⁵³⁾

The persuasive approach involved the use of voluntary workers, or council nurses, sometimes a combination of both, visiting the homes of children found to need medical treatment to see what steps the parents were taking to obtain treatment, and to persuade

(49) At West Bromwich the Stipendiary Magistrate held it to be "the mother's duty to take care of her children and keep them clean and free from vermin and the father's duty to see that the mother did hers...the mothers were sent to gaol for 21 days with hard labour, and the fathers were fined and warned that they would be sent to gaol if prosecuted again for a similar offence". West Bromwich C.B.C., Annual Report of the School Medical Officer for 1912, p.13.

(50) Lancet ii(1910), 1729.

(51) Medical Officer 2(1909), 253.

(52) Ibid., 4(1910),20.

(53) Sanitary Officer 1(1909-10), 240.

or cajole those who were reluctant to take action. The care committee system, in which groups of volunteer workers were attached to schools, visiting the homes of the pupils, was extensively used in London to fulfil a variety of purposes, including the investigation of family circumstances in order to determine eligibility for free school meals; general counselling work; helping children to obtain suitable employment on leaving school and, after the start of the vision testing programme, following up cases to see if any action had been taken by the parents. From 1907, this work was expanded to include the following up of all children with medical needs identified at inspection.⁽⁵⁴⁾ A similar or identical system was used in other areas, including Bristol, the West Riding of Yorkshire, and West Sussex.⁽⁵⁵⁾ In other areas following up was carried out by school nurses, performing these duties instead of or in addition to their work of

(54) See Maud F. Davies, School Care Committees (London: Thos. Burleigh, 1909); Idem, "The Work of the School Care Committee", School Hygiene 1(1910), 93-96; Margaret Frere, Children's Care Committees (London: P.S. King, 1910); Helen Bosanquet, Social Work in London, 1869-1912 (London: John Murray, 1914), pp. 249-65; National Conference on the Prevention of Destitution, Report of Proceedings, 1911 (London: P.S. King, 1911), pp. 308-58.

(55) Lancet ii(1909), 378; ii(1911), 259; Times, 14 April 1909, p. 11. The degree to which care committees were established by education authorities is difficult to determine. In 1925, when a number of factors may have contributed to a decline in care committee numbers, 146 out of 231 authorities responding to a questionnaire had no provision for school care committees. John H. Nicholson, School Care Committees (London: P.S. King & Son, 1925), p. 24.

treating ear infections and other complaints. Bilston and Blackburn⁽⁵⁶⁾ were areas where nurses were used to follow up cases, as was Somerset, where it was reported that treatment was obtained by 39 per cent of the parents who were visited by the nurses, compared to the 22 per cent obtaining treatment in cases where no visit was made.⁽⁵⁷⁾ This indicates that "following up" alone would not secure treatment for a majority of children. This led authorities to consider use of the third option, using their power of "attending to the health and physical condition of the children" under the 1907 Act.

The Board's policy on the use of this power was largely determined by Newman, for the Parliamentary debates had never explored the limits of this power. As L.A. Selby-Bigge admitted:

stress was laid [in the Parliamentary debates] on the point that provision would be chiefly for the treatment of minor ailments - but it does not appear to have been denied that the words would cover much wider application of their powers by the Local Education Authorities if they were willing to incur the expense. (58)

The only legal restriction was that treatment could be given only to children educated in public elementary schools. Circular 576 had said little on the issue of treatment, but with the start of medical inspection, Newman had to decide the Board's attitude to requests by local authorities for sanction to begin treatment schemes.

(56) Lancet i(1908), 1658, ii(1910), 428.

(57) Public Health 22(1908-9), 286.

(58) PRO Ed 50/7, memorandum by Selby-Bigge to Lindsell, 29 May 1908.

He suggested that the parameters of approved systems of treatment should be defined by reference to three basic principles; as the work was being performed under an Education Act, it should bear some relation to educational needs; the assumed link with the public health service indicated a predominantly preventative approach; while in general the:

Primary duty of the state is to point out defects and disease and....to leave treatment as far as possible to the ordinary channels and therapeutics and particularly to those channels which increase rather than decrease the sense of responsibility in the parents and guardians of the children. (59)

Such considerations were particularly important when considering whether the local authorities should be allowed to establish new avenues of treatment through the provision of local authority maintained and funded school clinics. Before approving a clinic scheme, it was important to ensure that:

1. treatment provided must be such as can be most effectively and efficiently done by a clinic than any other way
2. important to give all treatment provided by a Local Education Authority an "educational character". (60)

Given these considerations, Newman thought that a clinic was suitable for further, more detailed examinations of individual children, prescription of glasses, cleansing of vermin, treatment of ringworm, favus and other skin diseases, and such minor ailments as could be dealt with by a school nurse, such as discharging ears. This left

(59) Ibid., memorandum by Newman, 29 June 1908.

(60) Ibid.

some marginal cases, such as provision for operating on tonsils and adenoids, and dental treatment. In these cases:

On the whole I think we must press hospital treatment as far as possible, and where it is impossible we must allow these things to be included among those conditions suitable for treatment at a School Clinic (particularly teeth as at the voluntary clinic at Cambridge) (61)

This indicates Newman's basic approach to the problem. School clinics were most suitable in cases where existing provision was unsatisfactory or inappropriate. This was particularly the case with conditions which needed prolonged or frequent treatment, where treatment was of a wholly routine nature, or where treatment (X-ray treatment for ringworm excepted) was cheap to provide. Where these features were absent, then existing institutions should be given preference unless they proved unsatisfactory.

This apparent preference for the use of existing institutions for the treatment of school-children continues in Circular 596, which was the result of Newman's deliberations. This is reproduced in Appendix C. In the section on arrangements for amelioration and physical improvement in Circular 596, eight methods by which amelioration might be effected are suggested. The first four of these, the improvement of school arrangements; the exercise of powers under the 1893 and 1899 Acts; co-operation with the sanitary authority; and the giving of advice or direction to parents, are of

(61) Ibid. These "educationally related" conditions marked the limits of treatment under the School Medical Service, however provided, until 1919, when discussion commenced on the possibility of widening the scope of the treatment system. See PRO Ed 50/45, minute papers, 1919.

a routine nature. The Circular then goes on to suggest, successively, the use of a school nurse, the provision of spectacles, and contributing to hospitals and dispensaries, before turning to the Board's attitude towards requests for approval for school clinics. Clinics for the further examination of children raised no problems, but the use of clinics for treatment "gives rise, on the other hand, to questions of considerable difficulty".⁽⁶²⁾ Before sanctioning any such arrangements, the Board would want to know:

1. What precautions [have been] taken to ensure treatment only for those for whom adequate provision could not otherwise be made?
2. What precise defects [were] to be treated?
3. By whom, and on what terms?
4. [The] estimated cost - and how it is proposed to meet this. (63)

In practice, the Board's attitude to clinics was less restrictive than Circular 596 would suggest. Newman's concern was to prevent inexperienced authorities from undertaking work with which they were not fully conversant, and which might turn out to be extravagant or inefficient. This might cast doubt the concept of the clinic. So, according to L.A. Selby-Bigge:

Dr. Newman and I have, in several cases where Local Education Authorities showed signs of going in for expensive forms of treatment, advised them to proceed in the first instance by subsidising hospitals. (64)

(62) Board of Education, Circular 596/1908, issued 17 August 1908, para.7(h)

(63) Ibid.

(64) PRO Ed 125/11, Precedent Cover: West Sussex, July 1908.

Where the authority had experience of school medical work, the Board was more willing to allow some experimentation with new methods, and in fact the second scheme of treatment approved by the Board, in October 1908, was for a school clinic to be provided by the Bradford Education Committee. (65)

The authorities tended to choose schemes of treatment according to their own assessment of unmet needs, their political orientation, and the initiative and independence accorded to their medical staff. This meant that a small number of the more progressive authorities proceeded almost immediately to the provision of a clinic, but that the overall picture, in the earlier stages of the evolution of treatment provision, was one in which the majority of councils did not provide any form of treatment, or limited their activity to the less adventurous options listed by Newman.

Thus in Newman's first Annual Report, for 1908, the number of authorities which had obtained the Board's permission to employ school nurses was, at thirty seven, greater than those obtaining permission to provide spectacles, make arrangements with hospitals, or establish school clinics combined. This was despite some authorities being refused permission to employ nurses because the Board did not judge them to be sufficiently under the control of the school medical officer. (66)

(65) PRO Ed 125/8, Precedent Cover: Bradford, October 1908.

(66) BPP 1910/XXIII:1. op.cit., pp.90-92.

Where nurses were employed, the financial benefit derived by individual parents through free attendance was small, and many education authorities justified their expenditure on nurses, which in 1908 amounted to £1,800 over England and Wales as a whole,⁽⁶⁷⁾ by arguing that the cost was effectively recouped through the increased grant received due to the earlier return to school of ringworm and pediculosis cases.⁽⁶⁸⁾ With the provision of glasses and other forms of treatment, however, the value of the benefit to the individual raised the question of payment for the treatment received. The Board of Education itself was prepared to allow the provision of spectacles at a reduced rate, and free in necessitous cases,⁽⁶⁹⁾ but before sanction was given it was emphasised that it:

1. Must be ascertained that provision of spectacles [is] the best way of meeting the defect.
2. Prescription to be strictly appropriate to the optical needs of each child.
3. The spectacles should be simple and inexpensive.
4. No local voluntary agencies available.
5. Parents unable to provide suitable glasses.⁽⁷⁰⁾

Local authorities varied in their attitude to the question of payment in the first years of the School Medical Service. When

(67) Ibid., p.91.

(68) See e.g. East Ham M.B., Annual Report of the School Medical Officer for 1909, p.110.

(69) BPP 1910/XXIII:1, op.cit., p.86.

(70) PRO Ed 125/11, Precedent Cover: Monmouthshire, 5 February 1908.

Somerset added a full-time oculist to its medical inspection staff, it was prepared to provide free spectacles in necessitous cases, but expected such cases to be few in number.⁽⁷¹⁾ Parents were normally expected to pay for glasses provided at Brighton, where the spectacles usually cost between 9d. and 2/- a pair,⁽⁷²⁾ and at Cardiff,⁽⁷³⁾ while at Birmingham the cost in the necessitous cases was guaranteed by the local care committees. Even with this guarantee, only 336 children out of the 791 cases for whom glasses were prescribed eventually obtained them.⁽⁷⁴⁾

Where a local authority wanted to provide a more comprehensive system of treatment, two options were available. Either it could make an arrangement with a voluntary hospital to provide treatment on behalf of the council, or it could establish its own school clinics. The Board's policy was to encourage many councils to subsidise the hospitals in return for treatment facilities, even though the B.M.A. was, if anything, more opposed to the subsidization of the hospitals by the local authorities than it was to their indiscriminate and unsubsidized use by school-children.⁽⁷⁵⁾

Subsidization of the hospitals could be effected in several ways. One was for the local authority to subscribe to one or more

(71) Public Health, 22(1908-9), 282.

(72) Lancet i(1911), 1715.

(73) Ibid., ii(1911), 549.

(74) Ibid., i(1912), 1235.

(75) British Medical Journal i(1909), supplement, 252-53.

of the local voluntary hospitals, thereby obtaining "subscriber's letters" which could be given to children needing treatment. At Brighton, it was proposed to spend £100 a year on subscriptions to local hospitals for this purpose,⁽⁷⁶⁾ but opposition from the medical staff of the hospitals concerned prevented the scheme from being implemented.⁽⁷⁷⁾ In other areas, no opposition to such schemes was encountered.⁽⁷⁸⁾ Elsewhere, the council could strike a more direct bargain with the hospital. At Bristol, the education committee offered the Eye Hospital, and the local dispensary, payments to treat refraction cases. In exchange for the payments, these cases were to be seen at special hours, although the education committee undertook then to limit numbers and to "maintain order". The offer arose because of the increased demand on the outpatient departments following the initiation of medical inspection, and the need to ration access to the hospitals and retain their goodwill.⁽⁷⁹⁾ The London County Council had the most extensive arrangements with the voluntary hospitals.

Any authority which made arrangements with the local hospitals to treat school children had to satisfy both the medical staff

(76) Lancet i(1911), 1715.

(77) Ibid., i(1912), 1048.

(78) Shropshire C.C. subscribed for "letters of recommendation" to the Salop Eye, Ear and Throat Hospital for the entire pre-war period. Shropshire C.C., Annual Report of the School Medical Officer for 1914, p.42.

(79) Lancet ii(1913), 591.

and the governing bodies of the hospitals. The B.M.A.'s opposition to the use of the voluntary hospitals was not wholly due to concern for the position of the hospital staff. One of the grounds for this opposition was that the use of the voluntary hospitals increased the prestige of these institutions, and thereby damaged the interests of the general practitioner. A second reason was the B.M.A.'s view that it was wrong for staff who worked voluntarily to be asked to treat additional cases referred by the education authorities, whether or not the hospital received payment for them. For this reason, the Board of Education stressed that it was:

permissible for authorities to include among the conditions of contribution to this kind of institution a provision allocating reasonable remuneration to the medical staff responsible for carrying out the treatment provided.

This provision, if included in an agreement with a voluntary hospital, allayed one of the fears of the B.M.A.⁽⁸⁰⁾ Although the Board really wanted to take a stronger line in pressing for such payments to be made, it maintained an official posture of neutrality on the subject as to do otherwise might:

lead to embarrassing questions. I don't think we have yet arrived at the position that we won't sanction contributions to hospitals unless some part is allocated to payment of staff, though we have stated that such an arrangement is permissible. We should try to stick to the

(80) BPP 1910/XXIII:1, op.cit., p.88.

neutral position as long as possible.
Dr. Newman agrees [on] this point after
discussion (81)

Although the hospital staff could thus be mollified by making the appropriate payments, some opposition remained. Difficulties occurred at Hemel Hempstead, where the Committee of Management of the West Hertfordshire Hospital told the education committee that:

although the hospital might be prepared to treat suitable cases, and to accept payment from the school authority, it would be unfair to honorary medical staff, who might be called upon to exercise the charity by attending these children, for treating whom they would get nothing. (82)

The proposal by the London County Council to make arrangements with some of the hospitals in London to treat local school children prompted a number of severely critical remarks in the medical press from members of the hospitals' medical staff, for whom the memories of the Council's vision testing programme remained vividly in mind.⁽⁸³⁾ For the governing committees of the hospitals, however, the difficulties, though great, were of a different character. If the Council was prepared to pay an adequate sum to pay the costs of treating the children, there was no prima facie reason why a hospital should not do so. But two problems remained. Many of the hospitals were charitable

(81) PRO Ed 125/9, Precedent Cover: Isle of Ely, note by Selby-Bigge, 7 September 1909.

(82) Lancet i(1911), 563.

(83) See e.g. ibid., i(1909), 1347, 1484.

foundations restricted by covenant to providing treatment for the necessitous poor only. Any school children treated would therefore have to come within this category. Second, the hospitals were fearful lest payments from the Council should lead to a restriction of their autonomy, and possibly to representation of the Council on their governing bodies.

Thus, even when the hospital governors were prepared to entertain proposals to treat defective school children, they required agreement to a series of stringent conditions before doing so. When the London County Council negotiated with representatives of the London hospitals, it was asked:

if there would be any difficulty regarding the following conditions:

1. Grant to cover all extra expenditure.
2. Only cases to attend suitable for a free hospital.
3. Hours of attendance to suit hospital.
4. If extra staff are required, these to be appointed by the hospital.
5. Any payment wouldn't entitle Council to representation on Governing body of hospital.
6. Children to pass hospital almoners in usual way: (84)

The agreement eventually negotiated with the hospitals by the L.C.C. effectively conceded all these points. The council agreed to pay the hospitals for medical staff to be specially appointed to treat the children. The payment was £50 to cover the annual cost of a doctor working for half a day each week, paid regardless of the number of children presented for treatment, and a capitation fee of 2/- for each child actually attending. The cost

(84) GLRO, L.C.C. file PH/SHS/2/4, notes on an interview at Charing Cross Hospital, 9 June 1909.

of providing specialised equipment such as X-ray apparatus for the treatment of ringworm was also to be paid by the Council, but the L.C.C. thought the overall cost would not exceed 5/- per child.⁽⁸⁵⁾ Other councils came to similar agreements. In the first year of the School Medical Service, Newman gave eight authorities sanction to make arrangements with hospitals.⁽⁸⁶⁾

The practice of paying the hospitals to treat the school children produced changes in the service the hospitals provided for patients in this category, irrespective of general considerations of their suitability as treatment agencies. Once payments were made to the hospitals, they restricted their treatment of school children to those whom they were contractually obliged to treat. This meant that parents who, on their own initiative, took children to an outpatients department were frequently refused treatment.⁽⁸⁷⁾ Children from local authorities which had not concluded agreements with the hospital were also excluded, as Surrey's School Medical Officer complained:

The London Hospitals were formerly much resorted to by parents of Surrey school children; it is now growing difficult to obtain treatment in many of them for county children suffering from defects of any kind owing to the arrangements made by the London County Council with the hospitals for payment for treatment of London school children. (88)

In London, some hospitals which had not concluded agreements with the L.C.C. also now excluded child patients, on the ground that

(85) L.C.C., Education Committee, Minutes, 3 November 1909.

(86) BPP 1910/XXIII:1, op.cit., p.94.

(87) L.C.C., Children's Care (Central) Sub-Committee, Agenda, 1 December 1910.

(88) Quoted in Cruickshank, op.cit., p.40.

arrangements for their treatment had now been made elsewhere.⁽⁸⁹⁾

The exclusion of other school children, and the limitation of the numbers attending the outpatient departments of the hospitals under the agreements signed by the L.C.C. ought in theory to have improved the utility of the outpatient departments as an agency of treatment, by eliminating the former uncertainty about whether treatment would be obtained which had prevailed when a child was simply one of a throng of unscheduled visitors to the outpatient department. With the hospitals insisting on maximum autonomy, however, the problems of administering such schemes of treatment led to a sizeable leakage between the medical inspection at school and the attendance at the outpatient department. The complex bureaucracy required frequently meant long delays between inspection and treatment, while children were sometimes mistakenly sent when the hospital was not expecting them, or more than the stipulated number were sent.⁽⁹⁰⁾ When arrangements for treatment were made, children frequently did not attend.

This leakage between referral and treatment was due to a number of aspects of the hospital treatment schemes which continued to deter many parents from taking their children for treatment. Because many hospitals had been concerned that the outpatient departments were being "abused" by the attendance of patients

(89) Times, 28 October 1910, p.6. This may have increased the regressive potential of the L.C.C.'s scheme, as formerly "the persons attending different hospitals are of different social standing. The very poor are for the most part obliged to be content with the nearest hospital whereas the class of skilled artisans and such as earn good wages can and do pay the expenses of making long expeditions". Lancet ii(1910), 99.

(90) GLRO, L.C.C. file PH/SHS/2/10, Medical treatment at the London Hospital.

who were able to pay for the treatment of themselves and their families, and who therefore fell outside the charitable intentions of the foundation, they appointed almoners to investigate the circumstances of people attending the out-patient departments to ensure that they were suitable cases for treatment. (91) A condition of the arrangements made with the L.C.C. was that all the children sent should be suitable candidates for treatment by a charitable foundation. Thus at Charing Cross Hospital it was noted "that very stringent inquiries appear to be made as to the circumstances of parents, home visits being paid in many cases. About 70 per cent of the parents made inaccurate statements at the first inquiry". (92) These investigations frequently deterred parents from attending. Even when they remained willing, many of the difficulties of obtaining hospital treatment remained. In many cases, a visit to a hospital meant a considerable amount of travelling, while even in London, the fact that arrangements for treatment had been made with only a few hospitals meant that even parents who lived within yards of a hospital not participating in the treatment scheme had to travel considerable distances to reach a hospital with which the L.C.C. had concluded an agreement. Thus "St. Pancras people are taken past the Temperance and University College Hospitals

(91) Brian Abel-Smith, The Hospitals, 1800-1948 (London: Heinemann, 1964), p.118.

(92) GLRO, L.C.C. file PH/SHS/2/4, notes on an interview with the Lady Almoner, Charing Cross Hospital, 15 October 1909.

to Charing Cross".⁽⁹³⁾ Even in London, some areas were a considerable distance from any hospital participating in the treatment scheme. So:

To visit a hospital means, for an ailing child in the borough of Woolwich, a tedious and fatiguing journey for himself and his mother, or some other adult, of anything between one and two hours; usually a long period of waiting; very frequently, the discovery of some mistake or difficulty, so that no treatment is given; then the journey back again. If frequent visits are necessary, the expense becomes considerable. (94)

This summarises the problems faced by parents seeking hospital treatment for their children. Hospitals would not treat unaccompanied children, so treatment frequently meant that one parent, usually the mother, had to take time off work to take the child to hospital. The travelling costs for parent and child added to the cost of the visit, even before any charges for treatment were taken into account,⁽⁹⁵⁾ while hospital treatment usually required multiple visits, with even simple refraction cases needing two visits to a hospital.⁽⁹⁶⁾

For the local authority to make arrangements with the hospitals for treatment did not, therefore, deal with many of

(93) L.C.C., Children's Care (Central) Sub-Committee, Agenda, 1 December 1910.

(94) Quoted in Cruickshank, op.cit., p.52.

(95) In one recorded case a child required four visits to a hospital to obtain a pair of glasses. Although the family obtained concessionary fares as the father was a railway employee, travelling costs alone came to 9/7½d. Marion Phillips, The School Doctor and the Home (London: Womens Labour League, [1911] p.21.

(96) British Medical Journal i(1903), 616.

the problems of hospital treatment formerly evident. In theory, although not always in practice, formal arrangements with the hospital did at least increase the likelihood of the child obtaining treatment, as attendances were rationed, and treatment of those attending virtually guaranteed under the council's arrangement with the hospital. This avoided the chaotic free for all that characterised many hospital outpatients departments at this time. But against this, the administration of such arrangements with the hospital necessarily reduced the immediacy and spontaneity of the treatment process. Thus in London, parents who on their own initiative took their children to a hospital for treatment of some ailment, and had been fortunate enough to obtain some treatment:

have been given emergency treatment and told to apply to the head teacher of the school for a LCC voucher entitling to further treatment. But the head teacher is not supplied with these vouchers, which are only issued after a delay of some weeks by the Education Office. The delay has the purpose of allowing the parent to provide treatment by his own endeavours, but in the cases cited it has the practical effect of considerably delaying treatment, frequently of rendering the emergency treatment futile, and of exasperating parents and teachers alike. (97)

Such arrangements, however smoothly operated, could not conceal the basic unsuitability of hospitals for the treatment of many of the commoner conditions among school children of the period. For such conditions as discharging ears, where

(97) Lancet ii(1910), 1437.

daily treatment, at the least, was prescribed; for pediculosis and impetigo, which needed frequent attendance, the outpatient departments were unsuitable means of treatment. Even in cases where the outpatient departments seemed an appropriate avenue of treatment, as in the operative treatment of tonsils and adenoids, pressure on the hospital's facilities gave rise to "cases where the children, after operation, have to be sent home by tramcar or omnibus in a condition unpleasant to themselves and to all who see them".⁽⁹⁸⁾ The problems of securing attendance of cases at the hospitals, particularly if a number of visits were required, called into question the effectiveness and the financial efficiency of using the hospitals as the treatment agency for school children. Figures from the London County Council scheme below illustrate the issues involved:

(98) Ibid. At Charing Cross Hospital the pressure on facilities was such that children were "brought out of the operating room and laid on the floor of the ante-room in batches to recover consciousness, often with a considerable amount of blood on their garments where they are seen by other children passing through to be operated on". Replying to this complaint, the Hospital Secretary could only admit "it is true they are laid on the floor - a very safe place in my opinion....". GLRO, L.C.C. file PH/SHS/2/5, medical treatment at Charing Cross Hospital.

HOSPITAL TREATMENT OF SCHOOLCHILDREN IN LONDON ⁽⁹⁹⁾

Hospital	Number of children asked to attend up to 31 October 1910.	Number of children the hospital could have treated.	Number of children who attended up to 31 October 1910	Number of cases where outcomes of treatment investigated.	Number of cases in last column who attended until discharged	Cost per case	Percentage who attended until discharged
Belgrave	1809	1340	1024	326	298	5/8d.	91.4
Charing Cross	1941	1575	942	433	400	6/-d.	92.4
Hospital for Diseases of the Throat	316	750	131	40	33	4/1d.	82.5
London	4203	3467	3481	550	417	3/4d.	75.8
Metropolitan Ear, Nose and Throat	383	375	222	110	87	4/1d.	79.1
St. George's	1523	1416	960	237	221	7/6d.	93.2
Total	10175	8923	6760	1696	1456	4/8d.	85.8

From these figures, it is clear that there was a considerable shortfall in the number of children attending the hospitals, compared to the number for whom arrangements for treatment had been made. This was despite the L.C.C. making appointments for more than the contracted number of children. Thus overall attendances were only

(99) Lancet i(1911), 184.

77 per cent of contracted capacity, and only 68 per cent of those children asked to attend for treatment. With the Council's expenditure being partly a fixed payment for staff in attendance, and only partly a capitation fee based on the number of children attending, the shortfall in attendances increased the average cost of treatment per case to 4/8d.

Even when children attended, only 85.8 per cent attended until the hospital discharged them from further treatment, so the proportion of children asked to attend the outpatient department who actually obtained full treatment was reduced still further, to 57.8 per cent. Such figures suggest that to make arrangements with hospitals represented an inefficient and relatively expensive means of providing treatment for school children. Analysis of the figures for individual hospitals, however, indicates that these results might be influenced by factors peculiar to London, and may thus be atypical of hospital treatment schemes elsewhere in Britain, about which relatively little information is available. Those hospitals, such as St. George's, and Charing Cross Hospital, which were closest to other voluntary hospitals not participating in the L.C.C. treatment scheme had the greatest shortfall in numbers treated relative to capacity. This suggests that some parents continued to attempt to use other hospitals not in the treatment scheme, especially after the L.C.C. had introduced charges for treatment under the School Medical Service.⁽¹⁰⁰⁾ In contrast,

(100) It was suggested that difficulties experienced in getting children to attend Charing Cross Hospital for treatment under

hospitals such as the London, which had a virtual monopoly of voluntary hospital provision over a wide area of East London, found less difficulty in attracting the number of children for whom they had contracted to provide treatment. As a consequence, the per capita cost of treatment at the London was much lower than at St. George's or Charing Cross, though the difference diminishes when the smaller percentage of children who actually continued treatment until discharged at the London is taken into consideration. It is possible, therefore, that the relatively generous provision of voluntary hospitals in some areas of London, and the distribution of the school population in relation to hospitals within the treatment scheme, may have influenced the viability of treatment at voluntary hospitals in London. In other areas, though, the basic difficulties of using this form of treatment remained, even if the local authority could find a hospital whose staff and governing body were willing to reach agreement with the council over the use of the outpatient department. Some resistance to such agreements later arose when it was suggested that voluntary hospitals accepting grants from councils to treat school children suffered a loss in their subscription income from those who thought the hospital was no longer fulfilling its

the L.C.C. scheme was because the parents were "frightened of the 'recovery of cost' and [they] have gone to St. Bart's Hospital which is nearer their homes and has the not inconsiderable advantage of providing treatment free". GLRO, L.C.C. file PH/SHS/2/4, memorandum on medical treatment at Charing Cross Hospital, January 1910.

charitable duty of providing medical care for the necessitous poor, or from those parents who objected to both subscribing to a hospital fund, and paying for their childrens treatment under the School Medical Service. (101)

The Development of the School Clinic Concept

Such problems served to increase interest in the final option offered to local authorities in Circular 596, the establishment of a school clinic. The concept of the school clinic in England and Wales derived from two main sources, socialist idealism and the Prussian example. The former idea was embodied in the policies of the various emergent labour and socialist organisations from the 1880's onwards. These urged the provision of free school meals and medical treatment as part of a programme of "state maintenance" for school children. In 1906, the Social Democratic Federation was repeating long standing policies when it pledged:

to continue with redoubled vigour the agitation in favour of state maintenance for school children, and to urge on the Board of Education the necessity of such an extension of the physical side of education as shall place skilled medical advice within the reach of every child, and, by systematic medical inspection, secure records of the physical development of the children attending state supported schools. (102)

(101) L.C.C., Children's Care (Central) Sub-Committee, Agenda, 27 January 1911.

(102) Justice, 10 March 1906.

Although consistent in their demands for the provision of medical attendance for school children, much of the activity of the socialist groups was channelled into the related area of free school meals, where the absence of the need for professional aid made the possibility of direct action by socialists easier. The work of Margaret McMillan was an exception to this rule. In addition to her extensive work, in both Bradford and London, in the free school meals campaign, McMillan managed to persuade Joseph Fels, the naphtha soap tycoon, to fund an experimental school clinic at Devons Road School, Bow. Although pioneering in its intentions, the small attendance at the clinic after its inauguration in 1908 threatened to portray the clinic as a high cost method of treatment, and so in March 1910 it was closed.⁽¹⁰³⁾ In practical terms, the Bow clinic may have been accorded more significance than it possessed, and by the time its successor at Deptford opened in June 1910 many municipal clinics were already in operation. Its main significance was probably in symbolizing an alternative to the hospital treatment system favoured by the Moderate majority on the L.C.C. The influence of the socialists and the legacy of Margaret McMillan were, however, embodied in the opening of the first local authority clinic at Bradford in 1908.⁽¹⁰⁴⁾

After establishment of the School Medical Service, socialist and trade union organisations were prominent in pressing local

(103) See Margaret McMillan, The Life of Rachel McMillan (London: J.M. Dent & Sons, 1927), p.118.

(104) Idem, New Life....., pp.5-6.

local authorities to adopt treatment through school clinics. (105)

To some extent it is possible that this link with socialist idealism acted as a restraint on the support the Board of Education felt able to give the concept of the school clinic in the early years of the School Medical Service; at the least the clinic was attacked as a typical example of "municipal socialism". (106)

Clinics drew wider support from a recognition of their importance within the German educational system. As discussed in an earlier chapter, the Imperial rivalry with Germany led to increasing interest in the features of the social welfare provision believed to make a contribution to the military strength of that country. In this context, the role of the school clinic was first brought to the attention of largely medical audiences by the Prussophile Dr. W. Leslie Mackenzie, whose published work placed great emphasis on the value of the school clinic system in Germany. (107)

In March 1909, George Newman visited Germany to see the clinic system in operation. (108) By then, the German clinic system had become known to a wider audience through the publication of an extensive article in the Times in 1908. (109)

Support for the use of school clinics developed from these two sources through a combination of professional pressures and

(105) See e.g. Lancet i(1911), 686; Tottenham R.O., Tottenham U.D.C., Education Committee, Minutes, 13 March 1911.

(106) Times, 1 September 1908, p.8. Although the School Medical Service was largely free from matters of sectarian controversy, G.A.N. Lowndes suggests the Board was at first doubtful "whether Catholic children could be expected to use the clinics if they were provided by the L.E.A.'s". G.A.N. Lowndes, The Silent Social Revolution, 2nd ed. (London: Oxford University Press, 1969), p.176.

(107) See e.g. W. Leslie Mackenzie, The Health of the School Child (London: Methuen, 1906).

(108) Newman Diaries (D.H.S.S.), vol.1, 10-25 March 1909.

(109) Times, 23 August 1908, p.11.

the evidence of experience of other forms of treatment. The B.M.A. which accepted the need for the treatment of school children, but which, for reasons already discussed, disliked the use of hospital outpatient departments for this purpose, chose to support instead clinics, staffed by local practitioners, as a more acceptable alternative.⁽¹¹⁰⁾ A consequence of the adoption of this policy by the B.M.A. was to reinforce the opposition of hospital medical staff to the treatment of school children in hospitals, whether by agreement or otherwise, and the refusal of some hospitals to continue to offer treatment to such cases.⁽¹¹¹⁾ Eventually, the difficulties experienced in the operation of hospital treatment schemes were to lead to increasing use of clinics as an alternative. The early growth of school clinic provision in Britain reflects this divergence of rationales for the foundation of clinics. The first clinic provision derived from socialist or general humanitarian impulses, both with public clinics such as that at Bradford,⁽¹¹²⁾ and privately funded clinics such as the dental clinic at Cambridge.⁽¹¹³⁾ They were followed subsequently by clinics established on more pragmatic grounds, including the unavailability of alternative means of treatment, as with

(110) British Medical Journal ii(1908), supplement, 42.

(111) Cruickshank, op.cit., pp.40-41.

(112) McMillan, New Life..., p.5.

(113) School Hygiene i(1910), 247.

the Abertillery school clinic,⁽¹¹⁴⁾ the refusal of hospital staff to treat school children, which was the justification for establishing a school clinic at Brighton,⁽¹¹⁵⁾ or the unsatisfactory results of alternative methods of treatment, which prompted the increasing use of "treatment centres" in London after 1911⁽¹¹⁶⁾ Overall, therefore, few clinics were established in the early years of the School Medical Service, and Newman's Annual Report for 1908 notes only the clinic at Bradford as being fully operational.⁽¹¹⁷⁾

The Board's response to Bradford's request for sanction to establish a school clinic indicates that Circular 596 was intended primarily as a guide to inexperienced authorities, and would not prevent councils with prior experience in school hygiene establishing a clinic. As Newman's 1908 Annual Report explained, Bradford already had a number of potential avenues for the treatment of school children, including the Bradford Royal Infirmary, The Bradford Children's Hospital, and the Royal Eye and Ear Hospital, in addition to General Practitioners.⁽¹¹⁸⁾ Consequently, when the Bradford Education Committee applied, in June 1908, for permission to establish a school clinic, the importance of the precedent prompted Newman to make one of the very few visits he made to local

(114) Remmett Weaver, op.cit., pp.514-22.

(115) Lancet i(1912), 1048.

(116) L.C.C., Annual Report for 1914, vol.3, Public Health, pp.98ff.

(117) BPP 1910/XXIII:1, op.cit., p.97.

(118) Ibid., p.99.

authorities during 1908. At Bradford, he discussed the matter with the School Medical Officer, Ralph Crowley, and local councillors. They argued that Bradford's experience since the original appointment of James Kerr in 1893 showed that the majority of children remained untreated by the existing agencies.⁽¹¹⁹⁾ Although the Council had not used its powers under the 1907 Act to try other modes of treatment, including making financial agreements with the hospitals, Newman recommended approval of the proposed clinic, which was, in fact, already operational. The conditions the clinic was intended to deal with, minor ailments and ear diseases, the prescription of spectacles, and the X-ray treatment of ringworm, fell into the group of conditions Newman considered suitable for treatment in a clinic, and admissions to the clinic would be controlled as:

1. Only children in Public Elementary Schools in Bradford admitted, who aren't being treated in any other way.
2. Only children sent by Local Education Authority medical officers admitted. No parent, teacher, Attendance Officer, other doctor, School Inspector, Health Visitor etc., will be allowed to do so. (120)

Selby-Bigge concurred with Newman's recommendation, saying "this is the kind of temperate proposal which we should favour".⁽¹²¹⁾

The treatment of Bradford's application for sanction for a clinic suggests that the main restraint on the development of the clinic system in the early years was the local authorities suspicion

(119) Ibid.

(120) PRO Ed 125/8, Precedent Cover: Bradford.

(121) Ibid.

of the unfamiliar, coupled to some degree with the Board's desire that only fully experienced authorities should operate clinics initially. Despite the apparent slant of Circular 596, there was no policy of approving clinics only as a last resort.

With school clinics, local education authorities were providing a new kind of treatment system, and details of the early clinics demonstrate the experimental and varied nature of much of the early provision. Most operated in school buildings or from municipal offices, like the pioneer Bradford clinic, but others, especially those with some voluntary contribution involved, were housed in a variety of premises ranging from a block of six council flats in Sheffield, through a church room in Epping, a co-operative store room in Hindhead, to the dental clinic at Stanton where "a lady's drawing room is used for operations, and her garden acts as a waiting room".⁽¹²²⁾

The cost of equipment and salaries of staff, though sometimes covertly subsidised through the use of full-time inspection staff, or medical officers of health given token payments, also illustrates the considerable variation that existed between the various early school clinics. The larger municipal clinics contained equipment valued at hundreds of pounds. Nottingham's two clinics contained £418 of equipment, Bradford's £285,⁽¹²³⁾ Cardiff's £250.⁽¹²⁴⁾ On

(122) Cruickshank, op.cit., pp.130-31.

(123) Ibid., p.134.

the other hand, the equipment of the Tottenham school clinic cost £15, and that at Newport (England), £14. The salary costs of the clinics surveyed by Cruickshank also varied considerably. Eight had costs of less than £25, fifteen between £25 and £400, and seven above £400.⁽¹²⁵⁾ To some degree, however, this presents a misleading picture of the activities undertaken by the various clinics. Some clinics providing quite extensive schemes of treatment had low salary costs because they were staffed by the school medical officer, his assistants and school nurses, who received only small honoraria in addition to their normal salaries, as at Abertillery,⁽¹²⁶⁾ or who had a proportion of their normal salary attributed to the costs of the clinic, as at Bradford and Brighton.⁽¹²⁷⁾ Such considerations could be important when the clinics were obliged to charge for treatment. Conversely, where specialist staff had to be employed, staffing costs were much higher, as with the Coventry clinic, where a full-time dentist was employed at £300 a year.⁽¹²⁸⁾

(125) Cruickshank, op.cit., p.134.

(126) A.E. Remmett Weaver, "The Abertillery School Clinic", Public Health 24(1910-11), 388-93.

(127) PRO Ed 125/8, Precedent Cover: Bradford; Lancet i(1911), 1715.

(128) Ibid., p.1369.

The early clinics, therefore, were varied in character, inspired by a number of ideals and needs, and no sense represented a coherent system of treatment. By 1913, however, the experience of operating the gradually growing number of clinics had produced a significant amount of favourable, sometimes overtly propagandist, literature supporting the concept of the clinic, and proposals for the extension of the clinic system in areas which had already experienced its operation. Lewis D. Cruickshank's work on School Clinics at Home and Abroad is typical of the literature supporting the expansion of the clinic system. This contains a critical appraisal of the difficulties surrounding other forms of treatment, and a series of arguments for clinics, which Cruickshank saw as having advantages in both the administration and the application of treatment. Because the clinic was under the control of the education authority, problems of a leakage between inspection and treatment which affected other modes of treatment could be minimised, delays in providing treatment reduced, attendances controlled, non-attendance monitored, and inconvenience to parents and children alleviated.⁽¹²⁹⁾ Because the clinic was designed specifically to cater for the needs of school children, it could provide treatment for conditions which would otherwise not be dealt with adequately, particularly those needing frequent, continual treatment such as discharging ears; and could also offer more appropriate remedies for conditions such as vision problems or dental defects, which

(129) Cruickshank, op.cit., p.60.

went untreated or were inadequately dealt with by existing institutions.⁽¹³⁰⁾ Additionally, Cruickshank argued that the clinic had social and educational advantages, helping to build up the relationship between parents, children, teachers and doctors, and connecting the local authority more closely to problems of educational hygiene.⁽¹³¹⁾ Similar arguments for the "social" advantages of school meals and school clinics were advanced elsewhere, especially in socialist literature.⁽¹³²⁾

Undoubtedly, the gradual but accelerating growth of school clinic provision in the years immediately preceding the First World War was aided by the perceived advantages of this system of provision, and also by the pressures, both positive, as with the support of the B.M.A. for a clinic system, and negative, as with the refusal of some hospitals to provide treatment, on the local authorities. Two other factors helped to aid the spread of clinics. First, the experience of the early clinics showed that opposition to their establishment by local G.P.'s diminished rapidly when it was seen that the fears of diminished practice on which this opposition was based were unfounded.⁽¹³³⁾ Secondly, and more influentially, the increasing support given to the concept of the school clinic by Newman in succeeding Annual Reports encouraged

(130) Ibid., pp.58-59.

(131) Ibid., p.62.

(132) See e.g. McMillan, New Life.....; L. Haden Guest, The Case for School Clinics, Fabian Society Tract no. 154 (London: Fabian Society, 1911).

(133) School Hygiene 1(1910), 522.

more authorities to consider the advantages of providing clinics for both examination and treatment. (134)

Clinics were not without their disadvantages, not all of which were acknowledged by their enthusiasts. In London, some of the parents regarded the early treatment centres with distrust, and for some time public confidence in these new and unfamiliar institutions was lower than in the long established hospital outpatient departments. (135) In rural areas, considerable problems of providing treatment applied equally to clinics, as well as to the more established forms of provision. By 1914, this difficulty was being met by some rural counties by the use of temporary, travelling clinics, as in Devon where:

the School Dentist carries the portable equipment at the back of his motor car, and the work is carried out in any available part of the school. In Norfolk, the equipment is conveyed by caravan, in which the dental work is also carried out. (136)

These attempts to provide clinic facilities, despite the obvious problems in the rural areas, epitomise the acceptance of the school clinics as the most efficient vehicle for the treatment of the diseases of school children. Further evidence of this acceptance is the expansion and systematisation of clinics in areas where experience of their operation had already been obtained. Thus in

(134) See BPP 1911/XVII:449, op.cit., pp.139, 146-65; BPP 1912-13/XXI:439, op.cit., pp.132-47; BPP 1914/XXV:401, op.cit., pp.166-85.

(135) L.C.C., Children's Care (Central) Sub-Committee, Agenda, 30 May 1913.

(136) BPP 1914-16/XVIII:665, Board of Education, Annual Report of the Chief Medical Officer for 1914, Cd. 8055, p.123.

Monmouthshire, Remmett Weaver's demonstration of the value of the clinic concept led the County Council to agree in principle to establish other clinics, at a capital cost of £11,000 and an annual expenditure of £2,000. The main clinic was to be:

at Newport, with subsidiary clinics at Abergavenny, Blaina, Blainavon, Chepstow, Cross Keys, Maesycymer, Monmouth, Newbridge, Pontllanfraith, Pontypool, Rhymney, Usk and Tredegar. In the first instance, it is proposed to appoint two whole-time dentists, a whole-time ophthalmic surgeon, and four nurses. (137)

London, which at the end of 1910 had seventeen places of treatment for school children, mostly hospitals, had fifty seven such places, mainly "treatment centres" run on the lines of a school clinic, by the end of 1919. (138)

Although most local authorities, if they attempted any kind of treatment, restricted themselves to one or more of the options mentioned by Newman in Circular 596, there were some isolated examples of other modes of treatment being attempted. One method tried by a number of local authorities was the formation of a provident medical club, with the children as subscribers. This was suggested, but rejected, in London, (139) but in other areas more determined efforts were made to establish such a system.

Derbyshire, where Dr. Barwise, the County Medical Officer of Health, was a strong advocate of the idea, attempted to set up a county-

(137) Lancet ii(1912), 854.

(138) L.C.C., Annual Report of the Medical Officer of Health for 1919, p.68.

(139) L.C.C., Education Committee, Agenda, 9 December 1908, p.114.

wide medical club, with a turnover of £3,000 a year, which would provide for the treatment of 1800 dental cases, ophthalmic treatment for 1000 cases, operative treatment for tonsils and adenoids, where required, and treatment for ringworm cases. This scheme was to be funded by contributions of 2d. each quarter from most of the Derbyshire school children, it being anticipated that 80,000 out of the 90,000 children in the county's schools would contribute.⁽¹⁴⁰⁾ Barwise's calculations proved over-optimistic, for enquiries found only 40 per cent of the parents willing to contribute to such a scheme. Eventually, he attempted to start a pilot scheme in the Clay Cross area, covering 2,000 school children, with treatment being given by the school medical officers, as the local G.P.'s declined to co-operate.⁽¹⁴¹⁾ Even this limited scheme quickly collapsed.⁽¹⁴²⁾

The Derbyshire scheme and similar proposals in Norfolk and West Sussex were sanctioned by the Board of Education, but when the Carnarvonshire County Council asked for sanction for the similar scheme it proposed to establish, the Carnarvonshire Children's Medical Relief Fund, the Board re-appraised its policy. Fundamentally, the problem was that medical clubs usually required an initial contribution from the education authority to pay for publicity

(140) School Hygiene 1(1910), 247.

(141) Lancet ii(1911), 514.

(142) PRO Ed 125/8, Precedent Cover: Carnarvon, notes on the Derbyshire scheme.

and working capital, although the object was to establish a self-supporting scheme. It was this initial contribution for which the Board's sanction was needed, and this raised a problem of principle, for it meant that all ratepayers were making a contribution to a scheme from which only children who contributed subscriptions would eventually derive benefit. So although the Welsh Department of the Board supported the scheme, the eventual consensus view within the Board was that it was unable to:

defend a scheme under which the local education authority would contribute towards the expenses of treating children whose parents could afford to pay something in advance towards the cost of such treatment while they would refuse to provide or contribute toward the cost of the residue of children whose parents were either unwilling or unable to pay the cost of treatment in advance. (143)

With such official discouragement of new medical club schemes, and the failure of existing ones, the concept of provident provision for the treatment of school children within the School Medical Service did not progress further. Some such schemes did, however, continue as unofficial adjuncts to the Service in some areas. Despite the Board's refusal to sanction the Carnarvonshire scheme, some attempt was made within the County to continue to collect subscriptions until 1914 at least, although the numbers contributing declined considerably after the first two or three

(143) Ibid. Cumberland established a similar scheme. Medical Officer 3(1910), 304.

subscriptions. (144) Such contributory schemes were ineligible for grant aid when this became available, being, in any case, not officially part of the School Medical Service, and this served to lessen the attractions of such schemes for some local authorities. Interestingly, although the Board refused to sanction such schemes because they benefitted only their membership, their justification, in the eyes of their promoters, was seen as the altruistic sense they developed in the children:

it is believed that [a Medical Relief Fund] will engender and develop in the minds and hearts of the children a desire to help each other. Children....will have the privilege of assisting in providing means to lessen suffering....(145)

Payment for Treatment

Although abortive, the proposed provident schemes do serve to indicate the debate that took place about who should pay for treatment provided under the School Medical Service. The 1907 Act was vague on the subject of who should pay for the "amelioration and physical improvement" permitted, but a subsequent Act both clarified and complicated the situation. The Local Education Authorities (Medical Treatment) Act 1909 required education authorities to charge parents for the cost of treatment, unless the family were adjudged to be in necessitous circumstances. (146)

(144) Gwynedd R.O., Caernarfon, Bontnewydd School Medical Relief Fund Account Book, 1911-14.

(145) Gwynedd R.O., Caernarfon, Carnarvon C.C., School Attendance and Medical Inspection Committee, Minutes, 28 September 1911.

(146) Local Education Authorities (Medical Treatment) Act, 1909, 9 Edw.VII, ch.13.

This Act had its origins in the struggle between the Board of Education and the London County Council over who should bear the responsibility for the costs of the School Medical Service. When the Education Committee's recommendation that the L.C.C. should contract with the voluntary hospitals to provide treatment for school children came before the full Council, an amendment was moved by Hayes Fisher, a Moderate Councillor and Unionist M.P., that steps be taken to amend the 1907 Act to enable the L.C.C. to recover the cost of treatment from parents able to pay for it. In the confusion which followed, the motion was "talked out" by its own seconder, but by the time the adjourned debate resumed, the Education Committee had agreed to accept the proposed amendment. (147)

The object was thus to charge parents and thereby reduce the cost to the Council, although Fisher's motion implied that free treatment should remain available for those whose parents were unable to pay. The Local Education Authorities (Medical Treatment) Bill was introduced into Parliament almost immediately after the LCC debate, sponsored by Walter Guinness, M.P., who was also a Moderate L.C.C. councillor, but attracting support from all parties, including Labour members like Ramsey Macdonald. They were apparently convinced by the argument, articulated in the House of Lords by Lord Donoughmore, that many local education authorities

(147) Lancet i(1909), 1071

were diffident about using their powers under the 1907 Act because of the additional burden that would be placed on the rates.⁽¹⁴⁸⁾ With the wording of the Bill being similar to that of the Education (Provision of Meals) Act of 1906, there were also grounds for believing that the provisions for the recovery of costs from the parents would be as ineffective as they had proved under the 1906 legislation. Privately, the Board of Education was unhappy about the introduction of Guinness's Bill. Morant thought "the less attention we draw to the Bill so far as the public are concerned, the better".⁽¹⁴⁹⁾ Publicly, the Board felt unable to oppose its passage, accepting the arguments of its proponents in Standing Committee,⁽¹⁵⁰⁾ although the Earl of Crewe hoped its provisions would be interpreted liberally: "it would be very unfortunate if in any locality too hard a construction were placed upon the provision that the parent must pay if he is able to do so".⁽¹⁵¹⁾ The passage of the 1909 Act, with its requirement that the local education authority should impose a charge on parents, unless remitted on grounds of poverty, created further difficulties for authorities giving treatment.

First, it increased the unpopularity of some forms of treatment by introducing apparent anomalies and inconsistencies into the system.

(148) Parl. Deb. (Lords), 5th series, 2(29 July 1909), 842.

(149) PRO E1 50/3, written footnotes to memorandum on 1909 Act.

(150) Times, 19 May 1909, p.4.

(151) Parl. Deb. (Lords), 5th series, 2(29 July 1909), 843.

The use of the voluntary hospitals, in London and elsewhere, was particularly a case in point. Parents, who in London might already have been directed past or turned away from a hospital where the whole family had formerly enjoyed free treatment, would find on arrival at the hospital nominated by the L.C.C. that they were expected to pay for their child's treatment, even though other children under school age, and often the parents themselves, were still entitled to free treatment. Obviously, the existence of such charges increased the possibility of parents refusing to obtain treatment, or seeking treatment from sources outside the School Medical Service.⁽¹⁵²⁾ Furthermore, payment was often required even where parents had contributed to schemes such as the Hospital Saturday Fund in order to ensure free treatment for themselves and their dependants. This led the hospitals to fear a reduction in their subscription income due to former contributors no longer feeling they were getting good value for their subscriptions.⁽¹⁵³⁾

Second, among those councils who attempted to implement the Act fully, a cumbersome bureaucracy was required to assess cases and, where necessary, to collect charges. At a minimum, inquiries had to be made as to whether a child was necessitous, and thus eligible for free treatment, while many councils had a sliding

(152) Lancet ii(1910), 1437.

(153) L.C.C., Children's Care (Central) Sub-Committee, Agenda, 27 January 1911.

scale of charges, requiring a more prolonged and sophisticated assessment. The procedure adopted by the Somerset County Council for recovering the cost of spectacles supplied is reproduced diagrammatically overleaf. (154) This indicates the bureaucracy needed to deal with even the simplest system of levying charges, in addition to the administrative needs of the original medical inspection, and the re-examination by the County oculist. It is not surprising to note that the Medical Officer of Health for Somerset thought that:

an adequate clerical staff is very necessary to deal with the numerous forms, entries, etc., required and to cope with the correspondence entailed, particularly when the simple directions are not carried out. (155)

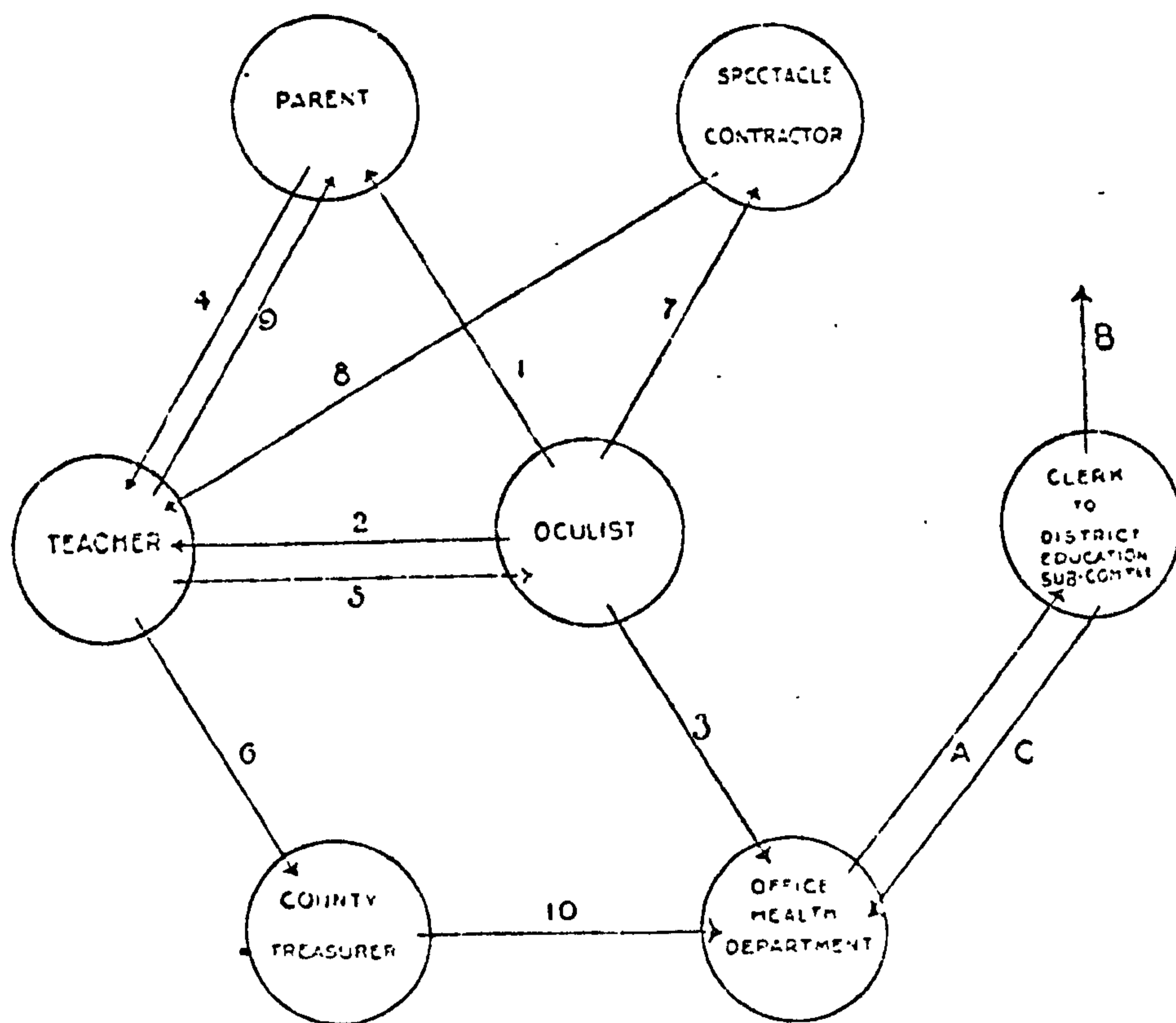
The L.C.C.'s more complex scale of charges, and the procedure adopted for the assessment and collection of these, which involved the intervention of at least six different officials, is also reproduced overleaf. (156)

Faced with such bureaucracies, the natural inclination of many parents was to avoid sending their children for treatment by the council. The assessment procedures were frequently criticised, and in London some school care committees refused to participate in the assessment procedure, in some instances as a protest against the principle of charging, but more often because the work of

(154) School Hygiene 1(1910), 464-65.

(155) Ibid,

(156) L.C.C., Children's Care (Central) Sub-Committee, Agenda, 27 January, 1911.



The following ten steps are necessary before a single child is provided with glasses, and in some cases steps A, B, C, have also to be carried out:—

- (1) Form M.I. 23. Notice of defect; cost of spectacles; how money to be paid.
- (2) Form M.I. 28. List of children for whom spectacles ordered.
- (3) Form M.I. 28. Duplicate to office with date when spectacles ordered.
- (4) 2s. 6d. paid by parent to teacher.
- (5) Certificate of payment so that Oculist can order the glasses.
- (6) 2s. 6d. paid by teacher to County Treasurer.
- (7) Glasses ordered after certificate of payment received.
- (8) Spectacles sent to teacher.
- (9) Spectacles sent by teacher to parent.
- (10) Return every few days of children for whom the 2s. 6d. has been paid.
- (A) Return to Clerk of Sub-Committee compiled from (3) and (10) of the children for whom spectacles required, but money not paid within two months.
- (B) Inquiries of Sub-Committee as to circumstances of these parents.
- (C) Recommendation in special cases for assistance from County funds.

There are besides the numerous notices which have to be prepared and sent out before the child is seen by the oculist.

A: SCALE OF CHARGES, L.C.C. TREATMENT SCHEME

Class	Income of std. family (5 ads. or 2 ads., 4 chn., after dedn. outg's.)	Ringworm cases. (Max. charge 3/-d per att. for max. 5 atts.)	Ear, Nose & Throat cases (Max. charge 1/8d per att. for 3 att.max)	Eye cases (Max. charge 1/4d per att. to max. of 3 attendances)
I	below 20/-	2/8d remitted	1/4d remitted	1/1d remitted
II	20/- to 22/5d	2/4d "	1/1d "	8d "
III	22/6 to 24/11d	2/1d "	8d "	4d "
IV	25/- to 27/5d	1/8d "	4d "	Full charge
V	27/6 to 29/11d	1/4d "	Full charge	"
VI	30/- to 32/5d	1/-d "	"	"
VII	32/6 to 34/11d	8d "	"	"
VIII	35/- to 37/5d	4d "	"	"
IX	above 37/6d	Full charge	"	"

For the purpose of calculation, any member of the household aged 14 or more was classed as an adult, and each child aged less than 14 was calculated as 0.75 per cent of an adult.

Further deductions from the charge could be made to allow for the cost of travelling to the place of treatment.

B: PROCEDURE FOR ARRANGING TREATMENT, AND ASSESSING AND COLLECTING CHARGE

1. Medical inspection takes place.
2. Child found defective, and mother given advice card.
3. School doctor or nurse enters particulars on school register.
4. Member of School Care Committee interviews mother on day of inspection and finds out:
 - a. If parents are able to obtain treatment from a private doctor.
 - b. If not, the Council's scheme is explained to the parent.
 - c. Details of family income, etc., are obtained.
5. School Care Committee apply to Education Officer for voucher card.

6. Assistant in Education Officer's Department meets the Secretary of the Care Committee and arranges hospital appointment.
7. Head Teacher fills in details of hospital appointment on voucher card and sends this to parents.
8. Secretary of the School Care Committee
 - a. Ascertains if the child attended for treatment, and notifies Divisional Superintendent of the charge to be made for each attendance
 - b. At the end of the month, notifies the Education Officer of the charge levied.
9. On discharge, the hospital notifies the Education Officer that the child has been discharged, with the number of attendances made.
10. Divisional Superintendent notified of charge to be made by the Education Officer.
11. Divisional Superintendent notifies parent of total charge, and ultimately calls to collect it.

assessment was seen as detrimental to the other objectives of the Care Committee. As a result, the assessment work in London fell severely into arrears, with more than half of the first 14,000 school children to receive treatment not having been assessed when the first report on the treatment and assessment procedure was made. (157)

Although some councils stressed that access to their clinics was given only to "children whose parents are not in a position financially (or for other reasons) to obtain treatment from other sources", (158) this usually meant virtually all elementary school children had access to a clinic. The L.C.C.'s scale of charges embraced all but the very highest paid members of the working class. In this sense, the clinic was universally accessible to its elementary school clientele. Only in Warrington was an attempt made to restrict clinic treatment to the children of the lowest paid. In this case only children whose parents net income was less than 3/-d per head were to be given treatment at all, although this treatment would be free of charge. (159) Treatment by the local authorities under the School Medical Service was not, therefore, generally envisaged as a service for the poor only. In the case of Warrington, pressure subsequently grew for a change in the system,

(157) Ibid.

(158) Wigan C.B., Annual Report of the School Medical Officer for 1909, p.19.

(159) Warrington C.B., Annual Report of the School Medical Officer for 1910, pp.16-17.

particularly as the level of eligibility was pitched at a lower level than that for free treatment at the local Infirmary, and "as a consequence, the thriftless and less deserving were treated at the clinic whilst the respectable working man's children were sent to accept it at a charitable institution". (160)

The provision of treatment within the School Medical Service, particularly through school clinics, had a further significance. Despite the apparent legal requirements imposed by the 1909 Act, there is evidence that many councils chose not to impose a charge. An L.C.C. inquiry in 1911 found only five out of twenty-two councils replying to a questionnaire were actually imposing charges for treatment in their clinics. In one of the five claiming to levy charges, Abertillery, no charge had yet been levied. (161)

The failure of some authorities to impose charges at all risked surcharge from the district auditor, but this risk was reduced by the policy of the Board of Education which, as it was later admitted, was essentially to allow local authorities to make up their own minds, rather than to stress the need for charges to be levied. (162) As a result, correspondence with the Board was actually cited as argument in favour of ignoring the requirements of the 1909 Act, and the legality of free treatment was not challenged on audit. (163) As a result, by 1918 the 1909 Act was

(160) Warrington C.B., Annual Report of the School Medical Officer for 1913, pp.42-43.

(161) L.C.C., Children's Care (Central) Sub-Committee, Agenda, 27 January 1911.

(162) PRO Ed 50/66, minute on "charges for treatment", 15 March 1923.

(163) Medical Officer 11 (1914), 74.

being described as "a dead letter" in Parliamentary debates. (164)

This was an exaggerated claim, for some areas did make considerable efforts to levy and collect charges for treatment. Nevertheless a survey undertaken by the Board of Education in 1921 indicates that in many areas the School Medical Service not only increased the possibility of children receiving medical treatment, but resulted in such treatment being given free at the point of demand. A survey, reproduced below, examined the extent to which councils levied charges:

CHARGES FOR MEDICAL TREATMENT, 1919-20 (165)

Areas making some charge for treatment for some ailments (Total:210)	Spectacles			Minor Ails.			Dental Trt.			Tonsil & Adens.			X-ray		
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)
	188	10	12	51	139	20	107	66	37	115	40	55	52	40	118
Areas not levying charges (Total:83)	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)
	-	57	26	-	78	5	-	47	36	-	41	42	-	23	60
Areas not providing treatment (Total:7)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Totals	188	67	38	51	217	25	107	113	73	115	81	97	52	63	178

- (1) Provided and charged for
 (2) Provided but not charged for
 (3) Not provided

(164) Parl. Deb. (Commons), 5th series, 104 (18 March 1918), 703.

(165) PRO Ed 50/60. Charges for treatment 1919-20.

Only with the provision of spectacles, and operations for tonsils and adenoids, were more councils found to be charging than those providing treatment free. In practice, free treatment was more widespread than even these figures suggest, for seventy one of the two hundred and ten councils claiming to charge for treatment had not received or recovered any parental payments during the 1919-20 financial year.⁽¹⁶⁶⁾ The Board thus faced considerable opposition from the local authorities when, under pressure from the Geddes Committee to produce savings in the net cost of the School Medical Service, it attempted to force all councils to charge for treatment.⁽¹⁶⁷⁾

The actual results of the imposition of charges for treatment were often disappointing. Although the Progressive Party claimed the L.C.C.'s scheme was "gradually abolishing the free medical treatment of school children",⁽¹⁶⁸⁾ the reality was different. Only £185 in parental payments for treatment had been received by the end of December 1910, but collection of this had necessitated the expenditure of an estimated £800 in salary costs, printing, stationery and book-keeping.⁽¹⁶⁹⁾ Even after changing to a simpler tariff system, the L.C.C. managed to recover less than half of the charges for

(166) Ibid. In some cases, such as the prescription of spectacles, the charge could be a direct transaction between parents and optician which would not be shown in the council's accounts.

(167) PRO Ed 50/66, minute on "charges for treatment", 15 March 1923.

(168) Times, 26 January 1911, p.10.

(169) L.C.C., Children's Care (Central) Sub-Committee, Agenda, 27 January 1911.

treatment outstanding. (170)

The provision of an Exchequer grant for the School Medical Service, after a delay of five years, coupled with the encouraging results of many early treatment schemes, particularly those involving the use of school clinics, produced a rapid expansion of the medical treatment provided under the School Medical Service in the years immediately prior to the First World War. More authorities provided treatment for a greater range of ailments, using school clinics to do so more frequently. The table below, from Newman's 1914 Annual Report, illustrates part of this process.

MEDICAL TREATMENT OF SCHOOLCHILDREN 1913-1914 (171)

Condition	No. of areas making provision in 1914					No. in 1913
	C.C.	C.B.	M.B.	U.D.	Total	
Minor ailments	28	63	86	27	204	123
Dental Defects	24	41	45	20	130	88
Defective Vision	40	56	71	28	195	N/A
Provision of Spectacles	24	49	60	32	165	125
Enlarged Tonsils and Adenoids	14	25	34	10	83	N/A
Ringwork (X-Ray)	10	31	15	12	68	N/A

(170) Ibid., 16 May 1912.

(171) BPP 1914-16/XVIII:665, op.cit., p.91.

As Newman's report emphasised, this was not just an increase in the number of authorities providing certain kinds of treatment, but an increase also in the number of children, even in authorities with long established systems of treatment, who were now receiving, and completing, satisfactory courses of treatment.⁽¹⁷²⁾ This was in part due to the increased use of the school clinic as a means of treatment, for the number of authorities providing treatment at school clinics increased from 139 in 1913 to 179 in 1914.⁽¹⁷³⁾ Thus by 1914, the necessity for the local authority provision for the medical treatment of school children, and the best means by which such provision should be made, were increasingly widely recognised and acted upon. The next chapter will examine the development and culmination of the provision of treatment during the War period 1914 to 1919.

Summary

The development of medical treatment by the local authorities during the 1908 to 1914 period was in many respects the most significant and remarkable aspect of the early history of the School Medical Service. Despite being under no compulsion to provide treatment, and lacking the incentive of a central government grant for most of this period, many of the local authorities nevertheless provided an expanding range of medical provision, relying increasingly on an entirely new channel of treatment, the

(172) Ibid.

(173) Ibid.

school clinic.

The causes of, and inspirations for, these developments have been explored in this chapter. The unsuitability of the existing avenues of treatment, combined with the disappointment felt by both professional staff and local councillors at the numbers otherwise obtaining treatment, led to the first experiments with the continental concept of the municipal school clinic. The success of these, combined with the arrival of a grant from the central government, accelerated the process of the municipalisation of medical care for school children. The next chapter will explore the way in which the First World War affected the development of this system.

CHAPTER NINETHE SCHOOL MEDICAL SERVICEDURING THE FIRST WORLD WAR,1914-1919The School Medical Service by 1914

Although the evidence presented in previous chapters has suggested an uneven but in general slow rate of development for the School Medical Service in the years before the First World War, by the year 1914 there had arguably been substantial movement towards uniformity of basic standards in medical inspection and administration. Coupled with the increased activity by local authorities in the non-mandatory areas of the School Medical Service, this suggested that the period of establishment and consolidation was nearing its conclusion. Several trends and events supported this view.

First, the expanded medical staff at the Board led to improvements in the standard of the work performed in many local education authorities. The original restriction on the size of the staff of the Medical Department had meant that the Board was frequently able to exercise control only by responding to queries from the local authorities, or by raising with them issues identified from the annual reports and other documentation it received from them. Letters to councils which had appointed an independent school medical officer asking "in what way the Local

Education Authority proposed to secure effective co-ordination between the work of the School Medical Service and the general Public Health Services?" represented the limit of the Board's powers in the first year of the Service. (1)

More detailed appraisal of local authority performance was dependent on the ability to visit and inspect. This evolved only gradually, even with the growth in numbers of the professional staff of the Medical Department. In 1912, more than forty local authorities had not been visited by the staff of the Medical Department since the establishment of the School Medical Service. (2) When visitations were eventually made, however, the Board was able to identify unsatisfactory practice, and to demand improvements. In the North Riding of Yorkshire, a council relying on "the part-time service of a School Medical Officer living a distance from the area of the authority", a visit by Eichholz in 1912 revealed an almost total lack of supervision and co-ordination of the part-time medical inspection staff. This meant:

there is no standard of measurements. Some children are measured with their boots on, others without, in some cases by tapes "correctly or incorrectly fixed", or by stands moveable or fixed, or by pencil marks on a door. The chest is measured in some cases with the coat on, in some cases without. Weighing may be by swing balances or by steel-yards, or by the machine in the village shop. (3)

(1) Clwyd R.O., Hawarden, Flintshire C.C., Medical Inspection Sub-Committee, Minutes, 13 May 1909.

(2) PRO Ed 23/203, memorandum, Newman to Selby-Bigge, 15 July 1912.

(3) Local Government Chronicle (1911), 939.

A subsequent visit by Newman, combined with a threat to withhold approval of the system, and thus jeopardise grant payments, forced the council to agree to a full time school medical officer and inspection system. (4)

The Board had less immediate success in Carmarthenshire, where another visit by Eichholz in June 1914 discovered that during 1913:

only 784 entrants and 493 leavers were examined, or, in other words, that about 1,300 entrants and 1,600 leavers escaped medical inspection altogether. It appears also that during this period no medical inspection was carried out in about 145 out of the 157 schools in the area, i.e. in about 92 per cent of the Authority's schools, that at least 10 schools were not visited at all during the two years 1912 and 1913, and that in the case of at least one school routine medical inspection was omitted altogether during the three years 1911, 1912 and 1913. (5)

The Board attributed this to indolence and incompetence on the part of the School Medical Officer (and Medical Officer of Health), Dr. Hughes. Even the appointment of an assistant had brought little improvement, for Dr. Thomas, the assistant, had been absent without leave for more than half the time since his appointment, and when working "the actual routine medical inspection of individual children is carried out by Dr. Thomas with such haste as to render the examination both incomplete and unreliable". So concerned was the Board that it withheld all grant for medical work for 1914. (6)

(4) Medical Officer 7(1912), 130.

(5) Dyfed R.O., Carmarthen, Carmarthenshire C.C., Education Committee, Minutes, 12 November 1914.

(6) Ibid.

The Board secured some improvements to the system of inspection, but the Council was unwilling to dismiss Dr. Hughes, who as a consequence was barred by the Board from being School Medical Officer while he remained Medical Officer of Health to the County.⁽⁷⁾ That such manifestly unsatisfactory authorities were being identified and action taken by the Board did mean that, by 1914, minimum basic standards of administration and inspection were, with rare exceptions, being achieved nationally.

Improvements in the quality of the Service also took place in basically satisfactory but not wholly efficient authorities as a result of visits from Medical Department staff. Thus when Carnarvonshire was visited it "was possible, after consultation with Dr. Eichholz, to improve upon a good many points in the machinery of the system",⁽⁸⁾ while in Anglesey, visits from the Board were followed by suggestions for improvements to a basically satisfactory system of inspection.⁽⁹⁾ Frequently, such advice was designed to strengthen the procedures for "following up", rather than the inspection process itself.⁽¹⁰⁾ The Medical Department was aiming, in the traditions of central government inspection, to use it as a positive, rather than simply a negative, form of

(7) PRO Ed 50/35, memorandum "Areas where the Medical Officer of Health is not the School Medical Officer", 1922.

(8) Carnarvonshire C.C., Annual Report of the School Medical Officer for 1910, p.5.

(9) Gwynedd R.O., Llangefni, Anglesey C.C., Medical Inspection Sub-Committee, Minutes, 26 February 1914.

(10) See e.g. Clwyd R.O., Denbigh, Denbighshire C.C., Medical Inspection of School Children Sub-Committee, Minutes, 20 April, 1910.

supervision. (11)

A second measure to encourage greater uniformity of practice was the publication, in Newman's Annual Report for the year 1912, of a set of standard tables for the return of statistics of medical inspection. These, Newman hoped, would overcome circumstances which, as explained in chapter six, "rendered it impracticable to furnish anything in the nature of national returns or statistics in regard to the physical condition of children attending Public Elementary Schools". (12) Although Newman hoped his standardised tables would be used in preparing the 1913 annual reports of local school medical officers, the November 1913 date of issue of his 1912 Annual Report suggests 1914 as a more likely date for the adoption of his suggested standard.

Perhaps the most important contribution towards the standardisation of provision and general development of the School Medical Service during this pre-war period, however, was the introduction of Exchequer grant in aid, first toward the cost of providing medical treatment and then, during the 1913-14 financial year, in aid of the general cost of the School Medical Service. The introduction of this financial grant had a profound effect on the attitudes of local authorities toward providing more than the basic medical inspection, and it also influenced the views of the Board of Education

(11) See John S. Harris, British Government Inspection (London: Stevens & Sons, 1955), p.2.

(12) BPP 1914/XXV:401, Board of Education, Annual Report of the Chief Medical Officer for 1912, Cd. 7184, p.24.

about the requirements it could reasonably expect from local authorities. The medical grant gave Newman more specific power, and hence perhaps a more exerciseable power, to penalise or to reward authorities with respect to the exercise of their medical functions than had been the case with the general education grant. Rarely, the power was used punitively, as when an unspecified education authority (actually Carmarthenshire) was denied any grant at all in one year of the system's operation.⁽¹³⁾ More generally, however, the grant appears to have been deliberately structured so as to encourage local authorities to provide services other than the basic medical inspection. Selby-Bigge later quoted the School Medical Service grant as an example of a grant intended to be "dynamic" and "directed to inducing local agencies to provide these additional facilities which at particular times seemed most necessary or most desirable".⁽¹⁴⁾ Procedure Minute M27, dated 30 June 1914, gives an indication of the way in which the grant to each authority was calculated in the period before the administrative constraints imposed by the First World War necessitated simplification of the system.

In theory, the rate of grant payable was 50 per cent of an area's expenditure on the School Medical Service, but minute M27 indicated that this should be broken down into three components

(13) BPP 1914-16/XVIII:665, Board of Education, Annual Report of the Chief Medical Officer for 1914, Cd.8055, p.20.

(14) Sir Lewis Selby-Bigge, The Board of Education (London: G.P. Putnam's Sons, 1927), pp.83-84.

for the purpose of calculating grant. A grant of 25 per cent of total expenditure on the School Medical Service was payable if the Board was satisfied with an authority's provision for medical inspection, with a further 15 per cent of total spending on the service payable if the council's provision for ancillary work and "following up" was also deemed satisfactory, and a maximum of 10 per cent of total expenditure being paid if a satisfactory and reasonably comprehensive system of medical treatment was in operation.⁽¹⁵⁾ Thus an authority whose work was limited to performance of the basic medical inspection could not hope to obtain a grant of more than 25 per cent of its total expenditure on the School Medical Service, and even this might be subject to deduction if aspects of the inspection were unsatisfactory. Five per cent of the total grant available could be deducted if a significant number of "entrants" or "leavers" were not subjected to the medical inspection.⁽¹⁶⁾ On the other hand, to qualify for the full 50 per cent grant, not only had an authority's systems of inspection and "following up" to be completely satisfactory, but it must also have:

in operation during the period a comprehensive scheme of treatment or a substantial instalment of one. The treatment of minor ailments only, or the provision of spectacles only, should not as a rule be considered a substantial instalment, and an allowance of 5 per cent [out of the 10 per cent allowed for treatment] only should be given. (17)

(15) PRO Ed 50/63, Medical Department procedure minute M27, 30 June 1914.

(16) Ibid.

(17) Ibid.

Although the regulations did not specify that the treatment should in fact be provided or arranged by the local authority itself:

In practice, however, it will be found that there are very few, if any, areas in which a satisfactory proportion of children suffering from "school diseases" obtain appropriate treatment unless provision is made by the Local Education Authority for the purpose. (18)

Thus only the most active local education authorities obtained the full grant. In the 1912-13 financial year, only sixty nine authorities qualified for the maximum grant, then paid for medical treatment only.⁽¹⁹⁾ As already indicated, a percentage of the grant could be deducted if aspects of the council's work were thought to be unsatisfactory. It was suggested that where the salaries of the medical staff employed were considered unsatisfactory, a 5 per cent deduction in grant could be made.⁽²⁰⁾ This was not simply an attempt to reinforce the policy of the B.M.A. so much as a view that inadequate salaries reduced the competence and commitment of the staff employed.

The most significant aspect of the adoption of this system for the payment of grant, however, is the inducement it gave to local authorities to develop their work under the School Medical Service beyond the duty of medical inspection and into the optional powers also included in the 1907 Act, for an extension

(18) Ibid.

(19) BPP 1916/VIII:149, Board of Education, Annual Report of the Chief Medical Officer for 1915, Cd. 8338, p.23.

(20) PRO Ed 50/63, Medical Department procedure minute M27.

of activities attracted additional grant as an extra percentage of the total cost of the Service, including the statutory duty of inspection. If a council introduced a comprehensive system of "following up", this would increase the cost of the School Medical Service to the council, but the additional 15 per cent grant, calculated on the total cost of both inspection and "following up", would perhaps mean that the net cost to the council of the extended service could be reduced. (21)

The publication in the period immediately preceding the War of calls from both Conservative⁽²²⁾ and Liberal⁽²³⁾ politicians for an extension of the School Medical Service, including measures making it compulsory for local authorities to provide treatment, indicate that there was now a considerable body of support for further development of the Service. At this point in time, however, Newman was opposed to the inclusion of a clause compelling local authorities to provide treatment in the Education Bill under discussion for introduction during the 1913 or 1914 Parliamentary

(21) For an example of the deployment of this kind of argument to justify the extension of provision for medical treatment see Hampshire C.C., Annual Report of the School Medical Officer for 1914, p.4.

(22) Samuel J.G. Hoare, The Schools and Social Reform, Report of the Unionist Social Reform Committee on Education (London: John Murray, 1914), pp.8-9. For an assessment of the influence of the Unionist Social Reform Committee and policy, see D.J. Dutton, "The Unionist Party and Social Policy, 1906-1914", Historical Journal 24(1981), 871-84.

(23) John Whitehouse, A National System of Education (Cambridge: Cambridge University Press, 1913), pp.40-41.

session. He argued that substantial advances could be made in the first instance by exerting indirect pressure through the use of the grant system. (24)

A further aspect of the provision of grant was that it allowed the Board finally to extend the scope of compulsory medical inspection. The initial restriction of the medical inspection to groups of "entrants" and "leavers" only was intended to reduce the financial costs of the School Medical Service to the local authorities in the absence of a central government grant. Although Newman thought two inspections during school life to be inadequate, political considerations precluded the introduction of a third, intermediate group of school children for fear of antagonising the local authorities further. (25) Even when the grant for medical treatment was introduced in the 1912-13 financial year, it was agreed:

that it would be better not to include a third age group this year in order not to spoil the effect of the generosity of the Government in providing money for medical treatment. If we accompanied the medical treatment grant with a requirement of additional medical inspection work from Authorities who will not share in the treatment money, we shall be assailed by the argument that we are imposing additional duties without redeeming the promise made long ago of additional Exchequer aid. (26)

(24) PRO Ed 24/625, "Some Notes on the Physical Basis of National Education", memorandum no.14 on the 1913 Education Bill, by George Newman, 22 March 1913.

(25) PRO Ed 50/45, memorandum by Newman, 12 February 1912.

(26) Ibid., memorandum by Selby-Bigge, 30 March 1912.

However, with the introduction of the general grant for the School Medical Service, the Government felt able to issue Circular 823 on 18 August 1913 giving notice that inspection of a third, intermediate group was to be required on 1 April 1915, the delay being necessary to allow areas to make the necessary arrangements. (27)

By 1914, therefore, Newman could be reasonably confident that the development and expansion of medical work in schools would progress with increasing rapidity. At first, there was every indication that this would be the case, for "during the early part of the year [1914] there was every indication that the year's work would be marked by exceptional progress and increasing effectiveness". (28) These expectations went unfulfilled, however, due to the outbreak of the First World War on 4 August 1914. The War immediately caused some disruption of medical services through the call up of Royal Army Medical Corps reservists and Territorial force volunteers, but the Board of Education's first response was to issue Circular 862 in August 1914, suggesting that the work of the School Medical Service should be maintained with "the minimum of interruption and irregularity". Although the Board recognised there would be some difficulties in continuing the normal work in some areas, the tenor adopted in Circular 862 indicates the Board's general expectation was that

(27) Board of Education, Circular 823/1912, issued 18 August 1913.

(28) BPP 1914-16/XVIII:665, op.cit., p.2.

the service would be able to continue normally.⁽²⁹⁾ For the remainder of 1914, it would seem that expectation was realised. Although some school medical officers left on war service, it was normally possible for their employing authority to make other arrangements or to obtain replacements, the only difficulties being those normally associated with a change in personnel.⁽³⁰⁾

Medical Inspection and the First World War

The progress of the War led to increasingly severe demands being made on the medical services in Britain, and the School Medical Service came under increasing strain through the resulting loss of medical personnel. Ironically, among those leaving early on temporary commissions was James Kerr, whose appointment as a Major in the R.A.M.C. seemed to symbolise once again the fundamental differences between him and the Quaker Newman. By February 1915, the difficulties caused by the enlistment of civilian medical staff in the Armed Forces had led the B.M.A. to establish a committee of the chairmen of its existing standing committees to seek ways in which the enlistment of medical officers by the Armed Forces could be regulated so as to protect the civilian medical services from undue and unnecessary disruption. In July 1915 this committee formed the nucleus of the Medical War Emergency Committee. This in turn became, in

(29) Board of Education, Circular 862/1914, issued August 1914.

(30) BPP 1916/VIII:149, op.cit., p.3.

October 1915, the Central Medical War Committee, which played a significant role throughout the War in controlling medical recruitment to the Armed Forces, and was delegated with the responsibility of supervising the enlistment of medical staff when conscription was introduced in 1916.⁽³¹⁾ The first issue for the committee, in its original incarnation, came in March 1915, when Sir Alfred Keogh, the Director-General of Army Medical Services in Britain, announced that some 2,000 medical officers were needed for the Army. This demand reportedly "caused considerable consternation" among medical men.⁽³²⁾

While the B.M.A.'s special committee of chairmen met Keogh to discuss how his demands could best be met,⁽³³⁾ the Armed Forces' need for medical officers was leading to more direct representations to the Board of Education about the resources taken up by the School Medical Service. A letter to the Board from the Army Council on 9 March 1915 referred to the "serious deficiency in the supply of medical men available to attend to the sick and wounded soldiers in this country" and asked if the Board could make arrangements with the local education authorities to secure the release of some school medical officers for Army service.⁽³⁴⁾ This request, and the inevitable reduction

(31) Sir William Grant MacPherson, Medical Services: General History 4 vols., History of the Great War based on Official Documents (London: HMSO, 1921-24), 1(1921), 144-45.

(32) Ibid., p.144.

(33) British Medical Journal i(1915), 645ff.

(34) PRO Ed 50/45, Army Council to Board of Education, 9 March 1915.

in the scope of the operations of the Service which it implied, led to a discussion within the Board as to how it could accede to the War Council's request without jeopardising the long term future of the School Medical Service. Newman wanted "to retain the fundamental principles of inspection and treatment" in any re-arrangement of operations, and suggested that any circular should "suggest as the irreducible minimum the following:

'The medical inspection of specials, and as much treatment as possible'". (35) Newman went on to comment that:

The less we say upon this question of the irreducible minimum, the better; but I think we must say something, otherwise we shall have Authorities thinking that we mean to shut down the School Medical service altogether. (36)

As a result of these consultations, the Board issued Circular 899 on 29 March 1915. In this the Board referred to the urgent need of the War Office for more medical staff, and stressed that they would not object to school medical staff volunteering for duty, even though this might lead to some dislocation of the School Medical Service in the area concerned. Although the circular suggested that temporary assistance might be sought from retired medical practitioners and others in order to help maintain the operations of the School Medical Service, it recognised that:

in many areas a temporary curtailment of the work of the School Medical Service may become inevitable. The Board do not desire to prescribe the way in which the curtailment should be

(35) Ibid., memorandum by Newman, 12 March 1915.

(36) Ibid.

effected except that they are of the opinion that the medical inspection of children of all ages who appear to be ailing and the maintenance of any treatment at present being undertaken by the authority should be regarded as the first charge on the time of the staff.

The circular went on to promise that any difficulties encountered by councils due to a reduction of their medical staff for unavoidable causes would not jeopardise payments of grants.⁽³⁷⁾

Further indications of the impact of the War on the development of the School Medical Service were contained in circulars issued by the Local Government Board on 11 and 25 March 1915, which announced the reduction of local authority capital spending to a minimum. This served to hinder development of the school clinic system to some degree.⁽³⁸⁾ Later, on 22 December 1915, the Board of Education issued Circular 935, which announced that the Board was willing to accept "short reports of a comparatively simple nature" from local school medical officers in respect of their annual reports for the 1915 year, due to the need for economy and the reduction in clerical and administrative staff resulting from the War.⁽³⁹⁾ This meant that most of Newman's standard tables, used by many areas for the first time in 1914, could not now be satisfactorily completed. Circular 974, dated 5 January 1917, extended this dispensation for a further year.⁽⁴⁰⁾

Sir Alfred Keogh's request for 2,000 doctors in 1915 proved to be only the start of a continuing and growing demand on the part of the Armed Forces for qualified medical personnel,

(37) Board of Education, Circular 899/1915, issued 29 March 1915.

(38) BPP 1914-16/XVIII:665, op.cit., p.3.

(39) Board of Education, Circular 935/1915, issued 22 December 1915.

(40) Board of Education, Circular 974/1917, issued 5 January 1917.

and by the first half of 1917, more than half the doctors in the country had been called up for service. By 1 January 1918 "it was estimated that the number [of doctors] left in civil practice was only 11,482 compared with 12,720 in military service".⁽⁴¹⁾ This general mobilisation of medical staff did not leave the School Medical Service unaffected. Reviewing the position in March 1917, Newman found that:

85 school medical officers, 231 assistant school medical officers, 81 medical officers undertaking work of a specialist nature, 163 school nurses, and a considerable number of school attendance officers, and clerks engaged in the work of the School Medical Service had joined H.M. Forces....In April 1917, consequent on further demands of the War Office, all medical men of military age were called up for immediate military service. (42)

Such demands resulted in further circulars being issued by the Board to advise the local authorities on how to deal with the situation now arising. Circular 950, issued on 12 May 1916 at the suggestion of the Central Medical War Committee, urged medical staff to declare their willingness to serve in the Armed Forces, while stressing again to the local authorities the need to maintain the basic minimum standard of service outlined in Circular 899.⁽⁴³⁾ In Circular 991, however, issued after the general call up of medical staff, the Board was forced to

(41) MacPherson, op.cit., I, 146-47.

(42) BPP 1917-18/XI:89, Board of Education, Annual Report of the Chief Medical Officer for 1916, Cd.8746, p.1. The immediate pre-war strength of the School Medical Service was 855 school medical officers and Assistant School Medical Officers, and 445 officers performing specialist duties. Ibid.

(43) Board of Education, Circular 950/1916, issued 12 May 1916.

admit that "in some areas, curtailment [of the School Medical Service] beyond the previous basic minimum would be unavoidable", and suggested that in these cases ailing children should be identified by school nurses and teachers, and subsequently examined by a school medical officer or private practitioner.⁽⁴⁴⁾

The issue of these circulars indicates that the demands of the War were reducing the local authorities ability to continue the normal provision of medical inspection, but also shows that the Board was concerned to ensure that at all times some form of medical supervision should remain. Newman's Annual Reports indicate the growing demand of the War made an increasing impact. In 1915, 48 authorities were restricting medical inspection to ailing children only for all or part of the year; by 1916 the number had grown to 92⁽⁴⁵⁾ and by 1917 to "about 100".⁽⁴⁶⁾ Even late in 1918, some authorities were being forced to adopt the ailing children basis of inspection,⁽⁴⁷⁾ and after the War, in 1919, many areas found it impossible to return to the normal standard of inspection during the year.⁽⁴⁸⁾

The number of children affected by the curtailment of

(44) Board of Education, Circular 991/1917, issued 27 April 1917.

(45) BPP 1917-18/XI:89, op.cit., p.1

(46) BPP 1918/IX:99, Board of Education, Annual Report of the Chief Medical Officer for 1917, Cd. 9206, p.2.

(47) Carnarvonshire C.C., Annual Report of the School Medical Officer for 1919, p.1.

(48) BPP 1920/XV:149, Board of Education, Annual Report of the Chief Medical Officer for 1919, Cmd. 995, p.1.

inspection was increased by the greater difficulty encountered by the larger urban authorities in maintaining a staff of medical inspectors. Smaller areas were disproportionately represented among those continuing the normal inspection of entrants and leavers.⁽⁴⁹⁾ In 1916 the areas inspecting on an ailing children basis consisted of 35 counties, 26 county boroughs, 19 municipal boroughs and 12 urban districts, a marked bias toward the larger authorities when compared with the overall distribution of education authority areas.⁽⁵⁰⁾

Although the suspension of normal medical inspection was in many cases due to the increasing unavailability of staff, Newman's not unfounded concern was that many councils would seize the opportunity offered by the departure of their regular medical inspection staff to economise, and suspend inspection and treatment when such action was not unavoidable. When Willesden abandoned normal inspection in 1915 it was "with a view to economy and owing to the shortage of doctors" that this action was taken,⁽⁵¹⁾ while the School Medical Officer for Edmonton, submitting his Annual Report for 1914, told the Education Committee that it:

is not one which affords me much satisfaction as it relates only to a trifle more than half the year as regards routine medical inspection, which ceased when the School Medical Inspector, Dr. Rock, left for war service on July 13th.

From July 13th, 1914 to February 1st 1915 you - deliberately and against the advice of the Board

(49) BPP 1916/VIII:149, op.cit., p.1. Manchester had lost half of its pre-war staff of 10 Assistant School Medical Officers by 1915, 4 having volunteered for military service. Manchester C.B.C., Annual Report of the School Medical Officer for 1915, p.6.

(50) BPP 1917-18/XI:89, op.cit., p.1

(51) Times, 29 November 1915, p.5.

of Education and your own expert officer - abandoned the routine medical inspection of the children in the public elementary schools...(52)

Bedfordshire was another area which was instanced by Newman as using the war conditions to economise on its expenditure on the School Medical Service.⁽⁵³⁾ Economies were sought due to the general pressure on councils to reduce expenditure, rather than because of the cost of the School Medical Service itself.

As the War progressed, therefore, the conduct of medical inspection by the various local authorities became increasingly less uniform. Some councils were virtually unaffected by the military requirements throughout the whole of the War period, and continued to inspect entrants and leavers, and in some instances an intermediate group also,⁽⁵⁴⁾ without any disruption to the medical inspection programme. Others maintained routine inspection only by employing temporary, in some instances a succession of temporary, assistants, leading to disruption and lack of consistency within the inspection programme. Where the routine inspection had to be abandoned, at least temporarily, local authorities resorted to a variety of devices to keep some semblance of inspection continuing. In London, ironically, the

(52) Edmonton U.D.C., Annual Report of the School Medical Officer for 1914, p.125.

(53) PRO Ed 50/45, minute by Newman, 13 January 1916.

(54) BPP 1918/IX:99, op.cit., p.2. Among authorities continuing to inspect three groups of schoolchildren throughout the War period were Warrington and Torquay. Warrington C.B.C., Annual Report of the School Medical Officer for 1918, p.4; Torquay C.B.C., Annual Report of the School Medical Officer for 1918, p.6. See also Times Education Supplement, 15 August 1917, p.351; 22 August 1917, p.359; 10 October 1917, p.438.

emergency system bore some resemblance to Kerr's earlier system of inspection, for "all entrants were submitted to a preliminary inspection by the school doctor, and only those selected by him were summoned for detailed inspection, and the parents informed."⁽⁵⁵⁾ Other large authorities, particularly large urban areas, were forced to restrict inspection to an ailing children only basis. These included Sheffield and Manchester.⁽⁵⁶⁾

Ailing children were selected either by a visiting school doctor who conducted a "march-past" reminiscent of the former L.C.C. system,⁽⁵⁷⁾ or by school nurses, as in Wiltshire and Lancashire,⁽⁵⁸⁾ where ailing children were then referred for examination by the remaining medical staff, or by teachers who, having successfully concluded an agreement with the B.M.A. regarding a demarcation and limitation of their responsibilities during medical inspection, found themselves undertaking considerable extra work during the period when medical resources were

(55) L.C.C., Annual Report for 1916, vol.3, Public Health, p.23.

(56) Times Education Supplement, 28 March 1918, p.144. Manchester C.B.C., Annual Report of the School Medical Officer for 1915, p.6.

(57) Times Education Supplement, 2 November 1916, p.15.

(58) Ibid., 16 November 1916, p.211; J.J. Butterworth, "Some Thoughts on School Medical Inspection", Public Health 29(1915-16), 111.

restricted. Newman acknowledged the importance of the teachers contribution at this time in his Annual Reports. (59)

The increasing number of authorities transferring to inspection on an ailing children basis brought a corresponding decline in the overall number of children inspected, although in some areas it was found that inspection of ailing children only produced as many cases as a full inspection of entrants, leavers and intermediates, (60) Nevertheless, by 1918 it was estimated that 34 per cent fewer children were receiving medical inspections in England and Wales than would have been the case if the full Code requirements for inspection had everywhere been fulfilled. (61) These figures, which conceal great divergencies of practice between authorities during this period, when combined with the continued delays in the forwarding of many of the local annual reports to the Board, which Newman repeatedly criticised, and with the depletion in the medical staff of the central Medical Department itself during this period, meant that little meaningful data could be collated, or supervision exercised, by the central Medical Department at this time.

Although some school medical officers were to use the introduction of ailing children examinations as a basis on which to argue for a more selective approach to medical inspection, (62)

(59) BPP 1917-18/XI:89, op.cit., p.4

(60) BPP 1918/IX:99, op.cit., p.2.

(61) BPP 1919/XXI:149, op.cit., p.2.

(62) See e.g. Butterworth, op.cit.

Newman himself considered the results of this system justified his adoption of routine inspection as the norm. The disadvantages of the ailing children system, he considered, were that:

First, it reduces the function of the school doctor to merely a detective process; he loses grasp of the larger purposes and of the preventive issues of school hygiene. Secondly, many children in need of careful supervision and attention escape that advantage. In London alone the percentage of defect necessitating advice in children entering school was found, in 1916, to be 22.7 per cent as against 35 per cent in 1915 and 1914....Third, the normal child is ignored and fourthly, the findings of medical inspection are more than usually incomplete and unstandardised. (63)

The essential problem with the ailing children system, Newman concluded in another Annual Report, was that "the School Medical Service is not a dispensary system; it is an educational system of preventive medicine". (64)

The War therefore caused severe problems for the administration of the medical inspection system, but the inspection process itself encountered few difficulties during the War other than those deriving from the shortage of, and turnover in, medical staff. An exception to this occurred in Northumberland in 1917, where the parents of 350 of the first 1,721 children to be inspected during the year objected. (65) It was later explained that the ground for these objections was:

"it is the first step toward conscription", the meaning of that apparently being that the Government were anxious to ascertain which were the healthiest boys and girls in order that the

(63) BPP 1917-18/XI:89, op.cit., p.27.

(64) BPP 1918/IX:99, op.cit., p.3

(65) Times Education Supplement, 5 April 1917, p.120.

the former might eventually be drawn into the Army or Navy and the latter into munition works. (66)

No other examples of this perceived association between medical inspection and conscription have been identified.

Apart from the difficulties encountered by some areas with regard to the performance of inspection, the War also caused considerable disruption to the systems of "following up". Even at the outset of the War, there was a considerable variation in the efficiency of the local authorities arrangements for this, (67) but the War saw a considerable depletion in the ranks of the voluntary workers used by many areas to perform some or all of this work. London, which prior to the War had 5,000 to 6,000 volunteers staffing its school care committees, found that by 1916 the number of such volunteers had been reduced to 1,000. (68)

Nevertheless, although much of the foregoing analysis of medical inspection and following up work during the War period may convey the impression that regression from former standards, or at best stability, were the main characteristics of the School Medical Service at this time, this would be to give a pessimistic and misleading picture of the situation. Despite the difficulties,

(66) Ibid., 7 June 1917, p.129.

(67) For example, of the 2,941 children recommended for treatment during 1915 in the area of Middleton M.B.C., the council had no information whether treatment was obtained in 2,104 cases. By contrast, Mountain Ash U.D.C., lacked information on only 125 of the 3,219 children recommended for treatment in 1915. BPP 1916/VIII:149, op.cit., p.61.

(68) Times Education Supplement, 19 October 1916, p.177.

positive developments did occur, and an indication of these is contained in the information given in the table overleaf, compiled from a number of Newman's Annual Reports.⁽⁶⁹⁾

One feature evident from this table is the impact of the War in stunting previous rates of growth of expenditure on the School Medical Service. The real rate of increase of the pre-War era was reversed, in real terms, in 1915-16, the first financial year falling completely within the War period. Even before adjusting for price inflation, spending increased by a mere 1.5 per cent on the previous base, as Newman himself noted.⁽⁷⁰⁾ Increases in real spending were to come only after the War, with the high percentage of growth in 1919-20 being an indication both of the return to normality and of the additional duties imposed on the local authorities by legislation to be discussed later in the chapter.

The figures also indicate why the cessation of routine medical inspection was necessary in many areas. In real terms,

(69) An attempt has been made in the table to produce an estimate of expenditure on the School Medical Service at constant prices, using indices of Retail Prices contained in Arthur L. Bowley, Prices and Wages in the United Kingdom, 1914-1920, Economic and Social History of the World War (Oxford: Clarendon Press, 1921), pp.70-71, and Brian R. Mitchell and Phyllis Deane, Abstract of British Historical Statistics (Cambridge: Cambridge University Press, 1962), pp.344-45.

(70) BPP 1917-18/XI:89, op.cit., p.14.

EXPENDITURE ON SCHOOL MEDICAL SERVICE, 1912-13 TO 1919-20 (£)

Date	1912-13	1913-14	1914-15	1915-16	1916-17	1917-18	1918-19	1919-20
Salaries of S.M.O.'s & Specialists	139,744	151,339	190,337	179,579	174,297	181,338	209,250	324,955
Salaries of School Nurses	37,120	43,212	57,586	66,439	71,725	91,163	117,250	172,509
Travelling Expenses	15,258	16,779	21,052	17,579	16,620	18,377	21,250	38,924
Drugs, Materials, Apparatus	7,378	9,808	14,069	11,440	9,987	14,510	20,750	40,555
Provision of Spectacles	1,650	2,155	3,681	4,023	4,063	4,826	6,700	11,963
Contribs. to External Bodies	23,628	27,459	39,315	43,403	44,843	50,603	58,350	76,861
Clerical Assistance, Premises, Stationery etc.	61,185	74,983	95,348	95,407	96,270	111,659	164,050	219,928
Total	285,993	325,735	411,428	417,870	417,805	472,475	597,600	885,695
Exchequer grant paid	125,830	148,429	192,414	196,893	198,637	225,475	N/A	N/A
Grant % total expenditure	43.9	45.5	46.7	47.2	47.4	47.6	N/A	N/A
No. L.E.A.'s with 50% grant	69	N/A	127	139	143	150	N/A	N/A
Expenditure at constant prices (July 1914 = 100)	284,570	320,921	396,557	325,085	271,008	259,780	283,727	406,049
Percentage change in expenditure on previous year	-	+12.77	+23.57	-18.02	-16.63	-4.14	+9.22	+43.11

salary payments to School Medical Officers and specialists in 1918-19 amounted to only 55 per cent of those made in 1914-15, and the position had not been fully recovered by 1919-20. Significantly, spending on nursing staff suffered less severely. At all times during the War period, it remained above its 1913-14 level in real terms. By 1919-20, it was already well above its level in 1914-15 and, even when curtailed from its 1914-15 peak, it suffered a less severe reduction than spending on medical officers. Other expenditure was, however, substantially reduced in real terms.

That some progress was nevertheless occurring is indicated by the growth in the proportion of expenditure refunded to the local authorities in Exchequer grant in aid of the School Medical Service during the War period, and the continued, if relatively slow, increase in the number of individual areas obtaining the full 50 per cent grant according to the principles of Procedure Minute M27, discussed earlier in this chapter. Although this was superseded by Procedure Minute M37 on 7 October 1914,⁽⁷¹⁾ and Newman, both in this and his various War-time Circulars, stressed that the Board would view sympathetically the problems of any local authority whose system of medical inspection was temporarily disrupted owing to staff shortages, the basic principles for the award of grant remained unaltered. Thus the implication of the growth in the overall average rate of grant paid is that during the War period local authorities were succeeding in improving their systems

(71) PRO Ed 50/63, Medical Department procedure minute M37, 7 October 1914.

of medical inspection, following up and treatment. The growth in the number of individual authorities receiving the full rate of 50 per cent grant indicates that during the War more councils succeeded in providing what Newman called "a comprehensive scheme of treatment or a substantial instalment of one".⁽⁷²⁾

It should be noted that information about the rate of grant paid to local authorities by the Board according to the system detailed in the Procedure Minutes would give a more detailed and informative indication of the general standard and variations in the quality of the work of the School Medical Service at area level than can normally be obtained from the Annual Reports of the Chief Medical Officer. Newman usually maintained a diplomatic silence on this most interesting question of the standard of local administration. Even when Carmarthenshire lost its entire grant because of the failings of its officers, the authority was not named in Newman's report, though the incident was publicised.⁽⁷³⁾ On one occasion only, in his Annual Report for 1916, did Newman divulge more than the minimum information on the rate of grant paid to different authorities. This report contains the table reproduced overleaf. This table indicates, perhaps not unexpectedly, that the larger County Borough authorities were relatively the most successful in obtaining the full 50 per cent rate of Exchequer grant.

(72) Ibid., Medical Department procedure minute M27, 30 June 1914.

(73) BPP 1914-16/XVIII:665, op.cit., p.20.

RATES OF GRANT PAID IN RESPECT OF THE SCHOOL MEDICAL SERVICE
1915 - 1916 (74)

Area (England)	50%	45%	40%	35%	30% or less
County Council	15	8	16	6	4
Urban District	20	6	4	6	4
Met. Borough	46	24	24	11	14
County Borough	46	12	14	5	1
London	1				
Area (Wales)					
County Council	3	3	4	1	2
Urban District	3	1	2	-	1
Met. Borough	1	1	2	1	-
County Borough	4	-	-	-	-
Total	139	55	66	30	26

Medical Treatment and the War

Analysis of the data from the summary table included in this chapter therefore suggests, paradoxically, that an expansion of the treatment available under the School Medical Service, as identified by an increase in the number of authorities obtaining the full rate of Exchequer grant, was taking place at a time when an unprecedented

(74) BPP 1917-18/XI:89, op.cit., p.16.

demand from the military authorities was causing a reduction both in the number of doctors employed within the School Medical Service and in the number of children they and their employing authorities were able and willing to inspect. Further information from the series of Annual Reports issued by Newman, though giving only a partial picture, supports this hypothesis, though Newman fails to explain, or indeed to comment on, the apparent paradox. The series of tables below, again collated from Newman's Annual Reports, indicate the continuing development of provision for medical treatment:

LOCAL AUTHORITIES MAKING PROVISION FOR MEDICAL TREATMENT

Year	Made some Provision	Provided Sch. Clinic.	Contributed to Hospital	Provided Spectacles
1914	266	179	75	165
1916	276	219	87	216
1917	279	231	95	223
1918	287	252	110	235
1920	309	288	168	282

From this table it is clear that there was a continuing growth in the number of authorities providing some form of medical treatment during the War years. A further table shows that this growth encompassed all the major areas of defect for which medical treatment of school children was provided.

TREATMENT PROVISION BY CLASS OF DEFECT

Type of defect	Y E A R		
	1916	1917	1918
Minor ailments	216	231	260
Dental Defects	146	151	169
Defective vision	221	226	242
Provision of specs.	216	223	235
Tonsils & Adenoids.	102	110	129
Ringworm (X-ray)	73	84	92

This growth meant that more and more authorities could claim to be making comprehensive arrangements for treatment as the War progressed, as the table below illustrates:

RANGE OF TREATMENT PROVISION BY LOCAL AUTHORITIES

Treatment available for	Y E A R		
	1917	1918	1919
All six classes of defect	31	44	54
Five classes of defect	66	72	88
Four classes of defect	57	67	78
Three classes of defect	58	49	40
Two classes of defect	35	29	19
One class of defect	32	26	19

Because of the generally more active policy of the larger urban areas in relation to treatment, the actual proportion of the school population covered by treatment schemes was somewhat larger than that suggested by these figures. For example, 61 per cent of the school population lived in areas providing dental treatment in 1916, although less than half the education authorities, 146 out of 318, were providing dental treatment in that year.⁽⁷⁵⁾ X-ray treatment for ringworm was available for 41 per cent of the school population, although only seventy three councils were recorded as providing this service in 1916.⁽⁷⁶⁾ A qualification to this, however, is that some authorities did not provide some forms of treatment throughout their areas.

A question arises, therefore, how and why did treatment facilities provided under the auspices of the School Medical Service continue to expand at a time during which the medical inspection of school children, and indeed civilian medical services in general, were frequently being put under severe strain by the military's demand for medical staff? A full answer to this question is impossible to provide from the information now surviving, but some of the contributory factors may be identified. First, the incentives to local authorities to undertake some expansion of treatment facilities, where possible, through the arrangements for the payment of grant described previously. Second, as the table on expenditure indicates, and as Newman's reports confirm,⁽⁷⁷⁾

(75) PRO RECO 1/665, item 35, Board of Education to Reconstruction Committee, 9 November 1916, p.4.

(76) Ibid.

(77) BPP 1917-18/XI:89, op.cit., p.1

replacement doctors were much more difficult to obtain than replacements for the school nurses. The relative stability of expenditure on nurses suggests that local authorities were able to continue and develop those areas of treatment, such as provision for the treatment of minor ailments, for which the services of school nurses were normally used, particularly as the cessation of routine inspection in some areas freed the nurses of some of their existing commitments. Third, an effect of the War would be to put increased pressure on avenues of treatment used by children for whom the local authority had made no previous provision. This, it would seem, led some councils to consider, or to be pressed to consider, devoting more of their own resources to the provision of treatment for school children. An illustration of the increased pressure on existing institutions caused by the War is the growth of hospital accommodation for wounded soldiers. Before the War, there were approximately 7,000 equipped beds in military hospitals in the United Kingdom. By the time of the Armistice, the number of such beds had increased to 364,133.⁽⁷⁸⁾ About 5.7 per cent of this total was in existing civilian hospitals.⁽⁷⁹⁾ These demands led to civilians, including school children being restricted or denied access to some hospital facilities.⁽⁸⁰⁾

Naturally the depletion of the civilian hospital staff as

(78) MacPherson, op.cit., p.71.

(79) Ibid., p.94.

(80) Gwynedd R.O., Llangefni, Anglesey C.C., Medical Inspection Sub-Committee, Minutes, 19 April 1917.

doctors were recruited into the forces or otherwise gave some of their time to the needs of the military, and the increasing amount of work being done by the remaining general practitioners, made it more difficult in many areas for school children to obtain treatment, even where such arrangements had previously been made. (81) Thus at Nottingham:

The treatment of children with adenoids and allied throat and ear diseases has been taken over during the year by the school medical staff in consequence of representations received from the Governors of the Children's Hospital as to the great pressure of work and the serious deficiency of medical staff at that institution, and an aural surgeon has been appointed (82)

while at Leeds:

To meet the demand for treatment arising from the medical inspection of school children, with which the local hospitals are now unable to cope, five branch clinics have been opened during the year in various parts of the city. (83)

In some areas, however, the exigencies of the War produced opposite trends, with the established medical services being used when circumstances forced the local School Medical Service to curtail its activities. When the eye surgeon retained by the Oxfordshire County Council departed for war service, cases were sent to the Eye Hospital in Oxford after financial terms had been agreed with the hospital authorities. (84)

(81) Butterworth, op.cit., p.112.

(82) Times Education Supplement, 10 October 1917, p.438.

(83) Ibid., 7 November 1917, p.486.

(84) Ibid., 16 November 1916, p.211. The war period created other difficulties in obtaining treatment. Full employment meant that "on account of the mothers and elder members of the family being at work and the father in the Army it has been exceedingly difficult to make any arrangements for children attending for medical treatment either at Hospitals, Private Surgeries, or at the [school] clinics". Manchester C.B.C., Annual Report of the School Medical Officer for 1916, p.7.

Essentially, therefore, it appears that the availability of the grant for medical work created a willingness, and the increased pressure on existing services made it a necessity, for local authorities to commit expenditure to a definite arrangement for the medical treatment of school children. Because of the variations in impact of the War's demand for medical staff, these arrangements varied from area to area depending on where surplus capacity for treatment existed. Nevertheless, one result was a considerable expansion of treatment through the means of school clinics in some areas, as the table below indicates:

NUMBER OF ATTENDANCES MADE BY CHILDREN AT SCHOOL CLINICS ⁽⁸⁵⁾

Area	1914	1918
Birmingham	21,280	60,713
Bradford	46,982	35,256
Leeds	17,060	70,069
Merthyr Tydfil	2,623	15,744
Sheffield	58,997	138,252
Willesden	2,517	18,214
London	398,000	846,000

Despite this progress, Newman stressed that the provision of treatment was by no means completely satisfactory. In his Annual Report for 1917 he noted:

(85) BPP 1921/XI:109, Board of Education, Annual Report of the Chief Medical Officer for 1920, Cmd. 1522, pp.69-70.

it is unsatisfactory to have to record (a) that during 1917, so far as the Board is aware,....39 authorities....had not in operation any approved schemes for securing the medical treatment of defective children in their areas; and (b) that in only some 30 areas out of 319 have the authorities made complete provision for the various defects found on inspection. (86)

Thus although the growth in the coverage of the School Medical Service was occurring even in the adverse conditions prevailing in the War period, the lack of comprehensive provision, and other perceived inadequacies in the coverage of the service, were leading to debates on the further steps which would be required after the War. The Report of the Departmental Committee on Juvenile Education in relation to Employment after the War, signed on 16 March 1917, recommended:

the extension to the whole adolescent period of the advantages of a school medical service, and also of clinical treatment, except insofar as that is rendered unnecessary in the case of young persons in employment who have already become eligible for medical benefits under the National Insurance Act. (87)

Confidential discussions as to whether education authorities should be compelled to provide comprehensive schemes of treatment were also taking place. In a submission to the Reconstruction Committee, the Board acknowledged that the question of whether the local authorities power to provide treatment should be made a duty was one of much difficulty, but after reviewing the existing situation the Board concluded:

(86) BPP 1918/IX:99, op.cit., p.39.

(87) BPP 1917-18/XI:313, Departmental Committee on Juvenile Education in Relation to Employment after the War, vol.1, Report, Cd. 8512, p.18.

experience has proved that unless provision for treatment is made by the Local Education Authority, a great mass of remediable defects will remain unremedied, that the provision of the necessary treatment can be successfully organised, and that the fears of ill effects arising from the provision have proved unfounded. This being so, it is suggested that the period of experiment may be regarded as ended, and that at the first opportunity steps should be taken in the direction of making it a duty of Local Education Authorities to provide or arrange for adequate facilities for medical treatment of certain defects revealed by medical inspection. (88)

These comments, drafted by Newman, indicate a commitment on the part of the Board to extending the functions of the School Medical Service by imposing an element of compulsion on local education authorities, and contrast with its pre-war attitude.

The Board was subsequently to become more cautious about implementing the policies for which it here declared its support. During preparation of the 1918 Education Bill the issues of medical inspection of secondary schools, and of compelling education authorities to provide treatment, received consideration. On the latter, Selby-Bigge counselled a cautious approach, arguing that the Board, rather than compelling authorities to provide treatment immediately, should instead proceed at first to use less obvious pressures, like making the grant regulations more stringent, and consider compulsion only when the bulk of the councils had already achieved a reasonable standard of provision. (89)

(88) PRO RECO 1/665, item 35, Board of Education to Reconstruction Committee, p.6.

(89) PRO Ed 24/1369, Education Bill, minute by Selby-Bigge, 6 March 1917.

Conflicting views were, however, present both inside and outside the Board. In June 1917 the Reconstruction Committee urged that "the duty of making adequate provision for medical treatment should be obligatory upon all Local Education Authorities",⁽⁹⁰⁾ while Newman himself, departing from the caution of his pre-war views, declared himself to be strongly in favour of the compulsory provision of treatment.⁽⁹¹⁾ Despite this Selby-Bigge continued to urge caution, writing "although I sympathise with Sir George Newman's object I think we should be wise to exhaust our existing powers of administration before taking such a step as he wishes."⁽⁹²⁾

In consistency with this view, when the provisions relating to the School Medical Service were first published as clauses 16 and 17 of the 1917 Education Bill, a forerunner of the eventual legislation, a provision making it a duty of the local authorities to provide treatment was not included, although the compulsory medical inspection was extended to secondary schools and other institutions, and the power to give treatment was also extended to cover pupils at these institutions.⁽⁹³⁾ This remained the intention of the Government when the Bill was re-introduced in 1918,⁽⁹⁴⁾ although in the intervening period the B.M.A. had expressed some reservations about the extension of treatment under the School Medical Service to adolescent scholars, and had

(90) PRO Cab 24/19, "Memorandum on the Education Bill by the Reconstruction Committee", June 1917. War Cabinet Paper G.T.1304.

(91) PRO Ed 24/1369, Education Bill, minute by Newman, 7 August 1917.

(92) Ibid., minute by Selby-Bigge 9 August 1917.

(93) BPP 1917-18/1:337, Education Bill [1917], Bill 89, cl.16;
BPP 1917-18/1:369, Education (No.2) Bill [1917], Bill 116, cl.16.

(94) BPP 1918/1:199, Education Bill [1918], as Introduced, Bill 3, cl.18.

suggested that any medical care provided should ideally be made as an integral part of a comprehensive public health scheme. (95)

Debates on the relevant clauses of the 1918 Education Bill were marked by two distinct and contrasting pressures to obtain amendments. First, the B.M.A. orchestrated a series of attempts to prevent the extension of medical treatment powers to children in the fourteen to eighteen age group attending secondary schools and other educational institutions. Second, pressure came from radical members of the House for the provision of medical treatment to be made a duty of local authorities.

The first of these pressures was manifested in a series of amendments tabled to clause 18 of the 1918 Bill during its Committee stage. An amendment by the Unionist M.P. Sir Philip Magnus to delete any references to treatment in the clause which, as drafted, extended the local authorities powers and duties under clause 13 of the 1907 Act to pupils attending secondary schools and other educational institutions, (96) was opposed by H.A.L. Fisher, the President of the Board of Education. (97) He offered to accept instead another amendment tabled by Sir Watson Cheyne, a Coalition Conservative M.P. and President of

(95) PRO Ed 24/1370, "The Medical Aspects of the 1917 Education Bill", printed memorandum by the B.M.A., 16 October 1917.

(96) Parl. Deb. (Commons), 5th series, 107(1 July 1918), 1457.

(97) Rt. Hon. Herbert Albert Laurens Fisher, FRS OM (1865-1940). Educated at Winchester and New College Oxford. Fellow of New College, 1888-1912. Vice-Chancellor, University of Sheffield, 1912-16. Liberal MP for Sheffield, Hallam 1916-18; Combined English Universities, 1918-26. President, Board of Education, 1916-22. Warden of New College, 1925-40.

the Royal College of Surgeons, which prohibited local education authorities from establishing a general domiciliary service of treatment for children and young persons, and required them to consider the extent to which they could use private medical practitioners for their work under the School Medical Service.⁽⁹⁸⁾

Privately, Newman had opposed this compromise, suggesting that Sir Watson Cheyne had been "merely put up by Dr. Brackenbury and Co. and the B.M.A."⁽⁹⁹⁾ Cheyne's amendment, once accepted by Fisher, eventually became clause 25 of the 1918 Education Act, providing:

A local education authority shall not....
 establish a general domiciliary service of
 treatment by medical practitioners for children
 or young persons, and in making arrangements for
 the treatment of children and young persons
 a local education authority shall consider
 how far they can avail themselves of the services
 of private medical practitioners. (100)

The second pressure, to make the provision of medical treatment compulsory, was in many ways one which contradicted the B.M.A.'s efforts to limit the scope of the service. Concern about the B.M.A.'s attitude, and also about the reaction of the local authorities, had influenced Selby-Bigge's earlier caution, and had led to the Board persuading one Labour M.P., Walter Goldstone, to withdraw an amendment he tabled making the provision of treatment compulsory. Goldstone was told that if the amendment were pressed, it:

will lead to considerable discussion on the side

(98) Parl. Deb (Commons), 5th series, 107(1 July 1918), 1470.

(99) PRO Ed 24/759, cl.18 of the Education Bill, 1918, undated note by Newman. Dr. Brackenbury was one of the leaders of the B.M.A.

(100) Education Act, 1918, 8 & 9 Geo. V, ch. 39, cl.25.

of the local education authorities, and also on the side of the British Medical Association, which is watching the development of the School Medical Service with great jealousy. He [H.A.L. Fisher] has little sympathy with them, but at this stage of the Bill he views with great apprehension anything which would take up Parliamentary time. (101)

Goldstone agreed not to press his amendment, but Arnold Rowntree, the Radical Liberal M.P. for York, was more persistent, and on 3 July 1918 he moved the adoption of a new clause which laid on education authorities:

The duty to provide for the medical inspection of children immediately before or at the time of or as soon as possible after their admission to a public elementary school, and on such other occasions as the Board of Education may direct, and to make such arrangements as the Board of Education may direct and approve for attending to the health and physical condition of the children educated in public elementary schools. (102)

Although Fisher demurred from accepting the amendment, numerous speeches in support of Rowntree led him to promise eventually that he would bring forward a draft clause making treatment compulsory at the Bill's Report stage.⁽¹⁰³⁾ This promise led to an immediate letter from the B.M.A. expressing its concern and asking for an audience with the Minister.⁽¹⁰⁴⁾ Newman was subsequently deputed to meet and attempt to placate a deputation from the B.M.A. a short time later.⁽¹⁰⁵⁾

(101) PRO Ed 24/759, Selby-Bigge to Goldstone, 25 June 1918. Goldstone had been a school teacher from 1892 to 1910, and was later to become General Secretary of the N.U.T., 1921-31.

(102) Parl. Deb. (Commons), 5th series, 107(3 July 1918), 1770.

(103) Ibid., col.1790.

(104) PRO Ed 24/681, B.M.A. to Board of Education, 4 July 1918.

(105) Ibid., undated memorandum by Newman.

The Board redrafted Rowntree's amendment to convey a less peremptory tone so that, as was explained to Rowntree, it would be "less likely to hurt the susceptibilities of Local Education Authorities who, as we know by experience are very suspicious of any proposal which gives to the Board power to issue mandatory directions".⁽¹⁰⁶⁾ As a result, the requirement to provide treatment was finally incorporated into the Act in clause 2(i)(b), which laid on the local education authority the duty:

to make, or otherwise to secure, adequate and suitable arrangements under the provisions of paragraph (b) of subsection (i) of section thirteen of the Education (Administrative Provisions) Act, 1907, for attending to the health and physical condition of children educated in public elementary schools. (107)

The extension of medical inspection to secondary schools, and the introduction of legislation compelling education authorities to provide treatment, led to a renewed and substantial increase in spending on the School Medical Service, as the summary table in this chapter indicates. War conditions, therefore, led to some restrictions on the activities of the School Medical Service, especially in relation to medical inspection work, but also saw, in many areas, an extension of the activities of the Service, particularly in the provision of medical treatment.

The signatories of the Report on Physical Deterioration had envisaged that medical inspection would provide information not otherwise available in a country without conscription. What was the condition of the people? The number of authorities failing

(106) Ibid., Selby-Bigge to Rowntree, 9 July 1918.

(107) 8 & 9 Geo.V, ch.39, cl.2(i)(b).

to complete routine inspection or to submit their annual reports within the time specified meant that the School Medical Service did not in fact fulfil this function during the First World War, although even without these difficulties, the problems encountered in ensuring the comparability of data in the pre-war period would have created difficulties. In fact conscription, and the results of medical examinations by the National Service Medical Boards, provided much of the information about the condition of the people.⁽¹⁰⁸⁾ This material reinforced pessimistic assumptions about the effect of the War on the health and condition of the population.⁽¹⁰⁹⁾

The evidence which was available in the annual reports of local school medical officers gave a more optimistic assessment of the effect of the War on the health of the children at least. Initial fears proved groundless, and by 1917 the consensus opinion was that the children were in better physical condition than before the War.⁽¹¹⁰⁾ The payment of separation allowances and the employment of women in munitions and other work produced a period of financial prosperity benefitting the children.⁽¹¹¹⁾

(108) BPP 1919/XXVI:307, Report on the Physical Examination of Men of Military Age by National Service Boards from November 1st 1917 to October 31st 1918, Cmd.504. For an evaluation of the impact of the data derived from the medical examination of conscripts, and an assessment of its reliability, see J.M. Winter, "Military Fitness and Civilian Health in Britain during the First World War", Journal of Contemporary History 15(1980), 211-44. An earlier critique by the Government Actuary's Department can be found among the Addison MSS Box 53, File 553, memorandum and letter by A.W. Watson, 22 April, 1920.

(109) See J.M. Winter, "The Impact of the First World War on Civilian Health in Britain", Economic History Review, n.s. 30(1977), 487-507.

(110) BPP 1918/IX:99, op.cit., p.8.

(111) BPP 1920/XV:149, op.cit., p.20.

Nevertheless, Newman used the prevailing anxieties to reinforce the lessons of the War for the School Medical Service:

The European War has now given new emphasis to the importance of the child as a primary national asset. The future and strength of the nation unquestionably depend upon the vitality of the child, his health and development, and upon his education and equipment for citizenship. (112)

Administrative Reform

In addition to the changes in educational legislation, the School Medical Service was also affected in the post-war period by the Ministry of Health Act, 1919. (113) This was intended to remedy the fragmentation of public medical services of which the establishment of the School Medical Service by the Board of Education was itself an example. Although this had disappointed the Webbs and other campaigners for a Ministry of Health, they had been heartened by the appointment of Arthur Newsholme to be Chief Medical Officer to the Local Government Board in 1908, again with the support and help of the Webbs. (114) It was anticipated that Newsholme would attempt to revive the idea of a Ministry of Health. Unfortunately, for the reformers, Newsholme's priorities differed from those of

(112) BPP 1917-18/XI:89, op.cit., p.vi

(113) Ministry of Health Act, 1919, 9 & 10 Geo.V, ch.21.

(114) Beatrice Webb, Our Partnership, ed. Barbara Drake and Margaret I. Cole, with an introduction by George Feaver (London: London School of Economics and Political Science Cambridge University Press, 1975), p.394; G.R. Searle, The Quest for National Efficiency (Oxford: Basil Blackwell, 1971), p.244. At the time Webb considered Newsholme "an administrative genius with an entirely new outlook on the whole question of Public Health". Passfield MSS, Diary of Beatrice Webb, vol. 26, pp.38-39, 18 January 1907.

Newman, and differences of opinion produced a cooling of the relationship between the two Chief Officers. Additionally, Newsholme was unable to break the domination of the Local Government Board's decision making and policy development by officials from the Poor Law section of the Board, which meant that:

letters addressed to the [Local Government] Board by or at the instigation of, Medical Officers of Health have not been answered by Sir Arthur Newsholme, who was apparently prohibited from writing an official letter, but have been answered by the non-medical secretarial staff, and frequently the anti-progressive and unimaginative character of these replies has made it obvious that they did not represent the views of Sir Arthur Newsholme in any way. (115)

As a result, the reformers became disillusioned with Newsholme. By 1915, the Webbs thought him "a failure" at the Local Government Board, being "weak and vain". (116) Newman was to go even further, describing Newsholme as "weak, vacillating, incompetent, untrustworthy and vain". (117) Newsholme responded by criticising many of Newman's policies in the books he published after his retirement from the Local Government Board. (118)

(115) Public Health 32(1918-19), 61. This domination was of long standing. See Jeanne L. Brand, Doctors and the State (Baltimore: Johns Hopkins Press, 1965), pp.22-36, 81-82.

(116) Newman Diaries (D.H.S.S.), vol.2, 18 December 1913.

(117) Ibid., vol.3, 29 October 1918.

(118) See e.g. Sir Arthur Newsholme, International Studies on the Relation between the Private and the Official Practice of Medicine, 3 vols. (London: George Allen & Unwin, 1931), 3, 196-206.

The prospects for the creation of a unified Ministry of Health were to suffer a further setback when Part I of the 1911 National Insurance Act, which provided certain medical benefits for insured persons, established an independent administrative system for the Health Insurance scheme.⁽¹¹⁹⁾ Sir Robert Morant, removed from the Board of Education following the furore over the "Holmes Circular" in 1911, was transferred to the National Health Insurance Commission.⁽¹²⁰⁾

The effect of this continuing multiplication of departments having some responsibility for the health of the people was illustrated by a passage in a B.M.A. pamphlet calling for the establishment of a Ministry of Health, which referred to:

the somewhat extreme but quite possible case of a large poor family with one mentally defective child in a non-county borough, where we may find the following medical officers of various authorities actively interested in the family even at the same time - the county Medical Officer of Health, with his Tuberculosis Officer and his Mental Deficiency Officer (County Council); the borough Medical Officer of Health, the Maternity and Child Welfare Officer, the medical officer who may be appointed to deal with cases of Measles and German Measles (Town Council); the School Medical Officer or Officers (Education Committee, or possibly two Education Committees, County and Borough); the Insurance Practitioner or Practitioners (Insurance Committee); the Poor Law Medical Officer or Officers (Board of Guardians).⁽¹²¹⁾

The original separation of school hygiene from the jurisdiction of the Local Government Board through the 1907

(119) National Insurance Act 1911, 1 & 2 Geo.V, ch.55. See Bentley B. Gilbert, The Evolution of National Insurance in Great Britain (London: Michael Joseph, 1966), pp.289-447, and W.J. Braithwaite, Lloyd George's Ambulance Wagon (London: Methuen & Co., 1957), pp.70ff.

(120) B.M. Allen, Sir Robert Morant (London: Macmillan, 1934), pp.254-63.

(121) British Medical Association, A Ministry of Health (London: B.M.A.1918), p.6.

legislation was to lead to particular difficulties for the Board of Education. The effect of the 1907 Act was to establish two departments with responsibilities for children of various ages. For the Board of Education, this power was limited to children attending public elementary schools which, depending on the admissions policy of the education authority concerned, meant children from a minimum of age three upward. The Local Government Board's powers, (or rather, the responsibilities of the Board, for much of the activity for which it was ultimately responsible had developed as autonomous actions by local authorities), derived in the first instance from the Public Health Act of 1875, under which some authorities from 1890 onwards had appointed "health visitors" to visit homes where births had occurred to give advice to the parents.⁽¹²²⁾ These appointments were made, somewhat dubiously, under the 1875 Act's power to appoint public health inspectors. This work accelerated after 1907, when the Notification of Births Act was passed.⁽¹²³⁾ This was an adoptive Act which required the registration of births in those areas deciding to apply it. By 1915, these areas contained some 80 per cent of the population. In these areas appointments of health visitors, still under the enabling provisions of the 1875 Act, continued to increase in number, and they were encouraged to visit homes where births had occurred.⁽¹²⁴⁾ Generally this work was confined to infants under the age of twelve months, and the Local Government Board

(122) See G.F. MacCleary, The Early History of the Infant Welfare Movement (London: H.K. Lewis & Co., 1933), pp.84-98.

(123) Notification of Births Act, 1907, 7 Edw.VII, ch.40.

(124) PRO Ed 24/1363, memorandum from Local Government Board, January 1918.

itself did little to encourage these developments in the first years after the passage of the Notification of Births Act, offering no grant in aid for the work.

In general therefore, the pre-war period saw the Board of Education providing, through the School Medical Service, medical care for children at school, and local authority public health departments, and thus ultimately the Local Government Board, being responsible for provision for infants under the age of one, in areas where the local authority had both adopted the Notification of Births Act and appointed health visitors. The situation was complicated by the fact that the Board of Education also gave small grants to voluntary agencies running "schools for mothers" and baby clinics which were deemed to be educative in nature.⁽¹²⁵⁾ The Board was thus technically trespassing on the territory of the L.G.B., partly because Newman considered the work of the School Medical Service could never be completely effective without action being taken in the field of infant health. In December 1911 he was urging J.A. Pease, then President of the Board of Education,⁽¹²⁶⁾ to allow the Board to take some action on the matter, even if it could not deal directly with infants below school age, for just

(125) See Jane D. Lewis, The Politics of Motherhood (London: Croom Helm, 1980), pp.89-109; G.F. MacCleary, The Maternity and Child Welfare Movement (London: P.S.King & Son, 1935), p.14.

(126) Rt. Hon. Joseph Albert Pease (1860-1943). Educated at Tottenham School and Trinity College Cambridge. A Quaker. Director of Pease and Partners and other colliery companies. Liberal M.P. for Tyneside, 1892-1900; Saffron Walden, 1901-10; Rotherham, 1910-17. Liberal Chief Whip, 1908-10; Chancellor of the Duchy of Lancaster, 1910-11; President Board of Education, 1911-15; Postmaster-General, 1916. Created Lord Gainford 1917.

as child health was the basis of adult health, so "eugenics and infant health is probably the basis of child health".⁽¹²⁷⁾ By 1912, a "Cabinet Council", presumably a Cabinet Committee, was discussing the division of maternity and child welfare work between the two Boards.⁽¹²⁸⁾

So long as the Local Government Board evinced little interest in developing this area of its activities, the overlap of functions went largely unremarked and unchallenged. In the 1913-14 period, however, attitudes changed under the impact of two developments. First, the Board of Education proposed, in its draft Education Bill of 1913, the inclusion of a clause allowing the Board powers to provide for the "care and training" of children under five, through nursery schools and creches. Pease argued that this:

would be entirely in accordance with the lines on which the School Medical Service is developing. It is being increasingly recognised that the promotion of the child's physical health and well-being is a matter with which the Local Education Authorities are intimately concerned, and they are probably more suited to carry out the provision, control and supervision than any other authority which can be suggested. ⁽¹²⁹⁾

This strategy was fully supported by Newman in his paper on the 1913 Bill five days later.⁽¹³⁰⁾ The Local Government Board and its medical staff were, however, horrified by a proposal

(127) Gainford MSS, Box 89, Newman to Pease, 27 December 1911.

(128) Newman MSS (Hereford), M4/159, notes by Sir George Newman for his proposed autobiography, entry for 22 October 1912.

(129) Gainford MSS, Box 109, paper by J.A. Pease, 17 March 1913.

(130) PRO Ed 24/625, "Some Notes on the Physical Basis of National Education", memorandum no. 14 of the 1913 Education Bill, by George Newman, 22 March 1913.

which, as Newsholme commented many years later:

had it been adopted, would have empowered Education Authorities to provide consultation centres, to make home visits, or otherwise to give medical assistance to mothers with regard to the care of their children from birth onwards. Writing many years afterwards, it is almost unbelievable that such preposterous proposals should have been advanced. (131)

With the Local Government Board thus antagonised by what it saw as an encroachment on territory legitimately its own, the importance of the question of responsibility for infant welfare work was increased when Lloyd George decided to make provision for a central government grant in aid of maternity and infant welfare services in 1914. The two Boards promptly engaged in a dispute over who should administer this grant, which was to be worth £230,000 by 1918-19. (132)

The resolution of the dispute between the two Boards required mediation by Viscount Haldane, the Lord Chancellor, who, after a series of dinners with the representatives of two parties to the dispute, (133) ruled that:

The medical examination and treatment of infants and young children who are not registered in any Nursery School, Creche, Day Nursery, School for Mothers or other school is prima facie for the supervision of the Local Government Board. The

(131) Sir Arthur Newsholme, The Last Thirty Years in Public Health (London: George Allen & Unwin, 1936), p.196.

(132) PRO Ed 24/1363, memorandum from the Local Government Board, January 1918.

(133) Newman, as a representative of the Board of Education, dined with him on 29 April 1914. PRO Ed 24/1377, note by Newman, 30 April 1914.

medical examination and treatment of children registered in any such institution is prima facie for the Board of Education. (134)

Haldane's award, basically upholding the sovereignty of the Local Government Board in relation to children of pre-school age, nevertheless contained so many loop-holes that the dispute between the two Boards was not ended. By October 1914 Sir Horace Monro, the Permanent Secretary to the Local Government Board, was complaining to Selby-Bigge of violations of the spirit of the Haldane adjudication by the Board of Education, and was likening the position of the Local Government Board to that "of a Belgium invaded by a hostile power".⁽¹³⁵⁾ These complaints had begun almost as soon as the adjudication had been issued.⁽¹³⁶⁾

The continuing dispute filled three thick files of correspondence at the Board of Education,⁽¹³⁷⁾ delayed payment of the grants for infant and maternity work,⁽¹³⁸⁾ and failed to reach a satisfactory solution even when a joint committee to administer the grant was tried as an experiment. The Local

(134) Ibid., copy of the Haldane award, 4 July 1914.

(135) Ibid., Monro to Selby-Bigge, 12 October 1914.

(136) Ibid., Sir Herbert Samuel to J.A. Pease, 27 July 1914.

(137) PRO Ed 24/1377-1379.

(138) Frank Honigsbaum, The Struggle for the Ministry of Health, Occasional Papers in Social Administration, no.37 (London: G. Bell & Sons, 1970), p.22.

Government Board attempted to extend the powers of the local authorities in 1915 by introducing legislation which made registration of births compulsory, and gave councils power of a much wider nature to provide creches and other services. This posed a direct threat to the schools for mothers and was met by objections from the Board of Education. The Local Government Board was eventually forced to amend the Bill to provide for a more limited extension of powers. (139)

The ability of the Board of Education to block the implementation of the Haldane award suffered a set-back in February 1916, with the publication of the Final Report of the Committee on the Retrenchment of Public Expenditure. This had been appointed in July 1915 to "inquire and report on what savings in public expenditure can, in view of the necessities created by the War, be effected in the Civil Departments without detriment to the interests of the State". (140) The overlapping provisions of the Board of Education and the Local Government Board having been drawn to the Committee's attention, the Committee declared it to be a "most unsatisfactory" situation, which could:

only lead to disputes and to an unnecessary inflation of staff. It is a difficult problem to decide between the two departments in this matter; but as long as there continue to be two medical branches we consider that, in all the circumstances, the only satisfactory solution would be that control of all institutions (including schools for mothers and day nurseries) providing

(139) PRO Ed 24/1363, memorandum from the Local Government Board, January 1918.

(140) BPP 1916/XV:181, Committee on the Retrenchment of Public Expenditure, Final Report, Cd. 8200, p.3.

in any way for the welfare from the health point of view of mothers or children under school age should be handed over by the Board of Education entirely to the Local Government Board for them to administer in connection with their public health work generally, and in co-operation with the local health authorities. (141)

The Committee went on to add that the "above arrangement: would, of course, be merely a makeshift, and it is very desirable in our opinion that the first opportunity should be taken of amalgamating the medical departments of the two branches together." (142)

These recommendations represented both an immediate blow and a long term threat to the medical activities of the Board of Education. Immediately, the Committee's proposals called for the Board's withdrawal from medical provision for the pre-elementary school child and the transfer of its existing activities in this field to the Local Government Board. This represented a substantial victory for the latter, and a retreat from the position the Board of Education had gained under the Haldane award which, even though it had awarded the Local Government Board the main interest in this age group, had not proposed that the Board of Education should relinquish its existing activities on the ground that it:

is, however, contrary to the public interest that a rigid line of demarcation should be drawn between the spheres of supervision of the L.G.B. and Education Board, and interlacing, and even over-lapping, must be provided for. (143)

(141) Ibid., p.16.

(142) Ibid.

(143) PRO Ed 24/1377, copy of the Haldane award, 4 July 1914.

In the long term, the Committee's proposals seem to envisage that the School Medical Service itself might be transferred to the Local Government Board, a prospect that appalled Newman.

Bolstered by this public declaration of support for its position, the Local Government Board renewed its attempt to strengthen the powers of the local authorities in the maternity and child welfare field. In June 1916 Walter Long, then its President, argued in a Cabinet paper for the introduction of legislation, irrespective of any objections the Board of Education might make,⁽¹⁴⁴⁾ and in October 1916 Sir Horace Monro told Selby-Bigge of the imminent introduction of legislation by his department.⁽¹⁴⁵⁾

In response the Earl of Crewe, who was then President of the Board of Education, suggested a compromise. The Local Government Board should provide all services, including creches, for children up to the age of two:

while the provision of nursery schools for children above that age should be regarded as a proper function of the Board of Education and of Local Education Authorities so far as is practicable, and that children attending such schools, which in time ought to become really numerous and important as universal avenues of approach to the Public Elementary School, should be regarded, both for health work and instruction, as entirely within the educational province. (146)

(144) PRO Cab 37/150/9, "Maternity and Child Welfare Work", Cabinet memorandum by Walter Long, 21 June 1916.

(145) PRO Ed 24/1363, Monro to Board of Education, 24 October 1916.

(146) Ibid., Earl of Crewe to Walter Long, 14 November 1916.

This suggested compromise, which left unresolved the responsibility for children above the age of two who were not attending an educational institution, was acknowledged to be a complete defeat by Newman, and a reflection of the Board's weakened negotiating position. For Newman, "to lose schools for mothers and creches in the twinkling of an eye without any compensating advantages is certainly very serious for the prestige and usefulness of the Board". (147)

For the Board of Education, however, the most important objective was to ensure the retention of administrative responsibility for the School Medical Service. Its control was threatened by the Report of the Committee on the Retrenchment of Public Expenditure, and by some of the discussion about the establishment of a Ministry of Health, discussed below. Above all, it was feared that an unreconstructed and unreformed Local Government Board wanted, and might succeed in obtaining, control. After a meeting between the two Permanent Secretaries, Selby-Bigge reported that Munro was willing to disclaim any desire to acquire control of the School Medical Service "at any future time", (148) but a subsequent letter from Munro said only that, from a Local Government Board standpoint, "we have regarded it as settled, for the time being at least, that the Education Authorities should have the power of [sic] scholars in the schools". (149)

(147) Ibid., memorandum by Newman, 15 November 1916.

(148) Ibid., note by Selby-Bigge on a meeting with Munro, 14 November 1916.

(149) Ibid., Munro to Selby-Bigge, 21 November 1916.

With Walter Long having circulated to the Cabinet his draft Bill on Maternity and Child Welfare, in the preface to which he asked for Cabinet support for the Bill against any objections the Board of Education might make,⁽¹⁵⁰⁾ a Government reshuffle meant a change of leadership at both Boards. H.A.L. Fisher became President of the Board of Education, Walter Long was succeeded at the Local Government Board by Lord Rhondda.⁽¹⁵¹⁾

Lord Rhondda was closer and more sympathetic to Newman, the Medical Department of the Board of Education, and Robert Morant than had been some of his predecessors. This was partly due to the influence of Christopher Addison,⁽¹⁵²⁾ who was one of the leading proponents of a Ministry of Health, and who was pressing for Newman to be given a leading role in directing any such ministry.⁽¹⁵³⁾ Addison took steps to introduce Newman to Rhondda at an early stage, for he quickly urged him "to go

(150) Ibid., draft of Notification of Births (Amendment) Bill, with note by Walter Long, 5 December 1916. Although a Cabinet memorandum, this does not appear in the Cab 37 series.

(151) David Alfred Thomas (1856-1918). Educated at Caius College Cambridge. Colliery owner and partner in a firm of coal shippers. Liberal M.P. for Merthyr Tydfil, 1888-1910, for Cardiff, 1910. President, Local Government Board, 1916-17; Minister of Food Control, 1917-18. Created Lord Rhondda, 1916; Viscount Rhondda, 1918.

(152) Rt.Hon. Christopher R. Addison MB FRCS (1869-1951). Son of a Lincolnshire farmer. Educated at Trinity College, Harrogate, and St. Barts. Hospital. Lecturer in Anatomy at St. Barts, then Hunterian Professor of Anatomy at Cambridge and London Universities. The originator of "Addison's Plane". Liberal M.P. for Hoxton, 1910-18; Shoreditch, 1918-22. Labour M.P. for Swindon, 1929-31, 1934-35. Parliamentary Secretary, Board of Education, 1914-15; Parliamentary Secretary, Ministry of Munitions, 1915-16; Minister of Munitions 1916-17; Minister of Reconstruction, 1917-19; President, Local Government Board, 1919; Minister of Health, 1919-21; Minister without Portfolio, 1921; Minister of Agriculture, 1930-31. Created Lord Addison, 1937; Viscount Addison 1945.

(153) Newman Diaries (D.H.S.S.), vol.3, 9 December 1916.

the whole hog at the Local Government Board and arrange for the creation of a Public Health Department making Newman Chief Medical Officer".⁽¹⁵⁴⁾ By April, Rhondda had accepted the arguments for a Ministry of Health, and secured Lloyd George's approval for legislation to introduce such a ministry.⁽¹⁵⁵⁾

But, although Lord Rhondda accepted the principle of a Ministry of Health, and was an admirer of Newman himself, among his earliest acts as President of the Local Government Board was the conclusion of an agreement with the Board of Education over the division of responsibility for child welfare work which reflected the strong position the Local Government Board had now achieved. This agreement gave responsibility for children under the age of five who were not at school or nursery school to the Local Government Board, and thus removed responsibility for schools for mothers and creches from the Board of Education. Implementation of this agreement was to be subject to ratification by the Prime Minister.⁽¹⁵⁶⁾ Although the agreement specified that the School Medical Service was to be the responsibility of the Board of Education, it did not explicitly exclude a future transfer of responsibility. However, the Board considered the retention of the School Medical Service to be an implicit part of the agreement, and was to quote the agreement in defence of its responsibilities

(154) Christopher Addison, Four and a Half Years, 2 vols. (London: Hutchinson, 1934), 2, 317.

(155) Newman Diaries (D.H.S.S.), vol.3, 5 April 1917.

(156) PRO Ed 24/1363, memorandum of agreement between H.A.L. Fisher and Lord Rhondda, 27 February 1917.

during the debates on the functions of the proposed Ministry of Health. In addition to concern about the effect on the School Medical Service of a transfer to the Local Government Board, the Board of Education also argued that there were organisational justifications for retaining the Service within the Board, for:

care for the physical welfare of the child cannot be separated from care for its mental welfare; the one is directly dependant on the other, and it is necessary that the two should be dealt with by the same authority both central and local. (157)

Lord Rhondda's conversion to the concept of a Ministry of Health and his basic sympathy with the views of Newman, Morant, Addison and the other reformers, has been referred to above. By 1917, the concept was enjoying revived support as the lessons of the War were analysed, (158) and Rhondda gave a considerable stimulus to the movement by circulating a Cabinet paper on "The Urgent Need for a Ministry of Health" on 27 March 1917, which, after referring to the "existing chaos" of health services organisation, argued:

These and other crying evils can only be remedied by the immediate establishment of one central Ministry of Health, in place of the two or three separate and competing Government Departments which at present separately supervise various elements in the national health problem. (159)

(157) PRO RECO 1/665, item 35, Board of Education to Reconstruction Committee, p.21.

(158) See e.g. Lancet i(1917), 461; Waldorf Astor, The Health of the People (London: Argus Printing Co., [1917]).

(159) PRO Cab 23/2, War Cabinet 115, 6 April 1917, Appendix; Margaret Mackworth, Viscountess Rhondda, D.A. Thomas, Viscount Rhondda (London: Longmans, Green, 1921), pp.266-67.

He proposed the introduction of a short Bill to introduce a Ministry of Health and Local Government. Rhondda's remaining tenure of the Presidency of the Local Government Board was brief, however, as he became Food Controller in July 1917. He was succeeded, to the dismay of the reformers, by W. Hayes Fisher, the former proponent of charges for medical treatment by the L.C.C.

The subsequent history of the movement for a Ministry of Health, and particularly the rearguard action fought by the Local Government Board to prevent this reform, or to retain control of medical services within the Board itself, is long and complex, and has been discussed extensively by other historians.⁽¹⁶⁰⁾ The final outcome of the campaign was a rather less comprehensive Bill than that desired by the reformers, and one which has been included in one historian's catalogue of "The Failure of Social Reform, 1918-1920".⁽¹⁶¹⁾ Within the confines of this more restricted legislation the new Ministry of Health was to be the responsibility of Addison, who became President of the Local Government Board in January, 1918, to oversee the transfer of functions to the Ministry of Health. He quickly discovered the somnolent state of affairs at the Board, writing to Lloyd George soon after his arrival:

I had heard various accounts of the condition of affairs in the Local Government Board, but I confess that what I found was far worse than anything I had apprehended. With the exception

(160) See Frank Honigsbaum, The Division in British Medicine (London: Kogan Page, 1979), pp.31-41; Bentley B. Gilbert, British Social Policy, 1914-1939 (London: Batsford, 1970), pp.101-37; Christopher Addison, Politics from Within, 1911-1918, 2 vols (London: Herbert Jenkins, 1924), pp.221-32.

(161) Philip Abrams, "The Failure of Social Reform, 1918-1920", Past and Present 24(1963), 43-64.

of one or two branches which stood out clearly from the rest, it seemed to be an office which failed to function, except very slowly, under constant stimulus, and often then very ineffectively. Looking back on my first three months here, I feel that it was rather as if I were punching a dough-pudding. It received the blows with equanimity and without recoil, but nothing happened. (162)

In relation to the School Medical Service, the Ministry of Health Act 1919 permitted administration of the Service to remain with the Board of Education, subject to the agreement of the Minister of Health, who acquired overall responsibility. (163) This arrangement effectively preserved the status quo desired by the Board of Education, and avoided schism between the systems of medical inspection and treatment, and other services administered by the Medical Department. This arrangement had not, however, gone unchallenged in Parliament, and in Standing Committee Members passed an amendment over-turning the original formula for attaining this objective, a clause delaying, for an unspecified length of time, the transfer of the School Medical Service to the Ministry of Health. (164) The amendment placed the Service directly under the Ministry of Health from its inception, but following a suggestion from Selby-Bigge, (165) Addison successfully persuaded the House to accept a further amendment giving the Ministry of Health power

(162) Addison MSS, Box 39, memorandum from Addison to Lloyd George, 31 July 1919.

(163) Ministry of Health Act, 1919, 9 & 10 Geo. V, ch.21.

(164) Times 19 March 1919, p.16.

(165) Addison MSS, Box 39, memorandum from Selby-Bigge, 25 March 1919.

to delegate responsibility for the day to day administration of the Service to the Board of Education.⁽¹⁶⁶⁾ Following the passage of the Bill, Newsholme was prematurely retired, and Newman took up the position of Chief Medical Officer, Ministry of Health, a position he was to hold until retirement in 1935. At the same time, he retained his post as Chief Medical Officer, Board of Education, and thus as head of the School Medical Service.

Thus, in the immediate post-War period, the School Medical Service saw an extension of its duty of inspection, and the introduction of mandatory treatment. These changes resulted in a major increase in expenditure on the Service. In addition, important administrative changes were made. By 1919, therefore, the School Medical Service had, as Newman expressed it, "reached the end of the pioneering period".⁽¹⁶⁷⁾

Summary

Newman's expectations of progress for the School Medical Service in 1914 were frustrated by the declaration of the First World War. This imposed demands on medical staff which affected all civilian medical services, including the School Medical Service. Curtailment of routine medical inspection became increasingly common during the War period, as councils were unable to appoint

(166) Parl. Deb.(Commons), 5th series, 114(9 April 1919), 2091-93, 2100-1.

(167) BPP 1919/XXI:149, op.cit., p.88.

replacements for doctors who had enlisted, or were conscripted.

Nevertheless examination of the statistics of the wartime period suggests that for the School Medical Service the picture was not wholly one of retrenchment. Treatment received a higher priority from the remaining medical and nursing staff, and some progress in this area is apparent.

This was amplified in post-war reconstruction, when further duties were placed on the local authorities. Inspection was extended to the secondary schools, and the provision of treatment facilities made compulsory, while the creation of the Ministry of Health changed, if only nominally, the administrative context within the service operated. By 1919 therefore the School Medical Service had apparently not only retained the widespread political support evident on its establishment, but had generated political and professional demands for further expansion of the system indicative of a widespread acceptance of the effectiveness and usefulness of supervision of the health of school children.

CONCLUSION

Charles Webster, in a critical analysis of the data produced by Newman's twin empires at the Ministry of Health and Board of Education in the 1930's, and the purposes for which they were deployed, suggests that statistics were "the pride and joy" of the School Medical Service.⁽¹⁾ Such an emphasis on the production of data would have been seen as entirely appropriate by the members of the various Government inquiries established in the wake of the Boer War. The ferment of discussion about the health and condition of the people stimulated by revelations of apparently widespread physical defect amongst volunteers, and reinforced by reports of disease and incapacity among soldiers actually considered fit for service in South Africa, had made the well-being of coming generations a matter of national concern. The resulting inquiries each recommended that the medical profession should be brought into a closer and more formal relationship with the schools, if only because, in a country without conscription, they formed the most accessible aggregations of subjects for anthropometric investigation.

The links between medical inspection and imperial need thus established led to the identification of the School Medical Service as one of the earliest examples of the way in which war has

(1) See Charles Webster, "Healthy or Hungry Thirties?", History Workshop 13 (1982), 110-29.

influenced the development of social policy in the twentieth century.⁽²⁾ Sir George Newman subsequently re-emphasised the relationship in his war-time Annual Reports, suggesting that the "European War has given new emphasis to the importance of the child as a primary national asset. The future and strength of the nation unquestionably depend upon the vitality of the child."⁽³⁾

Uncertainties remain, however, whether the period of introspection subsequent to the Boer War was a sufficient, or even a necessary precondition for the creation of a national School Medical Service. The extent to which the service, once established, pursued imperialist objectives as a priority is also questionable. A study of the contemporary literature, or of the detailed proceedings and recommendations of the Inter-Departmental Committee on Physical Deterioration, shows how numerous and divergent were the suggestions advanced for remedying the social evils given a new prominence and significance by the Boer War. Most such schemes foundered on the reluctance of the Balfour administration to contemplate reforms costly to either local rates or Exchequer revenues. Yet the concept of school medical inspection survived, to be implemented by the Liberal Government before other proposals which were arguably more likely to make an impact on the national health.

Part of the explanation lies in the negative attitude of the Local Government Board towards the extension of maternity and

(2) R.M. Titmuss, Essays on the Welfare State, 2nd ed. (London: Allen & Unwin, 1963), p.81.

(3) BPP 1917-18/XI:89, Board of Education, Annual Report of the Chief Medical Officer for 1916, Cd. 8746, p.vi.

child welfare work and other services for which it was responsible. But the advance of the School Medical Service was also due to the tradition of educational medicine that had been evolving, albeit gradually, over the previous decades.

Claims that the School Medical Service was in fact educational in its conception and orientation were made. Newman sometimes suggested this himself. Such claims are strongly contested by Professor Gilbert, who gives clear evidence that both Newman and Morant justified the service by appeals to social imperialist criteria, and concludes that "it was only among the reformers and educationalists themselves that....medical inspection appeared as an educational measure".⁽⁴⁾ Yet Professor Gilbert's objections may be less persuasive than they seem. It is true "that children had been 'compulsorily sitting in schools' for over a quarter of a century before the advent of feeding and medical inspection",⁽⁵⁾ but as the early chapters of this thesis suggest, for much of this period substantial structural and legal obstacles to the growth of medical work in schools existed. Despite these, the foundations for such work were laid, and the period after the 1902 Act, when for the first time education authorities of appropriate size, (and through their connection with public health authorities) powers and personnel were established, saw a significant extension of these activities. As the analysis in chapter three has indicated, most of this activity was directly educational in its purpose, with

(4) Bentley B. Gilbert, The Evolution of National Insurance in Great Britain. (London: Michael Joseph, 1966), pp.123-25; 147-48n.

(5) Ibid., p.124.

anthropometric investigations allied to the fears of physical deterioration being rare in occurrence.

This educational bias can arguably be discerned also in the priorities accorded to the various ameliorative services provided under the School Medical Service. The various treatment schemes available cannot be divided simply into those fulfilling educational needs and those related to the longer-term considerations that had exercised the social imperialists. They contributed to both purposes. Nevertheless, the balance between the immediate educational and longer-term national relevance of a form of treatment varied, and it may be suggested that the pattern of growth of treatment provision examined in chapter nine indicates that those activities making the greatest direct contribution to educational efficiency were given highest priority.

Although exact comparisons are fraught with difficulty due to variations in cost and in the magnitude of the problem, the position of dentistry within the School Medical Service is perhaps symbolic of the priorities adopted. Except where decayed teeth were causing pain, even extraction made less difference to a child's performance or attendance than the provision of spectacles or X-ray treatment for ringworm, where necessary. But the South African War had indicated the potential importance of conservative dental treatment. Many volunteers were rejected because of the poor condition of their teeth, and others were subsequently invalided home because dental caries prevented them from masticating

field rations properly. A militia battalion of the Cheshire Regiment had to be issued with mincing machines due to "a very general absence of grinding teeth amongst the men".⁽⁶⁾ The number of children with defective teeth was one of the more striking revelations of medical inspection, and caused concern to many.⁽⁷⁾ Despite all this, dental care was accorded a low priority by the local authorities, meaning that even in the 1930's the "school dental services [were] an area of the health services regarded with helpless dismay by Ministry of Health officials". School dentists deliberately under-estimated the extent of caries among school-children in order to reduce their task to a manageable level.⁽⁸⁾

Despite the apparent links between the School Medical Service and the various conflicts in which Britain was involved during the first part of this century, therefore, the actual operational priorities of the system seem to have been more in tune with sentiments first expressed in the 1890's, when it became realised that "the real and ultimate success of the school master must

(6) Quoted in Leslie J. Godden, ed., History of the Royal Army Dental Corps. (Aldershot: R.A.D.C., 1971), pp.2-4, from a report in the British Dental Journal 23 (1902), 23.

(7) King George V told Newman he had "read your reports and papers with great interest....what strikes me is the teeth, they are very bad....I hope something will be done for them". Newman Diaries (D.H.S.S.), vol.2, 19 July 1913.

(8) Webster, op.cit.

depend not only on his own abilities, but also and in greater degree upon the organic condition of the material with which he has to work".⁽⁹⁾ The retention of day-to-day control of the School Medical Service by the Board of Education after the formation of the Ministry of Health in 1919 is thus a reflection of the overall orientation of the system in the early years of its existence.

Even though medical inspection generated a mass of statistical information, this failed to satisfy the needs of those curious about the physical condition of the nation, for reasons explored in chapter six. It did, however, project an impression of widespread, if relatively minor, defects among children requiring remedial action. This buttressed arguments for continued expansion of the School Medical Service, acceptance of which saw a substantial growth in the staff employed. From the solitary figure of W.R. Smith in 1890, the number of doctors employed on a whole or part time basis caring for the health of school children had grown to 2,082 by 1921. This represented 9.1 per cent of all "physicians, surgeons, [and] registered medical practitioners" recorded in the 1921 Census.⁽¹⁰⁾

These figures, inevitably, aroused questions about the actual impact of such a significant input of personnel and related resources. Again, however, the statistics, although copious, are

(9) J. Strachan, "Health Conditions in School Life".
Edinburgh Medical Journal 41 (1895-96), 451.

(10) Board of Education, The Health of the School Child, 1921.
(London: H.M.S.O., 1922), p.28. Both figures refer to England and Wales only.

not illuminating. Any attempt to quantify the impact of the School Medical Service on the health of the children it was concerned with prior to 1919 faces inevitable difficulties irrespective of the reliability and usefulness of the data available. Fluctuations in real wages; changes in lifestyles imposed by the war; maternity and child welfare work and other services could all exert an influence also, while as Newman was quick to stress when he attempted to identify what had resulted from ten years work by the School Medical Service, it was "as yet incomplete in operation, inadequate in working and even in scope, insufficiently co-ordinated with other forms of State Medicine, and not yet yielding anything like its full measure of benefit".⁽¹¹⁾

He also considered it was still impossible to be categorical about the results from the existing provision. Newman's conclusion could not be based on the absence of statistical evidence, but probably to its unsuitability for the purpose of a strict evaluation of achievements. The emphasis on easily obtainable information meant, for example, that treatment statistics, while showing impressive rates of growth in both facilities provided and attendances made, were sometimes unable to specify the number of individual children treated, or whether there was a satisfactory outcome to the treatment provided.

Nevertheless, Newman was confident that the overall outcome of existing provision could be distinguished. He pointed to the "various returns which illustrate, though they cannot define or

(11) BPP 1918/IX:99, Board of Education, Annual Report of the Chief Medical Officer for 1917, Cd. 9206, p.165.

record with exactness, the kind of thing that is happening in regard to treatment, the large numbers who attend the centres provided for treatment, and the substantial numbers who thus find remedy or cure".⁽¹²⁾ After giving details of the numbers attending for treatment in London he argued such figures "can only mean that in London, and similarly all over the country, there is now going on (as there was not formerly) a reduction of malady and defect".⁽¹³⁾ In 1920 he estimated, although only by extrapolating from an incomplete set of local annual reports, that the Service was now ensuring the successful medical treatment of 400,000 school children in a year.⁽¹⁴⁾ It is probably impossible to make any more specific statement about the effects of the School Medical Service in the period under discussion.

Newman never publicly acknowledged what was, perhaps, the most significant aspect of the provision of medical care to school children other than its role in extending the possibility of treatment to many children who could not previously have expected to receive attention for the defects involved. The Liberal reforms of 1906-1914 have been seen as an intermediate stage, an incremental period, between the overtly deterrent provisions of nineteenth century laissez-faire ideology and the universalist framework of services provided after the Second World War. They represent a "social service state" rather than a welfare state.⁽¹⁵⁾

(12) Ibid., p.166.

(13) Ibid.

(14) BPP 1921/XI:109, Board of Education, Annual Report of the Chief Medical Officer for 1920, Cmd. 1522, p.3.

(15) See J. Roy Hay, The Origins of the Liberal Welfare Reforms 1906-1914, E.H.S. Studies in Social and Economic History (London: Macmillan, 1975), p.12.

The two pioneer Acts, that of 1906 allowing the provision of free school meals for necessitous children, and the 1907 Act establishing the School Health Service, seem to conform to this model. Once the 1909 Local Education Authorities (Medical Treatment) Act had imposed regulations governing payment for services virtually identical to those contained in the 1906 Act, both meals and medical treatment were to be available free to necessitous children, but a test of means was implicit in the scheme.

In practice, both services seem to have moved further towards a universal model of provision in some areas than is implied by the concept of the social service state. In neither case did parental payments for charges approach projected revenues. With school meals, local authority policies led to Board to warn that greater efforts could be made to collect fees.⁽¹⁶⁾ With medical treatment, however, the analysis in chapter seven suggests that the Board was at the least a passive supporter of a policy of providing free treatment, at least until the Geddes era forced it to take a more active and tougher stance. The advent of medical treatment for school children may thus have been a greater alteration in policy than has previously been envisaged.

Newman did not see the School Medical Service only in terms of the provision of identifiable services, however. He argued that it had had educational benefits also, including, contrary to some of the fears expressed on its foundation, "an awakening of,

(16) BPP 1910/XXIII:393, Board of Education, Report on the Working of the Education (Provision of Meals) Act, 1906, up to 31st March 1909, Cd. 5131, p.5.

or an increase in, the sense of responsibility of the parent".⁽¹⁷⁾

Although admitting this was impossible to prove, he argued that parental attendance or inspections supported his contention.

Newman's argument, though unprovable, is almost certainly correct. The School Medical Service did perform an educative, even missionary role that cannot be measured in quantitative terms. Even now, it is possible to find occasional reflections of the way in which the doctor's visit to the school, or the nurse's visit to the home, brought results beyond the observable surge of attendances at out patients department or school clinic. Blaxter and Patterson's study of Mothers and Daughters, in the Social Science Research Council's series on "transmitted deprivation", includes an investigation of "lay remedies" passed down by mothers or grandmothers to deal with ailments. One suggestion recorded is to rub paraffin into the hair to deal with "beasties in the heid".⁽¹⁸⁾ This is not in fact a lay remedy, but a memory of the standard advice dispensed by the early school medical officers for dealing with nits or vermin in the hair.⁽¹⁹⁾ The difficulties in following the supplementary advice sometimes, but not always, given, that the child should be kept away from naked flames must have resulted in

(17) BPP 1918/IX:99, op.cit., pp.167-68.

(18) Mildred Blaxter and Elizabeth Patterson, Mothers and Daughters, S.S.R.C./D.H.S.S. Studies in Deprivation and Disadvantage no.5 (London: Heinemann, 1982), p.147.

(19) "First comb the hair well with a moderately fine comb. Wash the hair thoroughly at night with hot water and soft soap. Dry hair thoroughly. Then rub paraffin oil well into the head and the hair, tie up the hair and head with a towel, leaving the paraffin on. Repeat all the above every night for three consecutive nights".

Berwick-upon-Tweed M.B., Annual Report of the School Medical Officer for 1909, p.21.

casualties.

By 1919, therefore, Newman could reasonably argue that the School Medical Service had accomplished much, although the copious statistics produced did little to help quantify its achievements, or to determine how efficiently they had been attained. With the new duties imposed by the 1918 Education Act, Newman could anticipate further growth in the Service. This did in fact occur, but over the next fifteen years and beyond it took place amidst an increasingly more critical discussion of the policies Newman pursued.

As the incidence of some of the problems such as uncleanliness declined, the continuation of the routine medical inspection and its attendant collation of statistics came to be questioned. A more selective approach to inspection, coupled with greater efforts to reduce the numbers escaping treatment, was suggested. This debate continues even today, but Newman was slow to respond, expressing doubts about routine inspection only when retirement was imminent.⁽²⁰⁾ The revival of the debate must have given some satisfaction to his former rival, James Kerr, then living in retirement, virtually forgotten, in Edinburgh.

Newman himself was to retire with many honours and amidst hyperbolic tributes ("the greatest hygienist since Moses"). But in posthumous appreciations, his best and most fruitful period was considered to be his time at the Board of Education before the First World War. At the Ministry of Health, he was considered a

(20) See John E. Lunn, "A Study of School Health Service work in the ordinary Day Schools" (Ph.D. thesis, University of Sheffield, 1966), esp. pp.26-45.

little aloof, and did not get to know the whole of his large staff, preferring to concentrate on preparation of his Annual Reports. (21) His conservatism on the policy of the School Medical Service and in other fields for which he was responsible have subsequently attracted criticism. (22)

Perhaps only a comprehensive biographical study of Newman's long and varied public service career can determine the full extent of his contribution to the nation's public health services. For better or worse, however, health work in schools shows, even today, some links with the system which Newman created three quarters of a century ago.

(21) Lancet i (1948), 888-89; See also Beattie in N.R. Beattie et al, "Aspects of the Life and Work of Sir George Newman", Society for the Social History of Medicine Bulletin 2(1970), 1-5.

(22) Webster, op.cit.

A P P E N D I X O N E

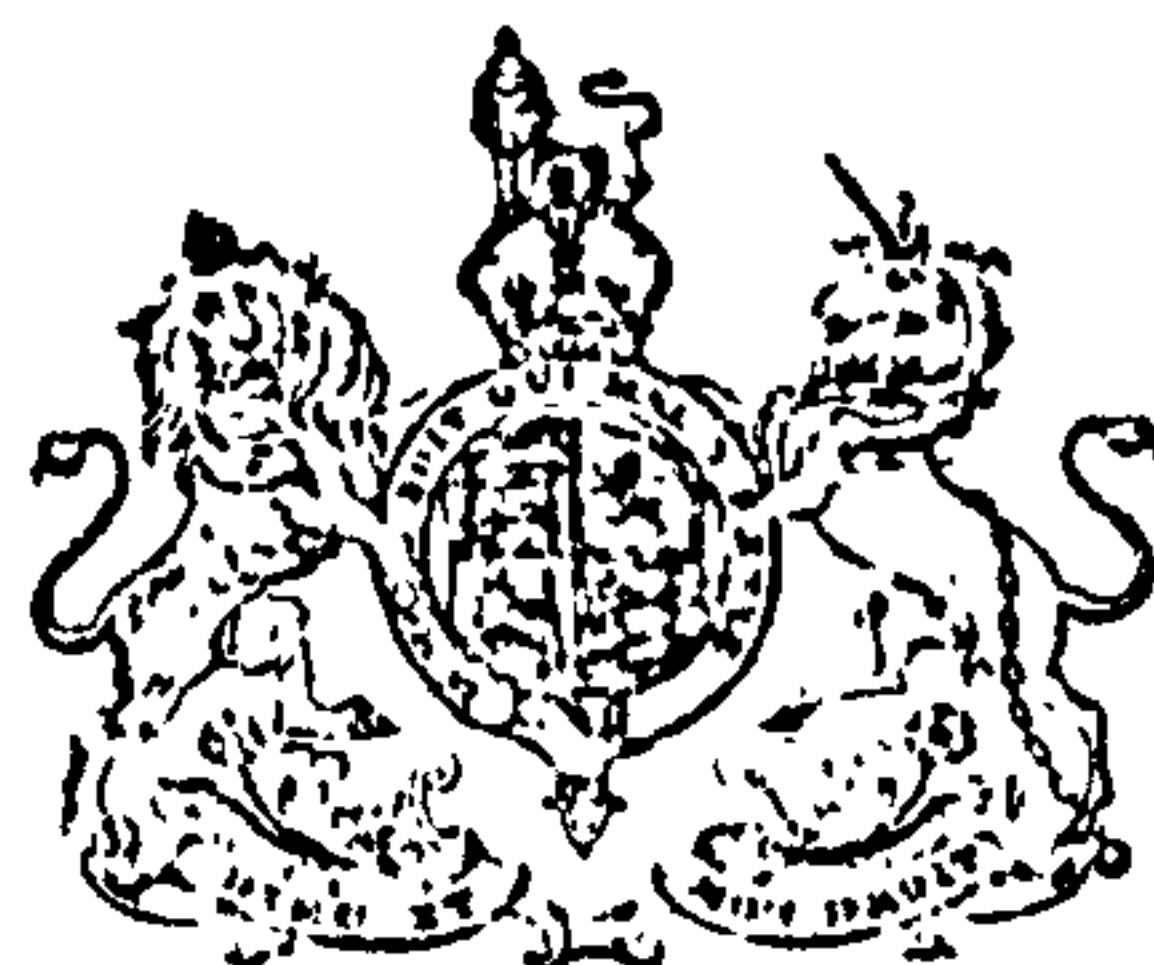
CIRCULAR 576

BOARD OF EDUCATION.**MEMORANDUM**

ON

MEDICAL INSPECTION OF CHILDREN.

IN

PUBLIC ELEMENTARY SCHOOLS,**under Section 13 of the Education (Administrative Provisions) Act, 1907.**

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2

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Memorandum on Medical Inspection of Children in Public Elementary Schools.

SCOPE AND PURPOSE OF THE ACT.

1. The Education (Administrative Provisions) Act, 1907, in so far as it concerns the medical inspection of school children, is the outcome of a steady movement of public opinion throughout the entire community. For some years past evidence has been accumulating that there exists in certain classes of the English people a somewhat high degree of physical unfitness which calls for amelioration, and, as far as possible, for prevention. The Legislature resolved that to grapple effectively with this problem, or at least part of it, it was necessary first to improve the health conditions, both personal and in regard to environment, of the children of the nation. A consideration of the gravity of the need led to the conclusion that medical inspection of school children is not only reasonable but necessary as a first practical step towards remedy. Without such inspection we not only lack data, but we fail to begin at the beginning in any measure of reform. The reasonableness of such inspection, if it is conducted on sensible lines leading to an improvement of the surroundings and physical life of the children, must become evident both to their parents and to the nation as a whole.

The Board desire therefore at the outset to emphasise that this new legislation aims not merely at a physical or anthropometric survey or at a record of defects disclosed by medical inspection, but at the physical improvement, and, as a natural corollary, the mental and moral improvement, of coming generations. The broad requirements of a healthy life are comparatively low and elementary, but they are essential, and should not be regarded as applicable only to the case of the rich. In point of fact, if rightly administered, the new enactment is economical in the best sense of the word. Its justification is not to be measured in terms of money but in the decrease of sickness and incapacity among children and in the ultimate decrease of inefficiency and poverty in after life arising from physical disabilities.

2. The section of the Education (Administrative Provisions) Act, 1907, which concerns medical inspection of school children (section 13) is as follows:—

“13.—(1) The powers and duties of a local education authority under Part III. of the Education Act, 1902, shall include—

[(a) Power to provide for children attending public elementary schools, vacation schools, vacation classes, play centres, &c.]

(b) The duty to provide for the medical inspection of children immediately before or at the time of or as soon as possible after their admission to a public elementary school, and on such other occasions as the Board of Education direct, and the power to make such arrangements as may be sanctioned by the Board of Education for attending to the health and physical condition of the children educated in public elementary schools:

Provided that in any exercise of powers under this section the local education authority may encourage and assist the establishment or continuance of voluntary agencies and associate with itself representatives of voluntary associations for the purpose.

(2) This section shall come into operation on the first day of January nineteen hundred and eight.”

From this it will be seen that two main provisions are incorporated in the section, namely, first, the duty, laid upon all Local Education Authorities, of the medical inspection of children at a stated time and on such other occasions as the Board of Education may direct; and secondly, the power given to all Local Education Authorities of making arrangements, to be sanctioned by the Board, for attending to the health and physical condition of the children in elementary schools.

3. Almost all Local Education Authorities have taken steps of some kind in the promotion of school hygiene, and many have conducted some form of medical inspection. Hitherto, however, such inspection has been concerned only or chiefly with children selected from the school or class as being in some way obviously defective or diseased. The general routine, where such inspection has been practised, has been for a medical man to visit schools at intervals, make a sanitary survey of the buildings, and examine more or less thoroughly children presented to, or selected by, him. Such cases have, however, as a rule, been imperfectly followed up and much of the advice given has been ignored or inappropriately applied. Much also has been left undone in the way of adapting the methods of teaching to the special physical needs of the children. Moreover, in many districts not only have serious defects of sanitation, such as bad lighting and lack of ventilation, injuriously affecting the children, been ignored, but even the means of preventing the extension of infectious diseases have been neglected in greater or less degree. The present Act is not intended to supersede the powers which have long been exercised by Sanitary Authorities under various Public Health Acts, but is meant to serve rather as an amplification and a natural development of previous legislation.

It is founded on a recognition of the close connection which exists between the physical and mental condition of the children and the whole process of education. It recognises the importance of a satisfactory environment, physical and educational, and, by bringing into greater prominence the effect of environment upon the personality of the individual child, seeks to secure ultimately for every child, normal or defective, conditions of life compatible with that full and effective development of its organic functions, its special senses and its mental powers which constitute a true education.

ORGANISATION.

4. The respective functions of the Board of Education and the Local Education Authorities are clearly defined by the Act. The duties thrown upon the Board consist in advising Local Education Authorities as to the manner in which they should carry out the provisions of the Act, and in supervising the work they are called upon to undertake; in giving such directions as may be necessary regarding the frequency and method of inspection in particular areas; and in considering and sanctioning such arrangements for attending to the health and physical condition of the children as may be submitted to them by individual Authorities. The Board will also collate the records and reports made by the Authorities and will present an annual report to Parliament.

The duty of carrying out the actual inspection has necessarily been entrusted by Parliament to the Local Education Authorities and not to the Board. Each Authority must therefore in due course appoint such Medical Officers or additional medical assistance as may be required for the purpose. Some time must inevitably elapse before all Authorities have their arrangements in working order, but it should be carefully borne in mind that, although the work is begun gradually, the initial organisation established by each Authority should admit of such expansion as will secure the thorough and efficient administration of the Act. In subsequent paragraphs some general guidance is given as to the minimum amount of inspection required.

5. In view of the varied influences which affect, directly or indirectly, the health of the children of the nation, it is manifestly of the highest importance that the administration of this Act should rest upon a broad basis of public health, and should not only secure for Local Education Authorities as much freedom as is consistent with adequate uniformity in the presentation of results for comparative purposes, but should also use to the utmost extent the existing machinery of Medical and Sanitary Administration, developing and supplementing it as required, rather than supplanting it by bringing into existence new agencies, partially redundant and possibly competing.

The Board view the entire subject of school hygiene not as a speciality or as a group of specialities existing by and of themselves but as an integral factor in the health of the nation. The application of this principle requires

that the work of medical inspection should be carried out in intimate conjunction with the Public Health Authorities and under the direct supervision of the Medical Officer of Health. The advantages of such unification of the Public Health services have already been recognised by the Inter-Departmental Committee on Medical Inspection and the Feeding of School Children, and also by the Local Government Board, who specifically require every Medical Officer of Health to report officially upon matters relating to the sanitary condition of all schools, including the "action taken (by the Sanitary Authority) in relation to the health of the scholars and for preventing the spread of infectious disease."

6. It is unnecessary to emphasise the objections to a dual jurisdiction in such matters as the sanitary control of school premises and the notification and prevention of the spread of infectious diseases in which the duties of the Medical Officer of Health and the School Medical Officer necessarily and obviously overlap. If they are to be effectively carried out the interests and activities of the School Medical Officer must extend over the whole external environment of the child. School hygiene cannot be divorced from home hygiene, and this in turn is intimately bound up with the hygienic conditions of the community. Efficiency and economy require, therefore, an organic relationship between the daily work of the school authority and of the authority responsible for the administration of the wider branches of public health, including the supervision of water and milk supplies, food, housing and sanitation, inquiries into matters affecting infant mortality (including ante-natal influences), home visiting by men and women inspectors, sanitary and bacteriological investigations, the provision of hospital accommodation, disinfection, the cleansing of verminous persons, the notification of the prevalence or otherwise of diseases, such as phthisis, affecting the adult population, and the consideration of social factors, such as the occupation of the parents, or the health, habits, and physical conditions of the family, all of which have a bearing, direct or indirect, upon the children's health.

Conversely this organic relationship will provide increased opportunity and facilities for the Medical Officer of Health to study all the conditions affecting the health of the community at all age-periods, and will bring him into closer touch with the personal hygiene of the population. While it is not expected that by establishing the necessary administration on the broad basis of public health all difficulties will be avoided, the Board are convinced that this is the only practicable method and that which is most likely to promote economy, harmony, and efficiency.

7. After careful consideration both of the present conditions of local sanitation, and of the developments most likely to serve the economical and efficient administration of this important branch of public work, the Board are of opinion that—

- (a) In county areas the County Council, which is the Local Education Authority, should instruct their County Medical Officer, who will be responsible for smooth and effectual administration, to advise their Education Committee and to supervise the new work, its actual execution being deputed wholly or partly to suitable medical colleagues or assistants (men or women), who either will be appointed specially for the purpose under him or will be local Medical Officers of Health, and to whom groups of schools may be allocated. Where no County Medical Officer has yet been appointed under the Local Government Act, 1888, it would seem that the new duties in regard to medical inspection of children now imposed on the county council will render it inadvisable any longer to postpone such an appointment, since in no other way will the council be able effectually to secure adequate control, economy, and efficiency in carrying out their new work, which must obviously be guided from the central county organisation.

- (b) In county boroughs the Town Council, which is at the same time both the Local Authority for Public Health, and also the Local Education Authority, should instruct their Medical Officer of Health to advise the Education Committee and should make him responsible for the new work or for the supervision of such medical assistance as is needed to carry it out. Where appointments of school medical officers already exist, the Board do not suggest that they should be disturbed, provided always that the officers are competent and sufficient for the new duties and that the arrangements for supervision by the Medical Officer of Health are satisfactory.
- (c) In non-county boroughs and urban districts which are Local Authorities for elementary education, the desirability of ultimately making similar arrangements, separately or in combination with contiguous districts, should be kept in view, though for the time being some variation may be requisite in accordance with local needs and circumstances.

That is to say, generally speaking, the work of inspection should be supervised by the Medical Officer of Health of the Authority which appoints the Education Committee; and when the work is obviously more than he can undertake unaided, it should be entrusted to one or more medical officers working under his supervision. In some districts it will be found convenient for such officers to be local Medical Officers of Health holding office within the county; in others, they may be registered medical practitioners specially appointed for this purpose. Provided that the principle of co-ordination of the medical services is secured in practice, and that the requisite personal and professional qualifications for the new work are present, it is clear that the functions of the school medical officer may be exercised by a medical officer of health, a poor law medical officer, a private practitioner, or, as occasion requires, a skilled specialist. When it is necessary to appoint officers for the purpose of the Act it is extremely important that persons of suitable qualifications and experience should be selected, even though they may not be called upon to give the whole of their time to these duties and it should be noted that there are many cases in which women are likely to be specially suitable. In making such appointments preference should be given to medical men and women who (1) have had adequate training in State Medicine or hold a Diploma in Public Health, (2) have had some definite experience of school hygiene, and (3) have enjoyed special opportunities for the study of diseases in children. The particular needs and circumstances of the area or group of schools concerned should receive due consideration, and great care must be taken to see that school hygiene really forms an integral and fundamental part of the public health administration of the district, and is not subordinated to other less important sanitary questions.

All school medical officers, whether they are holding statutory office as Medical Officers of Health in the area in which they are carrying out the new Act or not, must obviously work in close co-operation with the Sanitary Authorities throughout the county and must be kept informed as to the occurrence of notifiable diseases within their educational areas. This applies in a special degree to the County Medical Officer. It is imperative that the close inter-relation between school hygiene and general hygiene, particularly that of the home of the child, should be secured and maintained.

SUBSIDIARY AGENCIES.

8. The Board are convinced that the work of medical inspection cannot be properly accomplished by medical men without assistance. The teacher, the school nurse (where such exists) and the parents or guardians of the child must heartily co-operate with the school medical officer. In whatever way the system be organised, its success will depend, immediately and ultimately, upon the cordial sympathy and assistance of the teachers. Some Authorities will find that the teachers are able to undertake, without undue strain, a share of the work of furnishing data respecting each child, and even perhaps to carry out some portion of the inspection; and it is clear that

the successful application of the principles of hygiene to school life will depend almost entirely upon their efforts. What the mother is in the home, the teacher is in the school. Experience shows that when the teachers understand the necessities and opportunities of the situation they are both willing and able to take their share. Their co-operation in the work already done in this direction has been beyond praise. The school nurse and health visitor are also important agents in school hygiene. They may serve as links between the school and the home, and can assist in recording the results of inspection, in securing and maintaining personal cleanliness, and in carrying out medical advice concerning simple complaints. They are also able to give counsel in the home, to visit the children at home or in the school, and in many other ways to advance the cause of school hygiene. The Board are satisfied that this work offers a great field of valuable service for the school nurse, and they recommend that, wherever practicable, Education Authorities should secure, especially in rural districts, the benefit and true economy which may be thus obtained. It is essential, however, that the teacher, school nurse, or health visitor assisting in the administration of this Act should act strictly under the instruction and supervision of medical authority. Nor must the influence which the parent can exercise by example and precept be neglected. One of the objects of the new legislation is to stimulate a sense of duty in matters affecting health in the homes of the people, to enlist the best services and interest of the parents, and to educate their sense of responsibility for the personal hygiene of their children. The increased work undertaken by the State for the individual will mean that the parents have not to do less for themselves and their children, but more. It is in the home, in fact, that both the seed and the fruit of public health are to be found. All-round co-operation between school medical officer, teacher, nurse, health visitor, and parent will prove both effective and economical, and the full utility of the Act will not be secured unless, in advising Local Education Authorities, the medical officer pays careful attention to considerations of expenditure and to the relative urgency of the reforms he proposes to undertake.

CHARACTER AND DEGREE OF MEDICAL INSPECTION.

9. From what has been said it will be clear that the fundamental principle of section 13 of the new Act is the medical examination and supervision not only of children known, or suspected, to be weakly or ailing, but of all children in the elementary schools, with a view to adapting and modifying the system of education to the needs and capacities of the child, securing the early detection of unsuspected defects, checking incipient maladies at their onset, and furnishing the facts which will guide Education Authorities in relation to physical and mental development during school life. It is evident that—although this work involves (a) medical inspection of school children at regular intervals, (b) the oversight of the sanitation of the school buildings, and (c) the prevention, as far as may be, of the spread of infectious and contagious diseases, including skin diseases—action in these three directions will be incomplete unless (d) the personal and home life of the child are also brought under systematic supervision. The home is the point at which health must be controlled ultimately.

The character and degree of medical inspection will depend on the standpoint from which the subject is viewed, the difficulty being of course to attain a due sense of proportion and uniformity, particularly as to fundamental points. Valuable to science though the findings of a more thorough and elaborate medical examination might be, it is the broad, simple necessities of a healthy life which must be kept in view. It cannot be doubted that a large proportion of the common diseases and physical unfitness in this country can be substantially diminished by effective public health administration, combined with the teaching of hygiene and a realisation by teachers, parents, and children of its vital importance. The spread of communicable diseases must be checked; children's heads and bodies must be kept clean; the commoner and more obvious physical defects, at least, must be relieved, remedied, or prevented; schoolrooms must be maintained in cleanly condition, and they must be properly lighted, well ventilated, and not overcrowded; the training of the mental faculties must

not be divorced from physical culture and personal hygiene. It is these primary requirements which must first receive attention.

10. The directions given in this circular as to the degree and frequency of inspection refer only to the minimum medical inspection, the effectiveness of which will in future be one of the elements to be considered in determining the efficiency of each school as a grant-aided school. They are not intended to exclude other medical work, which the Board trust will be undertaken by Local Education Authorities according to their abilities and opportunities. For example, the re-testing of the eyesight of every child periodically would be most valuable; an annual measurement of height and weight; the more frequent examination of particular children, especially of those suspected to be suffering from deficient nutrition or found to be defective at former inspections; careful anthropometric surveys or special inspections at various ages of school life; and similar investigations of a special nature undertaken in particular districts, come within the category of additional medical work wholly desirable where practicable, and calculated to advance school hygiene. Such work, however useful, should be looked upon as subsidiary to the main purpose of the Act.

11. A consideration of these matters has led the Board to the conclusion that as far as practicable the statutory medical inspection should, at entrance or at subsequent inspection, take account of the following matters:—

- (1) Previous disease, including infectious diseases.
- (2) General condition and circumstances—
 - (a) Height and weight.
 - (b) Nutrition [good, medium, bad].
 - (c) Cleanliness [including vermin of head and body].
 - (d) Clothing [sufficiency, cleanliness, and footgear].
- (3) Throat, nose and articulation [mouth-breathing, snoring, stammering, tonsillar and glandular conditions, adenoids].
- (4) External eye disease and vision testing.
- (5) Ear disease and deafness.
- (6) Teeth and oral sepsis.
- (7) Mental capacity [normal, backward, defective].
- (8) Present disease or defect: [(a) Deformities or paralysis; (b) Rickets; (c) Tuberculosis (glandular, pulmonary, osseous, or other forms); (d) Diseases of skin and lymph glands; (e) Disease of heart or lungs; (f) Anaemia; (g) Epilepsy; (h) Chorea; (i) Ruptures; (j) Spinal disease; (k) Any weakness or defect unfitting the child for ordinary school life or physical drill, or requiring either exemption from special branches of instruction or particular supervision.]

It is unnecessary to discuss here the advisability or otherwise of including in a minimum inspection the various points appearing in this summary, or to add that commonly the findings as to organic defects will be of a negative character, the positive facts of the inspection being relatively few, and in part obtainable by the trained teacher or school nurse. (See par. 15.) Moreover, some of the above conditions will not require investigation in children on admission, when this takes place at or under five years of age. On the other hand, some defective children will require a more thorough examination than this minimum. Reasonable latitude must be allowed, and the summary must be taken only to indicate the points upon which the Board desire as much uniformity as possible in the minimum medical inspection, and must be adapted to the age-period. The Board propose to issue at an early date an examination form suitable to this inspection.

REGULATIONS.

12. The Board have decided under section 13 of the Act that *not less than three inspections* during the school life of the child will be necessary to secure the results desired.* The first inspection should take place at

* There will be special areas where the Board may from time to time require that the inspection should be at shorter intervals and of a more searching character, and also areas in which, owing to largeness of size or population, some exception may have to be made in the early years by way of reduction of the burden per annum.

the time of, or as soon as possible after, admission to school; the second at or about the third year (say, the seventh year of age); and the third at or about the sixth year of school life (say, the tenth year of age). A further inspection immediately before the departure of the child into working life would be desirable where practicable, and in some areas it may be best for this to take the place of the third inspection. Certain adjustments will be necessary in working out any standard in practice, as it will at once be evident that without such adjustment the first year (1908) would be unduly burdened with the inspection of the children newly admitted and of all the children already in school.

Provision should be made by each Authority, when the Act has been sufficiently long in operation to be in normal working, for the inspection in each year of (a) the children newly admitted; (b) the children in the school who in that year had matured for their second inspection; (c) those who had matured for their third inspection; and where practicable (d) those about to leave school might also be inspected. But in the first year (1908) it may prove impracticable to attempt more than the inspection of the children newly admitted and those leaving school; and in the second year (1909) the Board will be satisfied with the inspection of those newly admitted and those leaving, with the addition of children who have matured for their second inspection (which is perhaps the occasion of all others requiring the most thorough examination). Some such adjustment would tend to equalise the burden over successive years. It will be understood that the precise way in which the children are grouped in the school for medical inspection will vary according to the internal organisation and circumstances of each school. It may be most convenient, for instance, to carry out the inspection on an age basis rather than on a basis of period of school life. In subsequent years the Board may issue notice modifying the age periods for inspection in order to obtain facts respecting child physique at ages other than those included above.

The Board recommend that each Local Education Authority should encourage one or both of the parents of the child to be present at the first inspection, and to this end a notification should be sent to the parents as to the time and place at which it will take place. Whilst some trouble may be involved in inviting the parents, the Board believe that substantial gains would thus be secured, for by this means misunderstandings will be avoided and prejudice will be disarmed. Moreover, the parent is able to facilitate examination and provide information, and the medical inspector's opinion could be given clearly and directly to the persons most nearly concerned.

13. The following further regulations should be observed:—

- (a) The inspection should be conducted in school hours and on school premises, and in such a way as to interfere as little as may be with school work. The examination of each child need not, as a rule, occupy more than a few minutes.
- (b) The convenience of the teaching staff and the circumstances of each school must receive consideration, and in these matters and in the actual examination the medical officer will no doubt exercise sympathy and tact, giving due thought to the personal susceptibilities of those concerned.
- (c) The facts revealed by inspection must be entered in a register kept at the school, the confidential nature of many of the entries being carefully respected. A copy of the entries should be transmitted with the child to any other school to which he or she may go.
- (d) Every School Medical Officer should make an annual report to the Local Education Authority on the schools and children under his superintendence, which should be printed for facility of reference and in order that a supply of copies may be available for distribution among the members of the Authority and other persons interested. The Authority should send two copies of the report to the Board of Education as soon as possible after the end of the year under review.

- (e) In order to secure effective bases for comparison of the work done in different parts of the country, one uniform year must be taken, the year to be adopted being in all cases the calendar year, in order to correspond with the annual period fixed for the closely related report of the Medical Officer of Health.
- (f) The report should be concerned chiefly with the conditions and circumstances affecting the health of the children in the Elementary Schools of the district.
- (g) It should also contain statistical records of the number of children examined and of those re-examined or under medical supervision; the nature and results of the examination; the number of visits paid to classes; the number and character of the diseased conditions found at certain age periods; particulars as to blind, deaf, defective and epileptic children; the medical advice given both as to the prevention of conditions inimical to health and the remedy of diseased conditions that may be discovered, action taken, and so forth.
- (h) In addition to such records it will be well, as far as practicable, to make systematic comparisons of the individual and collective measurements and characteristics of the children in each school with standard and local records, both as a means of determining the condition of health of particular children or classes, for guidance in future action, and as part of the anthropometric survey to which this Act should contribute in due time. This part of the work, however, must be kept in a secondary position while so much remains to be done in the elementary essentials of school hygiene. It is to those essentials, and the manner and degree in which they have been dealt with in his district, that each school medical officer should devote the major portion of his report.

AMELIORATION AND PHYSICAL IMPROVEMENT.

14. The aim of the Act is practical and it is important that local Education Authorities should keep in view the desirability of ultimately formulating and submitting to the Board, for their approval under section 13 (1) (b) of the Act, schemes for the amelioration of the evils revealed by medical inspection, including, in centres where it appears desirable, the establishment of school surgeries or clinics, such as exist in some cities of Europe, for further medical examination, or the specialised treatment of ringworm, dental caries, or diseases of the eye, the ear, or the skin. It is clear that to point out the presence of uncleanness, defect, or disease does not absolve an authority from the consequent duty of so applying its statutory powers as to secure their amelioration and to prevent, as far as possible, their future recurrence or development. The subject of specific medical treatment is, however, one which will require subsequent consideration in the light of the findings of medical inspection and the collateral issues raised thereby, and it is clear that, speaking generally, and subject to the observations in the following paragraphs, local Education Authorities will be unable to formulate and submit for the Board's sanction any comprehensive scheme for the furtherance of this object until they have considered the results of their medical inspection in various directions.

15. In the meantime the authorities should take measures without delay, for dealing, through such agencies as are conveniently available, with what are commonly, though in a sense erroneously, regarded as minor ailments. To such ailments, measures of amelioration should immediately be applied. In a broad sense all such amelioration is "treatment." Indeed, properly administered, the Act must become something more than a mere record of disabilities and defects. It opens the way to new means of education and lays upon Education Committees duties involving "treatment" in a broad conception of the term. A few instances will make the matter clear. Thus in controlling ringworm it has been open to a Committee (a) to neglect the disease altogether; (b) to adopt a policy of exclusion from school of affected children; or (c) to supervise or carry out some method of amelioration. Up

to the present many Authorities have followed the first course. It is intended that in future they should, according to their abilities, adopt the third. Verminous heads and bodies form another illustration of a common condition in which amelioration can be secured by school nurses. Further, a careful survey should be taken of all available facilities for the promotion of the bodily cleanliness of school children. Wherever such facilities exist they should be utilised to the utmost, and where they are absent, the desirability, particularly in the more congested areas, of providing them, either in the schools themselves or at convenient centres, should be clearly recognised. It is of the utmost importance to remember that baths with the necessary accompaniments of soap, sponges, towels, &c., should be utilised, not merely for the immediate and obvious purpose of cleansing the bodies of the children, but also as a humanising influence and as the means of inducing habits and instincts of cleanliness and of inculcating practical lessons in the value of personal hygiene and in self-respect. The same is true of such other simple practical matters as the daily brushing and cleansing of the teeth, which is a subject well worth careful treatment in many of our elementary schools.

16. Practical amelioration is already undertaken by Local Education Authorities in checking the spread of infectious disease by exclusion of affected or susceptible children, supervision and medical examination of "contacts," disinfection of schoolrooms, and so on. Again, the modification of the teaching and work of the school and its adjustment to the physical capacity of the scholars is a form of "treatment" which, in the end, will bear much fruit. Thus the defective visual acuity of children, particularly young children, calls for early correction at the instance of the Education Authorities either alone or in conjunction with some voluntary society; but the rational treatment of some of these children will as a rule be an educational modification which avoids the necessity of spectacles, such modification for example as will diminish the prevalence of the bad habit of working the eyes at near distance, or ensure the adoption of suitable type of letter-press for the reader's eyes. Antecedent even to the discovery of such visual defects should come the removal, as the result of medical inspection, of unsatisfactory conditions of school life which are a common cause of fatigue and of injured eyesight. Obviously, such remedies are of greater importance to the eventual health of the community than the specific medical treatment of individuals.

17. Lastly, it must not be forgotten that Parliament itself has recognised the necessity of imposing some share of responsibility upon Education Authorities as to treatment in the broader sense in which the term is being used in this paragraph, by the special legislation provided in the Elementary Education (Blind and Deaf) Act, 1893, and the Elementary Education (Defective and Epileptic) Act, 1899. The powers conferred by these Acts are wide and furnish authorities with the means of placing needy cases under special treatment. The Board of Education have approved in various county boroughs arrangements under the last-named Act, and in other districts the subject is receiving attention. Nor must it be forgotten that in respect of defective nutrition considerable powers have been conferred on Local Education Authorities under the Education (Provision of Meals) Act, 1906. In all questions relating to the practicable means of amelioration and in some even affecting the arrangements for medical inspection, the Board are satisfied that the efficient local administration of the Act will depend in no small measure upon the good offices of School Managers, many of whom have already done so much in this sphere, and to whose interest and sympathy they cordially commend the new work.

18. This Circular is of a preliminary nature only, and concerns almost entirely the work of the new Act at its initiation. The Board recognise the importance of steady progress in these matters, and have at present under consideration the practicability of the further adaptation of educational methods to the physical and mental capacities of the normal and abnormal child, of special anthropometric and analogous investigations, and of improving the methods of dealing with infectious diseases in schools. Such questions as

school ventilation, the curricula of infant departments, the training of crippled, feeble-minded, blind, deaf, or mentally deficient and epileptic children, special schools for other types of afflicted children, physical culture for pupil-teachers, the standard of medical examination for pupil-teachers, for training college students, and for teachers, and other kindred subjects are also receiving their careful attention. Further, the Board are urging the necessity of giving special instruction in the principles of hygiene to all students in every type of training college, so that they may be able to deal profitably with this subject in the schools. To deal rightly and effectually with these matters will take time. The Board are desirous that the administrative machinery necessary for the appropriate working out, in various localities, of these and allied questions shall be the outcome of real organic growth rather than of a hasty attempt to impose one mechanical system upon all districts, irrespective of their requirements or resources. And in all steps taken the progressive unification of the medical services and the needs and circumstances of each community must continually be borne in mind.

Robert L. Ingham

BOARD OF EDUCATION,
WHITEHALL, LONDON, S.W.,

22nd November 1907.



A P P E N D I X T W O

CIRCULAR 582 .

Circular to Local Education Authorities.
Schedule of Medical Inspection.

Circular 582.

Letters should be addressed—
"The Secretary,
Board of Education,
Whitehall,
London, S.W.,"
and should show the complete postal
address and designation of the writer.

BOARD OF EDUCATION,
WHITEHALL, LONDON, S.W.,
23rd January 1908.

EDUCATION (ADMINISTRATIVE PROVISIONS) ACT, 1907, SECTION 13.

SIR,

1. The accompanying Schedule has been drawn up in response to requests which the Board of Education have received for further and more definite guidance as regards the details of the work of medical inspection than was given in the Memorandum (Circular 576) which was issued by the Board on 22nd November 1907. The Board have, indeed, been pressed by many Local Education Authorities to issue a complete set of Forms for use in carrying out the work directly or incidentally involved in the performance of these new duties. Any Forms which experience of the working of the Act may show to be necessary or desirable will be issued in due course, but for the present the Board think it expedient to leave considerable latitude, subject to the considerations hereinafter set out, in regard to the particular Forms or Schedules to be used in different cases or circumstances.

2. The chief difficulties to be considered are administrative rather than educational or scientific. There is comparatively little dispute as to the end in view, or as to the means which, from the technical standpoint of medical science and practice, should be adopted for its complete attainment.

But the existing resources of Local Education Authorities are (for practical purposes, at all events) not unlimited, the feelings and prejudices of parents have to be considered, and a new element has to be introduced into school life and organisation with the least possible disturbance and inconvenience. Moreover, in this case two departments of local public administration are brought for the first time into organic connection—those of public health and of public education.

3. The Board are fully aware of these difficulties, and in preparing their Memorandum and Regulations it was necessary for them to consider what system would best reconcile the theoretical and practical considerations, and overcome the divergence between the ultimate end and the end immediately attainable, or between the methods which are scientifically desirable and those which can be applied in existing circumstances at the initiation of the work under the Act.

4. In the accompanying Schedule the Board indicate the particulars, attention to which they regard as constituting the *minimum* of efficient medical inspection, and they consider that at least these particulars should be included in any other Schedule which the Local Education Authority may authorise for use in their Schools. It deliberately excludes many points of anthropometric or statistical interest which are worthy of attention, and

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1908.

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which it is hoped may receive attention in suitable districts. Nor does it profess to lay down the lines of a clinical study or of a scientifically complete medical examination. It is intended to indicate the methods which, in the Board's opinion, should be followed and the particulars which should be attended to for the purpose of determining the fitness of the individual child for school life, to guide the Authority in adapting education to the peculiarities or abnormalities of the child, and to prepare the way for measures for the amelioration of defects in the child or its environment.

A more elaborate and complete form could readily be devised, but the Board's knowledge of the circumstances in which the work is to be done leads them to believe that greater elaboration would in the majority of cases defeat its own end.

5. If this Schedule is properly used, few cases of serious physical weakness or defect will escape detection. Where the ordinary inspection shows the need of further and more searching medical examination a supplementary blank form should be used in which particular defects or diseases should be fully recorded. It may facilitate inspection if the Schedule is printed on cards* (8" by 5" or 10" by 6"). The Notes are included in the attached form for the convenience of the School Medical Officer, and should not be reprinted on the cards. Of course it is not necessary that negative findings on all the points mentioned in the Notes should be recorded.

It will be noticed that a space is reserved in the Schedule for "General Observations"; this may conveniently be used to record a general summary of the condition of the child, and any information which may be available as to the home environment, or other conditions affecting its health.

It is considered that the inspection of each child should not occupy on the average more than a few minutes, and that the child need only, as a rule, have its clothes loosened or be partially undressed. Time may be saved in the actual inspection by the Medical Officer if the entries in some of the spaces are filled in by the school authorities before his visit. The four columns in the Schedule are designed for the four inspections required during school life.

With regard to items 17 to 24 of the Schedule, while it is necessary that all indications of diseased or unsound conditions should be thoroughly investigated, needless medical examination of healthy children should, for obvious reasons, be avoided.

6. Where children are found to belong to that class of "defectives" for whose education special provision is or ought to be made under the Statutes relating to such children, such cases should be made the subject of a special report to the Local Education Authority.

7. All entries of the results of inspection in each individual case must be regarded as confidential.

I have the honour to be,

Sir,

Your obedient Servant,

Robert L. Morant

To
The Local Education Authority.

* Specimen cards are enclosed, but cards will not be supplied with the copies of this Circular which are placed on sale.

SCHEDULE OF MEDICAL INSPECTION
(Accompanying Circular 582).

4

NOTES FOR INSPECTING OFFICER.

*Reference
Number
of Note.*

*Reference
Number
of Note.*

1. Date of birth to be stated exactly, date of month and year.
2. "Other illnesses" should include any other serious disorder which must be taken into account as affecting, directly or indirectly, the health of the child in after-life, e.g., rheumatism, tuberculosis, congenital syphilis, small-pox, enteric fever, meningitis, fits, mumps, &c. The effects of these, if still traceable, should be recorded.
3. State if any cases of, or deaths from, phthisis, &c. in family.
4. Note backwardness.
5. Age to be stated in years and months, thus, 5½.
6. Insufficiency, need of repair, and uncleanliness should be recorded (good, average, bad).
7. Without boots, standing erect with feet together, and the weight thrown on heels and not on toes or outside of feet.
8. Without boots, otherwise ordinary indoor clothes.
Height and weight may be recorded in English measures if preferred. In annual report, however, the final averages should be recorded in both English and metric measures.
9. General nutrition as distinct from muscular development or physique as such. State whether good, normal, below normal, or bad. Under-nourishment is the point to determine. Appearance of skin and hair, expression, and redness or pallor of mucous membrane are among the indications.
10. Cleanliness may be stated generally as clean, somewhat dirty, dirty. It must be judged for head and body separately. The skin of the body should be examined for cleanliness, vermin, &c.; and the hair for scurf, nits, vermin, or sores. At the same time ringworm and other skin diseases should be looked for.
11. General condition and cleanliness of temporary and permanent teeth, and amount of decay. Exceptional features, such as Hutchinsonian teeth, should be noted. Oral sepsis.
12. The presence or absence of obstruction in the naso-pharynx is the chief point to note. Observation should include mouth-breathing; inflammation, enlargement, or suppuration of tonsils; probable or obvious presence of adenoids, polypi; specific or other nasal discharge, catarrh, malformation (palate), &c.
13. Including blepharitis, conjunctivitis, diseases of cornea and lens, muscular defects, (squints, nystagmus, twitchings), &c.
14. To be tested by Snellen's Test Types at 20 feet distance (= 6 metres). Result to be recorded in the usual way, e.g., normal V. = $\frac{6}{6}$. Examination of each eye (R. and L.) should, as a rule, be undertaken separately. If the V. be worse than $\frac{6}{9}$, or if there be signs of eye strain or headache, fuller examination should be made subsequently. *Omit vision testing of children under 6 years of age.*
15. Including suppuration, obstruction, &c.
16. If hearing be abnormal or such as interferes with class work, subsequent examination of each ear should be undertaken separately. *Apply tests only in general way in case of children under 6 years of age.*
17. Including defects of articulation, lisping, stammering, &c.
18. Including attention, response, signs of overstrain, &c.
The general intelligence may be recorded under the following heads:—
(a) Bright, fair, dull, backward;
(b) mentally defective; (c) imbecile.
Omit testing mental capacity of children under 6 years of age.
19. Under the following headings should be inserted particulars of diseased conditions actually present or signs of incipient disease. The extent of this part of the inspection will largely depend upon the findings under previous headings.
20. Include heart sounds, position of apex beat, anemia, &c., in case of anything abnormal or requiring modification of school conditions or exercises.
21. Including physical and clinical signs and symptoms.
22. Including chorea, epilepsy, paralysis and nervous strains and disorders.
23. Glandular, osseous, pulmonary, or other forms.
24. State particular form, especially in younger children.
25. Including defects and deformities of head, trunk, limbs. Spinal curvature, bone disease, deformed chest, shortened limbs, &c.
26. Including any present infectious, parasitical or contagious disease, or any sequelæ existing. At each inspection the occurrence of any such diseases since last inspection should be noted.
27. Any weakness, defect or disease not included above (e.g., ruptures) specially unfitting child for ordinary school life or physical drill, or requiring either exemption from special branches of instruction, or particular supervision.

SCHEDULE OF MEDICAL INSPECTION.

I.—Name _____ Date of Birth¹ _____
 Address _____ School _____

II.—Personal History :

(a) Previous Illnesses of Child (before admission).

Measles.	Whooping Cough.	Chickenpox.	Scarlet Fever.	Diphtheria.	Other Illnesses. ²
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(b) Family Medical History (if exceptional).³

—	I.	II.	III.	IV.	—	I.	II.	III.	IV.
1. Date of Inspection -					13. Ear disease ¹³ - -				
2. Standard and Regularity of Attendance. ⁴					14. Hearing ¹⁴ - -				
3. Age of Child ⁵ - -					15. Speech ¹⁵ - - -				
4. Clothing and footgear ⁶					16. Mental condition ¹⁶ -				
[III.—General Conditions.]					[V.—Disease or Deformity.] ¹⁶				
5. Height ⁷ - -					17. Heart and circulation ¹⁷				
6. Weight ⁸ - -					18. Lungs ¹⁸ - - -				
7. Nutrition ⁹ - -					19. Nervous system ¹⁹ -				
8. Cleanliness and condition of skin. ¹⁰					20. Tuberculosis ²⁰ - -				
Head - -					21. Rickets ²¹ - - -				
Body - -					22. Deformities, Spinal Disease, &c. ²²				
[IV.—Special Conditions.]					23. Infectious or contagious disease. ²³				
9. Teeth ¹¹ - -					24. Other disease or defect. ²⁴				
10. Nose and throat ¹² -									
Tonsils - -									
Adenoids - -									
Submax. and cervical glands.									
11. External eye disease ¹³									
12. Vision ¹⁴ - -									
	R.				Medical Officer's initials				
	L.								

General observations.

Directions to Parent or Teacher.

A P P E N D I X T H R E E

CIRCULAR 596

Circular 596.

17th August 1908.

*(Supplementary to Circulars 576 and 582.)***BOARD OF EDUCATION.**

Circular to Local Education Authorities under Part III. of the Education Act, 1902, on certain questions arising under section thirteen of the Education (Administrative Provisions) Act, 1907, and the Code of Regulations for Public Elementary Schools, 1908, viz. :—

- (A) The functions of the "School Medical Officer";
- (B) Provision for Medical Inspection of school children under the Code of 1908;
- (C) The Local Education Authority's Annual Report on Medical Inspection to the Board of Education; and
- (D) Arrangements for attending to the Health and Physical Condition of School Children.



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3

Circular 596.

17th August 1906.

Letters should be addressed—
 "The Secretary,
 Board of Education,
 Whitehall,
 London, S.W.,"
 and should show the complete postal
 address and designation of the writer.

BOARD OF EDUCATION,
 WHITEHALL, LONDON, S.W.
 17th August 1908.

Circular to Local Education Authorities under Part III. of the Education Act, 1902, on certain questions arising under section thirteen of the Education (Administrative Provisions) Act, 1907, and the Code of Regulations for Public Elementary Schools, 1908, viz.:—(A) the functions of the "School Medical Officer"; (B) provision for Medical Inspection of school children under the Code of 1908; (C) the Local Education Authority's Annual Report on Medical Inspection to the Board of Education; and (D) arrangements for attending to the Health and Physical Condition of School Children.

SIR,

1. I AM directed by the Board of Education to call the attention of the Local Education Authority to the provisions in the Code for 1908 which refer to the work of Medical Inspection of school children and to the functions of the "School Medical Officer." These provisions are contained in Articles 25 (c), 44 (g) and (h), 45 (b), 53 (b), and 58, and are referred to in paragraph 1 of the Prefatory Memorandum prefixed to the Code.

The Board also think it desirable to take this opportunity of supplementing their previous Circulars (Nos. 576 and 582) in various particulars and of dealing with certain questions arising in connection with the arrangements which Local Education Authorities are now empowered to make with the sanction of the Board of Education "for attending to the health and physical condition" of school children, and with the scope of the Annual Report on Medical Inspection referred to in paragraph 13 (d) to (h) of Circular 576.

A.—School Medical Officer.

2. It will be observed that the "School Medical Officer" of the Local Education Authority is for the first time recognised in the Code of 1908 as an officer having specific functions in the system of Public Elementary Education. This Officer is defined in Article 44 (g) as "a medical officer named by the Local Education Authority, and recognised as such by the Board." The functions specifically assigned to him (or her) by the Code are—

- (i) Those of reporting on the working and effect of any arrangements made under Article 44 (g) for educating children at "an open air school, school camp, or other place selected with a view to the improvement of the health and physical condition of the children."
- (ii) The power of advising or approving the closure of a school under Article 45 (b).
- (iii) The power of authorising the exclusion of certain children from a school on specified grounds under Article 53 (b), which grounds will be regarded as "reasonable grounds" under Article 53 (a).

3. One of the objects which the Board had in view in introducing these provisions into the Code was to secure that the responsibility for dealing with certain medical questions connected with Public Elementary Schools should, as far as possible, be placed in the hands of a single officer responsible to the County Council, County Borough Council, Borough Council or Urban District Council who are the Local Education Authority for the area in which a school is situated. The expression "School Medical Officer" is therefore substituted for the vague expression "medical authority," which was used in Article 45 (b) of the Code of 1907. The Board, however, also had in view the desirability of assisting Local Education Authorities to concentrate and organise, in the department of the School Medical Officer, all matters

of school hygiene, including medical inspection under the Act of 1907, and they assume that the School Medical Officer will, in addition to performing the specific functions assigned to him by the Code, also be made responsible by the Local Education Authority for supervising and controlling the general work of medical inspection.

The provisions of Article 57, under which the closure of a school or the exclusion of certain children can be *required* by the local Sanitary Authority (or by two members of the Sanitary Authority acting on the advice of the Medical Officer of Health) are retained, and arrangements must of course be made for securing close co-operation in this respect between the Sanitary Authority and its officers and the School Medical Officer, on whom the Local Education Authority will primarily rely in the numerous cases where no question of compulsory closure or exclusion arises. The School Medical Officer will naturally consider the matter from the point of view of education as well as from that of sanitation, and, while keeping in close touch with the Medical Officer of Health, will be in a position to advise the Local Education Authority on the difficult questions which often arise when the necessity of closing the school, as distinguished from exclusion of individual children, is under consideration. The Board do not, of course, contemplate that the work of certifying children for exclusion or of authorising the closure of schools or of medically inspecting school children, can or will, in large areas, be carried out entirely or personally by a single individual. Subordinate officers will in most cases have to be appointed, who will act under the direction of the School Medical Officer, and he will act on information coming to him through many channels.* But it is considered very important by the Board that a single individual should be charged with the organisation and control of the whole machinery of the School Medical Service and that he should be in a position to take responsibility for the acts of all persons taking part in the work, including those of Assistant Medical Officers, School Nurses, Attendance Officers, and Teachers, so far as they perform any functions in connection with the School Medical Service. The Board have, therefore, stated in Article 44 (g) that the recognition of separate School Medical Officers for separate parts of one area will be given in exceptional cases only. It will, of course, be understood that, in making these observations, the Board do not contemplate any infringement upon the ultimate responsibility of the Local Education Authority, nor have the Board in any way departed from the principle on which they laid stress in Circular 576, that, as far as practicable, the School Medical Service should be unified with the Public Health Service, (*see also* par. 7 (c) below).

B.—*Provision for Medical Inspection.*

4. As regards Articles 25 (c) and 58 (b), which require, as a condition of Grant, that satisfactory provision for the medical inspection of children shall be made, it is obvious that the best evidence of compliance with this condition would be afforded by (a) the appointment in each area of a competent School Medical Officer and a staff of qualified and suitable assistants under his supervision and control, and (b) the initiation of a carefully considered scheme for covering the ground. For this purpose the Board will require to be furnished with particulars of the appointments made by the Local Education Authority and with such information as will enable them to judge of the efficiency of the organisation adopted. Forms to be used for this purpose have been prepared and accompany this Circular (Form 9 M.I.). When this information is received, the Board will consider the system adopted in each area broadly and on its merits, with due regard to local circumstances and with no desire to impose a rigidly uniform system on Authorities whose circumstances are widely different. Even in cases where the system adopted is not such as the Board would themselves have suggested, they would be slow to withhold provisional approval from experiments so long as they do not conflict with the general principles laid down in Circular 576.

C.—*Annual Report.*

5. The Annual Report referred to in paragraph 13 (d) to (h) of Circular 576 should be made by the School Medical Officer to the Local Education Authority, who will send two copies of it to the Board of Education, with any observations

* Where no question of *compulsory* closure or exclusion arises, the School Medical Officer's certificate may of course be based on information given by the Medical Officer of Health.

which they may desire to submit, as soon as practicable after the expiration of the year to which it relates. It will be understood that Reports which are for the information of the Board of Education may well include statements of local circumstances and conditions which would be superfluous if they were intended only for the information of the Local Authority. The Annual Report should relate to the calendar year, and the first Annual Report should be made up to the 31st December 1908. It is not the intention of the Board to prescribe in detail the form which this Report should take, or to require at present the adoption of particular methods of analysing and tabulating the facts on which it is based. However desirable it may be, on abstract or scientific grounds, to secure uniformity in these Reports, the Board feel that the attainment of this quality must be preceded by such an amount of practical experience as is sufficient to show what particulars can or cannot be included in tabular forms which, when framed, must be capable of application to all parts of the country and all varieties of circumstances.

In this connection I am to call the attention of the Authority to the passage headed "Medical Inspection of School Children," on page 3 of the Memorandum on Annual Reports issued by the Local Government Board, dated December 19th, 1907 (M. 152).

6. As regards the scope of the Report, however, the Board consider that it is desirable that it should deal with the whole subject of School Hygiene, and should cover as much as possible of the ground indicated under the following heads. It is recognised that these heads suggest a degree of comprehensiveness which in many, and indeed in most cases, will not immediately be attainable. The Board have, however, considered it desirable to treat the plan of the Annual Report in such detail as to furnish Local Education Authorities with a standard, by reference to which they may regulate their arrangements for collecting and digesting the information which the work of the next few years will place at their disposal.

(a) General review of the hygienic conditions prevalent in the Schools in the area of the Local Education Authority in respect of such matters as surroundings, ventilation, lighting, warming, equipment, and sanitation, including observations on the type and condition of sanitary conveniences and lavatories, water supply for washing and drinking purposes, the cleanliness of schoolrooms and cloakrooms, arrangements for drying children's cloaks and boots, and the relation of the general arrangements of the School to the health of the children.

(b) General description of the arrangements which have been made for the co-relation of the School Medical Service with the Public Health Service and for the organisation and supervision of medical inspection, and an account of the methods of inspection adopted, including—

- (i) A statement of the extent (if any) to which the Board's Schedule of Medical Inspection has not been followed and the reasons for such departure;
- (ii) A statement showing the assistance given to the School Medical Officer and his assistants by nurses, managers of schools, teachers, attendance officers or other persons;
- (iii) A statement showing the methods adopted for securing the presence of parents at the inspection and their co-operation in the subsequent treatment of defects, together with a review of the effect of such methods;
- (iv) The extent to which disturbance of school arrangements was involved by the inspection. (Art. 13 (b) and 14 (h) of Code of 1908.)

(c) General statement of the extent and scope of the medical inspection carried out during the year, including—

- (i) The number of visits paid to Schools and Departments;
- (ii) The principle on which children have been selected for inspection; (at entrance, before leaving, by selection according to ages or otherwise);
- (iii) The number of children inspected (classified for age at date of inspection and for sex);
- (iv) The number of children referred for subsequent or further examination;
- (v) The number of children in respect of whom directions were given for treatment of defects, including a classified statement of such defects;
- (vi) The average time per head occupied by inspection.

(d) General review of the facts disclosed by medical inspection, under the headings contained in the Schedule to Circular 582, including tables showing the height and weight of children inspected (according to age at date of inspection and sex).

(e) General review of the relation of home circumstances and social and industrial conditions to the health and physical condition of the children inspected, so far as facts bearing on this point have come under notice.

(f) Review of the methods employed or available for the treatment of defects, such as defective eyesight, carious teeth, nasal obstruction or adenoids, tonsillitis, discharging ears, pediculosis, ringworm, and other skin diseases, including an account of the action of School nurses in obtaining or assisting in the treatment of such defects.

(g) Review of action taken to detect and prevent the spread of infectious diseases, including reference to action taken under Articles 45 (b), 53 (b) and 57 of the Code of 1908.

(h) Review of the methods adopted and the adequacy of such methods for dealing with blind, deaf, mentally or physically defective and epileptic children under the Acts of 1893 and 1899.

(i) Review of—

- (i) The methods and results of instruction in personal hygiene and temperance in the Public Elementary Schools in the area;
- (ii) The methods and results of physical or breathing exercises in the Schools;
- (iii) Arrangements for open air schools, school camps, &c., under Article 44 (g) of the Code of 1908.

(j) Account of miscellaneous work, such as the examination of Scholarship candidates, Pupil-Teachers, or teachers of any grade.

Two complete sets of any forms used by the Local Education Authority in connection with the School Medical Service should be sent to the Board together with the Report.

D.—Arrangements for Attending to the Health and Physical Condition of School Children.

7. In paragraphs 14 to 17 of Circular 576 reference was made to schemes, for the amelioration of the evils revealed by medical inspection, which might be submitted for the sanction of the Board under the latter part of section 13 (1) (b) of the Act of 1907. The Board are, of course, aware that neither they nor any other body are at present in a position to make any definite and final pronouncement as to the legitimate scope of such schemes or the conditions which will ultimately be found to govern their usefulness, nor have they any desire to anticipate the experience, extending over several years, which alone can afford a sound basis for the organisation of this work. It may be convenient, however, that they should indicate the order in which, in the Board's opinion, it is desirable that the Local Education Authority should consider the various methods and measures which are open to them in the exercise of the powers conferred by the section in question. Before sanctioning schemes involving large or unusual applications of the Authority's powers, the Board will satisfy themselves that full use has been made of the ordinary and less ambitious means available.

(a) *Improvement of the School Arrangements.*—The School Medical Officer will doubtless furnish the Local Education Authority with valuable advice as to improvements which can be made in the use of old school premises and in the design of new school premises for improving the health of the children educated in them. For instance, he will note and report to the Authority cases in which the ventilation of schools is defective, either as regards the means provided or as regards the use and maintenance of those means, and, if necessary, he will supply them with the results of scientific tests. He will, of course, call attention to the physical effects of bad ventilation, such as the prevalence of headaches, lassitude, and debility among the scholars, when they come under his notice. He will observe and report instances of bad positions in sitting and unsuitable design of desks or benches. As regards cases of defective eyesight, he will indicate such measures as can be taken to remedy or mitigate the defects by altering the position of the children in the class, or improving the lighting of the school in amount or direction, and he will call attention to the strain imposed on eyesight by the use of too small type in text books, the teaching of very fine sewing, &c. He will also be able to estimate the effectiveness of lessons on the subject of personal hygiene given in the school, and may be able to suggest improvements in the curriculum or in the methods of giving such lessons and bringing their importance home to the children. He may also be able to institute comparisons

between school and school in respect of the effect of physical exercises, and, in the case of children of weakly physique, he may be able to indicate the kind and amount of physical exercises which are suitable for them. He will observe the effect of holding classes in the open air, and call attention to cases in which the adoption of this arrangement is desirable. He will also be able to suggest to what extent and in respect of what children advantage should be taken of the facilities afforded by Article 41 (g) of the Code of 1908 for improving the health and physical condition of the children, by means of open air schools, school camps, &c., and, in cases where facilities exist for baths and swimming, he will sometimes find occasion to recommend a more extensive use of such facilities. And the beneficial influence of the School Medical Officer will not be exhausted even when he has done everything included in this formidable catalogue. The mere fact that the services of a specially skilled officer and staff are devoted by the Local Education Authority to the oversight of all matters affecting the health of the children in their Public Elementary Schools gives to the whole question of school hygiene a dignity and importance which cannot but produce a considerable effect on the minds of teachers, parents and children alike. From this point of view the School Medical Officer should be not merely a functionary charged with specific duties, but a pervading influence making, in the long run, for better hygienic conditions in the school and in the home.

(b) *Exercise of Powers under Special Acts relating to School Children.*—Medical inspection will probably indicate the necessity of having recourse to the Blind and Deaf Children Act, 1893, and the Defective and Epileptic Children Act, 1899, in the case of a considerable number of children who are at present educated in ordinary Public Elementary Schools. It will emphasise the desirability of taking advantage of the wide scope of the last-mentioned Act by establishing or contributing to the establishment of special schools or classes for physically, as distinguished from mentally defective children. It will also furnish the Local Education Authority with valuable information as to the necessity of exercising their powers under the Education (Provision of Meals) Act, 1906, and as to the best methods and effects of such exercise. It is extremely desirable that the School Medical Officer should be closely associated with this last-mentioned work wherever it is undertaken, though it is of hardly less importance that the methods adopted should be such as will secure the greatest educational effect in respect of the manners and conduct of the children concerned, as well as the best physical results.

(c) *Co-operation with the Sanitary Authority.*—Although the Act of 1907 has to some extent the effect of conferring on a Local Education Authority powers concurrent with those which it exercises as Sanitary Authority (or which in the case of a county are exercised by the authorities of the local sanitary areas in the county) it is extremely important that full use should be made of the powers exercisable in the latter capacity, and it is hoped that the special powers of medical inspection conferred on the Education Authority may have the result of greatly extending the influence and scope of the work hitherto performed solely by the Sanitary Authority. In such matters as the cleansing of persons, disinfection of school premises and homes, the provision and use of public baths, the enforcement of sanitary conditions in the home, or the detection or diagnosis of a prevalent disease in cases of emergency, it is expected that the Education Authority will take every opportunity of giving information to the Sanitary Authority and of invoking its assistance, whether under the general law, such as the Public Health Acts (including the Public Health Acts Amendment Act, 1907), or under special Acts, where applicable, such as the London County Council (General Powers) Act, 1907, or the Liverpool Corporation (General Powers) Act, 1908. It is, for instance, obvious, as regards infectious diseases, that a School Medical Officer who is occupied in carrying out a programme of systematic medical inspection in the schools of the area will often be unable to dislocate his programme in order to deal personally with an outbreak of infectious disease in a particular school. He must so organise his machinery that both he and the Sanitary Authority shall receive immediate information of any such occurrence (whether the disease is "notifiable" or not) by duplicate notices or otherwise, so that the matter may be dealt with effectively and without confusion at the earliest possible moment. Definite regulations should be made for this purpose.* Where the School Medical Officer is

* In this connection attention is called to the Memorandum issued in January 1908 by the Local Government Board "on the Circumstances under which the Closing of Public Elementary Schools or the Exclusion therefrom of particular Children may be required in order to prevent the spread of Disease." The subsequent issue of the Code for 1908 has rendered that Memorandum inapplicable in certain details, but its main principles remain unaltered, and close co-operation between the Education and Sanitary Authorities will obviate any risk of administrative confusion or conflict.

himself the Medical Officer of Health of a Sanitary Area no difficulty will arise, but where this is not the case it must be remembered that the ultimate responsibility for preventing the spread of infectious disease must remain with the Sanitary Authority, which is at present the sole repository of compulsory powers for closure of Public Elementary Schools of all kinds, or for exclusion of individual children from them.

(d) *Advice or Direction to Parents.*—Where medical inspection reveals any defect or malady in a particular child, the first step will naturally be to notify the parents, and, unless the ailment is a minor one which can be removed by home treatment or treatment (under the direction of the School Medical Officer) by the School Nurse, to urge upon the parent the desirability of obtaining treatment by an ordinary medical practitioner. In extreme cases of insanitary homes or conditions, the attention of the Sanitary Authority will, of course, be called to the matter.

(e) *The School Nurse.*—A School Nurse is capable of performing very useful and important functions, both in assisting in the work of medical inspection, and (under medical instructions) in applying, or showing the parents how to apply, remedies for minor ailments. Such matters as the antiseptic treatment of discharging ears, the treatment of sores and minor skin diseases, or minor diseases of the eye, such as blepharitis and conjunctivitis, the treatment of slight injuries resulting from accident, will fall within the scope of the work of the School Nurse. So far as the School Nurse can be regarded as assisting in the work of medical inspection, the sanction of the Board to her employment is not required. So far, however, as she is engaged in treating the minor ailments, or in visiting the children's homes for purposes of advice, her employment would require sanction as an "arrangement" for attending to the health and physical condition of the children. The Board would usually have no difficulty in sanctioning any well-considered scheme for this purpose.

(f) *Provision of Spectacles, &c.*—In cases where medical inspection shows that the provision of spectacles is necessary for the treatment of defective eyesight, the Board will be prepared to consider proposals from a Local Education Authority to provide suitable and inexpensive spectacles free of charge. They will, however, only sanction such an "arrangement" if they are satisfied that every endeavour will first be made to obtain the provision of the spectacles by the child's parents or by any voluntary associations which exist for the purpose. The Board will, of course, require that due precautions should be taken to secure accurate examination and appropriate prescription by qualified medical men of suitable experience.

(g) *Contributions to Hospitals, Infirmarys, Dispensaries, &c.*—Special attention should be paid to the powers referred to in the proviso to section 13 (1) of the Act, and the Board consider that, before the direct treatment of ailments is undertaken by the Local Education Authority, whether by means of a School Clinic or by themselves supplying and paying for medical treatment, full advantage should be taken of the benefits of such institutions. The Board will be prepared to entertain proposals for contributing to the funds of hospitals, dispensaries, and nursing associations, on terms of adequate advantage. Such contributions are specially desirable in the case of Eye Hospitals and Cottage Hospitals which are prepared to undertake minor surgical operations. It is permissible to include among the conditions of contribution a provision allocating a reasonable remuneration to the medical men working for such institutions. Among the associations to which contributions might properly be made are "childrens' care associations" who, by means of local sub-committees or local representatives, arrange for the individual treatment of poor school children by voluntary agencies or otherwise.

(h) *School Clinics.*—School Clinics may serve two purposes. They may be used for further and more scientific examination of cases in which medical inspection has indicated the existence of defects in a child which cannot conveniently be investigated on the premises of an ordinary Public Elementary School. For instance, the School Medical Officer may discover at his first inspection that a child is affected in respect of one or more of the particulars numbered 17 to 24 on the Schedule accompanying Circular 582, and it may be necessary for him to ascertain by further examination whether the child is fit to continue in attendance at a Public Elementary School, or whether any special precautions should be taken in the case of such a child if he continues to attend, or whether special provision should be made for his education in some other manner. Similarly, in the case of ocular defects, the detailed examination of the child may often be more expeditiously and thoroughly carried out at a School Clinic, where special appliances are available. So far as a School Clinic is used for such purposes, its establishment appears to fall within the scope of provision for medical inspection, but such a clinic should not be used merely for the purpose of enabling

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the ordinary inspection of school children to be carried out elsewhere than at the schools which they attend, nor, in ordinary circumstances, will the Board be prepared to approve, for the purposes of Article 14 (h) of the Code, attendance at a School Clinic as an inspection centre.

The establishment of School Clinics for purposes of *treatment* of defects revealed by inspection gives rise on the other hand to questions of considerable difficulty, and, before sanctioning the establishment of a School Clinic as an "arrangement" under section 13 (1) (b) of the Act, the Board will require to be furnished with detailed information as to the methods and scope of the work which it is proposed to do. They will, in particular, require to be informed—

- (i) what precautions the Local Education Authority will take to secure that only those children shall be treated in a School Clinic for whose treatment adequate provision cannot otherwise be made, whether by the parents or by voluntary associations or institutions, such as hospitals, or through the agency of the Poor Law ;
- (ii) what precise diseases and defects will be treated ;
- (iii) by whom and on what terms and conditions the treatment will be carried out and what will be its extent ;
- (iv) what is the estimated cost of the clinic in respect of buildings and equipment, maintenance and administration, and treatment, and how it is proposed to meet this cost, out of the rates or otherwise.

I am,
Sir,
Your obedient Servant,

Robert L. Morant

17th August 1908.

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Education in England and Wales and for purposes connected therewith.

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