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MEDICO-SOCIAL PROBLEMS OF EVACUATION

Dr. Walter Elliot declared the other day that the fact that the huge movement of evacuation had been carried through without injury to the public health was a "tremendous triumph." In some other aspects of the matter the triumph may be a little premature, but the evacuation is one of the most far-reaching social movements of modern times, and if it were not for the insistence of more clamorous events we should all be talking about it. Never before, except to a limited extent in pestilence, has there been any sudden mass migration in this country. Those who organized the evacuation last August were inclined to measure its success in terms of the efficiency of the transport arrangements. When, by the time war was declared, about one million children and a quarter of a million adults had been safely deposited in the reception areas there was a disposition to regard it as the first victory of the war. But this, immense undertaking as it was, was only the first deal of the cards—a strangely assorted pack dealt to largely unknown players—and the big problems had still to be solved: those, namely, of health, education, social welfare, economic policy, and, perhaps as important as any, psychological readjustment.

Complaint has been made of the indifference of parents who disregarded official appeals and kept their children in, or brought them back to, vulnerable areas. Unwise as they may have been, we are not sure that "indifference" is the right word. The family, after all, is the unit of English society, and the effect of war is to strengthen family bonds. Parents are not to be judged harshly for determining that, if calamity should approach, they will face it with their children. But the fact that, owing to the unwillingness of many of the parents, evacuation was only partial may be one reason for its success. If instead of only one-third—in London nearly one-half—of the total evacuable population under the official scheme going to the reception areas the whole three and a half millions had gone, the epidemiological and social picture might have been very different. Even so, the position in many places was complicated enough. In the reception areas of Surrey, for example, the native population of school children was almost doubled by the new arrivals, and that of the pre-school children suffered the addition of one-third.

From a medical point of view the first winter of evacuation has disappointed all forebodings. There is no need to repeat the figures showing a lessened incidence in almost all infections, as given by Dr. J. Alison Glover at the Royal Society of Medicine and reported at length in our last issue. Even the epidemics of chicken-pox and German measles which have occurred have been of an unusually mild character. Nor is it only a question of freedom from the common infections. For innumerable town children the country experience is reflected in better health and more normal growth.

At the same time a great deal has still to be learned. Billeting in privately occupied houses was accepted as inevitable in the Anderson report, owing to the great numbers concerned; but many people, disregarding financial considerations, have recommended a policy of collective accommodation in reconditioned buildings or in hutments or camps. There is a great deal to be said for regrouping families as much as possible, or even larger social units, in the reception areas, and for preserving the school unit, especially for children over 12, between whom and their foster-parents, we are told, difficulty frequently arises. The Cambridge Evacuation Survey—an admirable piece of work directed to the social and psychological aspects of the situation by a research committee, under the chairmanship of Mrs. Susan Isaacs, a well-known authority on child psychology—states that at least 2 per cent. of the children are permanently unsuitable for foster homes on account of nervous symptoms or difficulties of behaviour, and it is those who can best be dealt with in small groups of ten or fifteen. Another experience of the Cambridge Survey is that regular visits from parents (of which again there has been some complaint) have been found not to have a disturbing influence, and a suggestion is that in all evacuation areas centres should be available where parents may consult social workers about their children or other matters connected with evacuation. The social workers who are required seem to be of two classes: those who have had a general training in social service and those who have had special clinical experience of the nervous or difficult child. One of the disadvantages of the scheme as it is now working is that the teacher is too often called upon to be the social worker, a task for which he or she may not be fitted, and in any case the constraint between teacher and pupil, even outside the school, is a hindrance.

The Health Organization of the League of Nations has also been interesting itself in evacuation problems, but its reports on the subject, unavoidable in international documents, seem to be flattened out; and, of course, they lack the intimacy and experience of Cambridge. A subcommittee met at Geneva a month ago to discuss medico-social questions arising out of the movements of civil populations, not of children only. It was attended by representatives of nine countries, including Finland and Norway. The report it has produced illustrates alike the great virtue and the inherent vice of so much that has come from Geneva. It is comprehensive, and its recommendations are unexceptionable on theoretical grounds—indeed, in substance they have been followed by those concerned with evacuation in this country—but it can take no account of local conditions, which vary between different countries to an enormous extent, and

it seems to ignore the stress, the emergency, the excitement, the endless predicaments which must attend evacuation under the threat of war. It is a perfect textbook on evacuation if evacuation could be conceived as a peacetime measure deliberately adopted for some social end, with everything else at its normal. Before the transfer takes place the health authorities of the evacuation and the reception areas are urged to make preliminary arrangments to facilitate co-ordination. Liaison is to be established between the various medico-social services, especially those responsible for the reception, isolation, and medical supervision of open cases of tuberculosis, cases of infectious disease, and persons needing special care. In the reception areas there must be a great reinforcement of hospitals and other institutions, such as maternity homes, crèches, bathing establishments, and disinfection and disinfestation ovens. The prevailing sanitary standards must be improved, living accommodation inspected by qualified personnel, an adequate diet maintained by collective feeding and school canteens, and the purity of foodstuffs controlled. The report even urges as a matter of fundamental importance that so far as possible the accompanying personnel should be the same as that which had been in charge of the population transferred. This means public health officers, medical practitioners, dentists, sanitary inspectors, midwives, nurses, health visitors, social workers, and even first-aid parties.

All this, and much else, presupposes ideal conditions and long planning ahead. Evacuation is a different story with the invaders in the fjord of Oslo or the Gulf of Finland or on the plains of Warsaw. That the evacuation in Great Britain, partial as it was, and ill prepared in some respects, was unattended by calamity is due first of all to the measures taken to build up a health organization in this country, especially during the last twenty years, also to a highly developed sense of social duty, and to what we like to think as a British quality—a good-humoured acceptance of a situation and an ability to make the best of it. And, too, we were mercifully spared the threatened attack from the air.

THE CLASSIFICATION OF CAUSES OF DEATH

The Manual of the International List of Causes of Death, as adapted for use in England and Wales, Scotland, and Northern Ireland, which has just been published by the Stationery Office, is not the kind of literature a weary practitioner will turn to in leisure moments; it is emphatically of the class defined by Charles Lamb as books which are not books. Yet it would be a safe prophecy that in the next few years some medical men will draw incorrect conclusions from statistical data because they have not read the *Manual* or, at least, dipped into it. It may be that the younger generation does not turn to Lecky's *History of England in the Eighteenth Century* with the same readiness as older readers. In the fifth chapter, dealing with sanitary progress in the first half of the eighteenth century, we read that "it was noticed that from this time [the beginning of the century] the deaths from colic and dysentery decreased with an extraordinary rapidity. In each successive decennial period in the first half of the eighteenth century the annual average of deaths from this source was much less than in the preceding one, and the average in the last decennial period is said to have been little more than a tenth of what it had been in the first one." Lecky gave as his authority a brochure published by William Heberden the younger in 1801. Charles Creighton pointed out that what Heberden supposed to be dysentery, the entry "Griping in the Guts," was mainly the diarrhoea of infants, which, far from decreasing, was if anything increasing, but had been gradually transferred by the parish clerks to the heading "Convulsions." By considering the age distribution of the deaths and the curious Cox-and-Box behaviour of the two entries Heberden might have avoided the pitfall, but that would have involved a serial comparison of the statistics themselves.

The *Manual* gives definite information of changes of classification which will be made in the publications of the Registrar-General. It is not possible to mention them in detail. Thus the subheadings of Sections XI (Diseases of Pregnancy, Childbirth, and the Puerperal State) and XVII (Deaths from Violence) have been completely revised. In future much more informative subheadings will be available for serial comparisons than those of the old list. Much the most interesting change is the adoption of the certifying practitioner's preference when more than one cause of death appears on a certificate instead of following some more or less arbitrary office rule. We have referred to this more than once. In order to preserve comparability with past records this change will impose on the Office the need for publishing from time to time comparative tables showing the effect. In the text volume of the Annual Report for 1936 two examples were given—tuberculosis and cancer. The changes are not of negligible importance. Thus classification by order of statement rather than by rule would have reduced the number of deaths ascribed to cancer in 1936 by 4 per cent. The sites most affected were skin (a reduction of 15 per cent.) and breast (a reduction of 7 per cent.).

Although the *Manual* cannot be a medical practitioner's bedside book, it should be on his study bookshelf, to be consulted when the spirit moves him to write a paper—or even a letter to us—commenting on the rise (or fall) of a death rate.

WAR UNIT FOR CRANIAL SURGERY

The R.A.M.C. have approached the problem of cranial surgery in the field by constructing a mobile neurosurgical unit which is virtually self-contained. The vehicle of the unit is a motor lorry which carries a separate petrol engine and dynamo. The current which supplies the operating theatre also charges a 12-volt accumulator for the electromagnet. The equipment includes two sets of instruments, two folding operating tables with special