

Public health in crisis? Informing public health policy in Ireland, 1939- 53

Kelly Adamson, MA

Submitted for award of PhD

Supervisor: Dr Juliana Adelman

School of History and Geography

Dublin City University

December 2024

DECLARATION

I hereby certify that this material, which I now submit for assessment on the programme of study leading to the award of Doctor of Philosophy is entirely my own work, and that I have exercised reasonable care to ensure that the work is original, and does not to the best of my knowledge breach any law of copyright, and has not been taken from the work of others and to the extent that such work has been cited and acknowledged within the text of my work.

Signed: Kelly Adamson

Student number: 14485332

Date: 18 December 2024

CONTENTS

	Page
Acknowledgments	i
Abbreviations	iii
A note on terminology	v
A note on pseudonymisation	vi
List of Tables	vii
List of Figures	viii
Abstract	x
 Introduction	1
Section one: War and Health	24
 1 Firefighting in public health? Contextualising public health infrastructures 1939-53	25
1.1 Introduction	25
1.2 Workings of the Department of Local Government and Public Health	26
1.3 Finance	33
1.4 Other organisations involved in health policy negotiations	40
1.5 International influences	43
1.6 The role of the Catholic Church in health policy negotiations	45
1.7 The role of voluntary organisations in healthcare provisions	47
1.8 Developments in the post war period	53
1.9 Conclusion	58
 2 Flour, bread and efforts to reduce calcium deficiency, 1939-48	59
2.1 Introduction	59
2.2 Declining health performance in Ireland during the war	61
2.3 Public health consequences of extraction rates	65
2.4 Developments in Britain	72
2.5 Policy deliberations on flour fortification	74
2.6 Conclusion	78
 3 ‘Handicapped in our efforts’? State reactions to gastroenteritis and the ‘sick’ urban area, 1939-53	80
3.1 Introduction	80
3.2 Child and infant health during the first half of the twentieth century	82
3.3 Child and infant mortality in Ireland during the war	83
3.4 The problem of diarrhoea and enteritis	86
3.5 Public health measures and health policy deliberations	91
3.6 Educating Irish mothers	96
3.7 The ‘sick’ urban area	98
3.8 Were rural areas forgotten?	100
3.9 The Mother and Child Scheme	105

	Page
3.10 Public health oversight	107
3.11 Conclusion	109
Section two: Meaningful Populations	111
4 Who were the healthiest Irish people in the 1940s? Ireland's national nutrition survey, 1946-48	112
4.1 Introduction	112
4.2 International developments in nutrition	114
4.3 Methods of the Irish national nutrition survey	116
4.4 Class bias and the dietary survey	117
4.5 Class bias and the clinical survey	121
4.6 Results of the national nutrition survey	124
4.7 Policy implications of the survey	130
4.8 Conclusion	134
5 'He wants to go home': implications of the Mental Treatment Act, 1945	137
5.1 Introduction	137
5.2 Legacies of mental healthcare legislation abuse	139
5.3 Deteriorating conditions in Irish District Mental and Auxiliary Hospitals	145
5.4 Concurrent psychiatric developments	153
5.5 The Mental Treatment Act 1945	156
5.6 Public health oversight	161
5.7 Implications of the Mental Treatment Act	163
5.8 Conclusion	173
6 'Tuberculosis kills the young': public health approaches to tuberculosis, 1939-1953	176
6.1 Introduction	176
6.2 Historicising tuberculosis in Europe	178
6.3 Tuberculosis in Ireland during the war	181
6.4 Making a case for more resources: medical efforts	187
6.5 Making a case for more resources: charitable efforts	189
6.6 Public health interventions after the 'war proper'	194
6.7 Conclusion	207
Conclusion	209
Bibliography	223
Appendices	Page
A Relevant legislation relating to public health in Ireland, c. 1918-55	1
B The growth stages of cereals, 1954	4
C Responses to state efforts to maximise wheat supplies, 1941-42	5
D Supporting material for urban and rural infant mortality, 1939-49	7
E Supporting material for neo-natal mortality & infant mortality, 1932-46	9

CONTENTS continued

	Page
F Other mothercraft examples, c. 1936-48	10
G Access permissions and data protection measures of patient records	13
H Examples of materials transcribed from St. Conal's Hospital	22
I Supporting material for patient discharges in St. Conal's Hospital, 1939-44	24
J Leading causes of death in Ireland and in St. Conal's Hospital, 1939-44	26
K Admissions, discharges and deaths in district mental hospitals, 1929-55	28
L Supporting material for ICT in St. Conal's Hospital, Donegal, 1948-49	29
M Occupational therapy in St. Conal's Hospital, Donegal, c. 1941 & 1944	30
N Public health tuberculosis pamphlets targeting children	31
O BCG unit established in St. Ultan's Hospital, 1949	32
P 'Don't miss the bus!' & X-ray advantages public health posters, c. 1950	33

Acknowledgements

No combination of words can sum up my thanks for my supervisor and mentor, Dr Juliana Adelman. Besides introducing me to the subject many years ago, Juliana's expert insight, guidance, encouragement and efficiency throughout the PhD (and even before) has been a huge source of motivation and support. Her suggestions were always constructive and her corrections of drafts, followed by even more corrections of drafts, have greatly improved this thesis (and in fewer words, I might add). From start to finish, thank you, Juliana (and for your delicious curries).

I would also like to express my sincere gratitude to everyone in the School of History and Geography at DCU. To Professor James Kelly for his continuous guidance and support over the years, and to Dr William Murphy for giving me access to the personal diary of his uncle, John (Jack) O' Riordan. I am also deeply appreciative of Dr Susan Hegarty for her support of the 'Feeding Ireland Since the Famine' symposium in 2023. This symposium, along with many other endeavours, would not be possible without the help, generosity, and time of Gránia Shanahan. I am likewise thankful to my PhD colleagues, Noel Carolan and Michael Loughman, for their collaboration in organising the symposium. I am grateful to Anne-Marie Durkan, James Akpu, Mick Grant and my other PhD colleagues (past and present) for their assistance and for making this experience much more enjoyable (and much less serious too).

I would like to extend my appreciation to the staff of all institutions where I consulted materials. For source direction and guidance, special thanks are owed to Niamh Brennan of Donegal County Archives, to Brian Donnelly of the National Archives, to Harriet Wheelock of the Royal College of Physicians Archives, to Sarah Timmins of the Royal College of Surgeons Archives and Noelle Dowling of Dublin Diocesan Archives. Appreciation is extended to Therese Loftus, of Monaghan County Museum, and Eddie Lough, of Our Lady's Hospital, Ennis, who despite his retirement, went above and beyond in identifying alternative source materials in the absence of level one permissions. Thanks to the staffs of the National Library, Trinity College and University College Dublin Archives. I am likewise thankful for the provocative insights of Drs Catherine Corless, Brendan Kelly and Fiachra Byrne.

I would also like to acknowledge the financial support of the Government of Ireland Postgraduate Scholarship from the Irish Research Council, and the School of History and Geography's PhD Studentship in DCU, both have been instrumental in enabling me to pursue this research.

Finally, I am deeply grateful for the continuous support and encouragement of my friends and family, whom I've often neglected or been preoccupied for reasons of this research and whom, as much as I, are looking forward to me re-paying my taxes. The understanding and

ACKNOWLEDGMENTS

patience shown by those closest to me from start to finish is something I will always hold dearly. And to those, I look forward to settling my dues.

ABBREVIATIONS

<i>ARIMH</i>	<i>Annual Report of the Inspector of Mental Hospitals</i>
<i>ARRG</i>	<i>Annual Report of the Registrar-General</i>
BCG	Bacille Calmette-Guerin
<i>BJN</i>	<i>British Journal of Nutrition</i>
<i>BMJ</i>	<i>British Medical Journal</i>
<i>CE</i>	<i>Cork Examiner</i>
CMA	Chief Medical Advisor
CMO	Chief Medical Officer
DC	Dietetic Council
DDA	Dublin Diocesan Archives
<i>DÉD</i>	<i>Dáil Éireann Debates</i>
DIB	Dictionary of Irish Biography
DINC	Department of Industry and Commerce
DLGPH	Department of Local Government and Public Health
DOH	Department of Health
DOS	Department of Supplies
DTA	Department of An Taoiseach
ECT	Electroconvulsive Therapy
EPA	Emergency Powers Act
ESRB	Emergency Scientific Research Bureau
GEAC	Gastro-Enteritis Advisory Committee
HLTH	Health
HSE	Health Service Executive
ICA	Irish Countrywomen's Association
ICT	Insulin Coma Therapy
<i>IESH</i>	<i>Irish Economic and Social History</i>
<i>IH</i>	<i>The Irish Housewife</i>
IHA	Irish Housewives Association
<i>IHS</i>	<i>Irish Historical Studies</i>
<i>II</i>	<i>Irish Independent</i>
<i>IJMS</i>	<i>Irish Journal of Medical Science</i>
<i>IJMTS</i>	<i>Irish Journal of Mental Science</i>
INDC	Department of Industry and Commerce
<i>INM</i>	<i>Irish Nurses Magazine</i>
<i>IP</i>	<i>Irish Press</i>
<i>IT</i>	<i>Irish Times</i>
<i>IWW</i>	<i>Irish Workers Weekly</i>
<i>JMAE</i>	<i>Journal of the Medical Association of Éire</i>
NAI	National Archives of Ireland
NG	<i>Nenagh Guardian</i>
NHS	National Health Service
NLI	National Library of Ireland
NMRA	National Mass Radiography Association
NTS	National Tuberculosis Survey
NUIM	National University of Ireland Maynooth

List of abbreviations continued

ABBREVIATIONS

RCPI	Royal College of Physicians Ireland
RCSI	Royal College of Surgeons Ireland
RMS	Resident Medical Superintendent
RNHC	Royal National Hospital for Consumption Ireland
<i>SHM</i>	<i>Social History of Medicine</i>
TB	Tuberculosis
TCD	Trinity College Dublin
<i>TP</i>	<i>The Times Pictorial</i>
UCC	University College Cork
UK	United Kingdom
UN	United Nations
US	United States
WHO	World Health Organisation

A NOTE ON TERMINOLOGY

In this dissertation, certain terms that may seem flippant and insensitive – such as ‘mentally defective’, ‘lunatic’, ‘insane’, ‘idiot’, ‘feeble-minded’, ‘subnormal’, ‘legitimate’ and ‘illegitimate’ are used. The terms ‘mentally defective’, ‘lunatic’, ‘persons of unsound mind’ and ‘insane’ were often used interchangeably to refer to what would be considered ‘mentally ill’ by today’s standards. Meanwhile, the words ‘legitimate’ and ‘illegitimate’ in an Irish context were used to describe whether a child was born in (‘legitimate’) or out of wedlock (‘illegitimate’). These terms are historically accurate and were employed in official government debates, medical and statistical reports and newspapers at this time.

The period under examination provides an interesting insight into the evolving use of these terms, which had undergone legislative changes at (and around) the time, yet continued to be spoken by mouth, reminding us how legal changes often take time to influence the language used in practice.

In the 1931 Legitimacy Act which sought to amend the law relating to children born out of wedlock, the language is framed as below:

1. A legitimated person shall have the same rights and shall be under the same obligations in respect of the maintenance and support of himself or of any other person as if he had been born legitimate, and subject to the provisions of this Act, the provisions of any Act relating to claims for damages, compensation, allowance, benefit or otherwise by or in respect of a legitimate child shall apply in like manner in the case of a legitimated person
2. Where, after the commencement of this Act, the mother of an illegitimate child, such child not being a legitimated person, dies intestate as respects all or any of her real or personal property, and does not have any legitimate issue her surviving, the illegitimate child, or if he is dead, his issue, shall be entitled to take any interest therein to which he or such issue would have been entitled if he had been born legitimate.

In the 1945 Mental Treatment Act, words such as ‘patient’ and ‘hospital’ replaced words ‘lunatic’ and ‘asylum’.

Their use in this dissertation is to primarily reflect the prevailing attitudes of the time-period under consideration and does not indicate the candidate’s endorsement of this categorisation.

A NOTE ON PSEUDONYMISATION

In this dissertation, pseudonyms are for individuals whose names have not appeared in public records, in order to respect the anonymity and sensitivities of the patients, and of their relatives and descendants. This is in line with the conditions governing access to twentieth century patient records. This applies mainly in chapters five and six which engage with the records of Grangegorm District and Auxiliary Mental Hospital, St. Conal's District Mental Hospital and the Royal National Hospital for Consumption.

All other names are actual names as they have already appeared in official reports, newspapers and other documents within the public domain.

TABLES

	Page
0.1 Official government layout of public health services from 1947	4
1.1 Cost of the health services, 1947-48	56
2.1 Leading causes of death in Ireland, 1939-45	76
3.1 Child mortality in Ireland, 1939-49	84
3.2 Annual infant mortality rates per 1,000 in Ireland and neighbouring countries, 1930-50	86
4.1 Types of families in the national nutrition survey, 1946-48	118
4.2 Rising prices of foodstuffs in Ireland, 1939-46	129
4.3 Children's allowance rates, 1950	132
5.1 Average cost per patient in mental hospitals, 1930-40	147
5.2 Mental Hospital Committee expenditures, balances of debts and receipts, 1930-40	148
6.1 Expenditure on tuberculosis, 1922-53	196
6.2 X-ray examinations, 1951-54	203
6.3 Average age of patients on admission to Newcastle Sanatorium, 1935-57	206

FIGURES

	Page
1.1 State grant expenditure on key social services, 1931-38	28
1.2 Noël Browne, John Costello and Seán MacEntee at the 1948 election	30
1.3 James Deeny, pictured in 1944	32
1.4 Department of Agriculture appeal to farmers, 21 Apr.1945	37
1.5 Image of a 'Swap Market' in Berlin, <i>c.</i> 1948	38
1.6 New government office for the DINC and DOS, Nov.1942	39
1.7 Seán MacEntee and Seán Lemass, Dublin, 1947	40
1.8 Distribution of milk at Infant Aid Society, Dublin, <i>c.</i> 1949-50	49
1.9 CSSC staff serving meals to women and children at a food centre in Dublin, <i>c.</i> 1941-45	49
1.10 Official public health infrastructures in 1941	52
1.11 A child being examined in a routine school medical examination, <i>c.</i> 1950	54
1.12 Official public health infrastructures in 1947	55
2.1 Three children with rickets in Vienna, un-dated	66
2.2 Rickets depicted in French children, undated	67
2.3 Deaths of pulmonary TB, 1938-1944 and corresponding flour extraction rates	70
3.1 Leading causes of infant deaths under one year, 1936-46	85
3.2 Health pamphlet urging people to kill flies, 1950	87
3.3 Gastro-enteritis deaths in infants under two years of age in Ireland, 1940-48	89
3.4 Gastro-enteritis in children under two in Dublin, 1942-47	90
3.5 Case-fatality rate in children under two in Dublin, 1942-47	90
3.6 Legitimate and illegitimate infant mortality rate per 1,000 live births, 1939-1949	108
3.7 Ages at death in Irish institutions, 1940	109
4.1 Average weekly consumption of food in families in Dublin, 1946	126
4.2 Average weekly consumption of food in families in Large Towns, Oct. 1946-May 1947	127
4.3 Average weekly consumption of food in Farming Families and Farm Workers' Families, Oct. 1946-Sept. 1948	127
5.1 Patients in Irish district & auxiliary mental hospitals, 1926-55	145

List of figures continued

FIGURES

	Page
5.2 Expenditure, outstanding loans and capitation grants for Irish mental hospitals for the years ending 31 Mar. 1930-40	149
5.3 Grounds of discharge in St. Conal's hospital, 1939-44	150
5.4 Deaths and discharges in St. Conal's hospital, 1939-44	152
5.5 Age-groups of patients discharged from St. Conal's hospital, 1939-44	152
5.6 Comparisons of causes of death in Ireland and in St. Conal's hospital, 1939-44	153
5.7 Admissions, deaths and discharges into Irish district and auxiliary mental hospitals, 1933-55	163
5.8 Types of admissions into Irish district and mental hospitals, 1947-55	163
5.9 Physical treatments in St. Conal's hospital, May 1948-Dec.1949	167
5.10 Number of physical treatments in St. Conal's hospital, May 1948-Dec. 1949	167
5.11 Ectron ECT machine used in St. Davnet's hospital, Monaghan, c. mid-1940s	169
5.12 A close-up of universal controls: an ammeter, a voltmeter and a timer	169
5.13 Percentage of discharges to admissions in St. Conal's hospital, 1938-50	173
6.1 Deaths from tuberculosis (all forms) in Ireland between 1922-55	179
6.2 Operating theatre used in the Royal National Hospital for Consumption, 1936	186
6.3 Childhood TB deaths (all forms) in Dublin city, 1939-45	187
6.4 Type of TB deaths in Dublin city, 1939-45	188
6.5 A child receiving the BCG vaccine in Dublin Corporation, 1949	200
6.6 Example of the X-ray coach that was developed, c. 1954	202
6.7 The new X-ray 70mm films being read by the processing team in Dublin	204
7.1 Deaths from cancer, heart disease, TB and infant mortality, 1942-62	220

ABSTRACT

Author: Kelly Adamson

Student number: 14485332

Thesis title: Public health in crisis? Negotiating public health policy in Emergency Ireland, 1939-55.

Some of Ireland's most significant public health issues were addressed between 1939 and 1955 and yet this period, beyond neutrality and supply politics, has received little historical attention. Despite Ireland's neutrality during the Second World War (1939-45), the war created a severe economic squeeze situation. Examining health policy, and negotiations about policy reveals where the pressure points were.

This thesis examines five case studies, chosen due to their significance in government action:

1. Fortification of flour with calcium
2. Rise in diarrhoea and enteritis among infants
3. Implementation of the national nutrition survey
4. Introduction of the Mental Treatment Act 1945
5. New measures to combat tuberculosis

While historiography identifies this period as a crucial turning point for addressing infant mortality, mental illness, infectious disease and to a lesser extent, malnutrition, these accounts often overlook that consecutive Irish governments were not singularly focused on any health problem alone during the Emergency period. Studies focusing on diseases often appear in isolation, thus missing the importance of the interaction between initiatives occurring at the same time with many of the same people involved. Contrary to stand-alone histories on individual diseases in Ireland, this thesis demonstrates that Ireland experienced health crises across all these areas.

More babies died in Ireland during the war than before. Families also experienced food measures that fundamentally impacted their nutrition. Raising flour extraction rates stretched flour supplies but contributed to a rickets epidemic. Calcium deficiency, linked to the flour, further implicated rising bone and joint tuberculosis mortality among children. Simultaneously, Ireland's unusually high per-capita institutionalisation of the mentally-ill suggested a health system not fit for purpose, conflicting with Ireland's desire to appear progressive on the world stage.

Heart disease, cancer and senility accounted for half of all deaths but received less attention. This thesis also demonstrates that a key factor in negotiating policy rested with the Health Department's ability to produce tangible evidence of the increase of disease. Some of these issues were addressed because of wartime aggravation, whereas others reveal the Irish state's interest in the health of particular populations, especially in that of the youth and the *deserving* poor, at this time.

This research is the first to place health actions and diseases side-by-side. Asking how enthusiasm for addressing one disease might impact efforts to eradicate another gives insight to the balancing act of public health. Then, as now, there is often a tug-of-war between 'rescue' and 'preventative' measures.

INTRODUCTION

Some of Ireland's most pressing public health issues were addressed between 1939 and 1953 and yet historiographic coverage of public health in Ireland at this time is surprisingly lacking.¹ Writing in 1959, Brendan Hensey provided the first concrete overview of the development of the Irish health services.² Hensey joined the civil service in 1938 where he was assigned to the public health division of the Department of Local Government and Public Health.³ He was later transferred to the newly established Department of Health in 1947, where he served at all levels until he became secretary in 1973.⁴ He opened his book with a very concise definition of the health services: 'Health services', may be 'defined as those services under which public authorities arrange for the diagnosis, prevention, and treatment of human illness'.⁵

The story of the [health] services in the twentieth century falls naturally into two parts, that for the period up to the end of the Second World War and the developments since then.⁶

Nonetheless, few other historical works have focused on the Second World War and its aftermath as a turning point in Irish health services.

Other works have also traced wider developments in health reforms during the twentieth century. Writing in 1987, Ruth Barrington sought to explain the origins of 'one of the best health services in the world'.⁷ Like Hensey, Barrington was also writing from within the Department of Health, although Barrington's work adopts a more explicit historical lens. Both works traced a growing appetite for significant public health reform in Ireland throughout the twentieth century. Joseph Robins' rather celebratory compilation, *Reflections on health: commemorating fifty years of the Department of Health 1947-1997* (1997), echoes these sentiments.⁸ So too does Laurence Geary's observation in *The Irish healthcare system: an historical and comparative review* (2018), which explains how the mid-Victorian emphasis on individualism and self-help changed to a growing demand for the state to accept more responsibility for public health by the beginning of the twentieth century.⁹ Liam Delaney, Mark McGovern and James P. Smith

¹ References to Ireland in this thesis relate to the twenty-six counties when the Irish Free State was established in December 1922, which now comprises the Republic of Ireland. Ireland was officially declared a republic in 1949 following the Republic of Ireland Act 1948. See Republic of Ireland Act, 1948 (1948 no. 22) (21 Dec. 1948).

² Brendan Hensey, *The health services of Ireland* (2nd ed., Dublin, 1972).

³ Diarmaid Ferriter, 'Hensey, Brendan Joseph' in *Dictionary of Irish Biography (online)* (hereafter *DIB*), DOI: <https://doi.org/10.3318/dib.003952.v1>.

⁴ *Ibid.*

⁵ Hensey, *The health services*, p. 11.

⁶ *Ibid.*, p. 1

⁷ Ruth Barrington, *Health, medicine and politics in Ireland, 1900-1970* (Dublin, 1987), p. vii.

⁸ Joseph Robins (ed.), *Reflections on health: commemorating fifty years of the Department of Health 1947-1997* (Dublin, 1997).

⁹ The Health Insurance Authority, *The Irish healthcare system: an historical and comparative review* (Dublin, 2018), p. 20.

note that life expectancy rose on average of three years per decade in the twentieth century, while morbidity rates also declined.¹⁰ The age at onset of serious chronic illnesses also increased substantially, meaning that people could expect to live longer lives.¹¹ Improved conditions in childhood equipped many people with better health as adults.¹² Life expectancy also rose because of the sharp decline in infant mortality rates in Ireland from the mid-1940s onwards.¹³ Legislative changes that were introduced from the 1947 Health Act (which were amended in the 1953 Health Act) as well as increased state investment in health services, also played crucial roles.¹⁴ Miriam Wiley demonstrates that the commitment of state resources to health services increased substantially from 1947 to the point where this item, by 1997, accounted for one of the largest items of public expenditure.¹⁵ These developments were complimented by significant breakthroughs in medicine.¹⁶

The Second World War also marks a turning point in how healthcare was organised and funded. Virginia Crossman and Donnacha Seán Lucey's edited volume highlights the importance of a variety of different interests and stakeholders in the provision of public health resources, offering new perspectives of the relationship between state and voluntary healthcare in Ireland and Britain.¹⁷ Before 1947, when separate Departments of Social Welfare and Health were established, the Department of Local Government and Public Health was responsible for a wide range of public services. These included overseeing local government functions, public health, poor relief, the care of the mentally-ill (including mentally-ill criminals), health insurance, elections, maintenance and construction of public roads, and the registration of births deaths and marriages.¹⁸ In practice, this meant the department played an instrumental role in the coordination and supervision of road construction, housing and healthcare developments, and most of the country's social welfare programmes.¹⁹

Until 1947, local authorities were responsible for implementing public health services on the ground. Health services were funded through local rates with limited aid from state grants. The flaws of this system were seen where there were significant discrepancies in

¹⁰ Liam Delaney, Mark McGovern and James P. Smith, 'From Angela's Ashes to the Celtic Tiger: early life conditions and adult health in Ireland' in *Journal of Health Economics*, xxx, no. 1 (2011), p. 1.

¹¹ Ibid.

¹² Ibid.

¹³ Ibid.

¹⁴ Ibid.

¹⁵ Miriam Wiley, 'Financing the Irish health services: from local to centralised funding and beyond' in Joseph Robins (ed.), *Reflections on health: commemorating fifty years of the Department of Health, 1947-1997* (Dublin, 1997), p. 219.

¹⁶ Hensey, *The health services*, p. 1.

¹⁷ Donnacha Seán Lucey and Virginia Crossman note how voluntarism, central-local politics and the role of religion were key to shaping developments in healthcare in Ireland. See Lucey and Crossman (eds), *Healthcare in Ireland and Britain, 1850-1970: healthcare in Ireland and Britain from 1850: voluntary, regional and comparative perspectives* (London, 2014), p. 3.

¹⁸ Ministers and Secretaries Act, 1924 (1924, no. 16) (21 Apr. 1924).

¹⁹ Mary E. Daly notes how unemployment insurance was handled by the Department of Industry & Commerce, see Daly, *The buffer state: the historical roots of the Department of the Environment* (Dublin, 1997), p. 20.

healthcare opportunities by area.²⁰ These discrepancies were exacerbated by wartime conditions. Dramatic increases in the incidence of infant and tuberculosis (TB) mortality in urban areas saw mortality rates in Ireland climb higher than most other Western nations.²¹ Meanwhile, food shortages – the most visible sign of wartime adversity experienced in Ireland, led to an increased incidence of malnutrition. This culminated in severe epidemics of rickets in Irish children.²² Existing conditions in mental health hospitals also deteriorated where unchecked overcrowding led to a substantial increase in the incidence of infectious disease.²³ Infant mortality, food and nutrition, tuberculosis and the institutionalisation of the mentally ill emerged as four key concerns of Irish health authorities between 1939 and 1953. The importance of these is reflected in the structural layout of the health services from the Health Act 1947 (see table 0.1). The health provisions that were introduced by successive Irish governments thereafter sought to prioritise these core issues over other problems like heart disease, cancer and senility. Why did these health care measures gain prominence over others at this time? No one has answered this question.

Incidentally, the war created a crisis situation in Ireland and this provides a useful window for historical research on the development of Ireland's public health policy. Economic crises, like that experienced in Ireland during the war, can challenge states by forcing them to reduce expenditure.²⁴ In such scenarios, there is a tendency for governments to pursue reforms that are based on containing costs where possible while trying to enhance their efficiency.²⁵ Health systems depend on budgets, which usually encourage better cost containment, but which also limit their activities.²⁶ In other words, states may look to get 'more with less'.²⁷ As this dissertation will demonstrate, health policies were very much shaped by the supply situation during the war and economic factors after it.

²⁰ Wiley, 'Financing the Irish health services', p. 210.

²¹ For figures on infant mortality, please see *Annual Report of Registrar General, 1933-49* (hereafter *ARRG*), (Dublin, 1950), pp xxxii-xxxiii. Data taken for consecutive years. For figures on tuberculosis, see James Deeny, *Report of the National Tuberculosis Survey, 1950-1953* (Dublin, 1954), p. 27.

²² *Cork Examiner* (hereafter *CE*) 16 July 1943. Also see Department of Health (hereafter DOH), *National nutrition survey: parts i-viii: complete reports on dietary and clinical surveys* (Dublin, 1953).

²³ For detail on rising numbers in institutions, see consecutive years, *Annual report of the Inspector of Mental Hospitals 1955* (hereafter *ARIMH*) (Dublin, 1956). Tuberculosis was the second leading cause of death in St. Conal's Mental Hospital during the war period. See *Registrar of Discharges and Deaths in St. Conal's District Asylum, 1921-1946* (MED 4/5/5/2).

²⁴ Lorraine Frisina Doetter and Ralph Götze, 'Health care policy for better or for worse? Examining NHS reforms during times of Economic Crisis versus relative stability' in *Social Policy & Administration*, xlv, no. 4 (2012), p. 488.

²⁵ *Ibid.*

²⁶ *Ibid.*, p. 492.

²⁷ Sara Burke, Steve Thomas, Sarah Berry and Conor Keegan, 'Indicators of health system coverage and activity in Ireland during the economic crisis 2008-14, from 'more with less' to 'less with less', in *Health Policy*, cxvii (2014), pp 275-278.

INTRODUCTION

Health Service	Operated by
Public Assistance Service (includes medical assistance for the poor and the care of the destitute and aged).	Public Assistance Authorities i.e, Dublin, South Cork Boards of Assistance, Limerick Corporation and County Councils
The Tuberculosis Service	Health Authorities i.e., County Councils and County Borough Corporations
The Mother and Child Service	
The Infectious Disease Service	
Food Control Measures	
The Mental Health Service	Mental Hospital Authorities, which were either County Councils or Joint Boards which were established by two or more County Councils/Corporations

Table 0.1 Official government layout of Ireland’s public health services from 1947.²⁸

Crisis situations are also useful because they provide clear indications of where the pressure points of public health were, and so too, where government priorities lay. In their analysis on National Health Service (NHS) reforms, Lorraine Doetter and Ralph Götze argue that while severe economic crises can establish windows of opportunity for change, the ‘interaction of system-specific deficits and the role of ideas and political factors’ predominantly condition both the timing and content of state reforms.²⁹ In other contexts, economic crises can ‘stress the need for reforms without actually driving them’.³⁰ In normal times, certain socioeconomic groups are already at risk of having worse health than others.³¹ During bad economic times, these risks can be severely compounded. This was the case in Ireland during the Second World War.³²

Previous works on childhood illness, mental illness, TB, and, to a lesser extent, on malnutrition have focused on the diseases themselves rather than the process by which they

²⁸ Department of Health (hereafter DOH), *Health Progress, 1947-53* (Dublin, 1953), p. 4.

²⁹ Doetter and Götze, ‘Health care policy for better or for worse?’, p. 488.

³⁰ Ibid., p. 501.

³¹ Kai-Lit Phua, ‘Can we learn from history? Policy responses and strategies to meet healthcare needs in times of severe economic crisis’ in *The Open Public Health Journal*, iv (2011), p. 2.

³² Ibid.

came to government attention. There are many histories of disease in Ireland, most notably Elizabeth Malcom and Greta Jones' *Medicine, disease and the State in Ireland, 1650-1940* (1999) and Catherine Cox and Maria Luddy's edited volume on *Cultures of care in Irish medical history, 1750-1970* (2010).³³ The lack of scholarly scrutiny of the evolution of Irish health policy is peculiar in a comparative context given the attention it commands in other western countries at a time when there was a distinct shift toward the centralisation and the expansion of health services. For example, Britain's NHS was established on 5 July 1948 on the premise of 'health for all'.³⁴ Similar initiatives occurred in Italy, the Scandinavian countries, New Zealand and the US.³⁵ In Central Western Europe, Canada and Japan, a 'Bismarckian' system emerged post-war, where public and private providers offered access to healthcare via health insurance, while those without employment were guaranteed health insurance by the state.³⁶ Despite this, studies focusing on Ireland are symptomatic of wider trends within Irish historiography that focus on in-depth histories of individual diseases and medical disciplines, and not on the public health policies and decisions reacting to and informing them.

Though rich additions to Irish historiography, the above mentioned studies do not take into account the reality that the Irish government was not focused on singular health problems between 1939 and 1953. Instead, it tackled many things at once, all against the backdrop of wartime financial constraints. This dissertation addresses this gap: how were Irish public health services formulated between 1939 and 1953, who did they target and what impact did these health policies have on the lives of Irish people? This thesis will confirm that the period between 1939 and 1953 was crucial to the development of public health in Ireland and that consecutive Irish governments concentrated on addressing infant mortality, nutrition, tuberculosis, and the institutionalisation of the mentally-ill in their health policy. Some of these were addressed because the war intensified the problem whereas others reveal the Irish state's interest in the health of particular populations, especially in that of the youth and the poor, at this time. This introduction first reviews the relevant historiography concerning public health narratives in Ireland and beyond before explaining the structure of this thesis, and highlighting pertinent themes for exploration.

³³ Elizabeth Malcom and Greta Jones (eds), *Medicine, disease and the state in Ireland, 1650-1940* (Cork, 1999); Catherine Cox and Maria Luddy (eds), *Cultures of care in Irish medical history, 1750-1970* (London, 2010); Anne MacLellan and Alice Mauger (eds) *Growing pains: childhood and illness in Ireland* (Dublin, 2013).

³⁴ Martin Gorsky, 'The British National Health Service 1948-2008: a review of the historiography' in *Social History of Medicine* (hereafter *SHM*), xxi, no. 3 (2008), p. 438.

³⁵ Ibid. For developments in America, see John Duffy, *The sanitarians* (Illinois, 1992); John W. Ward and Christian Warren (eds), *Silent victories: the history and practice of public health in twentieth century America* (Oxford, 2007).

³⁶ Janina Kehr, Jacinta Muinde and Ruth J. Prince, 'Health for all? Pasts, presents and futures of aspirations for universal healthcare' in *Social Science & Medicine*, cccxix (2023), p. 3.

Key public health definitions and backgrounds

Before moving to these discussions, it is necessary to define the terms ‘health’ and ‘public health’. Though it may seem obvious, there are various definitions of ‘health’ and ideas of ‘being healthy’. These are often influenced by one’s own knowledge, experience and values.³⁷ This may also include people’s views of what ‘they are expected to do in their everyday lives, and the fitness they need to fulfil that role’.³⁸ In this way, the word ‘health’ itself is layered and contested.³⁹ On the one hand, it can be interpreted as the absence of disease.⁴⁰ Historically, our concept and measurement of health has focused for the most part on ill-health.⁴¹ Such an explicit focus on pathology likely arose from the fact that for ‘most of human existence’ the biggest health problem that societies faced was in ‘overcoming disease’.⁴² In this view, when we say someone’s health is not good, we think that they are suffering from an identifiable disease. Similarly, when we say a person’s health is good, we have in mind that they are not suffering from any serious illnesses.⁴³ In this view, ‘the healthy are those who are not biologically disadvantaged’.⁴⁴ This in turn created new problems in defining ‘disadvantaged’, which usually included shortened life spans and reduced fertility.⁴⁵ It also encouraged thinking on only two distinct categories, the healthy and the sick.⁴⁶ The targeted populations of any public health policy also means that ‘the healthy’ and ‘the sick’ are differentiated. Health may also be measured against one’s fitness and vitality.⁴⁷ In this view, health could also be defined according to one’s abilities where ‘health is being able to do things’.⁴⁸ In this perspective, one’s ill-health refers to one’s incapacity and this may be caused by the presence of disease, an accident, degeneration associated with aging and so forth.⁴⁹ However, there was a distinct shift in the ‘health problem’ by the middle of the twentieth century.⁵⁰

The most well-known definition of health was coined by the World Health Organisation (WHO) in April 1948 who defined ‘health’ as ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’.⁵¹ Though this may seem

³⁷ Rob Baggot, *Public health policy and politics* (Basingstoke, 2010), p. 1.

³⁸ Ibid.

³⁹ Ibid.

⁴⁰ Ibid.

⁴¹ Lester Breslow, ‘A quantitative approach to the World Health Organisation definition of health: physical, mental and social well-being’ in *International Journal of Epidemiology*, i, no. 4 (1972), p. 347.

⁴² Ibid.

⁴³ Ibid.

⁴⁴ Mildred Baxter, *Health* (2nd ed., Cambridge, 2010), p. 5.

⁴⁵ Ibid., p. 6.

⁴⁶ Ibid., p. 16.

⁴⁷ Baggot, *Public health policy*, p. 1.

⁴⁸ Ibid., p. 8.

⁴⁹ Ibid., p. 9.

⁵⁰ Breslow, ‘A quantitative approach to the World Health Organisation definition’, p. 347.

⁵¹ WHO, *Summary reports on proceedings minutes and final acts of the International Health Conference held in New York from 19 June to 22 July 1946*, (<https://apps.who.int/iris/handle/10665/85573>) (Accessed 8 Mar. 2024).

uncontroversial today, this was revolutionary in 1948 against a context marked by fervent anti-communism.⁵² Authored by League of Nations veteran Raymond Gautier, this definition drew heavily on the work of medical historian Henry E. Sigerist's book *Socialised Medicine in the Soviet Union* (1937).⁵³ It was Sigerist who originally coined the phrase that health is more than the absence of disease.⁵⁴ This definition was also symptomatic of the coming of 'positive health' definitions which were emerging mid-century when society's problem 'no longer consisted solely, or even largely, of being threatened by early death or specific diseases' because so much had been overcome through social measures and breakthroughs in medical science.⁵⁵

Instead, definitions of health focused more on the maintenance of health and its required constituents as opposed to combatting disease. To this end, the WHO's definition has been criticised for its utopian outlook. Common objections included the use of the word *complete* in its definition which seemed to suggest a condition of near 'perfect health'.⁵⁶ However, one may also interpret the WHO's definition holistically, whereby *complete* well-being may be understood as having every constituent for maintaining one's well-being – physical, mental and social.⁵⁷ Regardless of which side of the argument one finds oneself in, the WHO definition led directly to statements that established 'health for all' as a fundamental human right that governments should provide through 'adequate health and social measures'.⁵⁸ This was a strong political statement advocating for the involvement of governments in healthcare at a time when there was little political consensus on precisely what form this should take.

In its simplest form, public health is concerned with the provision of healthcare for the public by the nation state. It includes health care systems, agencies and services that protect our health and environment.⁵⁹ Governments may speak of a 'public health policy' for particular health problems and they may organise themselves with departments at national and local levels.⁶⁰ While everyone seems to know what public health is, there is often confusion about what it means in practice.⁶¹ With no universally agreed definition of 'health', definitions of 'health' and 'disease' may vary according to place and time. These terms play a crucial role in

⁵² Lars Throrup Larsen, 'Not merely the absence of disease: a genealogy of WHO's positive health definition' in *History of the Human Sciences*, xxxv, no. 1 (2022), p. 111.

⁵³ Ibid.

⁵⁴ Ibid., p. 124.

⁵⁵ Ibid., pp 346-48.

⁵⁶ Thomas Schramme, 'Health as complete well-being: the WHO definition and beyond' in *Public Health Ethics*, xvi, no. 3 (2023), p. 210.

⁵⁷ Ibid.

⁵⁸ World Health Organisation Interim Commission, *Official Records of the World Health Organization No. 2: Summary Report on Proceedings, Minutes and Final Acts of the International Health Conference Held in New York From 19 June to 22 July 1946* (Geneva, 1948), p. 100.

⁵⁹ Elena Andresen and Erin De Fries Bouldin, *Public health foundations: concepts and practices* (New Jersey, 2010), p. xv.

⁶⁰ Virginia Berridge, *Public health: a very short introduction* (Oxford, 2016), p.1.

⁶¹ Ibid.

determining what should and what should not be official focuses of concern.⁶² Public health may be the promotion of health and well-being of a population as a whole, the life expectancy of its members, and their resistance to and freedom from disease for ‘the common good’.⁶³ Public health can also be anticipatory – geared toward the prevention of illness among population groups rather than merely treating problems as they arise.⁶⁴ In this view, public health campaigns are aimed at vulnerable populations or specific sub-group populations such as children and the elderly.⁶⁵ This does not mean that every person in the target population benefits, but that the overall promotion of health and well-being for the common good is achieved.

International public health historiography has provided a wider international context for this research. Modern public health has its roots in the beginning of the eighteenth century with the emergence of the Industrial Revolution.⁶⁶ In Dorothy Porter’s comprehensive analysis of *Health, civilisation and the state* (2005), she traces the development of public health provision in Britain, Continental Europe and the United States (US).⁶⁷ For Porter, industrialisation made the ‘prevention of epidemics’ among workers the main focus of public health regimes.⁶⁸ Epidemiologists Elena Andresen and Erin D. Bouldin have likewise explored how industrialisation widened gaps in income, causing more people to become reliant on government assistance and thereby expanding state responsibility for its citizens.⁶⁹ Over time, this fed into sanitary reforms that based themselves around the belief that one’s environment was causing their disease.⁷⁰ Examples of ‘state medicine’ that followed included the compulsory notification of infectious diseases, the isolation of disease sufferers and their families and contact tracing.⁷¹ Graham Mooney shows how and why disease notification came about in Britain between 1840 and 1914.⁷² Mooney’s work is strategically positioned between ‘the great age of sanitary engineering in the mid-nineteenth century and a supposed ‘new’ public health in the early twentieth’.⁷³ He traces a distinct shift from the sanitary public health movement toward the ‘medical management of dangerous individuals’ – an area where the rights of the public and the

⁶² H. Tristan Engelhardt Jr., ‘The concepts of health and disease’ in H. Tristan Engelhardt Jr. and Stuart F. Spicker (eds), *Evaluation and explanation in the biomedical sciences* (Michigan, 1975), p. 125.

⁶³ Berridge, *Public health*, pp 1-3.

⁶⁴ *Ibid.*, p. 2.

⁶⁵ Muireann Quigley and John Harris, ‘Personal or public health?’ in Michael Boylan (ed.), *International public health policy and ethics* (New York, 2008), p. 17.

⁶⁶ Elena Andresen and Erin de Fries Bouldin, *Public health foundations: concept and practices* (New Jersey, 2010), p. 9.

⁶⁷ Dorothy Porter, *Health, civilisation and the state: a history of public health from ancient to modern times* (London, 2005).

⁶⁸ Porter, *Health, civilisation and the state*, p. 164.

⁶⁹ Andresen and Bouldin, *Public health foundations*, p. 9.

⁷⁰ Porter, *Health, civilisation and the state*, p. 164.

⁷¹ Graham Mooney, *Intrusive interventions: public health, domestic space, and infectious disease surveillance in England, 1840-1914* (Rochester, 2015); ‘A menace to the public health’ – contact tracing and the limits of persuasion’ in *The New England Journal of Medicine*, cclxxxiii, no. 19 (2020), pp 1806-1808.

⁷² Mooney, *Intrusive interventions*, p. 5.

⁷³ *Ibid.*, p. 6.

rights of individuals often conflicted.⁷⁴ Findings in bacteriology that led to the emergence of vaccines and new therapies for specific diseases also encouraged new ways of thinking about public health.⁷⁵ Over time, these developments meant that state efforts could be made to measure the strength of a nation in terms of the health of its subjects.⁷⁶

State concerns over population quality and quantity, not least bolstered by the huge loss of life in Europe during both wars, have attracted substantial academic enquiry across Europe. These concerns fed into prevailing public health rhetoric in different ways. In his analysis of *Modernism and eugenics* (2010), Marius Turda outlines that Europe experienced profound territorial, national and social transformations between 1870 and 1940, each carrying with them a wide range of political systems in quick succession.⁷⁷ This publication marks a distinct shift away from *eugenicist totale* histories which were previously told through the 'Nazi prism of social hygiene'.⁷⁸ In his book, he argues that eugenics was part of a much bigger bio-political agenda that included racial and social hygiene, public health and family planning.⁷⁹ This in turn was complimented by wider investigations into new connections between population questions and policies that extended beyond Germany as well as their relationship between public health and nationalism. In global terms, concerns about a declining birth rate preoccupied many nation states.⁸⁰ Even before the outbreak of First World War (1914-18), eugenicists in Britain sought to hide away the 'feeble-minded', alcoholics and women who gave birth to illegitimate children.⁸¹ Porter observes that some even flirted with the idea of a 'lethal chamber' for society's unwanted, though the most profound expression of this occurred in Germany during the Second World War which saw the killing of Jews, criminals, Gypsies, mentally-ill and dissenters.⁸² Similar explorations have also been carried out with regard to US policies surrounding marriage, sterilisation and immigration.⁸³ However, there were also positive applications.

Fears about population degeneration and differential population groups in Sweden at the start of the twentieth century gave impetus to 'social hygiene' where aims to minimise TB, venereal disease, alcoholism and poor living conditions became linked to the health of workers, soldiers, mothers and their children.⁸⁴ Elsewhere in Europe, many countries saw the establishment of ante-natal and baby clinics, school inspection services, provision of school

⁷⁴ Ibid.

⁷⁵ Berridge, *Public health*, p.4.

⁷⁶ Porter, *Health, civilisation and the state*, p. 164.

⁷⁷ Marius Turda, *Modernism and eugenics* (New York, 2010), p. 2.

⁷⁸ Ibid., p. 1.

⁷⁹ Ibid., p. 2.

⁸⁰ Lindsey Earner-Byrne, *Mother and child: maternity and child welfare in Dublin, 1922-1960* (Manchester, 2007), p. 3.

⁸¹ Porter, *Health, civilisation and the state*, p. 168.

⁸² Ibid., p. 168.

⁸³ Ian R. Dowbiggin, *The sterilization movement and global fertility in the twentieth century* (Oxford, 2008).

⁸⁴ Porter, *Health, civilisation and the state*, p. 174.

meals and family allowances in the 1930s and 1940s.⁸⁵ The twentieth century was also notably referred to as the ‘century of the child’.⁸⁶ With the interests of children and their welfare and well-being occupying a significant place in social policy, legal, medical and educational institutions across Europe, Allison James and Alan Prout argue that at no other time in history has the profile of the child been more examined.⁸⁷ These were not only designed to make motherhood easier and the lives of babies and infants safer, but they contributed to a wider demographic debate about national efficiency and what nation states perceived as integral to the construction and maintenance of their national futures – their children.⁸⁸

Similar initiatives also occurred in Ireland, but they had their own manifestations for different reasons.⁸⁹ Just like in Britain, the ‘feeble-minded’, alcoholics and illegitimate children were hidden away in state and religious-run institutions. For example, anyone deemed ‘dangerous’ or unfit for normal social roles could be admitted to Irish district mental hospitals on the basis of the evidence submitted by someone else.⁹⁰ As a result, the widely accepted belief that insanity was highly prevalent in Ireland remained largely unchallenged.⁹¹ This only occurred in the 1940s – when many European nations, except Ireland and a few other neutral countries, were at war.⁹² Instead, consecutive Irish governments embarked on a path which took them in a very different direction.

In his research on the Catholic Church in Ireland, Daithí Ó Corráin argues that aside from the absence of an anti-clerical left wing in Ireland, the Catholic Church not only played a key role in Ireland’s struggle for independence, but it played a crucial role in Ireland’s subsequent state-building project.⁹³ The ‘problem of the unmarried mother and her child’ became even more significant in post-independent Ireland as Catholic doctrines, particularly in the areas of family relations and sexual morality were made law.⁹⁴ From the report on the *Commission on relief*

⁸⁵ Ibid., p. 172.

⁸⁶ Allison James and Alan Prout (eds), *Constructing and reconstructing childhood: contemporary issues in the sociological study of childhood* (London, 2015), p. 1.

⁸⁷ Ibid. Recent urban histories have also explored urban planning and children’s needs, see Veera Moll and Hanna Kuusi, ‘From city streets to suburban woodlands: the urban planning debate on children’s needs, and childhood reminiscences, of 1940s-1970s Helsinki’ in *Urban History*, xlviii (2021), pp 125-142.

⁸⁸ Porter, *Health, civilisation and the state*, p. 187. For reading around children and nationalism, see Sharon Stephens, ‘Editorial introduction: children and nationalism’ in *Childhood*, iv, no. 4 (1997), pp 5-17.

⁸⁹ Ciara Boylan and Ciara Gallagher’s edited volume explores how children were ‘constructed’ by various actors (the state, church, youth organisations, charities etc.) See Boylan and Gallagher (eds), *Constructions of the Irish child in the independence period* (Basingstoke, 2018).

⁹⁰ Oonagh Walsh, ‘Cure or custody: therapeutic philosophy at the Connaught District Lunatic Asylum’ in Margaret H. Preston and Margaret O’hÓgartaigh (eds), *Gender and medicine in Ireland, 1700-1950* (New York, 2012), p. 70.

⁹¹ Brendan Kelly, *Hearing voices: the history of psychiatry in Ireland* (Dublin, 2016), p. 64.

⁹² Ibid., p. 64.

⁹³ Daithí Ó Corráin, ‘Catholicism in Ireland, 1880-2015: rise, ascendancy and retreat’ in Thomas Bartlett (ed.), *The Cambridge History of Ireland: 1880-Present* (Cambridge, 2018), p. 711.

⁹⁴ *Report of the commission on relief of the sick and destitute poor including the insane poor* (Dublin, 1927), p. 68. Also see Ó Corráin, ‘Catholicism in Ireland’, p. 718; Thomas Walsh, ‘Constructions of childhood in Ireland in the twentieth century: a view from the primary school curriculum, 1900-1999’ in *Child Care in Practice*, x, no. 2 (2005), pp 253-269.

of the sick and destitute poor including the insane poor (1927), there were two classes of unmarried women to be provided for, namely, those first-offenders who may be amenable to reform, and those who were ‘regarded as less hopeful cases’.⁹⁵ Beyond institutions, the concept of a ‘healthy mother’ was predominantly defined as a married woman who was responsible for ensuring her child’s well-being. This idea was reflected in the 1937 Constitution of the Irish Free State, which designated the Irish mother as the ‘primary caregiver’.⁹⁶ In line with this, Irish mothers became the focus of public health efforts that sought to reduce infant mortality and improve child health. This approach aligned with earlier typical voluntary charitable initiatives.⁹⁷ Rather than fundamentally re-working the system, the Irish Free State initially chose to maintain the status quo by backing existing structures and health strategies, thus reinforcing a model in which public health initiatives continued to rely heavily on bottom-up approaches. This trend persisted until after the Second World War.

The unique combination of national, international and religious factors that shaped Irish policies at this time suggests that there is ample scope for further historical analysis. Aside from the works of Hensey and Barrington, there are no other comprehensive histories on Ireland’s public health regime in the twentieth century. However, various health developments do feature briefly in major survey works. For example, Joseph Lee observes in *Ireland, 1912-1985: politics and society* (1989) how no Irish government took much genuine interest in public health until the Second World War, before exploring the famous Mother and Child Scheme.⁹⁸ This topic is also briefly discussed by Alvin Jackson and Thomas Bartlett in their respective histories of Ireland. However, the inclusion of health is due more to the opportunity it affords to examine key political figures and much less to any desire to assess the development of public health policy.⁹⁹ Irish historiography also remains relatively silent on how Ireland’s health regime related to international trends during this period. As mentioned, Ireland also sought to hide away mothers who had babies out of wedlock, and the mentally-ill. Aside from Greta Jones’ examination of the Northern Irish Belfast Eugenics Society between 1911 and 1915, wider questions of the extent to which Ireland shared in the general European preoccupation with biological theories about society remains largely untouched.¹⁰⁰ In Jones’ study, she argues that the failure of an Irish Eugenics Society in Dublin was due to the dominance of the Catholic Church in education,

⁹⁵ *Report of the commission on relief of the sick and destitute poor*, p. 68.

⁹⁶ Constitution of Ireland, 1937 (1 Jul. 1937).

⁹⁷ The Women’s National Health Association, founded by Lady Aberdeen in 1907, modelled itself on St. Pancras, which was a school for mothers in London. Dublin baby clubs also introduced ‘mothercraft’ to working-class mothers, a manifestation of the idea that motherhood could be taught, see Earner-Byrne, *Mother and child*, p. 60.

⁹⁸ Joseph Lee, *Ireland, 1912-1985: politics and society* (Cambridge, 1989), p. 313.

⁹⁹ Alvin Jackson, *Ireland 1798-1998: war, peace and beyond* (2nd ed., Oxford, 2010), p. 307; Thomas Bartlett, *Ireland: a history* (Cambridge, 2010), p. 478.

¹⁰⁰ Greta Jones, ‘Eugenics in Ireland: the Belfast Eugenics Society, 1911-1915’ in *Irish Historical Studies* (hereafter *IHS*), xxviii, no. 109 (1992), pp 81-95.

noting how the church was reluctant to condone interventions in family life that negative eugenics proposed.¹⁰¹ Her reasoning was that eugenic circles often advocated for intervention (either voluntary or state-sponsored) in reproductive and family life as a way to combat pauperism, which the Church was fervently against.¹⁰² The Church was in favour, however, of pro-natalism, a known eugenicist tenet arising out of concerns on population quantity. This found legislative resonance through the 1935 ban on contraceptives in Ireland.¹⁰³ As this thesis will show, successive Irish governments were also preoccupied with the social disposition of the poor as well as the ‘diseased urban area’.

Ireland’s demography has been a subject of debate among social historians. Ireland was unusual in Europe in terms of its demographic position. Since the Great Famine in 1845, Ireland had experienced a continuous population decline in every census, culminating in a population loss of over 3.5 million people by 1939.¹⁰⁴ This particular phenomenon has previously received attention within historiography.¹⁰⁵ In her book on the health of Irish mothers and children, Lindsey Earner-Byrne recognises that while it was hoped that improved public health would lead to an increase in population vitality, the desire to improve population health was genuine.¹⁰⁶ Similarly, Mary E. Daly observes a strong state interest in various segments of the population, including farmers, emigrants, and the marriage and fertility rates of Irish women.¹⁰⁷ This is important because not only did the outbreak of the Second World War test Ireland’s emerging sovereignty, it marked the highest point of post-independence state intervention and this occurred at a crucial time when the actions of the Irish government were increasingly subjected to external scrutiny.

Historiography of the Second World War and its aftermath

The historiography of the Second World War in Ireland tends to focus on themes of neutrality, diplomacy and censorship, all of which focus on the political context of the time. Ireland’s neutrality during the war was a significant issue not just for Ireland but also for Britain and the United States.¹⁰⁸ For example, Brian Girvin builds on prevailing narratives surrounding the

¹⁰¹ Ibid., p. 95.

¹⁰² Ibid., p. 88.

¹⁰³ Criminal Law Amendment Act, 1935 (28 Feb. 1935).

¹⁰⁴ D. Dempsey, ‘Facts and figures about Éire’s population’ in *The Irish Monthly*, lxxvii, no. 794 (1939), p. 530.

¹⁰⁵ Mary E. Daly, ‘Marriage, fertility and women’s lives in twentieth century Ireland (c. 1900-1970) in *Women’s History Review*, xv, no. 4 (2006), p. 571.

¹⁰⁶ Earner-Byrne, *Mother and child*, p. 3.

¹⁰⁷ Daly, *The slow failure: population decline and independent Ireland, 1922-73* (Wisconsin, 2006).

¹⁰⁸ See Robert Fisk, *In time of war, Ireland, Ulster and the price of neutrality, 1939-45* (London, 1983); Eunan O’ Halpin, *Defending Ireland: the Irish state and its enemies since 1922* (Oxford, 1999) and O’ Halpin, ‘Endword: Ireland looking outwards, 1880-2016’ in Thomas Bartlett (ed.) *The Cambridge history of Ireland: volume iv, 1880 to the present* (Cambridge, 2018), pp 809-838; Michael Kennedy, *Guarding neutral Ireland: the coast watching service and military intelligence, 1939-45* (Dublin, 2008).

political context of neutrality, which for him, had ‘little to do with national interest and everything to do with national ideology’.¹⁰⁹ This view is echoed by Ian Wood, who frames Ireland’s neutrality as a direct result of the legacy of Anglo-Irish relations and the nationalist sentiment that followed the War of Independence and the 1921 Anglo-Irish Treaty.¹¹⁰ For Wood, signs that independent Ireland would in a time of war occupy a policy of ‘non-belligerency’ can be found as early as February 1932 when Fianna Fáil came to power.¹¹¹

Fianna Fáil were determined to dismantle the provisions of the 1921 Anglo-Irish Treaty and extend Irish sovereignty. One manifestation of this was the non-payment to the British Treasury of land annuities which led to the economic war with Britain and formally ended with the 1938 Anglo-Irish Treaty.¹¹² Crucially in terms of wartime neutrality, the 1938 agreement saw the return of the Irish ports of Berehaven, Cobh and Lough Swilly on which much has been written. Tied to this was a strict censorship regime, which was seen by the government as a vital means to screen out information about the war and maintain a neutral stance among its people. However, Girvin’s observation that censorship was not only used to control public opinion but also used to further advance Fianna Fáil political interests is noteworthy.¹¹³ Often absent from each of these top-down histories is an in-depth focus on the impact that the war had on the lives of the Irish people. After all, the results of Ireland’s policy of neutrality had severe economic implications.

Only recently has the preoccupation of historical discourse on the Second World War in Ireland shifted from high politics to a broader social, cultural, and economic perspective.¹¹⁴ Clair Wills offers a more nuanced approach, where she emphasises the practicality of Ireland’s neutral stance, for Ireland was a vulnerable state with a small and ill-equipped army, ‘which could all too easily be swallowed up in a widespread war’.¹¹⁵ For Wills, neutrality also suited de Valera, who was convinced of the democratic right of smaller nations to protect themselves from conflicts involving bigger powers.¹¹⁶ Although Wills’ work refers to several health problems the country faced during the war, which does a great deal to underscore the human

¹⁰⁹ Brian Girvin, *The Emergency: neutral Ireland 1939-45* (London, 2006), p. 324.

¹¹⁰ Ian Wood, *Britain, Ireland and the Second World War* (Edinburgh, 2010), pp 1-3. Other notable works that focus on Irish foreign policy and diplomatic relations at this time include: Michael Kennedy, *Ireland and the League of Nations, 1919-1946* (Dublin, 1996); Dermot Keogh and Mervyn O’ Driscoll (eds), *Ireland in World War Two: diplomacy and survival* (Cork, 2004); Stephen Murphy, ‘Neutral diplomacy: an Irish perspective, 1939-1945’ (PhD, UCC, 2016).

¹¹¹ *Ibid.*, p. 11.

¹¹² For detail surrounding Irish economic policies of the 1930s see Tereza Pusova, ‘Irish economic policy in the 1930s and the authority of Eamon de Valera’ in *The Journal of European Economic History*, xlviii, no.i (2019), pp 9-29; Peter Neary and Cormac Ó Gráda, ‘Protection, economic war and structural change: the 1930s in Ireland’ in *Irish Historical Studies*, xxvii, no. cvii (1991), pp 250-266.

¹¹³ Girvin, *The Emergency*, pp 224-25.

¹¹⁴ Bryce Evans, *Ireland during the Second World War: farewell to Plato’s cave* (Oxford, 2016), p. 2.

¹¹⁵ Clair Wills, *That neutral island: a history of Ireland during the Second World War* (London, 2007), p. 1.

¹¹⁶ *Ibid.*

cost of neutrality, her focus is more on providing a glimpse into the impact of war on the Irish population. By contrast, this dissertation examines how the Irish government responded to these key health challenges.

In *Ireland during the Second World War: Farewell to Plato's Cave* (2016), Bryce Evans pays particular attention to the severity of Ireland's economic position during the war, noting how the 'priority of economic survival was just as pressing for the nascent state as its security'.¹¹⁷ An entire government department, the Department of Supplies, was used to navigate the supply situation for the duration of the war. The workings of this department were influenced significantly by the Emergency Scientific Research Bureau, an advisory body that was specifically set up in 1941 to tackle problems faced by agriculture, building, clothing, engineering, and food industries.¹¹⁸ It is only with an examination of these works, alongside Ciarán Bryan's dissertation on rationing during the war (or the 'Emergency' as the period of the Second World War was often termed in Ireland) that one can appraise just how precarious Ireland's wartime economic situation was.¹¹⁹ With the exception of Evans' work on food supplies, the development of public health policy also remains a minor component of most studies of the time.¹²⁰

While Ireland's neutrality protected her from direct combat, it did not protect the population from experiencing severe shortages in medical supplies, fuel, raw materials and vital foodstuffs. These shortages had serious implications for the provision of key health services in Ireland. On a national level, the large-scale hospital building projects that were initiated in the 1930s appeared to signal government interest in health reform before the war. However, this development was interrupted during the war when the Hospital Sweepstakes, which funded the building programme, closed for the duration of the war.¹²¹ This was due to scarcities in steel, timber, cement and mechanical appliances for sanitary and electrical plants.¹²² The situation was further exacerbated by the lack of Irish-owned merchant shipping. The scarcities inadvertently highlighted just how dependent Ireland was on Britain for trade and shipping.¹²³ While some hospital projects were completed in the early years of the war, this was done only with 'great difficulty'.¹²⁴ Meanwhile, plans that did not yet reach construction were abandoned.¹²⁵ It was not until several years after the war that enough materials became available for the resumption of

¹¹⁷ Evans, *Ireland during the Second World War*, p. 2.

¹¹⁸ Robert J. A. Bradley, 'The Emergency Scientific Research Bureau, 1941-1945' (PhD, TCD, 1991), p. 115.

¹¹⁹ Ciarán Bryan, 'Rationing in Emergency Ireland, 1939-48' (PhD, NUIM, 2014), p. 1.

¹²⁰ Evans, 'Food, the Emergency and the lower-class body, c. 1939-45' in David Durnin and Ian Miller (eds), *Medicine, health and Irish experiences of conflict* (Manchester, 2016), pp 45-60.

¹²¹ Hospital's Trust 1940 (Ltd), *Ireland's Hospitals 1930-1955* (Dublin, 1956), p. 17.

¹²² Barrington, *Health, medicine and politics*, p. 138.

¹²³ Bryan, 'Rationing in Emergency Ireland', p. 22. Also see Bryce Evans, 'A semi-state archipelago without ships, Seán Lemass, economic policy and the absence of an Irish mercantile marine' in *Working Papers in History and Policy*, no. vi (2012), p. 3.

¹²⁴ Hospital's Trust, *Ireland's Hospitals 1930*, p. 24.

¹²⁵ Ibid.

large-scale building projects.¹²⁶ In the immediate post-war period extensive demands were placed on the building industry where there were also shortages in skilled labour and supplies.¹²⁷ It was not until 1949 when these projects resumed.¹²⁸

Heightened fears surrounding the supply situation manifested in extensive government deliberations over how to manage existing medical supplies during the Emergency. Following the outbreak of war, Dr Conn Ward (medical doctor and politician) Parliamentary Secretary in the Department of Local Government and Public Health, urged the public, sanitary and mental hospital authorities to have the strictest economy in the use of medicines and drugs.¹²⁹ This position was also emphasised by James Hurson, Departmental Secretary and key civil servant of the Department, who noted that ‘very few of these are obtained from native sources and in present world conditions difficulties of supply have already arisen and may be expected to increase’.¹³⁰ Because of this, essential stocks necessary for the ‘preservation of life’ such as morphia, digitalis preparations, sera, tetanus and insulin were under close scrutiny by the Department of Local Government and Public Health where the emphasis was placed on using old stocks first.¹³¹ Because Ireland relied on external sources for the greater part of her medical supplies, regulations on therapeutic substances were also loosened to maximise existing supplies. For example, an Emergency Powers Order passed in 1942, revoked article 9 of the Therapeutic Substances Act, 1934.¹³² Though this was ‘so far as it related to a number of specified substances, subject to certain safeguards’, this essentially allowed some medicines to be sold past their sell-by dates during the war.¹³³ Meanwhile, dispensary patients were urged to bring in their own bottles for medicines, owing to the increasing shortage in glassware while it was only in exceptional circumstances that bottles were supplied to patients from the dispensary.¹³⁴ Similar care was to be taken to prevent the wastage of dressings, bandages, adhesive plasters, gloves, hypodermic syringes and rubber appliances ‘so as to ensure a long a life as possible for these items’.¹³⁵ Government deliberations on managing the complexities of the supply chain were also seen in other areas.

¹²⁶ Ibid., p. 25.

¹²⁷ Ibid.

¹²⁸ Ibid.

¹²⁹ Dr Conn Ward to James Hurson, 6 July 1941. Thereafter, to be sent to every Public Assistance Authority, Sanitary Authority and Mental Hospital Authority, (National Archives Ireland (hereafter NAI), TAOIS S/11445). For further detail relating to Ward, see Laurence W. White, ‘Ward, Francis Constantine (‘Con’) in *DIB (online)*, DOI: <https://doi.org/10.3318/dib.008917.v1>.

¹³⁰ Hurson to all public assistance, mental and sanitary authorities, 4 July 1941 (NAI, TAOIS S/11445).

¹³¹ Ward to all health boards and public assistance authorities, 21 Mar. 1942 (NAI, TAOIS S/11445).

¹³² Therapeutic Substances (Emergency Amendment), Order 1942 (1942, S. I. no. 555) (31 Dec. 1942); Therapeutic Substances (Saorstát Éireann) Regulations, 1934 (1934 S. I. no. 365).

¹³³ Dept. of Taoiseach memorandum on public safety in the event of a future emergency, 8 Aug. 1949 (NAI, TAOIS S/11445). This was to be part of a ‘War Book’ devised by John A. Costello on steps to be taken in the event of a future emergency.

¹³⁴ Hurson to all public, sanitary and mental hospital authority, 4 July 1941 (NAI TAOIS S/11445).

¹³⁵ Ibid.

Though rationing, food allowances, and a cheap fuel scheme did try to enforce a fairer distribution of vital commodities, these did not necessarily make things easier.¹³⁶ A fuel shortage, for example, fundamentally impacted the ways that people consumed their food. Nutritional standards suffered and so-called 'bread and spread' meals typified the daily routines of the poor. This proved particularly detrimental to health, considering deficiencies, such as calcium, rose during the war. A fuel shortage impacted how Ireland's public health professionals did their jobs. For example, county TB officers were only allowed to use as much petrol in a month as they used to use in two days.¹³⁷ These shortages in fuel had equally harsh consequences for the operations of other medical and dispensary officers. Barrington observes that district health nurses were no longer allowed to use motor cars, while the medical inspectors of the Department of Local Government and Public Health stopped travelling to areas outside of Dublin.¹³⁸

The war saw significant increases in childhood and tuberculosis mortality, particularly among the poor. Overcrowded sanatoria and mental institutions equally showed an Irish public health system not fit for purpose. Top-down emergency legislation continuously introduced and reintroduced ideas about quantities and qualities of foods that people should obtain and consume. Information about how these foods should be kept, cleaned, and cooked was equally prominent in government-sponsored bottom-up public memorabilia. Advice around early diagnosis and treatment for mental illness and TB pervaded public realms while Irish mothers were taught how best to look after their children. Meanwhile, coverage of social, economic and political issues associated with the war was tightly controlled through a strict censorship regime, which Donal Ó Drisceoil has previously explored.¹¹⁴ Any actions taken by the working classes in defence of their interests was perceived by the government as a direct threat to the status quo in the same way that restrictions on essential supplies and services were made.¹¹⁵ Yet, the effects of these public health initiatives have not garnered the historical attention they deserve.

A Case Studies Approach

This thesis will focus on five case studies where new health policies and initiatives were introduced between 1939 and 1953. In order, these are flour, bread and efforts to reduce calcium deficiency, efforts to address the rise in diarrhoea and enteritis among infants, the launching of a national nutrition survey, the introduction of the Mental Treatment Act 1945 and a new wave of government measures to reduce the incidence of tuberculosis (TB). These case studies reflect

¹³⁶ Barrington, *Health, medicine and politics*, p. 137.

¹³⁷ Ibid.

¹³⁸ Ibid.

a government focus on four key areas of public health which assumed a greater significance during this period: food and nutrition, infant mortality, mental illness and infectious disease. While some of these have received attention in the wider historiography, these studies have focused for the most part on individual diseases in isolation, thereby missing the importance of the interaction between public health initiatives occurring at the same time with many of the same people involved. Recurring themes include disease symptoms, its incidence, its implications for patients and their cures but these histories devote comparatively little attention to the critical analysis of the political negotiations involved in such endeavours.¹³⁹ Because there exists histories of stand alone illnesses already, questions about the motivations behind policy and policy changes are perhaps now more fruitful. A case study approach, for example, shows what drove public health reforms and what factors impeded them. It is therefore hoped that this approach can bring with it hidden histories that others may have missed.

Before introducing the chosen case studies in further detail, it is important to note that the *raison d'être* of this thesis is to examine the negotiations of Ireland's public health policy at a crisis point, and this brings with it a number of limitations. First, the focus of this work is on the 'problem' of specific diseases how consecutive Irish governments responded to it at a specific time period, i.e., between 1939-1953. While not a full history of public health policy developments in Ireland in the twentieth century, this thesis acknowledges the importance of historical trends prior, and immediately after, the period examined. Therefore, relevant pre and post-war developments are highlighted, particularly in chapters one and six. Second, using a case-study approach also brings limitations. While each case study could easily warrant its own detailed study, and some have already been explored in depth, this approach was chosen to capture the broader public health rhetoric rather than conducting comprehensive examinations of each disease.

The case studies chosen were selected due to their dominance in public health rhetoric and legislation at the time. Inevitably, not all areas of potential interest could be explored. For example, the Public Assistance Service (introduced in 1939), which included provisions for the medical assistance for the poor and the care of the destitute and aged, was also an important development during the period. However, the issue of the poor as a focus population is well covered in the selected case studies.

The title of this thesis poses the question: 'Public health in crisis?'. The term 'crisis' is a very interesting word for historians. The word originally comes from the Greek *krisis*, meaning

¹³⁹ Catherine Cox, *Negotiating insanity in the southeast of Ireland, 1820-1900* (Manchester, 2012); Ian Miller, *Reforming food in post-famine Ireland: medicine, science and improvement, 1845-1922* (Manchester, 2014); Greta Jones, *'Captain of all these men of death': the history of tuberculosis in nineteenth and twentieth century Ireland* (Amsterdam, 2001); Earner-Byrne, *Mother and child*.

decision or discrimination, and dates from the early seventeenth century.¹⁴⁰ In health terms, *crisis* was extended to disease when the disease either increased in intensity, went away or changed all together, signifying a crucial turning point in the direction of disease.¹⁴¹ That being said, the term ‘crisis’ has been since used in various general contexts where significant decisions were made or major challenges were encountered. After the war, Ireland established its first ever stand-alone public health department which brought about extensive plans for developing almost all sectors in the country’s health services. Britain also went about putting the ‘public’ in ‘public health’.¹⁴² Using the UK’s Beveridge Plan as a point of symbolic reference, Michel Foucault has observed how the 1940s, when almost 40,000,000 lost their lives in wartime, also marked the beginning of a new system of rights (specifically the right to health), morality and politics in the modern Western world.¹⁴³ In this view, can medical *crises* be good for people’s health?

Key argument and themes

This thesis has three premises. First, it argues that the Second World War and its aftermath was a critical period in Ireland for public health and for the development of public health policy. Wartime circumstances led to a dramatic increase in the incidence of disease in Ireland, only to be followed by a wave of public health reforms in the war’s immediate aftermath. While some healthcare measures were more effective than others, the Department of Local Government and Public Health (Department of Health from 1947) was just as focused on public health resources as were the Departments of Supplies, Finance, Industry and Commerce with the management of the supply situation. A significant factor in shaping public health policy was the Department of Local Government and Public Health’s ability to present concrete evidence of increased disease rates in Irish society – the second premise of this thesis. Nutrition, infant health, mental illness and TB were all considered in need of most attention, some of them becoming crises in part because of the war. The third premise of this thesis is that the evidence used to inform public health policy was largely drawn from the health circumstances of the Irish young and urban poor, thereby aligning public health policy with wider social attitudes. The impact that these health policies had on those suffering from disease was not always what the government had anticipated. While the relevant historiography of each of the case studies will be addressed in the individual chapters themselves, this research is the first to place disease and

¹⁴⁰ Randolph Strarn, ‘Historians and ‘crisis’ in *Past & Present*, lii (1971), pp 3-4.

¹⁴¹ *Ibid.*, p. 4.

¹⁴² Alex Mold, Peder Clark, Gareth Millward and Daisy Payling, *Placing the public in public health in post-war Britain, 1948-2012* (London, 2019).

¹⁴³ Michel Foucault, ‘The crisis of medicine or the crisis of antimedicine?’ in *Foucault Studies*, i (2004), pp 5-19. This was first of three lectures given by Foucault in October 1974 at the Institute of Social Medicine, State University of Rio de Janeiro, Brazil.

health actions side-by-side. Health policies may be designed according to their effects on mortality and morbidity, but they may also be designed to be cost effective.¹⁴⁴ Throughout the case studies, we can see the tension between a desire to improve health outcomes and a desire to minimise spending.

Thesis structure

The parameters of 1939 and 1953 were chosen to examine the impact of war and subsequent ‘emergency’ conditions in Ireland on public health. The earlier date marks the year in which the Second World War began, when Ireland began to experience the effects of a severe supply-squeeze situation. While these conditions largely improved in 1948, this extends to the 1953 Health Act, which is a natural end-point to ensure that coverage is given to the implementation of health developments that flowed from the war conditions.¹⁴⁵ Notably, the 1953 Health Act amended and expanded the 1947 Health Act, making hospital care free or heavily subsidised for 85% of the population and extending access to various health services.¹⁴⁶

This dissertation is divided into two sections: ‘War and Health’ and ‘Meaningful Populations’. The former examines Ireland’s health performance during the war. It begins with an examination of Ireland’s existing public health infrastructures before addressing the distinct rise in calcium deficiency and infant mortality, which were directly linked to wartime conditions. Section two on ‘Meaningful Populations’ deals largely with health policy developments introduced after the war. ‘Post-war healthy policy developments’ may have been an alternative focus, but it was felt that doing so would shift attention to the timing of these policies, rather than the specific population groups that public health measures were intended to target.

The thesis comprises six chapters:

Chapter one outlines the key players and key infrastructures involved in orchestrating public health in Ireland between 1939 and 1953. It explains how the health services worked, who operated and funded them, and how health laws were passed. It also sheds light on key legislative changes that occurred during this period. Detailed analyses of how the Irish health system evolved during the 1940s has been given relatively little attention by historians. This chapter helps to identify key actors and provides a frame for understanding the policy developments discussed later on. This has relied heavily on official reports of the Departments

¹⁴⁴ Albert R. Jonsen, ‘Bentham in a box: technology assessment and health care allocation’ in *Law, Medicine and Healthcare*, xiv (1986), p. 172.

¹⁴⁵ Bryan has extended his rationing analysis to the ‘Long Emergency’, which included the post-war years 1945-48. Although the Emergency Powers Act was revoked on 2 Sept. 1946, Ireland continued to experience supply issues, and many of the controls remained in place despite the act itself was repealed. See Bryan, ‘Rationing in Emergency Ireland’, p. 281.

¹⁴⁶ Lucey and Crossman (eds), *Healthcare in Ireland and Britain from 1850*, p. 15.

of Local Government and Public Health and later Health, of county medical officers of health and of health professionals, committees and councils, such as James Deeny, the country's Chief Medical Advisor (CMA), and the Dietetic Council, which was set up solely for addressing the health impact of deteriorating supplies.¹⁴⁷ Each of these are consulted alongside the activities of voluntary organisations and the Catholic Church. When taken together, one can see the extent to which existing deficits in Ireland's public health infrastructures contributed to poor public health performance during this period.

Chapter two uses a rising calcium deficiency during the war as a case study to examine the health effects of wartime food measures. It argues that Ireland's explicit focus on managing the supply situation during the war exacerbated public health. Focusing on flour extraction and fortification, this chapter charts a rising incidence of rickets and TB mortality in the face of severe food shortages. This chapter relies heavily on government records, particularly the files of the Departments of Local Government and Public Health, Industry and Commerce, Supplies, Agriculture and the Taoiseach (held in the National Archives of Ireland, Dublin). These have been used in conjunction with *Dáil Éireann Debates*, and the reports of medical doctors such as Edmund T. J. McWeeney (Department of Health medical officer), and William J. E. Jessop (physician and professor of physiology and biochemistry at Royal College of Surgeons until 1952). This has helped to underscore the complexities of dealing with this health crisis in government decision-making, which was caused in part by the concurrent global supply crisis, caused by the war. The *Annual reports of the registrar general* (several years) have also proved useful, especially for measuring the severity of the health situation at hand.

Chapter three also considers a health problem that was exacerbated by wartime conditions, focusing on government responses to epidemic diarrhoea and enteritis and its effects on infant mortality. It makes the argument that Ireland's distinct political and cultural context played a key role in crisis management of the period. For example, it shows a focus on educating mothers as opposed to cleaning up milk. While diarrhoea and enteritis has been touched on briefly in some of the wider historiography, there has been no stand alone study into the prevalence of this disease in Ireland. This is particularly surprising because the disease itself was the leading cause of death for infants under the age of one during the war. Despite the historical neglect, there is a large amount of data available on this subject, especially in the National Archives and in the *Annual report of the registrar-general*. The focus on combatting infant diarrhoea in urban areas also reveals other populations that were not targeted by public health policy at

¹⁴⁷ Bryan, 'Rationing in Emergency Ireland', p. 281.

the same time. For example, extremely high rate of deaths among illegitimate children resulted in little government action.¹⁴⁸

Chapter four shifts to post-war developments, examining Ireland's first ever national nutrition survey (1946-48). The first ever mention of the word 'nutrition' in relation to the Irish people in the Dáil only occurred in March 1940 by Ward.¹⁴⁹ Previously, any other mention of 'nutrition' in government debates always referred to the nutritional state of animals and not humans. Yet, the significance of this has not been realised within wider Irish historiography. This chapter uses the survey to analyse government views on which Irish people were considered to be the 'healthiest' and 'least healthy' during the 1940s. The national nutrition survey resulted in six published reports by the Department of Health. From these, the survey methodologies and key conclusions have been ascertained. Thus, this chapter also reveals how the Irish government were still determined to gather information relating to the poor. Analyses of these reports occurred alongside the published reports of those involved in the survey, for example, those of Deeny, D. Hourihane, Robert C. Geary, E. J. Sheehy and J. M. O'Connor.¹⁵⁰ Because the nutrition survey represented a time in which the Irish government sought to catch up on nutritional developments found elsewhere, this chapter engages extensively with wider national and international literatures on the subject, such as the works of Ian Miller, Charlotte Bilteroff, Juliana Adelman and Lisa Haushofer.¹⁵¹

Chapter five explores the Mental Treatment Act 1945 and its impact on Ireland's mental hospitals. It shows that there was a significant gap between policymakers' views of treatment and the treatment of those who were suffering from mental illness. Restrictions on access to twentieth-century records has made studying the history of twentieth century mental hospitals more difficult. For reasons of data protection and patient sensitivity, access to mental health records in Ireland are strictly controlled by the Health Service Executive (HSE) and for the period covered in this study are under embargo for 100 years. Permissions to access these records involve Freedom of Information requests to regional data controllers, some of whom may grant access, and others do not. The level of access also varies by region. Because of this,

¹⁴⁸ Daly, 'Death and disease in independent Ireland, c. 1920-1970: a research agenda' in Cox and Luddy (eds), *Cultures of Care*, p. 235.

¹⁴⁹ *Dáil Éireann Debates* (hereafter *DÉD*), 6 Mar. 1940, vol. 79, no. 2.

¹⁵⁰ James Deeny, 'Practical significance of the Irish National Nutrition Survey' in *BJN*, iv, no. 2-3 (Sept. 1950), pp 292-95; D. Hourihane, 'Objective, scope and general plan of the Irish National Nutrition Survey' in *BJN*, iv, no. 2-3 (Sept. 1950), pp 270-74; Robert C. Geary, 'Statistical plans and methods of the Irish National Nutrition Survey' in *BJN*, iv, no. 2-3 (Sept. 1950), pp 274-81; E. J. Sheehy, 'Agricultural implications of the results of the Irish national nutrition survey' in *BJN*, iv (Sept. 1950), pp 284-87; J. M. O'Connor, 'The origin and organisation of the Irish national nutrition survey' in *BJN*, vi, no. 2-3 (Sept. 1950), p. 269.

¹⁵¹ Miller, *Reforming food in post-famine Ireland: medicine, science and improvement, 1845-1922* (Manchester, 2014); Charlotte Bilteroff, *Eating right in America: the cultural politics of food and health* (Durham, 2013); Juliana Adelman and Lisa Haushofer 'Introduction: food as medicine, medicine as food', *Journal of the History of Medicine and Allied Sciences*, lxxiii, no. 2 (2018), pp. 127-134.

existing studies often incorporate examinations of legislation, alongside glimpses of patient records, where they were obtained.¹⁵² This chapter engages extensively with largely unused primary materials, which has been incredibly rewarding. Discussions around the records of St. Conal's District Mental Hospital, Letterkenny, Donegal, has not appeared in any publications to date, and these records were hugely insightful, bringing a rural perspective to this chapter. For urban comparison, these are used with records from St. Brendan's District & Auxiliary Mental Hospital, Grangegorman, Dublin.¹⁵³ Aside from these institutional accounts, a large quantity of printed primary material has been used. The *Annual reports of the inspector of mental hospitals* has formed a large part of this, and so too did the papers of practising psychiatrists and institutional attendants. Particular attention is also given to *Dáil Éireann Debates*, where necessary.

Chapter six examines the 'problem of tuberculosis' in Ireland and the measures introduced to combat the disease in the war's aftermath. The chapter argues that the Irish government initiated a significant wave of reforms because the disease was a leading killer of younger age-groups. Manuscript sources for this chapter include records from the Royal National Hospital for Consumption, Co. Wicklow and the records of the Irish National Anti-Tuberculosis League (INATL), held in Dublin Diocesan Archives. These records have been examined alongside official reports, such as the *Annual report of the registrar general* (several years). Valuable insights into medical perceptions and practices relating to TB in Ireland can also be gained from practitioners' biographies and institutional histories. Deeny wrote extensively about socio-economic determinants of the disease in his push for medical reform.¹⁵⁴ Noël Browne, once a TB patient before he became Minister for Health (1948-1951), likewise wrote about the devastating effects of TB both personally and professionally.¹⁵⁵ Both were no doubt motivated by the declining TB rate in other countries which confirmed wider medical capacity to reduce the incidence of the disease. However, historical works on participants in the fight against TB were often celebratory, and as Greta Jones has pointed out, 'reflected the optimism of the time'.¹⁵⁶ Notwithstanding, these sources can provide very valuable indicators of just how serious Ireland's TB problem was. Price, credited with the introduction of a national BCG vaccination scheme, wrote extensively on the incidence of TB in children and adolescents.¹⁵⁷ So too did

¹⁵² Kelly, 'The Mental Treatment Act 1945: an historical enquiry' in *History of Psychiatry*, xix, no. 1 (2008), pp 47-67.

¹⁵³ 'Level one' access, which is full coverage of patient records, was granted for these two institutions.

¹⁵⁴ Deeny, *To cure and to care: memoirs of a chief medical officer* (Dublin, 1989); Deeny, *The end of an epidemic: essays in Irish public health, 1936-65* (Dublin, 1995), pp 80-84; Deeny, *Report of the national tuberculosis survey, 1950-53* (Dublin, 1954).

¹⁵⁵ Noël Browne, *Against the tide* (Dublin, 2012).

¹⁵⁶ Jones, 'Captain of all these men of death', p. 3.

¹⁵⁷ Dorothy S. Price, 'Primary tuberculosis of the lungs in children' in *Irish Journal of Medical Science (hereafter IJMS)*, x (1935), pp 54-75; 'Tuberculosis in adolescents' in *IJMS*, xvi (1939), pp 124-129; 'The prevention of tuberculosis in infancy' in *IJMS*, xvii (1942), pp 252-255.

INTRODUCTION

Margaret Dunlevy, a physician and epidemiologist, who also played a key role in the BCG vaccine campaign in Dublin.¹⁵⁸

The compelling focus on the histories of individual diseases has often obscured the underlying process of health policy formulation, which were typically designed to maximise impact while being cost effective. In contrast, these case studies examine the concurrent rise in morbidity and mortality in Ireland at this time, making this dissertation the first to explore the complexities involved in designing public health strategies and interventions during this period. It will explore how health policies were developed in response to growing evidence of disease, highlighting the rather remarkable evidence-based policy approach taken. This took place during a period of significant changes in how morbidity data was collected and used, as reflected in the establishment of numerous health bodies. However, this process was also shaped by biases in the types of evidence considered and, consequently, in the populations prioritised for policy interventions.

¹⁵⁸ Margaret Dunlevy, 'Five years' experience of BCG vaccination in Dublin' in *Medical Officer*, xcii, no. 5 (1954), pp 53-6; 'The prevention of tuberculosis' in *IJMS*, vi, no. 313 (1952), pp 1-10.

Section one: War and health

CHAPTER ONE

FIREFIGHTING IN PUBLIC HEALTH? CONTEXTUALISING PUBLIC HEALTH INFRASTRUCTURES, 1939-53

1.1 Introduction

Ireland was an outlier in Europe during the Second World War in that she was one of very few neutral countries, whose population health actually declined. Granted, so-called ‘combat’ countries did not see perfect health either. Aside from deaths due to combat, the evacuation of people from hospitals and sanatoria, black-out conditions, the overcrowding of homes because of air raids and billeting, the numbers of ‘infectious’ patients drawn into industries and the ‘coming into contact with them of numbers of people who previously had led a relatively isolated life’ all combined to increase infections over pre-war rates among the general populations of countries like Britain and the Netherlands.¹ From a health perspective, however, the disaster was not as serious as that seen in previous wars.² For Marc Daniels, this applied particularly to the countries, such as Denmark and Sweden, where public health provisions were developed to a high degree during the inter-war period.³ These improvements were complimented by medical discoveries in the 1930s and the early war years which saw significant breakthroughs in the treatment of acute infections and in the prevention of diseases such as typhus, effectively reducing to relatively low proportions the toll that usually occurred in disease due to war.⁴ However, the same cannot be said for Ireland.

The purpose of this chapter is to contextualise the provision of healthcare services in Ireland between 1939 and 1953. This chapter will explain how public health decisions were made, funded, and passed at official levels. In their analysis of imperial and post-imperial healthcare before welfare states, Hannah-Louse Clark and Barry Doyle point out that healthcare was ‘not solely or even primarily’ the responsibility of many states at this time.⁵ Instead, it was provided by charities and benevolent individuals, voluntary groups, labour organisations, religious bodies and private labour in addition to central and local state authorities.⁶ A similar situation pertained in Ireland. A complete re-organisation of Ireland’s health services took place during this period (for listings of relevant health laws passed during this period, see Appendix

¹ Marc Daniels, ‘Tuberculosis in Europe during and after the Second World War’ in *British Medical Journal* (hereafter *BMJ*), ii, no. 4636 (1949), p. 1068.

² *Ibid.*, p. 1071.

³ *Ibid.*

⁴ *Ibid.*, p. 1065.

⁵ Hannah-Louse Clark and Barry Doyle, ‘Imperial and post-imperial healthcare before welfare states’ in *European Review of History: Revue Européenne d’Histoire*, xxviii, no. 5-6 (2021), p. 620.

⁶ *Ibid.*

A). While it is very difficult to measure the direct impact of the war on health policies in Ireland, there is general consensus that this period was a crucial turning point in the development and organisation of public health provisions as evidenced by substantive healthcare reform and increased state aid, particularly from 1947 onwards. This chapter examines key personnel that shaped public health provisions, which included the local authorities, the Department of Health, the medical profession and to a lesser extent, the Catholic Church and other voluntary organisations. This chapter reveals the extent to which existing deficits in Ireland's public health infrastructures contributed to poor public health performance during the Emergency period.

1.2 Workings of Department of Local Government and Public Health

Since Irish independence in 1922, the legal infrastructure that governed all aspects of public health was the Irish Legislature.⁷ The Legislature comprised of the acts and orders that were passed by the Dáil (House of Representatives) and the Seanad (Senate) – the two houses of the Irish Oireachtas. The most powerful of these two bodies is the Dáil, to which the government is directly accountable, while the Seanad can be seen as a 'revising chamber'.⁸ Because the majority of the senators elected represented various aspects of Irish economic life, Martin O'Donoghue observes that the Seanad assumed the role of 'a public forum for debate' whose motions reflected the economic issues that arose due to the war at this time.⁹ All government departments had to conform with the acts that were passed by the Legislature (see figures 1.9 and 1.10 for official public health layout in the 1940s). In general terms, the acts and orders that controlled the provision of health services did not lay down in detail how the health services, as enforced by the law, should operate.¹⁰ Instead, this responsibility was given to the Minister of Local Government and Public Health, and later to the Minister of Health when the Department of Health was established in 1947. Through consultations with their Department as well as relevant health boards and other executive agencies, the Minister issued guidelines and directives as to how such health laws would be implemented.¹¹ The Dáil had further influence on the actions of the Minister and his department through their debates on various hot topics and annual estimated costs. While politics may have influenced which health subjects got attention, is also important to consider that there were limits to the ministers' powers in relation to health policy. This was particularly relevant when it came to financing health provisions during the war.

⁷ Brendan Hensey, *The health services of Ireland* (2nd ed., Dublin, 1972), p. 43.

⁸ David McDaid, Miriam Wiley, Anna Maresso and Elias Mossialos, 'Ireland: health system review' in *Health Systems in Transition*, xi, no. 4 (2009), P.8.

⁹ Martin O'Donoghue, 'As nearly subservient' as it could be? Vocationalism and senatorial speaking behaviour in the Irish Senate 1938-45' in *Parliaments, Estates and Representation*, xxxvi, no. 2 (2016), p. 211.

¹⁰ Hensey, *The health services*, p. 43.

¹¹ Ibid.

The responsibilities of the Department of Local Government and Public Health (until 1947) were wide-ranging. They included the organisation of elections, determining constituent boundaries, providing housing initiatives as well as the country's overall health system.¹² While most of the country's social welfare programmes also fell under this department, unemployment insurance was handled by the Department of Industry and Commerce.¹³ Housing was a significant concern of Local Government which also tied into further involvement with building societies as part of its concern for available supplies and capital for housing.¹⁴ Responsibilities were also extended during the war years, when the Department devoted significant resources to overseeing the production of turf by local councils.¹⁵ In relation to health matters, responsibilities of the Minister for Local Government and Public Health included the drafting of regulations and the general supervision of the activities of the health boards and other agencies who were involved in providing health services.¹⁶ In his supervisory capacity, the Minister was responsible for determining methods of job appointments, salaries and the conditions of service which were held by various medical and administrative personnel.¹⁷

During the period examined in this dissertation there were six different cabinets each with different policy priorities.¹⁸ Fianna Fáil governed from 1938 until 1948 and again from 1951-54. This was interspersed by the first inter-party government from 1948 until 1951 which included Fine Gael, Labour, National Labour, Clann na Poblachta, Clann na Talmhan and some independents with Clann na Poblachta holding the Health portfolio. A second inter-party government, a minority coalition formed between Fine Gael, the Labour Party, and Clann na Talmhan, held office between 1954 and 1957. Disillusioned with the conservative economic policies of the Cumann na nGaedheal government, Fianna Fáil were committed to implementing its programme of economic self-sufficiency when the party first came to power in 1932.¹⁹ Initially, the party appealed to Irish manufacturers, the small farmers and the urban working class.²⁰ This resulted in a highly active Department of Local Government and Public Health, where housing became a major focus during the 1930s. This was in keeping with Fianna Fáil's desire to create more employment while also providing a market for many proposed new industries, such as those in furniture, joinery, bricks and cement.²¹ Thus, the lion's share of pre-war spending for the Department went towards housing rather than health (see figure 1.1). As

¹² Mary E. Daly, *The buffer state: the historical roots of the Department of the Environment* (Dublin, 1997), pp 4-5.

¹³ Ibid., p. 3.

¹⁴ Ibid.

¹⁵ Ibid., p. 4.

¹⁶ Hensey, *The health services*, p. 44.

¹⁷ Local Authorities (Officers and Employees) Act, 1926 (1926 no. 39) (28 Jul. 1926).

¹⁸ The dates of the elections were 1938, 1943, 1944, 1948, 1951, 1954.

¹⁹ Catherine Curran, 'Fianna Fáil and the origins of *The Irish Press*' in *Irish Communications Review*, vi (1999), p. 7.

²⁰ Ibid.

²¹ Mary E. Daly, *The buffer state: the historical roots of the Department of the Environment* (Dublin, 1997), p. 219.

shown, state expenditure on housing, which included grants to local authorities, building societies and utility bodies, and grants to the Land Commission for the improvement of various estates, increased substantially during this period, totalling £ 6,093,202 by the end of 1938. The higher estimates after 1936 can also be attributed to the rising costs of construction.²² Meanwhile, health spending rose steadily until 1936, where it also included new expenditures under the 1933 milk scheme, which extended to fuel in 1933 and meat grants in 1934. However, it began to decline in the years immediately leading up to the war, resulting in a significantly lower overall spend of £4,532,759.²³ The majority of health spending during this time was in the form of grants made to National Health Insurance, to which employees also contributed. Various health grants were also made to local authorities, covering areas such as tuberculosis, venereal disease and school meals. Housing continued to receive priority funding during the early 1940s, until building materials became increasingly scarce. That said, not all Fianna Fáil programmes were successful. For example, a substantial proportion of government funds were directed towards landowners, such as farmers and the urban middle classes, which had been

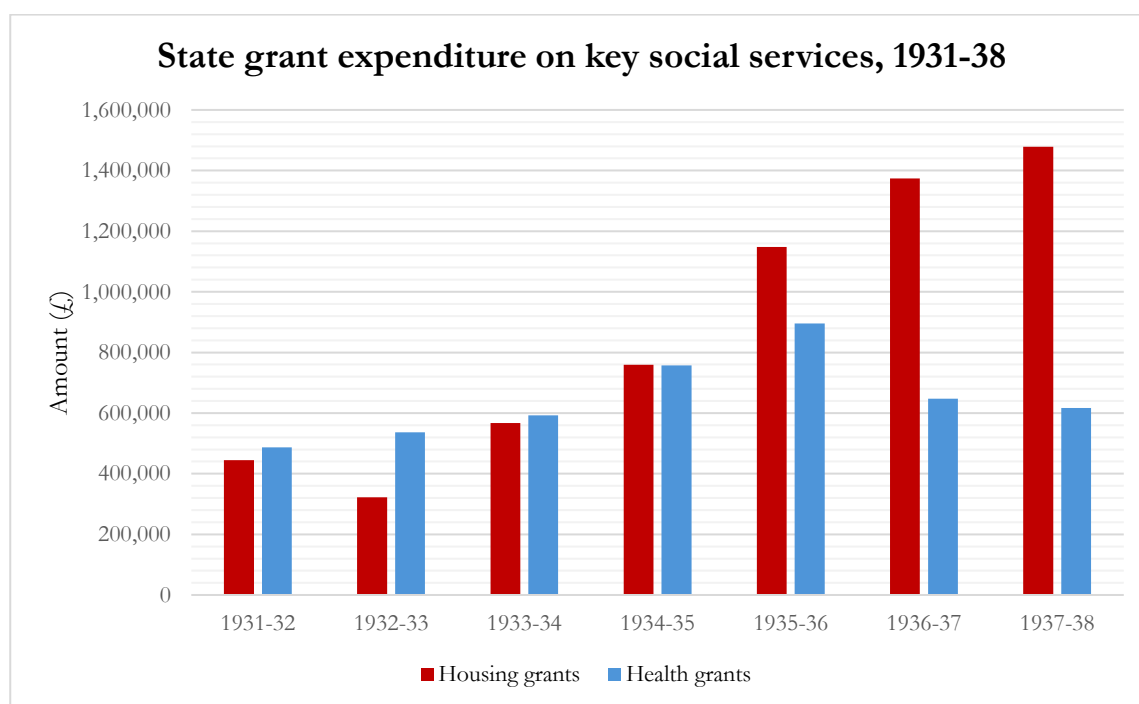


Figure 1.1 State expenditure on key social services, 1931-38 (1938 figures were listed as estimates, all other figures are exact).²⁴

evident in the 1920s, became even more pronounced in the 1930s.²⁵ This occurred despite the stated objectives of the 1931 and 1932 Housing Acts to prioritise the clearance of urban slums.²⁶

²² *DÉD*, 11 Apr. 1940, vol. 79, no. 11 (Patrick J. Rutledge).

²³ Department of Finance memorandum on social services spending, 1931-38 (NAI, FIN/F/200/23/36).

²⁴ *Ibid.*

²⁵ Daly, *The buffer state*, p. 248.

²⁶ *Ibid.*

Thus, the newly formed republican party, Clann na Poblachta, under the leadership of Seán MacBride, had early successes in the face of wider Fianna Fáil shortcomings at the presidential election in 1945, and again in the 1947 by-elections.²⁷ In particular, their social and economic policies were similar to those of the Labour Party.²⁸ Opposition parties, who were united by their shared goal of offering an alternative to Fianna Fáil government, campaigned on a 'Put [Fianna Fáil] out!' ticket. Together with Fine Gael, these opposition parties successfully managed to remove Fianna Fáil from power by forming a new government – a coalition between Fine Gael, Clann na Poblachta, the Labour Party, Clann na Talmhan and the National Labour Party.²⁹

Between 1939 and 1953, there were four different ministers with responsibility for health: Patrick J Ruttledge (1939-41), Seán MacEntee (1941-47); James Ryan (1947-48 and 1951-54), all members of Fianna Fáil, and Clann na Poblachta's Noël Browne (1948-51). Because the supply situation became particularly severe in Ireland from 1941 onwards when the country was subject to a harsh British trade squeeze, this study is mostly concerned with the activities of MacEntee, Ryan, and Browne.³⁰ MacEntee, a prominent right-leaning Belfast nationalist, was the Minister for Industry and Commerce at the beginning of the war, and only became the Minister for Local Government and Public Health in 1941.³¹ This is important because MacEntee came into the health role with first-hand experience of the management of the country's deteriorating supply situation as will be explored in Chapter Two. Ryan was a Wexford-born doctor and politician. Having completed his final examinations in 1942, Browne, was also a qualified doctor (see figure 1.2).³² The significance of this will be further alluded to in Chapter Six on tuberculosis, where substantial reforms were passed under both Ryan and Browne. Browne had a particular interest in TB – his parents and infant sister died from the disease, while he, his brother and two of his other sisters were also diagnosed with the disease.³³ Browne was the house physician in Newcastle TB sanatorium briefly in 1942 and went to work in English sanatoria before taking up a post as minister in 1948.³⁴ However, his endeavours in

²⁷ Brian Girvin, 'Stability, crisis and change in post-war Ireland, 1945-1973' in Thomas Bartlett (ed.), *The Cambridge history of Ireland: volume iv, 1880 to the present* (Cambridge, 2018), p. 386.

²⁸ Niamh Puirseil, 'Labour and coalition: the impact of the first inter-party government, 1948-51' in *Saothar*, xxvii (2002), p. 57.

²⁹ Ibid.

³⁰ Bryce Evans, *Ireland during the Second World War: farewell to Plato's cave* (Manchester, 2014), p. 45.

³¹ Ibid., p. 18; Tom Feeney, 'Seán MacEntee and the development of public policy in independent Ireland: thesis abstracts' in *IESH*, xxxiv (2007), pp 79-81.

³² Noël Browne, *Against the tide* (Dublin, 2012), p. 56.

³³ Ibid., p. 22.

³⁴ *Fiftieth annual report of the Board of Governors of the Royal National Hospital for Consumption in Ireland for the year ending 31 December 1942*, p. 12 (Royal College Physicians Ireland Archives (hereafter RCPI), RNHC/1/2/5). In 1945, Browne returned to Newcastle Sanatorium where he was made medical superintendent in 1945. For further detail, see Greta Jones, *'Captain of all these men of death': the history of tuberculosis in nineteenth and twentieth century Ireland* (Amsterdam, 2001), p. 169.

the Mother and Child Scheme did not meet with the same level of success, ultimately putting an early end to his ministerial career.³⁵ This will be discussed in Chapter Three.



Figure 1.2 Noël Browne, John Costello and Seán MacEntee (left to right) pictured at the 1948 election.³⁶

The Department Secretary, who served as the Minister's second-in-command, held administrative oversight of the Department and exercised authority over the various units. As the primary liaison between the Minister and the Department, the Secretary was responsible for ensuring that allocated funds were used in accordance with the purposes specified in the vote.³⁷ From 1922 until 1936, Edward P. McCarron was the Department Secretary. He was removed by Seán T. O'Kelly, then Vice-President of the Executive Council, over a controversial medical appointment in Dublin psychiatric hospitals.³⁸ Having served as one of most active departments of the Irish Free State, McCarron proved to be 'undoubtedly a man of outstanding ability' and 'an extremely active and reforming secretary'.³⁹ These qualities proved useful in his time under O' Kelly, whose priorities lay in slum clearance and housing-building between 1932 and 1939.⁴⁰ Even before Fianna Fáil came to power in 1932, McCarron publicly indicated a change in

³⁵ For reference, see John Horgan, 'Browne, Noel' in *DIB (online)*, DOI: <https://doi.org/10.3318/dib.001041.v1>.

³⁶ Re-produced from *Times Pictorial* (hereafter *TP*), 26 May 1951.

³⁷ Hensey, *The health services*, p. 45.

³⁸ Brendan O' Donoghue, 'McCarron, Edward Patrick' in *DIB (online)*, DOI: <https://doi.org/10.3318/dib.009569.v1>.

³⁹ Daly, *The buffer state*, p. 166.

⁴⁰ Cathal O' Connell, *The state and housing in Ireland: ideology, policy and practice* (New York, 2007), pp 31-35.

direction in housing policy, noting how policy should be targeted at the eradication of slums and over-crowded houses.⁴¹ This tied in with Fianna Fáil ambitions in its years in opposition, where the party was highly critical of the failure of Cumann na nGaedheal to introduce a comprehensive housing system, which Fianna Fáil corrected through notable housing programmes in the 1930s under the Housing Act 1931.⁴² Between 1932 and 1942, a total of 82,000 houses were built with state assistance.⁴³ Such was the emphasis placed by Fianna Fáil's on its housing programme that McCarron sought more staff, pointing out that 19,000 enquiries covering approximately 10,000 houses had been received by 27 October 1932.⁴⁴ McCarron was succeeded by James Hurson, who was previously assistant secretary and former Local Government Board official, though not as experienced as McCarron.⁴⁵

Between 1932 and 1946, Dr Conn Ward was the Parliamentary Secretary until his resignation over tax rows.⁴⁶ Ward was a key player in post-war public health planning, and thus will be present in each of the chapters. When Éamon de Valera announced in 1946 that a new Department of Health would be established, it was widely anticipated that Ward would become Ireland's first Minister of Health.⁴⁷ Although Ward was known for his 'legislative ambition' for far-reaching reforms, this did not do him any favours among the medical profession, who feared nationalisation of the health services.⁴⁸ Before this post, Ward took a number of public-facing roles: he was a medical officer for Scotstown in Monaghan in 1915 and for Dundalk in 1919.⁴⁹ Ward was also known to often consult with members of the Catholic Church on medical concerns, particularly Dublin archbishop John Charles McQuaid.⁵⁰ Next-in-line were the Chief Medical Adviser (CMA) along with four other assistant secretaries who had responsibility for the administration of an allocated set of services. They reported on any issues they faced to the Parliamentary Secretary directly.⁵¹ In 1944, Dr James Deeny was appointed Ireland's first ever CMA (see figure 1.3).⁵²

Lurgan-born Deeny became a key figure driving change in public health in Ireland between 1939 and 1953. Featuring prominently in each of the chapters, Deeny was particularly

⁴¹ Daly, *The buffer state*, p. 215.

⁴² *Ibid.*, p. 219.

⁴³ *Ibid.*, 221.

⁴⁴ McCarron to Dept. of Finance, 27 Oct. 1932 (NAI, FIN E36/7/32).

⁴⁵ Daly, *The buffer state*, p. 167.

⁴⁶ Ward resigned due to controversies over his tax irregularities. See Lindsey Earner-Byrne, 'Managing motherhood: negotiating a maternity service for Catholic mothers in Dublin, 1930-1954' in *SHM*, xix, no. 2 (2006) p. 269.

⁴⁷ Laurence W. White, 'Ward, Francis Constantine' in *DIB*. For further reference, see Elaine Byrne, *Political corruption in Ireland, 1922-2010: a crooked harp?* (Manchester, 2012), pp 47-48.

⁴⁸ *Ibid.*, p. 48.

⁴⁹ *IT*, 29 Jun. 1946.

⁵⁰ Eamonn McKee, 'Church-State relations and the development of Irish health policy: the mother and child scheme, 1944-53' in *IHS*, xxv, no. 98 (1986), pp. 167.

⁵¹ Hensley, *The health services*, p. 45.

⁵² *IT*, 19 Sept. 1944.

interested in the tenets of social medicine and as evidenced from his extensive publications in this area. His interests were in line with those found elsewhere in Europe and the US at this time, where health programmes were aimed at social factors, such as hygiene, housing and diet.⁵³ He was also unusual in his knowledge of developments in Northern Ireland and the UK, where



Figure 1.3 James Deeny pictured in 1944.⁵⁴

he contributed to several medical studies. Deeny concluded in 'The assessment of nutrition', published in 1938 that 'it is imperative that more thought should be given to the problem'.⁵⁵ During the same year, he conducted a survey of the nutritional status of male linen-factory workers in Lurgan. In February 1939, the results of this were published in the *British Medical Journal* and they indicated a distinct correlation between malnutrition, large families, and low-

⁵³ Paul Weindling, 'From germ theory to social medicine' in Deborah Brunton (ed.), *Medicine transformed: health, disease and society, 1800-1930* (Manchester, 2004) p. 239. In Britain, 'social medicine' was given its own academic discipline in the 1940s, see Dorothy Porter, 'Introduction' in Porter (ed.), *Social medicine and medical sociology in the twentieth century* (Amsterdam, 1997), p. 1.

⁵⁴ *TP*, 22 Sept. 1944.

⁵⁵ James Deeny, 'The assessment of nutrition' in *Ulster Medical Journal*, vii, no. 3 (1938), p. 213.

income levels.⁵⁶ Thereafter, he became renowned for his works on the relationship between poverty, nutrition, and illness as he wrote extensively around nutrition and vitamin deficiencies.⁵⁷ Indeed, it was Deeny who was given key lead on the state's first national nutrition survey in April 1946. This is important because it was in the same year that a full-scale campaign against diarrhoea and enteritis among infants was introduced – the state's official Gastro-Enteritis Committee was established in December 1946 with Deeny as acting chairman. Earlier, he had conducted a survey of infant mortality; and he later did the same for tuberculosis.⁵⁸ As CMA, his interests in these areas were reflected in the aims of the new Department of Health in 1947, as well as the health initiatives that were passed during this period. Together, this not only reminds us of the scope of Ireland's public health regime during the Emergency period, but that it faced significant public health problems. Often, this involved many of the same people who were operating against the same financial constraints.

1.3 Finance

Though there were some minor financial extensions granted, those responsible for financing the Irish health services remained largely unchanged during the first half of the twentieth century. It was the local authorities who bore the responsibility of paying for health provision in their area. These were initially aided by modest state grants that were introduced in late nineteenth century and continued after independence.⁵⁹ These local authorities were numerous – they included county councils, county borough councils, or joint boards of two or more councils, sanitary authorities, mental hospital authorities and public assistance authorities, who raised monies for various health services from local taxation received.⁶⁰ In the early twentieth century, grants such as the Estate Duty Grant and the License Duty Grant were carried over.⁶¹ Often, these went toward paying the salaries of medical staffs, schoolmasters and mistresses in workhouses and the sanitary authorities while a capitation grant was given per head for patients in mental institutions.⁶² These authorities operated separately and as Hensey notes, they were 'designed to meet a specific demand which could be answered by referring to the current social theory'.⁶³ In his view, the sick poor had to be housed, contagious fevers could not be left to spread, and those who were suffering from mental illness were institutionalised – it was 'these

⁵⁶ Deeny, 'Clinical and social survey of male linen weavers', in *BMJ*, i, no. 267 (Feb. 1939), pp 267-270.

⁵⁷ Deeny, 'Polycythaemia and vitamin C' in *BMJ*, ii, no. 4172 (1940), pp 864-6 and 'Riboflavin deficiency: with a case report' in *BMJ*, ii, no. 4272 (1942), p. 607.

⁵⁸ Deeny and Eric T. Murdock, 'Infant mortality in the city of Belfast' in *Dublin Journal of the Statistical and Social Inquiry Society of Ireland*, xvii (1944), pp 221-240. For TB, see Deeny, *Report of the National Tuberculosis Survey, 1950-53* (Dublin, 1954).

⁵⁹ Hensey, *The health services*, p. 22.

⁶⁰ *Ibid.*, p. 11.

⁶¹ *Ibid.*, pp 5-6.

⁶² *Ibid.*

⁶³ *Ibid.*, p. 2.

hard facts, and not any clear vision of where they were moving' that influenced the actions of public administrators.⁶⁴

During the 1920s, there were efforts to dismantle the Poor Law system, which had been a heavily criticised reminder of British rule. County hospitals and county homes replaced the workhouses spread throughout the country, while Poor Law Unions and Boards of Guardians were replaced with a system that sought to centralise local administration, and institutional relief in each county. While the Irish Free State sought to improve conditions, reformers feared that a new relief system could lead to an increase in welfare dependency following the closure of the workhouses.⁶⁵ Official policy-making was also heavily influenced by what Lucey describes as 'highly moralistic attitudes' regarding sexuality and illegitimacy, which were emphasised by the increased Catholicism of the Irish Free State.⁶⁶ Mother and baby homes, along with other institutions, such as industrial schools and orphanages thus confined individuals who failed to meet up to prevailing social doctrines.⁶⁷ Further, in practice, local authorities were neither able nor encouraged to consider their services in relation to a wider and bigger health system as a whole. Local authorities showed little initiative in using their powers and 'many even refused to apply in their districts those asks'.⁶⁸ It is therefore necessary to view these health infrastructures individually; not as part of a fully-functioning health service that we would recognise today. There was not even a single department dedicated solely to public health up until 1947, when local government was separated out.

This is not to say there were no financial changes in the health services. There were subtle increases in state expenditure in the post-independence period. For example, special grants were introduced for the first time to cover half of the cost of the TB service, the school medical services and child welfare schemes.⁶⁹ A similar grant met 75% of the expenditure required to combat venereal disease.⁷⁰ In 1932, a fixed grant was designed to finance the provision of free milk by local authorities to children of lower socio-economic backgrounds.⁷¹ The Hospital's Trust Fund became another important source of funds for the health services in the 1930s.⁷² The income of this fund came from the Irish Sweepstakes on horseracing which was legalised by the Irish State in 1930 'for the sake of the hospitals' despite an inherent political

⁶⁴ Ibid.

⁶⁵ Donnacha Seán Lucey, *The end of the Irish Poor Law? : welfare and healthcare reform in revolutionary and independent Ireland* (Manchester, 2015), p. 189.

⁶⁶ Ibid., p. 190.

⁶⁷ Ibid.

⁶⁸ Morgan Crowe, 'The origin and development of the public health services in Ireland' in *IJMS*, vi, no. 265 (Jan. 1948), p. 3.

⁶⁹ Hensey, *The health services*, p. 14.

⁷⁰ Ibid.

⁷¹ Ibid.

⁷² Public Hospitals Act, 1933 (1933 no. 18) (27 Jul. 1933).

dislike and suspicion of the sweepstakes.⁷³ Marie Coleman observes that, much to the British government's dismay, the promoters aimed to sell most of their tickets outside of Ireland (owing to Ireland's small population), specifically in Britain and North America despite the prohibition of gambling in these areas.⁷⁴ These funds were used for capital expenditure and to pay for any debts incurred on the back of the expenses of the voluntary hospitals.⁷⁵ This source proved invaluable for Ireland's voluntary hospitals who were otherwise struggling to meet the rising costs of maintenance at this time.⁷⁶ In 1933, the Hospital Commission was established by the Public Hospitals Act.⁷⁷ This provided for far more extensive government investigations about the conditions and needs of hospitals throughout the country.⁷⁸ However, there was still little co-ordination among these hospitals, who were determined to maintain control of their own affairs despite the new state allocation of funds.⁷⁹ Apart from these developments, the financial conditions remained largely unchanged until after the war.

The 1930s were years of crisis and change in Ireland in political and economic terms.⁸⁰ In their analysis on protectionism and structural change in the 1930s, Peter Neary and Cormac Ó Gráda note that reduced levels of employment and falling trade output in the final years of the Cumann na nGaedheal government (in power since independence in 1922) meant that when Fianna Fáil came to power in 1932, they were influenced by both severe economic pressures and by their ideological commitments.⁸¹ In this way, the distinctly protectionist policies associated with de Valera and Seán Lemass – two 'key men of the new regime' – aimed to create jobs quickly in the short-term and to build a sustainable industrial base that would be geared for the home market in the long-term.⁸² This had important implications for the Irish Exchequer. Bielenberg and Ryan argue that the Irish Department of Finance after independence in 1922 was closely modelled on that of the British Treasury.⁸³ Mary Daly likewise notes that Finance even had a direct telephone line to the British Treasury until the 1940s.⁸⁴ Like the British Treasury, Ireland's Department of Finance had a preeminent position within the civil service by

⁷³ Marie Coleman, *The Irish sweep: a history of the Irish Hospital Sweepstake, 1930-87* (Dublin, 2009), p. 15.

⁷⁴ Substantial amounts of money leaving Britain at a time of economic depression was of particular concern for the British authorities, see Coleman, 'A terrible danger to the morals of the country': the Irish Hospitals' Sweepstake in Great Britain 1930-87' in *Proceedings of the Royal Irish Academy: Archaeology, Culture, History, Literature*, cv, no. 5 (2005), p. 197 and p. 202.

⁷⁵ Hospital's Trust 1940 (Ltd), *Ireland's Hospitals 1930-1955* (Dublin, 1956), p. 17.

⁷⁶ Ibid.

⁷⁷ See Section 17, Public Hospitals Act, 1933 (1933 no. 18) (27 Jul. 1933).

⁷⁸ Ibid.

⁷⁹ Coleman, *The Irish Sweep*, p. 54.

⁸⁰ J. Peter Neary and Cormac Ó Gráda, 'Protection, economic war and structural change: the 1930s in Ireland' in *IHS*, xxvii, no. 107 (1991), p. 250.

⁸¹ Ibid.

⁸² Ibid.

⁸³ Andy Bielenberg and Raymond Ryan, *An economic history of Ireland since independence* (Oxfordshire, 2013), p. 10.

⁸⁴ Mary E. Daly, 'The Irish Free State and the Great Depression of the 1930s: the interaction of the global and the local' in *IESH*, xxxviii (2011), p. 21.

retaining the control of all financial activities of the other government departments.⁸⁵ However, when Fianna Fáil came to power in 1932, there were some key changes to their powers. Important financial measures, such as the preparation of the budget, which was previously the responsibility of the Department of Finance, became the responsibility of both the Minister of Finance and the wider Cabinet.⁸⁶ In turn, this led to conflict surrounding economic policies of the 1930s between the Departments of Finance and of Industry and Commerce.⁸⁷ Prior to the outbreak of the war ‘the influence of the Department of Industry and Commerce in directing economic policy increased, while conversely the Department of Finance lost its premier status’.⁸⁸ As Elaine Byrne notes, the Department of Industry and Commerce had more control over the country’s economic policy than any other government department at this time.⁸⁹ This paved the way for Lemass to hold a very powerful position during the war.

Following the outbreak of the war, the Emergency Powers Act 1939 provided the legislative framework by which the state could take control over all supplies and services that were deemed ‘essential to the life of the community’.⁹⁰ On paper, provisions may have conferred upon the Department of Finance far-reaching powers in relation to initiating emergency orders, though as Fanning notes, the Department was less concerned with implementing their own orders than with dealing with the orders coming from other departments, notably Supplies, Industry and Commerce, Agriculture and Defence.⁹¹ This included controls on essential imports, exports, supplies and services.⁹² It likewise extended government control to the movement, storage, sale and distribution of goods.⁹³ In effect, this allowed Fianna Fáil to pass orders without detailed interrogations in the Dáil. Like other nation states during the war, the Irish government assumed significant powers over the public, and ‘not least because the national food supply assumed paramount importance’.⁹⁴ Other government departments likewise took on far-reaching interventionist projects during the war. For example, the Department of Agriculture enforced a compulsory tillage scheme that required Irish farmers to till wheat and other essential crops during the war while tillage inspectors ensured, where possible, that these quotas were met.⁹⁵ Public notices were also issued by the Department of Agriculture through

⁸⁵ Bielenberg and Ryan, *An economic history*, p. 10. Also see Ronan Fanning, *The Irish Department of Finance: 1922-58* (Dublin, 1978), p. 308.

⁸⁶ Bielenberg and Ryan, *An economic history*, p.13.

⁸⁷ Ibid.

⁸⁸ Ibid., pp 14-15.

⁸⁹ Byrne, *Political corruption in Ireland*, p. 38.

⁹⁰ Emergency Powers Act (hereafter EPA), 1939 (1939 no. 28) (3 Sept. 1939).

⁹¹ Fanning, *The Irish Department of Finance*, pp 309-310.

⁹² Emergency Powers Act (hereafter EPA), 1939 (1939 no. 28) (3 Sept. 1939).

⁹³ Ibid.

⁹⁴ Evans, ‘Food, the Emergency and the lower-class body, c. 1939-45’ in David Durnin and Ian Miller (eds), *Medicine, health and Irish experiences of conflict* (Manchester, 2016), p. 45.

⁹⁵ Evans, ‘Coercion in the Irish countryside: the Irish smallholder, the state, and compulsory tillage, 1939-49’ in *IESH*, xxxviii (2011), p. 1.

newspapers (see figure 1.4). In other areas, the Department of Justice, helped by the Gardaí, used extensive measures to combat the upsurge of crime within the black markets that came with the introduction of wartime rationing in Ireland.⁹⁶ Coverage was also given to market incentives elsewhere (see figure 1.5).

Bryce Evans argues that security and survival were the main priorities for the Irish government during the war.⁹⁷ The stabilisation of the Irish economy was imperative to maintaining this security. In the anticipation that shortages would occur, the Department of

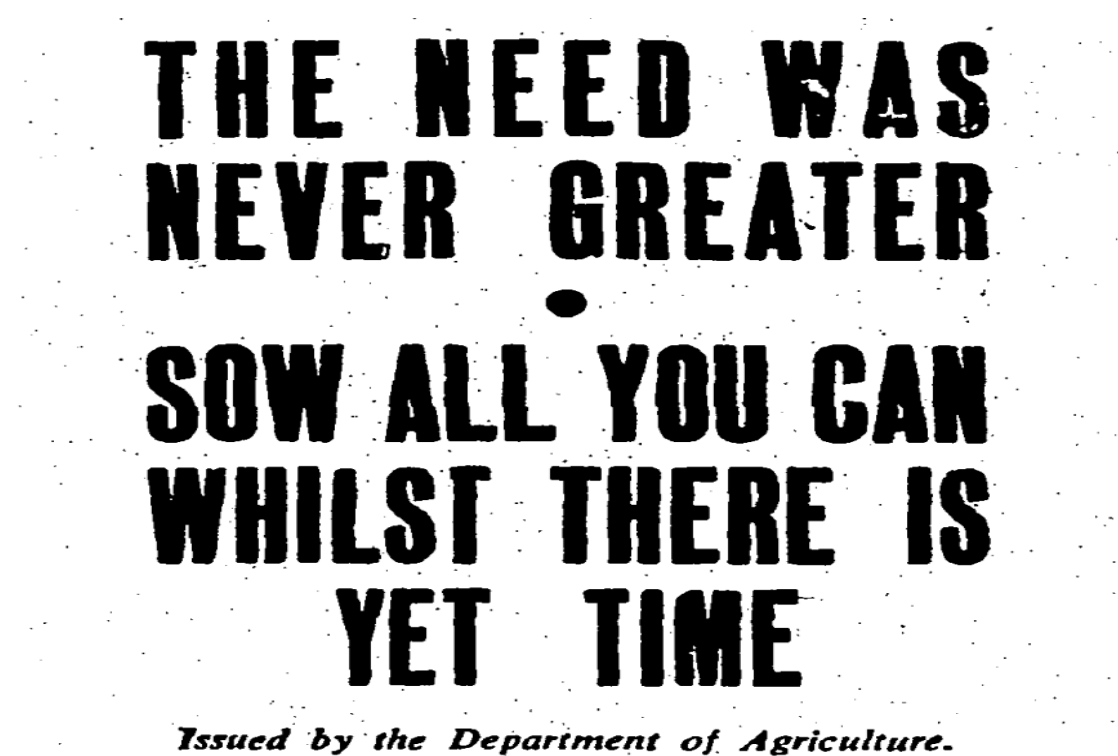


Figure 1.4 Department of Agriculture appeal to farmers, warning of the severity of the food situation in Ireland, 21 April 1945.⁹⁸

Supplies, established in 1938 under the Department of the Industry and Commerce, came into effect on 8 September 1939.⁹⁹ Lemass left the Department of Industry and Commerce at the beginning of the war and was transferred to the head of the newly established Department of Supplies – a department given substantial powers through the Emergency Powers Act. A further cabinet reshuffle in August 1941 meant that Lemass regained control of his old department while also maintaining his position as Minister for Supplies.¹⁰⁰ Importantly, the work of this department came from a business standpoint and focused on maintaining supplies and controlling rationing for the duration of the war (see figure 1.5). As Minister for Supplies,

⁹⁶ Evans, *Ireland during the Second World War*, p. 9.

⁹⁷ *Ibid.*, p. 1.

⁹⁸ *TP*, 21 Apr. 1945.

⁹⁹ Evans, *Ireland during the Second World War*, p. 19.

¹⁰⁰ *Ibid.*, p. 163.

Lemass was charged with the ‘treatment, keeping, storage, movement, distribution, sale, purchase, use and consumption’ of all goods and commodities throughout the war period.¹⁰¹ This is particularly relevant to Chapter Two on calcium deficiency – a direct result of Irish economic policies at this time. When it came to financing health initiatives during the war period, the scale of additional powers that Lemass assumed at this point cannot be ignored.



Figure 1.5 Image of a ‘Swap Market’ in Berlin, c. 1948.¹⁰²

Through funding allocations the Departments of Industry and Commerce and Finance, not the Department of Local Government and Public Health, were ultimately responsible for the introduction of health measures. Wartime circumstances saw the Department of Industry and Commerce and the Department of Local Government and Public health attempting to fulfil their basic functions in difficult economic conditions. On the health side, MacEntee’s Department of Local Government and Public Health focused on combatting disease. In relation to local government, the same department was also responsible for the maintenance of roads, the provision of water and fire-fighting services and the organisation of the local elections.¹⁰³ Though this department was a spending department, the extent of funds available for health services not funded by local rates depended on funding allocations from the Department of

¹⁰¹ Record of Activities (NAI, IND/HER/3/15, p. 2).

¹⁰² *TP*, 10 Jan. 1948. ‘Swap’ Markets were used in Berlin in an attempt to control and regularise the black market amid food shortages. Here, all participants paid an entrance fee, and brought their goods in the hopes of exchange.

¹⁰³ *IT*, 7 Nov. 1944.

Industry and Commerce and the Department of Finance. In normal times, health policy was influenced by submissions made by the Minister for Local Government and Public Health to the Minister for Finance, who then considered the proposal from a cost perspective alongside the Department of Industry and Commerce.¹⁰⁴ However, the latter was

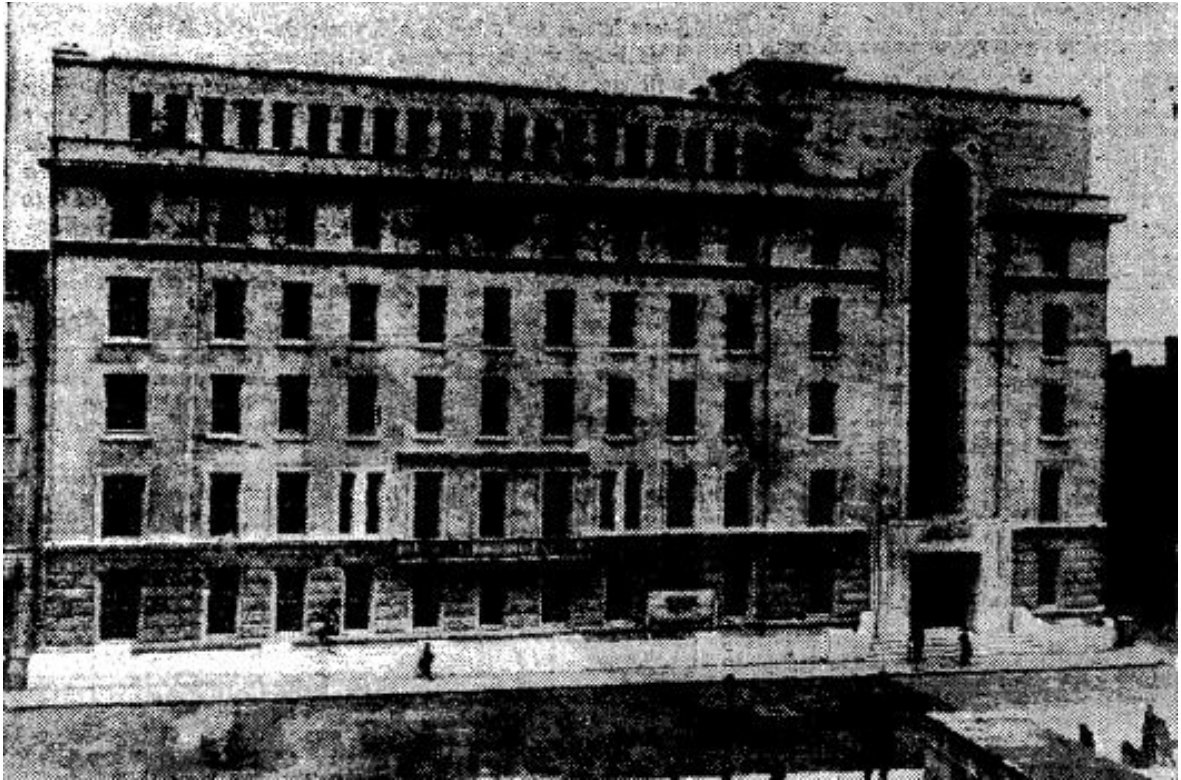


Figure 1.6 New government office for the Departments of Industry and Commerce and Supplies on Kildare Street, Dublin, on the site of an old hotel, November 1942.¹⁰⁵

heavily bound by the state resources that Ireland had during the war – and this was determined by Lemass at this crisis juncture. Not helping this situation were internal relations – both Lemass and MacEntee have been portrayed as continuously at odds with one another, although this view has recently been challenged (see figure 1.7).¹⁰⁶ This is important because further Emergency Orders passed during the war such as those that increased flour extraction rates, loosened milk regulations and loosened regulations on therapeutic substances, focused on maximising the existing supply situation and not on public health. To instigate any specific public health action, the minister for the Department of Local Government and Public Health then had to point out how the policy of Industry and Commerce was affecting public health outcomes.

¹⁰⁴ Hensey, *The health services*, p. 44.

¹⁰⁵ *IT*, 14 Nov. 1942. This was the first time both departments would share the same office building.

¹⁰⁶ Tom Feeney, *Seán MacEntee: A Political Life* (Dublin, 2009), p. 234.



Figure 1.7 Seán MacEntee (left) and Seán Lemass looking over the programme of the Fianna Fáil 21st Anniversary Celebration, held in the Capital Theatre, Dublin, 1947.¹⁰⁷

1.4 Other organisations involved in health policy negotiations

Advisory organisations also played a key role in negotiating Ireland's public health policies during the Emergency period. Established as a limited liability company in January 1937, the Medical Research Council sought to organise and carry out medical research in Ireland.¹⁰⁸ Initial subscribers included those with research interests in social and preventative medicine such as Joseph Warwick Bigger, who was Professor of Preventative Medicine and Bacteriology in Trinity, William J. E. Jessop, who was Professor of Physiology in the Royal College of Surgeons and J. M. O' Donovan, Professor of Medicine in University College Cork, among others.¹⁰⁹ Later in 1946, Bigger was also a member of the official Gastro-Enteritis Committee which sought to combat infant mortality in urban areas.¹¹⁰ Jessop was also interested in nutrition – he became a prominent member of the Dietetic Council (as will be discussed below) as well as the Medical Association of Éire. From the outset, the council was allocated £10,000 per year by the Hospitals Commission who directed funds on behalf of the Sweepstakes, as well as the

¹⁰⁷ *TP*, 24 May 1947.

¹⁰⁸ *IT*, 30 Jan. 1937.

¹⁰⁹ *Ibid.*

¹¹⁰ Department of Local Government and Public Health (hereafter DLGPH) memorandum on the Gastroenteritis Advisory Committee (hereafter GEAC), c. Sept. 1946 (NAI, HLTH M34/vol.2).

Department of Local Government and Public Health.¹¹¹ Up until the outbreak of war, its main concern was with research into the causes and cures of diseases and proportions of its funds were given to research projects in these areas.¹¹²

Following requests from the Department of Industry and Commerce and the Council of the Federation of Irish Manufactures, the Emergency Scientific Research Bureau (hereafter ESRB) was established on 20 February 1941. Because the ESRB tackled industrial problems faced by agriculture, clothing, food, building and engineering industries, its activities feature most in Chapter Two on calcium deficiency.¹¹³ In supporting the Department of Supplies, this bureau was advisory and it comprised leading businessmen and scientists who examined the possibilities of using indigenous raw materials where wartime shortages were most serious.¹¹⁴ Professor J. J. Dowling was the bureau's chairman – he was a founding member of the Institute of Physics and had been a fellow-student with de Valera at Blackrock College, which was accredited by the Royal University of Ireland.¹¹⁵ He was also a notable figure in the Federation of Irish Manufacturers Ltd.¹¹⁶ Other key members included Dr T. S. Wheeler and Professor M. A. Hogan, both of whom were influential scientists in their fields (chemistry and geology).¹¹⁷ As Bradley points out, all members were Dublin residents, and this made possible 'almost daily contact' with fellow bureau officers and those of the Department of the Taoiseach.¹¹⁸ Initially proposed for the duration of one year, the bureau continued for a further three years until dissolution in March 1945 with its members paid 'an honoraria at a rate of £300 per year'.¹¹⁹ Although it existed independently outside the direct control of the Department of Industry and Commerce under the Department of the Taoiseach instead, its purpose was to advise, with the Department of the Taoiseach ultimately holding the last say.

In a memorandum addressed to the Department of the Taoiseach in May 1941, Lemass, conscious of the country's deteriorating food supply, urged that 'a committee of qualified people, including experts in human and animal nutrition, should be set up to survey the whole question of our present and future food supplies and to make recommendations for their most economic use'.¹²⁰ The urgency of this request was driven by increasingly precarious supply situation at this time. Thus, the Dietetic Council was established by the Medical Association of

¹¹¹ *IT*, 22 Feb. 1937. Also see Hensey, *The health services*, p. 150.

¹¹² Hensey, *The health services*, p. 150.

¹¹³ Robert J. A. Bradley, 'The Emergency Scientific Research Bureau, 1941-1945' (PhD, TCD, 1991), p. 115.

¹¹⁴ *Ibid.*, p. 110.

¹¹⁵ *Ibid.*, p. 122.

¹¹⁶ *Ibid.*

¹¹⁷ *Ibid.*, pp 122-124.

¹¹⁸ *Ibid.*, p.120.

¹¹⁹ Cabinet Committee minutes on emergency problems, 6 Feb. 1941 (NAI, TAOIS/S 12282).

¹²⁰ Seán Lemass memorandum on food supplies, 9 May 1941 (NAI, TAOIS/S 121131).

Éire on 24 October 1941 in reaction to the growing food supply crisis.¹²¹ Deliberations of this council feature most in Chapter Two alongside the ESRB. This council consisted of members of the Medical Association of Éire with an interest in nutrition, and its function was to make recommendations to the government on food issues during the war. This was essentially a body representative of the medical profession in Ireland set up to 'be available to give advice on to the government on dietetics if the need arose'.¹²² Jessop was a prominent member of the Dietetic Council. During the 1940s, he became interested in rickets surveys before becoming heavily involved in the research around the national nutrition survey, which would later be complimented by his engagement in dental surveys. These eventually culminated in the fluoridation of all Irish water supplies in 1964.¹²³ Dr William Fearon was also among its members, and he had previously spent two years as a Mackinnon biochemistry research student of the UK's Royal Society under the direction of Sir Frederick G. Hopkins, who won the 1929 Nobel Prize for medicine having become a pioneer in vitamin research.¹²⁴ Fearon also developed a keen interest in nutrition and public health in Ireland, as seen in his publications and later involvement in the later national nutrition survey.¹²⁵ Other key members included Dr P. T. O'Farrell and Dr J. Mowbray, who specialised in diets at their host organisations.¹²⁶ Like the ESRB, most of the council's members were Dublin residents.¹²⁷

Any examination of the efficacy of these bodies and their influence in informing health policy must consider the economic climate in which they operated. Bradley notes that Ireland was 'virtually isolated from the available marketplaces of the world' by the military blockade that was imposed by the Allies to prevent the movement of supplies between Germany and Italy, beginning in September 1939.¹²⁸ Second, Britain responded to Ireland's insistence on neutrality through a series of severe economic sanctions in attempts to force Ireland into siding with the Allies. These sanctions worsened in severity from late 1940 onwards.¹²⁹ This position highlighted the extent to which Ireland was economically reliant on Britain at precisely the time when the British government showed very little sympathy toward Ireland's difficulties.¹³⁰ What this meant was that the investigations and projects launched by each of these bodies were subjected to, and at times, interrupted by economic uncertainties. While substantial funds were

¹²¹ Ciarán Bryan, 'Rationing in Emergency Ireland' (PhD, NUIM, 2014), p. 246.

¹²² ESRB memorandum on rickets and flour, 11 Jun. 1943 (NAI, TAOIS/S 12064).

¹²³ W. J. E. Jessop, 'Medical research in Ireland' in *Hermathena*, xcix (1964), pp 34-37.

¹²⁴ Patricia M. Byrne, 'Fearon, William Robert', in *DIB (online)*, DOI: <https://doi.org/10.3318/dib.003028.v1>.

¹²⁵ For relevant works of William R. Fearon, see Fearon and Dorothy L. Foster, 'The autolysis of beef and mutton' in *Biochemical Journal*, xvi, no. 5 (1922), pp 564-571; Fearon et al., 'The national problem of nutrition (with comments)' in *Studies: An Irish Quarterly Review*, xxvii, no. 105 (1938), pp 12-34, Fearon and G. C. Dockeray, 'Antenatal nutrition in Dublin: a preliminary survey' in *IJMS*, (1939), pp 80-84.

¹²⁶ *Nenagh Guardian*, 18 Oct. 1941, p. 3.

¹²⁷ *Ibid.*

¹²⁸ Bradley, 'The Emergency Scientific Research Bureau' p. 254.

¹²⁹ Evans, *Ireland during the Second World War*, p. 6.

¹³⁰ Bradley, 'The Emergency Scientific Research Bureau', p. 255.

initially allocated to the Medical Research Council, it was perceived by the Council that much more could be done by way of financing further medical research.¹³¹ Their position was such that if they had more money some of the ‘brilliant young men (doctors) who go abroad could be kept at home’.¹³² For the ESRB, fluctuations in supplies determined the nature of the topics for their investigation, their order of precedence, and whether particular investigations could meet their successful conclusion or their early determination.¹³³

1.5 International influences

International developments in public health provisions, especially those in Britain, had a significant impact on Irish policymakers’ discourse on reforms in the 1940s. While Irish politicians sought to develop policies that showcased Ireland’s independence from Britain, the political and geographical reality ensured that British expertise and developments continued to have a decisive impact on various healthcare measures.¹³⁴ The publication of Sir William Beveridge’s *Social insurance and allied services* in December 1942, which anticipated the extension of the remit of the State in welfare provision in the post-war years, profoundly influenced debates on Irish social policy.¹³⁵ In Ireland, the Beveridge Report prompted wider debate around post-war planning, and a variety of proposals for the reform of Irish society emerged towards the end of the war. Evidence of this can be found in the extensive coverage given to the topic in the Irish press, what Steven Curran terms as the same post-war planning ‘fever’.¹³⁶ While MacEntee may have found the report as bearing ‘in every characteristic to those totalitarian organisations’ he opposed, he also acknowledged a need for greater government control for public health matters as early as 1944.¹³⁷ This occurred in a context where the country faced numerous social problems – higher rates of malnutrition, infant mortality, tuberculosis, and emigration during the war, and precisely when the Irish state lacked a coherent policy to address these issues. The short-term changes precipitated in Ireland by these discussions were the introduction of children’s allowances in 1944 and the establishment of separate Departments of Health and Social Welfare in 1947.¹³⁸ Lucey observes that the threat of war also forced the

¹³¹ *IT*, 16 Dec. 1940.

¹³² *Ibid.*

¹³³ Bradley, ‘The Emergency Scientific Research Bureau’, pp 255-256.

¹³⁴ Donnacha Seán Lucey and Virginia Crossman, *Healthcare in Ireland and Britain, 1850-1970: voluntary, regional and comparative perspectives* (London, 2014), p. 13. Also see John Privilege and Greta Jones, ‘Crisis and scandal: government, local government and health reform in Northern Ireland, 1939-44’ in *IESH*, xlii (2015), p. 33.

¹³⁵ The Beveridge Report is often regarded as the ‘blueprint’ of the British welfare state. See Lindsey Earner-Byrne, *Mother and child: maternity and child welfare in Dublin, 1922-1960* (Dublin, 2007), p. 108 and Martin Powell, ‘Framing Beveridge’ in *Social Policy Administration*, lvi (2022), p. 217.

¹³⁶ Steven Curran, ‘Could Paddy leave off from copying just for five minutes’: Brian O’ Nolan and Éire’s Beveridge Plan’ in *Irish University Review*, xxxi, no. 2 (2001), p. 356.

¹³⁷ Seán MacEntee, ‘Address on Beveridge and full employment, 1945’ (UCD Archives, Seán MacEntee papers P67/276, p. 118). Also see, *IT*, 9 Nov. 1944.

¹³⁸ Adrian Kelly, ‘Catholic action and the development of the Irish welfare state in the 1930s and 1940s’ in *Archivum Hibernicum*, liii (1999), p. 113.

Northern Ireland government to accept a greater role in the lives and health of its citizens, and their Ministry of Health and Local Government was established for the first time in 1944.¹³⁹

Meanwhile, the Beveridge Report was cautiously welcomed by members of the Catholic Church in Ireland, who were often at the forefront of these social policy issues.¹⁴⁰ This is because the Beveridge Report itself largely dealt with comprehensive measures of social security for the poor, when ‘through sickness, accident, or age, [the worker] cannot take work, he and those dependent on him are helpless’.¹⁴¹ For Cornelius Lucey, a high-profile Catholic figure and chair of Philosophy and Political Theory in Maynooth (1929-1950), ‘we in this country cannot afford to ignore the Report...if it proves successful there, then we must perforce adopt it too or provide something just as good, if not better’.¹⁴² Similar thought can also be found in the Dignan plan, published in 1945. For Dr John Dignan, bishop of Clonfert, ‘as Ireland is a Christian and Catholic country, our social services ought to be Christian’, and this was represented in his plan for far more radical healthcare reform.¹⁴³ Instead of state centralisation of health matters, Dignan proposed a very similar plan that involved bringing the country’s social services and health schemes under the sole control of the National Health Insurance Society (NHIS) which would have central and regional committees where the church would be represented.¹⁴⁴ Within this, the services of district medical officers of health and most other doctors and nurses would have been transferred to the NHIS - with a Minister in ‘remote control’ only.¹⁴⁵ Watching these developments with ‘anxious eyes’, Irish doctors were concerned with the loss of their private employment status amid wider fears of socialised medicine. The Medical Association of Éire, for example, sought far-reaching reforms, but outside of state control.¹⁴⁶ The Dignan Plan was ultimately rejected by MacEntee, and Minister for Finance, Seán T. O’Kelly was likewise not prepared to amend legislation ‘to raise funds for the Red Cross’.¹⁴⁷ Like the government in Northern Ireland, Fianna Fáil were also tasked with striking a careful balance between state reform and state control of public health under their improvement proposals.¹⁴⁸

¹³⁹ Lucey, ‘On the brink of universalism: the emergency hospital services in Second World War Northern Ireland’, in Durnin and Miller (eds), *Medicine, health and Irish experiences of conflict, 1914-45*, pp 179-180.

¹⁴⁰ Kelly, ‘Catholic action and the development of the Irish welfare state’, p. 112.

¹⁴¹ Cornelius Lucey, ‘The Beveridge Report and Éire’ in *Studies: An Irish Quarterly Review*, xxxii, no. 125 (1943), p. 36.

¹⁴² *Ibid.*, p. 37.

¹⁴³ *IT*, 18 Oct. 1944.

¹⁴⁴ *Ibid.*

¹⁴⁵ *Ibid.*

¹⁴⁶ *Ibid.*, 7 Nov. 1944. Also see Daithí Ó Corráin, ‘The Catholic Church and the Irish State, 1916-73’ in Gladys Ganiel and Andrew R. Holmes (eds), *The Oxford handbook of religion in modern Ireland* (Oxford, 2024), p. 154.

¹⁴⁷ *IT*, 25 Jan. 1945.

¹⁴⁸ John Privilege, ‘The Northern Ireland government and the welfare state, 1942-8: the case of health provision’ in *IHS*, xxxix, no. 155 (2015), p. 459. Also see Kelly, ‘Catholic action and the development of the Irish welfare state’, p. 113.

1.6 The role of the Catholic Church in health policy negotiations

Church-state relations played an important role in public health policy negotiations during this period. To this end, the role of the Catholic Church will appear throughout the case studies, most prominently in Chapter Three, which focuses on infant mortality and the mother and child. While the 1940s may have been the most significant decade of public health reform in Ireland since independence, state directions in the management of public health before this were largely left to the discretion of the health authorities and voluntary bodies, with the Catholic Church playing a major role. Ó Corráin observes that the Catholic Church was ‘uniquely well placed to contribute to the state-building project in terms of enhancing national unity and self-definition, providing an unmatched institutional presence, and inculcating a Catholic moral order’ following independence.¹⁴⁹ On the one hand, Roman Catholics accounted for 92.6% of the population by 1926.¹⁵⁰ Tied to this, Ó Corráin notes that several bishops shared friendships with government representatives and civil servants.¹⁵¹ When talks of a new Seanad began in the late 1930s, some commentators sought to introduce a Seanad that had Catholic social teaching and vocationalist ideas at the forefront.¹⁵² However, this did not come to fruition due to de Valera’s reluctance to have an upper house that would have the power to ‘do battle with the Dáil’.¹⁵³ Notwithstanding, government ministers often sought the advice of the clergy on state matters, and tension arose when they failed to do so as evidenced in the diocesan records.¹⁵⁴ On the other hand, consecutive Irish governments were happy for the church to continue performing state functions, particularly in areas of health, welfare and education.¹⁵⁵ Similarly, Brian Girvin observes that this satisfied the newly independent state’s aim to demarcate Irish values and behaviour from those in Britain.¹⁵⁶ Because of this, the policies that the state pursued were often in line with the interests of the church.¹⁵⁷ This can be evidenced by the Censorship of Publications Act (1929), the Ban on Contraceptives (1935) and Divorce Ban (1937), which reinforced Catholic moral and social codes for a significant amount of time.¹⁵⁸ Similarly, Donnacha Seán Lucey and Virginia Crossman note that legislation concerning adoption, fostering and incest were implemented in inter-war Britain, but not in Ireland.¹⁵⁹

¹⁴⁹ Ó Corráin, ‘The Catholic Church and the Irish State’, p. 151.

¹⁵⁰ Ibid.

¹⁵¹ Ibid.

¹⁵² O’ Donoghue, ‘As nearly subservient’ as it could be?, p. 214.

¹⁵³ Ibid., pp 214-215.

¹⁵⁴ In 1954, McQuaid criticised the previous Fianna Fáil government’s ‘policy of keeping the Church severely in its own sphere’. See McQuaid memorandum on the new government, 26 Jul. 1954 (DDA, McQuaid papers, XVIII/23/15).

¹⁵⁵ Ó Corráin, ‘The Catholic Church and the Irish State’, p. 152.

¹⁵⁶ Brian Girvin, ‘An Irish solution to an Irish problem: Catholicism, contraception and change, 1922-1979’ in *Contemporary European History*, xxvii, no. 1 (2018), pp 4-5.

¹⁵⁷ Ó Corráin, ‘The Catholic Church the Irish State’, p. 151.

¹⁵⁸ The contraceptive pill was only available on prescription in Ireland from 1963. See Laura Kelly, *Contraception and modern Ireland: a social history, c. 1922-1992* (Cambridge, 2023), p. 2 and p. 130.

¹⁵⁹ Lucey and Crossman, *Healthcare in Ireland and Britain*, pp 13-14.

The extent of influence that the Catholic Church had over health policy was especially prominent in areas of child and maternal health. There is consensus on the extent to which motherhood and family were elevated in status under the Irish Free State.¹⁶⁰ This was not unique to Ireland – Earner-Byrne observes that during the 1920s and 1930s, there was a heightened focus on motherhood and childhood as crucial factors influencing national vitality and public health on an international scale.¹⁶¹ However, this became entwined with dominant religious discourse in Ireland.¹⁶² Lucey and Crossman also note that the moral ethos of the Free State made maternal and child support difficult, despite the country's high infant mortality rate.¹⁶³ According to Catholic teaching:

The individual person, the family, the professions and voluntary institutions have certain fundamental rights which the State must respect. The individual has, for instance, a right to personal liberty and freedom from vexatious interference; parents have the right of providing for the health and education of their children.¹⁶⁴

This was part of the hierarchy's response to the Health Act, 1947, which promised a free and universal medical service to mothers and children. From the outset, the Catholic Church saw expanded state intervention as an intrusion into individual and familial rights. The church was fervently against socialism and feared that state intrusion would take from the autonomy of the voluntary hospitals.¹⁶⁵ The Catholic archbishop of Dublin John Charles McQuaid's reasoning was that if the state were going to provide more funds to these hospitals, that they would 'be anxious to have some sort of supervision'.¹⁶⁶ While McQuaid acknowledged the good intent of the scheme and the high infant mortality rates in Dublin, he was adamant that the government trust the voluntary bodies, leaving the actual running of the scheme to them.¹⁶⁷ Due to opposition from the church, medical profession and voluntary bodies, a free and universal health system akin to Britain's NHS was never fully implemented in Ireland.¹⁶⁸ While the Health Act 1953 was largely similar to the Health Act 1947, it introduced eligibility criteria based on income, which varied across the different services offered.¹⁶⁹ From a policy perspective, debates over the form that public health reforms should take took a lot of time and support away from core issues in health that still demanded resolution.

¹⁶⁰ Kelly, *Contraception and modern Ireland*, p. 4.

¹⁶¹ Lindsey Earner-Byrne, *Mother and child: maternity and child welfare in Dublin, 1922-1960* (Manchester, 2007), p. 2.

¹⁶² Kelly, *Contraception and modern Ireland*, p. 4.

¹⁶³ Lucey and Crossman, *Healthcare in Ireland and Britain*, p. 14.

¹⁶⁴ Statement of the Irish Hierarchy on the Health Act, 1947, undated, c. 1947 (for private transmission to An Taoiseach) (Dublin Diocesan Archives (hereafter DDA), McQuaid papers, XVIII/25/3/1), p. 1.

¹⁶⁵ Throughout the 1930s, Catholic action groups engaged in an anti-communist campaign. See Enda Delaney, 'Anti-communism in mid-twentieth century Ireland' in *The English Historical Review*, cxxvi, no. 5 (2011), p. 886.

¹⁶⁶ McQuaid memorandum on the Health Act, 1947 (DDA, McQuaid papers, XVIII/25/4/1).

¹⁶⁷ *Ibid.*

¹⁶⁸ Lucey and Crossman, *Healthcare in Ireland and Britain*, p. 14.

¹⁶⁹ Health Act, 1953 (1953 no. 26) (29 Oct. 1953).

1.7 The role of voluntary organisations in healthcare provisions

On the ground, voluntary hospitals played a key role in the provision of healthcare services for the poor in urban areas. Many of these hospitals were established by Anglo-Irish nobility from the early nineteenth-century.¹⁷⁰ The most successful of these were run by religious orders that were based in Dublin.¹⁷¹ With forty-five hospitals ranging in size from 46 beds to 450 beds in 1945, Dublin, in proportion to its size, had a greater number of voluntary general hospitals than any other city in the world.¹⁷² These hospitals played a major role in the alleviation of sickness and the care of disease in Dublin through the provision of beds and through their out-patient departments. Deeny has noted that they had an ‘open door’ policy wherein they consistently aimed to maintain the demands on their services.¹⁷³ Effectively, this meant that the ‘vast bulk of the medical care of the poor, the near poor and the lower middle classes’ in Dublin was provided by these hospitals.¹⁷⁴ However, conditions were far from ideal. While they were provided with new equipment and money for improvements from the Irish Sweepstakes, they were often located in buildings that were ‘so out-dated that they can no longer be regarded as suitable for hospital services’.¹⁷⁵ Meanwhile, voluntary hospitals located in the countryside suffered because of the migration of the population to urban suburbs, like those around Dublin. What this meant was that a significant amount of local clientele had left rural areas, making the economic maintenance of voluntary hospitals in rural areas very expensive.¹⁷⁶ This inadvertently increased the demand placed on Dublin hospitals.¹⁷⁷ This also led to differences in healthcare provision in rural and urban areas – a consistent theme throughout this study.

Smaller voluntary organisations also played an instrumental role in providing public health services on the ground during the Emergency period. The bulk of these operations occurred in child and maternal welfare in poorer areas. As early as May 1940, the Infant Aid Society (non-denominational) in Dublin was delivering milk ‘of the highest standard’ to children under five years of age whose parents were unable to buy key supplies.¹⁷⁸ They administered milk on behalf of Dublin Corporation, and also held weekly pop-up welfare clinics for expectant and nursing mothers where talks were given by health visitors on the subject of ‘mothercraft’ (see figure 1.8).¹⁷⁹ St. John Ambulance was another voluntary organisation that was heavily

¹⁷⁰ Hensey, *The health services*, p. 6.

¹⁷¹ Ibid.

¹⁷² Deeny memorandum on the medical services of Dublin, c. 1945 (Royal College of Surgeons Ireland Archives (hereafter RCSI) IP/Deeny papers/1/2/1/27).

¹⁷³ Ibid.

¹⁷⁴ Ibid.

¹⁷⁵ Ibid.

¹⁷⁶ Ibid.

¹⁷⁷ Ibid.

¹⁷⁸ *IT*, 28 May 1940.

¹⁷⁹ *Report on the state of public health in the city of Dublin for the two years ending 31 December 1940* (Dublin, 1941), p. 92. Extract re-produced from DOH, *Report of the Department of Health, 1949-1950*, pp 22-23.

involved in child and maternal welfare in Dublin as they sought to clothe and provide extra nourishment for expectant and nursing mothers.¹⁸⁰ Though the organisation had been feeding the poor since the 1920s, there was a marked increase in its feeding centres during the war years.¹⁸¹ Meanwhile, to counteract non-Catholic influences in the social services, McQuaid established the Catholic Social Service Conference (CSSC) in 1942 to work on the ground with 'poor Catholic children' (see figure 1.9).¹⁸² By the end of 1943, the CSSC had established sixteen pre and post-natal welfare centres and this also fed into other areas of maternal nutrition.¹⁸³ For Earner-Byrne, Dublin became 'a centre of religious rivalry' that contributed significantly to an emergence of a welfare consciousness.¹⁸⁴ These voluntary bodies can also be viewed as advocacy groups. For example, A. Byrne, a representative of the Infant Aid Society had his concerns of rising milk prices voiced in the Dáil as they explored how this spilled over into degrading the quality of the milk that was distributed.¹⁸⁵ In other areas, St. John Ambulance was in receipt of £1,800 from Dublin Corporation but this was not sufficient for the number of cases presented to them where there were 'many poor women starving in Dublin'.¹⁸⁶ The subsequent call for increased funds was published on the front page of the *Irish Times*. While these organisations represented different ideological interests, they often worked hand-in-hand with each other.

Despite sharing common goals of eliminating the suffering caused by disease, there was no real integration between the work of these voluntary bodies, the health authorities run by local county councils and corporations, and the work of government organisations. Many voluntary hospitals had outpatient departments which were organised by the religious order in charge and public assistance dispensaries were provided for and maintained by the public assistance authorities.¹⁸⁷ The Public Assistance Act 1939 replaced the term 'poor relief' with 'public assistance' while the State was divided into 'public assistance districts'.¹⁸⁸ Although these public assistance authorities operated under the general direction and control of the Minister for Local Government and Public Health, they were typically representative bodies of county councils and corporations.¹⁸⁹ In practice, these services were also operating independently of the other health services that were provided by the county councils and corporations in local areas. What this meant was that the public assistance authorities, public health and voluntary

¹⁸⁰ *IT*, 1 November 1942.

¹⁸¹ Earner-Byrne, *Mother and child*, p. 97.

¹⁸² *Ibid.*, pp 91-92.

¹⁸³ *Ibid.*, p. 98.

¹⁸⁴ Earner-Byrne, 'Managing motherhood: negotiating a maternity service for Catholic mothers in Dublin, 1930-54' in *SHM*, xix, no. 2 (2006), p. 262.

¹⁸⁵ *DÉD*, 16 Feb. 1944, vol.92, no. 9.

¹⁸⁶ *IT*, 1 Nov. 1942.

¹⁸⁷ Public Assistance Act, 1939 (1939 no. 27) (8 Aug. 1939).

¹⁸⁸ DOH, *Outline of proposals*, p. 31.

¹⁸⁹ *Ibid.*



Figure 1.8 Distribution of milk at Infant Aid Society, Dublin, c. 1949-50.¹⁹⁰



Figure 1.9 CSSC staff serving meals to women and children at a food centre in Dublin, c. 1941-45.¹⁹¹

¹⁹⁰ DOH, *Report of the Department of Health, 1949-1950*, pp 22-23.

¹⁹¹ Re-produced from Bryan, *Rationing in Emergency Ireland*, p. 203.

bodies involved in the provision of health services were ‘developed and [were] developing independently’.¹⁹² This led to a situation in which some public health issues were overlooked. Commenting on this, Deeny noted that:

It is precisely because of the gap between them that much preventable illness occurs. Particularly is this the case in infant and child health where one set of specialists in the Children’s Hospitals simply act in a curative capacity treating the cases which come to their doors and disregarding to a large extent the causes operating to bring about disease.¹⁹³

This was further complicated by the fact that many private practitioners sought part-time work under government bodies to supplement their incomes.¹⁹⁴ They too were largely concerned with curing the problems that came, and not on investigations as to why these problems arose in the first place. While other small organisations on the ground had preventative health aspects to them, such as the provision of clean milk, they were primarily concerned with very poor populations – a small proportion of the population only. The wartime situation was such that even Dr Robert McDonnell, former Medical Officer of the Department of Local Government and Public Health, claimed in 1944:

Our public health authorities are only playing at epidemiology. It is like a fire brigade watching a number of fires recurring in a district but taking no steps to inquire into the cause.¹⁹⁵

One of the most striking features of health service provision in Ireland, both during and prior to this period is the extensive number of departments, personnel, advisory bodies, councils, authorities, and voluntary organisations that were involved in healthcare provision. As shown in figure 1.10, there were six main entities involved in the provision of healthcare resources (indicated in bold). These were the Mental Health Authorities, Boards of Assistance, Boards of Health, Public Assistance Authorities, County Councils and Corporations and voluntary hospitals. In this scenario, these bodies simply carried out their specific public health responsibilities without going beyond their assigned roles.¹⁹⁶ This, combined with a consistent lack of coordination and communication between these bodies highlighted where the discrepancies in Ireland’s health system were. Writing in January 1948, after there were significant health reforms, Morgan Crowe, a Dublin doctor who had worked in the UK, observed that:

It is peculiar to have Public Health and Poor Law activities, both having much in common, run without regard for each other. We find, for example, in every county on the one hand various public health services assembled under the Medical Officer of Health, and on the other hand dispensary doctors, a general hospital

¹⁹² DOH, *Outline of proposals*, p. 31.

¹⁹³ Deeny memorandum on the medical services of Dublin, c. 1945 (RCSI IP/Deeny papers/1/2/1/27).

¹⁹⁴ DOH, *Outline of proposals*, pp 16-17.

¹⁹⁵ *IT*, 31 Oct. 1944.

¹⁹⁶ Crowe, ‘The origin and development of the public health services in Ireland’, pp 16-17.

and perhaps a fever hospital, all centred on promoting community well-being, but yet completely divorced in both approach and management... When it is realised that each organisation is financed from the same source, it seems ludicrous.¹⁹⁷

This anomaly was at its worst in Dublin where, for example, the Gastro-Enteritis Control Section of Dublin Corporation, founded on request of the Department of Local Government and Public Health, had no formal association with St. Clare's Gastro-Enteritis Hospital simply because the hospital was not under Dublin Corporation management.¹⁹⁸ Ireland did not really have a co-ordinated public health system. Most health bodies were concerned with curative medicine and dealing with the direct problems that faced them instead of engaging in long-term measures of prevention. On the other hand, the care of the mentally-ill formed 'perhaps the greatest single unit in the health services of the time'.¹⁹⁹ However, these were, as Hensey has noted, 'simply lunatic asylums' until 1945 and most in need of reform when the Mental Treatment Bill sought to revolutionise how mental illness was viewed.²⁰⁰

This lack of communication also occurred on a macro level. Writing in 1949, John A. Costello, then Taoiseach, noted in hindsight that it was 'highly desirable that a number of inter-departmental committees should be set up prior to any future emergency to deal with matters of mutual concern'.²⁰¹ In his view, nutritional problems of food purity would need to be discussed with the Department of Health, Department of Industry and Commerce and the Department of Agriculture, with recommendations of a special committee operating communications between them. In particular, he noted how:

Co-ordination in this sphere is of special importance as during the last emergency many decisions, with health implications, on rationing were made without consultation with the Department dealing with matters.²⁰²

This is important because regulations like these posed serious health concerns in areas like infant mortality, TB and nutrition. They also raised questions about disease outbreaks in hospitals during the war.

¹⁹⁷Ibid., p. 17.

¹⁹⁸ Ibid., p. 17.

¹⁹⁹ Hensey, *The health services*, p. 7.

²⁰⁰ Ibid.

²⁰¹ Department of Taoiseach memorandum on public safety, 8 Aug. 1949 (NAI, TAOIS S/11445).

²⁰² Ibid.

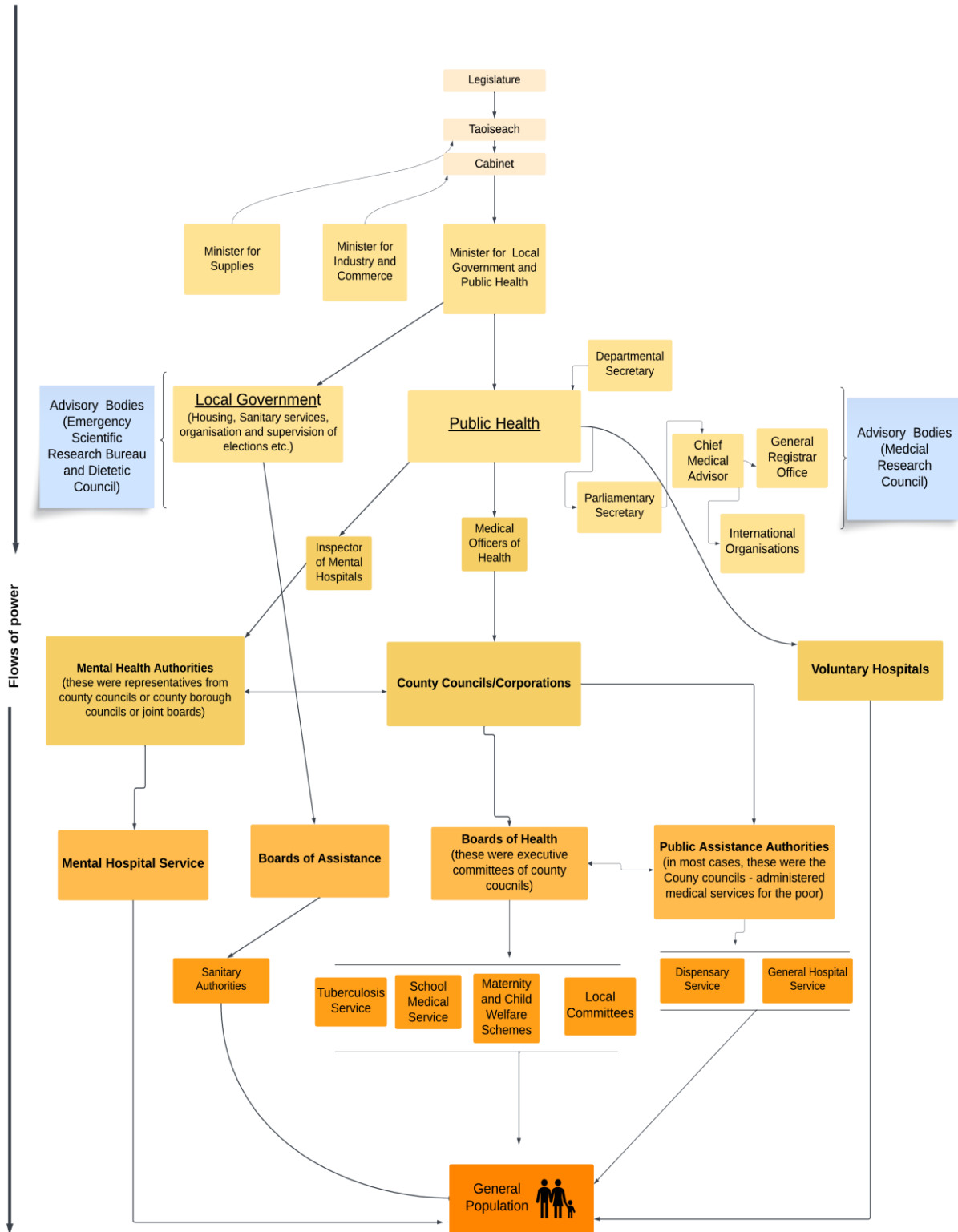


Figure 1.10 Flowchart outlining the official public health infrastructures in 1941.²⁰³

²⁰³ Data collected and re-produced from DOH, *Outline of proposals for the improvement of health services* (Dublin, 1947), pp 11-27 and Hensey, *The health services*, p. 42.

The case-study approach of this thesis will show that areas of health concern were linked in different ways. For example, nutrition has an impact on other areas of health by decreasing one's resistance to a primary infection of disease. It was this awareness that paved the way for the term 'nutrition' itself to become embedded within government debates during this period. Childhood malnutrition may also lead to problems later in life and this explains why the nutrition levels of the Irish child and Irish mother were given special significance in the national nutrition survey that was launched in 1946. There was also cross-over between nutrition, rickets and TB mortality. TB proved particularly devastating in part because many Irish people chose to avoid the sanatorium due to the loss of earnings that coincided with long stays in treatment.²⁰⁴ Concerns about the impact of treatment on household finances saw people struggle to choose between their health and their wealth. A case-study approach also provides a useful way to identify how wartime circumstances affected existing policies and healthcare institutions. A lack of heating in 1947 due to fuel shortages, for example, was cited as a contributory factor in an upsurge in deaths inside mental institutions during a notoriously cold winter.²⁰⁵ Diseases like mental illness and TB were eating away at substantial proportions of the working and therefore tax-paying populations. When Ireland's public health issues were viewed collectively, the Department of Health outlined in 1947:

The need for a new approach to health problems becomes clearly evident on consideration of the present high mortality rate amongst the younger age groups of the population and of the economic waste involved in illness and disability.²⁰⁶

The urgency of healthcare reform became entangled with high mortality rates among younger age groups and the perceived 'economic waste' of high morbidity. Thus, as we will see in the case studies, government initiatives tended to focus on particular population groups where there was an expectation of a tangible outcome.

1.8 Developments in the post-war period

The years immediately after the war brought about substantial developments in the provision of Ireland's health services. In January 1947, Ryan established a new Department of Health through the Ministers and Secretaries (Amendment) Act, one that was no longer tied to matters of Local Government.²⁰⁷ Implicit in the establishment of a health department separate to welfare provision was an expectation to expand health services in relation to the prevention of disease, diagnosis, and improved prognosis at a later stage. This occurred in conjunction with the Health Act 1947 which sought to modernise Ireland's public health regime through the provision of

²⁰⁴ *IT*, 13 Sept. 1943. For further detail, see Jones, *'Captain all these men of death'*, p. 163.

²⁰⁵ *ARIMH, 1947 and 1948* (Dublin, 1949), p. 12.

²⁰⁶ DOH, *Outline of proposals*, p. 18.

²⁰⁷ Ministers and Secretaries (Amendment) Act, 1946; Health (Transfer of Departmental Administration and Ministerial Functions) Order, 1947 (1947 no. 58) (11 Mar. 1947).

several prevention services. The functions of this department included the effective co-ordination of health measures, measures for the prevention and cure of disease, physical defects and mental disease as well as the regulation, training and registration of medical personnel.²⁰⁸ Meanwhile, responsibility for water supplies, sewage waste and other sanitary services remained with the Department of Local Government, though it was anticipated that the Department of Health would provide advice on the medical side if questions arose.²⁰⁹ Several changes were also made to the structural layout of public health in the 1940s. From 1947, there were two main entities involved in the provision of public health resources – the Mental Hospital Authorities and the County Councils/Corporations (see figure 1.12). Within this, the county councils became the sole co-ordinating body of sanitary services, dispensary services, and hospitals services while the Mental Hospital Authorities remained a separate entity (see figure 1.12). In health terms, legislation on the infectious disease service, a school medical service and an anti-TB service were updated.²¹⁰ This also included the supervision and standardisation of food supplies and a proposed health service for women and children, the latter of which did not materialise after the controversy that followed.²¹¹ Together, this reflected the growing centralisation of Ireland's public health regime.



Figure 1.11 Picture of a child being examined by the nurse in a routine school medical examination, c. 1950.²¹²

²⁰⁸ DOH, *Outline of proposals*, p. 9.

²⁰⁹ Hensey, *The health services of Ireland*, p. 19.

²¹⁰ DOH, *Outline of proposals*, p. 11.

²¹¹ *Ibid.*, p. 21.

²¹² DOH, *Report of the Department of Health, 1949-1950*, pp 54-55.

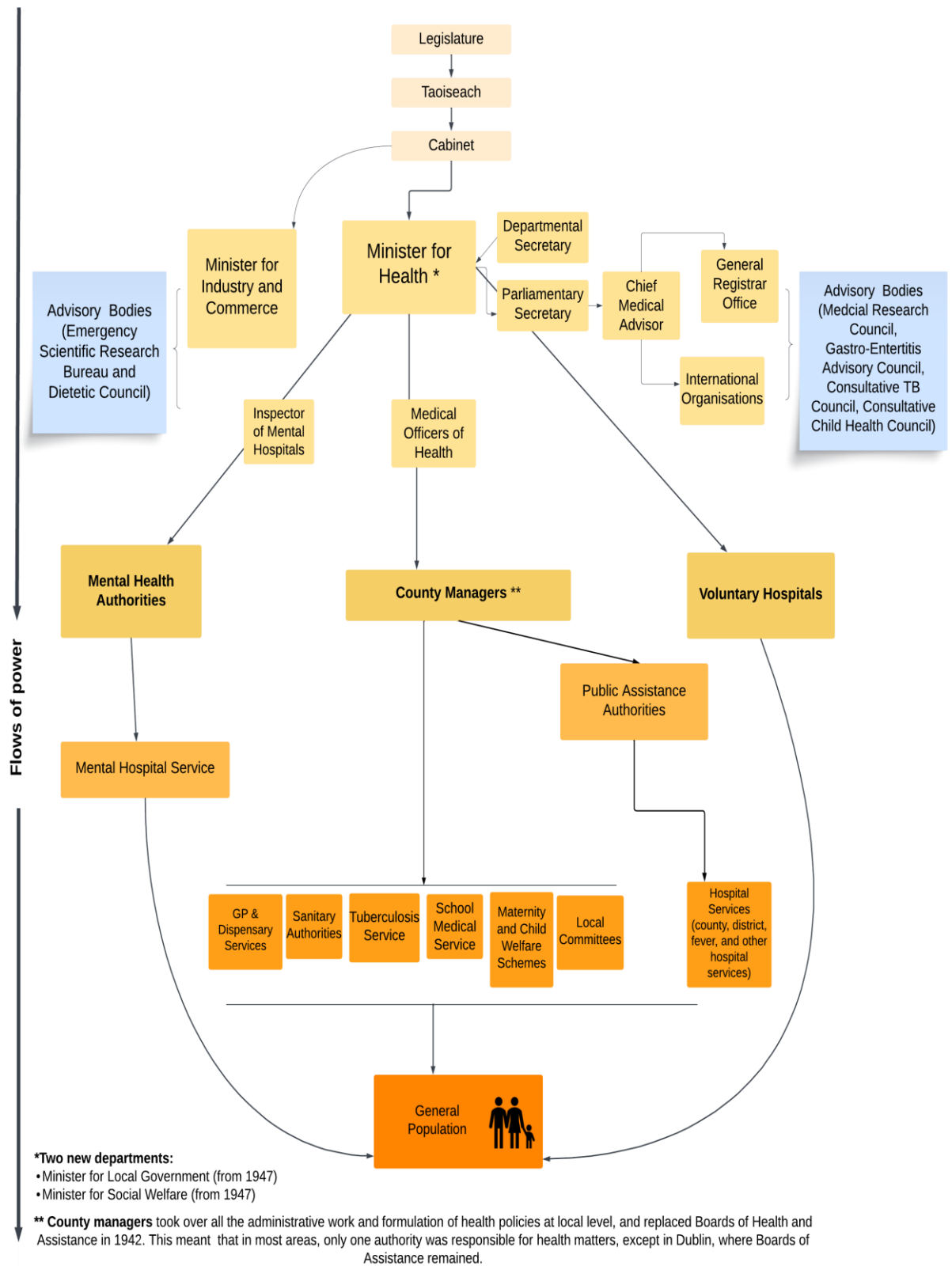


Figure 1.12 Flowchart outlining the official public health infrastructures in 1947.²¹³

²¹³ Data collected and re-produced from DOH, *Outline of proposals*, pp 11-27; *Report of the Department of Health, 1949-50*, pp 19-26; Hensey, *The health services*, p. 42.

The structural re-organisation of the health services occurred alongside a more generous pledge of increased state expenditure under the Health Services (Financial Provisions) Act, 1947. What this meant was that the state pledged to meet for each health authority, the full amount of any increase in the cost of its services until the total cost was twice the amount met by that authority from local taxation from the year ending 31 March 1948.²¹⁴ When this cost had been reached, the additional cost of the health provisions was divided equally between the two.²¹⁵ In other words, the state agreed to match the money received from local authority rates.²¹⁶ This position favoured the local ratepayers, meaning healthcare could be further developed and expanded on at local levels with the state Exchequer bearing any increase in cost that was incurred. Before this Act was passed, local finances bore the greater part of the cost of the local

Year ended 31 March	Total Cost (£million)	Met by State (£million)	Met by local authorities (£million)
1948	5.7	0.9	4.8
1949	6.6	1.8	4.8
1950	7.4	2.6	4.8
1951	8.5	3.7	4.8
1952	10.4	5.2	5.2
1953	10.5	5.25	5.25
1954	11.2	5.6	5.6
1955	12.4	6.2	6.2
1956	14	7	7
1957	15.7	7.85	7.85
1958	15.9	7.95	7.95
1959	16.4	8.2	8.2
1960	16.6	8.3	8.3
1961	17.7	8.85	8.85
1962	19.4	9.7	9.7
1963	20.5	10.25	10.25

Table 1.1 The cost of the health services in each year since 1947-48 and the amount in each case met by the State and by the Local Authorities.²¹⁷

²¹⁴ Health Services (Financial Provisions) Act, 1947 (1947 no. 47) (27 Dec. 1947).

²¹⁵ Ibid.

²¹⁶ Ibid.

²¹⁷ DOH, *Select Committee on the health services: memorandum from the Department of Health on Irish health services* (Dublin, 1964), p. 63.

health services from local taxation, and these were supplemented only by modest state grants.²¹⁸ While there is no comprehensive budget breakdown for the Department of Local Government and Public Health after 1932, there is evidence to indicate that housing continued to receive priority funding until the early 1940s, when building materials became increasingly scarce. For example, budgetary estimates provided by the Minister for Local Government and Public Health, Patrick J. Rutledge in 1941 include a sum of £702,380 while a total sum of £364,905 was allocated to health services alone.²¹⁹

In 1947, state grants provided only 16% of the total cost of healthcare while the local authorities met the remaining 84%.²²⁰ Between 1948 and 1963, the total cost of the local health services rose from £5.7 million to £20.5 million while the state's direct contribution was almost twelve times as great as it was in 1947/48 (see table 1.1). As shown, the cost of the expansion in the health services that took place since 1947 was largely financed by the Exchequer. This expansion included the provision of free diagnosis and sanatorium treatment for tuberculosis patients with maintenance allowances, an extension of hospital and specialist services, an improved health examination and clinic services for national school children, maternity cash grants, a maternity care and infant welfare service and a scheme of health provisions for disabled persons.²²¹

The Health Services (Financial Provisions) Act 1947 not only allocated significant additional funds to Irish health services but it also marked a clear shift in the country's approach toward centralising public health services overall. While the additional financial assistance from the government was not intended to change the traditional framework of a health service on the ground which was historically 'strictly local in character', it did allow for this to occur under the supervision and general direction of the central authority.²²² In this way, it is necessary to assume that the government perceived that the health failures of the Emergency period suggested that the centralisation of the country's health services would deliver better health outcomes. This was on the back of health services being divided among different sets of local authorities, where the services themselves were not unified in such a manner that they could be seen as a unit with 'a conscious aim-the safeguarding and betterment of the health of the people'.²²³ From the establishment of the Department of Health, Ireland saw the introduction of a group of services that were, for the first time, organised and co-ordinated together for the

²¹⁸ DOH, *Report of the Department of Health, 1949-1950*, p. 62.

²¹⁹ Ibid.

²²⁰ Miriam Wiley, 'Financing the Irish health services: from local to centralised funding and beyond' in Joseph Robins (ed.), *Reflections on health: commemorating fifty years of the Department of Health, 1947-1997* (Dublin, 1997), p. 210.

²²¹ DOH, *Select Committee on the health services*, p. 63.

²²² Ibid., p. 64.

²²³ Ibid., p. 2.

shared purpose of improving population health. However, this was a half-way meeting point between the state and the local authorities only, which enabled the government to intervene in health matters to such a degree that it was accepted by those, like the Catholic Church, who were traditionally against state intervention. As long as the local authorities still bore half the cost of the health services, it was reasonable to leave the administration of the provisions in their hands, with only guidance and supervision from the central authority.²²⁴ This set the tone for later arguments in health administration in the 1960s.²²⁵

1.9 Conclusion

Examining Ireland's health policy at this crucial juncture provides a useful opportunity to identify the weaknesses of the country's existing public health provisions. Rising disease rates indicated how ineffective Ireland's governmental policies and health infrastructures were at this time. The 1940s marks a turning point in the direction of Irish health provisions, as evidenced through healthcare reforms and increased state aid. The years immediately after the war brought about substantial developments in the extensions of health services. The actions that occurred in health spheres not only demonstrated the growing powers of the medical profession in Ireland, but they outlined an increased recognition of the importance of maintaining public health in political spheres. This was no outlier in global health trends. After all, the publication of Britain's Beveridge Report in 1942 coupled with the introduction of the NHS in 1948 suggested a growing responsibility on the state's behalf for the well-being of their populations. Further consolidation of health services occurred in developments of the 1953 Health Act which saw fewer bodies involved in administering the services: the county council became the sole health authority, administering all health services apart from the Mental Treatment Service. The remaining chapters of this thesis examine five case studies representing different health crises between 1939 and 1953 to show how this changing policy landscape affected healthcare on the ground.

²²⁴ DOH, *Select Committee on the health services*, p. 66.

²²⁵ Ibid.

CHAPTER TWO

FLOUR, BREAD AND EFFORTS TO REDUCE CALCIUM DEFICIENCY, 1939-48

2.1 Introduction

Food shortages were among the most visible indicators of wartime adversity experienced in Ireland.¹ There is general consensus among historians that extreme shortages of imported goods such as food and fuel exacerbated existing conditions as many families struggled to make ends meet in the face of price increases.² Similarly, wider historiography on Irish neutrality has reached also consensus on the importance of economic survival to the Irish Fianna Fáil government at this time. While attempts to ensure the state's economic vitality were 'carried out [with] the best intention: the prevention of starvation': the means to achieve this end has not received the same historical coverage.³ Following the emergence of war, the state implemented a 'Grow More Wheat!' campaign. This was part of a wider propaganda project that repeated the slogan 'Grow More Wheat!' in political speeches across towns, cities and public propaganda.⁴ Irish farmers were asked to 'supply the food requirements of Irish men, women and children' and phrases like 'Remember the Nation's Bread Supplies Depend On You' were common.⁵ Compulsory tillage orders that required Irish farmers to till wheat and other essential crops were the most aggressive forms of the campaign while the use of tillage inspectors ensured, where possible, that these quotas were met. Not so common in printed public materials, however, was the use of the term 'black' in relation to bread. In January 1941, the phrase 'black bread' was banned by the censor.⁶ This black loaf embodied the contradictions involved in the state's efforts to feed its population during the war.

The black loaf was a result of changes to flour extraction necessitated by wartime shortages. Alongside maximising wheat production, Fianna Fáil sought to minimise the amount of wheat wastage during the war by increasing rates of extraction.⁷ Extraction refers to the flour milling process: the extraction rate describes the amount of the wheat grain that is used to make

¹ A condensed version of this research has appeared in a working-copy in *IESH*. See Kelly Adamson, 'Arán an Lae Amáireach': flour extraction and fortification in Emergency Ireland, 1939-1948' in *IESH*, 1, no.1 (2023), pp 93-111.

² Aisling Farrell, 'Harassed housewives fight the consumers battle': the formation of the Irish Housewives Association and the campaign for price control, clean food, and equitable distribution in the Ireland of the 'Emergency' in *Saothar: Women's Special Issue*, xxxvi (2012), p. 49.

³ Bryce Evans, *Ireland during the Second World War: farewell to Plato's cave* (Manchester, 2014), p. 12.

⁴ *Ibid.*, p. 137.

⁵ *IE*, 20 Apr. 1942.

⁶ Donal Ó Drisceoil, *Censorship in Ireland, 1939-1945: neutrality, politics and society* (Cork, 1996), p. 256.

⁷ Flour extraction refers to the percentage of the grain and wheat that is used to make flour during the milling process. Flour with higher extraction rates has more of the bran and germ whereas flour that white flour is made from involves a low extraction rate, containing only the starch. Flour with over 90% extraction contain more of the soluble salt content of phytic acid which reduces the level of calcium that can be digested.

flour. Before the war, it was normal practice in Ireland to make wheaten bread from flour that was extracted at 70-75 per cent.⁸ As flour was among the most severe wartime shortages, one resolution to poor wheat supplies was to increase the rate that flour was extracted from wheat, thereby using more of the wheat crop itself. The rate that flour was extracted from wheat was continuously increased, measuring at 100 per cent on some occasions during the war. High extraction flours produced a loaf of a dark, grey-brown colour: the ‘black bread’ that became common in the Irish vernacular.⁹ However, close to 100 per cent extraction meant that the Fianna Fáil government were encouraging millers to create a product that contained matter that the human body simply could not digest. Flour supplies had been increased by reducing the quality of the flour itself.¹⁰ New findings in medical research showed the detrimental health effects of high extraction rates. As early as 1940, studies in Britain confirmed that more toxins (phytic acid) were present in flour extracted at higher rates.¹¹ The high phytic acid content reduced human absorption of calcium, thereby limiting the intake of a nutrient vital for human growth. While these findings were known in Ireland, extraction rates were not lowered until December 1943 and flour was not fortified with calcium until June 1946. Meanwhile, the Irish medical profession implicated calcium deficiency as a factor in the rising incidence of rickets and increased tuberculosis mortality during the war which followed on the heels of the increased extraction rates.

The economic circumstances of war had significant implications for public health, and by association, for the public health measures that Ireland could afford. This chapter will examine a health crisis that was created by the war and by a failure of pro-active policymaking. By mapping flour extraction rates alongside the incidence of disease, this chapter argues that political short-terminism exacerbated public health problems as symbolised by the black loaf. While high extraction flour temporarily relieved wartime supply pressures, it had severe health effects on the wider population, and exacerbated tensions between the Department of Industry and Commerce and Department of Local Government and Public Health. Such was the prioritisation of key supplies, that scientific warnings against the use of high extraction flours were ignored. Struggles to reach viable compromises resulted in unnecessary delays that ultimately contributed to a rickets epidemic and a higher tuberculosis (TB) mortality rate. It took this visible health emergency for the Irish government to take action to reduce extraction rates

⁸ *IP*, 8 Jan. 1941. In Britain, flour was usually extracted between 68-75% up until April 1942. Thereafter, the extraction rate increased to 85% until Jan. 1945, when it was lowered to 80%, see H. E. Magee, ‘Application of nutrition to public health: some lessons of the war’ in *BMJ*, I (Mar. 1946), p. 476.

⁹ *IP*, 9 Jan. 1941.

¹⁰ Akihiro Takei, ‘The political economy of the Irish flour milling industry, 1922-1945’ in Andy Bielenberg (ed.), *Irish flour milling: a history 600-2000* (Dublin, 2003), p. 150.

¹¹ Department of Supplies (hereafter DOS) memorandum on ‘nutritive value of high extraction flours’, 29 Mar. 1941 (NAI, TAOIS S/12064).

and fortify flour with calcium. These changes were too little too late for those who had already suffered. Nonetheless, the response suggests that rising rickets and TB mortality were treated as public health priorities once they had been proven to exist. An investigation of how this crisis was allowed to occur and what factors encouraged a response reveals the oppositional factors involved in initiating public health policy as well as providing insights into the direction of the newly independent state.

2.2 Declining health performance in Ireland during the war

The war gave heightened visibility to the existing vulnerabilities of the state. One of the harsh realities of Irish independence was that the social and economic expectations of pre-independent Ireland did not fall into place. Instead, poverty increased, infant and TB mortality were higher in Ireland than in many other developed western nations.¹² The city slum was a particular ‘symbolic challenge’ to Fianna Fáil and was perceived by Irish cabinet members to be a place where petty crime and social irresponsibility was endemic. For renowned medical professor Theobald W. T. Dillon, the urban poor were:

The last to be employed, the first to be discharged...they leave school at 14 in a state of incredible ignorance. They have no chance of employment in a steady trade; dressed in rags, inarticulate, dirty and often dishonest they drift into the street corner gangs which are the despair of social workers and the police.¹³

However, the toughest indicator of wartime adversity that Irish people experienced was a fall in real wages when a Wages Standstill Order, which outlawed industrial action for greater pay, came into effect in May 1941.¹⁴ Meanwhile, the Catholic Church fervently opposed any use of birth control, and this was supported by the government through a ban on the importation and sale of contraceptives from 1935. Gerard Fee has also noted that prevailing Catholic teaching undermined the government’s willingness to intervene in social matters during the war.¹⁵ This led to a situation in which some poor families had more children than they could comfortably feed, clothe and house.¹⁶

Where does bread come into this? By the early twentieth century, tea and bread already formed the staple diet of the labouring classes in Ireland.¹⁷ In general, wars tend to lower incomes and reduce consumers’ purchasing power, often leading people to substitute more

¹² Moira Maguire, *Precarious childhood in post-independence Ireland* (Manchester, 2009), p. 2.

¹³ Evans, ‘The Construction Corps, 1940-48’ in *Saothar*, xxxii (2007), p. 1. Also see T. W. T. Dillon, ‘Slum clearance: past and future’, *Studies*, xxiv (1945), pp 13-20.

¹⁴ Evans, *Ireland during the Second World War*, p. 7.

¹⁵ Gerard Fee, ‘The effects of World War II on Dublin’s low-income families, 1939-1945’ (PhD dissertation, UCD, 1996), p. 237.

¹⁶ Maguire, *Precarious Childhood*, p. 3.

¹⁷ Juliana Adelman, ‘Food in Ireland since 1740’ in Eugenio F. Biagini and Mary E. Daly (eds), *The Cambridge social history of modern Ireland* (Cambridge, 2017), p. 237.

expensive foods, like meat, with cheaper alternatives, such as bread.¹⁸ Of the 100 Dublin families that Charles Clancy Gore surveyed in his examination of nutritional standards in 1943, bread was ‘undoubtedly the largest single item’ bought while meat was usually saved as a treat on weekends.¹⁹ Where families were larger in size, there was increased dependence on ready-cooked foods – bread among the most notable. Expenditure on bread by twenty-five families with nine or more members accounted for at least 50% of the family’s total expenditure on food expenses.²⁰ To put this into perspective, the per capita of consumption of wheat in Ireland was exceeded only by that of Bulgaria in Europe. Furthermore, Ireland’s consumption was also higher than that found in France which was renowned for its high consumption of wheat during the war years.²¹ For Gore, what was happening in the larger families was a distinct shift to bread in the place of more nutritive but less filling foods.²²

Housewives may have opted out of cooking full meals for larger families for several reasons. Cooking a full and nutritious meal for two kids was undoubtedly an easier task than cooking the same for a family of five or more, and it was also cheaper, less labour-intensive and produced less food waste as food choice became increasingly limited as families grew. Further, the impact that food shortages had on everyday lives was significant. Gore noted that the cost to adequately feed an adult male at Dublin prices was 14s. weekly.²³ Gore found that only 1% of adults and 2% of the children examined were consuming appropriate amounts of food per the standard.²⁴ To make matters worse, 15.9% of persons examined could afford on average between 2s and 4s on food per week.²⁵ Where families lived in one or two rooms during the war, the range of cooking facilities was limited because of the loss of coal.²⁶ In accommodation where small fire-grates existed, the use of different sources of fuel such as turf and wood could not be facilitated.²⁷

In Britain, the concept of ‘total war’ meant that attention was paid to domestic issues and basic living was made easier with health and social care initiatives. On the contrary, the half-hearted approach of the Fianna Fáil government meant that food shortages were ‘both real and

¹⁸ Giovanni Federico, ‘Natura non fecit saltus: the 1930s as the discontinuity in the history of European agriculture’ in Brassey et al., *War, agriculture, and food*, p. 16.

¹⁹ Charles C. Gore, ‘Nutritional standards of some working-class families in Dublin, 1943’ in *SSSI*, xxvi, no.2 (1943-1944), p. 244.

²⁰ *Ibid.*, p. 253.

²¹ *Nenagh Guardian* (hereafter *NG*), 18 Oct. 1941.

²² Gore, ‘Nutritional standards’, p. 252.

²³ *Ibid.*, p. 243.

²⁴ *Ibid.*, p. 253.

²⁵ *Ibid.*, p. 250. Here, 684 people were examined (348 children and 336 adults), and 109 of these were consuming between 2-4s. worth of food.

²⁶ Irish Country Women’s Association (ICA) press cuttings in an un-named newspaper, c. Mar. 1942 (NLI, MS 39,886 21/07).

²⁷ *Ibid.*

anticipated' from the war.²⁸ Flour quotas were linked to Ireland's broader supply-chain that was already provoking a tug-of-war between Irish business and the Irish government. Attempts by the Department of Supplies to maintain supplies of medicines and foods at the beginning of the war were met with the non-cooperation of several native firms.²⁹ These firms were reluctant to co-operate because the Department of Supplies had failed to guarantee any losses that they might experience in doing so.³⁰ For example, vitamin D supplies in Ireland during the war were inadequate 'chiefly due to an unresolved conflict between the Department of Supplies and Irish Oil and Cake Supplies', Ireland's biggest importer of the vitamin at that time.³¹

Each shortage was also affected by a broader supply chain that was severely disrupted by wartime. All of this was made worse by Ireland's vulnerable trade relationship with Britain due to the state's insistence on Irish neutrality. For example, anxiety surrounding the risk of wartime shortages resulted in a surge in panic buying, and this led to the price of basic foodstuffs rising substantially.³² This situation was exacerbated by economic sanctioning by the British Board of Trade on 2 January 1941 in attempts to undermine Irish neutrality. Exports to Ireland of food, animal feeding, fertilisers, agricultural machinery, electrical goods, iron and steel and cardboard were subjected to licenses, and these licenses were, as Bryan has argued, deliberately withheld by specific British government departments.³³ This supply squeeze was organised by Lord Fred Leathers, British Minister of War Transport, whom Evans points out as the same man who received the blame for aggravating the Bengal Famine by refusing to divert food to India in the summer of 1943.³⁴ This was very worrying to an Irish government, who, in response rationed coal, turf, fuel oil and kerosene in Ireland in the same year.³⁵ The effect that this had alongside a shortage of available Irish ships led to a complete system of rationing in Ireland by May 1942. A severely jeopardised trading relationship with Ireland's leading trade partner (UK) and a lack of available Irish ships to import food backed up MacEntee's observation that Fianna Fáil had to rely entirely on producing food in Ireland.³⁶ Coal and petrol were also very important to food distribution and consumption in Ireland.

Even as a predominantly agricultural country, there was no quick fix for Ireland's wheat shortage. As a crop, it could not be produced inside six months, requiring instead anywhere

²⁸ Juliana Adelman, 'Food in Ireland since 1940', p. 238.

²⁹ Evans, 'Food, the Emergency and the lower-class body, c. 1939-45' in David Durnin and Ian Miller (eds), *Medicine, health and Irish experiences of conflict* (Manchester, 2016), p. 48.

³⁰ Department of Industry and Commerce (hereafter DINC), 'Historical Survey', undated (NAI, IND/HER/3/C1-C2).

³¹ Evans, 'Food, the Emergency', p. 48.

³² Evans, *Ireland during the Second World War*, p. 44.

³³ Ciarán Bryan, 'Rationing in Emergency Ireland, 1939-1948' (PhD, NUIM, 2014), p.44.

³⁴ Evans, 'Food in Ireland during the 1930s and 1940s' in Máirtín Mac Con Iomaire and Dorothy Cashman (ed.), *Irish food history: a companion* (Dublin, 2024), p. 660.

³⁵ Evans, *Ireland during the Second World War*, p.45.

³⁶ *DÉD*, 17 Jan. 1941, vol. 8, no. 10.

between ten and twelve months (Appendix B).³⁷ So serious was the wheat shortage in the 1941 harvest that Ireland had only nine months' worth of wheat left, leading Lemass to impose export restrictions on the malting of barley.³⁸ Beer exports were also banned from March 1942.³⁹ While official bread rationing was not introduced in Ireland until 1947, flour supplies were tightly controlled as Fianna Fáil attempted to have an even distribution among the population (Appendix C).⁴⁰ The most interventionist of all was the compulsory tillage scheme, which encouraged farmers to till their land for wheat and cereal crops rather than dairy or grazing use.⁴¹ While wheat acreage did increase during the first year of the war, the amount of oats and barley fell by 80,000 acres.⁴² Malting barley was a key process in the manufacture of whiskey and beer. There was a surge in demand on the British war front for Guinness throughout the war period, adding more complexity to the existing wheat shortage in Ireland.⁴³

While scholars such as Daly, Bryan and Fee have given attention to government policy in recent times, the devastating impact that this food situation had on the lives of the Irish people is deserving of more scrutiny. There were bread queues. Some reports detailed waits of over two hours.⁴⁴ This was, as one *Irish Independent* article noted, a 'soul-destroying hardship': many people cycled to do their weekly shop to conserve their petrol rations.⁴⁵ At the annual meeting of the Irish Countrywomen's Association on 12 March 1942, de Valera urged people living in rural Ireland to eat alternative foods like potatoes instead of bread in an attempt to decrease rural bread consumption.⁴⁶ His reasoning was that bread supplies should be prioritised for the urban population, citing that city people had previously stood by the farmers during the economic war.⁴⁷ Irish housewives were also targeted by the government-commissioned cookbook, *Flour Economy* by Maura Laverty. This encouraged Irish women to use flour sparingly within the home.⁴⁸ Public and radio talks were held while food production lectures emphasised the scarcity of food supplies. For example, the following series on Radio Éireann gave advice on home economy amid wartime shortages: *Between Ourselves* and *Food and Health* (1941), *For the Housekeeper* and *Meeting the Wheat Shortage in the Home* (1942), and *Making and Mending in the Home*

³⁷ Ibid.

³⁸ *IP*, 21 Feb. 1942. Also see Fee, 'The effects of World War II', p. 68; Evans, *Ireland during the Second World War*, p. 19.

³⁹ Evans, *Ireland during the Second World War*, p. 25.

⁴⁰ Bryan, 'Rationing in Emergency Ireland', p. 103.

⁴¹ Evans, 'Coercion in the Irish countryside: the Irish smallholder, the state and compulsory tillage, 1939-49', *IESH*, xxxviii (2011), p.1.

⁴² Mary E. Daly, *The first department: a history of the department of agriculture* (Dublin, 2002), p. 233.

⁴³ Ibid.

⁴⁴ *IP*, 14 May 1942.

⁴⁵ *II*, 14 May 1942. For further information on petrol rations, see Evans, *Ireland during the Second World War*, p. 56.

⁴⁶ *Connacht Tribune*, 14 March 1942.

⁴⁷ ICA press cuttings in an un-named newspaper, c. Mar. 1942 (NLI, MS 39,886 21/07).

⁴⁸ Michael Cronin, *Impure thoughts: sexuality, Catholicism and literature in twentieth century Ireland* (Manchester, 2012), p. 157.

and Habits for Health (1943).⁴⁹ Rationing aside, initial government efforts favoured a bottom-up approach through increased production and by educating the people of different methods of production to save supplies. Unbeknownst to the public, however, were the health effects of government measures like flour extraction.

2.3 Public health consequences of extraction rates

Early successes in the national food campaign were limited as existing wartime shortages worsened. In response, the Department of Supplies issued a series of emergency orders that changed the composition of the bread itself. Although flour becomes more nutritious at higher levels of extraction, beyond a 90% extraction rate its phytic acid content impedes the absorption of necessary calcium into the body.⁵⁰ Beyond 92% extraction, there is material in the flour that cannot be digested by the human body.⁵¹ Limited wheat reserves in late 1940 prompted the Department of Supplies to raise extraction rates to 75% and later to 80%.⁵² On 27 January 1941, this rate was increased to 90%.⁵³ Less than three months later, Emergency Powers ordered that flour must be extracted at an even higher 95% rate to conserve supplies.⁵⁴ So scarce were wheat supplies that bread or any other wheaten foods could only be served at one course in catering establishments throughout the country from March 1941.⁵⁵ Further attempts at the preservation of wheat supplies eventually culminated in 100% extraction from February 1942 right through to December 1943.⁵⁶ As early as 16 March 1942, the Dietetic Council warned Lemass that high extraction rates ‘would be very serious especially in growing children’.⁵⁷ In the council’s view, calcium carbonate should have been added at once to the flour to minimise the side effects of the phytic acid.⁵⁸ However, Lemass disregarded these suggestions because there was no concrete evidence to suggest that a calcium deficiency existed in Ireland. Instead, experiments of the ESRB and the Department of Supplies focused on the aesthetic qualities of the bread, confirming that there were no dramatic changes to its flavour, colour or shelf-life when it was produced with flour extracted at higher rates.⁵⁹

The prevalence of rickets in Ireland increased substantially during the war. Rickets is a deficiency disease that occurs in growing infants and children, and it is associated with a vitamin D deficiency and a lack of calcium. This leads to the development of skeletal abnormalities

⁴⁹ Clair Wills, ‘Women writers and the death of rural Ireland’ in *Eire-Ireland*, xli, no. 1 (2006), p. 202.

⁵⁰ W. J. E. Jessop to DOS, 16 Apr. 1942 (NAI, TAOIS S/12064).

⁵¹ Ibid.

⁵² Ibid.

⁵³ *IP*, 27 Jan. 1941.

⁵⁴ *IE*, 12 Apr. 1941.

⁵⁵ *Belfast Newsletter*, 21 Mar. 1941.

⁵⁶ Ward to de Valera, 17 Feb. 1945 (NAI, TAOIS S/12064).

⁵⁷ Jessop to DOS, 16 Apr. 1942 (NAI, TAOIS S/12064).

⁵⁸ Ibid.

⁵⁹ *IP*, 27 Jan. 1941.

which in turn can lead to significant disturbances in bone growth (figures 2.1 and 2.2).⁶⁰ In 1942, Dublin paediatricians noted an increase in rickets cases that were



Figure 2.1 Three children with rickets in Vienna, un-dated.⁶¹

radiologically diagnosed in children's hospitals.⁶² Between 1939 and 1941, studies indicated an increase from 10 cases per 1,000 children to 23 cases per 1,000 children of those examined in the National Children's Hospital, St. Ultan's Hospital and Temple St. Hospital.⁶³ After this, another Irish investigation coincided with a rickets survey done in England, Wales, Scotland and Northern Ireland by the British Paediatric Association. Some 365 children were selected at random for examination from the outpatient departments of children's hospitals and welfare

⁶⁰ H. Pringle, R. A. Reynolds and Jessop, 'The incidence of rickets in Dublin', in *JMAE*, xii, no. 72 (1943), p.67.

⁶¹ Photo re-produced from the Wellcome Collection (<https://wellcomecollection.org/works/kpftgz5u>) (1 Aug. 2024).

⁶² E. T. J. McWeeney memorandum on rising incidence of rickets in Dublin's main children's hospitals, 1939-42, 20 Oct. 1943, p.4 (NAI, HLTH B/106/10).

⁶³ Pringle et al, 'The incidence of rickets', p. 68.

centres in Dublin.⁶⁴ Those presenting for examination were mainly children of the poor, though some had benefitted from the remittances of a father who had pursued work in England.⁶⁵ This survey indicated that the incidence of rickets in Dublin had risen from 10 cases per 1,000 children under four years of age in 1939 to 230 cases per 1,000 by 1943.⁶⁶ Additionally, it was reported that for every case of rickets in 1930, there were ten by 1943, although concrete figures on this are scarce.⁶⁷ Nonetheless, some reports had cases that were ‘so bad that [children] required orthopaedic treatment to remedy deformities’.⁶⁸ These figures

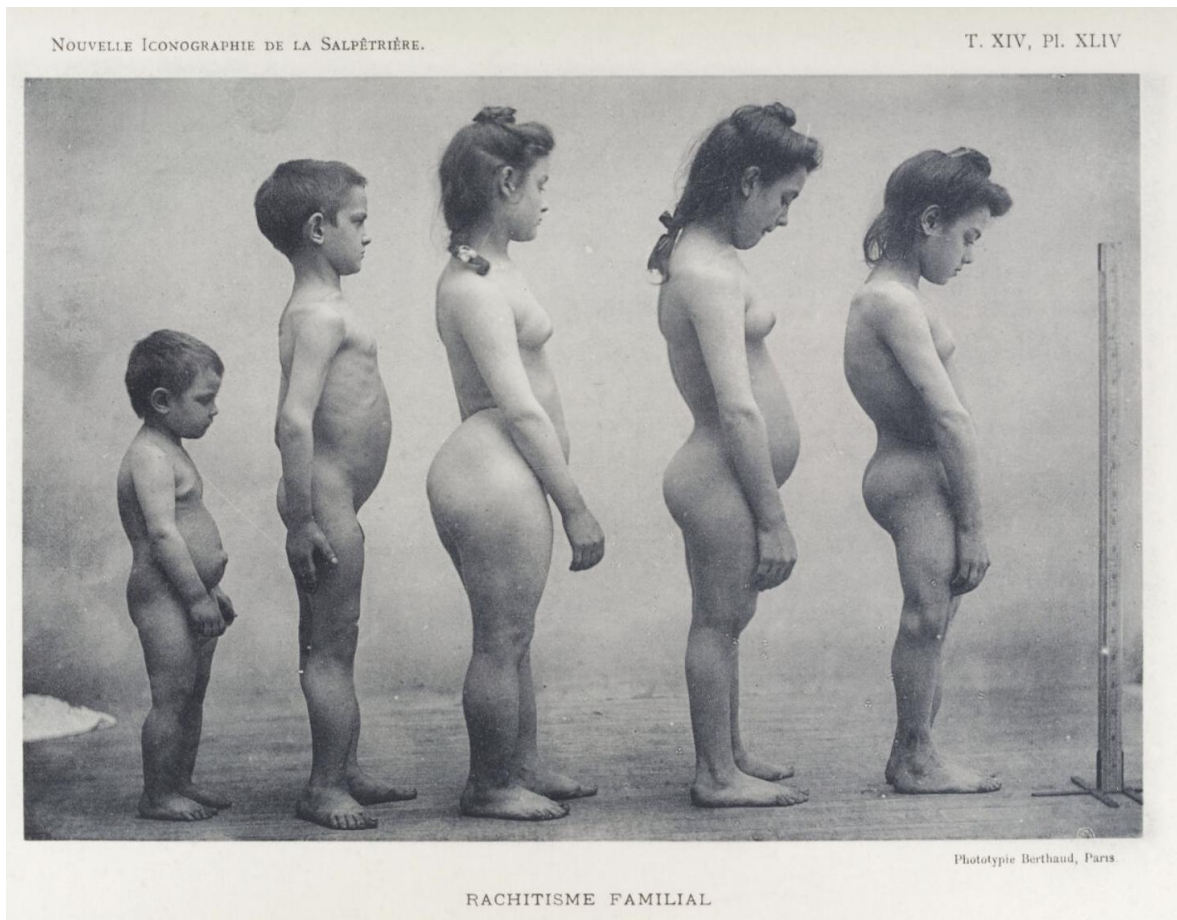


Figure 2.3 Rickets depicted in French children (side-view) with caption ‘Rachitisme familial’ (family rickets).⁶⁹

were four times higher than that found in any English city examined.⁷⁰ Britain, on the other hand, did not share the same level of wheat shortage as that experienced in Ireland. The British Ministry of Health also fortified certain foods, including bread, with vitamins and minerals as

⁶⁴ Ibid.

⁶⁵ Ibid, p. 69.

⁶⁶ *IE*, 16 July 1943.

⁶⁷ *IT*, 27 May 1943.

⁶⁸ Deeny to DOS, 30 Oct. 1944 (NAI, TAOIS S/12064).

⁶⁹ Photo re-produced from Wellcome Collection (<https://wellcomecollection.org/works/g2nu7639>) (1 Aug. 2024).

⁷⁰ McWeeney memorandum on rising incidence of rickets, 20 Oct. 1943, p.6.

early as 1941.⁷¹ Despite early losses at sea for British merchants, merchant shipping in Britain still brought food across the Atlantic, and by the spring of 1940, Britain's Ministry of Food was the sole importer of cereals as well as many other foods.⁷²

To prevent rickets in children, vitamin D and calcium intake had to be optimal. Vitamin D is essential for allowing the human body to absorb calcium and other vital nutrients.⁷³ Of the children who were examined in the second rickets investigation, most of the mothers were 'emphatic' that the child examined received the same diet as his elder brothers and sisters who had shown no symptoms of the disease.⁷⁴ The staple diet in all cases was bread and butter whereas any decrease in intake of vitamin D was minimal.⁷⁵ Daily per capita intakes of vitamin D only fell slightly from 1.9 µg in 1940 to 1.5 µg in 1942 due to wartime restrictions on fatty fish and margarine and some manufactures were already fortifying margarine with vitamin A and vitamin D.⁷⁶ Not helping the situation here was an earlier cut-off in supplies of fish liver oil in 1942 from Norway and Newfoundland due to wartime conditions.⁷⁷ None of the children who had rickets were taking cod-liver oil regularly (a rich source of vitamin D for high-latitude countries), but neither were any of their elder brothers and sisters.

The only dietary factor whose change directly correlated with the increase in the incidence of rickets was the rising rate of flour extraction. Outside of the diet, there were no significant changes in weather and there were no abrupt changes in social behaviour that were enough to change the outdoor exposure patterns of children during the war.⁷⁸ In this way, changes in UV exposure could not be used as a causative factor. These factors led Jessop to conclude that it was more likely that the sudden increase in rickets was due to the related increase in the extraction rate of the flour rather than a decrease in the intake of vitamin D.⁷⁹ Dr Geary, of the Statistics Branch of the Department of Industry and Commerce, claimed that while 'statistically neither inadequate milk alone nor inadequate vitamin D alone is significantly related' to the incidence of rickets, the combined inadequacy of both did have a potentially very significant relationship.⁸⁰

The main sources of vitamin D in the diet were milk, butter and eggs. At the time, the medical profession agreed that a child should have at least 0.75gm of calcium per day and this

⁷¹ Helen Lightowler and Helen Macbeth, 'Nutrition, food rationing and home production in the UK during the Second World War' in Paul Collinson and Helen Macbeth (eds), *Food in zones of conflict: cross disciplinary perspectives* (Oxford, 2017), p. 115.

⁷² *Ibid.*, p. 109.

⁷³ Pringle et al, 'The incidence of rickets', p. 67.

⁷⁴ Jessop, 'Results of rickets surveys in Dublin' in *BMJ*, vi (Sept. 1950), p. 289.

⁷⁵ *Ibid.*

⁷⁶ Irish Robertson, 'The role of cereals in the aetiology of nutritional rickets: the lesson of the Irish National Nutrition Survey, 1943-48' in *British Journal of Nutrition* (hereafter *BJN*), xlv, no. 17 (1981), p. 18.

⁷⁷ *Kerry Champion*, 14 Feb. 1942.

⁷⁸ Robertson, 'The role of cereals', p. 20.

⁷⁹ Jessop, 'Results of rickets surveys', p. 289.

⁸⁰ *Ibid.*, p. 291.

could have been obtained from little over a pint of milk.⁸¹ Despite the fact that 100% extraction flour contained more calcium than white flour, higher quantities of phytic acid content prevented it from being absorbed into the human digestive system, proving detrimental to public health amid other wartime shortages. A person reliant on bread now needed to consume an excess of calcium from other sources to make up for the effects of phytic acid. This occurred at a time in which there were also shortages in milk. In Dublin, 40,000 gallons of milk were consumed on a daily basis – the equivalent of about half a pint per head of the population.⁸² Eggs were a ‘luxury which few poor families [could] afford’.⁸³ The quick-fix methods of wartime rationing became visually apparent in the bodies of lower-class children. So serious was this issue that the chief medical officer, James Deeny, advised having all junior classes in city schools examined for evidence of rickets and signs of malnutrition.⁸⁴ The Dietetic Council called for an immediate reduction in flour extraction rates to 85% and for the government to fortify flour with calcium.⁸⁵ This relationship between high phytate bread and high rates of rickets in children has been observed since in other places where calcium sources are also limited such as in rural Iran and among Bantu children in South Africa.⁸⁶

Flour extraction rates also became enmeshed in debates about another growing public health crisis: the rising incidence of tuberculosis in Ireland. TB is a chronic bacterial disease that is caused by the growth of *bacillus mycobacterium tuberculosis* in bodily tissues.⁸⁷ Home to 20% of the total population, Dublin accounted for over one-quarter of all TB deaths during the war years.⁸⁸ This proved alarming when the disease was in retreat in most other developed nations.⁸⁹ While there was a proven epidemiological correlation between rickets and calcium, there were suggestions as to the possible relationship between calcium and TB. In particular, Theobald Dillon and Parliamentary Secretary of the Departments of Local Government and Public Health, Dr Conn Ward, raised questions as to whether a lack of calcium could weaken one’s resistance to a primary TB infection or if the advanced tertiary case of the disease might be positively influenced by the administration of calcium.⁹⁰ In Dublin alone, numerous doctors were alarmed by an increase of the number of bone fractures in young children while the severity

⁸¹ Pringle et al, ‘The incidence of rickets’, p. 67.

⁸² Ibid., p. 68.

⁸³ Ibid.

⁸⁴ Deeny to DOS, 30 Oct. 1944 (NAI TAOIS S/12064).

⁸⁵ ESRB memorandum on the Dietetic Council (hereafter DC), rickets and flour extraction, 11 Jun. 1943 (NAI TAOIS S/12064).

⁸⁶ For detail relating to Iran, see H. Amirhakimi, ‘Rickets in a developing country: observations of general interest from Southern Iran’ in *Clinical Paediatrics*, xii, no. 2 (1973), pp 88-90. For comparison in South Africa, see Robertson, ‘The role of cereals’, p. 21.

⁸⁷ M. Porta, *A Dictionary of Epidemiology* (5th ed., New York, 2008), p. 247.

⁸⁸ ARRG, 1939-45 (Dublin, 1946), pp 14-78. Data taken over consecutive years.

⁸⁹ Ibid.

⁹⁰ Dillon to Dr Ward, 22 Oct. 1943 (NAI, TAOIS S/12064).

of the onset of TB among the younger age groups proved equally worrying.⁹¹ Jessop attributed both of these to a calcium deficiency that arose from the removal of calcium from the body by high extraction flour.⁹² In a letter to de Valera in February 1945, Dr Ward argued for the addition of calcium to bread by presenting the correlation between increased TB deaths and calcium deficiency.⁹³ With calcium levels lower ‘under inferior economic conditions’, he included a list of death rates to correspond with rising flour extraction rates – the highest increase measured at 1,014 at the time of 100% flour extraction (see figure 2.1).⁹⁴

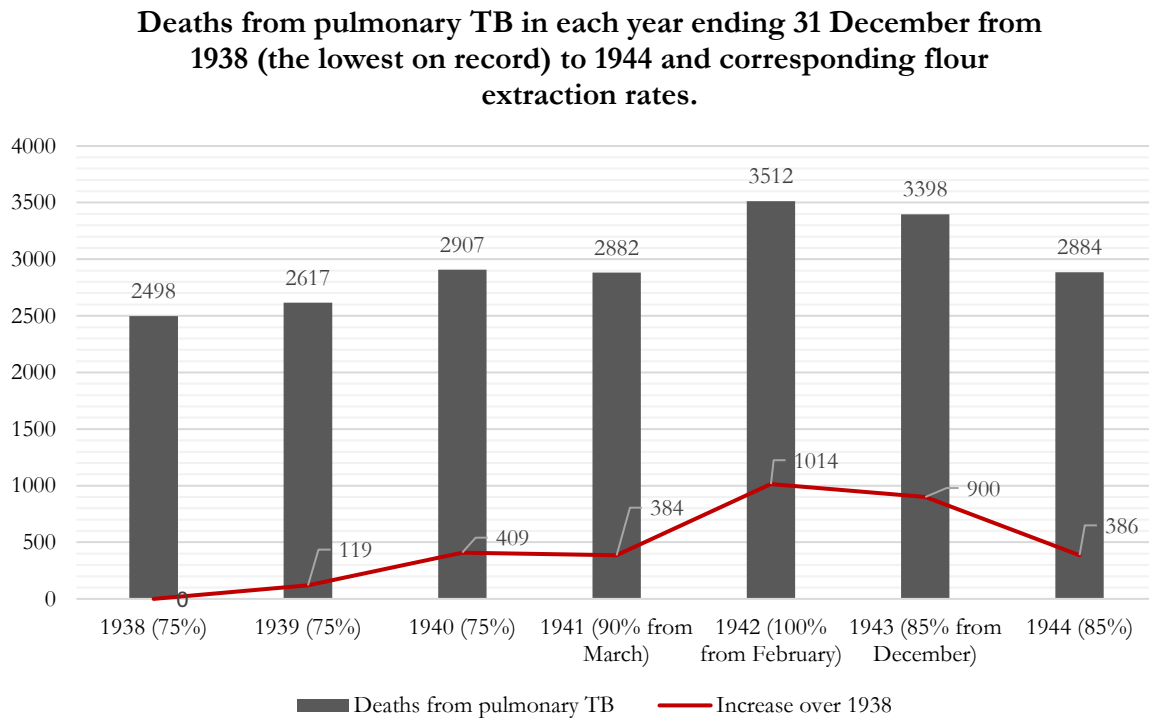


Figure 2.1 Deaths of pulmonary TB, 1938-1944 and corresponding flour extraction rates.⁹⁵

Less than a month later, renowned paediatrician, Dr Dorothy Price observed that recovery from TB relied heavily on the deposition of calcium in the form of a lime in the affected areas, effectively isolating the lesion and facilitating a cure.⁹⁶ As far as Ireland’s public health officials were concerned, flour should be fortified at once, and any associated increase in cost should be acknowledged as an essential production expense.⁹⁷

⁹¹ ESRB to Department of Taoiseach, 18 Nov. 1943 (NAI, TAOIS S/12064).

⁹² Ibid.

⁹³ Ward to de Valera, 17 Feb. 1945 (NAI, TAOIS S/12064).

⁹⁴ Ibid.

⁹⁵ Ibid.

⁹⁶ DLGPH memorandum on the addition of calcium to flour, 9 Mar. 1945 (NAI, TAOIS S/12064). For information about the investigations of Dr Dorothy Price, see Anne Mac Lellan, ‘Alone among neutrals: Ireland’s unique experience of tuberculosis during the Second World War’ in Durnin and Miller (eds), *Medicine, health and Irish experiences of conflict, 1914-1945*, p. 69; Margaret Ó hÓgartaigh, ‘Price, Dorothy Stopford’ in *DIB (online)*, DOI: <https://doi.org/10.3318/dib.007498.v1>.

⁹⁷ DOS memorandum on the addition of calcium to flour, 11 Mar. 1945 (NAI, TAOIS S/12064).

TB was another issue that was closely linked to the country's milk problem during the war. Clinical tests for bovine TB at that time involved injecting cows with tuberculin, and those who 'exhibited a rise in temperature' were deemed more likely to have bovine TB.⁹⁸ While these tests appeared to differentiate between which animals were infected and those that were not, they could only detect bovine TB at an advanced stage – meaning that milk from an infected cow or herd could have been sold up until this point.⁹⁹ To make matters worse, the tuberculin used for tests was also in short supply.¹⁰⁰ In 1942, the Irish Housewives Association (IHA) became interested in the milk issue following their investigations into the work of the Dublin Marketing Board.¹⁰¹ Their findings indicated that as little as three or four percent of all milk consumed in Dublin was of the highest quality i.e., milk sourced from tuberculin-tested herds.¹⁰² These findings proved particularly controversial as they coincided with outbreaks of epidemic proportions of infant gastro-enteritis in Dublin – the main cause of which was already known to be the consumption of contaminated milk supplies and this will be explored further in chapter 3 on infant mortality. The apparent uneasiness that surrounded the milk question was further alluded to on 11 April 1945 by Galway-based Clann na Talmhan MP (Irish National Agricultural Party), Michael Donnellan:

Tuberculosis publicity over-emphasising the prevalence of tuberculosis in cattle, and the danger of drinking milk except from tuberculin-tested cows has created such uneasiness that milk is now regarded not as a complete food but as a potential poison.¹⁰³

This underscores the complexities involved in tackling issues associated with milk supplies, where one solution for health could be detrimental for business. This can also be extended to health in that milk was the main source of calcium at this time. It likewise reminds us of the extent to which the government had to balance the interests of multiple stakeholders.

Milk price was a significant factor in the distribution and consumption of milk during the war period. The well-off sections of the population were able to buy highest-grade tuberculin-tested milk whereas the poorer segments of the population were forced to settle for whatever they could get their hands on. In 1944, Patrick J. Halliden, Clann na Talmhan TD, noted that the price of milk doubled since the beginning of the war.¹⁰⁴ This had a serious knock-on effect on the operations of Dublin's Infant Aid Society – a non-denominational voluntary organisation that distributed free milk to expectant and nursing mothers. For example, the

⁹⁸ Keir Waddington, 'To stamp out 'so terrible a malady': bovine tuberculosis and tuberculin testing in Britain, 1890-1939' in *Medical History*, xlviii (2004), p. 32.

⁹⁹ Evans, 'Food, the Emergency', p. 56.

¹⁰⁰ Ibid.

¹⁰¹ Farrell, 'Harassed housewives', p. 52.

¹⁰² Ibid.

¹⁰³ *DÉD*, 11 Apr. 1945, vol. 96, no. 17.

¹⁰⁴ *DÉD*, 22 Mar. 1944, vol. 93, no. 2.

£30,000 state grant made to the operations of the Infant Aid Society in Dublin was no longer adequate by February 1944.¹⁰⁵ According to A. Byrne, a representative of the Infant Aid Society, the increase in the price of milk had caused the society to reduce the amount of highest-grade milk being distributed by the society in efforts to meet continuous demand.¹⁰⁶ Up until this point, the society had only distributed milk of the highest quality, but they were then faced with seeking alternative supplies because of the rising cost. In this way, the quality of the milk that was distributed to those most in need was significantly reduced. Whether by choice or economic situation, poorer families not only 'ate less well' in urban areas such as Dublin, but the milk intake in these families was also significantly below international recommendations.¹⁰⁷

2.4 Developments in Britain

Meanwhile, Britain had avoided calcium deficiency by fortifying flour with acid calcium carbonate in 1941. At the same time, it was estimated that 80% of the distribution of milk in London was carried out by one firm, United Dairies, which reduced price competition and milk waste.¹⁰⁸ Members of the Irish medical profession used the advances of the British Ministry of Health as a means of highlighting the weaknesses found in Ireland. In a letter from Dillon to Dr Conn Ward, Dillon expressed his views on England's rationing system:

The rise in the TB death rate which appeared in England during the first two years of this war has in fact been checked with surprising ease during a period of strict rationing, which however was characterised by a determined effort to maintain the calcium intake at the optimum level for all sections of the population by adding calcium to the bread, [and] providing milk for children and expectant mothers.¹⁰⁹

The British TB death rate, Dillon claimed, was neutralised with a sound food policy. The per capita incidence of rickets and TB was also lower in Britain than in Ireland.¹¹⁰ The general state of public health in Britain had improved despite the more direct wartime adversities.¹¹¹ While Britain's rationing system and the provision of welfare foods raised nutritional levels among the most destitute of the population, rationing in Ireland affected the poor worst of all.¹¹² In Britain, industrial canteens gave more meat, sugar and fats per meal in the public restaurants while a rural pie scheme was also introduced for agricultural workers.¹¹³ Their nutritional advice was practical, as found through the Woolton Pie analysis of this chapter's opening. Pricing

¹⁰⁵ *DÉD*, 16 Feb. 1944, vol. 92, no. 9.

¹⁰⁶ *Ibid.*

¹⁰⁷ Evans, 'Food, the Emergency', p. 56. Also see *National nutrition survey part I: methods of dietary survey and results from the Dublin investigation* (Dublin 1953), p. 56.

¹⁰⁸ *DÉD*, 21 May 1941, vol. 25, no. 13.

¹⁰⁹ T. Dillon to Ward, 22 Oct. 1943 (NAI, TAOIS S/12064).

¹¹⁰ DLGPH memorandum on the addition of calcium to flour, 14 Mar. 1945 (NAI, TAOIS S/12064).

¹¹¹ *Ibid.*

¹¹² Wills, *That neutral island*, p. 243.

¹¹³ Bryan, 'Rationing in Emergency Ireland', p. 279.

regulations were also enforced with an iron hand as the price of every dietary article was checked and rechecked.¹¹⁴

This did not apply to Ireland. Extraction rates were not lowered until December 1943 and flour was not fortified by government order with calcium until June 1946, a considerable time after the war had ended.¹¹⁵ Instead of taking the word of existing British science, both Lemass and MacEntee insisted on doing their own investigations. These took a significant amount of time. The Dietetic Council was tasked with proving a calcium deficiency existed in Ireland, before they establish its effects on the incidence on rickets and TB mortality. There were no final conclusions reached as to whether the increased prevalence of these diseases was because of the flour, a deficiency of vitamin D, a deficient calcium intake or a combination of these factors.¹¹⁶ Further, the visual precursors of both diseases did not occur overnight while investigations involved substantial planning, paperwork and personnel. Although it was not possible to show by animal experiments that calcium influenced the development of TB, the apparent links between the two were enough to warrant measures that could ensure adequate calcium intakes for all sections of the population.¹¹⁷ Besides, it was believed that the addition of calcium would cause no harmful effects in conditions where deficiency was already apparent.¹¹⁸ Investigations into appropriate extraction rates and calcium reserves demanded the work and co-ordination of the Dietetic Council and the ESRB – this was also time consuming. For example, the Dietetic Council ran numerous investigations into the dangers of bread made from high extraction flour as well as the use of potato in manufacturing bread. This involved surveys of bakeries that were already manufacturing bread with up to 20% potato.¹¹⁹ Similarly, the research bureau awaited results from investigations by the Geological Survey into potential calcium reserves for baking.¹²⁰ Even before doing so, both bodies looked to Britain for guidance.¹²¹ The political tensions between Lemass and MacEntee then led to continuous debate over what should be prioritised and when.

¹¹⁴ *Tuam Herald*, 5 Dec. 1942.

¹¹⁵ For information on timing of changes to extraction rates, see Ward to de Valera, 17 Feb. 1945 (NAI, TAOIS S/12064); *DÉD*, 16 Nov. 1943, vol. 91, no. 16 & *DÉD*, 1 Dec. 1943, vol. 92, no. 4. For information on flour fortification, see M. R. Epstein, W. Kidney, W. Collis, H. Pringle, R. A. Reynolds, S. Douglas and W. J. E. Jessop, 'The incidence of rickets in Dublin', *JMAE*, xxvi, no. clii (1950), p. 23.

¹¹⁶ *Tuam Herald*, 5 Dec. 1942.

¹¹⁷ Dillon to Ward, 22 Oct. 1943 (NAI, TAOIS S/12064).

¹¹⁸ ESRB memorandum on the Dietetic Council, rickets and flour extraction, 11 June 1943 (NAI, TAOIS S/12064).

¹¹⁹ Jessop to DOS, 16 Apr. 1942 (NAI, TAOIS S/12064).

¹²⁰ DOH to Department of the Taoiseach, 2 Jun. 1944 (NAI, TAOIS S/12064).

¹²¹ DLGPH memorandum on measures suggested and taken for meeting the nutritional requirements in the State, 3 May 1944 (NAI, TAOIS S/12064).

2.5 Policy deliberations on flour fortification

Wartime circumstances saw the Department of Industry and Commerce and the Department of Local Government and Public Health attempting to fulfil their basic functions in difficult economic times. The main functions of MacEntee's department lay in health measures designed to combat disease. However, through funding allocations, it was Lemass' department that was ultimately responsible for the introduction of these measures. Higher extraction rates temporarily relieved complexities associated with wartime shortages, but this also had severe effects on public health. Internal deliberations on how best to manage the situation led to unnecessary delays in finding practical solutions, which eventually culminated in a higher TB mortality rate and severe rickets epidemic among children.

The first record of public health concerns voiced against high extraction rates was by the Dietetic Council in April 1942 – two months after extraction rates were raised to 100 %. From this point onwards, public health arguments that favoured reduced extraction rates were pitched to Lemass in ways that marketed themselves as in the wider interests of the Department of Industry and Commerce. For example, the Dietetic Council reported that bread made from 100% extraction flour was 'merely diluted' as it did not necessarily increase the bread's nutritive value.¹²² To get the same nutrition, the consumer would have to eat more of the very thing that Ireland faced difficulties in generating. Additionally, the council noted better keeping properties of bread made from 85% extraction than those of higher extraction.¹²³ This being so, the council believed that bread made at lower extraction levels was 'less likely to be wasted', thereby appeasing demands of the Department of Supplies to conserve wheat reserves in the first place.¹²⁴ These debates provided sufficient rationale for the eventual decrease in flour extraction rates, which occurred in December 1943.

These arguments and the coincidence of increased TB mortality and higher flour extraction may seem convincing in retrospect, but Lemass was not immediately in favour of flour fortification. From the outset, he acknowledged rickets and TB in a much wider context and asked why the public health regime was so fixated on this issue. He pointed out that mortality rates from heart disease far exceeded the number who died from TB yet he 'knows no medical authority is in favour of increased calcium intake for persons suffering from heart disease'.¹²⁵ There were still over 1,000 small millers whose plants were only capable of producing wheaten meal at the equivalent of 100% extraction.¹²⁶ There were also a number of smaller mills

¹²² DC memorandum on flour extraction, 28 Sept.1943 (NAI, TAOIS S/12064).

¹²³ Ibid.

¹²⁴ Ibid.

¹²⁵ Ibid.

¹²⁶ Ibid.

used by wheat growers in their own homes.¹²⁷ In short, Lemass argued that lowering extraction rates and calcium fortification would impact many firms who did not possess the capacity to change their methods. Further, he was dubious of the benefit in terms of reducing TB mortality and of the insistent prioritisation of TB and rickets as opposed to other diseases.

In response, MacEntee compared fortification to the addition of chemical substances known as ‘improvers’ to flour to improve its appearance without regard for nutritional quality before the war. He insisted that calcium, ‘a mineral essential to human life’, should be added to flour without question.¹²⁸ Regarding smaller operations, he observed that a significant portion of the flour consumed by the farmers of this scale was used for their own consumption.¹²⁹ Besides, the calcium intake among this social group was generally deemed satisfactory.¹³⁰ The use of oatmeal and buttermilk among this class meant that they were not considered at risk of deficiency.¹³¹ MacEntee’s rationale was that any calcium shortage arising from 100% extraction would be offset by the small farmer’s access to other calcium-rich food sources.¹³²

Rickets and TB were only two of several public health concerns during the war, yet their prevalence took centre stage in Irish cabinet deliberations. With minimal change observed throughout the 1940s, heart disease was the primary cause of death, accounting for 21.9% of all deaths during the war period (see table 2.1).¹³³ Following this was senility (14.3%) and cancer (9.2%).¹³⁴ As can be observed, deaths from heart disease rose substantially during the war, and would continue to do so for the remainder of the decade. With minimal efforts to address heart disease, Lemass was baffled at the public health fixation with flour fortification. The response to rising rates of rickets and TB suggests that Fianna Fáil prioritised issues directly exacerbated by wartime circumstances, immediate crises in public health, rather than confronting larger problems such as heart disease that were previously identified.

Lemass may have been baffled by the focus on flour fortification and its relationship to TB and rickets but these public health issues had more visibility than heart disease or other senile diseases.¹³⁵ Both diseases carried visible implications. Clinical manifestations of rickets include short stature and the bowing of the long bones.¹³⁶ Further, the rickets epidemic was

¹²⁷ Ibid.

¹²⁸ DLGPH memorandum on ‘the Addition of Calcium to Flour’, 14 Mar. 1945 (NAI, TAOIS S/12064).

¹²⁹ Ibid.

¹³⁰ Ibid.

¹³¹ Ibid.

¹³² Ibid.

¹³³ *ARRG, 1939-45* (Dublin, 1946), consecutive years, pp xv-xviii.

¹³⁴ Ibid.

¹³⁵ For analyses of disease visibility, see Tony Hope, ‘Rationing and life-saving treatments: should identifiable patients have higher priority?’, *Journal of Medical Ethics*, xxvii, no. 3 (2001), pp 179-185.

¹³⁶ Gary S. Firestein (ed.), *Kelley and Firestein’s Textbook of Rheumatology* (London, 2016), p. 1744.

Leading cause of death, 1939-45	Total number of deaths	% of overall mortality
Heart disease	65,791	21.9%
Senility	43,231	14.3%
Cancer	27,577	9.2%
Tuberculosis	26,856	8.9%
Stroke	18,580	6.2%
Pneumonia	12,869	4.3%
Bronchitis	11,695	3.9%
Other	80,212	26.7%

Table 2.1 Leading causes of death in Ireland, 1939-45.¹³⁷

particularly emotive in a country with a disproportionately higher infant mortality rate compared to most other European nations.¹³⁸ Between 1940 and 1944, infant mortality in Ireland increased from 66 to 79 deaths per 1,000 births.¹³⁹ Infant deaths were particularly high in Dublin, rising from 91 to 117 deaths per 1,000 births.¹⁴⁰ In 1943 – the year that flour was extracted at 100% – infant mortality was particularly severe with 83 deaths per 1,000 births across Ireland and 126 deaths per 1,000 births in Dublin alone.¹⁴¹ This is not to say that rickets was a causative factor in rising infant mortality rates; this has been attributed to premature birth, gastro-enteritis, bronchial disorders and injury at birth.¹⁴² However, childhood diseases proved emotive in the context of high infant mortality. While not directly blamed for deaths, rickets was present in 90% of children worldwide who died before the age of four in the early twentieth century.¹⁴³ Because of this, emphasis was placed on foodstuffs that were essential to the growth of children, an issue that will be further discussed in Chapter Four on the nutrition survey.¹⁴⁴ The idea that children represented the future generation may explain why little by way of state action occurred for those suffering from heart disease or senility – diseases associated with ageing. TB, a prominent public health concern since the late nineteenth century, was continuously monitored by the Irish medical profession during the war. Listed as the most common cause of death in

¹³⁷ Ibid.

¹³⁸ Miller, 'Nutritional decline', p. 321.

¹³⁹ *ARRG, 1940*, p. xxxii.

¹⁴⁰ *ARRG, 1940-44*, pp xxxii-xxxvi.

¹⁴¹ *ARRG, 1943*, p. xxvi.

¹⁴² Ibid., p. xxxiii.

¹⁴³ P. Jaminet and S. Jaminet, *Perfect Health Diet: Regain Health and Lose Weight by Eating the Way You Are Meant to Eat* (New York, 2012), p. 205.

¹⁴⁴ A national nutrition survey was carried out in the Irish Free State in 1947-48. There was particular outrage at levels of milk and cheese consumption of the lower-classes. For discussion, Department of Health, *National Nutrition Survey Parts i-vii: Complete Reports on Dietary and Clinical Surveys* (Dublin, 1953).

older children aged between 5 and 15, TB was also a major cause of death among adolescents and young adults under the age of 45.¹⁴⁵

Both a reduction in extraction rates and the fortification of flour with calcium were enacted after several years of advocacy by the Dietetic Council, Deeny and MacEntee. Yet these stories exemplify how economic concerns competed with public health interests in Ireland. Because important foodstuffs and fuel faced significant supply issues, Raymond and Bielenberg argue that one of the consequences of the war in economic terms was the introduction of economic planning.¹⁴⁶ Backing up their argument, they note how an Irish Cabinet Committee on Economic Planning met 58 times between 1942 and 1945.¹⁴⁷ Rather than resulting in a total government plan on how best to deal with the economy, it responded instead to severe economic circumstances as they came.¹⁴⁸ This has been viewed as a form of hyper centralisation where Departments of Supplies, Industry and Commerce and Finance sought to deal with the economic situation while at the same time anticipating problems that may have emerged later, as exemplified through the establishment of the Central Bank in 1943.

The Dietetic Council initially advocated for the fortification of flour with calcium in 1942, but the matter was set aside for the duration of the war. Lemass approved a reduction of flour extraction rates in December 1943, the simpler of the two options available at the time. Reducing flour extraction rates mainly entailed the collaboration between two acting parties: Fianna Fáil and the flour millers. Conversely, flour fortification not only depended on Fianna Fáil and the cooperation of flour millers, but it also necessitated the identification and examination of existing calcium reserves (which were eventually identified by the Geological Survey and sourced in Ireland), the cooperation of relevant industries, and the implementation of stringent price controls. Acid calcium phosphate was eventually added at a rate of 24 ounces per 280lb sack of flour starting from June 1946, marking the implementation of this measure four years after initial calls.¹⁴⁹ Meanwhile, there existed a recognised public health hazard (phytic acid), leading to preventable morbidity and, in some cases, mortality.

Food fortification is a very specific public health intervention. Historically, food fortification is a top-down method that used by governments to address a deficiency among a population or sub-group population.¹⁵⁰ Crucially, it is a form of preventative medicine that aims

¹⁴⁵ *ARRG, 1939* (Dublin, 1940), p. xix.

¹⁴⁶ Andy Bielenberg and Raymond Ryan, *An economic history of Ireland since Independence* (Oxfordshire, 2013), pp 15-16.

¹⁴⁷ *Ibid.*, p. 15.

¹⁴⁸ *Ibid.*, p. 16.

¹⁴⁹ Department of Agriculture memorandum on substances added to flour, 1 Jun. 1949 (HLTH B102/37) and Ward to de Valera, 2 Jun. 1944 (TAOIS S/12064).

¹⁵⁰ For international reading on food fortification at this time, see W. H. Sebrell, 'The public health aspect of fortification of foods with vitamins and minerals' in *The Milibank Memorial Fund Quarterly*, xvii, no. 3 (Jul. 1939), pp 241-247.

to minimise malnutrition at a future stage. As opposed to a success story of how calcium deficiency was avoided, flour fortification in Ireland exemplified how economic concerns could be prioritised over public health. Fortification contrasts, for example, with the infomercials and flour economy cookbooks issued at the beginning of the war. The consequences of this were warned of, but the Department of Supplies had to balance economic demands with health. Crucial decisions in this juggling act had significant consequences for the health of the poor. Introduced only after the identification of a serious rickets epidemic and a higher TB mortality rate, flour fortification in Ireland's case was unique – introduced instead as a reactionary measure to correct the mistakes made under wartime rationing.

Paradoxically, flour fortification moved the 'medicine' further away from the population group that needed it most. Fortification increased the cost of the food being produced.¹⁵¹ In Ireland, the price of flour rose by 60% between 1939 and 1946, only to reduce to 2s. 10d. per stone a couple of years later.¹⁵² To make matters worse, pre-war wage levels were not restored until 1949.¹⁵³ Rising flour costs ultimately reduced access to the 'treatment' for the health problems that high extraction had caused.

2.6 Conclusion

The outbreak of war plunged Ireland into a state of economic emergency, and the prioritisation of rickets and TB may be attributed to Fianna Fáil's reaction to issues exacerbated by wartime conditions. Constrained by financial pressures and the very real threat of war, Fianna Fáil focused on short-term gains (the management of the immediate supply situation) at the expense of long-term public health. Ironically, wheat supplies could have been saved if people ate smaller amounts of bread that had lower rates of flour extraction as opposed to producing high quantities of high extraction brown bread that was neither nutritious nor nice to eat. While the Dietetic Council belatedly succeeded with fortification, this was only after war had concluded (1946). This reminds us that Fianna Fáil were considering the potential impact on industry and business (as well as cost) in devising a public health strategy.

If the infomercials of the early war years are anything to go by, Fianna Fáil consistently adopted an approach that placed the burden on the public rather than on businesses whenever possible.

Notwithstanding, the fortification of flour with calcium represented a distinct shift in government policy as the medical community had their voices legislatively acknowledged in this top-down approach. Rather than a means to an end, the story of flour extraction and fortification in Ireland brought a number of other and much bigger issues to the fore. Crucially,

¹⁵¹ Ibid., p. 243.

¹⁵² *The Irish Housewife* (hereafter *IH*), Dec. 1946, p. 52 and again, Dec. 1949 p. 82.

¹⁵³ Henry Patterson, 'The Irish Working-Class and the Role of the State, 1850-2016' in Biagini and Daly (eds), *The Cambridge Social History of Modern Ireland*, p. 156. For more information on wage restoration, see Henry Patterson, *Ireland Since 1939: The Persistence of the Conflict* (London, 2007), p. 65.

CHAPTER TWO

the health issues that occurred with flour extraction highlighted the extent to which nobody actually knew what levels of nutrition existed in Ireland. Commenting on rickets in June 1946, P. G. Dooley, editor of the journal of the Medical Association of Éire noted:

The problem of rickets and its attempted solution by tinkering with the flour, cannot in my view be separated from the wider problem of ill-health in general and positive health in particular.¹⁵⁴

This view is important. ‘Tinkering with the flour’ was not only a story of how Fianna Fáil focused on short-term gains at the expense of long-term public health. Calcium deficiency was just one issue that spurred debate on the nutrition ‘problem’. Nutrition became closely linked with child mortality rates in Dublin. The next chapter, focusing on gastro-enteritis outbreaks in Dublin, also addresses a health crisis caused in part by wartime conditions. Mothers became the primary focus of health propaganda and mothercraft education that was aimed at reducing infant mortality by improving public knowledge of appropriate feeding practices.¹⁵⁵ To this end, the government took a similar approach, and again avoided direct intervention during the war years, opting instead to promote the personal responsibility of mothers for disease prevention.

¹⁵⁴ P. G. Dooley, ‘The report on rickets in Dublin’ in *JMAE* (Jun. 1946), pp 30-31.

¹⁵⁵ Lindsey Earner-Byrne, *Mother and child: maternity and child welfare in Dublin, 1922-1960* (Manchester, 2007), p. 59.

CHAPTER THREE

‘HANDICAPPED IN OUR EFFORTS’? STATE REACTIONS TO GASTROENTERITIS AND THE ‘SICK’ URBAN AREA, 1939-53

3.1 Introduction

Infant mortality was not exactly a new problem in Ireland. However, like rickets, it was exacerbated by wartime conditions. In Moira Maguire’s revealing examination of childhood in independent Ireland, she contrasts the alleged commitment of the newly independent Irish state to ‘the care and well-being of children’ with a detailed analysis of the opposing realities of their everyday lives.¹ More babies under the age of one died in the 1940s than in the 1930s in Ireland.² In 1939, the infant mortality rate in Ireland was 66 per 1,000 births, and this rose to 83 per 1,000 in 1943.³ Because of this, government interest in childhood illness during the war focused for the most part on infant mortality. Within this broad category, huge emphasis was placed on combatting gastroenteritis in Dublin – a contagious bacterial disease that initially presented as reluctance to take feeds, followed by vomiting, diarrhoea and sometimes death.⁴ Because more deaths occurred in Dublin from this disease than elsewhere, it was argued by Minister for Local Government and Public Health, Seán MacEntee, that a solution to the problem in Dublin would lessen the country’s overall death rate.⁵ In addition, research findings in the epidemiology and treatment of this disease could be applied elsewhere. As a result, direct health policy interventions by Fianna Fáil involved both top-down and bottom-up measures. These included a renewed mothercraft campaign, amendments to existing disease notification legislation, the establishment of an official Gastroenteritis Advisory Committee (GEAC) and the allocation of a special hospital for gastroenteritis cases in St. Clare’s, Glasnevin.

While this was practical on paper, it ignored the fact that the overall rural death rate was also on the rise (see Appendix D). For example, maternal mortality was higher in rural areas than in urban (see Appendix D). Even within the category of child mortality, deaths of children under the age of five from congenital debility, pneumonia and tuberculosis far outnumbered those from gastroenteritis for the same period. Nonetheless, government policy and attention were focused on infant deaths in urban areas, especially in Dublin, and in these contexts gastroenteritis stood out. Maternal provision in rural areas did not receive the same attention as

¹ Moira Maguire, *Precarious childhood in post-independence Ireland* (Manchester, 2009), p. 1.

² *ARRG, 1930-49* (Dublin, 1950), pp xxxiii-xxxvii.

³ *ARRG, 1946* (Dublin, 1947), p. xxxii

⁴ *IP*, 11 Jan. 1949. Also see James Deeny, *The end of an epidemic: essays in Irish public health 1935-65* (Dublin, 1995), pp 66-67.

⁵ *IT*, 14 Jun. 1946.

those in urban environments. In relation to mother and child health, rural areas were only occasionally addressed by the Irish government when they were critiquing something, such as the use of handywomen and non-traditional practices.⁶

When measuring the level of state intervention, we assume that the more serious health issues among children received the most attention. In the same way, one could assume that the areas where disease was most prevalent would also receive more attention. But this was not the case. Instead, the preoccupation with gastroenteritis throughout the war period is revealing: it shows policy makers' perception of which population was most vulnerable, which were the urban poor. But there were other populations that were less visible. Children born out of wedlock, for example, were left outside of the state's push for health reform. Maguire alludes to the circumstances of legitimate and illegitimate children, noting how lawmakers attempted to show themselves caring while 'their social policies repeatedly ignored the needs and best interests of the neediest of Irish children', thereby offering glimpses into the health conditions that some children endured.⁷ Sarah-Anne Buckley and Caroline McGregor examine 'problem populations' of Irish authorities: poor children, illegitimate children and unmarried mothers.⁸ To this end, Lindsey Earner-Byrne's examination of the health of the Irish mother and child is crucial to understanding the interweaving of state, church and voluntary responses to a rising incidence of disease, especially when it came to gastroenteritis, and the emergence of the welfare state in Ireland following the war.

High rates of infant mortality, rising during the war, proved problematic in a state that wished to appear modern, progressive and 'healthy' on the world stage. Thus, the interventions to combat gastroenteritis reveal Fianna Fáil concerns that the urban poor were 'sick', an attitude that mothers were in some part to blame, and a reluctance to regulate business in favour of educating people to behave in certain ways. Reluctance to interfere with business and agriculture during the 1940s may have also been politically motivated given Fianna Fáil losses in rural support at the end of the 1930s, and again in the 1943 election when the Labour Party won its highest ever percentage of the vote.⁹ Further signs of political instability for Fianna Fáil can be found in the summer of 1946 when Clann na Poblachta was established. By examining where health action occurred and indeed, where it did not, this chapter will use diarrhoea and enteritis

⁶ Ciara Breathnach, 'Handywomen and birthing in rural Ireland, 1851-1955' in *Gender & History*, xxviii, no. 1 (2016), pp 34-56.

⁷ Maguire, *Precarious childhood*, p. 2.

⁸ Sarah-Anne Buckley and Caroline McGregor, 'Interrogating institutionalisation and child welfare: the Irish case, 1939-1991' in *European Journal of Social Work*, xxii, no. 6 (2019), pp 1062-1065.

⁹ Brian Girvin, 'The dominance of Fianna Fáil and the nature of political adaptability in Ireland' in *Political Studies*, xxxii (1984), pp 463-464. Also see Niamh Puirseil, 'Labour and coalition: the impact of the first inter-party government, 1948-51' in *Saothar*, xxvii (2002), pp 55-57; Philip Ollerenshaw, 'Neutrality and belligerence: Ireland, 1939-45' in *Thomas Bartlett (ed.), The Cambridge history of Ireland* (Cambridge, 2018), p. 356.

to elucidate the aims of child welfare provision between 1939 and 1953. It makes the argument that Ireland's distinct political and cultural context played a key role in crisis management of the period. In so doing, it will demonstrate the extent to which the body politic of the newly independent state fed into child welfare provision.

3.2 Child and infant health during the first half of twentieth century

The development of maternal and childcare provisions in the twentieth century occurred in response to concerns around population change in much of Western Europe, particularly in the wake of huge losses suffered during the First World War (1914-1918). At the same time, Europe was experiencing a dramatic demographic transition from high to low birth and death rates, the result being an 'aging' of the population as the proportion of the over 65s substantially increased.¹⁰ Historians have generally agreed that developments in child welfare occurred in part as a response to the so-called 'degeneration of the race' in industrial societies whereby healthy children became the answer to a whole host of socio-political dilemmas necessary for future development and defence. In Ireland, Mary E. Daly observes that the country had the lowest marriage rate in the world in 1935 and yet, the typical family size was among the highest.¹¹ So alarming were the findings of the 1936 census that some suggested that 'the trend of population in Éire and in other countries is an actual and important social problem which should be of interest to each one of us'.¹² The demographic problem in Ireland was not just about population decline, but also age distribution which owed as much to low marriage rates as to the prevalence of disease. Daly notes that Irish couples who had been married for twenty years in 1946 had twice as many children as their British counterparts with the Irish average at 4.39 and British coming in at 2.16.¹³ This meant that Irish children were more susceptible to poverty and disease as family size was already high. Lindsey Earner-Byrne likewise argues that few nation states had embraced modernity without showing any signs of fear, manifesting in censorship, protective gender-based legislation, repression of sexual behaviour and propaganda.¹⁴ In Britain, concerns were expressed to replace dying soldiers with a new generation and this was manifested through enhancing the public health presence, such as increasing the number of health visitors, antenatal clinics, day nurseries and nursery schools.¹⁵ Colin Heywood observes how attempts by Fascist

¹⁰ Colin Heywood, *Childhood in modern Europe* (Cambridge, 2018), p. 195.

¹¹ Mary E. Daly, 'Marriage, fertility and women's lives in twentieth-century Ireland (c. 1900-1970) in *Women's History Review*, xv, no. 4 (2006), p. 571.

¹² D. Dempsey, 'Facts and figures about Eire's population' in *The Irish Monthly*, lxxvii (1939), p. 529.

¹³ *Ibid.*, p. 573.

¹⁴ Lindsey Earner-Byrne, 'Reinforcing family: the role of gender, morality and sexuality in Irish welfare policy, 1922-1944' in *The History of the Family*, xxxiv, no. 4 (2012), p. 361.

¹⁵ Peter J. Atkins, 'White poison? The social consequences of milk consumption, 1850-1930' in *SHM*, v, no. 2 (1992), p. 224.

and Nazi governments to maintain high birth rates found expression by discouraging contraception and providing incentives for parents to have big families.¹⁶

In Ireland, the development of child and maternal welfare was gradual, disconnected and varied from county to county during the first half of the twentieth century. Up until the 1920s, much of Ireland's public health was orchestrated through the Poor Law system, which was introduced in 1838 on the basis of the British model. Initially, the Irish Free State followed through on the mandate of the 1919 Democratic Programme to rid the country of the 'foreign' poor law system.¹⁷ Measures included the Local Government Acts of 1923 & 1925 and the establishment of a nationwide Hospital Commission in September 1933.¹⁸ However, Earner-Byrne argues that structural changes aside, many of the changes were symbolic as the economic circumstances of the inter-war period left many mothers negotiating between limited official relief and charitable welfare services to ensure minimum family health.¹⁹ While all workhouses were scheduled to close, workhouses that were the biggest and in best condition were used as the county hospitals with child and maternity wards included in most areas.²⁰ However, the availability and quality of the services provided were uneven.²¹ This meant that Ireland's child welfare provision particularly precarious position upon the outbreak of war.

3.3 Child and infant mortality in Ireland during the war

In Ireland, the mortality of children under the age of five years rose substantially during the war. In 1938 pre-war for example, 5,146 children under the age of five died from various causes in the Irish Free State.²² This figure peaked during the war period in 1943 at 6,641 deaths.²³ Within this, infant mortality or deaths of children under the age of one occupied a substantial proportion of this increase (see table 3.1). For the same period, infant mortality increased from 3,794 in 1938, also peaking in 1943 at 5,319; representing an increase from 61 infant deaths per 1,000 in 1938 to 83 deaths per 1,000 in 1943.²⁴ While there is much we do not know about the sudden deaths of children, there were several common causes of child deaths at this time. For children under five but older than one, the most common causes were pneumonia, tuberculosis,

¹⁶ Heywood, *Childhood in modern Europe*, p. 196.

¹⁷ The Democratic Programme, 1919 (21 Jan. 1919). Also see Donnacha Séan Lucey, 'Irish partition and poor law reform in interwar Northern Ireland' in *European Review of History*, xxviii, no. 5-6 (2021), pp 793-813.

¹⁸ Local Government Act, 1923 (1923, no. 9) (28 Mar. 1923); Local Government Act, 1925 (1925 no. 5) (26 Mar. 1925); Public Hospitals Act, 1933 (1933 no. 18) (27 Jul. 1933).

¹⁹ Earner-Byrne, *Mother and child: maternity and child welfare in Dublin, 1922-1960* (Manchester, 2007), p. 1.

²⁰ Mary E. Daly, 'An atmosphere of sturdy independence': the State and Dublin hospitals in the 1930s' in Elizabeth Malcolm and Greta Jones (eds), *Medicine, disease and the state in Ireland, 1650-1940* (Cork, 1999), p. 237.

²¹ Central funds went towards paying for half of the child welfare schemes with local authorities meeting the rest. See Earner-Byrne, *Mother and child*, p. 3.

²² *ARRG, 1938*, (Dublin, 1939), p. xxxvi.

²³ *ARRG, 1943* (Dublin, 1944), p. xxxi.

²⁴ *Ibid.*, p. viii and *ARRG, 1938*, p. viii.

diphtheria, whooping cough, measles and congenital malformations.²⁵ For infants under one, causes included but were not limited to premature birth, congenital debility, pneumonia, diarrhoea and enteritis. The prevalence of poor sanitation and inadequate feeding often accounted for a substantial proportion of these deaths (see figure 3.1). Infant deaths under one were still prevalent in the 1930s, despite being higher in the 1940s. Fluctuations in infant deaths

YEAR	Child deaths under 5 years (all causes)	Infant Deaths under 1 years (all causes)	Percentage of infant deaths of child mortality under 5 years
1933	5,384	3,742	69.5%
1934	4,959	3,664	73.8%
1935	5,560	3,988	71.7%
1936	5,836	4,309	73.8%
1937	5,748	4,121	71.6%
1938	5,146	3,794	73.7%
1939	4,830	3,691	76.4%
1940	4,826	3,759	77.8%
1941	5,328	4,175	78.3%
1942	5,826	4,591	78.8%
1943	6,641	5,319	80%
1944	6,484	5,198	80.1%
1945	5,842	4,739	81.1%
1946	5,250	4,390	83.6%
1947	5,743	4,687	81.6%
1948	4,094	3,313	80.9%
1949	4,138	2,415	58.3%

Table 3.1 Child mortality under five years and infant mortality under one year, 1933-1949.²⁶

during this period were likely a result of the gradual development of maternal and infant health services, which relied mostly on voluntary efforts until after the war.²⁷ Furthermore, there was no major overhaul of centralised health measures to address infant mortality, leaving individual areas to manage isolated disease outbreaks on their own.

Meanwhile, the generous development of child welfare schemes in other countries had ‘achieved good results’.²⁸ Most other developed nations saw a gradual reduction in infant

²⁵ See causes of death in *ARRG, 1933-49* (Dublin, 1950), consecutive years, pp xxxii-xxxiii.

²⁶ Ibid.

²⁷ Earner-Byrne, *Mother and child*, pp 25-26.

²⁸ *Report on the state of public health in the city of Dublin for the year ending 31 December 1940* (Dublin, 1941), p. 91.

mortality, uninterrupted by war.²⁹ With the exception of the harsh winters of 1940 and 1941, infant mortality in England returned to its pre-war downward trend.³⁰ Indeed, an infant

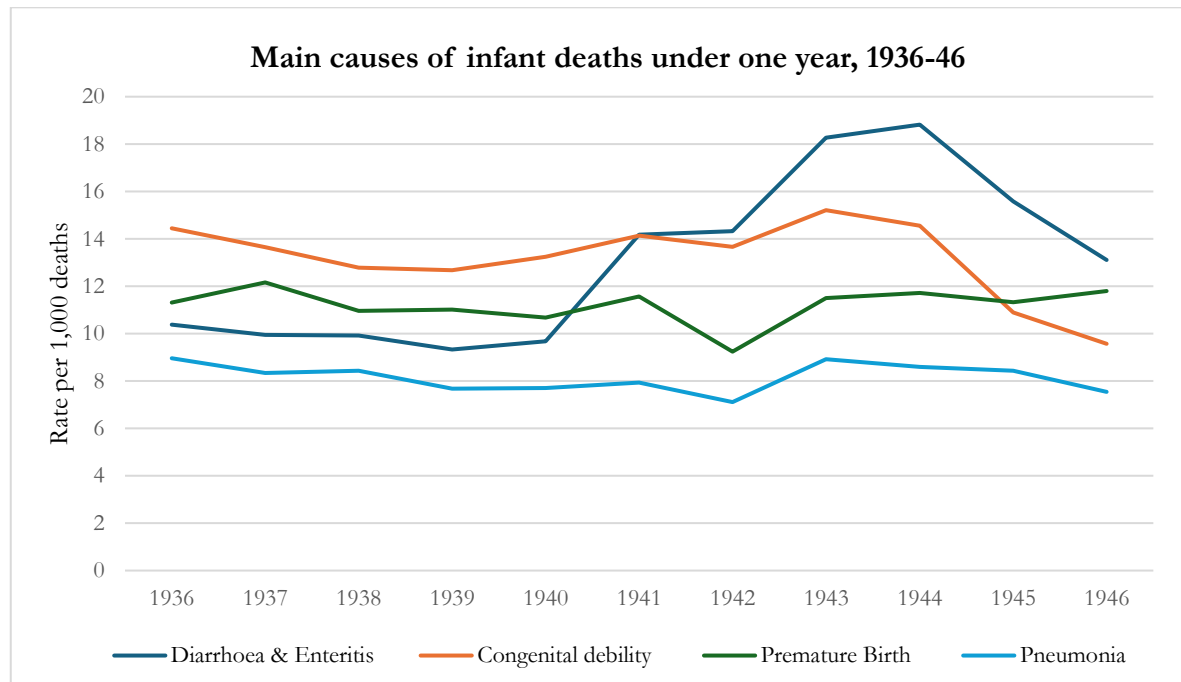


Figure 3.1 Leading causes of infant deaths under one year, 1936-46.³¹

mortality rate of 46 per 1,000 was recorded for England and Wales in 1943, two countries that were directly involved in the war (see table 3.2). With the exception of the early war years, high infant mortality rates in Northern Ireland and Scotland resumed downward trajectories from 1943 onwards. Further, infant mortality in Northern Ireland and Scotland was notably higher than in Ireland for most of the 1930s – a situation that has been attributed to more maternal care options being available in Ireland, particularly in Dublin, as well as better overall living conditions.³² For example, Dublin had a strong tradition of maternity hospitals, it had more midwives available relative to the population and the hospitalisation of births happened more quickly than in Belfast.³³ Meanwhile, high infant mortality rates in Scotland during the 1920s and 1930s have been attributed to poor housing conditions, which were particularly prone to overcrowding.³⁴ In Ireland, infant mortality figures were collected and printed annually

²⁹ Ibid.

³⁰ Sasso Lo, Jeffrey C. Schiman and Robert Kaestner, 'Infant mortality and well-being: evidence from wartime Britain' in *Labour Economics*, lx (2019), p. 13.

³¹ *ARRG, 1933-49* (Dublin, 1950), pp xxxii-xxxiii.

³² Lucia Pozzi and Liam Kennedy, 'Too long a sacrifice? Maternal mortality in Northern Ireland during the first half of the twentieth century' in *Annales de Démographie Historique*, (2020), p. 152.

³³ Ibid.

³⁴ C. H. Lee, 'Regional inequalities in infant mortality in Britain, 1861-1971: patterns and hypotheses' in *Population Studies*, xlv, no. i (1991), p. 64.

Years	Ireland	Northern Ireland	England & Wales	Scotland
1930	68	68	60	83
1931	69	73	66	82
1932	79	83	65	86
1933	73	80	64	81
1934	70	70	59	78
1935	78	86	57	77
1936	82	77	59	82
1937	73	77	58	80
1938	67	75	53	70
1939	66	70	50	69
1940	66	86	55	78
1941	74	77	58	83
1942	69	76	49	69
1943	83	78	49	65
1944	79	67	46	65
1945	71	68	46	56
1946	65	54	43	54
1947	68	53	41	56
1948	50	46	34	45
1949	53	45	32	41
1950	46	40	30	39

Table 3.2 Annual infant mortality rates per 1,000 live births in Ireland and neighbouring countries, 1930-50.³⁵

by the Registrar-General, and Fianna Fáil were aware of lower infant mortality rates reached in other areas. Awareness of declining rates in other countries highlighted to MacEntee and Irish medical circles alike that infant mortality was preventable, and with due resources, could offset the excessive national overall death rate.³⁶

Speaking at a meeting with the Public Health Committee of Dublin Corporation on 25 September 1946, MacEntee noted:

Now, we will all agree that we cannot afford to lose upwards of 500 babies a year in Dublin and maybe another 500 throughout the country from a disease which apparently people elsewhere have been able, if not to completely eliminate it, at least control so as to prevent it becoming endemic.³⁷

By contrasting Ireland unfavourably with other countries, MacEntee sought to emphasise the urgency of the situation at hand.

³⁵ *ARRG, 1930-50* (Dublin, 1951), pp xvii - xxxii.

³⁶ *IT*, 14 Jun. 1946.

³⁷ Minutes of meeting on gastroenteritis in Dublin Corporation, 25 Sept. 1946 (RCSI, Deeny papers, 1/2/18/4).

3.4 The problem of diarrhoea and enteritis

Official focus on infant mortality in the war led to a preoccupation with the control of gastroenteritis in Dublin (also called ‘diarrhoeal enteritis’ and ‘summer diarrhoea’).

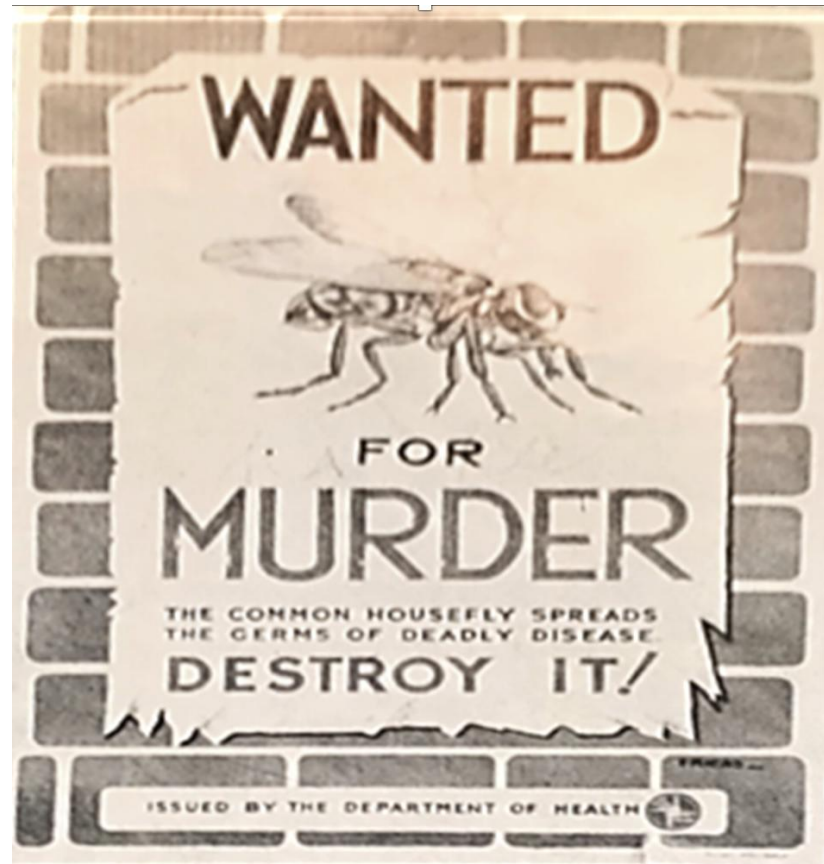


Figure 3.2 Health pamphlet urging Irish people to kill flies, 1950.³⁸

Attacking healthy and weak infants, its main incidence was in children under five while those aged two and under proved particularly vulnerable. The time from onset to death was anywhere between a few hours and eight weeks.³⁹ While the cause diarrhoea and enteritis had not been discovered until the early 1970s, the disease itself was blamed on an impure milk supply.⁴⁰ The category ‘diarrhoea and enteritis’ therefore accounted for a number of bacterial and viral diarrhoea infections, including shigella, salmonella and e-coli.⁴¹ The medical profession regarded food contamination arising from a disregard for cleanliness and storage on the behalf of the milk suppliers as well as mothers as likely culprits, while its prevalence during the summer months was widely attributed to flies as secondary carries of the infection (figure 3.2).⁴² To

³⁸ DOH, *Report of the Department of Health, 1950-1951* (Dublin, 1952), p. 54.

³⁹ Deeny, *The end of an epidemic*, p. 62.

⁴⁰ *IP*, 11 Jan. 1949. The 1970s ushered in a new era in gastroenteritis aetiology. In 1972, the first norovirus causing the disease was identified in an outbreak in Norwalk, California. Shortly afterwards in 1974, several other viruses were identified, particularly the rotavirus infection, which was the most common cause found in children with gastroenteritis. For further information, see Bas B. Oude Munnink and Lia van der Hoek, ‘Viruses causing gastroenteritis: the known, the new and those beyond’ in *Viruses*, viii, no. xli (2016), pp 1-10.

⁴¹ Medical Research Council of Ireland, *Report of the gastroenteritis survey Dublin city 1964-1966* (Dublin, 1967), pp 3-4.

⁴² *Limerick Leader*, 29 July 1944.

combat this, breastfeeding was vigorously encouraged by MacEntee as a way of minimising a child's exposure to 'bad' milk and a way of increasing infants' immune resistance. Because rising rates in the incidence of this disease occurred at a time when breast-feeding was also declining, the Irish medical profession believed that much could be done by way of a focus on prevention.⁴³

Diarrhoea and enteritis reached epidemic proportions during the war period, accounting for a total of 5,856 infant deaths under two years of age between 1940 and 1945.⁴⁴ While infant deaths occurred due to other illnesses, there was no such increase in stand-alone-deaths from a single disease other than diarrhoea and enteritis (see figure 3.1). To put this into perspective, approximately 500-600 deaths occurred each year from the disease between 1935 and 1941, a period that the country's CMA, James Deeny described as 'endemic'.⁴⁵ Beginning in 1941, the disease reached epidemic levels, where the annual death toll rose to 805.⁴⁶ In 1943, there were 1,233 deaths of infants under two years of age from this disease (approximately 22-23 deaths per week).⁴⁷ Such a high number of infants dying from a single cause highlights just how serious these diarrhoeal outbreaks were. Figures remained high until 1948, when deaths from this disease dropped to pre-war levels.⁴⁸

In social terms, the problem was in towns and cities, and to a much lesser extent in the country countryside.⁴⁹ Within this, cases among the poor labouring classes were more frequent while towns with effective water and sewage systems had lower mortality rates.⁵⁰ Dublin was disproportionately affected (see figure 3.3). Of the 5,856 infant deaths under two that occurred between 1940 and 1945, 46% of these occurred in Dublin.⁵¹ This fuelled arguments that the 'excessive national infant mortality rate is in fact largely due to the increased number of deaths occurring in Dublin'.⁵² While there are no records specifying the incidence of gastroenteritis by specific Dublin localities, available evidence suggests that the overall infant mortality rate was higher in slum areas.⁵³ Poor housing conditions were widely cited as a contributing factor to this high mortality rate, with Matthew J. Russell, Dublin's Medical Officer, using this as a basis to highlight the substandard housing in the city.⁵⁴ As a result, the welfare clinics run by the Infant

⁴³ Deeny, *The end of an epidemic*, p. 61.

⁴⁴ *ARRG, 1940-1945* (Dublin, 1946), consecutive years, pp 20-24.

⁴⁵ Deeny, *The end of an epidemic*, p.64.

⁴⁶ *Ibid.*

⁴⁷ *ARRG, 1943*, pp 20-24.

⁴⁸ *ARRG, 1948* (Dublin, 1949), p. xxviii.

⁴⁹ Deeny, *The end of an epidemic*, p. 64.

⁵⁰ *Ibid.*

⁵¹ *ARRG, 1940-1945*, pp 20-24.

⁵² Deeny, *The end of an epidemic*, pp 64-65.

⁵³ *IT*, 29 Sept. 1938.

⁵⁴ *Report on the state of public health in the city of Dublin*, pp 92-93.

Aid Society were primarily held in slum areas.⁵⁵ In July 1939, for example, a new combined welfare clinic and dining hall was opened on the north side of Dublin city in Killarney Street, where it was ‘actually built into the block of flats’ itself.⁵⁶ Between 1942 and 1946, there was also a sharp increase in the case-fatality rate in Dublin, adding further support to this idea (see figures 3.4 and 3.5). Disturbingly, 40% of all diarrhoea and enteritis cases in children under two years of age in Dublin in 1944 resulted in death.⁵⁷ However, figures may be distorted by the introduction of mandatory notification for diarrhoea and enteritis in 1943, which may have seen some reluctance among parents to report cases. Notwithstanding, MacEntee believed that the yearly losses through preventable disease were ‘more of a drain’ on the country’s vitality and resources than were temporary losses caused by emigration.⁵⁸

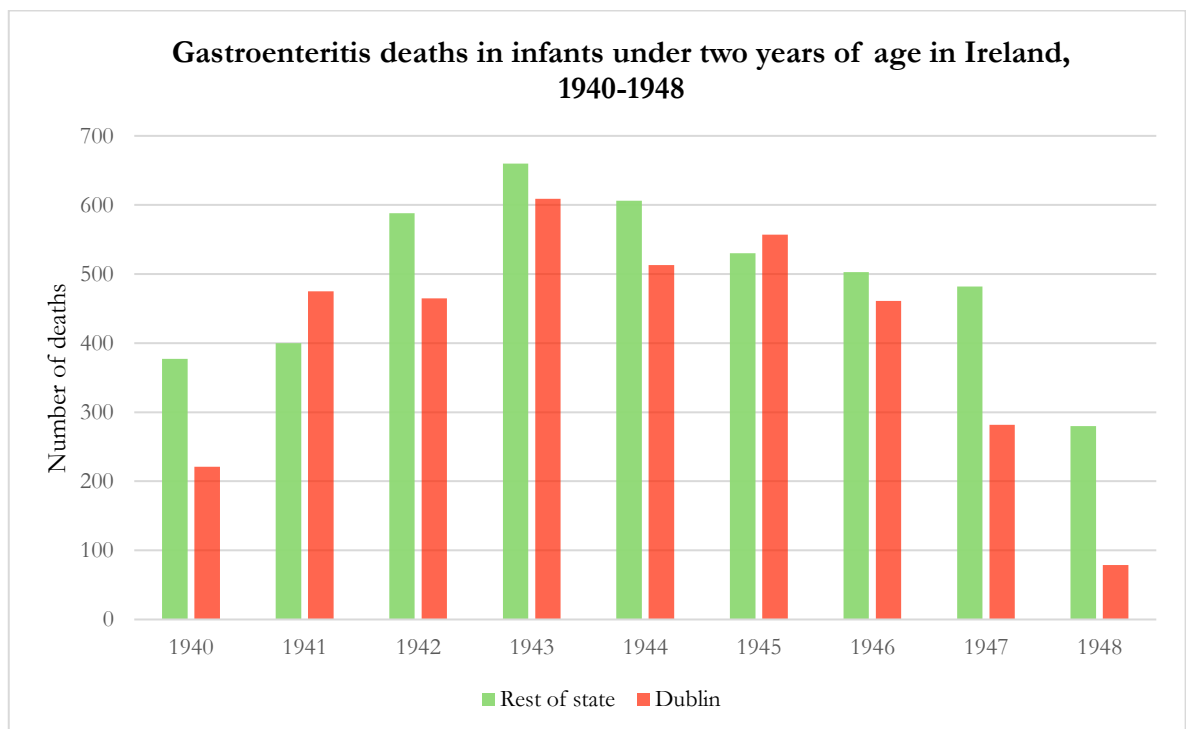


Figure 3.3 Gastroenteritis deaths in infants under two years of age in Ireland, 1940-48.⁵⁹

⁵⁵ Ibid.

⁵⁶ *DÉD*, 2 April 1941, vol. 82, no. 9 (Patrick J. Rutledge – then Minister for Local Government and Public Health).

⁵⁷ W.P O' Callaghan (Medical director of Dublin Corporation) to Deeny, 1 Dec. 1948 (RCSI, Deeny papers 1/2/18/1).

⁵⁸ *IT*, 14 Jun. 1946.

⁵⁹ *ARRG*, 1940-1948, consecutive years, pp xvii-xxi.

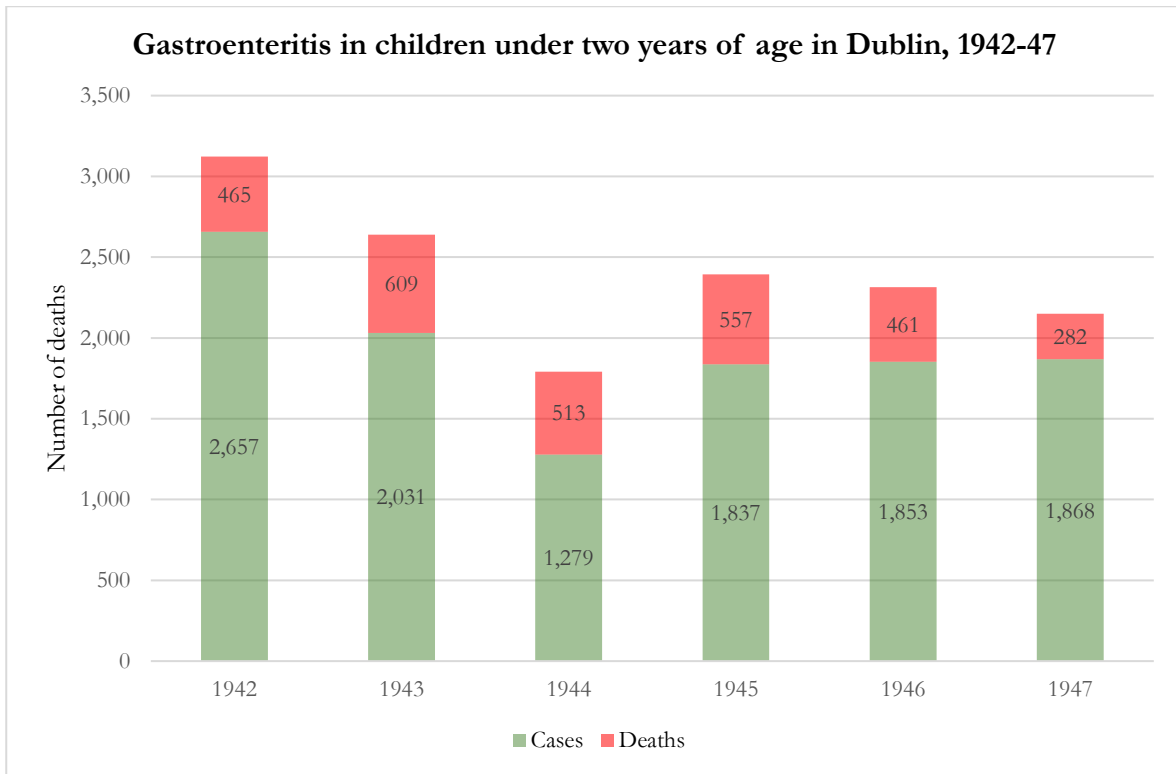


Figure 3.4 Gastroenteritis in children under two in Dublin, 1942-47.⁶⁰



Figure 3.5 Case-fatality rate in children under two in Dublin, 1942-47.⁶¹

⁶⁰ W. P. O' Callaghan (Medical Director in Dublin Corporation) to Deeny, 1 Dec. 1948 (RCSI, Deeny papers, IP/ 2/1/18/1). This source does not include data relating to early years, 1939 and 1940.

⁶¹ Ibid.

3.5 Public health measures and health policy deliberations

Targeted public health measures introduced against gastroenteritis were enhanced as the 1940s progressed. These measures focused almost exclusively on Dublin because of higher mortality rates in the city than in rural areas (see figure 3.3). Because of the outbreaks of gastroenteritis in Dublin city, MacEntee established a small Committee of Investigation in 1943.⁶² The committee appointed two researchers who were employed by the Medical Research Council: one whose role was to examine the medico-social aspects of the disease, and the other with a view to determining its bacteriological aspects.⁶³ This committee had a number of findings but the ‘most important fact’ revealed was that the disease proved almost exclusively limited to children who were artificially fed, noting that ‘breastfed infants were rarely attacked’.⁶⁴ On a public front, the disease was also made a ‘notifiable infectious disease’ in 1943 for those cases occurring in children under two years of age in certain urban areas and county boroughs.⁶⁵ Parents were required to notify their dispensary doctor who then sent a nurse to the family home to assess the severity of the infection and for follow-up.⁶⁶ In December 1946, a much bigger and official Gastroenteritis Advisory Committee was established under MacEntee to advise the Department of Local Government and Public Health on further measures to be taken to combat this disease. Members of this committee were experts in infant welfare and children’s diseases, and MacEntee anticipated that they would maintain close contact with other organisations such as Dublin Corporation and maternity hospitals to advise and co-ordinate research by way of prevention.⁶⁷ A Gastroenteritis Control Section, managed by Dublin Corporation, was also established concurrently.⁶⁸

Meanwhile, MacEntee noted that the Dublin Board of Assistance used St. Clare’s Hospital in Glasnevin, Dublin solely for the treatment and isolation of diarrhoeal cases in June 1946.⁶⁹ At the time, MacEntee claimed that St Clare’s was the ‘only one of its kind in the world’.⁷⁰ International networking efforts were maximised as the advice of doctors from the US and Britain were also used to combat this health problem.⁷¹ For example, Dr G. D. Cummings, an American laboratory director, came to Dublin and visited children’s hospitals and held informal talks with Irish doctors who were in close contact with the enteritis campaign.⁷² The advice

⁶² Deeny, *The end of an epidemic*, p. 65.

⁶³ Ibid.

⁶⁴ Ibid., p. 68.

⁶⁵ Public Health (Infectious Diseases) (Amendment) Regulations, 1941, 1943, and 1947.

⁶⁶ Gastroenteritis Advisory Committee (hereafter GEAC) minutes, 7 Jan. 1948 (NAI HLTH M34/2, vol.1).

⁶⁷ *DÉD*, 23 Oct. 1946, vol. 103, no.1.

⁶⁸ GEAC minutes on general outline, undated, c. Dec. 1946 (NAI HLTH/M34/2 vol.1).

⁶⁹ *DÉD*, 18 Jun. 1946, vol. 101, no. 15.

⁷⁰ Ibid.

⁷¹ *II*, 26 Nov. 1946.

⁷² Ibid.

given by Cummings focused on improving diagnosis, with Dublin doctors able to isolate a particular type from cases which appeared to be the same.⁷³ MacEntee's strategy was to tackle Dublin and then to disseminate any effective measures and information immediately to the county medical officers of health in other areas.⁷⁴ Notwithstanding, there were three clear options for the Fianna Fáil government to lessen the incidence of diarrhoea and enteritis. One was through enhanced public health facilities to cope with and isolate disease outbreaks. A second option was to strengthen regulations of the quality and quantity of milk. Finally, they could educate mothers and specifically encourage breastfeeding.

The path to each of these options was not straightforward. In terms of enhancing a public health presence and facilities to cope with the disease, MacEntee arranged a meeting with Dublin Corporation on 25 September 1946.⁷⁵ At this meeting, MacEntee urged the Dublin Corporation to 'set up some interim organisation to deal' with diarrhoea and enteritis.⁷⁶ In particular, he wanted the Corporation, who already had an established child welfare service, to set up a team of specialists that would focus on the early detection of cases, the institutional measures for disease control, investigations into the causation and modes of transmission, evaluation of deaths from the disease as well as the education of mothers in childcare.⁷⁷ However, members of Dublin Corporation were more interested in highlighting the social and medical aspects of the disease in relation to existing problems in housing and hospital care.⁷⁸ For Councillor Patrick J. Cahill of Dublin Corporation (later Lord Mayor of Dublin between 1947-48), outbreaks of the diarrhoeal epidemics demonstrated that more work needed to be done in relation to child welfare and existing hospital facilities.⁷⁹ Adding to this, Martin Sullivan, member of Dublin Corporation, noted that because of the existing pressures on space in the hospitals, they were forced to discharge the mothers four to eight days after birth, whereas breastfeeding was only introduced after three days.⁸⁰ In his view:

The first thing we can do in a practical way to bring about a diminution in the serious death rate is to do all we possibly can to give an extended period in the hospital to the mother after birth [to establish appropriate breastfeeding practices]. If there is no possibility of doing it within the hospital, then how can we do it outside?⁸¹

⁷³ *Sunday Dispatch*, 16 Jan. 1949.

⁷⁴ *DÉD*, 23 Oct. 1946, , vol. 103, no.1.

⁷⁵ Minutes of meeting in Dublin Corporation between MacEntee, Deeny and members of Dublin Corporation Public Health Committee, 25 Sept. 1946 (RCSI, Deeny papers 1/2/18/4).

⁷⁶ *Ibid.*

⁷⁷ *Ibid.*

⁷⁸ *Ibid.*

⁷⁹ *Ibid.*

⁸⁰ *Ibid.*

⁸¹ *Ibid.*

This is an important point. While Dublin Corporation agreed to fund an extension of their maternity and child welfare scheme, they questioned whether this would be of any benefit given that mothers may have already established their feeding practices before leaving hospital.⁸² In response, MacEntee reminded the corporation of the need to be pragmatic:

The Department is fully appreciative of the fact but we have to also realise that we cannot provide 150 beds overnight; that it would take some years before this could be done... We have to go ahead and deal with the problem as we find it with whatever means we have at our disposal.⁸³

MacEntee reminded the corporation that even if they had capacity to provide extra beds it would be ‘very difficult to decide’ on the order of preference for which beds were required, i.e., in cases of TB, and accommodation for general and children’s hospitals.⁸⁴ Notwithstanding, there was tension between the Department, which on the one hand, wanted a special organisation dealing with this acute problem. On the other hand, the view of the Corporation was that improvements could only be met by an extension of the present maternity and child welfare scheme. Although an official Gastroenteritis Advisory Committee was eventually established three months later alongside a control section within Dublin Corporation, these deliberations not only remind us of the extent to which MacEntee’s department were firefighting in public health, but also of the complexities involved in devising a quick and effective solution.

Milk is an especially important food for infants and young children who receive, through its protein, necessary material for growth and development. Milk is vital for the building up of new tissue including teeth, bones and muscle. On the flipside, there was also known potential for milk to be contaminated. A number of other infant and childhood diseases, such as tuberculosis, typhoid fever, diphtheria and scarlet fever, were known to be transmitted through milk. This understanding was reflected in frequent references to the country’s milk problem in political debates throughout the first-half of the twentieth-century.⁸⁵ In terms of milk regulations, an official Milk and Dairies Act was passed by the Dáil in 1935.⁸⁶ Given that milk could give rise ‘to an outbreak of serious illness’ in infants and young children, Dr Conn Ward, Parliamentary Secretary to the Department of Local Government and Public Health, noted that the aim of the milk bill was to improve the quality and purity of the milk to safeguard from infection and contamination.⁸⁷ There was to be mandatory supervision of the health and

⁸² Ibid.

⁸³ Minutes of meeting in Dublin Corporation between MacEntee, Deeny and members of Dublin Corporation Public Health Committee, 25 Sept. 1946 (RCSI, Deeny papers 1/2/18/4).

⁸⁴ Ibid.

⁸⁵ *DÉD*, 10 Jul. 1924, vol. 8, no.9.

⁸⁶ Milk and Dairies Act, 1935 (1935 no. 22) (14 Jun. 1935).

⁸⁷ *DÉD*, 14 Nov. 1934, vol. 54, no.1.

condition of the cows, production methods as well as the handling and distribution of the milk.⁸⁸ This involved inspections by health and veterinary officers with defective businesses to be reported and prosecuted, while the farmers themselves were required to hold a licence.⁸⁹ One such case demonstrates the difficulty of implementing these rules in practice. On 27 February 1941, the sanitary inspector for Sligo, Patrick Flynn, inspected the premises on which Thomas Carter was producing his milk to sell to the local population.⁹⁰ The premises were found to be in a 'filthy condition' with the floor of the milk cart littered with old hay and straw and the lids of the milk left off and thus opening the milk to contamination and flies.⁹¹ Carter alleged that he did not know he was meant to be registered and that he had actually been selling milk in the town for thirty years previous without complaint.⁹² Fined £5, Carter promised to clean up his premises going forward while the milk in Sligo continued to be delivered 'just as it might have been one hundred years ago'.⁹³ Sligo equally had unusually high infant mortality numbers throughout the 1940s (see Appendix D).

There were a number of key issues. In the first instance, there were numerous similar complaints made by medical officers in other areas who did not otherwise secure the same outcome. In 1939, Kilkenny's medical officer Kathleen G. McColgan-Barry noted how the greatest difficulty in safe milk production in rural areas was tracking down the unregistered milk suppliers in the area, hoping to this end that the sanitary officer would go some way to alleviate this problem.⁹⁴ Concerns over the quality and quantity of milk produced in Cork were voiced in 1941 and again in May 1949.⁹⁵ The act was essentially 'a penal Act' where 'you tested the milk and if it was defective you prosecuted'.⁹⁶ While this was effective in some instances, there was little incentive given to the farmers through this law to enhance the quality of the milk being distributed. Even into the 1950s, the number of Grade A producers increased very little.⁹⁷ There were equally no large-scale initiatives to educate farmers on how best to produce their milk nor many incentives for farmers to learn. On a government level, the rising cost of milk production throughout the war was a significant concern for Dr James Ryan, then Minister for Agriculture, who faced an enduring dilemma. On the one hand, he was committed to keeping milk prices

⁸⁸ Honoria Aughney (County Medical Officer of Health, Wexford), 'The production and distribution of milk in County Wexford' in *IJMS*, ccclxvi (Jun. 1956), pp 244-245.

⁸⁹ Milk and Dairies Act, 1935.

⁹⁰ *Western People*, 12 Apr. 1941.

⁹¹ *Ibid.*

⁹² *Ibid.*

⁹³ *Ibid.*

⁹⁴ *Fifth annual report of the county medical officer of health, Kilkenny for 1939* (Kilkenny, 1940), p. 30.

⁹⁵ *Annual report of the county medical officer of health, Cork County Borough for 1941* (Cork, 1942), p. 76. For later concerns of milk production, see *DÉD*, 29 May 1949, vol.115, no. 12.

⁹⁶ Aughney, 'The production and distribution', p. 258.

⁹⁷ *Ibid.* 'Grade A' milk was milk that was tested negative for tuberculin and expected to have been produced in sanitary and hygienic surroundings.

affordable for consumers.⁹⁸ As both a medical doctor and politician, Ryan understood the crucial role of milk in preventing malnutrition among children, a point he continued to emphasise when advocating for policy changes based on the national nutrition survey results in the late 1940s. On the other hand, as Minister for Agriculture, he also feared that rising prices might reduce the number of farmers involved in milk production.⁹⁹

In terms of the milk investigations, the veterinary inspectors took bacteriological counts of the milk while the health inspector examined the farming premises for any signs of unhygienic surroundings. However, this was complicated by the fact that the health inspectors were not always fully trained in farming techniques while the veterinary inspectors were employed on a part-time basis only.¹⁰⁰ Further, regional distribution meant that a significant amount of time passed between the bacteriological samples and household consumption. Even if the milk was pasteurised by the household, the risk of contamination was significant at a time when households were urged to maximise food consumption by minimising their waste. Economical cookbooks proliferated throughout the 1940s, including Maura Laverty's government-commissioned *Flour economy: practical recipes for breads, cakes, etc., based on potatoes and oatmeal* published in 1941.¹⁰¹ Households often mixed the morning's milk with the previous night's milk without cooling to the appropriate temperature first, resulting in 'sour milk straight away'.¹⁰² Tightening milk regulations was no quick-fix: it required training of several different people and co-operation with farmers and households, a challenge that persisted into the 1950s.

With no official cure for diarrhoea and enteritis, government and medical attention focused on prevention. Breastfeeding infants was seen as the safest way to avoid morbidity. This suited an Irish government which was already enforcing a rigorous inspection of tillage.¹⁰³ Through a persistent advocacy of breastfeeding, the government hoped that by eliminating the 'middle-man' (the milk supplier) they could ensure that more babies were receiving clean milk and thereby limiting the risk for external contamination. Early investigations into the incidence of diarrhoea and enteritis found that cases were higher among artificially fed infants.¹⁰⁴ Dr R. Ellsworth Steen claimed that 'the breast-fed child was five times less likely to die than the

⁹⁸ *DÉD*, 3 April 1941, vol. 82, no. 10.

⁹⁹ *Ibid.*

¹⁰⁰ Aughney, 'The production and distribution', p. 258.

¹⁰¹ Maura Laverty, *Flour economy: practical recipes for breads, cakes, etc., based on potatoes and oatmeal* (Dublin, 1941).

¹⁰² Séan McCarthy (Cork Mayor) to Noël Browne, 1 Jul. 1949 in 'General Schemes: milk supply for children', (NAI, HLTH B132/28).

¹⁰³ For further reading on state-farmer relations at this time, see Bryce Evans, 'Coercion in the countryside: the Irish smallholder, the state and compulsory tillage, 1939-45' in *Irish Economic and Social History*, xxxviii, I (2011), pp 1-17; Peter Moser and Tony Varley, 'Corporatism, agricultural modernization and war in Ireland and Switzerland, 1935-1955' in Paul Brassey, Yves Segers and Leen Van Molle (eds), *War, agriculture, and food: rural Europe from the 1930s to the 1950s* (New York, 2012), pp 137-155.

¹⁰⁴ *DÉD*, 14 Jun. 1944, vol. 94, no. 4 (MacEntee).

artificially fed child' in 1944.¹⁰⁵ There was also evidence to suggest that breast-fed infants developed immunity from not only diarrhoea and enteritis but also diphtheria (depending on whether the mother was previously vaccinated against it).¹⁰⁶ Infants of older ages were also found to have enhanced resistance to diarrhoeal infections.¹⁰⁷

Yet breastfeeding rates were declining. From a survey of 1,549 mothers in 1939, it was found that 26% of Dublin mothers breast-fed their babies compared to 40% just a year previous.¹⁰⁸ While there was an increase in the number of mothers who opted to combination feed via breast and bottle, there was also an increase in the numbers of babies fed from the bottle alone.¹⁰⁹ In September 1943, the front page of one article in the *Irish Times* noted that 95% of mothers in Dublin were capable of breastfeeding.¹¹⁰ Because of this, it was recommended that every means be taken to encourage the breastfeeding of infants. Further messages promoting breast-feeding appeared in the *The Irish Press* – a newspaper founded to assist Fianna Fáil in 1931.¹¹¹ Additional measures by MacEntee included a call for the nourishment of nursing mothers through the dining centres of voluntary organisations and the early medical treatment of infants infected with the disease.¹¹² However, this solution did not have immediate effect. Breastfeeding rates continued to decline while it was likely that this advice would be only applicable to a parent's next child. The only immediate practical solution was the boiling of the milk for at least two minutes, which was intended to be an option of last resort. Further, promotion of breastfeeding lent itself to wider intrusions into the running of the family home.

3.6 Educating Irish mothers

Throughout the 1940s and 1950s, substantial attention was given to the education of the 'Irish mother' in government and medical discussions aimed at curbing infant mortality (see Appendix F).¹¹³ Inherent in any criticism of bottle-feeding was the idea that mothers were neglecting their maternal responsibilities to their children. In this view, the tendency to bottle-feed was put down to the 'fact that it is so much easier to put a baby on the bottle than to go

¹⁰⁵ *IT*, 18 May 1944.

¹⁰⁶ GEAC to DC members on 'progress made' in diarrhoea and enteritis campaign, 3 Dec. 1947 (NAI, HLTH M34/2 vol.1).

¹⁰⁷ GEAC minutes, 7 Jan. 1948.

¹⁰⁸ *Report of the state of public health in the city of Dublin*, pp 92-93.

¹⁰⁹ *Ibid.*, p. 93.

¹¹⁰ *IT*, 17 Sept. 1943.

¹¹¹ *IP*, 20 Jan. 1944 and 31 May 1945. Other examples can be found throughout the 1940s. For further information relating to Fianna Fáil and the *IP*, see C. Curran, 'Fianna Fáil and the origins of the Irish Press' in *Irish Communications Review*, vi (1996), pp 7-17.

¹¹² *DÉD*, 14 Jun. 1944, vol. 94, no. 4.

¹¹³ Earner-Byrne, *Mother and child*, p. 64. Also see Mary Hatfield, Jutta Kruse and Róna Nic Congáil (eds), *Historical perspectives on parenthood and childhood in Ireland* (Dublin, 2018). For reading on maternal education in the US, see Milton Kotelchuck, 'Safe mothers, healthy babies: reproductive health in the twentieth century' in John W. Ward and Christian Warren (eds), *Silent victories: the history and practice of public health in twentieth century America* (Oxford, 2006), pp 105-134.

through the tedious process of waiting for the breast milk to return to the breast'.¹¹⁴ The apparent lack of proper feeding had also been listed as the main problem among school children in the lead up to the school medical service scheme.¹¹⁵ To this end, it was 'hoped that the technical classes will bring forth better educated types of mothers and mothers who will be better able to cook varying nourishing dishes to feed their children'.¹¹⁶ Other critiques included a lack of cleanliness and hygiene in the family home as well as the unhygienic methods of milk production and consumption.¹¹⁷ Mothers were urged to boil milk for at least two minutes for all infants up until two years of age.¹¹⁸ This advice initially consisted of boiling the milk for ten minutes.¹¹⁹ However, this was reduced by the official gastroenteritis advisory committee to two minutes to make the task less onerous task for the mother.¹²⁰

Gastroenteritis was also addressed through didactic publicity campaigns. By 1938, the three maternity hospitals in Dublin were giving medical attention to over 10,000 women each year.¹²¹ In these hospitals, mothers were educated on how best 'to look after their babies'.¹²² The use of bill-posting and short talks to expectant and post-natal mothers were recommended with the idea being that these would be provided by voluntary organisations such as St. John Brigade and the Irish Catholic Social Service Conference.¹²³ Furthermore, in a weekly clinic by the Infant Aid Society, there was a talk given by a health visitor on some subject of 'mothercraft'.¹²⁴ These were often timed to be more frequent when diarrhoeal outbreaks were anticipated, such as during the summer months.¹²⁵ In her exploration of maternal and child health, Earner-Byrne explores how mothercraft was equally a primary concern of Dublin Corporation.¹²⁶ Pamphlets were also handed out to parents at baby clubs and by nurses of the maternity and child welfare service during the course of their home-visiting.¹²⁷ The government viewed the Irish mother as someone requiring education in 'the art and practice of mothercraft' as a means to correct their failures.¹²⁸ This was not unique to Ireland – Rachael Kitchens argues that state emphasis on parental education in Australia in the early twentieth century can be understood as part of a

¹¹⁴ *Report of the state of public health in the city of Dublin*, p. 92.

¹¹⁵ *Fifth annual report of the County Medical Officer of Health, Kilkenny, 1938* (Kilkenny, 1939), p. 42.

¹¹⁶ *Ibid.*

¹¹⁷ *Annual report of the county medical officer of health, Cork 1941*, p. 76.

¹¹⁸ GEAC minutes, 28 Jan. 1948 (NAI, HLTH M34/2 vol.1).

¹¹⁹ *Ibid.*, 25 Feb. 1948.

¹²⁰ *Ibid.*

¹²¹ *IT*, 27 Nov. 1938.

¹²² *Ibid.*

¹²³ GEAC minutes, 24 Mar. 1948 (NAI, HLTH M34/2 vol.1).

¹²⁴ *Report on the state of public health in the city of Dublin*, p. 92.

¹²⁵ GEAC minutes, 24 Mar. 1948 (NAI, HLTH M34/2 vol.1).

¹²⁶ Earner-Byrne, *Mother and child*, p. 59. For international readings about mothercraft, see Rima D. Apple, *Mothers and medicine: a social history of infant feeding, 1850-1950* (Wisconsin, 1987); Apple, 'Constructing mothers: scientific motherhood in the nineteenth and twentieth centuries' in *SHM*, viii, no. 2 (1995), pp 161-178.

¹²⁷ Note on publicity campaigns against diarrhoea and enteritis, 15 Aug. 1950 (NAI, HLTH B132/28).

¹²⁸ *Irish Nurses Magazine* (hereafter *INM*), Feb. 1941.

‘civilising process’.¹²⁹ This focus on improving ‘mothercraft’ in official and medical realms brought government intervention further into the private realms of the household.

The emphasis on the behaviours of Irish mothers was also prominent in the work carried out by Gastroenteritis Control Section of Dublin Corporation, which was involved in the close monitoring of disease notifications. After a notification was made by a parent whose sick infant showed symptoms, a ‘specially trained’ public health nurse visited the home with the ‘object of ascertaining the existence of feeding irregularities or other conditions of aetiological significance’.¹³⁰ Further, these visits were perceived to have educational value for mothers through their emphasis on breastfeeding, discussions and advice on likely causative factors and thereby lessening the risk of further diarrhoeal outbreaks in the home.¹³¹ Additional work carried out by the control section of Dublin Corporation included a particular focus on high incidence areas.¹³² While the areas themselves were not individually listed in the archives, it was mentioned that ‘careful examination’ was given to infant care in these areas, and information gathered by any personnel included notes on social conditions, age-groups, whether breast-fed and whether babies were previously in institutions.¹³³ This in turn suggests that the government and medical profession were distinguishing between types of mothers and types of infants who they thought were more at risk.

3.7 The ‘sick’ urban area

More deaths in urban areas from gastroenteritis and other key infectious diseases of infancy and childhood meant that infant mortality was increasingly seen as an urban problem. A healthcare campaign in Dublin meant that those who showed symptoms were more readily able to receive treatment. Besides the isolation hospital in St. Clare’s, there were a number of voluntary organisations in Dublin working against this disease. For instance, Dublin’s Infant Aid Society administered milk on behalf of Dublin Corporation and they also held weekly welfare clinics for expectant and nursing mothers.¹³⁴ Pre-natal and post-natal mothers were seen and advised by nurses on their infants and children until they reached five years of age.¹³⁵ Where infants showed signs of diarrhoeal disorders at the welfare clinics, they were referred to hospital.¹³⁶ The provision of extra nourishment for necessitous expectant and nursing mothers was also given

¹²⁹ Rachael Kitchens, ‘Mothercraft not learnt by instinct’: an investigation of the infant welfare movement in Australia 1919-39’ in *Children Australia*, xxxi, no. 1 (2006), p. 31.

¹³⁰ Undated note on the operation of Gastroenteritis Control Section of Dublin Corporation, c. 1947 (NAI, HLTH M34/2 Vol.1).

¹³¹ Ibid.

¹³² General outline of scope and functions of Gastroenteritis Control Section of Dublin Corporation, undated, c. Dec. 1946 (NAI, HLTH M34/2 Vol.1).

¹³³ Ibid.

¹³⁴ *Report on the state of public health in the city of Dublin*, p. 92.

¹³⁵ Ibid., p. 94.

¹³⁶ GEAC minutes, 22 Dec. 1952 (NAI, HLTH B132/28).

by the welfare department of St. John Ambulance, to which the city authorities were making an annual grant.¹³⁷ Further, accurate reporting of this disease was more likely in Dublin due to the presence of the special gastroenteritis service that was available. Equally, the Gastroenteritis Advisory Committee was aware that there were both extra services and extra reporting of this disease in Dublin compared to elsewhere.¹³⁸

This is not to say that focus on the urban area was irrational. The incidence of gastroenteritis had more visibility in Dublin than elsewhere. After all, tenement conditions in inner-city areas provided ample opportunity for causative bacteria to rise in epidemic proportions. However, a focus on the living conditions of urban slums significantly influenced the types of information gathered by Ireland's public health regime. For instance, one of the first duties of the first research committee that was established was to examine the medico-social aspects of the disease. Here, it was found that the disease itself was not evenly distributed in Dublin, but rather it was concentrated in poorer districts.¹³⁹ Further, it was found that only 52 of the 1,233 infant deaths from diarrhoea and enteritis came from professional and middle-class families, while the remainder came from poorer classes, such as unskilled and labouring families.¹⁴⁰ This would later feed into a focus on home hygiene in the urban area which in turn gave further impetus for demands for improved welfare and better housing.

Let us take the mandatory notification of diarrhoea and enteritis as an 'infectious disease' in 1943 as an example. This act defined 'diarrhoea and enteritis' as any condition in an infant under two years associated with frequent motions and constitutional disturbance.¹⁴¹ In fact, the definition itself was purposely made wide as the 'intention was to save lives by making it possible for all children under two years who might have suspicious symptoms to receive treatment'.¹⁴² However, this only provided for the notification and treatment of the disease in 'County Boroughs, Boroughs, and in certain urban and rural districts' (this included all county boroughs, Dublin County Health District and rural districts included Cork, Limerick and Waterford).¹⁴³ It was not until 1 July 1947 that this act was amended to apply to the whole country and there was disagreement in official health spheres as to whether that should be the case.¹⁴⁴ This, coupled with the fact that the Gastroenteritis Advisory Committee dealt exclusively with Dublin raises questions about urban disease and visibility.

¹³⁷ *Report on the state of public health in the city of Dublin*, p. 94.

¹³⁸ GEAC minutes, 22 Dec. 1952 (NAI, HLTH B132/28).

¹³⁹ Deeny, *The end of an epidemic*, p. 67.

¹⁴⁰ *Ibid.*, p. 68.

¹⁴¹ GEAC minutes, 22 Dec. 1952 (NAI, HLTH B132/28).

¹⁴² *Ibid.*

¹⁴³ Public Health (Infectious Diseases) (Amendment) Regulations, 1943 (1943 S. I. no. 258) (30 Jun. 1943).

¹⁴⁴ Public Health (Infectious Diseases) (Amendment) Regulations, 1947 (1947 S. I. no. 297) (26 Jun. 1947). For further information on disagreements, see GEAC minutes 22 Dec. 1952 (NAI, HLTH B132/28).

The act of mandating the disclosure of an infectious disease has been previously noted as a ‘participatory’ public health triumph and likewise, a snapshot of the balance between rights, responsibilities and competing interests.¹⁴⁵ The systematic reporting of infectious disease was mandated throughout the United Kingdom from 1899, and was by no means a new welfare measure in the Second World War. Instead, it was originally British legislation that Ireland carried over following independence. It made a doctor’s hitherto confidential diagnosis of an infectious disease public information to be systematically monitored.¹⁴⁶ In terms of childhood illness, the parents were responsible for the notifications of a disease in their offspring as well as further prevention of disease spread within the household. During the war, diarrhoea and enteritis was declared an ‘infectious disease’ but this only applied to certain districts, suggesting that the disease did not count as ‘infectious’ in remote rural areas. The focus on urban areas generated more reliable information about case frequency, which could be further broken down by sex, age and space.¹⁴⁷ Diarrhoeal deaths also took place in rural areas, but they did not receive the same level of attention. Areas with high disease rates, like that found in Dublin, thus became ‘problem’ areas.

3.8 Were rural areas forgotten?

In rural areas, by contrast, parents were not required to report cases to their local dispensary officer and were instead left to their own devices. This reflects a wider government strategy during the period of only intervening when it was perceived as a necessity. Ciara Breathnach’s exploration of the use of handywomen in rural Ireland demonstrates that rural areas often received fewer interventions.¹⁴⁸ Further, government debates leading up to the nationwide notification of gastroenteritis in 1947 were focused on the impact that these figures could have on Ireland’s health information which was subsequently relayed to the WHO.¹⁴⁹ This in turn raises the idea of ‘health’ in a different sense of the word. The Fianna Fáil government did not want Ireland, as a single collective whole, to be seen as ‘unhealthy’ on the world stage. It had devised a strategy that seemed targeted to improve health statistics rather than one to provide services to all affected by the disease.

Only cases with relatively severe symptoms were seen by the doctors in rural areas. Even in Cork, where the disease was also made ‘notifiable’, efforts by way of prevention were

¹⁴⁵ Graham Mooney, *Intrusive interventions: public health, domestic space, and infectious disease surveillance in England, 1840-1914* (Rochester, 2015), p. 2.

¹⁴⁶ Ibid., pp 2-4.

¹⁴⁷ Ibid., p. 10.

¹⁴⁸ Breathnach, ‘Handywomen and birthing in rural Ireland’, pp 41-45.

¹⁴⁹ Drs MacCormick and Fanning of DOH were particularly concerned about releasing Irish figures from this disease. See GEAC minutes, 22 Dec. 1952.

compounded by a severe housing problem and serious public health understaffing.¹⁵⁰ Critiquing fourteen years of Fianna Fáil rule, Daniel Morrissey (Fine Gael TD for Tipperary) told the Dáil, 'I saw slums in the City of Cork last week that I did not believe existed in any part of Europe, much less in the second city of the State'.¹⁵¹ In August and September 1942, there was a severe epidemic outbreak of diarrhoea and enteritis in Cork at a time in which the public health officials were already overloaded with other health issues.¹⁵² Attendances at the diphtheria immunisation clinic were averaging 400 per week and this called for a concentration of all available services, at the expense of attention to other ailments such as diarrhoea.¹⁵³ The medical officer of Cork, J. C. Saunders noted that 'we were handicapped in our efforts to cope with this epidemic by the demands made on our staff through the diphtheria epidemic which continued unabated while the diarrhoea outbreak was in full swing'.¹⁵⁴ One health visitor for every 400 annual births was deemed an 'accepted standard'.¹⁵⁵ Between 1933 and 1942, the average number of births registered in Cork was 1,693.¹⁵⁶ Cork should have had at least six health visitors, but that number was three.¹⁵⁷ Other factors and health pressures were at play. It is thereby necessary to place the focus on diarrhoea and enteritis into the context of wider public health issues in rural Ireland during the period.

Gastroenteritis was not the only cause of child deaths. Deaths from pneumonia and congenital malformations for the same period in children under five years of age far outnumbered those from diarrhoea and enteritis.¹⁵⁸ Both neo-natal and maternal mortality rose in rural areas during the war (Appendix E).¹⁵⁹ One such case of the latter that received coverage was the devastating account of John McCann, an Offaly man, whose wife Catherine, died during child birth to twins due to an inability to locate a midwife in time. McCann cycled six miles to Daingean only to be told that the district midwife was ill and off-duty and that her substitute resided in Rhode, a further eight miles away. In the meantime, his wife and two unborn babies died.¹⁶⁰ Even in the wider context, the rural death rate for all ages was higher than urban mortality for most of 1940s, something that with the exception of some years in the 1930s due to the economic war with Britain, had not been seen in Ireland since 1911.¹⁶¹

¹⁵⁰ *Annual report of the county medical officer of health, Cork*, p.62.

¹⁵¹ *DÉD*, 18 Jun. 1946, vol.101, no. 15.

¹⁵² *Annual report of the county medical officer of health, Cork*, p. 62.

¹⁵³ *Ibid.*, pp 61-62.

¹⁵⁴ *Ibid.*

¹⁵⁵ *Ibid.*, p. 62.

¹⁵⁶ *Ibid.*

¹⁵⁷ *Ibid.*

¹⁵⁸ *ARRG, 1939-49*, consecutive years, pp xxii-xvi.

¹⁵⁹ *Ibid.*, pp xxxiii-xxxvii.

¹⁶⁰ *INM*, May 1942.

¹⁶¹ *ARRG, 1949*, p. 24.

While nurses in rural Ireland attempted to raise awareness about rural problems, Fianna Fáil were pre-occupied with the control of diarrhoea and enteritis in Dublin. Issues of hospital infrastructure and accessibility as corroborated by increases in neo-natal and maternal deaths were key issues throughout rural Ireland.¹⁶² In John McCann's account, he had cycled to two different places, but to no avail. Two years later in June 1944, MacEntee himself noted that the roads were tarred to such an extent in Galway that it was dangerous for horses to travel on them.¹⁶³ For MacEntee, the conditions of roads in some rural areas had been allowed to deteriorate so seriously that it was in the best interests of public safety and the state that experienced county surveyors be called in to examine this matter in rural areas.¹⁶⁴ This was an issue well known nationwide with many people in the medical profession showing a reluctance to take up jobs because of the working conditions.¹⁶⁵

Interestingly, the story of John McCann proved a focus point to rally Irish nurses and midwives against working conditions, who argued that if a 'locum tenens was available, the probability was that the woman's life could have been saved'.¹⁶⁶ For the Irish Nurses Association, blame here was on the Department of Local Government and Public Health who 'had consistently refused...to pay more than two guineas a week to locum tenens, and at that figure, no locum would take on the work because remuneration was inadequate'.¹⁶⁷ This in turn fed into statements of the abuses of the system which included cases of dispensary doctors doing locum in two different districts, some in another county, just to increase their weekly take-home pay.¹⁶⁸ This is not to say that Dublin did not have issues of its own. Rather, this highlights how attention was often focused on the urban area as long being associated with issues of disease visibility, poverty and malnutrition. An increased rural death rate throughout the 1940s suggested that there were other causes of death and other problem areas. Yet, official attention was lacking. Preoccupation with gastroenteritis has something to say about Ireland's social values: it was the urban working-class infant that was perceived as 'sick' and it was the working-class mother who had to change her ways.

On 17 September 1945, Francis O' Brien died in a one-roomed tenement in Dublin from suspected diarrhoea and enteritis.¹⁶⁹ He was found dead in his pram in a condition of advanced emaciation with his body covered in sores.¹⁷⁰ His death certificate could not be issued

¹⁶² Ibid.

¹⁶³ *DÉD*, 14 Jun. 1944, vol.94, no.4.

¹⁶⁴ Ibid.

¹⁶⁵ *INM*, May 1942.

¹⁶⁶ Ibid.

¹⁶⁷ Ibid.

¹⁶⁸ Ibid.

¹⁶⁹ Actual name used as it has been published in official *Dáil Éireann debates*.

¹⁷⁰ *DÉD*, 1 May 1946, vol.100, no.17 (James M. Dillon).

because a medical practitioner was not called in to attend Francis during his illness but he had nevertheless showed signs of a diarrhoeal infection before his death.¹⁷¹ There was no apparent attempt made by the social services to come to the assistance of Francis' family in the aftermath, even though public authorities knew that there were four other children in the household, one of whom was suffering from rickets.¹⁷² When this matter was raised in the Dáil by James M. Dillon (Fine Gael TD), the Department of Local Government and Public Health's position was that the family were in receipt of all supports from the government leading up to his death. A total of £2 6s. from public funds went to Francis' parents, his family were also visited on a number of occasions by an inspector from the National Society for the Prevention of Cruelty to Children as well as domiciliary visiting services.¹⁷³ Equally, his family were receiving free milk and free bread daily from the charitable organisation, St. Vincent de Paul.¹⁷⁴ When his death was notified, the Gardaí came to the property to inspect.¹⁷⁵ His mother said that he had been sick for six days with diarrhoea while both parents admitted that they did not take him to the doctor; the reason given was that Francis was teething and that when their other children were teething they also suffered from diarrhoea and got well when given hot milk.¹⁷⁶ The Department of Local Government and Public Health had also previously recommended heating milk in cases where a mother was unable to breastfeed. MacEntee then went on to say to Dillon that:

Every endeavour...was made to get the parents of the child to avail themselves of the services...they failed to that. I am not going to ascribe to them the reasons for their failure...The mother, apparently was in weak health. The father does not seem to have been physically strong either.¹⁷⁷

The implication was that the parents did not avail of the help that was there and it was they, not the government, who were at fault. Responsibility and blame for Francis' death was put on his family and this ties in with the state's wider outlook in the 1937 Constitution that characterised the family as holding primary responsibility for children's health. Within this, the state saw its role as doing everything it possibly could to help Francis' family care for him via public funds, medical personnel and infrastructure as well as additional nourishment the food initiatives of the voluntary organisations, but it was ultimately left to the parents to avail of these provisions. The provision of children's allowance from August 1944 onwards was also intended to help poor families cope.¹⁷⁸ On the other hand, tight enforcement of milk hygiene and the provision

¹⁷¹ Ibid.

¹⁷² Ibid.

¹⁷³ Ibid.

¹⁷⁴ Ibid.

¹⁷⁵ Ibid.

¹⁷⁶ Ibid.

¹⁷⁷ Ibid.

¹⁷⁸ Mel Cousins, 'The introduction of children's allowances in Ireland, 1939-1944' in *IESH*, xxvi (1999), p. 48.

of free medical care for mothers and children might have helped prevent Francis' death. But these measures could not all be pursued at once – there was a war, finances were tight and resources were considerably limited. Instead, actions on diarrhoea and enteritis focused on the education of working-class mothers suggesting that it was primarily their duty to prevent infant deaths. The rise in bottle-feeding encouraged an idea that the poor Irish mother was 'lazy' and ignorant.

If the poor and urban tenement mother was blamed for not preventing the spread of diarrhoea and enteritis, one might assume that outbreaks occurred only in home settings. But this was not the case. Outbreaks of gastroenteritis were prominent in Dublin hospitals. One such outbreak occurred in the Rotunda, one of Dublin's leading maternity hospitals in 1946. While the Gastroenteritis Advisory Committee noted that very few babies died from the infection in hospitals before the war, the war years proved a turning point. Here, 44 babies over 5.5 lbs and 72 babies under 5.5 lbs died in the nursery from this disease of those admitted from the labour ward.¹⁷⁹ A further 30 babies from the puerperal ward had also succumbed.¹⁸⁰ The committee noted:

When it is realised that 22 out of the latter were all normal full-term healthy babies who became infected with enteritis in the hospital the full tragedy of the present situation will be realised. It is only too clear that our present methods of infant care are all too inadequate.¹⁸¹

The committee was right, accommodation at the Rotunda, with its eighteenth-century wards, was very much inadequate. Ventilation was insufficient, the hospital was not fly proof, cots were often exposed to draught and babies could be exposed to infection from visitors.¹⁸² If one baby became sick and survived the immediate infection, they might still spread an epidemic among the particularly vulnerable premature babies when moved to the nursery. The only immediate solution to this was an isolation department, which they did not have the capacity for until mid-1946 when St. Clare's was used. However, some key issues remained. While hospitals were encouraged not to take in cases of infectious diseases, they were not always able to avoid it. In 1947, there were instances where hospitals took in open TB cases and put them beside surgical cases, which is a 'very dangerous thing' as observed by the then Minister for Health, James Ryan.¹⁸³ Yet another incident occurred in 1948 where milk from the largest and highest grade herd was found to be tuberculous and yet was still being consumed in Cork Street Fever hospital

¹⁷⁹ Infant mortality numbers in Dublin maternity hospitals, 1919-46, undated *c.* Jan. 1947 (NAI, HLTH B132/28).

¹⁸⁰ *Ibid.*

¹⁸¹ *Ibid.*

¹⁸² *Ibid.*

¹⁸³ *DÉD*, 6 May 1947, vol.105, no. 16.

and at schools.¹⁸⁴ Despite these risks, families were consistently urged by Deeny to avail of the school milk supplies, as will be shown in the next chapter. Bacterial conditions aside, increasing numbers of patients were not matched by an increase in nursing levels. This was an issue all too familiar nationwide. Details on rising neo-natal deaths in Dublin's maternity hospitals can be found in Appendix E.

3.9 The Mother and Child Scheme

High rates of gastroenteritis, which drove infant mortality rates higher during the war, made matters of child and maternal welfare more visible to the Fianna Fáil government. Thereafter, the importance placed on child and maternal welfare when the war ended culminated in the controversial 'Mother and Child' scheme that aimed to provide free medical care for mothers and children.¹⁸⁵ This proposed free hospital and medical attention to mothers (before, during and after birth) and children up until the age of sixteen, as well as free dental attention for both mothers and their children.¹⁸⁶ Like flour fortification, this was a top-down public health approach which, on paper, would go a great way towards providing healthcare measures to those most in need. However, Fianna Fáil lost power in February 1948, before the provisions of the act could be implemented.¹⁸⁷

From the outset, the Mother and Child scheme received unprecedented scrutiny from members of the Irish medical profession and the Catholic Church, both of whom feared increased state interference in their areas of concern. For the Irish medical profession, who had played the more significant role in opposing the scheme, free healthcare would eliminate the income they earned from paying patients while requiring them to do more work to meet the increased demand.¹⁷⁸ Early fears around such a scheme being set up in Ireland closely followed the Beveridge Plan, when Medical Association of Éire set up a committee to consider the reorganisation of the medical services in Ireland, publishing its first report in 1944.¹⁸⁸ Similar changes in health policy in countries such as Australia, Belgium, Britain and Canada had likewise prompted similar responses from practitioners.¹⁸⁹ In November 1950, the Irish Medical Association held a referendum, where it asked its members:

1. Do you agree to work a Mother and Child Scheme which includes free treatment for people who are able to pay for their own medical care?
2. Do you agree to work such a scheme if private practitioners are excluded?

¹⁸⁴ Deeny to B. Brady, 22 May 1948 (NAI, HLTH B132/28).

¹⁸⁵ Health Act, 1947 (1947 no. 28) (13 Aug. 1947), section 21.

¹⁸⁶ DOH, *An mháthair is a leanbh: Mother and child: what the new service means to every family* (Dublin, 1951).

¹⁸⁷ Daithí Ó Corráin, 'The Catholic Church and the Irish State, 1916-73' in Gladys Daniel and Andrew R. Holmes (eds), *The Oxford handbook of religion in modern Ireland* (Oxford, 2024), p. 155.

¹⁸⁸ Eamonn McKee, 'Church-state relations and the development of Irish health policy: the Mother and Child Scheme, 1944-53' in *Irish Historical Studies*, xxv, no. xcvi (1986), p. 162.

¹⁸⁹ *Ibid.*, p. 163.

3. What if private practitioners are included?¹⁹⁰

The overwhelming majority, roughly 80% of its 1,886 members, were against the working of the scheme.¹⁹¹ The medical profession was joined by the Catholic Church, who shared their concern for increased state intervention in health matters.

In October 1947, the hierarchy gave a statement to de Valera on its concerns about the moral dimensions of the act, which they believed violated the rights of the family and the church.¹⁹² While Archbishop John Charles McQuaid recognised that the purpose of the scheme was good in the context of high infant mortality rates, he questioned the government's proposed means of addressing the issue.¹⁹³ For the hierarchy, provisions of health education and free medical care were particularly contentious as they conflicted with Catholic moral teaching and the rights of family.¹⁹⁴ Health education was of significant concern amid Church fears that gynaecological care could include information on contraception and abortion – these were in direct conflict with moral questions on which the 'Catholic Church has definite teaching'.¹⁹⁵ In terms of the latter, Bishop of Ferns, James Staunton, asserted that the right to provide for 'the health of children belongs to the parents, not to the State', whereby the state 'has the right to intervene only in a subsidiary capacity, to supplement not to supplant'. He also pointed out that the government should consider providing additional hospital facilities and taxation relief to large families instead of imposing a 'costly bureaucratic scheme of nationalised medical service'.¹⁹⁶ In a letter to Mgs. Glennon, Patrick Dargan summed up the situation as such:

Some months ago, during a discussion in the Archbishop's [McQuaid] house on the length of time the present Government was likely to survive, a very responsible [unnamed] member of the Government said that he believed it would fall, not on the question of the Social Security Bill, but on the question of the Health Bill.¹⁹⁷

These events took place during political change. While Fianna Fáil lost power in 1948 to a five-party administration led by John A. Costello and a politically inexperienced Noël Browne as Minister of Health, the Health Act was left in a position that was, according to

¹⁹⁰ H. E. Counihan, 'The Medical Association and the Mother and Child Scheme' in *IJMS*, clxxi, no. 2 (2002), p. 113.

¹⁹¹ *Ibid.*

¹⁹² Statement of the Irish Hierarchy on the Health Act, 1947, undated, c. 1947 (for private transmission to An Taoiseach) (DDA, McQuaid papers, XVIII/25/3/1), p. 1.

¹⁹³ McQuaid memorandum on the Health Act, 1947, undated (DDA, McQuaid papers, XVIII/25/4/1).

¹⁹⁴ McQuaid became Archbishop in 1940. John Cooney notes that no churchman exercised the same level of power as he did before his death in 1973, see Cooney, *John Charles McQuaid: rule of Catholic Ireland* (Dublin, 2012), p. 2.

¹⁹⁵ The hierarchy were against education of mothers in relation to sex relations, chastity and marriage. See James Staunton (Bishop of Ferns) to John A. Costello, 10 Oct. 1950 (DDA McQuaid papers, XVIII/23/4/1/3).

¹⁹⁶ *Ibid.*

¹⁹⁷ Patrick Dargan to Mgs. Glennon, 31 May 1950 (DDA, McQuaid papers, XVIII/28/2/2).

Archbishop McQuaid, ‘legal chaos’ and ‘utterly unworkable’ for many doctors.¹⁹⁸ While Browne sought to introduce the reforms of the Health Act 1947, this met further resistance from both the Church and medical profession, which would eventually lead to his resignation in April 1951. The Health Act 1953, amending its 1947 and 1950 predecessors, re-introduced means testing, and the government also committed to considering the Church’s criticisms, thereby pacifying both the medical profession and the Church.¹⁹⁹ The need to balance the influence of both the medical profession and the Church posed challenges to achieving more substantial public health reform. However, the Health Act 1953 marked a significant step forward because for the first time it provided access or heavily subsidised access to healthcare for the majority of the Irish population.

3.10 Public health oversight

Another area of excess infant deaths was in institutional care. As shown in figure 3.6, ‘illegitimate’ children were almost four times more likely to die than ‘legitimate’ children between 1939 and 1949.²⁰⁰ While numbers of ‘illegitimate’ child deaths were high in the 1930s, they peaked in 1944 at 273 per 1,000 live births, while the rate for babies born to married mothers was 72 per 1,000.²⁰¹ While not all children born out of wedlock went into mother and baby homes and Magdalen Laundries, a substantial number did. Deaths in institutions were listed by cause in the reports of the Registrar-General up until 1941. Common causes included congenital debility, diarrhoea and enteritis, premature birth and pneumonia. Another cause of death that can only found in institutional deaths is a ‘lack of care’ including unstated forms of accidental violence making it clear that the authorities were aware of care deficits and abuse in institutions.²⁰² Recent historiography has focused on responsibility for various institutional outcomes.²⁰³ Mother and baby homes were visited by the Gastroenteritis Advisory Committee. Indeed, there was special

¹⁹⁸ McQuaid memorandum on the new government, 26 July 1954 (DDA, McQuaid papers, XVIII/23/15).

¹⁹⁹ James Ryan outlined to McQuaid that the State is willing to consider Church criticisms before moving to implement its proposals, see Ryan to McQuaid, 10 Sept. 1952 (DDA, McQuaid papers, XVIII/27/4/1).

²⁰⁰ Further reading on this can be found in Liam Delaney, Mark E. McGovern and James P. Smith, ‘Infant mortality in Mother and Baby Homes in twentieth century Ireland’ in *Population Research and Policy Review*, xlii, no. lxvii (2024), pp 1-22.

²⁰¹ *ARRG, 1944*, p. viii.

²⁰² *ARRG, 1939*, p. 22.

²⁰³ Buckley and McGregor, ‘Interrogating institutionalisation and child welfare’, pp 1062-1065. Also see Buckley, ‘Found in a ‘dying’ condition’: nurse-children in Ireland, 1872-1952’ in Elaine Farrell (ed.), *She said she was in the family way: pregnancy and infancy in modern Ireland* (London, 2012), pp 117-133.

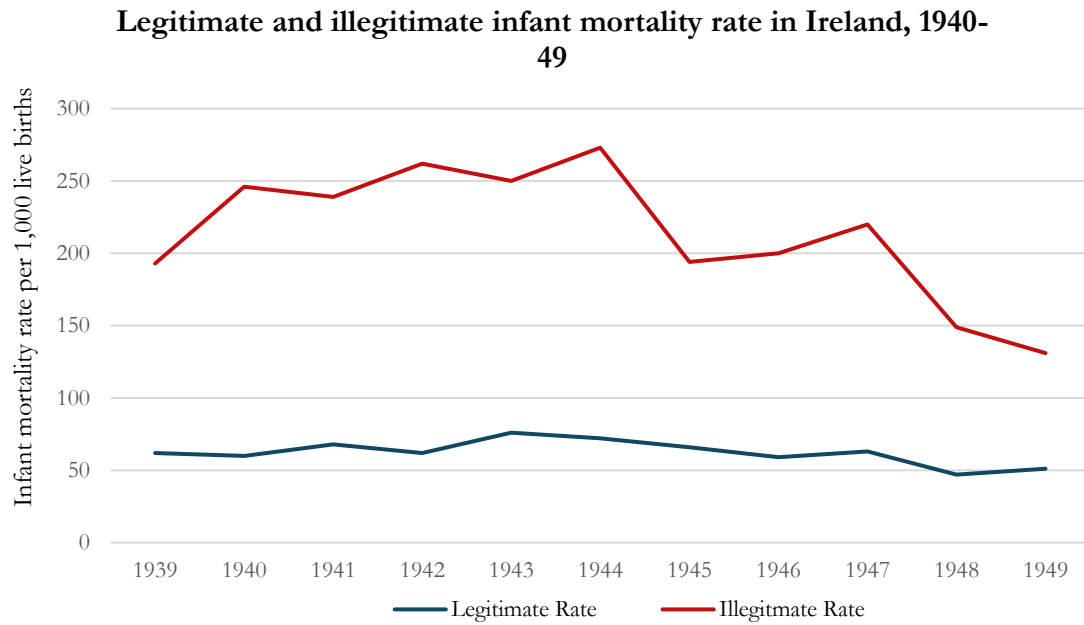


Figure 3.6 Legitimate and illegitimate infant mortality rate per 1,000 live births, 1939-1949.²⁰⁴

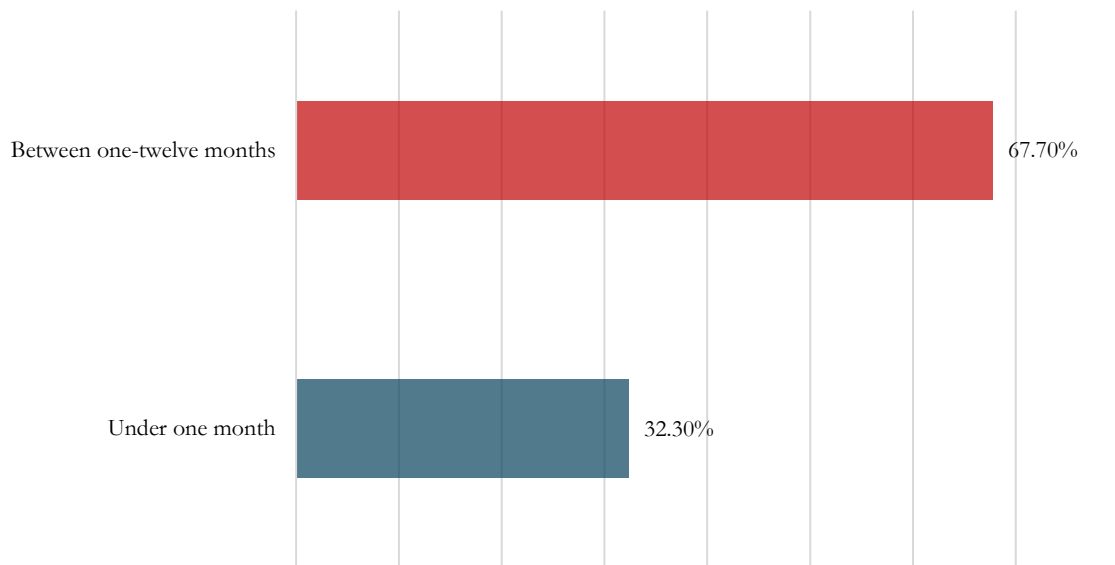
attention paid to the Regina Coeli of St. Legion of Mary in Dublin's North Great Brunswick Street. It was found that:

If standards for occupancy were stipulated so that overcrowding could be checked, more stringent requirements in facilities for food preparation, storage etc. insisted upon, the chances of contracting gastro-enteritis in a maternity home would be lessened.²⁰⁵

The Regina Coeli was one of very few mother and baby homes where mothers and babies could actually be together, which was unusual for its time. There is little further information on other maternity homes that were visited by the Gastroenteritis Committee and there is also little or no information on whether suggestions about the Regina Coeli home were followed-up. The large proportion (32.3%) of infant deaths that occurred throughout the war in these institutions occurred during the first month of the infant's life (see figure 3.7). Like that found in rural areas, this would suggest problems in the immediate medical infrastructure and accessibility.

²⁰⁴ *ARRG, 1939-49*, consecutive years, p. viii.

²⁰⁵ GEAC minutes, 7 Jan. 1948 (NAI, HLTH M34/2, vol.1).

Age at death in Irish institutions, 1940**Figure 3.7** Ages at death in Irish institutions, 1940.²⁰⁶

Yet, this did not receive the same level of attention as did the diarrhoeal outbreaks in Dublin tenements. Instead, the real irony lies in official treatment of such cases. The education of mothers, home visits, pre-natal and ante-natal care and enhanced midwives training were not implemented in these institutions. For babies who were unfortunate enough to be born out of wedlock, and where mothers entered these homes, they usually lacked access to public health measures.

3.11 Conclusion

The preoccupation with gastroenteritis throughout the 1940s highlights policymakers' perception of which population was most vulnerable. The rise in gastroenteritis mortality in Dublin, particularly in working-class areas, meant that Dublin received special attention. On paper, this was practical. Cases there were more frequent than in any other place in the country, housing conditions enhanced the risk of epidemics and this increased the numbers of infant deaths. Given the relatively short time-frame in which diarrhoeal deaths occurred, public health attention to this issue was warranted. On the one hand, Fianna Fáil responses to the diarrhoeal epidemics were merely reactionary; they were combatting issues amplified directly by wartime conditions. The relative speed of deaths during epidemic periods gave increased urgency to the problem.²⁰⁷ However, this also draws attention to government priorities and the beliefs that

²⁰⁶ *ARRG, 1940*, p. 19

²⁰⁷ Karen E. Jenni and George Loewenstein, 'Explaining the 'identifiable victim effect' in *Journal of Risk and Uncertainty*, xiv (1997), p. 237.

shaped their approach. Despite the urgency of the crisis, Fianna Fáil emphasised personal responsibility for health.

For example, Fianna Fáil paid more attention to mothercraft than the enforcement of strict milk hygiene and regulation. Implementing disease notification also made victims partly responsible for disease prevention. This reflected a general government reluctance to intervene in familial health matters, partly because it was expensive and partly because they believed that it was not their place. This was further emphasised in the deliberations around the death of baby Séan. While Fianna Fáil recognised the need to regulate milk during the war, they were already moderating farming practices necessary for wartime food rationing in a continuous negotiation between what money should be spent and where. The proposed Mother and Child Scheme may have signalled a desire for a more top-down approach after the war, but this led to significant opposition from both the medical profession and the Catholic Church.

This chapter reveals that the government mainly focused on Dublin to address the war-time increase in infant mortality, neglecting higher mortality rates in rural areas and mother and baby institutions. The key points of the gastroenteritis campaign such as clean milk and breastfeeding might have been applied equally to infants inside institutions or indeed to rural mothers. The focus on urban mothers by both state and people suggests a further reason that these institutions were ignored. The women in these places were already considered ‘unsuitable’ mothers because they had a child out of wedlock. However, there are areas in other institutions that did warrant government intervention as will be explored later in Chapter Five. The next chapter will examine Fianna Fáil attitudes to health through the lens of food in the immediate aftermath of war. Similar to the themes addressed in this chapter, the portrayal of poor health was largely associated with the lower socio-economic classes, who were primarily held responsible for their health by the government. Additionally, this chapter will highlight a notable shift in government policy, reflecting efforts to align with health developments occurring in other regions.

Section two: Meaningful populations

WHO WERE THE HEALTHIEST IRISH PEOPLE IN THE 1940s? IRELAND'S NATIONAL NUTRITION SURVEY, 1946-48

4.1 Introduction

In 1946, Ireland launched its first-ever national nutrition survey, exemplifying wider post-war initiatives by Fianna Fáil to address and rectify health issues impacted by the war. Following on from the official recognition that there was a direct relationship between good nutrition and health, Seán MacEntee voiced concerns about nutrition levels of the Irish population in 1944.¹ This was after high flour extraction rates were found to have increased the incidence of rickets and TB mortality as explored in Chapter two. MacEntee wanted to know the actual amounts of foods consumed in Ireland and the food habits of the people, and what these amounts meant when they were compared with known international nutrition requirements.² After consultations with the Medical Research Council on how best this knowledge could be gained, it was agreed to postpone the national nutrition survey until after the 'Emergency proper' had ended.³

By examining several representative population groups across the country, the dietary survey aimed to determine the nutritional status of the general population. It collected data from nearly three thousand families, each divided into geographic and socio-economic categories.⁴ This dietary survey was complimented by a clinical survey that specifically focused on 'those groups of the population generally regarded as 'vulnerable' in the nutritional sense', i.e., schoolchildren, adolescents and expectant and nursing mothers.⁵ Approximately 15,000 schoolchildren were examined in total, together with small groups of adolescents and expectant and nursing mothers.⁶ This trend was not unusual in the development of public welfare systems during the first half of the twentieth century, when many countries assumed roles in promoting 'good' and 'better' nutrition.⁷ However, the significance of this in Ireland at this time has not been recognised.⁸

Despite the relevance of nineteenth-century Irish food discourse to examinations of twentieth century Irish dietaries, most leading studies in food history in Ireland focus on the

¹ DOH, *National nutrition survey part i: methods of dietary survey and results from the Dublin investigation* (Dublin, 1948), p. 5.

² Ibid.

³ Ibid.

⁴ DOH, *Health progress, 1947-53* (Dublin, 1954), p. 18.

⁵ DOH, *National nutrition survey part vii: clinical survey* (Dublin, 1952), p. 7.

⁶ DOH, *Health progress*, p. 18.

⁷ James Deeny, 'Practical significance of the Irish National Nutrition Survey' in *BJN*, iv, no. 2-3 (Sept. 1950), p. 293.

⁸ Ibid.

pre-independence period. With the exception of Leslie Clarkson and Margaret Crawford's *Feast and famine: food and nutrition in Ireland, 1500-1920* (2005) and Ian Miller's *Reforming food in post-famine Ireland: medicine, science and improvement, 1845-1922* (2014), there has been no comprehensive account of Ireland's experience of nutrition that includes a large portion of the twentieth century.⁹ Miller examines the ways in which Irish eating habits were dramatically transformed between the famine and independence. He has argued that while the Irish diet diversified after the Famine, nutritional well-being suffered as diets changed.¹⁰ This was part of what Miller explored as progress toward civilising the Irish and 'raising them into more sophisticated beings'.¹¹ During the early decades of the twentieth century, intense research internationally into the identification and synthesis of many notable vitamins and minerals coincided with a new vocabulary that transformed public perceptions of food.¹² New emphasis was placed on food quality as opposed to food excess or as Miller puts, 'how much the Irish ate now seemed of less importance than what they ate'.¹³ With Crawford and Clarkson, he has also provided new perspectives on the connections between eating, health and disease.¹⁴

In Miller and David Durnin's edited volume, *Medicine, health and Irish experiences of conflict, 1914-45* (2017), Bryce Evans examines 'Food, the Emergency and the lower-class Irish body, c. 1939-45'.¹⁵ More recently Evans reminds us of the importance of food in Ireland during this period, amidst the very real and looming threat of starvation and shortly before the centenary of the Great Famine.¹⁶ But aside from these works, there has been little exploration of the health effects that wartime food shortages had on the Irish population, whether these effects were sustained, and whether the chosen health policies pursued were effective. By name, the national nutrition survey signalled a distinct shift in government policy after the war, recognising nutrition as a national goal and not as something that should be left to chance in Irish households. The survey provided Fianna Fáil with an opportunity to identify the food needs of the country by comparing the national dietary to the scientific ideal of a nutritious diet.

The survey, rather than a neutral instrument, reveals ideas about health and food. Rather than using the survey findings as a base for sustained policy intervention aimed at curbing

⁹ Works focusing on nutrition in Ireland as follows: Leslie Clarkson and Margaret Crawford *Feast and famine: food and nutrition in Ireland, 1500-1920* (Oxford, 2001); Ian Miller, *Reforming food in post-famine Ireland: medicine, science and improvement, 1845-1922* (Manchester, 2014).

¹⁰ Miller, 'Hunger and starvation in modern Ireland' in Máirtín Mac Con Iomaire and Dorothy Cashman (eds), *Irish food history: a companion* (Dublin, 2024), p. 627.

¹¹ Miller, 'Nutritional decline in post-famine Ireland, c. 1851-1922' in *Proceedings of the Royal Irish Academy: Archaeology, Culture, History, Literature*, cxv (2015), p. 313.

¹² *Ibid.*, p. 309.

¹³ *Ibid.*, p. 310.

¹⁴ Miller, *Reforming food in post-famine Ireland*, pp 2-4.

¹⁵ Bryce Evans, 'Food, the Emergency and the lower-class Irish body, c. 1939-1945' in David Durnin and Miller (eds), *Medicine, health and Irish experiences of conflict, 1914-45* (Manchester, 2016), pp 45-60.

¹⁶ Evans, 'Food in Ireland in the 1930s and 1940s' in Máirtín Mac Con Iomaire and Dorothy Cashman (eds), *Irish food history: a companion*, p. 660.

malnutrition, the survey re-enforced existing Fianna Fáil ideas about who was healthy and who was not. Long-term strategies and planning by way of improving nutrition standards were also astonishingly absent from the survey reports. Instead, the survey results were monotonous, indicating that nutrition levels were mainly satisfactory among all categories of the population, that those of higher incomes enjoyed a greater variety of foodstuffs than those who did not possess the means, and that Dublin's poorest and largest families had deficient calcium intakes.¹⁷ Through an examination of the survey methodologies, findings, and policy implications, this chapter argues that it was Irish farmers' who were perceived to be the 'healthiest' Irish people at this time whereby 'health' in the sense of food was entrenched within wider nationalistic goals of self-sufficiency and agricultural autonomy. This chapter shows how efforts to enhance the health of the poor through flour fortification evolved into a critique of their diet in its entirety.

4.2 International developments in nutrition

The nutrition survey can be seen as an attempt by the Fianna Fáil to bring Irish health standards into line with international developments. International research into the identification and synthesis of many notable vitamins and minerals in the early decades of the twentieth century coincided with a new vocabulary that transformed public receptions of food.¹⁸ Up until this point, one's dietary habits were attributed to food availability, cooking mechanisms and taste. When scientific breakthroughs in nutrition equipped the medical field with a means to examine the value of food against wider dietary patterns, the discourse around food was transformed. This not only meant that food was aligned with its nutritional value for the first time, but it also became equated with purity and hygiene.¹⁹ Because these were tangible factors that could be counted, nutrition science thus offered a quantifiable framework that allowed people to distinguish between what constituted a 'healthy' and 'unhealthy' diet.²⁰ The experience of the First World War combined with nutrition science suggested that countries who were better able to maximise their food resources emerged with higher levels of health.²¹

Juliana Adelman and Lisa Haushofer have highlighted how both medical practitioners and nutrition scientists have consistently shaped their inquiries and research methodologies in response to prevailing political and social challenges.²² Food, and food supplies, were also very

¹⁷ DOH, *Part i: results from the Dublin investigation*, p. 11.

¹⁸ Miller, 'Nutritional decline in post-famine Ireland', p. 309.

¹⁹ *Ibid.*, pp 309-311.

²⁰ Charlotte Bilteroff, *Eating right in America: the cultural politics of food and health* (Durham, 2013), p. 15.

²¹ Paul Weindling, 'The role of international organisations in setting nutritional standards in the 1920s and 1930s' in Harmke Kamminga and Andrew Cunningham (eds), *The science and culture of nutrition, 1840-1940* (Amsterdam, 1995), p. 319.

²² Adelman, Juliana and Lisa Haushofer, 'Introduction: food as medicine, medicine as food', *Journal of the History of Medicine and Allied Sciences*, lxxiii, no. 2 (2018), pp. 127-134. Also see Haushofer, *Wonder foods: the science and commerce of nutrition* (California, 2022).

important to governments and philanthropic organisations alike for maintaining social stability.²³ Paul Weindling has observed the extensive organisation of massive feeding programmes in Central Europe after the First World War, though these initiatives varied in scale and reach.²⁴ The global food-supply situation was exacerbated by the Great Depression in 1929, which saw international agricultural tariffs severely affecting the domestic food markets of many European nations.²⁵ In 1935, the League of Nations, which Ireland had been a member since 1923, established a Mixed Committee on the Problem of Nutrition to compile general reports on the health and economic aspects of nutrition globally.²⁶ This marked the first time where nutrition became a serious public health concern of global significance, and ‘with international authority’.²⁷ Meanwhile, Ireland’s Departments of Foreign Affairs and Local Government and Public Health closely monitored the resulting research findings.²⁸ It is no coincidence that Ireland’s survey occurred in October 1946 – Ireland joined the Food and Agriculture Association (FAO) of the UN just one month before.²⁹

Elsewhere, the British Ministries of Health and of Food commissioned the Oxford Nutrition Survey (ONS) to monitor the possible health effects of wartime rationing early in 1941.³⁰ The main aim of this survey was to identify ‘the incidence, cause, severity and distribution of malnutrition in England’, and the survey continued alongside wartime disruptions until 1950.³¹ In Britain, findings of the ONS survey directly informed wartime food policy and vitamin supplements were tested early-on among factory workers.³² Nutritional surveys were also conducted by the ONS in other European countries, including the Netherlands, where data was gathered on the Dutch Famine, which occurred when the Nazi regime imposed a food blockade on the country between November 1944 and March 1945.³³ In the immediate post-war years, other national and regional nutrition surveys were launched in Europe, South Africa, Australia, Siam and Turkey as well as in Ireland.³⁴

²³ Alice A. Weinreb, *Modern hungers: food and power in twentieth century Germany* (Oxford, 2017), p. 6.

²⁴ Weindling, ‘The role of international organisations’, p. 319.

²⁵ Janet M. Campbell, ‘The nutrition report’ in *International Affairs*, xvii, no. 2 (1938), p. 252.

²⁶ *Ibid.*, p. 253.

²⁷ In 1936, copies of League of Nations minutes from Geneva Conference, 15 Dec. 1936 were forwarded shared between the Departments of Foreign Affairs and Local Government and Public Health. See, ‘Study of the methods for determining the state of nutrition in children’, Dec. 1936 (NAI, DFA 2/31/208).

²⁸ *Ibid.*

²⁹ DOH, *Report of the Department of Health, 1949-50* (Dublin, 1951), p. 26.

³⁰ Hugh M. Sinclair, ‘Wartime nutrition in England as a public health problem’ in *American Journal of Public Health and the Nation’s Health*, xxxiv, no. 8 (1944), p.828.

³¹ *Ibid.*

³² Jan Lambertz, ‘Calculating war, calculating peace: the Rockefeller Foundation and science research in Britain’ in *European Review of History*, xxx, no. 6 (2023), p. 845.

³³ Rachel R. Huxley, B. B. Lloyd, M. Goldacre and H. A. Neil, ‘Nutritional research in World War 2: the Oxford Nutrition Survey and its research potential 50 years later’ in *BJN*, lxxxiv (2000), p. 248.

³⁴ Josep L. Barona, ‘Nutrition and health: the international context during the inter-war crisis’ in *SHM*, xxi, no. 1 (2008), p. 96.

4.3 Methods of the Irish national nutrition survey

The dietary survey in Ireland involved a series of home visits by ten trained female investigators who visited family homes to observe their eating habits and food consumption rates between 1946 and 1948.³⁵ In total, 2,670 families were selected for investigation or approximately one family to every 1,000 persons of Ireland's population.³⁶ The families were categorised according to their backgrounds, i.e., 'Dublin', 'Large and Small Towns', the 'Congested Districts', 'Farming Families' and the 'Families of Farm Workers'.³⁷ In most cases, the investigators visited each home twice over the period of one week. The attention of the investigators was mainly focused on comparing the weight of foodstuffs and their nutritional value at the start of the week to those leftover at the end. The nutrients found in the diet of each group were then calculated by converting the total weight of each food used to its nutrient equivalent found in food composition tables as outlined by 'Nutritive Values of Wartime Foods'.³⁸ The nutrient requirements of the various population groups were calculated on the basis of the recommendations of the League of Nations Technical Commission on Nutrition (1936 and 1938).³⁹ Housewives were also given a 'log-book' to write down the prices of all food that was bought as well the amount of food that was consumed in return for a small cash payment.⁴⁰ All food was subsequently costed according to local rates, and any food that was home-grown was costed in order to provide a basis of comparison with others.⁴¹ The investigators also noted the living conditions and income levels for each household. For example, the number of people living in the family home was observed, the number of rooms were counted, and notes were made of a household's fixed outgoings such as rent, fuel and light.⁴² Records were kept of the kind of meals consumed by various members of the household i.e., whether meals were cooked or uncooked, and whether dinners consisted of a combination of meat and vegetables or included puddings and so on.⁴³ Where households did not measure up to these standards, it was assumed that they did not enjoy a full measure of health. For example, the dietary survey claimed

³⁵ D. Hourihane, 'Objective, scope and general plan of the Irish National Nutrition Survey' in *BJN*, iv, no. 2-3 (1950), p. 272.

³⁶ Figure based on the sum of family numbers in each group surveyed in DOH, *National nutrition survey parts i-vii: complete reports on dietary and clinical surveys* (Dublin, 1953).

³⁷ Individual reports for each population sub-group category (Dublin, Large and Small Towns, Congested Districts, Farming families and Farm workers' families) are outlined in DOH, *National nutrition survey: parts i-vii: complete reports*.

³⁸ DOH, *Part vii: clinical survey*, p. 7.

³⁹ *Ibid.*

⁴⁰ The sum of 2s. 6d. was paid to each housewife after completing the log-book. See Hourihane, 'Objective, scope and general plan', pp 270-272.

⁴¹ *Ibid.*, p. 271.

⁴² Hourihane, 'Objective, scope and general plan', p. 271.

⁴³ *Ibid.*, p. 271.

that household diets consistently did not meet standard nutritive requirements as family size grew in Dublin, Large and Small Towns and the Congested Districts.⁴⁴

The clinical survey targeted the examination of the nutrition level of an individual. Carried out by a trained male medical investigator who had spent some time training in Britain beforehand, the clinical examination specifically targeted primary-school children, adolescents and expectant and nursing mothers.⁴⁵ The clinical assessment involved two parts. The first was an examination of the nutritional state of the individual by the medical investigator to identify any signs of malnutrition that included gingivitis, goitre, rickets and so forth.⁴⁶ The 'state of nutrition' was subsequently recorded under three categories: 'good', 'fair', and 'poor' and divided along regional boundaries.⁴⁷ The anthropometric examination involved a survey of heights and weights.⁴⁸ Boys were measured wearing trousers and stockings, girls wearing vests, knickers and stockings and adolescents done without cardigans, jackets and shoes.⁴⁹ However, in order to obtain accurate conclusions about a national population, the samples chosen should have included individuals with characteristics similar to the national population chosen, i.e., one would expect the same number of households to be chosen from each of the same areas and socio-economic backgrounds. This was not the case.

4.4 Class bias and the dietary survey

Typically, the point of sampling strategies in survey research is to obtain data from a population sample that is representative of the wider population of interest. On paper, a 'national nutrition survey' denoted a survey of the 'national' population at large. In other words, one would imagine that the population samples were chosen in the hope that overall figures could then be accurately represented on a national basis. To this end, samples were divided geographically (see table 3.1).⁵⁰ The rationale was that families of all backgrounds across the country would be captured. These families were selected with the help of Roy C. Geary, a leading statistician from the statistics branch of the Department of Industry and Commerce.⁵¹ When this branch was re-organised as the Central Statistics Office under the Department of the Taoiseach in 1949, Geary became its director.⁵² The sampling technique that was used engaged extensively in population

⁴⁴ DOH, *Part i: results from Dublin investigation*, p. 15. Also see: DOH, *Part II: dietary survey of the Congested districts* (Dublin, 1953), p. 13; *Part iii: dietary survey of Large and Small towns* (Dublin, 1953), p. 12.

⁴⁵ DOH, *Part vii: clinical survey*, p. 7. For further detail on the training of the clinical investigator, see Hourihane, 'Objective, scope and general plan' p. 272.

⁴⁶ DOH, *Part viii: clinical survey*, pp 7-10.

⁴⁷ *Ibid.*, p. 10.

⁴⁸ *Ibid.*, p. 7.

⁴⁹ *Ibid.*, p. 9.

⁵⁰ Robert C. Geary, 'Statistical plans and methods of the Irish National Nutrition Survey' in *BJN*, iv, no. 2-3 (Sept. 1950), p. 275.

⁵¹ C. J. Woods, "Geary, Robert Charles ('Roy')" in *DIB (online)*, DOI: <https://doi.org/10.3318/dib.003437.v1>.

⁵² *Ibid.*

and census data that was already gathered by the Department.⁵³ However, the Department of Health deliberately introduced a significant class bias when samples were chosen for both the dietary and clinical survey:

In general principle, the Department of Health decided not to adhere rigidly to the tenets of random sampling in the town areas but to bias the sample generally towards the poorer sections of the community.⁵⁴

Notwithstanding, the extent of bias present varied from sample to sample.

Type of family	Number of families in sample
Families living in Dublin City	500
Families living in thirteen large towns	329
Families living in forty-nine small towns	516
Farming families	948
Families of farm labourers	177
Families living in the congested districts	200
Total number of families surveyed	2670

Table 4.1 Categories of families surveyed in the national nutrition survey, 1946-48.⁵⁵

In Dublin city, chosen families were assigned to three grades: slum, artisan and middle-class. Although it was intended to base the entire nutrition survey on random sampling, the average social grade of families chosen in the Dublin sample were from lower income backgrounds. To do this, the Dublin City sample was selected from four wards, namely, Mountjoy, Rotunda, Crumlin and Drumcondra.⁵⁶ After all, the ‘majority of the slum families resided in Mountjoy and Rotunda, the artisan families in Crumlin and the middle-class in Drumcondra’.⁵⁷ Almost four fifths of the families surveyed in Dublin came from predominantly working-class backgrounds.⁵⁸ Bias can also be found in the small and large towns, where families larger than average were chosen.⁵⁹ Further, any household that belonged to the professional classes – such as that of a solicitor or a clergyman, were deliberately excluded from the survey of these areas.⁶⁰ The intention was to bias the representation toward the less wealthy sections of the community. Evidence of this bias can also be found in the rural investigations and the

⁵³ Census data was used to ascertain information on the geographical distribution of the population, as well as social status and size of families. *Ibid.*, p. 275.

⁵⁴ *Ibid.*

⁵⁵ *Ibid.*

⁵⁶ *Ibid.*, p. 274.

⁵⁷ *Ibid.*, pp 247-275.

⁵⁸ Figure based on family numbers included in classified sampling. See DOH, *Part i: results from Dublin investigation*, p. 8.

⁵⁹ Geary, ‘Statistical plans’, p. 275.

⁶⁰ DOH, *Part iii: dietary survey of the Large and Small towns*, p. 5.

congested districts where ‘conditions of life are hard’.⁶¹ Indeed, all families surveyed in the Congested Districts were ‘poor’ and lived in ‘rural slums’.⁶² This is a peculiar choice of terminology at this time. The term ‘Congest Districts’, as the survey itself acknowledges, referred to areas mainly along the Western seaboard, where land was of the poorest quality and living conditions were ‘generally harder than elsewhere’.⁶³ It had its origins when the Congested Districts Board of Ireland was established in 1891 as part of the British government’s ‘constructive Unionism’ policy that sought to pacify Irish agrarian unrest.⁶⁴ As Ciara Breathnach notes, ‘congested’ in its nineteenth century context was a misleading term, as not all areas identified were overpopulated.⁶⁵ Instead, it was a euphemism for poverty that was caused by an over-dependency on small land holdings – a view seemingly shared by the national nutrition survey.⁶⁶ Ironically, the Fianna Fáil government adopted this term, using it in the same way as British government had previously – to categorise different rural social classes.

On the other hand, the sample of farming families were chosen from the Agricultural Statistics List.⁶⁷ Several District Electoral Divisions (DED) were chosen in each county that were roughly proportional to the county’s farming population.⁶⁸ The sample of farm labourer’s families were selected by obtaining addresses from the farming families that they visited.⁶⁹ When taken together, there was awareness of flaws in sampling methodologies from the outset. However, Geary’s reasoning was that ‘while the statistician may cavil at this bias he cannot withhold sympathy from its intention’.⁷⁰ For Geary, the aim of the official investigations into dietary habits was not so much about ascertaining unbiased national averages of the various factors. Rather, he believed it was to:

Identify the sectors where remedial action is necessary and to measure accurately the deficiencies, if any. These enquiries are expensive and there must seem to be but little point in securing proportional representation in the sample of the more affluent sections of the community in regard to which one knows in advance no problem is likely to arise.⁷¹

Geary explained the bias by ‘good’ intention: identifying the spaces where deficiencies were most likely to exist, putting health authorities in a position where they could more accurately apply remedies. However, implicit in his rationale is that deficiencies were most likely present

⁶¹ Geary, ‘Statistical plans’, p. 276.

⁶² DOH, *Part iii: dietary survey of Large and Small towns*, p. 5. Also see *Part ii: dietary survey of the Congested Districts*, p. 13.

⁶³ DOH, *Part ii: dietary survey of the Congested Districts*, p. 3.

⁶⁴ Ciara Breathnach, *The Congested Districts Board of Ireland, 1891-1923* (Dublin, 2005), p. 11.

⁶⁵ Ibid.

⁶⁶ Ibid. Also see DOH, *Part ii: dietary survey of the Congested Districts*, pp 3-4.

⁶⁷ Geary, ‘Statistical plans’, p. 276.

⁶⁸ Ibid.

⁶⁹ Ibid.

⁷⁰ Ibid., p. 275.

⁷¹ Ibid.

in people that had less money to spend on foodstuffs. In this way, the sampling technique used simultaneously reflected and perpetuated attitudes about the poor as unhealthy.

The methods used in the dietary survey thus reinforced assumptions that poor households would have poor housing, overcrowding, too many children and not enough nutrients. Instances such as overcrowding were used by the Department of Health to explain any discrepancies that arose in survey findings. For example, it was continuously alleged that household diets did not meet standard requirements as family sizes grew in Dublin, the Large and Small Towns, and the Congested Districts Samplings as survey equated satisfactory nutrition with one's economic standing.⁷² From initial examinations of the consumptions of 'vitally important foods' of milk, eggs, meat and potatoes, the survey noted 'the trend is as might be expected' with 'practically all items showing decreasing consumption as the number of persons in the family increases'.⁷³ While this idea coincides with long-standing beliefs surrounding disease as most prominent among the poor, the Department of Health did not just assume that poor people had poor diets and were unhealthy. They blamed them for it. The idea was that if the government could see how the poor spent their money, it could pinpoint wasteful spending on 'monotonous' diets of 'bread and spread' and then suggest better ways for them to spend their money to improve their health.⁷⁴

The survey did not cover all areas equally. While the rural investigations were initially carried out alongside the survey of the large and small towns, it was no longer feasible for the investigators to visit rural families who lived more than five miles away from the town areas where the investigators were staying as the survey progressed.⁷⁵ Remote areas visited were in close proximity to town centres, and it is possible conditions were worse in areas not visited by the investigators.⁷⁶ While Crawford has previously pointed out that the increase in grocery outlets throughout the country had balanced food shopping habits by the 1940s, Bryan has noted that it was commercial travellers, not grocery shops, that serviced the more remote areas of the West at this time.⁷⁷ These commercial travellers were particularly hit by petrol rations during the war.⁷⁸ People in these areas often struggled to locate available transport – a problem the survey's investigators also shared.⁷⁹ However, the nutrition survey failed to capture the

⁷² DOH, *Part ii: dietary survey of the Congested Districts*, pp 12- 13; *Part iii: dietary survey of Large and Small towns*, p. 12.

⁷³ DOH, *Part i: results from the Dublin investigation*, p. 9.

⁷⁴ Deeny, 'Practical significance of the Irish national nutrition survey', p. 293.

⁷⁵ DOH, *Part ii: survey of the Congested Districts*, p. 4.

⁷⁶ Ciarán Bryan, 'Rationing in Emergency Ireland, 1939-1948', (PhD, NUIM, 2014), p. 273.

⁷⁷ *Ibid.*, p. 273. Also see Margaret Crawford, 'Was Ireland nourished? James Deeny and the Irish National Nutrition Survey' in Brenda Collins (eds), *Industry, trade and people in Ireland, 1650-1950: essays in honour of W. H. Cranford* (Belfast, 2005), p. 263.

⁷⁸ Bryan, 'Rationing in Emergency Ireland, 1939-1948', p. 274.

⁷⁹ Evans, 'Food in Ireland in the 1930s and 1940s', p. 656.

experiences of those who deviated the most from these averages. Therefore, it is important to take the findings of the survey with some caution.

4.5 Class bias and the clinical survey

Class bias can also be found throughout the techniques used in the clinical survey. Targeting groups of the population that were regarded as most vulnerable, or ‘those in whom nutritional defects might be expected’, the clinical survey focused on three specific populations: school-children, adolescents and nursing mothers.⁸⁰ It was in these categories of the Irish population that nutritional-based anxieties were most vividly manifested. After all, the bodies of the Irish mother and child were increasingly brought under state surveillance through several preventative health campaigns that aimed to improve maternal and child mortality at the same time, as explored in Chapter Three. In the case of children, 14,835 school-children were selected in correspondence with the areas covered in the dietary survey.⁸¹ Their age was taken along with details of the number of people in their families, their father’s occupation and in rural areas, the size of their father’s agricultural holding.⁸²

Bias can also be found in the areas that the clinical survey examined. While the selection of expectant and nursing mothers that were to be clinically examined was to initially follow the same format as the dietary, i.e., from chosen areas to capture various backgrounds in Dublin, Large and Small Towns, Congested Districts and so forth, this proved not to be the case owing to ‘administrative reasons’ that were not disclosed in the report.⁸³ Instead, all 520 adolescents and 320 expectant and nursing mothers who were examined came solely from Dublin city.⁸⁴ Similar to the rickets surveys that were carried out in the early 1940s, the expectant and nursing mothers who were examined were those attending for free treatment at Dublin Corporation’s maternity and child welfare clinics and clinics attached to Dublin’s maternity hospitals.⁸⁵ Without the means for paid treatment, this suggests that all mothers examined were from poor backgrounds. Again, particulars of the husband’s employment and number of other children were noted.⁸⁶ Just like the dietary survey, the clinical survey aligned ‘good’ nutrition with higher household incomes. Similar thought on the purchasing power of any given family can also be evidenced from James M. Dillon’s observation on nutrition:

At present if a man is an agricultural labourer and has two or three children, every subsequent child born into that household is a menace to that family’s

⁸⁰ DOH, *Part vii: clinical survey*, p. 7.

⁸¹ *Ibid.*, pp 7-9.

⁸² *Ibid.*, p. 8.

⁸³ *Ibid.*, pp 7-9.

⁸⁴ *Ibid.*

⁸⁵ *Ibid.*, p.9.

⁸⁶ *Ibid.*, p. 17.

existence...Every additional mouth born into that home means that the children already in it are going to learn the meaning of malnutrition and semi-starvation.⁸⁷

A recent study carried out by public health researchers, Ilse Dijkstra and Klasien Hortsman, on European social epidemiological research and policy advice between 1977 and 2019 demonstrates that social epidemiological research itself plays a role in contracting and sustaining health inequalities.⁸⁸ But this is not an entirely new phenomenon. If ‘categorising people in a certain way informs expectations about them, and hence, co-influences how they are studied and understood’, the clinical survey’s sole focus on adolescents and nursing and expectant mothers in Dublin is no coincidence.⁸⁹ Similarly, Deborah Lupton has explored how the operations of public health policy have valorised some groups and individuals and marginalised others.⁹⁰ To this end, she highlights how medicine and public health have strongly coercive elements in that they set out to shape and influence human behaviours in certain ways.⁹¹ This builds on Foucault’s observation that:

Medicine must no longer be confined to a body of technique for curing ills and of the knowledge that they require; it will also embrace a knowledge of *healthy man*, that is, a study of *non-sick man* and a definition of the *model man*. In the ordering of human existence, it assumes a normative posture, which authorizes it not only to distribute advice as to healthy life, but also to dictate the standards for physical and moral relations of the individual and of the society in which he lives.⁹²

As explored in Chapter Three, problems of infant health were particularly pronounced in Dublin while public health measures designed to reduce gastro-enteritis and infant mortality largely centred on educating and changing the behaviours of Irish mothers.

The urban poor were a ‘problematic’ population for a number of reasons. Historically, anti-urban sentiment was a common phenomenon in cities across Europe in the aftermath of the Industrial Revolution. However, this disdain for urban life took a particular tone in the formulation of Irish identity at the turn of the twentieth century. In the late nineteenth-century, Belfast was regarded as the fastest-growing city in Britain, and its economic prosperity was equated with Unionism.⁹³ This fed into views of ‘the country is Irish, the city, British’.⁹⁴ Labour unrest and the Dublin 1913 Lockout hardened these views, especially within the Catholic Church who believed that unemployment would draw the Irish toward socialism, which would

⁸⁷ *DÉD*, 8 May 1941, vol 83. No. 2.

⁸⁸ Ilse Dijkstra and Klasien Horstman, ‘Known to be unhealthy’: exploring how social epidemiological research constructs the category of low socioeconomic status’ in *Social Science & Medicine*, cclxxxv (2021), pp 1-11.

⁸⁹ *Ibid.*, p. 2.

⁹⁰ Deborah Lupton, *The imperative of health: public health and the regulated body* (London, 1995), p. 5.

⁹¹ *Ibid.*, p. 10.

⁹² Michel Foucault, *The birth of the clinic* (London, 1976), p. 35.

⁹³ Mary E. Daly, ‘An alien institution? Attitudes toward the city in nineteenth and twentieth century Irish society’ in *Études Irlandaises*, x (1985), p.185.

⁹⁴ Mervyn Horgan, ‘Anti-urbanism as a way of life: disdain for Dublin in the Nationalist imaginary’ in *The Canadian Journal of Irish Studies*, xxx, no. 2 (2004), p. 41.

then be followed by atheism.⁹⁵ Mary Daly observes that one Dublin city-centre branch of the Society of St. Vincent de Paul stopped dispensing material aid at the peak of the labour unrest in order to focus their resources on the ‘spiritual education of the poor’.⁹⁶ This was followed by government reluctance post-independence to invest in urban industries in favour of agriculture as the main Irish industry, allowing an idyllic rural Ireland to arrive at the forefront of Irish identity alongside the Catholic Church.⁹⁷ However, these ideas were in conflict with the realities of everyday life in the post-independence period.

While poverty was not exactly new, it was rising post-independence.⁹⁸ During the first decade of Irish independence, the circumstances of the Irish poor became synonymous with Irish political determination to see ‘the shadow of the coloniser banished’.⁹⁹ At the same time, the housing conditions of Dublin, which had deteriorated during the First World War, continued to show further decline.¹⁰⁰ It is thus no coincidence that some notable cabinet members, such as Seán Lemass and Seán T. O’ Kelly (former President of Ireland (1945-59) and Tánaiste (1932-45)), who were both raised in inner-city Dublin, sought far-reaching social reforms in the 1930s.¹⁰¹ Lemass, known for his political pragmatism, was heavily involved in Fianna Fáil housing initiatives in the 1930s while O’ Kelly as the then Minister for Local Government and Public Health, oversaw these developments.¹⁰² In Dublin, Ruth McManus notes that over 14,492 new homes were constructed between 1932 and 1940, double what was built between 1887 and 1931.¹⁰³ However, most housing projects were suspended for the duration of the war due to shortages in supplies. David Dickson notes how building activities in Dublin were scaled back drastically after 1940.¹⁰⁴ While Dublin Corporation had the ‘Rialto Project’, where fifteen blocks were planned, the site itself prepared only to be left for post-war completion.¹⁰⁵ For the rest of the war, the Corporation reverted to a policy of refurbishing old housing stock, especially in Gardiner Street and Summerhill, where some tenement properties saw improvements.¹⁰⁶ However, Dickson also notes how large numbers of building workers had emigrated to Britain by 1942 in search of work.¹⁰⁷ While Fianna Fáil introduced various welfare

⁹⁵ Daly, ‘Attitudes toward the city’, p. 187.

⁹⁶ Ibid.

⁹⁷ Ibid.

⁹⁸ Lindsey Earner-Byrne, *Letters of the Catholic Poor, 1920-1940* (Cambridge, 2017), p. 26.

⁹⁹ Ibid., p. 27.

¹⁰⁰ Daly, ‘Attitudes toward the city’, p.188.

¹⁰¹ For reference, see Patrick Maume, ‘O’Kelly, Seán’ in *DIB (online)*, DOI: <https://doi.org/10.3318/dib.006840.v1>.

¹⁰² Robert J. Savage, *Seán Lemass* (Dublin, 2014), p. 7. Also see Cathal O’Connell, *The state and housing in Ireland: ideology, policy and practice* (New York, 2007), p. 31.

¹⁰³ Ruth McManus, *Dublin 1910-1940: shaping the city & suburbs* (Dublin, 2002), p. 220.

¹⁰⁴ David Dickson, *Dublin: the making of a capital city* (London, 2014), pp 505-6.

¹⁰⁵ Ibid.

¹⁰⁶ Ibid., p. 506.

¹⁰⁷ Ibid.

and housing mechanisms that redirected resources to the most vulnerable during the 1930s, the results of these measures were difficult to see against a harsh international economic depression and the economic war with Britain.¹⁰⁸ This manifested in acute instances of rising disease, especially in urban areas. Consequently, the increased attention given to Dublin in the survey is noteworthy. As a capital city and the very space in which internal and external interests meet, there is much evidence to suggest that the critiques of the poor household in the survey were part of wider government attempts to clean up the city.

4.6 Results of the national nutrition survey

One failure of the nutrition survey was its inability to empathise with the groups of the population that it sought to affect most. The survey showed that ‘roughly half the population, the 600,000 farm families’ had enough or more than enough to eat.¹⁰⁹ In these households only one-third of all meals taken consisted of simple meals of bread and spread while half of all meals were cooked.¹¹⁰ Consumption of milk, meat, eggs, fruit and vegetables also increased where families had more land.¹¹¹ This further fed into government views that ‘the best-fed people in the country’ were the farmers, claimed by James Larkin Jnr (Labour Party TD for Dublin and son of prominent trade unionist Jim (‘Big Jim’) Larkin, who established the Irish Transport and General Workers Union in 1909).¹¹² Even in those groups of the farming community that had the smallest and poorest farm holdings, the intake of calories and nutrients in farming families ‘reached very satisfactory’ levels.¹¹³ Overall, the diets in this population sample ‘were found to be excellent’ as ‘good’ health standards were aligned with those who had access to a range of different foods.¹¹⁴ This was an expected observation as Irish country dwellers were known for their ‘greater ability to live off the land’.¹¹⁵

Perceptions of Irish rural communities as completely self-sufficient had previously underpinned Fianna Fáil rhetoric surrounding a utopian Irish Ireland, where ideas around farmers and Irish agriculture were central to forging a distinct Irish national identity.¹¹⁶ Who this was in Ireland in the 1940s was the middling farmer, a notable beneficiary of the new Irish state following the transfer of lands after Irish independence from Britain. Politically, many nationalists believed that the system of land ownership that existed in the Ireland under British

¹⁰⁸ Earner-Byrne, *Letters of the Catholic Poor*, p. 57.

¹⁰⁹ Deeny, ‘Practical significance of the Irish national nutrition Survey’, p. 293.

¹¹⁰ *Ibid.*, pp 12-13.

¹¹¹ DOH, *Part iv: dietary survey of Farming Families* (Dublin, 1950), p. 12.

¹¹² *DÉD*, 1 Jun. 1950, vol. 121, no.8. For reference, see Diarmuid Ferriter, ‘Larkin, James’ in *DIB (online)*, DOI: <https://doi.org/10.3318/dib.004684.v2>.

¹¹³ DOH, *Part iv: dietary survey of Farming Families*, p. 12.

¹¹⁴ *Ibid.*, p. 13.

¹¹⁵ Evans, ‘Food in Ireland in the 1930s and 1940s’, p. 656.

¹¹⁶ Clair Wills, ‘Women writers and the death of rural Ireland’ in *Eire-Ireland*, xli, no. 1 (2006), p. 195.

rule was responsible for the lack of investment in agriculture and poverty among farmers.¹¹⁷ In their view, the farmers had no interest in investing in their farms for higher outputs because it was the landlords who would reap the fruits of their work, either in the form of higher rents or eviction.¹¹⁸ Daly has observed how these ideas were reflected in rise in cultural nationalism that coincided with the land question in the late nineteenth-century, where Gaelic League enthusiasts were led to the western seaboard ‘in search of native Irish speakers and the remnants of their indigenous culture’, ultimately producing an idealised image of the Irish peasant in the process.¹¹⁹ So when the Irish Free State was established in December 1922, the state that emerged was to be an ‘overwhelmingly agricultural country’ as land ownership was returned.¹²⁰ The post-independence Gaeltacht resettlement schemes, which saw the establishment of Gaeltacht areas for Gaeltacht families outside of traditional Gaeltacht areas, are further evidence of this.¹²¹

Ireland’s agricultural conditions may have provided an adequate supply of food for the majority population, but this did not necessarily mean that everyone received sufficient quantities of nutritive foods. Poor families were blamed for their food choices as opposed to the Department of Health taking any blame for the circumstances of their poverty. The dietary survey consistently highlighted a tendency among those with higher incomes to consume a greater variety of foods (see figures 4.1, 4.2 and 4.3). The poor were also criticised for consuming the more ‘simple meals of the tea and bread and butter type’.¹²²

It emerges, for example... that families of different social grades but of approximately the same proportion of children to adults, and the same average food-expenditure, bought significantly different quantities of important foods.¹²³

The survey report also noted that the survey ‘brings out the need for food education to encourage the spending of money to the best nutritional advantage.’¹²⁴ Other critiques of the so-called ‘bread and spread’ meal were found across the surveys of Dublin and that of Large and Small Towns.¹²⁵ As opposed to understanding that the people were buying the most calories for the least amount of money, this implies that they should have been enjoying a more varied diet once the war had ended, like that seen in the diets of the Farming Families and Farm Workers’ Families (see figure 4.3). In other words, the problem now in eating too much bread was not because of broader supply issues in wheat that the country faced only a couple of years before but that the poor should be choosing to eat a more varied diet once the war was over.

¹¹⁷ Daly, *The first department: a history of the Department of Agriculture* (Dublin, 2002), p. 4.

¹¹⁸ *Ibid.*

¹¹⁹ Daly, ‘Attitudes toward the city’, p. 181.

¹²⁰ *Ibid.*

¹²¹ Examples of these include *Ráth Chaim*, Baile Ghib and Kilbride in Co. Meath, see Tom O’Donoghue and Teresa O’Doherty, *Irish speakers and schooling in the Gaeltacht, 1900 to the present* (Gwerbestresse, 2019), p. 143.

¹²² DOH, *Part ii: dietary survey of the Congested Districts*, p.3.

¹²³ DOH, *Part i: results from the Dublin investigation*, p. 15.

¹²⁴ *Ibid.*

¹²⁵ *Ibid.*, p. 13. Also see DOH, *Part iii: dietary survey of Large and Small towns*, p. 11.

For Deeny, the survey ‘must also be read in terms of the natural frugality of the Irish people, who are extremely simple and conservative in their food tastes.’¹²⁶ The government thus distanced themselves from the problem of malnutrition: a problem that only a few years ago they had been responsible for.

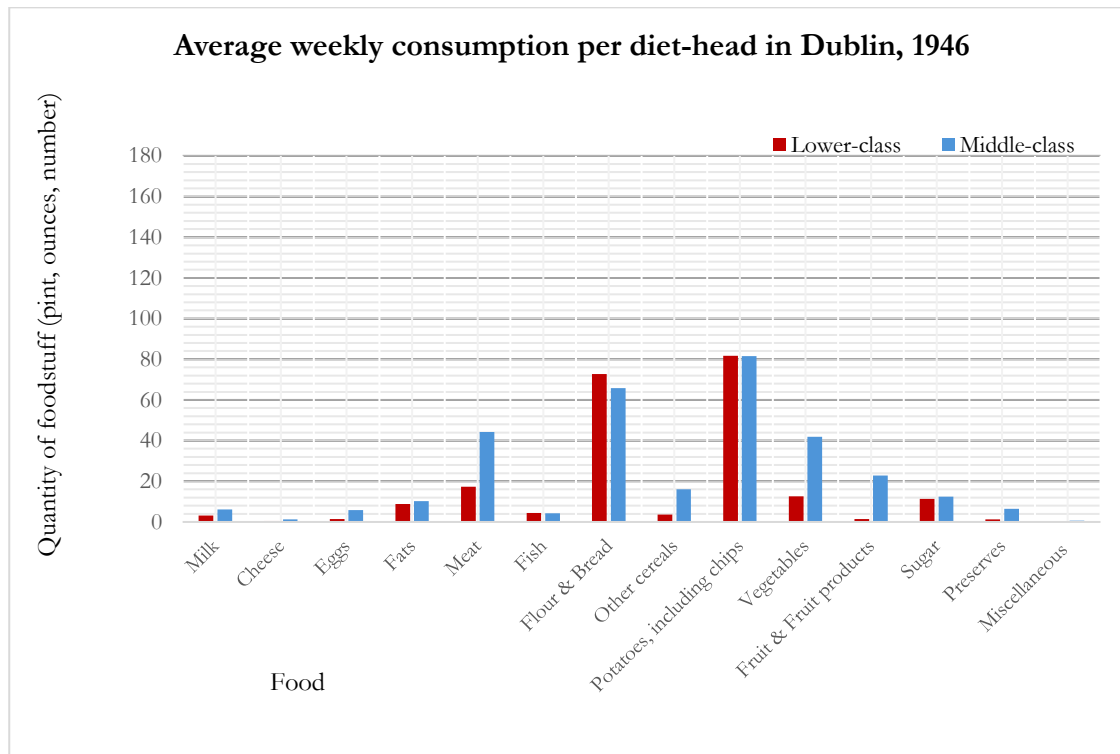


Figure 4.1 Average weekly consumption of food per diet head in lower-class and middle-class families in Dublin, 1946.¹²⁷

Irish household diets were significantly affected by wartime conditions. While the ‘war proper’ was over, the Emergency Powers Act was only revoked one year later on 2 September 1946.¹²⁸ Because Ireland continued to face supply issues, many of the controls introduced under the Emergency Powers Act remained in place well after the war had ended, what Bryan observes as the ‘Long Emergency’.¹²⁹ Rationing continued, and prices of foodstuffs remained high (see table 4.2).¹³⁰ As shown, the price of margarine had the biggest increase while prices of liver and corned beef (both of which have high protein content) also rose substantially. In this way, it is reasonable to assume that the Irish poor continued to consume less variety of foods. As shown in figures 4.1 and 4.2, the evidence suggests that the lower-classes also spent more money on more filling, but less nutritive foods, such as flour and bread. To this end, the diet consisted of

¹²⁶ Deeny, ‘Practical significance of the Irish national nutrition survey’, p. 295.

¹²⁷ Data re-produced from DOH, *Part i: results from Dublin investigation*, pp 23-24.

¹²⁸ Bryan, ‘Rationing in Emergency Ireland’, p. 281.

¹²⁹ Ibid.

¹³⁰ Figures accumulated from *Irish Housewife* (hereafter *IH*), Dec. 1946, p. 52.

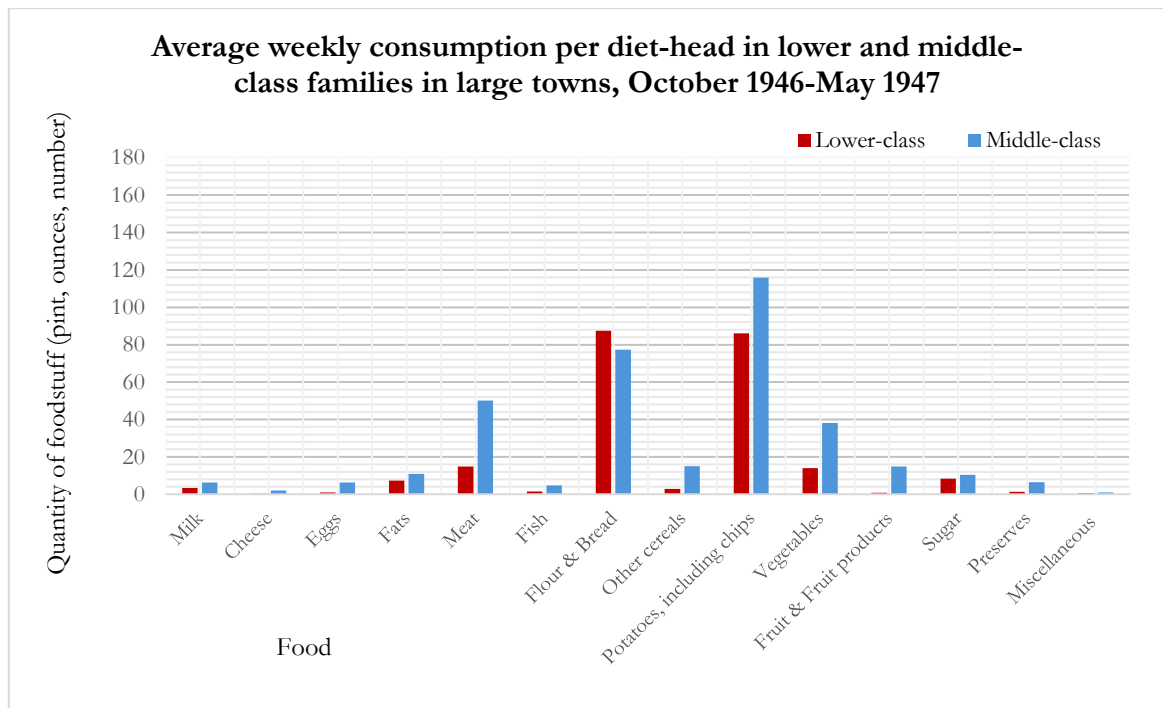


Figure 4.2 Average weekly consumption of food per diet head in lower-class and middle-class families in Large Towns, October 1946-May 1947.

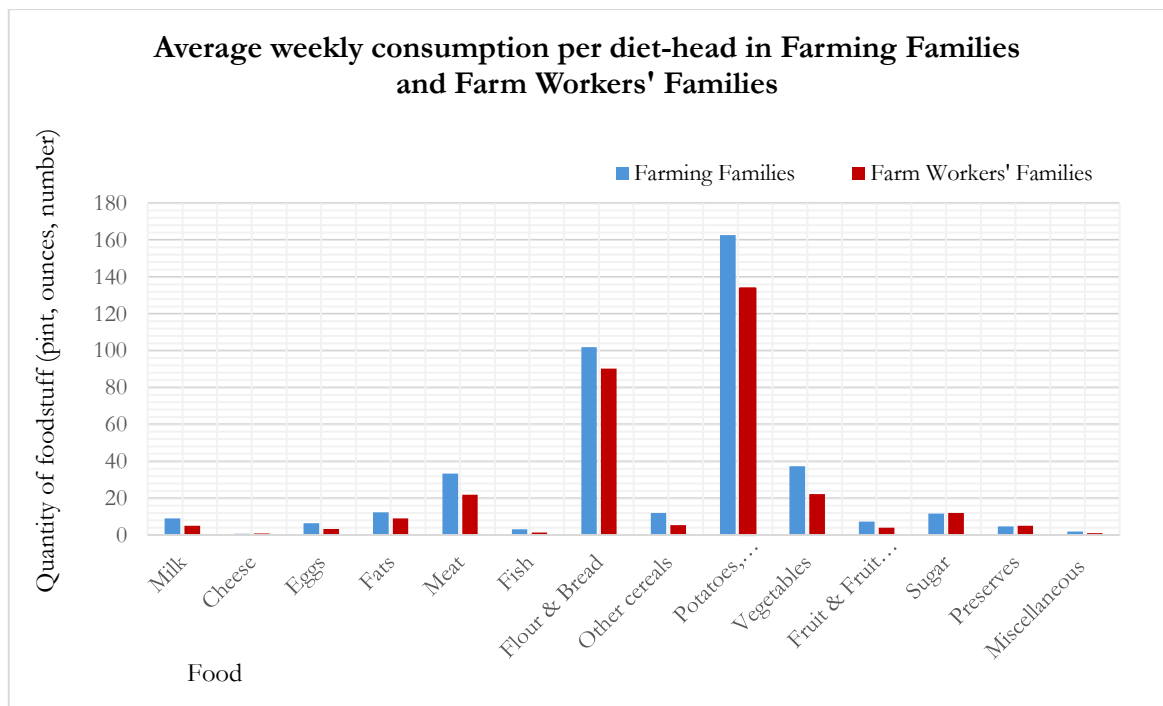


Figure 4.3 Average weekly consumption of food per diet head in Farming Families and Farm Workers' Families, October 1946-September 1948.¹³¹

¹³¹ Data re-produced from DOH, *Part iv: dietary survey of Farming Families* (Dublin, 1949), p. 16 and DOH, *Part v: dietary survey of Farm Workers' Families* (Dublin, 1950), p. 16.

bread and butter in the mornings and evenings, while jam and fish were occasionally added to supplement breakfast and tea.¹³² These foods also cost less to prepare.

Fuel shortages also led to an increased reliance on ready-cooked foods, and results suggest that these habits were maintained after the war proper had ended. Another contributing factor here was Ireland's so-called 'fuel famine' in 1947 in which Dublin and towns were particularly affected. This came after a particularly bad year for turf in 1946 which saw turf hauliers on strike.¹³³ The dietary surveys of Dublin, Large and Small towns, as well as the Congested Districts were carried out during this fuel crisis, and yet there was no mention of this in any of the reports.¹³⁴

The biggest concern of the nutrition survey was deficient calcium intake that was found in Dublin's poorest and biggest families.¹³⁵ As per the advice of the advisory committee on nutrition, the desired amount of milk was between 1-2 pints daily for children, 2 pints for expectant and nursing mothers and ½ pint was a good rule of thumb for adults.¹³⁶ In all Dublin families surveyed, calcium intake was 87% of the desirable amount.¹³⁷ In the lowest income group of slum families, calcium intake was only 51% of standard requirements, and artisan families consumed only 77% of requirement amount, or 2.7 pints of milk per head weekly.¹³⁸ The only exception to this finding in Dublin was among upper-class families, whose calcium intake was satisfactory. This problem also persisted in the small and large towns, but to a much lesser degree (95% and 86% respectively).¹³⁹ While Fianna Fáil anticipated that some of this deficiency would be remedied via flour fortification in June 1946, milk consumption in larger families still fell seriously below standard requirements, leading to the conclusion that 'the greater the need for milk, the less that need is met'.¹⁴⁰ Further, findings from the Dublin sample of the clinical survey indicated a 17.3% incidence of rickets in schoolchildren – not that far off the 1943 rickets survey that found the disease in almost one in every four Dublin children.¹⁴¹ These findings were disturbing given the rickets epidemic identified a few years before.

¹³² Adelman, 'Food in Ireland since 1740', p. 237.

¹³³ Ibid., p. 302.

¹³⁴ The dietary surveys were carried in Dublin between Apr.-Aug. 1946; in Large and Small Towns October 1946-May 1947, Congested Districts Sept. 1946-April 1947, Farming families Oct. 1946-Sept. 1948, and Farm Workers' families Oct. 1946-Sept. 1948.

¹³⁵ DOH, *Part i: results from the Dublin investigation*, p. 11.

¹³⁶ DOH memorandum on milk consumption, 20 Jul. 1948 (NAI, TAOIS S/12064).

¹³⁷ DOH, *National nutrition survey: parts i-vii: complete reports*, p. 11.

¹³⁸ Ibid.

¹³⁹ DOH, *Part iii: dietary survey of Small and Large towns*, p. 10.

¹⁴⁰ DOH, *Part i: results from the Dublin investigation*, p. 12.

¹⁴¹ DOH, *Part vii: clinical survey*, p. 18. Figure based on averages assumed from tables on boys and girls across various Dublin backgrounds.

Food Items	1939 Prices	1946 Prices	Increase %
<i>Margarine</i>	8d.	1s. 8d.	150%
<i>Liver</i>	10d.	1s. 10d.	120%
<i>Corned Beef Brisket</i>	7d.	1s. 2d.	100%
<i>Potatoes by stone*</i>	10d. - 1s.	1s. 6d. - 2s.	80-100%
<i>Tea</i>	2s.	3s. 8d.	83%
<i>Sausages (Pork)</i>	1s. 3d.	2s. 2d.	73%
<i>Bacon (Rashers)</i>	1s. 9d.	3s.	71%
<i>Sugar</i>	3d.	5d.	66%
<i>Flour by stone*</i>	2s. 6d.	4s.	60%
<i>Eggs (doz.)</i>	1s. 11d.	3s.	56%
<i>Mutton by breast*</i>	9d.	1s. 4d.	55%
<i>Cheese</i>	1s. 4d.	1s. 9d.	31%

**Prices are per lb. for food, unless stated otherwise.*

Table 4.2 Rising prices of foodstuffs in Ireland, 1939-45.¹⁴²

Romanticised visions of the healthiest Irish people were politically and economically far apart from real-life conditions. The largely agricultural Irish Free State that emerged onto the world stage did so in the middle of an agrarian depression, as observed by Patrick Doyle.¹⁴³ The final stages of the Anglo-Irish war coincided with the end of the agrarian boom that had begun during the First World War (1914-1918).¹⁴⁴ While Patrick Hogan was appointed the Minister for Agriculture in the country's first provisional government on 20 January 1922, Daly has found that he had 'more time' for larger commercial farmers, who were producing the bulk of Irish exports than for small farmers.¹⁴⁵ However, the shift of power in 1932 from Cumann na nGaedheal to Fianna Fáil was significant, symbolising the transfer of power from the political party that supported the Anglo-Irish Treaty to a party comprised of Republicans who were opposed to it.¹⁴⁶ While Fianna Fáil gave more attention to the needs of smaller farmers than the previous government during the 1930s, they did suspend the payment of British land annuities

¹⁴² *IH*, Dec. 1946.

¹⁴³ Patrick Doyle, *Civilising rural Ireland: the Co-operative movement, development and the nation-state, 1889-1939* (Manchester, 2019), p. 4.

¹⁴⁴ Daly, *The first department*, p. 4.

¹⁴⁵ *Ibid.*, p. 101.

¹⁴⁶ Doyle, *Civilising rural Ireland*, p. 190.

under the land purchase legislation, ultimately prompting the ‘Economic War’ with Britain- the main buyer of Irish agricultural goods.¹⁴⁷ Although farmers may have had many compensations in ‘the possession of land, in health, in security, in being free from direct taxation, in adequacy of food, in low rents and in other aspects which add up to a reasonable standard of happiness’, this did not apply to all, and especially so in the lead up to the Second World War.¹⁴⁸ When they emerged in 1939, self-sufficiency was transformed ‘from an ideal into a matter of national survival’.¹⁴⁹ Examples of this were found in the Chapter Two, where Irish farmers were consistently reminded of their duties in feeding the nation.

4.7 Policy implications of the survey

From a practical point of view, Deeny believed that the nutrition survey:

Has first of all given us a defined picture of the food situation in Ireland, which we had not before...We know now that generally the people of this country are very well fed, that there are small groups of poor persons, particularly those in large families in cities and towns, whose diet is defective in some respects and often monotonous.¹⁵⁰

These findings provided a means to identify population needs, by measuring ‘what is being done, against what could or should be done in the matter of ensuring a satisfactory diet for everyone’.¹⁵¹ In this way, there is much to be learned from the government’s response to what the survey identified as these population needs – improvements to so-called ‘bread and spread’ meals, monotonous diets and a calcium deficiency among those who earned less. Deeny acknowledged that efforts to improve national dietary would fall into two categories: relatively small short-term goals to counter-act specific deficiencies and then long-term projects to improve living conditions of the people by increasing productivity and purchasing power.¹⁵²

Despite the survey’s best intentions to capture the positions of the poor and vulnerable populations, there was little concrete policy change in its aftermath. Slight deficiencies and diet monotony aside, the findings of the survey undermined previous views during and after the war that mal nutrition in Ireland was common.¹⁵³ So ‘satisfactory’ were the survey results that Deeny pointed out that ‘they do give rise to a difficulty which is the fact that so many people are so

¹⁴⁷ Ibid., p. 166. Also see Daly, *The first department*, p. 162; Tony Farley, ‘Gaining ground, losing ground: the politics of land reform in twentieth century Ireland’ in Fergus Campbell and Tony Farley (eds), *Land questions in modern Ireland* (Manchester, 2013), p. 44.

¹⁴⁸ Geary, ‘Irish economic development since the Treaty’ in *An Irish Quarterly Review*, xl, no. 160 (Dec. 1951), p. 411.

¹⁴⁹ Daly, *The first department*, p. 209. For further reading around the decline of small farmers in Ireland, see Andy Bielenberg and John O’ Fagan, ‘The Irish working-class and the role of the state, 1850-2016’ in Eugenio F. Biagini and Daly (eds), *The Cambridge Social History of Modern Ireland* (Cambridge, 2017), p. 205.

¹⁵⁰ Deeny, ‘Practical significance of the Irish national nutrition survey’, p. 293.

¹⁵¹ Ibid.

¹⁵² Ibid., p. 295.

¹⁵³ J. M. O’Connor, ‘The origin and organisation of the Irish national nutrition survey’ in *BJN*, vi, no. 2-3 (Sept. 1950), p. 269.

well fed that it makes a difficult to make nutrition a real issue for the few not so well nourished'.¹⁵⁴ These findings were then deliberated in cabinet debates, but they almost always came up in a positive light. The only negative commentary on the survey in the cabinet was the delays involved in its publication, which Dr James Ryan (Minister for Health and Social Welfare, January 1947-February 1948) pointed out in March 1948:

The longer we go on the more out of date it becomes so that from the point of view also I think it should be published as soon as possible.¹⁵⁵

In his view, delays in publishing findings meant that the results lost meaning when it came to advocating for increased state supports. After all, Ryan believed that the survey could be used to help the government 'make up their minds as to what additional amount would be required by way of social welfare for people who are not in a position to help themselves'.¹⁵⁶ In the interim, his successor, Noël Browne took a slightly different approach as he raised questions about whether to include in the official publication of the national nutrition survey a table outlining Dublin's milk consumption.¹⁵⁷ With the exception of calcium, Browne believed the nutrient intake was 'broadly speaking, satisfactory at all levels of income, food expenditure and family size'.¹⁵⁸ Although these findings were included in the survey's full publication in 1953, this was likely because they could have been inferred from a careful examination of the other survey tables, rather than due to a desire for a full disclosure of the clinical state of nutrition in public records.¹⁵⁹

In terms of the actions that occurred, the government introduced a Land Reclamation Scheme to tackle the monotony of diet in rural districts, where £40 million was spent on draining marshes and bogs, fertilising poor land and reseeded vast areas.¹⁶⁰ Other smaller schemes included grants for tomato houses and a scheme of Parish Advisory Agricultural Agents.¹⁶¹ However, each of these measures were incentives for would-be farmers and landowners. For the calcium deficiency, one might expect immediate government measures to include increases in children's allowance, increases in the amounts of milk provided in the Free Milk Scheme, or even price controls on calcium-rich foodstuffs. None of this happened. Even as late as June 1949, Thomas Derrig (Fianna Fáil TD for Carlow-Kilkenny Constituency) claimed that 'nothing has been done about children's allowances', three and a half years since the survey was carried out in Dublin.¹⁶² Even though the children's allowance system that was put in place for married

¹⁵⁴ Ibid., pp 293-294.

¹⁵⁵ *DÉD*, 10 Mar. 1948, vol. 110, no. 4.

¹⁵⁶ Ibid.

¹⁵⁷ DOH memorandum on milk consumption, 20 July 1948 (NAI, TAOIS /S12064).

¹⁵⁸ *DÉD*, 1 July 1949, vol. 116, no. 11.

¹⁵⁹ Ibid.

¹⁶⁰ O'Connor, 'The origin and organisation of the Irish national nutrition survey', p. 294.

¹⁶¹ Ibid.

¹⁶² *DÉD*, 30 Jun. 1949, vol. 116, no. 10.

men since 1944 was framed within wider concerns for the upkeep of large families, the system that was introduced provided incremental payments to families with two or more children, meaning parents got less money for the more mouths they had to feed (see table 4.3).

Number of children	Amount payable per week
One child	7s.
Two children	14s.
Three children	18s. 6d.
Each additional child	4s. 6d.

Table 4.3: Children's allowance rates, updated 1 April 1950.¹⁶³

While these amounts eventually saw notable increases under the Social Welfare (Children's Allowances) Act, 1952, Patrick Beegan, Fianna Fáil TD, noted that payments were still only issued to married men, and problems of access remained in relation to widows where the payment was normally discontinued.¹⁶⁴ To this end, Finola Kennedy notes that William T. Cosgrave, the Leader of the Opposition at the time when Children's Allowances were first introduced, proposed the allowances should be paid to mothers, as they were most directly involved in meeting the family's needs.¹⁶⁵ This was rejected by Lemass, and child benefit was not paid to mothers until 1974, when Cosgrave was Taoiseach.

One of the key recommendations of the national nutrition survey was an emphasis on food education.¹⁶⁶ This not only involved raising awareness of the 'right' foods to buy; but also how foods should be cooked, and to the skills needed to fulfil these duties. While this shift back to a bottom-up approach to food policy may have suited the coalition's stance 'not to rock the boat', the education in 'good cookery' was not a new phenomenon in Ireland.¹⁶⁷ Miller has noted that it was in the early twentieth century that post-famine anxieties were beginning to be tackled in Ireland.¹⁶⁸ These anxieties were concerned with malnutrition and lack of knowledge of cookery and hygiene.¹⁶⁹ However, this position was hardened by an international rise in the

¹⁶³ DÉD, 4 Apr. 1951, vol. 125, no. 1 (Seán MacEoin, Minister for Defence).

¹⁶⁴ DÉD, 3 Jun. 1953, vol. 139, no. 5.

¹⁶⁵ Finola Kennedy, *Cottage to crèche: family change in Ireland* (Dublin, 2001), p. 217. For reference, see Eunan O'Halpin, 'Cosgrave, William Thomas' in *DIB (online)*, DOI: <https://doi.org/10.3318/dib.002077.v1>.

¹⁶⁶ DOH, *National nutrition survey: parts i-vii: complete reports*, p. 15.

¹⁶⁷ Niamh Puirseil, 'Labour and coalition: the impact of the first inter-party government, 1948-51' in *Saothar*, xxvii (2002), p. 60.

¹⁶⁸ Miller, 'Nutritional decline', p. 321.

¹⁶⁹ Ibid.

sensitivity to the health of infants and children. As Rutledge, Minister for Local Government and Public Health, pointed out in April 1940:

As time marches on, and as the children of to-day are the men and women of tomorrow, it is obvious that the training our girls receive under vocational education schemes will have very far-reaching effects in the future. The homes will be better, the dietary will be better, the cookery will be better, and in general, we may look forward to a brighter era as far as nutrition is concerned.¹⁷⁰

The ‘education of the people to buy the right things’ was not unique to Ireland; it was also prominent in UK medical discourse on nutrition at the same time.¹⁷¹ Similar to Fianna Fáil’s handling of significant outbreaks of gastro-enteritis during the war, the emphasis was on girls’ education as the solution to the nation’s nutritional issues, reflecting a policy stance that endorses minimal change.

Up until this point, family decisions about what to eat were primarily left to the housewives, though there was a temporary rise in nutritional awareness during and after the famine when critics recommended substitutes for the potato. Notwithstanding, it was widely accepted that Irish housewives’ ‘fundamental interests [were] centred on their homes, and the health and happiness of their families’.¹⁷² In the same way, it was the housewife who primarily bore the health responsibilities of her family. Even though there were substantial developments in medical science during the first half of the twentieth century, it was the housewife who tended to the needs of family members that fell ill, often with ‘the remedy in her own hands’.¹⁷³ When it came to food, the housewife was expected to notify the shopkeeper of any poor conditions and to refuse to buy ‘dirty food’.¹⁷⁴ However, the survey made these family decisions visible to the state through inspections. Household visits by women who were strangers to the families brought their private dietary habits under official examination for the first time. Implicit in state efforts to educate Irish women on the ‘right’ foods to buy and the ‘right’ ways to cook them is the notion that Irish households had been doing things incorrectly. As much as this highlights state attitudes towards Irish women, it also serves as a useful marker of official strategy.

State efforts to improve conditions were complicated by an inherent distaste for government intervention in private matters, which could also draw opposition from the Catholic Church and would be costly for the Irish state at a time in which Europe was only beginning to recover from the ramifications of war. According to Deeny, in Ireland ‘where freedom and liberty are prized, any administrative action in nutrition must be conditioned by the national

¹⁷⁰ Ibid.

¹⁷¹ Geoffrey H. Bourne, *Nutrition and the war* (Cambridge, 1940), p.3.

¹⁷² *IH*, Dec. 1948.

¹⁷³ Extract on public health matters, 1946 (NAI, Tweedy Papers, PRIV 98/17/1/5/1).

¹⁷⁴ Ibid.

dislike of regimentation or control'.¹⁷⁵ Because there was no longer a milk shortage in Dublin, Deeny believed that the problem lay instead in the public's choice not to consume the required amounts of milk.¹⁷⁶ He ignored the fact that the price of milk was almost three times higher in Dublin than in farming areas. Retail prices of milk during the first half of the survey period were 3s. 7d. per pint delivered to the door or 3s. 2d. per pint loose in the shops whereas the price on farms was 1s. 3d. per pint.¹⁷⁷ The price of bottle deliveries also rose during the second half of the survey to 4s. 25d. per pint bottle.¹⁷⁸ Mentioning that all the milk given in the school meals was not consumed, Deeny implied that the poor were at fault for not availing of this service, despite the fact that only 3.5 pints of milk were given in schools (desired amount was around 7 pints of milk per week):

I would point out also that all the milk given in the school meals is not consumed...There is no doubt that the services provided already are not fully utilized.¹⁷⁹

For Deeny, there should have been no child under five years of age in Dublin without milk as the Infant Aid Scheme was already in place, even though there were questions raised to the quality of this milk some years before.¹⁸⁰

Look at the rickets problem and then consider that there are literally dozens of centres and dispensaries where mothers can get free cod-liver oil and other preparations.¹⁸¹

As seen throughout the Chapter Two, the 'rickets problem' was a controversial issue, and Deeny was behind arguments to the Department of Supplies to reduce extraction rates and to fortify the flour with calcium. The finger of blame had moved to the working-class now that the war was over. This allowed the new coalition government to return to Fianna Fáil's bottom-up approach of educating the masses on the value of foods rather than increasing welfare benefits or introducing price controls.

4.8 Conclusion

The report of the nutrition survey suggested that nutritional deficits stemmed not from food composition but from the management of Irish households themselves. The evaluation of foodstuffs in relation to household earnings defined satisfactory nutrition as mainly an economic issue, and this is further indicated by the critiques of the 'bread and spread' meals

¹⁷⁵ Deeny, 'Practical significance of the Irish national nutrition survey', p. 293.

¹⁷⁶ *Ibid.*, p. 294.

¹⁷⁷ E. J. Sheehy, 'Agricultural implications of the results of the Irish national nutrition survey' in *BJN*, iv (1950), p. 285.

¹⁷⁸ *Ibid.*

¹⁷⁹ *Ibid.*

¹⁸⁰ *Ibid.*

¹⁸¹ *Ibid.*

typical of lower-income diet. This perspective suggested that those with monotonous diets did not enjoy a full measure of health at least in part because of poor food choices rather than low income alone. The view that the urban poor were unhealthy was reinforced while the middling farmers, who by circumstance had access to a wide range of foodstuffs, were confirmed as the most healthy citizens. Rather than providing a framework from which a national nutrition policy could be based, the nutrition survey in Ireland marked a point where ideas about nutrition and health became 'greened' as good nutrition became aligned with wider nationalist ideals of an idealised rural Irish society. This supports Evans's observation that the Irish people, whether in town or country, survived 'often *despite* rather than *because of* government policies behind the management of food', contrary to de Valera's vision of a self-sufficient Ireland.¹⁸²

This chapter has examined Ireland at a specific time where ideas about nutrition and health were first talked about on government levels. Up until this point, nobody really knew what levels of nutrition existed in Ireland. It is important to re-emphasise that there were several people involved in these debates on nutrition and health, each coming into this with pre-existing ideas with different interests and expectations. Speaking at a talk on the nutritive value of bread in the Royal College of Physicians on 20 January 1944, Dr Robert A. McCance (Reader in Medicine at Cambridge University), noted:

They knew now that national health owed more to the control of epidemic disease, to improvement in nutrition than to anything else, and in consequence of that medical men and administrators had responsibilities which they never had before.¹⁸³

In response, William Fearon, member of the Dietetic Council claimed:

we were being made not only food conscious but food conscientious.¹⁸⁴

This is important. When these questions of the relationship between one's diet and disease were first raised, nutrition was framed as a factor in the development of other diseases that were occurring at the same time. For example, questions of nutrition were also paramount to medical discussions around rickets and TB at the same time, as explored previously in Chapter Two. The nutrition problem was also closely linked to the child mortality rate. For Alfred Byrne (Independent TD), defects in childhood were partly due to 'want of proper feeding', i.e. sufficient amounts of the 'right' kinds of foods to ward off the onset of disease.¹⁸⁵ The politics of nutrition science in Ireland therefore encompassed more than just debates over food intakes and requirements. The issues were deeper and more extensive, ranging from the country's overall health performance to the realities of household wages and living conditions. All of

¹⁸² Evans, 'Food in Ireland in the 1930s and 1940s', p. 663.

¹⁸³ *IP*, 21 Jan. 1944.

¹⁸⁴ *Ibid.*

¹⁸⁵ *DÉD*, 4 Jul. 1947, vol. 107, no. 8.

CHAPTER FOUR

which were central components of government policy post-war to catch up on incentives that were occurring elsewhere. Thus, food control measures were embedded in the official layout of the new Department (see table 0.1).

CHAPTER FIVE

‘HE WANTS TO GO HOME’: IMPLICATIONS OF THE MENTAL TREATMENT ACT, 1945

5.1 Introduction

Ireland’s Mental Treatment Act 1945 aimed to revolutionise admission procedures in Ireland and to provide for the prevention, treatment and care of those with mental disorders in Irish institutions. During a Dáil debate on the new legislation, Helena Concannon (Fianna Fáil TD), remarked that:

while almost the whole outside world is a victim of the worst form of insanity which has ever afflicted humanity – total war – we are privileged to spend this beautiful spring day planning, at our undisturbed leisure, for the cure and care of our mentally afflicted and for the prevention of mental disease among our people.¹

This quote reminds us just how significant this time was for the coming piece of social legislation. Just days earlier, the front page of the *Irish Press* had noted how the forces of the Nazi state were crumbling in the face of consecutive Allied victories in Europe, while the US retribution on Japan for the Pearl Harbour attacks was also underway.² The Fianna Fáil government, by virtue of its neutrality, focused on domestic affairs in Ireland as they sought to push the act through the Dáil. Similar to the Irish national nutrition survey, plans to revolutionise mental health care policy were well underway during the war.³ Official deliberations on legislative reforms began as early as August 1941. Out of sync with the ‘modern concept of mental disorder and its treatment’, the existing laws surrounding lunacy were perceived as ‘defective in many ways’.⁴ It was admitted that the bill was long over-due, and steps had already been taken in England and Northern Ireland.⁵ New provisions were to work towards decreasing asylum numbers and removing the stigma around this disease. To this end, the bill was praised for being as up-to-date as it could have been and ‘one of the most important that has been introduced by either of the two governments’ since independence.⁶ The passage of the bill was also an example of how the Irish government sought to catch up with developments in Northern Ireland and the UK.

¹ *DÉD*, 19 Apr. 1945, vol. 29, no. 25.

² *IP*, 14 Apr. 1945, p. 1.

³ See DLGPH memorandum on proposed bill dealing with the amendment of lunacy laws, 27 Aug. 1941 (NAI TAOIS S/12573).

⁴ DLGPH memorandum on proposed bill dealing with the amendment of lunacy laws, 27 Aug. 1941 (NAI TAOIS S/12573).

⁵ *DÉD*, 19 Apr. 1945, vol. 29, no. 25 (Seán Ruane).

⁶ *Ibid.*

Until the 1930s, treatments for mental illness were primarily focused on patient management through restraints, sedative drugs and seclusion.⁷ These were mainly ‘management’ interventions, and therefore not usually administered with curative aims. However, psychiatric developments in the 1930s and 1940s, influenced by the experiences of two world wars, prompted a renewed interest in mental health as well as a determination that institutions should perform a curative function with the aim of discharge.⁸ New therapies such as insulin coma therapy (ICT), electroconvulsive therapy (ECT) and lobotomy were introduced into Irish district and auxiliary mental hospitals and they equipped the Irish medical profession with new ways to treat mental illness, especially in its most severe and long-term manifestations such as chronic schizophrenia and manic depression.⁹ Together, these developments prompted a focus on early diagnosis and treatment, as well as the widespread belief that prompt intervention could increase the likelihood of recovery. This shift in approach was reflected in the Mental Treatment Act 1945, which emphasised early diagnosis and early treatment.

The act itself also came at a crucial turning point in the development of other significant public health reforms during the 1940s. In contrast to the previous chapter where nutrition was given a heightened importance due to its role in other illnesses such as tuberculosis and the health of infants and children, the issue of ‘mental illness’ was approached with less urgency, as demonstrated by the cabinet debate of this chapter’s opening. In part, this was because there was no tangible evidence that suggested an increase in the number of people institutionalised with mental illness as a direct result of the war, though one could assume that people’s experiences of mental illness may have been exacerbated because of wartime conditions. Instead, Fianna Fáil were dealing with an existing problem, ‘inheriting an overcrowded and under-funded mental healthcare system’ from the UK, only to see Ireland’s asylum residence increase steadily during the first two decades of Irish independence.¹⁰

The aim of this chapter is to examine the introduction and immediate post-war impact of the Mental Treatment Act on the patients it primarily affected. New medical views and psychiatric treatments may have led Fianna Fáil to change legislation to facilitate patient movement in and out of district mental hospitals, but this does not necessarily mean that patients benefited. This will involve an examination of the motivations for the Act through

⁷ Fiachra Byrne, ‘Madness and mental illness in Ireland: discourses, people and practices, 1900 to c. 1960’ (PhD, UCD, 2011), p. 77.

⁸ Brendan Kelly, *Hearing voices: the history of psychiatry in Ireland* (Dublin, 2016), pp 142-144.

⁹ The introduction of new therapies in Irish mental institutions occurred gradually throughout the 1930s and 1940s. For further details, see ‘General conditions’ in *Annual report of the Inspector of Mental Hospitals* (hereafter *ARIMH*), 1939-1950 (Dublin, 1951). For conditions treated, see G. E. Berrios, ‘The scientific origins of electroconvulsive therapy: a conceptual history’ in *History of Psychiatry*, viii, no. 29 (1997), pp 105-119.

¹⁰ Verusca Calabria and Lynsey T. Cullen, ‘Deinstitutionalisation and the move to community care: comparing the changing dimensions of mental healthcare after 1922 in the Republic of Ireland and England’ in *History of Psychiatry*, xxxv, no. 2 (2024), p. 144. For figures, see *ARIMH, 1922-1955* (Dublin, 1956), consecutive years.

analyses of *Annual Reports of the Inspectors of Mental Hospitals* and contemporary medical works of practising psychiatrists and attendants – the same evidence that was used to inform the legislation. Insights will also be drawn from admission records in Grangegorman Mental Hospital in Dublin and the *Registrar of Deaths and Discharges* in St. Conal's District Mental Hospital, Donegal, allowing comparison of urban and rural mental hospitals (Appendix G outlines these permissions).¹¹ To examine the impact of the legislation, this chapter will outline hospital usage post-war, and careful consideration will be given to a treatment book in St. Conal's hospital, which contains the treatment records of 141 patients over an eighteen month period. For a view of the types of data gathered, see Appendix H.

This chapter contends that Fianna Fáil's primary goal was to decrease the number of patients in these institutions to reduce their financial burden on the hospitals and the Exchequer. While these reforms aimed to modernise mental health care in Ireland, they also prioritised cost-cutting, often at the expense of patient experience. Efforts to quickly reduce populations in mental hospitals were unsuccessful, and patient numbers peaked in the 1950s, exacerbating existing pressures on the system. Meanwhile, the new therapies were the closest thing that the psychiatric profession had to a cure in most acute cases, but the continued use of these treatments to manage behaviour amid mounting institutional pressure suggests that the act had failed to change the 'management culture' of the mental hospitals.

5.2 Legacies of mental healthcare legislation abuse

In the nineteenth and twentieth centuries, asylums were the main form of care for patients suffering from mental illness in Ireland and elsewhere in Europe. While these were intended as a public resource and as places of care for distressed and 'very often violent individuals', a person could only access care if they were certified as a 'Dangerous Lunatic', or as a lunatic, idiot or person of unsound mind.¹² To be admitted, a person was considered by the asylum manager, physician and a medical certificate of insanity followed by legal assurances of poverty from the patient's family. The 1838 Dangerous Lunatics (Ireland) Act and the Central Criminal Lunatics Asylum Act 1845 changed the admission procedures to include evidence under oath of how dangerous a person was.¹³ On this conviction, patients had to be classed as dangerous to self or others while the accusation against them required that they be detained for an indefinite period.¹⁴

¹¹ Level one access to the records of Grangegorman and St. Conal's District Mental Hospitals was granted for the purposes of this PhD. It is with regret that the same was not secured for the records of other institutions, despite many Freedom of Information requests. The writings of psychiatric doctors will be used to fill necessary gaps on details in other institutions, as will departmental records.

¹² Joseph Robins, *Fools and mad: a history of the insane in Ireland* (Dublin, 1986), p. 146.

¹³ Kelly, 'The Mental Treatment Act 1945 in Ireland: an historical enquiry' in *History of Psychiatry*, xix, no. 1 (2008), p. 52.

¹⁴ In the early twentieth century, Connolly Norman (RMS of Richmond Lunatic Asylum) encouraged his students to keep in mind any nuances in 'normal behaviours' when assessing one's mental state, see *Connolly Norman lectures, Grangegorman*, 10 Mar. 1905, (RCPI, CN/1/4).

The ease with which someone could be detained for an indefinite period of time meant that this system could be misused and abused by friends and family, and for various reasons. Because patients could be admitted on the evidence of another person, this allowed for what Oonagh Walsh notes as ‘quite exceptional powers of committal to ordinary citizens’.¹⁵ As opposed to an unusually high incidence of insanity in Ireland, the argument has been made that the asylum possessed significant social influence in Ireland.¹⁶ Rather than Irish people having some unusual pre-disposition to insanity, the system that was in place was significantly abused.

Following the foundation of the Irish Free State in 1922, Brendan Kelly argues that both Cumann na nGaedheal and subsequently Fianna Fáil ‘simply took over the Irish asylum system’ and there was therefore no essential re-evaluation of the then widely accepted idea that insanity was very prevalent in Ireland.¹⁷ This may be further emphasised by a lack of investigations into the incidence of mental illness – there were no official investigations into the rise in mental illness between 1922 and 1945. Even when the Mental Treatment Act was passed, this did not coincide with any new government investigation. However, this is not to say that there were no inquiries into the conditions of the institutions. As early as 1927, the Commission on the Relief of the Sick and Destitute Poor, including the Insane Poor, urged a re-evaluation of existing provisions for the mentally-ill, and recommended a voluntary admission status in addition to the provision of outpatient clinics.¹⁸ Despite this, no legislative action by way of reform came until the Mental Treatment Act 1945. This is surprising because the care of the mentally-ill formed what Hensey calls ‘the greatest single unit in the health services at the time’, as seen in Chapter One.¹⁹ Because of this, it is necessary to examine the evidence that informed the new legislative reforms at this time.

In some scenarios, abuses of the existing laws surrounding mental illness in Ireland meant that mental illness or evidence of mental illness was not always the clear reason for committal. Using the records of the Carlow District Asylum in the nineteenth-century, Catherine Cox moves beyond a strictly institutional approach to provide a cultural and social history of the asylum, noting the extent to which poor law guardians, magistrates, dispensary and asylum doctors and patient families each manoeuvred around the boundaries of the existing asylum system to fit their needs.²⁰ Most committals were done by family members, and it was not uncommon for families to remove relatives from these institutions to work in the summer

¹⁵ Oonagh Walsh, ‘Cure or custody: therapeutic philosophy at the Connaught district lunatic asylum’ in M. Preston and M. Ó hÓgartaigh (eds), *Gender and medicine in Ireland, 1700-1950* (New York, 2012), p. 72.

¹⁶ Catherine Cox, *Negotiating insanity in the southeast of Ireland, 1820-1900* (Manchester, 2012), p. 240.

¹⁷ Kelly, *Hearing Voices*, p. 64.

¹⁸ Saorstát Éireann, *Report of the Commission on the Relief of the Sick and Destitute Populations, including the Insane Poor* (Dublin, 1927), pp 114-115.

¹⁹ Brendan Hensey, *The health services of Ireland* (2nd ed., Dublin, 1972), p. 7.

²⁰ Cox, *Negotiating insanity in the southeast of Ireland*, p. 240.

and then return them again in the winter.²¹ When the vitality of the traditional Irish family unit is placed within a wider context of high unemployment and chronic migration, then it is unsurprising that the existence of an asylum in any given area equipped the community with ‘a major source of social security’.²² This may be further emphasised by the rather prominent pattern of over-representation within asylums in the West of Ireland.²³

While the reasons for committal varied from family to family, there are instances where patients were admitted because they posed a particular type of ‘problem’ that was not related to mental illness itself. For example, John, a middle-aged labourer was admitted by his wife on a Dangerous Lunatic Form to Grangegorman Mental Hospital in June 1940 for having threatened the life of his wife and son.²⁴ While he appeared ‘dull’ and only ‘mildly depressed’ on admission, he denied that he had in any way threatened his wife or any member of the family, and was discharged ‘recovered’ less than a month later.²⁵ Another patient, unemployed, was admitted by his brother in October of the same year.²⁶ This man was rambling and voluble in speech, and stated that ‘he had been doing the housework at home for his brothers and as a result got a nervous breakdown’.²⁷ In May 1942, another patient, twenty years old, spent a full year in Grangegorman because he stole a telephone directory from a kiosk.²⁸ On admission, this patient appeared ‘dull, apathetic’ and ‘confused’, and could not be traced afterwards when a nurse from Grangegorman After-Care Committee tried to locate him.²⁹ As evidenced, the first patient was committed on the grounds of domestic violence, and not mental illness *per se*. The second, admitted seemingly as a result of a brotherly-quarrel over household duties, equally did not specify admission by reason of insanity. Notwithstanding, there is evidence to suggest that this patient could have been difficult to deal with, or perhaps had some form of learning disability while the last patient was admitted seemingly for theft. None of these patients had a specific diagnosis of mental illness. However, this was not unique to Ireland. People were admitted for similar reasons in the UK. In her compelling examination of the ‘moral imbecile’ category introduced under Britain’s 1913 Mental Deficiency Act, Sarah Wise explores how this new diagnosis allowed children and adolescents, who appeared to show anti-social tendencies could

²¹ Kelly, *Hearing voices*, p. 3.

²² Brennan, Damien, *Irish insanity: 1800-2000* (London, 2013), p. 68.

²³ Kelly, *Hearing voices*, p. 3.

²⁴ Real name of patient has been pseudonymised for reasons of anonymity. See *Grangegorman After-Care Committee report, 1940-1944* (NAI, PRIV/1223/13/1 A1), pp 1-2.

²⁵ Ibid.

²⁶ Ibid., p. 15.

²⁷ Ibid.

²⁸ Ibid., p. 120.

²⁹ Ibid.

be sent to colonies with no time period.³⁰ By the late 1940s, an estimated 50,000 people were detained in Britain under this category.³¹

Evidence gathered in Ireland from both Grangegorman and St. Conal's hospitals suggests that family members perceived the asylum as a space of care for their relatives. In December 1942, Stephen, aged nineteen and 'epileptic since infancy' was admitted by his mother to Grangegorman on the basis of 'violence'.³² While he had two epileptic seizures while there, the Grangegorman After-Care Committee noted that 'he was rational most of the time' - enough reason for his discharge three months later.³³ When his mother received the news of his discharge, she wrote a letter to the committee, claiming:

But I am not able to look after him as I am in delicate health and my husband is at work all day so I would like you to tell him that he would have to stay another few months until he is better as I would take him only I have nobody to look after him.³⁴

This demonstrates the extent to which his mother was a key negotiator in his discharge and how a family's circumstances might impede their ability to provide care. Instances such as this can also be found in the records of St. Conal's hospital. Between January 1939 and October 1944, 12% of the patients who died in St. Conal's hospital died within three months.³⁵ This suggests that some patients may have been brought to the mental hospital when they were already suffering from physical diseases such as heart and kidney disease, pulmonary tuberculosis, syphilis, cancer and cerebral haemorrhage.³⁶ While not all of these diseases showed symptoms in every case, TB, syphilis and kidney disease did and these worsened gradually closer to the onset of death. For instance, research has shown that a pulmonary TB sufferer could have the disease for a duration of three years before death or recovery, and it is probable that the patient's experience of this disease was magnified at such a time as when they were committed.³⁷

Over sixty percent of those who died in St. Conal's hospital within three months were over fifty-five years old.³⁸ County homes, originally remodelled from the old workhouses of the

³⁰ Sarah Wise, *The undesirables: the law that locked away a generation* (London, 2024).

³¹ *Ibid.*, pp xvii-xviii.

³² *Grangegorman After-Care Committee report, 1940-1944* (NAI, PRIV/1223/13/1 A1), p. 104.

³³ *Ibid.*

³⁴ *Ibid.*

³⁵ *Registrar of discharges and deaths in St. Conal's hospital*, 6 Jan. 1939- 17 Nov. 44 (MED 4/5/5/2).

³⁶ *Ibid.*

³⁷ E. W. Tiemersma, Marieke J. Van de Werf, Martien Borgdorff, Brien Williams and Nico Nagelkerke, 'Natural history of tuberculosis: duration and fatality of untreated pulmonary tuberculosis in HIV negative patients: a systematic review' in *Plos One*, vi, no. 4 (2011), p. 9.

³⁸ *Registrar of discharges and deaths in St. Conal's hospital*, 6 Jan. 1939- 17 Nov. 44 (MED 4/5/5/2). Five months, from May-Sept. 1943, are missing from the data for unknown reasons. This omission is not expected to have a significant impact on the overall statistical findings. For example, in 1940, 1941, and 1942, 64% of those who died within three months were over the age of fifty-five. In 1944, 60% of those who died were over the age of fifty-five. For available data in 1943, 50% of those who died were over the age of fifty-five, with the expectation that this percentage would be higher if the missing records were included.

1920s, were intended to care for the aged and infirm, but conditions were far from satisfactory.³⁹ Despite being theoretically reserved for this population, these homes became ‘repositories for all types of conditions of poor persons’.⁴⁰ By the 1940s, the county homes housed a diverse population group including the elderly, mentally ill, people with long-term illnesses, and unmarried mothers with their children – a ‘miscellaneous population for which no special provision had been made’.⁴¹ Although some improvements were made to these buildings during the inter-war period, most improvements were made to the county hospitals and the homes generally failed to provide satisfactory homes which they were not designed to serve in the first place.⁴² Historians such as Sarah-Anne Buckley and Ciara Breathnach have examined these county homes in relation to the predicaments of unmarried mothers and their children, but they were also an important place of care for the elderly.⁴³

In 1938, concerns over the growing use of the asylums to house a variety of populations were voiced by John Dunne, Grangegorman Chief Resident Medical Superintendent (RMS).⁴⁴ In relation to the elderly, Dunne observed that:

A considerable number of old people who have merely become troublesome on account of their age are certified and detained in the mental hospital. My experience is that the majority of these old people merely need supervision, care and comfort. They are fairly easily managed, and it is repugnant to think that they should have to associate for the remaining years of their life with the troublesome insane.⁴⁵

Dunne believed that the mental hospital was not an appropriate place for the elderly, and that they should be housed away from the parent institution in a villa colony.⁴⁶ In his view, the elderly, like senile, epileptic and chronic patients, were incurable.⁴⁷ The predicaments of chronic patients, he believed, were a direct result of the absence of a voluntary admission status, whereby patient conditions had significantly worsened over time because these patients went without treatment.⁴⁸ It was these patients that ‘swell our numbers’, making it more difficult for the institutions to perform a curative function.⁴⁹ Because of little government action, Dunne advocated that chronic patients be handed over to the religious orders, where ‘only those with a true vocation and the highest altruistic and charitable motives are capable of withstanding the

³⁹ DOH, *First report of the Department of Health, 1945-1949* (Dublin, 1950), p. 62.

⁴⁰ Hospital's Trust Ltd., *Ireland's Hospitals, 1930-1955* (Dublin, 1956), p. 16.

⁴¹ DOH, *Reconstruction and improvement of county homes* (Dublin, 1953), p. 7.

⁴² Hospital's Trust Ltd., *Ireland's Hospitals, 1930-1955* (Dublin, 1956), p. 16.

⁴³ Jyoti Atwal, Ciara Breathnach and Sarah-Anne Buckley (eds), *Gender and history: Ireland, 1852-1922* (London, 2023). For discussions on county homes, see pp 130-139 and pp 77-89.

⁴⁴ *Joint Committee Grangegorman Report no. 1070*, 3 Mar. 1938, p. 184 (DDA, McQuaid papers, 2/39/1/4).

⁴⁵ *Ibid.*, p. 195.

⁴⁶ *Ibid.*

⁴⁷ *Ibid.*, pp 194-195.

⁴⁸ *Ibid.*, p. 190.

⁴⁹ *Ibid.*, p. 184.

dreary work of constant association and attendance to them'.⁵⁰ At this time, it is important to note that the Catholic Church was not directly involved in the provision of psychiatric care. While there were chaplains in the mental hospitals and religious figures on the Boards of Governors, these institutions were, as Kelly notes, linked to other government institutions, such as prisons and workhouses, rather than general medical hospitals, where the Catholic Church were directly.⁵¹

Dissatisfied with little government improvements to improve the conditions found in Irish district and auxiliary mental hospitals, Dunne wrote to Archbishop John Charles McQuaid, in November 1942, where he enclosed a copy of this report.⁵² Although Dunne acknowledged that there were rumours of new legislation coming, this was happening without the advice of those 'best qualified to advise'.⁵³ By contrast, McQuaid had taken an interest in the educational areas of Ireland's psychological branch of medicine. The archbishop came from a medical family – his father, two siblings and uncle were doctors, and he had met with Dunne to discuss these matters.⁵⁴ This is an important point because in the absence of sustained government intervention, the medical profession advocated increased charitable endeavours into these areas, even if it was to simply push the Department of Local Government and Public Health into remedial action.

This is not to say that people were not admitted to the district mental hospitals due to mental illness. Focusing explicitly on the twentieth century, Fiachra Byrne examines the experiences of patients in Grangegorman and Our Lady's District Mental Hospital in Clare and St. Patrick's, Dublin. He focused on how patients constructed their experience with doctors and the influence of families in the wider processes of committal, discharge and diagnosis of mental illness.⁵⁵ In March 1941, an admission warrant in Grangegorman detailed a patient that 'has been obsessed with the idea that he will take his wife's life'.⁵⁶ On admission, the patient explained that he had been 'greatly troubled by the fear that he would injure his wife'.⁵⁷ Even after the Mental Treatment Act 1945, there is evidence of patients using the 'voluntary admission' status to place themselves into the asylum for a break away from conditions on the outside. In July 1949 for example, Denis decided, after a trial away from St. Conal's District Mental Hospital in Donegal, that he was actually 'happier' inside the institution, for it was 'too quiet outside'.⁵⁸ This

⁵⁰ Ibid., pp 195-196.

⁵¹ Kelly, *Inside Grangegorman* (Dublin, 2023), p. 130.

⁵² John Dunne to John C. McQuaid, 24 Nov. 1942 (DDA, McQuaid papers, L2/39/1/2).

⁵³ Ibid.

⁵⁴ Ibid. For reference, see Deirdre McMahon, 'McQuaid, John Charles' in *DIB (online)*, DOI: <https://doi.org/10.3318/dib.005755.v1>.

⁵⁵ Byrne, 'Madness and mental illness in Ireland', p.7.

⁵⁶ *Grangegorman After-Care Committee report, 1940-1944* (NAI, PRIV/1223/13/1 A1), p. 25.

⁵⁷ Ibid.

⁵⁸ Real name of patient has been fictionalised for reasons of anonymity. See *Observations and treatment book in St. Conal's hospital*, 30 Jul. 1949 (MED 4/5/8/3).

supports wider arguments that the mental hospital also offered its patients refuge from the harsh realities of the outside world.⁵⁹ When this is examined in light of the above, the evidence corroborates David Wright and Roy Porter's definition of the asylum as 'a contested site' that was not only a space for care and cure, nor just a 'convenient place for locking up inconvenient people', but one that was 'many things at once'.⁶⁰ Ireland had more psychiatric beds than beds available in TB sanatoria and prisons combined.⁶¹ This had significant implications for the conditions of these asylums.

5.3 Deteriorating conditions in Irish District Mental and Auxiliary Hospitals

With the exception of the two world wars, residence in Irish mental hospitals increased steadily after independence (see figure 5.1). As shown, the number of patients in Irish district and auxiliary mental hospitals in 1926 was 16,708 and this represented a 5.3% increase on the country's 1922 independence figure. By 1951, this had increased to 18,797 patients, over three times the percentage increase seen two decades previous. Damien Brennan suggests that

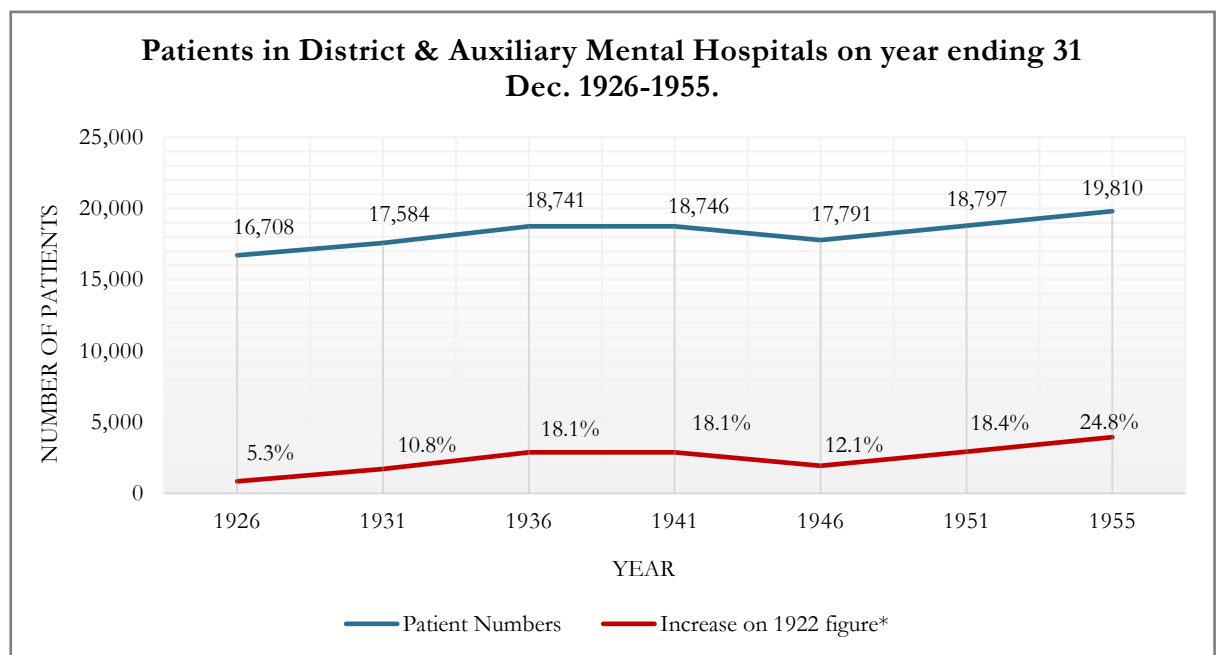


Figure 5.1 Patients in Irish District & Auxiliary Mental Hospitals, 1926-1955 with corresponding increase from Irish independence.⁶²

Ireland's rate of asylum usage was higher than anywhere else in the world in the first half of the twentieth century.⁶³ Ireland had the highest number of beds per capita in Western Europe by

⁵⁹ Mark Finnane, *Insanity and the insane in post-famine Ireland* (London, 1981), p. 13.

⁶⁰ David Wright and Roy Porter (eds), *The confinement of the insane* (Cambridge, 2003), p. 4.

⁶¹ Kelly, *Inside Grangegorm* (Dublin, 2023).

⁶² ARIMH, 1922-1955. Data taken from consecutive years, pp 21-46.

⁶³ Damien Brennan, *Irish insanity: 1800-2000* (London, 2013), p. 65.

the mid-twentieth century, making it seem as if an epidemic of mental illness was in full swing.⁶⁴ Adding substance to this belief was the frequency of asylum usage in the UK by Irish immigrants – a phenomena relatively well-recognised within Irish historiography.⁶⁵

A rising mental hospital patient population in Ireland posed an increasing financial burden on the mental hospitals themselves as well as on the Irish Exchequer. In 1935, there were a total of eighteen district and auxiliary mental hospitals in the Irish Free State.⁶⁶ Unlike other Irish institutions that catered for vulnerable people, such as mother and baby homes and industrial schools, Irish district mental hospitals were state-run and defrayed by the rates of the County and County Borough Councils.⁶⁷ The mental hospitals also received state grants from the Hospital Sweepstakes via the Hospital Trust Fund (from 1930) as well as a capitation grant that paid a per-capita price per patient in these hospitals.⁶⁸ While patient contributions were made to these hospitals from patients who had the means, the amounts received did little to alleviate institution costs.⁶⁹ There were a number of factors in hospital costs. Typical expenditures included salaries and wages, superannuation, provisions and groceries, medicines and medical appliances, clothing, bedding and furniture, fuel and light, farm and garden, repairs, and repayments of loans.⁷⁰ In relation to the loans, it should be noted that these hospitals were in capital debt since before Irish independence and merely carried these debts over year on year.⁷¹ Meanwhile, the expenses of each institution varied, and often this depended on the standard of care and treatment (which included the dietary, proportion of staff to patients etc.), the area of land attached to the mental hospital and whether revenue could be generated from the farm to offset other costs, as well as the size of the mental hospital.⁷² Usually, the bigger the institution the lower the average cost per patient.⁷³ For example, institutions with large farms attached were often self sufficient and supplied the needs of the hospital.⁷⁴ These institutions also received income from farm produce sold to nearby towns and they received higher capitation grants than those hospitals with fewer patients.⁷⁵

⁶⁴ Simon Goodwin, *Comparative mental health policy: from institutional to community care* (London, 1997), p. 26.

⁶⁵ Cox, Hilary Marland and Sarah York, 'Itineraries and experiences of insanity: Irish migration and the management of mental illness in nineteenth-century Lancashire' in Cox and Marland (eds), *Migration, health and ethnicity in the modern world* (London, 2013), pp 36-60.

⁶⁶ *ARIMH, 1935* (Dublin, 1935), p. 11.

⁶⁷ *Ibid.*

⁶⁸ *Ibid.*

⁶⁹ *Ibid.*

⁷⁰ *ARIMH, 1941* (Dublin, 1942), p. 11.

⁷¹ *ARIMH, 1935*, pp 13-14.

⁷² *Ibid.*, p. 14.

⁷³ *ARIMH, 1941*, p. 13.

⁷⁴ *Ibid.*, p. 14.

⁷⁵ *Ibid.*, p. 44.

Year ended 31 March	Average cost per patient		
	£	s.	d.
1930	43	4	0
1931	42	14	11
1932	41	8	11
1933	40	16	0
1934	39	17	8
1935	39	18	6
1936	42	3	1
1937	43	1	8
1938	46	10	2
1939	48	5	4
1940	50	11	4

Table 5.1 Average cost per patient in all district mental hospitals in the ten financial years up to 31 March 1940.⁷⁶

Rising patient numbers during the first two decades of Irish independence exacerbated the financial woes of the Irish mental hospitals. On an institutional level, more patients meant more beds, more mouths to feed and more treatment services to provide. While Cormac Ó Gráda and Kevin Hjortshøj O'Rourke maintain that Ireland performed as well as it could have on a national level during the inter-war period, agriculture suffered badly on the back of the Great Depression and the Economic War as inflation increased.⁷⁷ The average cost per patient in Irish mental hospitals also rose concurrently (see table 5.1). These average costs did not include sums that were used by the mental hospitals to go towards repayment of loans (see table 5.2). Between 1930 and 1940, the expenditure of district mental hospitals grew by 24%, while their collective debt balances increased by 46%. Not only were there more patients in mental hospitals, but these patients were getting more expensive to maintain. To make matters worse, growing expenditure in these institutions was not met by a corresponding increase in state funding as there was only a 9% increase in the amount the state's capitation grant (see table 5.2 and figure 5.2). While this confirms what Dermot Walsh and Antoinette Daly describe as 'what many saw as obstructionism as a means to keep costs down', the situation was such that Irish mental hospitals had more patients than they could support.⁷⁸ Historians have previously questioned why it took so long in Ireland to reform mental health legislation from the old

⁷⁶ *ARIMH, 1935*, p. 15 and *ARIMH, 1941*, p. 13.

⁷⁷ Cormac Ó Gráda and Kevin Hjortshøj O'Rourke, 'The Irish economy during the century after partition' in *The Economic History Review*, lxxv, no. 2 (2022), p. 340.

⁷⁸ Dermot Walsh and Antoinette Daly, *Mental illness in Ireland: reflections on the rise and fall of institutional care, 1750-2002* (Dublin, 2004), p. 34.

Year	Expenditure £	Outstanding capital debt £	Capitation Grant £	Daily average number of patients
1930	834,971	468,743	148,702	17,328
1931	826,751	452,086	150,768	17,409
1932	813,120	513,257	153,252	17,549
1933	806,346	519,674	150,155	17,742
1934	807,955	550,287	152,786	18,038
1935	824,740	558,934	154,495	18,366
1936	878,246	642,558	161,888	18,500
1937	914,003	664,782	155,764	18,635
1938	987,823	765,672	159,888	18,852
1939	1,046,308	796,007	162,648	18,910
1940	1,103,447	869,057	163,207	18,993

*Figures are rounded to the nearest pound.

Table 5.2 Mental Hospital Committee expenditures, balances of outstanding capital debt and receipts of government capitation grant for the years ending 31 March, 1930-40. This has been placed alongside corresponding increase in the average number of patients.⁷⁹

Victorian lunacy laws.⁸⁰ For Barrington, this was the result of a precarious financial position in which the Free State found itself after independence.⁸¹ Tom Feeney suggests that some areas of healthcare reform were left behind due to the state's reluctance to legislatively interfere with issues that involved family welfare, over which the Catholic Church held considerable influence.⁸² This was particularly relevant to delayed discussions around the development of child guidance clinics in Ireland, where the management of Ireland's industrial and reformatory schools were mainly left to religious orders.⁸³

The length of time that people spent in Ireland's district mental hospitals posed a significant burden on these institutions. A closer look to the length of patient stays demonstrates that new cases/admissions of mental illness had a significantly higher chance of being discharged 'recovered' than patients who had spent more than three years in the mental hospital (see figure 5.3). Further details on patient residences in St. Conal's hospital can be found in

⁷⁹ *ARIMH, 1935*, pp 13-15 and *ARIMH, 1941*, pp 10-14.

⁸⁰ Calabria and Cullen, 'Deinstitutionalisation and the move to community care', p. 144.

⁸¹ Ruth Barrington, *Health, medicine and politics in Ireland* (Dublin, 1987), pp 86-8.

⁸² Tom Feeney, 'Church, state and family: the advent of child guidance clinics in independent Ireland' in *Social History of Medicine*, xxv, no. 4 (2012), p. 850.

⁸³ As early as the 1930s in Britain, delinquent behaviour by children were beginning to be viewed as symptoms of underlying psychological disorders, though this caused much unrest among Catholic Hierarchy in Ireland. See Feeney, 'Church, state and family', p. 851 and McQuaid to L. Murray, Secretary of the Department of Education, 29 Feb. 1956 (DDA, McQuaid papers, D11/4/1).

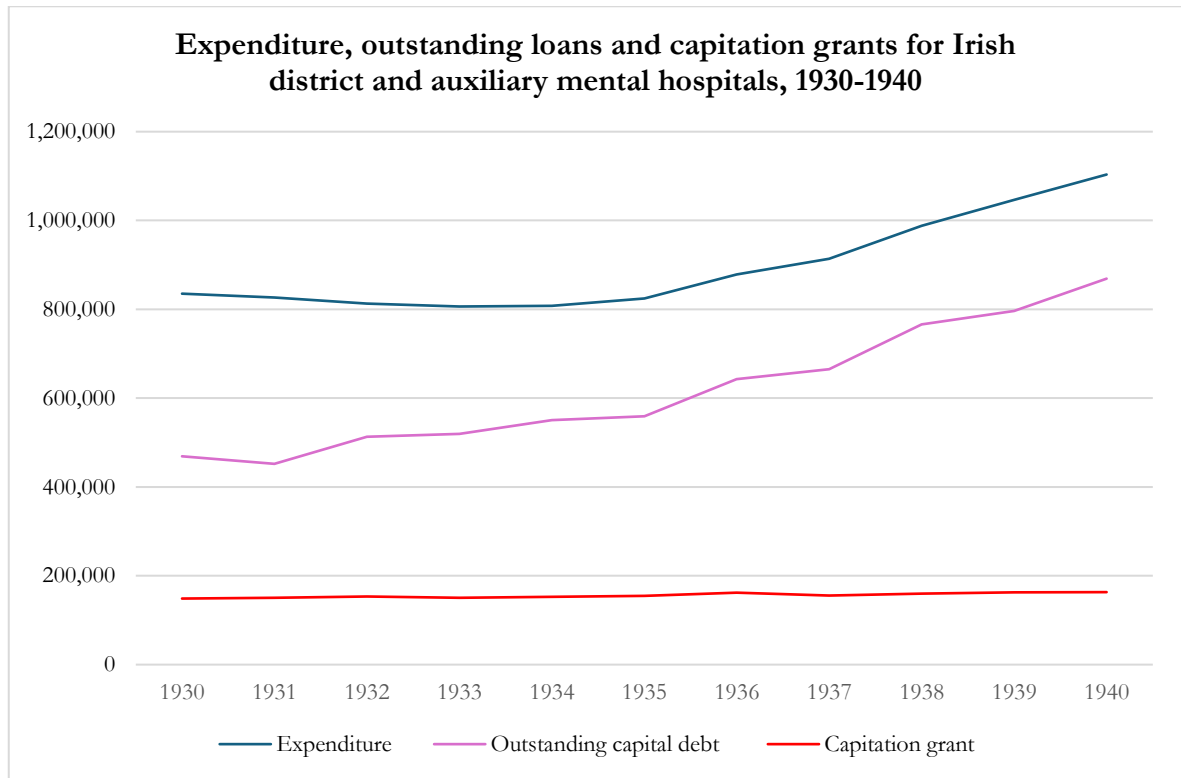


Figure 5.2 Expenditure, outstanding loans and capitation grants for Irish mental hospitals for the years ending 31 March 1930-40.⁸⁴

Appendix I. For those that had been a patient for over ten years, their chances of recovery and subsequent discharge were extremely low. Indeed, only one patient that spent over twenty years in St. Conal's hospital was discharged 'recovered' while an even higher number of long-stay 'incurable' patients remained in the institution itself.⁸⁵ On paper, one would expect that the longer you had to spend in a hospital was an indication of how serious one's medical concerns were, and thereby necessitating continued treatment. However, even people admitted without a very serious diagnosis could end up in the hospital for a long time. For some, like the famous case of Hanna Greally, this meant detainment in an institution against her will for much of her adult life. Committed by her mother, Baby Murray in 1943 to St. Loman's District Mental Hospital, Mullingar for 'a rest', Greally spent nineteen years in St. Loman's District Mental Hospital, Mullingar after her mother died six months later.⁸⁶

⁸⁴ *ARIMH, 1935*, pp 13-15 and *ARIMH, 1941*, pp 10-14.

⁸⁵ *Ibid.*

⁸⁶ *Ibid.*

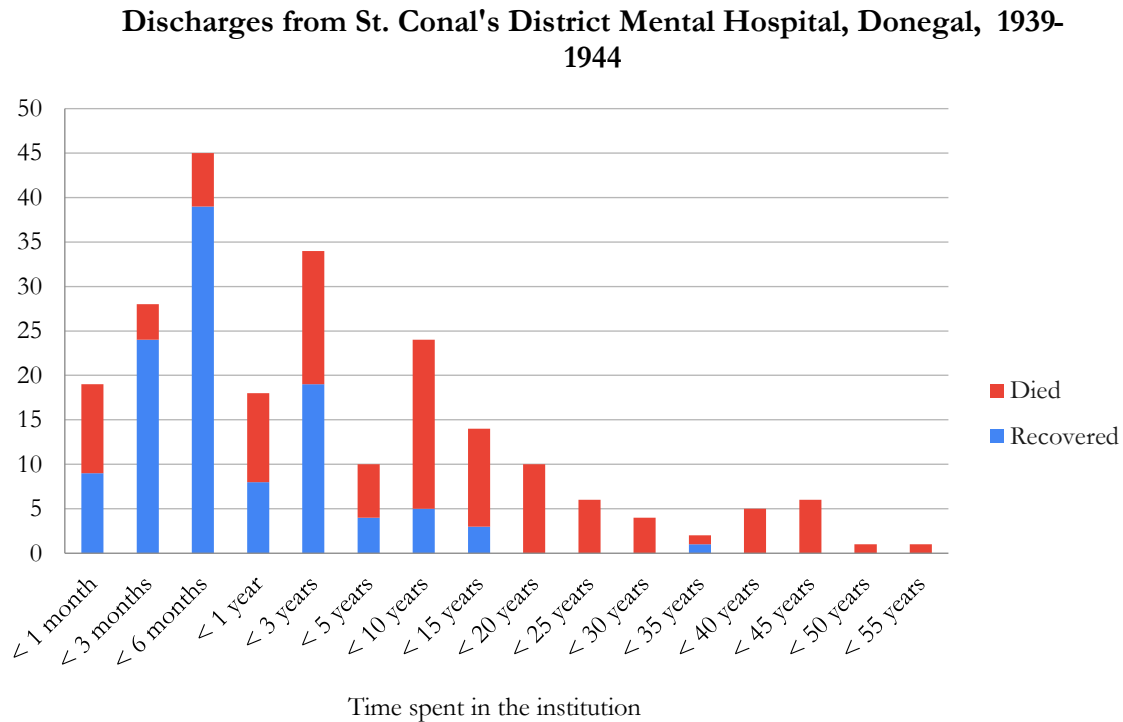


Figure 5.3 Grounds of discharge in St. Conal's District Mental Hospital, 1939-1944.⁸⁷

An examination of the 1930s and 1940s annual reports of the inspector of district and auxiliary mental hospitals can offer a glimpse into conditions experienced on the ground in these institutions. Each year, inspectors drew up reports on the country's district and auxiliary mental hospitals, a process carried on from UK rule to Irish independence. From a policy perspective, these reports shaped the reforms of the 1940s. Prior to the emergence of the 'modern treatments', these inspections were focused for the most part on the official infrastructures that were attached to any given hospital as well as the capacity of the institution against rising institutional populations. In the main, the attention of the inspectors throughout the 1930s was on the physical conditions of the asylums as well as the 'treatment' of their patients. Comments were rather limited by each institution, and they generally noted whether the institution was overcrowded, its state of upkeep and if it was clean, its source of power be it electricity or artificial (gas) lighting, and whether adequate fire drills were in place.

Though conditions varied from institution to institution, there are some common issues. The patients had fixed schedules with set rising and sleeping times, set clothing, a poor and monotonous diet and dreary exercise yards.⁸⁸ Often, these activities were carried out by the patients in the immediate company of large numbers of other people.⁸⁹ In this setting, Chow

⁸⁷ *Registrar of discharges and deaths in St. Conal's hospital, Donegal*, 6 Jan. 1939- 17 Nov. 44 (MED 4/5/5/2).

⁸⁸ Edward Boyd Barret, 'Psychotherapy and our asylums' in *An Irish Quarterly Review*, xiii, no. 49 (Mar. 1924), p. 30.

⁸⁹ Winnie Chow and Stefan Priebe, 'Understanding psychiatric institutionalization: a conceptual review' in *Psychiatry*, xiii, no. 169 (2013), p. 1.

and Priebe describe how the patient's normal social roles were taken away; and with little to no treatment options available before the act, patients complied or in some cases, went against the rules and regulations of their respective institution.⁹⁰ There is also evidence to suggest that a significant number of abuses occurred in these institutions. An informative account of this is the case of Reverend Clarence Duffy who was admitted to Monaghan mental hospital after 'a nervous breakdown' for a period of six months in 1937.⁹¹ After continuously criticising the hospital's conditions and a physical altercation between Duffy and an attendant, he was at once rendered powerless and threatened with 'the needle' – a sedative that made the patients who failed to abide by the rules and regulations 'stupid'.⁹² Instances such as this corroborate Kelly's account that the country's mental hospitals often operated around a behavioural modification system ahead of the Mental Treatment Act 1945.⁹³ Not helping this situation was the extent of overcrowding, which was endemic to all institutions.

A closer look to the records of St. Conal's Hospital confirms that the proximity of people in these institutions meant that they were spaces in which infectious disease could, and did spread. The most poignant finding from records in St. Conal's hospital was that patients were almost as likely to die inside the institution as they were to be discharged 'recovered' between 1939 and 1944 (see figure 5.4).⁹⁴ Here, 52.3% of patients in St. Conal's were discharged 'recovered' while 47.5% of patients died during the same period. Heart disease was the leading death dealer both in and outside St. Conal's hospital, where it accounted for 50% and 21.44% of deaths respectively (see figure 5.6 and Appendix J). Outside the mental institutions, deaths from heart disease were most common in those who were older than forty-five.⁹⁵ The rather high percentage found in St. Conal's hospital correlates with the age profile of those who died between 1939 and 1944, who had an average age of fifty-six years (see figure 5.5).⁹⁶ The evidence also suggests that younger people were more likely to be discharged alive than older people (see figure 5.5). Deaths from tuberculosis were more than twice as frequent inside St. Conal's hospital as in the general population. This trend was consistent with other mental hospitals during the same period, such as Grangegorman, Cork, Killarney and Ballinasloe, where high incidences of TB deaths were also recorded.⁹⁷ The problem of infectious disease was

⁹⁰ Ibid.

⁹¹ Reverend C. Duffy, *It Happened In Ireland* (New York, 1944), p. 18.

⁹² Ibid., p. 28.

⁹³ Kelly, *Hearing voices*, p. 317.

⁹⁴ Ibid.

⁹⁵ ARRG, 1944 (Dublin, 1945), p. 56.

⁹⁶ Registrar of discharges and deaths in St. Conal's hospital, Donegal, 6 Jan. 1939- 17 Nov. 44 (MED 4/5/5/2).

⁹⁷ ARLMH, 1941, p. 9.

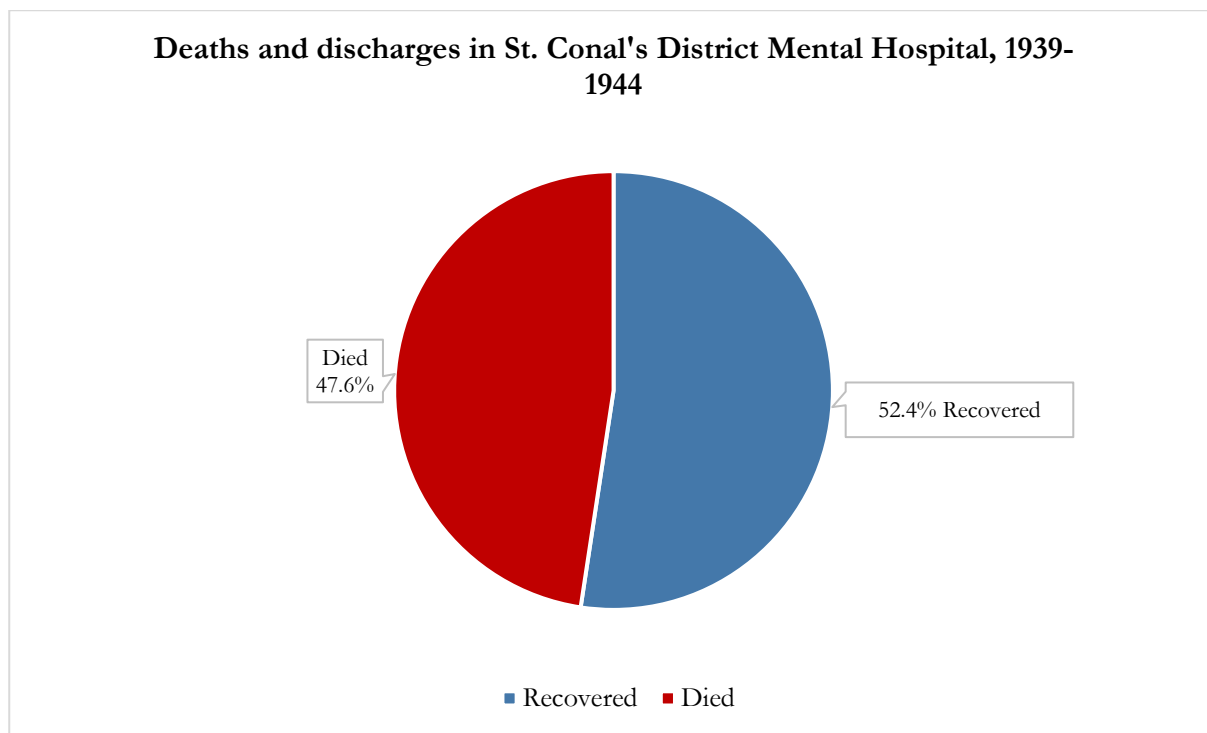


Figure 5.4 Deaths and discharges in St. Conal's District Mental Hospital, 1939-1944.⁹⁸

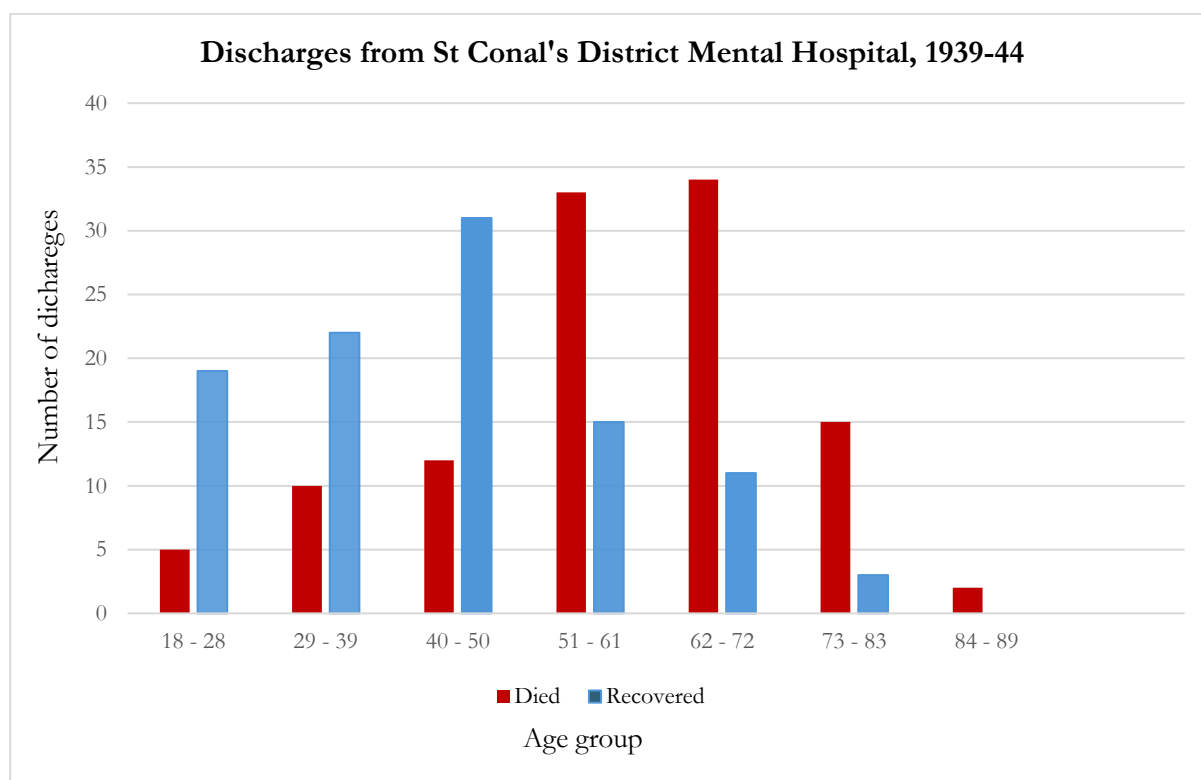


Figure 5.5 Age-group of patients discharged from St. Conal's Hospital, 1939-1944.⁹⁹

⁹⁸ *Registrar of discharges and deaths in St. Conal's hospital, Donegal*, 6 Jan. 1939- 17 Nov. 44 (MED 4/5/5/2). The omission of five months is not expected to have a significant impact on the overall results of this statistical investigation. For instance, between 1940 and 1942, 51% of patients were discharged 'recovered', while 49% died. In 1944, 55% were discharged 'recovered', while 45% of patients 'died'. For the available data in 1943, 41% were discharged 'recovered', while 55% of patients were discharged as 'deceased'.

⁹⁹ Data compiled from *Registrar of discharges and deaths in St. Conal's hospital, Donegal*, 6 Jan. 1939- 17 Nov. 44 (MED 4/5/5/2).

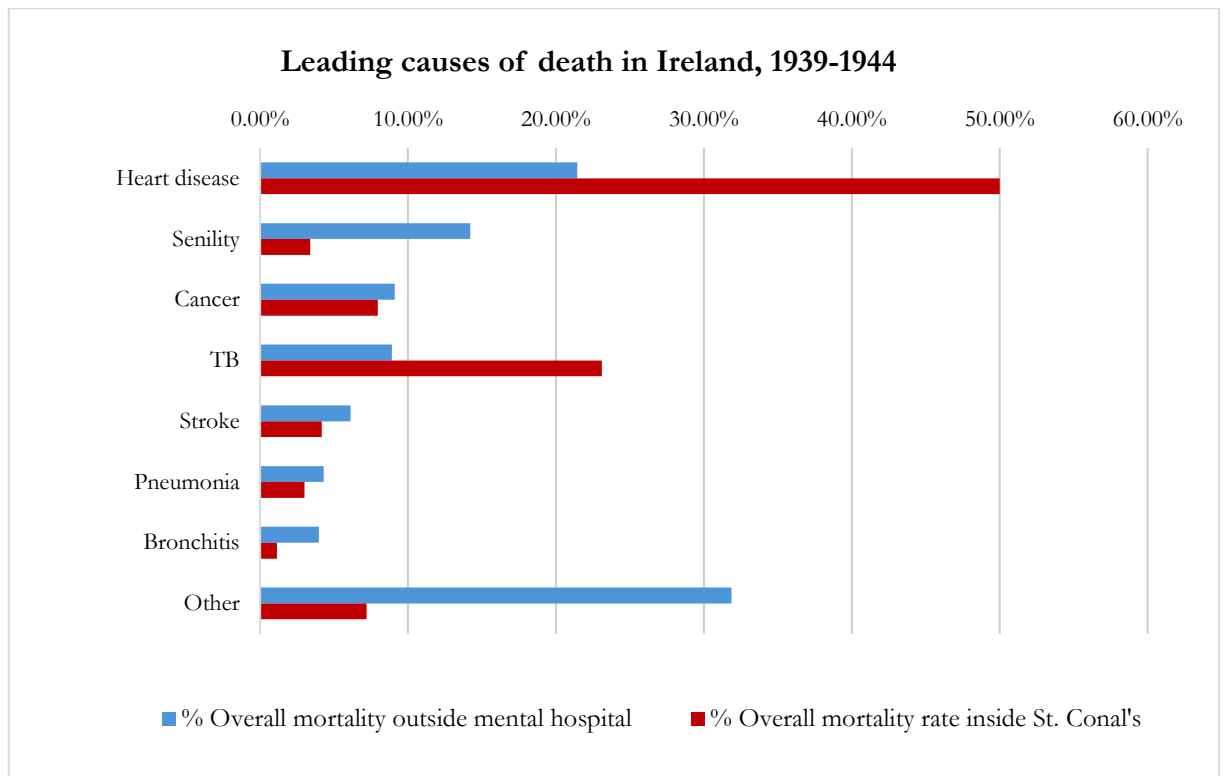


Figure 5.6 Comparisons of the leading causes of death in Ireland, and in St. Conal's hospital, 1939-1944.¹⁰⁰

compounded by a lack of segregation of patients with different diseases and a lack of trained nurses and attendants.¹⁰¹ In St. Conal's hospital, TB was the leading cause of death among those below the age of 40.¹⁰²

5.4 Concurrent psychiatric developments

Up until the 1930s, common treatments included chains, restraining chairs, hot and cold baths (hydrotherapy) and seclusion.¹⁰³ Restraint included various forms of straitjackets and the tying of patients to beds with sheets, though this occurred to varying degrees in Irish institutions.¹⁰⁴ Troublesome patients were routinely secluded in padded rooms and those who refused food normally underwent forced tube feeding.¹⁰⁵ Drugs such as morphine, bromides, barbiturates and chloral hydrate were also used.¹⁰⁶ These had little scientific curative value. This, coupled with the uses of these drugs corroborates Byrne's observation that while therapies for those suffering from mental illness were not entirely absent up until this point, they were solely limited to

¹⁰⁰ Data compiled from *Registrar of discharges and deaths in St. Conal's hospital, Donegal*, 6 Jan. 1939- 17 Nov. 44 (MED 4/5/5/2) and *ARRG*, consecutive years, pp xv-xviii.

¹⁰¹ *DÉD*, 4 Aug. 1948, vol. 112, no. 11 (Roderick J. Connolly).

¹⁰² *Registrar of discharges and deaths in St. Conal's hospital, Donegal*, 6 Jan. 1939- 17 Nov. 44 (MED 4/5/5/2).

¹⁰³ Byrne, 'Madness and mental illness in Ireland', pp 77-82.

¹⁰⁴ *Ibid.*, p.77.

¹⁰⁵ *Ibid.*, pp 85-86.

¹⁰⁶ *Ibid.*

managing the patient, and had little hope of a promising medical intervention.¹⁰⁷ However, new medical views and psychiatric treatments aimed to shorten the duration of mental illness, prompting a renewed interest in mental health as well as a determination that institutions should perform a curative function with the aim of discharge. These views of mental illness were influenced by coming of the two world wars, where experiences during war made people realise that anyone could break down in stressful situations, in stark contrast to pre-existing theories of degeneration.¹⁰⁸

The emergence of physical therapies during the 1930s and 1940s equipped the Irish medical profession with new ways to combat mental illness. Because these treatments were perceived to shorten the course of disease, they were believed by the Irish medical profession to be a ‘factor of economic importance to the institution, and particularly to the affected individual’.¹⁰⁹ On a macro-level, an examination of the 1940s annual reports highlights a distinct transition from these institutions as warehousing the unwarranted toward viable ‘medical’ treatment institutions. While the inspectors’ observations still accounted for the physical infrastructure of the asylums, they were equally keen to note whether any ‘forms of modern treatment’ were carried out and to what curative extent.¹¹⁰ In 1942, treatment along ‘modern lines’ was available in nine of twenty-two district mental hospitals.¹¹¹ Ten years later, the report of the Department of Health noted that ‘the full range of modern treatments including electro-shock treatment, electro-narcosis, insulin therapy and leucotomy is now available to all patients in district mental hospitals’.¹¹² This is an important point because when the new mental health reforms were introduced in the 1940s, they were almost always brought up in the context of using treatments to encourage patient discharge. When Fianna Fáil introduced the Mental Treatment Act, there was a whole new armoury to combat mental illness.

The introduction of modern treatments, though consistently encouraged by the inspectors, was gradual and varied by institution and according to its demands. Dunne was the first to introduce insulin-coma therapy in Ireland in 1938 in Grangegorman District Mental Hospital. Thereafter, this treatment was used widely in Irish institutions up until the 1960s. Prior to his appointment as Resident Medical Superintendent (RMS) at Grangegorman District Mental Hospital, he spent twelve years working as assistant medical officer there and had introduced malarial treatment for general paralysis of the insane.¹¹³ Dunne was later appointed

¹⁰⁷ Ibid., p. 77.

¹⁰⁸ Ibid.

¹⁰⁹ J. Delany and J. R. Shea ‘Observations on the treatments of psychosis by electrically-induced convulsions’ in *IJMS* (Jun. 1944), p. 193.

¹¹⁰ *ARIMH, 1941*, p. 17.

¹¹¹ See ‘General conditions’ in *ARIMH, 1942* (Dublin, 1943), pp 15-24.

¹¹² DOH, *Report of the Department of Health 1952-1953* (Dublin, 1954), p. 45.

¹¹³ Kelly, ‘Physical sciences and psychological medicine: the legacy of Prof John Dunne’ in *Irish Journal of Psychological Medicine*, xxii, no. ii (2002), p. 67.

President of the Royal Medico-Psychological Association of Ireland in 1955.¹¹⁴ In a typical course of ICT treatment, a patient received five to six comas per week as well as increasing dosages of insulin for several weeks until the psychiatrist declared the patient cured or incurable.¹¹⁵ Patients fasted the night before they were given dosages of insulin in the mornings.¹¹⁶ In the main, psychiatric doctors and nurses were most interested in the type of ‘coma’ that occurred: whether it was ‘deep’, ‘light’ and for how long.¹¹⁷ This was because the prevalent scientific reason was that the comas, not the insulin, seemed to result in the remission of schizophrenia and so the likelihood of a quick recovery was increased by the number of comas a patient had.¹¹⁸

After being given treatment in the morning, a patient’s coma was terminated by the administration of glucose, either nasally or intravenously. In some cases where the patient failed to wake up initially, or where it was difficult to enter a vein, as was common in obese patients, adrenalin and electro-convulsive therapy (ECT) were administered to bring the patient back to consciousness.¹¹⁹ Although ICT was gradually introduced into other Irish mental hospitals throughout the 1930s and early 1940s, this occurred at a time in which the use of ICT for schizophrenic patients was intensely debated from the outset in wider international spheres. Indeed, animal and post-mortem studies published at the time showed the ICT was associated with extensive and irreversible brain damage ‘whose extent correlated with the number of comas received’.¹²⁰ The mortality rate was also high, estimated between 2-5%.¹²¹ Notwithstanding this and after numerous test cases, Professor John Dunne and Dr Eveleen O’ Brien some months later concluded that ‘insulin coma therapy was still a valuable treatment once used with due care’.¹²² There were likewise no deaths reported in St. Conal’s Hospital that were attributed directly to ICT between May 1948 and December 1949.¹²³ However, there was an unusual interruption in the use of ICT treatment, which was suspended from 15 July to 12 October 1948, despite patients not having completed their prescribed course.¹²⁴ This disruption may have been caused by an unreported incident or, alternatively, the broader insulin shortage at the time. When it resumed, patients were only initially given very small dosages of insulin (ten units) with

¹¹⁴ Ibid.

¹¹⁵ Deborah Doroshow, ‘Performing a cure for schizophrenia: insulin coma therapy on the wards’ in *Journal of the History of Medicine and Allied Sciences*, lxii, no. 2 (2007), p. 214.

¹¹⁶ Kelly, *Hearing voices*, p. 171.

¹¹⁷ *Observations and treatment book in St. Conal’s hospital*, 28 May 1948- 30 Dec. 1949 (MED 4/5/8/3).

¹¹⁸ Samuel H. Kraines, *The therapy of the neuroses and psychoses* (Chicago, 1948), pp 487-489; Kingsley Jones, ‘Insulin coma therapy in schizophrenia’, *Journal of the Royal Society of Medicine*, xciii (2000), pp 147-149.

¹¹⁹ Ibid., p. 489.

¹²⁰ Robert Freudenthal and Joanna Moncrieff, ‘A landmark in psychiatric progress? The role of evidence in the rise and fall of insulin coma therapy’ in *History of Psychiatry*, xxxi, no.1 (2021), p. 73.

¹²¹ Kelly, *Hearing voices*, p. 170.

¹²² J. Dunne and E. O’Brien, ‘Insulin therapy’ in *JMS*, lxxxv, no. 356 (1939), pp 498-504.

¹²³ *Observations and treatment book in St. Conal’s hospital*, 28 May 1948- 30 Dec. 1949 (MED 4/5/8/3).

¹²⁴ Ibid.

small increases by session thereafter while new patients to ICT would be given only ten on first round.

ECT was another ‘shock treatment’ that gained currency in Irish district mental hospitals during the 1940s. Of all the physical treatments used, ECT is the only treatment that is still used today. Developed by Ladislav Joseph Meduna and Ugo Cerletti in Rome in 1938, the procedure involved the use of electricity, applied across the brain, to bring on an epileptic-type seizure (convulsion). In its initial years, these seizures were introduced using chemicals such as Cardiazol, Metrazol and Triazol as opposed to electricity.¹²⁵ Notwithstanding, the rationale for all forms of convulsive therapy was that the convulsion disrupted the patient’s thinking and thereby restored some form of normality. Like ICT, ECT was usually administered in the morning before a patient’s breakfast and the patient, where possible, would not have had a sedative the night before (if this was the case he or she was given a higher voltage).¹²⁶ It also became increasingly clear that ECT had higher recovery levels in patients with manic depression rather than patients with schizophrenia.¹²⁷ Irrespective of common side effects including confusion, disorientation, bone breakages and memory loss, this treatment was widely used throughout Ireland in the 1940s and 1950s. In April 1942, Dunne introduced ECT at Grangegorman, this was followed by Ballinasloe in September 1942 and Cork in 1943 and it was available in all institutions by 1952.¹²⁸ In June 1944, medical superintendents at Ballinasloe were extremely celebratory of this treatment noting how 700 patients received this shock therapy and ‘so far no complications have been observed’.¹²⁹ In 1950, Dunne likewise noted substantial recovery rates with the treatment in Grangegorman with 209 out of a total of 327 patients with ‘involuntary melancholia’ recovered.¹³⁰ After the first treatment, mania was reported to have been subdued, while suicidal thoughts and tendencies faded upon second and third treatments.¹³¹ Thus the Mental Treatment Act 1945 was introduced against a backdrop of renewed medical enthusiasm for mental hospitals to perform a therapeutic function.

5.5 The Mental Treatment Act 1945

The Mental Treatment Act, or its official title, ‘An act to provide for the prevention and treatment of Mental Disorders and the care of the persons suffering therefrom and to provide for other matters connected with the matters aforesaid’ aimed to revolutionise policy for the

¹²⁵ Kelly, *Hearing voices*, p. 173.

¹²⁶ Kraines, *The therapy of the neuroses*, p. 494.

¹²⁷ Berrios, ‘The scientific origins of electroconvulsive therapy’, p. 116.

¹²⁸ Kelly, *Hearing voices*, p. 174.

¹²⁹ Delany and Shea, ‘Observations on the treatment of psychosis’, p. 195.

¹³⁰ Dunne, ‘Survey of modern physical methods of treatment for mental illness carried out in Grangegorman Mental Hospital’, *JMAE*, xxvii (1950), p.5.

¹³¹ Edward Shorter and David Healy, *Shock therapy: a history of electroconvulsive treatment in mental illness* (New Jersey, 2007), p. 31.

care of the mentally-ill in Ireland.¹³² Coming into effect on 1 January 1947, the final act contained XIV parts and 284 sections, and this was after 310 amendments were made in the committee stage of the bill's passage.¹³³ The provisions of the act were largely administrative: it provided mental hospital districts and authorities, inspectors, committal provisions, land acquisitions by mental hospital authorities, the superannuation of district mental hospital employees as well as the regulation of private and charitable mental institutions.¹³⁴ On the ground, each district mental hospital was to have a chief resident medical superintendent who lived on the hospital's grounds while mental hospital committees were set up to help with the running and order of the hospitals.¹³⁵

Up until this point, a patient had to be certified as either a 'lunatic' or an 'idiot', or as a 'person of an unsound mind' that posed a dangerous threat to others on admission. The Mental Treatment Act 1945 made it possible to admit patients as voluntary, temporary or as a person of unsound mind.¹³⁶ A voluntary patient was a patient who, acting on his or her own accord, submitted him or herself voluntarily for treatment in a district mental hospital, and they could subsequently leave the premises at any time by giving three days' notice to the resident medical superintendent. A temporary patient was a patient who was defined as suffering from mental illness and was believed to require no more than six months suitable treatment inside the hospital. This application could be made to the hospital by the husband or wife, relative of the person or by any other person and had to be accompanied by a certificate from an authorised medical officer who had examined them no more than fourteen days before.¹³⁷ Procedures for the admissions of those of 'unsound mind' were maintained, and this allowed for the involuntary detention for an indefinite period by a husband, wife, relative or any other person without an automatic review of status.¹³⁸ Together, it was perceived by Senator, Luke J. Duffy and government members that these provisions would establish 'a completely new code', getting 'away from the whole conception of treatment and mental disease'.¹³⁹

Because wider psychiatric developments implied a distinct shift away from 'management' to 'curative' institutions, one of the aims of the Mental Treatment Act 1945 was to de-criminalise mental illness. Evidence of this can be found in the language and terminology used in the legislation where words like 'lunatic' and 'asylum' were replaced by 'patient', 'person

¹³² Mental Treatment Act, 1945 (1945 no. 19) (22 May 1945).

¹³³ *DÉD*, 19 Apr. 1945, vol. 29, no. 25 (Luke J. Duffy).

¹³⁴ Mental Treatment Act, 1945.

¹³⁵ *Ibid.*

¹³⁶ *Ibid.*

¹³⁷ DLGPH explanatory memorandum on Mental Treatment Bill 1944, 13 Nov. 1944 (NAI TAOIS S/12573A).

¹³⁸ Kelly, 'The Mental Treatment Act 1945 in Ireland: an historical enquiry' in *History of Psychiatry*, xix, no. 1 (2008), p. 58.

¹³⁹ *DÉD*, 19 Apr. 1945, vol. 29, no. 25.

of unsound mind’ and ‘mental hospital’.¹⁴⁰ This fell into wider worldwide trends that saw mental illness as an organic disease, that like others, had potential to be cured if caught early on. Before the act, there was no legal way for a person to submit themselves voluntarily for treatment nor any temporary admission. Instead, admission to a mental hospital was secured by means of a committal order similar to ‘the committal of a criminal’.¹⁴¹ As Duffy noted on the bill’s passing:

I have recollection myself of seeing in the old days the police coming to an unfortunate little house in the country with a warrant to arrest a young man or woman, planting the patient on a sidecar and driving him off to a lunatic asylum. It was a very sad spectacle... That system now disappears. It is now very largely a matter for doctors, trained people, to say whether or not a person is of unsound mind, whether or not his case should be treated in a mental hospital or whether it is a case for detention in a criminal lunatic asylum.¹⁴²

The Mental Treatment Act confirmed that mental illness was a disease to be dealt with at the hands of the medical profession. This fell into global trends that saw mental illness as a disease that, like others, had the potential to be cured. The same can be said of England’s Mental Treatment Act 1930 and Northern Ireland’s Mental Treatment Regulations (1932).¹⁴³ The United States likewise saw several amendments that changed the term ‘insane’ to ‘mentally ill’ in the early 1950s.¹⁴⁴

The new medical treatments of the 1930s meant that the emphasis of wider expert and government opinion was on identifying and treating young cases of mental disease.¹⁴⁵ In the Dáil debates on the act, Dr Conn Ward, Parliamentary Secretary of the Minister of Local Government and Public Health, emphasised that ‘there are greater possibilities of effecting a cure’.¹⁴⁶ The provision for voluntary patients was expected to help people who may have experienced mental illness but were suffering in silence in their own homes.¹⁴⁷ Senator Seán T. Ruane likewise noted how it was regarded by some people as a kind of ‘slur or stigma’ on the family, while others sought even harder to keep their mental anguish a secret so that they would not be committed by their family members.¹⁴⁸ Ruane has observed what followed as ‘only a prelude to what happened when the police came to take away the person, very often under severe restraint...committed to an institution’.¹⁴⁹ For those people who were taken to mental

¹⁴⁰ Mental Treatment Act, 1945.

¹⁴¹ DLGPH memorandum on proposed bill dealing with the amendment of lunacy laws, 27 Aug. 1941 (NAI TAOIS S/12573).

¹⁴² *DÉD*, 19 Apr. 1945, vol. 29, no. 25.

¹⁴³ Mental Treatment Act (England), 1930 (1930 no. 1083) (10 July 1930); The Mental Treatment Regulations (Northern Ireland), 1932 (1932 no. 101) (23 Sept. 1932). Switzerland also passed laws in the 1930s. For more information about international legislative contexts, see Kelly, ‘The Mental Treatment Act, 1945’, p. 65.

¹⁴⁴ Goodwin, *Comparative mental health policy: from institutional to community care* (London, 1997), p. 8.

¹⁴⁵ Mental Treatment Act, 1945.

¹⁴⁶ *DÉD*, 19 Apr. 1945, vol. 29, no. 25.

¹⁴⁷ *Ibid.*

¹⁴⁸ *Ibid.*

¹⁴⁹ *Ibid.*

hospitals, Ruane observed ‘it would be a very appropriate notice to put over the portals of these institutions “abandon hope all ye who enter here”’.¹⁵⁰ It was thought that in the absence of voluntary patient status there were large numbers of patients presenting with more acute and permanent forms of mental illness and that this explained Ireland’s issues of overcrowding and high numbers in permanent residence. The act also provided for outpatient wards, consulting rooms and clinics where affected individuals could come and seek advice on treatment.¹⁵¹ After all, a lengthy residence in a mental hospital was a matter of economic importance for the individual too where one or two years ‘may spell disaster to a breadwinner’.¹⁵² Similarly for those ‘who would be much happier living in private dwellings than in mental institutions’, the act allowed ‘boarding out’ which entailed allowing a patient out for a ‘trial’ or ‘parole’ period and also allowed for patients to be transferred to an institution other than the one that he or she was admitted.¹⁵³ Despite efforts to de-stigmatise the language surrounding mental illness, the act still used terms such as ‘parole’ and ‘trial’, which linked mental illness with criminality. The use of the Garda Síochána, as is still the case today in relation to involuntary patients, was also maintained in cases of detaining individuals deemed to be of ‘unsound mind’.

Another key aspect of the act was the provision made for ‘temporary’ patients. This allowed for the legal involuntary detention of a patient for up to six months.¹⁵⁴ This applied to patients who required not more than ‘six months suitable treatment’ and who were unfit on account of their mental state to apply for treatment as a voluntary patient or for addicts believed to require six months preventative and curative treatment.¹⁵⁵ Should their recovery not be achieved, this period could be extended for a period of two years by the Resident Medical Superintendent (RMS) from the date of the application and medical cert.¹⁵⁶ Ward also stated that these two categories of patient would have their own accommodation in the district mental hospitals, where they would be separated from others experiencing more severe forms of mental illness.¹⁵⁷ Segregation was not a new idea, and can be seen in the Irish Poor Law system, where hospitals had been keen to separate classes of patients with the idea that one group might contaminate another either morally or physically.¹⁵⁸ While it was still possible under the act to admit someone as a ‘person of unsound mind’, it was hoped by the government and wider

¹⁵⁰ Ibid.

¹⁵¹ Mental Treatment Act, 1945.

¹⁵² Delany and Shea, ‘Observations on the treatment of psychosis’, p. 193.

¹⁵³ Mental Treatment Act, 1945.

¹⁵⁴ Ibid.

¹⁵⁵ Ibid.

¹⁵⁶ C. B. Molony (RMS Waterford Mental Hospital), ‘The new Mental Treatment Act and its application to general practice’ in *Medical Association of Éire*, xviii (Mar. 1946), p. 52.

¹⁵⁷ *DÉD*, 19 Apr. 1945, vol. 29, no. 25.

¹⁵⁸ Archbishop Paul Cullen criticised the Irish Poor Law system in the 1860s for mixing the ‘criminal’ and ‘respectable’ classes in infirmaries and the workhouse system. See Virginia Crossman, ‘Facts notorious to the whole country: the political battle over Irish Poor Law reform in the 1860s’ in *Transactions of the Royal Historical Society*, xx (2010), pp 162-163.

psychiatric profession alike that the provision for persons of unsound mind was to be only rarely used and instead, all patients were to be given ‘the benefit of the doubt’.¹⁵⁹ Besides, ‘remembering the recent great advances in successful therapy, and that patients will probably get the benefit of two years’ treatment before they need to be finally put under certificate as a person of unsound mind’.¹⁶⁰

Together, the ‘voluntary’ and ‘temporary’ provisions can be interpreted as a distinct shift in official and medical attitudes toward mental illness in Ireland. Even before the new legislation was passed, the enthusiasm for new treatments that were gradually being introduced into Irish district mental hospitals led to inspectors fears in 1942 that a highly developed occupational therapy unit in Killarney could even ‘result in the exclusion of other proved methods of treatment’.¹⁶¹ A year later, the inspectors recommended that insulin coma therapy be introduced on the basis that it was deemed ‘the most valuable in cases which hitherto were regarded as incurable’.¹⁶² Crucially, this was little more than a decade after insulin was heralded a ‘miracle drug’ in the treatment of diabetes.¹⁶³ Similarly, ‘good results’ obtained in Sligo by modern methods were reflected in high rates of recovery (67.4%) based on the number of admissions in 1942.¹⁶⁴ Similar results were also found in the immediate aftermath of the Mental Treatment Act 1945 in Donegal. This further corroborates the argument that these treatments and by extension, the Mental treatment Act 1945, were framed within a wider dialogue that anticipated patient discharge.

The most controversial feature of the ‘temporary’ admission provision of the act was its allocation for ‘addicts’. Because it was unlikely that an addict would necessarily want to seek treatment in a district mental hospital for a cure for their addiction, Ward believed that the most appropriate part of the bill for dealing with them was that relating to ‘temporary patients’.¹⁶⁵ While it was noted that the Medical Association of Ireland were strongly in favour of having a provision of its kind implemented in the bill, there was a sense of bewilderment among the wider psychiatric profession about this.¹⁶⁶ There was nothing similar in the British Mental Treatment Act 1930 or in any other country at that time except in Switzerland, where such provisions made for addicts appeared to ‘work very well in practice’.¹⁶⁷ What this meant was that a husband, wife or relative of an alleged addict, accompanied by a certificate from a

¹⁵⁹ Molony, ‘The new Mental Treatment Act’, p. 52.

¹⁶⁰ Ibid., p. 51.

¹⁶¹ Ibid., p. 21.

¹⁶² *ARIMH*, 1943 (Dublin, 1944), p. 23.

¹⁶³ Insulin was discovered in the early 1920s and was thereafter used to treat those suffering from diabetes. See Kirsten E. Gardener, ‘The art of insulin treatment’: diabetes, insulin and the 1920s’ in *Journal of Medical Humanities*, xl (2019), pp 171-172.

¹⁶⁴ *ARIMH*, 1943, p. 24.

¹⁶⁵ *DÉD*, 19 Apr. 1945, vol. 29, no. 25.

¹⁶⁶ Ibid. Also see Molony, ‘The new Mental Treatment Act’, p. 53.

¹⁶⁷ Molony, ‘The new Mental Treatment Act’, p. 53.

dispensary doctor was able to place an addict in an institution with an indicative six month time-frame to be discharged thereafter. The idea was that while it might have been easy for a doctor to say that someone was suffering from a mental illness, it was ‘not so easy to say that the alleged addict is incapable of managing himself or his affairs’.¹⁶⁸ There was, as Molony has put, potential in this situation for an ‘unfortunate medical superintendent’ to ‘thereby become the final actor in the drama of having the alleged addict locked up for six months, maybe two years’.¹⁶⁹

It might be expected that the six month time frame had been based on scientific evidence on recovery times for specific ailments. This was not always the case. The responsibility was given to relatives and medical practitioners to allocate the status of ‘temporary’ to a patient based on an expectation that he or she was suffering from some form of ‘temporary’ mental illness that was anticipated to last six months. From a psychiatric perspective, it was likewise ‘difficult for an doctor (even an experienced psychiatrist) to certify that a patient is unlikely to recover *within six months*’ just as it was impossible to accurately determine that patient required ‘not more than six months suitable treatment’.¹⁷⁰ In like manner, the issue of addiction could have been ‘very troublesome’ for doctors to deal with while perhaps six months preventative and curative treatment ‘could be the best thing in the world for some addicts’.¹⁷¹ As with voluntary admission, there was no further comment on what this ‘suitable treatment’ would have entailed. Whether this was simply intended to facilitate a space away from temptations for people suffering from alcoholism or whether they should receive a particular type of treatment was not specified. Commenting on the bill’s final stage in April 1945, Ward claimed that at least 30% of the people, who under the old law were committed as dangerous lunatics, were discharged cured within six months in recent years.¹⁷² His reasoning was that the ‘scientific treatment of mental illness has advanced very substantially’ in the previous decade, referring to ECT and ICT.¹⁷³ This suggests that the real purpose of the voluntary and temporary provisions was to control the length of residencies and limit the powers of the public to have someone committed for an indefinite period of time. The act also called for more frequent patient reviews, thus making it harder to keep patients long-term.¹⁷⁴

5.6 Public health oversight

When Dáil debates that surrounded the introduction of the proposed bill are examined alongside the provisions that were eventually made, it is clear that the legislation was still more

¹⁶⁸ Ibid.

¹⁶⁹ Ibid.

¹⁷⁰ Ibid., p. 52.

¹⁷¹ Ibid., p. 53.

¹⁷² *DÉD*, 19 Apr. 1945, vol. 29, no. 25.

¹⁷³ Ibid.

¹⁷⁴ Calabria and Cullen, ‘Deinstitutionalisation and the move to community care’, p. 148.

about management in most of its particulars than it was about prevention and cure. Duffy encouraged Oireachtas members to see the bill in its bigger picture:

It seems to me that those who complain of the expense which will be involved in giving effect the proposals in this Bill see only one side of the picture. They see the cost of clinics, the cost of curative treatment, the cost of dealing in a decent, human fashion with people who are subnormal; but they omit looking at the other side of the question where very considerable sums of money will be saved to the community by ensuring that mentally defective people will be cured as rapidly as possible, and taken out of the institutions where already their up-keep, their management, and attendance cost a vast sum of money.¹⁷⁵

Costs arising out of the Mental Treatment Act 1945 were perceived as a long-term financial investment. Yet all of this emphasis on ‘curative’ treatment and dealing with people in a ‘human fashion’ had not eliminated the idea that these people, who were unfortunate enough to suffer from mental disease, were ‘subnormal’ and ‘mentally defective’. Even though the act had removed stigmatising language surrounding mental illness, it had failed to remove it from the speech of those cabinet members passing the act through.

A key area that cabinet members criticised was the available information surrounding the incidence of insanity in Ireland. While Ward spent a significant amount of time explaining the various parts of the bill, there was no concrete detail given to the spread of mental illness across the country or whether there was a difference between rural and urban areas, between small and large centres of population, and whether insanity was on the increase.¹⁷⁶ There was also no information given to the cabinet members on the steps taken to prevent insanity, let alone its inherent causes. Ward did acknowledge that there were several issues relating to the running of mental institutions, but there was no time actually taken to launch concrete investigations into the incidence of mental illness that, at the same time, were launched for other health issues, such as the national nutrition survey of the same decade. There was equally no nation-wide campaign raising awareness of mental illness, as there was in the case of TB.¹⁷⁷ Such information might have played a crucial role in prevention of mental illness. This is significant because the information for much of the above was available annually from the inspectors of mental hospitals and reports of the Department of Local Government and Public Health where detail was gathered as to the numbers of people in urban and rural Irish institutions, as well as the pressures experienced by their staff members. Instead, the focus for Fianna Fáil was on the problems that mental illness caused on official infrastructures, rather than the issue of mental illness itself. In this way, the problem was not so much about Irish insanity as it was about its control.

¹⁷⁵ *DÉD*, 19 Apr. 1945, vol. 29, no. 25.

¹⁷⁶ *Ibid.*

¹⁷⁷ *Ibid.*

5.7 Implications of the Mental Treatment Act

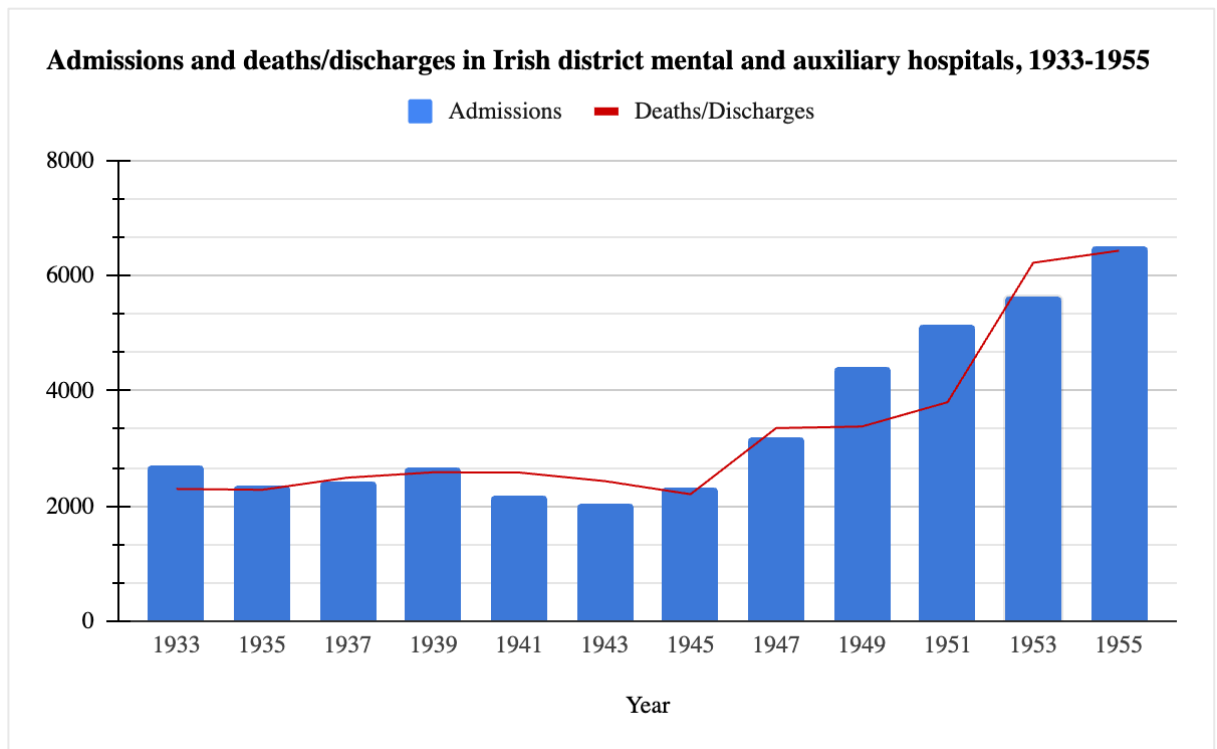


Figure 5.7 Admissions, deaths and discharges into Irish district and auxiliary mental hospitals, 1933-1955.¹⁷⁸

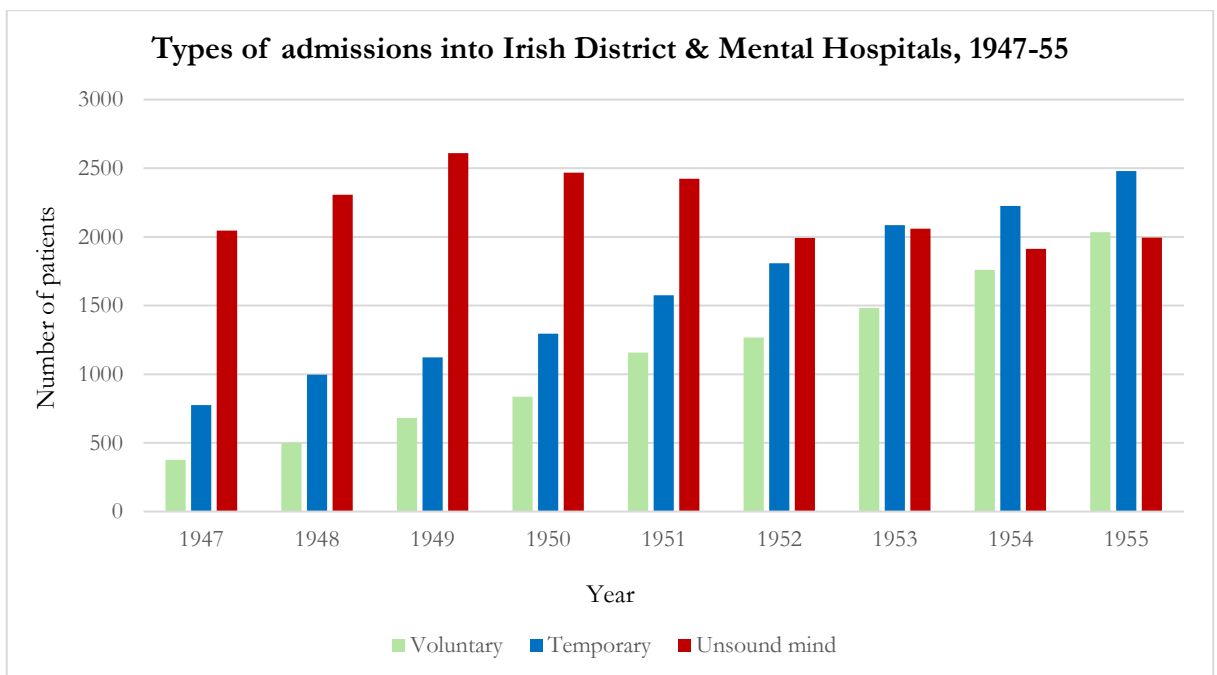


Figure 5.8 Types of admissions into Irish District and Mental Hospitals, 1947-55.¹⁷⁹

¹⁷⁸ *ARIMH, 1933-1955* (Dublin, 1956). Consecutive years.

¹⁷⁹ *ARIMH, 1947-1955*. Consecutive years, pp 46-52.

Ironically, the Mental Treatment Act was a significant factor in increasing patient numbers between 1947 and 1955 (see figure 5.7). As shown, hospital numbers rose significantly when the act came into effect in 1947, whereas the rise was only steady during the decade before. A more detailed view of patient numbers can be found in Appendix K. The number of voluntary and temporary patients admitted to district and auxiliary mental hospitals more than doubled between 1947 and 1954, while the number of people admitted indefinitely as ‘persons of unsound mind’ did not dramatically decline (see figure 5.8). This result was not intended by the government or the wider psychiatric profession. By 1960, numbers in Irish psychiatric hospitals had risen to 20,506.¹⁸⁰ One in every 70 Irish people above the age of 24 was in a mental institution.¹⁸¹ This put additional pressures on the district mental hospitals that were already experiencing significant problems of overcrowding, infectious disease and regulation of patients. The impact that this had on the institutions was captured in an interview with Professor Ivor Browne (successor to Chief Psychiatrist at Grangegorman John Dunne in 1966):

Around 1860 you had a large hospital with up to 1,000 beds, with no mechanical restraint, very little suicide, very little disturbance and almost the entire patient population involved in the full school curriculum of that period. By the turn of the century you had this appalling mess with patients doing nothing and large wards with tremendous disturbance.¹⁸²

Despite enthusiasm for curative treatment, no directions were given on how new treatments were to be used in the hospitals. Although Ward commended modern medical science’s ability in the ‘early treatment of mental illness’, details on the administration of treatment was limited.¹⁸³ Entitled ‘General Duty of the Mental Hospital to Provide Treatment, Maintenance, Advice and Services’, it provided for:

Where a) a person is ordinarily resident in a mental hospital district, and b) such person requires, by reason of mental illness, any treatment, maintenance, advice or service, the mental hospital authority for such mental hospital district shall, subject to the provisions of this Act, provide such treatment, maintenance, advice or service for such person.¹⁸⁴

The act simply provided that one suffering from any form of mental illness had access to treatment and that the mental hospital authority would facilitate this treatment. While the routine of the hospitals itself was as much of a treatment as were the more ‘medical’ treatments of occupational and physical therapy, it was up to the attending medical practitioner to decide the approach. In the context of the wider reforms of this bill, this undoubtedly imposed an extra

¹⁸⁰ Kelly, ‘The Mental Treatment Act 1945’, p. 62.

¹⁸¹ Ibid.

¹⁸² David Healy, ‘Interview: in conversation with Ivor Browne’, *Psychiatric Bulletin*, xvi (1992), p. 3.

¹⁸³ *DÉD*, 19 Apr. 1945, vol. 29, no. 25.

¹⁸⁴ Mental Treatment Act, 1945.

burden on medical officers with no provision for any extra remuneration for them.¹⁸⁵ Fine Gael senator Michael Hayes raised this issue in the bill's deliberations as he criticised the tendency in legislation 'to take certain people who have professional duties to perform, to praise them and to give them more work and deny them extra pay'.¹⁸⁶ Aware that the government was working on reforms prior the passage of the legislation, there were calls by the relevant local authorities to expedite the reforms of the bill which they had anticipated would lessen their workload.¹⁸⁷

A lack of worldwide consensus on the efficacy of each of these treatments meant that patients given them, were effectively subjects of psychiatric experimentation. Insulin coma therapy, ECT and deep sleep therapies were different treatments that were designed to treat different mental disorders. In the case of ICT, wider experience with diabetic patients had already made physicians familiar with symptoms that occurred from 'too much' insulin.¹⁸⁸ In diabetic cases, insulin was widely used as a means of increasing the patient's appetite and saw patients have 5 to 15 units shortly before mealtime while a typical medicinal routine for a diabetic included 2-4 insulin shots a day.¹⁸⁹ ICT, on the other hand, involved giving shock dosages of insulin in order to produce a hypoglycemic-like state. In Ireland, these 'shock' dosages were astonishingly high and they included anything from 100 units of insulin to 460 units of insulin in a single dose – slightly higher dosages than were found in use in Britain at the same time.¹⁹⁰ While ICT was thought to have more promising results in schizophrenia which was among the most severe forms of mental illness, there was no consensus on how these comas actually worked, only that they seemed to result in remissions of specific disease symptoms. Similarly, the exact mechanism that produced the therapeutic effect of ECT was unknown.¹⁹¹ In historic terms, physicians had not been trained to believe that convulsions were curative but rather they perceived them to be symptomatic of an underlying brain illness.¹⁹² There were even some doctors who believed that the deliberate introduction of a convulsion through ECT was a dangerous way of opening *Pandora's Box* while the idea of using electricity to produce a convulsion as a means of shocking a patient's nervous system and brain back into a state of equilibrium seemed bizarre to many patients.¹⁹³ Nevertheless, it had been observed to have an

¹⁸⁵ *DÉD*, 19 Apr. 1945, vol. 29, no. 25.

¹⁸⁶ *Ibid.*

¹⁸⁷ DLGPH to Department of Taoiseach, 30 Apr. 1943 (NAI, TAOIS S/12573).

¹⁸⁸ Kraines, *The therapy of the neuroses*, p. 484.

¹⁸⁹ *Ibid.*

¹⁹⁰ ICT was used extensively throughout the UK during this period. Dosages as high as 440 units were used in Devon. See Nicola Baur, 'Family influence and psychiatric care: physical treatments in Devon Mental Hospital, c. 1920s – 1970s' in *Endeavour*, xxxvii, no.3 (2013), p. 178.

¹⁹¹ Kraines, *The therapy of the neuroses*, p. 503.

¹⁹² Shorter and Healy, *Shock Therapy*, p. 9.

¹⁹³ *Ibid.*

effect in depressive psychoses, though there was no definite scientific consensus on this only a ‘clinical impression’.¹⁹⁴

An insight into the use of physical treatments can be derived from a treatment book from St. Conal’s hospital, where the medical attendants recorded daily treatments and patient responses.¹⁹⁵ Treatment programmes were rarely linear. Dosages changed, treatments were halted owing to improvements, dis-improvements or side effects, and treatment programmes were often re-started for no recorded reason. The treatment book contains the treatment records of 141 patients over an eighteen month period between May 1948 and December 1949.¹⁹⁶ Three physical therapies were used in total: ECT, ICT and somnifaine deep-sleep therapy.¹⁹⁷ They were used in conjunction with other therapies: it was not uncommon for patients to have ECT and ICT in the morning and occupational therapy in the afternoon.¹⁹⁸ Somnifaine therapy involved the daily application of somnifaine over a two-week period to produce a prolonged narcosis; the idea was that a prolonged narcosis would relax the overstimulated brain and so cure the patient from their mental illness.¹⁹⁹ The drug itself was a strong soporific, and it was among the first sedatives used in Europe in the early 1920s with a curative aim, as opposed to the use of sedatives to manage behaviour on the wards.²⁰⁰ ECT was the most extensively used treatment among the physical therapies in St. Conal’s (see figure 5.9). The number of patients subjected to ECT (110 patients) was more than double than those subjected to somnifaine deep sleep therapy (44 patients) and almost triple the amount who were put on ICT (40 patients) for the same period.²⁰¹ Of these treatments, ICT was the most labour-intensive (see Appendix L).

Despite their specific indications, treatments were not always matched to diagnosis. Patients diagnosed with schizophrenia should receive ICT, those with manic depression were suited for ECT, and deep sleep therapy should have been preferred for patients experiencing episodes of mania and obsessional neurosis and so forth. One could assume ECT was used more widely in St. Conal’s because of the prevalence of manic depression as opposed to schizophrenia. However, many of the same patients were subjected to a combination of these therapies over the same 18-month period (see figure 5.10).²⁰² While there are no admission records containing patient conditions available for the same period, there is evidence indicating

¹⁹⁴ Kraines, *The therapy of the neuroses*, p. 503.

¹⁹⁵ *Observations and treatment book in St. Conal’s hospital*, 28 May 1948- 30 Dec. 1949 (MED 4/5/8/3).

¹⁹⁶ Ibid.

¹⁹⁷ Ibid.

¹⁹⁸ Ibid.

¹⁹⁹ Ibid.

²⁰⁰ Nicole Baur, ‘Family influence and psychiatric care: physical treatments in Devon mental hospitals c. 1920-1970s’ in *Endeavour*, xxxvii, no.3 (2013), p. 178.

²⁰¹ *Observations and treatment book in St. Conal’s hospital*, 28 May 1948- 30 Dec. 1949 (MED 4/5/8/3).

²⁰² Ibid.

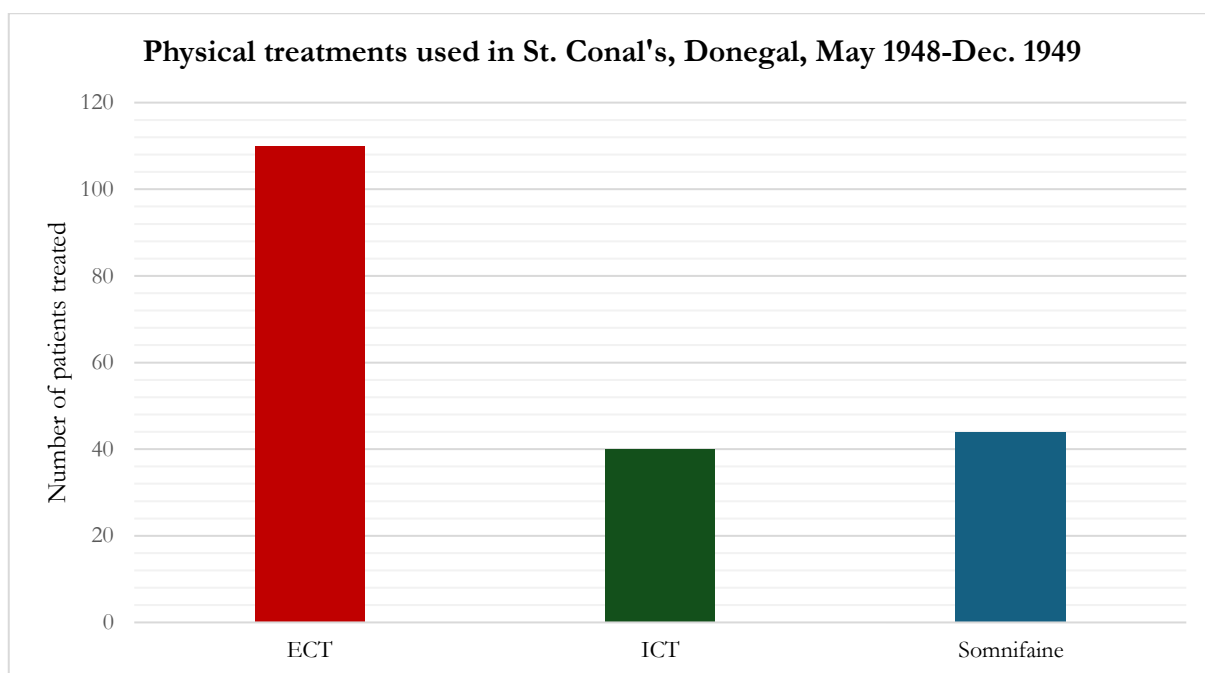


Figure 5.9 Physical treatments in St. Conal's District Mental Hospital, May 1948-Dec. 1949.²⁰³

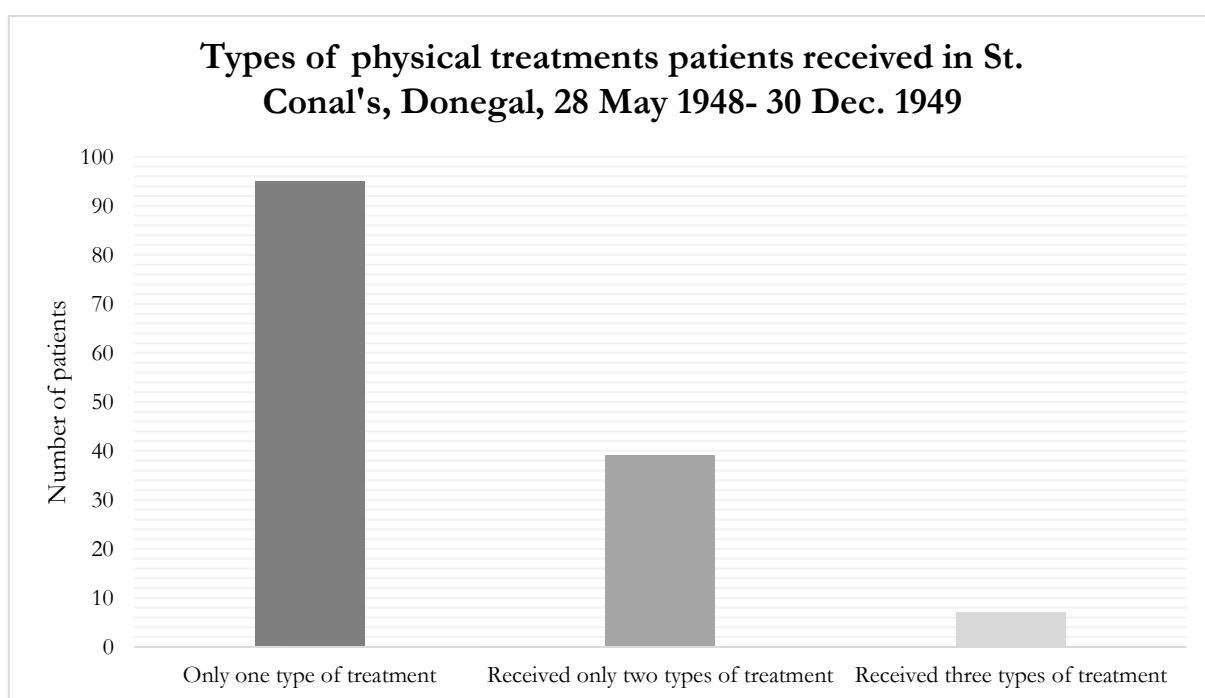


Figure 5.10 Number of physical treatments in St. Conal's District Mental Hospital, May 1948-Dec. 1949.²⁰⁴

that when one of these treatments failed to achieve a cure, another was administered, and this cycle was sometimes repeated until the attendant deemed the patient's condition improved.²⁰⁵

²⁰³ Data taken over a period of 18 months from *Observations and treatment book in St. Conal's hospital*, 28 May 1948-30 Dec. 1949 (MED 4/5/8/3).

²⁰⁴ Ibid.

²⁰⁵ Ibid.

Deviating away from the wider scientific theories that shaped the treatments in the first place, this practice was at odds with the very same medical interventions that were intended to target specific mental diseases and their symptoms only.

Access to available medicines and equipment was an important factor in the usage of the physical therapies in Irish mental hospitals during the 1940s. As early as September 1942 in Ballinasloe, the change from inducing convulsions with chemicals such as metrazol, cardiazol and triazol, to using the electro-shock machine was welcomed during the war period when ‘owing to war conditions, the convulsive drugs became unobtainable in this country’.²⁰⁶ There was also an insulin shortage.²⁰⁷ In 1942, insulin was included on the Department of Local Government and Public Health on a list that detailed medicines that were necessary for ‘the preservation of life’.²⁰⁸ Emphasis was placed on using perishables, such as insulin, up before replacing stocks with newer versions.²⁰⁹ Adding complexity to this was the rising cost of insulin during the 1940s – something that St. Conal’s was very much aware of. So much so that the costs of insulin-coma therapy were included in the treatment book as the medical superintendent attempted to maximise his supplies.²¹⁰ Based on a course of therapy spread over twelve weeks with an average shock dosage of 200 insulin units, the cost of ICT per patient was £3 9*d.* and that was before costs of glucose at £3 12*d.* and blood sugar was added 15*d.*²¹¹ Costing an average £7 16*d.* per patient before nursing wages were added, the medical superintendent noted how on the basis of 20 patients receiving ICT in a year, this was £156 on insulin related medicines alone.²¹² However, within the first four months of 1949, fourteen patients had already received a course of insulin therapy suggesting that the real cost was considerably higher.²¹³

Meanwhile, the electro-shock machine simplified the administration of convulsive therapy. Though attention to detail was required by the institutional attendants when they carried out the procedure, ECT could be administered by two nurses or attendants alone. Less labour-intensive than ICT, the administration of ECT incorporated a portable machine with three buttons (an ammeter, a voltmeter and a timer for interrupting the current) that was connected to an ordinary electric outlet and the patient via electrodes (see figures 5.11 and 5.12).²¹⁴ For doctors, this electric shock method was easier to administer than the metrazol method.²¹⁵ The metrazol method saw patients terrified of dying as they waited twenty seconds

²⁰⁶ Delany and Shea, ‘Observations on the treatments’, p. 193.

²⁰⁷ DLGPH to each Board of Health and Public Assistance, 21 Mar. 1942. (NAI TAOIS S/11445).

²⁰⁸ Ibid.

²⁰⁹ Ibid.

²¹⁰ *Observations and treatment book in St. Conal’s hospital*, 28 May 1948- 30 Dec. 1949 (MED 4/5/8/3).

²¹¹ Ibid., 18 Apr. 1949.

²¹² Ibid.

²¹³ Fourteen patients were already on a course of insulin therapy by 18 Apr. 1949. Ibid.

²¹⁴ Kraines, *The therapy of the neuroses*, p. 496.

²¹⁵ Ibid.

between the injection of metrazol itself and the convulsion whereas an induced convulsion via electric shock apparatus usually brought about amnesia which ensured patients forgot any disturbing sensations they may have experienced.²¹⁶ In turn, the labour involved was significantly reduced.



Figures 5.11 and 5.12: Left, Ectron ECT machine used in St. Davnet's, Monaghan, c. mid 1940s.²¹⁷ Right, a close-up of universal controls: an ammeter, a voltmeter and a timer.²¹⁸

The Medical Association of Éire may have welcomed the Mental Treatment Act as an 'enlightened and humane' piece of legislation, but an examination of how treatments were used in the immediate aftermath of the Mental Treatment Act 1945 highlights the extent to which the act failed to change the 'management culture' of the hospitals themselves. Institutional records reveal that these treatments continued to be used to subdue troublesome patients rather than treat specific mental illness, and this coincided with a significant rise in patient numbers post 1945 (see figure 5.7 and 5.8).²¹⁹ In July 1949, a patient in St. Conal's was prescribed a course of ECT because he had tried to escape.²²⁰ This was not all that dissimilar from the case of Hanna Greally in St. Loman's Hospital in Mullingar some years previous where she was given ICT after an attempted escape and her refusal to eat.²²¹ In the same month in St. Conal's, another patient was given three rounds of ECT because she was 'very restless and aggressive'.²²² Another

²¹⁶ Ibid., p. 497.

²¹⁷ Image sourced from World Within Walls Collection, available on DRI, (<https://repository.dri.ie/catalog/th83m027m>) (Accessed 2 Aug. 2024).

²¹⁸ Image sourced from Science Museum London, available on Wellcome Collection (<https://wellcomecollection.org/search/images?query=n76whrxq>) (Accessed 2 Aug. 2024).

²¹⁹ Molony, 'The new Mental Treatment Act', p. 51. Dr Conn Ward also mentions that the association was strongly in favour of the act's temporary admission clause, see *DÉD*, 19 Apr. 1945, vol. 29, no. 25.

²²⁰ *Observations and treatment book in St. Conal's hospital*, 28 May 1948- 30 Dec. 1949 (MED 4/5/8/3).

²²¹ Hanna Greally, *Bird's nest soup* (2nd ed., Dublin, 1986), pp 30-31.

²²² *Observations and treatment book in St. Conal's hospital*, 2 Jul. 1948. (MED 4/5/8/3).

attendant's account saw the same patient some months later appearing 'confused, restless and violent' in the morning in the day-room and subsequently given four rounds of ECT in the afternoon.²²³ Because the patient was still 'confused and violent' afterwards, she was given a further round of ECT followed by a sedative.²²⁴ While her 'restlessness' and 'violence' could have been interpreted as evidence of disease deterioration that thereby necessitated ECT, this was a stand-alone occurrence. In the aftermath, the patient was not listed as being on a course of ECT, which should have been the case if it was used with a primary curative aim. A full course of ECT at the time was anything from a month to seven months of repetitive treatment, rather than a single day.²²⁵ Some months later, another patient who appeared 'very disturbed and restless' was given ECT four times in a single day despite the fact that records denote that ECT usage in St. Conal's was mainly confined to once in the mornings.²²⁶ This was followed by sedation before being put to bed at 7pm in the institution's padded room in May of the same year.²²⁷ This patient resumed a course of somnifaine therapy the next day.

Similar examples can also be found in the records of Grangeegorman Mental Hospital in the early 1950s. In the night nurses' report book, Nurse Kenny noted that she gave a patient sedatives because she deemed them 'troublesome' in February 1951.²²⁸ Although the patient slept for a couple of hours after this, she was subsequently put in a restraint jacket for two hours, with no reason given.²²⁹ On the same night, Nurse McSherry sedated a different patient because she was 'noisy' and 'talkative' – this patient slept afterwards, but awoke to be given another sedative.²³⁰ Writing on the use of ECT in Irish mental hospitals, Irish psychiatrist L. F. Noonan noted in the *British Medical Journal* upon his move to the UK that:

I came to regard the E.C.T. switch as a whip in the hands of the operator... A whip, however, is not a scientific instrument. Need one add more?²³¹

These examples suggest that these treatments were still used as a management tool for difficult patients' behaviour as opposed to their mental conditions.

Questions of whether this 'management culture' was inherently good or evil are complex. On the one hand, the institutional records reveal accounts of alleged physical abuse by the attendants. In October 1948, a patient in St. Conal's had a large swelling on his face and a cut on his ear, and alleged that he was hit in the face by the attendant.²³² No further details

²²³ Ibid. 19 Dec. 1948.

²²⁴ Ibid.

²²⁵ Ibid.

²²⁶ Ibid.

²²⁷ Ibid. 1 May 1948.

²²⁸ *Head night nurse report book*, 5 Feb. 1951 (PRIV/1223/8/1).

²²⁹ Ibid.

²³⁰ Ibid.

²³¹ L. F. Noonan, 'Physical therapy of mental disorder' in *BMJ*, i (May, 1947), p. 778.

²³² *Observations and treatment book in St. Conal's hospital*, 21 Oct. 1948 (MED 4/5/8/3).

were included in the treatment book, only that the attendant in charge claimed that he did not hit the patient, insisting instead it was another patient, reminding us of the power-dynamics that were at play behind these walls.²³³ Another account detailed a patient who had a large swelling beside his eye and claimed he was assaulted by an attendant and a note that ‘he [the attendant] denies this’.²³⁴

There are, however, examples of attendants who sought resolutions to incidents for the greater good. For example, another patient rested in his bed due to severe bruising on his leg as the attendant noted he was kicked by another patient, with the other patient subsequently ‘not allowed to wear boots again’.²³⁵ Accounts in Grangegorman also reveal the complexities of managing the patients, where a female patient was ‘very abusive...threatening to throw water from the bucket on the patient beside her’.²³⁶ On 22 November 1948 a patient in St. Conal’s, ‘attempted to cut his throat with a knife at dinnertime’ and became ‘resistive and violent’ afterwards when the attendants tried to defuse the situation.²³⁷ While this gives insight into the complexities of patient management, it equally offers insight into the patient’s frame of mind; dinnertime would have been among the only opportunities for a patient to use sharp objects. He was subsequently removed from the kitchen and sedated so that he could no longer inflict any further harm.²³⁸ Similar accounts can be found in Grangegorman, where a nurse, upon hearing a patient coughing in February 1952 reported that:

I removed the bed clothes and discovered patient attempting to choke herself by pressing her fingers on her throat and neck. Removed to observations ward downstairs immediately.²³⁹

The actions of the attendants in these instances saved the lives of both patients. Rather poignantly, however, one patient was found dead in his bed three weeks later.²⁴⁰ While there was no record of suicide in the inspector reports for that specific year, the attendant did note that the patient was given paraldehyde (anti-convulsive sedative) some hours earlier because he ‘refused to remain in bed’.²⁴¹

Of course, it is also possible that an attending physician interpreted a patient’s actions as evidence of decline in their mental condition. Although the treatments seemed to function akin to a punishment and reward system, there were also significant numbers of patients subjected to physical therapies when they were thought to be ‘deteriorating’. The patient above

²³³ Ibid.

²³⁴ Ibid., 18 Oct. 1948.

²³⁵ Ibid., 27 Jan. 1949.

²³⁶ *Head night nurse report book*, 12 Feb. 1952 (PRIV/1223/8/1).

²³⁷ *Observations and treatment book in St. Conal’s hospital*, 22 Sept. 1948. (MED 4/5/8/3).

²³⁸ Ibid.

²³⁹ *Head night nurse report book*, 17 Feb. 1952 (PRIV/1223/8/1).

²⁴⁰ *Observations and treatment book in St. Conal’s hospital*, 23 Oct. 1948. (MED 4/5/8/3).

²⁴¹ Ibid.

was placed on a course of ECT in St. Conal's after he had attempted to cut his throat, suggesting that the attendants in St. Conal's interpreted his actions as reason for treatment.²⁴² Another case in 1948 saw an ICT patient throwing furniture around the operating room ahead of his procedure in St. Conal's.²⁴³ When he was calm, he stated that the institution's staff were laughing at him and that 'the voices' told him the attendants were reading his mind.²⁴⁴ Though the phenomenon of 'hearing voices' is an occurrence reported in a number of mental disorders (schizophrenia, severe depression, bipolar disorder, psychosis and PTSD), it was historically considered very common in schizophrenic patients alone. Given that ICT was aimed at schizophrenic patients at this time, the patient's ICT treatment in this case may have been justified by symptoms exhibited.

The evidence also suggests that members of the Irish psychiatric profession genuinely cared for the recovery and livelihoods of their patients. In the first instance, the attendants of these hospitals kept detailed records on whether patients made any progress. A rather poignant account in St. Conal's treatment book detailed a female patient in December 1948, who had been given both ECT and ICT. Having only slightly improved in her mental state, the attendant noted that she worried that she would never fully recover enough to be discharged.²⁴⁵ Another attendant's account detailed concerns of a somnifaine patient who struggled to sleep, noting how he was worried about his wife, while another sympathised with a patient who 'wants to go home'.²⁴⁶

Hospital staff were aware of the role they played in this broader shift that saw once warehouse-like institutions become viable treatment hospitals. In a series of exchanges in the *Lancet* on the effects of ICT in 1952, it was argued that the therapeutic benefits that attendants saw from ICT were derived as much from environmental changes as the treatment itself, where those receiving treatments like ICT received 50-100 times more medical and nursing care on the clock as the general time given to patients that were not given these therapies.²⁴⁷ This was often reciprocated by some patients who volunteered themselves for physical treatments in the hope that they would be cured, some were even 'anxious for treatment'.²⁴⁸ Elsewhere, existing historiography has noted that the heavily supervised space of the insulin unit coupled with the medical equipment it contained established an environment that some likened to an operating room.²⁴⁹ For Doroshov, ICT provided the psychiatric profession with a space to build upon

²⁴² Ibid., 1 Oct. 1948.

²⁴³ Ibid., 20 Dec. 1948.

²⁴⁴ Ibid. 20 Aug. 1948 and 20 Dec. 1948.

²⁴⁵ Ibid. 22 Dec. 1948.

²⁴⁶ Ibid. 5 Aug. 1948.

²⁴⁷ Harold Bourne, 'The insulin myth' in *Lancet*, cclxii, no. 6793 (Nov. 1952), p. 965.

²⁴⁸ *Observations and treatment book in St. Conal's hospital*, 20 Dec. 1949 (MED 4/5/8/3).

²⁴⁹ Doroshov, 'Performing a Cure', pp. 224-225.

their therapeutic focus, and there are glimpses of this in this regard.²⁵⁰ Following the act, St. Conal's was commended by government inspectors for its use of modern treatments with a 'very satisfactory' number of patients discharged recovered in 1947 and 1948.²⁵¹ A closer look at admissions to and discharges from St. Conal's hospital corroborates the inspectors' findings (see figure 5.13). As shown, the percentage of admissions to discharges in 1947 and 1948 were 79.4% and 82.1% respectively, and this was something St. Conal's hospital had not seen in the previously in the 1940s.²⁵² These figures were found as a side-note in a treatment book in St. Conal's hospital, further reminding themselves of the progress that they were making.

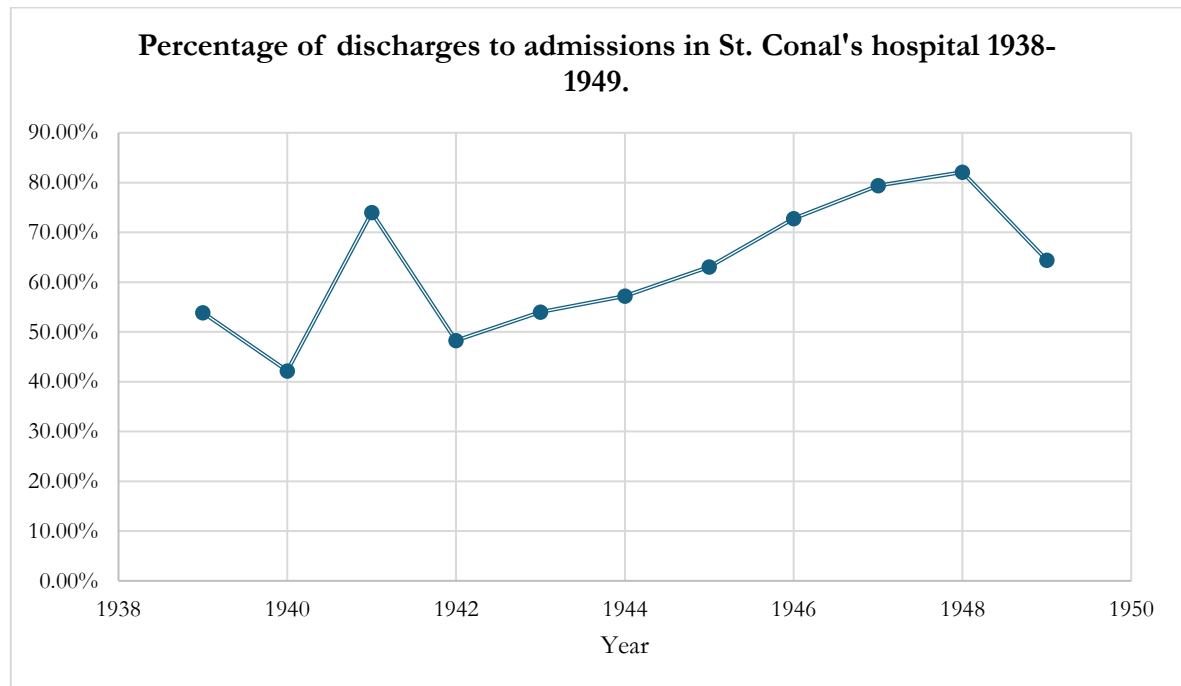


Figure 5.13 Percentage of discharges to admissions in St. Conal's hospital, 1938-50.²⁵³

5.8 Conclusion

Overall, the Mental Treatment Act of 1945 had a significant impact on the running of Irish public mental institutions as well as on the circumstances of those patients housed within. From a policy perspective, high patient numbers implicated lunatic asylums as a growing economic burden on an already stained Irish government, whose reforms in this area occurred alongside other significant developments in the field of public health at the same time. New laws may have radically and belatedly transformed the old lunacy discourse of the Victorian legislation with the 'inmates' becoming 'patients' and the 'asylums' becoming 'hospitals', but an examination of the act's provisions suggests that the new act was still more concerned with

²⁵⁰ Ibid.

²⁵¹ ARIMH, *1947-1948* (Dublin, 1949), p. 22.

²⁵² *Observations and treatment book in St. Conal's hospital*, undated, c. Jan. 1950 (Med 4/5/8/3).

²⁵³ Ibid.

patient management than patient cure in most of its particulars. Despite Fianna Fáil's aim to dramatically revolutionise mental healthcare in Ireland, efforts to quickly reduce populations in mental hospitals were unsuccessful, and patient numbers peaked in the 1950s.

The image of the policymakers spending a 'beautiful spring day planning, at [their] undisturbed leisure' for measures to alleviate the circumstances of those suffering from mental illness at the chapter's opening further underscores the apparent disconnect between the policymakers and the individuals whom their policies were intended to help.²⁵⁴ Rather poignantly, the records of the institutions reveal that the act had failed to change the 'management culture' of the mental hospitals. Instead, these measures brought temporary relief to the management of otherwise 'difficult' patients while the same 'difficult patients' were unwittingly rendered subject to a new wave of psychiatric experimentation. New treatments may have provided Fianna Fáil with a new armoury to combat mental illness in its most severe forms, but these were also used in conjunction with older treatments, reminding us that these institutions did not just simply bring in a new wave of treatments at the expense of others. New legislation could not really change the management culture, which suggests that the interests of the government was on reducing patient numbers, and not on enhancing patient experiences. Besides, such a focus on 'early diagnosis' and 'early treatment' aligned reasonably well with prevailing political and medical discourse in Ireland, which favoured a 'profitable' return to Irish society of the young and working populations. In turn, this had a significant impact on longer-staying populations, who, with the exception of occupational therapy, were doing little to nothing at all (see Appendix M). By the late 1950s, the pharmaceutical industry had started marketing a number of anti-psychotic drugs including chlorpromazine.²⁵⁵ These were major tranquillisers that may have managed the worst symptoms of schizophrenia and other severe psychotic disorders, but like ICT, modern drugs and anti-depressants continue to be used on the basis of observed changes in behaviour and on reported thoughts and feelings, without a consensus on how these drugs caused these effects and how they impacted normal brain functions.²⁵⁶ Notwithstanding, these pharmaceutical advances, coupled with advances in the understanding of mental health and changing public perceptions of mental illness encouraged a distinct shift toward community care in Ireland in the mid-1960s and 1970s, following similar patterns of deinstitutionalisation elsewhere.²⁵⁷

A focus on reducing patient numbers raises again the question of the populations that the Irish government were most concerned with targeting for public health measures. After

²⁵⁴ *DÉD*, 19 Apr. 1945, vol. 29, no. 25 (Seán Ruane).

²⁵⁵ Calabria and Cullen, 'Deinstitutionalisation and the move to community care', p. 148.

²⁵⁶ Freudenthal and Moncrieff, 'A landmark in psychiatric progress?', p. 75.

²⁵⁷ Calabria and Cullen, 'Deinstitutionalisation and the move to community care', p. 148.

independence, consecutive Irish governments began shaping policies separately from Britain.²⁵⁸ Unlike other healthcare reforms, however, developments to Ireland's mental health policy stalled, with Victorian lunacy laws dictating provisions until 1945, which as Calabria and Cullen have pointed out, then 'remained unchanged until the *Planning for the Future* Green Paper of 1984, with the next shift in policy in 2001.²⁵⁹ This was unusual by international standards, as evidenced by frequent changes made to mental healthcare policies in other countries like Britain throughout the twentieth century.²⁶⁰ Delays to reforming these laws are even more striking and ironic in an Irish context, where mental healthcare was perhaps the most centralised form of healthcare and thus the area over which government could exercise the most direct influence.

²⁵⁸ Ibid., p. 143.

²⁵⁹ Ibid., p. 142.

²⁶⁰ Ibid., p. 147.

CHAPTER SIX

‘TUBERCULOSIS KILLS THE YOUNG’: PUBLIC HEALTH APPROACHES TO TUBERCULOSIS, 1939-1953

6.1 Introduction

In a Dáil debate on 16 June 1942, James M. Dillon (brother of renowned professor and anti-tuberculosis campaigner Theobald W. T. Dillon) and several government TDs spoke on the urgency of addressing the country's tuberculosis (TB) problem.¹ James Dillon was one of the few parliamentary voices opposing Ireland's policy of neutrality at this time.² 'TB is the third greatest killer in this country,' Dillon argued, 'It is only surpassed by heart disease and cancer. But heart disease and cancer largely kill the old. Tuberculosis kills the young.'³ During the war, deaths from TB in Ireland suggested that the country was 'the only neutral country in Europe to suffer from wartime conditions' despite the absence of direct war.⁴ In the debate, TB was framed as a health problem that needed to be examined because it 'kills the young' and not the old, in contrast to heart disease and cancer. Between 1939 and 1953, references to TB and its unusually high incidence among younger age-groups were also very common in other government debates and memoranda, papers by medical personnel as well as voluntary organisations. While TB was the third leading cause of death for much of the 1940s, it was the single leading cause of death among people aged between 15 and 45.⁵ This is not to say that TB did not kill at all ages, it did. But rather, it was the mortality of the 'young' that attracted government attention, albeit belatedly due to the scarcity of supplies during the war. Whereas much of the existing historiography of TB in Ireland has focused on the social and environmental context of the disease, this chapter argues that the emphasis on it as a disease affecting the young was equally as significant in shaping public health policy. Furthermore, this focus on young people was closely tied to concerns about national vitality.

Existing historiography on TB in this period in Ireland has focused for the most part on the disease in its social and economic settings. Greta Jones draws attention to the 'tuberculosis epidemic in Ireland', which spanned from the late nineteenth-century to the 1950s

¹ *DÉD*, 16 Jun. 1942, vol. 87, no. 9.

² Donal Lowry, 'New Ireland, old empire and the outside world, 1922-49: the strange evolution of a 'dictionary Republic' in Mike Cronin and John M. Regan (eds), *Ireland: the politics of independence, 1922-49* (London, 2000), p. 164. James Dillon resigned as deputy leader of Fine Gael in 1942 over neutrality and was afterwards elected as an Independent TD in elections between 1943 and 1951 before he re-joined Fine Gael in 1952, becoming leader in 1959, see Maurice Manning, *James Dillon: a biography* (Dublin, 1999).

³ *DÉD*, 16 Jun. 1942, vol. 87, no. 9.

⁴ Marc Daniels, 'Tuberculosis in Europe during and after the Second World War' in *BMJ*, ii, no. 4636 (Nov. 1949), p. 1067.

⁵ *ARRG, 1939* (Dublin, 1940), p. xix.

– an epidemic that persisted for much longer than most comparable countries.⁶ Jones’ study became the first social history of TB in Ireland, where she notes the 1940s as ‘landmark years’ for TB in Ireland, citing reasons of changes to the management of the disease after the war as well as the forging of new attitudes toward it.⁷ Anne Mac Lellan builds on this view in her article on Ireland’s unique experience of TB during the Second World War. She finds that Ireland’s experience of TB was broadly similar to a combatant country like Britain as opposed to the experience of other neutral countries.⁸ For Mac Lellan, this complicated efforts to blame the war for the shifting epidemiological patterns, noting how an increased number of deaths in Ireland began to provoke a response at national level from leading medical doctors, government members and voluntary organisations alike.⁹

This chapter argues that doctors, voluntary organisations and government members used the idea of TB as a leading killer of the young and working populations in their advocacy for further government action to combat the disease. Second, it contends that most post-war government actions in relation to TB were designed to address the needs of the young and working populations. This was not an entirely new phenomenon. Internationally, Lynda Bryder explores the concept of ‘pre-tuberculous children’ and its policy implications in relation to disease prevention in Britain, France, Germany and the US during the interwar years.¹⁰ Teemu Ryymin extends Bryder’s analyses to Norway, demonstrating how children’s TB became a significant part of anti-TB efforts in the 1920s.¹¹ More recently, Nelleke Bakker examines children and the anti-tuberculosis campaign in the Netherlands from 1900-1940, noting how a focus on the young resulted in the expansion of food distribution networks, open-air schools, summer health camps and residential institutions.¹² Similarly, Michael Harrison and Michael Worboys frame TB as a ‘disease of civilisation’ in its wider context and this is supported by M. Ashraf’s observation that TB attacked ‘the economically productive’ populations in the UK.¹³ This chapter will examine similar developments in Ireland. As found in the other case studies,

⁶ Greta Jones, *Captain of all these men of death: the history of tuberculosis in nineteenth and twentieth century Ireland* (New York, 2001), p.3.

⁷ *Ibid.*, p. 188.

⁸ Anne Mac Lellan, ‘Alone among neutrals: Ireland’s unique experience of tuberculosis during the Second World War’ in David Durnin and Ian Miller (eds), *Medicine, health and Irish experiences of conflict, 1914-45* (Manchester, 2016), p. 67.

⁹ *Ibid.*, p. 67.

¹⁰ Lynda Bryder, ‘Wonderlands of buttercup, clover and daises’: tuberculosis and the open-air school movement in Britain, 1907-39’ in R. Cooter (ed.), *In the name of the child: health and welfare, 1880-1940* (London, 1992), pp 72-95.

¹¹ Teemu Ryymin, ‘Tuberculosis-threatened children?: the rise and fall of a medical concept in Norway, c. 1900-1960’ in *Medical History*, lii (2008), p. 347.

¹² Nelleke Bakker, ‘Fresh air and good food: children and the anti-tuberculosis campaign in the Netherlands c. 1900-1940’ in *History of Education*, xxxix, no. 3 (2010), p. 344.

¹³ Mark Harrison and Michael Worboys, ‘Tuberculosis in Britain, Africa and India, 1900-39’ in Lara Marks and Michael Worboys (eds), *Migrants, minorities, and health: historical and contemporary studies* (London, 1997), p. 117. Also see M. Ashraf, ‘Changing patterns of tuberculosis in England and Wales’ in *The Journal of the Royal Institute of Public Health and Hygiene*, xxxi, no. 4-6 (Dec. 1968), p. 123.

concrete government measures to combat TB were introduced after the war had ended, with significant enhancements occurring post-1947. Short and long-term government programmes consisted of expansions to sanatorium beds and staffing (1946 onwards), the provision of monetary allowances for TB patients (1947), the Medical Research Council's TB Chemotherapy Unit and Scheme for the Protection of Hospital Staffs (1947), enhanced health promotion and education (1948 onwards), the development of the BCG vaccination programme (1949), the introduction of a nationwide mass-radiography service (1950), and the provision and organisation of after-care and rehabilitation for TB sufferers (1952). Didactic anti-TB posters were also common (see Appendix N). But this concentration on the young in relation to TB was not simply because of higher disease numbers. State emphasis on improving the health of the younger generations was part of a wider public health rhetoric that emphasised the importance of the young in other aspects of public health policy at the same time as explored in chapters three and four.

6.2 Historicising tuberculosis in Europe

TB is a chronic and contagious bacterial disease that is caused by the growth of bacillus mycobacterium tuberculosis in bodily tissues.¹⁴ While the disease can affect any part of the body, it was most commonly found in the respiratory system, a form known as 'pulmonary TB'.¹⁵ TB could also infect the skin, bloodstream (miliary TB) and bones, joints and spine.¹⁶ Like rickets, TB also 'cruelly changed the bodies of its sufferers'.¹⁷ Symptoms of pulmonary TB included but were not limited to fever, chest pain, lengthy coughing outbursts and severe weight loss. Children, who were often affected by non-pulmonary TB, showed manifestations of *tuberculosis mesenterica* (infection of the mesenteric glands and intestines) and *scrofula*, where sufferers experienced large swellings in the armpits, neck and elsewhere.¹⁸ Children also suffered significantly from miliary TB, which riddled the skin in lesions or TB of the joints.¹⁹ This could deform the joint and potentially lead to a hunchback.²⁰

There are many reasons why TB gained increased political attention in Europe during the first half of the twentieth century. During this period, there was a remarkable fall in TB death rates in several regions in Europe, which signified a substantial step forward in controlling the disease.²¹ By 1938, for example, in England, Wales, Scotland, Holland, Belgium, Denmark

¹⁴ M. Porta, *A Dictionary of Epidemiology* (5th ed., New York, 2008), p. 247.

¹⁵ Alan F. Carthy, 'The treatment of tuberculosis in Ireland from the 1900s to the 1970s: a case study of medical care in Leinster' (PhD dissertation, NUIM, 2015), p. 6.

¹⁶ *Ibid.*

¹⁷ Susan D. Jones, 'Mapping a zoonotic disease: Anglo-American efforts to control bovine tuberculosis before World War I' in *Osiris*, ii, no. 19 (2004), p. 134.

¹⁸ *Ibid.*

¹⁹ *Ibid.*

²⁰ *Ibid.*

²¹ Daniels, 'Tuberculosis in Europe', p. 1066.

and Germany, TB mortality had fallen below 75 per 100,000 of the population while in Norway, Sweden, Italy and Switzerland, it was below 100.²² In 1885, Denmark had one of the highest TB mortality rates recorded in Europe at nearly 300 per 100,000 and yet in 1945, it was 33 per 100,000 – the lowest rate recorded in Europe.²³ That being said, TB rates rose in every European country that was seriously affected by the Second World War. Discussions in the 1940s in Europe among medical practitioners thus focused on the nature of the wartime increase, citing that the additional deaths in wartime could have been from patients who under normal conditions may have lived a little longer or alternatively, the wartime increase could have been among those patients who would have normally overcome their disease and survived.²⁴ Ireland also experienced a decline in TB rates, which slowed down following the onset of the Second World War and led to similar medical and government investigations (see figure 6.1).

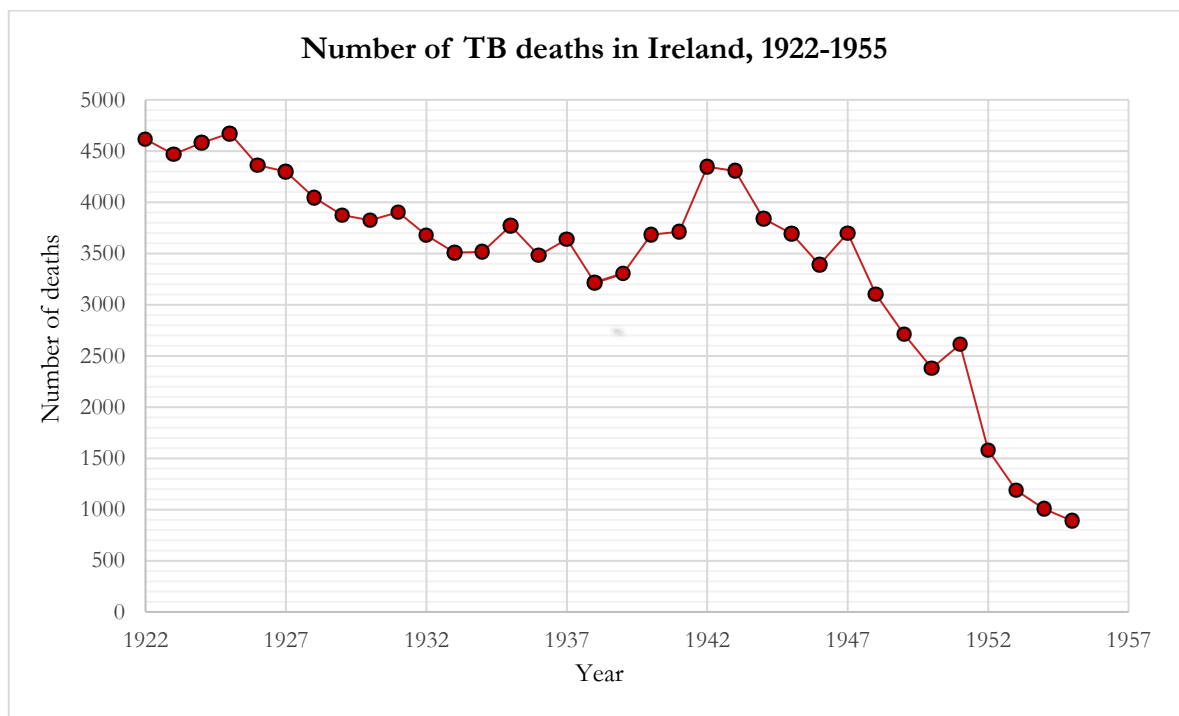


Figure 6.1 Deaths from tuberculosis (all forms) in Ireland between 1922-55.²⁵

In Ireland, England, Wales, Belgium and France, TB mortality rates rose in the first years of the war and fell in the later years of the war.²⁶ For Daniels, there was ‘enough in the chaos’ during the first two years of the war to explain mortality increases in these countries up until 1941.²⁷ In England and Wales, air raids coupled with an anticipated invasion led to the

²² Ibid.

²³ Ibid., p. 1067.

²⁴ Ibid., p. 1071.

²⁵ *ARRG, 1922-1955* (Dublin, 1956), consecutive years.

²⁶ Ibid., 1067.

²⁷ Ibid.

evacuation of sanatoria and some hospitals to make room for war casualties.²⁸ Some of these TB patients were drawn into industry.²⁹ Overcrowding in homes and black out conditions also increased because of billeting and air raids while the ‘coming into contact with them of people who had previously led a relatively isolated life’ created favourable conditions for a 13% increase in TB mortality in England and Wales during the first two years of the war.³⁰ However, this was remedied to a large degree by 1942 when health and social services were re-established quickly and government measures targeted those who were otherwise perceived to be more seriously affected by wartime disruptions. To this end, mothers and children actually benefitted from strict wartime rationing measures when calcium was added to bread and milk was provided for children and expectant mothers.³¹ Conditions in Belgium likewise improved and almost as many sanatorium beds were available by 1942 as before the war.³² Double rations were given out by Belgium dispensaries, not only to patients suffering from chronic TB but to those whose lesions had been previously active within the past five years.³³ Investments in health and social infrastructures in these countries during and after the war meant that the wartime surge in the incidence of TB was relatively well resisted.³⁴

Political, medical and philanthropic attention in Ireland focused on TB among the young because mortality data suggested it was a leading cause of death for youths and young adults. Speaking in the same Dáil debate in June 1942, James M. Dillon pointed out that out of every 100 people who died between the ages of 15 and 35 in 1939, 51 of these died from TB in one form or other.³⁵ This proved particularly damning when the country had reached an all-time low in 1938 with regards to the number of people dying from the disease (see figure 6.1). While TB was not the leading cause of death at the beginning of the war, it was the leading cause of death among people aged between 15 and 45 years old.³⁶ At the same time, TB accounted for almost half of all deaths in the 25-35 age group.³⁷ A similar pattern can also be identified throughout the war years. When deaths from TB peaked in Ireland in 1942, for example, it was the leading cause of death in children between the ages of five and fifteen where one in four of these deaths was attributed to some form of the disease.³⁸ Similar figures were also found in 1943.³⁹ Although the sharp decline in TB mortality can be attributed to significant

²⁸ *Ibid.*, p. 1068.

²⁹ *Ibid.*

³⁰ *Ibid.*

³¹ T. W. T. Dillon to Dr Conn Ward, 22 Oct. 1943. (NAI, TAOIS S/12064).

³² Daniels, ‘Tuberculosis in Europe’, p. 1067.

³³ *Ibid.*

³⁴ *Ibid.*

³⁵ *DÉD*, 16 Jun. 1942, vol. 87, no. 9.

³⁶ *ARRG*, 1939 (Dublin, 1940), p. xix.

³⁷ *Ibid.*, p. xviii.

³⁸ *ARRG*, 1942 (Dublin, 1943), p. xviii.

³⁹ *ARRG*, 1943 (Dublin 1944), pp xxii-xxiv.

public health reforms from 1947 onwards, Ireland stood out as the only neutral country in Europe to experience wartime conditions in terms of TB deaths at that time. Jones' observation that national histories of TB may highlight similarities and differences in TB experiences is important.⁴⁰

In Ireland, there was no direct combat; the same black-out conditions did not apply, and the sanatoria were likewise not emptied for soldiers. Yet, the war seemed to exacerbate Irish children's and adults' experience of TB.⁴¹ Between 1939 and 1945, a total of 26,886 people died from TB in Ireland, representing a 22% increase on the numbers recorded between 1933 and 1938.⁴² For Deeny, the country's Chief Medical Adviser (CMA), the most striking aspect of TB mortality in Ireland was that a large proportion of deaths were occurring in early adult ages.⁴³ This was unusual – trends in other countries demonstrated that mortality from TB was shifting to much older age groups.⁴⁴ In France and Sweden, the TB death rate was at its highest in those aged over 45 years old from the early 1930s.⁴⁵ While TB was still a leading cause of death among the 'economically active' cohorts of the British population, there was a higher TB mortality rate among those aged over fifty years old than those of younger ages by 1936.⁴⁶ TB also became 'a disease of aged persons' in the US at the same time.⁴⁷ Further, TB mortality in wider Europe during wartime was not as significant as it was in previous wars, and this applied especially to countries such as Denmark and Sweden where public health services were substantially improved during the inter-war years.⁴⁸

6.3 Tuberculosis in Ireland during the war

An examination of existing TB public health infrastructures is crucial to understanding the problem of TB in Ireland during the war. Alan Carthy points out that voluntary organisations, and not political initiatives, first brought anti-tuberculosis measures into public focus in the late nineteenth and early twentieth centuries.⁴⁹ This remained largely the case until the 1940s, where non-governmental voluntary organisations and medical professionals were responsible for initiating anti-tuberculosis measures.⁵⁰ This is an important distinction because unlike mental

⁴⁰ Jones, *'Captain of all these men of death'*, pp 6-7.

⁴¹ Mac Lellan, 'Alone among neutrals', p. 66.

⁴² *ARRG, 1933-45* (Dublin, 1946), consecutive years, pp xxxii-xxxiii.

⁴³ James Deeny, *Report of the national tuberculosis survey, 1950-53* (Dublin, 1954), p. 30.

⁴⁴ *Ibid.*

⁴⁵ Gunnar Dahlberg, 'Mortality from tuberculosis in some countries' in *British Journal of Social Medicine*, iii, no. 4 (1949), p. 220.

⁴⁶ *Ibid.*

⁴⁷ Deeny, Draft plan of institutional treatment of tuberculosis, 1945 (RCSI/IP/Deeny/1/2/18/98/File B).

⁴⁸ *Ibid.*

⁴⁹ Carthy, 'The treatment of tuberculosis', p. 86. Charitable and voluntary organisations also played a key role in the provision of other health services where the state was absent, see Laurence M. Geary, *Medicine and charity in Ireland, 1718-1851* (Dublin, 2004).

⁵⁰ Shane Lehane, *A history of the Irish Red Cross* (Dublin, 2019), p. 133.

illness, the Irish Cumann na nGaedheal government did not inherit a system of existing state-run public institutions that catered for people suffering from TB.⁵¹ Instead, campaigns by voluntary organisations, such as the National Association for the Prevention of Tuberculosis and the Women's National Health Association, who were responsible for introducing sanatorium treatment to the poor by promoting the erection of public sanatoria.⁵² The first purpose-built sanatorium was the Royal National Hospital for Consumptives, which opened in 1896 at Newcastle in County Wicklow.⁵³ In 1910, Heatherside Sanatorium opened in Cork, and Dublin County Borough opened Crooksling in 1911.⁵⁴ Meanwhile, the Tuberculosis (Ireland) Act and the 1911 Insurance Act enabled public money to be used by the local authorities to build sanatoria.⁵⁵ In compensation for this charge, state grants were given to county councils while the Hospitals' Trust Fund and Sweepstakes (from 1930) also contributed to providing bed accommodation for people suffering from TB.⁵⁶ To this end, Jones explores how Lady Aberdeen used a combination of private donations and financial assistance from the local authorities under the Insurance Act to build Peamount Sanatorium, which opened in 1912.⁵⁷ The religious orders also became involved, as evidenced by the establishment of St. Mary's Sanatorium in Finglas, Dublin and Our Lady of Lourdes Sanatorium in Dun Laoghaire.⁵⁸ Sanatorium housing thus provided the basis of treatment for TB patients in Ireland up until the 1950s, where an 'open-air life, a regular and ordered routine, a nourishing and plentiful diet, and a carefully controlled system of graduated rest and exercise' were in place.⁵⁹

The focus of Irish historiography on TB's economic and social settings is no coincidence. Aside from developments in the first decade of the twentieth century, consecutive Irish governments made slow progress in establishing an effective organisation to combat TB during the interwar years, placing the country in a particularly vulnerable position upon the outbreak of war. It was only in 1926 that the organisation of TB county health units began on a large-scale, and it took a further eight years until each county and county borough had a TB scheme with a county medical officer in place in 1933.⁶⁰ These schemes included the provision

⁵¹ Though the institutionalisation of people considered a risk of contagion has been an effective measure for disease control since ancient times, most control programmes for TB in western countries generally only started in the 1890s, amid new medical ideas that favoured a 'rest' treatment and good climate. See Flurin Condrau, 'Urban tuberculosis patients and sanatorium treatment in the early twentieth century' in Peter Shapely and Anne Borsay (eds), *Medicine, charity and mutual aid: the consumption of health and welfare in Britain, c. 1550-1950* (London, 2007), p. 183 and p. 192.

⁵² Carthy, 'The treatment of tuberculosis', p. 86.

⁵³ Jones, *'Captain all these men of death'*, p. 159.

⁵⁴ Ibid.

⁵⁵ Ibid.

⁵⁶ Ibid.

⁵⁷ Ibid., p. 160.

⁵⁸ Ibid.

⁵⁹ *Forty-ninth annual report of the Board of Governors of the Royal National Hospital for Consumption in Ireland for the year ending 31 December 1941*, p. 11 (RCPI, RNHC 1/2/5).

⁶⁰ Ibid.

of an assistant medical officer who was able to provide a TB dispensary service where people could be examined, diagnosed and referred for treatment.⁶¹ Although most counties either had small local sanatoria or access to them by the outbreak of war, many of these institutions were lacking in funds, in medical equipment, and in an appropriate number of beds.⁶² In October 1944, there was approximately 2,675 TB beds available in public and voluntary sanatoria, county hospitals and county homes in Ireland – a deficit of 4,325 of the desired amount of beds on the basis of how many people were dying each year.⁶³ For Irish medical professor, Theobald W. T. Dillon, the most significant failure to deal with the TB problem lay in:

The tendency to set up an elaborate organisation which has all the appearances of efficiency and to fail to supply it with adequate means to carry out the task assigned.⁶⁴

In his study on the TB bed shortage, Dillon noted that approximately 1,600 of these beds were situated in sanatoria that had minimal equipment and poor conditions.⁶⁵ TB patients also occupied beds in general hospitals, often for long periods where space could have been used for other patients.⁶⁶ Meanwhile, Caoimhghín Breathnach and John B. Moynihan note that Dillon's statistical papers on TB 'must have been particularly irksome to the government authorities, when his brother James could put the argument in a nutshell in *An Dáil*'.⁶⁷ Similar to nutrition and infant mortality with the GEAC, concrete government measures by way of combatting TB were put on pause for the duration of the war.⁶⁸

The emergence of the war had a significant impact on diagnosing TB in Ireland. In the early 1940s, Dillon argued that a successful anti-tuberculosis campaign was dependent on three factors – early diagnosis, early treatment and provision for the patient and their family until they recovered.⁶⁹ Early diagnosis was important because it was believed that if a patient was diagnosed when the disease was in its early forms that there was a better prognosis.⁷⁰ For example, a person might go to a sanatorium for treatment, where they would be housed away from the general population. This, in turn, would limit contagion within the wider community where spread of disease among industry workers was a real fear.⁷¹ Early diagnosis was best

⁶¹ Conn Ward to Irish Red Cross Society, 8 Mar. 1943 (DDA, McQuaid papers, XVIII/26/28).

⁶² *Ibid.*, p. 229.

⁶³ Dillon calculated Ireland's bed shortage based on two new TB cases per death. See Dillon, 'Tuberculosis and the bed shortage: tuberculosis bed needs in southern Ireland' in *IJMS*, vi, no. 226 (Oct. 1944), pp 517-520.

⁶⁴ Dillon, 'Tuberculosis: a social problem' in *Studies: An Irish Quarterly Review*, xxxii, no. 126 (Jun. 1943), p. 171.

⁶⁵ *Ibid.*

⁶⁶ *Ibid.*

⁶⁷ *Ibid.*, p. 170.

⁶⁸ Caoimhghín S. Breathnach and John B. Moynihan, 'The academy's foray into the politics of phthisis (tuberculosis) 1940-1946' in *IJMS*, clxxiii, no. 1 (2004), p. 49.

⁶⁹ Ward to Irish Red Cross Society, 8 Mar. 1943 (DDA, McQuaid papers, XVIII/26/28).

⁷⁰ Dillon, 'Tuberculosis: a social problem', p. 172.

⁷¹ *Ibid.*

⁷¹ Deeny, *Report of the national tuberculosis survey*, p. 247.

achieved by a combination of tuberculin testing and radiography.⁷² Tuberculin testing, which emerged in the 1930s as the ‘first line of defence’ in efforts to rule out bovine TB, was also developed to test humans for TB.⁷³ Bryce Evans observes, however, that the tuberculin used for tests was in short supply due to wartime conditions, and was ‘neither standardised nor readily available’.⁷⁴ It was not until March 1945 that there were investigations by Irish doctors, such as Edmund McWeeney, into the efficacy of tuberculin tests for humans, where it was concluded that the ‘Mantoux test’ was most accurate.⁷⁵ These initial examinations were based on a survey of 800 ‘young boys’ who were aged between 7-16, and selected from Artane Industrial School in Dublin.⁷⁶ In relation to animal testing to prevent bovine TB, only 5% of the total quantity of milk sold in the Dublin area in January 1947 was sold as highest grade milk that was obtained from herds where the animals had passed the prescribed tuberculin tests.⁷⁷ There was even less high grade milk supplied to the Dublin area during the war itself.

Radiography was also used to diagnose TB. This involved the imaging of the chest in order to detect early signs of the disease. In ideal circumstances, this was before any lung damage occurred and then the patient could be admitted to a sanatorium for treatment.⁷⁸ Dillon observed that:

It is a pity to have early cases for admission when the beds are occupied by patients with extensive disease, whom we might improve, but very rarely cure while the early cases are gradually becoming extensive themselves.⁷⁹

While there was X-ray apparatus available in Ireland prior to the outbreak of the war, these were oftentimes outdated and unevenly distributed. In 1937, Newcastle’s resident medical superintendent C. D. Hanan claimed that the X-ray apparatus was old, and the timing system for exposures was irregular.⁸⁰ A new x-ray machine known as a ‘Tomograph’ was sought, but this was expensive.⁸¹ In 1940, the county medical officers still had no x-ray facilities available for every suspected TB case.⁸² Brownswood sanatorium in Enniscorthy, Wexford had special rooms for the installation of x-ray equipment, but ‘the special rooms are empty’ with no x-ray

⁷² Dillon, ‘Tuberculosis: a social problem’, p. 172.

⁷³ Keir Waddington, ‘To stamp out ‘so terrible a malady’: bovine tuberculosis and tuberculin testing in Britain, 1890-1939’ in *Medical History*, xlviii (2004), pp 30-31.

⁷⁴ Bryce Evans, ‘Food the Emergency and the lower-class Irish body’ in David Durnin and Ian Miller (eds), *Medicine, health and Irish experiences of conflict, 1914-1945* (Manchester, 2016) p. 56.

⁷⁵ E. J. McWeeney, *Report on TB survey in Artane Industrial School, 24 Mar. 1945* (RCPI, EJTM/2).

⁷⁶ Ibid.

⁷⁷ *DÉD*, 22 Jan. 1947, vol. 104, no.1.

⁷⁸ Russell, ‘The advantages of mass x-ray, undated extract (RCPI, RE/14).

⁷⁹ *Forty-ninth annual report of the Board of Governors of the Royal National Hospital for Consumption in Ireland for the year ending 31 December 1940* (RCPI, RNHC/1/2/5) p. 11.

⁸⁰ *Forty-sixth annual report of the Board of Governors of the Royal National Hospital for Consumption in Ireland for the year ending 31 December 1938*, p. 13 (RCPI, RNHC/1/2/5).

⁸¹ Ibid. The cost of the tomograph at this time was estimated to be £900.

⁸² *Forty-eighth annual report of the Board of Governors of the Royal National Hospital for Consumption in Ireland for the year ending 31 December 1940*, p. 11.

equipment therein.⁸³ Instead, dispensary buildings were provided for them and this is where they kept their stethoscopes.⁸⁴ Because of this, people were often sent elsewhere for investigation.⁸⁵ In 1943 modern science ‘supplied in the miniature film technique a most useful instrument’ for examining quickly large numbers of people suspected to have the disease.⁸⁶ Though available by 1943, it was not possible to obtain the apparatus in Ireland until after the war.⁸⁷

Available treatment options were also profoundly impacted by the war. While Dr Dorothy Price imported the Bacilli Calmette Guérin (BCG) vaccine from Sweden to Ireland in 1937, Mac Lellan observes that this had to be used within a very short time-span.⁸⁸ The ability to secure further supplies was subsequently interrupted by the emergence of the war.⁸⁹ Not helping this situation was a lack of credibility within the wider medical and political spheres in England and the US on the efficacy of the vaccine itself.⁹⁰ This meant that there was no medical cure for TB that was in widespread use in Ireland in the early 1940s. Instead, there was a very distinct medical regime in the sanatoria.⁹¹ On arrival, patients were either put into beds as quickly as possible, or they were exposed to fresh air.⁹² It was also common that windows were kept open throughout the wards during the day and night while patient beds were often wheeled out on to the verandas if they were well enough.⁹³ Patient references to the weather, beyond the norm, were also common in this respect.⁹⁴

There were a number of surgical techniques used in the sanatoria to minimise the damage caused by TB (see figure 6.2). As well as bodily and mental rest, the sanatoria also extended ‘rest of the affected lung itself’ for sufferers of pulmonary TB through artificial pneumothorax.⁹⁵ This involved collapsing of the affected lung to give the ‘diseased portion every

⁸³ *IT*, 17 July 1941.

⁸⁴ Dillon, ‘Tuberculosis: a social problem’, p. 172. If any abnormal sounds were picked up from the stethoscope examination, this was said to be already at an advanced case of the disease. For more information on this, see *Forty-eighth annual report of the Board of Governors of the Royal National Hospital for Consumption in Ireland for the year ending 31 December 1940* (RCPI, RNHC/1/2/5), p. 11.

⁸⁵ *IT*, 17 Jul. 1941.

⁸⁶ Dillon, ‘Tuberculosis: a social problem’, p. 172.

⁸⁷ *Ibid.*

⁸⁸ Mac Lellan, ‘Alone among neutrals’, p. 70. For information on Dr Dorothy Price, see O’ hÓgartaigh, ‘Price, Dorothy Stopford’ in *DIB (online)*; Liam Price, *Dr Dorothy Price: an account of twenty years fight against tuberculosis in Ireland* (Oxford, 1957).

⁸⁹ Margaret Dunlevy, ‘The prevention of tuberculosis’ in *IJMS*, vi, no. 13 (Jan. 1952), p. 8. BCG was named after the French workers, Palmette and Guérin, who developed it between 1908-1920. For further information on BCG vaccine, see: McWeeney Lecture Notes, 20 Nov. 1947, p. 2 (RCPI, EJTM/2).

⁹⁰ McWeeney Lecture Notes, 20 Nov. 1947, p. 2 (RCPI, EJTM/2).

⁹¹ Jones, *Captain all these men of death*, p. 160.

⁹² *Ibid.*

⁹³ *Ibid.*

⁹⁴ John (Jack) O’ Riordan spent much of 1942 as a patient at Crooksling Sanatorium, where detailed observations of the weather, his health and his emotions were frequently noted. See Jack O’ Riordan diary entries, Apr. – Aug. 1942.

⁹⁵ *Forty-fourth annual report of the Board of Governors of the Royal National Hospital for Consumption in Ireland for the year ending 31 December 1936*, p. 12 (RCPI, RNHC/1/2/5).

chance of healing'.⁹⁶ Where artificial pneumothorax was not possible, or in cases to enhance its effect, surgical operations were carried out to interrupt



Figure 6.2 Operating theatre used in the Royal National Hospital for Consumption, 1936.⁹⁷

the phrenic nerve.⁹⁸ Thoracoplasty was used in cases considered to be incurable, and involved the removal of substantial portions of one's ribs on the side to allow the chest wall to fall in, and therefore collapsing the affected lung.⁹⁹ Writing with the benefit of hindsight on the efficacy of the sanatoria, Condrau has noted how the treatment regime afforded in the sanatoria has been branded essentially as 'a waste of time', noting that by means of cross-infection, the sanatorium allegedly 'contributed to the problem that it pretended to solve'.¹⁰⁰ To this end, Breathnach similarly observes that often parents in Ireland were reluctant to bring their children into Crooksling Sanatorium being 'crowded as it was with cases of open tuberculosis'.¹⁰¹ At that time, however, the purpose-built sanatorium was increasingly believed by the Irish medical profession and Fianna Fáil to be the most effective way of treatment.¹⁰² Patient views of the sanatoria remain less clear, though there are some insightful accounts. For example, in the diary

⁹⁶ Ibid., p. 12-13.

⁹⁷ *Forty-sixth annual report of the Board of Governors of the Royal National Hospital for Consumption in Ireland for the year ending 31 December 1938*, p. 13 (RCPI, RNHC/1/2/5).

⁹⁸ *Forty-fourth annual report of the Board of Governors of the Royal National Hospital for Consumption in Ireland for the year ending 31 December 1936*, p. 13 (RCPI, RNHC/1/2/5).

⁹⁹ Ibid., p. 12.

¹⁰⁰ Condrau, 'Urban tuberculosis', p. 187.

¹⁰¹ Caoimhghín S. Breathnach, 'Margaret Dunlevy (1909-2002) and the conquest of childhood TB in Dublin' in *Ulster Medical Journal*, lxxv, no. 1 (2016), p. 23.

¹⁰² Jones, 'Captain all these men of death', p. 160.

of Jack O' Riordan, he noted on 21 July 1942 that he was 'now looking forward to my going home it will certainly be a change to get away from this place and start life on the new'.¹⁰³ Other accounts by Jack include references to winning and losing in games of cards and snooker with his fellow patients¹⁰⁴, difficulties in obtaining cigarettes¹⁰⁵, and having to write the "certs" despite the feeling of tiredness and sickness'.¹⁰⁶

6.4 Making a case for more resources: medical efforts

In the 1940s, children's experience of TB played a significant role in medical efforts to demand further resources against the disease. The incidence of childhood TB increased and the severity of the cases in children in Dublin appeared to be much worse than before (see figure 6.3 and 6.4).¹⁰⁷ The most common form of TB in children was TB meningitis, or TB of the meninges and central nervous system.¹⁰⁸ TB meningitis is still the most severe form of infection that TB

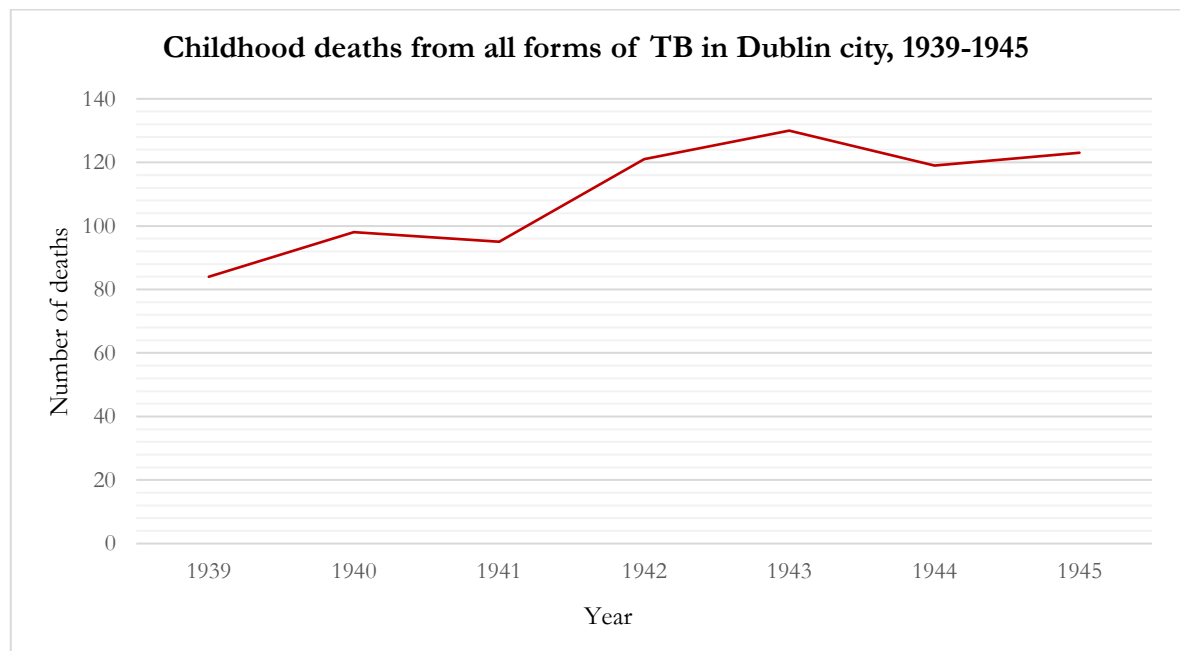


Figure 6.3 TB deaths (all forms) in Dublin city, 1939-45.¹⁰⁹

can cause, 'causing the death or disability in more than half of those affected' with the disease in 2015.¹¹⁰ Just as there were links between pulmonary TB and malnutrition, this also became linked to existing fears regarding the increased malnutrition among children caused by the war. Price suspected that this could be related to the high extraction brown bread which was already

¹⁰³ Jack O' Riordan diary, 21 Jul. 1942.

¹⁰⁴ Ibid., 22 Jun. 1942.

¹⁰⁵ Ibid., 21 Jan. 1942.

¹⁰⁶ Ibid., 26 May 1942.

¹⁰⁷ Price to W. J. E. Jessop, 26 Oct. 1943 (TCD Archives, Dorothy S. Price papers, 7536/410).

¹⁰⁸ Dunlevy, 'Prospect of childhood tuberculosis in Dublin', p. 353.

¹⁰⁹ Ibid., p. 354.

¹¹⁰ M. E. Török, 'Tuberculous meningitis: advances in diagnosis and treatment' in *British Medical Bulletin*, cxiii (2015), p. 117.

found to be interfering with the body's ability to absorb calcium.¹¹¹ She feared that this was preventing the healing of TB among children because the calcium deposits within the body were not moving 'at the normal rate'.¹¹²

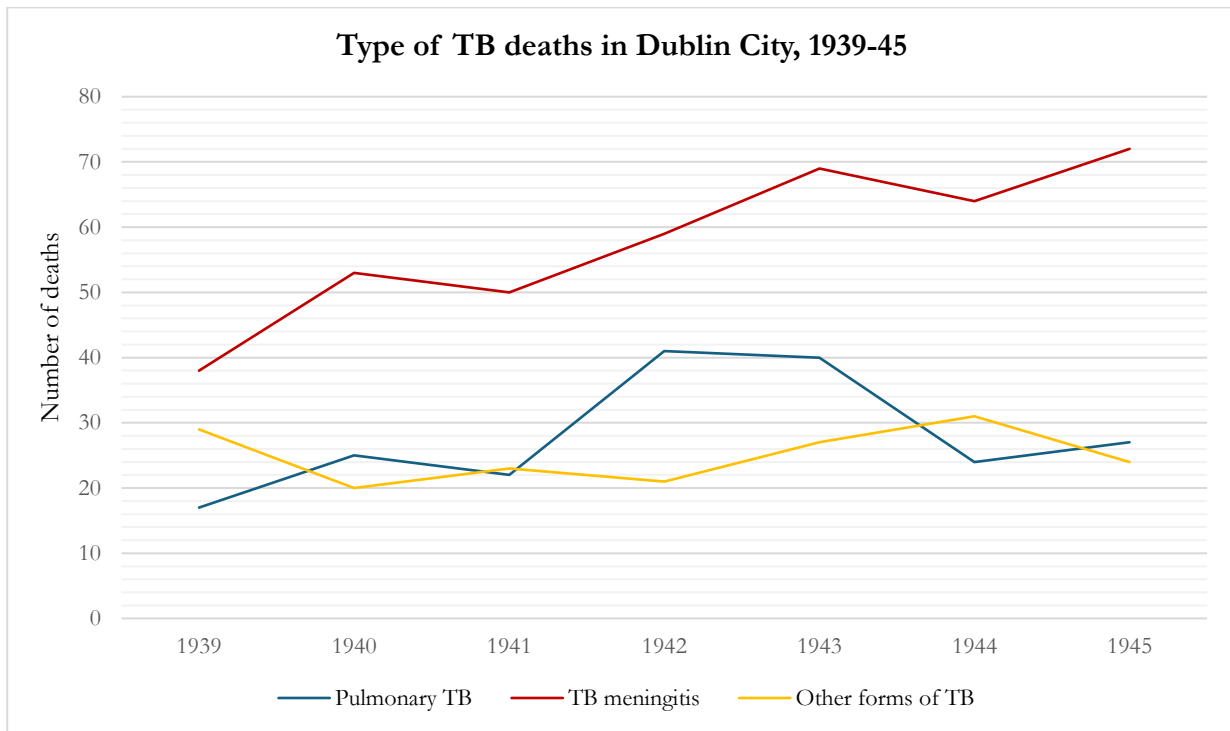


Figure 6.4 Type of TB deaths in Dublin city, 1939-45.¹¹³

Meanwhile, W. J. E. Jessop continued to campaign for the fortification of bread with calcium.¹¹⁴ He recommended that daily vitamin D allowances be doubled in St. Ultan's Children's Hospital, and that plenty of milk was to be given apart from standard meals – this was implemented.¹¹⁵ Although vitamin D helped to prevent a primary infection, calcium was still seen by Price as of vital importance in the healing process.¹¹⁶ Because of this, St. Ultan's hospital began to give five to ten grains of calcium in tablet form to children after their breakfast and tea, in addition to calcium received from daily milk allowances and cod liver oil.¹¹⁷ While this may have alleviated the TB experiences of those children in St. Ultan's hospital, this brought more attention to the need for further resources to be allocated on a national level. Dublin Corporation were also very concerned with the 'problem of childhood tuberculosis in Dublin', and this fed into the establishment of a 'special medical centre for the control and study of childhood primary

¹¹¹ Price to Jessop, 26 Oct. 1943 (TCD Archives, Dorothy S. Price papers, 7536/410).

¹¹² Ibid.

¹¹³ Ibid.

¹¹⁴ Mac Lellan, 'Alone among neutrals', p. 68.

¹¹⁵ Ibid.

¹¹⁶ Ibid., p. 69.

¹¹⁷ Ibid.

infections' in 1945.¹¹⁸ Initially, the clinic was held once per week, but these sessions extended to the full-time working of this clinic shortly afterwards.¹¹⁹ Further evidence of the extent to which children's experience of TB was used in medical cases for further resources can be found in the publications of Price, as well as those of Margaret Dunlevy, who worked in Crooksling Sanatorium before taking up her post in the Collier TB Dispensary, Dublin.¹²⁰

6.5 Making a case for more resources: charitable efforts

Dissatisfied with existing provisions and an increase in TB death rates among the young and working populations, discussions among public health medical officers and TB officers on the possibilities around the formulation of a voluntary anti-tuberculosis league began in October 1942.¹²¹ From the outset, it was envisioned by Drs Price and John Duffy that there was a 'need for a united effort' to combat TB, with this need 'greater now than it has ever been'.¹²² Price, who had developed links with Professor Arvid Wallgran (the main campaigner behind BCG in Sweden) throughout 1937 and 1938, was advised by Wallgran in 1939 that Ireland could benefit from a national anti-tuberculosis league similar to the one already set-up in Sweden.¹²³ Throughout 1942 – the year the TB deaths peaked, Price grouped together people from various backgrounds.¹²⁴ These included professors of medicine from Irish universities, representatives of county medical officers of health, TB officers, politicians and public figures.¹²⁵ Although the league was intended to be an independent voluntary organisation that would work with both social service industries and charities on the ground, these plans quickly became subsumed within an opportunistic Catholic hierarchy, who shared in their concerns of the high rate of death among young people when compared to other countries.¹²⁶

At a time in which matters of social and health policy were of particular concern to the Catholic hierarchy in Ireland, it is not surprising that the proposition of an anti-TB league received episcopal scrutiny. Dublin Archbishop, John Charles McQuaid took a keen interest in

¹¹⁸ Dunlevy, 'Prospect of childhood tuberculosis in Dublin', p. 354.

¹¹⁹ Ibid.

¹²⁰ Price and Dunlevy published a number of medical papers on children's TB between 1940 and 1955. See Price, 'Note on the tuberculous phlycten' in *IJMS*, xv (1940), pp 327-330; 'Report of a tuberculin survey amongst children in Dublin hospitals made by the Irish Paediatric Association' in *IJMS*, (1941), pp 241-55; 'The prevention of tuberculosis in infancy' in *IJMS*, xvii (1942), pp 252-255; *Tuberculosis in childhood* (Dublin, 1942); 'Is BCG vaccination a practical proposition for Eire' in *IJMS*, xxi (1946), pp 779-782; 'The need for BCG vaccinations in infants' in *Tubercle*, xxx, no. 1 (1949), pp 11-13; 'Analysis of BCG vaccinations' in *IJMS*, cccxxxviii (1954), pp 56-64; Dunlevy, 'Prospect of childhood tuberculosis in Dublin' pp 353-360; 'Five years' experience of BCG vaccination in Dublin' in *Medical Officer*, xcii, no. 5 (1954), pp 53-6.

¹²¹ *IT*, 17 Feb. 1943.

¹²² Price and John Duffy to McQuaid, 1 Feb. 1943 (DDA, McQuaid papers, XVIII/26/6/1).

¹²³ Mac Lellan, 'Alone among neutrals', p. 71.

¹²⁴ Ibid.

¹²⁵ Ibid.

¹²⁶ McQuaid, Comments on the report issued by the tuberculosis committee of the Royal Irish Academy of Medicine, undated, c. Jun. 1942 (DDA, McQuaid papers, XVIII/26/3/3).

its development early on.¹²⁷ Although there is evidence to suggest that he was genuinely concerned about the rising incidence of TB among the poor and larger families, he was just as concerned that any anti-TB campaign not be conducted without oversight by Catholic authorities.¹²⁸ For McQuaid, ‘such a campaign can be carried through in Éire only by the [Irish] Red Cross Society’.¹²⁹ His reasoning was that the society already had government patronage, was already operating nationwide and had a large membership of trained workers.¹³⁰ The Irish Red Cross Society was established on 6 July 1939 as an explicitly non-denominational organisation in line with others found in other countries.¹³¹ While the government emphasised the society’s non-denominational nature by choosing not to appoint all religious and clergymen to the society’s first central council, Shane Lehané notes that within a short time, it became seen as a predominantly Catholic organisation.¹³² This may be attributed to the society’s grass-roots members, when they began a widespread practice of electing local Catholic clergy as chairs of branches and also electing local bishops on the central council.¹³³ Although this may have caused what one *Irish Times* article noted as ‘a delicate situation’, the Irish National Anti-Tuberculosis League (INATL) was officially formed by Dillon on 15 February 1943 under the auspices of the Irish Red Cross Society.¹³⁴ Its medical members were satisfied in part that it was ‘one concentrated effort’ to combat TB.¹³⁵ McQuaid was content that the campaign would be conducted with Catholic interest and that the society would ‘find ample opportunities for devoting its trained energies to an anti-tuberculosis campaign with undistracted attention’ at the end of the war.¹³⁶ And lastly, the Irish Red Cross found itself in what Lehané observes as a ‘controversy largely not of its own making’.¹³⁷

Voluntary organisations, like that of INATL, played an important role in making a case for focusing attention on TB which eventually shaped government policies in the war’s aftermath. One of the main objectives of the INATL was to launch a public TB campaign to create ‘an enlightened public opinion on the problems of tuberculosis’.¹³⁸ This involved a

¹²⁷ Shane Lehané, *A history of the Irish Red Cross* (Dublin, 2019), p. 134.

¹²⁸ McQuaid, Comments on the report issued by the tuberculosis committee of the Royal Irish Academy of Medicine, undated, c. Jun. 1942 (DDA, McQuaid papers, XVIII/26/3/3). Also see, Lehané, *History of the Irish Red Cross*, p. 134.

¹²⁹ McQuaid, ‘Comments on report issued by TB Committee of Royal Irish Academy of Medicine, un-dated c. 1942 (DDA, McQuaid papers, XVIII/26/3/3).

¹³⁰ Ibid.

¹³¹ Lehané, *A history of the Irish Red Cross*, p. 19.

¹³² Ibid., p. 20.

¹³³ Ibid.

¹³⁴ *IT*, 17 Feb. 1943. Also see Meeting agenda of Irish National Anti-Tuberculosis League, 15 Feb. 1943 (DDA, McQuaid papers, XVIII/26/14/2).

¹³⁵ Price and John Duffy to McQuaid, 1 Feb. 1943 (DDA, McQuaid papers, XVIII/26/6/4).

¹³⁶ McQuaid to Rev. P. P. Molony (McQuaid’s representative of the INATL), 9 Feb. 1943 (DDA, McQuaid papers, XVIII/26/6/4).

¹³⁷ Lehané, *A history of the Irish Red Cross*, p. 135.

¹³⁸ Programme of the INATL, undated, c. 1943 (DDA, McQuaid papers, XVIII/26/13/1).

campaign of TB education across the country via newspapers, pamphlets, circulars and posters, publications, radio talks, films, as well as window exhibits in towns and cities.¹³⁹ For the INATL, it was imperative that children and adolescents receive ‘special attention’, and co-operation was sought with the educational authorities in primary and secondary schools in this regard.¹⁴⁰ This built on anti-TB propaganda that was already featuring prominently in schools.¹⁴¹ Within weeks of commencing its campaign, the INATL initiated plans for the establishment of a preventorium for children under five years of age who had a primary TB infection.¹⁴² In collaboration with Archbishop McQuaid, it obtained a building from the Sisters of Mercy at Ballyroan, Rathfarnham, in Dublin.¹⁴³ McQuaid donated £1,000 towards its establishment, and was infuriated when the INATL published an anti-TB brochure with no mention of his services in November 1943.¹⁴⁴ The INATL also targeted young factory workers and entrants into industry, university students, applicants into medical schools and sanatoria personnel, as well as those involved in the public services and sports clubs.¹⁴⁵ In relation to infants of tuberculous mothers, the league campaigned for the routine testing of infants and mothers already known to have TB, the boarding out facilities or admission to a preventorium, helpers in the home of tuberculous mothers and an increased number of nurses and health visitors.¹⁴⁶ The organisation indicated from the outset that it hoped to carry out an investigation into the links between TB and malnutrition amid suspicions of a higher incidence of TB among the malnourished.¹⁴⁷ The organisation was also a main campaigner for ‘social insurance against tuberculosis’, where no effective provision for the aftercare of those suffering from TB existed.¹⁴⁸ For the INATL, a lack of financial provisions given to TB sufferers undergoing sanatoria treatment meant that tuberculous workers did not want to go into to treatment and lose the ability to pay for the upkeep of their families.¹⁴⁹

The activism of the INATL was much to the annoyance of the Department of Local Government and Public Health which feared that the if the ‘impression were to be created that the spread of tuberculosis could be prevented by State action in public measures alone’, this would be of ‘grave concern’.¹⁵⁰ Although Dr Conn Ward, Parliamentary Secretary of the Department of Local Government and Public Health expressed his gratitude to the Irish Red

¹³⁹ Ibid.

¹⁴⁰ Ibid.

¹⁴¹ *IT*, 13 Sept. 1943.

¹⁴² Lehané, *A history of the Irish Red Cross*, p. 158.

¹⁴³ Ibid., 158.

¹⁴⁴ McQuaid to Monsignor Daniel Molony, 22 Nov. 1943 (DDA, McQuaid papers, XVIII/26/46).

¹⁴⁵ Programme of the INATL, undated, c. 1943 (DDA, McQuaid papers, XVIII/26/13/1).

¹⁴⁶ Kevin Malley, ‘The Irish national anti-tuberculosis league and its aims’ in *IJMS*, xviii (1943), p. 50.

¹⁴⁷ McQuaid, ‘Comments on report issued by TB Committee of Royal Irish Academy, un-dated c. 1942 (DA, McQuaid papers, XVIII/26/3/3).

¹⁴⁸ Programme of the INATL, undated, c. 1943 (DDA, McQuaid papers, XVIII/26/13/1).

¹⁴⁹ Ibid.

¹⁵⁰ Ward to Irish Red Cross Society, 8 Mar. 1943 (DDA, McQuaid papers, XVIII/26/28).

Cross Society for taking on such an important project, he was fearful of the organisation creating a situation in which the Department could be blamed for the recent upsurge in TB deaths. In a letter to the Irish Red Cross Society, Ward sought to remind the society that it was ‘not possible before the war to carry out the far-reaching re-organisation of public facilities’ for treating TB.¹⁵¹ On the scarcity of beds, Ward noted that while there were sustained efforts to maximise sanatoria capacities serving the Dublin area where the shortage was most acute, construction could not be implemented due to the scarcity of essential materials.¹⁵² Ward sought to defend the state’s position by reminding the society that:

Indeed, owing to the large amount required to be set aside for the endowment of voluntary hospitals the monies at the moment available in the Hospitals Trust Fund would be insufficient to meet the cost of these units and other pressing hospital requirements.¹⁵³

At this time, many of the country’s voluntary hospitals were owned and controlled by religious communities, without interference from the Local Authorities or Minister for Local Government and Public Health, though they received financial aid from the Sweepstakes.¹⁵⁴ Ward therefore attempted to shift the finger of blame away from the failures of the existing government, who had ‘other pressing hospital requirements’ to fulfil. This shift in blame was also alluded to in his reference to the work of the local authorities, the medical profession and the general public, citing that ‘no medical measures will be fully effective unless there is wholehearted co-operation on the part of the medical profession and of the general public’ when it came to disease notifications.¹⁵⁵ As early as 1908, the Tuberculosis Prevention (Ireland) Act provided for the compulsory notification of an open TB infection and this also gave local authorities the power to build and maintain TB hospitals and to appoint TB medical officers and bacteriologists.¹⁵⁶ The act relied on the detection and diagnosis of TB and the subsequent disclosing of this information to the relevant health authorities – something that the general population proved unwilling to do. Likewise, there was a considerable time lapse between when a patient decided to consult their doctor and when they were eventually diagnosed. For Ward, this was a situation that was still ‘far from satisfactory’.¹⁵⁷ Although Ward acknowledged that the existing provisions could be expanded in the war’s aftermath, this letter highlighted the very clear tension between the government’s willingness to improve provisions and the expectation

¹⁵¹ Ibid.

¹⁵² Ibid.

¹⁵³ Ibid.

¹⁵⁴ International Hospital Federation, *Report of the study tour of hospitals in Ireland, May 21st – 31st 1956* (Dublin, 1956), p. 7. Two thirds of the monies raised by the Sweepstakes were given to voluntary hospitals, see Irish Hospital Trust, *The success of the Irish Hospital Sweepstakes* (Dublin, 1971), p. 11.

¹⁵⁵ Ward to Irish Red Cross Society, 8 Mar. 1943 (DDA, McQuaid papers, XVIII/26/28).

¹⁵⁶ D. O’ Donnell, ‘The epidemiological history of tuberculosis in Ireland’, 1970 (RCPI, EJT/2), p. viii.

¹⁵⁷ Ward to Irish Red Cross Society, 8 Mar. 1943 (DDA, McQuaid papers, XVIII/26/28).

that the people should be responsible for their own health – a theme that was also apparent in chapters on gastro-enteritis, nutrition, and mental illness.

While consecutive Irish governments may have emphasised the need for ‘early diagnosis’ and ‘early treatment’, this was at odds with the services then in place. Within ‘early diagnosis’, it was expected that the individual was going to take action to improve their health through notification. But with these expectations around disease management came wider public criticisms of the government infrastructures in place for the TB sufferer. For example, severe bed shortages meant that there were long waiting lists for people to enter sanatoria, with some estimates in 1945 being between two and six months for adults, and six to nine months for children.¹⁵⁸ These waiting lists put additional pressures on the sanatoria, where it was found that patients were often being discharged earlier than they should, only to avail of very little aftercare measures.¹⁵⁹ For those who could not enter a sanatorium, Fianna Fáil and the Irish medical profession continuously advised the public to mimic the sanatorium way of life at home where possible.¹⁶⁰ Even if a patient recovered well enough to return home, they were returning to the very same conditions that caused their disease in the first place.¹⁶¹ There was no effective provision for ‘modern treatment or aftercare’ until after the war, leading to wider public criticisms.¹⁶² Because of this, the INATL continued to push for adequate after-care and rehabilitation, especially concerning young workers, a provision which they believed was ‘largely overlooked’ by the government.¹⁶³

The Post-Sanatoria League (PSL) was another voluntary organisation that campaigned against TB and focused on the predicaments of the young and working populations. The organisation was established in the Mansion House in Dublin on 27 Dublin 1944 by a group of ex-TB sufferers, ‘whose personal experience places them in a better position than any other section of the community’ to study and understand the economic and social aspects of the TB problem.¹⁶⁴ Although the purpose of the organisation was to lobby the government to introduce further anti-TB measures, the organisation had a particular concern for the after-care and rehabilitation of TB patients.¹⁶⁵ For Bryan, this provided further evidence of the ‘preeminent position of the sanatoria in the [government’s] fight against TB’ in government discourse.¹⁶⁶ In their memorandum to the Department of Local Government and Public Health, the PSL

¹⁵⁸ Post-Sanatoria League memorandum on tuberculosis to the DLGPH, 25 Mar. 1945 (DA, McQuaid papers, XVIII/26/59), p. 13.

¹⁵⁹ Ibid.

¹⁶⁰ Jones, *Captain all these men of death*, p. 160.

¹⁶¹ *IT*, 3 Oct. 1941. Also see Deeny, ‘The development of the Irish tuberculosis services’ in *IJMS*, cliv (1958), p. 31.

¹⁶² Dillon, ‘Tuberculosis: a social problem’, p. 172.

¹⁶³ INATL memorandum on re-organisation, 5 Nov. 1944 (DDA, McQuaid papers, XVIII/26/59).

¹⁶⁴ Post-Sanatoria League memorandum on tuberculosis to the DLGPH, 25 Mar. 1945 (DDA, McQuaid papers, XVIII/26/59), p.

¹⁶⁵ Ibid.

¹⁶⁶ Ciarán Byran, ‘Rationing in Emergency Ireland, 1939-1948’ (PhD, NUIM, 2014), p. 268.

emphasised that the majority of TB patients were of the ‘wage-earning classes’ as they called for an introduction of payments made to TB sufferers and their families.¹⁶⁷ For those who took time for treatment, the wages of these people ‘ceases with illness’, and the PSL sought to emphasise just how inadequate government policy was in this area.¹⁶⁸ In this situation, the people had to rely on monies, food vouchers, fuel, clothes, bed and bedding etc. from the National Health Insurance Society (NHIS), the Public Assistance Authorities and charitable organisations – which in the organisation’s view, were ‘grossly inadequate allowances’.¹⁶⁹ The PSL also campaigned for the introduction of mass-radiography, with the following population groups specifically targeted: children leaving school, entrants to the army, civil service and professions.¹⁷⁰ In relation to children, the PSL advocated that all school-children should be taught of the importance of hygiene ‘with special reference to the manner in which they should live in order to avoid contracting tuberculosis’.¹⁷¹

6.6 Public health interventions after the ‘war proper’

When the war ended, the provision of additional TB beds was a significant aim for Fianna Fáil. To this end, the Tuberculosis (Establishment of Sanatoria) Bill, 1945 gave powers to the Department of Local Government and Public Health to build new hospitals for TB patients.¹⁷² This significant piece of legislation officially recognised existing TB waiting lists and the need for expansions in this provision. The Public Health Bill 1945 and the Tuberculosis White Paper (1946) were also crucial, and together meant that TB was placed as a high priority when Ireland’s Department of Health was established in 1947.¹⁷³ Between 1946 and 1952, advantage was taken of the decrease in other infectious diseases to use empty space for TB patients. For example, beds in fever, mental, district, and military hospitals that were not being used at full capacity were used for TB purposes.¹⁷⁴ Existing sanatoria were also refurbished where conditions were particularly bad, and this satisfied previous PSL campaigns to improve the conditions of the sanatoria.¹⁷⁵ This was no doubt influenced by Browne’s appointment of Charles O’Connor, a prominent member of PSL, as his private secretary in 1948 when he became Minister for

¹⁶⁷ Ibid, p. 3.

¹⁶⁸ Ibid.

¹⁶⁹ Ibid., pp 3-4. The maximum weekly amount of sickness benefit paid by NHIS was 15s. per week for a maximum of six months. The maximum amount of disablement benefit thereafter was 7s. 6d. Those qualified to receive this also received weekly supplies of bread, butter and milk. However, not everyone qualified – 11.4% of patients receiving them. At the same time, it was estimated that minimum weekly required for males was 21s. 9d. and 13s. 6d.

¹⁷⁰ Ibid., p. 14.

¹⁷¹ Ibid., p. 15.

¹⁷² Tuberculosis (Establishment of Sanatoria) Act, 1945 (1945 no. 4) (6 Mar. 1945).

¹⁷³ Carthy, ‘The treatment of tuberculosis’, p. 65.

¹⁷⁴ Deeny, *National tuberculosis survey*, p. 231.

¹⁷⁵ Deeny, ‘The development of the Irish tuberculosis services’, p. 31.

Health.¹⁷⁶ Where bed accommodation was inadequate, as was the case in some country homes and older district hospitals, these were either discontinued or only used for admission for temporary purposes.¹⁷⁷

In 1951, there were 4,803 TB beds in use and the waiting list numbered 381.¹⁷⁸ By 1952, it was estimated that these efforts had secured an additional 2,000 beds throughout the country.¹⁷⁹ By 1953, there were 6,129 beds occupied and the waiting list was halved.¹⁸⁰ This was no doubt aided by the introduction of a significant medical breakthrough in the treatment of TB. The introduction of chemotherapy through the antibiotic streptomycin had a significant impact on the length of time patients spent in the sanatoria and on patient numbers.¹⁸¹ While small quantities of streptomycin were released for use in Ireland from late 1946, they were strictly controlled by the Department of Local Government and Public Health (Department of Health from 1947).¹⁸² However, improved production methods and increased medical experience and confidence with the treatment meant that by January 1950, these controls were relaxed.¹⁸³ Thereafter, streptomycin was widely used alongside another new drug para-aminosalicylic acid (PAS), while a much cheaper drug, isoniazid, further enhanced treatment options in 1952.¹⁸⁴ It was also anticipated that space gained would provide a variety of uses when TB was to be eliminated.¹⁸⁵ This work was hugely important to the anti-tuberculosis campaign, especially when it was perceived by Ward and the wider medical profession that the greatest problem that TB posed was the advanced case and the satisfactory isolation of this patient.¹⁸⁶ However, all of this was only made possible to dramatic changes in public expenditure on TB.

Expenditure on TB services by the local authorities and the government increased continuously from 1927 (see table 6.1).¹⁸⁷ Within this, the biggest increase in this spending occurred outside of the war period: first in 1932 and then again in 1947. While there was a modest increase in spending during the war, a significant shift in the public health approach to TB occurred in 1947 when expenditure on TB services nearly doubled the figures spent four years earlier.¹⁸⁸ This occurred alongside a more generous regime of increased state expenditure

¹⁷⁶ John Horgan, *Noël Browne: passionate outsider* (Dublin, 2000), p. 68.

¹⁷⁷ Deeny, 'The development of the Irish tuberculosis services', p. 31.

¹⁷⁸ *Ibid.*, p. 32.

¹⁷⁹ Deeny, *National tuberculosis survey*, p. 231.

¹⁸⁰ Deeny, 'The development of the Irish tuberculosis services', p. 32.

¹⁸¹ Carthy, 'The treatment of tuberculosis in Ireland', p. 338.

¹⁸² *Ibid.*, p. 339. Chemotherapy was also strictly controlled in the UK, see Clare Leeming-Laham, 'Unravelling the 'Tangled Web': chemotherapy for tuberculosis in Britain, 1940-1970', *Medical History*, lix, no. 2 (2015), p. 161.

¹⁸³ Carthy, 'The treatment of tuberculosis in Ireland', p. 339. Streptomycin was also very expensive, at 33s. 9d. a gram where adults required one-two grams daily for approximately four months. This was another reason for delays in lifting controls. For further detail, see *IT*, 26 Jan. 1951.

¹⁸⁴ Carthy, 'The treatment of tuberculosis in Ireland', p. 339.

¹⁸⁵ Deeny, 'The development of the Irish tuberculosis services', p. 31.

¹⁸⁶ *DÉD*, 31 Jan. 1945, vol. 95, no. 14 (Dr Conn Ward).

¹⁸⁷ Deeny, *National tuberculosis survey*, p. 231.

¹⁸⁸ *Ibid.*, 189.

following the Health Services (Financial Provisions) Act, 1947. What this meant was that from the tax year ending 31 March 1948, the state agreed to bear the increase in cost for each of the health authorities until the cost of the services provided by the health authority was being shared equally between the Exchequer and the local rates.¹⁸⁹ In other words, the cost of funding health services was thereafter divided equally on a fifty-fifty basis between local authority rates and the Irish Exchequer.¹⁹⁰ This had significant implications for both short and long-term government programmes to combat tuberculosis.

Payments made in financial years	National TB grant and block grant	Local authority expenditure	Total
1922/23	£21,115	£21,115	£42,230
1927/28	£41,276	£41,276	£82,552
1932/33	£114,749	£86,999	£201,748
1937/38	£132,220	£104,470	£236,690
1942/43	£156,226	£128,476	£284,702
1947/48	£325,506	£297,756	£623,262
1952/53	Total expenditure was £2,070,000, of which, approximately 50% was by Local Authorities.		

Table 6.1 Expenditure on TB over five year intervals, 1922-53.¹⁹¹

While substantial works were underway to increase the number of TB beds, the Irish cabinet was tasked with encouraging people to enter into the sanatoria for treatment, as outlined by medical practitioner and member of the Opposition, Dr Thomas O'Higgins to wider cabinet members on 31 January 1945:

Very often tubercular cases present themselves in a rather advanced state and when asked: 'how long have you been complaining?', very frequently the answer is: 'Some months', and occasionally, 'Some years'. The patient is then asked: 'Why did you not get advice earlier?' and the reply is: 'I am earning so much a week in a good job. I could not afford to lie up, because if it were known that I had tuberculosis, I would be out of my job'.¹⁹²

As opposed to Ward's criticism of the general public for their role in driving disease numbers up, O'Higgins argued that if the government was going to tackle the problem in a big way, then

¹⁸⁹ DOH, *Select committee on the health services: memorandum from the Department of Health on submissions made on financing and administration of the health services* (Dublin, 2012), p. 5.

¹⁹⁰ Health Services (Financial Provisions) Act, 1947 (1947 no. 47) (27 Dec. 1947).

¹⁹¹ Deeny, *Report of the national tuberculosis survey*, p. 189.

¹⁹² DED, 31 Jan. 1945, vol. 95, no. 14.

‘tackling it in a big way means tackling it in an expensive way’.¹⁹³ In this view, the centres of tuberculosis infection were in workshops and businesses, where large proportions of the population went ‘day after day’.¹⁹⁴ This view was shared by Patrick Cogan, an Independent TD, who sought to highlight the importance of being practical in their solution to a TB problem ‘which not only affects the lives of great many of our people but also affects the nation inasmuch as it tears away a large section of our people from life itself and, to a large extent, from the enjoyment of life, and from doing efficient work in building up the nation’.¹⁹⁵ These views were only beginning to be voiced in parliamentary debates in Ireland in 1945 – two years after the very same issue was rectified in Britain, by introducing maintenance payments to TB sufferers and their families from 1943.¹⁹⁶ William Norton, Labour Party TD, noted how in Britain, these payments operated from the time a person left work until he or she was restored to a full working capacity whereas ‘in this country the position seemed to be that a person was all right when he was in a sanatorium and no attention at all was paid to his wife and children at home’.¹⁹⁷ In this way, developments elsewhere contributed to the perceptions of the Irish cabinet that where TB was most prominent was in the workplace, with the country’s workers as its primary victims. Maintenance payments for TB sufferers and their families were seen as the only solution to this problem, which was only introduced in legislative terms belatedly in 1947 amid government and local authority rows over who would bear the cost of this financial incentive.¹⁹⁸ Nonetheless, the provision of maintenance payments by the local authority under the Infectious Disease (Maintenance) Regulation of 1947 proved a far-reaching social reform. The inter-party government continued this approach when it came to power in 1948.

These payments were a noteworthy contribution made on the ground to those suffering from TB and other specified infectious diseases. They also applied to their families. This formed a crucial part of the Health Act 1947, where cash allowances as well as food and clothes vouchers were given to patients and their dependents while sanatorium services became free for all.¹⁹⁹ Speaking in the Dáil on health estimates, Browne was pleased to mention that the introduction of monetary allowances, which came into effect on 1 March 1948, had the ‘desired effect of increasing substantially the numbers coming forward for treatment’.²⁰⁰ Weekly amounts differed, and depended on the income of the person from other sources.²⁰¹ Notwithstanding, a

¹⁹³ Ibid.

¹⁹⁴ Ibid.

¹⁹⁵ Ibid.

¹⁹⁶ Ibid.

¹⁹⁷ Ibid.

¹⁹⁸ *DÉD*, 5 Apr. 1946, vol. 100, no. 11 (Debate between Ward, General Mulcahy, William F. O’Donnell, Maurice E. Dockrell and Alfred Byrne).

¹⁹⁹ Health Act, 1947 (1947 no. 28) (13 Aug. 1947).

²⁰⁰ *DÉD*, 1 Jul. 1949, vol. 116, no. 11.

²⁰¹ Deeny, *National tuberculosis survey*, p. 233.

rent allowance of up to 15s. per week was payable, and in some cases, allowances were given to match local rates on the homes of patients or purchase amounts for those who were in the process of buying their own homes.²⁰² Preferential allocation of local authority housing was also given to TB patients who were living in poor household conditions.²⁰³ Footwear, clothing, beds and bedding, and chalets were also issued to those in need while foods, like eggs, milk and butter were given to people who were not receiving other allowances (such as Children's Allowance).²⁰⁴ Browne also noted that further developments were introduced in September 1948 where the existing infectious disease regulations extended their eligibility to include a domestic help allowance for a married woman who was receiving institutional treatment, and whose husband was unable to make proper provision for the care of the family.²⁰⁵ However, this was met with some public opposition on the ground.

As shown in table 6.1, the local authorities also increased their expenditures on public health services. Between 1943 and 1948, the expenditure of the local authorities on TB services increased by 43%. These financial improvements did inadvertently place financial burdens back on the society. In a letter to the editor of the *Irish Times* in November 1949, C. J. O'Connell noted:

The minister must be aware that the majority of patients in this country pay for medical treatment – directly or indirectly. Private patients not only pay for their own treatment, but in addition pay through increased taxation for the 'free' treatment afforded by the Minister's Department. All patients...whether for tuberculosis or any other disease must – under the Control Order – have certain tedious and expensive laboratory tests carried out. Who pays for these? Of a certainty somebody must pay.²⁰⁶

In this way, the expansion of healthcare services came at an additional cost. Arguments were such that those who were paying for their treatment, had to pay twice. Once through health provider they attended i.e., a sanatorium, and again through payment of higher tax. Despite this, Irish historiography remains relatively silent on how these improvements in public health were received by the Irish public. Similar manifestations of this can be found in throughout the newspapers at this time.

Payments to TB sufferers and their families occurred alongside significant medical breakthroughs during the period. Though the BCG vaccine was initially introduced into St. Ultan's Children's Hospital in Dublin from Sweden under the direction of Price in 1937, the use of vaccine was shelved for the duration of the war.²⁰⁷ In medical terms, the main aim of the

²⁰² Ibid.

²⁰³ Deeny, 'The development of the Irish tuberculosis services', p. 31.

²⁰⁴ Deeny, *National tuberculosis survey*, p. 233.

²⁰⁵ DÉD, 1 Jul. 1949, vol. 116, no. 11.

²⁰⁶ *IT*, 29 Nov. 1949.

²⁰⁷ Dunlevy, 'The prevention of tuberculosis', p. 4.

vaccine was to produce a degree of immunity without risk to the individual by producing an artificial primary infection in those who are vaccinated.²⁰⁸ By this point, vaccination against TB with BCG had long passed its experimental stage and it was the dominant remedy used in Scandinavia ‘where more than 1 million people have been vaccinated’ by September 1947.²⁰⁹ Irish interest in the vaccine was intensified under the newly formed Department of Health of the same year, where McWeeney, as a medical officer of the Department, was sent to Scandinavia to make ‘a special study’ of the subject.²¹⁰ When he returned, he was co-opted on to an official BCG Committee set up by the Medical Research Council at the request of James Ryan, Ireland’s Minister for Health at the time.²¹¹ The purpose of this committee was to consider the advisability of the using the vaccine as a means of increasing resistance to TB, to advise on the population groups that should be vaccinated and to advise on the measures to be used to control the import and manufacture of BCG itself.²¹² Though McWeeney did not detail the specific names of those involved in the committee itself, members included Deeny, two university professors of bacteriology, a hospital pathologist and a bacteriologist, two ‘distinguished medical consultants’, a county medical officer of health, and a ‘pioneer worker in the BCG who has an international reputation in the field of childhood TB’, which was presumably, Dr Price.²¹³ It was the work of Dr Price that led to the establishment of the National BCG centre in St. Ultan’s Hospital in 1949, and this was followed by the subsequent establishment of the a national BCG vaccination scheme.²¹⁴ Even so, it was anticipated that there would be significant delays in having a mass BCG vaccination campaign owing to the training of medical personnel and procurement of supplies (see figure 6.5 and Appendix O).²¹⁵ Because of this, the vaccine was used on ‘special groups’ only.²¹⁶ An examination of the control groups that were used in its initial years provides an indication of which groups of the population were perceived as most vulnerable.

Between 1949 and 1952, children, industry workers and frontline medical staff occupied the main population groups vaccinated under the BCG national campaign (see figure 6.5). Initially, the committee recommended that the following population groups be vaccinated: new-born infants who were born of TB infected mothers in Dublin, or into families where there was a known case, children under 5 years old who lived in a household with a definite source of

²⁰⁸ Ibid., p. 3.

²⁰⁹ Lecture delivered by J. Heimbeck to Ireland’s Medical Research Council in UCD, 23 Sept. 1947. The lecture script was printed by the *IJMS* in Dec. 1947, pp 689-698 (RCPI, EJT/2).

²¹⁰ McWeeney lecture notes on BCG vaccine, 20 Nov. 1947, p. 12 (RCPI, EJT/2).

²¹¹ Ibid., p. 12.

²¹² Ibid., p.12.

²¹³ Ibid., pp 12-13.

²¹⁴ Carthy, ‘The treatment of tuberculosis in Ireland’, p. 63.

²¹⁵ McWeeney memorandum on the application of the BCG vaccine, 10 Feb. 1947 (RCPI, EJT/2).

²¹⁶ Ibid.

infection, hospital nurses who were TB negative and all pupils and staff at residential schools.²¹⁷ The committee recommended that school authorities allow investigation as to the presence of any source of TB infection among the pupils and staff while ‘parents and guardians of pupils should be asked to allow tuberculin treating as part of the investigation’.²¹⁸



Figure 6.5: A child receiving the BCG vaccination in Dublin Corporation, 1949.²¹⁹

As protocol, the committee anticipated that those vaccinated should then be reasonably protected at home for six weeks or until TB positive, having developed antibodies from the artificially controlled introduction of TB into one’s immune system.²²⁰ Nonetheless, it was realised that this was not always possible if the person vaccinated was already housed in an infective environment, for example in institutions.²²¹ To this end, initial work with parents on the ground helped, where parents seemed ‘willing enough and intelligent enough to co-operate in securing such matters as avoidance of milk-borne infection, keeping the child out of crowds and securing its attendance as required’.²²² While it was perceived by the Irish medical profession

²¹⁷ McWeeney lecture notes on BCG vaccine, 20 Nov. 1947, p. 12 (RCPI, EJTM/2).

²¹⁸ Ibid.

²¹⁹ DOH, *Report of the Department of Health, 1949-50* (Dublin, 1951), p. 32.

²²⁰ McWeeney lecture notes on BCG vaccine, 20 Nov. 1947, p. 12 (RCPI, EJTM/2).

²²¹ McWeeney memorandum on the application of the BCG vaccine, 10 Feb. 1947 (RCPI, EJTM/2).

²²² Ibid.

that the provision of more adult beds in the sanatoria meant that children had less chances of being exposed to TB, there were still fears of the chances of infection in the home from a ‘friend, nursemaid or domestic’.²²³ Such was the importance placed on children amid fears of potential TB infections already existing in their homes, the BCG vaccination was offered to all infants in Dublin’s maternity hospitals, and in 1951, Dunlevy noted that each week there was increase in the number of people availing of this service.²²⁴ By January, 1952, it was estimated that approximately 50,000 vaccinations were carried out throughout the country.²²⁵ Surveys of primary schools were also carried out under the BCG scheme in 1952.²²⁶ This scheme was also applied to the benefit of students, nurses and others who were coming in from rural areas to work in Dublin.²²⁷ Emphasis was placed on children, as well as those who were close to a primary infection. Meanwhile, the regular x-ray exams of adults that ran concurrently provided the Irish medical profession with a very practical means of identifying the spaces where the disease was most prominent.

Ireland was slow to introduce mass X-ray screenings of the population for TB. In 1936, Brazilian radiologist Manoel de Abreu constructed a radiographic machine alongside Siemens that was used in a chest survey of patients at the German Hospital of Rio de Janeiro.²²⁸ Thereafter, similar initiatives were introduced in Europe, North America, Japan and Australia.²²⁹ Sweden introduced mass radiography for new military conscripts in 1940 and began the mass screening of civilians as early as 1942.²³⁰ Similarly, Britain used mass-radiography initially on Navy recruits in 1940, while surveys of the general population occurred incrementally in the post-war period.²³¹ The US also began by screening recruits for the US army between 1940 and 1945 until it was applied more broadly to the general population between 1946 and 1949.²³² While Ireland had ordered x-ray equipment as early as 1943, there were significant supply issues internationally, and the UK also shared in limited supplies.²³³ Because of this, the use of the x-ray in early diagnosis was initially only available at major hospitals like the Mater Misericordiae Hospital and Crooksling sanatorium in Dublin and Newcastle sanatorium in Wicklow until June

²²³ Dunlevy, ‘The prevention of tuberculosis’, pp 5-6.

²²⁴ *Ibid.*, p. 6.

²²⁵ *Ibid.*, p. 8.

²²⁶ Dunlevy, ‘Prospect of childhood tuberculosis in Dublin’, p. 357.

²²⁷ Dunlevy, ‘The prevention of tuberculosis’, p. 3.

²²⁸ Solveig Jülich, ‘In light of media: mass miniature radiographic surveys for tuberculosis in Sweden, c. 1940-1970’ in *Media History*, xxii, no. 2 (2016), p. 202.

²²⁹ *Ibid.*

²³⁰ *Ibid.*, p. 203.

²³¹ F. J. Bentley and Z. A. Leitner, ‘Mass radiography with special references to screen photography and pulmonary tuberculosis’ in *BMJ*, i, no. 4143 (Jun. 1940) p. 882. Also see Arthur McIvor, ‘Germs at work: establishing tuberculosis as an occupational disease in Britain, c. 1900-1951’ in *SHM*, xxv, no. 4 (2012), p. 814.

²³² Georg T. Verlag, ‘Report on mass radiology of the chest in the United States’ in *Rofó*, lxxv, no. 1 (1952), pp 50-57.

²³³ *DÉD*, 1 Feb. 1943, vol. 95, no. 15 (Dr Conn Ward).

1946 when it was introduced in Dublin more broadly.²³⁴ One year later, Cork County Council had an x-ray unit and by July 1948, there were twenty-six x-ray units operated by the health authorities.²³⁵ In the sanatoria, it was also not uncommon for patients to work alongside doctors in the labs developing X-ray films.²³⁶

Plans for a portable x-ray machine in Ireland were enhanced in July 1950 when the first miniature mobile camera used was demonstrated at the sixth International Congress of Radiology in London.²³⁷ On 29 November 1950, the Department of Health established ‘An Comhlachas Naisiunta Slua-Radioghrafachta Teoranta’ or, the National Mass-Radiography Association.²³⁸ It was envisaged to administer a national radiological service which would be available and free for all, as well as being voluntary and confidential to each person (see Appendix P).²³⁹ As well as containing a substantially better x-ray in terms of image quality, these machines were mobile – the equipment was light, easily transported and the current that was required to power it was met by using any fifteen amp power socket.²⁴⁰ This meant that they



Coaches with Generators have been developed. The Mass X-Ray unit works in the coach.

Figure 6.6: Example of the X-ray coach that was developed, c. 1954.²⁴¹

²³⁴ Carthy, ‘The treatment of tuberculosis in Ireland’, p. 65.

²³⁵ Deeny, *National tuberculosis survey*, p. 232. Also see *DÉD*, 20 Jul. 1948, vol.112, no. 5 (Dr Noel Browne).

²³⁶ During his time as a patient in Crooksling, Jack O’ Riordan often worked alongside doctors in developing x-ray films and writing certificates. For example, see Jack O’ Riordan diary, 26 May 1942.

²³⁷ National Radiography Association (hereafter NRA), *First report, 1954* (Dublin, 1955), p. 5.

²³⁸ *Ibid.*, p. 5.

²³⁹ *Ibid.*

²⁴⁰ *Ibid.*

²⁴¹ NRA, *First report, 1954*, p. 1.

could travel to areas where there was otherwise no x-ray equipment available (see figure 6.6 and 6.7).²⁴² This was in line with the initial aim of the organisation to identify the ‘hidden case’ of TB, the ‘person who looks fit and feels well’. Initially, it was perceived that the best way to achieve this was to x-ray the ‘largest possible percentage of the apparently healthy’.²⁴³ By 1954, the total number people who were x-rayed was 501,379 – a figure representing 18.58% of the total population (see table 6.2).²⁴⁴ Despite that the concept of ‘mass radiography’ seemed to provide a means by which large groups of the population could be easily and quickly examined for the existence of TB, this was not the case in practice.

Total examinations carried out by 31 December.	
1951	23, 870
1952	140, 670
1953	308, 600
1954	501, 379

Table 6.2 X-ray examinations, 1951-54.²⁴⁵

On paper, the Mass Radiography Association sought to survey as much of the population as possible with a view to ascertain the incidence of TB in a given area, or among a given group. As Solveig Jülich has found in Sweden, ‘the public’ thus became a category that had to be established.²⁴⁶ A core element of mass-radiography involved the visitations of the x-ray vans to different areas that included schools, factories and public sessions for the people to be x-rayed. In some cases, special committees were set up to supervise the scheme, and they reached out to prominent local business and professional men while trade union leaders were also asked to encourage employees further.²⁴⁷ Organisations like Macra na Feirme, Muintir na Tíre and the Countrywomen’s Association were used to raise awareness.²⁴⁸ Likewise, propaganda ‘impressing upon everyone the advantages of early x-ray’ formed a notable aspect of the work.²⁴⁹ Factory sessions were held from 9:30am to 5:00pm.²⁵⁰ School sessions had availability from 9:30am until closing time.²⁵¹ On the other hand, public sessions usually only began at 2:30pm and ended at 5pm, though there was a night session held from 7.00pm until

²⁴² Ibid., p. 1.

²⁴³ Ibid., p. 31.

²⁴⁴ Ibid., p. 6.

²⁴⁵ Ibid.

²⁴⁶ Jülich, ‘In light of media: mass miniature radiographic surveys’, p. 209.

²⁴⁷ NRA, *First report*, p. 40.

²⁴⁸ Ibid., p. 35.

²⁴⁹ Ibid., p. 39.

²⁵⁰ Ibid.

²⁵¹ Ibid.

9.30pm.²⁵² Of the 194,664 x-rays that were carried out in 1954, 156,435 (80.4%) of these were carried out on people aged 39 and under.²⁵³ On the other hand, only 19.6% of x-rays were done on those aged 40 and over.²⁵⁴ Unfortunately, the same level of detail is not available for earlier years, though the age profile of respondents is likely to be similar. This suggests the association, regardless of their intention, focused on industry-based workers and schoolchildren. In areas where it was not possible for the van to visit, it was anticipated that leaflets detailing the dates of visitations should be drawn up in factories, libraries, cinemas and shops, where employees were asked to attend the public sessions, and parents were asked to bring their children to other schools.²⁵⁵ Effectively, if the x-ray van was not in one's specific business or locality, the sessions themselves proved difficult to attend.



70mm. films are read direct by means of a desk viewer.

Figure 6.7 Photo of the new X-ray 70mm films being read by the processing team in Dublin.²⁵⁶

It might be expected that the association would have been keen to survey places that had ‘an unduly high incidence of respiratory tuberculosis’, such as that found in mental hospitals.

²⁵² Ibid.

²⁵³ Ibid., p. 18.

²⁵⁴ Ibid.

²⁵⁵ Ibid., p. 40.

²⁵⁶ Ibid., p. 9.

In 1954, for example, the association found the incidence of TB at 35.4 per 1,000 in mental hospitals – which was significantly higher than that found in any other group examined.²⁵⁷ In fact it was already known that TB was very prominent in mental hospitals, as demonstrated in the previous chapter. Despite this, the association's interest in mental hospitals was how high rates in them might affect their ability to ascertain 'a definite opinion' on the geographical distribution of TB.²⁵⁸ In fact, treatment options available to patients in mental hospitals who contracted TB had previously featured in a Dáil debate on the Tuberculosis (Establishment of Sanatoria) Bill in January 1945, not because of health concerns of the patients themselves, but because of their capacity to spread the disease to the workers of these institutions:

The proportion of mental hospital workers in my constituency who have been affected by tuberculosis recently has been very great and I wonder if they contracted the disease from patients. Is there proper segregation of the patients suffering from tuberculosis in the mental hospitals or is it a result of their work amongst those patients that attendants have contracted the disease?²⁵⁹

In the initial years of the BCG vaccine, this was not extended to patients in mental hospitals in the same way that it was to students in residential schools despite the fact that overcrowding, made worse by official reforms, allowed the disease to thrive. The vaccine was not extended to patients as it was to hospital staff under the hospital staff protection schemes.

This emphasis on the young and working populations in Ireland's anti-TB campaign had a number of consequences in disease trends. Speaking at an address to at the annual general meeting of the National Mass Radiography Association on 26 February 1958, MacEntee, then in his second term as Minister for Health told the association:

Tuberculosis was at one time largely a disease of the younger age groups. It took men and women in the early flower of their maturity. To-day, thanks to the advance of modern science, to the activities of organisations such as yours, to the general development of our health services and to the generous assistance of the State, the incidence of the disease has been greatly reduced over the younger age groups, while its morbidity is tending to become more marked among their elders.²⁶⁰

He was right – the success of the anti-tuberculosis campaign had significantly reduced the number of TB deaths among the young, working and would-be working populations. Between 1947 and 1952, Dublin city, which had the highest number of tuberculosis deaths, had managed to get an 82% reduction in childhood TB deaths while substantial progress was also made in reducing the incidence of the disease among young adults.²⁶¹ Rehabilitation facilities, which

²⁵⁷ Ibid., p. 21.

²⁵⁸ Ibid., p. 14.

²⁵⁹ *DÉD*, vol.95, no. 14, 31 Jan. 1945 (Michael J. Kennedy).

²⁶⁰ NRA, *National mass-radiography association: second report* (Dublin, 1957), p. 17.

²⁶¹ Dunlevy, 'Prospect of childhood tuberculosis', p. 353.

catered for the return of patients into some form of work, were also substantially improved.²⁶² Between 1948 and 1958, the average age of a person who died from TB rose from 33 years old to 48 years old.²⁶³ Because of this, MacEntee noted that while some ten years ago the government was 'disposed to direct our admonitions and propaganda more immediately to the younger sections of our population, to-day it is necessary to bring home to older people a realisation of the fact that it is probable that among them the main sources of infection are now to be found'.²⁶⁴ The admission records of Newcastle sanatorium show a concurrent shift in the age of patients (see table 6.3).²⁶⁵ As shown, the average age of TB patients on admission ranged between 29 and 31 years between 1935 and 1955, only to dramatically increase to 39 years in 1957. By 1961, the average age of patients on admission to Newcastle sanatorium rose even further to 46 years.²⁶⁶ This suggests that TB was no longer a significant concern for those of younger age groups.

Year	Average age on admission
1935	29
1937	29
1939	28
1941	28
1943	29
1945	27
1947	28
1949	29
1951	30
1953	31
1955	31
1957	39

Table 6.3 Average age of tuberculosis patients on admission to Newcastle Sanatorium, 1935-57.²⁶⁷

While TB was now more prevalent among the older age cohorts this is not to say that it became just as rampant in the older populations as it was formerly on the younger cohorts. In 1955, there were only 889 deaths from this disease – the lowest on record yet achieved.²⁶⁸ To this end, there was a distinct change in approach from the anti-tuberculosis campaign. For

²⁶² DOH, *Health progress, 1947-53* (Dublin, 1953), p. 14.

²⁶³ NRA, *National mass-radiography association: second report*, p. 17.

²⁶⁴ Ibid.

²⁶⁵ Data taken from *Registrar of patients, 1935-1957* (RCPI, RNHC/ 4/2, RNHC/ 4/3).

²⁶⁶ Data taken from *Registrar of patients, 1961* (RCPI, RNHC/ 4/3).

²⁶⁷ Data taken from *Registrar of Patients, 1935-1957* (RCPI, RNHC/ 4/2, RNHC/ 4/3).

²⁶⁸ *ARRG, 1955*, p. xvi.

example, the National Mass-Radiography Association noted in 1958 that ‘special propaganda’ must be directed at the over forty-fives.²⁶⁹ The association noted that planning representatives should say ‘the older age groups’ and call them out specifically when they organised public sessions, and sponsored press articles.²⁷⁰ Emphasis was also placed on locating older people in the county homes and hospitals, where mass-radiography should be brought to them.²⁷¹ Meanwhile, public sessions going forward were to be held in the main thoroughfares of the cities and towns and a new, simplified radiography card was introduced in 1957.²⁷² Progress was also made in rural areas where as many as four localities were visited by a unit in a single day.²⁷³ Notwithstanding, this distinct shift in emphasis occurred in TB, and not on other diseases which had more fatalities. The number of deaths from cancer and heart disease (all forms), which affected older population groups disproportionately, rose significantly between 1942 and 1962 while the TB death rate reduced.²⁷⁴ At the same time, infant mortality rates significantly reduced, the result of a health policy that had long focused on the younger generations.²⁷⁵

6.7 Conclusion

Examining TB as a disease affecting the young in Ireland during this period offers valuable insights into the urgency surrounding the disease and the targeted public health measures that were introduced in response. It demonstrates, for example, that age was a critical factor in attracting official attention, perhaps even more significant than one’s social or economic status. As seen in the other case studies, there was a distinct rise in the incidence of TB during the war and, no matter which way the TB mortality figures of the period are shaped, the fact remains that it was one of the most lethal diseases of the young – it affected children, workers and their families. Furthermore, it sheds light on government strategy, offering a clearer understanding of how health policy is formulated and the factors that inform and influence its development. Against a backdrop of limited funds, it was ‘essential to make a careful estimate of the probable return on money spent in different ways before deciding on the distribution of expenditure’.²⁷⁶ Nowhere was this policy more evident than in the case of TB, which affected the young, working and would-be working populations. In efforts to secure funding and in the initiatives that were pursued, there was a continued emphasis on TB in younger populations.

²⁶⁹ NRA, *National mass-radiography association: second report*, p. 10.

²⁷⁰ *Ibid.*, p. 13.

²⁷¹ *Ibid.*

²⁷² *Ibid.*, p. 5.

²⁷³ *Ibid.*

²⁷⁴ *ARRG, 1942-62* (Dublin, 1963), consecutive years, p. xxv, p. xx and p. xxviii.

²⁷⁵ *Ibid.*

²⁷⁶ Dillion, ‘Tuberculosis: a social problem’, p. 169.

Piecemeal solutions to the ‘TB problem’ in Ireland meant that there was a high risk of the spread of TB among the wider population up until 1947. From a public health perspective, not dealing with the TB problem was presented as costing the state more money than it realised:

If diagnosis is late, treatment insufficient because of a shortage of beds or inadequate equipment or both, and aftercare crippled for lack of personnel and funds, the most that can be hoped for is the prolongation of life. Now it is certainly a good thing to prolong life; but when this involves prolonging at the same time risk of infection for others, and when the expenditure on the deficiency medical services leaves no balance to be applied to providing extra food and accommodation for the patient and his family, there is no gain from the public health point of view.²⁷⁷

In the case of TB, it was believed by the Irish medical profession that solving the TB problem would ‘promise rapid return for relatively small expenditure’.²⁷⁸ This was by no means unique to Ireland. In his analysis on changing patterns of TB in England and Wales, M. Ashraf noted that developments in the treatment of TB provided additional contributions to their gross national product.²⁷⁹

This chapter has argued that the Irish government initiated a significant wave of reforms in the war’s aftermath because the disease was a leading killer of the younger age groups. The steady progress of public health measures, sanatorium treatment, disease maintenance payments, BCG vaccine and mass-radiography completely fundamentally changed the patterns of TB in Ireland between 1947 and 1953. And by that point, these targeted public health measures meant that TB became a disease that affected the old more than the young, satisfying the country’s appetite for a speedy return on its investment. These public health measures were part of a wider public health rhetoric that prioritised the health of the young and working populations over others. Ireland’s campaign against TB during the 1940s corresponds with the picture presented by Bryder and Ryymin in relation to the UK and Norway, although at a much later stage. This was influenced by the general preoccupation with the health of the young in many nation states following the end of the First World War.²⁸⁰ Unlike during the Second World War, which saw many nation states combat TB to build up an effective citizenry for war, neutral Ireland tried to catch up with public health developments in the years after.

²⁷⁷ Ibid., p. 169.

²⁷⁸ Ibid., p. 164.

²⁷⁹ Ashraf, ‘Changing patterns of tuberculosis in England and Wales’, p. 123.

²⁸⁰ Colin Heywood, *Childhood in modern Europe* (Cambridge, 2018), pp 176-180.

Conclusion

This thesis has shown how the Second World War and its aftermath was a critical period for public health and for the development of health policy in Ireland. During the war, a crucial aspect of shaping public health policy lay in the Department of Local Government and Public Health's capacity to advocate for and justify chosen measures to Departments of Finance and Industry and Commerce. As demonstrated, Ministers for Health tended to focus on the young and urban poor, aligning public health initiatives within wider social dilemmas in Ireland. While it is commonly assumed that the most severe health issues garner the most attention, and areas with higher disease prevalence are prioritised, this was not always the case. Therefore, governments define 'health' and 'ill-health' alongside the process of making health policies. Focusing on the war and its aftermath also illuminates where the pressure points of public health were, raising questions about patterns of disease in Ireland, vulnerability to illness, and the underlying reasons for these vulnerabilities.

This thesis has focused on the medical areas that attracted substantial government attention and significant reform between 1939 and 1953: nutrition, infant mortality, mental illness and TB. Using a case-study approach to examine the negotiations of public health policy, this thesis places health crises relating to these areas within their immediate social and political backdrop. Highlighting the significant challenges faced by country's health authorities who were simultaneously tackling multiple health concerns at once, this work builds on existing historiography of public health in twentieth-century Ireland where more focus has been on individual diseases, leaving out the policy negotiations that informed the measures to combat them. Earner-Byrne notes that the Emergency highlighted just how dire the social conditions were at this time.¹ The same conditions gave rise to epidemics of gastro-enteritis during the early war years, encouraging a more interventionist approach from the government than before. New ideas about nutrition took hold just before the war, and the war created a food supply crisis. The 1940s were landmark years for TB in Ireland as the disease took on a symbolic significance in the push for social reform.² Finnane was among the first to note that the Mental Treatment Act 1945 signalled a major reconstruction of the mental health system, a legacy that continues to shape contemporary Irish mental health services, as corroborated by Kelly's more recent

¹ Lindsey Earner-Byrne, 'Managing motherhood: negotiating a maternity service for Catholic mothers in Dublin, 1930-1954', *SHM*, xix, no. 2 (2006), pp 261-262.

² Greta Jones, *'Captain of all these men of death': the history of tuberculosis in nineteenth and twentieth century Ireland* (Amsterdam, 2002), pp 187-188.

analysis.³ While undoubtedly true, questions of why these healthcare reforms came about at precisely the same time on the government agenda have been left unanswered. This thesis has examined the reasons why these areas all attracted government attention at this particular time in Irish history.

War and health

The economic circumstances of war had significant implications for the timing and type of the public health measures that Ireland implemented. As demonstrated in Chapter One, a combination of pre-existing deficits in Ireland's public health system and a rapidly deteriorating supply situation resulted in a precarious situation for the nation's health outcomes during the war. Pre-existing deficits included the dispersed nature of health providers that were already engaged in the provision of public health resources. The local authorities, the Department of Local Government and Public Health, the medical profession, voluntary associations and the Catholic Church often worked independent of one another, all with the same goal yet completely divorced in approach. While new bodies and organisations such as the Dietetic Council, the ESRB and the Department of Supplies were established to help navigate some of these core issues, they were the first of their kind in Ireland, and therefore did not have any example to follow. Instead, they reacted and responded to problems as they arose. With the exception of mental health, the absence of a centralised public health structure meant that there was a range of bodies and organisations involved in providing health services. Local authorities, charitable and voluntary organisations, and the Catholic Church thus became existing stakeholders with which the state had to negotiate as it took more interest in health. In this way, the war highlighted the acute vulnerability and the limited problem-solving capacity Irish state, whose independence was only seventeen years old when the war started.

This is not to say that the activities of these bodies were to no avail. Aside from the Department of Local Government and Public Health and the county councils and corporations, each of the organisations involved in the provision of health services had a significant impact on government policy formulations in both the short and long-term. In the short-term, for example, the Medical Research Council grew both in size and importance throughout the 1940s as it became a crucial body in advising on infant mortality and in the organisation of the rickets examinations (1943), the national nutrition survey (1946-48) as well as the national tuberculosis survey (1950-53). Other advisory committees established by the Medical Research Council during this period include the following: the TB Chemotherapy Unit (1947), the Consultative Cancer Council (April 1948), the Consultative Child Health Council (May 1948), and the

³ Mark Finnane, *Insanity and the insane in post-famine Ireland* (London, 1981), p. 221; Brendan Kelly, 'Mental health law in Ireland, 1945-2001: reformation and renewal' in *Medico-Legal Journal* (2008), lxxvi (2008), pp 65-72.

CONCLUSION

Consultative Council on Tuberculosis (May 1948) (as depicted in figure 1.12).⁴ One of the short-term advantages of the ESRB in health matters alone was its investigations into appropriate Irish calcium reserves for flour fortification, and this helped reduce the incidence of rickets in Ireland after the war had ended. In the long-term, Robert Bradley argues that the biggest contribution of the ESRB lay in its legacy, noting how their activities meant that the impact of science and technological advances on the promotion of the economic and social progress of the country were beginning to be realised.⁵

The emergence of the war in 1939 saw Fianna Fáil focus on basic survival through the management of the immediate supply situation. This had a number of consequences, and not just in health matters. Raymond Ryan and Andy Bielenberg highlight that one of the economic impacts of the war was the introduction of economic planning where the government's response was initially often limited to reacting to severe economic challenges as they emerged.⁶ This thesis observes the same for health, whereby the country's Department of Local Government and Public Health was just as concerned with public health resources as were the departments of Supplies, Finance, and Industry and Commerce with the supply situation. This thesis has shown that the approach to managing scarce resources resulted in a notable rise in the incidence of some diseases. For example, the war saw increased levels of malnutrition, as evidenced by epidemics of rickets. The mortality rate for children under five during the war rose by 18% compared to the period between 1933 and 1938 (see table 3.1). Additionally, TB mortality figures showed a 22% increase.

The fact that this occurred suggests that the most 'vivid' concern for Fianna Fáil during the early years of the war were the shortages as expert medical opinion was consistently sidelined in favour of managing the country's supply chain. Chapter Two on calcium deficiency not only highlights just how precarious Ireland's supply situation was, but it demonstrates the extent to which political short-terminism can exacerbate public health problems. Rising extraction rates may have alleviated wheat shortages in the short-term, but this had severe consequences for long-term public health, as evidenced by the growing incidence of disease. The black loaf was implicated in rising rates of TB. Relaxed regulations on milk quality, which exacerbated the concurrent TB situation, also rendered the government partly responsible for a higher incidence of infant mortality through diarrhoea and enteritis. In other areas, acute shortages of key medicines, such as insulin used for new therapies in overcrowded asylums, also impacted one's experience of illness. Delays in obtaining essential medical supplies in relation to TB after the war inevitably lead to more death and disease. To this end, John A. Costello's 1949 'War Book'

⁴ DOH, *Report of the Department of Health* (Dublin, 1951), pp 23-24.

⁵ Robert Bradley, 'The Emergency Scientific Research Bureau, 1941-45' (PhD, TCD, 1991), p. 271.

⁶ Andy Bielenberg and Raymond Ryan, *An economic history of Ireland since Independence* (Oxfordshire, 2013), pp 15-16.

CONCLUSION

to help manage medical supplies in any future emergency would be an invaluable source in any further research on the impact of the war on people's access to crucial medical supplies.

To address these health crises, the medical profession, the Department of Local Government and Public Health, and various voluntary organisations had to draw attention to how short-term economic policies impacted long-term public health outcomes. For example, in Chapter Two on calcium deficiency, it was the Dietetic Council that demonstrated the links between calcium deficiency, TB mortality, and the growing crisis of rickets among children. It is only with this information that Fianna Fáil took action to extract flour at lower rates and fortify flour. In Chapter Five on mental illness, it was the advocacy of the medical profession and Department of Local Government and Public Health. In Chapter Six on tuberculosis, the Department only took action after the advocacy of voluntary organisations (INATL and Post-Sanatoria League). Such a strong focus on the aftercare of TB sufferers by both organisations likewise sought to highlight the faults associated with the government's fixation on immediate bed supply, which offered little incentive for people to follow the government's advice. Ironically, this had a bigger impact on public health in the long-term where 'infectious' individuals remained in homes, workplaces and public spheres. In spite of evidence on the impact of their decisions, Fianna Fáil consistently attempted to distance themselves from pressing public health issues during the war, opting instead for bottom-up approaches where possible.

If the Department of Local Government and Public Health was effectively firefighting in public health and dealing with problems as they arose, then the process by which healthcare resources were allocated is particularly noteworthy. Throughout many of the case studies, the government opted for 'bottom up' methods that either relied on individual responsibility or the work of voluntary groups. As discussed in Chapter Three on diarrhoea and enteritis, Irish mothers were told by the government to breastfeed their babies to reduce the risk of disease as opposed to the government launching an investigation to identify contaminated milk supplies. Besides, addressing the milk question at this time would have proved particularly problematic for Irish farmers who had been hard hit during the Economic War just a decade previously. Voluntary organisations such as the Infant Aid Society, St. John Ambulance Brigade and the CSSC were already engaged on the ground, suiting an Irish government whose resources were strained. In Chapter Four on nutrition, food policy recommendations focused for the most part on educating the Irish people on the nutritive value of foodstuffs – a very cheap solution. In Chapters Five and Six, early government action focused largely on 'early diagnosis' and 'early treatment', yet the country lacked the institutional facilities to cope in these areas.

CONCLUSION

Several case also studies reveal the extent to which Ireland's distinct political and cultural context played a key role in the management of a health crisis. Continuous emphasis on the importance of breastfeeding may have helped Fianna Fáil indirectly help Irish families by teaching them best practice but this also protected them from the potential opposition of the Catholic Church had they become more directly involved in private family matters. In terms of the maternal advice given in the home visits by public health nurses, it is worth asking how likely it was that these mothers took up this advice in practice? The most practical advice given was to boil milk and yet, emphasis was continuously put on declining breastfeeding rates. This suggests that Fianna Fáil, with no immediate cure for gastro-enteritis, were more concerned with ascribing blame than introducing a concrete solution. This policy stance was carried over into the post-war period. For example, in relation to Chapter Four, the focus in malnutrition shifted to Irish households who were 'choosing' not to eat the right foods despite the fact that wartime inflationary measures were still in place after the war. In the case of mental illness and TB, a push on 'early diagnoses' and 'early treatment' merely assumed that those with serious conditions of disease did not seek help quick enough. However, these health crises received a significant amount of attention in the immediate post-war period.

In terms of the timing of public health measures, a substantial proportion of concrete healthcare measures were introduced in a rush after the war. For example, flour was fortified with calcium only after the rickets epidemic was identified. Apart from bottom-up initiatives and the mandatory reporting of diarrhoea and enteritis in 1943 (limited to towns and principal cities), the most tangible measures taken to address the rising infant mortality rate were the establishment of the official Gastroenteritis Advisory Committee and the deployment of St. Clare's Hospital in Glasnevin – these actions only commenced in 1946. It was only July 1947 when mandatory disease notifications in relation to gastro-enteritis were extended nationwide. A national nutrition survey was also launched in 1946. The Mental Treatment Act came into effect from 1947. A wave of measures to go against TB were introduced from 1946 onward, such as the provision of more TB beds, monetary allowances, BCG scheme and mass-radiography. In part, the government's response may be interpreted as a reaction to the wartime increase of disease in Ireland. These failures, coupled with poor economic conditions significantly reduced the popularity of the Fianna Fáil government. This may have opened the way for the country's first ever inter-party government following the 1948 general election, but they were largely implementing health legislation passed by Fianna Fáil. Ultimately, Noël Browne's insistent push on the health bill was enough to bring down the government, as suspected by Archbishop John Charles McQuaid. While there were attempts of Fianna Fáil to tread carefully once they got back in office in 1951, they were replaced again, except this time

CONCLUSION

by the country's second inter-party government, led again by Costello in 1954. However, it is also important to note that the actions that consecutive governments took also occurred in response to issues that they perceived would harm the country's international reputation.

As demonstrated, Ireland was one of very few neutral countries whose health performance declined during the war. This occurred at a time where public health was improving in other countries, including those directly engaged in the war. This meant that many of the health crises experienced in Ireland, such as rising malnutrition, infant mortality and TB, could have been prevented. This was known by members of the Fianna Fáil cabinet, who consistently cited developments elsewhere in official reports and parliamentary debates. On an international front, rising rates of disease indicated how ineffective Ireland's governmental policies and health infrastructures were at this time. These issues were embarrassing because they were part of a larger set of health and economic problems among the population where the state compared poorly to the UK that it had recently left. At a time in which ideas of 'positive health' were first emerging, the extent to which one nation's health could be considered better or worse than another's increasingly depended on factors like infant mortality, prevalence of TB, mortality of middle-aged persons and so forth. This also occurred at precisely the time where there was a growing demand for increased state intervention in health areas and growing discontent with the existing housing and sanitation infrastructures. Poor social conditions, such as inadequate housing, for example, which became linked to health, were frequently cited as examples of further government failures.

This research has also revealed attempts by consecutive Irish governments to downplay Ireland's mortality data and conceal health statistics. For example, in Chapter three, there were deliberations over what counted as 'gastroenteritis', even though the definition was deliberately made wide, as exemplified by Francis' case, raised in the Dáil. The same rhetoric fed into debates on whether to extend the notification of diarrhoeal cases nationwide in 1947, where there was some hesitancy in official spheres as to whether it should be done because it was perceived that this would drive disease figures higher than they were. This happened because Ireland's infectious disease notifications and deaths were reported to the WHO at this time, causing concern among the Department of Health's medical officers, who feared that the Irish data might result in negative assessments by the WHO. Attempts to downplay raw data is not a uniquely Irish problem. Definitions of infant mortality, 'live' and 'still' birth are still very pertinent political issues today, where changes to these definitions allow countries to manipulate their data.⁷

⁷ For information on conceptual frameworks, see C. Gourbin and Godelieve Masuy-Stroobant, 'Registration of vital data: are live births and still births comparable all over Europe?' in *Bulletin of the World Health Organisation*, lxxiv,

CONCLUSION

Similarly, there were deliberations in Chapter Four on whether to include calcium results in their entirety in the publication of the survey results. Despite recognising an existing calcium deficiency among the poorer population, the nutrition survey also noted that it was likely to decline on account of the fortification of baker's flour. The government then reduced the quantity of calcium in flour a year later. Ironically, the fortification of bread with calcium increased its cost, thereby moving it further away from poorer population groups who needed it most. The fact that bread dominated cabinet debates was partly influenced by earlier arguments that the Irish poor were poorly fed following the Famine and this reflected the age-old idea of disease as most vividly manifesting among the poor. While Miller explores how the consumption of a varied diet was seen as progress toward civilising the Irish, this research highlights how determined Fianna Fáil was to showcase the true health of the Irish to the world. After all, the nutrition survey sought to paint a favourable picture of nutrition in Ireland, so favourable that its results made it difficult for any *real* policy change to occur thereafter. Yet this was symptomatic of a significantly more interventionist approach when the war ended, where Ireland followed the lead of other countries who had adopted more centralised public health systems. Despite this, the impact of the international context on health and welfare developments during this period remains a largely untouched aspect in Irish historiography. Thus, this research places the Irish case within international public health historiography, where focus has been on the emergence of the welfare state in Britain and the US, giving less attention to smaller nations.

Ireland presents a uniquely compelling case where the state not only sought to enhance existing health services but also to achieve better outcomes than her former coloniser. The launching of Ireland's first ever national nutrition survey in 1946 is a prime example of the government attempting to catch up with her neighbours. In the first instance, the nutrition survey was based on known international nutrition requirements – those laid down by the League of Nations. Secondly, both the female investigators and the clinical's survey's medical officer were trained for three months in London, by the British Ministry of Health, prior to the survey. Ireland also joined the Food and Agriculture Association (FAO) of the UN in September 1946 – one month before the nutrition survey began. The Mental Treatment Act 1945 provides another example of how Fianna Fáil sought to align themselves with developments elsewhere. As demonstrated in Chapter Five, there was no evidence to suggest that the incidence of mental illness was rising in Ireland during the war. Nineteenth-century legislation concerning institutionalisation was significantly outdated, which culminated in significant legacies of

no. 4 (1995), pp 449-460; G. Masuy-Stroobant, 'The determinants of infant mortality: how far are conceptual frameworks really modelled' in Robert Franck (ed.) *The explanatory power of models* (Dordrecht, 2002), pp 15-30.

CONCLUSION

legislative abuse by various people within Irish society. England had passed their Mental Treatment Act in 1930, followed by Northern Ireland in 1932. Other jurisdictions, such as Switzerland, also updated laws in the 1930s. New legislation reflected concurrent international psychiatric developments, which contributed to a new psychiatric discourse that focused on treatment and cure. This is evident in the introduction of ‘modern’ treatments into Irish mental hospitals during the 1940s. Ireland also introduced the ‘addict clause’, a measure that was not introduced in Britain. Furthermore, Ireland focused more on developments related to TB in Scandinavia, rather than following the lead of its UK counterparts.

Public health regimes are not born in a vacuum – a great degree of thought, planning and organisation goes into the formulation of any health policy. Current debates in health policy centre around preventative and rescue medicine, the latter concerned primarily with a known ailment that needs to be addressed right away. This so-called ‘rescue medicine’ often clashes with preventative healthcare, as expanding healthcare provisions usually come with an increase in cost. Notwithstanding, we assume that health policy should reduce the suffering for the most amount of people. We also assume that all causes of suffering would be addressed by health policy equally. However, even in the best public health regimes across the world, the best treatment for all patients in all scenarios cannot be guaranteed.⁸ When making healthcare choices, who do you save and what do you do? In general, those who are in need are in need now, which adds urgency to an unfolding situation. However, does this mean public health resources should be directed to those problems that are most visible? Certainly, in the case of diseases like TB and rickets, one’s ill-health was visible, leading to abnormalities of growth. On the other hand, deaths from heart disease, cancer and senility together accounted for almost half of all deaths of all ages between 1939 and 1953 but official attention to these issues was lacking. This in turn raises important questions of the political motivations behind the introduction of public health reforms as well as the populations whom these health measures sought to affect most.

These case studies show how public health concerns competed with one another for funding. A major theme of this study is disease visibility, or how easy it was to see a disease. This can be interpreted in a variety of ways. First, the symptoms of disease can be visible on the human body such as in TB and rickets. This made it easier to differentiate between the ‘sick’ and the ‘healthy’. Research has shown that tangible examples have a much stronger impact on people’s opinions and actions compared to detailed statistical data.⁹ Disease symptoms can thus

⁸ Tony Hope, ‘Rationing and life-saving treatments: should identifiable patients have higher priority?’ in *Journal of Medical Ethics*, xxvii, no. 3 (2001), p. 179.

⁹ Karen E. Jenni and George Loewenstein, ‘Explaining the ‘identifiable victim effect’ in *Journal of Risk and Uncertainty*, xiv (1997), p. 237.

CONCLUSION

reinforce the perceptions around disease, where the sick are portrayed as helpless and sympathetic – as was the case in Ireland, particularly in the ‘malnourished child’ depictions found in Chapter Two. Similarities can also be found in relation to the TB sufferer. These symptoms were equally as visual with people suffering and likely to continue to suffer if consecutive Irish governments chose to ignore the issue. They also unfolded in real time, which may have added urgency to the rising incidence of certain diseases in Ireland during the war. This may in part explain why there was little attention given to heart disease and some forms of cancer, where victims may show no symptoms and where they are usually older people.

Disease numbers, which include incidence and mortality rates, can also provide a visible marker as to how serious a public health problem was. Disease figures can be found in consecutive *ARRG*, health reports as well as relevant surveys. This information was crucial in driving change in Ireland’s public health policy, yet they remain a minor component of most public health Irish historiography. In relation to infant mortality and TB, rising rates during the war signalled to the Irish government that these two issues required further attention, ultimately influencing crucial changes in the government’s approach to these problems. Meanwhile, reports of the ‘malnourished child’ in the rickets investigations also brought new perspectives to the importance of food in health.

Meaningful populations

In different ways, each of these case studies have something interesting to say about the state’s values and interests. Crisis situations, more than any other time, can provide a clearer and more valuable insight into the areas most prioritised by the country’s health authorities. They can therefore be used to examine which populations received attention, those who were overlooked and the reasons for these disparities. Unlike that found in the other case studies, the ‘identifiable’ problem with mental illness in Ireland was not only about the number of cases presenting, but the financial strain that growing numbers had placed on country’s state-run institutions. This suggests that government views of the health of those housed within state-run mental hospitals were of secondary concern to the financial burden that these people placed on the government and local authorities. While mental illness is symptom-based like many other diseases, it is not necessarily a visible disease. Where mental illness is made visible however is through statistics. In Ireland, these statistics, which detailed an abundance of material ranging from admissions to discharges were collected on an annual basis by department inspectors. At this time, the per capita incidence of mental illness as recorded in the *ARIMH* was higher than TB. A hidden cost beyond this was the damage done to the Irish economy. Similar concerns were also found in the case of TB in Ireland, which affected primarily the young and working populations at this

CONCLUSION

time. Because of this, government priorities focused on early diagnosis and treatment that aimed to increase discharge rates and minimise the length of time one spent in the mental hospital.

These case studies also reveal that there were profound discrepancies in public health provision in urban and rural areas. For example, more deaths in urban areas from diseases like diarrhoea and enteritis and TB meant that they were increasingly seen as an urban problem. A higher incidence of calcium deficiency in urban areas also led to the same conclusions. Granted, poorer tenement conditions in inner city areas provided ample opportunity for causative bacteria to rise in epidemic proportions. However, this focus on urban slums, particularly in Dublin, introduced a bias into the types of information gathered and presented by Ireland's Department of Health while the solutions that followed equally targeted urban areas specifically. In Ireland, there were obvious examples that could be gathered on the ground in close proximity, which meant that more knowledge of the incidence of disease could be found in the urban area, and more quickly. This also meant that the calculation of case frequencies proved more reliable in urban areas. This information could then be further broken down by sex, age and space. However, just as Dijkstra and Hortsman observe, categorising people in a certain way can inform expectations about them, influencing how they are examined and understood.¹⁰ In Ireland, this conjured an image of the 'sick urban area' which in this case, was Dublin along with over-populated towns.

Despite often being portrayed as 'healthier' in Chapter Four on the nutrition survey, rural areas experienced higher and rising overall death rates during this period (see Appendix D). Fianna Fáil may have also positioned themselves as the leaders of the smallholder cause, but the numbers of small farms in Ireland were in decline, leading to the growth of larger farms and the marginalisation and emigration of young people and women from rural areas.¹¹ There were several outbreaks of infectious disease in state and voluntary-run settings, but commensurate government attention to these incidents was lacking. For example, Sligo had an unusually high rate of infant mortality during the 1940s, which coincided with complaints about poor conditions in local milk production as explored in Chapter Three (see Appendix D). In Offaly, John McCann's wife and two unborn children died due to a lack of access to a midwife. Milk from the Ireland's largest and highest-grade herd, found to be tuberculous, was still consumed in Cork Street Fever Hospital and in schools throughout the country under the Free Milk Scheme in 1948.¹² Despite these problems, healthcare investment, except for top-down

¹⁰ Ilse Dijkstra and Klasien Horstman, 'Known to be unhealthy': exploring how social epidemiological research constructs the category of low socioeconomic status' in *Social Science & Medicine*, cclxxxv (2021), p. 2.

¹¹ R. C. Geary, 'Irish economic development since the Treaty' in *An Irish Quarterly Review*, xl, no. 160 (Dec. 1951), p. 411. Also see, Tony Farley, 'Gaining ground, losing ground: the politics of land reform in twentieth-century Ireland' in Fergus Campbell and Tony Farley (eds), *Land questions in modern Ireland* (Manchester, 2013), p. 44.

¹² Deeny to Brady, 22 May 1948 (NAI, HLTH B132/28).

CONCLUSION

legislation (belated), was primarily focused on Dublin. This urban-focused approach extended to education and employment opportunities, facilitating further rural-to-urban migration.

The issue of youth and the investment of the state in its working population is a recurring theme in chapters on diarrhoea and enteritis, calcium deficiency and nutrition, and TB. This focus on the young was not simply because of higher disease numbers. This thesis contends that the government emphasised improving the health of the younger generations in many of its public health policies at the same time. When the issue of nutrition emerged, it was in the context of the impact of calcium deficiency and the incidence of rickets in young children. Reforms of Irish district mental hospitals sought to cure patients and return them to normal working life, although these specific measures later backfired. The same can be said for the sanatoria in a chapter on TB where those aged between 0 and 45 years of age were targeted – the otherwise working and ‘would be’ workers of Irish state. The result of the Irish government’s prioritisation of ‘young’ diseases over those of the ‘old’ was a deterioration of the health of the elderly – an indication of what would become the country’s next public health focus from the 1960s. As shown, deaths from heart disease and cancer grew significantly by 1962, while deaths from infant mortality and TB went into sharp decline (figure 7.1). Without adequate cures for diseases of the elderly like cancer and heart disease, they were also very difficult to sell from a policymaker’s perspective. Instead, bottom-up measures, such as warnings against tobacco use and encouragement to exercise remain a central component of government strategy, reflecting a focus on changing the people’s behaviour.

Targeted populations in public health between 1939 and 1955 were the Irish young and the urban poor. While health policies may be designed to have an impact on morbidity and mortality statistics, they can also be designed in relation to their costs relative to other available options. What happened in Irish public health policy can therefore say something important about the type of Irish society that existed. What happened in Irish public health policy can therefore say something important about the type of Irish society that existed. While the state has been seen to act in the people’s best interests by aiming to prolong life and minimise death where possible, the means to achieve this end has also aimed to produce certain kinds of subjects and bodies. This adds to broader international public health historiography, where Lupton observes how policy can both differentiate and marginalise population groups. This research further illustrates that similar processes occurred in Ireland, where public health policies, much like those elsewhere, contained strongly coercive elements designed to shape and influence behaviour. While Lupton builds on Foucault’s observation, it is also important to place this into

CONCLUSION

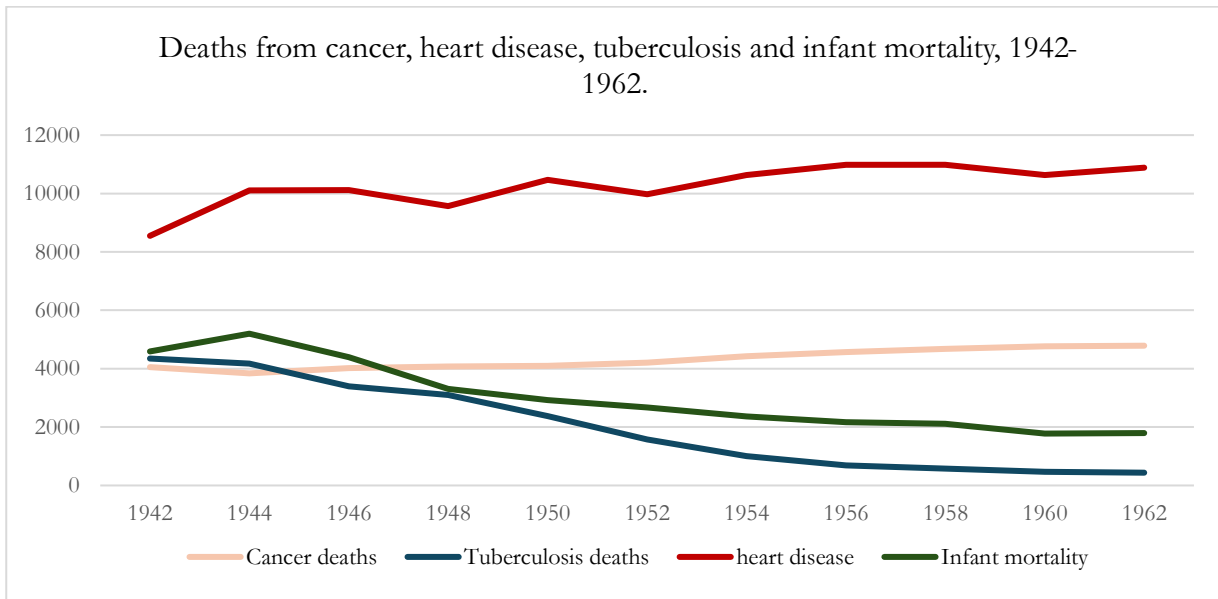


Figure 7.1 Numbers of deaths from cancer, heart disease, TB and infant mortality, 1942-1962.¹³

a larger context, where the wider twentieth century, as Eric Hobsbawm has characterised, was ‘an age of extremes’.¹⁴

On the one hand, it was marked by oscillating moods and events ranging from early twentieth-century catastrophe, through a golden age in the decades after the Second World War, to a period of global crisis and collapse between 1973 and 1991. On the other hand, the twentieth century was characterised by a tendency to classify people, practices and political systems in simple binary terms, an approach to knowledge and experience that had first gained legitimacy during the Enlightenment.¹⁵

On the ground then, there were very distinct contrasts made between:

Seemingly oppositional categories such as: reason and emotion; sanity and insanity; self and other; normal and pathological; capitalist and communist; public and private; female and male; creativity and conformity.¹⁶

In a medical context, each of these case studies outline that this also occurred in Ireland where the *sick man* was constantly compared to the *model man*, albeit in different ways at different times. In chapters on calcium deficiency and nutrition, the *sick man* was the poor man who had to be encouraged to eat a more varied diet like that of the *model man*, the rural Irish farmer who had benefited most from Irish independence. In Chapter Three on diarrhoea and enteritis, the *sick child* was most commonly found in poorer urban areas, while the *model child* had *model parents* that knew best on how to appropriately feed and look after their children. The same is indicated in a chapter on tuberculosis. However, healthcare opportunities were extended to the poor only,

¹³ ARRG, 1942-62, consecutive years, pp xx-xxviii.

¹⁴ Eric Hobsbawm, *The age of extremes: the short twentieth century 1914-1991* (London, 1994).

¹⁵ Mark Jackson and Martin D. Moore (eds), *Balancing the self: medicine, politics and the regulation of health in the twentieth century* (Manchester, 2020), p. 2.

¹⁶ Ibid., pp 1-2.

CONCLUSION

and not on babies born out of wedlock and those housed away from society, such as those in mental hospitals. Contrary to popular belief, public health resources rarely go to the areas that are most in need as identified by mortality statistics. Instead, they tend to be allocated where the case for them is most effectively argued.¹⁷ In Ireland, this meant that public health allocations were not solely dictated by a desire to address illness. Rather, it depended on who the government wanted to be healthy.

This thesis has shown the extent to which public health was in crisis in Ireland between 1939 and 1953. The experience of crises in the areas of nutrition, infant mortality, mental health and TB profoundly reshaped Irish health services, ultimately laying the groundwork for the system of public health that we recognise today. This transformation eventually led to a perception in some circles that Ireland's health service was among the best in the world by the late twentieth century.¹⁸ From this perspective, the health crises of this period resulted in improvements in public health, an idea initially proposed by Hensey, who distinguished between public health in Ireland before and after the war.¹⁹ While the works of Hensey and Barrington correctly identify this period as a turning point, this dissertation has raised the question of why and how these changes occurred at this time.

The prevalence of histories of individual diseases has obscured the political reasons and motivations behind policy changes. This dissertation is the first to explore the complexities involved in the simultaneous design of multiple public health strategies and interventions. Starting in 1939, with the outbreak of war and a fundamentally flawed public health system which involved numerous complex bodies, this dissertation concludes with the 1953 Health Act, which marked the first time Ireland provided free or subsidised healthcare to the majority of its population. The war and the resultant shortage of supplies in Ireland placed significant strain on the Irish healthcare system, where endemic health issues such as infant mortality and malnutrition were significantly exacerbated. Short-term political decisions therefore carried with them severe health implications as demonstrated in Chapter Two.

This dissertation is also the first to ask why some diseases were prioritised over others at this time. In some areas, health policies were developed not only in response to a growing incidence in disease, but also as a consequence of an increasing volume of data and surveys used to document these trends. The availability of statistical data on diseases such as TB and infant mortality gave the government a compelling rationale for reform, enabling the Department of

¹⁷ Flurin Condrau, 'Urban tuberculosis patients and sanatorium treatment in the early twentieth century' in Anne Borsay and Peter Shapley (eds), *Medicine, charity and mutual aid: the consumption of health and welfare in Britain, c. 1550-1950* (London, 2007), p. 189.

¹⁸ Ruth Barrington, *Health, medicine and politics in Ireland, 1900-1970* (Dublin, 1987), p. vii.

¹⁹ Brenden Hensey, *The health services of Ireland* (2nd ed., Dublin, 1972), p. 1.

CONCLUSION

Local Government and Public Health (later Department of Health) to demand more public funds for health initiatives. Meanwhile, the role of voluntary bodies in raising awareness about diseases and vulnerable populations also proved instrumental. After all, this period saw a demonstrable increase in the number of new bodies and new investigations, such as those of the Medical Research Council, which organised surveys on rickets, nutrition and TB, and the Dietetic Council, which consistently pushed for the lowering of flour extraction rates. Equally as important was the government's focus on cost considerations. This remained a recurring pressure throughout the period and explains in part why diseases such as heart disease and cancer were ignored. This also explains the reasons why research was at times manipulated for political agendas, downplaying mortality data to the WHO, and ultimately favouring a policy stance comprising bottom-up measures. In conclusion, this dissertation highlights the complex interplay of health data, political priorities, and public health advocacy in shaping Ireland's health policy during this period. This demonstrates how the prioritisation of certain diseases over others was not merely a response to public health needs, but also a product of strategic, social and economic factors where health policy was informed by far more than just scientific and medical considerations. While this dissertation was originally intended as a study in the social history of medicine, the completed work is a synthesis of Ireland's social, economic, political and medical history and explorations into each of these areas are thus crucial for understanding the scope, timing and pace of public health reform in Ireland at this time.

BIBLIOGRAPHY

Primary sources

A. Manuscripts

Donegal County Archives

Records of Donegal District Lunatic Asylum/St. Conal's Mental Hospital (MED 4/)

Dublin Diocesan Archives (DDA)

Archbishop John Charles McQuaid papers (XVII/)

Diocesan Hospital Collection (L2/)

National Archives of Ireland (NAI)

Department of Health files (HLTH/B)

Files relating to GEAC (HLTH/M)

Department of Taoiseach files (TAOIS/S)

Department of Industry and Commerce files (INDC)

Department of Finance files (FIN)

Department of Foreign Affairs files (DFA)

Private collections:

Hilda Tweedy papers (PRIV 98/17)

St. Brendan's Hospital/Grangegorman papers (PRIV/1223)

National Library of Ireland (NLI)

Irish Countrywomen's Association papers (MS 39,886)

Royal College of Physicians Archives (RCPI)

Connolly Norman papers (CN/1)

Edmund McWeeney papers (EJTM/2)

Living History Project (LMH)

Matthew and Angela Russell papers (RE/14)

Private collections:

Newcastle Sanatorium (The Royal National Hospital for Consumption) (RNHC/1/2/5)

Royal College of Surgeons Archives (RCSI)

Deeny papers (RCSI/IP/Deeny)

Trinity College Dublin Archives

Dorothy Price papers (MS/7536)

University College Dublin Archives

Seán MacEntee papers (P67/276)

Other private collections:

Diary of John (Jack) O’Riordan, 1942

B. Official reports & publications

Annual report of the county medical officer of health, Cork County Borough for 1941-2 (Cork, 1943).

Annual report of the Inspector of Mental Hospitals, 1929-55 (Dublin, 1956).

Annual report of the Registrar-General, 1933-54 (Dublin, 1955).

Fifth annual report of the county medical officer of health, Kilkenny for 1939 (Kilkenny, 1940).

Health Progress, 1947-1953 (Dublin, 1953).

Ireland’s hospitals, 1930-1955 (Dublin, 1956).

National mass-radiography association: first report, 1954 (Dublin, 1955).

National mass-radiography association: second report (Dublin, 1957).

National nutrition survey parts i-vii: complete reports on dietary and clinical surveys (Dublin, 1953).

Reconstruction and improvement of county homes (Dublin, 1953).

Report of the Department of Health, 1949-53 (Dublin, 1954).

Report of the Commission on the relief of the sick and destitute populations, including the insane poor
(Dublin, 1927).

Report of the gastro-enteritis survey Dublin city, 1964-1966 (Dublin, 1967).

Report of the Tribunal of Enquiry into the milk supply in Dublin (Dublin, 1946).

Report on vital statistics, 1955-1962 (Dublin, 1963).

Select Committee on the health services: memorandum from the Department of Health on Irish health services
(Dublin, 1964).

C. Dáil Éireann, Parliamentary Debates

Dáil Éireann Debate, Jul. 1924, vol. 8.

_____, Nov. 1934, vol. 54.

_____, Sept. 1939, vol. 77 – Jun. 1953, vol. 139

D. Relevant statutory legislation, directives, and orders

Constitution of Ireland, 1937 (1 Jul. 1937).

Criminal Law Amendment Act, 1935 (28 Feb. 1935).

Emergency Powers Act, 1939 (1939 no. 28) (3 Sept. 1939).

Health Act, 1947 (1947 no. 28) (13 Aug. 1947).

_____, 1953 (1953 no. 26) (29 Oct. 1953).

Health Services (Financial Provisions) Act, 1947 (1947 no. 47) (27 Dec. 1947).

Health (Transfer of Departmental Administration and Ministerial Functions) Order, 1947 (1947 no. 58) (11 Mar. 1947).

Infectious Diseases Regulations, 1948 (1948 no. 99) (24 Mar. 1948).

Local Authorities (Officers and Employees) Act, 1926 (1926 no. 39) (28 Jul. 1926).

Local Government Act, 1923 (1923 no. 9) (28 Mar. 1923).

_____, 1925 (1925 no.5) (26 Mar. 1925).

Mental Treatment Act (England), 1930 (1930 no. 1083) (10 Jul. 1930).

Mental Treatment Act, 1945 (1945 no. 19) (22 May 1945).

The Mental Treatment Regulations (Northern Ireland), 1932 (1932 no. 101) (23 Sept. 1932).

Milk and Dairies Act, 1935 (1935 no. 22) (14 Jun. 1935).

Ministers and Secretaries Act, 1924 (1924, no. 16) (21 Apr. 1924).

Ministers and Secretaries (Amendment) Act, 1946 (1946 no. 38) (18 Dec. 1946).

Public Assistance Act, 1939 (1939 no. 27) (8 Aug. 1939).

Public Health (Infectious Diseases) (Amendment) Regulations, 1943 (1943 S. I. no. 258) (30 Jun. 1943).

Public Health (Infectious Diseases) (Amendment) Regulations, 1947 (1947 S. I. no. 297) (26 Jun. 1947).

Public Hospitals Act, 1933 (1933 no. 18) (27 Jul. 1933).

Republic of Ireland Act, 1948 (1948 no. 22) (21 Dec. 1948).

Therapeutic Substances (Saorstát Eireann) Regulations, 1934 (1934 S. I. no. 365).

Therapeutic Substances (Emergency Amendment), Order 1942 (1942 S. I. no. 555) (31 Dec. 1942).

Tuberculosis (Establishment of Sanatoria) Act, 1945 (1945 no. 4/1945) (6 Mar. 1945).

Tuberculosis Prevention (Ireland) Act, 1908 (15 Jul. 1908).

E. Contemporary newspapers/periodicals

<i>Belfast Newsletter</i>	<i>Irish Press</i>
<i>Connacht Tribune</i>	<i>Irish Times</i>
<i>Cork Examiner</i>	<i>Kerry Champion</i>
<i>Dublin Opinion</i>	<i>Limerick Leader</i>
<i>Information Bulletin</i>	<i>Nenagh Guardian</i>
<i>Irish Examiner</i>	<i>Sunday Dispatch</i>
<i>Irish Housewife</i>	<i>Tuam Herald</i>
<i>Irish Independent</i>	<i>Western People</i>
<i>Irish Nurses Magazine</i>	<i>Woman's Life</i>

F. Pamphlets

Department of Local Government and Public Health, *A simple guide to a wholesome diet* (Dublin, 1942).

Department of Health, *An mháthair is a leanbh = Mother and child: what the new service means to every family* (Dublin, 1948).

G. Contemporaneous medical works (Irish)

Aughney, Honoria, 'The production and distribution of milk in County Wexford', *Irish Journal of Medical Science*, ccclxvi (Jun. 1956), pp 243-258.

Crowe, Morgan, 'The origin and development of the public health services in Ireland', *The Irish Journal of Medical Science*, vi, no. 265 (1948), pp 1-19.

Barret, Edward B., 'Modern psycho-therapy and our asylums', *Studies: An Irish Quarterly Review*, xiii, no. 49 (Mar. 1924), pp 29-43.

Deeny, James, 'Practical significance of the Irish national nutrition survey', *British Journal of Nutrition*, iv, no. 2-3 (1950), pp 292-95.

_____, *Report of the national tuberculosis survey, 1950-1953* (Dublin, 1954).

_____, 'The development of the Irish tuberculosis services', *The Irish Journal of Medical Science*, 154 (1985), pp 29-33.

_____, *The end of an epidemic: essays in Irish public health, 1936-65* (Dublin, 1995).

BIBLIOGRAPHY

- Delany, J., and J. R. Shea, 'Observations on the treatment of psychosis by electrically induced convulsions', *Irish Journal of Medical Science*, xix (Jun. 1944), pp 193-195.
- Dillon, Theobald W. T., 'Tuberculosis and the bed shortage: tuberculosis bed needs in southern Ireland', *Irish Journal of Medical Science*, vi, no. 226 (Oct. 1944), pp 517-530.
- , 'Tuberculosis: a social problem', *Studies: An Irish Quarterly Review*, xxxii, no. 126 (Jun. 1943), pp 163-174.
- Dooley, P. G., 'The report on rickets in Dublin', *Journal of the Medical Association of Éire*, (Jun. 1946), pp 30-31.
- Dunlevy, Margaret, 'The prevention of tuberculosis', *The Irish Journal of Medical Science*, vi, no. 313 (Jan. 1952), pp 1-10.
- , 'Prospect of childhood tuberculosis in Dublin', *Irish Journal of Medical Science*, xxviii (1953), pp 353-360.
- , 'Five years' experience of BCG vaccination in Dublin', *Medical Officer*, xcii, no. 5 (1954), pp 53-6.
- Dunne, John, and Eveleen O'Brien, 'Insulin therapy', *Journal of Mental Science*, lxxxv, no. 356 (1939), pp 498-504.
- Dunne, John, 'Survey of modern physical methods of treatment for mental illness carried out in Grangegorman Mental Hospital', *Journal of the Medical Association of Éire*, xxvii (1950), pp 4-9.
- Epstein, M. R., W. Kidney, W. Collis, H. Pringle, R. A. Reynolds, S. Douglas and W. J. E. Jessop, 'The incidence of rickets in Dublin', *Journal of the Medical Association of Éire*, xxvi, no. clii (1950), pp 19-24.
- Fearon, William R., and Dorothy L. Foster, 'The autolysis of beef and mutton', *Biochemical Journal*, xvi, no. 5 (1922), pp 564-571.
- Fearon, William R., George O'Brien, E. J. Sheehy, T. W. T. Dillon, Henry Kennedy, James M. Dillon and Edward Coyne, 'The national problem of nutrition (with comments)', *Studies: An Irish Quarterly Review*, xxvii, no. 105 (1938), pp 12-34.
- Fearon, William R., and G. Dockeray, 'Ante-natal nutrition in Dublin: a preliminary survey', *Irish Journal of Medical Science*, (1939), pp 80-84.
- Geary, Roy C., 'Statistical plans and methods of the Irish national nutrition survey', *British Journal of Nutrition*, iv, no. 2-3 (Sept. 1950), pp 274-281.
- , 'Irish economic development since the Treaty', *An Irish Quarterly Review*, xl, no. 160 (Dec. 1951), pp 399-418.
- Gore, Charles C., 'Nutritional standards of some working-class families in Dublin, 1943', *Journal of the Statistical and Social Inquiry Society of Ireland*, xvii, no. 1 (1943/1944), pp 241-253.

BIBLIOGRAPHY

- Hourihane, Desmond, 'Objective, scope and general plan of the Irish national nutrition survey', *British Journal of Nutrition*, iv, no. 2-3 (1950), pp 270-274.
- International Hospital Foundation, *Report of the study tour of hospitals in Ireland, May 21st -31st 1956* (Dublin, 1956).
- Jessop, William J. E., 'Medical Research in Ireland', *Hermathena*, xcix (1964), pp 27-41.
- _____, 'Results of rickets surveys in Dublin', *British Medical Journal*, vi (Sept. 1950), pp 289-92.
- Jessop, William J. E, H. Pringle and R. A. Reynolds, 'The incidence of rickets in Dublin', *Journal of the Medical Association of Éire*, xii, no. 72 (1943), p. 67.
- Malley, Kevin, 'The Irish national anti-tuberculosis league and its aims', *Irish Journal of Medical Science*, xviii (1943), pp 48-50.
- Molony, C. B., 'The new Mental Treatment Act and its application to general practice', *Medical Association of Éire*, xviii (Mar. 1946), pp 51-53.
- Noonan, L. F., 'Physical therapy of mental disorder', *British Medical Journal*, i (May, 1947), p. 778.
- O'Connor, J. M., 'Origin and organisation of the Irish national nutrition survey', *British Journal of Nutrition*, vi, no. 2-3 (Sept. 1950), p. 269.
- Price, Dorothy S., 'Primary tuberculosis of the lungs in children', *Irish Journal of Medical Science*, x (1935), pp 54-75.
- _____, 'Tuberculosis in adolescents', *Irish Journal of Medical Science*, xvi (1939), pp 124-192.
- _____, 'Note on the tuberculous phlycten', *Irish Journal of Medical Science*, xv (1940), pp 327-330.
- _____, 'Report of a tuberculin survey amongst children in Dublin hospitals made by the Irish Paediatric Association', *Irish Journal of Medical Science*, (1941), pp 241-255
- _____, 'The prevention of tuberculosis in infancy', *Irish Journal of Medical Science*, xvii (1942), pp 252-255.
- _____, *Tuberculosis in childhood* (Dublin, 1942).
- _____, 'The need for BCG vaccinations in infants', *Tubercle*, xxx, no. 1 (1949), pp 11-13.
- _____, 'Analysis of BCG vaccinations', *Irish Journal of Medical Science*, cccxxxviii (1954), pp 56-64.
- Sheehy, E. J., 'Agricultural implications of the results of the Irish national nutrition survey', *British Journal of Nutrition*, iv (1950), pp 284-287.

H. Contemporaneous medical works (international)

- Bentley, F. J., and Z. A. Leitner, 'Mass radiography with special references to screen photography and pulmonary tuberculosis', *BMJ*, I, no. 4143 (Jun. 1940), pp 879-883.
- Bourne, Geoffrey H., *Nutrition and the war* (Cambridge, 1940).
- Bourne, Harold, 'The insulin myth' in *Lancet*, cclxii, no. 6793 (Nov. 1952), pp 964-968.

BIBLIOGRAPHY

- Campbell, Janet M., 'The nutrition report', in *International Affairs*, xvii, no. 2 (1938), pp 251-253.
- Dahlberg, Gunnar, 'Mortality from tuberculosis in some countries', *British Journal of Social Medicine*, iii, no. 4 (1949), pp 220-227.
- Daniels, Marc, 'Tuberculosis in Europe during and after the Second World War', *British Medical Journal*, ii, no. 4636 (Nov. 1949), pp 1135-1140.
- Deeny, James, 'The assessment of nutrition', *Ulster Medical Journal*, vii, no. 3 (1938), pp 206-214.
- , 'Clinical and social survey of male linen workers', *British Medical Journal*, i, no. 267, (1940), pp 267-270.
- , 'Polycythaemia and vitamin C', *British Medical Journal*, ii, no. 4172 (1940), pp 864-866.
- , 'Riboflavin deficiency: with a case report', *British Medical Journal*, ii, no. 4272 (1942), p. 607.
- Deeny, James, and Eric T. Murdock, 'Infant mortality in the city of Belfast', *Dublin Journal of the Statistical and Social Inquiry Society of Ireland*, xvii (1944), pp 221-240.
- Kalinowsky, L., and P. Hoch, *Shock treatments and other sematic procedures in psychiatry* (New York, 1950).
- Kraines, Samuel H., *The therapy of the neuroses and psychoses* (Chicago, 1948).
- Maggee, H. E., 'Application of nutrition to public health: some lessons of the war', *British Medical Journal*, I (Mar. 1946), pp 475-82.
- Sakel, Manfred, *Schizophrenia* (New York, 1958).
- Sebrell, W.H., 'The public health aspect of the fortification of foods with vitamins and minerals', *The Milbank Memorial Fund Quarterly*, xvii, no. 3 (Jul. 1939), pp 241-247.
- Sinclair, Hugh M., 'Wartime nutrition in England as a public health problem', *American Journal of Public Health and the Nation's Health*, xxiv, no. 8 (1944), pp 838-842.
- Verlag, Georg T., 'Report on mass radiology of the chest in the United States', *Röfo*, lxxv, no. 1 (1952), pp 50-57.
- World Health Organisation, *Report of the Interim Commission to the First World Health Assembly* (Jun. 1948).
- World Health Organisation Interim Commission, *Official Records of the World Health Organization No. 2: Summary Report on Proceedings, Minutes and Final Acts of the International Health Conference Held in New York From 19 June to 22 July 1946* (Geneva, 1948).

I. Other printed primary material

- Dempsey, D., 'Facts and figures about Eire's population', *The Irish Monthly*, lxxvii (Aug. 1939), pp 529-535.
- Dillon, Theobald W. T., 'Slum clearance: past and future', *Studies*, xxiv (1945), pp 13-20.
- Duffy, Rev. Clarence, *It happened in Ireland* (New York, 1944).

BIBLIOGRAPHY

- Greally, Hanna, *Bird's nest soup* (Dublin, 1987).
- Laverty, Maura, *Flour economy: practical recipes for breads, cakes, etc., based on potatoes and oatmeal* (Dublin, 1941).
- _____, *Kind cooking* (Kerry, 1955).
- Lucey, Cornelius, 'The Beveridge Report and Éire', *Studies: An Irish Quarterly Review*, xxxii, no. 125 (1943), pp 36-44.

J. Later works

- Browne, Noël, *Against the tide* (Dublin, 2012).
- Deeny, James, *To cure and to care: memoirs of a chief medical officer* (Dublin, 1989).
- Department of Health, *Select committee on the health services: memorandum from the Department of Health on submissions made on financing and administration of the health services* (Dublin, 2012).
- Irish Hospital Trust, *The success of the Irish Hospital Sweepstakes* (Dublin, 1971).
- Medical Research Council of Ireland, *Medical Research Council of Ireland annual report for the year ended 31 December 1986* (Dublin, 1987).
- Price, Liam, *Dr Dorothy Price: an account of twenty years fight against tuberculosis in Ireland* (Oxford, 1957).

Secondary sources

A. Published works

- Adamson, Kelly, '“Arán an Lae Amáireach”: flour extraction and fortification in Emergency Ireland, 1939-1948', *Irish Economic and Social History*, 1, no. 1 (2023), pp 93-111.
- Adelman, Juliana, 'Food in Ireland since 1940' in Eugenio F. Biagnini and Mary E. Daly (eds), *The Cambridge Social History of Modern Ireland* (Cambridge, 2017), pp 233-243.
- Adelman, Juliana and Lisa Haushofer, 'Introduction: food as medicine, medicine as food', *Journal of the History of Medicine and Allied Sciences*, lxxiii, no. 2 (2018), pp 127-134.
- Amirhakimi, G.H., 'Rickets in a developing country: observations of general interest from Southern Iran', *Clinical Paediatrics*, xii, no.2 (1973), pp 88-92.
- Anderson, Andy B., Peter H. Rossi and James D. Wright, *Handbook of survey research* (New York, 2013).
- Andresen, Elena and Erin de Fries Bouldin, *Public health foundation: concept and practices* (New Jersey, 2010).
- Apple, Rima D., *Mothers and medicine: a social history of infant feeding, 1850-1950* (Wisconsin, 1987).
- , 'Constructing mothers: scientific motherhood in the nineteenth and twentieth centuries', *Social History of Medicine*, viii, no. 2 (1995), pp 161-178.
- Ashraf, Muhammad, 'Changing patterns of tuberculosis in England and Wales', *The Journal of the Royal Institute of Public Health and Hygiene*, xxxi, no. 4-6 (Dec. 1968), pp 114-124.
- Baggot, Rob, *Public health policy and politics* (Basingstoke, 2010).
- Bakker, Nelleke, 'Fresh air and good food: children and the anti-tuberculosis campaign in the Netherlands c. 1900-1940', *History of Education*, xxxix, no.3 (2010), pp 343-361.
- Barona, Josep L., 'Nutrition and health: the international context during the inter-war crisis' in *Social History of Medicine*, xxi, no. 1 (2008), pp 87-105.
- Bartlett, Thomas (ed.), *The Cambridge history of Ireland: volume iv, 1880 to the present* (Cambridge, 2018).
- Barrington, Ruth, *Health, medicine and politics in Ireland, 1900-1970* (Dublin, 1987).
- Baten, Joerg, and Robert Millward, 'Population and living standards, 1914-1945' in Stephen Broadberry and Kevin H. O'Rourke (eds), *The Cambridge economic history of modern Europe: 1870-present* (Cambridge, 2010), pp 232-264.
- Baur, Nicole, 'Family influence and psychiatric care: physical treatments in Devon Mental Hospitals c. 1920-1970s', *Endeavour*, xxxvii, no.3 (2013), pp 172-183.
- Baxter, Mildred, *Health* (2nd ed., Cambridge, 2010).
- Berridge, Virginia, *Public health: a very short introduction* (Oxford, 2016).

BIBLIOGRAPHY

- Berrios, G. E., 'The scientific origins of electroconvulsive therapy: a conceptual history', *History of Psychiatry*, viii, no. 29 (1997), pp 105-119.
- Bielenberg, Andy and John O'Fagan, 'The Irish working-class and the role of the state, 1850-2016' in Eugenio F. Biagnini and Mary E. Daly (eds), *The Cambridge Social History of Modern Ireland* (Cambridge, 2017), pp 195-211.
- Bielenberg, Andy and Raymond Ryan, *An economic history of Ireland since independence* (Oxfordshire, 2013).
- Biltekoff, Charlotte, *Eating right in America: the cultural politics of food and health* (Durham, 2013).
- Boylan, Ciara and Ciara Gallagher (eds), *Constructions of the Irish child in the independence period* (Basingstoke, 2018).
- Breathnach, Caoimhgh S., 'Margaret Dunlevy (1909-2002) and the conquest of childhood TB in Dublin', *Ulster Medical Journal*, lxxxv, no. 1 (2016), pp 23-25.
- Breathnach, Caoimhgh S., and J.B Moynihan, 'The academy's foray into the politics of phthisis (tuberculosis) 1940-1946', *Irish Journal of Medical Science*, clxxiii, no. 1 (2004), pp 48-52.
- Breathnach, Ciara, 'Handywomen and birthing in rural Ireland, 1851-1955', *Gender & History*, xxviii, no. 1 (2016), pp 34-56.
- _____, *The Congested Districts Board of Ireland, 1891-1923* (Dublin, 2005).
- Brennan, Damien, *Irish insanity: 1800-2000* (London, 2013).
- Breslow, Lester, 'A quantitative approach to the World Health Organisation definition of health: physical, mental and social well-being', *International Journal of Epidemiology*, i, no. 4 (1972), pp 347-355.
- Brunton, Deborah (ed.), *Medicine transformed: health, disease and society, 1800-1930* (Manchester, 2004).
- Bryder, Linda, *Below the magic mountain: a social history of tuberculosis in twentieth-century Britain* (Oxford, 1988).
- _____, 'Wonderlands of buttercup, clover and daises': tuberculosis and the open-air school movement in Britain, 1907-39' in R. Cooter (ed.), *In the name of the child: health and welfare, 1880-1940* (London, 1992), pp 72-95.
- Buckley, Sarah-Anne, and Caroline McGregor, 'Interrogating institutionalisation and child welfare: the Irish case, 1939-1991', *European Journal of Social Work*, xxii, no. 6 (2019), pp 1062-1072.
- Buckley, Sarah-Anne, Ciara Breathnach and Jyoti Atwal (eds), *Gender and history: Ireland, 1852-1922* (London, 2023).
- Burke, Sara, Steve Thomas, Sarah Berry and Conor Keegan, 'Indicators of health system coverage and activity in Ireland during the economic crisis 2008-14, from 'more with less' to 'less with less', *Health Policy*, cxvii (2014), pp 275-278.

BIBLIOGRAPHY

- Byrne, Elaine, *Political corruption in Ireland 1922-2010: a crooked harp?* (Manchester, 2012).
- Calabria, Verusca, and Lynsey T. Cullen, 'Deinstitutionalisation and the move to community care: comparing the changing dimensions of mental healthcare after 1922 in the Republic of Ireland and England', *History of Psychiatry*, xxxv, no. 2 (2024), pp 141-157.
- Carey, Sophia, *Social security in Ireland, 1939-1952* (Dublin, 2007).
- Cashman, Dorothy and Máirtín Mac Con Iomaire (eds), *Irish food history: a companion* (Dublin, 2024).
- Clarke, Hannah-Louise, and Barry Doyle, 'Imperial and post-imperial healthcare before welfare states', *European Review of History: Revue Européenne d'Histoire*, xxviii, no. 5-6 (2021), pp 617-635.
- Clarke, Marie, 'Education for the country girls: vocational education in rural Ireland 1930-1960', *Journal of the History of Education Society*, iii, no. 3 (2022), pp 422-437.
- Clarkson, Leslie, and Margaret Crawford, *Feast and famine: food and nutrition in Ireland, 1500-1920* (Oxford, 2001).
- Clear, Caitríona, *Social change and everyday life in Ireland, 1850-1922* (Manchester, 2007).
- Chow, Winnie S., and Stefan Priebe, 'Understanding psychiatric institutionalization: a conceptual review', *Psychiatry*, xiii, no. 169 (2013), pp 1-14.
- Clifford, Liam, 'Institute for Industrial Research and Standards Ireland', *Journal of Information Science*, I, no. 3 (1979), pp 181-185.
- Coleman, Marie, 'A terrible danger to the morals of the country': the Irish Hospitals' Sweepstake in Great Britain 1930-87', *Proceedings of the Royal Irish Academy: Archaeology, Culture, History, Literature*, cv, no. 5 (2005), pp 197-220.
- _____, *The Irish sweep: a history of the Irish Hospital Sweepstake, 1930-87* (Dublin, 2009).
- Collinston, Paul, and Helen Macbeth (eds), *Food in zones of conflict: cross-disciplinary perspectives* (Oxford, 2017).
- Condrau, Flurin, 'Urban tuberculosis patients and sanatorium treatment in the early twentieth century' in Peter Shapely and Anne Borsay (eds), *Medicine, charity and mutual aid: the consumption of health and welfare in Britain, c.1550-1950* (London, 2007), pp 183-285.
- Cooney, John, *John Charles McQuaid: rule of Catholic Ireland* (Dublin, 2012).
- Counihan, H. E., 'The Medical Association and the Mother and Child Scheme', *Irish Journal of Medical Science*, clxxi, no. 2 (2002), pp 110-115.
- Cousins, Mel, 'The introduction of children's allowances in Ireland, 1939-1944', *Irish Economic and Social History*, xxvi (1999), pp 35-53.
- Cox, Catherine, and Maria Luddy (eds), *Cultures of care in Irish medical history, 1750-1970* (London, 2010).
- _____, *Negotiating insanity in the southeast of Ireland, 1820-1900* (Manchester, 2012).

BIBLIOGRAPHY

- Cox, Catherine and Hillary Marland (eds), *Migration, health and ethnicity in the modern world* (London, 2013).
- Crawford, Margaret, 'Was Ireland nourished? James Deeny and the Irish national Nutrition Survey' in Brenda Collins (ed.), *Industry, trade and people in Ireland, 1650-1950L essays in honour of W.H Crawford* (Belfast, 2005), pp 253-276.
- Cronin, Michael, *Impure thoughts: sexuality, Catholicism and literature in twentieth century Ireland* (Manchester, 2012).
- Cronin, Michael, and John M. Regan (eds), *Ireland: the politics of independence, 1922-49* (London, 2000).
- Crossman, Virginia, 'Facts notorious to the whole country': the political battle over Irish Poor Law reform in the 1860s', *Transactions of the Royal Historical Society*, xx (2010), pp 157-169.
- Curran, C., 'Fianna Fáil and the origins of the Irish Press', *Irish Communications Review*, vi (1996), pp 7-17.
- Curran, Steven, 'Could Paddy leave off from copying just for five minutes': Brian O'Nolan and Éire's Beveridge Plan', *Irish University Review*, xxxi, no. 2 (2001), pp 353-375.
- Daly, Antoinette and Dermot Walsh, *Mental illness in Ireland: reflections on the rise and fall of institutional care 1750-2002* (Dublin, 2004).
- Daly, Mary E., 'An alien institution? Attitudes toward the city in nineteenth and twentieth-century Irish society', *Études Irlandaises*, x (1985), pp 181-194.
- _____, *The buffer state: the historical roots of the Department of the Environment* (Dublin, 1997).
- _____, 'An atmosphere of sturdy independence': the State and Dublin hospitals in the 1930s' in Elizabeth Malcolm and Greta Jones (eds), *Medicine, disease and the state in Ireland, 1650-1940* (Cork, 1999), pp 234-252.
- _____, *The first department: a history of the Department of Agriculture* (Dublin, 2002).
- _____, 'Marriage, fertility and women's lives in twentieth-century Ireland, c. 1900-1970', *Women's History Review*, xv, no. 4 (2006), pp 571-585.
- _____, *The slow failure: population decline and independent Ireland, 1922-73* (Wisconsin, 2006).
- _____, 'The Irish Free State and the Great Depression of the 1930s: the interaction of the global and the local', *Irish Economic and Social History*, xxxviii (2011), pp 19-36.
- Delaney, Enda, 'Anti-communism in mid-twentieth century Ireland', *The English Historical Review*, cxxvi, no. 5 (2011), pp 878-903.
- Delaney, Liam, Mark McGovern, and James P. Smith, 'From Angela's Ashes to Celtic Tiger: early life conditions and adult health in Ireland', *Journal of Health Economics*, xxx, no. 1 (2011), pp 1-10.

BIBLIOGRAPHY

- _____, 'Infant mortality in Mother and Baby Homes in twentieth century Ireland', *Population Research and Policy Review*, xlii, lxvii (2024), pp 1-22.
- Dickson, David, *Dublin: the making of a capital city* (London, 2014).
- Dijkstra, Ilse, and Klasien Hortsman, 'Known to be unhealthy': exploring how social epidemiological research constructs the category of low socioeconomic status', *Social Science & Medicine*, cclxxxv (2021), pp 1-11.
- Doetter, Lorraine F., and Ralph Götze, 'Health care policy for better or for worse? Examining NHS reforms during times of economic crisis versus relative stability', *Social Policy & Administration*, xlv, no. 4 (2012), pp 488-505.
- Doroshov, Deborah, 'Performing a cure for schizophrenia: insulin coma therapy on the wards', *Journal of the History of Medicine and Allied Sciences*, lxii, no. 2 (2007), pp 213-243.
- Dowbiggin, Ian R., *The sterilization movement and global fertility in the twentieth century* (Oxford, 2008).
- Doyle, Patrick, *Civilising rural Ireland: the Co-operative movement, development and the nation-state, 1889-1939* (Manchester, 2019).
- Duffy, John, *The sanitarians* (Illinois, 1992).
- Earner-Byrne, Lindsey, and Diana Urquhart, 'Gender roles in Ireland since 1740' in Eugenio F. Biagnini and Mary E. Daly (eds), *The Cambridge Social History of Modern Ireland* (Cambridge, 2017), pp 312-326.
- Earner-Byrne, Lindsey, 'Managing motherhood: negotiating a maternity service for Catholic mothers in Dublin, 1930-1954', *Social History of Medicine*, xix, no. 2 (2006), pp 261-277.
- _____, *Mother and child: maternity and child welfare in Dublin, 1922-1960* (Manchester, 2007).
- _____, 'Reinforcing the family: the role of gender, morality and sexuality in Irish welfare policy, 1922-1944', *The History of the Family*, xxxiv, no. 4 (2008), pp 360-369.
- _____, *Letters of the Catholic Poor, 1920-1940* (Cambridge, 2017).
- Evans, Bryce, 'The Construction Corps, 1940-1948', *Saothar*, xxxii (2007), pp 19-31.
- _____, 'Coercion in the Irish countryside: the Irish smallholder, the state and compulsory tillage, 1939-49', *Irish Economic and Social History*, xxxviii (2011), pp 1-17.
- _____, 'A semi-state archipelago without ships: Seán Lemass, economic policy and the absence of an Irish mercantile marine', *Working Papers in History and Policy*, no. iv (2012), pp 1-18.
- _____, *Ireland during the Second World War: farewell to Plato's Cave* (Manchester, 2014).
- _____, 'Food, the Emergency and the lower-class Irish body, c. 1939-45' in David Durnin and Ian Miller (eds), *Medicine, health and Irish experiences of conflict, 1914-1945* (Manchester, 2016), pp 45-59.
- _____, 'Food in Ireland in the 1930s and 1940s' in Máirtín Mac Con Iomaire and Dorothy Cashman (eds), *Irish food history: a companion* (Dublin, 2024), pp 649-663.

BIBLIOGRAPHY

- Engelhardt Jr, H. Tristan and Stuart F. Spicker (eds), *Evaluation and explanation in the biomedical sciences* (Michigan, 1975).
- Fanning, Ronan, *The Irish Department of Finance: 1922-58* (Dublin, 1978).
- Farley, Tony, 'Gaining ground, losing ground: the politics of land reform in twentieth-century Ireland' in Fergus Campbell and Tony Farley (eds), *Land questions in modern Ireland* (Manchester, 2013), p. 44.
- Farrell, Aisling, 'Harassed housewives fight the consumers battle': the formation of the Irish Housewives Association and the campaign for price control, clean food, and equitable distribution in the Ireland of the 'Emergency' *Saothar: Women's Special Issue*, xxxvi (2012), pp 49-60.
- Farrell, Elaine (ed.), *She said she was in the family way: pregnancy and infancy in modern Ireland* (London, 2012).
- Feeney, Tom, 'Seán MacEntee and the development of public policy in independent Ireland: thesis abstracts', *Irish Economic and Social History*, xxxiv (2007), pp 79-81.
- _____, *Seán MacEntee: A Political Life* (Dublin, 2009).
- _____, 'Church, state and family: the advent of child guidance clinics in independent Ireland', *Social History of Medicine*, xxv, no. 4 (2012), pp 848-862.
- Finnane, Mark, *Insanity and the insane in post-famine Ireland* (London, 1981).
- Fisk, Robert, *In time of war: Ireland, Ulster and the price of neutrality, 1939-45* (London, 1983).
- Fitzgibbons, Michael, 'Fifty years of Irish industrial and science policies, 1960-2010: a critical analysis', *Administration*, lix, no. 3 (2011), pp 118-125.
- Fotheringham, Stewart, Mary H. Kelly, and Martin Charlton, 'The demographic impacts of the Irish famine: towards a greater geographical understanding', *Transactions of the Institute of British Geographers*, xxxviii, no. 2 (2013), pp 221-237.
- Foucault, Michel, *The birth of the clinic* (London, 1976).
- _____, 'The crisis of medicine or the crisis of antimedicine?' in *Foucault Studies*, i (2004), pp 5-19.
- Freudenthal, Robert, and Joanna Moncrieff, 'A landmark in psychiatric progress?' 'The role of evidence in the rise and fall of insulin coma therapy', *History of Psychiatry*, xxxi, no.1 (2021), pp 65-78.
- Gardener, Kirsten E., 'The art of insulin treatment': diabetes, insulin and the 1920s', *Journal of Medical Humanities*, xl (2019), pp 171-180.
- Geary, Laurence M., *Medicine and charity in Ireland, 1718-1851* (Dublin, 2004).
- Girvin, Brian, 'The dominance of Fianna Fáil and the nature of political adaptability in Ireland', *Political Studies*, xxxii (1984), pp 461-470.
- _____, *The Emergency: neutral Ireland, 1939-45* (London, 2006).

BIBLIOGRAPHY

- _____, 'An Irish solution to an Irish problem: Catholicism, contraception and change, 1922-1979', *Contemporary European History*, xxvii, no. 1 (2018), pp 1-22.
- Goodwin, Simon, *Comparative mental health policy: from institutional to community care* (London, 1997).
- Gijswijt-Hosfra, Marike, and Hilary Marland (eds), *Cultures of child health in Britain and the Netherlands in the twentieth century* (Amsterdam, 2003).
- Gorsky, Martin, 'The British National Health Service 1948-2008: a review of the historiography', *Social History of Medicine*, xxi, no. 3 (2008), pp 437-460.
- Gourbin, C. and Godelieve Masuy-Stroobant, 'Registration of vital data: are love births and still births comparable all over Europe?', *Bulletin of the World Health Organisation*, lxxiv, no. 4 (1995), pp 449-460.
- Harris, John and Muireann Quigley, 'Personal or public health' in Michael Boylan (ed.), *International public health policy and ethics* (Dordrecht, 2006), pp 15-29.
- Haushofer, Lisa, *Wonder foods: the science and commerce of nutrition* (California, 2022).
- Healy, David and Edward Shorter, *Shock therapy: a history of electroconvulsive treatment in mental illness* (New Jersey, 2007).
- Healy, David, 'Interview: in conversation with Ivor Browne', *Psychiatric Bulletin*, xvi (1992), pp 1-9.
- Hensey, Brendan, *The health services of Ireland* (2nd ed., Dublin, 1972).
- Heywood, Colin, *Childhood in modern Europe* (Cambridge, 2018).
- Hope, Tony, 'Rationing and life-saving treatments: should identifiable patients have higher priority?', *Journal of Medical Ethics*, xxvii, no. 3 (2001), pp 179-185.
- Horgan, John, *Noël Browne: passionate outsider* (Dublin, 2000).
- Horgan, Mervyn, 'Anti-urbanism as a way of life: disdain for Dublin in the Nationalist imaginary', *The Canadian Journal of Irish Studies*, xxx, no. 2 (2004), pp 38-47.
- Huxley, Rachel R., B. B. Llyod, M. Goldacre and H. A. Neil, 'Nutritional research in World War 2: the Oxford Nutrition Survey and its research potential 50 years later', *British Journal of Nutrition*, lxxxiv (2000), p. 247-251.
- Jackson, Alvin, *Ireland 1798-1998: war, peace and beyond* (2nd ed., Oxford, 2010).
- James, Allison, and Alan Prout (eds), *Constructing and reconstructing childhood: contemporary issues in the sociological study of childhood* (London, 2015).
- Jamiet, Paul and Shou-Ching Jamiet, *Perfect health diet: regain health and lose weight by eating the way you are meant to eat* (New York, 2012).
- Jenni, Karen E., and George Loewenstein, 'Explaining the 'identifiable victim effect'', *Journal of Risk and Uncertainty*, xiv (1997), pp 235-257.
- Jones, Greta, 'Eugenics in Ireland: the Belfast Eugenics Society, 1911-1915', *Irish Historical Studies*, xxviii, no. 109 (1992), pp 81-95.

BIBLIOGRAPHY

- _____, *'Captain of all these men of death': the history of tuberculosis in nineteenth and twentieth century Ireland* (Amsterdam, 2001).
- Jones, Kingsley, 'Insulin coma therapy in schizophrenia', *Journal of the Royal Society of Medicine*, xciii (2000), pp 147-149.
- Jones, Susan D., 'Mapping a zoonotic disease: Anglo-American efforts to control bovine tuberculosis before World War I', *Osiris*, 2:19 (2004), pp 133-148.
- Jonsen, Albert R., 'Bentham in a box: technology assessment and health care allocation', *Law, Medicine and Healthcare*, xiv (1986), pp 172-174.
- Jülich, Solveig, 'In light of media: mass miniature radiographic surveys for tuberculosis in Sweden, c. 1940-1970', *Media History*, xxii, no. 2 (2016), p. 201-16.
- Kehr, Janina, Jacinta Muinde and Ruth J. Prince, 'Health for all? Past, presents and futures of aspirations for universal healthcare', *Social Science & Medicine*, cccxix (2023), pp 1-8.
- Kelly, Adrian, 'Catholic action and the development of the Irish welfare state in the 1930s and 1940s', *Archivium Hibernicum*, liii (1999), pp 107-117.
- Kelly, Brendan, 'Physical sciences and psychological medicine: the legacy of Prof John Dunne', *Irish Journal of Psychological Medicine*, xxii, no. ii (2002), pp 67-72.
- _____, 'The Mental Treatment Act 1945: an historical enquiry', *History of Psychiatry*, xix, no. 1 (2008), pp 47-67.
- _____, 'Mental health law in Ireland, 1945-2001: reformation and renewal', *Medico-Legal Journal*, lxxvi (2008), pp 65-72.
- _____, 'Searching for the patient's voice in Irish asylums', *Med Humanities*, xlii (2016), pp 87-91.
- _____, *Hearing voices: the history of psychiatry in Ireland* (Dublin, 2016).
- _____, *Inside Grangegorman* (Dublin, 2023).
- Kelly, Laura, *Contraception and modern Ireland: a social history, c. 1922-1992* (Cambridge, 2023).
- Kennedy, Finola, *Cottage to crèche: family change in Ireland* (Dublin, 2001).
- Kennedy, Michael, *Ireland and the League of Nations, 1919-1946* (Dublin, 1996).
- _____, *Guarding neutral Ireland: the coast watching service and military intelligence, 1939-45* (Dublin, 2008).
- Keogh, Dermot, and Mervyn O'Driscoll (eds), *Ireland in World War Two: diplomacy and survival* (Cork, 2004).
- Kitchens, Rachael, 'Mothercraft not learnt by instinct': an investigation of the infant welfare movement in Australia 1919-39', *Children Australia*, xxxi, no. 1 (2006), pp 31-36.

BIBLIOGRAPHY

- Kotelchuck, Milton, 'Safe mothers, healthy babies: reproductive health in the twentieth century' in John W. Ward and Christian Warren (eds), *Silent victories: the history and practice of public health in twentieth century America* (Oxford, 2006), pp 105-134.
- Kuusi, Hanna, and Veera Moll, 'From city streets to suburban woodlands: the urban planning debate on children's needs, and childhood reminiscences, of 1940s-1970s Helsinki' in *Urban History*, xlviii (2021), pp 125-142.
- Lambertz, Jan, 'Calculating war, calculating peace: the Rockefeller Foundation and science research in Britain', *European Review of History*, xxx, no. 6 (2023), pp 841-860.
- Larsen, Lars Thorup, 'Not merely the absence of disease: a genealogy of WHO's positive health definition', *History of the Human Sciences*, xxv, no. 1 (2022), pp 111-131.
- Lee, C. H., 'Regional inequalities in infant mortality in Britain, 1861-1971: patterns and hypotheses', *Population Studies*, xlv, i (1991), p. 64.
- Lee, Joseph, *Ireland, 1912-1985: politics and society* (Cambridge, 1989).
- Leeming-Latham, Clare, 'Unravelling the "Tangled Web": chemotherapy for tuberculosis in Britain, 1940-1970', *Medical History*, lix, no. 2 (2015), pp 156-176.
- Lehane, Shane, *A history of the Irish Red Cross* (Dublin, 2019).
- Lo, Sasso, Anthony T., Jeffrey C. Schiman and Robert Kaestner, 'Infant mortality and adult wellbeing: evidence from wartime Britain', *Labour Economics*, lx (2019), pp 12-29.
- Lucey, Donnacha Seán, and Virginia Crossman (eds), *Healthcare in Ireland and Britain, 1850-1970: voluntary, regional and comparative perspectives* (London, 2014).
- Lucey, Donnacha Séan, 'Irish partition and poor law reform in interwar Northern Ireland', *European Review of History*, xxviii, no. 5-6 (2021), pp 793-813.
- Lupton, Deborah, *The imperative of health: public health and the regulated body* (New South Wales, 1995).
- Mac Lellan, Anne, and Alice Maugher (eds), *Growing pains: childhood illness in Ireland 1750-1950* (Dublin, 2013).
- Mac Lellan, Anne, 'Along among neutrals: Ireland's unique experience of tuberculosis during the Second World War' in David Durnin and Ian Miller (eds), *Medicine, health and Irish experiences of conflict, 1914-1945* (Manchester, 2016), pp 61-78.
- Maguire, Moira, *Precarious childhood in post-independence Ireland* (Manchester, 2009).
- Malcom, Elizabeth and Greta Jones (eds), *Medicine, disease and the state in Ireland, 1650-1940* (Cork, 1999).
- Manning, Maurice, *James Dillon: a biography* (Dublin, 1999).
- Marks, Lara and Michael Worboys (eds), *Migrants, minorities, and health: historical and contemporary studies* (London, 1997).
- Marmot, Michael and Richard Wilkinson (eds), *Social determinants of health* (2nd ed., Oxford, 2005).

BIBLIOGRAPHY

- Masuy-Stroobant, 'The determinants of infant mortality: how far are conceptual frameworks really modelled' in Robert Frank (ed.), *The explanatory power of models* (Dordrecht, 2002), pp 15-30.
- Maugher, Alice, *The cost of insanity in nineteenth-century Ireland* (London, 2017).
- McCabe, Ciarán, *Begging, charity and religion in pre-famine Ireland* (Liverpool, 2018).
- McDaid, David, Miriam Wiley, Anna Maresso and Elias Mossialos, 'Ireland: health systems review', *Health Systems in Transition*, xi, no. 4 (2009), pp 1-268.
- McIvor, Arthur, 'Germs at work: establishing tuberculosis as an occupational disease in Britain, c. 1900-1951', *Social History of Medicine*, xxv, no. 4 (2012), pp 812-829.
- McKee, Eamonn, 'Church-state relations and the development of Irish health policy: the mother and child scheme, 1944-1953', *Irish Historical Studies*, xxv, no. 98 (1986), pp 159-194.
- McManus, Ruth, *Dublin 1940-1940: shaping the city & suburbs* (Dublin, 2002).
- Miller, Ian, *Reforming food in post-famine Ireland: medicine, science and improvement, 1845-1922* (Manchester, 2014).
- _____, 'Nutritional decline in post-famine Ireland, c. 1851-1922', *Proceedings of the Royal Irish Academy: Archaeology, Culture, History, Literature*, cxv (2015), pp 1-17.
- _____, 'Hunger and starvation in modern Ireland' in Máirtín Mac Con Iomaire and Dorothy Cashman (eds), *Irish food history: a companion* (Dublin, 2024), pp 624-647.
- Mold, Alex, Peder Clark, Gareth Millward and Daisy Payling, *Placing the public in public health in post-war Britain, 1948-2012* (London, 2019).
- Mooney, Graham, *Intrusive interventions: public health, domestic space, and infectious disease surveillance in England, 1840-1914* (Rochester, 2015).
- _____, 'A menace to the public health': contact tracing and the limits of persuasion', *The New England Journal of Medicine*, ccclxxxiii, no. 19 (2020), pp 1806-1808.
- Munnink, Bas. B. Oude, and Lia van der Hoeek, 'Viruses causing gastroenteritis: the known, the new and those beyond', *Viruses*, viii, no. xli (2016), pp 1-10.
- Neary, Peter and Cormac Ó Gráda, 'Protection, economic war and structural change: the 1930s in Ireland', *Irish Historical Studies*, xxvii, no. 107 (1991), pp 250-266.
- Nic Congáil, Riona (ed.), *Historical perspectives on parenthood and childhood in Ireland* (Dublin, 2018).
- Nisbett, Richard E., and Lee Ross, *Human interference: strategies and shortcomings of social judgement* (New Jersey, 1980).
- O'Connell, Cathal, *The state and housing in Ireland: ideology, policy and practice* (New York, 2007).
- Ó'Corráin, Daithí, 'Catholicism in Ireland, 1880-2015: rise, ascendancy and retreat' in Thomas Bartlett (ed.), *The Cambridge history of Ireland: volume iv, 1880 to the present* (Cambridge, 2018), pp 726-764.

BIBLIOGRAPHY

- _____, 'The Catholic Church and the Irish State, 1916-73' in Gladys Ganiel and Andrew R. Holmes (eds), *The Oxford handbook of religion in modern Ireland* (Oxford, 2024), pp 145-162.
- O'Donoghue, Martin, 'As nearly subservient' as it could be? Vocationalism and senatorial speaking behaviour in the Irish Senate, 1938-45', *Parliaments, Estates and Representation*, xxxvi, no. 2 (2016), pp 211-231.
- O'Donoghue, Tom and Teresa O'Doherty, *Irish speakers and schooling in the Gaeltacht, 1900 to the present* (Gewerbestresse, 2019).
- Ó'Driscóil, Donal, *Censorship in Ireland 1939-1945, neutrality, politics and society* (Cork, 1996).
- Ó'Gráda, Cormac, and Kevin Hjortshøj O'Rourke, 'The Irish economy during the century after partition', *The Economic History Review*, lxxv, no. 2 (2022), pp 336-370.
- O'Halpin, Eunan, *Defending Ireland: the Irish state and its enemies since 1922* (Oxford, 1999).
- Patterson, Henry, *Ireland since 1939: the persistence of the conflict* (London, 2007).
- _____, 'The Irish working-class and the role of the state, 1850-2016' in Biagini and Mary E. Daly (eds), *The Cambridge Social History of Modern Ireland* (Cambridge, 2017), pp 145-160.
- Phua, Kai-Lit, 'Can we learn from history? Policy responses and strategies to meet healthcare needs in times of severe economic crisis', *The Open Public Health Journal*, iv (2011), pp 1-5.
- Pozzi, Lucia, and Liam Kennedy, 'Too long a sacrifice? Maternal mortality in Northern Ireland during the first half of the twentieth century', *Annales de Démographie Historique*, (2020), pp 141-177.
- Porter, Dorothy, *Health, civilisation and the state* (London, 2005).
- _____, (ed.), *Social medicine and medical sociology* (Amsterdam, 1997).
- Porter, Roy, and Daivd Wright (eds), *The confinement of the insane* (Cambridge, 2003).
- Powell, Martin, 'Framing Beveridge', *Social Policy Administration*, lvi (2022), pp 217-229.
- Privilege, John, 'The Northern Ireland government and the welfare state, 1942-8: the case of health provision', *Irish Historical Studies*, xxxix, no. 155 (2015), pp 439-459.
- Privilege, John, and Greta Jones, 'Crisis and scandal: government, local government and health in Northern Ireland, 1939-44', *Irish Economic and Social History*, xlii (2015), pp 33-52.
- Puirséil, Niamh, 'Labour and coalition: the impact of the first inter-party government, 1948-51', *Saothar*, xxvii (2002), pp 55-64. 60.
- Pusovva, Tereza, 'Irish economic policy in the 1930s and the authority of Eamon de Valera', *The Journal of European Economic History*, xlvii, no. I (2019), pp 9-29.
- Robertson, Iris, 'The role of cereals in the aetiology of nutritional rickets: the lesson of the Irish National Nutrition Survey, 1943-48', *British Journal of Nutrition*, xlv, no. 17 (1981), pp 17-22.

BIBLIOGRAPHY

- Robins, Joseph, *Fools and mad: a history of the insane in Ireland* (Dublin, 1986).
- , (ed.), *Reflections on health: commemorating fifty years of the Department of Health, 1947-1997* (Dublin, 1997).
- Ruane, Joseph, and Jennifer Todd, 'The Irish working-class and the role of the state, 1850-2016' in Eugenio F. Biagini and Mary E. Daly (eds), *The Cambridge Social History of Modern Ireland* (Cambridge, 2017), pp 177-192.
- Ryymin, Teemu, 'Tuberculosis-threatened children': the rise and fall of a medical concept in Norway, c. 1900-1960', *Medical History*, lii (2008), pp 347-364.
- Savage, Robert, *Seán Lemass* (Dublin, 2014).
- Schramme, Thomas, 'Health as complete well-being: the WHO definition and beyond', *Public Health Ethics*, xvi, no. 3 (2023), pp 210-218.
- Stark, James F., *The cult of youth: anti-ageing in modern Britain* (Cambridge, 2020).
- Starn, Randolph, 'Historians and 'crisis'', *Past & Present*, lii (1971), pp 3-22.
- Stephens, Sharon, 'Editorial introduction: children and nationalism', *Childhood*, iv, no. 4 (1997), pp 5-17.
- Tiemersma, Edine, Marieke J. Van der Werf, Martien Borgdorff, Brien Williams and Nico Nagelkerke, 'Natural history of tuberculosis: duration and fatality of untreated pulmonary tuberculosis in HIV negative patients: a systematic review', *Plos one*, vi, no. 4 (2011), pp 1-13.
- Török, M. E., 'Tuberculous meningitis: advances in diagnosis and treatment', *British Medical Bulletin*, cxiii (2015), pp 117-131.
- Turda, Marius, *Modernism and eugenics* (New York, 2010).
- Waddington, Keir, 'To stamp out 'so terrible a malady': bovine tuberculosis and tuberculin testing in Britain, 1890-1939', *Medical History*, xlviii (2004), pp 29-48.
- Walsh, Oonagh, 'Cure or custody: therapeutic philosophy at the Connaught District Lunatic Asylum' in Preston, M., and M. Ó hÓgartaigh (eds), *Gender and medicine in Ireland, 1700-1950* (Syracuse, 2012), pp 69-85.
- Walsh, Thomas, 'Constructions of childhood in Ireland in the twentieth-century: a view from the primary school curriculum, 1900-1999', *Child Care in Practice*, x, no. 2 (2005), pp 253-269.
- Warren, Christian, and John W. Ward (eds), *Silent victories: the history and practice of public health in twentieth century America* (Oxford, 2007).
- Weindling, Paul, 'The role of international organisations in setting nutritional standards in the 1920s and 1930s' in Harmke Kamminga and Andrew Cunningham (eds), *The science and culture of nutrition, 1840-1940* (Amsterdam, 1995), pp 319-332.
- Weinreb, Alice A., *Modern hungers: food and power in twentieth-century Germany* (Oxford, 2017).

BIBLIOGRAPHY

Wills, Clair, 'Women writers and the death of rural Ireland', *Eire-Ireland*, xli, no. 1 (2006), pp 192-112.

_____, *That neutral island: a history of Ireland during the Second World War* (London, 2007).

Wise, Sarah, *The undesirables: the law that locked away a generation* (London, 2024).

Wood, Ian, *Britain, Ireland and the Second World War* (Edinburgh, 2010).

B. Theses and unpublished works

Bradley, Robert J. A., 'The Emergency Scientific Research Bureau, 1941-1945' (PhD, TCD, 1991).

Bryan, Ciarán, 'Rationing in Emergency Ireland, 1939-1948' (PhD, NUIM, 2014).

Byrne, Fiachra, 'Madness and mental illness in Ireland: discourses, people and practices, 1900-1960' (PhD, UCD, 2011).

Carthy, Alan F., 'The treatment of tuberculosis in Ireland from the 1890s to the 1970s: a case study of medical care in Leinster' (PhD, NUIM, 2015).

Fee, Gerard, 'The effects of World War II on Dublin's low-income families, 1939-1945' (PhD, UCD, 1996).

Murphy, Stephen, 'Neutral diplomacy: an Irish perspective, 1939-45' (PhD, UCC, 2016).

C. Reference works

Dictionary of Irish Biography

Firestein, Gary (ed.), *Kelley and Firestein's textbook of rheumatology* (London, 2016).

Porta, Miquel (ed.), *A dictionary of epidemiology* (5th ed., New York, 2008).

D. Internet sources

Behind the Walls'. Documentary. Produced by Mary Raftery. Dublin: RTÉ, 2011

(<https://m.youtube.com/watch?v=PvxOon7CWZL>). (Accessed 15 April 2023).

Wellcome Collection (<https://wellcomecollection.org/search/images?query=n76whrxq>) (Accessed 2 Aug. 2024).

Wellcome Collection (<https://wellcomecollection.org/works/kpftgz5u>) (1 Aug. 2024).

Photo re-produced from Wellcome Collection

(<https://wellcomecollection.org/works/g2nu7639>) (1 Aug. 2024).

World Health Organization (1948). *Official records of the World Health Organization No.2: Summary Reports on Proceedings Minutes and Final Acts of the International Health Conference held in New York from 19 June to 22 July 1946*, (<https://apps.who.int/iris/handle/10665/85573>) (Accessed 8 March 2024).

BIBLIOGRAPHY

WHO, *Summary reports on proceedings minutes and final acts of the International Health Conference held in New York from 19 June to 22 July 1946*, (<https://apps.who.int/iris/handle/10665/85573>) (Accessed 8 March 2024).

World Within Walls Collection, available on Digital Repository of Ireland (<https://repository.dri.ie/catalog/th83m027m>) (Accessed 2 Aug. 2024).

APPENDIX A

List of relevant legislation relating to public health

Although key laws are dealt with in the main body of this work, there was an extensive number of laws passed dealing with health before, during and immediately after the Emergency.

Establishment & functions of Dept. of Health

Year	Title	Comment
1925	Local Government and Public Health Act (no. 5)	Re-organised Poor Law Services
1939	Public Assistance Act (no. 27)	Captured health of the poor
1940	County Management Act (no. 12)	Established one person as county managers in every country
1941	Local Government Act (no. 23)	Act to make better provision in relation to local government
1945	Health Bill	Act to make better provisions in relation to public health, extended public health acts 1878 to 1931
1946	Local Government Act (no. 24)	Enhanced provisions in relation to local government
1946	Ministers and Secretaries (Amendment) Act (no. 38)	Established separate Department of Health, enacted 1947
1947	Health (Transfer of Departmental Administration and Ministerial Functions) Order (no. 58)	Division of responsibilities and legislation between Department of Health and Department of Local Government following own entities
1947	Health Services (Financial Provisions) Act (no. 47)	Made provisions for the state to pay for the cost increases associated with the expansion of health services
1947	Agriculture and Health (Transfer of Departmental Administration and Ministerial Functions) Order (no. 417)	Transferred to the Minister of Health certain functions of the Minister for Agriculture under Milk and Dairies Act 1935
1949	Health (Transfer of Departmental Administration and Ministerial Functions) Order (no. 256)	The Anatomy Act, 1832 and State Lands (Workhouses) Act, 1930 transferred from Local Government to Public Health
1950	Health (Transfer of Departmental Administration and Ministerial Functions) Order (no. 138)	Pharmacy Act (Ireland) 1875 and Dangerous Drugs Act (1934) transferred from the Minister for Justice to Minister of Health
1952	The Vital Statistics and Births, Deaths and Marriages Registration Act (no. 8)	Authorised the collection and publication of vital statistics and extended orders relation to registration
1953	Health Act (no. 26)	Amended Health Act 1947.

General health legislation.

Year	Title	Comment
1908	Tuberculosis Prevention (Ireland) Act	Compulsory notification of open TB case

1915	Notification of Births (Extension) Act (no. 64)	Compulsory notification of births
1929	Children's Act (no. 24)	Persecution of parents for non-attendance at school, and the transfer of children to industrial schools)
1933	Illegitimate Children (Affiliation Orders) Act (no. 17)	Made provision for the imposition of the father of an illegitimate child of the obligation to contribute to child support
1934	Registration of Maternity Homes Act (no. 1)	Critical to the operation and safety of children placed in Ireland's mother and baby homes
1945	Tuberculosis (Establishment of Sanatoria) Act (no. 4)	Better provision for the establishment of sanatoria for people suffering from TB
1945	Mental Treatment Act (no. 19)	Comes into force Jan. 1947. Voluntary admission procedures added for first time
1948	Infectious Diseases Regulations (no. 99)	Treatment free of charge for any listed infectious disease
1949	Infanticide Act (no. 16)	Provided that if a woman who wilfully caused the death of her child being under the age of 12 months, may be convicted of infanticide
1954	Boarding-out of Children Regulations (no. 101)	A child could be boarded out by a health authority until he/she reached the age of 16.

Sale of Food & Drugs, Food Standards & Hygiene Legislation

Year	Title	Comment
1928	Public Health (Saorstát Éireann) (Preservatives in Food) Regulations (no. 54)	Regulations on food preservatives and increased powers given to sanitary authorities to inspect food production and preparation
1933	Free Milk Scheme	Distribution of milk to school-going children
1935	Sale of Food and Drugs (Milk) Act (no. 3)	Act amended earlier food and drugs acts (1875-1907) in relation to milk and certain lactic products
1935	Milk and Dairies Act (no. 22)	Provided better provisions in relation to the production and sale of milk to improve milk quality
1943	Public Health (Saorstát Éireann) (Preservatives in Food) Regulations (no. 74)	Prohibited the presence in any food article the introduction sodium or potassium nitrate exceeding 200 parts per million
1947	Section V of Health Act	Regulations made on food and drink for the protection of public health (preparation, importation, storage, distribution and exposure of food for human consumption)
1950	Food Hygiene Regulations (no. 205)	Tightened regulations on the selling of diseased, contaminated, unfit foods for human consumption

Regulation of Medical Professions

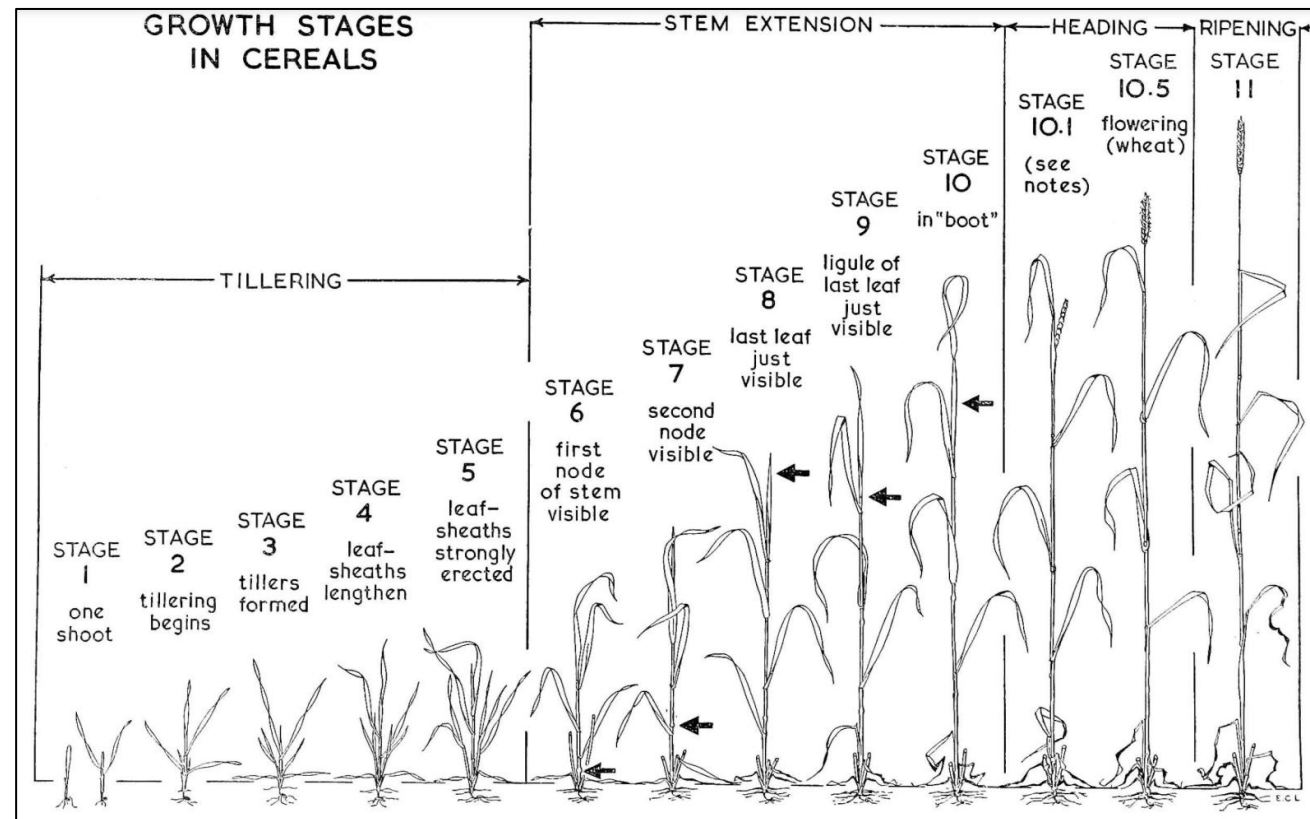
Year	Title	Comment
1918	Midwifery Act (Ireland)	Recognised midwifery as its own profession, distinct from nursing

1927	Medical Practitioners Act (no. 25)	Made provisions for the registration and control of persons practicing medicine and surgery
1944	Midwives Act (no. 10)	Provided for better opportunities in relation to the enrolment, certification and training of midwives
1950	Nurses Act (no. 27)	An Bórd Altranais set up under Nurses Act 1950 - took over functions formerly exercised by General Nursing Council and Midwives Board with additional powers - essentially the registering and controlling of nurses and midwives in the country
1951	Pharmacy Act (no. 30)	Improvements in pharmaceutical profession, enhanced training opportunities
1951	Medical Practitioners Act (no. 29)	Graduates to undergo a period as resident doctors for a period before entering profession fully
1955	Medical Practitioners Act (no. 1)	Amended Acts 1927 and 1951. Practitioners to have a recognised degree or diploma

Sources: Irish Statute Book, (<https://www.irishstatutebook.ie/>) (Last accessed 1 Jul. 2024); Hensey, *The health services*, pp 155-171.

APPENDIX B

The growth stages of cereals.



Source: Reproduced from E. C. Large, 'Growth stages in cereals illustration of the feekes scale' in *Plant Pathology*, iii, no. 4 (1954), p. 128.

Appendix C

There were a range of responses to the state's efforts to maximise wheat supplies, many deserving of their own paper.

A 'No Bread for Breakfast League' was established in March 1942. This is exemplary of the some of the efforts made on the ground by the Irish people to conserve wheat supplies. Source: *IT*, 17 Mar. 1942.



WHEAT, FLOUR AND BREAD

FIVE RESTRICTION ORDERS

Caterers May Serve Bread at One Course Only

EXPORT OF SAUSAGES PROHIBITED

FIVE new Orders have been made by the Government, restricting the use of wheat flour and bread. The effect of these Orders, which come into force to-day, is:—

- Bread at one course only at meals in catering establishments.
- Extraction of flour from wheat to be 95 per cent., instead of 90 per cent. as at present.
- Sale of flour by millers restricted to the average monthly sales of September, October and November last.
- Wheat or flour must not be fed to livestock and animals generally.
- Export of sausages is prohibited.

Every menu card shall exhibit the words: "It is illegal to serve wheaten foods at more than one course." Under this condition, if bread is taken with soup it will not be permissible to have bread with any other course at the same meal. Neither will it be permissible to have any other foodstuff derived from wheat, such as pies, pastries, puddings or biscuits. Such bread or pies, pastries, etc., may not be supplied unless demanded by the customer and separately paid for, and the quantity may not exceed four ounces.

Large quantities of flour have been exported in the form of sausages, and the trade is increasing. The export prohibition is made solely to conserve flour supplies.

Source: *IT*, 21 Mar. 1941.

RESTAURANT MEALS

Whenever possible sweets containing wheaten food will be excluded from table d'hôte menus. This decision has been taken by the Hotel, Restaurant and Catering Association in Dublin, following a discussion with the Department of Supplies on the new Order restricting the serving of wheaten food in restaurants to not more than 4 ounces per meal. Soups thickened with flour, ices and wafers, sausages, semolina and biscuits are some of the items which come into the category of wheaten foods. These wheaten foods may not be served unless specifically demanded by a customer, and the Association says that it is not the actual flour or bread content of a dish which counts—it is the total weight of any dish. In future an additional charge of 1d. for bread or rolls served with lunches or dinners will be made.

Source: Source: *IT*, Mar. 1941.

APPENDIX C (continued)

APPLE TART

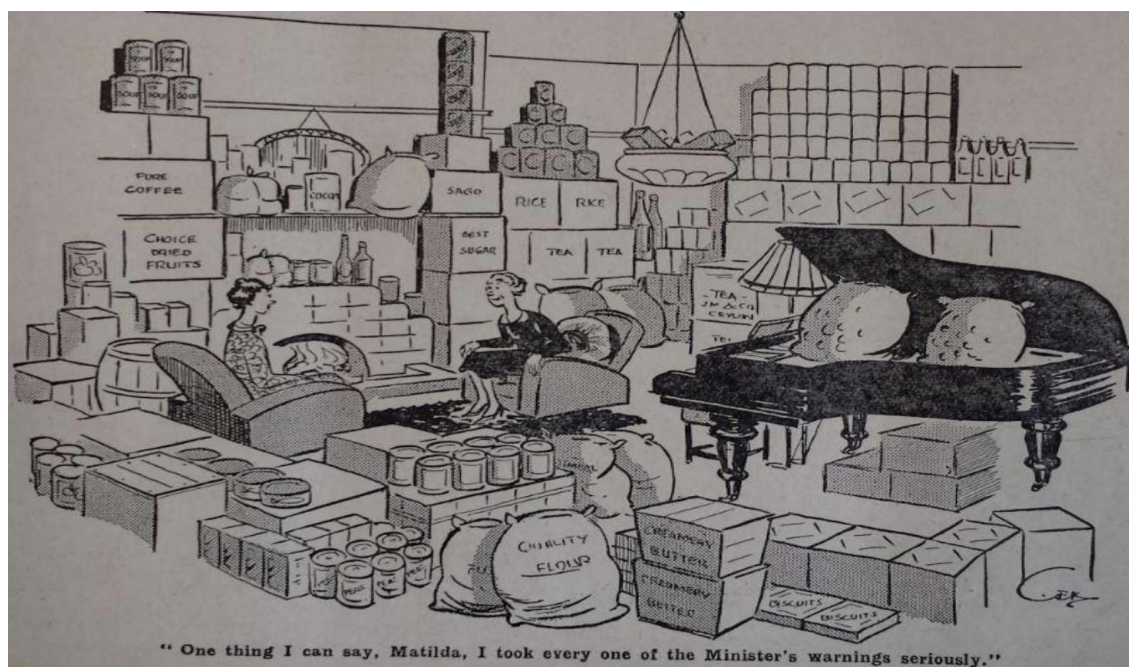
"That is terrible," said the manager of a large Dublin hotel when told about the Order which forbids the serving of bread at more than one course. He mentioned that apple tart, for example, was a very popular course, especially among professional men, such as barristers, and apparently they would not be able to serve it any more. Moreover, there were people who because of stomach complaints could not eat potatoes but bread throughout their lunch or dinner. He hoped, however, that the Order would not affect such people, and that permission would be given to serve bread on doctors' orders.

FACING THE FACTS

TO THE EDITOR OF THE IRISH TIMES.
SIR.—The Minister who “faced the facts” has advised us to reduce our bread consumption by one-sixth, except in the case of the “very poor.” I, for one, can assure him he need have no fear. None but the “very poor,” who are familiar with the saying, “Die, dog, or eat a hatchet,” will eat the disgusting mixture of bran and pollard which is being offered at the price of wheaten bread. I, for one, prefer to go hungry than face it.

Source: *IT*, 12 Mar. 1941.

Outrage the middle-class. *IT*, 21 Mar. 1941.



In some situations, rations led to hoarding, see criticisms of a middle-class housewife hoarding supplies. Source: *Dublin Opinion*, 1 Feb. 1941.

APPENDIX D

1. Urban and rural death rates (per 1,000 population) alongside infant mortality rates (per 1,000 live births), 1940-48.

Overall rural death rate higher than urban in some years (indicated in bold).

Year	Urban death rate (all causes)	Rural death rate (all causes)	Infant mortality urban areas	Infant mortality rural areas
1940	14.26	14.11	85	55
1941	14.68	14.79	99	58
1942	14.27	13.91	90	58
1943	14.58	14.51	110	67
1944	14.86	15.62	105	65
1945	14.01	14.74	93	58
1946	13.15	14.5	80	56
1947	14.3	15.24	80	60
1948	11.56	12.7	52	49
1949	11.95	13.36	8	48

Source: *ARRG, 1940-48* (Dublin, 1949). Consecutive years.

2. Maternal mortality in Ireland, 1939-49.

Year	Deaths	Rate in urban areas (per 1,000 births)	Rate in rural areas (per 1,000 births)
1939	218	3.12	3.56
1940	208	2.76	4.24
1941	182	2.55	3.59
1942	163	1.81	2.85
1943	145	1.48	2.71
1944	156	1.89	2.67
1945	159	1.98	2.6
1946	137	1.26	2.47
1947	130	1.41	2.18
1948	104	1.4	1.68
1949	116	1.42	2.03

Source: *ARRG, 1949-50* (Dublin, 1951), p. viii.

APPENDIX D (continued)

3. Infant mortality rate per 1,000 births in Sligo and Dublin, 1939-48.

Year	Sligo	Dublin
1939	102	90
1940	77	91
1941	70	114
1942	75	98
1943	128	126
1944	85	117
1945	132	111
1946	68	92
1947	138	85
1948	98	46

Source: *ARRG, 1948* (Dublin, 1949), p. xxxvi

APPENDIX E

1. Neo-natal mortality in Ireland, 1939-49.

Year	Rate per 1,000 live births
1939	29
1940	27.9
1941	30.3
1942	27.4
1943	33.2
1944	33.2
1945	31.6
1946	29.3
1947	28.8
1948	23.2
1949	24.6

Source: *ARRG, 1950*, p. xlix.

2. Infant mortality numbers in Dublin's maternity hospitals, 1932-46. There is a very high number of neo-natal deaths during the war years.

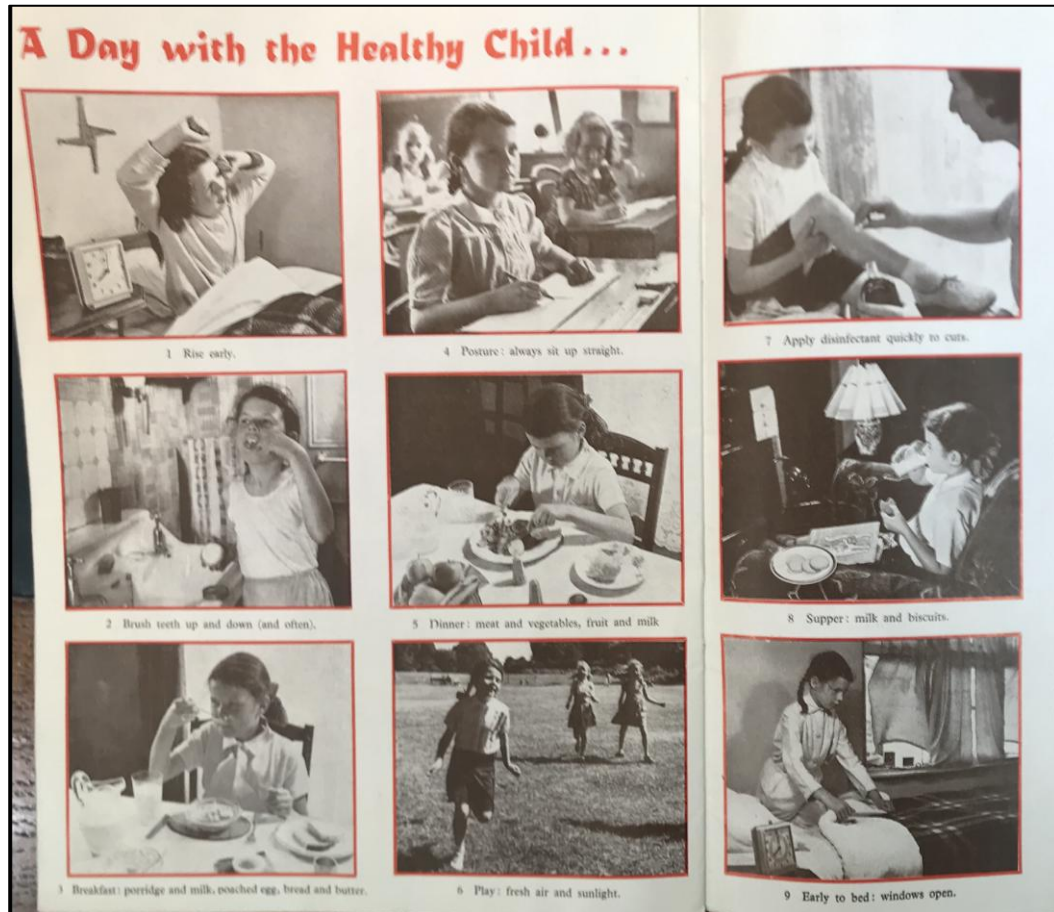
Years	Neo-natal deaths	Percentage in terms of total deliveries
1932-33	61	2.6
1933-34	29	1.1
1934-35	22	0.8
1935-36	83	2.9
1936-37	127	4.7
1937-38	82	3.3
1938-39	67	2.2
1939-40	45	1.5
1940-41	39	1.2
1941-42	84	2.4
1942-43	144	3.8
1943-44	127	3.4
1944-45	122	3.1
1945-46	96	2.7

Source: Infant mortality numbers, Dublin maternity hospitals, 1919-1946, undated, *c.* Jan 1947 (NAI, HLTH: M 34/2).

APPENDIX F

Mothercraft was not solely about feeding. Instead, it extended to a number of topics.

1. 'A day with a healthy child'.



Source: Department of Health, *An mháthair is a leanbh = Mother and child: what the new service means to every family* (Dublin, 1948).

(APPENDIX F continued)

2. A mother pictured with her child, 1936.



‘Good eating habits are important’.

Source: *Woman’s Life*, 18 Jul. 1936.

3. ‘A mother pictured with her child, 1936.

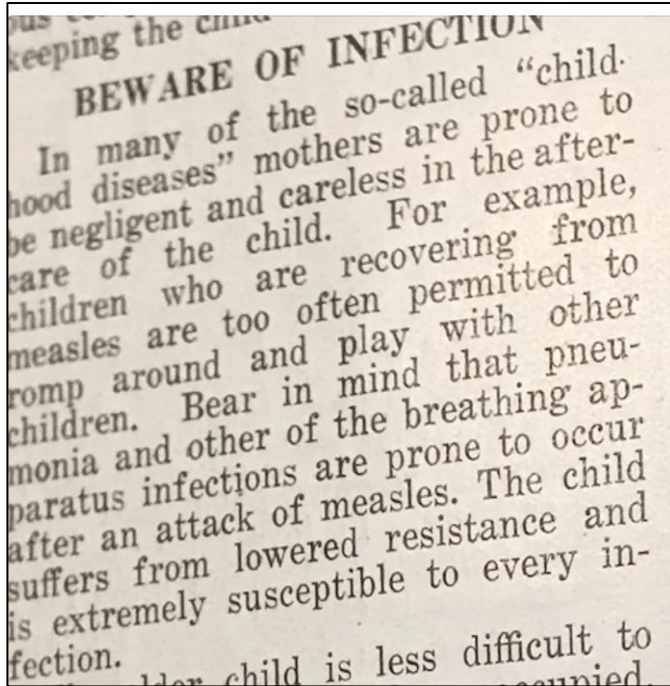


‘Happy babies... Fresh air, sunshine and plenty of milk’.

Source: *Woman’s Life*, 8 Aug. 1936.

(APPENDIX F continued)

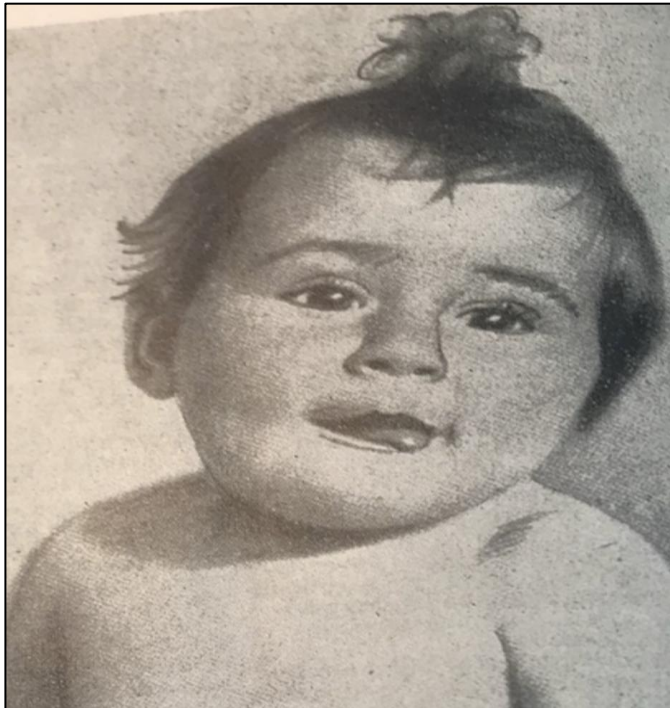
4. Article warning mothers to beware of infection, 1936.



'Mothers are prone to be negligent and careless'.

Source: *Woman's Life*, 8 Aug. 1936.

5. Photo of a baby with incorrect posture, 1936.



'The importance of good posture... Teach your child to sit correctly'.

Source: *Woman's Life*, 22 Aug. 1936.

APPENDIX G

1. Grangegorman Access Permissions (condensed version)



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Archives of St. Brendan's Mental Hospital, Grangegorman and constituent and predecessor institutions at the National Archives

It is agreed that requests for access shall be divided into Level One, Level Two and Level Three depending on the identity of the applicant and the purpose of the request for access.

Level One: clinical or other academic research access to records irrespective of the date on which created

Level Two: genealogical or other access to records of an individual patient that are less than one hundred and twenty years old

Level Three: general access to any and all types of records that are one hundred and twenty years or older

It shall be the responsibility of the HSE to consider access requests and to determine the level of access to be granted in each case.

Level One

Level One access shall in principle entitle the applicant to view such parts of the entire collection of the archived material as are necessary and relevant to their research project irrespective of the contents of the material or the date on which they were created. Before a request for Level One access will be entertained the applicant must satisfy the HSE, at a minimum the following criteria:

1. The applicant must be engaged in clinical, historical or sociological academic research to post-graduate degree level which must be described in detail by the applicant
2. An application must be accompanied by a reference from a health authority, academic institution or Government agency as appropriate depending on the applicant's identity and affiliation. The referee must recommend the applicant's request for access.
3. The qualifications of the applicant in the area of research being undertaken and a detailed summary of the substantial and authoritative research already carried out and published by the applicant must be provided.
4. The applicant must undertake in writing for the HSE not to disclose verbally and orally or otherwise any detail which may identify individual patients, their families, relatives or next of kin or any identifying information in printed or oral

format, and must complete and submit the appropriate Seventh Schedule or Fourth Schedule forms where relevant.

5. The HSE shall be fully responsible for ensuring that all criteria listed under Level One access shall be compiled with prior to notifying approval of the applicant's for sanction to the National Archives.
6. It is hereby expressly agreed that the Depositor shall be entitled to request any additional information and to add to or vary any of the above conditions when sanctioning a request for Level One access.
7. The applicant shall permit the National Archives to independently verify the HSE Level One approval and to make such verbal or written enquiries as it considers necessary to establish the authenticity of the access request granted by the HSE.
8. The Depositor reserves at all times the right to inspect, prior to publication, the applicant's research for the purposes of verifying the absence of any confidential information. The Depositor shall be entitled to require the applicant to delete any references to what it considers to be confidential information. In this regard the applicant must if he/she wants to include any personal or confidential material identifying any individual patient request separate, prior approval from the Depositor. An application form for this purpose is included as the Seventh Schedule hereto.
9. The Applicant must undertake in writing not to use any information gathered from accessing the material for any purpose other than those stated in the original application.

FIRST SCHEDULE

Form for Level One access

Name: Kelly Adamson

Permanent address: 233 Phibsborough Road, Dublin 7, Co. Dublin

Temporary address (if relevant): _____

Email: Kelly.adamson3@mail.dcu.ie

Tel: 087-4307722

Qualifications of applicant:

BA (Hons.) in English Literature and History (DCU, 2017), MA in History (DCU, 2020), HGPT PhD Track in Public Health Policy, 1940s (DCU, 2020-present)

Details of current research:

My research asks why some areas of public health attracted most government attention during the 1940s, thereby offering insight into the complexities of introducing health measures in the modern nation-state. My focus is on the following areas: nutrition, infant mortality, tuberculosis and the institutionalisation of the mentally-ill.

Details of research completed and publications:

Referee: Juliana Adelman, Assistant Professor of History, Dublin City University

Jan

Signature:

agree to comply with and be bound by the terms and
access set out in the loan agreement between


05/07/2021

Application approved/refused (please indicate as appropriate) by Dublin North City Mental Health Services on behalf of the HSE

Print Name: Brendan Kelly

Brendan Kelly

Signature: _____

Position: Consultant Psychiatrist (HSE), Professor of Psychiatry (TCD)

Date: 6 July 2021

APPENDIX G (continued)

DATA PROTECTION UNDERTAKING

I understand that it is my responsibility under the **Data Protection Acts 1988 and 2003**, to ensure that the personal data contained in any archives to which I am being granted access, is used solely for the purpose of historical research and not for any purpose which could cause damage or distress to the subjects of the data.

I further understand that the Acts require that the results of my research, or any resulting statistics I publish or use, are not made available in a form that identifies any living individual featured in the data. The personal data I gain access to will not be disclosed to any other individual. I undertake to protect from unauthorised disclosure to any party, any copies of material, or any notes taken during my research in the National Archives, which contain personal data.

FULL NAME (BLOCK CAPITALS) : KELLY ADAMSON

READER'S TICKET NUMBER : 98365

SIGNATURE : 

DATE : 05 / 07 / 2021

APPENDIX G (continued)

2. St. Conal's access permissions (condensed).

Local Government Archives Services

Donegal County Council Archives Service

Application Form for Access to Closed Archives

Please read the Access Policy before completing this form.

Please note that if, at a later stage, you wish to re-use the information gathered from the research carried out for this project, for a different purpose, you will need to inform the Archives Service.

The Archives Service reserves the right to verify the information you supply.

This form will not be used for any purpose other than that stated. It will be retained securely for 30 years in the case of applications for access for the purpose of producing publications and research projects and will then be destroyed. For routine enquiries forms will be held securely for two years and then destroyed.

Please note that failure to observe the conditions to which you have agreed may result in being refused future access to archives.

Please note that in the case of a breach of the conditions of access, all other archives in Ireland will be informed, with a view to restricting future access to 'closed archives'.

In all requests for access documentary evidence of identity is required.

Name of applicant:

Kelly Adamson

Please give reference number(s), titles and descriptions of archives you wish to gain access to:

- Med 4/2/10: Administration (British Medical Journal, 1946)
- Med 4/3/1: Ledgers Supplier Accounts (1940s)
- Med 4/3/2: Financial Statement Books Expenditure (1940s)
- Med 4/5/5/2: Register of Discharge and Death (1940-46)
- Med 4/5/6: Medical Journals (1920s-31)
- Med 4/5/8: Treatments (1930s-1940s)

- Med 4/5/8/3 + 4: Administered Therapies (1948/49), (1949-51)
- Med 4/5/9: Labour books (1940s)
- Med 4/7/1: Head Attendants Report Books (1940s)
- Med 4/7/2: Matron Report Book (1940s)
- Med 4/8: Night observation books (1940s)
- Med 4/10/2: Want Books (1940s)

Category of Researcher please tick as appropriate:

- A person who is referred to in the archives
- A person acting on behalf of a person mentioned in the archives, who is incapacitated (i.e. having a 'Power of Attorney')
- A nominated next-of-kin of a person mentioned in the archives
- A professional working on behalf of a client (e.g. solicitor, social worker)
- **A researcher engaged in *bona fide* research**

If you are a professional please state the organisation for which you work, the position you hold within it and the nature of your current enquiry. You may be required to provide proof of your position.

I am a PhD researcher attached to the Irish Research Council and Dublin City University.

If you are a researcher engaged in *bona fide* research, you may be required to provide an appropriate reference (e.g. from a research supervisor, an officer of a historical society or a peace commissioner). Please explain in detail:

Please see supervisor reference attached.

(1) The nature of the proposed publication or production (if you intend to publish or broadcast information found in the archives) or planned outcome of your research:

While materials housed in the archives form a vital element of my thesis on public health policy, I am very conscious of GDPR, and individual names or information tying circumstances to specific people, will not be used.

(11) The institution to which you are attached (if applicable):

Dublin City University

(111) Your status at this institution (e.g., whether third level student or academic researcher)

Third Level PhD student

If a third level student, please give the name and title of your Department and Supervisor:

Faculty of Humanities and Social Sciences

If you are a third level student, please give the names of two nominees/referees, not related to you, who undertake to vouch for you

Dr Juliana Adelman, Dr Will Murphy

Declaration

I have read the Donegal County Council Archives Access Policy and request access to the archives specified above on the understanding that the information contained therein is confidential.

I understand that it is my responsibility under the Data Protection Acts 1988 to 2018 and the GDPR to ensure that the personal data contained in any records or archives to which I am being granted access are used solely in connection with historical research and not for any purpose which could cause damage or distress to the subjects of the data. I undertake not to use personal data to which I have been given access in order to contact any individuals referred to in the archives.

I further understand that the Acts require that the results of my research, or any resulting statistics I publish or use, are not made available in a form that identifies any living individual featured in the data without their consent. The personal data I gain access to will not be disclosed to any other individual. I undertake not to disclose other personal data on individuals seen in the course of obtaining what is necessary for my own work.

I undertake to protect from unauthorised disclosure to any party, any copies of material, or any notes taken during my research, which contain personal data.

I understand that these conditions are designed to protect the privacy of those mentioned in the archives.

I understand that breach of the Access Policy or of any of the conditions outlined in this application form will result in future refusal of access to closed archives. I further

understand that in the case of a breach of the conditions of access, all other Archives Services in Ireland will be informed with a view to restricting future access to 'closed archives'.

A handwritten signature in dark ink, appearing to read 'Kelly Adamson', written over a horizontal line.

Signed: _____

Address: 233 Phibsborough Road, Dublin 7

Telephone number: 087 4307722

Email address: kelly.adamson3@mail.dcu.ie

Date: 22.06.22

APPENDIX G (continued)

3. Copy of approach and protection measures (condensed version; included in FOI requests to HSE).

Protection measures:

I would like to emphasise that I am not looking for any personal details of patients in the hospital. Instead, I am concerned with the treatments used (sedatives, ECT, ICT, new drug therapies, restraint, etc.) and the changes that occurred in the institutions (as reflected by the Mental Treatment Act 1945). In this, my research is not focused on individual patients, but rather, on underscoring policy impacts and outcomes. I can assure that it is focused on volumes of changes, personnel and treatments as such and not on the minute circumstances of patients themselves. I have been trained on research ethics, and I am equally trained in data protection of case-sensitive records.

My current privacy approach for sensitive medical data focuses on the detection and removal of patient identifiers from the data prior to data analysis. This is followed by a careful examination of any indirect identifiers that eliminates the risk of patient identification. In the case where access is granted, individual subject identifiers will be further removed by data clustering where I will pair patient identifiers based on the similarity of a health, medical or social concept. Examples include status (voluntary/involuntary/recovered/discharged), treatment (occupational/physical), and gender (male/female).

Therefore, I can ensure my data outputs will **not refer to any individual's physiological, mental, economic, cultural and/or social identity, in so far as the data subject could be identified**, as outlined by the EU framework on data protection. Above all else, I am aware that these records contain very sensitive information and I am very conscious of patient confidentiality throughout my research. To protect patient information, I am willing to:

- Sign a confidentiality agreement in which I agree to adhere to the regulations and data-protection of individuals concerned and of sources dealt with
- Where there are names or any other identifying information, these names are **redacted**. Individual names, dates of committal, addresses and any other identifying information will not be included in research outputs.
- In rare cases where identifying information is noted by myself for research purposes, subjects will not be identified by names alone. Strategies here include: 'Case X' and pseudonyms. Where this method is used, there will be no other identifying details concerning the patient used that could potentially tie 'Case X' to his/her real identity. I.e. where they are from, their address, date of committal etc.
- In presentations, **aggregate findings, not individual-level data** will be reported to the public. In this particular example, patients are **grouped** by gender and treatment, and not examined on an individual basis, **nor on an individual institution.**

Conducting policy-based research, I am more interested in volumes as opposed to precise data on patients and on institutions. For example, access to St. Davnet's is not driven by a desire to examine St. Davnet's in isolation, but to add to other aggregate findings found in a number of institutions. Further, access to these records is paramount to ensure an appropriate coverage of institutions from a rural and urban perspective.

- Methods for handling and securing data will be password-protected and encrypted (as is currently the case with my research into the records of other mental institutions and child-care services).
- Any identifying information gathered will be further anonymised.

APPENDIX H

A view of the kinds of data transcribed from the records of St. Conal's Hospital, Donegal.

1. *Observations and Treatment Book in St. Conal's Hospital*, May 1948-Dec.1949 (MED 4/5/8/3). Data-set contains records of 141 patients.

Clipboard Font Alignment Number Styles Cells Editing							
Patient name							
A	B	C	D	E	F	G	
Date	Months	Treatment	Patient name	Observations	Gender	Units	
11/6/48	June	Electrotherapy	Patient 53	2nd	male	-	
11/6/48	June	Electrotherapy	Patient 85	2nd	male	-	
11/6/48	June	Electrotherapy	Patient 58	5th	male	-	
11/6/48	June	ICT	Patient 21	240 units deep coma, 40m n.f	female	240	
11/6/48	June	ICT	Patient 73	300 units, epileptic form of seizure @ 10.30, n.f	female	300	
11/6/48	June	ICT	Patient 106	340 units, deep coma 30m, n.f	female	340	
11/6/48	June	ICT	Patient 152	200 units, good coma, 45m oral feed	male	200	
11/6/48	June	ICT	Patient 59	260 units, restless, 50m n.f	male	260	
11/6/48	June	ICT	Patient 139	340 units, light coma 60m, n.f	male	340	
11/6/48	June	ICT	Patient 135	400 units, light coma, 40m, n.f	male	400	
11/6/48	June	ICT	Patient 46	140 units deep coma, 40m	male	140	
11/6/48	June	ICT	Patient 155	260 units, drowsy and drank glucose	male	260	
12/6/48	June	Somnifaine Therapy	Patient 130	6th day satisfactory	male	-	
14/6/48	June	Somnifaine Therapy	Patient 130	Condition is satisfactory	male	-	
14/6/48	June	Electrotherapy	Patient 128	11th seizure	male	-	
14/6/48	June	Electrotherapy	Patient 78	6th	male	-	
14/6/48	June	Electrotherapy	Patient 85	3rd second series	male	-	
14/6/48	June	Electrotherapy	Patient 53	3rd second series	male	-	
14/6/48	June	Electrotherapy	Patient 70	1st	male	-	
14/6/48	June	Electrotherapy	Patient 36	1st	male	-	
14/6/48	June	Electrotherapy	Patient 113	5th	male	-	
14/6/48	June	Electrotherapy	Patient 57	4th of 4th series	male	-	
14/6/48	June	Electrotherapy	Patient 58	sub-convulsive	male	-	
14/6/48	June	ICT	Patient 106	200 units, drowsy, drank glucose, total 14 comas	female	200	
14/6/48	June	ICT	Patient 21	240 units, fairly good coma, 50m, n.f	female	240	
14/6/48	June	ICT	Patient 59	260 units, had epileptic form seizure	male	260	

APPENDIX H (continued)

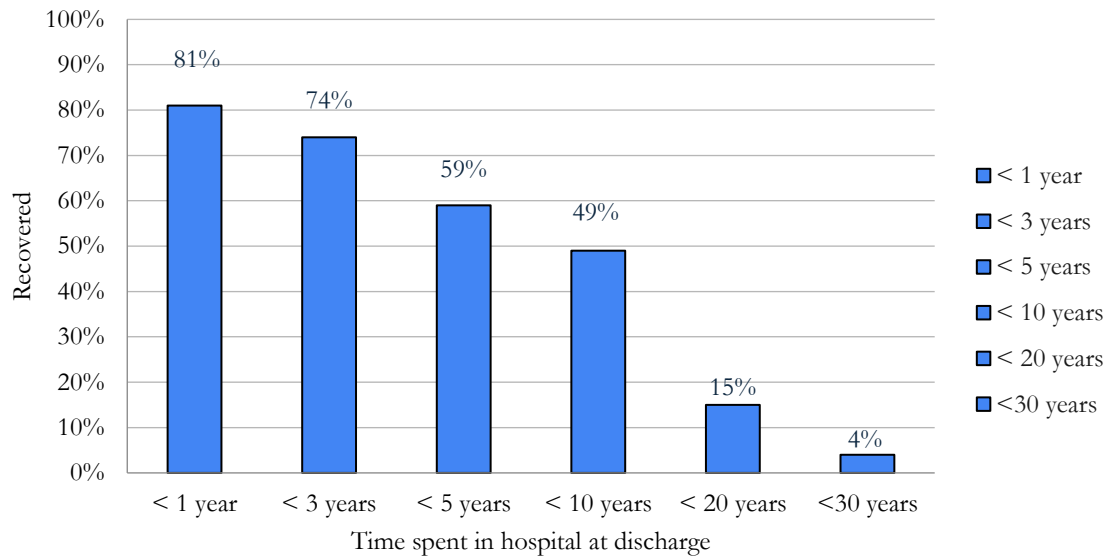
2. *Registrar of Discharges and Deaths in St. Conal's Hospital, 1939-44 (MED 4/5/5/2).* Data-set contains records for 555 patients over a five year period, 1939-1944.

B	C	E	F	G	H	I	J	K	L	M
Date of last admiss	Duration of disease on admis		Cause of death	Recovered/R	Post-mortem	Age at death	Length of residence in asylum	Grouped length of residencies	Observations	Gender
07/07/1934	18 months	Patient 1	-	Recovered	-	74	4 years, 184 days	< 5 years	Recovered	female
25/9/1938	1 month	Patient 2	-	Recovered	-	65	109 days	< 6 months	Recovered	male
1/3/1924	6 months	Patient 3	-	Recovered	-	60	14 years, 317 days	< 15 years	Recovered	male
17/06/1930	3 weeks	Patient 4	Bronchitis	-	no	69	8 years, 215 days	< 10 years	Died	male
22/4/27	12 months	Patient 5	Heart disease	-	no	71	11 years, 273 days	< 15 years	Died	male
24/03/1938	3 months	Patient 6	Cerebral haemorrhage	Died	no	61	210 days	< 1 year	Died	male
24/03/1938	3 weeks	Patient 7	Septic throat	-	no	48	313 days	< 1 year	Died	male
26/11/1934	3 years	Patient 8	-	Recovered	-	26	4 years 66 days	< 5 years	Recovered	male
16/3/1935	1 week	Patient 9	Heart disease	-	no	72	3 years 322 days	< 5 years	Died	male
9/8/23	2 years	Patient 10	Heart disease	-	no	not stated	15 years, 176 days	< 15 years	Died	female
11/4/1938	6 months	Patient 11	-	Recovered	-	26	302 days	< 1 year	Recovered	male
5/4/1926	5 days	Patient 12	Pulmonary tuberculosis	Died	no	45	12 years 342 days	< 15 years	Died	female
18/1/1915	1 week	Patient 13	Cerebral haemorrhage	Died	no	74	24 years 28 days	< 25 years	Died	male
30/9/1910	1 month	Patient 14	Senility	-	no	61	28 years 140 days	< 30 years	Died	male
27/04/1938	1 week	Patient 15	Pneumonia	Died	no	51	302 days	< 1 year	Died	male
01/02/1939	1 week	Patient 16	-	Recovered	-	no stated	23 days	< 1 month	Recovered	male
4/2/1939	2 months	Patient 17	Cerebral haemorrhage	Died	no	73	24 days	< 1 month	Died	male
13/10/1938	1 week	Patient 18	-	Recovered	-	49	140 days	< 6 months	Recovered	female
28/12/1937	3 days	Patient 19	-	Recovered	-	61	1 year 64 days	< 3 years	Recovered	female
23/11/1925	1 year	Patient 20	Heart disease	-	no	63	13 years 109 days	< 15 years	Recovered	male
20/02/1939	12 days	Patient 21	-	Recovered	-	not stated	22 days	< 1 month	Recovered	male
6/12/1931	1 year	Patient 22	-	Recovered	-	not stated	8 years 4 months	< 10 years	Recovered	male
20/06/1931	1 week	Patient 23	Pulmonary tuberculosis	Died	no	not stated	8 years 6 months	< 10 years	Died	female
22/03/1939	1 week	Patient 24	Senility	Died	no	76	16 years 306 days	< 20 years	Died	female
22/02/1939	1 week	Patient 25	-	Recovered	-	40	29 days	< 1 month	Recovered	male
01/09/1938	4 days	Patient 26	Bronchitis	-	no	59	1 year 215 days	< 3 years	Died	male

APPENDIX I

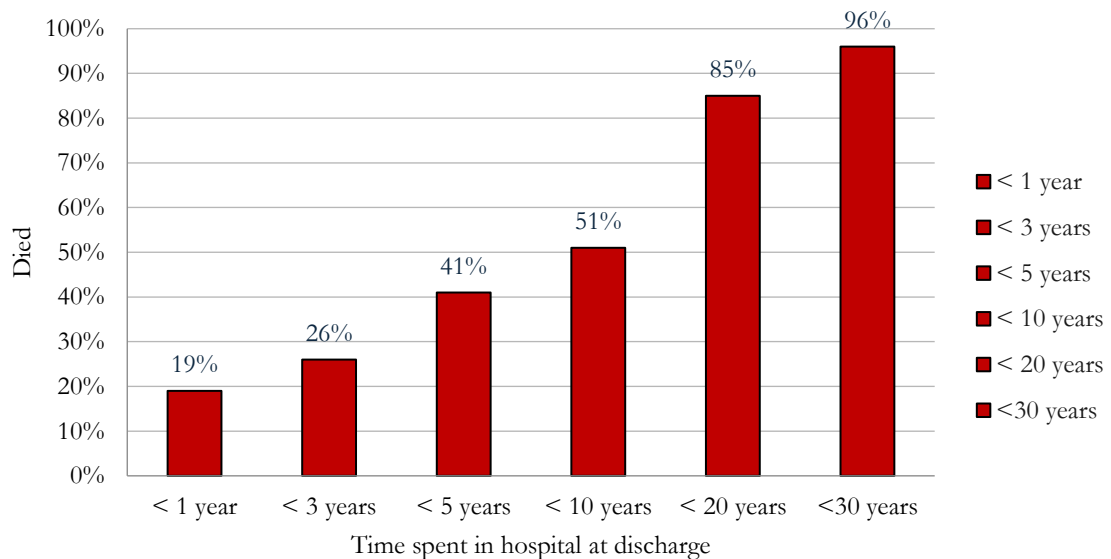
1. Time patients spent in the institution at discharge (recovered) in St. Conal's Hospital, 6 Jan. 1939-11 Nov. 1944.

'Recovered' discharges by the amount of time patients spent in St. Conal's Hospital, 6 Jan. 1939 - 11 Nov. 1944.



2. Time spent in the institution at discharge (death), in St. Conal's, 6 Jan. 1939-11 Nov. 1944.

Death discharges by the amount of time patients spent in St. Conal's Hospital, 6 Jan. 1939 - 11 Nov. 1944.



Source: *Registrar of Discharges and Deaths in St. Conal's Hospital, 1939-44* (MED 4/5/5/2).

APPENDIX I (continued)

3. Length of residences *before* discharge in St. Conal's Hospital, Donegal, 1939-44.

Grouped length of residencies % of patients	
< 3 months	9.70%
< 6 months	22%
< 1 year	12.80%
< 3 years	14.92%
< 5 years	3.05%
< 10 years	8.45%
< 20 years	9.87%
< 30 years	5.02%
< 55 years	10.93%

Source: *Registrar of Discharges and Deaths in St. Conal's Hospital, 1939-44* (MED 4/5/5/2).

APPENDIX J

Leading causes of death in Ireland and corresponding percentages, 1939-1944.

Leading causes of death	1939	1940	1941	1942	1943	1944	% of Overall Mortality
Heart disease	8,552	8,922	9,329	8,578	9,264	11,011	21.44%
Senility	6,216	5,780	6,438	5,788	6,089	6,634	14.20%
Cancer	3,755	3,797	3,810	4,039	4,045	4,197	9.10%
TB	3,296	3,686	3,723	4,331	4,306	3,836	8.90%
Stroke	2,461	2,681	2,715	2,623	2,653	2,753	6.11%
Pneumonia	1,961	1,843	1,883	1,707	1,870	1,895	4.30%
Bronchitis	1,919	2,010	1,927	1,457	1,435	1,579	3.97%
Other	13,558	12,984	14,015	12,908	13,918	15,344	31.87%

Source: *ARRG, 1939-1944* (Dublin, 1945). Consecutive years.

APPENDIX J (continued).

Leading causes of death in and outside St. Conal's District Mental Hospital, Donegal, 1939-1944.

Leading Cause of death	% Overall mortality (general population)	Inside
Heart disease	21.44%	50%
Senility	14.20%	3.40%
Cancer	9.10%	7.95%
TB	8.90%	23.10%
Stroke	6.11%	4.16%
Pneumonia	4.30%	3%
Bronchitis	3.97%	1.13%
Other	31.87%	7.19%

Source: *ARRG, 1939-44* (Dublin, 1945); *Registrar of Discharges and Deaths in St. Conal's District Asylum, 1939-1944* (MED 4/5/5/2).

APPENDIX K

Numbers of admissions, discharges and deaths in District Mental & Auxiliary Hospitals, 1929-1955.

Between 1929 and 1955, there were only five years where the numbers leaving mental hospitals surpassed those coming in (see those in bold). Four of these years were during the war, presumably some who otherwise would have been admitted went to work. In every other year, numbers coming in were more than that going out (indicated in red).

Year	Admissions	Discharges (alive)	Deaths	Total Out
1929	2696	1283	1116	2399
1930	2348	1174	1099	2273
1931	2486	1249	1107	2356
1932	2578	1264	1070	2334
1933	2703	1295	1001	2296
1934	2618	1347	1081	2428
1935	2362	1210	1071	2281
1936	2443	1182	1026	2208
1937	2423	1251	1241	2492
1938	2639	1310	1054	2364
1939	2682	1409	1176	2585
1940	2421	1292	1201	2493
1941	2193	1292	1289	2581
1942	1943	1156	1396	2552
1943	2036	1262	1170	2432
1944	2188	1210	1103	2313
1945	2306	1264	940	2204
1946	2544	1182	999	2181
1947	3198	1,985	1367	3352
1948	3804	2426	1019	3445
1949	4415	2916	1016	3932
1950	4601	3138	1182	4320
1951	5159	3693	1274	4967
1952	5070	3584	1154	4738
1953	5627	4154	987	5141
1954	5898	4435	1121	5556
1955	6508	5125	1206	6331

Source: *Report of the inspector of mental hospitals, 1929-1955* (Dublin, 1956). Data taken for consecutive years.

APPENDIX L

1. Number of treatment sessions. ICT was the most labour intensive, as shown.

Number of treatment sessions	Female	Male	Grand Total
Electrotherapy	83	700	783
ICT	358	578	936
Somnifaine Therapy	29	304	333
Grand Total	470	1582	2052

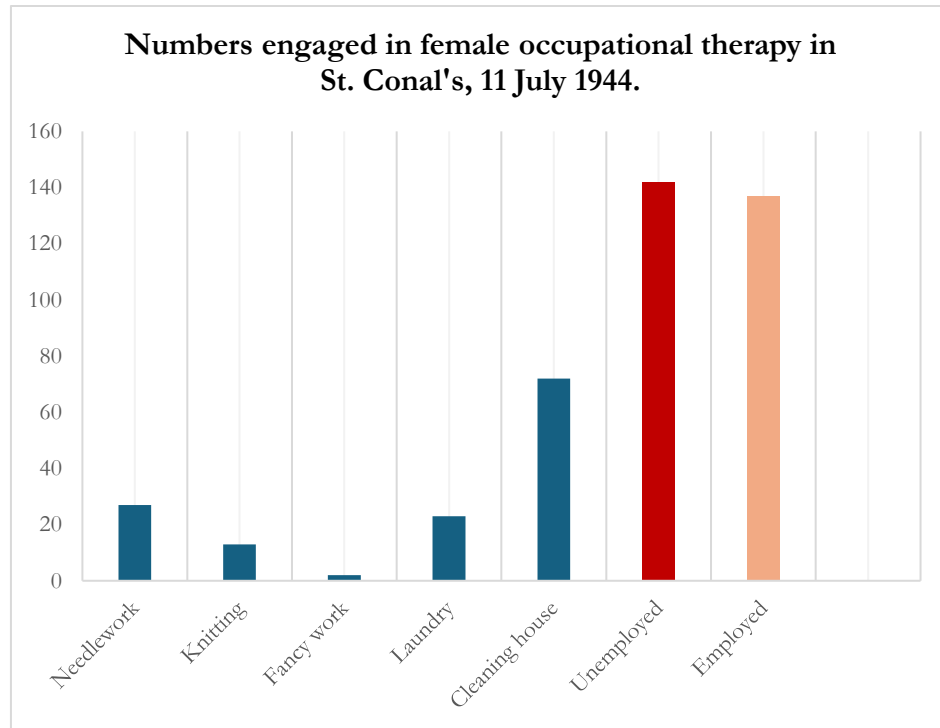
2. Sum of insulin units given (to all patients combined) in St. Conal's hospital, May-1948-Dec. 1949.

Insulin dosages varied considerably by patient, and by session. Astonishingly high dosages were often given to patients in St. Conal's hospital, compared to elsewhere.

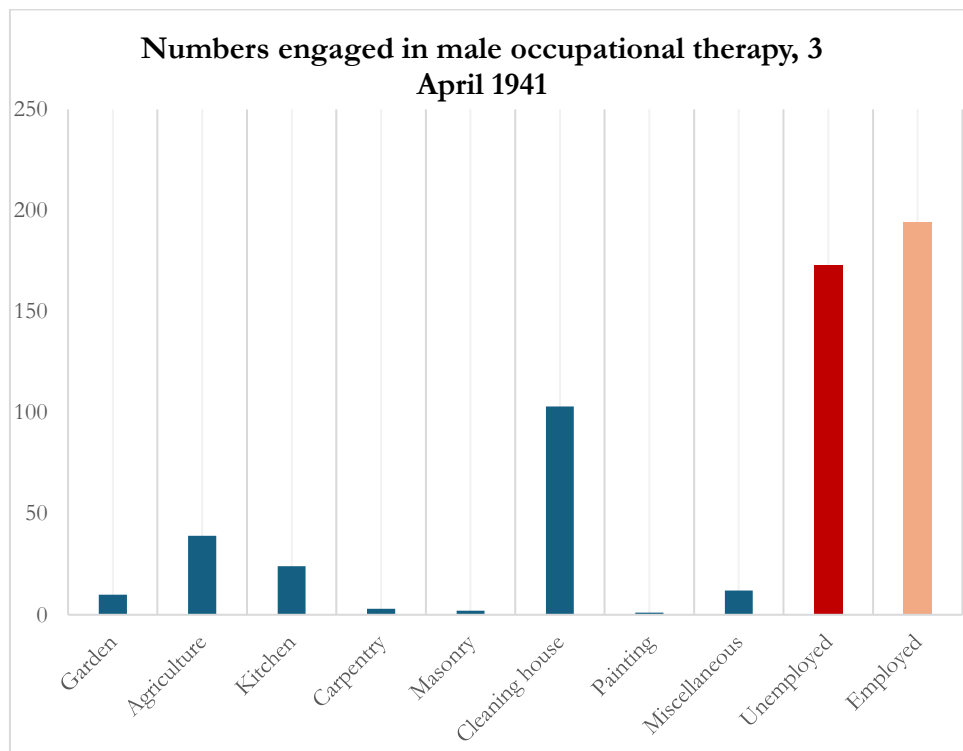
Date - Year-Quarter	Sum of Units
1948-Q2	26520
1948-Q3	4380
1948-Q4	30960
1949-Q1	35100
1949-Q2	43250
1949-Q3	120
1949-Q4	0
1950-Q1	13320
Grand Total	153650

Source: *Observations and Treatment Book in St. Conal's Hospital*, May 1948-Dec. 1949 (MED 4/5/8/3).

APPENDIX M



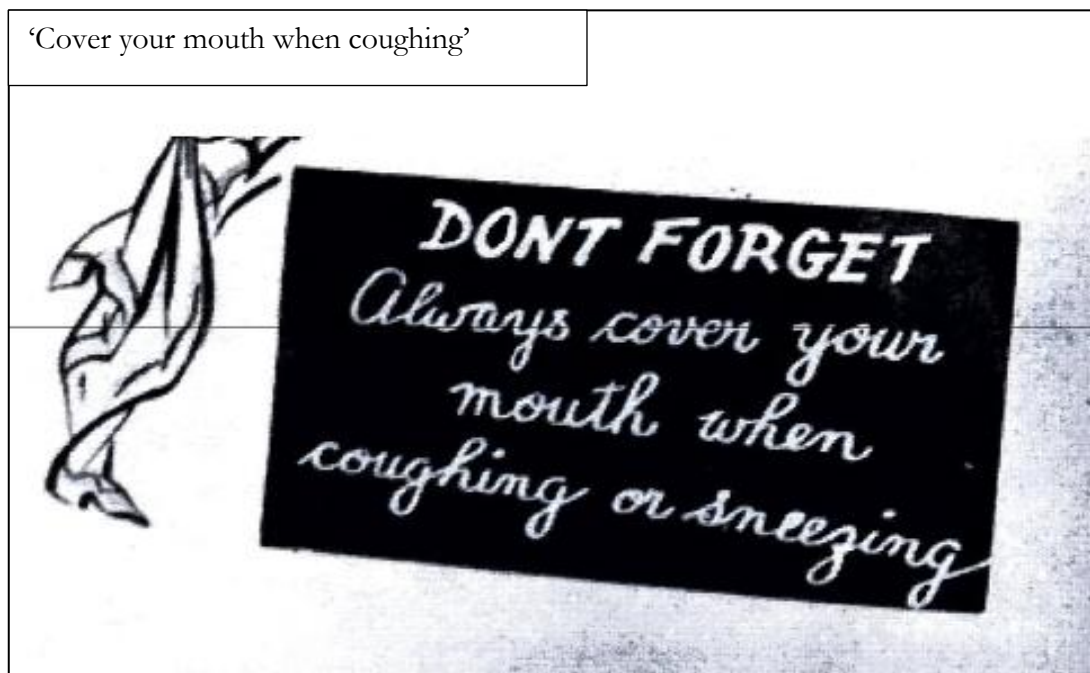
Source: *Matrons report book*, Jun. 1944-Dec. 1944 (MED/4/7/2/6).



Source: *Head attendant report book*, May 1940-Apr. 1942 (MED/4/7/1/25-26).

APPENDIX N

Public health pamphlet targeting children in relation to tuberculosis.



Source: DOH, *The first standard of health* (Dublin, 1950). Illustrations by Warner.

APPENDIX O

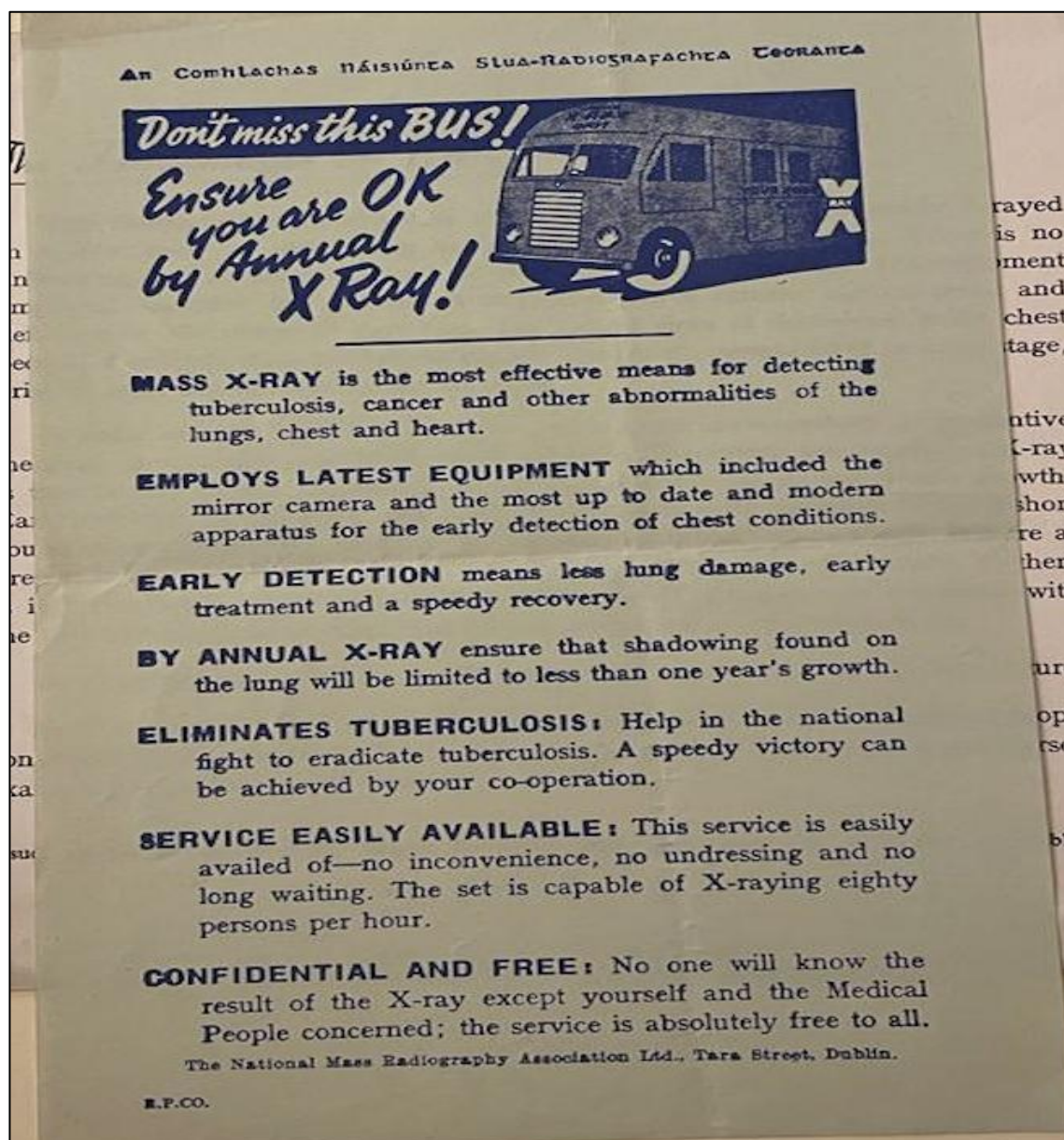
A photograph of the BCG unit established in St. Ultan's Hospital , 1949.



Source: (DOH, *Report of the Department of Health, 1949-50* (Dublin, 1951), p. 33.

APPENDIX P

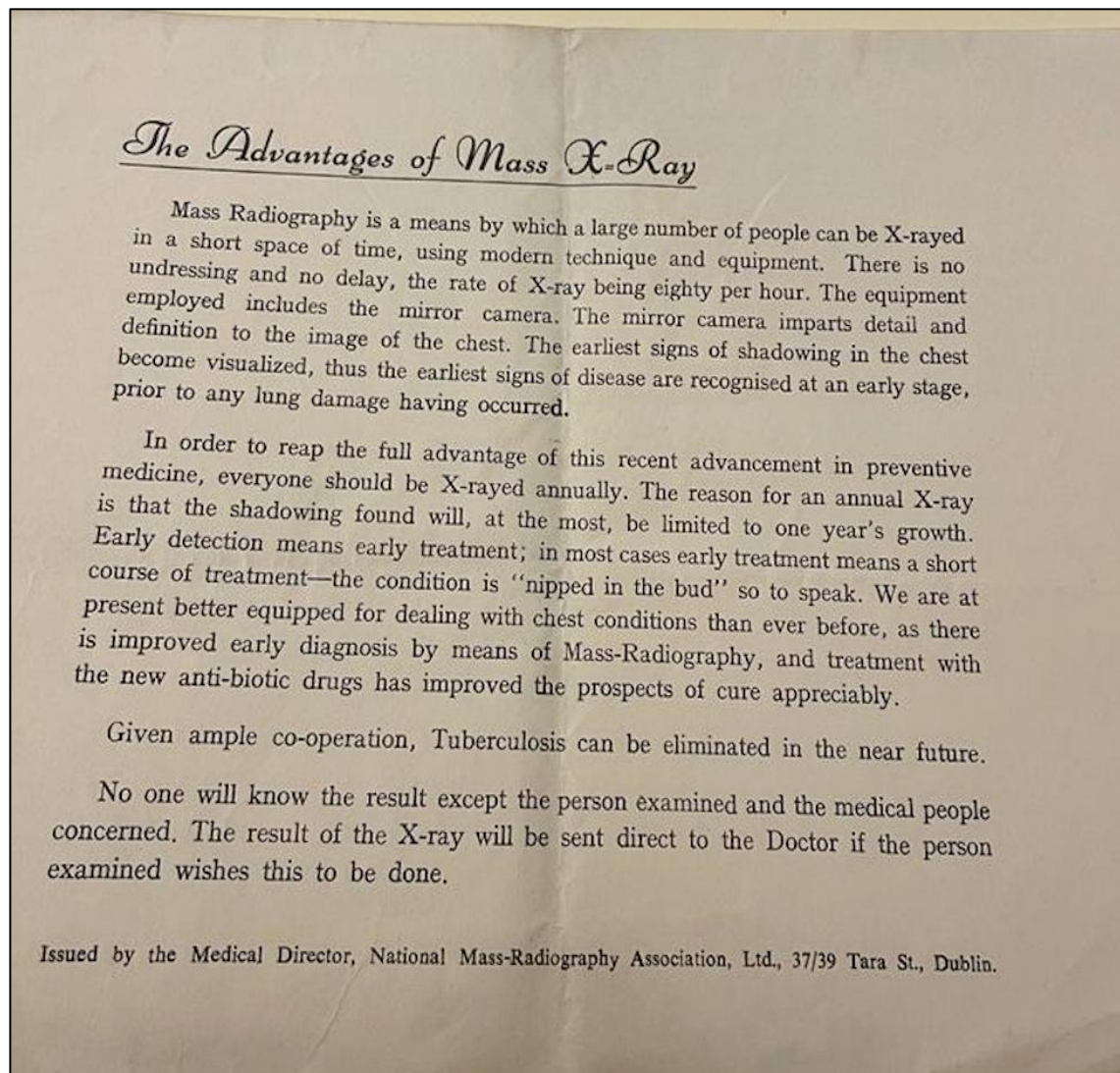
1. 'Don't miss this Bus!' public health poster, undated c. 1950.



Source: Russell ephemera (RCPI RE/14).

APPENDIX P (continued).

2. 'The advantages of Mass X-Ray' public health poster, c. 1950.



Source: Russell ephemera (RCPI RE/14).