Chapter VII

FORMATION OF
THE NORTHERN IRELAND TUBERCULOSIS AUTHORITY

Before partition, the Local Government Board for Ireland received reports from their Inspectors on the health of the community, and each year produced a very large report of their own. The Inspectors were well aware of the ravages of tuberculosis. They told the Board about it. They quoted the Registrar General’s Annual Report: ‘In 1905 there were close on 12,000 deaths in Ireland due to the disease . . . . Tuberculosis in all forms was responsible for a death rate of 2·7 per thousand . . . . A further unsatisfactory feature is the fact that the death rate from tuberculosis in Ireland stands at a far higher figure than either England or Scotland’. Though the Board were probably impressed they took no action until 1907.

They then submitted their Thirty-fifth Annual Report to His Excellency John Campbell, Earl of Aberdeen. In it they proposed a systematic plan for dealing with tuberculosis. There were four elements:

(i) Advanced cases should be admitted to hospital, segregation of highly infectious patients from healthy persons being in itself a great safeguard against infection.

(ii) Where the disease is in its early stages and capable of being arrested, sanatoria should be provided where persons affected could be sent for proper treatment.

(iii) In large centres of population, dispensaries should be provided where advice could be obtained and the latest method of treatment tried.

(iv) Local committees appointed by the Sanitary Authorities to deal with the question of tuberculosis would be very beneficial.

In spite of this good advice nothing was done. It must have been a most frustrating experience to have been a medical inspector. Also in 1907, Surgeon Colonel D Edgar Flint reported visiting a tenement house ‘where I found the mother of a family suffering from phthisis. She had been in hospital for six weeks and had recently been discharged. The woman had a family of six; four others had died in the last few years, the mother said “of delicacy”. The return of this poor woman to her tenement home is regrettable in view of her condition and the history of her family. She did not appear to have been instructed in taking ordinary precautions in her own, and her family’s and her neighbours’ interests’.

The Local Government Board reported to His Excellency that though they had been requested by their Inspectors to have consumption listed as a notifiable disease: ‘We feel unable to accede to this request. We consider pulmonary tuberculosis to be quite different in development and method of infection to such diseases as small-pox, diphtheria, enteric fever, typhus, etc. No unnecessary restriction should be placed on the liberty of the consumptive patient’.

Dr Brendan MacCarthy, though he was clearly preoccupied with an outbreak of enteric fever in Ballyconnell and Swanlinbar Dispensary Districts, and another in Drumahair Dispensary District, found time to comment on pulmonary
tuberculosis in his area. He reported that small committees had been formed to consider the steps to be taken against the spread of tuberculosis. Committees were formed in Coleraine Urban District, Limavady Rural District, Londonderry No 1 and No 2 Rural Districts, Londonderry County Borough, Strabane No 1 and No 2 Rural Districts, among other places. 'With the exception of the committees formed by the Rural District Council of Londonderry and that formed by the Corporation of Londonderry I do not think any of the committees have ever met to discuss or study the question or taken any steps to deal with it. Some Sanitary Authorities had caused posters to be displayed and distributed leaflets giving information as to consumption and its prevention. A few Sanitary Authorities had agreed to pay for the examination of the sputum of infected cases. But no action at all had been taken by Clones Urban District Council, Dromore Urban District Council, Enniskillen Urban District Council and No 1 and 2 Rural District Council, or Omagh Urban District Council. Advice given to the Local Government Board was never acted upon . . . . It was a difficult and tedious task to seek co-operation among the Sanitary Authorities for the establishment of sanatoria'.

After the partition of Ireland and the formation of the Northern Ireland Government things began to improve. Members of the new Parliament were continually expressing their anxiety about the very high death rate and urged the Government to do something about it. In 1942 a Select Committee was formed to consider the Health Scheme in Northern Ireland. They reported in 1944:

'Tuberculosis

61. Your Committee have heard witnesses from many of the tuberculosis administrative authorities and the tuberculosis officers in Northern Ireland. There are eight schemes in operation, one for each of the six counties and one for the County Borough of Belfast and one for Londonderry. Nineteen medical officers and one part-time orthopaedic surgeon are employed outside the City of Belfast. There are 105 beds provided by local authorities for tuberculosis patients. Sixty additional beds are available in a private Sanatorium at Rostrevor and ten in Ballymena. There are also certain facilities in some of the voluntary hospitals throughout the area.

62. In County Antrim there are twelve tuberculosis dispensaries under a tuberculosis officer and one assistant. There is no sanatorium although there are facilities for early pulmonary cases in the District Hospitals of Ballycastle and Larne, but advanced cases are also admitted to these hospitals and this is considered most undesirable. Cases are also sent to the Forster Green Hospital, Belfast, and non-pulmonary cases are admitted to cottage and district hospitals.

63. In County Armagh there are four dispensaries and a sanatorium at Drumarg under one tuberculosis officer. This Sanatorium has no X-ray apparatus and no facilities for surgical treatment, in fact the TB Services in this county are totally inadequate. There are 33 beds here for all types of pulmonary cases. Non-pulmonary cases are admitted to the Armagh County Infirmary and the Lurgan District Hospital where X-ray examinations can be carried out.

64. County Down has 13 dispensaries under one tuberculosis officer and two assistants. There is no county sanatorium but patients are sent to the Forster Green Hospital, Belfast, to the Royal National Hospital for Consumptives at
Newcastle, Co Wicklow, and to Rostrevor Sanatorium. Non-pulmonary cases are sent to the various general hospitals in the county.

65. In County Fermanagh there are 8 dispensaries under one tuberculosis officer. There is no sanatorium and no X-ray facilities other than those at the County Hospital, Enniskillen. Patients with pulmonary disease are sent to the Forster Green Hospital, Belfast, or to the Royal National Hospital, Newcastle, Co Wicklow. Advanced cases are sent to the Union Hospital and certain cases to one or other of the Belfast hospitals. Non-pulmonary cases are admitted to the county infirmary where X-ray examinations can be carried out.

66. County Londonderry has four dispensaries in charge of a tuberculosis officer. There is no sanatorium, pulmonary cases being sent to Rostrevor or the Forster Green Hospital. Non-pulmonary cases are admitted to the Cottage Hospital, Coleraine or Portrush, or to the City and County Hospital, Londonderry, or Dalriada Hospital, Ballycastle. Advanced cases are treated in the Union Infirmary.

67. In County Tyrone there are 6 dispensaries and a sanatorium containing 32 beds at Dungannon where patients can have X-ray examinations under one tuberculosis officer. X-ray facilities are also available at the Tyrone County Hospital, Omagh. Advanced cases are admitted to the Union Hospitals and non-pulmonary cases to the county hospital.

68. Londonderry County Borough — The county borough has a scheme under the charge of the medical officer of health for the city. There is no sanatorium but X-ray facilities are available in the City and County Hospital. Patients are sent to the Forster Green Hospital, and Rostrevor Sanatorium. Some are sent to England and to the Londonderry City and County Hospital. There are no open air schools but arrangements exist for the admission of suitable cases to the Papworth Village Settlement, Cambridge. Advanced cases are admitted to the Union Hospital, Londonderry.

69. Belfast County Borough has a municipal sanatorium at Whiteabbey where there are 265 beds. There are three resident medical officers, one of whom is the medical superintendent. Cases are not admitted from outside the borough except for certain small areas which are within the Belfast rural dispensary areas. Seventy beds are available at the Belfast Union Infirmary, bringing the total of beds up to 335. Six doctors are in daily attendance at the two city dispensaries, at one of which X-ray examinations can be made.

70. There are two Open Air Schools, one at Whiteabbey and the other at Ventnor. At Ventnor Hospital they have 44 beds for the treatment of bone and joint tuberculosis in children under the charge of a part-time visiting surgeon. This is the only hospital in Northern Ireland dealing exclusively with non-pulmonary cases and this is quite inadequate.

71. Forster Green Hospital is a voluntary hospital administered by a board of management. There is a medical superintendent and three resident doctors for 200 beds. The surgical treatment of pulmonary tuberculosis is a feature of the institution and operations are performed gratuitously by an honorary visiting surgeon. By arrangement with the county councils cases are admitted from Antrim, Down, Fermanagh and Londonderry. The Murray Trust defray the cost
of a certain number of wholly necessitous persons who appear to have a reasonable chance of recovery. The fund at present is sufficient for about 22 patients.

72. It will therefore be seen that there is a considerable divergence of facilities in the various county areas and it would be much more satisfactory from every point of view if all the schemes were co-ordinated by some central authority, such as a Ministry of Health; this would ensure that there would be uniformity of facilities and administration throughout Northern Ireland. Your Committee are satisfied that there is a serious lack of bed accommodation for tuberculosis patients — in fact about 500 additional beds are required and the problem as to how this is to be overcome raises the question of the extension of the existing sanatoria, or the building of new sanatoria, or a combination of both.

73. Your Committee are convinced that two additional sanatoria are required. One might be situated in the north part of the Province and the other somewhere in the neighbourhood of Belfast. These two sanatoria, together with Whiteabbey and Forster Green, would enable the treatment of the disease to be more or less centralised in these four sanatoria where there would be a competent staff of surgeons and doctors who would be available at any time. Your Committee are of opinion that it is much better to have these large sanatoria adequately staffed with all the necessary equipment than to have various isolated sanatoria under-staffed and under-equipped, and that even while the initial expense might be heavy it would be cheaper in the end to run four large sanatoria than it at the moment to keep various smaller ones in operation. This is all the more necessary because within recent years remarkable advances in treatment have taken place and surgical operations designed to ensure rest to the diseased lung are undertaken daily at every modern sanatorium.

74. The modern treatment of tuberculosis demands not only the provision of fresh air and suitable buildings but the services of an experienced and adequate staff of medical and surgical specialists. Radiology plays a very important part in the diagnosis of tuberculosis and the services of an expert radiologist are essential, together with ample facilities for a bacteriological laboratory.

75. The sites for these new sanatoria should be carefully selected and there should be ample provision for outdoor exercise and suitable work. In the interests of the patients and their relatives there should be adequate transport facilities.

76. One essential requirement is the open air school. It may be necessary for children to spend several years at such a school and during this time their education should not be neglected. Some of the existing sanatoria might be utilised for certain convalescent patients who would benefit by a change of air and scene after a prolonged stay in the main sanatoria and before discharge to their own homes.

77. Facilities should be provided for dealing with advanced cases within the grounds of the sanatoria. There should also be provision for private patients who would be able to pay for treatment.

78. Another problem, which though difficult in many respects is not impossible of solution, is the care of dependents of tuberculous patients who are in hospital. At present there is little or no provision for the care of children whose parents may require hospital treatment. Relatives and friends sometimes take the children into their homes but in many cases this is not possible and the parent cannot go to
hospital and leave the children uncared for at home. This is a tragedy and is a very serious menace to the public health. The tuberculous father is often discouraged from having early treatment on account of financial considerations and the only solution that we can see to this problem at the moment is by a system of family allowances in such cases.

79. After-care should include medical treatment and nursing where necessary, and training for suitable re-employment. After-care committees are an important part of any tuberculosis scheme.

80. Two further questions have been considered by your Committee — (i) the question of notifiability and (ii) the question of compulsory removal. As a result of the evidence submitted we are of the opinion that all cases of clinical tuberculosis should be made compulsorily notifiable. With regard to the compulsory removal of the patient from the home it is agreed that it is highly desirable to isolate these infectious cases.

81. Your Committee are deeply concerned with the tuberculosis situation in Northern Ireland, especially with the lack of progress made in many areas in the treatment of the disease from the standpoint of individual and communal welfare, and they recommend that the Government should take immediate steps to ensure a speedy improvement in the measures which can be taken to deal with this most urgent problem. It is a fact that there has been a decrease in the death rate from the disease, but this reduction has been very slow. Your Committee are satisfied that much more could be done by energetic measures to assist local authorities in the carrying out of their various schemes'.

Following consideration of this Report the Northern Ireland Government set up a Health Advisory Council under the chairmanship of Mr Howard Stevenson, a well-known Belfast surgeon — 'to advise the Minister of Health and Local Government upon matters he might refer to them from time to time, to draw his attention to matters which seemed fit for him to consider, and to advise him of the general administration of the Health and Medical Services'.

The better to do this the Council set up a Tuberculosis Committee; they reported in 1946: 'This committee set itself the immediate task of considering the whole question of the attack on tuberculosis as a medical and social problem and of advising the Council on the measures which the Minister ought to be urged to adopt'.

Anxious that there should be no delay in pressing forward with this important work the committee completed its inquiries within three months, with the result that the Council within four months of its establishment was able to present the Minister with a comprehensive recommendation:

'One concentrated attack on tuberculosis is needed and to achieve this a single authority for Northern Ireland is advisable;

Only a unified scheme gives promise of real success;

There should be ample local authority representation on the new body;

500 additional beds for pulmonary tuberculosis should be regarded as the absolute minimum;

While the authority's main duty should be to deal with tuberculosis, it should have power also to treat non-tuberculous chest diseases and non-tuberculous orthopaedic defects;
Prevention and education must have a prominent place in any tuberculosis scheme;
The general care of patients, including their dental treatment, must be thought of in planning their long stay in hospital;
Special provision is urgently needed for cases in which tuberculosis occurs during pregnancy;
The Treatment Allowances Scheme should be extended to include all cases of pulmonary tuberculosis instead of being limited to those in which there is good prospect of early return to fitness’.

On the specific question of prevention the Council was in favour of the following four steps:
‘It should be made possible for a doctor coming across a suspected case of tuberculosis to make a “provisional intimation” before notifying the case finally on diagnosis;
All forms of tuberculosis should be compulsorily notifiable;
There should be power to require contacts of tuberculous patients to submit to medical examination;
There should be power for the Courts to order the removal to hospital of an infectious person’.

The Committee then went on to examine the question of a safe milk supply in the light of modern medical opinion and of the realities of the present position in Northern Ireland. As a result the Council had no difficulty in agreeing on a recommendation in favour of widespread pasteurisation. The Council thought it right to advise the Minister that ‘bovine infection through milk plays a much smaller part in the causation of tuberculosis than is often assumed; the most liberal estimate is ten per cent. Still, that is a serious problem in terms of death, crippling and human suffering’.

As a result of this report the Northern Ireland Tuberculosis Authority was set up. There were to be 17 members on the Authority, four nominated by the Minister of Health, the remaining 13 from the various county and borough councils. There was power to co-opt a further two members. The Authority was similar to schemes in use in Lancashire and Wales, and the Welsh pattern was used for Northern Ireland.

It is only right that those of our Ulster citizens who carried out what was a most formidable task so successfully should not be forgotten (Fig 11). They were (in the first instance):

Alderman Percival Brown, CBE (Chairman)
Alderman D Hall Christie (Vice-Chairman)
Mrs M J Beattie, MBE, JP Mr F S McKinley
Mr W J Black, JP Mr Andrew Millar
Councillor T W Harpur Councillor Samuel Orr, JP
Councillor J Hopkins Mr Alfred Russell, JP
Councillor W Johnston Alderman A Scott, JP
Dr D G Kennedy, JP Professor W J Wilson, MD, DSc
Mr James N Lamont
Fig 11.

SOME EARLY MEMBERS OF THE NORTHERN IRELAND TUBERCULOSIS AUTHORITY

WILLIAM HARVEY (Secretary)
DR BRICE CLARKE (Director of Tuberculosis Services)

SIR PERCIVAL BROWN (Chairman)
ALFRED RUSSELL, JP
ANDREW SCOTT, JP

T W HARPUR
W E G JOHNSTON
PROFESSOR W J WILSON
The Act defined the duties of the newly created Authority:
(a) the accommodation and treatment of patients suffering from tuberculosis, including their general care, their care and maintenance during treatment, their after-care and their industrial rehabilitation.
(b) the discovery of cases of tuberculosis.
(c) the prevention of tuberculosis.
(d) the giving of advice to, and the education of, the public and tuberculosis sufferers, with respect to the best means of preventing and treating the disease.
(e) the initiation of courses of instruction to medical students, doctors and nurses.
(f) the performance of any function transferred to it or vested in it by virtue of the Act.

Their task was indeed a formidable one. Among Northern Ireland’s population of some 1,300,000 there were known to be 14,235 sufferers from tuberculosis. It was certain that the number would increase as improved methods of diagnosis were introduced. The death rate was 85 per 100,000.

The newly formed Authority took stock of their assets. The very comprehensive report of the Select Committee had made the position clear. The standard of patient care available differed widely over the province; in some cases it was adequate, in others there was no more than a county workhouse with a small hospital attached, understaffed and lacking in facilities. On 31 December 1947 they had access to about 1,200 beds. There was a waiting list of some 750. This was a most unsatisfactory state of affairs.

In addition, in Belfast there was a central clinic equipped with both a static X-ray and with a mobile miniature radiography unit. Both the Dungannon and Armagh hospitals had clinics where X-ray facilities were available. There was a particularly well-equipped and active diagnosis unit at the County Hospital Omagh.

The Authority made two appointments which were to prove very valuable to the future well-being of the service. They were Dr R Brice Clarke, Director of Tuberculous Services, and Mr William Harvey, Secretary of the Northern Ireland Tuberculosis Authority.

The Authority looked for more beds. There was an unoccupied hospital in Londonderry, which had been an American naval hospital during the war. This they acquired on loan from the War Department, and re-named it St Columb’s Hospital. It was to provide 156 more beds. They planned to extend Dungannon Hospital to provide 100 beds. The Manor House at Crawfordsburn was purchased with the idea of turning it into a hospital of 80 beds primarily for children. They planned to turn the Orthopaedic Hospital at Greenisland into a modern hospital with 120 beds. They made overtures to secure beds in various other hospitals for the use of tuberculous patients, with such success that by the end of 1948 the number of available beds had gone up to 1,302. They decided to re-name the hospitals which had come into their care to avoid using the terms consumption or tuberculosis in the titles.

To improve efficiency the province was divided into five regions, each with an
experienced doctor to be in administrative charge, to co-ordinate the clinical and hospital services in the area. They then set to work to create more out-patient clinics. These were recognised as being particularly important in the control of tuberculosis, not only as diagnostic centres for new patients, but also to supervise the well-being of those patients who had been discharged from hospital. This was essential since tuberculosis was very liable to recur. In the apparently cured patient the disease might only be quiescent.

It was not enough to diagnose and treat patients with tuberculosis: effective welfare arrangements were essential so that those diagnosed as suffering from tuberculosis could be helped and advised in their own homes, and contacts could be detected and advised to attend the clinic. This was often a very difficult task: the attitude of 'what I don't know won't hurt me' was difficult to overcome. The Authority set up a system of trained health visitors attached to each clinic. Dr Clarke recorded in his Annual Report or 1948: 'The reception which a patient receives when first visiting a tuberculosis clinic may make all the difference to that patient's future co-operation and peace of mind. It is no light thing to attend a clinic for the first time and await a verdict that may jeopardise one's whole future, not only as regards employment but as regards normal home life as well. One learns from the lips of many patients how much a reception by a kind and tactful health visitor may help in the struggle ahead'.

The attendance of the health visitor at the clinic not only served to stimulate their interest and keep them acquainted with methods of diagnosis but the patient was given added confidence to know that the health visitor was familiar with his clinical condition. The health visitor was able to advise on the general hygiene of the home conditions; beds and bedding were supplied on loan; milk and extra nourishment were provided. Many tuberculous patients were found to be sharing beds or bedrooms with other members of the family — in one case a tuberculous mother had four children in bed with her. Chalets were provided so that patients could sleep outside. On occasion it was possible to re-house a family to secure isolation of the sufferer. Home nursing services could be provided and home helps, and when the tuberculous mother had to be admitted to hospital there were resident nurseries available where the children could be looked after.

Apart from the four clinics just mentioned — Belfast, Coleraine, Dungannon and Omagh — 44 other clinics were taken over. Most were quite lacking in any facilities and were often little more than a room rented for the purpose in a private house. New clinics were planned, as often as possible to be in association with a general hospital, which had many advantages. Patients preferred to attend a hospital they were already familiar with, and there was the benefit for the physician in charge of the clinic to have access to all the facilities of a general hospital.

In the report of 1949 there is a record of the work done in the various clinics during the year: Total attendance 54,870; radiological examinations 40,604; surgical procedures 15,900; cases examined for the first time at the clinic, including contacts, 18,000. Dr Clarke reported that 'more than half of the adults in Northern Ireland had been infected with the Tubercle Bacillus. The aim of the physician is to diagnose tubercle at the earliest stage . . . . it is frequently necessary to observe the patient for a period before a definite diagnosis can be
made . . . . it is important that no person is labelled tuberculous without the exercise of the greatest care . . . . this procedure saves many hospital beds and also minimises the social and economic consequences of being labeled tuberculous.

A central laboratory was established in 1947 at Whiteabbey, under the care of Dr L. Violet Reilly. An immense amount of work was required. Not only were all the bacteriological investigations, and all the routine work required of a hospital laboratory, carried out, but the sanatorium laboratory was involved in much more special typing and culture work, and the Whiteabbey laboratory served as a centre for typing and for all the other specialised work required. Investigations necessary on the then new drugs, streptomycin and para-amino-salicylic acid, increased the work load. Laboratories were also established at St Columb’s Hospital in Londonderry, and at the Dungannon Chest Hospital under the care of Dr J H C Johnston.

Dr Reilly wrote in her report on the work carried out in 1958: ‘With the continuing fall in the death rate from tuberculosis it might have been expected that examinations for the detection of the tubercle bacillus would be less numerous, but this has not been the case. In fact the number of examinations of sputum has increased during the past year. Since control of the disease depends to a large extent on the early detection of the infectious case it seems highly desirable that these laboratory examinations should continue to be done if control is to be maintained or improved. The number of patients suffering meningeal and miliary tuberculosis has shown a further decrease’. This volume of work and high standard of care continued over the years.

The Authority had to ensure a proper standard of treatment for tuberculous sufferers all over the province, and they had to provide an adequate number of beds. Dr Clarke pointed out that ‘Canadian experience had shown that there was a definite relationship between the death rate from tuberculosis in a community and the sanatorium accommodation: at least two beds per annual tuberculous death is required. When one takes into account the isolation of the infectious patient, the educational value of sanatorium treatment, the curative resources at present available, and the excellent prospects of better means of therapeutics in the near future, one cannot doubt that additional beds will pay a big dividend to the community’.

In the early stages of tuberculosis patients do not feel ill; perhaps they notice that they are easily tired, but to begin with that is about all the disturbance that the disease produces. By the time that the patient is coughing and producing sputum containing the bacillus the disease is well advanced.

When the Tuberculosis Authority took on their responsibility, Dr Brice Clarke estimated that at least half the adult population in the Province had been infected by tuberculosis, and that there were at least 3,000 undiagnosed active cases. The most important single investigation for detecting an early case was a good quality X-ray of the chest, which could demonstrate an otherwise undetectable lesion.

The Authority found that only four of the hospitals and clinics they had taken over had X-ray equipment, and some of this was obsolete. Their first task was to install new X-ray equipment of the latest type. This they did in the Dungannon Chest Hospital, the Dungannon Clinic, the Armagh Chest Hospital, St Columb’s Hospital
Londonderry, in Coleraine and in Enniskillen. There was a mobile mass radiography unit in Durham Street; they ordered another for Londonderry, and realising how essential such units were they continued to buy more so that by the time the Authority was disbanded in 1959 they had five.

In the first year of operation, 30,000 persons were X-rayed, 164 of whom, hitherto unsuspected, were found to be in the early stages of tuberculosis, and 87 of whom had tubercle bacilli in their sputum. The mobile mass radiography units made it possible for workers in factories, children at school, and their teachers, to be X-rayed with very little disturbance of their activities. It is almost certain that the decline of tuberculosis in Ulster, when it came after the war, was in some part due to the operation of the mobile radiological units.

By 1958 it was clear that the Tuberculosis Authority had accomplished its task. There was now no waiting list and there was a substantial number of empty beds. The final report came in March 1959 when the Tuberculosis Authority's functions were transferred partly to the Hospitals Authority and partly to the local health and welfare committees.

In 1946 20 people were dying each week from tuberculosis and three times as many new cases were occurring. When the Tuberculosis Authority finished its task, only two deaths each week were occurring as a result of tuberculosis.

The report of the Tuberculosis Survey Northern Ireland, 1982 commented on the Tuberculosis Authority: 'The legacy of this remarkable tuberculosis organisation, the creation of which pre-dated the Northern Ireland Health Service, can be seen in the fact that the incidence of tuberculosis in the Province is substantially lower today than in the other areas of the British Isles'.

By 1981 the Eastern Health Board had doubts about the cost-effectiveness of the Mass Radiography Service and on 5 January 1981 decided to seek the opinion of their Chief Administrative Medical Officer, who consulted his colleagues in the other Health and Social Services Boards. They in turn consulted the chest physicians and radiologists. Following this review they decided to terminate the service with effect from 1 December 1983, and to 'mothball' the equipment so that it could be resurrected if it was required.

ADDENDUM TO CHAPTER VII

B R Clarke

Brice Clarke joined the Army in the First World War when he was still a medical student. He came back to Queen's University with a Military Cross, and having had the experience of being a Tank Commander on the Western Front. He qualified with Honours in 1921. After a series of appointments in chest hospitals he became Medical Superintendent in the Forster Green Hospital.

In 1943 he transferred to become Medical Superintendent of the Whiteabbey Chest Hospital and the Greenisland Hospital for Children, shortly afterwards becoming Chief Tuberculosis Officer for Belfast.

With the coming of the Northern Ireland Tuberculosis Authority he became Director of Tuberculosis Services in the province; later consulting physician for
chest diseases and lecturer in tuberculosis at Queen's University. He received the honour of CBE.

He wrote articles on tuberculosis in various journals, and the section on tuberculosis in the 9th edition of Whitla's *Dictionary of Treatment*. In 1952 he published a major work, *Causes and prevention of tuberculosis*. On his retirement he devoted his interests to his garden at Hillsborough where he died in June 1975.

**William Harvey**

William Harvey was appointed as a very young man a clerk in the Borough offices of Newtownards. He rose to become Town Clerk, and was later honoured by being appointed Mayor. While he was Town Clerk the Northern Ireland Tuberculosis Authority appointed him as Secretary, and he retained this office until the Authority gave up its responsibilities in 1959.

He then became Secretary of the Northern Ireland Hospitals Authority, and, when this was reorganised, Chief Executive Officer to the Eastern Health and Social Services Board.

He was also invited to serve on the Senate of Queen's University and in 1959 was awarded the OBE. On his retirement from the Eastern Board he was appointed Honorary Treasurer of the University. On his final retirement from the University he was awarded the degree of Doctor of Literature (*Hon Caus*). He is now living in the south of England.