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THE LOUSE AND THE LAW

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It is now nearly fifty years since the core public health legislation of England and Wales was subject to complete revision. Before too long it is to be expected that the Public Health Act 1936 and the Public Health (London) Act 1936 will be replaced and already thought is being given in diverse quarters as to what the new legislation should contain.

In consequence, those concerned with the control of the three types of human lice have had their minds unusually concentrated on the law, not only as concerns what might be desirable in the future, but also in regard to the current position.

Infection or Infestation?

It fell to the Patents Court recently to attempt the impossible task of deciding whether lice are a pest or a medical problem. The case was an appeal by a pharmaceutical company against the refusal of the Patents Office to grant a patent in respect of an improved head-lice control method, on the grounds that preparations for such a purpose are medicines and the law does not normally permit the patenting of medicines. (Stafford Miller and the Patents Office, 1980).

The ruling was that lice are a pest rather than a disease and that louse control preparations are not medicines and can be patented.

Exactly the opposite point of view is taken by the Committee for the Safety of Medicines, whose ruling is that lousiness is a disease and that curative agents are medicines which under the Medicines Act 1968 require Product and Production Licences and that anyone wishing to test such substances on people requires a Clinical Trials Certificate and that such trials can only be done under qualified medical supervision.

One of the factors taken into consideration by the Patents Court was the fact that the publications of medical entomologists, including my own, almost always referred to “infestations” of lice rather than to “infections”. Having given thought to this I came to the conclusion that lousiness is an ailment with recognisable and consistent symptoms caused by a specific contagious entity and in consequence entitled to the term “infection”, which I have used henceforth. The term “infestation” I now reserve for inanimate materials containing pests and so regard lousy clothing as infested but their owner as infected.

The terminology is unimportant except in that words influence attitudes. The major legislation concerning lice never mentions them, using words such as “verminous” and “unclean”. Not even leprosy is now described as unclean, and it is surely unnecessary now to describe, for example, a perfectly clean child who has been unfortunate enough to contract head lice as a “verminous person in need of cleansing”, instead of as a person with head lice in need of curing. From which it may be inferred that my sympathies are with the Medicines Act rather than the Patents Court, although lice are undoubtedly both a pest and a disease.

The Public Health Acts

Section 85 of the Public Health Act 1936 allows the responsibility for “verminous persons” to be borne by Medical Officers of Health and the Sanitary Inspectors, or, in updated terms, Community Physicians and Environmental Health Officers.

People may be cleansed at their own request or, if known to be verminous, may be cleansed by order of the courts upon application by the appropriate officer, but that is all. This act pays no heed to strategic questions nor to preventive medicine in regard to reinfection.

In practice the Act is also defective in two other respects. It gives permissive powers but fails to impose a duty upon the Community Physician or the Environmental Health Officer. They may cure people of their lice if they wish but they don’t have to. Also, the Act gives no powers of examination and so, unless a person admits to lousiness, all its provisions, including compulsory treatment, must fail for lack of proof of the condition.

Nevertheless the Act can be a powerful means of dealing with those few people who by consistently refusing to co-operate in curative measures place their fellow citizens at risk of contracting lice.

On the initiative of Mr. W.O. Boddy, then Principal Environmental Health Officer for Leeds, suitable amendments to the Public Health Act 1936 were incorporated into Section 49 of the West Yorkshire Act 1980. These allow compulsory examination of a person or his clothing if there is reasonable cause to suspect that they are lousy, with subsequent powers both to offer treatment and to enforce it following application to the courts. This is an important model for other local Acts of Parliament and must be taken into consideration in any re-enactment of the Public Health Acts.

The Education Acts

Local authorities were given powers to deal with lousiness under the Education Acts 1921-1937 and these were consolidated in the Education Act 1944. Section 54 provides for the compulsory inspection of schoolchildren for “vermin” and for treatment to
be provided. Related sections empower a Cleansing Notice to be issued to parents or guardians requiring them to "cleanse" a child. Failure to comply may result in a Cleansing Order whereby compulsory treatment will be enforced and non-co-operation punished by the courts. Not only parents may be fined, for the children over the age of criminal responsibility may themselves be proceeded against. This makes lousiness the only childhood ailment which is in effect illegal, although the actual offence is failure to comply with an order to cease to be lousy.

Section 69 provides for compulsory medical examination, and a medical officer may order exclusion from school pending treatment. A head teacher alone has no powers of exclusion from school for this cause. Health visitors and school nurses have no powers to compel treatment of lice without a legal Cleansing Order being duly served on the parents or, in the case of older children, upon the pupil himself.

Once again the wording of this Act is to the effect that local authorities "may" inspect, although if they do and lice are found they must offer treatment. The choice as to whether or not they inspect in the first place is theirs, and neither parents nor head teachers can requisition inspections.

National Health Service Act 1977

Here firmer mention is made of statutory duties and obligations laid upon the authorities. The Secretary of State must provide inspection and treatment of medical conditions for all children in state schools at appropriate intervals. He is given no choice. Although lousiness is not specifically mentioned it is difficult to believe that with the precedents set by the Education Acts that medical inspections provided under the National Health Service Act could possibly exclude lousiness. (See Burr 1982)1.

By Statutory Instrument the Regional Health Authorities must exercise these functions of inspection and treatment on behalf of the Secretary of State. No discretion is allowed here; the instruction is "must" rather than "may". Consequently, the Regional Health Authorities are not allowed the option of failing to come to terms with the louse problem amongst schoolchildren. The final responsibility rests with them.

National Aspects

Although certain duties of inspection and treatment laid on the Secretary of State are now delegated to Regional Health Authorities, other functions are not and remain directly with the Department of Health and Social Security. They may be collectively thought of as the duty to lead and the duty to guide, but nothing in law defines how this is to be done.

Certainly the Secretary of State can provide no kind of leadership unless he knows what the national position is and what trends are operating. The collection, collation and publication of statistics is a central function. We have a series of statistical reports stretching back into the last century and which are the envy of other countries for they are almost unique. They are of the utmost importance to control workers and parasitologists alike.

Unfortunately the statistics are concerned only with schoolchildren, for they were originally a function of the Education Department. In practice, therefore, they concern only the head louse and we have remarkably little detailed knowledge concerning the other two lice.

These figures have been supplemented by occasional scientific surveys commissioned by the Ministry of Health. The latest of these was by Maddock (1949)2 comparing the head louse situation for the whole population, (not just schoolchildren), with the similar survey by Mellanby (1941)3. Because of the inevitable lag in publication, the periods actually compared were 1938-40 and 1947. Both these surveys showed that the routine figures underestimated the true situation.

Both surveys also showed peak incidence in preschool children and in industrial cities, whereas the present remarkable increase in head lice might have a reduced bias toward the very young (Donaldson 1975)4, and seems to be most obvious in middle-class, suburban and rural areas (Health Trends 1981)5. A new complete survey would be helpful in order to quantify these trends.

The statistics are based on school inspections which must be made by Regional Health Authorities. However, the purpose of head inspections has changed in recent years. Routine inspections are an expensive and inefficient method of louse control, especially in low density infection areas, but an annual inspection is an essential measure of efficiency of control by other methods. Thus the trend is to employ head inspections only for statistical purposes. In this new situation new guidelines are needed on the conduct of statistical surveys for head lice, and of course such national guidance can only come from the central authority vested in the Secretary of State.

The function of national leadership is well exemplified in the matter of training. Many of those
charged with the management and development of louse control came to realise that they knew too little about the fundamental biology of the pests, about the newer control products available and about the theory of modern strategic aspects. In response, the Children’s and Nursing Divisions of the DHSS set up Human Louse Control Management Courses in conjunction with University departments. The Welsh Office took parallel action. These courses have been outstandingly successful, and not only in the United Kingdom, for there have now been participants from every continent.

Present day louse control seeks to replace the main responsibility onto patients or their parents, supported by accurate health education and specially trained advisers. Those unable to respond to their responsibilities to themselves or their children need sympathetic help which it is the duty of Regional Health Authorities to provide. The responsibility for national guidelines, for national statistics and for high level national and international training initiatives lies with the DHSS. The role of the Environmental Health Officers needs to be more clearly defined particularly in view of their changed relationship with local medical services, but their part, especially as regards the clothing louse, is essential.

Those drafting any new legislation concerning human louse control will find that attitudes and practices have changed out of all recognition since 1936, but that although much welcome progress has been achieved all three human lice are still very much with us. Therefore it is desirable that proper and comprehensive consultation is held with knowledgeable and informed sources before any changes are made.

References


