D. Boys and Girls' Camping Committee

1. To arrange campships for a limited number of less fortunate children.

2. To pool and clear on all available camp information.

3. To work toward the future establishment of more adequate permanent camp sites in the Clark County area.

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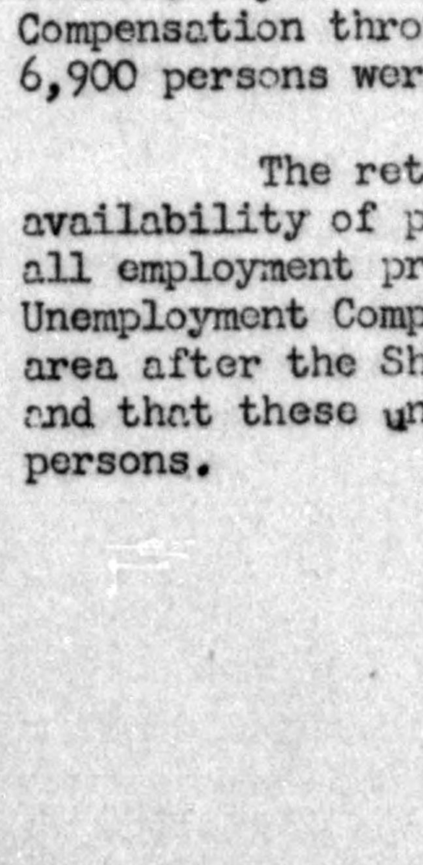
COMMUNITY DEVELOPMENTS -- MAY 1945 to FEBRUARY 1946

Social change in Vancouver has been rapid indeed during the nine months which this report attempts to cover. V.E. Day in May and V.J. Day in August had direct effects upon the population, the employment situation, the funds available for community services, and upon the kind of services needed by children and adults of the community.

A brief review of this period reveals a number of significant developments, which, with their social repercussions, have been a matter of interest to the Child Care Committee:



Employment

The decline in employment at the Kaiser Shipyard, Vancouver's principal industry, has been steady since May 1945. This decline is shown by the following figures:

| Date | Number of Employees |
|---|---|
| May 1, 1945 | 28,500 |
| August 4, 1945 | 24,300 |
| September 20, 1945 | 12,500 |
| February 1, 1946 | 7,825 |
| April 1946 | Yard to be Closed |

After V. J. Day, when Shipyard terminations began at an accelerated rate, harvest and cannery work took up much of the immediate slack. By September, however, jobs for women, for youths under 18 years of age, and for Negro men were scarce. By October 1945, approximately 2,000 persons were drawing Unemployment Compensation through the local U. S. E. S. office, and late in January 1946 about 6,900 persons were receiving such benefits while actively seeking work.

The return to the community of large numbers of veterans and the greater availability of public housing here than elsewhere have contributed to the over-all employment problem. At the end of January, 1200 veterans were drawing Unemployment Compensation. It has been estimated recently that in the Vancouver area after the Shipyard closes there will be at least 9,000 persons unemployed, and that these unemployed will be the breadwinners for 5,000 families or 19,000 persons.

## Schools

School enrollment figures for the Vancouver district are also significant:

| Date | Actual Enrollment |
|---|---|
| May 1945 | 10,300 |
| October 1945 | 9,200 |
| February 1946 | 8,600 (plus 300 kindergarten pupils) |

The decrease indicated by these figures has been less rapid than that anticipated last Spring.

In May 1945 several schools were still on double shift. By Fall, however, the completion of school additions, long awaited, at last made it possible to have single sessions in all buildings.

In January 1946, the Vancouver Public Schools were able to start kindergarten classes for the first time. To date these have been established in seven elementary school buildings, and the plan is to extend the program for five-year-olds in other areas as quickly as possible.

Late in January 1946, the Vancouver Public Schools started their first class for physically handicapped children. Located in Hough School, this class takes children from the Vancouver and outlying districts who are unable to participate in regular classroom work. The Vancouver Kiwanis Club contributed a substantial sum for special equipment for the children to be enrolled.

Another important new educational feature begun locally in January 1946 was the program to assist young veterans in securing their High School diplomas and making up specific work required for college entrance. It is anticipated during 1946 hundreds of former Vancouver students will be sped on their way to the college or vocational work they want to do through this program.

Clark Junior College has also been reopened during this period, with classes offered on a non-tuition basis beginning in January 1946.

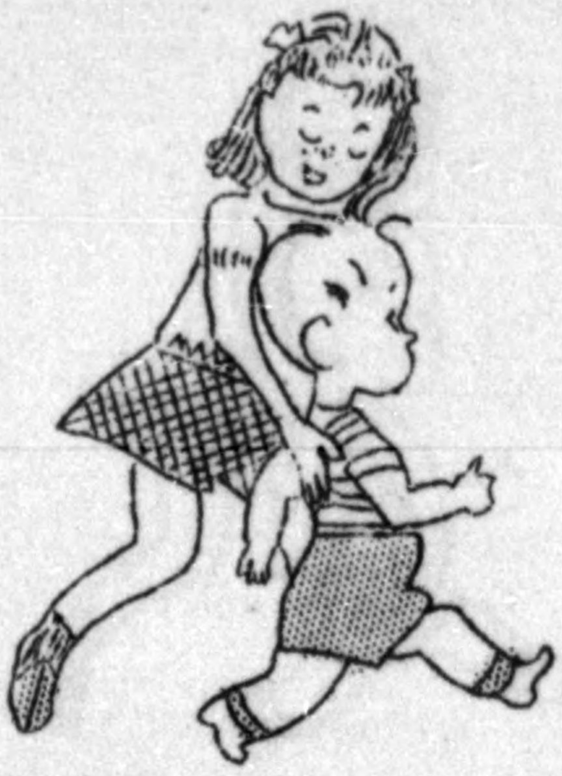
* * * * *

## Guidance Clinic

During the last nine months, an expansion of mental hygiene services has been possible through increased aid from the Community Chest. In October 1945 the Clark County (Child) Guidance Clinic added to its staff a clinical psychologist on a half-time basis. Also, in October the Clinic changed its function to include service to adults as well as children. The Clinic hopes to have more psychiatric time available as soon as more psychiatrists return to the Portland area.

At the present time the Guidance Clinic is faced with a financial problem, since the Vancouver Public Schools will not be able to contribute the salary for a half-time Executive Secretary for the Clinic during the 1946-47 school year as they have done during the last two years.

## Child Service Centers



The need for group care of children has of course shifted as the pressure for women in industry has slackened. At the same time surveys have shown that a certain number of mothers must continue to work to support their families, and that there will therefore be a continued need for a stable program of child care in the community

The trend in enrollment in the Child Service Centers is indicated by the following figures:

| Date | Enrollment | No. of Centers |
|---|---|---|
| June 1945 | 1206 | 8 |
| October 1945 | 500 | 5 |
| November 1945 | 400 | 5 |
| February 1946 | 255 | 5 |

After March 1, 1946 there will be three Child Service Centers in operation -- all located in the Housing Projects. Since Federal funds terminate on February 28, 1946, the plan is for the Public Schools to operate the centers with increased State aid and parents' fees. The three centers will be open to all children without being limited to those whose mothers are employed.

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## Child Welfare

Over this period the County Welfare Department reports an increase in the number of mothers with dependent children who are applying for financial aid to maintain their own homes, and a decrease in the number of requests for foster home care for children while mothers work.

Monthly assistance grants of Aid to Dependent Children in Clark County have been as follows:

| Date | Number of Families | Number of Children |
|---|---|---|
| May 1945 | 54 | 115 |
| September 1945 | 64 | 149 |
| January 1946 | 87 | 221 |

Another public child welfare program is that of individualized casework service to children who have personality or behavior difficulties, or who are in need of protection, or who are dependent, or in need of foster home care. The County Welfare Department reports the following numbers of children receiving this type of service in Clark County.

| Date | Total Children | Under Supervision in Foster Hom |
|---|---|---|
| May 1945 | 658 | 170 |
| September 1945 | 514 | 176 |
| January 1946 | 446 | 168 |

## U. S. O. - Travelers Aid Service

On October 1, 1945 one of the community's most helpful wartime agencies, the U. S. O. - Travelers Aid Service, closed its Vancouver unit due to what was felt to be a declining need for its services. This casework agency opened in Vancouver in August 1943 principally to serve newcomers to the area.

* * * * *

## Detention Facilities

Construction was started in June 1945 on the County's new home where children may be detained while awaiting disposition of their cases by the Juvenile Court. Located at 11th and Esther Streets in Vancouver, the building will accommodate as many as 12 boys and 7 girls. It will be ready for use sometime in March 1946.

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## Public Recreation

In the last nine months Vancouver has witnessed a number of changes in its recreation picture. The threatened termination of Federal funds for the public program became a reality on December 31, 1945. Curtailment of children's recreation was begun as soon as the summer playground program ended, and it has been fortunate that children can now be in school for longer hours than they were during the war period. In December, the Community Chest granted the Greater Vancouver Recreation Association enough additional funds to carry most essential parts of the youth program through May 31, 1946. Supervision of the Trapedero Club and Teen Canteen, dancing and boxing, and teen-age basketball leagues is thus assured till June.

During this same period adult recreation took an upswing as a result of the building improvements made by the School Board at Memorial Hall. Adult education funds from the State and fees from participants have helped to set the adult arts and craft center, woodworking classes, and a civic band in operation.

In September 1945 the Vancouver School Board agreed to accept responsibility on a continuing basis for operation of the public recreation program -- within the limits of the funds available to it. (In the Summer of 1945 many civic groups had signed petitions asking the School Board to accept this responsibility.) Plans now need to be made for setting up a year-round budget for the public recreation program, and for securing the necessary public and private funds to support it.

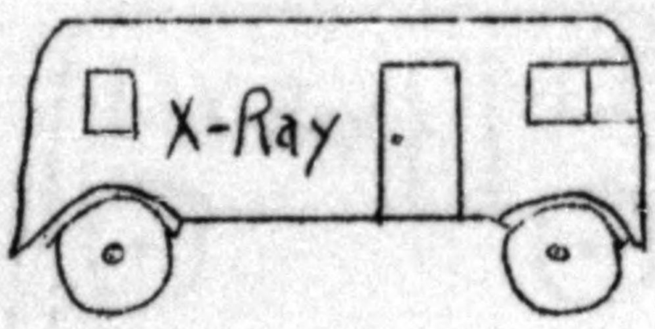
During the Fall and Winter months, much thinking and planning have been done on the matter of creating a Living War Memorial of the community recreation center -- type for Vancouver. Planning on this has not yet been put into action.

## Private Youth Serving Agencies

Both Boy Scouts and Girl Scouts have recently employed full-time executives with offices in Vancouver to serve this area. This marks a real forward step in these two youth programs.

Since the Summer of 1945, also, there has been considerable thinking and planning done in the direction of establishing both a Y.M.C.A. and a Y.W.C.A. in Vancouver.

## Health




The acquisition of a mobile X-ray unit for tuberculosis case-finding work represents a forward step in Clark County's public health program. The unit was purchased by the Clark County Tuberculosis League, and was turned over to the County-City Health Department for operation in June 1945.

The Well-Baby Clinic, under the auspices of the Health Department, reopened in November 1945 at the Downtown Clinic in the Kirch Building. This clinic is held on alternate Fridays for all infants and pre-school children who are not regularly attended by a private physician for well-baby care.

With the beginning of the 1945-46 school year, the Health Department also intensified its program of school health examinations throughout the county. Teachers and nurses now work together to determine which children need to be examined by the physician.

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## THE COMMITTEES AT WORK -- MAY 1945 to FEBRUARY 1946

### A. On Inter-Agency Coordination and Planning

The values inherent in the existence and active functioning of these committees are more difficult to describe than are their specific activities. These less tangible values are nevertheless very real. The Committees themselves, we believe, have provided helpful channels for groups and organizations which might not otherwise have gotten together to do so, in considering and working on their common interest - the needs of children. Being able to come together on the "neutral" ground of a Committee sponsored by no single operating agency has in itself been helpful.

Through reports made in meetings, or given between meetings to the secretary, members representing a wide variety of organizations and agencies have been able:

1. To pool information on developments as to children's needs and available resources for meeting them.
2. To study ways of taking care of unmet needs.
3. To refer problems to the suitable organizations and agencies.
4. To use their combined influence upon occasion to secure needed action.

Throughout the nine months' period which this review covers, the Child Care Committee and its sub-committees have received regular reports on the various agency programs, including those of:

| | |
|---|---|
| Child Service Centers | Greater Vancouver Recreation Assn. |
| Guidance Clinic | U. S. O. - Travelers Aid Service |
| County Welfare Department | Washington Children's Home Society |
| County-City Health Department | U. S. Employment Service |
| Vancouver Public Schools | Farm Labor Office |
| Visiting Teacher Service | Department of Labor and Industry |
| Juvenile Court | Agricultural Extension Service |
| Probation Department | Boy Scouts |
| Sheriff's Office | Girl Scouts |
| Police Department | Campfire Girls |
| Teen-Age Clubs | Council of Churches |

The Committees have maintained a continued interest in the programs of all these agencies, and have stood ready to assist whenever their help was needed.

In addition to the more general coordinating work suggested above, the Committees have done the following specific pieces of inter-agency work during the last nine months:

1. Presented the need for a Social Service Exchange as a part of the Community Council plan. - September 1945 to date.

2. Formed a "campship bureau" through which organized groups could assist less fortunate children in attending camp - May to August 1945

3. Pointed up the need for setting up a clearance system next year on Christmas giving by organizations to families in need. - December 1945.

B. <u>On Child Care (Group and Individual) and Case-work Services to Individual Children</u>

1. Through the Foster Care Committee, assisted in the interpretation of children's needs and the requirements of the foster boarding home programs of Clark County Welfare Department and Washington Children's Home Society.

(a) Sponsored a Mothers' Day dessert luncheon in honor of foster mothers - May 1945.

(b) Aroused interest of many women's organizations in providing a small stock of clean, used clothing in a range of sizes for emergency wear by children coming to the County Welfare Department for foster home care - June 1945 to January 1946.

(c) Aroused interest of similar groups in providing a small supply of toys and play materials to be given to children needing emergency foster home care - October 1945 to January 1946.

(d) In Committee meetings had talks and participated in discussions on "Foster Home Finding", "The Problems of Unmarried Mothers and Their Babies" , and "The Group Care of Children" - November, December 1945 and January 1946.

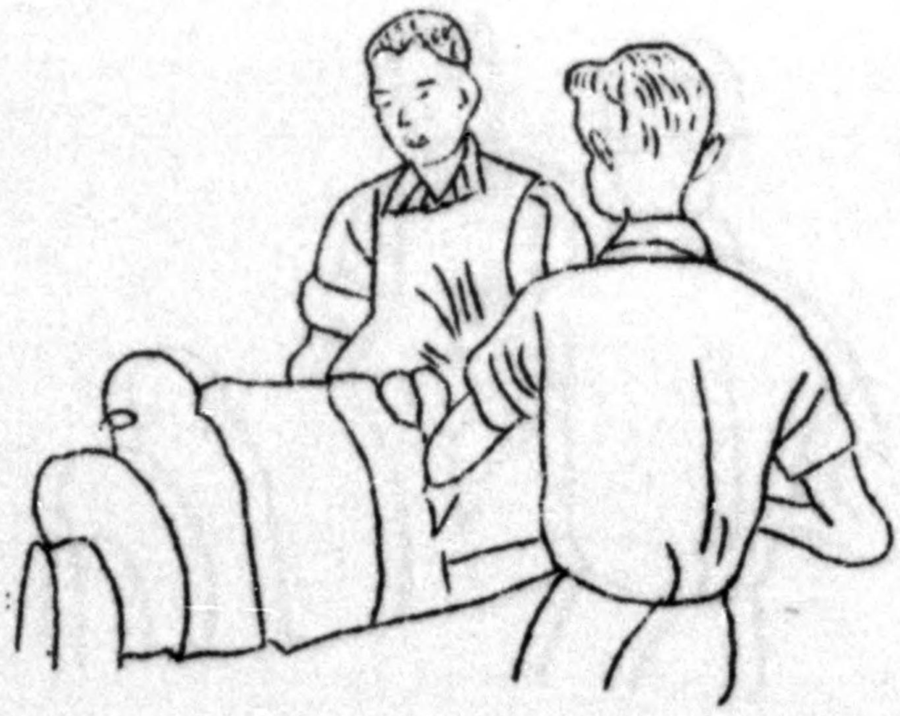
(e) Placed classified advertisements in Vancouver, Camas, Washougal, and Ridgefield newspapers seeking additional foster boarding homes for Clark County Welfare Department and Washington Children's Home Society - November and December 1945.

2. Sent telegrams and letters to Washington Congressmen and to the House and Senate Appropriations Committees informing them that war worker needs were not diminishing here, and urging passage of full Federal Works Agency appropriation to continue funds for child care and other educational programs - May 1945.

3. Sent letters to Washington Congressmen and to the Senate Committee on Education and Labor urging re-enactment of the Lanham Act - June 1945.

4. Sent telegram to President Truman, and letters to Washington Congressmen urging continuation of Federal funds for child care services beyond October 1945, and through the reconversion period; advising them that State and local funds were inadequate, and that many young mothers and service wives must continue working and would therefore need care for their children - August 1945.

C. <u>On Education</u>



1. Recommended to the Legislative Interim Committee for the Investigation of Juvenile Delinquency that State aid be provided to encourage local school districts to maintain adequate programs of vocational education - July 1945. (Juvenile Protection)

2. Recommended also to the Legislative Interim Committee for the Investigation of Juvenile Delinquency that further consideration be given to raising the compulsory school attendance age in the State (if possible to 18 years or high school graduation) with continuation school classes provided to make part-time work possible for older boys and girls - July 1945. (Juvenile Protection)

3. Sponsored a community-wide Back-to-School campaign to call the attention of teen-agers to the values of returning to school - September 1945. (Juvenile Protection)

(a) Secured the cooperation of the press and radio, the Chamber of Commerce and Vancouver merchants, the Central Labor Council and its member unions, the schools, churches, and P.T.A.'s in planning and putting this campaign into action.

(b) Placed "Back-to-School" posters in offices and store windows, and placards on the outside of city busses.

(c) Sent "Fact Sheets" to a broad mailing list of employers and other interested citizens.

(d) Provided material on the advantages of returning to school for newspaper editorials and radio broadcasts.

4. Sent letters to Washington Congressmen and to the House Committee on Education in support of the bill pending in Congress which would provide grants-in-aid to the States for vocational education purposes - December 1945. (Juvenile Protection)

D. On Health

1. Recommended to the Legislative Interim Committee for the Investigation of Juvenile Delinquency that it give all possible encouragement to further the development of mental health clinics under public auspices in the State of Washington - July 1945. (Juvenile Protection)

2. Sent letters to Washington Senators and to the Senate Committee on Education and Labor in support of the National Mental Health Bill, which would provide grants-in-aid to States for extension of mental health work in local communities - December 1945 and February 1946.

E. On Employment of Children and Youth

1. Expressed interest in having a Job Counseling and Placement Service for Youth established in the community - May 1945. (Juvenile Protection)

2. Recommended to the Legislative Interim Committee for the Investigation of Juvenile Delinquency that action be taken to clarify and strengthen State laws regulating the employment of minors and to centralize the issuance of work permits in a single agency - July 1945. (Juvenile Protection)

3. Studied and made recommendations upon the "New Order for the Regulation of the Employment of Minors" under consideration by the State Industrial Welfare Committee - October 1945. (Juvenile Protection)


(a) Recommended that children working in street trades be clearly and fully covered under the work permit system; that boys under 14 and girls under 18 years of age not be permitted to work in street trades, except that boys 12 years of age and over be permitted "to distribute printed matter on regularly established routes in residential districts."

(b) Recommended that the Department of Labor and Industry require the signature of a school official on the

application for a work permit received from a minor who is either in or out of school.

(c) Recommended that a school health statement accompany each minor's application for a work permit, along with proof of age and the necessary signatures.

(d) Recommended that the combined hours of work and school for minors not exceed a total of 8 per day.

(e) Commented that, although 16 years is the desired minimum age for employment for both boys and girls, it would be unwise to raise the age for boys covered by Labor and Industry Orders from 14 to 16 years, so long as the Courts are empowered to issue permits for children as young as 12 years of age.

(f) Recommended that the proposal to prohibit both boys and girls under 18 years of age from employment in bowling alleys be included in the final Order.

4. Encouraged local schools, police and probation departments to have representation at the State Industrial Welfare Committee's public hearings in Olympia - September 1945. (Juvenile Protection)

5. Sent letters to Washington Congressmen in support of amendments to the child labor provisions of the amendments to the Fair Labor Standards Act (to directly prohibit employers in interstate commerce from employing oppressive child labor) - February 1946.

F. <u>On Delinquency Prevention and Treatment of Children in Trouble</u>

1. Made a report to the Legislative Interim Committee for the Investigation of Juvenile Delinquency, and presented it at the public hearing held in Vancouver. Made the following specific recommendations (in addition to those mentioned elsewhere in this report under Education, Health, Recreation, and State-wide Planning - July 1945. (Juvenile Protection)

(a) Recommended that the present Juvenile Court Law be reviewed along with other Laws of the State affecting children, and that consideration be given to making revisions to bring all such Statutes into line with present day needs and at the same time into better relation with one another.

(b) Recommended that consideration be given to encouraging the establishment of certain new facilities for treating and caring for children who are in difficulty or potentially in difficulty. (Facilities suggested were parental schools in various parts of the State, and one small psychiatric treatment center for emotionally disturbed children.)

(c) Recommended that consideration be given to improving and making more adequate the present State institutional facilities for training and rehabilitation -- through providing adequate funds, buildings and equipment; making use of rehabilitation resources such as forestry work; and securing qualified personnel to work within the institutions and in the field on follow-up or parole work. (Institutions referred to were: the Boys and

Girls Training Schools, Custodial Schools, and the State Reformatory.)

2. Recommended to the Interim Committee that it return to Vancouver for further hearings in the Spring of 1946. - September 1945. (Juvenile Protection)

(3) Reviewed the Detention Home budget as presented to the County Commissioners - September 1945. (Juvenile Protection)

(4) Sponsored a prevue of the March of Time film "Teen-Age Girls" - September 1945 (Juvenile Protection)

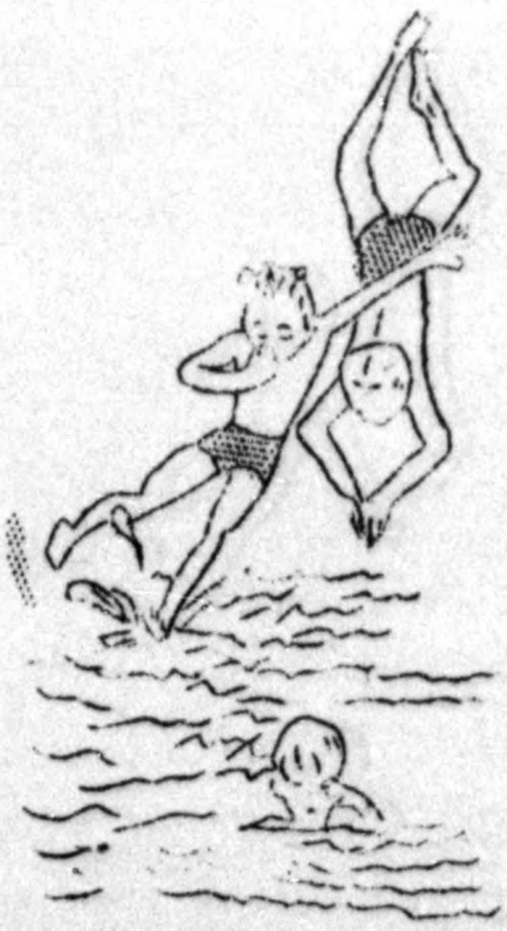
(5) Held a "round-table" discussion on the situation of teen-age unrest which seemed to be growing as jobs became harder to find.(Continuation and strengthening of recreation services and expansion of the vocational training program were recommended informally as remedial measures) - December 1945 (Juvenile Protection)

(6) Presented the need for more adequate street lighting around Memorial Hall to the City Commission, and urged immediate installation of lights there - January 1946. (Juvenile Protection)

G. <u>On Recreation and Leisure-Time Programs</u>

1. Through the Boys and Girls' Camping Committee, channeled community interest in improving summer camp facilities and in helping a few boys and girls, who would otherwise be unable to do so, to attend camp -- May through August 1945.

(a) Gathered information about camps in Washington and Oregon which would be open to Clark County children.



(b) Advised local organizations of the special needs of a number of boys and girls; received campship contributions from the American Legion, the Elks Lodge, Gyro Club, Kiwanis Club, Junior Chamber of Commerce, Rotary Club, Soroptimist Club, and the Vancouver Council of Churches.

(c) With the funds received, sent 19 boys and girls to summer camps.

(d) Urged County Commissioners in preparing the 1946 County Budget to investigate all possibilities of improving the Lewisville camp site; offered Committee's help to Commissioners in securing the most-needed improvements (a safe running water supply, and additional latrines in scattered locations).

2. Sent representatives to the public meeting called by the Greater Vancouver Recreation Commission to settle the question: "Who will administer the community's public recreation program on a continuing basis?" - May 1945.

3. Signed petition, circulated by Greater Vancouver Recreation Commission,

asking Vancouver School Board to accept continuing responsibility for the public recreation program - June 1945.

4. Sent letters to Washington Congressmen and to the Senate Committee on Education and Labor urging re-enactment of the Lanham Act to meet the continued need for financing community recreation facilities - June 1945.

5. Recommended to the Legislative Interim Committee for the Investigation of Juvenile Delinquency that the Legislature provide State financial aid on a continuing and more fully adequate basis for the operation of community recreation programs - July 1945. (Juvenile Protection)

6. Expressed concern over the future financing of the public recreation program on a local basis; appointed a committee to stand ready to assist the Greater Vancouver Recreation Commission - October 1945 to date.

7. Reviewed plans for City Park expansion and for establishment of a City Park Board - November 1945. (Juvenile Protection)

8. Endorsed the Youth Builders organization and its efforts to secure improved recreational facilities for youth - May 1945. (Juvenile Protection)

9. Reviewed with interest the developments toward establishment of Y.M.C.A. and Y.W.C.A. programs in the community - June 1945 to date.

H. <u>On Coordinated Public Interpretation of Community Services Available; Publicity on Committee Activities</u>

1. Prepared and distributed an "Annual Report of Activities" for the period April 1944 to April 1945.

2. Requested and received an annual allotment of $480.00 from the Vancouver Community Chest for use in giving coordinated interpretation and publicity to all of the community's programs for children.

3. With these funds prepared and distributed a printed "Directory of Community Services in the Vancouver Area." - February 1946.

4. Distributed mimeographed minutes of all committee meetings to a mailing list of approximately 125 persons.

5. Prepared news stories and posters for use in Community Chest campaign. September 1945.

6. Released news stories on regular Committee meetings.

7, See section on <u>Child Care</u> for foster home publicity, and section on <u>Education</u> with regard to publicity and interpretation done in the Back-to-School campaign.

I. On State-wide Planning

1. Recommended to the Legislative Interim Committee for the Investigation of Juvenile Delinquency that consideration be given to re-establishing an official State Committee, with adequate professional staff, (a) to carry out State-wide functions of study, planning and coordination of services to children and youth, and (b) through State staff and local professional personnel to encourage a similar approach to problems on the part of local communities. - July 1945 (Juvenile Protection)

J. On the Vancouver Community Council Plan

1. Contributed the Section on "Community Welfare Services" for the VANCOUVER CITY PLANNING COMMISSION REPORT - May 1945.
This included:

(a) Statements as to the services rendered by the eight social agencies of the community.

(b) Facts about private fund-raising through the Community Chest.

(c) Information about study and planning for community welfare

(d) A statement of unmet needs requiring future attention. These included among others:

(1) Study and planning to consider the need for the formation of a Council of Community Agencies, made up of citizen representatives and official members from public and private agencies in the fields of family and child welfare, health, education, recreation, housing, employment and other related activities.

(2) The development of a more adequate Social Service Exchange registration and clearance to the end that an improved quality of service may be given to individuals and families by all agencies of the community.

(3) The integration of new or special programs for service and assistance to veterans with those of the existing social agencies.

2. Following up on interest in the above report expressed by several Community Chest Board members, appointed a Study Committee (see page 6) to explore the need for and possibilities of a Community Council for the Vancouver area - June 1945.

3. Received report of the Study Committee which after agreeing upon the need for a Community Council, was considering methods of sponsorship, including:

(a) The Community Chest

(b) Local government (city-county)

(c) Community Chest and local government as joint sponsors.

Recommend further study - August 1945.

4. Arranged for Mr. Guy Thompson, Pacific Area Representative of Community Chests and Councils, Inc. to come to Vancouver to meet with the Study Committee and to speak at a public meeting on the work of Community Councils -- September 1945.

5. Invited the Community Chest to appoint representatives from its Board to work further with the Study Committee - September 1945.

6. Accepted the final report of the Study Committee which then recommended appointment of another committee to meet with representatives of the Community Chest to devise a concrete plan for organization and financing of a Council, and for presenting and interpreting such plan to the organizations and agencies which might be interested in participating in the Council - October 1945.

7. Appointed the Community Council Planning Committee (see page 6)

A group of five from this committee met with the Community Chest Board for preliminary consideration of plans. The Chest Board endorsed the Council idea in principle asking the Planning Committee to continue its work - November 1945.

8. Planning Committee made a written report of the proposed plan and submitted it with an explanatory letter to approximately 60 community organizations and agencies in the Greater Vancouver Area; asked opinions and endorsements of the plan in principle - December 1945.

9. Planning Committee reported that there was much interest in the plan, but that the problem of finance was unsolved. The Community Chest, which could not completely finance the Council in 1946, suggested seeking support of City and County government to make the Council a joint project. Planning Committee then presented Plan (see following pages) to City and County Commissioners - January 1946.

10. Central Child Care Committee went on record recommending that the long range-goal should be for complete financial sponsorship of a Community Council to be assumed by the Community Chest - January 1946.

11. Central Child Care Committee clarified its own aims in regard to the Council, stating that it would expect to go out of existence as the Council took over its broader functions - January 1946.

12. Representatives of the Planning Committee met with the City Commissioners and the chairman of the Community Chest for joint discussion of the plan -- February 1946.

13. Learned from both County and City that they were legally unable to make a direct contribution to support of a Council of this kind. - February 1946.

14. Members of the Planning Committee participated in a discussion of the Council Plan at the Annual Meeting of the Community Chest - February 1946.

In the following four pages the most recent statement of the Vancouver Community Council Plan is given:

# VANCOUVER COMMUNITY COUNCIL PLAN

January 29, 1946

## Purpose of a Community Council

1. To promote the general welfare of the community by serving as a clearing-house and central coordinating body in health, welfare, recreation and other related fields of community service.

2. To prevent duplication of effort in these fields.

3. To locate unmet needs.

4. To help in the adjustment of existing services to meet changing conditions.

## What a Community Council Would Do in the Vancouver Area

1. Serve as a continuous fact-finding body about the community and its people, providing information, when desired, for the Community Chest, City Commission, and Board of County Commissioners.

Example: Population and employment trends
Statistics on services of the various agencies
Disease rates
Extent of crime and delinquency

2. Make joint studies on specific problems.

Example: Problem of teen-agers out of work and out of school.

3. Provide a "neutral" meeting ground for bringing together representatives of the various agencies in a particular field to develop mutual understanding and better working relationships.

Example: Meetings at which each group work or recreation agency explains its program and plans -- to help them reach agreements as to use of facilities or to determine "who does what."

4. Serve as a clearinghouse among all the agencies and civic organizations on new developments, changes in plans and programs, etcetera

Example: Regular meetings serving purpose similar to that of the Central Child Care Committee during recent years.

5. Operate certain common services.

Example: Campship bureau
Clearinghouse on Christmas-giving
Social Service Exchange

6. Help to keep the public informed on a year-round basis about the services offered by the various agencies, and about problems needing attention in the community at a given time.

Example: Directory of community services
Newspaper publicity

7. Provide a means whereby representatives of agencies and citizen groups could take joint action to bring about improvements in social conditions or in the community programs for health, welfare, recreation and related services.

Example: Support of Federal and State legislation on matters such as child labor, mental health, vocational education, recreation.

Support of local measures such as those which would encourage continuation of an adequate recreation program.

It is to be understood that this kind of organization carries out its work through methods of education, and voluntary cooperation, and that it has no administrative authority over any agency or organization in the community. It runs no programs itself with the possible exception of those"common services" suggested in(5) above.

Membership

In the Council as a whole there should be representatives from:

(1) Organized groups which have an interest in one or more fields of community service (e.g. Rotary Club, Chamber of Commerce, Central Labor Council, American Legion, P. T. A., etcetera.)

(2) Public and private agencies working in the fields of health, welfare, recreation, education, housing, employment, etcetera.

Organization and Finance

These recommendations are made with regard to organization and finance although much more detailed planning still needs to be done if the Council plan is to be put into action.

(1) The Community Council should be closely related to the Community Chest.

(2) The Secretary of the Community Council should, if possible, serve also as Secretary of the Community Chest, carrying in addition to other duties responsibility for the executive work of the Chest drive.

(3) Since the Community Chest cannot entirely finance the Council, plans should be worked out for a sharing of responsibility for support from City and County as well as from Community Chest funds.

(4) The Council itself (a "delegate body" representative of many organizations and agencies) should have a good deal of autonomy.

(5) The executive secretary of the Council should be selected, according to the personnel standards set up, by a joint Personnel Committee composed of representatives of the Community Chest Board, the City and County Commissions, and the Council's Executive Committee.

(6) The Council as a whole should probably meet bi-monthly or quarterly, with the Executive Committee meeting more frequently. Officers should be elected from the Council membership.

(7) The Council as a whole should be broken down into sections according to special fields of interest such as group work or recreation, health, family and child welfare. These sections would necessarily be more active than would the Council as a whole.

## Staff

To function effectively the Council, or the Chest and Council together, should employ an executive secretary on a full-time basis and should give that person necessary clerical assistance. The executive secretary should have a professional knowledge of community organization methods and should be qualified in both the money-raising and social planning fields.

## Expenses Involved

The following are the estimated annual expenses necessary to provide adequately for the staff, housing, and operation of a Community Chest and Council organization, including year-round publicity and campaign expenses:

| | | | |
|---|---|---|---|
| SALARIES | Executive Secretary @ $275.00 per month | $3300.00 | |
| | Office Secretary @ $150.00 per month (bookkeeper, stenographer, receptionist) | 1800.00 | |
| | Extra Help in Office during Campaign @ $150.00 | 300.00 | $5400.00 |
| TRAVEL | Travel and Out-of-Town Meetings | 300.00 | 300.00 |
| OFFICE | Rent @ $35.00 per month | 420.00 | |
| | Telephone and Telegraph | 120.00 | |
| | Stationery, Mimeograph and Office Supplies | 100.00 | |
| | Postage | 150.00 | 790.00 |
| INTERPRETATION | Printing | 300.00 | 300.00 |
| AFFILIATION | Membership in Community Chests & Councils, Inc. (@ .0025 of local Chest budget) | 100.00 | 100.00 |
| | Total | | $6890.00 |

(The above expenses do not include the capital outlay required for setting up an office the first year.)

Reasons for Seeking Public Support for the Council

In terms of both interest and finance, the support of an organization of this kind should be a community project. Since in this county a large share of the direct services which this Council will help to coordinate are paid for from public funds (e. g. health, welfare, recreation, and education), it seems only logical that a part of the cost for this auxiliary, expediting service should also be borne at public expense.

During the war, it has been largely public funds which have supported a similar organization, the Clark County Child Care Committee. In 1945 approximately $4250.00 was contributed toward the Child Care Committee's $4765.00 budget by the County Welfare Department, and $35.00 plus office space and telephone by the Office of Civilian Defense.

The Community chest has shared in support of the Child Care Committee to the extent of $480.00 per year. To make the Community Council plan possible the Community Chest is willing to contribute a good deal more than it has put into the Child Care Committee, particularly if the joint plan is adopted.

From the survey of opinion of many civic groups and agencies, it has been found that a Community Council on a permanent basis is a much-needed organization in this area. Without contributions from the City and County, as well as the Vancouver Community Chest, it will be impossible to finance such a Council on a sound basis during the present year. This need is considered to be sufficiently urgent to constitute an emergency "in the interest of the general welfare."

COMMUNITY COUNCIL STUDY AND PLANNING COMMITTEES

| | | |
|---|---|---|
| V. B. Anderson | Henry DeYoung | Dr. S. P. Lehman |
| Miss Elizabeth T. Bannister | Dr. Paul F. Gaiser | George B. Lloyd |
| Joe P. Brockel | Mrs. Oscar L. Hanson | Mrs. C. E. Loan |
| Mrs. Edith Allen Brown | Carl T. Heins | R. R. Mikesell |
| Mrs. Sarah V. Case | John A. Hungate | E. R. Sensenbrenner |

Eva Santee
(Miss) Eva Santee, Chairman

ES:ef

## THE CHILD CARE COMMITTEE LOOKS TO THE FUTURE

With reconversion under way nationally and locally, a major concern of the Child Care Committee is that the values gained in wartime in our community be conserved for peacetime utilization. Under pressure of war problems the Vancouver area geared itself to meet the needs of children as best it could with the resources it had -- in funds, facilities, and personnel. New programs were set up, and old services were altered and expanded as necessary.

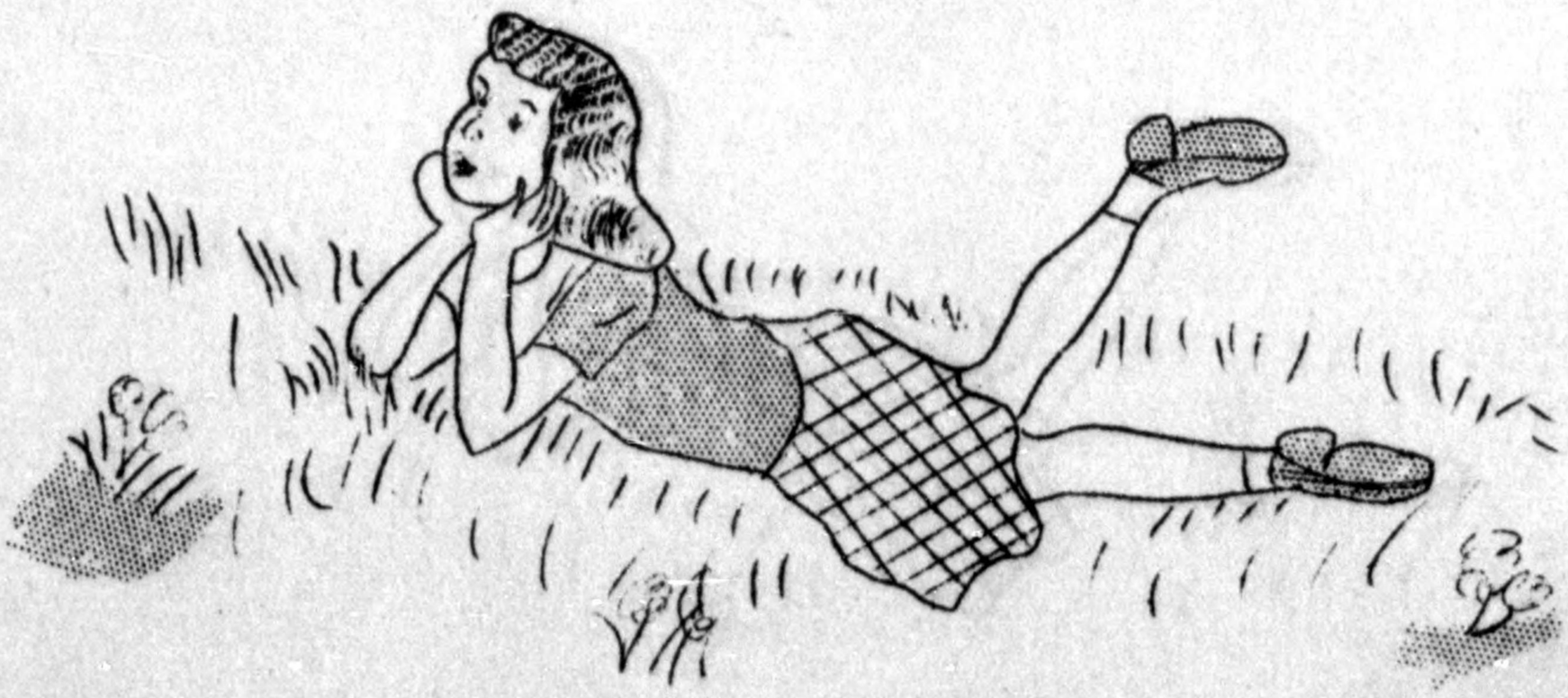
Also under war pressures, a pattern was developed among agencies and citizen groups for working, thinking and planning together to meet children's needs. This has proved to be a helpful pattern, and the Child Care Committee, in encouraging formation of a broader Community Council, has hoped that it may be carried on beyond the beginnings which the Child Care Committee itself has made.

Today many of the agencies are in the process of evaluating their wartime services in the light of changing needs and reduced funds. Taking stock in this way is important, for there are still neglected spots in our social picture and, too, there may be aspects of existing programs which have outlived their usefulness.

As indicated on the first page of this Report, the Child Care Committee has spent considerable time and effort during the last eight months in trying to "work itself out of a job." If a Community Council is formed, the Child Care Committee as such will no longer be needed.

Now, however, immediate financing for the Council plan is doubtful. The Child Care Committee is therefore proceeding into a reconversion period of its own -- to continue as an independent voluntary organization, until such time as a Council can be established on a sound basis.

Is an organization like the Child Care Committee -- or a Section on Children of a Community Council -- still needed in Vandouver now that the war is over? We believe that it is -- to develop community awareness of children's needs; to keep alert to the effects of social change upon the children of the community; to foresee problems before they become acute; to see to it that new needs are met without delay; and to encourage efforts throughout the community which will help to prepare children for rich, purposeful and creative living.



A3

# SUMMARY OF QUARANTINE REGULATIONS

This pamphlet contains a summary of important points in the Ohio Quarantine Regulations concerning common communicable diseases. Full details can be found in the complete regulations.

Children are affected by quarantine more than any other large group. As a general rule, except in smallpox, adult contact wage earners are permitted to work unless they are food handlers, beauty parlor operators, barbers, or come in contact with groups of children.

CARL A. WILZBACH, M. D.
Commissioner of Health.

# IMPORTANT RULES GOVERNING THE CONTROL OF COMMUNICABLE DISEASES

**All children who have been quarantined must present release cards from the Health Department before being re-admitted to school.**
**Exposure of a contact ceases after release of quarantine or change of address.**
**Immunity is established by certificate of a physician or a health department record.**

| DISEASE | PATIENT RELEASED FROM QUARANTINE | SUSCEPTIBLE CONTACTS MAY RE-ENTER SCHOOL | IMMUNE CONTACTS MAY RE-ENTER SCHOOL | PATIENT MAY RETURN TO SCHOOL. | USUAL INCUBATION PERIOD |
|---|---|---|---|---|---|
| CHICKENPOX | When recovery is complete and all scabs have disappeared. | On release of quarantine. | With certificate from a physician that they have had chickenpox. | On release of quarantine. | 14-21 days |
| DIPHTHERIA | Recovery and 2 successive negative nose and throat cultures. First release culture not to be taken before 9th day of disease. | Negative cultures after exposure ceases. | Negative cultures after exposure ceases. | On release of quarantine. | 2-7 days |
| GERMAN MEASLES | When recovery is complete; at least 7 days after onset. | 14 days after release of quarantine or change of address. | May attend with certificate of immunity from physician. | On release of quarantine. | 14-21 days |
| MEASLES | When recovery is complete; at least 7 days after onset. | 14 days after release of quarantine or change of address. | May attend with certificate of immunity from physician. | On release of quarantine. | 12-14 days |
| MENINGOCOCCUS MENINGITIS | When recovery is complete; at least 14 days after onset. | On release of quarantine or 14 days after exposure ceases | On release of quarantine or 14 days after exposure ceases. | On release of quarantine. | 2-14 days |
| MUMPS | On disappearance of swelling. | Under observation. | Under observation. | On release of quarantine. | 12-26 days |
| POLIOMYELITIS (Infantile Paralysis) | When recovery from acute manifestation is complete; at least 3 weeks after onset. | 21 days after release of quarantine or change of address. | 21 days after release of quarantine or change of address. | On release of quarantine. | 7-14 days |
| SCARLET FEVER | When recovery is complete, desquamation has ceased, and any discharge from ears has ceased; at least 21 days after onset. | On release of quarantine or 7 days after change of address. | On release of quarantine or change of address, and with a certificate of immunity from a physician. | On release of quarantine. | 2-7 days |
| SMALLPOX | When recovery is complete and desquamation has ceased. | 17 days after release of quarantine, or vaccination within 4 days after exposure and change of residence. | When exposure ceases. Immunity to depend upon previous recovery from the disease or successful vaccination within 5 years. | On release of quarantine. | 8-16 days |
| WHOOPING COUGH | At least 14 days from development of characteristic cough. | 14 days after release of quarantine or change of address. | With certificate from a physician that they have had whooping cough. | On release of quarantine. | 7-14 days |
| TINEA, IMPETIGO, SCABIES, VENEREAL DISEASES, TUBERCULOSIS | When non-infectious. | When non-infectious. | When non-infectious. | When non-infectious. | |

# NOTIFIABLE DISEASES

(Regulation 2, Ohio Sanitary Code)

CLASS "A"

| | | |
|---|---|---|
| Chickenpox | Meningococcus Meningitis | Smallpox |
| Diphtheria | Mumps | Tuberculosis, all forms |
| Influenza | Paratyphoid fever | Tularemia (rabbit disease) |
| Lethargic Encephalitis | Pneumonia | Typhoid fever |
| Malaria | Poliomyelitis | Undulant fever |
| Measles | Scarlet fever | Whooping cough |
| Measles, German | Septic sore throat | |

CLASS "B"

| | | |
|---|---|---|
| Chancroid | Gonorrhea | Syphilis |

CLASS "C"

| | |
|---|---|
| Erysipelas | Puerperal septicemia |

Diarrhea and enteritis under two years of age.

CLASS "D"

Ophthaimia neonatorum, any inflammation of the eyes of the newborn.
Trachoma

CLASS "E"

| | | |
|---|---|---|
| Anthrax | Leprosy | Tetanus |
| Cholera, Asiatic | Milk Sickness | Trichiniasis, in man |
| Dysentery | Plague | Typhus fever |
| Food poisoning | Rabies, in man | Yellow fever |

Foot and mouth disease, in man.

CLASS "F"

Any disease or disability contracted as a result of the nature of the person's employment, including the following diseases or disabilities and not excluding others:

| | |
|---|---|
| Anilin poisoning | Dinitrobenzene poisoning |
| Arsenic poisoning | Lead poisoning |
| Benzine (gasoline) poisoning | Mercury poisoning |
| Benzol poisoning | Naphtha poisoning |
| Bisulphide of carbon poisoning | Natural gas poisoning |
| Compressed-air illness | Phosphorus poisoning |
| Brass poisoning | Turpentine poisoning |
| Carbon monoxide poisoning | Wood alcohol poisoning |

Forms for reporting communicable diseases may be secured by calling the CINCINNATI HEALTH DEPARTMENT, CHerry 5300, line 352.

# MEDICAL LICENSURE
## State of Mississippi

*Laws and Extracts of Laws*
*Governing Licensing of*
*Physicians and the*
*Practice of Medicine*

MISSISSIPPI
STATE BOARD OF HEALTH
JACKSON, MISSISSIPPI

# LAWS AND EXTRACTS OF LAWS

## Also Rules and Regulations

## GOVERNING THE LICENSING OF PHYSICIANS AND THE PRACTICE OF MEDICINE

### State of Mississippi

### A. LICENSING OF PHYSICIANS

Section 5848, Code of 1930. "Duty to obtain license.—Every person who desires to practice medicine must first obtain a license to do so from the State Board of Health: . . . "

Section 5849. "How license obtained—diploma required.—Every person who desires to obtain a license to practice medicine must apply therefor, in writing, to the State Board of Health at least ten days before the date of the examination and must be examined by said board touching his learning on the following branches of medicine, viz: anatomy, chemistry, obstetrics and gynaecology, materia medica and pharmacology, physiology, pathology, surgery, hygiene, physical diagnosis, histology and bacteriology, theory and practice of medicine, diseases of the eye, ear, nose and throat, and if the applicant be found by the board, upon examination, to possess sufficient learning in said branches and to be of good moral character, the board shall at once issue him a license to practice medicine, which shall be signed by all members of the board present at said meeting; provided that no applicant shall be granted a license unless said applicant shall hold a diploma from a reputable medical college that requires a four years' course of at least thirty-two weeks for each session."

It is further provided in this section that an applicant may take an examination on the first two years of his medical course and return after the completion of his four years' course and take the examinations on the last two years of medicine.

The Board of Health holds examinations for license to practice medicine on two days in the latter portion of June each year in the city of Jackson, Mississippi. The examination fee is $10.25.

Section 5854. License must be recorded—This section requires that each license must be recorded with the Circuit Clerk of the county in which the licensee resides within sixty days from the date of the issuance of the license or it becomes void. Also, that "whenever the licensee shall change the county of his residence and of usual practice, he must, under like penalty, file the original or certified copy of the license, or of the record thereof, in the office of said clerk, in the county into which he shall move and practice, within sixty days of the time of such removal, to be there recorded in like manner and under like penalty."

Section 5855 provides that if a license to practice medicine be lost, the State Board of

Health may in its discretion issue a new license.

Section 5856 provides that the Secretary of the State Board of Health may issue a temporary license to anyone to practice medicine on presentation of medical diploma and application to take the examinations, which temporary license will be good until the next regular meeting of the Board for holding examinations.

Section 5959. "Non-residents.—Licensed physicians who reside without this state and whose practice of medicine extends into it, may obtain license to practice medicine in this state without being examined as to their learning, by presenting a written application for license, in the form prescribed, to the State Board of Health; . . ."

This license is good only in the county designated on the same and must be recorded in the office of the Circuit Clerk as provided for regular license.

Section 5860. " . . . The Board of Health may grant license to practice medicine without examination as to learning to graduates in medicine who ho'd license to practice medicine from another state, provided the requirements in such state are equal to those required by the State Board of Health of this state; and it is further provided that the State Board of Health of Mississippi may affiliate with the national board of medical examiners in granting license to practice medicine in Missisippi."

## B. PRACTICE OF MEDICINE

Section 5858. "Practice of Medicine Defined —The practice of medicine shall mean to suggest, recommend, prescribe, or direct for the use of any person, any drug, medicine, appliance or other agency, whether material or not material, for the cure, relief, or palliation of any ailment or disease of the mind or body, or for the cure or relief of any wound or fracture or other bodily injury or deformity, or the practice of obstetrics or midwifery, after having received, or with the intent of receiving therefor, either directly or indirectly, any bonus, gift, profit or compensation; provided, that nothing in this section shall apply to females engaged solely in the practice of midwifery.

## PENALTIES FOR PRACTICING MEDICINE WITHOUT LICENSE

Chapter 279-Laws of 1932—"An Act Providing Penalties for Practicing Medicine or Surgery Without a License and Amending Section 1099 of the Mississippi Code of 1930.

Section 1. Be it Enacted by the Legislature of the State of Mississippi, that Section 1099 of the Mississippi Code of 1930 be Amended so as to Read as Follows:

"1099. If any person shall practice as an attorney and counsellor-at-law, or shall practice as a physician or surgeon, or shall practice as a dentist, or shall practice as a pharmacist, with-

out having first been examined and obtained a license as required by law, he shall, on conviction, of the first offense, be punished by a fine of not less than One Hundred Dollars ($100.00) or more than Two Hundred Dollars ($200.00) or by imprisonment in the county jail not less than three months or more than twelve months or both; and such person, upon conviction of the second offense against this Act, shall be punished by fine of not less than Two Hundred Dollars ($200.00) or more than Five Hundred Dollars ($500.00) or by imprisonment in the penitentiary not less than one year or more than two years, and such person, upon conviction of any succeeding offense, shall be punished in the discretion of the court; provided, however, that such punishment shall in no case exceed the payment of a fine of Five Thousand Dollars ($5,000.00) or imprisonment for five years.

Section 2. That this Act shall take effect and be in force from and after is passage." (Approved May 18, 1932.)

## THE STATE BOARD OF HEALTH MAY SUSPEND OR REVOKE A MEDICAL LICENSE

Chapter 32; HB No. 120; Special Session of 1938, provides that the State Board of Health "may on its own initiative or on complaint suspend or revoke for any cause named below any license that it has issued that authorized any person to practice medicine, osteopathy, or any other method of preventing, diagnosing, relieving, caring for, or curing disease, injury, or other bodily condition; and said board is furthermore authorized and empowered to direct the cancellation in the office of the clerk of any circuit court of any record of any license so suspended or revoked.

"(a) The causes for which a license may be suspended or revoked and the record of such license cancelled are as follows:

"(1) The habitual personal use of opium, of coca leaves, of cannabis, or of any preparation or derivative of any of them, hereinafter referred to as 'narcotic drugs'.

"(2) Administering, dispensing, or prescribing any narcotic drug aforesaid otherwise than in the course of legitimate professional practice and for the prevention, alleviation, or cure of disease or for the relief of suffering, and not primarily for the purpose of catering to the cravings of an addict.

"(3) Conviction of violation of any federal or state law regulating the possession, distribution, or use of any narcotic drug aforesaid.

"(4) The use of alcohol or of any beverage or liquor containing alcohol, or of any drug, in such manner as incapacitates the licentiate for professional practice.

"(5) Procuring, or attemption to procure, or pretending to procure, or aiding or abetting in procuring or pretending to procure, an abortion that is not necessary to preserve the life of a pregnant woman.

"(6) Conviction of a misdemeanor involving moral turpitude or of a felony.

"(7) Fraud or deception in obtaining a license to practice."

## C. RULES AND REGULATIONS

(a) Rule adopted October 22, 1917—"After January 1, 1919, all applicants for license to practice medicine in the state of Mississippi must have graduated from a Class 'A' medical school, as classified by the American Medical Association."

(b) Reciprocity Regulations adopted October 22, 1917—"All applicants desiring to obtain reciprocal license in the State of Mississippi must comply with the following requirements:

"1. The applicant must be a graduate of a reputable medical college. This includes only those colleges in Class A and B as classified by the American Medical Association, which requires the standard as specified in the Medical Practice Act, (Medical colleges that require a four years' course of at least thirty-two weeks for each session.)

"2. The applicant must obtain his license in the State from which he comes, by written examination, and not by registration, and he must have stood said examination for license, after date of graduation.

"3. The applicant must obtain, on the application blank, the endorsement of the secretary of the board of medical examiners of the state in which the applicant holds license.

"4. The certificate on back of application blank must be filled in by the secretaries of the county and state medical societies, showing that said applicant has been a member in good standing for the past twelve months.

"5. When a student has obtained a medical degree from a Class A or B Medical college, and has as much as one year's work as interne in a reputable hospital he will be granted reciprocal license upon presenting a certificate from the superintendent of the hospital in which he has served as interne, provided said physician who has served as interne presents application for reciprocity immediately upon finishing his interneship following graduation in medicine and before the regular practice of medicine, and endorsement from two reputable physicians which will be accepted in lieu of membership in county and state society, but said applicant must present a certificate showing that he has paid fee and applied for membership in county society of the county in Mississippi in which said applicant will practice.

"6. All applicants for reciprocal license must present recommendations as to moral character from at least two reputable physicians.

"7. No applicant will be granted license through reciprocity in the State of Mississippi, who has failed on the examinations before the State Board of Health within five years preced-

ing the date on which said applicant applies for reciprocity.

"8. Applicants may obtain temporary license, pending the meeting of the Board, by presenting the regular blank properly filled out in every detail, and paying a fee of $50.50, such license to be void after the first meeting of the Board. If the Board shall approve the applicant's credentials, he will be issued a permanent license.

"9. Fee must be paid by postoffice or express money order, or New York or New Orleans exchange. Personal checks will not be accepted.

"10. Affidavit must be made as to all the facts contained on the blank."

(c) Rule adopted December 5, 1939.—Graduates of Foreign Schools—"It is hereby ordered by the Mississippi State Board of Health

"A. That, from this date, graduates of only recognized medical schools in the United States and Canada be permitted to take the examinations for license to practice medicine in this State; and that graduates of only medical schools in the United States and Canada heretofore graded A and B be granted medical license by reciprocity in the State of Mississippi.

"B. That if any individual makes application for license to practice medicine in Mississippi who is a graduate of a foreign medical school, he or she must show satisfactory proof to this Board:

"First: That he or she is a bona fide citizen of the United States.

"Second: That the applicant cannot be recognized unless the Council on Medical Education of the American Medical Association shall certify that the school from which the applicant graduated is or was at the time he or she graduated a standard medical school.

"Third: That the applicant must have spent a minimum of one year as an interne or resident in an approved hospital in the United States or Canada.

"C. That the applicant must then pass before this Board satisfactory written examination for license to practice medicine.

"D. That this regulation shall supersede a resolution passed by this Board on June 26, 1934 with reference to licensing of graduates of foreign medical schools."

A.1

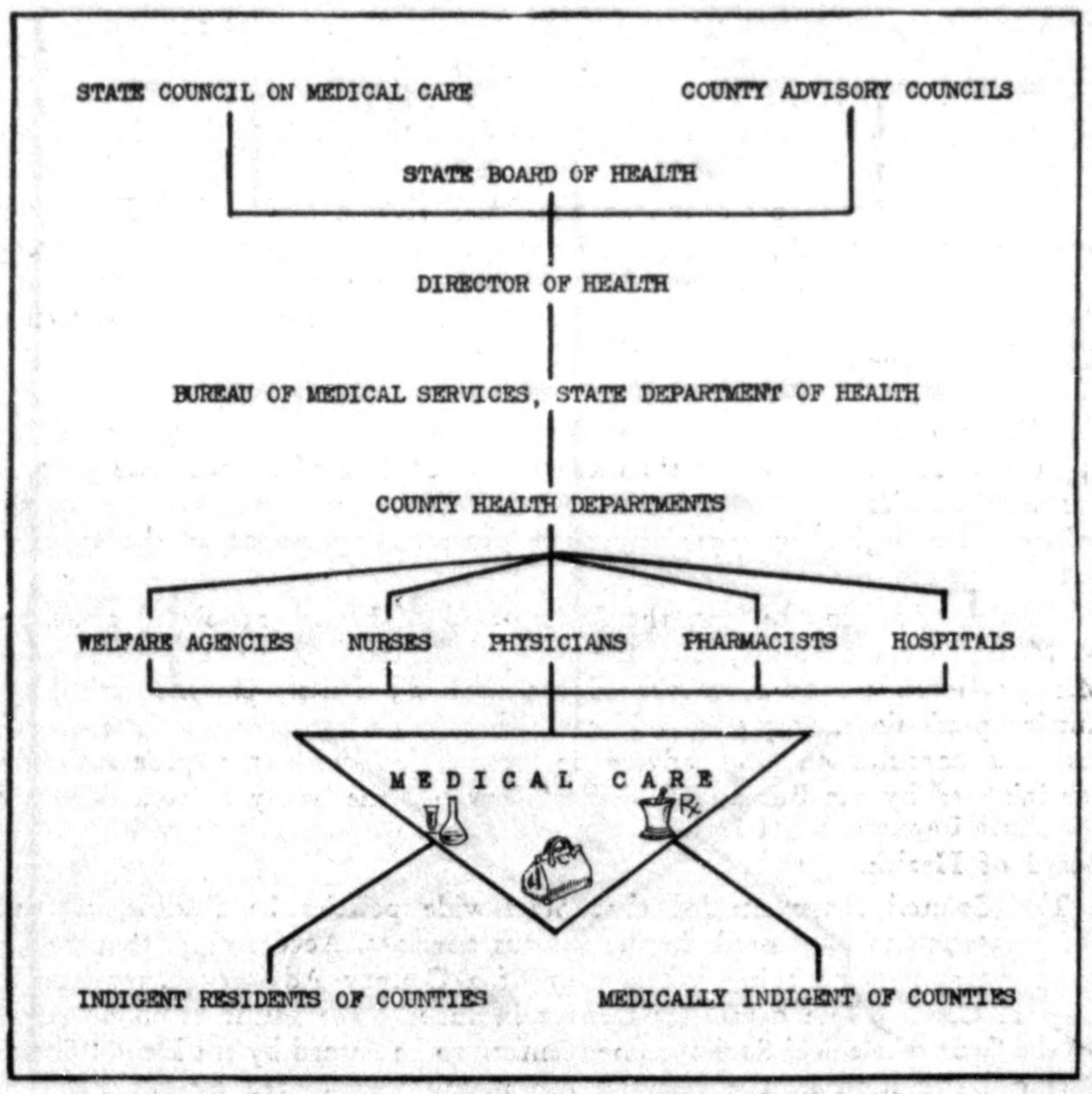
# *Maryland* HEALTH BULLETIN

**STATE DEPARTMENT OF HEALTH**
**R. H. Riley, M.D., Dr. P.H., Director 2411 North Charles Street, Baltimore**

**Volume 17 October, 1945 Number 8**

**CONTENTS**






**Medical Care for Counties of Maryland**

Entered as second-class matter, May 12, 1930, at the Post Office at Baltimore, Maryland, under the acts of August 24, 1912. Published monthly

# MEDICAL CARE

A medical care program for the indigent and medically indigent of the counties has been inaugurated in Maryland. The 1945 Session of the General Assembly established a Bureau of Medical Services, within the State Department of Health, to administer the program recommended by the Medical and Chirurgical Faculty of Maryland and also to perform duties in connection with the licensing of hospitals and the administration of chronic disease hospitals slated for postwar contruction. The law became effective on June 1 and this Department and other cooperating agencies have made every effort to put the medical care program in operation as promptly as possible.

The enactment of this law to establish medical care was the culmination of a movement that began in 1939, when the Medical and Chirurgical Faculty suggested that the State Planning Commission appoint a Committee on Medical Care to survey the problems of getting adequate care to the residents of this State. This committee, which is composed of representatives of all agencies interested in the matter officially or on a voluntary basis, first met in January, 1940. In the years following, a field survey and other investigations were carried out to determine the availability of proper care. In April, 1944 the Committee published its report, recommending establishment of a medical care program for the indigent and also the medically indigent — those normally self-supporting but unable to pay the costs of needed medical care — of the counties. They suggested that the program be administered by the State Department of Health and that a Council on Medical Care should be created, representing medical and nursing professions, hospitals, public health and welfare agencies.

The report was presented to the Medical and Chirurgical Faculty at its annual meeting in April, 1944 and was approved unanimously by that group. The Faculty sent it to Governor O'Conor with the request that he recommend the necessary legislation. A bill putting this plan for medical care into effect was written, passed by the State Legislature and became law on February 9, 1945 when signed by the Governor.

For the first two years an appropriation of $200,000 per year was approved. This is much less than the estimated cost of an adequate program for the counties of Maryland, but it is the general opinion that it will suffice for a beginning, especially since prosperity prevailed at the time the bill was passed.

As provided in the law, the State Board of Health appointed a Council on Medical Care promptly and the group held its first meeting on May 24. Members include representatives of the medical, dental, pharmaceutical and nursing professions, hospitals, public health and welfare agencies. The Council provides consultation and advice in connection with the program being administered by the Bureau of Medical Services, the newly created Bureau of the State Department of Health. However, final authority rests with the State Board of Health.

The Council recommended that State-wide policies be flexible, allowing for adaptation to local needs in the various counties. Accordingly, they decided upon the appointment in each county of a County Advisory Committee on Medical Care. These committees must include: three members to be named by the County Medical Society; one member to be named by the Dental Society having jurisdiction in the county; one member appointed by the Maryland Pharmaceutical Association; the executive of the County Welfare Board; the Chairman of the Board of County Commissioners or his delegated representative; and the County Health Officer, who is to serve as Chairman. Individual

counties could appoint additional members at their own discretion, but it was suggested that the total number of members should not exceed ten. It was recommended that health officers naming additional members choose representatives from such groups as Negroes, the Department of Education, nurses, local hospitals or public health lay organizations.

According to the recommendations of the Council on Medical Care, each county is required to submit an accurately and completely defined program to the Bureau of Medical Services. Services are to begin in each county soon after its plan has been received and approved.

Certified clients of the Public Welfare Department are eligible for care under this program. The eligibility of the medically indigent will be determined by the County Health Officer, or his designated agent, on the basis of medical and social factors. Consideration will be given to the cash income, other resources—such as home grown food, special expenses or debts and the size of the family. Important factors are the diagnosis, probable length and cost of the illness, whether the patient is the chief wage earner or a dependent, the outlook for complete recovery or the likelihood of recurrence, the probable effect on future earning capacity, and whether or not the family would have to go into debt to pay the costs of needed care. Eligibility for care under other programs and any insurance that the patient may have are also considered.

The scope of its local program is determined by each county. Services may include home and office care, surgery, obstetrical services, consultation, dental care, bedside nursing care, drugs, laboratory services and clinics. Other types of service may be inaugurated with the approval of the Bureau of Medical Services. The local program is to be determined by the most pressing needs of the area and by the amount of money available.

Funds have been allocated to the counties in proportioin to the number of persons receiving assistance from the County Board of Public Welfare. In many counties several agencies were already providing medical care. This program will not duplicate or replace any existing services, but it may supplement them or inaugurate new services.

To simplify and facilitate administration of the State-wide program a uniform fee schedule has been adopted for all counties. Rates were determined in large part according to recommendations made by County Advisory Committees. Since few counties would provide all the services mentioned in the fee schedule at the beginning, each county was advised to reproduce the part applicable to its own program and distribute it among the physicians and dentists of the area. It is believed that a uniform rate throughout the State is especially important in cases where a physician lives near a county line and practices in more than one county.

A system whereby expenditures could be strictly limited to the funds available was necessary. Accordingly the funds on hand for each county have been set up in monthly amounts. In cases where the total bill exceeds the total monthly allowance available disbursements will be prorated on a percentage basis. Thus, if bills for the month totaled $1,000 when the monthly funds available amounted to only $800 it would be necessary to pay physicians at the rate of four-fifths of the amount that they had earned according to the published fee schedule, or eighty cents to the dollar. This policy is not considered desirable but has been adopted as the only practical means of keeping expenditures within the limits of the funds available.

Physicians and dentists are to submit a single report of services rendered to each patient. This report is to be sent to the County Health Officer, who will review it. Reports approved by the County Health Officer are sent to the Bureau of Medical Services, which issues payment.

If the Health Officer questions the accuracy or the validity of any report received from a physician, pharmacist or dentist of his county he has the right to seek the advice of the County Advisory Committee. On the other hand, any physician or other person who has rendered medical services may present his case to the County Advisory Committe if dissatisfied with the payments received.

The general policies governing the administration of the medical care program have been based upon recommendations made by the Council on Medical Care. In determining these policies that group has given full weight and consideration to the opinions expressed by County Advisory Committees on Medical Care. There has been an attempt to balance two more or less opposed principals. The importance of allowing individual counties the greatest possible freedom to adapt the program to their peculiar needs was generally recognized. At the same time, a reasonable degree of uniformity throughout the State was held desirable in order to simplify administration, record keeping and future evaluation of progress.

By September 21 the Chief of the Bureau of Medical Services could report that twenty counties had submitted final plans for their medical care program. These plans had been received from Allegany, Anne Arundel, Baltimore, Calvert, Caroline, Carroll, Cecil, Dorchester, Frederick, Harford, Howard, Kent, Montgomery, Prince George's, Queen Anne's, St. Mary's, Somerset, Washington, Wicomico and Worcester Counties. Programs were actually in operation in a majority of these counties. Most of the final plans included requests for consultation service. Seven of them included specialty clinics in the plans submitted, the types most frequently requested being ophthalmology, nose and throat and psychiatry clinics. Nearly all of the remaining counties were working on their final plans by the end of August. Since the law inaugurating the medical care program did not go into effect until June 1, and funds were not available for its administration until July 1, this may be considered very satisfactory progress.

Maryland's medical care program results from the cooperative efforts of physicians, dentists, pharmacists, public health authorities and welfare agencies to bring adequate care within the reach of those who cannot afford to pay for needed services. Attempts are being made to provide better quality medical care to the indigent and medically indigent residents of our counties by providing services of physicians and dentists, clinics in specialty fields, diagnostic laboratory services, consultation service and bedside nursing care. Policies have been formulated with the full cooperation of all the groups concerned, and a continued unified effort is essential to the success of this undertaking. The program is a new venture in public health and one that may be accompanied by errors. It is believed, however, that vigilance to detect these mistakes and willingness to correct them will help to insure its success. Above all, needs of groups intended to benefit from the medical services must be kept in the foreground, for the entire medical care program has been established for the sole purpose of serving these sections of our population.

(Continued to page 72)

## Table 1. Reported Cases of Notifiable Diseases in Maryland, August, 1945

| AREA | Typhoid fever and paratyphoid fever | Infectious mononucleosis | Rocky Mt. spotted fever | Rheumatic fever | Measles | Scarlet fever | Chickenpox | German measles | Whooping cough | Mumps | Diphtheria | Septic sore throat | Vincent's angina | Dysentery | Diarrhea | Erysipelas | Poliomyelitis | Meningococcic encephalitis | Epidemic meningitis | Meningitis (other forms) | Tuberculosis (all forms) | Syphilis | Gonorrhea and chancroid | Gonorrheal ophth. | Ophthalmia neon. | Other venereal diseases | Tetanus | Malaria * | Broncho-pneumonia | Lobar pneumonia | Pneumonia unspecified | Conjunctivitis | Scabies | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Maryland State** | 9 | 1 | 2 | 6 | 9 | 50 | 22 | 5 | 228 | 28 | 28 | 10 | 9 | 7 | 30 | 3 | 26 | 1 | 5 | 1 | 307 | 972 | 590 | 6 | 2 | 6 | 1 | (28) | 26 | 33 | 6 | 4 | 20 | 2,453 |
| **Baltimore City** | 1 | 1 | .. | .. | 4 | 20 | 19 | 1 | 208 | 17 | 25 | 1 | 4 | 2 | 28 | 2 | 7 | .. | 4 | .. | 149 | 760 | 335 | 5 | .. | 3 | 1 | .. | 18 | 22 | .. | 4 | .. | 1,641 |
| **Total Counties** | 8 | .. | 2 | 6 | 5 | 30 | 3 | 4 | 20 | 11 | 3 | 9 | 5 | 5 | 2 | 1 | 19 | 1 | 1 | 1 | 158 | 212 | 255 | 1 | 2 | 3 | .. | (28) | 8 | 11 | 6 | .. | 20 | 812 |
| **Allegany** | .. | .. | .. | .. | .. | 2 | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | 4 | 11 | 8 | .. | .. | .. | .. | .. | 1 | .. | .. | .. | .. | 26 |
| **Anne Arundel** | .. | .. | .. | 5 | 1 | 3 | .. | .. | 1 | .. | .. | .. | .. | .. | 1 | .. | .. | .. | 1 | .. | 13 | 12 | 7 | .. | .. | .. | .. | (19) | .. | 1 | .. | .. | .. | 45 |
| **Baltimore** | 1 | .. | .. | .. | 1 | 8 | 1 | .. | 1 | 6 | .. | .. | .. | .. | .. | .. | 1 | 1 | .. | .. | 73 | 27 | 17 | .. | .. | .. | .. | .. | 3 | 2 | 1 | .. | .. | 150 |
| **Calvert** | .. | .. | .. | .. | .. | .. | .. | .. | 1 | 1 | .. | .. | .. | .. | .. | .. | 2 | .. | .. | .. | 1 | .. | 3 | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | 8 |
| **Caroline** | 1 | .. | .. | .. | 2 | 3 | .. | .. | 10 | .. | .. | 7 | .. | .. | .. | .. | .. | .. | .. | .. | 7 | 8 | 2 | .. | .. | .. | .. | .. | 1 | 1 | .. | .. | .. | 36 |
| **Carroll** | .. | .. | .. | 1 | .. | .. | 1 | .. | 2 | .. | .. | .. | 1 | .. | .. | .. | .. | .. | .. | .. | 4 | 1 | 1 | .. | .. | .. | .. | .. | 1 | 1 | .. | .. | .. | 13 |
| **Cecil** | 1 | .. | .. | .. | 1 | .. | .. | .. | .. | .. | 1 | .. | .. | .. | 1 | .. | 1 | .. | .. | .. | 1 | 6 | 29 | 1 | .. | .. | .. | .. | .. | .. | .. | .. | .. | 40 |
| **Charles** | 1 | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | 1 | .. | .. | .. | .. | 1 | 9 | 13 | 4 | .. | .. | .. | .. | (5) | .. | .. | .. | .. | .. | 10 |
| **Dorchester** | .. | .. | .. | .. | .. | 1 | .. | .. | .. | .. | .. | .. | .. | .. | 1 | .. | .. | .. | .. | .. | 1 | 1 | 2 | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | 29 |
| **Frederick** | .. | .. | 1 | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | 2 | 1 | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | 5 |
| **Garrett** | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | 3 | .. | .. | 1 | 1 | .. | .. | .. | 2 | 33 | 96 | .. | .. | 2 | .. | (1) | .. | 1 | .. | .. | 17 | 3 |
| **Harford** | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | 7 | .. | 2 | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | 156 |
| **Howard** | .. | .. | .. | .. | .. | 3 | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | 5 | 1 | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | 12 |
| **Kent** | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | 11 | .. | .. | .. | 10 | 18 | 18 | .. | .. | .. | .. | .. | 1 | 1 | .. | .. | .. | 6 |
| **Montgomery** | .. | .. | 1 | .. | .. | 6 | .. | 3 | 1 | 2 | 2 | 1 | .. | .. | .. | .. | .. | .. | .. | .. | 9 | 24 | 11 | .. | .. | .. | .. | .. | .. | 1 | .. | 1 | .. | 75 |
| **Prince George's** | .. | .. | .. | .. | .. | 3 | 1 | 1 | 3 | 1 | .. | .. | .. | 2 | 1 | .. | 3 | .. | .. | .. | 2 | 1 | .. | .. | 1 | .. | .. | .. | .. | .. | .. | .. | .. | 61 |
| **Queen Anne's** | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | 2 | 2 | .. | .. | 1 | .. | .. | .. | .. | .. | .. | .. | .. | 4 |
| **St. Mary's** | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | 1 | 2 | 1 | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | 5 |
| **Somerset** | 2 | .. | .. | .. | .. | .. | .. | .. | .. | 1 | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | 1 | 5 | 3 | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | 7 |
| **Talbot** | 1 | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | 1 | .. | .. | .. | .. | .. | .. | 3 | 3 | 30 | .. | .. | .. | .. | (3) | .. | .. | .. | .. | 3 | 10 |
| **Washington** | .. | .. | .. | .. | .. | 1 | .. | .. | .. | .. | .. | .. | .. | .. | 1 | .. | .. | .. | .. | .. | 6 | 21 | 10 | .. | .. | .. | .. | .. | .. | 2 | 2 | .. | .. | 41 |
| **Wicomico** | 1 | .. | .. | .. | .. | .. | .. | .. | 1 | .. | .. | .. | .. | .. | 1 | .. | .. | .. | .. | .. | 2 | 14 | 5 | .. | .. | 1 | .. | .. | .. | 2 | 2 | .. | .. | 44 |
| **Worcester** | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | 26 |

*Malaria Cases were contracted outside the United States.

Table 2. Births, Stillbirths and Deaths, Under One Year. Preliminary: Corrected Residence Only Within State. August, 1945

| AREA | Births (exclusive of stillbirths) | | | | | | | | | Stillbirths | | | Deaths of infants under one year (exclusive of stillbirths) | | | | | | Deaths by cause and list number | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Color | | Attended by | | | | | | | | | | Color | | Age | | | | | | | | | |
| | | | | Physician | | Midwife | | Other | | | | | | | | | | | | | | | | | |
| | All births | White | Colored | White | Colored | White | Colored | White | Colored | All stillbirths | White | Colored | All infant deaths | White | Colored | Under 1 day | 1-29 days | 1-11 months | Infectious diseases (1-44) | Respiratory diseases (104-114) | Diarrhea and enteritis (119) | Premature birth (159) | Injury at birth (160) | Other early infancy (158,161) | All other causes |
| **Maryland State** | 3,589 | 2,877 | 712 | 2,820 | 534 | 55 | 178 | 2 | .. | 152 | 103 | 49 | 148 | 96 | 52 | 37 | 50 | 61 | 7 | 14 | 38 | 43 | 16 | 10 | 20 |
| **Baltimore City** | 1,598 | 1,171 | 427 | 1,152 | 375 | 19 | 52 | .. | .. | 86 | 51 | 35 | 72 | 40 | 32 | 16 | 19 | 37 | 4 | 8 | 25 | 17 | 7 | 2 | 9 |
| **Total Counties** | 1,991 | 1,706 | 285 | 1,668 | 159 | 36 | 126 | 2 | .. | 66 | 52 | 14 | 76 | 56 | 20 | 21 | 31 | 24 | 3 | 6 | 13 | 26 | 9 | 8 | 11 |
| **Allegany** | 175 | 174 | 1 | 173 | 1 | .. | .. | 1 | .. | 7 | 7 | .. | 4 | 4 | .. | 2 | 2 | .. | .. | .. | 1 | 1 | 1 | .. | 1 |
| *Cumberland | 92 | 91 | 1 | 91 | 1 | .. | .. | .. | .. | 5 | 5 | .. | 2 | 2 | .. | .. | 2 | .. | .. | .. | 1 | .. | .. | .. | 1 |
| **Anne Arundel** | 185 | 145 | 40 | 143 | 30 | 2 | 10 | .. | .. | 5 | 4 | 1 | 5 | 3 | 2 | 2 | 3 | .. | .. | 1 | .. | 2 | .. | 1 | 1 |
| *Annapolis | 40 | 31 | 9 | 31 | 7 | .. | 2 | .. | .. | 2 | 2 | .. | 1 | .. | 1 | .. | 1 | .. | .. | .. | .. | .. | .. | 1 | .. |
| **Baltimore** | 458 | 420 | 38 | 419 | 38 | 1 | .. | .. | .. | 18 | 16 | 2 | 16 | 12 | 4 | 3 | 5 | 8 | 1 | 3 | 2 | 4 | 3 | .. | 3 |
| **Calvert** | 15 | 4 | 11 | 4 | 8 | .. | 3 | .. | .. | 2 | .. | 2 | 1 | .. | 1 | 1 | .. | .. | .. | .. | .. | 1 | .. | .. | .. |
| **Caroline** | 26 | 20 | 6 | 19 | 2 | 1 | 4 | .. | .. | 1 | 1 | .. | 5 | 5 | .. | 3 | 2 | .. | 1 | .. | .. | 2 | 1 | 1 | .. |
| **Carroll** | 43 | 40 | 3 | 40 | 3 | .. | .. | .. | .. | .. | .. | .. | 1 | 1 | .. | .. | 1 | .. | .. | .. | .. | .. | 1 | .. | .. |
| **Cecil** | 55 | 51 | 4 | 51 | 4 | .. | .. | .. | .. | 4 | 4 | .. | 5 | 2 | 3 | 1 | 2 | 2 | .. | .. | 2 | .. | 1 | 1 | 1 |
| **Charles** | 44 | 25 | 19 | 20 | .. | 5 | 19 | .. | .. | 1 | .. | 1 | 3 | 1 | 2 | .. | 1 | 2 | 1 | .. | 1 | .. | 1 | .. | .. |
| **Dorchester** | 43 | 22 | 21 | 21 | 13 | 1 | 8 | .. | .. | 6 | 1 | 5 | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| *Cambridge | 18 | 10 | 8 | 9 | 4 | 1 | 4 | .. | .. | 5 | 1 | 4 | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| **Frederick** | 103 | 93 | 10 | 88 | .. | 5 | 10 | .. | .. | 2 | 2 | .. | 10 | 9 | 1 | 3 | 6 | 1 | .. | .. | 3 | 5 | 1 | 1 | .. |
| *Frederick City | 37 | 33 | 4 | 32 | .. | 1 | 4 | .. | .. | 1 | 1 | .. | 5 | 4 | 1 | 2 | 3 | .. | .. | .. | .. | 3 | 1 | 1 | .. |
| **Garrett** | 39 | 39 | .. | 26 | .. | 13 | .. | .. | .. | .. | .. | .. | 2 | 2 | .. | 1 | 1 | .. | .. | .. | .. | 1 | .. | 1 | .. |
| **Harford** | 80 | 77 | 3 | 77 | 3 | .. | .. | .. | .. | 2 | 2 | .. | 3 | 1 | 2 | .. | 1 | 2 | .. | .. | 2 | 1 | .. | .. | .. |
| **Howard** | 31 | 27 | 4 | 27 | 4 | .. | .. | .. | .. | 1 | 1 | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| **Kent** | 35 | 19 | 16 | 19 | 9 | .. | 7 | .. | .. | 1 | .. | 1 | 2 | 1 | 1 | .. | 1 | 1 | .. | .. | .. | .. | .. | 1 | 1 |
| **Montgomery** | 145 | 131 | 14 | 130 | 11 | 1 | 3 | .. | .. | 3 | 3 | .. | 3 | 1 | 2 | 1 | 1 | 1 | .. | .. | .. | 2 | .. | .. | 1 |
| **Prince George's** | 115 | 101 | 14 | 99 | 2 | 2 | 12 | .. | .. | 2 | 2 | .. | 2 | 2 | .. | .. | 1 | 1 | .. | .. | 1 | 1 | .. | .. | .. |
| **Queen Anne's** | 20 | 16 | 4 | 16 | 2 | .. | 2 | .. | .. | 1 | 1 | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| **Saint Mary's** | 69 | 49 | 20 | 49 | 11 | .. | 9 | .. | .. | 1 | 1 | .. | 3 | 3 | .. | 2 | .. | 1 | .. | .. | 1 | 2 | .. | .. | .. |
| **Somerset** | 26 | 11 | 15 | 11 | 5 | .. | 10 | .. | .. | 1 | 1 | .. | 3 | 2 | 1 | 1 | 1 | 1 | .. | 1 | .. | 1 | .. | .. | 1 |
| **Talbot** | 39 | 31 | 8 | 31 | 2 | .. | 6 | .. | .. | 5 | 3 | 2 | 2 | 2 | .. | .. | .. | 2 | .. | 1 | .. | .. | .. | .. | 1 |
| **Washington** | 127 | 126 | 1 | 125 | 1 | .. | .. | 1 | .. | 1 | 1 | .. | 2 | 2 | .. | 1 | .. | 1 | .. | .. | .. | 1 | .. | 1 | .. |
| *Hagerstown | 59 | 58 | 1 | 58 | 1 | .. | .. | .. | .. | .. | .. | .. | 1 | 1 | .. | 1 | .. | .. | .. | .. | .. | 1 | .. | .. | .. |
| **Wicomico** | 83 | 64 | 19 | 62 | 7 | 2 | 12 | .. | .. | 2 | 2 | .. | 2 | 2 | .. | .. | 1 | .. | .. | .. | .. | 1 | .. | .. | .. |
| *Salisbury | 47 | 39 | 8 | 38 | 7 | 1 | 1 | .. | .. | .. | .. | .. | 1 | 1 | .. | .. | 1 | .. | .. | .. | .. | 2 | .. | .. | .. |
| **Worcester** | 35 | 21 | 14 | 18 | 3 | 3 | 11 | .. | .. | .. | .. | .. | 2 | 1 | 1 | .. | 1 | 1 | .. | .. | .. | 1 | .. | 1 | 1 |

* Town of over 10,000; data are also included in county figures. (Baltimore City is not part of any county.)

Table 3. Maternal Mortality. Preliminary: Corrected for Residence Only Within State. August, 1945

| AREA | All maternal deaths | Color | | Deaths by cause and International List number | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Infection (140, 147) | | Accidents and hemorrhage (141, 143, 146) | | Toxemias (144, 148) | | Other causes (142, 145 149, 150) | |
| | | White | Colored | White | Colored | White | Colored | White | Colored | White | Colored |
| Maryland State | 8 | 6 | 2 | 1 | .. | 1 | 1 | 1 | .. | 3 | 1 |
| Baltimore City | 5 | 3 | 2 | .. | .. | 1 | 1 | 1 | .. | 1 | 1 |
| Total Counties | 3 | 3 | .. | 1 | .. | .. | .. | .. | .. | 2 | .. |
| Anne Arundel | 1 | 1 | .. | .. | .. | .. | .. | .. | .. | 1 | .. |
| Dorchester | 1 | 1 | .. | 1 | .. | .. | .. | .. | .. | .. | .. |
| *Cambridge | 1 | 1 | .. | 1 | .. | .. | .. | .. | .. | .. | .. |
| Talbot | 1 | 1 | .. | .. | .. | .. | .. | .. | .. | 1 | .. |

The counties omitted from the table had no maternal deaths.
*Town of over 10,000; data are also included in county figures. (Baltimore City is not part of any county.)

(Continued from page 68)

## BUREAU OF CHEMISTRY SEMINARS: 1945-1946

Seminars of the Bureau of Chemistry, which are held on the first and third Tuesdays from October to May inclusive, will be resumed on October second. As in the past, the first meeting each month will be devoted to topics of general public health interest and alternate sessions to chemical or technical subjects. Meetings are held in the Library (Room 302) of the State Health Department Building, 2411 North Charles Street at 4.30 p.m. and are open to those interested. Topics and speakers for the fall schedule are as follows:

**October 2—Tuberculosis Control Program.**
Leroy R. Allen, M.D., Acting Deputy State Health Officer in the Bureau of Communicable Diseases in Charge of Tuberculosis Control, State of Maryland Department of Health.

**October 16—Recent Advances in Drug Therapy.**
S.W. Goldstein, Ph.D., Staff.

**November 6—Medical Care Program in Maryland.**
Dean Roberts, M.D., Chief, Bureau of Medical Services, State of Maryland Department of Health.

**November 20—The Silicosis Survey.**
W.F. Reindollar, Sc.D., Staff.

**December 4—Activities of the Food and Drug Administration.**
William A. Queen, Chief, Division of State Cooperation, U. S. Food and Drug Administration.

**December 18—Decomposition of Foods.**
Margarethe S. Oakley, M.S., Staff.

**January 8—Causes of Food Poisoning.**
F. A. Korff, Director, Bureau of Food Control, Baltimore City Health Department.

**January 22—The Role of the Photoelectrometer in Clinical Chemistry.**
Muriel C. Wellmann, A.B., Staff.

Table 4. Death Rates and Deaths, All Ages. Preliminary: Corrected for Residence Only Within State. August, 1945

| AREA | Total death rate per 1,000 population | Total deaths | Deaths by color | | Deaths by age | | | Deaths by cause and 1938 International List number | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | White | Colored | Under 25 | 25–44 | 45 and over | Typhoid fever (1,2) | Scarlet fever (8) | Whooping cough (9) | Diphtheria (10) | Tuberculosis (13–22) | Syphilis (30) | Influenza (33) | Measles (35) | Cancer (45–55) | Diabetes (61) | Cerebral hemorrhage (83a,b) | Diseases of heart (90–95) | Pneumonia (107–109) | Diarrhea & enteritis under 2 years (119) | Nephritis (130–132) | Puerperal (140–150) | Motor vehicle (170) | Other accidents (169, 171–195) | All other causes |
| **Maryland State** | 9.7 | 1637 | 1282 | 355 | 249 | 228 | 1160 | 1 | .. | 3 | 2 | 103 | 27 | .. | .. | 224 | 49 | 138 | 437 | 33 | 41 | 144 | 8 | 37 | 89 | 301 |
| **Baltimore City** | 10.0 | 792 | 575 | 217 | 116 | 127 | 549 | .. | .. | 1 | 1 | 62 | 19 | .. | .. | 120 | 23 | 58 | 204 | 20 | 27 | 68 | 5 | 13 | 33 | 138 |
| **Total Counties** | 9.4 | 845 | 707 | 138 | 133 | 101 | 611 | 1 | .. | 2 | 1 | 41 | 8 | .. | .. | 104 | 26 | 80 | 233 | 13 | 14 | 76 | 3 | 24 | 56 | 163 |
| **Allegany** | 9.4 | 65 | 64 | 1 | 10 | 6 | 49 | 1 | .. | .. | .. | .. | 1 | .. | .. | 5 | 4 | 5 | 23 | .. | 1 | 4 | .. | 1 | 4 | 16 |
| *Cumberland | ** | 44 | 43 | 1 | 6 | 4 | 34 | .. | .. | .. | .. | .. | 1 | .. | .. | 5 | 2 | 4 | 16 | .. | 1 | 3 | .. | 1 | .. | 11 |
| **Anne Arundel** | 10.1 | 66 | 54 | 12 | 8 | 13 | 45 | .. | .. | .. | 1 | 2 | .. | .. | .. | 8 | 2 | 7 | 21 | 3 | .. | 4 | 1 | 1 | 2 | 14 |
| *Annapolis | ** | 12 | 10 | 2 | 2 | 2 | 8 | .. | .. | .. | .. | .. | .. | .. | .. | 3 | .. | 1 | 4 | .. | .. | .. | .. | 1 | .. | 3 |
| **Baltimore** | 7.4 | 127 | 112 | 15 | 22 | 19 | 86 | .. | .. | .. | .. | 3 | 1 | .. | .. | 15 | .. | 11 | 42 | 4 | 2 | 12 | .. | 5 | 6 | 26 |
| **Calvert** | 10.0 | 9 | 7 | 2 | 3 | 2 | 4 | .. | .. | .. | .. | .. | .. | .. | .. | 3 | .. | .. | .. | .. | .. | .. | .. | .. | 2 | 4 |
| **Caroline** | 12.5 | 17 | 14 | 3 | 5 | 3 | 9 | .. | .. | 1 | .. | 2 | .. | .. | .. | 1 | 1 | 2 | 3 | .. | .. | .. | .. | .. | 1 | 6 |
| **Carroll** | 11.3 | 38 | 37 | 1 | 4 | 3 | 31 | .. | .. | .. | .. | 3 | .. | .. | .. | 7 | 2 | 3 | 10 | 1 | .. | 3 | .. | 2 | 1 | 6 |
| **Cecil** | 14.7 | 40 | 34 | 6 | 10 | 5 | 25 | .. | .. | 1 | .. | .. | 2 | .. | .. | 5 | .. | 5 | 9 | .. | 2 | 1 | .. | 4 | 6 | 5 |
| **Charles** | 6.5 | 11 | 5 | 6 | 5 | 1 | 5 | .. | .. | .. | .. | 3 | .. | .. | .. | .. | .. | .. | 3 | .. | 1 | .. | .. | 1 | 1 | 2 |
| **Dorchester** | 14.1 | 29 | 17 | 12 | 2 | 3 | 24 | .. | .. | .. | .. | 1 | 1 | .. | .. | 6 | 1 | 4 | 6 | .. | .. | 3 | 1 | .. | 1 | 5 |
| *Cambridge | ** | 12 | 6 | 6 | 1 | 1 | 10 | .. | .. | .. | .. | 1 | .. | .. | .. | 3 | .. | .. | 2 | .. | .. | 2 | 1 | .. | 1 | 2 |
| **Frederick** | 12.1 | 53 | 49 | 4 | 10 | 1 | 42 | .. | .. | .. | .. | 1 | .. | .. | .. | 7 | 5 | 6 | 15 | .. | 3 | 3 | .. | .. | 3 | 10 |
| *Frederick City | ** | 19 | 17 | 2 | 5 | 1 | 13 | .. | .. | .. | .. | 1 | .. | .. | .. | 3 | 2 | 1 | 4 | .. | .. | 2 | .. | .. | .. | 6 |
| **Garrett** | 5.1 | 8 | 8 | .. | 2 | 1 | 5 | .. | .. | .. | .. | .. | .. | .. | .. | 1 | .. | 1 | 3 | .. | .. | .. | .. | .. | 1 | 2 |
| **Harford** | 9.3 | 34 | 28 | 6 | 5 | 4 | 25 | .. | .. | .. | .. | 1 | .. | .. | .. | 5 | .. | 2 | 12 | .. | 2 | 1 | .. | 1 | 1 | 9 |
| **Howard** | 3.8 | 6 | 5 | 1 | 1 | .. | 5 | .. | .. | .. | .. | 1 | .. | .. | .. | 1 | .. | 1 | 2 | .. | .. | 1 | .. | .. | .. | .. |
| **Kent** | 18.0 | 20 | 16 | 4 | 4 | .. | 16 | .. | .. | .. | .. | .. | .. | .. | .. | 3 | 2 | 1 | 5 | .. | .. | 4 | .. | .. | 2 | 3 |
| **Montgomery** | 6.0 | 53 | 46 | 7 | 5 | 6 | 42 | .. | .. | .. | .. | 1 | 1 | .. | .. | 8 | 1 | 4 | 16 | .. | .. | 3 | .. | 1 | 6 | 12 |
| **Prince George's** | 7.6 | 76 | 59 | 17 | 9 | 11 | 56 | .. | .. | .. | .. | 13 | 1 | .. | .. | 7 | .. | 8 | 10 | 2 | 1 | 14 | .. | 3 | 4 | 13 |
| **Queen Anne's** | 7.7 | 8 | 8 | .. | .. | .. | 8 | .. | .. | .. | .. | 1 | .. | .. | .. | 1 | .. | 1 | 3 | .. | .. | 1 | .. | .. | .. | 1 |
| **Saint Mary's** | 11.9 | 18 | 12 | 6 | 7 | 1 | 10 | .. | .. | .. | .. | 1 | .. | .. | .. | 1 | .. | 3 | 1 | .. | 1 | .. | .. | 2 | 2 | 7 |
| **Somerset** | 10.2 | 15 | 9 | 6 | 6 | 5 | 4 | .. | .. | .. | .. | 1 | .. | .. | .. | 1 | .. | 1 | 3 | 1 | .. | 2 | .. | .. | 3 | 3 |
| **Talbot** | 15.3 | 21 | 17 | 4 | 3 | 2 | 16 | .. | .. | .. | .. | .. | .. | .. | .. | 4 | 3 | .. | 7 | 1 | .. | .. | 1 | 1 | 2 | 2 |
| **Washington** | 11.1 | 66 | 61 | 5 | 3 | 6 | 57 | .. | .. | .. | .. | 1 | .. | .. | .. | 10 | 2 | 10 | 24 | .. | .. | 8 | .. | .. | 3 | 8 |
| *Hagerstown | ** | 34 | 30 | 4 | 2 | 4 | 28 | .. | .. | .. | .. | 1 | .. | .. | .. | 5 | 1 | 4 | 12 | .. | .. | 4 | .. | .. | 2 | 5 |
| **Wicomico** | 16.1 | 45 | 33 | 12 | 7 | 6 | 32 | .. | .. | .. | .. | 3 | 1 | .. | .. | 4 | 2 | 4 | 12 | .. | 1 | 10 | .. | 1 | 2 | 5 |
| *Salisbury | ** | 20 | 16 | 4 | 2 | 3 | 15 | .. | .. | .. | .. | 1 | .. | .. | .. | 1 | 2 | 1 | 6 | .. | .. | 6 | .. | .. | 1 | 2 |
| **Worcester** | 12.3 | 20 | 12 | 8 | 2 | 3 | 15 | .. | .. | .. | .. | 3 | .. | .. | .. | 1 | 1 | 1 | 3 | 1 | .. | 2 | .. | 1 | 3 | 4 |

*Town of over 10,000; data are also included in county figures. (Baltimore City is not part of any county.)
†Includes 8 deaths in the Glenn Dale Tuberculosis Sanatorium for Washington, D. C. residents.
** Rates omitted because population data not available.

A1

# WISCONSIN
## STATE BOARD OF HEALTH
# Quarterly Bulletin

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# WISCONSIN STATE BOARD OF HEALTH

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## Madison 2, Wisconsin

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# FLUORINE AND DENTAL HEALTH

F. A. BULL, D. D. S., M. S. P. H.
*Supervisor, Dental Education*

There has been considerable interest shown recently in the role that fluorine plays in the reduction of dental caries in areas where the public water supply contains appreciable amounts of fluorine.

For several years the Wisconsin State Board of Health has been interested in this study and has conducted surveys in Wisconsin areas having fluorine naturally present in their water supplies and compared them with areas having little or no fluorine in their drinking water. The results of these surveys show that there is only one-third as much dental decay in the fluoride areas as there is in the non-fluoride areas.

Table I shows the dental caries experience of the permanent teeth of junior high school students (12 to 14 years) in Green Bay where 2.3 p.p.m. of fluorine is naturally present in the drinking water, and Sheboygan where only .05 p.p.m. or practically no fluorine is present in the water supply. In Green Bay, 30 percent of the children had no dental caries experience while in Sheboygan, less than 3 percent had no dental caries experience.

**Table I**

**SURVEY GREEN BAY–SHEBOYGAN**

**12–14 yrs. incl.**

**PERMANENT TEETH**

**Green Bay—2.3 p.p.m. Fluorine**
**Sheboygan— .05 p.p.m. Fluorine**

| | Total Pupils Examined | Teeth Filled | Teeth Carious | Teeth Extracted | Need Extraction | D. M. F.* |
|---|---|---|---|---|---|---|
| Green Bay Born | 1647 | 2729 | 1343 | 236 | 65 | 2.62 |
| Sheboygan | 1887 | 11993 | 2754 | 1287 | 206 | 8.54 |

Similar surveys have been carried out by the U. S. Public Health Service in various sections of the United States and in every instance this same ratio of dental decay between fluoride and non-fluoride areas has been found in the permanent teeth.

* Average number of teeth decayed, missing or filled per pupil examined.

However, there had been very little significant data on what effect, if any, fluorine has on the deciduous teeth. In 1945, the Wisconsin State Board of Health began a survey on the effects of fluorine on the deciduous teeth. The kindergarten children (5 to 6 years) were surveyed in Green Bay and Sheboygan, the same cities that were used in making the survey of permanent teeth and the results are tabulated in Table II. Here we find that there is only one-fourth the amount of decay in deciduous teeth in the fluoride area (Green Bay) as we have in the non-fluoride area, Sheboygan. In Green Bay, 58 percent of the kindergarten children had no dental caries experience, while in Sheboygan 20 percent had no dental caries experience.

**Table II**

**SURVEY GREEN BAY–SHEBOYGAN**

**Kindergarten Children 5–6 Years**

**DECIDUOUS TEETH**

**Green Bay—2.3 p.p.m. Fluorine**
**Sheboygan— .05 p.p.m. Fluorine**

| | Total Pupils Examined | Teeth Filled | Compound Fillings | Posterior Teeth Extracted | Posterior Teeth Needing Extraction | Teeth Carious | Compound Cavities | D. M. F. |
|---|---|---|---|---|---|---|---|---|
| Green Bay | 557 | 188 | 66 | 18 | 23 | 504 | 226 | 1.25 |
| Sheboygan | 416 | 573 | 414 | 80 | 192 | 1355 | 795 | 4.80 |

As a result of the many surveys that have been conducted throughout the United States, it has been determined that approximately 1 p.p.m. of fluorine in drinking water gives the same immunity from dental decay as higher amounts of fluorine do. This is an important finding as we know that high amounts of fluorine in the water, over 2.0 p.p.m., produces mottling or discoloration of the teeth that is objectionable. With only 1 p.p.m. of fluorine, there is no mottling of the teeth and still the teeth have the same immunity from dental decay.

Recently several cities in the United States have begun the artifical addition of 1 p.p.m. of fluorine to their public water supplies in an effort to reduce dental decay. Newburgh, New York; Grand Rapids, Michigan; Sheboygan, Wisconsin; Brantford, Ontario; Midland, Michigan, and Marshall, Texas are already adding fluorine to their water and several other cities, among them, Evanston, Illinois, are in the process of installing equipment to add fluorine to their public water supplies.

All of these fluorination projects are being carried out under the strict supervision of state and local boards of health and dental societies. The health professions will follow them closely as this is the first time that any public health measure to prevent dental caries has been inaugurated. Should they prove successful, we will have found a simple method of greatly reducing the amount of dental decay in our population.

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## WISCONSIN BUILDS MEN

### I. PHYSIQUE

Wisconsin added to her laurels as a healthful place to live by placing second among the states in point of defect-free registrants examined by selective service during a crucial year of World War II.

An official report covering the year ending March 31, 1943, discloses that 54.8 percent of draft-age Wisconsin men were found to have no limiting defects, a record surpassed only by the 59.3 score attained by Kansas.

The federal report included a study of health by four age groups of draft-age men. This breakdown revealed that Wisconsin's high ranking was effected through its youngest fighting men, the group 18 to 24 years of age, 66.5 percent of whom were found to be free of defects, while three other age groups up to 44 years showed Wisconsin men to average high above the national average, among those examined during the period covered by the report.

General surprise was expressed in state public health circles over the fact that the four lowest-ranking states in the comparison, reading from the bottom of the list, were Vermont, Massachusetts, New Hampshire and Maine.

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### II. CHARACTER

RALPH KUHLI
*Junior Social Hygiene Lecturer*

Thousands of young men, away from home for the first time while in the service, were subject to acute nostalgia and loneliness. In their search for feminine companionship they were beset by all of the age-old temptations of the flesh. Young soldiers lived through social situations that would put a strain on the most mature adult.

Correct sex information and especially good character traits are not acquired in one meeting nor by reading one booklet. Wisconsin is doing a better job each year in building men of fine character.

### War Record is Good

Surgeon General Parran of the U. S. Public Health Service emphasized one sign of progress when he reported that Wisconsin and New Hampshire had the lowest rates in the nation for syphilis among white selectees; namely, six-tenths of one percent. Earlier, during the Second Army maneuvers near Camp McCoy, only four new cases of gonorrhea were found among 60,000 soldiers. The Surgeon of the Sixth Corps Area, U. S. Army, wrote that this was "a low incidence of these diseases such as has probably not been attained in any previous military concentration of this magnitude".

### Training is Directed at Youth

This year syphilologists are publicly stating for the record that penicillin and rapid treatment have not broken the chain of infection because not enough early cases are diagnosed and treated. These medical specialists are saying that promiscuity is the main problem and that syphilis and gonorrhea are signs of it. Sex character education is part of the solution and venereal disease information is included in the subject matter.

Since World War I, Wisconsin homes and schools have done better every year answering casually and accurately the first sex questions of children, helping boys and girls grow up, share sports and hobbies, and inform them on the venereal diseases. This has helped produce the healthy men from our state for military service, and it is my opinion after almost three years overseas with them, that it is the only adequate preparation for the loneliness and temptations that our teen-age men meet over there.

### GIs Believe in Marriage

It is very impressive to be a part of a foreign theater full of loud soldiers who deride heroics and to hear them quiet down at any movie of family life. Very young men take seriously their physical ability to become fathers. No one laughs at the idea of mail from a girl back home. Soldiers think babies have the right to be born healthy and they like kids.

All this, Wisconsin has recognized and uses in a broad social hygiene program that includes every constructive approach avail-

able. The primary objective is character development from childhood to parenthood. The secondary objective is minimizing such problems as syphilis and gonorrhea.

### Co-operation Succeeds

No one link in the Wisconsin chain is important to the exclusion of others in developing character: law, medicine, education, the church and community service each help in their respective areas.

I. The people of the state support laws requiring premarital blood tests, the use of a one percent silver nitrate solution in the eyes of new-born children to prevent blindness caused by gonorrhea the reporting of syphilis and gonorrhea to the State Board of Health, the suppression of prostitution, and the prohibition of advertising for self treatment of genito-urinary infections.

II. The medical program is based on diagnosis and treatment by the private physician with the state providing assistance for diagnosis and treatment of indigents, and for the epidemiological investigation of contacts and suspects. Current emphasis is being placed upon reporting, case finding and rapid treatment with penicillin.

III. Sex character education by the home, the church and the school continues to improve, aided by a quarter century of social hygiene meetings with young people by lecturers from the State Board of Health. Wisconsin schools are now integrating more and more sex character education into school guidance, class, and social activities.

IV. Community service in this program is developing facilities and leadership for co-recreation, premarital guidance and community support for the law enforcement officials in suppressing prostitution. Holding the line against the post-war return of prostitution and developing co-recreation centers is the trend now.

### Expediency is Only a Wartime Policy

While America fought a shooting war, we did the best we could with what we had and could get. Now we are holding gains made and improving on wartime expediency. Our moral reconversion includes strengthening every link of the above chain so that more of our children grow to healthy parenthood. Each of us tends to underestimate his sphere of influence and the importance of his part of the chain. Progress measured by wartime statistics encourages us to fight the exception and have the fun of helping this broad and effective program continue to improve our state.

## CANCER STUDY FOR THE HIGH SCHOOL

Cancer control, as a major health problem in the United States, merits attention not only in programs of research but in programs of education, in the opinion of the joint committee on health problems in education, serving the National Education and the American Medical associations.

Instruction concerning the nature of cancer and known methods of prevention and control should be included in the high school course of study, along with other important health problems facing the American people today, the committee advises.

High school students are interested in such information, the committee believes, and scientific facts should be taught to them so that fears may be allayed, intelligent action as future adults be promoted, and families favorably influenced by the information which students relay to adult relatives.

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## MILESTONES AND MILLSTONES

### A THUMBNAIL HISTORY OF TUBERCULOSIS

ALLAN FILEK, M. D.
*Director, Division of Tuberculosis*

A skeleton has been found, presumably from the period of the stones ages, which showed evidences of tuberculosis of the spine. It is highly probable however that tuberculosis existed in man before the dawn of history, long before picture writing first recorded man's actions. The Indo–Aryans in 1500 B.C. thought that it developed from over-fatigue, sorrow, fasting, pregnancy and chest wounds. It was impure and no Brahmin was allowed to marry into a family where it existed.

To the school of Alexandria, founded by the Greeks, we owe the introduction of autopsies. Erasistratos recommended cabbage, probably the red variety, for hemoptysis, cautioning against overwork and fatigue, and so probably was the first advocate of rest.

### The First T.B. Hospital

It is of interest to note that scrofula was considered contagious in 1609 and the first hospital for any form of tuberculosis was the Hospital Saint-Marcoul founded in Rheims in 1645 by a pious

lady. Gladback in 1697 reported the case of a physician said to have become consumptive from the practice of tasting sputum for diagnosis. Van Swieten stated that the kiss of a wife dying of phthisis took the hair off a spot on her husband's head. Ferdinand VI of Spain in 1751 and Philip of Naples in 1782 issued edicts concerning public health, making notification obligatory upon the physician, friends and attendants under penalty of exile. The furniture, bed and bedding were to be burned and the room renovated. The clothes of a patient at Nancy were burned in 1750. Popular opinion, and the economic loss entailed, before long, brought about the repeal of these laws.

About 1760 a beginning in methods of physical examination was made when Auenbruger, probably the most illustrious man of his century, advocated the use of percussion. The prognosis was still considered hopeless and the list of drugs was suspiciously long. Milk was used less during this period and some recommended simple foods and very small quantities so as not to fatigue the stomach. Walking, swinging, carriage and horseback riding were advocated. Quinine became fashionable when tuberculous Louis XIV bought it as a secret remedy paying for it the equivalent today of about $10,000. To avoid the cough caused by cold bed clothes it was advised that the patient go to bed with his clothes on.

### The Greeks Had No Word For It

Bovine tuberculosis had an interesting history. It was not mentioned in the old Hebrew or Greek writings but was recognized toward the end of the 17th century and animals suffering from it were considered unclean. It was not connected with tuberculosis; in fact, like syphilis when first recognized as an epidemic it too was called the French disease.

In the 19th century Laennec presented his classical treatise on auscultation and later Villemin presented his proof of the infectiousness of tuberculosis. At this period whatever was new was apparently proper for the treatment of tuberculosis. The various elements were prescribed like iodine, potassium iodide, chlorine, iron, carbon dioxide, oxygen, nitrogen, hydrogen, compressed air, fluorine, creosote, ergot, quinine, lime water. Prompton Hospital for consumptives was founded in 1841 in London and later special wards were established in Bellevue Hospital and the City Hospital in New York City.

We can't, of course, fail to mention the discovery of the tubercle bacillus by Robert Koch, in 1882.

### Three Phases of T.B. Discoveries

If we like, we might divide the history of clinical tuberculosis into three periods; the period of symptoms, which extends from remote antiquity to the discovery and application of percussion about the middle of the 18th century; the period of physical findings, from 1760 to 1860, from the introduction of percussion to the treatment of pulmonary tuberculosis in institutions and the third period, the period of the sanatorium. This last period needs further subdivision. 1860 to 1900 might be termed the rest period; 1900 to 1915 might be known as the period of roentgenology; 1915 to the present day could be called the period of surgical treatment.

In 1696 a pupil of Malpighi reported the cure of a patient suffering from pulmonary tuberculosis following a sword thrust resulting, of course, in an open pneumothorax and called to the attention of the physician the probable value of treatment of phthisis.

In 1834 an Irish physician practicing in London is said to have used the open method of artificial pneumothorax in one case at least with excellent results—for at autopsy 11 months after treatment was begun the tuberculosis of the lungs was almost healed (cause of death was unknown).

### Saranac Lake, 1884

Edward Livingston Trudeau was the founder of the first sanatorium in America for the treatment of pulmonary tuberculosis in persons of moderate means. His sanatorium was opened near Saranac Lake in 1884.

In 1887 Dr. Robert W. Philip opened in Edinburgh the first tuberculosis dispensary in the world.

The first state sanatorium at Rutland, Massachusetts, was opened in 1898.

In 1889 Dr. Herman M. Biggs took the first step in his plans for the administrative control of tuberculosis in New York City by formulating, at the request of the then Commissioner of Health, a brief and comprehensive statement regarding the contagiousness of tuberculosis in man.

Professor Wilhelm Conrad Roentgen, Director of the Physical Institute of the University of Wurzburg, made his experiments

with the cathode rays late in October of 1895. We needn't mention the rapid strides that were made and can pass over the development of tomography, the method of radiographing different layers of the body and the numerous other improvements which now permit mass x-ray examinations.

### Getting Down to Wisconsin

Deaths were reported in Wisconsin as early as 1854. Cases were reported by Board of Health rule in 1895 which apparently was two years before the compulsory notification of tuberculosis was finally adopted in New York in the face of great opposition in 1897, although New York City may have made it a reportable disease in 1893. Public health nursing and home supervision for tuberculosis cases began about 1903; the N. T. A. was organized in 1904; the Wisconsin Legislature made it a reportable disease in 1905; the W. A. T. A. was organized in 1908. Wisconsin was admitted to registration of deaths area in 1908.

Now going back a bit—the report of the Wisconsin State Board of Health in 1876 states "Evidence has been accumulated from many stating the evil consequences of breathing impure air. One authority says after 20 years' study of the subject, 'Many cases of consumption, heart disease and kindred evils originate in the foul air of school rooms and other crowded places'. . . . Soil moisture is well known to be one of the most prolific causes of tuberculosis disease".

In 1894 the Board of Health reports stated "For the year ending September 30, 1894 from 648 localities 903 deaths are reported. It is impossible to estimate the exact number of deaths that occur from this disease in the state at the present time. Statistics in relation to these are the most vital importance as it is now recognized that this is one of the preventable diseases with which we have to contend".

### The Cattle Are Suspect

In 1899 the report states that "There is no longer any doubt but what tuberculosis can be contracted by meat and milk of animals and that many deaths from consumption can be prevented by proper precautions being taken along these lines. The investigations of the Board show that while tuberculosis among dairy herds

is not as prevalent in this state as in some of the eastern states yet there is a sufficient amount of it to cause anxiety and to stimulate the most active efforts to prevent its further spread and, if possible, to eradicate it altogether".

A physician reporting to the Board stated that "Consumption is much more prevalent than formerly; this is attributable in many instances to the absurd insufficiency of dress for the proper protection of the chest and feet, especially of females, and to the attendance of young people thus insufficiently protected at balls, dancing parties. . . This physician thought that traveling home at late hours with the temperature 10 and 15° below zero was partly responsible and "suggested holding such reunions in the afternoons".

### Wisconsin Slowly Awakens

In 1901 Assemblyman J. C. Karel from Milwaukee introduced a bill asking for an appropriation of $100,000 for a site and building for a tuberculosis sanatorium. The bill failed and in the Legislature of 1903 L. Albert Karel, a brother, again introduced a bill which was indefinitely postponed. Assemblyman Karel put up a strong fight and while his bill failed he was able to have adopted a joint resolution providing for a tuberculosis commission composed of three appointed by the Governor to study the tuberculosis problem. After adoption of the resolution Governor La Follette appointed three men who reported to the Legislature of 1905 following which a bill was introduced and passed establishing the State Sanatorium. The law contained the provision that the State Board of Control was to attend to the financial phases of the institution but that an advisory committee was to be appointed to select a site, employ an architect and formulate plans and specifications for the construction of the various buildings. The tuberculosis commission of three was then disbanded and an advisory committee of five members was appointed, Professor Russell of the University, Michael Ravn of Merrill, Dr. Gustave Schmitt of Milwaukee, Dr. Kellogg of Portage and Dr. C. A. Harper of Madison. The committee reported to the Legislature that in 1900 there were 2,175 deaths on file in the office of the Secretary of State and that probably 2,500 people a year died of the disease, a death rate of 105 per 100,000 population.

### Your Committee Recommends

Their suggestions for preventing the disease were:

(1) Anti-spitting laws.
(2) Compulsory notification of all cases to boards of health.
(3) Since it is essentially a house disease they recommended thorough disinfection.
(4) Education of the masses for years to come.
(5) Treatment in sanatoria.

The reasons why the state should build a sanatorium were:

(1) From a humanitarian standpoint the state should aid.
(2) From a business point of view it is more economical.
(3) The sanatorium stops further spread by removing contagion from the home.
(4) Educational influence of the sanatorium in that the discharged patient becomes a messenger of the gospel of hygienic living.
(5) Because of the possibility of rigid discipline and close medical supervision.
(6) A cure effected at home is likely to be more lasting than one secured in different climatic surroundings.

Two of the committee of five visited many sanatoria in existence in the eastern United States and Canada and finally chose an area near Wales consisting of 210 acres for the site of the present state tuberculosis sanatorium which was opened in November of 1907.

### River Pines, 1906

River Pines Sanatorium organized by a group of Milwaukee physicians on August 17, 1906 was Wisconsin's first sanatorium. It is difficult for us to visualize those days when there were no sanatoria for the care of the tuberculous. Even at that time with the first sanatoria constructed the work was not over and "Make the sanatorium the first resort of the tuberculous—not the last" soon became the battlecry. That cry still continues to be sounded as evidenced by the W.A.T.A.'s exhibit at the centennial of the Milwaukee County Medical Society a few weeks ago. We still have over 2,500 cases of active tuberculosis not treated in sanatoria, and hundreds of vacant beds.

The second and concluding part of this historical sketch will appear in our next issue.—*Editor*.

# INTERSTATE COOPERATION IN STREAM POLLUTION CONTROL

L. F. WARRICK
*State Sanitary Engineer*

In the same way that an upstream community has moral obligations to fulfill toward downstream communities in keeping its surface waters reasonably free of pollution, upstream states located on national waterways have moral obligations toward downstream states.

The location of Wisconsin and Minnesota at the head of the Mississippi valley led these two states to become prime movers in a regional sanitation plan which evolved as follows:

In 1925 the legislatures of Wisconsin and Minnesota enacted measures which provided a framework for regional action against pollution of the Mississippi, and later in the same year a conference at Red Wing, Minn., saw the formation of an interstate group, which invited participation of interested federal agencies in instituting stream sanitation measures. During the next decade this group accomplished a great deal toward proving that interstate cooperative action has definite advantages in the abatement of stream pollution. Chief among these advantages are the benefits of simultaneous action by communities in states bordering a common stream, and the economy found in conducting joint studies of common problems.

## The Partners Get to Work

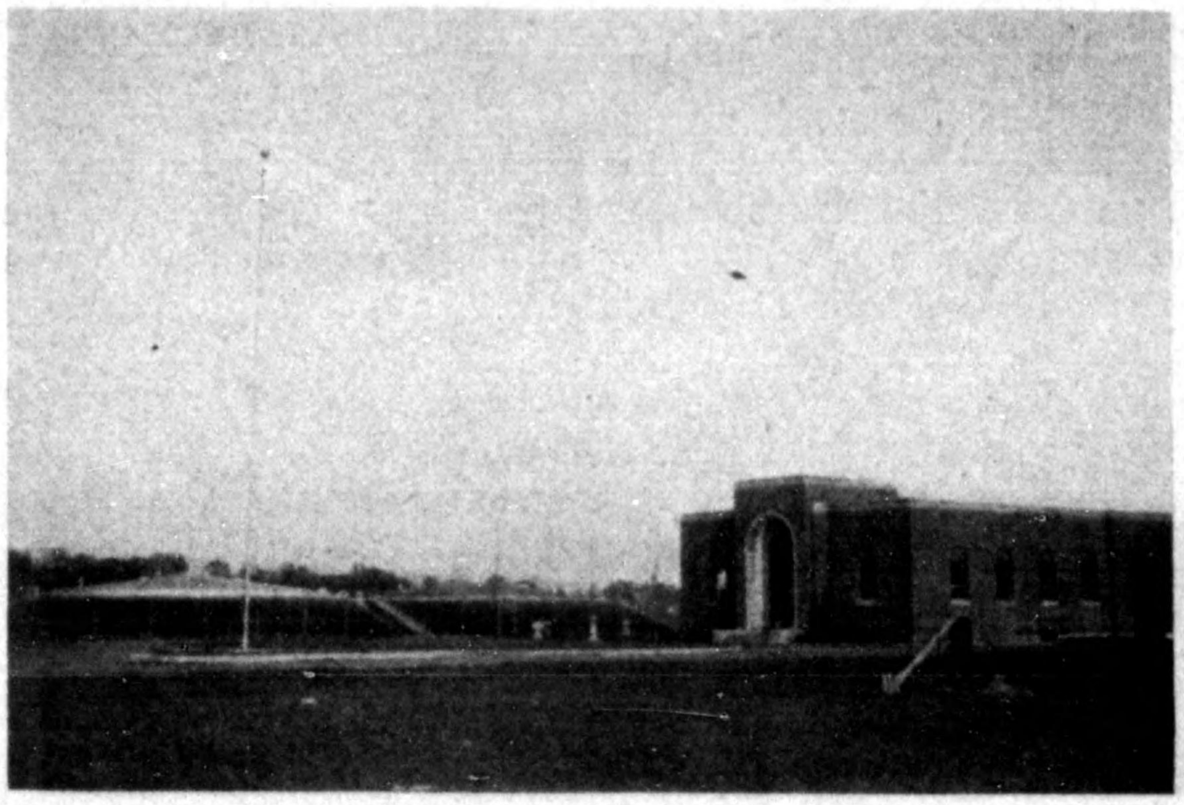
To illustrate these advantages, the first project launched by Wisconsin and Minnesota in 1925–6 can be cited appropriately. The estimated cost of making a thorough study of Mississippi River pollution between the Twin Cities and La Crosse was $19,800, and this sum was made available from the following sources:

| | |
|---|---|
| U. S. Public Health Service | $ 6,000 |
| State of Wisconsin | 4,400 |
| State of Minnesota | 4,400 |
| City of St. Paul | 2,500 |
| City of Minneapolis | 2,500 |
| | $19,800 |

The results of this study furnished the essential background for the project of abating pollution of the great river in its upper reaches. It brought about concerted action on the part of cities located on both banks of the river, and gross pollution of the river was abated through sewage treatment.

### The USPHS Can Lend a Hand

In regard to federal cooperation in projects of this kind, it was in 1893 that Congress authorized the U. S. Public Health Service to cooperate with state and municipal boards of health in the enforcement of their respective rules and regulations, and in 1912 authorized studies and investigations, either directly or indirectly, of navigable streams and lakes of the country.



**Sewage Treatment Works for the Twin Cities, officially opened May, 1938, have removed a large pollution load from the Upper Mississippi River.**

At a meeting in Milwaukee in October, 1935, representatives of the health departments of five states in the upper Mississippi basin laid plans for the development of a cooperative program to solve problems of mutual concern relating to stream sanitation.

The health commissioners of Illinois, Iowa, Minnesota, Missouri and Wisconsin adopted what is known as the Upper Mississippi River Drainage Basin Sanitation Agreement. This agreement pro-

vided for consultation and joint action in dealing with common problems, particularly those of a sanitary engineering nature. Under this agreement between the state health departments, two boards were created, viz., a Board of Health Commissioners and a Board of Engineers.

### Now There Are Six States

In July, 1941, Indiana became the sixth signatory to the Upper Mississippi River Drainage Basin Sanitation Agreement, and entered upon joint studies looking toward pollution abatement and other phases of stream sanitation.

The value of interstate cooperation in the control of water pollution is well shown in an intensive study of high-rate filtration plants undertaken in 1941 under the direction of the Board of State Health Commissioners, Upper Mississippi River Basin Sanitation Agreement. This project sought technical data desired by all of the signatory states, but which represented an outlay of funds and an assignment of research personnel too extensive to be assumed by a single state.

Results of this study, published in pamphlet form in March, 1943, along with findings of similar cooperative studies, have proved of definite practical value in state control of water pollution as achieved through sewage treatment plant construction and operation.

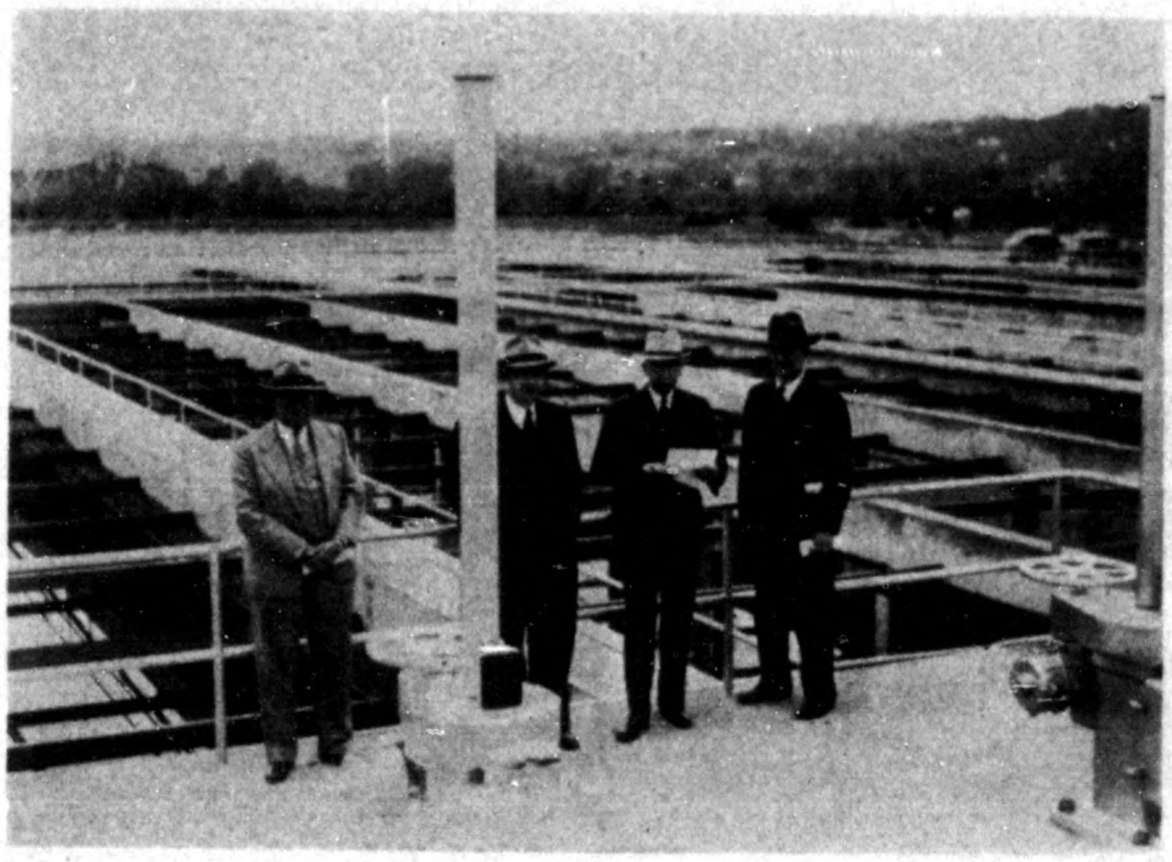
### Malaria Receives Attention

Activities under the Upper Mississippi River Drainage Basin Sanitation Agreement include stream sanitation procedures other than the abatement of pollution. During the summers of 1940 and 1941 the Board of Health Commissioners authorized a malaria survey of the Upper Mississippi for data on the prevalence of anopheles mosquitoes and their breeding places, and on the incidence of malaria. In the summer of 1942 a further study was made under the same auspices, this one in quest of further information concerning malaria incidence in the region. Results, now available in a pamphlet entitled, "Report on Malaria Survey Along the Upper Mississippi River", have furnished a helpful background for Mosquito–Malaria Control projects, some of which were undertaken near wartime establishments in the Basin.

The foregoing observations indicate, then, that interstate activities in stream sanitation not only serve to protect the interests

of downstream states in relation to uses made of the common stream by upriver states, but offer direct reciprocal returns to all the participants regardless of relative location along the waterways.

Behind all these activities looms the incontrovertible principle that no body of water, large or small, should be burdened with a troublesome pollutional load. Not only domestic sewage but trade



**La Crosse Sewage Treatment Works takes care of pollution from the largest municipality along the Mississippi River in Wisconsin.**

wastes of all types are included in this category, for, in addition to the hazards of waterborne diseases, a polluted body of water deteriorates through loss of free oxygen suffered in its biochemical conflict with both human and industrial wastes. When the supply of free oxygen in a body of water is decreased excessively in this manner, fish and other desirable aquatic life suffer to the extent of being depleted or eliminated, and nuisances occur.

## Continuous Action Necessary

The abatement of lake and stream pollution goes forward in continuing programs. Plenty of impetus is given to these activities by the public, some of it based on the public health, some on fish

and game conservation, some on aquatic sports, some on the interests of agriculture, and some on esthetic considerations.

Using a river or lake as a makeshift means of waste disposal is a primitive practice which has no remaining justification in the light of growing knowledge of the right ways to deal with sewage and wastes of all types.

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## NEW RICHMOND SOLVES A SCHOOL HEALTH PROBLEM

RALPH E. JOLLIFFE
*Superintendent of Schools*

Ringworm of the scalp is an infectious disease which in recent years has spread from the eastern coast of the United States toward the west. Its presence was discovered in New Richmond in the summer of 1944 when a child went to his family physician for treatment. By September the disease was apparently localized on the child's scalp and it did not seem to be spreading, so, after careful examination, the child was permitted to enter school. In November a second child was discovered to have the same infection. In this case the infected area was shiny and scaly, the hair broken off, leaving the child practically bald. The infection must have been present several months before it was discovered, as this condition represents an advanced stage of the disease. The child with this condition was immediately excluded from school and referred to his family physician. Later, on the assumption that the infection was an unimportant, low-grade, ringworm, commonly called bovine ringworm, the child was allowed to return to school.

In March, 1945 a child in another family, but living in the same apartment building as one of the earlier cases, contracted the disease. In April two more infected children were discovered by the school nurse. All three children were placed under treatment by their family physicians and returned to school. However, the disease continued to spread, and, during the summer of 1945, it made great headway—reaching a high of twenty-three cases.

### The Problem Proves Complex

Skin experts told us that our situation was grave—that this was not an epidemic of bovine ringworm (Trichophyton gypseum), but one of the two more serious types: Microsporon Audouini or

Microsporon lanosum. The first, we learned, is easily recognized and treated by physicians; the latter two are difficult to diagnose and very resistant to treatment by applications. Little wonder, then, that such questionable home remedies as ashes of burned paper, kerosene and lard, gun powder and lard, iodine, and all kinds of soaps, failed to check the infection.

After a conference between the health officer and local physicians, our health officer recommended that a clinic be held for the examination of all school children during the last week of August. The children were examined and fifteen suspected cases were referred for further examination by their family physicians. Two of the fifteen suspected cases were later found to be negative, and the remaining thirteen children were sent to a dermatologist for diagnosis and treatment. The treatment involved considerable trouble and expense for the children's parents, since it required frequent trips to St. Paul, a city thirty-five miles from New Richmond, to the office of a dermatologist. Some families lacked the financial means to pay for these treatments, and assistance for them was obtained from the Community Chest.

### Careful Isolation Required

Children with the infection were excluded from the public and parochial schools and from all gatherings including theaters, barber shops, and other places where they might come in contact with non-infected children. Such exclusion meant that these children were deprived of education and association with other children for many weeks. It takes weeks, and sometimes months, to bring a case of this type of ringworm under control. The community then came face to face with a real health problem which involved:

1. Discovery of all children with ringworm of the scalp.
2. Diagnosis and treatment for all children who need it.
3. Segregation of infected children in order to check the spread of the disease.
4. Continued education of infected children during the weeks required for treatment.

5. Education of the parents and general public in prevention and control solution of the problem required many steps and the cooperation of parents and children as well as private and public organizations.

On recommendation from a consultant dermatologist, the Superintendent of Schools ordered a Wood Light. This light, used in a

dark room, emits filtered ultra-violet rays which aid in locating the infection in a few seconds. The ringworm patches appear as glossy, fluorescent areas under the lamp. The lamp was paid for by the Parent–Teacher Association and became the property of the public schools.

### The Authorities Take a Hand

The epidemic was brought to the attention of the members of the Board of Education by the Superintendent of Schools, who proposed the establishment of a segregated school room for ringworm infected pupils, so that these children might continue their studies without interruption, and return to their regular classes and classmates when the disease was cured.

Then the mayor called a special meeting of the City Council at which the Superintendent of Schools and the Board of Education were asked to discuss the ringworm problem and its solution. The Board of Education appealed to the Council for financial assistance. As a result of the meeting, the City Council agreed to appropriate $1,800 to match a similar amount appropriated by the Board of Education. It was also decided that the school nurse would be:

1. Put on a full-time basis.
2. Given special instruction in performing epilations and zipping.
3. Taught the necessary precautions for preventing the spread of ringworm, in order that she may, in turn, instruct the teachers, parents, and children.

It was further decided that an extra teacher would be hired to teach the children in the segregated classroom. Representatives from the American Legion offered a room in their building to be used as a "ringworm school."

### The Patients' Education Proceeds

The special school room was opened early in October with an enrollment of thirteen children. In December a dermatologist from St. Paul, with the aid of the Wood Light, examined the children of both the public and parochial schools. This examination revealed five more positive cases which were placed under treatment and enrolled in the "ringworm school."

Some parents cooperated by promptly taking their children to St. Paul for treatment. A few were skeptical at first and wanted to try their own remedies and devices before seeking professional

advice and treatment. The opposition to control measures was small and easily overcome when parents became aware of the seriousness of the disease. The Board of Education made a ruling that no child who had had the infection would be permitted to attend regular classes until he had been examined by a dermatologist and declared free from infection.

The Wood Light was used every day for examination by the school nurse. It had no theuropeutic value, but it was useful in finding the infected hairs so that they could be plucked. At the peak of the infection, sometimes one hundred hairs a day needed to be plucked from a single case. A local ringworm clinic was also set up to which children of pre-school age were brought for examination. Those children in New Richmond, having the disease, ranged from one to twelve years of age. It was much more prevalent among boys than girls. Some experts believe that the short hair of the boys makes them easy victims of the disease which attacks the scalp.

### Course of the Outbreak

The segregated school continued throughout the school year. Seventeen cases of school age were cured and allowed to return to the public and parochial schools. Two cases cured were of pre-school age. At the height of the epidemic, seventeen children were attending the segregated classroom. Then the number steadily decreased because children who responded to treatment were returned to their regular classes, and no new cases developed. During the summer of 1946 the remaining cases reached the arrested stage—"ringworm school" was definitely over.

The disease is an annoyance especially to the children suffering from it, because it isolates them from their playmates and usual activities for a long time. Sometimes it takes three to six months to cure a case of ringworm even with professional treatment. The child reaction to the affliction is shown by the wish of one little boy who, when asked what he wanted for Christmas, could think of just one thing, "Please see that I get rid of this ringworm so I can go to shows, to the playground, to regular school, and can be with my friends."

### Why Treatment is Advisable

If untreated the disease may disappear in time, so some people may think that all of this precaution and expense in caring for

ringworm is not justified. One boy, whose infection was allowed to take its course until nature eventually cured it, has bald patches where no hair will grow, and the hair on the surrounding area is course and scrubby. A comparison among the recovered cases shows the need for adequate treatment. Where treatment was good the recovery is satisfactory, but some youngsters will bear the scars of the disease for the rest of their lives—baldness in spots on their scalps. The expenditure of time and money to control and prevent the disease seems fully justified when one considers the better future appearance and greater happiness of the children.

All during the epidemic the editor of the local newspaper showed active cooperation through the publication of daily articles explaining the seriousness of the epidemic and outlining the community program to check it. One of the articles he published was a reprint of a scientific paper about ringworm, which had been presented earlier before the Ramsey County (Minnesota) Medical Society and published originally in the Journal–Lancet in June, 1945. In a succeeding issue of the newspaper, there appeared an editorial comment which indicates the public reaction to the article, quote, "We published the feature (ringworm paper) and promptly forgot about it . . . . . until we began getting comments from parents. Judging from the interest manifested in the article by parents, a great majority of them read it . . . . ."

New Richmond is one of the twenty experimental and demonstration health centers in the Wisconsin Cooperative School Health Program. The ringworm epidemic gave the people of New Richmond a vital experimental health problem upon which to work. The way in which it was handled demonstrates what cooperative planning and action with local resources can do for the protection and promotion of child health. With this start and with this experience New Richmond is on the march in school health.

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## PENICILLIN DISTRIBUTION TO PHYSICIANS

**The State Board of Health has a limited supply of penicillin available for use in the treatment of early syphilis. While this supply lasts, it will be distributed among private physicians upon request. The request should include the amount of penicillin desired, the name of the patient and the stage of the disease.**

# NEW FEDERAL LAW SUPPORTS HOSPITAL SURVEY

VINCENT F. OTIS
*Director, Hospital Survey*

On August 13, 1946, President Truman signed the Hospital Survey and Construction Act (S. 191) which is now known as Public Law 725. The program calls for two distinct and important phases, (1) Survey and planning and, (2) Construction. The State Board of Health has been conducting a state-wide hospital survey during the past year in anticipation of the final passage of this legislation.

## Funds For Survey and Planning

Under this legislation limited sums of Federal money will be available to each State for planning and constructing modern hospital and public health facilities. The law authorizes an appropriation of $3,000,000 to assist states in (1) surveying overall needs for hospitals and allied facilities and (2) developing plans for utilizing the survey. Upon approval of its application, Wisconsin will be entitled to an allotment of approximately $32,000 according to a preliminary estimate. Under the law, the Federal grant cannot exceed one-third of the total state survey and planning costs. Congress has already appropriated $2,350,000 for carrying out the survey and planning but *has not appropriated any funds for actual construction.* The Act merely authorizes appropriations for construction up to $75,000,000 a year for a period of five years. However, it remains for the next session of Congress to actually appropriate the funds.

## State Must Apply For Survey and Planning Funds

In making application for Federal funds to assist in surveying and planning, the State must (1) designate a state agency to administer this phase of the program, (2) designate a state advisory council to advise the agency, (3) provide for developing a state construction program. In most states, as in Wisconsin, the State Board of Health has been conducting the hospital surveys. The State Board of Health appointed 12 members to a State Hospital Advisory Committee in April, 1945 to help formulate the program. To qualify for Federal funds the Advisory Council will need to include representatives of nongovernment organizations or groups,

and of state agencies, concerned with the operation, construction, or utilization of hospitals, including representatives of the consumers of hospital services selected from among persons familiar with the need for such services in urban or rural areas to consult with the state agency. Wisconsin's application for funds will be filed as soon as all requirements have been carried out.

### State Plan For Construction

The actual construction phase of the program may not be started for a number of months, perhaps a year. Wisconsin must prepare an overall State plan which will conform with the regulations prescribed by the Surgeon General and approved by the Federal Hospital Council and the Federal Security Administrator. Such a plan must (1) designate a State agency to carry out the construction phase of the program, (2) designate a State Advisory Council to advise the agency and (3) show the needs for additional facilities to be constructed, *listed in order of relative urgency,* and (4) provide for methods of administering the plan. Specifically it means that every hospital and related institution must submit schedules of information and the reports carefully analyzed, together with other related social and economic factors, before a plan for construction can be developed. Some Wisconsin hospitals have been slow in completing the survey questionnaires and are now urged to speed up this important task to avoid unnecessary delays in the plan for construction. All the facts concerning every institution caring for the sick must be available if intelligent plans are to be made.

### Construction Funds

As stated before, Congress has *authorized* appropriations up to $75,000,000 each year for five years for construction. *No money for construction has yet been appropriated.* Such an appropriation is not possible until Congress reconvenes. Since time is needed for completing surveys and planning, the delay in appropriating construction funds should not impede the progress of the program.

On the basis of the $75,000,000 authorization, Wisconsin will be entitled to a allotment of $1,622,775 (preliminary estimate) for construction during the fiscal year ending June 30, 1947 if the State plan is approved before that date. Since the Federal grant is only one-third of the cost of construction, it means that Wisconsin would be entitled to $8,113,875 for the five-year period. In other words,

a hospital construction program totaling over $24,000,000 would be possible when two-thirds of the state and local funds are added to the Federal grant.

### Applications For Individual Construction Projects

Application forms for construction will be made available for distribution by the designated State agency when funds are appropriated for construction by Congress. However, before applications for construction can be considered, the State plan must be approved by the Surgeon General. The applications must be approved first by the State agency and then by the Surgeon General. Before the applications are finally approved assurance must be given that (1) the project conforms with the State plan, (2) two-thirds of the construction costs are available in nonfederal funds, and (3) adequate financial support will be provided for maintenance and operation after construction is completed. Many inquiries have been received by the State Board of Health asking how to apply for Federal aid. Therefore, emphasis should be given to the fact that no application forms will be ready until funds are appropriated for construction, probably not until the summer of 1947.

To prevent popular misunderstanding of the program the following facts are to be kept in mind: (1) No funds have yet been appropriated for construction; (2) When funds are available the State survey must be completed and the State plan approved before construction applications can be accepted by the Public Health Service; (3) Construction applications, when made available, must be submitted to the State agency and recommended by the agency to the Surgeon General; (4) The application must give assurance that two-thirds of the total cost of any construction project will be available from nonfederal funds. When definite rules and regulations are drafted they will be made available to anyone interested in the hospital program.

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The average age at death is compiled from death records. Life expectancy is not the same thing, for it has to do with a person's prospects at any given age. These prospects are more favorable than the average age at death. The average age at death deals with the past, life expectancy with the future.

# GRADE "A" SIDE LIGHTS

C. K. LUCHTERHAND
*Milk Sanitarian*

The past few months have brought out many inquiries in regard to the Standard Milk Ordinance which is recommended by the U. S. Public Health Service. Many health officers have not had occasion to work with this type of regulation, while others have been misinformed to the effect that they fear government supervision, should this uniform milk ordinance be adopted in their respective communities. In allaying these fears it might be well to state why this uniform ordinance was set up.

In order to correct the chaotic condition which existed in milk regulations throughout the United States, where regulations were as varied as the personal opinions of the men who wrote them, making acceptance of milk from one market to another difficult, the U. S. Public Health Service appointed a board of consultants called the Public Health Service Sanitation Advisory Board. This board is composed of 16 outstanding men in the fields of public health, dairy industry, equipment manufacturing, sanitary engineering, bacteriology and laboratory equipment; also the U. S. Department of Agriculture, Bureau of Dairy Industry. It was this board which wrote up the first ordinance back in 1924, long before some of the code's present critics were thinking about public health and uniformity of control regulations. Its recommendations, which were based on numerous experiments and the wide experience of experts in the above mentioned field, were used as a guide to formulate the uniform requirements.

## Standardizing Pasteurization

The Advisory Board meets annually for the purpose of bringing the code up to date in order to meet any new advances in science which might be beneficial to milk sanitation and public health. Many of the fundamental requirements in milk sanitation and public health are as sound today as they were back in 1924. The requirements for pasteurization are very specific, which they should be, because pasteurization is a safety factor and a public health measure only.

Besides unifying regulations throughout the nation in order to make acceptance in other markets easier, this code is very specific and interprets each and every requirement. It leaves nothing to

personal opinion or the imagination of individual inspectors. Besides the interpretation, each requirement has a public health significance which makes such requirement more understandable to the man who will have to submit to the regulations. When the grade "A" ordinance is adopted it is the ordinance of that city and is not under any federal supervision. The local inspector, who is responsible to the city council and city health officer, is charged with the enforcement. Upon request, advisory assistance is furnished by the State Board of Health.

### Gaining Results Without Court Action

The grading portion of the code is invaluable to the local health officer because court cases can be avoided. When a distributor has complied with the requirements of the code, he is allowed to use a grade "A" label. Should he fail to comply with the items of temperature control, bacteria counts or type of cap on bottle, he is requested to place a red "B" label on each cap. Should more serious violations appear, the health officer orders the "C" label and advises the consumer to use such milk for cooking purposes only. The housewife, who has now been educated in the significance of grade "A", will take her distributor to task and refuse to buy such products until the requirements are fully met. In this way the consumer aids the health officer in enforcing his milk ordinance. In resorting to court action or the revocation of license, antagonism is very often aroused and the desired result, namely compliance, is not realized.

The term, grade "A", should not be confused with the butter fat content in a bottle of milk. The housewife has all too often been mislead by this. It is the local health department's duty to educate her to the fact that permission to use the grade "A" label is only granted after all sanitation requirements are met which are necessary to protect the consumer from communicable diseases transmitted by milk. Nutritionists are agreed that the major portion of the food value of milk is below the cream line.

### Concerning Raw Milk

The standard ordinance and code also allows grade "A" raw milk for the purpose of taking care of those communities where the consumer has not been educated to the benefits derived from the protective measure, pasteurization. In this way the consumer is given limited protection, but the best that can be said about grade "A" raw milk is that it is only as good as any raw milk can be

*without pasteurization.* Demand grade "A" pasteurized milk! Each and every health officer in order to fully fulfill his responsibility to the mothers and youngsters in his community should recommend to his city council that an ordinance be passed requiring proper pasteurization of all milk supplies regardless of whether or not it is the grade "A" ordinance. The grade "A" program can be worked in later.

### Nine Wisconsin Cities Have the Ordinance

To date, nine (9) cities have been reported to have adopted the uniform standard ordinance. They are: Eau Claire, Elkhorn, Lake Geneva, Delavan, Williams Bay, Fontana, Janesville, Augusta, and Sheboygan. Eau Claire has been grading its milk supply for better than a year, while the other cities are carrying out their educational programs in preparation for grading.

Reports received to date indicate that health officials in at least twenty-two (22) Wisconsin cities and villages have recommended and have had ordinances enacted requiring the compulsory pasteurization of all milk and milk products sold for human consumption. With a little more educational work in certain areas, other cities may follow suit. Should any health officer or city officials desire help in this type of educational program, they are invited to contact the State Board of Health where such services are made available to local health departments.

Questions and comments from local health officers are always appreciated. For the future, let's think and talk pasteurized milk and work toward that grade "A" label.

## WITH THE WISCONSIN EDITORS

Next month's state examination for nurse registration will be taken by more than 600 applicants, the largest number for a single examination in state records. It is an encouraging sign, for few of us would relish a trip to the hospital knowing that nurses were not available. Good surgery or medical treatment requires good nursing too. In fact, it's a major part in a patient's recovery. Girls who are wondering what to take up for a vocation can find plenty to challenge their skill and ingenuity in this profession and a ready demand for their services when they have finished.

—*The Waterford Post.*

## WELL CONSTRUCTION NOTES

Bruce Dimmitt, sanitary engineer of District 6 with headquarters at Green Bay, recently filed the following report,—

"Continuing the study of safe wells and how to keep them safe, I have taken a photograph of a well in which the casing has failed.

"To the best of the knowledge of the present owner (the location is the town of Buchanan, Outagamie county), the well was constructed about 1900. Soil formation at the well is of dense red clay.

"The deterioration of the casing is most pronounced starting at a point approximately 18 inches below the surface of the natural ground and continuing to a point approximately 30 inches below the natural ground line. The casing above and below the area described shows less deterioration.

"During such a progressive failure as must have occurred here, a dangerous situation probably existed for a considerable length of time before investigation was started, since the portion involved could not be routinely inspected.

"Such occurrences show the need of (1) periodic analysis of water supply quality and (2) the need of additional protection of well casing in the upper portions in order to have a balanced design from the standpoint of length of service.

"It would seem that some research could be done in the rate of deterioration of well casing in various types of soil and at varying depths below the ground surface, with known methods of protection such as bitumen, portland cement and others. The findings of such a study could be made the basis of code revisions designed to

obtain wells which would provide safe drinking water over a longer period of time."

### Manslaughter, at Least

Death due to disease induced by drinking polluted water is just as real as death caused by poison, bullets or drunken drivers. It seems illogical that persons responsible for unsafe water supplies so often escape the punishment that is visited upon those who cause death by other means.

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## DEPARTMENTAL NOTES

Louis F. Warrick, state sanitary engineer, journeyed to Caracas, Venezuela, late in September to address a health and sanitation conference sponsored by the Institute of Inter–American Affairs. He was one of six American speakers who presented various public-health procedures to representatives of fourteen countries of South America, Central America, and the West Indies.

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Dr. Carl N. Neupert, state health officer, and Dr. Allan Filek, director of the Division of Tuberculosis, attended a five-day conference on local health units held in September at the University of Michigan. As a representative of the State and Territorial Health Officers Association, Dr. Neupert served on the arrangements committee for the conference. The meeting was the twentieth of its kind, supported by the W. K. Kellogg Foundation.

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Dr. Marshall W. Meyer was welcomed back to the Department in September, after having spent six months with the State Health Department of Florida. On his return he was named venereal disease control officer.

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Dr. Glenn Hough, reporting back from service in the armed forces in September, was assigned as district health officer of District 2, with headquarters at Elkhorn.

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Irene Erickson, R. N., a University of Minnesota graduate, took up duties with the Industrial Hygiene Unit in October. Catherine Chambers, R. N., is on a year's leave of absence from the Unit for further study at the University of Wisconsin. Another newcomer to the Unit is Maxine Pepper, assistant clerk stenographer.

## NOTES FROM OUR FILM LIBRARY

A new edition of the directory of health films available for free loan in Wisconsin was published in August, 1946. It lists more than 100 titles, grouped according to subject, and described briefly. If your group has not received a copy of this directory, one may be obtained by addressing State Board of Health, State Office Bldg., Madison 2, Wisconsin.

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When a request is received and can be complied with, this department ships the film prepaid. The only expense incurred by the borrower is that of return transportation charges, including insurance.

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Ordering a film as far in advance as possible is urged as the surest means of gaining use of a chosen film. Due to the popularity of many of the listed films, it is also urged that second and third choice films be listed in a request for a certain film on a date which the borrower has chosen, or if your first choice is the only film you are interested in, please list first, second and third choice of dates on which your group could use it.

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The film "Motherhood, Life's Most Important Job", which proved so popular as a silent picture, has been done over by its producers as a sound film. Its length is 11 minutes, and a copy is available for loan.

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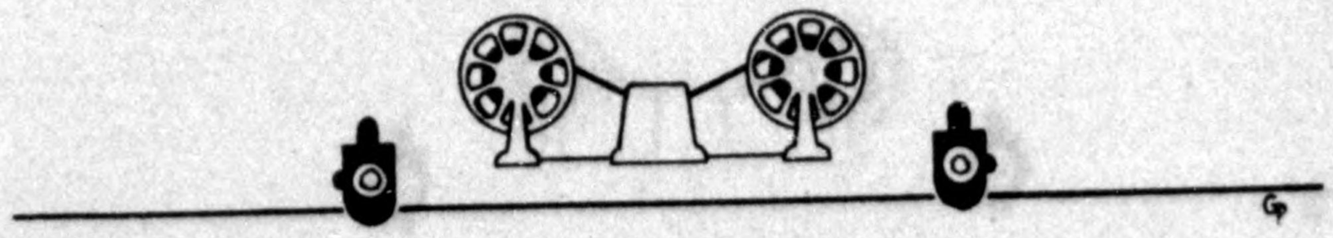
New films made available for distribution by this department since publication of the film directory include the following:

Something You Didn't Eat—The story of nutrition told dramatically by the Walt Disney Studios. Time, 15 minutes. Sound, color.

This Is T. B.—A new approach to an perennial problem. Time, 12 minutes. Sound.



## AVERAGE AGE AT DEATH IN WISCONSIN

| Year | Age |
|---|---|
| 1910 | 40 |
| 1915 | 45 |
| 1920 | 42.9 |
| 1925 | 48.8 |
| 1930 | 51.8 |
| 1935 | 55.9 |
| 1940 | 59.7 |
| 1945 | 61.6 |

**The 1945 figure, however, did not include our war dead, because the records of the Armed Forces were not available.**

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## COUNTY HEALTH DEPARTMENTS

In Maryland the State Department of Health carries on its public health program largely through the County Health Departments. Each of the State's twenty-three counties has its own full-time health Department, supported jointly by this Department and the county. The physicians, public health nurses, sanitarians and other personnel of these local health units come into close contact with the people in clinics, conferences, schools, places of business and even in their own homes.

In 1934 Maryland became the first State to have a full-time health department in every county. In that year Caroline County, the last county to do so, organized its health department on a full-time basis. This was the culmination of a movement that had produced its first results in 1922 when the Allegany County Health Department began to render this type of service.

Although it was not until the second quarter of this century that we achieved the goal of a full-time health department for each county, the development of health service in the counties has a long history. The value of local service for the rural sections was recognized many years ago.

In 1874 the General Assembly of Maryland established a State Board of Health, making this the sixth state to provide for public health functions on a State-wide scale. In 1875 the first annual report of the State Board of Health recommended that each county and large town appoint a health officer. A law enacted by the State Legislature in 1877 authorized the State Board of Health to make it obligatory for the Boards of County Commissioners to organize Local Boards of Health and to appoint physicians as health officers. Other significant legislation was passed in 1880 and 1887. The local Boards of Health were organized in most counties before 1886.

County Boards of Health were organized in nineteen counties in the month of May, 1893, and an additional county appointed its Board in 1896. However, the health officers devoted only part-time to their public health duties until 1914. Before that time most of the actual work in rural areas and small towns was carried out by personnel of the State Department of Health.

An act of the Legislature of 1914 divided the State into ten Sanitary Districts. Under this law the State Board of Health was authorized to appoint a Deputy State Health Officer for each district.

Full-time health service for each county was provided for in legislative enacted by the General Assembly in 1922. This law states that: "The local board of health of each county may, whenever they shall deem it necessary or desirable, require that any qualified physician appointed by such board as county health officer shall be trained in sanitary science, public health and hygiene and shall not, so long as he shall hold that office, engage in any other occupation which would conflict with the performance of his duties as health officer."

When the way was thus cleared by legislative action the various counties began, some of them almost immediatly, to plan the organization of their health departments for full-time service. This was done in the following chronological order:

| Year | Full-time Health Department Established |
|---|---|
| 1922 | Allegany County |
| 1923 | Montgomery County |
| 1924 | Baltimore, Calvert, Carroll and Frederick Counties |
| 1927 | Talbot and Prince George's Counties |
| 1928 | Harford County |
| 1929 | Wicomico and Cecil Counties |
| 1930 | Washington, Kent and Anne Arundel Counties |
| 1931 | Worcester, Garrett, Dorchester and Queen Anne Counties |
| 1932 | Somerset, Howard, Charles and Saint Mary's Counties |
| 1934 | Caroline County |

It is notable that all of these departments were organized for full-time public health work before financial assistance for this purpose was made available from the Federal Government.

A law enacted in 1931 divided the State into twenty-three Sanitary Districts, replacing the ten districts created in 1914. The State Board of Health was empowered to appoint a Deputy State Health Officer in each of these Sanitary Districts, which now correspond to the twenty-three counties into which Maryland has long been divided. The Deputy State Health Officer and the County Health Officer are always the same person, who performs the closely related duties of both offices. Often he also serves on the Boards of Health of incorporated towns within his county.

Besides the Health Officer, the staff of every County Health Department must include at least two public health nurses, one sanitarian and one clerk. Most counties have much more than this minimum personnel. The larger and more densely populated counties require the services of many more workers in public health, and their staffs often include assistant medical health officers and supervising nurses. They work in close cooperation with personnel from the Central Office of the State Department of Health.

Within its county each of the County Health Departments carries on activities similar to those of the State Department of Health. A public health program, generalized in its main features but adapted to the peculiar needs of each area, is administered by every Deputy State and County Health Officer for the benefit of residents of his county. Clinics, conferences, school health work, better sanitation, communicable disease control measures, nursing and medical services are provided. They attempt to carry the benefits of present-day progress in medicine and public health to the people living in rural sections and small towns of this State--regardless of age, race or economical level.

Marylanders living within the corporate limits of Baltimore City, which is not a part of any county, are served by the Baltimore City Health Department. That department, the oldest municipal health department in the United States, dates back to 1793 when the first local Board of Health was established. Continuing its long and distinguished tradition, the City Health Department provides a modern and progressive public health program for Baltimoreans. The Health Commissioner of Baltimore City is an ex-officio member of the State Board of Health, and the Director of the State Department of Health is a Consultant to the City Health Department.

There has long been close and effective cooperation between the two health departments.

The State and County Health Departments are very closely related. The health officer represents both the County Board of Health and the Director of this Department. As County Health Officer he has legal authority delegated to him by the County Board of Health. In his capacity of Deputy State Health Officer he carries out instructions of the State Department of Health and enforces within his county the health laws enacted by the General Assembly and Rules and Regulations of the State Board of Health.

Each health officer is expected to participate actively in medical and public health activities in his county. He must under State law be a licened physician registered in Maryland and it is taken for granted that he will belong to the County Medical Society. In reality there has been understanding and cooperation beteen private physicians and health officers. This is indicated by the fact that one County Health Officer was elected President of his County Medical Society, and another has been elected President of the Medical and Chirurgical Faculty.

In physical characteristics and population the various sections of Maryland vary considerably. Tidewater country and mountains, rolling farmlands and industrial areas are included in the 9,941 square miles of our comparatively small State. Southern Maryland and the Eastern Shore have large Negro populations, but there are relatively few colored residents in the Blue Ridge and Alleghany Mountains of Western Maryland. This diversity has made it necessary to adjust the health program to the needs of these sections. Each county presents a more or less individual problem, according to the land, population, average income, and the occupations and industries represented.

In spite of this needed diversification and adaptation to local conditions many important features of the public health program are general throughout the State. For instance, each of the twenty-three health officers receives reports from physicians of his county as to cases of communicable diseases. Each must keep informed of health conditions in neighboring counties and, indeed, throughout the State. The State Department of Health supplies pertinent information concerning births, deaths, causes of death and the incidence of reportable diseases. These facts guide the health officers in the control of disease and the prevention of unnecessary deaths. Clinics and conferences for expectant mothers, infants, pre-school children and patients with venereal diseases and tuberculosis are also conducted in all counties. Tuberculosis clinics are held in cooperation with the Maryland Tuberculosis Association. Public Health nursing and school health examinations and inspections are common to all, and each health officer is charged with administering the medical care program inaugerated in his county, under the Law of 1945. The local health department also assists in sanitary supervision of water and sewerage supplies, dairies, seafood, shellfish and canning industries, swimming pools, camps and restaurants. Orthopedic clinics are held in all counties in cooperation with the personnel of the division of Services for Crippled Children of this Department. Dental clinics are also held with the assistance of the Division of Oral Hygiene and the County Dental Society. Laboratory service is provided for the counties by the Branch and Central Laboratories operated by the Bureau of Bacteriology and the Bureau of Chemistry.

The Director of the State Department of Health and the professional staff of the Central Office are ready to provide consultation, advice and guidance. Physicians, nurses, sanitary engineers, nutritionists and other members of this Department make frequent trips into the counties to confer with personnel of the County Health Departments, assist in clinics or make inspections. Annual and Quarterly Conferences are the occasion of somewhat more formal meetings of staffs of State and County Health Departments for mutual exchange of ideas and to hear talks on various public health subjects by speakers who are authorities in their respective fields.

It is believed that understanding of the health program by the people is desirable—even essential—to assure the success of activities intended to prevent and control disease. County Health Departments attempt to help those who live within their counties to become informed concerning the various phases of their programs and their underlying purposes. Newspaper publicity, talks, lectures, motion pictures, radio and other means of disseminating information are used to inform professional and lay groups concerning their personal and community health problems. In additional to helping individuals to better health, these educational activities create informed public opinion and active support of the public health work. In many counties organizations and individual citizens have made substantial contributions to the success of the health program through gifts of money, equipment and volunteer services.

The health services rendered to the people of Maryland by their full-time health departments now constitute a generalized and well-balanced program. Traditional public health functions are carried out and newer services such as medical care have been added. During the years to come the State Department of Health hopes that the recruitment of additional professional personnel will enable the State and Counties to intensify and enlarge their public health programs. Additional types of work are not contemplated at present but it should be possible to render more complete services of the types now provided by the State and County Health Departments.

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# PENNSYLVANIA'S HEALTH

DEPARTMENT OF HEALTH

COMMONWEALTH OF PENNSYLVANIA

OCTOBER - DECEMBER 1946

☆

# The Governor of Pennsylvania

JOINS WITH THE

# Secretary of Health

IN WISHING

# A Merry Christmas

AND A

# Happy New Year

TO ALL OF THE

READERS OF

# Pennsylvania's Health

# PENNSYLVANIA'S HEALTH

PUBLISHED UNDER THE DIRECTION OF
EDWARD MARTIN
Governor

HARRY W. WEEST, M. D.
Secretary of Health

JOSEPH M. THOMPSON
Editor

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# Public Health Projects Pledged in Platform

Pennsylvania's Governor-elect, Attorney General James H. Duff, campaigned on a platform in which public health needs of the Commonwealth were given a prominent place.

Of particular interest to public health workers are the following paragraphs from the Platform:

**". . . We pledge continued liberal appropriations for State aid to hospitals and the maintenance of State Health Department institutions for the treatment of tuberculosis, and to extend the scope of clinics for crippled and spastic children. We favor the wide extension of diagnostic clinics for the early detection of major diseases, especially tuberculosis, cancer and mental disorders.**

**"We pledge continued appropriations for cancer research, the eradication of venereal diseases, the care and treatment of rheumatic fever and rheumatic heart disease and for research dealing with the nutrition of children. . . .**

**"We will expand appropriations for complete medical and dental examinations for pupils and teachers.**

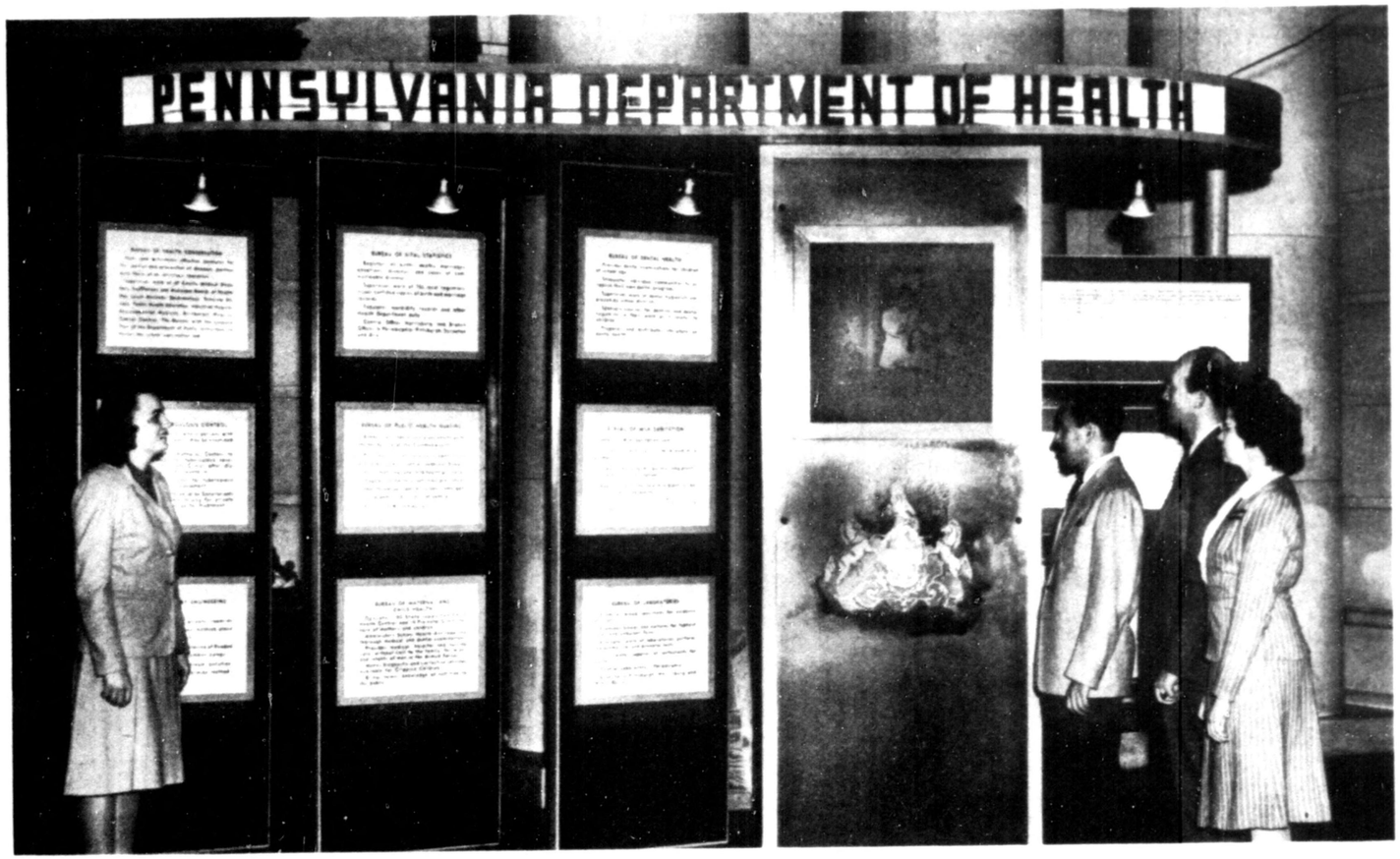
**"We favor strengthening the State's safety and health laws and will support increased appropriations to expand inspection and enforcement in order to guarantee men and women a safe and healthful place to work in all classes of industry. . . ."**

These proposals, pledges and recommendations forecast a continued advance by public health forces in Pennsylvania during the next four years. Much of the groundwork for such a program was laid by Governor Edward Martin and the 1945 Pennsylvania General Assembly.

The State's health is the concern of all the people just as conservation of natural resources is a public and State matter. Great progress has been made in the prevention and treatment of disease but many preventable deaths still occur and support of public health measures by the individual taxpayer and the community as a whole will pay dividends in lives saved and suffering relieved. The health of many individuals becomes the health of a people.

**As legislative proposals having to do with public health are introduced at the next session of the Legislature they will be reported in PENNSYLVANIA'S HEALTH, and the need for such measures will be explained.**

**—J. M. T.—**




NEW DIORAMIC EXHIBIT WHICH SHOWS ACTIVITIES OF THE STATE HEALTH DEPARTMENT

# Crippled Children's Program Covers State's 67 Counties

The Crippled Children's Division of the Pennsylvania Department of Health administrates the program for Crippled Children in Pennsylvania. This program is designed to assist crippled children in obtaining needed care and treatment for their handicaps.

It is the purpose of the Division to locate and have knowledge of all crippled children in the State under the age of 21, regardless of race, creed or color, and to offer assistance, where needed, in their care.

In order to provide such service the 67 counties of the Commonwealth are divided into 17 districts of one or more counties each, and Crippled Children's Clinics are held in each district two to eight times yearly depending upon the need. At the clinics crippled children are examined by an orthopedic surgeon, and a plan of treatment is formulated. This plan may include surgical procedures for correction of deformities, the use of braces or physiotherapy, or a combination of all three of these measures. The primary objective is to secure the maximum improvement for each child. The treatment program recommended at the clinic is then carried out by the surgeon in cooperation with the Crippled Children's Division.

**A total of 75 Orthopedic Diagnostic Clinics were held during 1946 in addition to the regular weekly clinics at the State Hospital for Crippled Children.**

Hospitalization for surgical treatment is provided at 43 hospitals throughout the State as well as at the State Hospital for Crippled Chlidren, Elizabethtown. Dr. Tom Outland is chief surgeon of the hospital. Dr. William C. Edwards is chief of the Crippled Children's Division which functions under the State Health Department's Bureau of Maternal and Child Health.

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## COMMUNITIES AIDED ON DENTAL CARE

The State Health Department's clinical dental program for school and pre-school children in 1945-'46 aided 90 communities by paying for 12,693 clinician hours.

During the school year 9,490 children were treated and 5,833 children had all dental defects corrected.

The dental clinics were located in 32 counties throughout Pennsylvania. Under the direction and advice of the Bureau of Dental Health the communities have raised the funds to purchase and install the necessary equipment. Local dentists are appointed to serve as clinicians. State funds are used to pay these dentists a limited fee.

These clinics are sponsored by School Boards, Boards of Health or some other tax-supported agency or government unit.

# Bigger Federal Grants for Child Health

Pennsylvania shares in the increased Federal funds allotted to the State for promoting child health services to the extent of $98,290 for 1947, it was announced recently by the Children's Bureau in Washington.

The Bureau of Maternal and Child Health, Pennsylvania Department of Health, will receive $67,044 of the increased allotment and the State Crippled Children's Program $31,246.

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## Facilities Surveyed

A survey to determine how much medical and health services Pennsylvania children are receiving at present was launched by the American Academy of Pediatrics in September of this year. Questionnaires prepared by the Society were sent to every physician, dentist, hospital and public health agency in the State as part of a nationwide program aimed at stimulating local groups to see the need for child health services within their own communities and to evaluate existing facilities.

The State Health Department is cooperating in the study which has the endorsement of the State Medical Society and the State Dental Society. Dr. John McK. Mitchell, of Philadelphia and Bryn Mawr, is director of the Pennsylvania study. Its results will be made available to all interested groups at State, county or town levels for the purpose of planning for local needs.

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A nine-member committee appointed by Governor Martin is making a survey of hospital facilities in Pennsylvania. The committee, headed by Dr. Hubley Owen, of Philadelphia, as director, is studying the condition and extent of hospital facilities throughout the State and will recommend what improvements are needed.

The survey is required to qualify the State for new Federal-aid hospital grants under the Hill-Burton Act. Pennsylvania's share—$4,760,915 a year for the next five years—is to be used for all non-profit hospitals, State, city and privately operated. In addition the State will also receive $209,243 to finance its survey and draw up expansion plans for the institutions.

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Dr. Howard K. Petry, of Harrisburg, is the new President of the Medical Society of the State of Pennsylvania. Dr. Elmer Hess, of Erie, was chosen President-elect of the Society at its 96th annual convention in Philadelphia.

# Five Rheumatic Heart Clinics Established This Year

The fifth Rheumatic Heart Clinic to be established this year by the Pennsylvania Department of Health was opened on October 25, 1946 in the Harrisburg Polyclinic Hospital.

Twenty-seven patients who had a history of Rheumatic Fever or Rheumatic Heart Disease were registered on the first day of the clinic. Upon request of the family physician these patients will be given appointments for thorough examinations of the heart.

Dr. Allen W. Cowley, of Harrisburg, is Director of the Clinic. Its objective is to register all patients in Harrisburg and the vicinity who are afflicted with Rheumatic Fever or Rheumatic Heart Disease so that an organized plan may be developed for their diagnosis and treatment.

The Harrisburg Clinic is held on the second and fourth Fridays of each month at 10 A. M. Anyone under the age of 21 who has a history of Rheumatic Fever or Rheumatic Heart Disease may register by telephone (Hbg. 7361), or by mailing a coupon form carried in the local press. Patients who are registered with the clinic will be examined upon request of the family physician, and in each case the referring physician will receive a full report of findings and recommendations for treatment.

Specialists certified by the American Board of Internal Medicine are in charge of the clinics.

Dr. Wakefield E. Stitzel, of Altoona, was named director of the Rheumatic Heart Clinic opened recently in that city. It is in Mercy Hospital. The other three clinics are located in Williamsport, Erie and Allentown.

**REGISTRATION OF RHEUMATIC FEVER PATIENTS**

Mail To: Rheumatic Heart Clinic
Harrisburg Polyclinic Hospital

Name .....

Address .....Age.....

Signature of Physician

..... M. D.

# Tuberculosis Sanatoria Treat 6,626 Patients

A total of 6,626 tuberculosis patients were treated in Pennsylvania's three State supported sanatoriums during the biennium, dating from June 1, 1944, to May 31, 1946. In the previous 1942-'44 biennium, 6,465 patients were treated in the sanatoria.

The three large tuberculosis sanatoriums maintained by the State Department of Health are located as follows: Pennsylvania Sanatorium No. 1 (Mont Alto), at South Mountain, Franklin County; Pennsylvania Sanatorium No. 2 (Cresson), Cambria County and Pennsylvania Sanatorium No. 3 (Hamburg), Berks County.

Any citizen of Pennsylvania is eligible for treatment in these institutions if the patient involved, or his family is unable to assume the financial burden.

## Admission Procedure

The procedure of admission to the sanatoria begins with the family physician, or with one of 90 State sponsored tuberculosis clinics that are strategically located throughout the Commonwealth so that easy access may be had to them. Patients may enroll in the clinics on their own initiative or be referred to them by their own private physician. At the clinic the patient is studied and, if found to have tuberculosis, or is in need of further diagnosis the clinic submits a request for admission to a State sanatorium. As soon thereafter as possible arrangements are made for admission and the patient is transferred from the jurisdiction of the clinic to the State sanatorium where he begins active treatment for his disease.

For many individuals tuberculosis can be arrested even after clinical symptoms such as fatigue, loss of weight, pain in the chest or low grade fever, have appeared. In too many other cases the disease is well advanced before treatment is sought, so that a long period of convalescence is required. The discovery of early lesions in the lung is very important to combat successfully this disease which takes an annual toll of approximately 4,000 lives a year in Pennsylvania.

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### *Music and Health*

**"Worry and strain can do weird things to the human body. All kinds of disability have been traced to it, even loss of voice and to eyestrain. Music can undo much that worry and strain do. Learn to know and to like some kind of music, whether it be Beethoven's Fifth Symphony, Viennese waltzes or modern melodies. Use it for your own happiness and benefit. You need it in this modern strife . . ."—Josephine Lowman.**

# Department News

Dr. John W. Brown has been appointed Industrial Hygiene Physician for the Pittsburgh area. A veteran of World War II, Dr. Brown aided in the organization of the Remagen Prisoner of War Camp in Germany and did work in preventive medicine and hygiene among the 178,000 German prisoners confined there. He has been awarded the Bronze Star, the Purple Heart with two oak leaf clusters, the Combat Medical Badge and the European Theater Ribbon with four campaign stars. Dr. Brown's headquarters are in the Eureka Savings Building, 3400 Forbes Street, Pittsburgh.

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Dr. William F. White, of Wellsboro, was appointed State Medical Director for Tioga County on September 30, 1946.

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Dr. Charles C. Custer, Medical Director of Mont Alto State Tuberculosis Sanatorium, South Mountain; and Dr. Henry A. Gorman, Medical Director of Hamburg State Tuberculosis Sanatorium, Hamburg, announced their retirement on October 1, 1946. Both physicians had service records of 25 years in the Pennsylvania Department of Health.

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Dr. A. R. Judd, Chief Chest Surgeon at Hamburg State Sanatorium for the past several years, has been appointed Medical Director of the Institution.

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Public health nurses recently appointed in the Department include the following: Martha H. Gross, Wilkes-Barre; Helen W. Zielinski, Wilkes-Barre; Mrs. Mary W. Sudell, West Chester; Mrs. Lillian Tresca, Snydertown; Mary Elizabeth Rowles, Emporium.

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Miss Ruth Roth, of Pittsburgh, Nutrition Consultant, resigned on September 13, 1946, to accept a position with the Public Health Federation of Cincinnati, O. Miss Roth had served in the State Health Department since 1937. Her successor is Mrs. Alice L. Van Winkle, Falk Clinic, 3601 Fifth Avenue, Pittsburgh.

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Miss Rebecca Hastings, Advanced Physiotherapist at the State Hospital for Crippled Children, Elizabethtown, for the past six and a half years has resigned. A specialist in training cerebral palsied children, Miss Hastings has joined the staff of the Pennsylvania Society for Crippled Children to do survey work in that field.

# Veterans' Care Program Expanding in State

The Veterans Administration in the Branch 3 area (Pennsylvania, New Jersey and Delaware) is expanding its residency teaching program, opening new out-patient clinics and planning for the establishment of pharmacies and dental laboratories.

Reporting on current VA medical activities in the tri-state area, Dr. Henry R. Carstens, Branch 3 medical director, described the residency teaching program as "courses of post-graduate training for doctors assigned to VA hospitals." The courses were begun at Aspinwall Hospital with the cooperation of the University of Pittsburgh Medical School. Coatesville Hospital has been selected as a teaching hospital for residency in neuropsychiatry. Affiliated with Coatesville VA institution in this program are four medical colleges in the City of Philadelphia. These are: Temple University, University of Pennsylvania, Jefferson Medical College and Women's Medical College.

The out-patient treatment of veterans contemplates the addition of orthopedic clinics, cardiac clinics and general examining clinics according to Dr. Carstens. Shortage of space, both in hospitals and regional offices is handicapping the VA medical service today. Provision of the best medical care possible for our sick and injured war veterans is the goal of the VA hospitalization program. More than 3,500 beds are now available (as of October 23, 1946) in VA hospitals in Pennsylvania.

Medical rehabilitation, one of the newly established sections of the medical service, is functioning in the Branch 3 area. Also in operation for VA hospital patients is the program of physical medicine, consisting of three sections—physical therapy, occupational therapy and the newly added phase of corrective physical rehabilitation.

In connection with medical rehabilitation the VA plans to use the talent and skills of organized community volunteer groups. Such volunteer groups could assist in occupational therapy, educational retraining, pre-vocational shop retraining, activities for the blind, etcetera. They could also perform clerical duties and assist in the transportation of patients. All volunteer personnel will work under the close supervision of hospital chiefs of physical medicine or chiefs of retraining and medical rehabilitation. All will receive proper indoctrination before being permitted to work with patients.

## Cancer Recording Started

The Cancer Division of the State Department of Health has begun the installation of a Standard Record system in hospitals throughout the State. Photostatic copies of cancer case records with the name of the patient blanked out, will be filed in the office at Harrisburg. These records will be coded on punch cards so that qualified individuals at any time can obtain statistical data relating to cancer. This record system has the official approval of the Cancer Commission of the State Medical Society.

The Division has prepared a handbook for Secretaries of Tumor Clinics in Pennsylvania. Instructions on how to establish an individual record registry and follow-up system in an individual hospital are included in the manual. The foreword by Dr. Robert F. McNattin, Chief, Division of Cancer, states that "every case that is diagnosed or treated in your hospital should have a tumor sheet."

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## RABIES AND BOTULISM

The advisory Health Board at its last session ruled that physicians who treat persons attacked by dogs or other animals are required to report the cases to the municipal health officer.

The latter official is also required to acquaint victims of dog or animal bites with the dangers of rabies in cases where bitten persons are not treated by a physician.

Botulism, a form of food poisoning caused from eating improperly canned or processed foods, and epidemic diarrhea prevalent among new born babies were added to the list of reportable diseases.

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## The Black Bag

"Long established as the badge of the profession, the public health nurses' black leather bag contains no mysteries. It contains the few articles a public health nurse needs in carrying on her work—butcher type aprons carefully folded in an envelope shaped bag, towels, liquid soap to wash and clean instruments, rubbing alcohol, cotton, tongue depressors, throat sticks, scissors, forceps, a hemostat used to handle the sterilized dressings, tubes and funnels for giving enemas and catheterizations, a hypodermic needle and a syringe, aromatic spirits of ammonia and three thermometers."—*Johnstown Democrat.*

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A 54.9 per cent increase in highway traffic deaths in the first seven months of 1946 compared with the corresponding period last year is reported for Pennsylvania by the State Bureau of Highway Traffic Safety.

# Prenatal Blood Tests Up 300 Per Cent

E. S. EVERHART, M. D., *Chief*
*Venereal Disease Division*

There has been a gratifying increase in the number of prenatal blood tests performed by the State Health Department's laboratories since the prenatal testing Act of 1939 was amended last year (1945).

The original Act of 1939 required that a blood test be made as soon as possible after diagnosis of a pregnancy. When a specimen of the patient's blood was sent to the State Laboratory for a Wassermann test it was incumbent upon the physician to make a statement that the woman was unable to pay for the test.

In 1945, at the request of the State Department of Health, the Legislature amended the original Act so that pregnant women could receive the advantage of the free blood testing service provided by the State Health Department. Before the Act of 1945 laboratory service was free to all persons in the Commonwealth without question except to the pregnant woman. This injustice was corrected by the 1945 law.

There has been an increase in prenatal blood tests performed by the State Laboratories of almost 300 per cent in 1946 as compared to 1945. As a consequence there should be a corresponding increase in the number of cases of syphilis discovered in pregnant women and, therefore, a corresponding reduction in the number of children born with syphilis.

The Pennsylvania Department of Health is looking toward the day when no child in the Commonwealth shall be born with syphilis. This will be an attained accomplishment when syphilis is discovered early in pregnancy and proper treatment is instituted at once.

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***Penicillin*** is a substance derived from a green mold which has been found to destroy certain kinds of bacteria. A solution of it is injected directly into a vein for treatment.

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**Every three minutes someone in the United States dies of cancer. It accounts for one out of every eight deaths.**

# Two Way Attack on V.D. and T.B.

HORACE C. SCOTT, M. D.

*Deputy Secretary of Health, Commonwealth of Pennsylvania*

Adequate scientific and comprehensive educational activity, and a suitable and complete therapeutic program are the channels through which effective results may be attained in the control of venereal disease and tuberculosis among Negroes in the Philadelphia area.

These two lines of attack will entail first, the institution by highly qualified personnel of direct and intensive courses of instruction for young peoples' clubs, adult organizations, religious agencies, etcetera; and secondly, expansion of existing medical facilities and the creation of new and more specialized medical control centers.

In addition to the direct presentation of information to the clubs and organizations at regular periods supplemented by graphic displays, films, photographs and other modes of visual instruction, there might well be established a program along everyday practical lines which could be carried into the home itself.

To initiate the above outlined course of action it is planned to hold a meeting in Philadelphia to which will be invited leaders of some 25 civic and welfare organizations. The public health structure now extant in Pennsylvania will be explored, and every effort will be made to obtain the closest possible cooperation from these representative leaders.

Given trained personnel, the full cooperation of the various organizations, and the support of the press, a thorough educational program can be launched and sustained. Such a program should produce desirable and beneficent results.

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*Oldest Hospital*

Pennsylvania Hospital, Philadelphia, is the oldest institution for the medical care of the sick and wounded in the United States. It was founded in 1751.

# "Public Health in Pennsylvania" Studied By Club Women

Club women from all parts of the Commonwealth attended a three day institute on Public Health in Pennsylvania November 19-21, 1946 in the Senate Caucus Room of the State Capitol, Harrisburg.

Held under the joint auspices of the Pennsylvania Department of Health and the State Federation of Women's Clubs the conference was addressed by such outstanding speakers as: Wilson G. Smillie, M. D., Professor of Public Health and Preventive Medicine, Cornell University, New York; Harvey Perkins, M. D., Dean of Jefferson Medical College, Philadelphia; F. S. Crockett, M. D., Chairman of the Committee on Rural Health, American Medical Association, Lafayette, Ind.; E. M. Gearhart, Chicago, Consultant in Home Safety, National Safety Council; and Mrs. Marty Mann, Executive Director, National Committee for Education on Alcoholism, Sponsored by the Yale University Plan for Alcohol Studies.

A School of Instruction featured the closing day of the institute. The three day program was arranged by Mrs. Edna M. Kech, Chief, of the State Health Department's Division of Health Education; and Dr. Martha L. Bailey, Chairman of the Health and Welfare Committee of the State Federation of Women's Clubs.

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## Workshop Held

The Second Annual Workshop in Health Education held August 12-31, 1946 at State College, Pa., drew an attendance of more than 150 teachers, school nurses, and health educator. Noted leaders in education and health addressed the sessions which were conducted under the joint sponsorship of the Pennsylvania Department of Health, the Pennsylvania State Department of Public Instruction, and The Pennsylvania State College. Theme of the Workshop was: "Health Education in the Elementary School."

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Worry and tension may bring on an ulcer or cause an old condition to flare up.

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Arthritis causes more disability in temperate climates than any other single disease. It does not usually lead to a fatal outcome, but is the chief offender when it comes to disability, loss of earning power, and suffering.

# Pennsylvania's Health

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**Christmas Seals**


**. . . Your Protection**
**Against Tuberculosis**

Unless signed with the name and title of an Officer of the State Health Department all opinions expressed in this publication are the opinions of the individual writer and must not be construed to represent either the policy of the Health Department or the editorial policy of Pennsylvania's Health.

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# NORTH DAKOTA HEALTH NEWS

VOL. 1, NO. 4
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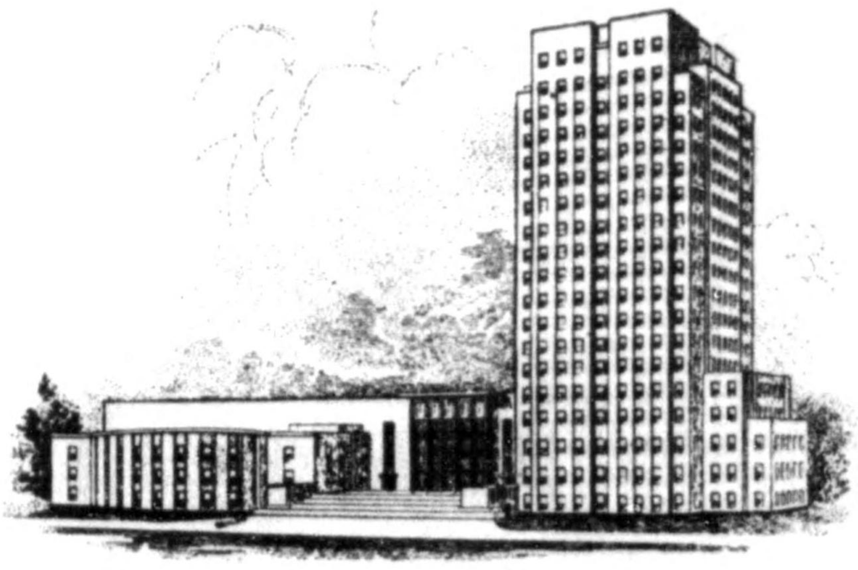

"THE HEALTH OF THE PEOPLE IS REALLY THE FOUNDATION UPON WHICH THEIR HAPPINESS AND ALL THEIR POWERS AS A STATE DEPEND." (DISRAELI 1796)

Published Quarterly
By
NORTH DAKOTA
STATE
DEPARTMENT
OF HEALTH

# NORTH DAKOTA STATE DEPARTMENT OF HEALTH

**Bismarck, North Dakota**

George F. Campana, B.A., M.D., M.P.H.
State Health Officer




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Editor
BERNARDINE CERVINSKI

# NORTH DAKOTA HEALTH NEWS

Vol. 1 December, 1946 No. 4


## STREAM POLLUTION

Increasing industrialization, and an ever increasing awareness of the problem of stream pollution, brought on by agitation from public health authorities, organized sportsmen groups, and others during the past few years has been responsible for the initiation of Federal anti-pollution legislation. This has taken place in the form of several bills introduced to Congress over a period of several years. A compromise between two of the original bills (Barkeley-Spence and Mundt) finally emerged as the Mansfield Bill (HR 6024) to engage the present spotlight on Federal pollution control legislation.

The new bill incorporates some rather rigid enforcement features; it requires the classification of navigable waters into "Sanitary Water Districts" with prescribed standards of purity; it creates a Water Pollution Advisory Board in the USPHS with representatives of the Departments of War, Interior, Commerce and Agriculture, and provides for cooperative administration by the U. S. Public Health Service with state and interstate agencies. Appropriations were recommended in the amount of $100,000,000 annually to be allocated to state and interstate agencies for surveys and special investigations, and $1,500,000 annually for administration of the Act. Loans to industries for the construction of waste treatment works were also considered.

The compromise bill met a highly variable reception, although many of the proponents of the two former bills appeared willing to accept the proposed concessions, and to support the measure in its final form.

The bill placed the responsibility for the control of pollution of "navigable waters" in the hands of the Federal Government, and as such would place a great many of the intra and interstate waters under Federal supervision. This may be questioned on the basis of the great many pollution control programs operating satisfactorily within the states and of the functional interstate committees where interstate streams are concerned. While the general rate of progress has been slow, due to a great many factors,

Dumping garbage on the ice of a river constitutes an individual stream pollution problem.

it has been positive. Stream pollution has been recognized as a problem, and it is being worked upon. Whether it is desirable to give impetus to the corrective measures through Federal participation, supervision, or funds depends upon many factors. These might include the legal powers of the political unit, its financial condition, technical services available to it, and a clear cut solution to a particular problem. Where these conditions satisfactorily obtain, Federal participation probably is not only unnecessary, but perhaps undesirable, since outside influence may upset the normal ability of the unit to supervise, operate, or maintain the facilities provided.

On the other hand, it must be recognized that exploitation of streams has been practiced in some regions, to the detriment of downstream areas, and that the same situations which have permitted these conditions to develop and exist would represent a difficult obstacle insofar as clearing the stream is concerned. It would thus be extremely difficult for one political unit to clean its own yard, when the stream comes from another political unit having little legal power or finances with which to operate. In such cases it may be necessary for over-all assistance on the part

A disposal system which presents a municipal pollution problem.

of the Federal Government and its establishment of minimum standards for the quality of the stream.

Regardless of the level of the political unit concerned with the problem of industrial wastes, the advisability of making public moneys available to industry on a loan basis, or otherwise, for waste treatment appurtenances may be questioned. Technical services would be available through many of the researches at present completed, or under way. The solution of new problems might best be done by trained groups at present in the field. At this point public assistance should stop, except for such supervision or checking as would normally be provided. Congress recognizes the stream pollution problem and in view of the fact that a start must be made some place, legislation similar to the Mansfield Bill will probably be introduced at the next session.

North Dakota has initiated a project designed to collect background data for a program of stream pollution work. An extensive survey of the Red River was conducted cooperatively with the Minnesota State Department of Health and the U. S. Public Health Service during 1938 and 39. The survev has led to the development of an Interstate Sanitation Committee comprised of representatives

of Minnesota, South Dakota, and North Dakota agencies, and to the establishment by this Committee of minimum standards as regards waste disposal practices in the Red River water shed. At present a preliminary study is being made of the Souris River in the north central part of the state. This was initiated partly at the request of interested groups in the Minot area, and partly because it was realized that it was necessary to establish the extent of pollution problems in the state. Under the proposed diversion plans for the Missouri River Valley area, many streams will benefit by having additional waters diverted to their water shed. It has been stated by those responsible for over-all planning that the intent is to require that NO undue pollution be permitted. This will require an evaluation of those streams to be affected, an estimation of the natural organic load, of the load introduced by municipal or industrial wastes, and the ability of the stream to handle the load imposed. These factors will necessarily depend to a large extent on the stream flow, but the base data may be used for the establishment of treatment standards for those cities concerned.

EARL ARNOLD
Associate Sanitary Engineer

## CANCER

The death rate from Cancer has almost doubled since the beginning of the century. In terms of the annual number of deaths from this cause, cancer constitutes a public health problem of the first magnitude. Part of this increase in the cancer death rate is, of course, due to the fact that there is a greater proportion of older persons, that is, persons of the cancer age in the population than was the case in 1900. Cancer is at present the second most important cause of death in North Dakota. The State Health Department cognizant of this fact created the regulation making cancer a reportable disease on March 16, 1944.

Collateral to this government activity, the North Dakota Division of the American Cancer Society has been organized and has enjoyed considerable activity. The program of the society includes education, research and service. The educational work is carried on through the press, radio, and descriptive literature. The research program of the society is controlled by a special committee on growth which has been named by the National Research Council. The service program of the society is a new development and the society is pledged to assist whatever deficiencies are known to exist.

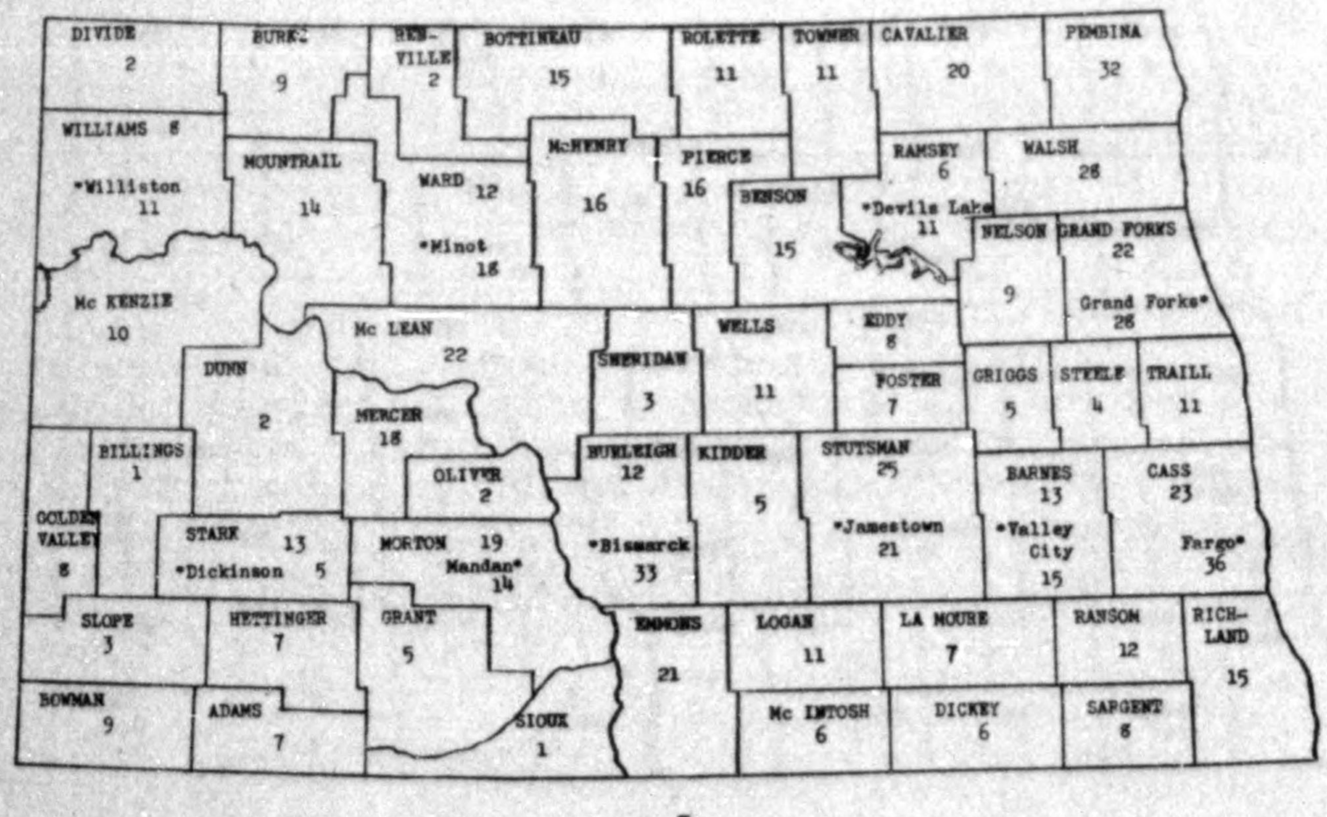
The North Dakota State Medical Association approves in

principle the objectives of the American Cancer Society. It also approves the development of a program of service to cancer patients including the development of cancer detection clinics, established only with the approval of the local district medical society in conformity with the broad principles of policy which will be forthcoming from the committee on cancer of the North Dakota State Medical Association.

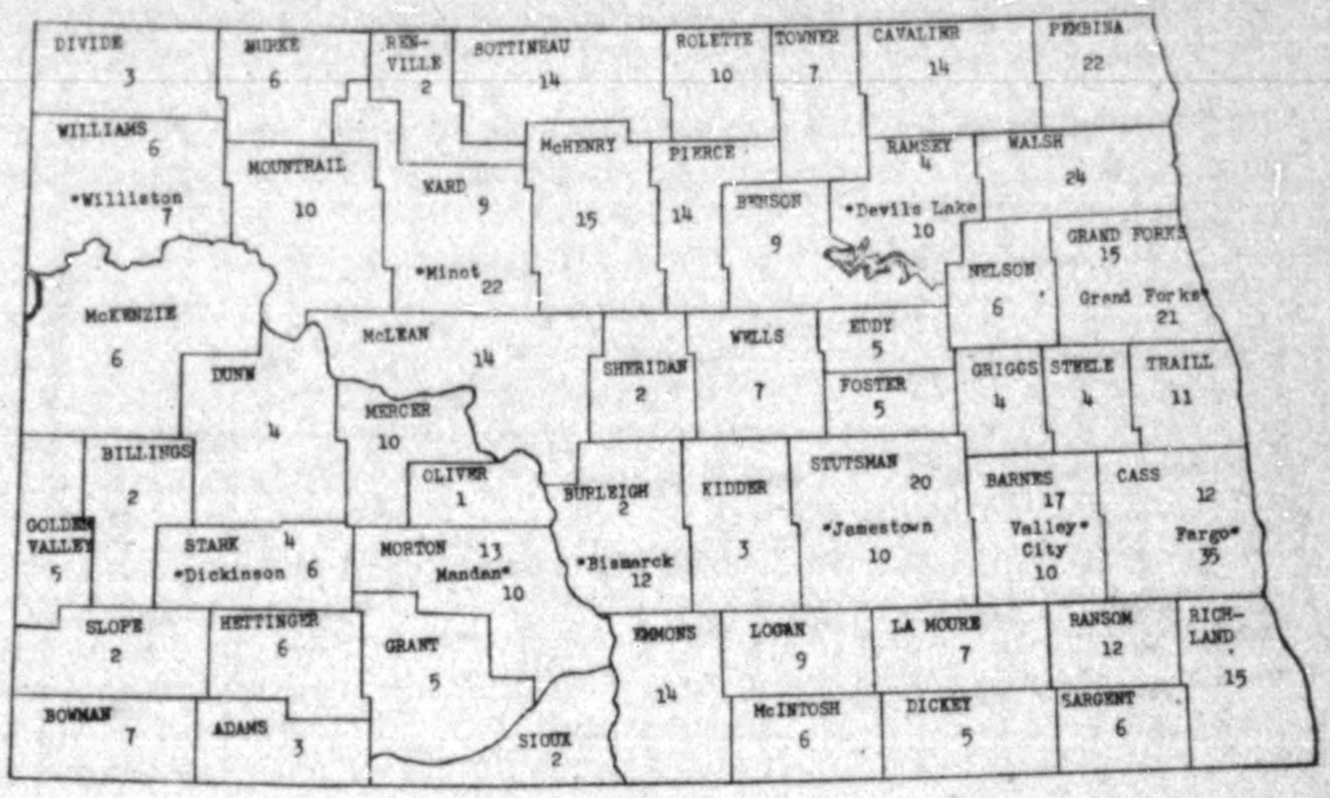
At the present time local pathologists are examining tissues in Bismarck, Minot, and Fargo. Several hospitals in North Dakota now submit specimens to the University medical school for diagnosis. A majority of these are operating on a contract basis, paying a set fee per month for all tissue examinations. Private practitioners who submit specimens to the University are charged a nominal fee per examination.

Research is concerned with the gathering of information as to the cause of cancer and its treatment. The North Dakota State Department of Health expects to expand this activity during the ensuing year. State provisions to facilitate the diagnosis and treatment of cancer are meager and in a developmental stage. Laboratory facilities for tissue diagnostic service are available in twelve other States. In North Dakota tissue diagnostic service is authorized by law but the legislature has never considered an appropriation for that purpose desirable.

CHART 1—CANCER CASES



## CHART 2—CANCER DEATHS




Eight medical schools or hospitals of state universities operate cancer clinics which offer both clinical, diagnostic and treatment services and one offers only diagnostic service.

The medical center at the University of North Dakota is authorized by law to extend services to all the people of North Dakota but the legislature has never appropriated any monies for such expansion. Control programs approach the subject through health education of the public and encouragement of regular examination in the hope that early diagnosis may be obtained. The division of Public Health Education in the Department of Health has increased its activities by 300%.

Perhaps an increased availability of diagnostic and treatment centers as part of community medical service, might contribute to earlier diagnosis and more effective therapy. But it seems likely that until more specific action is taken to coordinate all state activities both public and private, the State Health Department's program in cancer control must remain spotty, incomplete, and ineffective.

### The Extent of the Problem in North Dakota

| | 1945 |
|---|---|
| Number cancer cases reported | 772 |
| Number cancer deaths reported | 581 |
| Number of deaths reported occurring outside of State | 37 |

The figures indicate that many more people are leaving the State to receive diagnosis and treatment than is necessary.

**The Need of a Program**

1. 4.7 percent of cases occurred in counties that have no hospital, maternity home or nursing home.
2. 8.5 percent of cases occurred in counties where the population is less than six inhabitants per square mile.
3. 12.4 percent of cases occurred in counties where population exceeded 5,000 inhabitants per full time physician.
4. 9.8 percent of cases occurred in counties where the median average of the rural population was 71 percent.

WILLIAM SMITH, M.D.
Acting State Health Officer

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## THE SOCIO-ECONOMIC STUDY OF NURSES

At the request of the National Nursing Council, the United States Bureau of Labor Statistics is beginning a nation-wide study of the socio-economic satus of nurses. Wartime nursing shortages that still continue, and national plans for expanded health facilities, which will require increasing numbers of nurses, makes such a comprehensive study necessary.

Each nurse who receives a questionnaire has a serious responsibility to answer promptly and fully. Her report on her experience will represent a number of nurses besides herself. The National Nursing Council represents the five national nursing organizations.

The Bureau of Labor-Statistics will send a questionnaire to a large representative sampling of perhaps 40,000 registered nurses, to determine salaries, hours, working conditions and job attitudes. The survey is only a part of the study. Recipients of questionnaires will be chosen carefully from all parts of the country and all types of nursing, in order to give an accurate picture of the national situation. While the Bureau of Labor-Statistics will conduct the study, the National Nursing Council will assume responsibility for establishing new professional standards based on the study.

In addition to the questionnaires, face-to-face interviews will be held with a smaller group to determine why nurses leave their profession for other fields.

When the information is compiled, a comparative analysis will be made with similar information about such workers as social workers, teachers, dietitians and librarians.

IRENE M. DONOVAN, R.N.
Director,
Public Health Nursing