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Benefits (1) Medical treatment
(2) Off duty allowance
(3) After-care allowance
(4) Disability pension
(5) Disability allowance
(6) Bereaved family's pension
(7) Burial fees

PART 5 National Assistance (PA)

1. This system principally aims to insure the minimum livelihood needs to those who are destitute. It must not be applied until all other measures for maintenance of livelihood have been considered.

2. All those who are unable to maintain a minimum living standard are elligible.

3. In respect to assistance all applicants must be given equal rights and opportunities.

4. Types of assistance: a) Livelihood assistance
b) Educational assistance
c) Housing assistance
d) Medical aid
e) Maternity aid
f) Burial aid

(Institutionalisation and benefit in kind may be considered in lieu of housing and livelihood assistance.) Medical aid is generally granted by actual medical care. All other aids are granted in cash.

5. The mayors of cities, towns and villages, where the applicant resides, is responsible for the determination and execution of the assistance.

6. Facilities and extent of medical aid are similar to those of the social insurance system.

PART 6 Public Health

1. There shall be a prefectural central hospital and model health centers for health and sanitation services as well as high standard medical care.

2. The prefecture shall designate a public local hospital for each health center area and a district hospital which serves an area of several health centers.

3. Private medical agencies should be permitted to use the above facilities.

4. Medical facilities

a) Clinics and maternity homes (1 clinic to 2,000 inhabitants)
(Maternity homes wherever needed)
b) Dental clinics wherever needed.
c) Hospitals, (1) Central general hospitals - 200 to 400 beds at least
(2) Local general hospitals - 100 beds at least

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(3) Special hospitals: a) TB hospitals
b) Leper sanatoria
c) CD wards

5. Health & Sanitation

a) Health Centers: one for every 100,000 inhabitants
b) C class health centers must be improved to meet a designated
c) Standard Health Centers may have branches
d) Each prefecture shall have a model health center
e) Increase of public health nurses is to be considered
f) Laboratories are to be adequately facilitated.

6. T.B. Control

Examination
a) Periodic physical examination of all employed persons (at least once a year)
b) Those unemployed between ages 6 and 30 to be examined at least once a year.
c) Additional examinations for T.B. families and T.B. communities.

Prevention

a) Inoculations for all between age 1 to 30 once a year
b) Additional inoculations for T.B. families and T.B. communities as needed.

T.B. Determination

There shall be a special organ for T.B. determination in each Health Center district.

T.B. Institutions

a) Sanatoria
b) Hospitals
c) Rest Camps
d) After care (follow-up) institutions

T.B. research and training facilities for T.B. specialists.

PART 7(a) - Social Welfare - General

1. Welfare stabilization center - 1 for each 100,000 inhabitants - (case work center)

2. Welfare measures - indoor (institutions) and outdoor (home) relief

3. Welfare investigations

(b) Physically Handicapped Persons Welfare

1. Rehabilitation consultations at welfare stabilization centers

2. Medical and physical examinations

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(1)

Draft of Local Administration Investigation Committee Conference in regard to Redistribution of Administrative Business (1).

A. Communicable Diseases Prevention

1. Designation of Legal Contagious Diseases - Minister
2. Acceptance of Reports —— Minister
3. Order of Aid based on Governor's Request - Minister
4. Qualification of Prevention Work Officials - Minister
5. Execution of Quarrantine - Governor
6. Executing Agency - Governor
7. Order of Aid for City, town, village - Governor
8. Establishment of Catagious Disease Hospital - Governor and city, town, village heads.
9. Restricted use of running water and others causing influence to another city, town village. Negotiation between Governor and city, town heads.
10. Other restrictions - city, town village heads.
11. Health Center Chief should offer cooperation of technical aspect to city, town, village heads.

B. Abolition of Local Epidemic Prevention Agency Office.

C. VD Prevention

1. Establishing hospitals - Governor
2. Entire Abolishment of Welfare Minister's Approving Power.
3. Governor's Administrative measures - entirely to city, town and village heads.
4. Health Center chief should have technical cooperation with city, town, and village heads.

D. Preventive Vaccination

1. Periodical Vaccinations - city, town, village heads.

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2. Extra Vaccinations - Restriction of authority of Minister and Governor in ordering emergency vaccinations.

3. Execution of vaccinations - besides entrusting to health center, general practitioners would participate.

E. TB Control

1. Authority Limit of Welfare Minister - All abolished excepting Acceptance of Reports.

2. Sanitoria - To, Do, Fu and Prefectural Governments are responsible to establish.

3. Authority Limit of Governor - all to be confered to city, town, village heads.

4. In plants, schools, so on, those who are immediately responsible should be the direct supervisors.

5. Regulation of Daily Life Relief Fund - Absorb to Daily Life Security.

F. Prevention method.

1. Abolish Minister's authority to order to establish Sanatorium. Establish National Sanatorium.

2. Administrative authority of Mayor to be equal to that of governor.

3. Physician's report - to be addressed to city, town, village heads - then to the governor.

G. Trachma - Authority Limit of Minister and Governor - Entirely to city, town and village heads.

H. Animal Parasites -

Authority Limit of Minister and Governor - entirely to city, town village heads.

1. Mental Diseases

1. Standards of Hospital and Consulting Place - by Law.

2. Designation of Examining Physician, and admission procedure - same as the present.

3. Authority Limit of Governor - entirely to city, town, and village heads.

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C O P Y

suspense date 15 Sep. 50

Administrative Review

Place: Welfare Bureau, Tokyo-To

Date: 10 March 1950 (10:00 - 17:15)

Subject: 3rd Conference for Review of Findings of Review of Motogi Minsei Kan

Participants: KaCAFF:
Roland J. Artigues, Welfare Officer
Miss Obana (J.N.), Advisor

Welfare Bureau:
Mr. Miki, Acting Chief
Mr. Sekioka, Protection Section Chief
Mr. Momata, Guidance Division, Protection Section
Mr. Tsukamoto, Investigation Division, General Affairs Section

1. Duplicated Medical Aid Applications:

a. Occupation Aid

There are practically no medical aid applications from recipients of occupation aid as the latter are so very few. The limit of amount of grant in occupation aid is so low that for all intents and purposes the program is impractical. The few occupation aid cases opened have been for help in starting a street stall business; or when a person, having found a job, needed work clothing. Having verified the purchase of the needed items, the local office closes the case. Occupation aid cases are not expected to repay the money.

b. Birth Aid

There have been some medical aid applications from birth aid cases, but very few. A birth aid case is considered active until (following Japanese tradition) the infant has had its 7th daily bath. If another member of the family needs medical care during this period, a duplicated medical aid application is made. However when the mother's condition indicates she may have complication, or when complications set in after the birth of the child, the case becomes medical aid rather than birth aid. All treatment needed by the infants is classified as medical aid.

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2. Termination of Medical Aid Cases:

a. Medical aid cases are usually terminated by the patient-recipient either advising the local office of completion of treatment or by not requesting a new medical ticket. For cases lasting longer than the first month the local office inquires of the family, at the time of the issuance of the second and succeeding medical tickets, as to the financial eligibility. This inquiry is usually made at the office. Cases lasting beyond 3 months are usually reinvestigated by a home visit. In addition cases are usually discussed at the monthly Minsei Kai meeting - as the Minsei-iin are in close touch with their families.

b. Continuing medical need for treatment is verified by requiring a physicians statement of condition prior to the issuance of subsequent medical tickets; or special visit to the doctor in suspicious and long term cases.

3. Payment of Initial Consultation Fee in Rejected Applications:

The "Written Request to Doctor" is in duplicate, the doctor retaining one part. This is submitted by him for payment independent of the subsequent "medical tickets" covering cost of actual treatment. In this way the doctor receives payment for the initial consultations fee regardless of the subsequent rejection. This finally was proposed as the basic reason for maintaining the system of dual visits to the local office in the medical aid application procedure.

4. The ward medical investigation committees find many discrepancies in the bills presented by the doctors, usually overcharges, excess treatment, and unnecessarily expensive treatment. The committee reduces these bills (usually obvious situations) on their own initiative. These reductions are usually accepted by the doctors as the committee follows the ceilings prescribed by the Welfare Ministry. When a doctor continues to overcharge, he is removed as a participating doctor.

5. Regulations re Re-Visits for Eligibility:

There are no Ministry requirements covering the frequency of re-investigations. The Tokyo To Welfare Bureau has a regulation still in effect that the Minsei- iin visit their families monthly. As the bureau is free to make its own regulations, and as the Minsei-iin are no longer involved in administration, a committee has been set up (Momata, Kawakami, and Imaizumi) to study this matter and draft regulations.

6. Abolition of Private Workshops in Public Buildings:

Min Sei Hatsu 180 of February 22, 1950 from the Governor of Tokyo To the Prevocation Association is the official receipt for the take over of the 3 workshops that remained in public buildings into 1950. All assets

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were taken over with no remuneration by the To. The officials also produced a letter from the Welfare Ministry of 21 December 1949 approving the To plan to take over operation of all 26 workshops operated by the Prevocation Association. At present there are no private workshop using public facilities.

7. Subsidy to Tokyo Dining Hall Association:

The officials reported that the subsidy of ¥250,000.00 to the Dining Hall Association was legal as that body is a Foundation Juridical Person.

8. The officials have not yet grasped the significance and need for drastic reorganization of local offices in spite of recent apparent agreement with the suggestions and analyses of Welfare Officer. In answer to an inquiry as to plans for implementing Hatsu Sha No. 72 the response was merely a discussion of additional budget needed for personnel and in-service training.

9. Non-DLSL Minsei-iin Activities:

In a review of this subject the following were cited as regular, expected activities of the Minsei-iin without reference to the Welfare Office. It was stated that the Minsei-iin act as private citizens (neighbors) - but that the particular citizen is responsible because he is the Minsei-iin. It was pointed out that the Homen-iin formerly held these responsibilities. Prior to the establishment of the Homen-iin the citizens were in the grip of "town bosses" (Oyabun) - a very undesirable situation. It is now feared that the abolition of the Minsei-iin would tend to encourage the communists to take over and win wide support among the poor!

a. Those good scholars who might have to withdraw from school due to financial inability to pay tuition are referred by the school authorities to the Minsei-iin. Upon their recommendation the tuition is waived.

b. Also referred to the Minsei-iin by both public and private hospitals are patients who entered under their own financial resources, but are now unable to meet their committments. Certification of inability to pay by the Minsei-iin leads to either a reduction or cancellation of the bill. When the patient is determined to be able to pay the Minsei-iin exerts pressure for payments.

c. Persons desiring employment in a workshop may be referred directly, if after investigation, the Minsei-iin approves.

d. Minsei-iin also certify on a priority basis those seeking to pawn personal belongings. As available loan money is limited, those persons approved by Minsei-iin are given preference.

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e. The Minsei-iin are also active in establishing priorities of need among the day laborer groups for placement by PESO. Those day laborers who do not earn ¥4,500 monthly are eligible to receive relief work through PESO. As available jobs are less than the total potential need, the certification by the Minsei-iin acts towards getting the jobs to those most in need.

f. Minsei-iin certify eligibility for use of the subsidized dining halls operated by the Public Dining Hall Association of Tokyo.

g. Either through the family's own initiative or by referral from a neighbor the Minsei-iin also acts as a consultant to families in working out personal maladjustments. He handles such cases on his own responsibility and judgement - but refers the more difficult ones to the Family Court. Families have been trained over the past 30 years (since the establishment of the Homen-iin system) to take all of their problems and difficulties to the Minsei-iin.

10. The bureau officials agreed to cooperate in making two studies of medical aid applications and grants in 26 local offices: one local office in each ward; and one town in each of the 3 gun (districts).

11. a. It was agreed to begin an administrative review in Ogikubo Minsei-Jimusho of Suginami ward on 20 March 1950. This local office was selected to effect a tie-in with the review, by Mrs. Kent of KCAR Welfare Section, of the operation of the Medical Social Worker in the Suginami Health Center.

b. Mr. Momata, Mr. Kawakami, and Mr. Ezuki will study the local administration of the Urawa City Welfare Department on 17 and 18 March 1950.

/s/ Roland J. Artigues
/t/ ROLAND J. ARTIGUES, DAC
Public Welfare Officer

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PUBLIC WELFARE SECTION
KANTO CIVIL AFFAIRS REGION
APO 500

ANK/rn

21 April 1950

SUBJECT: Continuation of the Administrative Review of Suginami Health Center's Medical Social Division

TO: Mr. William H. James, Chief
Public Welfare Section, KaCAR

1. The undersigned Welfare Officer, Annabelle H. Kent, and Noboru Koyama (JN) conferred with Miss Debuchi, Chief medical social worker, on the following matters.

2. Miss Debuchi reported that the case conferences to be held by the doctors with the PHN's and MSW's will begin on 24 April and are to be held every Monday and Friday thereafter at 1 p. m. Only the staff members concerned with cases selected for discussion will attend. Miss Debuchi feels that these case conferences will be of help in bringing better service to patients. She is particularly interested in the value these conferences will have in pointing up to the doctors the social and economic aspects of TB patients who are not receiving adequate care at home and why they "should be considered for hospitalization".

3. Miss Debuchi reported that it is difficult for the MSW to provide adequate social service to patients because the doctors who see cases are not assigned to specific clinic services. Patients rarely see the same doctor twice and as a result diagnosis and treatment plans are frequently changed. Although on the Center's plan of organization the Center's ten doctors are assigned specific services and functions, in practice, this has never been true. The doctors see patients as they can spare the time. For example, the doctors theoretically assigned to TB and VD see each others patients as well as patients on other services.

4. A supply of UNICEF skim milk is to be received very soon which is to be distributed to persons receiving medical aid and for juveniles under 18 years of age who have TB. The MSW in cooperation with the medical staff will be responsible for the selection of patients who fall into these categories. However, Miss Debuchi is concerned over the matter of distribution as the Supply Division and Nutuition Division claim they have no staff for this purpose. Welfare Officer pointed out the various reasons why the distribution should be done by the Supply Division and not by the Medical Social Division.

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5. The MSW's have never made requests of the welfare office to issue supplementary funds for patients in need of special diets. Recommended that cases requiring special diets be discussed with the physician and nutritionist so that such requests where necessary are made in writing of the welfare office.

6. About two or three requests for medical information are made to the MSW's by welfare officials each week. These requests generally concern cases which might be considered for livelihood aid if a medical problem exists. For example, on 20 April 1950 the welfare official of the Iogi Minsei Jimusho referred the following case for a medical report:

a. Hidehiko Komatsu - patient, age 18 years, 255 - Mukaicho, Suginami Ward. This boy's father had applied for supplementary livelihood aid for himself, wife, patient widowed daughter and the latter's three young children because the father was too old to work and had no income. The widowed daughter is a school teacher. The welfare officials stated the family was not eligible for any help unless the high school boy was sick. The Center's medical finding revealed no physical defects.

b. Miss Debuchi feels the welfare office should not require children in high school to quit school to go to work.

7. Tentative arrangements were made to complete this administrative review in May when representatives from both KsCAR Health and Welfare Sections can meet with the Center staff.

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PUBLIC WELFARE SECTION
KANTO CIVIL AFFAIRS REGION
APO 500

AHK/mm

24 March 1950

SUBJECT: Continuation of the Suginami Health Center's Medical Social Division Administrative Review (Tokyo-To) on 22 March 1950 and 24 March 1950.

TO: William H. James, chief
Public Welfare Section

1. The undersigned Welfare Officer, Annabelle H. Kent, with Noboru Koyama (JN) on 22 March and with Tatsuko Ohara (JN) on 24 March, conferred with the following Health Center personnel on activities carried on in the Medical Social Division:

a. Dr. Tsukahara, director of Health Center (present part of the time).
b. Miss Debuchi, medical social worker
c. Miss Ishi, medical social worker (present part of time)
d. A Center nutritionist
e. Mr. Tachibana, General Affairs Section's Med.Aff.Div.

2. Exemption or Reduction of Medical Fees:

a. The applications for these exemptions are secured from the medical social workers. After the patient or family member is interviewed he completes his part of the form and is told to take it to the Minsei-iin for his approval and seal. (The latter corrects previous report as the patient or family member always takes it to Minsei-iin and not the medical social worker.

b. The Medical Social Division's statistics on 11 consultations for exemption of medical fees in February revealed;

(1) A duplicate count as some patients returned more than once to consult on this matter.

(2) Only one of the three applications which were to be taken to Minsei-iin has been returned. In some cases the approval for exemption of fees takes two or three months. No follow-up is done by the medical social worker to determine what happened to the applications which are not returned.

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c. Some exemptions of fees concern patients who are given free Sentonin from LARA supplies, free VD treatment under VD Prevention Law or DLSL livelihood aid cases who can secure medical care under DLSL.

3. Referral for Social Insurance: No referral sheet or any other form is used for this purpose. Medical social workers inform the person of his benefits under these programs and is told how to proceed.

a. Only members of government-managed Health Insurance programs are eligible to receive care in the Center. Members of Health Insurance societies or associations are not eligible, because no agreement has been worked out between these groups and the Tokyo-To Health Bureau.

4. LARA Supplies:

a. The Supply Division has been receiving LARA supplies such as milk, suger, and canned foods for children under three years of age for over a year. The last supply was exhausted in January 1950.

b. When the Supply Division receives an allocation it turns it over to the Nutrition Division who are responsible for the distribution.

c. The doctors in the Center fill out a referral form for LARA supplies indicating the amount necessary. This form is taken by the family member to the medical social worker who judges the family's eligibility and if deemed in need the medical social worker places her seal on this form. The family member then takes the form to the Nutrition Division, who issues the LARA supplies in accordance with the commodities on hand. This may be less then the doctor requested. Once this form has been approved by the doctor and medical social worker the family continues to receive LARA supplies monthly until the patient reaches three years of age.

d. The Nutrition Division's record on the Center's Milk Station includes the following on each case;

Date
Name,of baby, age, sex, and
Amount milk issued
" of sugar issued
" of other items issued
Seals of family

e. About 50% of the patients receiving these LARA supplies are referred from the Minsei-iin and the remainder from the clinic doctors. Each of these patients must be examined by the doctor prior to receiving LARA supplies.

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5. Health Center rates for physical examination including a small chest X-ray and blood test is 85 yen. A problem exists in relation to cost of sputum examinations. These are done at a private laboratory and costs 120 yen each. Even DLSL cases have had to pay this fee out of their grants since February as no agreement exists between the laboratory and welfare program. A laboratory technician who will do sputum examination is to be added to the Center Staff in April. Part of the problem regarding payment for the sputum examination is due to fact that the client receives one medical card and this remains with the center until it is forwarded to the welfare office for payment.

6. In the Center all medical fees charged must be paid prior to the examination of the patient. These payments are made to the Accounts Section of the General Affairs Division. Patients whose medical care is paid for under the DLSL have their clinic card stamped to this effect. The medical social worker maintains these medical cards and forwards them at the end of the month to the welfare office (Minsei Jimusho) for payment.

7. Referrals for Maternity Aid under Child Welfare Law:

a. The doctors refer these cases to medical social worker and she in turn refers them to the child welfare official for the area by giving the patient a referral slip. There are two child welfare officials in Suginami Ward - one is stationed in the Suginami Minsei Jimusho and the other in Ogikubo Jimusho. Each carries one half of the Suginami Ward area.

b. Only in patient maternity care is covered by Child Welfare Law and home deliveries are paid for under DLSL.

c. Prior to issuing a referral slip to the child welfare official the medical social worker makes a rough determination of their financial eligibility. DLSL cases are automatically eligible. If the patient is not DLSL recipient she determines whether their income is not enough to pay for maternity care.

d. Application for free or part pay hospital care cases under the Child Welfare Law are taken by the patient to the child welfare officials. These are returned within two or three days.

8. Patient Load:

a. An average of 200 patients a day is seen at the Center (includes immunizations). Since last fall about 20 pneumothrax case and 150 persons for TB examinations have been turned away per month. These are mostly persons covered with Health Insurance who can receive these services elsewhere or persons with sufficient income to pay private doctors. If such persons strongly object they are given appointments to come back to the Center at another time.

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b. The lack of building space is the reason for turning away the above patients. As a result Dr. Tsukahara, last fall and frequently since, has conferred with Tokyo-To Health Bureau and the Suginami Ward Assembly to take steps to build another Health Center in Suginami Ward.

9. Eugenics Cases:

a. The Medical Affairs Division of the General Affairs Department is responsible for the eugenics program. They accept all the necessary forms and submit them to the Eugenics Committee. They call the committee together and handle all of its clerical and secretarial work.

b. Only those cases which request abortions for economic reasons come to the attention of the Medical Social Division. However, not all this group are referred to social service. When the Center doctors refer them, the medical social worker investigates their financial situation and then sends the patient to the General Affairs Division for the form which the patient must take to the Minsei-iin for his seal and endorsement. Some such cases come to social service before they are seen by the doctor.

c. Each such case must submit the Minsei-iin's endorsement and a physician's statement to the General Affairs Division prior to the Eugenics Committee review.

d. Examples of eugenics cases handled by social service: Mrs. Tanaka, age 33, come to attention of social service on 14 January 1950 when she brought her DLSL "initial medical ticket" for a examination because she was pregnant and "thought she needed medical treatment. Her husband, a writer, has TB and family is poor. After the Center doctor's examination, she came back to the medical social worker as she was disappointed that the doctor had found nothing wrong with her. She then told the medical social worker that what she really wanted was an abortion. As a result the medical social worker referred her back to the Minsei-iin via the Medical Affairs Division for the Minsei-iin endorsement so that she could have the abortion for economic reasons. (The medical social worker did not know whether the husband was under treatment for TB or not and has never heard from or about the patient since.)

e. On 14 February, Mrs. Hattori, age 41, was referred to the medical social worker from the Medical Affairs Division because she could not pay for the abortion which was approved by the Eugenics Committee. This family of seven persons had an income of 6,000 yen per month. So the medical social worker thought she was eligible for medical aid under DLSL, and referred her to the Minsei-iin Jimusho. (The Medical Social Division has had no further contact on the case.)

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f. On 7 February, Mrs. Asano, age 42, was referred to social service because she could not afford to pay the fee of 3,000 yen the designated doctor had asked to do the abortion. Mrs. Asano's case had been approved by the Eugenics Committee for financial reasons. Subsequently the Medical Affairs Division appointed one of the designated physicians in her area to do the abortion. The official price is 770 yen. The medical social worker referred Mrs. Asano to the Minsei-iin for approval of medical costs under DLSL and informed her if the case was not approved she could go back to the appointed doctor and ask him to give her permission to go to another doctor or hospital. This release must then be brought to the Medical Affairs Division in order to have another doctor or hospital appointed. The Medical Social Division has had no further contact on the case and does not know what happened on it.

g. On 9 February, Miss S., age 32, was referred by Medical Affairs Division to medical social worker because she could not afford to pay abortion fee. (Income of 9,000 yen and family of five persons.) Medical social worker referred her to the Minsei-iin and has had no further contact on case.

h. Case of Ai Komatsu, 1-83, Amanuma, Suginami Ward, Ogikubo Minsei Jimusho: In summer of 1949, Mrs. Komatsu had requested an abortion because of financial reasons. She was a recipient of livelihood aid under DLSL. The family consisted of Mrs. Komatsu and two small children - the husband had been jailed because of stealing. In August immediately after the abortion the Minsei-iin said the mother must be able to work so he decided that only the children should be given livelihood aid. The grant was cut to about 1,000 yen per month. The mother tried to get a job but couldn't, so she came back to the medical social worker asking her help in securing an increased grant. As a result the medical social worker discussed the case with the Minsei-iin, but he said he would not increase the grant as the mother can work. The medical social worker has had no further contact on this case since August and does not know what happened. This case was approved for an abortion on basis of "infitration of the lung" actually she had no such diagnosis. But the Minsei-iin had advised mother to have the abortion and when doctor could find nothing wrong the doctors finally gave the "medical diagnosis" as at that time abortion for economic reasons were not allowed.

i. One case was cited of an unmarried girl who was seven months pregnant for whom an abortion was approved (her mother was in a mental hospital and two brothers were in jail) on the basis of mental illness in the family since it might be "hereditery".

10. Miss Debuchi reported that most of the abortion cases approved for economic reasons come about as a result of the Minsei-iin's advice to the family. A new referral from the Minsei-iin received on this

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date revealed that an abortion was recommended because the mother had two children and the husband's earning were marginal and if another child was born the family would need help under DLSL.

11. The doctors do not give birth control information to the women seen unless they request such. Miss Debuchi, however has initiated discussion on this matter with patients and advised them to discuss the matter with their doctors.

12. Miss Debuchi reported that patients usually desire abortions because they do not think they can afford another child. Doctors recommend abortion up through the eighth month of pregnancy. However, most are done between the fifth and sixth month of pregnancy. Recently more have been done in the third or fourth month because more persons are acquainted with the Eugenics Law. Miss Debuchi has heard of no deaths occurring as a result of the abortions approved by the Eugenics Committee but stated some cases became quite ill after the abortion.

13. Mr. Tachibana, chief of Medical Affairs Division, reported that;

a. An average of 45 cases a month was approved for abortions last year. Of this number, 25% was due to economic reasons. This year around 60 cases are being approved per month and about 33% are due to economic reasons.

b. About 120 pregnant women a month are examined in the Health Center.

c. Statistics on abortions approved during Jan. and Feb. 1950:

(February) Total - 59

Physical reasons - 46
Economic reasons - 13

Breakdown on Physical reasons

Kidney infection	7
High blood pressure	1
Beri beri	10
Pleurisy	5
Infiltration of lungs	7
Catarrh of pulmonary apex	3
Arthritis	1
Mother had a baby within the year	1
Vomiting	9
Pleurisy affecting heart	2

46

(January) (Number was less because of holidays.)
Total - 31

Physical reasons - 21
Economic reasons - 10

Breakdown Physical reasons

Vomiting	9
Beri-beri	4
Bronchitis	1

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Infiltration of lungs	4
Kidney disease	2
Inflamation of pulmonary apex	1

14. Reception Record of Division:

a. Includes list of only those cases who come to Social Service for the first time. Case records are prepared on only those which the Medical social worker thinks may need follow-up.

15. Another list of new cases was kept in February which included following information on each;

Date accepted,
Patient's name, address,
Referred from,
Kind of medical condition,
Sex, age, occupation,
Number of family members,
Income,
Medical treatment cost, such as DLSL, Insurance, etc.,
Contacts such as home visits, or office interview,
Housing,
Actions taken.

16. In March, another list combining above with old cases was kept in addition to the reception record and daily diary which included the following additional topical headings to those listed above;

Reason for disease,
What prevents medical treatment,
Working ability,
Referrals and reasons,
Number of clinic record,
Case number.

17. Miss Debuchi is of the opinion that at least two more medical social workers are necessary and one clerical work - making a total staff of five, in order to do an adequate job. Furthermore, at least two medical social workers should be assigned to the TB service.

ANNABELLE H. KENT

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

Mr Tokuyama

PUBLIC WELFARE SECTION
KANTO CIVIL AFFAIRS REGION
APO 500

AHK/mm

27 March 1950

SUBJECT: Continuation of the Administrative Review of the Suginami Health Center's Medical Social Division - 27 March 1950

TO: William H. James, Chief
Public Welfare Section, KaCAR

1. The following summarizes the data secured from Miss Debuchi, Chief medical social worker of the Center on 27 March 1950.

2. Eugenics Law Cases.

a. Source of Referral.

(1) Some are referred by the Minsei-iin, some are self-referred and some are referred by the Medical Affairs Division of the Center's General Affairs Section.

(2) The Minsei-iin refer such cases to the medical social worker in order to find out how or what to fill out on the form which is to be signed by the Minsei-iin.

(3) Those referred from the Medical Affairs Division concern cases which have been approved for abortions because of economic reasons and the Minsei-iin thought the family could pay for the cost of the abortion. After these persons inform the Medical Affairs Division they cannot meet the cost, they are referred to the medical social worker.

b. In cases referred by the Minsei-iin the medical social worker states that she first asks them a "lot of questions" about their financial situation and when she thinks they are eligible she goes to the medical affairs division for the form which she gives the applicant to take to the Minsei-iin for completion and his seal. Eligibility is determined in accordance with "Welfare Ministry Public Health Bureau and Social Affairs Chief" instruction, Eisho Hatsu #852 dated 17 August 1949, which stipulates that cases for abortion can be approved on the basis of economic reasons if their income is not more than 50% over the Welfare Ministry Minimum Living Aid Standards. ("Standards will be approximately 150% of Minimum Standards of DLSL") Miss Debuchi could not recall

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rejecting any case referred to her by the Minsei-iin. When such families have regular income the calculation is simple but if their income is not regular or if the head of the family claims no income the financial determination is difficult and Miss Debuchi states she must rely in "judgement" and her experience. She tries to decide the eligibility in such cases by determining whether family can get along with one more family members or not.

c. In about 5% of the cases coming to the attention of the medical social worker the husband applies for the abortion stating that his income is not sufficient. In these cases the medical social worker has not intervened the wife because the "husband knows best about the family's income".

d. For example of cases approved for abortions per the "Eugenics File Application" of the Medical Affairs Division, see Inclosure 1.

e. The Eugenics Committee is composed of the following persons:

(1) Mrs. Imai - Minsei-iin (a well known Catholic woman who is opposed to all abortions)

(2) Mr. Hiratsuka - Chief of the Welfare Section of the Suginami Ward Office

(3) Dr. Tsukahara - Director of Suginami Health Center

(4) Dr. Nakayama - Representative of Physician's Assn.

(5) Dr. Takakusa - a physician in the community.

f. In reviewing several of the committee statements on the eugenics cases approved it was found that Mrs. Imai considered them all unsuitable for abortions and the other members of the committee considered them all suitable.

3. Relationship of Medical Social Workers and Public Health Nurses:

a. No standard or guide has been developed which could be helpful to the public health nurses in selecting cases for referral to social services. As a result some public health nurses refer cases to the medical social service and some do not. The types of cases referred by the public health nurses are somewhat as follows:

(1) TB cases which need hospitalization and cannot afford to pay for care or are not willing to accept the physician's recommendation for admission to a hospital. If the patients can pay the cost or are covered with

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Health Insurance the public health nurse makes the arrangement with the hospital. (The latter contradicts an earlier statement of the medical social workers in which it was stated medical social division handles all hospital admissions.) Whenever the Daily Life Security Law is indicated the case is referred to the medical social worker.

(2) Clinic cases which are in need of public assistance, that is appear eligible or appear almost eligible are referred to the medical social worker by the public health nurses.

(3) Cases in which the husband is ill and the wife wishes to place the children so she can go to work are referred by the public health nurse for placement of the children in either nursery or institution.

b. Miss Debuchi reports that some public health nurses refer cases to the Minsei-iin without going thru the medical social worker. She is aware of this as some such cases ultimately are referred to the medical social worker because the Minsei-iin refused to accept or act upon the referral. However she thinks all cases which are to be referred to the child welfare officials are first referred to the medical social worker.

c. Miss Debuchi cited one instance in which the public health nurse referred a case because the patient, an adult son with TB, could not get along with his mother. This "selfish son" resented his mother and was "not kind" to her. Hospitalization had not been recommended by doctor as the public health nurse reported the Home was favorable from a physical standpoint. But since the son could not get along with his mother the public health nurse asked the medical social worker to talk with him. Subsequently it was decided to place him in a hospital. At first he did not wish to go, but later agreed. While arrangements for admission were being made he died at home.

d. Miss Debuchi feels that the public health nurses do not as a whole understand the function of medical social service - or are confused about its function. In addition there is not enough co-operation between the two services "may be cause the medical social workers do not fully understand the function of the public health nurse and the public health nurse do not fully understand the function of medical social workers".

e. Miss Debuchi also feels that the public health nurses may become disappointed when they refer cases to the medical social workers and then the Minsei-iin or welfare officials fail to approve special

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diets, or other grants or hospital medical costs. The public health nurses refer two types of cases in this group, those which are obviously eligible for DLSL and those which are not. In the former the medical social worker's persistent efforts with the Minsei-iin and welfare offices eventually result in approvals. On the latter, the medical social worker explains to the public health nurse why the case is not eligible.

4. Procedures in Handling "Health Guidance Slips" under Child Welfare Law:

a. These cards are for expectant and nursing mothers and children under 18 years of age who are in need of health guidance or medical treatment and cannot afford to pay cost.

b. The child welfare official initials these cards. (Only seal on card is that of child welfare official.) Then the patient or family member presents the card to the Center's receptionist. The receptionist then routinely refers these persons to the medical social worker.

c. The medical social worker then asks the persons "why he comes" and "what he wants" after this she takes the patient and slip to the doctor in charge of the maternal and child health clinic and leaves the patient with the doctor. Most of those cases are referred for health examinations prior to institutional placement. The doctors then fill out a certificate on the basis of the examination and gives the certificate to the client to take to the child welfare official. In case the patient or family member is not sure of what he is required to receive from the doctor, the medical social worker asks the patient to return to her with the certificate before leaving the clinic in order to be sure the child welfare official will be receiving an adequately filled out certificate.

d. The necessity for routinely referring all these cases to the medical social worker is two fold:

(1) To avert their being sent home without being seen as many persons are turned away each day. In these cases the person need not stand in line but can immediately approach the receptionist.

(2) To be sure the child welfare official secures the proper kind of a certificate.

e. These services are paid for out of a special budget provided under Tokyo-To for welfare business.

f. Some of these cases are provided with treatment for VD or TB and some are later referred to the nutritionist for health guidance.

ANNABELLE H. KENT

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EXAMPLES OF CASES APPROVED FOR ABORTION IN FILE

"Records for Application for Abortion"

Application for Operation of Abortion

The person who sahll receive operation:

Permanent Domicile: 139, 3, Ogikubo, Suginami-ku
Address: Ditto
Present Address:
Name: Misao Nakata 33 yrs.
Date of birth: 13 February 1916
Occupation: Spouse Employee of Occupation Forces.

Reason of application: No. 2, Item 1, Art. 13, Eugenics Law

Health Examination: 2 months in pregnancy, have customary miscarriage, and sciatica.

Applicant is (designated doctor): Medical Department:
Address: c/o Obstetrics Dept., Tokyo Railway Hospital, #902, 5, Sendagaya, Shibuya-ku, Tokyo-To
Name: Keiso Hosaka

Appendix: Past miscarriage in 1930
1931
1948

Remark: Date of reception of application: 27 Oct 1949
Reception Number : #191 Tachibana (Seal)

I apply for the investigation of suitability of abortion under provision in Item 1, Art. 13 of Eugenics Law -

To: District Eugenics Investigation Board

27 October 1949

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

Investigation Record

Date of investigation: 7 Nov. 1949

Decision Suitable / Unsuitable Seal of Committee (Nakayama), (Tsukahara), (Takayanagi) (Imai)

Examination Suitalbe / Unsuitable Reason:

Chief of Committee: (Tsukahara) Director: (Katagiri) Clerk: (Tachibana)

Remark:

Reception of enforcement report: (Yes) No

Opinion Sheet

Misao Nakata 33 yrs.
#139, 3, Ogikubo, Suginami-Ku

I consider the above named person is in pregnancy for two months, have customary miscarriage and sciatica and continuance of pregnancy shall give difficulty for her body.

27 Oct 1949

Doctor: Takeshi Nagao (Seal)

c/o Obstetrics Dept., Tokyo Railway Hospital,
#902, 5, Sendagaya, Shibuya-ku, Tokyo-to

Investigation Record

Date of investigation: 6 Feb 1950

Decision: Suitable / Unsuitable Seals: (Nakayama), (Takayanagi), (Tsukahara), (Hirano) (Imai)

Examination: Suitable / Unsuitable Reason:

Chief of Committee: (Tsukahara) Director: (Katagiri) Clerk: (Tachibana)

Remark:

Reception of enforcement report: (Yes) No

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Application for Operation of Abortion

Person who shall receive operation:

Permanent Domicile: Toda, Shimizu Village, Sunto Gun, Shizuoka Pref.
Address: #145, 3, Nishiogi, Suginami-ku
Present address: ditto
Name: Chiyo Hattori
Date of birth: 10 Jan 1907
Occupation: The person None
Spouse None

Reason of application: Have five children, husband is unemployed, and is l living on small earning of homework. suffering from morning-sickness for two weeks.

Health examination: She is threatened to harm her body if she continues pregnancy and deliver child.

2 months in pregnancy, morning-sickness
(Economic reason)

Applicant: Medical Dept: Obstetrics and surgery

(Designated doctor) Address: #17, 2, Nishiogikubo, Suginami-ku
Name of doctor: Shuzo Imai (Seal)

Remark: 5 children, all healthy

Appendix:

I apply for investigation on suitability of operation of abortion under the provision of Item l, Art. 13, Eugenics Law

To: District Eugenics Examining Board: 28 January 1950

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

Opinion Sheet

The person who shall receive abortion: Present Address: #145, 3, Nishiogi-kubo, Suginami-ku
Name: Chiyo Hattori
Occupation: None
Date of birth: 10 Jan 1907

Medical history of the person: Pleurisy (10 yrs. ago)

Present health condition of the person: Nutrition is middle class, do not recognize any disease at present, has morning-sickness, and is declined a bit.

Opinion of doctor for influence of childbirth and pregnancy on health condition: She is afraid to be malnutritioned.

26 Jan 1950

Address: #107, 3, Nishiogikubo, Suginami-ku
Doctor: Kohei Hattori (Seal)

Notice for description: (1) If the person has any disease, write the condition in "Present health condition of the person."

(2) In the "opinion of doctor for influence of childbirth and pregnancy on health condition", describe such as follows. You are not necessarily required to write the suitability of aobrtion.

Physical reason - - - - - be threatened to be difficult in Nutrition.

Economic reason - - - - - be afraid to be malnutritioned.

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Opinion Sheet

Address: #145, 3, Nishiogikubo, Suginami-ku
Name: Chiyo Hattori No occupation
Date of birth: 10 Jan 1907 41 yrs.

1. Living condition:

(1) Family condition

			Occupation	Monthly income
Yasushi Hattori	Family head	40 yrs.	None	¥3,940 (unemployment insurance)
Chiyo	Wife	41	None	¥3,000 (Sewing home-work)
Takahisa	1st son	14	None	3rd grade of Sugi Middle School
Mitsuo	2nd son	11	None	6th grade of Primary School
Taro	3rd son	8	None	3rd grade of Primary School
Masahiko	4th son	6	None	
Masako	1st daughter	3	None	

(2) Economical condition

As indicated above, the family has difficulty in economical condition, and childbirth shall make her become recipient of DLSL and give harm for her health.

2. Opinion: I recognise the need of abortion with the above reason.

I hereby present my opinion as above.

27 Jan 1950

Kimei Iin: Namiji Ishibashi (Seal)

To Chief of Eugenic Examining Board of Suginami District.

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Investigation Record

Date of investigation: 27 Feb 1950

Decision: Suitable Unsuitable Seals: Nakayama, Imai, Takayanagi, Tsukahara

Examination: Suitable Unsuitable Reason

Chief of Committee: Tsukahara Director: Katagiri, Chief of General Affairs Division Clerk: Tachibana

Remark:
Reception of enforcement record: Yes No

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Application for operation of abortion

The person who shall fecieve operation:

Present Domicile: #334, 6, Omiyamae, Suginami-ku
Present Address: ditto
Name: Yuki Ono
Date of birth: 4 Jan 1910
Occupation: Spose Gardener

Reason of application: Economical reason, No. 2, Art. 13, Eugenics Law

Health examination: 3 months in pregnancy, morning-sickness

Applicant: Medical Dept: Obstetirics, Address: 206, Nakadori, Suginami-ku
Doctor: Tadao Ichinose (Seal)

Remark: 5 children, all healthy

Appeneix:

I apply for investigation on suitability of operation of abortion under provision of Item 1, Art. 13, Eugenics Law.

To: District Eugenics Examining Board

Received on 22 Feb 1950
Reception Number: #339

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Opinion Sheet

The person who shall receive operation:

Present address: 334, 6, Omiyamae, Suginami-ku
Name: Yuki Ono
Date of birth: 4 Jan 1910
Occupation: Gardener

Medical history of the person: None

Present health condition of the person: 3 months in pregnancy, lost appetite.

Opinion of doctor for influence of child birth and pregnancy on health condition: She is afraid to be malnutritioned.

16 Feb 1950

c/o Ogikubo Hospital, 206, Nakadori, Suginami-ku

Doctor: Shinichi Watanabe (Seal)

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Certificate for Poverty

Address: 334, 6, Omiyamae, Suginami-ku

Familyhead	Gardener (daily)	Katsuzo Ono, 46 yrs	Income ¥7,500
Wife		Yuki 39	
1st daughter		Aiko 14	
2nd daughter		Kimiko 10	
2nd son		Kenji 8	
3rd daughter		Misako 4	
3rd son		Tetsuo 2	

Income of family head is ¥ 7,500 as daily gardener.

I certify that the above family is in need with the income of the family head and many family number.

15 Feb 1950

#318, 6, Omiyamae, Suginami-ku
Minsei-Iin: Tomitaro Motohashi (Seal)

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

Opinion Sheet

Address: 139, 1, Iogi-cho, Suginami-ku

Name: Tomoko Motohashi 33 yrs.

Family member:

Setoji	Family head	34 yrs.	Unemployed	¥4,000 (Unemployment insurance)
Tomoko	Wife	33		
Sato	Mother	69		
Kazuo	1st son	8		
Isao	2nd son	6		
Sachiko	1st daughter	3		
Mitsuo	3es son	1		

Economical condition: The family head is unemployed at present, and could hardly maintain living with unemployment insurance.

With the situation of family member and income, I recognize the need of abortion.

10 March 1950

Minsei Iin: Soji Yamaguchi, 83, 3, Iogi, Suginami-ku

To Suginami District Eugenics Examining Board.

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Opinion Sheet

Address: 1347, Matsunoki-cho, Suginami-Ku

Name: Shige Kato 31 yrs.

1. Kanae Kato	Familyhead	37 yrs	Y-7,500	Employee of Railway Corp.
Shige	Wife	31 yrs		
Kimiko	1st daughter	7 "		
Atsuko	2nd "	6 "		
Mutsuro	1st son	3 "		

2. Economical Condition: With the income of familyhead, the family is hardly maintaining the living.

It is impossible to increase the expense any more because if it does, the family will be in need, so I submit my opinion that the abortion is necessary.

Misei Iin: Heiwa Warita (Seal)

26 Feb 1950

To: Suginami District Eugenics Examining Board

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

Opinion Sheet

Address: 139, 2, Nishiogikubo, Suginami-ku

Name: Yoshi Kuroda

Date of birth: 28 March 1921

Family member:

Hiroshi	Family head	46 yrs.	¥1,300	Day laborer
Yoshi	Wife	29 "		
Akiko	1st daughter	10 "		
Kiku	2nd "	8 "		
Miyako	3rd "	6 "		
Yumi	4th "	3 "		

The family head is day laborer with irregular working days and their living is in difficulty. I recognize the need of abortion considereing the above situation.

15 Feb 1950

Minsei Iin: Ryuko Taguchi (Seal)

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

Opinion Sheet

Address: 2, Amanuma, Suginami-ku

Name: Toyoko Imai

Date of birth: 8 Nov 1926 (23 yrs.)

Family member:

Masao	Family head	27 yrs	¥4,000	Delivery-man
Toyoko	Wife	23 "		
Shoichi	1st son	3 "		
Hideko	1st daughter	1 "		

Economical Condition

As indicated above, the family is in hardship of living and continuance of pregnancy will make the family become recipient and do harm for health of mother.

I submit my opinion that abortion is necessary with the above reason.

Minsei Iin: Terue Takeda (Seal)

2 March 1950

To: Suginami District Erugenics Examining Board

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

Opinion Sheet

Address: 730, 3, Amanuma, Suginami-ku

Name: Tomiko Sekiguchi

Date of birth: 15 August 1919 (31 yrs.)

Family member:

Toji,	Family head	41 yrs.	¥6,000	Bag manufacturer
Tomiko	Wife	31 yrs.		
Masakatsu	1st son	7 yrs.		
Kazumi	1st daughter	4 yrs.		

Economical Condition:

I lend the room for my job, but due to recent depression, my job is also in difficulty. So if wife delivers baby, our living condition will become receipient of DLSL and I should like my wife to get abortion.

I recognise the need of abortion with the above reason and submit my opinion.

16 Jan 1950

Minsei-iin in charge: Umon Takagi (Seal)

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Opinion Sheet

Address: 308, 3, Asagaya, Suginami-ku

Name: Yachiyo Yamada (sewing home work)

Date of birth: 29 Jan 1920

Family member:

Mikiyo	Family head	40 yrs.	¥6,000	Company employee
Yachiyo	Wife	31		
Haru	Mother	64		
Kiyomi	1st daughter	6		
Kiyohiko	1st son	4		
Kiyoaki	2nd son	2		

The economical condition of the family is in hardship of living and continuance of pregnancy will make the family become recipient of DLSL and also do harm for health of mother.

11 March 1950

Minsei Iin : Tadae Kodama (Seal)

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Opinion Sheet

Address: 316, 2, Amanuma, Suginami-ku

Name: Shizue Maeda

Date of birth: 1908 (42 yrs.)

Family member:

Katsuyoshi	Family head	43 yrs.	Unemployed
Shizui	Wife	42	
Yoshitomo	1st son	12	
Toshibumi	2nd son	9	
Emiko	1st daughter	7	
Suiko	2nd "	5	

Economical Condition: ¥ 6,000 Irregular daily laborer

The family is in hardship of living with the above income and continuance of pregnancywill make the family become recipient and do harm for health of mother.

I submit my opinion that abortion is necessary with the above reason.

3 March 1950

Minsei Iin: Terue Takeda

To: Suginami District Eugenics Examining Board

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

Opinion Sheet

Address: 254, Shinmachi, Suginami-ku

Name: Ayako Noda

Date of birth: 30 March 1924 (25 yrs.)

Husband Koichi died on 20 Jan 1950. He was employee of Railway Corp.

Economical Condition: The person is now at her parent's because she has no property to support herself. Parents is 74 yrs. and 71 yrs. unable to support her. Also her elder brother has 5 children also cannot support her. If she delivers child, it will be difficult for her to support her living. So I recognize the need of abortion.

9 March 1950

Minsei Iin: Kisao Sato (Seal)

To: Suginami District Eugenics Examining Board

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Opinion Sheet

Address: #7, Shinomiya-cho, Suginami-ku

Name: Jugoro Kudo

Date of birth: 28 Jan 1902

Jugoro	Janitor of MPB	¥8,400	48 yrs.
Yukie, Wife			41
Shuntatsu, 1st son			16
Atsuko, 3rd daughter			13
Masako, 4th daughter			11
Hiroko, 5th "			8
Tatsuo, 3rd son			3

With the income of family head, the family is in need of living, and continuance of pregnancey will make the family become recipient of DISL and do harm the health of mother.

I submit my opinion that aobrtion is necessary with the above reason.

Minsei Iin: Giichi Iguchi (Seal)

2nd March 1950

To: Suginami District Eugenics Examining Board

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

Opinion Sheet

Address: 86, 1, Mishogikubo, Suginami-ku

Name: Ryuko Kobayashi

Date of birth: 20 Jan 1917 (33 yrs.)

Family member:

Eijiro	Family head	39 yrs.	TB since 1949
Ryuko	Wife	33 yrs	¥3,500 Helping other's
Kazuo	1st son		

The family is in hardship of living with the above economical condition, and continuance of pregnancy will make the family become recipient of DISL, also do harm for health of mother.

I hereby recognize the need of abortion and submit my opinion as above.

Chief of Ogikubo Minsei Jimusho, Toichi Tanizaki (Seal)

15 Feb 1950

To: Suginami District Eugenics Examining Board

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

Opinion Sheet

Address: 415, 2, Koenji, Suginami-ku

Name: Masako Miura

Date of birth: 20 March 1920

Yuichi Miura	Family head
Masako	Wife
Yukichi	1st son
Makoto	2nd son

The above family has income of ¥7,500, the family head's as the employee of Transportation Bureau of Tokyo-To and if any more baby be born, it will be difficult for the family to take care, and I recognize the need of abortion.

3 March 1950

Minsei Iin: Saburo Kawai

408, 2, Koenji, Suginami-ku

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

Certificate for abortion

Address: 195, 1, Horinouchi, Suginami-ku

Name: Masako Kinoshita

Family member:

Masatoku	Family head	41 yrs.	¥7,500	Employee of Motor-car Co.
Masako	Wife	33		
Masao	1st son	11		
Fumio	2nd son	9		
Misako	1st daughter	7		
Kazuko	2nd daughter	3		

I recognize that childbirth will add more difficulty in their living condition and need of abortion.

13 Feb 1950

Minsei Iin: Mitsuyoshi Maruyama (Seal)
68, 1, Horinouchi, Suginami-ku

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

Opinion Sheet

Address: #84, Sanya-cho, Suginami-ku

Name: Sukago (CHIKAKO) Kageyama

Date of birth: 28 March 1913 36 yrs.

Family Member:

Torakichi Kageyama	Family head	37 yrs.	Unemployed	Weak
Chikako	Wife	36	None	
Kan	1st son	13		
Hyo	2nd son	12		
Ten	3rd son	9		
Akira	4th son	6		

Economical Condition: ¥5,010 (from unemployment insurance)

The family head is unemployed at present and the family is in need for living. If the mother continues pregnancy, the family will be recipient of DLSL and also her health will be harmed.

I recognize the need of abortion with the above reason and present my opinion.

25 Feb 1950

Minsei Iin Shizuo Yamada (Seal)
#25, Sanya-cho, Suginami-ku

To: Suginami District Eugenics Examining Board

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

Certificate

Address: 248, 6, Asagaya, Suginami-ku

Name: Inosuke Tsuruta

I am the employee of Eguchi Confectionary Manufacturing Company at 220, 6, Asagaya with the salary of ¥6,500 supporting wife and 5 children. Recently wife was found to be in pregnancey and I think childbirth will add more hardship to our family economical situation. So I should like to let my wife receive operation for abortion and ask you certificate for our living condition.

I certify above statement.

16 March 1950

Minsei Iin: Yasuko Yuasa (Seal)

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Inion
Operation Sheet

Address: 477, 1. Koenji, Suginami-ku

Name: Cho Sugiyama

Date of birth: 23 Jan 1905

Familyhead:	Sosaku	45 yrs.	Railway employee	¥8,500
Wife:	Cho	40		
1st son:	Ryodo	18		
1st daughter:	Yukiyo	15		
2nd daughter:	Akimi	7		

Economical Condition: 1. Monthly income ¥8,500
1. Debt ¥30,000 (Repayment ¥2,000 in a month)

The family is in need of living with the abovereason and the continuance of pregnancy will make the family become recipient of DLSL and do harm for health of mother.

I submit my opinion that the abortion is neccessary with the above reason.

Minsei Iin: Jiro Suzuki (Seal)

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

Opinion Sheet

Address: 863, 1, Asagaya, Suginami-ku

Name: Hiroshi Takase (Boiler man)

Date of birth: 18 Nov 1919

Family member:

Hiroshi	Family head	30 yrs.	¥5,000
Tomi	Wife	29	
Kazuaki	1st son	5	
Masako	1st daughter	3	
Kikuo	2nd son	1	

The family is in hardship of living with the above income and family member and continuance of pregnancy will make the family become recipient of DLSL and also do harm for health of mother.

7 March 1950

Minsei Iin: Kokichi Oguri (Seal)

To: Suginami District Eugenics Examining Board

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

Opinion Sheet

1. Address: 490, 4, Omiyamae, Suginami-ku

Name: Kinjiro Kurosawa

Date of birth: 27 Oct 1905

Occupation: Employee of Occupation Forces

Family member

Kinjiro	Family head	¥8,000	47 yrs.
Nakae	Wife		40
Hiroyasu	1st son		12
Eiko	1st daughter		10
Nobuyuki	2nd son		9
Shigeko	2nd daughter		7
Tomoko	3rd daughter		5
Masao	3rd son		2

2. Health examination

Nakae, wife is in 3 months' pregnancy.

The above named person is in need for living with his income and I submit it for your consideration.

1 March 1950

Minsei Iin: Tomitaro Matohashi (Seal)

To: Suginami District Eugenics Examining Board

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

Certificate

Address: 14, Seiho-cho, Suginami-ku

Name: Kenji Sasaki

Family member:

Kenji	Family head	39 yrs.	¥4,800	Daily laborer
Chiyo	Wife	31		
Toshiko	1st daughter	2		

Chiyo, wife, is in 3 months' pregnancy and the family is in hardship of living with the income of family head as daily laborer. I hereby recognize the need of abortion with the economical reason.

14 March 1950

Minsei Iin: Tsutomu Koshie (Seal)
110, Seicho-cho, Suginami-ku

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

Mr Jentsweber I

PUBLIC WELFARE SECTION
KANTO CIVIL AFFAIRS REGION
APO 500

AHK/hs

21 April 1950

SUBJECT: Continuation of the Administrative Review of Suginami Health Center's Medical Social Division - 18 April 1000-1500

TO: William H. James, Chief
Public Welfare Section, KaCAR

1. The undersigned Welfare Officer, Annabelle H. Kent, and Tatsuko Ohara (JW), adviser, read two medical social records (see inclosure 1) and conferred with the following Center officials:

a. Dr. Tsukahara, Director of Center.

b. Dr. Ogimura, Chief of Service Section.

c. Dr. Obana, Chief of Prevention Section.

d. Miss Debuchi, Chief of Medical Social Division.

e. Miss Isshi, medical social worker.

f. Miss Irayoshi, Chief of Public Health Nurse Division.

2. Medical aid cards under DLSL.

a. When the patient brings a medical card under the DLSL to the clinic, the receptionist immediately refers him to the Medical Social Work Division. The medical social worker then takes the card; and if the patient is to pay part of the cost, the medical social worker accepts the money from the patient. At the close of the day the medical social worker takes the money received and the cards to the Accounts Section for their seals on the cards. These payments are made by the patient at the beginning of the month on the basis of the welfare office's share of the client's partial charge for the month.

b. At the time the patient brings his medical card to the medical social worker she stamps the patient's clinic card as a medical aid case under DLSL and notes thereon in ink the month for which the card is valid. Then each month thereafter when the client brings his medical card he takes it to the medical social worker so she can collect any partial payment and stamp the clinic card accordingly.

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c. After the patients are seen in the clinic they bring their clinic record to the medical social worker so she can write on the medical card the date of treatment, kind of treatment and points. The client then returns the clinic record to the clinic.

d. At the end of the month the medical social worker turns in all the medical aid cards under DLSL (about 30 cases a month) to the General Affairs Section, who then proceeds to add up the points and cost thereof prior to submitting them to the ward office for payment.

e. The chief medical social worker states they must keep the cards until the end of the month so that they can record thereon the treatment given and paints. If the patient fails to bring his clinic record after a treatment the medical social worker later checks the clinic record and completes the medical aid card.

3. Conference with Miss Inoyoshi, chief public health nurse, for purpose of determining the relationship between medical social workers and public health nurses and any problems between the two. (Miss Debuchi insisted on being present during this interview.)

a. Miss Inoyoshi reported that before the clinic had medical social workers, the public health nurses were doing some kind of social work. But present she does not know exactly what the medical social workers are doing. When the public health nurses need social information they confer with the medical social workers. Their only trouble is"there is not enough medical social workers." Because of the lack of a sufficient staff of medical social workers the public health nurses are asked by the medical social workers to visit patients to tell them when to go to hospitals for admissions.

b. She feels that the medical social workers are asking the public health nurses to do too much. For example they are asked to investigate financial situations of families and they do not feel they are experts on this. She would like to the public health nurses to be helpful to the medical social workers from other points of view.

c. The public health nurse referrals to the medical social workers concern tuberculosis cases who cannot pay for treatment or who cannot be admitted to hospitals because of lack of beds. They also refer child welfare cases to the medical social workers.

d. The medical social workers refer cases to the Public Health Nurse.

(1) For social investigations which the medical social workers cannot do.

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(2) For investigation on additional social data which which medical social workers do not have time to secure.

(3) For informing patients that they can be admitted to hospitals.

e. The public health nurse pointed out that their primary purpose is the same as that of the medical social workers, namely giving service to patients. But the public health nurse's responsibility is nursing and that of the medical social worker is taking care of patient's financial troubles, helping them resolve domestic problems and other social problems and giving spiritual guidance.

f. She states that actually in practice their responsibilities are not so clear. When the public health nurse visits there are often social problems which the family wishes to discuss. The public health nurses of course must and often give some guidance. The extent to which help with social problems should be given is not clear. The public health nurse thought that in some case both the medical social worker and public health nurse should visit some cases at the same time (discussed briefly referral of some such cases to the medical social worker when the situations warrant study and planning by the medical social worker. The inadvisability of both going out together was also pointed out.)

g. The public health nurse questioned the medical social worker referring cases for social investigation - these concerned mainly cases in which the medical social worker receives a telephone call from private citizens stating that so-and-so is ill with TB and needs medical care. (Suggested here that the medical social worker take their referrals to the physician in charge of the Service Division, who would decide who is to investigate the case - this was acceptable to the public health nurse)

h. The public health nurse also questioned the medical social worker's referrals which concern visits to arrange for the patien's admission to a hospital when a bed is available. Since most hospitalisations are arranged by the medical social workers, the public health nurses feel the medical social workers should make these visits.

4. Conference with Dr. Tsukahara, Dr. Ogimura and Dr. Obara (Miss Debuchi, chief medical social worker, insisted on being present) for purpose of determining extent of understanding of medical social intergration and co-ordination of this service with that of other clinic services, and any problems in relation to the medical social program which the doctors feel should be covered in forthcoming in-service training sessions.

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a. The doctors stressed that the medical social workers have their own status and should be treated as experts in their own field but that as long as their job title is that of clerks they will not have professional status. They feel something should be done about this at Ministrial level.

b. Dr. Ogimura stated that as medical social workers are badly needed and since they cannot get trained medical social workers he wondered about some of the public health nurses being trained as medical social workers and to use these persons in the dual capacity until they are fully trained as medical social workers. He states that he recognizes that these are two separate fields, but as it is almost impossible to secure trained medical social workers the easiest way would be to take some public health nurses and train them in medical social work rather than to pick up school graduates without any experience.

c. Dr. Tsukahara did not fully agree with Dr. Ogimura because;

(1) There is a shortage of public health nurses and even the ones they have trained are not fully qualified.

(2) He feels it is possible to train new persons and that this should be done. He feels the medical social workers need more education and their salaries should be better.

(3) If some public health nurses are selected for training as medical social workers, they may have prejudices about medical social work and will not make good medical social workers.

d. Dr. Tsukahara also pointed out that;

(1) It is very convenient for the doctors to have medical social workers. Before they had this service when the patients complained about their social problems the doctors did not know what to do. But now with the medical social workers cannot solve all the social problems he knows they are doing their best and a heavy burden has been taken off the doctor's shoulders. He knows there is a need for co-ordination of this service with all the others - but in the meantime the doctors are "just enjoying their good feeling". He stated that doctors who work without medical social workers do not know what it is to have this good feeling. Before the Center had medical social workers he did not want to see patients with social problems.

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He was afraid to face these people. Since the medical social workers are doing something for patients with social problems he now feels free to treat such patients medically.

e. Dr. Ogimura agreed with Dr. Tsukahara and stated he feels the same way. Before they had medical social workers he had to give consultation on social problems. Recently one of their public health nurses who was transferred came back to see him and complained they had no medical social workers in her Center and that the public health nurse had to do everything.

f. Subsequent to Welfare Officer's discussion concerning the use of the case conference method under the leadership of the physician as one means of co-ordinating the function of the medical social worker with that of the other services the doctors commented as follows;

(1) Dr. Ogimura feels the doctors do not have the leadership or are not using it. When public health nurses came into the clinic some doctors began to feel that they were being used by the public health nurses as they were telling the doctors how to treat their patients. He feels the doctors must give orders to the public health nurses as to when to visit, how, etc. He feels the doctors have not been strong leaders as a result of having a feeling of being used by the public health nurses and at times the medical social workers the doctors have not been giving much information to either of them.

(2) Dr. Ogimura feels that there is some confusion over the function of the medical social workers. When he looked at the medical social records the other day he found pictures of lungs but important instruction on food and how the patient should be taken care of were not written on their record. He does not say the medical social workers should not know the medical situation but the additional information on the doctor's instructions on food and how the patient should be taken care of should be in the social record. He blames no one because all are overworked but feels each service is functioning too independently. After doctors see cases and refer them to the public health nurses or medical social workers they do not follow the cases because of pressure of work. He feels there should be more doctors and that some of the cases should go to private doctors.

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g. Dr. Tsukahara states something should be done about having medical social workers in all hospitals and clinics - private and public.

h. Dr. Obara remarked that it is very important for the doctors to take the leadership and indicated that more detailed instructions should be given to both the public health nurses and medical social workers.

i. Areas and point s which the doctors would like to have taken into consideration and covered at in-service training sessions on medical social work;

(1) Role of physician as the leader of the medical team.

(2) Clear delineation of function and responsibilities of the medical social workers and public health nurses.

(3) Clarification on order giving and co-operation between the members of the team.

(4) Ideal methods of functioning of all members of the clinical team.

(5) Ideal methods of record keeping, organization, basic operation and policy with regard to medical social function and its relation to other services in Center.

(6) Inclusion of dosters in medical social in-service training sessions.

2 Incl

ANNABELLE H. KENT

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

Cases Selected by Chief Medical Social Worker as Example of Their Best Case Record on Sakai, Chie

1. Translation of data on medical social record:

Patient - ChiedSakai
Address - 1-804, Nishi Ogikubo, Suginame Ward
Family Members-

Sakai, Torajá	- Head	- age 55
Sakai, Sato	- Wefe	- age 50
Sakai, Shusaku	- Eldest son	- died 30 October 1948
Sakai, Chie	- Female	- age 22 - "inflammation of lungs"
Sakai, Hisae	- Female	- age 19 - in college.

Case referred from first Health Consultation Center. Family lives in four-room house. Family head is a peddler earning 250 yen per day. Wife - hospitalized 7 March 1950 in Inogashira Mental Hospital - nervous. Eldest son - 28, died 30 October 1948 from tuberculosis. Chie, patient, is suffering from inflammation of lungs. Last child is going to high school.

Relatives - Sukagawa, Motochi - Mother's home in Niigata Prefecture. Only daughter is married - TB. Wife's younger brother Sukegawa Kuidhi lives in Nishi Ogikubo and is a dentist. Brother in Niigata Prefecture. Sakai, a painter, has family of 11 persons. Hamada, wife's sister in Kitatama Gun. Wife's sister's family - sister has four children - needy. Family lives in Repatriates Camp.

It seems that the family is earning 4,500 to 5,000 yen per month.

Family Situation: Brother Shusaku suffering from TB for two years. Father has something wrong with his "brains". Second daughter Hisae peddles with father - income 2,500 yen per month. Chie, the patient, inflammation of left lung and with proper treatment will recover soon. After the war, therfamily suffered from financial troubles. Mother come to consult about treatment costs.

Family-head had wholesale business of chinaware but had to close the shop in July 1942. Then family-head got job at union of chinaware store - lost this job in March 1945 because air raid.

10 August - ppplication for reduction of fees. First treatment to be given on 13 August 1948.

27 September - Family applied for livelihood aid under DLSL, and case is still under investigation. Shusaku is receiving medical aid under the DLSL - hospitalized in Ogikubo.

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8 October - Home visit made. House clean. Family does not have much furniture and family seems to be suffering from financial troubles. Went to see Minsei-iin to talk about application procedures for medical aid.

19 October - Came with medical card - treatment given free of charge.

8 Mardh - Treatment. The client came with medical card.

27 February - Came to consult about treatment costs of 450 yen per month.

7 March - Home visit made.

13 March - Came with sister.

17 March - Patient came - talked with her and her father.

2. The foregoing case data recording in addition to being sketchy and lacking in organized presentation lacked complete information on dates (no year was recorded) as well as the signatures of the persons who recorded the data.

3. In discussing the recorded data with the chief medical social worker and the other medical social worker Miss Ishi, the following was revealed;

a. Both medical social workers had handled case. However, Miss Isshi seemed to know the case better.

b. The first contact could not be recalled except that the patient Chie could not afford to pay cost of clinic treatment.

c. Miss Isshi stated when the patient came to her and said she could not pay. She tried to get a picture of the family's financial situation. The brother, Shuseku, at the time was in bed receiving medical aid under DLSL and she talked with patient about her also applying for medical aid under DLSL. Then Miss Isshi visited the home when she recalled finding terrible conditions - home was dirty and shabby. Her ill brother Shusaku was not receiving proper care. She talked with the parents and they decided to apply for livelihood aid under DLSL. Miss Isshi recalled discussing the case with the welfare office and being informed about middle of October 1948 later that the case was rejected per livelihood aid because a daughter was in high school and father was working. However, the welfare office approved medical aid for Chie.

d. Lathe Miss Isshi learned from the patient that the welfare office had only approved partial medical aid costs. Chie was to pay around 400 yen per month toward costs (at thetime the welfare office policy required clients to pay partial payments at the welfare office.

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Some six months ago the policy was changed requiring clients to pay their share of costs directly to the doctor, clinic, or hospital. Each time she had to pay for part of costs, the patient came to see the medical social worker because she was unable to do so.

e. Chie has been receiving pneumothrax treatments every ten days since October 1948. Her condition has not shown any improvement. As a result the medical social worker thinks girl should be hospitalized. The medical social workers have never had discussed the social situation of this patient with the clinic doctors.

f. Mother of patient was hospitalized in 7 March 1950 and discharged 13 April 1950 because of "some neurotic condition." Mother in queer - still sits in one room all day and stares into space. Mother is also frightened at slightest noise. Chie has shown some of the same behavior as she becomes very fearful whenever she hears any one knock at the door at home.

g. The mother was admitted to mental hospital on 7 March by a private doctor in the community. At the time hospitalization was recommended the father and Chie came to see the medical social worker about medical aid for themother. Chie stated they applied for medical aid at the welfare office (Ogikubo Minsei Jimusho) but were told they were not eligible. The family was also concerned over the 450 yen per month Chie was supposed to be paying towards her cost of medical care.

h. Afterwards, the medical social worker con acted the welfare office official and was told that they would authorize free care for Chie but the family would have to pay 600 yen a month towards the mother's hospitalization. The reason for this decision on the part of the welfare office was because the younger daughter was going to college and earning 1,000 yen per month.

i. The mother's early discharge was attributed to thefact that the family was unable to pay their share of the cost of mend care.

j. When Miss Isshi, the medical social worker visited on 7 March, she found that the family lacked food and were not able to purchase their staple foods. They were living on sweet potatoes. Miss Isshi then went to the Minsei Jimusho to explain the family's desperate situation. The welfare official said they could do nothing more for the family as the Hogo Daicho (record) showed thefather's income as 6000 yen per month and the daughter as 1,500 yen per month. Miss Isshi learned the family-head at the most earned 4,000 yen per month and sometimes less as he could not peddle on rainy days. The daughter earned 1,000 yen per month. Since October 1949 the family's rental was 500 yen per month.

k. Miss Isshi stated she thinks all members of family have TB. However, the father, mother and younger sister have never agreed to come to the clinic for examination. This she thinks may be due to their inability to pay. The public health nurse has never visited this family.

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4. Welfare Officer discussed the case with the medical social workers in light of their findings and need for further planning. Emphasis was placed on the importance of discussing the social situation with the doctor and ascertaining from him the patient's physical condition. Any recommendation for Chie's hospitalization should come from the doctor. The need for a public health nurse contact with the case was discussed as planning with the welfare office to meet the needs of family's economic and medical situation.

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Case Record Data on Miyamoto Family

Case Name - Miyamoto, Harukichi, Patient

Family members -

Miyamoto, Harukichi - age 42 - head

Miyamoto, Nobuko - age 17 - daughter

Miyamoto, Hideo - age 11 - son

Miyamoto, Kimio - age 9 - son

Family-head has inflamation of lungs. Two younger children, Hideo and Kimio, are with Hamada Family. Live in house of two rooms - rent 82 yen.

Relatives -

Hamada, Chutaro - Niigata Prefecture. Mr. Hamada is husband of family-head's sister.

Present Situation: Patient got sick in July, diagnosis "Ulcer of stomach". In February this year had a cold, but did not recover from cold for two months, so examined on 7 April at this Health Center and told he had TB. He got so upset that he said he eas going to kill himself and children. Once he had an engineering business in Kobe City and was well-off. But he got burned out in war. Lost his wife in December 1945. He has been working as a chimney cleaner - small income and has been selling his own furniture.
Patient needs immediate hospitalization and something must be done for the children.

Incl 2[3]

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Protection Process

10 April - Home visit made. Visited Welfare Office about application procedures for public assistance. Visited Mr. Igarashi.

12 April - Nobuko, girl of 17, Hideo and Kimio come to Health Center for examinations.

13 April - Patient accommodated under DISL. Isshi visited welfare office for public assistance for family. Visited patient.

15 April - Hospitalized at Kohoku Hospital. In afternoon Nobuko came. Nobuko wanted to consult medical social worker about hospital's request for three go of rice and 100 momme of (?) for ten days.

17 April - Visited Harukichi at hospital. Patient complained that the hospital was not well equipped and that the meals were terrible. He said he was cheated and wept. May have to be placed in some other sanatorium.

Uegi attened the conference - asked to take care of family while head in hospital and that Nobuko should carry food.

20 April - Decision was made to employ Nobuko in Health Center as desk worker staring 21 April. New room going to rent - consult about it.

24 April - Mr. Tanaka, a neighbor, came - talked about a room which Nobuko thinks she can rent to some one else. Family who wants to rent this room consists of mother and

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man of 24. Mr. Tanaka said they are respectable and good family.

27 April - Livelihood home visit. Saw Harukichi - he was very grateful.

1 May - Mrs. Tanaka came about family who wanted to rent room - they changed their mind because of disagreement with Mr. Igarashi. Mrs. Tanaka was told Miss Isshi would see Mr. Igarashi as soon as possible.

8 June - Heard the patient was seriously ill and visited him in hospital.

9 June - The word came that patient was dying. Visited him in hospital and heard that sister, her husband, nephew and two children came to see him day before. He was still conscious and worried about the children. About 7 o'clock sister, husband and nephew came and sister said that she would take carr of children. Patient nodded and passed away.

10 June - Miss Isshi went to family with koden (obituary) money for family. Isshi visited Mr. Igarashi and discussed future of Nobuko.

11 June - Nobuko's brothers came to Health Center for TB examinations. They are going back to country to live with grandfather.

11 June - Visited Mr. Igarashi, Nobuko's grandmother, sister sister's husband and grandfather. Discussed future of family.

Mr. Igarashi is grandfather of Nobuko. He does not like

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family very much and does not want responsibility for whole family. Says Nobuko should live with brothers and take care of them. Medical social worker wished to talk with Nobuko. Medical social worker talked with Igarashi about new constitution and individual rights.
Igarashi got angry and finally agreed to listen and to help Nobuko manage. Adviced them when any more troubles the members of family should get together and discuss the problem.

(Two children went to Niigata and Nobuko is living with grandfather.)

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PUBLIC WELFARE SECTION
KANTO CIVIL AFFAIRS REGION
APO 500

AHK/hs

5 April 1950

SUBJECT: Conference with Sagami Health Center's Chief Medical Social Worker on 4 April 50 (1000-1200)

TO: William H. James, Chief
Public Welfare Section

1. The following forms prepared by the medical social worker as a result of previous MacCall suggestions were reviewed;

a. Medical social work case record.

(1) Folder.

(2) Face sheet (see inclosure 1).

(3) History sheet (see inclosure 2).

b. Master card for alphabetical index file (see inclosure 3).

c. Referral sheet to community agencies (two copies - one for medical social record. See inclosure 4).

2. Other Matters Discussed.

a. Group conferences of medical social workers and public health nurses should be held under the physicians leadership and not by the medical social worker as had happened on one occasion.

b. A day sheet for statistical purposes should be developed. Welfare officer agreed to draft one for discussion in April.

c. Referrals of patients for livelihood assistance continue to be a major difficulty. A recent case example is cited below.

d. The case of Izumi Okumura (a TB patient of the Center) came to the attention of the medical social worker on 3 March 1950 when the patient's mother asked the medical social worker to help her secure a medical card for the patient. The mother at the time reported that she had applied for livelihood aid at the welfare office on 30 January 1950, but as yet had not received any relief grant. The medical social worker immediately got in touch with the welfare office and succeeded in having them issue a medical card on 6 March for the patient. On 23 March the mother received a letter from the welfare office advising that a grant of 2,2000 yen had been

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approved. However, she had only received 1,000 yen up to that time. On 24 March admission for the son to the hospital was arranged and the mother had to use the 1,000 yen for transportation of the son to the hospital and for some required bedding. As yet the grant for the mother's needs has not been straightened out and the welfare office has done nothing to reimburse transportation and bedding costs.

ANNABELLE H. KENT

4 Incls
1. Med Soc Face Sheet
2. History Sheet
3. Mater Card
4. Referral Ltr Form

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MEDICAL SOCIAL FACE SHEET

Case Number:

Clinic Number:

Date Opened:

Date Closed:

Name:

Present Address:

Home Address:

Referral from:

Doctor in charge:

Public Health Nurse in charge:

Name of Minsei-Jimusho:

Condition of Disease:

Family Members:

Name	Relationship	Age	Occupation	Income	Education	Health

Housing:

Living Situation:

Income:

Working Person:

Others:

Total:

Property:

Expenses:

Rental:
Food:
Light:
Clothing:
Education:
Sanitation:
Culture:
Medical:
Miscellaneous:
Total:

Debts:

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Patient's Name: Family Name: Clinic No.:

Date of Birth: Address:

HISTORY SHEET

Date	Actions	Signature

Encl 2

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MASTER CARD

Medical Social Record Number:

Clinic Record Number:

Clinic Service:

Name of Patient:

Address:

Family Members:

Name	Relationship	Age

Date Opened:

Date Closed:

Date Opened:

Date Closed:

- - - -

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REFERRAL LETTER FORM

TO: _____ ADDRESS: _____

FROM: Suginami Health Center, Medical Social Division.

Date:

Case Name:

Address:

Name of Patient:

Summary of Liaison:

Please advise this division of your disposition on this matter.

Encl 4

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MEDICAL SOCIAL SERVICE IN THE HEALTH CENTER

DVW
1 March 1948

I. PURPOSE OF MEDICAL SOCIAL WORK

The broad concept of medical care has never been limited to treatment of physical illness, but has combined treatment for illness with treatment of unfavorable social factors. It is recognized that the influence of environmental and emotional conditions upon illness frequently determines effectiveness of medical care. Medical social service is one of the methods now utilized so that proper consideration is given to the family and social and economic situation of the client. Consideration of his illness is not limited to the organic illness itself, or to the patient. Consideration must also be given to the family situation and general conditions in the community.

The primary concern of medical social work is the social and financial problems related to illness. Such factors as poor home conditions, diet and worry may contribute to the patient's illness and retard or prevent normal recovery. In many cases the greatest need of the individual is for information and advice concerning welfare and other agencies in the community which can be of assistance to him in solving his health problems. It is obvious that many individuals are not aware of the existence of programs which are operating to aid him and members of his family. In times of illness the individual, in addition to medical treatment, may need assistance concerning environmental factors. While there has been growing recognition of the influence of environmental and emotional conditions upon illness, the process of medical care has become more complicated, which makes it difficult for the sick person and members of his family to understand and to cooperate in the treatment program. Medical social work has developed as one means of helping to solve these problems in the total medical care program.

Medical social work exists because it is recognized that medical treatment by itself is frequently not a complete solution to the medical problem presented. It is being increasingly recognized that medical treatment is only one part of the entire rehabilitation program. For example, many doctors contend that it is a waste of time and medicine to treat a prostitute for venereal disease as long as she will remain a prostitute. Medical treatment, therefore, must be regarded as one aspect of a total program to make it possible for the individual to be rehabilitated. Another example is industrial accidents. The worker may lose an arm or leg in an accident and receive proper medical care. This medical care, however, must be regarded as one part of the total process of his rehabilitation. In addition to proper amputation the worker may need appliances and vocational training which will enable him to again become a useful worker and able to support his family.

II. DEVELOPMENT OF MEDICAL SOCIAL SERVICE

A. In the United States. Medical social work in the United States was begun under the sponsorship of physicians and other persons who recognized that adequate medical care included the social needs of ill persons. The first such work was begun in 1905 in the Massachusetts General Hospital. Since that time there has been a gradual development of medical social service departments in all types of hospitals. Although medical social service first began in hospitals, its usefulness as a part of the total medical care program was generally recognized and gradually medical social workers became a part of non-institutional health programs. Especially during the past fifteen years there has been an increasing rise of medical social service in public health programs other than hospitals. Public health and public welfare programs have developed independently and although administered

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by separate governmental organizations it is recognized that there are many mutual problems. Through the use of medical social service as part of the welfare organization and as a part of the public health agency it has been possible for programs to operate more effectively.

B. In Japan. Medical Social service has never developed to any extent in Japan. There are only a few hospitals, such as Izumibasi Charity Hospital, Tokyo City Sanatorium and Zensei Hospital (leprosy) which have provided "personnel consultation services" to patients and their families. These services included friendly advice or home visits, talking problems over with patients, and making discharge arrangements, and are given by untrained volunteers or clerks. The Saisei-kai Hospital in Tokyo established a "social department" which, besides giving consultation services described above, operates a day nursery for children of patients or their attendants. Formerly the workers at this hospital were the persons who received training at the training institute conducted by the Central Social Work Association (now the Japan Social Work Association). The person in charge of the department at present is experienced in welfare work in a medical setting.

The medical social service department of St. Lukes' Hospital in Tokyo was influenced by western standards. Although the department was established by a Japanese worker who had received social work training in the United States, it was developed by an American worker. Several of the medical social workers on the staff did graduate study in social work in the United States and therefore became familiar with the programs developed there. Special effort was made to develop social case work. As far as it is known this is the only agency in Japan where social case work has been practiced to any extent. The social service department cooperates with St. Luke's College of Nursing in giving the students lectures on social aspects of nursing and providing field work training at the department. Following the end of the war there has been a considerable decrease in the medical social service work of the hospital because of the lack of competent workers. There is, however, a separate medical social service department in the hospital and it is hoped that their work can be strengthened and developed in the future.

III. RESPONSIBILITIES OF WORKERS

The medical social worker's responsibility as part of the medical care program includes the following. The duties and responsibilities which may be assigned to the medical social worker are set forth in the suggested job description. (see inclosure 2)

1. To help the patient and his family to understand medical and social difficulties and reasons for them. In many cases the patient does not understand the cause or nature of his illness. He and members of his family do not understand the necessity for following the program of treatment established by the doctor. For example, in the treatment of tuberculosis and venereal disease, it is frequently necessary to explain to the patient and to members of his family the causes of the disease and how it is communicated and the need for lengthy care in order for treatment to be effective. The medical social worker through interviews with the patient and members of his family provides them with needed information concerning the medical problem and the treatment prescribed.

2. To secure an understanding of the patient and his situation which is useful to the physician and to others concerned with his medical care. The doctor frequently finds it necessary to secure information concerning the patient's work and home conditions in order to make a correct diagnosis and prescribe proper treatment. The medical social worker can be of assistance to the doctor and save his time by understanding what type of information will be useful and securing it from the patient.

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3. To enable the patient to make good use of the resources available in the community. Before becoming ill many persons do not know of the health and welfare services which are available to help them. It is the responsibility of the medical social worker to have a thorough knowledge of the community's resources, to understand what the prescribed course of treatment requires and to help the patient secure the assistance which he needs.

4. To help plan and carry through a program of medical care treatment established by the doctor. It is frequently impossible for the patient to carry out without help the plan of treatment prescribed by the doctor. For examole, the doctor may prescribe complete rest for the head of the family, but the patient considers this impossible since he has a family for which he must work and support. He needs additional help if the doctor's plan of treatment is to be carried out. In other cases isolation of the sick member of the family is prescribed because of danger of contagion. Since homes of many poor families are overcrowded, such isolation is frequently difficult and almost impossible.

5. Liaison. An additional and important responsibility of the medical social worker is to interpret to welfare agencies the services which are offered by the health center or other agency. In many cases the staff of welfare agencies do not understand the services provided by the health center. It is necessary, therefore, for some member of the staff of the health center to assume responsibility for providing information to welfare agencies. In other words, the medical social workers on the staff of the health center maintains liaison between the center and welfare organizations. Medical social workers must understand the work done by the welfare agencies so that their programs can be explained to the patients and to members of the health center staff. It is also necessary for medical social workers to understand the work done by the health center so that accurate information can be provided to welfare agencies. Medical social workers should also have a part in the development of procedures for referring persons from the welfare agencies to the health centers and vice versa. In many cases the effectiveness of the health program is restricted because of the "red tape" of referrals. Although services are theoretically available, ill persons do not receive them. It is only through complete understanding between the health and welfare agencies that it is possible to secure for eligible persons maximum benefits of the health and welfare programs available. The job of the medical social worker in the health center, therefore, has two main aspects: to assist individual patients - to advise and counsel; and to work with welfare groups in the community to bring about better understanding of the work done by the health center.

It is not sufficient to merely establish such facilities as the health center and assume that the persons needing services will find the center of their own accord. A person who is not ill pays little attention to the clinics and hospitals available in the community for he usually assumes that he will not become ill. When he does become ill, he is, therefore, at a loss as to what to do. Services of the health center must be brought to the attention of the persons who need them.

IV. METHODS OF WORK

A. Community Resources. Medical social workers should know the welfare agencies in the immediate community which the center serves. A knowledge of other services available in the city, prefecture and nation is also needed. For example, there may not be in the area serviced by the health center, specialized facilities to provide treatment and training for blind and other handicapped persons. The medical social worker must know whether such facilities exist in other places; or should at least know how to find out whether such services exist.

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Through the establishment and maintenance of a social resources file the worker can develop needed information about the community. (See inclosure 1) Over a period of time the medical social worker will become an authority concerning the areas of need of health and welfare services in the community. The medical social worker can be of assistance in recommending the development of additional health and welfare programs which are needed.

B. Interviewing. The medical social worker will carry out many responsibilities through interviews with patients and members of his family. Such interviews are for the purpose of providing needed information to the patient and securing information from the patient. In some cases it may be advisable for the medical social worker to visit the homes of patients but it is expected that most home visits will be done by other members of the health center staff or by a welfare agency.

C. Payment for Health Services. Many persons needing services of the health center or other medical agencies are frequently unable to pay for the medical care needed for themselves and members of their family. Because of their inability to pay, many persons go without medical and dental care which is needed. It is frequently assumed that the charging of small fees does not prevent persons from securing needed care but in actual practice we find that a small fee becomes a large amount of money in the opinion of the person who has no money. The medical social worker can be of assistance in determining a policy establishing the amount of fees and in the application of policies to determine when fees should not be charged. Help is also needed in securing for the patient necessary drugs and medicines prescribed by the doctor. The doctor may prescribe the best drugs possible for a particular patient but they will not do him any good unless he is able to secure them.

Although the medical social worker will be concerned with the problems of fees and the ability of persons to pay fees, the function of the worker must not be regarded as merely a "fee collector". The business office of the General Affairs section must not be permitted to shift their responsibilities to the social service worker. With a specialized knowledge of the Daily Life Security Law and the social insurance programs the medical social service worker may be of assistance to the patients and the center in securing payment for needed medical treatment.

V. ADMINISTRATIVE RESPONSIBILITY. It is to be emphasized that the medical social service worker is a member of the staff of the health center, and as such, functions as a part of the medical team. The medical social worker does not operate independently of other units in the center but in cooperation with other members of the staff. It is the responsibility of the medical social worker to assist in carrying out the plan established by the administration and not to establish a separate or different plan. The proposed organization of the health center and the place of the Division of Medical Social Service in relation to other sections and divisions is set forth in the "Introduction to The Model Health Center Demonstration".

The medical social worker should be thoroughly qualified as a welfare worker. Since he or she will be employed in a health agency he/she must, in addition to being qualified as a social worker, have a broad knowledge of the medical field. Suggested minimum qualifications are set forth in the job description (Inclosure 2). The worker is not employed by a welfare agency to work in the health center but is employed by the center itself, as a member of the health center staff. The presence of medical social workers on the staff emphasizes the fact that cooperation between the medical and welfare agencies is needed if the basic purposes of the health center program are to be achieved.

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RESOURCES FILE FOR MEDICAL SOCIAL WORKER IN THE HEALTH CENTER

1. It is recommended that the medical social worker in the health center develop and maintain a social resources file which will index all welfare agencies in the community served by the center. The file is for the purpose of enabling the worker to know of the existence, location and purpose and resources of each agency which may be of assistance to clients of the health center and which may be referring persons to the center. The file should also include agencies, regardless of location, which are located outside the health center district but which provide special services. The file should be arranged in such a way that additional information may be added as it is secured. A card file is usually found most satisfactory. Spot maps may also be found useful to record information needed in daily work.

2. Information about each agency may include the following:

a. Name of agency
b. Address-Directions as to how to get there - what is the nearest car stop, etc.
c. Telephone number
d. Name of persons in case of making contact
e. Functions or programs of the agency
f. Schedules of clinic days and hours
g. Fees
h. Application procedure.
i. Facilities, such as capacity of institution and eligibility requirements.

3. Information concerning the following types of agencies will also be found useful.

a. Family social work agencies

(1) Minsei-iin Offices
(2) Minsei Kan
(3) Minsei-iin
(4) Other agencies who give assistance to needy families
(5) Homes for the aged.

b. Agencies for Mothers and Children

(1) Orphanages
(2) Day nurseries
(3) Homes for mothers and children
(4) Child Welfare Centers
(5) Homes for handicapped children: Feeble minded; Crippled; Deaf and mute.
(6) Homes for delinquent children

c. Medical Agencies: Health Centers; clinics including VD clinics; Sanatoria; Preventoria; General hospitals; Maternity hospitals; Mental hygiene clinics and mental hospitals; Leprosaria, etc.

d. National agencies which provide information service:

Japan Social Work Association
All Japan Minsei-iin Federation
Boshi Aiiku Kai

e. Agencies for economic protection

(1) Agencies which provide housing and lodging

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(2) Employment agencies, vocational guidance, rehabilitation work shops.
(3) Agencies which provide scholarships
(4) Agencies which provide loans
(5) Agencies which aid special groups such as repatriates

f. Settlements

g. Public Welfare Agencies

The file should contain data concerning prefectural city and ward departments of welfare.

h. Related Agencies

The worker will find it useful if the file also contains information concerning police stations, schools and similar establishments in the community which refer persons to the health center and with which the medical social worker may have a working relationship.

Incl. 1

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SUGGESTED "JOB DESCRIPTION" OF THE MEDICAL SOCIAL SERVICE WORKER IN THE HEALTH CENTER

Note: The following statement sets forth the desirable qualifications and responsibilities of the Medical Social Worker in the Health Center. Although duties assigned to a particular worker may vary in different centers because of local conditions, in general the following should be applicable. It is expected that additions and changes will be found necessary with further experience in medical social service work.

1. Supervision.

Medical Social Service should be established as a separate division of the Public Health Services Section. The Chief of the Medical Social Service Division is therefore under the supervision of the Chief of the Public Health Services Section. Medical Social Service is a separate service and not a part of the business office of the center.

2. Duties and Responsibilities:

a. To maintain liaison with welfare agencies in the area served by the health center; to provide information to these agencies concerning the policies of the center concerning intake and services available by the center.

b. To provide information to members of the staff of the health center concerning the programs of the welfare agencies and explain how the welfare programs may be of assistance to the clients of the health center.

c. To maintain a social service resources file containing partinent data concerning welfare agencies.

d. To interview patients and members of his family to aid them to understand medical and social difficulties and reasons for them.

e. To secure an understanding of the patient and his situation and to provide relevant information to the doctor and other members of the health center staff concerning the patient.

f. To determine whether the patient has problems related to his sickness which may interfere with the success of treatment recommended.

g. To refer patients directly or indirectly through Minseiin (in case of welfare clients) to a proper agency in order to meet his social or medical needs which can not be met within the health center itself. To provide information to the agency to which a referral is made concerning the patients medical situation and the plan of treatment recommended by the health center. To provide information to the patient concerning the program of the agency to which a referral is made.

h. To give service to the patient and his family in adjusting their problems which have no direct relation to sickness in absence of appropriate agencies in the community.

i. To supervise additional employees assigned to the Division of Medical Social Service.

3. Qualifications.

a. Education: Graduation from middle school plus three years of additional education. It is preferable that education include

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special training in social work, the social sciences and biological sciences.

b. Previous experience should include:

(1) Employment in medical agency which has provided the individual with a knowledge of medical terminology and methods.

(2) Employment in a welfare agency or closely related programs which provided a knowledge of welfare programs in the community.

Incl. 2

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MEDICAL SOCIAL SERVICE IN THE HEALTH CENTER

FB
3 October 1949

The foregoing basic information on "Medical Social Service in the Health Center" was presented to the Japanese Health Officers at the Model Health Center demonstration held in March 1948. Also, it has been incorporated into the "Outline of Functions of the Health Center" which is in Japanese. This same material was made available (with some additions regarding medical social work in hospitals) to Health and Welfare officers through Public Health and Welfare Technical Bulletin (TB PH-WEL 14) dated August 1948, subject: Medical Social Service.

All model health Centers, and eventually all health centers in Japan are expected to have a functioning medical social service unit. In line with this policy representatives from 45 prefectural Model Health Centers, (Yamanashi was missing) who either already had, or were to have the responsibility for medical social service, attended a ten day school on Medical Social work at the Institute of Public Health in February 1949. (See Incl 1 for background and training of these people).

The presence of medical social workers in hospitals, such as national sanatoria, Saisekai (charity hospitals) and those of the Japanese Red Cross is important to the medical social service program in the health centers because of the close cooperation necessary to fully utilize these resources for the care of patients. Therefore, it is well to note here that during the three months' course in medical social work which was given starting in May 1949 at the Japan School of Social Work, Suginami Health Center was used for field work placement. There were seven representatives from health centers in this course and they all had an opportunity to actually participate in the medical social work program at Suginami Health Center. The other members of this course were from the above mentioned hospitals, and it is interesting to note that of the 35 students only seven were men.

Since medical social service in the health center is new, and the workers have very little, if any, experience or training in this field, minimum standards need to be developed. Such action is contemplated by the Ministry of Welfare, but not yet fully accomplished. Jobs need to be clearly defined in order not to confuse the work of the medical social worker with that of the doctor, public health nurse, or clerks in the business offices. Everyone in the health center should understand what the medical social workers can contribute to the solving of the problems brought to them. The director of the health center must understand the functions of the Medical Social Service and must hold his workers responsible for accomplishment of these functions.

The following charts have been prepared as examples of what should be looked for when evaluating the medical social service in the health center.

Charts: (1) Sources of Referral

a. Within the Health Center, doctors, nurses, business offices, etc.

b. Outside the Health Center, Social agencies, patients themselves, other medical agencies, etc.

(2) Number of cases handled per month for a year

(3) Services rendered (including use of community resources)

(4) Financial status of patients served

(5) Problems presented

(6) Activities of the medical social worker

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a. Interviews in the health centers

b. Home visits

c. Visits to other agencies, etc.

The case record is to the medical social worker what the medical chart is to the doctor. Therefore, case records should be reviewed as to adequacy of necessary and relevant information and for the analysis of the problem presented and how they are met. You will be shown some actual case records from health centers.

Education regarding the services available through medical social service is essential. A Kamishibai which has been successfully used in showing the work of the medical social worker in a family with many social problems is being presented here today.

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FB
3 October 1949

Subject: Background and Training of Medical Social Workers Attending the School for Medical Social Workers in Model Health Centers during February 1949.

1. Present were representatives from 45 prefectures (none came from Yamanashi) with 3 extra from Kyoto. Following is information regarding members of the group.

Men	30		Women	18
Age range	20 - 29	10		
	30 - 39	18		
	40 - 49	11		
	50 - 59	7		
	61	1		
	Unknown	1		

The youngest was 24 and the oldest 61.

Educational background.

Primary school	1
2 years beyond primary school	1
Part of high school	2
High school graduate	17
Part of semmon gakko	2
Graduate of semmon gakko	15
Part of college	1
College graduate	5

Experience in social work or related fields.

(Several had experience in more than one field.)

Social work	18
Public health	15
None	16
Unknown	3

Those holding a license
(Several had more than one license)

Without license	31
With license	15
of which there are	3 doctors
	3 public health nurses
	2 nurses
	1 midwife
	2 health administrators
	6 primary school teachers
	5 high school teachers

Those having other duties besides being the medical social worker in the health center (18 out of 48)

Minsei-iin	2
Relief of widows	1
Health statistics	2 (in the health center)
Health education	6 (in the health center)
Public health nurse	1 (in the health center)

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Office work	1	(in the health center)
Chief of General Affairs Bureau	2	
Chief of Information Section	1	
Chief of Mother & Child Section	1	
Requested by the Civil Affairs Teams for supervisory purposes	1	

Incl 1

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MEMORANDA (MAY 1949)

1. Interneship: a. I-Hatsu No, 263: Basis for establishment of Medical Interneship in Japan.

b. Hospitals and health centers presently approved in each prefecture.
c. Deficiencies: 1. Failure to give concise responsibility in various services.
2. Failure to schedule services properly in conformity with a rotational system.
d. One-month of interneship is to be spent in public health.
e. Since directors of hospitals approved for training interms do not have experience in such a program and no provision is made in the reference directive for its operation and management.
f. A study will be made of presently approved hospitals and health centers in each prefecture with a view to more efficient utilization and distribution of these young doctors.
g. Attention should be directed toward improvement of other hospitals in other attain future approval.
h. Attention should be given to the already established intern training institutions, to insure that both intern and hospital are deriving maximum benefit from the intern system.

2. Allocation of Streptomycin for Okayama Prefecture:
a. Will be allocated to Okayama Medical University Hospital and National Hospital, as well as other hospitals. Both hospitals mentioned are to receive 1,200 grams each. Patients can be treated with amount not in excess of 40 grams.
b. Other hospitals if they have facilities for pathological study and dissecti n can receive allocation through the Prefectural Health Department.

3. Interview with Mr. Speer(Narcotic Agent):
a. Dr. Fukuda is negligent.
b. Narcotic agents are to handle investigations.
c. Economic Investigation Board has been investigating the Okayama Drug Manufacturing Co.(Case handled under the E.I.B.).
d. In future if anything turns up that may involve narcotics, get narcotics agent on the job.

5. Testing the Chlorine content of water (Japanese method):
1 gram of Orthotolidene Powder put into one liter of dilute HCL. Then ut 3 drops of this reagent into a tube of water to check chlorine content.

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Medical Internships

A great many changes have occurred in the last few years and are still underway; most if not all of which point the way to progress. Nevertheless, there are some things which have not received the appropriate attention they deserve. I have particular reference to the Medical Internship Program.

Internship constitutes one of the most important formative periods in a doctor's life. It is during this period that theory garnered from textbooks is tested and applied. It provides a test not only of what has been learned in medical school but also how effective the intern is in utilizing his knowledge of disease in the treatment of the patient. Fundamentally, medical science embraces not only treatment of disease, but also treatment of the patient. The full meaning of this is best exemplified by cases of illness in which psychosomatic factors play an important part.

Realization of the importance of internship prompted the issuance of Citation No. 263 which provides the basis for establishment of Medical Internship in Japan. However, this directive lost a good deal of its effectiveness because no provision is made in this directive for the operation and management of the interne system.

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Furthermore, more often than not, hospital authorities do not have experience in such a program. Thus efficient distribution of these young doctors has not been made, with detriment not only to the hospital but also (what is more important) to the interne himself, who in a short time will have the responsibility of treating patients in his own practice.

The chief deficiencies (at the present time) of the present system are: @ failure to give concise responsibilities in various services and @ failure to properly schedule services in conformity with a rotational system.

The inevitable result of these 2 deficiencies combined with a lack of precedent results in the squandering of the interns time as well as the waste of skilled service to the hospital.

Therefore, I should urge that something be done to improve this state of affairs either by each hospital and health center individually, or by the formation of a committee of doctors to make a study of the presently approved hospitals and health centers with a view to more efficient utilization of young doctors. Remember that the medical profession has a definite responsibility toward these young men; and it is only natural that this be so; for in a short time they too will be representatives of the medical profession at large. What they do and how they function will affect the prestige of the medical profession.

A great deal is being accomplished in the improvement of medical education, the formulation of a code of ethics and in the improvement of hospitals. We should not neglect the improvement of the intern system. Such is necessary if we are to have a balanced program for total improvement of medical education and the elevation of the medical profession to new heights of honor and respect.

SCHEDULE FOR INTERNESHIP TRAINING IN KURASHIKI H.C.

Prepared by Dr. Kanooka, Director

Date	Week	Hour	Subject	Hour		Hour	
29 Aug.	Mon.	9-10	Meaning of Public Health	10-12	Assist in T.B. Clinic	13-16	Assist in V. D. Clinic
30 Aug.	Tues.	9-12	Outline of H.C. Activities				Assist in Mass Examination
31 Aug.	Wed.	9-12	Observation of Water Work and Sewage				Attend the lecture given at Kurashiki Central Hospital
1 Sept.	Thurs.	9-12	Health Statistics			13-16	Self study of Health Statistics on the basis of reference books
2 Sept.	Fri.	9-10	Outline of V.D. Control	10-12	Assist in V.D. Clinic	13-16	〃
3 Sept.	Sat.	9-12	Observation of Sanitation Teams. Guided by Sanitary Inspector)				
5 Sept.	Mon	9-10	How to diagnose pregnant women	10-12	Assist in maternal and well-baby clinic	13-16	Assist in Kurashiki City Pregnant women clinic
6 Sept.	Tues.	9-12	T.B. Control			13-16	Attend V.D. Discussion Meeting
7 Sept.	Wed.	9-12	Pneumothorax Treatment (Explanation)			13-16	Assist in Kurashiki City Pregnant women clinic
8 Sept.	Thurs.	9-12	Assist in Mass Examination of stool			13-16	Self-study of communicable diseases
9 Sept.	Fri.	9-12	〃			13-16	Attend the lecture given at Kurashiki Central Hospital
10 Sept.	Sat.	9-12	Observation of Hayashima T.B. Sanatorium				
12 Sept.	Mon.	9-12	Assist in T.B. Clinic			13-16	Assist in chemical water test and bacteriological count of milk
13 Sept.	Tues.	9-12	Observation of Milk Processing Plant			13-16	Inspection of eating establishment with food inspector
14 Sept.	Wed.	9-12	Inspection of fish, vegetable markets with food inspector			13-16	Attend food inspectors' conference
15 Sept.	Thurs.	9-12	Assist in making health statistics			13-16	Assist in making health statistics
16 Sept.	Fri.	9-12	〃			13-16	〃
17 Sept.	Sat.	9-12	How to diagnose babies pointers will be given				

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Date	Week	Hour	Subject	Hour		Hour	
19 Sept.	Mon.	9-12	Assist in Baby Clinic			13-16	Guidance of Nutrition
20 Sept.	Tues.	9-10	Communicable Disease Control	10-12	Environmental Sanitation	13-16	Home Visiting with P.H.N.
21 Sept.	Wed.	9-10	Eugenics Protection Law (Explanation	10-12	Assistiin maternity clinic	13-16	Observation of slaughter house
22 Sept.	Thurs.	9-12	Medical Social Service (Explanation			13-16	Attend P.H. Conference

REMARKS: (1) The guidance and direction concerning T.B. will be given by the Chief of Public Health Section. The director will be responsible for giving guidance concerning all other items except T.B. In case anything should happen to the director, other staff concerned will give guidance.

(2) In case communicable diseases should break out, this schedule will be changed, and internes will be used temporarily for contact tracing or prevention.

(3) The schedule shall be subject to change according to the change of schedule of Health Center activities.

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May 26, 1950.

My dear General Sams and Colonel Johnson:-

This is an English version of the summary of my talks given at the meetings of local medical societies in Kanagawa Prefecture.

My idea expressed in it is not the one which has recently happened to occur to me, but the one I hold almost for these 20 years.

My talks have called forth reaction which I did not in the least expect. Those who attended the meetings have expressed satisfaction of being enlightened in knowing the difference of medical and pharmacentical word between America and Japan. The Kanagawa Prefectural Medical Society has the draft of my talks printed and is going to distribute its copies to prefectural medical societies throughout the country and to the members of the House of Councilors and of the House of Representatives.

I wish to present this paper before you for your kind attention.

Very sincerely yours,

Tatsuo Kibata, M.D.

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HEADQUARTERS
KANTO CIVIL AFFAIRS REGION
PUBLIC HEALTH SECTION
APO 500

26 May 1950

Conference with Dr. Kijima, Hiratsuka Mutual Hospital

Dr. Kijima, Hiratsuka Mutal Hospital, desired to present the document to Col Johnson with his letter.

Purpose of the letter is just for the referrence only, however, Dr. Kijima thinks that there are may some useful suggestions in it.

According to Dr. Kijima, Col Johnson has not asked for this document, but it was learned that the papers will be distributed to all concerned throughout the country even to the House of Representative by the Kanagawa Prefectural Medical Society at where he had made a speech previously.

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EDUCATION AND PRACTICE OF MEDICINE AND PHARMACY IN THE STATES

Private View on

1. Social Health Insurance Policy
2. Separate Practice of Medicine and Pharmacy
3. Medical Treatment Act

Talks given by

Tatsuo Kibata, M. D.

At the meetings

1. Hiratsuka City Medical Society on Feb. 24, 1950
2. Yokohama City Medical Society on March 4, 1950
3. Koza-Gun Medical Society and Sagamihara National Hospital on March 16, 1950
4. Yokosuka City Medical Society and Miura-Gun Medical Society on March 24, 1950
5. Aiko-Gun Medical Society on April 14, 1950

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It gives me great pleasure to speak before you at this meeting to-day. Though I have given you my willing consent to speak before the Prefectural Medical Society to-day, I am afraid that I am not qualified to speak on the subject in accordance with the laws and regulations of the States, for I have never studied such laws and regulations, nor have I ever read any literature on the subject.

However, I have had training both in Japan and in America. I am a graduate of the Okayama Medical School in 1914, and a graduate of the Medical School of Columbia University, New York, in 1920. I have taken post-graduate research work in Japan and in America. Besides a Japanese license, I have license to practice medicine and surgery in the State of New York and the State of California, having passed the examinations of the Medical Boards of both States. I have practiced the profession in the States for a number of years. I went to the States four times, having crossed the Pacific Ocean eight times, and twice have I traveled the American continent from the West to the East and visited various medical schools and hospitals.

Therefore, it may not be too much to say that I am one of the Japanese medical men who know best the American circle of medicine and pharmacy.

However, it has already been 17 years since I left the States, and I am a post-war repatriate from Tsingtao, China, and, therefore, I may lack the latest knowledge about the American medicine.

But, so far as I have been informed by the medical officers of the Occupational Forces, there seems to be little changes in the medical and the pharmaceutical circle of America during these years.

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Therefore, I am quite sure that you will understand or will get some idea as to how different and what points are different in the medical and the pharmaceutical world of America and Japan from what I am going to tell you to-day.

To-day, I will take up only the points which differ between America and Japan, and in the following order:-

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I MEDICAL EDUCATION

In those days when I was in the medical school of Columbia University about 30 years ago, medical education in the States was not standardized so much as it is now.

There were more than 30 schools of A-one class, such as Harvard, John Hopkins, Columbia, Cornell, Pennsylvania, Chicago, Stanford, etc. There were also a number of B or C class schools. However, by the continuous and strenuous effort and enlightenment of the American Medical Association, these inferior schools have been either closed or improved.

To-day, there are 71 medical schools in the States. They are all highly standardized and approved by the Council on Medical Education and Hospitals of the American Medical Association. The medical educational system has been newly adopted in our country since the end of the war. This system is almost the same as American system. I will, therefore, tell you on points which, I believe, differ in America and in Japan.

1) Americans prefer substance to name.

   Japanese vice versa.

As I think the Japanese have a bad peculiarity to prefer names to substances, I want to point this out.

I am surprised that the word "Daigaku" which means literally "Big School" or University is used too much in Japan. I wonder if they feel as though they are discredited by not using the word "Daigaku". For instance, whereas it is sufficient to say So & So Igakko (medical school), they say So & So Iku-Daigaku (medical big school). And it is funny that they translate verbatim So and So

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Ika-Daigaku as So & So medical university. University is an institution having more than one special school on science or art. If only one department, the word College should be used. In the States, such A-one school as Harvard or John Hopkins, etc., is called School of Medicine or Medical School. It is self-evident that an institution where medicine is taught is a professional school and nobody would think it to be a medical institution of a Grammar or a High school grade.

2) Entrance Requirements.

No donation is extorted in America, as is widely and openly exercised in Japan.

On the whole, they require 2 or 3 years premedical training, almost the same as in Japan. In any medical schools in the States, they require first of all good moral and ethical standing. Candidates for a medical school are required "brain", "health" and "money". In a big university like Columbia, they have an employment agency where they take the good office to find part-time jobs for students working their way through school. This privilege is denied to medical students for the following reasons:-

1. Medical school course is difficult. The students cannot follow the course satisfactorily by self-supporting, wholely or partially.

2. They fear that those who go through the medical school in needy circumstances tends to spoil the medical ethics after they take up practice.

Of course, most medical schools have funds for scholarship or fellowship which are granted for well qualified, excellent students.

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Extortion of money has been and is being widely and openly exercised as an entrance requirement in some medical schools, especially in private medical schools in our country. But never have I heard such evil and shameless requirements in America.

3) Method of Education in America is Individual Educational System.

(a) In America, education is practical. Lecture is secondary and practical training (lab. work and clinical work) primary. In Japan, lecture is primary and practical training secondary.

(b) In America, up-to-date education is given to students, the latest knowledge being taken up from international literatures. In Japan, a professor reads his note or book and students take notes.

(c) In America, a great stress is laid upon individual education, and, therefore, there are no marked inferior (scum) students. In Japan, education is given in a mass, and, therefore, there are some inferior students that graduate without being noticed.

(d) In America, a roll call is very strict, more so than the people of this country actually think, while in Japan, the students' attendance is very irregular and the roll calls lax. (explained by examples)

(e) In America, medical students are very busy and have no time to idle away. In Japan, the students idle their time away too much in private meetings and so forth.

4) Abundant Materials for Practical Education in the States.

Clinical facilities in the States are so abundant, that I should say it surpasses all of your imaginations. If I would tell you the following illustration, you would understand how much material for

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practical training is in American medical schools.

In most of the medical schools in the States, they require actual practice of delivery of no less than 6 obstetric cases for each student before he is granted an M.D. diploma. A school must have, therefore, at least 600 obstetric cases a year, if it is to grant 100 diplomas. When I was in Columbia Medical about 30 years ago, each one of my class-mates of one hundred had practiced 12-13 obstetric cases. So, Columbia had per year at least 1200-1300 obstetric cases for students' practice. A credit in obstetrics is given when a student has followed up both the mother and the new-born for one week after the delivery. As it is an obstetric case, it is obvious that another student cannot use it over again after the finish of delivery.

How is it in Japan? A student who can see a delivery from a distance may consider himself lucky, to say nothing of an actual care of a delivery.

When I was a student, my group-mates of ten were receiving practical training in internal medicine in the Presbyterian Hospital in New York, one of the hospitals under the control of Columbia Medical. Each one of us had about 15 in-patients under one's charge. There were, therefore, at least 150 in-patients for students' practical utility.

How many in-patients do they have in the Medical School Hospital of Tokyo University, the biggest medical school in our country? Altogether one thousand at most, I guess. And how many of this number can be used for students' practice? Not more than 20%, I guess. That is 200 inpatients altogether, at most, is'nt it? If these 200 patients

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are divided by the number of departments, how many patients in one department? Ten or twenty at the most in each department, isn't it? Now, you can imagine how much material for practical training of students is in the States, and how poor is it in our country. Where does the reason for this difference lay? It is because the system in the States is good and poor in Japan.

The above fact is a problem we must give a serious consideration.

5) Huge Teaching-staff in the States.

Teaching-staff of medical schools in the States are very large as compared with that of Japan. In some of the medical schools in the States, the number of teachers may be more than that of students. They can hold so many teachers in medical schools in the States because the services of most of these teachers, especially in clinical medicine are being rendered free to the schools on subject basis. Most of these teachers earn their living in their outside profession, and give their free time to school for nothing, or for a very small remuneration.

In Japan, as you know very well, a professor takes sole possession of the whole department and holds his own sphere of influence as a monarch. Such a chair-syetem, in no way, is allowed in the States. This difference between America and Japan is, I believe, a very important phase which requires a serious study for change.

I believe this sole control of each department by one professor in a medical school is the main cause which leads to many evils in the medical world in this country.

I believe it is not too much to say that the present status of

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the separation between society and medical world, school-cliques, degrading of medical ethics, retrogression and development to deformity of medicine in this country to-day are all traceable to this bad organization of our medical schools.

6) Difference between Japan and America in Receiving Degrees.

In the States, Doctor of Medicine (M. D.) is the highest and the only degree in medicine. There is no other degrees given to medical doctors in the States.

PH.D. (Doctor of Philosophy) in America is the degree which is comparable with "HAKUSHI" in Japan. In Japan, "HAKUSHI" is called "title", not "degree". But, PH.D in the States and "HAKUSHI" in Japan are both academic degrees. An M.D. is a professional one. A doctor in medicine may be a PH.D., acquired in other field of study, and as such, it does not mean in the States that as a doctor, he is better than those who have only M.Ds. This is generally acknowledged by doctors and by the public in the States.

The most of Japanese PH.Ds. in medicine (IGAKU-HAKUSHI) are nothing but NEZUMI-HAKUSHI (mouse PH.D.), USAGI-HAKUSHI (rabbit PH.D.), or BIKIN-HAKUSHI (germ PH.D.). Therefore, it is quite irrational to put the academic degree of IGAKU-HAKUSHI (PH.D.) above the professional degree of IGAKUSHI (M.D.) in Japan, for it is like putting a fifth wheel to a coach.

As I have pointed out at the beginning, the Japanese have a bad peculiarity to prefer names to quality. I feel strongly that a sound development of medicine in our country cannot be expected without an immediate reformation of this kind. And I do not hesitate to say that

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Japanese PH.D. in medicine has been and is the hotbed which brings about school-cliques and leads medicine astray from the right path.

I wish to call the attention of men who are sincere in reformation of this fact.

II PHARMACEUTICAL EDUCATION, PHARMACY

1) History in the States.

I will take California State as an example.

1. Until 1925-6, a school of pharmacy was two years course after the completion of high school course. As a Pharmacy Graduate (PH. G.), the graduate was qualified to take the State Board examination.

2. Between 1925-6 and 1930, the pharmaceutical schools became 3 year system. As a Pharmaceutical Chemist (PH.C.), the graduate could take the State Board examination.

3. From 1930 to date, the schools became four year system. The graduate is granted Bachelar of Science (B.S.). They are required one-half year of practical training before they are allowed to take the State Board examination.

4. At present, it is said that a 6 year system is going to be put into effect within a few years. By this, the graduate is to be granted Doctor of Pharmacy (D.PH.) which corresponds to M.D.

In the curricula of the pharmaceutical schools of the present 4 year system, drug-store, food analysis, hospital pharmacy, clinical chemistry and manufacturing are included in America. In the pharmaceutical schools in the States, the curricula necessary for pharmacists

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are well set up and taught.

In the schools in Japan, they lack such curricula. They give, however, trainings necessary for chemists. It can be said, therefore, that Japanese schools of pharmacy are not real schools of pharmacy, but they are schools of chemistry.

In the States, they teach everything concerning drugs, that is, raw materials - pharmaceutical products - uses. In Japan, they teach only raw materials - products.

In America, they teach

Raw Materials	Pharmaceutical products	Uses
In Japan, they teach this part. This part of training is good for chemists and manufacturing technicians.		In Japan, they do not teach this part. This part of training is more essential for pharmacists.

Therefore, Japanese pharmacists up to the present cannot be considered well qualified ones. It can be said that there are no pharmacists in our country from the American point of view.

The above fact should be taken seriously into our special consideration, if we want to set up plans for the separation of practice in medicine and pharmacy in our country.

2) Drug-store (Pharmacy) in the States.

You will find drug-stores in any places, mostly situated as a corner house or at a good business site. Other business stores close at 5 or 6 p.m., but drug-stores are open till late in the evening.

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and even on Sundays, if not all day long. There are pharmacies which do business only to make up physicians prescriptions. But they are few in number. Almost 99% of pharmacists in the States do side-business, such as soda-fountain, retail of hygienic materials, cigarettes and stationary, etc.

There is no regulation that physicians should not compound and dispense medicines to their patients. It is not compulsory in the States. But, generally the physicians do not dispense medicines as for their ethics.

However, in the States, pharmacists do not compound and dispense medicines without physicians' prescriptions. Such practice is not maintained in our country.

Moreover, in the States, commercial morality is well observed among manufacturers, wholesalers and retailers of drugs. Even physicians cannot buy medicines directly from makers or wholesalers. Buying must be done always through retailers.

In Japan, this commercial morality is not maintained at all.

3) Advertisements of Drugs.

In the States, the advertisements of pharmaceutical products are extremely continent in direct opposition to our country. Except in the case of a few "patent medicines", pharmaceutical products are not advertised in news-papers, general magazines and posters in the States. Advertisements of drugs are done directly from manufacturers to physicians and pharmacists. This is a matter of course.

Whether drugs are good or not, even pharmacists cannot judge, to say nothing of the public.

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I believe that the advertisement of drugs in news-papers, in general magazines and posters as is done in our country is more than wicked.

My rough survey about 20 years ago revealed the expense spent for advertisements of drugs in this country amounted to some hundred million yen a year. Due to damages of manufacturing plants during the war and to insufficient raw materials after the war, the present pharmaceutical production must be less than that of the past. And yet, I guess the figure amounts to at least some billion yen which is spent yearly for advertisements of drugs in this country to-day.

If these advertisements are stopped, it is evident that the cost of production can be cut down ever so much, enabling us to buy medicines cheaper.

And this amount is by no means small, if compared with 3 billion yen expended extra by the Government for the payment of medical service fees of social health insurance system for the last year.

I emphasize that a strict and a strong step should be taken at once to prohibit the advertisements of medicines.

III HOSPITALS

1) Organisation of Hospitals is Different in America and in Japan.

Generally speaking, American hospitals are organized and maintained on a non-profit basis, and many of them are supported by the interest of funds, by voluntary contributions, income from endowments, earning from care of private patients, and from the payment by cities, counties and states for the care of indigent patients.

In order to make it easier to understand, will you please just

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imagine a hospital with no clinics, no physicians. The hospitals is well constructed, fully equipped, and has hotel-like bed rooms. The employees on full time salary basis in this hospital are nurses, clerks, technicians and house-keepers, etc. The hospital is opened for private practitioners in the neighbourhood area.

If the hospitals have clinics (out-patient departments), these clinics are all opened for indigent patients only. And the hospitals with clinics also have facilities to admit indigent patients. These indigent patients receive free medical care from the medical-staff of the hospital, specialists in all branches of medicine who have private practice in the neighbourhood.

In Japan, hospitals are generally organised and maintained on self-supporting basis. They employ medical-staff, business clerks and so forth, all on full time salary basis. And hospitals are supported by earnings from care of patients of all classes.

In America, the medical-staff is generally working on the basis of free service, and, therefore, the hospitals can save much of their running expense. This is an outstanding difference with the Japanese hospitals.

Such small private hospitals as you see throughout our country are never found in the States. What is called a hospital in the States is the one like St. Lukes Hospital in Tokyo. Hospitals like the St. Lukes are found everywhere in the States.

American hospitals are big and fully equipped, clean and well managed, and their facilities are opened for the use of private practitioners on non-profit basis. In Japan, the hospitals are self-supporting on profit making basis, most of them are small, poorly

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equipped, carelessly managed, unclean, noisy, and their facilities are closed for any outside private practitioners.

In discussing our Medical Treatment Act, this marked contrast between the American and the Japanese hospitals should be taken into a serious consideration.

2) Fees.

3) Nurses.

American nurses are generally well trained. They do routine work precisely. You can safely trust them with the care of patients. For those patients who need a great deal of extra care, special nurses are put on duty. If such patients are private patients, the patients pay the fees for the nurses. If such patients are indigent, the hospital pays the expense for special nurses.

4) Interns, Residents.

About 30 years ago when I graduated from the medical school, internship was required neither by states to qualify for the Medical Board examination, nor by the Medical schools for the candidates for M.D. degrees.

At present, twenty-four states require one year internship for Medical Board examination, and seven schools require one year internship for candidates of M.D. degree. One of these 7 schools suspends diploma until the finish of internship.

Therefore, the internship may be classified into two.

(1) Internship required for candidates of M. D. degree:- at present, this internship is of one year system. For this kind of internship, training is given by rotary system, just as they are presently carried on in this country.