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FIFTY-FIRST ANNUAL CONFERENCE

1952

SURGEON GENERAL
PUBLIC HEALTH SERVICE

AND

CHIEF, CHILDREN'S BUREAU

WITH

STATE AND TERRITORIAL HEALTH OFFICIALS

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

PROCEEDINGS

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AND

REPRESENTATIVES OF
STATE HOSPITAL SURVEY AND CONSTRUCTION AGENCIES

December 8 - 11, 1952
Washington, D. C.

The Federal Security Agency on April 11, 1953, became the
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NOTE: The annual meeting of the Association of State and Territorial Health Officers, held simultaneously with this Conference, will be reported separately by the Association. This Proceedings reports only those sessions and recommendations which were a part of the General Conference.

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of the

ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICERS

1952--1953

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ARTHUR THOMAS McCORMACK AWARD

Dr. Earle G. Brown, Health Commissioner, Nassau County, New York, received the Arthur T. McCormack Award for meritorious public health work from Dr. Daniel Bergsma, chairman of the awards committee of the Association of State and Territorial Health Officers.

Other recipients of this award, honoring the name of the former State Health Commissioner for Kentucky, have been:

Dr. Walter L. Bierring, Iowa Commissioner of Health since 1933, and former President of the Iowa State Board of Health and State Board of Medical Examiners from 1914 to 1922.

Dr. Albert J. Chesley, Secretary and Executive Officer of the Minnesota State Board of Health since 1921, and an associate of the State Board of Health since 1902.

Dr. Stanley H. Osborn, Connecticut Commissioner of Health since 1922, and former District Health Officer in Massachusetts.

Dr. Felix J. Underwood, State Health Officer of Mississippi since 1924, and promoter of the new School of Medicine of the University of Mississippi. Dr. J. A. Milne accepted the award in Dr. Underwood's absence.

Dr. Edward S. Godfrey, State Health Officer of the Territory of Arizona from 1908 to 1912, and of New York State from 1936 to 1947. In the absence of Dr. Godfrey, Dr. H. E. Hilleboe accepted the award for presentation to him.

The late Dr. Cornelius A. Harper, Wisconsin State Health Officer from 1904 to 1939. Dr. C. N. Neupert accepted the award for presentation to the family of Dr. Harper.

Dr. Thomas F. Abercrombie, first county health officer in Georgia; lifetime director emeritus of the Georgia State Department of Public Health; and former State Health Officer of Georgia from 1917 to 1947.

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over the opposition of short-sighted and faint-hearted men. All of us here -- all the American people -- are, in a very real sense, reaping the benefits of advanced thinking, bold experimentation, and courageous pioneering.

In the press of our day-to-day activities, we don't often have the opportunity to stand back and look at the structure that has been created. But we have in fact created a structure that is enduring and that has met the test of time. Out of the working partnership of local, State, and Federal agencies has developed the kind of relationship which enables you to meet here today and reach decisions which will profoundly influence the direction of health services in this country.

The machinery for action-in-partnership is here and it works. It has become a part of our social heritage, extending beyond individuals and beyond shifts in political alignments. The only real danger we face is to fall victims of the twin evils of arrogance and complacency -- to lose that sense of hopefulness and vision and hard work that brought us where we are today.

You here know far better than I the results of the partnership, solidified with the enactment of the Social Security Act in 1935 and extended into many specialized health fields in the last 15 years. At the risk of "carrying coals to Newcastle" let me mention a few of these results. And as I do, let us again recall that these achievements didn't just happen; they were fought for and worked for and paid for by you and by the people of the United States.

Today we in this Nation can expect to live longer than our ancestors -- an average of 68 years. What makes this figure so impressive is the swiftness of the change -- the average is 5 years better than the record of a decade ago, 10 years better than 1930, 21 years better than in 1900. Virtually all children born today can expect to survive the first year of life, a year once fraught with so much peril. The same heartening story can be told for almost any disease against which the partnership has directed its concerted efforts--tuberculosis, syphilis, malaria, the infectious diseases of early childhood. Badly needed hospitals and health centers are being built. Research, so much of it sponsored and carried out under Federal-State auspices, has uncovered causes and cures for many diseases.

Even as you sit back, however, and reflect on the achievements of the past, you are wrestling with the problems of the present, in part created or intensified by those very victories. Fifty years ago, for example, one out of every 25 persons was 65 years of age or older. Today over 13 million people are 65 or older--one out of every 12 of us.

The changing environment, the mobility of our population, the swift pace of industrial expansion, also bring you face to face with new problems. Today's health problems are much more subtle and complicated than they were in the past. We know that health is affected, and that illness is aggravated by noise, by smoke, by crowding, by new inventions, and by internal and external tensions.

The greater the awareness of these factors, the more effective will health services be. This means that health workers must ally themselves with other social forces in the local and national community. The partnership must not only grow stronger between the various levels of government -- local, State, and Federal -- but must also branch out laterally. Adequate health services in the future call for genuine integration with related social programs, such as welfare, rehabilitation and education, and for close rapport with other community services that affect health, such as housing and community planning.

Let's look briefly at the elements of the partnership and at the philosophy from which it stems. It is a philosophy, I think, that is accepted by all. It is based on respect and trust, on the recognition of individual rights and mutual responsibilities. The flow of power is a natural one, from the individual citizen to his local community and then to his larger community, the State and the Federal government. The interrelationship between the citizen and his government, and within the various levels of government is delicate and subtle, yet strong, like a fine fibre.

The structure that binds us together is, in fact, unique in man's governmental efforts. It is an American invention, rooted in our social fabric and peculiarly suited to our geographical needs. It has developed out of a combination of circumstances--our pioneering traditions, our strong community bonds, our patterns of emerging social obligations. At its base is a federated system of government--a system of local, State, and Federal authorities -- with each member of the partnership having its own set of duties, powers, and obligations.

The American federated system is also unique in its sources of strength and its possibilities for action. It preserves and extends local independence and at the same time permits national concentration on national problems. Our citizens have different loyalties without necessarily having conflicting loyalties. We meet national needs best when local resources are strongest.

It is true that problems may not always be the same. The needs of some States may differ somewhat from the needs of other States, and local problems may not always be comparable to those of the State. But there is a core of problems that require joint undertaking, that confront all the people of the United States. And these problems demand the united effort of our Federal-State-local system.

The result of the system then has been a fusion of effort which helps us to pull together our resources instead of scattering them or instead of quarreling over them. It is this kind of teamwork that has enabled you to undertake cooperative endeavors, to share ideas, resources, and facilities for a common national goal.

This is not to imply that all our endeavors have been marked by complete harmony. Nor would we want to pay the costs of such a harmony, the costs of smugness and stagnation. We have had differences, but they have been honest differences. But from these differences, from the hammering out of compromises, has come greater understanding and a higher kind of unity.

When we come to the differentiation of responsibilities, we find that certain broad categories of responsibility fall, quite typically and quite naturally, to the Federal partner, just as others fall to the States and the communities. For example, it is an accepted obligation of the Federal partner to conduct research and experimentation in new health techniques; to develop and set nationwide standards; to collect national statistics of various kinds; and to meet problems which are interstate, international or so new or so fluid that no State or local agency could possibly undertake them.

Financial aid is, of course, an important type of assistance offered by central to local governments. But it is by no means the only or even the most important kind of aid. I think the grant-in-aid principle is firmly established in this country; it is one of the buttresses of our federated system of government. It's to be expected, however, that at any particular time one member of the partnership may be stronger in resources than another, and that there will need to be a continual balancing of forces in the interests of greatest economy and productiveness.

More important than the financial aid, it seems to me, is the necessity for all groups to do their share in a unified, constructive way. In other words, the Federal-State health system is not a matter of giving, but a process of sharing.

Sometimes it is charged that the Federal Government dominates the States. In the tension and exaggeration of the recent campaign -- and before -- there were many claims about Federal encroachment on the rights of the States. I know something about the Federal regulations governing grants for health purposes. And I see nothing in the Federal-State system that prevents any State from seizing the initiative and blazing the trail in new health programs. I think the States have not been stifled because they have been the recipient of Federal grants. I do not know of many bold experiments or new programs that have been vetoed in Washington.

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Certainly there have been experiments, new programs, new techniques. There will be more. There must be more if there is to be real progress. The flexibility of the Federal-State structure, its adaptability for many kinds of uses, leaves room for a wide variety of new programs, for administrative and technical pioneering.

This very meeting is evidence not of Federal coercion, but of healthy give-and-take discussion and of general agreement on goals to be reached and methods to be followed. Here we find a core of dedication, of good will, of social conscience and professional comptence that will enable this Nation to attain new levels of health.

I think we can all take pride in the health structure we have built, in our strong chain of health defenses. It has carried us a long way in a relatively short span of years. Despite calumnies, despite setbacks, despite the fears of some, it will carry us much further. I am confident that the people, as well as the health professions, will be satisfied with no less in the future.

. . . . .

DR. SCHEELE: Mr. Thurston spoke of local, State, and Federal cooperation and partnership. One of the things that impresses one about partnerships is that they are not necessarily static. The members of the team or the firm can change. New people buy into the firm and some folks move out. One of the things that has been wonderful to watch as time has passed is the fact that while the Conference of State and Territorial Health Officers with the Surgeon General of the Public Health Service was created by Congress about 50 years ago, more recently some new partners have come into this enterprise meeting together here in Washington at least once a year. These are mental health authorities and our hospital authorities in the States. Also, and of importance, is the U. S. Children's Bureau.

As has been our custom now for many years, we are very happy to introduce the boss of the Children's Bureau, Dr. Martha M. Eliot. Martha has changed her spots a bit in times past. She has been Medical Director of WHO--we lost her for a little while, you remember. And now we have her back as the Chief of the Children's Bureau.

So it gives us a great deal of pleasure to call on Dr. Martha Eliot to be your next speaker.

ADDRESS

Martha M. Eliot, M. D., Chief
Children's Bureau, Social Security Administration

This is the second time I have addressed you as Chief of the Children's Bureau. During the past year I have given much thought to ways in which we can be of service to mothers and children and to improving the ways we have of working together to achieve our objectives. I have talked individually with many of you and have profited much from these discussions.

During the year I have had an opportunity to see the progress that you have made in your programs for mothers and children. It is truly an impressive record--a record which reaffirms our confidence in the success of the grants-in-aid principle in public health. This progress is all the more impressive because it is made in the face of acute shortages of personnel, mounting costs in providing services, and at a time when we have great increases in the numbers of children.

We have been hearing so much about the increase in our aged population that many people are left with the impression that the United States is growing old, that we are becoming a nation of old people. While it is true that the aged are increasing in number, I am happy to report that as a nation we are maintaining our youth. In fact we are actually growing younger faster than we are growing older. There are now about 48,000,000 children under 18 years of age. During the past decade, while the population over 65 years of age increased 37 percent, the population under 5 increased 55 percent. These children are now greatly increasing our elementary school-age population and will soon be moving on into the adolescent years. This fact of course has many implications for our health, welfare, and education programs for children and youth. It means that during the current decade we will be facing new and greater responsibilities in the provision of services.

Some of the characteristics of this child population are of significance to us. Forty-three percent of our children live in rural areas and almost one-half of them in families with an income of less than $3000 a year.

The importance of these facts can be illustrated by the variations in the reductions in infant and maternal mortality. You know quite well the impressive reduction in infant and maternal mortality for the United States as a whole. There are, however, many counties, largely rural, which lag a decade or more behind the more metropolitan counties. The majority of the counties where higher infant mortality rates prevail are in the southeastern and southwestern parts of the country, where some of our most economically depressed families live, the migratory workers, Negroes, Spanish speaking people, and Indians. These are people who are living under serious disadvantages. They need our help.

The needs in such areas are basic in character--adequate nutrition, housing, sanitation, public health services, maternal and child health services. Equally important is the acceptance and utilization of these services by a population which often does not understand too well what they are.

But the leading cause of infant mortality throughout the nation is prematurity. At least 7 percent of all live-born infants are premature and about 60 percent of deaths in the first month of life are associated with prematurity. The inclusion of birth weight reporting on birth certificates by the States is now making it possible through the matching of birth and death certificates to increase greatly our information about prematurity. For over a decade health departments have done considerable educational work in the area of prematurity,

loaning incubators, providing consultation to hospitals, giving nursing care in the home, and providing opportunities for nurses and physicians to obtain additional training in this field. These efforts have been considerably accelerated and extended in the past five years. Among the newer significant developments has been the increase in the number of State health departments which are working with hospitals and medical schools in developing centers for the care of premature infants--centers which serve as the focal point of community programs for premature infants. Such programs are demonstrating that mortality among prematures can be reduced appreciably; these good results are even being extended to infants weighing less than two pounds.

The birth of a premature infant constitutes a serious economic problem for almost every family in which it happens. The average duration of hospitalization is thirty days and the average cost per infant is almost $500. For small prematures the cost naturally runs even higher. Therefore we find it very encouraging that 16 State health departments are assisting families in the costs of medical and hospital care, at least in demonstration areas. The development of such programs, though still in their inception, are among the outstanding accomplishments of health departments in recent years.

The increased knowledge about prematurity gained from these programs, together with an appreciation of what the financial burden of premature birth means to families is leading State health departments to give more consideration to the possibilities of reducing the incidence of prematurity.

This involves in the first place extending prenatal care facilities so that women can have good care during pregnancy. We know that women who have poor or no prenatal care are about three times as likely to have a premature baby as those who have good prenatal care. The major known causes of prematurity are complications of pregnancy, which are not only prone to cause premature labor, but also to decrease the chances of survival among premature infants. For these reasons, several States which have been active in caring for premature infants are also directing their attention to their maternity programs and are increasing prenatal care services, and planning for providing medical and hospital care for women with complications of pregnancy. Herein lies the greatest possibility of reducing the incidence of prematurity, lowering the costs of care for premature infants, reducing the number of blind infants with retrolental fibroplasia, and lowering fetal and infant mortality.

Since your last meeting, you have received copies of the pamphlet "Better Health for School Age Children" prepared by a committee composed of staff members of the Children's Bureau, Office of Education, and the Public Health Service. You have probably seen the summary of this pamphlet in the Journal of the American Medical Association of November 8, 1952. I think that this pamphlet through its clear and specific statements on health services for children of school age constitutes a real contribution to the literature in this field. I recommend it to your attention.

Health services for children of school age constitute a considerable proportion of the maternal and child health programs of many States. Health and education departments are giving greater attention to the use of screening techniques for finding children in need of medical attention and to assisting these children in securing the services they need. If less time were spent on frequent examinations of children in the schools and more time on screening and follow-up, on medical consultation to the school, and on the utilization and development of local resources for diagnosis and treatment, most school health programs would undoubtedly be more productive of good results.

Earlier in this paper I referred to the fact that children living in rural areas are at a disadvantage in some respects. They certainly are in respect to receiving the specialized medical care they may need. Medical specialists are for the most part concentrated in urban areas. Children in rural counties moreover receive considerably less medical supervision than those in or near cities. But it is particularly with regard to specialized services such as

those for premature infants and crippled children, that rural children are at a disadvantage. With our greatest medical skills in the teaching medical centers, one of our major problems is to help children in rural areas also have the benefit of such skills.

State maternal and child health and crippled children's programs have pioneered in bringing to rural areas specialized services for certain groups of children, such as premature infants and children with orthopedic and other handicaps. In recent years, several health departments have also developed pediatric consultation clinics in rural areas which bring the services of a well-trained pediatrician associated with a teaching hospital to the area at regular intervals. Not only are significant services thereby provided children who are referred for consultation by physicians in private practice and by public schools and other community services, but the clinic also serves a teaching purpose in the consultative relationship between the pediatrician and local practitioner. Children in need of further diagnostic work or treatment which cannot be obtained locally are provided these services in an urban teaching hospital which in this respect takes on a regional function. This relationship of the local pediatric or special clinic with the teaching hospital is a most important factor in raising the quality of care. The extension of arrangements such as these would greatly improve the quality of care for children throughout the country.

The State agencies have continued to make noteworthy gains in the past year in extending services for crippled children. This is a group of children for whom there is much support from the public. Parents' groups particularly have become much more active in recent years in supporting these services. Although some of these groups have tended to emphasize individual crippling conditions, they are nevertheless a constructive force which can be of great assistance to all of us in program development.

The State agencies are continuing the extension of services for crippled children and are experimenting with new types of services. Many of you heard at the American Public Health Association meeting the first report on the epilepsy demonstration program in Maryland. Since the beginning of this program in 1950, some seven or eight other States have also begun epilepsy programs and others are planning them. Through the active participation of organized public health services, the benefits of research in therapy can be brought to epileptic children all over the country.

I am glad to report progress also in the further development of the regional congenital heart disease program which I discussed briefly last year. California's program is now in operation serving the far west, Alaska, and Hawaii. The program centering in Illinois is underway and the plans for Texas and Maryland have been approved. Programs such as these are representative of the dynamic nature of public health today and its readiness to experiment with new methods of providing service.

Interesting developments are also taking place in the provision of services for children who have cleft palate. This group of children has been included in virtually all of the State crippled children's programs since the passage of the Social Security Act, but recently in a number of States, some of the traditional concepts of treatment are being questioned and modified. Again the necessity of considering first the child as a growing individual, and secondly the fact that he has a defect in a particular part of his body is being emphasized. Surgery for cleft palate is not the solution for all children, and for those who do need surgery, careful consideration must be given to the age at which this will be done. Many children, have satisfactory speech with the aid of a prosthesis, without surgery. Too many children who have had several operations, still do not have a closed cleft or satisfactory speech. One of the most encouraging aspects of the newer concepts in this field is the recognition that the care of the child with a cleft palate is not the province of the surgeon alone. Some of the best work is being done in those centers where each child is carefully studied by a team--the plastic surgeon, pediatrician, orthodontist, prosthodontist, speech therapist, medical social worker, public health nurse and others--which considers all the aspects of the situation and reaches agreement on what is the best procedure to be followed for this

particular child. Such team work offers new opportunities for greatly improved services in a technically difficult area. Opportunities for training in this field are being offered through the University of Illinois Medical School and Services for Crippled Children in Illinois.

The need for personnel continues to be a major problem and probably will continue to be for some time. Progress, I believe, is being made in improving the teaching of preventive medicine and public health in medical schools so that more medical students will be graduating with some knowledge of the modern concepts and services of public health agencies and an increased respect for public health. Because of this shortage of personnel we continue to emphasize the need for increasing opportunities for training. The principal means of doing this is through the provision of adequate stipends for fellowships. This is essential if we are to maintain our gains of the last few years.

I would like to turn now to a different problem, that of the children of migratory agricultural workers. Their number varies with the season of the year, but there are between 250,000 and 1,500,000 such children. They are, economically and socially, the most depressed group of children in the country. They grow up without having enough of anything--they lack enough food, adequate shelter and clothing, adequate medical care and education. Sickness and mortality rates are high among them and they contribute to the high infant mortality rates in the southeast and southwest. Their problem is fundamentally an economic one, and its solution lies in social and industrial measures that will eventually stabilize this population group. While they are with us, however, they constitute a serious health problem to which we need to direct our attention. Some of you have already introduced measures which are helping these families.

Part of the difficulty lies in the fact that though this group is receiving particular attention in some localities, in many others their needs are ignored. To be effective, not only must the several agencies involved within a State make a concerted effort but there must also be cooperative interstate efforts. Among the measures needed to ameliorate the situation are the following:

Adequate housing.
Environmental sanitation.
Health and medical care services for infants and expectant mothers.
Health education that will reach these different cultural groups.
Interstate cooperation.

One of the principal causes of death among infants and children of migratory workers is dysentery, a fly-and water-borne disease. Adequate sanitary engineering, fly control, screening of houses will do much to reduce this mortality. Even as we help peoples in Europe, Asia, and Latin America to adopt such measures, we have the same problem in our own country.

Bringing adequate health services to these families is not a simple matter. I know, as you know, that one of the basic problems in providing services for migrants is the lack of coverage by local health units. When we have the basic services in public health we need in the rural areas, at least some of the migrants' health problems will be solved, or the mechanism will be available for solving them. May I say here and now that I would give the strengthening of the local health units a very high priority among our public health needs and I will do all I can to further their establishment. Going back to the migrants, even with basic coverage attained, the job of increasing services suddenly for large numbers of people for a short period of time is a difficult one.

Mobile units may have to be considered if we are to do this. Probably additional staff--physicians, nurses, medical-social workers, nutritionists, health educators--will be needed to provide individual services and to make arrangements with social agencies for welfare

services. In view of the poor resources these families have, the provision of medical and hospital care must be included. The exchange of information between States on a planned basis would help to maintain the provision of services.

Measures such as these are essential, even though admittedly they do not reach the heart of the problem which is an economic one. The provision of day care centers would constitute another constructive health as well as welfare measure. Since both parents and older children in these families usually work, young children are commonly left pretty much on their own. In a few States, day care is being provided but additional financial support is needed if any headway is to be made in the provision of this service.

State and local health and welfare departments which have the basic organization to do the job must take the responsibility for the administration of health and welfare services to meet the needs of migrants. Migrants should not be set off from the rest of the population, but should be enabled to participate in all community services to the extent possible. With State and local agencies working closely together, migrants will have a chance to become part of the communities in which they work.

One of the most serious by-products of the general insecurity brought about by periods of international unrest--a period such as we are now again experiencing--is the marked increase in juvenile delinquency. There are many people who feel that the emphasis given to infants and children in the first half of this century is now shifting to youth and to the social and psychological problems of adolescence. This is a period when youth is naturally in revolt against the adult world. In seeking their own place in the world and establishing their identity, adolescents tend to band together. They may easily fall into antisocial patterns of behavior with which we are familiar in this country. They may also be exploited as in totalitarian countries. It is our responsibility to understand the behavior of adolescents and to help direct it into constructive channels.

Because this problem is becoming increasingly serious, the Children's Bureau during the past year has been giving a major part of its attention to it. We have established in the Division of Social Services a newly organized Juvenile Delinquency Branch. A Special Juvenile Delinquency Project is being financed through private contributions to the Child Welfare League of America. This special project is working closely with the Children's Bureau. We have had a series of conferences with many leaders in this field and with public and private agencies, one of the most recent being with the National Health Council. The Children's Bureau has published several factual pamphlets about juvenile delinquency, and the December issue of The Child is entirely devoted to this subject. A few of the facts we have brought to public attention include:

> About 350,000 children were referred to the juvenile courts in this country in 1951. Most of these boys and girls are 15-17 years old. About 1,000,000 were picked up by the police for delinquent behavior. The number of delinquent children seen in juvenile courts has increased 19% between 1948 and 1951.

As a result of the increased birth rate, it is expected that by 1960 there will be 45% more children between 10 and 17 than there were in 1950. Even if the rate of delinquency did not increase, this will mean that the number of children picked up by police will rise from 1,000,000 to 1,500,000.

We can do much to prevent delinquency and we can provide juvenile delinquents with the treatment they need much better today than we have in the past. Because of the importance of this subject, I am delighted that Dr. George Gardner of the Judge Baker Foundation, Boston, is here today to talk with us about this problem from the point of view of the psychiatrist.

What the focus and scope of the Children's Bureau research program should be has been carefully considered by the Bureau's staff during the past year. In this planning, the Bureau's

previously published studies were reviewed, the present activities of the Bureau were analyzed, and the recommendations of groups of research experts in various fields that the Bureau had called together were taken into account.

On the basis of the facts disclosed by this review and analysis, the Bureau concluded that the focus of its studies should be the children whose health and welfare are in jeopardy. Among these children are those who are handicapped, socially or physically; those who are homeless, temporarily or permanently; or those who are neglected or mistreated or unwisely handled by their parents; the children of unmarried mothers; delinquents and those in danger of becoming delinquent; those who suffer from crippling diseases or conditions or from diseases that lead to crippling; and those whose intelligence is below par, and so on. Also included are children who live under social or economic conditions which may handicap their development--the children of migrant laborers and others whose income is very low; children who are the objects of prejudice and discrimination; young children whose mothers are employed outside the home; youths who are employed at too young an age or under conditions endangering their health and welfare, and the like. Both the children and their families and the circumstances and conditions thought to be adverse would be the objects of study. The aim of the research would be to add to the store of knowledge needed for the formulation of sound social policy and for the effective carrying on of services in these children's behalf.

Within this broad scope, the subject chosen for study now and in the near future is the evaluation of child health and welfare programs, with emphasis on the effectiveness of particular forms of service in aiding individual children and their parents.

That evaluation of health and welfare programs and practices is needed is obvious. Large sums of money are spent by the Federal, State, and local governments to promote children's health and welfare. The needs of children and their parents for aid in these respects are great, and it is to the advantage of all of us that the physical and emotional health and social functioning of children and youth be the best possible.

To carry on evaluation studies of this nature is a huge and long-range task. We hope to be able to make a start at it in 1954 by providing research consultation to State departments of health and welfare that want our help in undertaking evaluative studies in any of the following program areas:

1. Foster care of children who are homeless, neglected, or, for one reason or another, need care outside their own homes.
2. Adoption services.
3. Delinquency control and services to delinquents.
4. Health supervision of children--through child health conferences or school health programs.
5. Services to crippled children, especially those services that are not medical.

As examples of specific questions that might be asked under the latter two topics, the following have been proposed by our research division:

First, in regard to school health services:

Is the health of school children improved through school health services? How do various methods of providing such services compare in their results? Why do some parents not follow recommendations? To what extent do ignorance, low income, poor relations with teachers, lack of interest, etc., account for this?

Second, with regard to services to crippled children:

What proportion of the children who are treated for crippling conditions are enabled to function well socially as well as physically, or in spite of their physical handicaps? Why do some do well and others not so well?

Because our present staff is small, there is a limit, of course, to the amount of consultation services along these lines that we would be able to give. We feel, however, that such studies are very important. Accordingly, our staff is already engaged in preparing a report on the methodology of this kind of research, which is the first step in undertaking such studies.

There is another important problem about which I have little to report this year but which is becoming of increasing concern to public agencies. As I know you are aware, the parents of mentally retarded children are increasing their efforts to secure help for these tragic youngsters. For public agencies, when both funds and personnel are short, priorities must be given to certain activities, and unfortunately, the mentally retarded are not high on the list. Yet as we learn more about them, we find that many of them, with help, do not need to be utterly non-productive and a financial drain. Access to good diagnostic services is the first step in a constructive approach to this problem. We hope that in the near future health, education, and welfare agencies can give consideration to how our resources can best be utilized in helping these children and their families.

The various subjects I have touched on today demonstrate again the Bureau's broad interest in children and the intimate relationship between child health and child welfare. The physical, social, and emotional problems of children are basic to growing up and are inseparable. Only as all the professions involved work together in a genuine spirit of service to children can the interests of children be served in the way we all want them to be served--to the highest possible degree. This is not new to you; the Chiefs of the Children's Bureau have always maintained this point of view--and I shall continue to do so.

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DR. SCHEELE: Martha and I seem to be competing. She has the children and I have all the people who are getting old. She says that she has the most important program and I say the old people are the most important program. But as Mr. Thurston said, we compromise and get along together. Actually, I suppose if one looked over the Public Health Service program, he would find that 98 percent of what we do is really for children. Of course, the end result benefits the adult as well. So it is one big happy family and we believe in children and we believe in the old folks too.

I mentioned, too, the fact that we have here represented a number of groups from the States, and by the same token this annual conference has grown, too, by the presence of visitors and observers at the conference. We have with us in the audience this morning a number of folks from other organizations. Dr. Atwater is here from the American Public Health Association. Dr. Harry Weaver is here from the National Foundation for Infantile Paralysis. Dr. Perkins is here from the National Tuberculosis Association. We have a representative from the World Health Organization and the Pan-American Sanitary Bureau, and members of the armed forces. Many other organizations are represented here. It seems to me that this helps to make our conference and our relationships a success.

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REPORT ON THE NATION'S HEALTH PROGRAMS

Leonard A. Scheele, M. D.
Surgeon General, Public Health Service

Once more the Conference of State and Territorial Health Officers with the U. S. Public Health Service, established by Congress as a statutory function fifty years ago, has assembled. In recent years, the effectiveness of this annual exchange of views has been strengthened by the companion conference with the U. S. Children's Bureau and by concurrent conferences with the State Hospital and Mental Health Authorities. These actions testify to the common interests of health administrators from all parts of the country, and to their desire to work together as a united force for the protection and promotion of the Nation's health.

Each official member of this Conference is in public service. It is a part of our business to be aware of the social, economic, and political forces that shape the future of the people and communities we serve. It is a part of our business to be statesmen. We in the health professions come from many scientific disciplines. As professional workers, we tend to place the highest values on our technical knowledge and skills. But as statesmen, we are challenged to be something more than good technicians.

These are days when everyone of us would like to know what the approaching new year holds for public health. Undoubtedly there will be reasonable pressure for economy in governmental health programs. Our wisdom should lead us to study the needs, set priorities, plan better, and work harder. If we do these things, we are sure to find that continued progress in public health is assured.

In the meantime, we have a great deal of business to attend to. The surest proof that we are thinking and acting as statesmen in public health will be to give our very best attention to the programs we are now operating and to look ahead at the pressing problems which must be solved. I shall not attempt to cover the full range of activities and problems in which you of the States and Territories and we of the Public Health Service are jointly involved. Instead, I shall call your attention to a few developments during the past twelve months which seem to me worthy of your earnest thought and--in many cases--action.

Recommendations of the 1951 Conference

The Progress Reports on Recommendations made by the Association at the 1951 Conference have been widely circulated in advance of this meeting. Therefore, I shall not duplicate the material by a detailed discussion of Public Health Service actions. If you have any questions or wish to discuss any problems, I hope that you will feel free to come to me directly, or to any other member of our staff while you are in Washington.

In general, I believe that some progress has been made in most of the items requiring joint committee work or the assemblage of information on the part of the Federal agencies and the States. A number of research projects have been launched in the Public Health Service as a result of recommendations by the States. However, in instances where Public Health Service action in implementing a recommendation was dependent upon Congressional action with respect to additional appropriations or new legislation, there has been little progress.

International Health Programs

We need to keep well in mind the fact that our country is still in a period of international emergency and national mobilization. The development of strong defense against the spread of communism beyond the countries now dominated by Soviet Russia requires continued

sacrifices by every American. We continue to do our share as part of the United Nations forces in Korea. We continue to build strong armed forces at home and abroad. We provide economic and technical assistance to underdeveloped areas that need help to become strong allies. Public health workers have had an important share in the technical assistance programs from the beginning, sharing knowledge and skills with others in the control of disease and the promotion of health.

As you know, the Public Health Service has had responsibility for staffing and supervising the health programs for the Mutual Security Agency and the State Department's Technical Cooperation Administration. At present, they sponsor United States assisted health programs of varying scope in thirty-five countries--chiefly in the Middle East, Southeast Asia, and Latin America, and including India, Formosa, the Phillippines, and Liberia.

Many State and local health agencies have joined with the Public Health Service in staffing these overseas health programs. We have made sacrifices in spite of the general shortage of public health personnel. I am happy to report that we have made a very good showing. We have not provided all the personnel that our own Government and the struggling health agencies of underdeveloped countries have asked for; but we have not done badly. These programs are so vital to the survival of a free world that the Public Health Service intends to tighten its belt so as to help meet their minimum staff requirements and we will continue to call on you for help.

On the agenda of this Conference, we have provided an opportunity for all of us to consider how the State and Territorial Health Officers may participate fully and actively in the planning and development of our cooperative health programs overseas. Dr. H. van Zile Hyde, Director of the Health and Sanitation Staff of the Technical Cooperation Administration will take part in this discussion and will present a plan for your consideration.

Emergency Activities

The Public Health Service has made repeated attempts to build up a more extensive and vital inactive reserve corps, particularly for active duty in the event of full mobilization or disaster and to provide officers for assignment to the States for duty in defense-impacted areas. We have not been able to do this because we have not had the funds.

We are, however, about to launch an experimental expansion of the Inactive Reserve Corps in the engineer component. Much of the recruitment will be from sources other than State and local health departments. The idea is to have available a reserve of engineers who could be called to duty in the vicinity of their usual place of employment. Industries, public utilities companies, universities, and units of governments other than health agencies having engineering personnel will be important sources of recruitment, as will health departments. We plan to use our present engineering staff as recruiting agents and to keep inactive reservists informed on developments in the general field of environmental health. We expect also to give engineer reservists opportunities to serve on active duty for short periods--from a few weeks as special consultants, to a year or two on special missions. Later we hope to conduct special training programs along the lines employed by military reserve organizations. Through this demonstration program we hope to gain experience that will be of inestimable value in the eventual development of an expanded Inactive Reserve.

The Public Health Service is staying at the front in another mobilization field--namely, materiel requirements for civilian health and medical services. During the past year, we have developed a smoothly running organization to handle the allocation of critical metals for construction of hospitals and health facilities. What we are now concerned with is the specialized technical staff work that must be done if civilian health supplies are to be available in the event of full mobilization.

This means that experienced and technically competent personnel must be available to work with industry in projecting potential demands and productive capacity four or five years ahead. The Defense Production Agency has delegated this responsibility to the Public Health Service. Our Division of Civilian Health Requirements has made a great deal of progress in developing the basic data with the active cooperation of the health and medical supply and equipment industries, and with the military forces.

We expect in the immediate future to begin similar evaluations of facility requirements in the event of full mobilization. It will be important for State and hospital survey and construction agencies to participate in developing the data. We shall need to know what it takes to keep the existing hospital and health plant going; and what will be needed four or five years ahead for renovation and repair of buildings, replacement of equipment, maintenance of supplies, and so on.

We are especially concerned with items that are already in short supply, as well as with those that will become critical under full mobilization. For example, we have already completed our study of penicillin requirements and production, and our proposals for increased production have been approved by the Defense Production Agency. Our recommendations will soon be completed on such items as surgical bandages, sutures, dental supplies and equipment, hypodermic needles and syringes, X-ray film and machines, and so on.

With the data which we have developed and shall develop, the Public Health Service intends to keep abreast of the production situation so that civilian interests may be guarded in the face of increased demands and heightened competition for essential supplies and equipment.

Environmental Health Programs

I am happy to report many encouraging signs that our environmental health programs are turning to the practical solution of some of the critical problems created by new environmental factors in our rapidly changing society.

Slow but steady progress has been made, for example, in public health control of hazards incident to the use of radioactive materials and radiation-producing machines. Several State health departments are operating radiological health programs. I would call your attention especially to the pilot programs initiated in recent months by the New Jersey and the California State Health Departments. Impressive progress also has been made on the Colorado Plateau in controlling radiation hazards inherent in the mining and milling of uranium.

I am particularly happy that our friends from the Atomic Energy Commission are participating in this Conference for a joint discussion of problems related to radioactive materials. Their presence here represents the kind of teamwork between Federal agencies and State health authorities that gets the desired results.

We can report substantial progress in several of our long-established sanitation activities. The program for the certification of interstate milk shippers has reached a point where additional financial support for the Public Health Service's share in the joint activities is essential. The State and Territorial Health Officers have recommended this program for the past eight years, and we in the Public Health Service have done everything in our power to implement it adequately. Despite the lack of adequate funds, we have conducted during the past year a demonstration project which has been highly successful. We have shown that effective certification of interstate milk shippers can be achieved with the active participation of State and local health departments, agricultural agencies, and the dairy industry. If this modern method for the marketing of safe milk is to be extended beyond the limited area covered by our demonstration, all of the States and the Public Health Service will have to increase their activity.

The development of a poultry sanitation ordinance and code is going forward satisfactorily. This project is being conducted with full participation by the poultry industry and law enforcement agencies.

I note that the Executive Committee of the Association of State and Territorial Health Officers has been considering the need for appropriate legislation and supporting control measures in connection with the practice of feeding raw garbage to swine. The Public Health Service has been cooperating closely with the U. S. Department of Agriculture for some months and we believe that joint planning and action in this field will bring about better control of many swine diseases, including those of public health importance.

Public health agencies have been concerned about the feeding of raw garbage to swine for many years, since this practice is known to be the source of trichinosis in man. A noteworthy joint conference on trichinosis is being held this week in Chicago under the auspices of the American Medical Association, the American Veterinary Medicine Association, and the American Public Health Association.

Up to now, our mutual efforts to get action in this field have not been successful, chiefly because many people in the hog-raising industry were not convinced of its value. Since last summer's costly outbreak of infectious vesicular exanthema in swine has been traced to the feeding of raw garbage, there is alarm and greater readiness to cooperate in correcting this practice. Now is the time for State health departments to cooperate with their State agricultural agencies in legislation and control. The Public Health Service is tightening up its interstate action in this field and we are prepared to give the States technical and consultative service for their intra-State operations.

There is still a large residuum of substandard housing which presents basic sanitation problems--chiefly in urban and suburban areas. These problems are not limited, as we have sometimes supposed, to "rural slums." The "fringe areas" are still growing faster than are our efforts to prevent serious sanitation problems. The mobilization effort itself has brought with it a variety of housing sanitation problems. More than this, the high morbidity and mortality rates from home accidents, the relation of housing conditions to cardiovascular disease, arthritis and rheumatism, the problems of aging, and many other conditions that rank high among the Nation's unsolved health problems, point day after day to the health agency's responsibility for action in the hygiene of housing.

At present only 10 State health departments are actively assisting local health agencies in the development of housing programs. A few others have specific plans. Nearly 100 local health departments, however, have taken active part in programs to improve housing conditions in their areas during the past few years.

Only 13 States and 25 local health departments are conducting active programs in home accident prevention. In home accident prevention, the Public Health Service and the participating States have made some progress in developing the basic data essential for planning in this field. We feel that the time has come to pull together recently acquired knowledge and experience and to evaluate what we have learned. Such an effort will be made next month when representatives of State, county, and municipal health agencies, voluntary organizations, and Federal agencies meet at Ann Arbor for a Conference on Home Accident Prevention. I hope that the States will participate actively in this conference.

The Report of the House Select Committee to Investigate the Use of Chemicals in Foods and Cosmetics--the Delaney Committee--focuses our attention on the growing importance of our chemical environment as it affects human health. Much remains to be learned about the potential hazards, as well as the potential benefits, that may be inherent in the manufacture and widespread use of the many new chemical compounds which are being introduced each week.

Public health agencies can no more ignore the challenge of the new environment than our professional ancestors could ignore the environmental hazards of their day. With respect to our knowledge of the health effects of the chemical environment, we are just about at the same level of understanding as public health pioneers were three-quarters of a century ago in their knowledge of bacterial causes of disease. Our first steps, therefore, must be through research programs, aimed at finding answers to the fundamental questions posed by our rapidly changing environment.

Before passing on to other health programs, I would like to announce that our Environmental Health Center will move into its new laboratory next year. I see that Dr. Leslie A. Chambers, Chief of the Research and Development Branch, is scheduled to tell you about this splendid research facility. We are sure that the expanded research program made possible by the Center will make important contributions to environmental health.

Fluoridation Programs

In the promotion of dental public health, the fluoridation of public water supplies needs to be skillfully interpreted to the people of our communities. Although more than 500 towns are now benefiting from fluoridation, the progress in applying this preventive measure has been impeded in some communities by misinformation. There have been some court actions, referenda, and opposition by groups and individuals.

I believe you will agree that such situations are not uncommon in the history of public health. The early efforts to install chlorination of water supplies met with opposition, sometimes with unfounded fears of "poisoning." Public health statesmanship here consists in convincing the skeptics that our epidemiologic and laboratory studies are valid and that the benefits of fluoridation are not to be discarded lightly in the face of uninformed opposition.

Communicable Disease Control

During the past few years, the Public Health Service has been emphasizing the epidemiological approach in its communicable disease control and microbiological research programs. There is an urgent need for revitalizing the field of epidemiology. New disease entities are being identified; new agents for prevention and control of well known infections are being tested; and the problems of identifying the etiological agents in unusual outbreaks are increasing. Future progress in the control of communicable disease thus depends upon the efficiency of our epidemiologic techniques. In the presence of disasters or enemy attack, success in protecting large populations from rapid spread of disease depends upon a well-organized, highly efficient, nationwide epidemiological service.

The Sectional Research Program in Microbiology--set up in the Microbiological Institute--and the Epidemic Intelligence Service--set up in the Communicable Disease Center--are the two major contributions of the Public Health Service to the attainment of such an organization. I may say that the Institute and the Center are developing their programs together as a team.

The Sectional Research Program has progressed satisfactorily during the year. At present, no less than 98 laboratories, organized in 11 sectional groups, are participating in the program. More than 10 percent of the participating laboratories are in State and local health departments, and representatives of several State laboratories are on the advisory committee helping us to develop this program. The Public Health Service has awarded research grants to those laboratories requiring aid in order to participate and next year we hope to increase the amount available for these grants.

I would greatly appreciate your advice on ways to extend this activity. The aim of the Sectional Research Program is to encourage laboratory and epidemiologic research on

infectious agents through the operation of a nationwide network of regional and coordinating laboratories especially skilled in microbiological investigations. The participating laboratories, for example, have been working intensively on techniques for rapid diagnosis of viral infections. There is no doubt that we need more effective procedures in the epidemiologic investigation, diagnosis, and therapy of infectious diseases, including immunization procedures. The Sectional Research Program attempts to meet some of these needs.

As you know, efficient morbidity and mortality reporting is a fundamental requirement in the investigation and control of communicable disease. The increasing strength of State activities in vital statistics and morbidity reporting is evidence of progress in this field.

Plans are going forward for an expanded program of State and national reporting of animal diseases. Although the collection of data on animal diseases is a function of the Department of Agriculture, the Public Health Service has offered consultative assistance in the planning stages because we have had many years of experience in the reporting of human diseases. I hope that the State health departments will offer similar assistance to their State agriculture agencies.

Reports by several investigators within the past few months indicate that we may be on the threshold of development of one or more useful active immunization agents for poliomyelitis. The value of gamma globulin in preventing paralytic poliomyelitis has been reported. Some research remains to be done. A special session of State Health Officers to discuss the problems of use and distribution of gamma globulin is scheduled for later this morning.

Specialized Disease Control Programs

By the end of this fiscal year, our venereal disease control programs will have attained almost complete conversion to outpatient treatment of syphilis. This is indeed a triumph and one in which all of us share. It is the result of research, pharmaceutical production, and public health and private medical practice. Research in serology and penicillin therapy gave us the bases of our case-finding and rapid treatment programs. Intensive epidemiologic investigations improved our contact tracing. Evaluation of therapeutic regimens brought about standards of syphilis therapy. Now every private physician can be an efficient venereal disease officer, giving treatment to ambulatory patients in his office; while State and local health departments maintain the important supporting services of case-finding, contact tracing, referral, treatment of many of the patients unable to pay for private care, and education.

I am happy to congratulate our Federal, State, and local venereal disease workers on their achievement--not only because I can say to them, "Well done"--but because in many ways they have been the road-breakers for progress in the control of many other serious diseases.

Our goal in tuberculosis, cancer, heart disease, arthritis and other chronic diseases is to attain just such levels of control--with every practicing physician a health officer, giving outpatient treatment--either preventive or curative--in his office. Thus the Public Health Service continues to support an unremitting search for case-finding techniques that may be applied on a wide scale and for therapies that may ultimately be placed in the hands of the general practitioner as well as the specialist.

State and local health departments are now in a position to take yet another cooperative program to their medical societies. Sufficient scientific evidence has been accumulated to bring about authoritative agreement by medical specialists on the prevention of rheumatic fever.

As you know, the American Heart Association, the Children's Bureau, the Public Health Service, the foundations, and other voluntary agencies have long looked forward to the day when a sound preventive program against this serious disease could be proposed and endorsed. Recently, the American Heart Association and its affiliated Council on Rheumatic Fever and Congenital Heart Disease formed a Committee on Prevention of Rheumatic Fever. This group has prepared a report and a recommendation on its forthcoming publication will be presented to you. Early in 1953, this report will be widely circulated throughout the medical profession.

Essentially, the Committee on Prevention of Rheumatic Fever proposes two main lines of action: (1) early and adequate treatment with penicillin of all cases of streptococcal infections; and (2) long-term prophylactic use of sulfadizine or oral penicillin in rheumatic patients.

I earnestly suggest your favoring action, not only upon the recommendation that will be presented, but also upon implementation of the community programs which it would make possible. I believe that the authoritative endorsement which will be coming from the leading specialists in this field will be a milestone on the road to control of rheumatic fever and its crippling companion, rheumatic heart disease.

I want to turn back to our venereal disease control programs for a moment to mention another type of service that may have far-reaching results. State health departments are establishing about seventy Prevention and Control Centers in strategically located urban clinics throughout the Nation. The aim here is to provide for cities and their surrounding areas the best venereal disease diagnosis, treatment, epidemiologic services, and education. From these will radiate services to physicians, local health centers, hospitals, and social agencies in the area. There are opportunities in these centers for professional training, for cooperation with universities and medical schools.

Certainly, facing up to the problems of chronic disease and an aging population, public health agencies need to encourage and develop many new types of partnership. There is strong support for chronic disease control and for health services to the aging. Yet State and local health services in most of these fields are scanty and scattered.

While new techniques for chronic disease control and hygiene of the aging remain in a twilight zone between experiment and wide-spread use, it may be that a "bridge" type of community institution with research, educational, and limited service functions is needed to speed the sound application of scientific advances.

Recently the University of Buffalo School of Medicine released the first annual report of its Chronic Disease Research Institute. This project is an interesting experiment in new partnerships and worthy of your attention. The Public Health Service made available its Buffalo hospital which we were closing and which could be easily converted into the type of facility envisaged by the group of community and State health statesmen who planned the Institute. The New York State Health Department provided a grant-in-aid, and entered into active cooperation with the University. Support for various departments of the Institute came from the National Foundation for Infantile Paralysis, the New York State Association for Crippled Children, the New York State Department of Mental Hygiene, the Western New York Heart Association and the Arthritis and Rheumatism Foundation. The Governing Board is chaired by the Dean of the School of Medicine, and includes representatives from local hospitals, the New York State Department of Health, and the Public Health Service. An able staff has done outstanding trail-blazing in its first full year of teamwork.

Let me quote from the report:

"The future plans of the Institute are inherent in its purpose: to do research in the field of chronic disease, to discover better and faster means of returning the chronically ill to maximal living within their individual limitations and to teach these newer, better

techniques for handling the most complex problems in rehabilitation to medical personnel throughout the Niagara Frontier. The University of Buffalo Chronic Disease Research Institute is a small but complete institution actively serving medical science and education within the community."

Would that there were more "small, complete institutions" serving such a purpose within more communities where the problems of the chronically ill have previously been neglected. Perhaps this modest beginning will give us valuable clues to a broad attack on our major health problems.

In this connection, let me bespeak your earnest consideration of the recommendations submitted to several of your Committees by the Office of Vocational Rehabilitation. At the 1950 Conference it was recommended that the Public Health Service and the State health agencies undertake studies of the public health aspects of rehabilitation. During the fiscal year 1952, a Public Health Service Committee and Task Force on Rehabilitation was formed with the cooperation of the Office of Vocational Rehabilitation. We are in the process of preparing the final report.

Community action for the improvement of rehabilitation facilities and services is widespread at the present time. In many areas, communities--spurred by the passage of legislation for Federal aid to the permanently and totally disabled--are planning and developing Service programs with a minimum of health department participation. Unless State health officials move quickly and think through their responsibilities in this field, they stand to lose opportunities for significant leadership in improving health services generally, and particularly in the fields of chronic disease and impairment where we already have operating programs.

Health Resources

In reviewing the Agenda for this Conference, I have been impressed by the number of items accepted for consideration by the Hospital Committee--and even more impressed by the breadth of vision reflected in those tentative recommendations. Obviously, the State agencies are vitally interested in the hospital survey and construction program in all its ramifications and in its potentialities for better health services to the American people. The agenda items of this Committee lead me to suspect that you are interested in some changes. We shall await your recommendations with interest.

State health and hospital agencies are increasingly involved in the licensure of hospitals and related institutions. At their request, the Public Health Service has undertaken a compilation of existing regulations for institutional licensure throughout the country. We are preparing guide materials for the development of licensing procedures and techniques.

Licensure as a phase of hospital and related institutional care is destined to come into greater prominence as programs for the aging, for convalescent care, and rehabilitation expand. The subject requires a great deal more study--but such study requires more funds than the Public Health Service has yet had to devote to it.

The shortage of professional and technical personnel which has engaged our attention for the past ten or twenty years continues to be a serious problem. I am happy to report that several State health agencies have been active in the implementation and conduct of nursing surveys initiated in their jurisdictions during the past year. Some divisions of hospitals in State health departments also have taken the initiative in stimulating hospitals in their area to evaluate the utilization of nursing personnel. I hope that the coming year will see increased activity in both these fields.

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Trained workers, never available in numbers adequate to meet the needs of organized services and institutions, are in steadily increasing demand from a number of sources. We must, therefore, make strenuous efforts toward more effective utilization of our present supplies of professional and auxiliary health personnel. It is highly probable that a number of duties now performed by physicians can be delegated to non-medical personnel. Critical evaluation of all activities, constant and intensive recruitment, inservice training, careful consideration of salary levels, opportunities for advancement and satisfying work experiences--taken together--must constitute our main weapons against the current shortage. Essentially, this means that we must try to get well qualified workers into public health, or workers with the potentiality for high qualifications, and we must make our field a career service for them--one which they need not and will not leave for another. These are all problems the Public Health Service shares with you.

Stock-Taking

As I have reviewed many activities in public health practice, the many problems that remain to be solved, and the limited resources which we possess for dealing with the problems, I have come up to the hard core of the problem, as I am sure you must have.

We in the Public Health Service believe that the time has come when we should carefully re-examine the entire concept and structure for the delivery of community health services. The present pattern was developed about thirty years ago. For more than a quarter of a century, it has served its purpose well.

However, new forces have emerged in the total social fabric. We are confronted with many new problems. Marked changes have occurred in the physical environment. The general standard of living has improved markedly. There are better means of communication and transportation. New scientific bases are available for prevention, diagnosis, and treatment of illness. There is a wider public understanding of personal and community health problems.

Are we taking advantage of these many new technological, social, and economic forces to make available the best possible health services at the lowest per capita cost? Are we organizing and administering programs that merely maintain the status quo, or are we getting down to the "grass roots" and finding out what precisely are the health needs and the best means of meeting them? Are we experimenting with new techniques?

In approaching a study of the amount and kinds of nursing service required to meet the minimum needs of local health departments, the Public Health Service has run head-on into the basic fact that studying the needs of a single type of service is not enough. We have too long fractionated our approach. It is not enough merely to extend the study to cover other types of public health personnel. We must go much deeper.

Today's leading public health problems, particularly those associated with the chronic diseases and impairments, with an aging population, and the chemical environment, require a wide range of professional skills, facilities, and services. We have become increasingly aware that the newer programs do not always fit into the traditional structure. Many local health organizations as now constituted cannot cope with the problems. Local health organization is indispensable, and it must be strengthened; it must learn new ways of organization as well as new operating techniques.

The basis of any new direction in the delivery of local health service must be carefully planned after well-conducted studies. Such studies must be theoretically sound and so designed as to yield results applicable to the whole field of public health, not merely to the solution of discrete problems. They must be of sufficient scope and longitude to ensure valid conclusions. They must be focused more upon the human community, than upon the professions which serve the community. They must draw upon the social sciences for their design, methodologies, and conduct.

The need for such appraisal of current practices and for the development of more effective and economical methods for different types of communities is, I am sure you will agree, of vital concern to your Association and to all health officials. The Public Health Service hopes to begin the difficult first step of such studies--the planning--in the near future. We cannot--we will not--promise you any hasty "appraisal" or any quick results. But we shall do our best to add some useful knowledge to the science and art of public health.

Conclusion

In conclusion, let me express the pleasure that the entire Public Health Service staff feels in welcoming every State and Territorial representative to this Conference. The Nation's health programs and organizations have been created by the people through their Congress, their State legislatures, and local governments. We have a long and honorable record of working together, of stability, and of responsibility for the public trust invested in us. I am sure that in this week of joint discussions, we shall find much satisfaction in planning together for progress in public health; -- and much inspiration as we recognize the many opportunities for greater service to mankind through our individual and joint efforts.

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(A short recess was taken)

DR. SCHEELE: The State Health Officers will be especially interested in the problems ahead for every one of them, in particular the distribution of gamma globulin in use as a preventive of paralytic poliomyelitis, measles, etc. Because of the varied use, and because there are so many problems in the field of production and in the field of distribution, we are complying with your request to fill you in on the latest information on this subject. So we have this morning Dr. Aufranc, who is the Director of the Health Resources Program Staff of the Office of Defense Mobilization.

Many of you know Dr. Aufranc in his present work, and knew him in his other work in the Public Health Service and in the defense emergency organizations.

In his position he has worked with the Health Resources Advisory Committee, the Committee which is commonly known as the Rusk Committee; and he has worked especially with that group's Subcommittee on Blood.

It just goes to show how versatile a Public Health Service man is. It wasn't so many years ago Dr. Aufranc was a venereal disease officer and many of you knew of him then.

Dr. Aufranc will bring us up to date on the gamma globulin field.

DR. AUFRANC: Thank you, Dr. Scheele.

NEW DEVELOPMENTS IN THE USE OF GAMMA GLOBULIN IN POLIOMYELITIS

W. H. Aufranc, M. D., Director
Health Resources Program
Staff, Office of Defense Mobilization

During the past few days I have had the privilege of discussing with some of you the complex problem now confronting us relative to the use of gamma globulin in the prevention of poliomyelitis. This blood fraction is, as you know, currently used in management of measles and infectious hepatitis. The potential need now for additional supplies of gamma globulin places a further responsibility upon those already collecting large quantities of blood for the treatment of shock by the Department of Defense and the Federal Civil Defense Administration.

From the standpoint of the Health Officer the control of all communicable diseases is important, but the complexity of this problem only grows when one attempts to consider just how to use one product, now in very short supply, to do the greatest good for a given population considering the psychological factor that poliomyelitis with its paralysis has upon the public.

In the Journal of the American Medical Association for October 25, 1952, there appear three scientific reports dealing with the evaluation of Red Cross gamma globulin for the prevention of paralytic poliomyelitis. It is the opinion of those of us in the Office of Defense Mobilization concerned with this problem that these reports should be of interest to all health officers. While the results reported do not in themselves offer an ideal procedure for the practical management or control of this disease, they do offer hope for the possible prevention of a dreaded disease and by so doing place a rather complex responsibility upon health officials. During the course of this discussion I will advise you of some of the actions taken by our groups in connection with this problem, but would first like to review as briefly as possible the series of events that have led up to our actions and to state just how the Office of Defense Mobilization happened to become concerned with the problems of gamma globulin and poliomyelitis.

Shortly after the beginning of the Korean War in 1950 there was a sudden demand for whole blood for our fighting men in Korea. In rather rapid order the National Security Resources Board (through its Health Resources Officer) requested the American National Red Cross to assume the responsibility, as it had done during World War II, for the furnishing of whole blood for Korea and for the creation of a Department of Defense plasma stockpile, as well as to plan for collection of a plasma stockpile for a civil defense need. During these early days our staff worked with the Department of Defense, the American National Red Cross and the Bureau of the Budget in the frustrating problems of estimating military requirements for whole blood and dried plasma, the processing plants needed, and the potential blood collections. Certain requirements and estimates were obtained and the blood collection and processing program got under way.

The Health Resources Office of the National Security Resources Board continued to participate in the rapidly expanding programs of medical requirements, both manpower and materials, for the Department of Defense and at the same time created the framework of the Health and Special Weapons Defense program of the Federal Civil Defense Administration established early in 1951.

Shortly after the passage of the Defense Production Act and the creation of the Office of Defense Mobilization, the Health Resources staff was transferred to the Office of Defense Mobilization where it continued to be concerned with health manpower, medical supplies, and especially the problem of blood procurement for defense purposes.

In June 1951, the Department of Defense, Federal Civil Defense Administration and the American National Red Cross requested the Office of Defense Mobilization to assume the over-all responsibility for allocation of blood to the Department of Defense and the Federal Civil Defense Administration, there being one source and two claimants for blood. The Director of the Office of Defense Mobilization appointed a Subcommittee on Blood to study this problem and on December 10, 1951, the President directed a letter to all Federal agencies and departments requesting cooperation in this program. To date this group, the Subcommitte on Blood, through the Health Resources Advisory Committee and its staff is operating the present National Blood Program and making allocations of the end product, plasma, to the Department of Defense and the Federal Civil Defense Administration.

Early in 1952 the National Foundation for Infantile Paralysis invited the Office of Defense Mobilization to review its first field trials in Provo, Utah, on the use of gamma globulin for the prevention of poliomyelitis. After many conferences with members of various professional and governmental groups, the Office of Defense Mobilization decided that it did not have an interest and a definite responsibility in this problem. This earlier report was promising and if subsequent reports and studies did prove of equal promise the need for gamma globulin would have a serious impact on the need for blood for the Department of Defense and the Federal Civil Defense Administration. It was then agreed that the Office of Defense Mobilization would release the following statement: (May 26, 1952)

At the suggestion of representatives of the National Foundation for Infantile Paralysis, the Subcommittee on Blood of the Health Resources Advisory Committee met on April 28, 1952, in Boston, Massachusetts, to review the current studies being conducted by Dr. William McD. Hammon of the University of Pittsburgh, under a grant from the National Foundation for Infantile Paralysis, to determine the effectiveness of human gamma globulin (immune serum globulin) in the prevention of poliomyelitis.

This meeting was participated in by representatives of the following organizations:
National Foundation for Infantile Paralysis, Inc.
U. S. Department of Defense
Association of State and Territorial Health Officers
American National Red Cross
U. S. Public Health Service
University of Pittsburgh
Health Resources Advisory Committee of the Office of Defense Mobilization, and the Subcommittee on Blood
American Medical Association

It was the consensus of those present that results of the studies to date were inconclusive. It was felt that a statement regarding the status of the studies should be secured from Dr. Hammon and released to responsible agencies. This statement, which follows, is intended for internal administrative use by these agencies and is not intended for public release.

"Animal experiments have indicated the desirability of determining whether human gamma globulin is of any value in the control of poliomyelitis in man. Field studies are now being carried out by Dr. William McD. Hammon and his group to determine whether protection can be demonstrated against naturally occurring poliomyelitis in children, and if so, under what conditions. The results of the pilot human field trials of last summer were inconclusive, due to the very limited numbers of cases occuring in the observed population. Additional field trials will be conducted this summer."

Shortly after this release, the Subcommitte on Blood met jointly with the Health Resources Advisory Committee to consider the problem to be faced in the future should

further studies substantiate that gamma globulin was of definite value in the prevention of poliomyelitis. After consultation with members of the professional and governmental groups it was decided that the Public Health Service would be asked to study the potential problem and furnish us with recommendations.

Among these recommendations were the problems that would confront the State Health Officers with respect to epidemic areas and the means of conserving a limited supply. I hope this group will give support to the Subcommittees of this organization now discussing this problem with members of the National Research Council and other persons interested in this problem.

Shortly after the release of Dr. Hammon's recent series of reports, the Health Resources Advisory Committee and the Subcommitte on Blood of the Office of Defense Mobilization participated in a series of discussions with the National Foundation of Infantile Paralysis, American National Red Cross, Department of Defense, Federal Civil Defense Administration and the National Research Council regarding the problem of collecting the amount of blood needed to meet minimal needs. This group agreed that the American National Red Cross because of its long experience was the most logical group to consider this important job. Therefore, the Director of the Office of Defense Mobilization on November 21, requested the American National Red Cross to consider assuming this responsibility and on Monday, December 8, 1952, E. Roland Harriman released a statement in response to Mr. Fowler's request which in part reads as follows:

The following statement was issued on December 8, 1952, by E. Roland Harriman, President of the American National Red Cross during a press conference in the New York Chapter Headquarters, 315 Lexington Avenue.

"The Red Cross has been called upon to undertake an immediate and dramatic expansion of its participation in the National Blood Program to make available all the gamma globulin possible for the prevention of paralysis from poliomyelitis. Experiments conducted over the past two years in Provo, Utah; Houston, Texas; and Sioux City, Iowa, under the auspices of the National Foundation for Infantile Paralysis, and as a part of their total research program have demonstrated the effectiveness of this treatment. The Red Cross provided the gamma globulin used in the experiments without cost.

"The acceptance by the Red Cross of the request of the Office of Defense Mobilization to undertake this program places a vast new responsibility upon the Red Cross and in turn upon the American people. It takes approximately one pint of blood to make an average dose of gamma globulin as used for poliomyelitis. One injection protects a child for a period of one to five weeks following exposure.

"Estimates based on past experience indicate that polio may strike an epidemic proportion in at least 150 counties next summer and if so at least two million children in those counties may be exposed to the disease. Since gamma globulin is also needed for the modification of measles and in the prevention of infectious hepatitis there will of necessity be a shortage of the serum at the height of the polio season.

"After a full study by the National Research Council, in collaboration with agencies and groups concerned with the problem, they recommended to the Office of Defense Mobilization that the maximum blood fractionation capacity of this country be put to work immediately in an effort to meet the minimal epidemic needs for poliomyelitis by the summer of 1953. The request by the Office of Defense Mobilization to the Red Cross followed. The Board of Governors of the Red Cross in view of the imperative need for this gamma globulin agreed to assume its full share in carrying out the program.

"This is a formidable undertaking. No large quantities of gamma globulin are available. The total processing facilities of the country at the present time are limited but the processing laboratories have been asked to work at full capacity starting now. Even so it is not anticipated that the laboratories will be able to produce the total quantity of gamma globulin needed for polio in the epidemic areas during the summer of 1953. However, it is planned to continue maximum production in preparation for 1954.

"The Red Cross will not allocate or distribute the gamma globulin. Since the amount of globulin needed will far exceed the expected supply, the Office of Defense Mobilization has requested the National Research Council to consult with appropriate professional, industrial and governmental groups to determine the most feasible and equitable method of allocation and distribution in time for the next polio season.

"The Red Cross will furnish its total supply of gamma globulin to the allocation agency without charge for the product in keeping with the policy now governing our distribution of blood and blood products. Over and above this new project we must continue to meet the day-by-day blood needs of civilian hospitals and of the Korean wounded and continue to build the Nation's plasma reserve through the 61 Blood Centers operated by the Red Cross and the Centers operated by the cooperating Blood Banks. In all, the Red Cross--and private blood banks cooperating with it--must collect blood at the rate of approximately five million pints a year if this total program is to be carried out successfully.

"Fortunately, we are well organized and equipped to meet this new challenge. The Red Cross has a World War II experience in which over 13 million pints of blood were collected for the Armed Forces. Since our present blood program was inaugurated in 1948 we have collected with the help of cooperating community blood banks over 7,800,000 pints of blood for civilian use and for national defense. In addition we have distributed through health offices to physicians for prevention of measles and hepatitis 3,457,435 units (2 cc viles) of gamma globulin.

"While this new expansion of our program will draw heavily upon the financial and volunteer resources of the organization, I am confident that we will be able to do the job successfully if we receive the same help from the American people that we have always had in the past. We will need the help of community blood banks, of physicians and volunteer workers. We must draw heavily upon the generosity of the American people both for the blood needed in the production of gamma globulin and for the additional money to finance this new phase of the Blood Program. The gamma globulin for poliomyelitis in additional costs for equipment, personnel and processing is estimated to require approximately 7 million dollars. Originally our budgetary requirements for all other Red Cross Programs for the forthcoming year totalled 86 million dollars. Now with the additional cost of gamma globulin production we ask the American people for 93 million dollars in our March 1953 campaign.

"We have responded to this emergency appeal and all our chapters have been alerted relying upon the cooperation of everyone concerned. We are confident that the people in turn will respond with blood and money so that within the near future new hope for children who are exposed to polio will be piling up in blood bottles across the Nation and the pipe line to processing facilities will be kept full."

The Red Cross acceptance of this responsibility for collection of blood with which to make gamma globulin does not begin to solve the many problems that will face the medical profession and those in public health. It seems to me that we must look to this group for considerable guidance in the problems of how to make the most of these recent scientific findings, because the public will look to this group for guidance as usual in the control measures necessary for another infectious disease. By tradition, and a certain number of laws, health officers are expected to assume leadership in the control of infectious diseases. The Office of Defense Mobilization solicits your counsel to our advisory group, the National Research Council, for the proper management of this urgent problem.

. . . . .

DR. AUFRANC: I have just had passed to me the rate at which the Red Cross is collecting blood at the present time, and I think you would not even have to have a pencil to tell how much more we have to collect.

For the week of November 24 to 30, 1952, the total of 36,911 pints were collected. I think that was the week of Thanksgiving which, incidentally, is a pretty good week anyway. For the year 1952 through November 30, there has been collected for defense needs only a little over one million pints.

DR. OTIS ANDERSON: Thank you very much, Dr. Aufranc.

Our next speaker this morning will be Dr. George Gardner, of Boston. Dr. Gardner is one of the Nation's most prominent child psychologists. He has been the Director of the Judge Baker Foundation for the past ten years, and was on the clinic staff for two years before assuming that position. He has also been the psychiatrist of the Juvenile Court of Boston since 1936, Lecturer in Child Psychiatry at Tufts College Medical School since 1943, Associate Professor in Psychiatry at Boston University Medical School since 1946, Lecturer on Social Relations at Harvard University since 1946, and is the author of many papers and articles in the field of child psychology.

It is a pleasure to have Dr. Gardner with us this morning and he will speak to you on the subject, "Mental Health and Juvenile Delinquency."

Dr. Gardner.

THE PSYCHIATRIST'S ROLE IN THE DIAGNOSIS AND TREATMENT OF THE DELINQUENT CHILD

George E. Gardner, Ph.D., M.D.
Director, Judge Baker Guidance Center, Boston, Massachusetts

The roles which one believes the psychiatrist and his co-workers in the psychiatric clinic can and should play in the diagnosis and treatment of the juvenile delinquent will vary with one's hypothesis as to the basic cause of a juvenile delinquent act or crime in general. If, on the one hand, one firmly believes that delinquency and crime are caused in the main by adverse and pathological economic and social conditions surrounding the delinquent, i.e., that extrinsic factors are of greatest significance in driving the child on to antisocial behavior, one will, of necessity, emphasize the need for the amelioration of these defects by the elimination of poverty, poor housing, lacks in recreational and educational facilities, etc. If, however, one stresses the all-important effect of the intrinsic personality factors as motivating anti-social behavior--intrinsic factors such as needs for security, love, "wantedness" and prestige--one will assume that regardless of the alterations of the external environment of the child in the form of supplying beneficial material needs, the child's delinquent acts will continue. They will continue (it is alleged by this second group) because the child's delinquent acts represent a compromise--a neurotic and disabling compromise--between his internal instinctual drives of aggression and sex and the demands of society that he must not give expression to them.

Now there has been amassed a tremendous amount of data by professionals adhering to each of these basic hypotheses, and it is not my intention to dwell at length upon them--except to state that neither group (at least not in the last half century) has held an undisputed center of the stage. This quarrel or conflict as to the etiology of crime reminds one of the remark ascribed to two friends debating a heated point by Mark Twain:

> "With fiendish glee from morn till night
> You argue all day long
> My friends you either both are right
> Or you may both be wrong."

Rather than argue these points, I shall encompass in my remarks a practical approach relative to the psychiatrist's role in this area of atypical child-behavior which will include: (1) a general working rule for the selection of those cases the psychiatrist would wish to see--and presumably treat; (2) some types of delinquencies that we in psychiatry feel need psychotherapeutic help; (3) a brief clinical conference on three cases committing the same delinquency to demonstrate the need or lack of need of psychiatric help in each; and (4) a statement as to how these psychiatric needs--at least at present in the area of diagnosis --and later, we hope, in the area of treatment--can be met.

I. In general, one may say that the psychiatrist feels that whenever the situation surrounding the delinquent child at the moment--his reality situation--is not enough to account for his antisocial behavior, this behavior probably has its roots in some internal conflict and the child probably needs psychiatric help. In ordinary terms, if the delinquency "just doesn't make sense" either from the standpoint of the act itself or from the standpoint of the seeming lack of necessity on the part of the child to act in that manner (or both), the delinquency looks suspiciously like a neurotic act. This general definition is as significant in the great number of cases that it excludes from the psychiatrist's concern as it is in the small number of cases indicated for special help.

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II. And now on the basis of this definition let us list a group of specific cases which we see from time to time and on which both the psychiatrist and the judge can agree. The list is tentative and is based purely on clinical observation. It does not arise from any elaborate all-inclusive theory regarding the fundamental nature of juvenile crime.

A. The sex offender. Children brought to the court for lewd practices, heterosexual, homosexual or other abnormal sex activity have been referred to the psychiatrist ever since the latter has concerned himself with delinquent problems, and there is little need to re-emphasize here the saness of this long-established court practice. However, it might be well to note here that the psychiatrist from time to time is confronted with cases where, owing to some experience in the early life of the child, other crimes (notably stealing) have become linked to the drive for sexual gratification. The only hint I know that may be of value to the judge and his associates in detecting such an emotional hookup is the "senselessness" of the act or suspicions aroused as to the role of the child's associates.

B. The runaway child who has committed no other offense. To be sure, the child who runs away may be running from some intolerable home situation characterized by abuse, maltreatment, hunger, extreme deprivation. If so, the reality situation alone may account for his behavior and no psychiatric treatment is necessary. However, the court and the psychiatrist have seen so many instances where the child has not run away in the face of the most inhuman treatment at the hands of parents, foster parents and siblings that both the judge and the psychiatrist should be suspicious of some internal conflict when dealing with the runaway. It is my opinion from clinical contact with these cases that all runaways should have the benefit of at least a few interviews with the psychiatrist before we ascribe the act to the reality situation alone and thus content ourselves with merely changing the external forces surrounding the child.

C. Truancy unassociated with other delinquency in a child of normal intelligence. It seems obvious that the child who has the innate ability to advance grade by grade with his fellows but refuses to attend school probably absents himself because of some personality defect. He is unhappy and probably is not so because of some superficial difficulty with a particular teacher or classmate. He should have help to appreciate his own problems and to re-evaluate them.

D. The solitary delinquent. The child who steals or commits other offenses alone should be referred. Because it is our experience that children almost invariably steal with one or more children as partners, we have become suspicious of the personality makeup of those few children who steal alone, and we have felt that at least a modified psychiatric investigation should be carried out with them. This refers, of course, principally to cases where the theft is committed outside the child's own home.

E. The child surrendered to the court for stubbornness. A child who limits his antisocial behavior, agression, and unmanageableness to the confines of his home probably should be studied by the psychiatrist. A thorough investigation of the intrafamilial reactions as they affect this child and in turn determine his behavior is needed. This presupposes a program of study and treatment that may very likely extend to other members of the family group.

F. The delinquent of superior intelligence. Since the formulation and widespread use of standardized measures of intelligence, we can no longer hold the former belief that delinquency is due solely to mental incompetency or to a "moral degeneration" which is attributable in turn to lack of intellect. On the contrary, we know that most of our delinquents have average intelligence as measured by age level tests. (The test results with the last 400 boys appearing before the Boston Juvenile Court gave an average IQ of 92.) Not infrequently we find boys of definitely superior intelligence with an IQ above 115, appearing before us and we have felt that psychiatric investigation and treatment were indicated in all of these cases. Perhaps this

is due to a persistence of the obverse of our notion mentioned above wherein we now feel that crime should not exist in the presence of superior ability, or perhaps we are moved by our feeling that here is a boy whose contribution to society may be outstanding if we can but straighten him out. Whatever may be our true motivation in these referrals, it would seem that the nonattainment of mature social standards in a boy of superior intellect is probably due to an emotional factor--a neurosis if you will--that prevents him from incorporating adult standards and principles. Hence we refer him for psychiatric treatment.

G. Psychiatric consultation is necessary in those cases where the possibility of organic brain damage, psychosis, convulsive disorder or feeblemindedness exists. Post-encephalitic cases and children suspected of having congenital or acquired syphilitic infections should be referred to the psychiatrist. By examination he can establish or rule out these conditions and in turn can outline the best medical or medico-educational program to be followed in each instance.

The foregoing list is a tentative one, and from observation of deliquents as they appear before the court I would assume that about 5 to 7 percent of all court cases would fall into one or more of these categories. This may appear to some psychiatrists a very small number of delinquents referable to their clinic, but it is to be emphasized again that these are cases (A. to F. above) for psychiatric treatment, not cases referred for diagnosis only, and they do not include the cases involving stealing, which I will deal with presently. But the need for the facilities accurately determining which children do need treatment, including psychiatric treatment, is a serious one and I shall return to this topic later.

III. At this point I would like to hold with you a psychiatric clinic on three cases all charged with the same offense (and the most frequent delinquent offense)--stealing. In considering these cases with me, you will be able to discern, I believe, the relative psychiatric treatment needs or the absence of such needs.

A. The first case is the case of Frank, who at the age of 13 is before the juvenile court for the eighth time and for the fourth time on a charge of stealing. Frank steals money or anything that can be converted into money, and with the money he buys candy, goes to the movies, treats his friends. He steals alone or in the company of his colleagues. He has already been in a correctional school for one year.

Family and past personal histories are as follows: Frank lives with his mother, maternal grandmother who is blind and feeble, five sisters, and three brothers in a six-room apartment in the second floor of a three-story house located in a fairly poor residential section of Boston.

The father has been before the courts exactly 20 times in the past twenty years on such charges as assault and battery, drunkenness, stealing, nonsupport, and threatening his wife. The mother has been in court one time charged with adultery. One older brother has been in the juvenile court 14 times, and on two occasions was committed to the reform school. His charges were breaking and entering, larceny, malicious destruction of property, and truancy. A second brother has been in juvenile court twice, once for truancy and once for larceny.

Frank's mother claims that her mother and the older sisters supervise the children in her absence, though it is quite apparent that supervision is minimal. The home itself is poorly furnished, and due to the mother's separation from her husband eight months ago there are times when she and the children do not have enough to eat.

Frank occasionally attends the local community house. He enjoys football somewhat, but tends to spend his time when at home reading funny-books and crime magazines, and when not home, hanging around undesirable areas of the city. He is an irregular attendant at church.

Frank entered kindergarten at five. Repeated the first grade and is now repeating the eighth. His marks are for the most part C's and D's. He is occasionally truant or absent from school.

While under observation at a local boys' club Frank is seen by the worker to be an "extremely thin, dirty, and unkemp appearing boy though he was quiet and cooperative. He lacked the physical qualifications to do rugged, competitive work in the gymansium, though he was a good competitor and seemed to like athletics."

Frank himself gives no reason for his delinquent behavior except to state that he gets in with the wrong boys, and adds that all the boys in his neighborhood steal and that the only unfortunate part seems to be in his mind that he got caught. He makes repeated assertions of good intentions, but finds that he is unable to carry them out. He wishes no one to be blamed except himself.

Hence, in the case of Frank we probably could say that we have the classical use of delinquency arising in a home and community devoted to delinquent behavior--a broken home, poor economic conditions, mother working, little or no supervision of children, father a drunkard and criminal, mother also known to the courts, and two brothers also delinquent. Presumably in such a case the role of neurotic strivings is minimal, or at least is minimized in importance by the more or less expected rational response to such admittedly adverse social and parental relationships. Obviously only an intensive psychotherapeutic approach would reveal the primary gains so well overshadowed all through, and these factors have been very well brought out by Alexander and Healy in just such cases. And in Frank's case the failure of repeated attempts at rehabilitation through manipulative procedures does emphasize that something more is at work here. However, the case serves to emphasize that there are cases of stealing where the irrational, the patternized-repetitive (almost compulsive), i. e., the neurotic features, are on the surface nonapparent and seem to be non-operative as the all-important portion of the atypical behavior.

Assuming then that this case may be the extreme perfect example of the alleged non-neurotic type of stealing, let us pass on to a brief review of a case with a slightly different background and type of expression. And let us apply our same questions to it as we go along.

B. Charles is a 15-year-old boy who is before the court on four complaints of breaking and entering. Previous to this, at the age of ten, he broke into and entered an empty shed, but charges were never pressed and the case was dropped. Associated with the complaint of breaking and entering is a poor school adjustment in that Charles, though of high intelligence, refuses to do his schoolwork and wishes to leave school.

Family history reveals that the mother and father had a very stormy marital career for one year, at which time the father was convicted of a series of thefts and sentenced to prison. At this time the boy was a few months old. However, his father was paroled when the patient was five years of age, but was returned to serve a twenty-year sentence after he had broken his parole by resorting to breaking and entering and stealing. He still is in prison. Following the father's absence from the home, the mother had considerable difficulty in making both ends meet, and moderate deprivations existed from time to time. The mother has always worked and has been out of the home to a certain degree, leaving the supervision of the boy to relatives or friends. When Charles was six years old, she obtained a divorce from her husband and subsequently remarried.

At the present time Charles is repeating the eight grade. He had previously repeated grade 7, so this is his fourth year in the junior high school. However, on the revised Stanford-Binet Charles has a mental age of 17 years and 11 months and an IQ of 124, which places him in the class of superior intelligence.

It is some of the material from the interviews which we wish to stress in this boy's case. In the first place, a detailed review of his four stealing episodes reveals that he himself acquired no money from them, nor did he receive any of the goods stolen, such as a camera, knives, knapsacks, etc., to use himself. They were taken by the other boys involved with him, and he himself stated he didn't want them. Each instance of stealing was in the company of one or more boys, all of whom had records in the juvenile court of his district, and all of whom were known to Charles to have such records. It is to be noted that Charles never has stolen from home.

In relation to school, Charles knows that he is able to do the work but he wants to leave school. He does not want to get an education. On the contrary, he wishes to go to work in the merchant marine. He disdains the navy or marine corps as a way of "seeing the world" and states that he wants to go in the merchant marine because "they are a bunch of hoboes. I like them. There are no bosses. You can go anywhere you want to go when you want to go."

Charles states that his only interest in school is in art work, and he states, "I draw cartoons." When told we would like to see an example of his sketches, he draws a cigarette-smoking, tough-looking man wearing a striped shirt with a goose-necked collar. This man has a patched face and wears a derby hat. He says this is a cartoon character. He has no cartoon plot, but has many pictures, and he will bring them in next time he comes. When we try to arrange a possible attendance at the classes in art at the children's museum, he says he is not interested because "they probably make you draw thing you don't want to." When we ask him if his cartoon character is a sad, happy or funny character, the boy says, "He is a tough guy, but he is an all right one underneath." Following this the boy brings in more of his cartoons, and these are seen to be pictures of thugs and men with beaten-up faces. Two or three of them have to do with prison scenes, and one of them depicts a prison cell (seen by the bared windows) wherein all that one sees is a pair of feet obviously hanging down from the cell and with a small stool kicked out from under them. He states this is a picture of man who has hung himself in jail. Other pictures have to do with prize fighters in various positions of fighting.

Companions sought by Charles are inevitably those who have court records. For example, he goes two and a half miles from his house to play with a boy who is on probation, and on this long walk passes many of his schoolmates who have never been in trouble. He has nothing against the latter, but feels that he wants to play with boys who have been "in trouble."

At the present time Charles is interested in securing a part-time job, not only because he feels that it is a way of finally breaking away from school entirely, but also because of a desire on his part to earn money and bring it home to his mother, that she may have some of the fun that she has missed during his early life. Again, it will give him a chance to show his stepfather that he can contribute to the mother's support too.

Hence, in this case we find a subtle combination of actual deprivations in early life and neurotic strivings, both of which find their expression in stealing and allied delinquent acts. The all-consuming drive behind this boy's delinquency seems to be that he feels that he must be a criminal like his father, or at any rate he is not to succeed where his father failed. Hence he deliberately sets out to destroy himself in the community by his delinquencies, in school by an educational block (we must bear in mind, of course, that he is a boy of superior intelligence), and he has set his heart upon a vocation or type of work that will enable him to associate with, and in fact be, a "hobo" or a "bum." His drawings bear out his ambitions and his fears in relation to this particular drive.

Finally, we can state also that additional material demonstrated that these self-directed tendencies toward failure and destruction come about as secondary to aggressive tendencies directed toward the father.

C. The third case, Albert, will, I hope, exemplify the extreme end of our comparative scale of boys who steal, in that the secondary material gains seem to feature little or not at all as motivating factors, and the neurotic factors seem to be all-powerful.

Albert is 16 years of age, the son of parents who are able to supply him with the needs and luxuries of a boy of his age in his community. His father died when our patient was five years old, and his mother remarried when he was ten. Albert is of superior intelligence and is now in the third year in high school despite the fact that he has been removed from several schools because of stealing.

When he was eight, mother first discovered women's clothes in his room. Asked Albert about it, found that he had taken them from her closet. She scolded him and he seemed quite upset, and mother assumed that the problem had been dropped. However, periodically this has cropped up again all through his life and now in its ramification is the most serious of his difficulties. The matter had increased now so that Albert has several times broken into houses in the neighborhood and stolen women's clothes.

In interview the boy says, "I want to stop but I can't. I say I will stop, but the next day I do it. I've been taken out of schools because of it. I began stealing women's clothes when I was six or seven years old. I liked to get dressed up in it. I just liked to get dressed up in this thing, and mother caught me in it and she stopped me. I had the door locked. She took it away and hid it. Some time later, a month or two, I found it again, dressed up in it, and she caught me again. I cried and put on my own clothes. Then it stopped for about three years. It started again as I finished the sixth grade (at ten or eleven). I suddenly got this urge again to wear women's clothes."

Little comment is needed to emphasize the neurotic elements in this case of stealing because they are obvious. It will be noted, too, how this stands in contrast to the other two cases of stealing cited--each of the three taking its proper place along a scale of increasing psychiatric importance. In addition it is easy to understand in such a case where the primary neurotic gains are uppermost--even to the seeming exclusion of secondary or material gains--in such cases manipulative procedures or changes in the environmental (economic or social) setup would have no effect whatsoever on the impulse to steal. Only insight derived from self-study under guidance offers hope for a redirection of these instinctual drives.

These cases are cited, then, to emphasize the varying psychiatric needs of delinquent children. They demonstrate a gradient, if you will, which runs from those cases where the detrimental external factors almost alone can account for the delinquency to those expressions in behavior -- as in the last case -- that seem to have no reference whatsoever to present economic or social inadequacies.

IV. Now from this brief survey I think we can make certain hypotheses:

A. All delinquent children need treatment of some kind whether it be medical, psychiatric, educational, placement, supervision--or new shoes and clothes and proper food.

B. A second assumption can be that all delinquent children do not need psychiatric treatment.

C. But it immediately follows, in the third place, that though all delinquent children may not need intensive psychiatric treatment, all delinquent children need the benefit of a psychiatric diagnosis--a procedure that will determine accurately--and in the first instance--whether or not they do need psychiatric treatment. They need a psychiatric diagnosis--and this diagnosis, I assure you, means more than a test of intelligence and a physical examination.

The only answer to the problem of supplying these minimal psychiatric needs of a basic diagnosis in a juvenile court is the presence of a practicing or consulting psychiatrist within, or closely affiliated with, the court structure. Because of the shortage of trained psychiatrists--and particularly because of the even more acute shortage of trained child psychiatrists--these minimal diagnostic (to say nothing of minimal treatment) needs of delinquent children are not being met. What is needed basically are (1) more training facilities in this field, and equally important (2) the determination to advocate the placement of such psychiatric personnel within the court structure once they are trained.

Other needs in this area of psychiatric treatment are equally serious:

(1) Residence centers for preliminary diagnosis of cases that are unable to be kept at home during their pre-adjudication period are needed--centers (not merely "detention homes") where adequate care and thorough medical, psychological, and sociological studies can be made.

(2) We desperately need schools and hospitals that are geared to the long term intensive residence treatment of these boys and girls. In this connection, we particularly need foster home and residence treatment centers and programs for girls who are delinquent--and more than in relation to any single group, we need them for Negro children--both boys and girls.

Only under such conditions can we be assured that the proper medico-social treatment programs dealing with the delinquent child even approximate the best that we have in the form of comprehensive child care.

. . . . .

DR. ANDERSON: Thank you very much, Dr. Gardner, for a very interesting presentation.

Our next speaker on the program will be Dr. John C. Bugher, who has been with the Atomic Energy Commission, Division of Biology and Medicine, for the past two years; first as Deputy Director and then as Director of the Division. Prior to that time he was for many years connected with the Rockefeller Foundation in New York City, and is well known for his work in the field of virus and disease control efforts in combatting yellow fever in South America and Africa, and for his research in malaria and other tropical diseases.

Dr. Bugher.

RADIOLOGICAL HEALTH PROTECTION

John C. Bugher, M. D.
United States Atomic Energy Commission

Mr. Chairman, ladies and gentlemen: Without attempting to comment on what might be a reasonable question as to why a pathologist happens to be concerned with atomic bombs, it is sufficient to remark that to have a pathologist discussing with public health officials the problems of development of atomic weapons is in itself a pertinent commentary on the age in which we live, because we come directly into various fields of interest and concern to the broad domain of the public health and welfare.

I wish to speak particularly on the operation of the Nevada Test Site where we have established an area well equipped and well developed, devoted to experimental procedures in connection with nuclear detonations. The reason for the Nevada Test Site is a very simple one. The first series of test detonations were carried out overseas with expenditure of a great amount of money and a vast amount of scientific time. The demands of the program and the rate at which development needed to take place were such as to make it imperative that not only could costs be reduced in terms of dollars, but also that the costs could be reduced in terms of man-hours, of scientific man-hours, of which we do indeed have a limited supply. After very careful consideration by a committee, it was elected that a test site could be established in the western part of the United States remote from major population concentrations, and that this operation could be continued with safety provided certain considerations were observed at all times. The area which was finally selected was part of a bombing range belonging to the Air Force and comprises approximately five thousand square miles northwest of the town of Las Vegas, Nevada.

At the time, there were not only the questions of remoteness and separation from population concentrations, but likewise the question of the climate. It was desired to have an area in which rainfall was relatively low and in which free run-off of water would be either nonexistent or minimal, and that area does meet those requirements very well.

During the period since the Spring of 1951, when the test site became active, there have been twenty detonations, an average practically of one a month. When you stop to think of that, it is in itself a surprising amount of effort.

The detonations are experiments in physics, experiments in nuclear reactions taking place in very short-time intervals. However, due to the expense of these operations, it has been important also to combine with the physical experimentation the structural tests and the biological and medical experimentation, which can best be done with such detonations, so that in every case we have a complicated pattern.

In connection with the detonations themselves, there are certain dangers that must be carefully avoided and minimized. The first of these pertains to blast. I think you are aware that at times a blast wave is capricious and will be reflected and transmitted to surprisingly long distances. It is of no great difficulty to protect the personnel conducting the tests from blast. The structures which are permitted are in themselves blast resistant and adequate shielding is available. But occasionally a reflection from an inversion layer may occur and a blast wave may bounce. That has occured a number of times. At least on one occasion it jumped and went into Las Vegas breaking number of plate glass windows.

Now these events can be anticipated as knowledge has advanced concerning the transmission of shock waves. It is possible to predict that such things may happen and consequently to warn the people of communities within a reasonable distance not to stand in front of glass windows at the time of the expected detonation.

Another aspect of hazards is the thermo-radiation, and that, practically speaking, is limited to the immediate area itself. However, the thermo-radiation, the intense light and heat which are propagated, may be injurious to the retina of the eye for a good many miles, and particularly that is true if the individual happens to be using binoculars. So we must then insure that all persons in association with the test site itself are instructed not to look in the direction of the detonation with unprotected eyes.

The third element of hazard with which we are concerned is in the nuclear radiation. Here we deal first with the immediate radiation of the detonation. Mostly represented by gamma rays and neutrons, pertaining essentially to the area within two to three miles of the detonation, the immediate radioactivity thus is of consequence only to the test personnel themselves. Here again accurate knowledge and predictions have assured a very satisfactory record. We have had no injuries at all from radiation within the proximity of the detonations.

The other side of the radiation story deals with the events that follow upon the ascent of the radioactive cloud, which is then carried off in a direction depending upon its height and upon the wind conditions at that time.

Roughly about 11 percent of the energy of the bomb is contained in the radiation of the fission products resulting. These have decay periods which vary enormously. Some decay very rapidly and are gone within a short time; others have lives that may go as high as twenty-five years. This material drifts across the country at altitudes depending upon the energy of the device which released it, and presents certain problems which I wish to discuss with you in more detail.

While we can predict, and do within reasonable limits, the height to which the cloud is likely to go, and we do know at the time of detonation the wind directions, the wind velocities, temperatures, and the humidities, up to well beyond 40,000 feet, and while we may be able to predict what the behavior of the cloud will be within the immediate one hundred miles, let us say, of the test site, there are always certain vagaries in the upper air currents which will give a marked dispersion. Oftentimes we find that vortices form in the upper atmosphere, and we may have transport of material to pathways which are broader than those which one might anticipate from the simple wind patterns prevailing at the time of detonations.

If there is a clearly unfavorable meteorological pattern which would expose individuals in nearby communities, the detonation is simply postponed until conditions are acceptable. But once the shot is off, the cloud is followed by airborne survey teams and cloud-tracking airplanes of the Air Force for as much as a thousand miles as it drifts across the country.

We have on the ground also a very effectively working network of fallout stations which are directed to collect air samples and the particles which fall from the radioactive cloud as it passes over the country. These samples all go into our New York Operations laboratory where they are assayed quantitatively for their radioactivity. At the end of each series, we have a complete story as to what happened in the light of what was thought to happen or predicted to happen before the detonation.

In no instance have we had fallout from the radioactive cloud which has been a hazard to people off the test site itself. We do have intense fallout areas, of course, in the immediate area of the detonation, but at no time have we had dangerous areas established in the populated areas outside the test site proper. However, we have found that the photographic industry has experienced difficulties and it also has been quite clearly shown that storm tracks, air movements, do tend to pass over Rochester, New York, with surprising frequency so that

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perhaps one could hardly expect to find an area where photographic manufacturers would be more exposed to difficulties of this sort. The matters involved are entirely trivial as far as biological effects are concerned, but to the photographer they are matters of considerable concern.

But beyond all this lies a problem of communication and information of the public. We may say after the event everything was fine, but I am sure some of you have been faced with the situation that radioactive material has been detected by some prospector with a Geiger counter or by somebody working with carbon^{14} who had called in to try to find out why he can't do his work any more.

On one occasion last spring a cloud taking off from the Nevada Test Site with high velocity went right over the Salt Lake City area, and for a period of hours they had an unusual amount of activity there which was, at its peak, about ten milliroentgens per hour.

Now, in terms of total dose given to people, that amount would be of no consequence at all. But one would be concerned with procedures in which delicate radiation measurements were being made and it would be reasonable that such people should have some prior information. It is an important thing to be able to establish the degree of the problem beforehand, and it does lie inevitably in the field of public health.

In the last detonation of that same series last spring, no particular concentrations occurred near the test site. But as the cloud was passing over Chicago, there was a rainstorm originating from a very high level, so that in a matter of an hour's time there was a deposit over Chicago of radioactivity comparable to but a little less than that which I spoke about at Salt Lake City previously. That happened to coincide with a minor accident in one of the reactors at the Argonne Laboratory and there was an immediate unfounded report that this reactor contaminated the city of Chicago, whereas the two events had no relation at all.

Now, as these test series continue (and there is no prospect that they will appreciably diminish, nor is there any prospect that they will terminate in any foreseeable time) we do have a problem of knowing in advance what the probabilities are, and of being able to inform the people who are most likely to need advance information. We also need to be able to reassure the public when it has questions, and to offer them reliable and authoritative information which will allay most of the apprehension which inevitably arises during this time.

It is quite clear that these operations can be carried on with perfect safety within the operational framework that we have now. I would like, however, to suggest to this group that there originate from the public health leaders and the directors of the States a program of the transmission of information.

We feel this is a public health procedure and we are more than eager to back up any plan that you may have. I would suggest that each State Director should be responsible for the dissemination of information within his State, and the answering of questions which people may have to raise concerning any hazards which exist or which they fear may exist. To achieve this, we can supply in advance of the test series considerable background information which may be passed on as the State Director feels may be necessary to the smaller units within the State.

At the time of the detonation, we can also get to the State Director, or to such person as he may designate, whatever additional information there may be pertaining to the particular detonation, either prior to it or immediately after. That can be done by telephone. We can also establish centers of more detailed technical information within the Atomic Energy Commission's own network to which during the test series the State Director of Public Health, or whomever he may designate, may at any time address an inquiry and get a specific answer to it.

Now, whether that were to be done by State organizations working individually, or whether it would be preferable to conduct such activities by way of areas, is something that we could work with in either case. But the point would be -- and the thing I would like to suggest here -- is that the prime responsibility for seeing that people are adequately informed ahead of any type of event of this sort be carried by the State organization. We can work through the communications network we have at our disposal in practically any manner you may desire.

The main purpose is to insure not only that people are safeguarded -- that no injury is experienced by people or by animals; the second purpose is to insure that the people themselves know that they are not being so exposed. And these two things could both be accomplished by the type of organizational pattern suggested.

Thank you very much.

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DR. ANDERSON: Thank you very much, Dr. Bugher, for a very interesting discussion on a subject of such current and vital interest.

(Announcements)

DR. ANDERSON: If there are no other announcements, the first General Session stands adjourned.

(Whereupon, at 1:00 p.m. the meeting was adjourned.)

GENERAL SESSION, DECEMBER 11, 1952 WITH THE PUBLIC HEALTH SERVICE AND THE CHILDREN'S BUREAU

(Dr. Leonard A. Scheele, Surgeon General, Public Health Service, and Dr. Martha M. Eliot, Chief, Children's Bureau, presiding.)

DR. SCHEELE: Ladies and gentlemen, our first speaker this morning is Dr. Leslie Chambers who will discuss the progress of the new laboratory building which will house the Environmental Health Center in Cincinnati, Ohio. Dr. Chambers has been Director of Research at that Center since October 1950. Before joining the Public Health Service, Dr. Chambers was Chief of the Physical and Chemical Division of the Chemical Corps, U. S. Army. He served in that capacity from 1946 to 1950. From 1932 to 1946 he was associated with the University of Pennsylvania, first as Instructor of Pediatrics, then as Associate Professor of Medical Physics, and as Lecturer, Assistant Professor, and Associate Professor of Biophysics. He was Assistant Professor of Biology at Texas Christian University from 1930 to 1932.

Dr. Chambers.

THE NEW ENVIRONMENTAL HEALTH CENTER

Leslie A. Chambers, M. D.
Public Health Service

The approaching completion of a new laboratory building to house the activities of the Environmental Health Center at Cincinnati obviously influenced the selection of the topic assigned to me for discussion at this time. The new structure will be finished early in 1953, but certain circumstances not fully understood by me have so delayed the procurement and installation of equipment that we cannot occupy the laboratories until near midsummer. The new facility, constructed at a cost of $4,000,000 and incorporating about $300,000 in new equipment in addition to the furnishings and instruments already in use, will make possible the consolidation of all of our work in one building; provide quite adequate and safe equipment and space for continuance of our existing research, training, and service programs; and enable an orderly reorientation of the programs toward well defined objectives.

A shift from a set of three inadequate structures to a shining new one does not constitute the creation of a new center; nor is it a move of particular consequence to the public health services of the Nation. It will be justified only by the degree to which it is used to amplify the quality and quantity of the Center's contribution to State services in the form of new knowledge, new control techniques, and effective communication of scientific and technical developments to control agencies.

During its developmental history, the EHC has progressively accepted certain elements of a dual responsibility. On the one hand it represents the expert technical and laboratory arm of several divisions of the Bureau of State Services having operational programs related to environmental health. In this role it functions conjointly with the Water Pollution Control Division, the Division of Sanitation, and the Division of Engineering Resources. To a considerable degree this function results in the assumption of investigative, survey, and evaluation functions related directly to control activities within States. There is inherent in all control activities a necessary requirement for unquestioning acceptance of the infallibility of authority. If Standard Methods requires the use of pipettes with blue markings, there can be no question raised as to why red is forbidden. If it has been accepted for forty years that the

coliform index determines the bacteriological quality of drinking water, there can be no question raised as to how valid the assumption is under present day conditions.

This "control mindedness" is an unquestioned attribute of successful sanitation practice. It therefore must be present within the EHC and must be provided to a degree determined by the technical assistance requirements of the Federally centered control programs and by the volume of requests for specialized technical control services from the States.

On the other hand the Center has the much broader and equally essential function of research--the establishment of facts about physical, biological, and chemical parameters in the environment and the nature of their impacts on human well being. Corollary to this function is the adaptation of old, or development of new devices and techniques for measurement and eventual control of adverse factors in man's surroundings. Here again the function is basic to the broad responsibilities of Sanitation, Water Pollution Control, and other Divisions of the U. S. Public Health Service and is contributory, in a continuing manner, to State and municipal safeguarding of the public health.

But in this second case the mental attitudes of the investigators cannot be bound by the acceptance of authority. When a question is raised as to means of determining whether drinking water contains more than the recommended level of radioactivity, or hexavolent chromium, or coliform organisms, they will try to devise a method, but they will also question whether there is any basis for the recommendation. Given any new environmental situation, they will want to determine all of the facts about it, not simply those facts which will enable its control at current levels.

Both of these functions are part of EHC activities. It is our belief that both will be immeasurably strengthened by organizational separation coupled with adequate integration of the two at the staff level. To this end we are working out a reorganization which will put in the hands of one group of qualified individuals the broad responsibility for technical services related to control activities of Federal, State, and local health agencies. Their functions will include field surveys and investigations of local import as contrasted with studies leading to the development of general principles of general applicability. This group will also be responsible for such laboratory evaluations as fall within the special competence of EHC, and for the provision of technical laboratory assistance, consultation, and guidance in the solution of unusual and difficult problems as requested by State authorities and operating divisions of the Federal service, and related to their control responsibilities. And, finally, they will be responsible for the specialized sanitation training program offered by the Center including the training courses related to radiological health.

To meet effectively the responsibilities of the Center in research--that is to determine the nature and magnitudes of developing environmental health problems and to develop techniques and devices for their reasonable control--a second grouping of competent individuals is planned. While their activities will be broadly dictated and directed by the overall objectives of the public health programs they support, it is expected that this group will contain specialists from a wide variety of disciplines selected for their technical skill, unfettered imagination, eternal skepticism of authority, and complete subservience to the whole truth about phenomena even though it may not be tasteful to empire builders, budgeteers, city planners, or public health doctrineers. They will measure and analyze environmental factors as natural phenomena; as variables in a complex including man; as objects of unbiased curiosity. When there is sufficient understanding of the phenomenon, regulatory techniques and instrumentation will be developed. The whole objective will be the determination of the effects of the environment on man and vice versa, and the invention of practicable means for keeping man's environment tolerable by him.

There is no intention to isolate this group after the manner of the hypothetical "workers in ivory towers". Their activities must be suitably knitted into the operational framework

of public health services so that they can provide the long range projected base for environmental health activities of the future, and the very substantial knowledge and methodology required now. But experience has taught us, as it has many others before, that these two types of activity--objective research and authoritative control--can seldom be encompassed by the same mind. Almost invariably one or the other becomes lost, or the attempted fusion results in confusion of purpose. If we can separate the two types of functions within the Environmental Health Center and obtain reasonable synthesis of the two by appropriate staff work it seems certain that our usefulness to the Federal, State and local health authorities will be increased both in the senses of immediate need and of longer range application of new knowledge.

While transfer to new facilities and internal readjustment to the recognition of its dual function are preoccupying factors just at present, there are certain new kinds of undertaking and numerous new project plans which may shed some light on the nature of the "New Center". Here are a few of them:

1. Within the past six months a small group of highly skilled specialists has been set up under the designation "Public Health Analytical Group". Their objective is the accumulation of available facts pertaining to environmental health problems, and the examination of the facts by logical and mathematical methods included broadly in the term "Operational Analyses". This group will provide a substantive base on which to plan investigative, training, and control programs. Their analyses will assign probable magnitudes to developing problems, measure the effectiveness of current techniques in controlling recognized hazards, provide objective evaluations of training procedures, and attempt to predict the changes in environmental pressures incidental to probable future changes in population level, geographic distribution, industrial expansion, economy, and reduced availability of critical raw materials. Establishment of this crystal ball gazing group is admittedly an experiment as related to public health operations, but the spectacular success of similar groups in dealing with complex probability functions in modern military operations, leads one to suspect that the venture will be fruitful.

2. It is expected that our communications arm--the specialized sanitation activity--will be relied on increasingly to expedite the synthesis of new facts and methods from the laboratories into the general body of knowledge available to public health operators and officials. The new courses offered in the past year have tended toward brief, intensive instruction in recently developed techniques. For example, one course solely on the determination of phenols in water was well attended. Another will be offered early next summer on the determination of fluorides. It is expected that this tendency toward a topical curriculum will be accelerated.

3. An addition to the Center's range of investigative responsibility will be made at the beginning of the new fiscal year by transfer from the Division of Occupational Health of the study of community air pollution in Detroit being carried out for the International Joint Commission. While this project is pitifully supported at present its transfer places on us by implication responsibility for community air pollution studies insofar as budgetary support can be obtained for such work.

4. The specter of war has caused acceleration of planning to solve certain problems which might become of critical importance in an emergency. For example, certain studies of the effectiveness of current water treatment practices in the elimination of pathogens other than the enteric bacteria have been started this year and will be amplified during the next few months. Special attention will be paid to selected viruses including the etiological agent of infectious hepatitis.

Current work on the rapid detection of pathogenic micro-organisms, viruses, and toxins is expected to be broadened early next year. The addition of staff competence in

biophysics and biochemistry will make this possible. Physical methods of identification, chiefly spectrophotometric, will be explored as intensively as the budget will permit, as will optical methods for the early measurement of specific precipitin reactions involving minute quantities of antigen.

While interest in this group of studies is sharpened by the possibility of war, the results will be of much greater value if peace prevails.

5. Activation of research in sewage and solid waste sanitation with a philosophy of conversion to use rather than disposal is projected for the coming year. Sanitary engineering has long looked with pride on the success of its efforts to dispose of these by-products of human existence. For two reasons a reversal of viewpoint now seems advisable and necessary: Advisable from the public health workers' point of view because successful conversion of the wastes to economically valuable forms would greatly accelerate their abatement as threats to community health. Necessary from the standpoint of the farseeing conservationist who recognized the immediate, or at least eventual, need for use and repeated reuse of the basic raw materials required for human and animal nutrition. It is not unreasonable to suppose that a city's wastes may one day be regarded as a carefully conserved asset. Drastically new principles of waste handling will need to be investigated and developed, but a genuinely imaginative research team should be able to assist materially both in accelerating sanitation and conserving essential materials.

I have mentioned only the most recently activated and most definitely contemplated of a long list of appropriate activities for the Center. Development of analytical methods, techniques of measurement of parameters of air, water, and food contamination, studies of the effects of industrial pollutants, including radioactive substances on water quality, aquatic ecology, studies of taste and odor control in water, development of methods for control of biological growths in water supplies, and many other elements of our current program will, of course, be continued to some kind of practical conclusion. Addition of skilled scientists in categories not now represented at the Center is expected to add impetus to solution of many of the continuing projects.

This is by no means a complete presentation of our sketch for the New Environmental Health Center. Nor have I intended to present it to you as a prospectus agreed upon by all those in the three chains of command which will eventually determine its fate. In the first chain are my superior officers in the Public Health Service, none of whom have reviewed or approved what has been said. However, almost all the various components have been discussed with them often so I do not anticipate dissent in principle. In the second chain of command are the several echelons subservient to the Bureau of the Budget. These are capable of making or breaking the best laid of plans and are, to me at least, thoroughly unpredictable. They are, I suspect, governed in their decisions by two things--one, the effectiveness with which we present the public need for services we are able to render; and, two, the force of non-governmental requirements for such services.

This means, gentlemen, that you and your associates, as articulate spokesmen of the publics you serve, are the third and most authoritative chain of command. Our function, as an element of the Bureau of State Services, is assistance to you and your operations. Your guidance in our selection of objectives is actively sought and will always be carefully considered and followed within the limitations of the budget, competence, and legal authority.

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DR. SCHEELE: The topic that concerns every State and Territorial Health Officer and is with us constantly in the Public Health Service is personnel, where to get them--a shortage of personnel.

I suppose probably the biggest problem or topic of discussion these days in medical circles generally, county medical societies, State medical societies, and certainly it was

at the recent meeting of the American Medical Association, is that of doctor draft and what is to happen next June when Public Law 779 expires.

This personnel problem is, of course, of importance to you in the States. It is of importance to everyone. It seemed to us you might like to hear some of the background of Washington thinking, both in the military services and in the selective service system itself with reference to physician utilization, dentist utilization and the problems that lie ahead. And so we have asked Colonel H. W. Glattly to talk to you this morning. He is Chief of the Personnel Division of the Surgeon General's Office of the Army, which position he has held since 1951. In this capacity, Colonel Glattly is responsible for the procurement and assignment of all Army medical personnel. He has been a Regular Army Officer since his graduation from the University of Iowa Medical School in 1926. He has served in Washington since the war, first with the Office of the Inspector General and then with the Surgeon General of the Second Army. During the war Colonel Glattly served on Bataan and has received the Silver Star, and Oak Leaf Cluster, Legion of Merit, Bronze Star and Commendation Ribbon. He is the spokesman general for the armed forces on this subject of manpower needs.

We are, therefore, very happy to present to you this morning Colonel Glattly. I might tell you that Colonel Glattly and Colonel Eanes, who follows him, are going to allow time at the end of their formal presentations for you to ask questions and to have discussion, because it seemed to them - and this, I am sure, is very sound - that their presentations would be much more meaningful to you if you could sort of get into some free discussion.

NEED FOR RE-ENACTMENT OF PUBLIC LAW 779
(Doctors' Draft Act)

Colonel H. W. Glattly
Army Surgeon General's Office

Dr. Scheele, Members of the Association and guests. I do want to state that although I am here in the uniform of a medical officer of the Army, I would rather, this morning, that you consider me as representing the Armed Forces Medical Policy Council in the Department of Defense. And may I say too, that although this professional procurement device applies to physicians, dentists and veterinarians, for simplicity of presentation I shall not always use the sequence but will simply refer to the group as physicians and the application can be made where it is appropriate.

There is probably no subject that is currently of more importance of of more general interest to the American medical profession at large than the future of Public Law 779, the so-called Doctor Draft Act.

However, since I am sharing this hour with Colonel Eanes from Selective Service, and since we want time for questions and discussion, this morning I am merely going to give you a sort of thumbnail sketch of the present status of the Act to include its essentiality to the future conduct of good medical services to the Armed Forces, and then to indicate to you certain changes that we feel should be incorporated in any revision and extension of this Act.

This law was passed, as you will remember, in September of 1950 by the 81st Congress as an emergency measure to support the medical, dental and veterinarian services of the Armed Forces that were then very rapidly expanding as a result of the crisis in Korea.

Affecting, as it does, three major professional groups, it of course smacks of class legislation, a fact that is understandably distasteful to the three affected professional associations. It was, therefore, extremely fortunate that at the time this Act was considered in August of 1950, a more or less united front was presented by the three associations and the Department of Defense with respect to the more important features that they desired to have incorporated into this Act.

This law expires 30 June next year. And we feel it is of vital importance that this same united front again be achieved prior to the consideration of a revision and extension of this Act by the new 83rd Congress next spring.

In the interests of successfully carrying out this major project in the field of concurrences, the Department of Defense, represented primarily through its Armed Forces Medical Policy Council, has been holding a series of meetings and conferences with various policy groups of the three professional associations. As a result of these meetings and conferences we are very happy to state that at the present time all three associations--the American Medical, Dental, and Veterinary Medical Associations--have now gone officially on record as supporting an extension of this procurement device to provide the needed numbers of physicians, dentists and veterinarians for the Armed Forces.

Last Thursday, in Denver, the House of Delegates of the American Medical Association supported the recommendations of its Reference Committee on Military Medical Affairs to this effect.

This whole program that we have been carrying on for the last three or four months has been largely one of education. And that is why I am sure Colonel Eanes agrees with me that we welcome the opportunity to be here with you this morning. I can think of no group before whom we have appeared in the past three or four months that is in a better position to assist us in this program of education. And for that reason, we are very much indebted to you, Dr. Scheele, for including this topic on your agenda for this conference.

Now, in our presentations before these groups we have broken the subject down into two parts. First, we felt that it must be proved more or less beyond a shadow of a doubt that there was no change or combination of changes in the medical services of the Armed Forces as now conducted that would obviate the necessity of a renewal of this Act, that there was no expedient or combination of expedients that could be introduced that would enable us to provide adequate medical services to the Armed Forces without a legislative procurement device.

Second, we brought up the question of the kind of Act we should have for the future. Should it be the law as now written or are there changes that should be incorporated in its revision and extension?

In considering the first of these parts--and may I say that our major effort was devoted to this part; that is, the essentiality of this Act--we have made only two assumptions. You cannot plan without assumptions.

The first assumption is that the strength of the Armed Forces will remain relatively unchanged for the planning future. We have no reason today to base our plans on any other assumption. The second is that we will plan in such a way that there will be no serious deterioration in the caliber of professional medical attendants that we are going to provide our soldiers, sailors, airmen and marines.

In developing part one of this subject, we went into quite some detail on the question of Armed Forces requirements for physicians. You can understand that if our present estimate of requirements were not accepted by these groups, any projections we might make for our future needs for physicians would, of course, be extremely suspect in their minds. However, this morning I believe that this topic would not be of too much immediate interest to you ladies and gentlemen. Consequently I am going to just touch on two or three points with respect to this particular subject. May I have the first slide, please.

(Slide)

The Ratio Question

Physician Strength	Troop Strength	Ratio
3,700	1,000,000	3.7
3,700	1,050,000	3.5
3.700	950,000	3.9

Number one, we have belabored at quite some length one fact with respect to requirements. You cannot take a military force of any size and apply a ratio to it and come up with realistic requirements for physicians. They just simply are not adapted to that sort of thing. If we were to have operated on a ratio of physicians to total military strength over the past several years, we would alternately have found ourselves in one of two undesirable positions. We would either have had far more physicians than we needed or there wouldn't have been enough to carry out our mission. I shan't go further into that topic--except to say that this

is true because there are so many vitally necessary medical activities that have to be conducted in the medical services of the Armed Forces that don't vary with changes in strength.

These various activities are taken into consideration in developing requirements. Basically, every single medical activity in the Army, Navy, and Air Force is gone over, position by position. The sum of this survey is our requirements.

But I do want to mention just one or two things that are this year especially affecting our requirements.

First there is training. The majority of these physicians that are coming into the service have never had experience as medical officers--at least any prolonged experience. Those in Priority One have had less than 90 days - and the individuals that we are going to be taking into the service in the immediate future, the Priority Three group, will never have been in uniform before in their lives. We therefore have to give them a short course of indoctrination so that they can properly assume their position and can protect not only themselves but the individuals that they are to serve.

The training required is going to be given at Fort Sam Houston, down in San Antonio, at our Medical Field Service School, just for the Army Medical Service alone. This school will take in somewhere between 300 and 500 physicians every month for the rest of this year. That many will be going for this eight-week training period. Now, that adds considerably to your requirement.

(Slide) Calculating Requirements--Part I

1. Troop strength, deployment and mission.
2. Military assumptions.
3. Determination of bed requirements.
    a. Health
    b. Geographical areas
    c. Type of troops
    d. Mission
4. Determination of outpatient workload.
5. Training.
6. Research and development.
7. Induction and separation activities.

Number 7 on the slide is induction and separation activity. You know that our Armed Forces today are in a constant turnover. The average period of service is two years. You build up in 1950-51 and then in 1953 you have a complete turnover in your whole force. In the Army alone we are doing 800,000 separation examinations this fiscal year. We are going to have to bring in that many more men and train them. Medically speaking, that means a lot of work.

May I have the next slide, please.

(Slide) Calculating Requirements--Part II

8. Noneffectives
    a. Sick
    b. Enroute
9. Position-by-position calculation, by speciality, to staff above
    a. Manning guides
    b. Tables of organization (reduced)
    c. Tables of distribution

10. Screening of requirements
    a. General staff
    b. Health Resources Advisory Committee
    c. Armed Forces Medical Policy Council
    d. Department of Defense
11. Authorizations are then further restricted by budgetary limitations

The next item I wanted to call to your attention was the fact that so many people, we are afraid, believed that the Armed Forces, with a procurement device such as Public Law 779, had what amounted to more or less a blank check to draw unlimited numbers of these professional people from the manpower pool that was made available. So I invite your attention to Number 10. We want you to know that nothing could be further from the truth, that there is a very elaborate system set up to police us, even if we wanted to go out and squander professional manpower. And may I say that this policing begins right in the personnel divisions of the offices of the three Surgeons General. It is to our own interest. We know that a physician who is fully occupied in his profession is not too unhappy, even if he is in uniform. But if he is brought in under a compulsory procurement device and is not kept occupied, he becomes a nuisance of the first order. He will write his professional societies; he will write his Congressman and his Senators; and we just don't enjoy carrying on that type of correspondence. (Laughter) So it is to our own interest that we keep this requirement down to the bare minimum, that it be extremely realistic. But that is only the first part of the game.

We come up with what we feel is the minimum number of physicians--and I will use the Army here just as an example--to carry on the Army Medical Service. What happens next? I have to sell that to G-1 of the General Staff. Why? Because each year's budget--and you just heard the word "budget" mentioned by the previous speaker-- provides for just so many officers for the entire United States Army, and these must be split up between infantry, cavalry, artillery, signal corps, ordnance, medical and so forth.

There is never enough for each arm or service to carry out its mission in the fashion and the way that it feels it ought to carry it out. So there is a terrific tug of war going on in G-1 all the time between all the arms and services, each one crying to get more.

This is a very effective policing device. I can only put an additional 100 physicians in uniform by taking them away from infantry, signal, ordnance and so forth.

Well, after it has been sold to the General Staff of the Department of the Army, the figure then goes up to the Department of Defense, and it starts its round there through the Armed Forces Medical Policy Council, who first look it over, then send it to the Health Resources Advisory Committee, the group headed by Dr. Howard Rusk. Every quarter we have to appear before that committee and defend our requirement for physicians--that is, the Army, the Navy and the Air Force have to. The members of that committee ask us a great many questions. They go into any changes that we have made from the previous meetings we have had with them.

After we have sold it to that group, it goes to the Assistant Secretary of Defense, Mrs. Rosenberg's office, and she and her people take a great deal of interest in this particular manpower subject. They inquire very carefully into any changes that we might make, especially any increases in our requirements.

And then finally it is approved by the Armed Forces Medical Policy Council.

Now, you see, that is quite an elaborate policing set-up so we cannot squander and waste too much professional manpower. I just wanted to make that point clear.

May I have the next slide, please.

(Next slide)--Estimated Medical Corps Gains Required by Department of Defense--Projected Through Fiscal Year 1955 (See p. 48)

We will now jump right to a little picture of what our future needs are for physicians in the Armed Forces. This slide begins in October, 1953. We have made this slide three times already. We are always too conservative.

Starting in October, we are in Priority Two. I am sure everyone here has a pretty good idea of the definition of the four priorities as outlined in Public Law 779. Ones and Twos, you know, have had the ASTP or V-12 training or were deferred to continue their education; and Ones with less than 90 days of service as a medical officer, the Twos with less than 21-months' service as a medical officer. The Priority Threes are those registered under the Act who have never been in uniform 24 hours in any capacity, and the Priority Fours are those who have been in uniform at least 24 hours and who would not otherwise have been classed as One or Two.

You can see Two is a small group. It is not going to last us long. This shows it runs until January. Colonel Eanes is afraid we cannot even make the December call from that particular group. Next is the very small group of regular draft and you see it in the next and following fiscal years, getting larger each year. This group is made up of the physicians who are coming out of internships and who up to that time have been registered under the Regular Draft Act and have been carrying draft deferment cards in their pockets. As you know, the composition of our professional schools at the top towards the junior and senior classes is still largely veterans, and therefore they are not included in this Act except under Priority Four. As a result, it is not until you get down to the freshman class that the non-veteran becomes greatly in the majority. However, this is a group I will say more about because it becomes increasingly important with each fiscal year. But you will see that we require for the balance of the fiscal year '53--in addition to all other sources that we have--roughly 3,200 Priority Threes, the following year 3,400 and the following year 5,400.

Next slide, please.

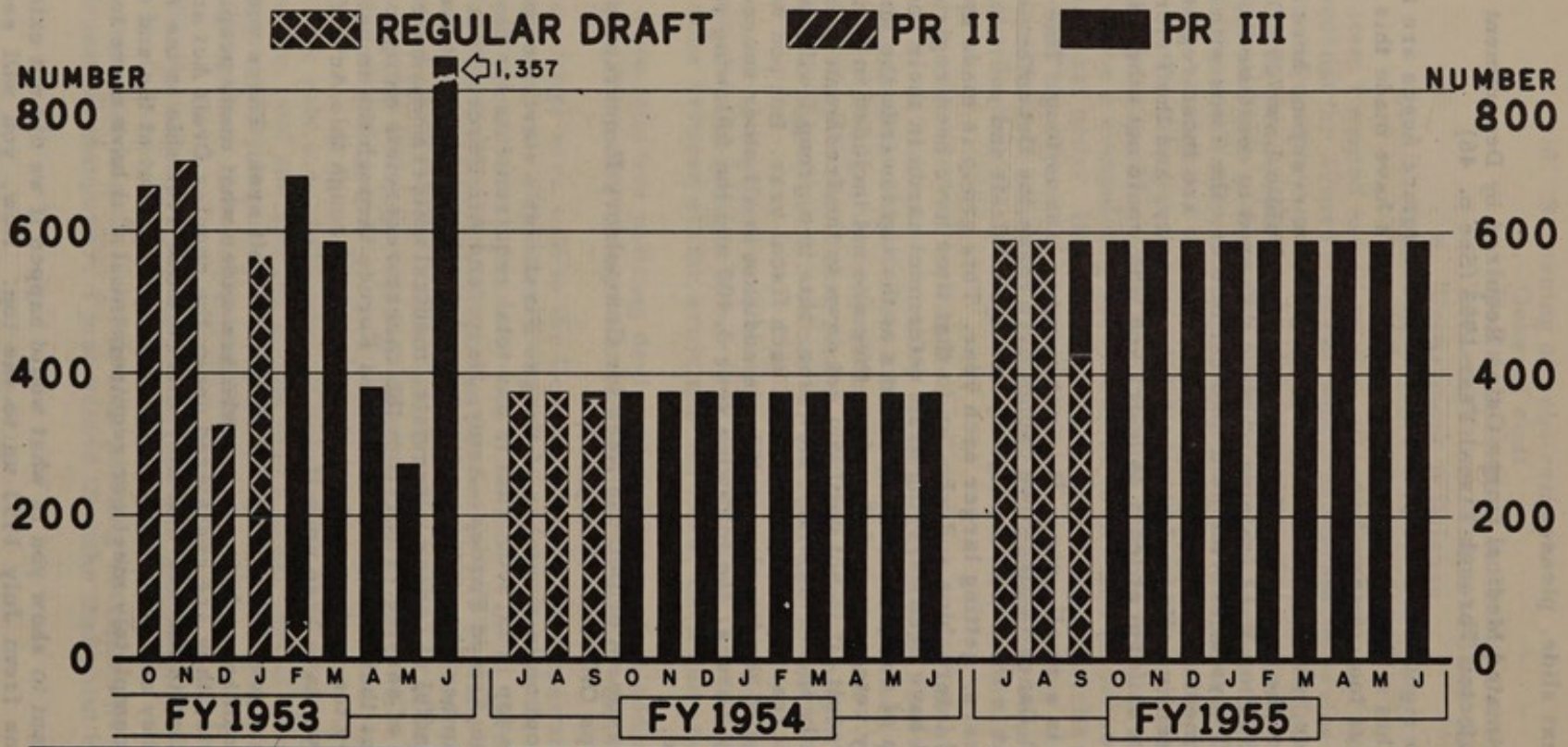
(Next slide)--Department of Defense Need for Compulsory Procurement of Medical Corps Officers. (See p. 49)

This slide points out quite a number of things. First, let's start over on the left-hand side. The figure at the top is 13,500. That is our total requirements for physicians in the medical services of the Armed Forces--Army, Navy, and Air Force. That is being provided as of today, by this number of regulars, slightly under 4,000. Then we have the narrow line which represents a handful of career reservists, medical officers who have voluntarily come in for various periods of service. Then from the career reservists on up to the top of the slide are the physicians that came into the Armed Forces through the impetus of Public Law 779. Seven out of every ten in the service today came in through this Act. You can see how completely dependent we have been upon it.

I next want to invite your attention to the Regular Draft area. There you see projected, up to fiscal 1958, the numbers of physicians who are under what many people have termed double jeopardy--that is, they are registered under the regular Draft Act and also under Public Law 779. And that is the way that they will be made available to the Armed Forces during these years. They are practically non-existent today, but at the end of fiscal year 1958 they will almost completely meet our requirement. I will have more to say about them later.

The next thing I want to show you is what would happen if we did not extend the law. Let's draw an imaginary line from July 1953 up to the top. Now, you will see that in fiscal

ESTIMATED MEDICAL CORPS GAINS REQUIRED BY DEPT. OF DEFENSE —— PROJECTED THROUGH FY 1955

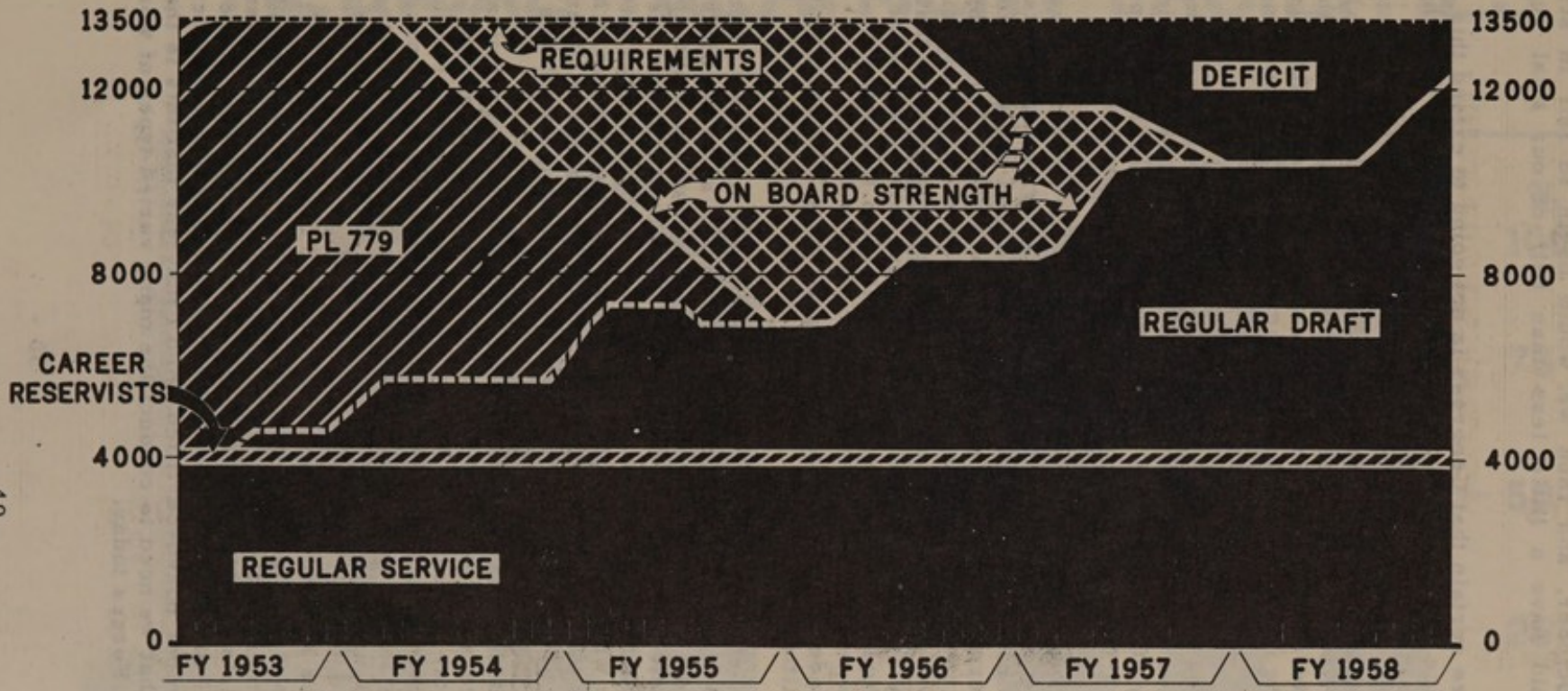


FY 1953	
REGULAR DRAFT	420
PRIORITY II	1,885
PRIORITY III	3,195
TOTAL	5,500

FY 1954	
REGULAR DRAFT	1,116
PRIORITY III	3,384
TOTAL	4,500

FY 1955	
REGULAR DRAFT	1,602
PRIORITY III	5,398
TOTAL	7,000

DEPARTMENT OF DEFENSE NEED FOR COMPULSORY PROCUREMENT OF MEDICAL CORPS OFFICERS



REQUIREMENTS TO AVOID ABOVE DEFICIT

REGULAR DRAFT ▶	420	1100	1600	2600	3600	4500	◀ REGULAR DRAFT
PL 779 ------ ▶	5080	3400	5400	1900	3400	----	◀ ----- PL 779
TOTAL ------ ▶	5500	4500	7000	4500	7000	4500	◀ ----- TOTAL

'54 about 1,100 of this Regular Draft group will be available, so that would last us until about September or October, and then we would begin to fall in strength until in June of 1955 we would have a little less than half of our total requirement for physicians.

Incidentally, we are certain that Congress is not going to extend this Act longer than the regular Selective Service Act, which is June of 1955. At that time this whole subject will have to be reviewed again.

If this Act, Public Law 779, were extended, we would end up in fiscal '55, with our full complement on board. Now, if the law is not extended beyond that date, there will be enough of the physicians registered under the Regular Draft Act to last us for a good many months. And then, because of the increasing strength in the Regular Draft the remaining deficit would be quite small.

Now, we feel, ladies and gentlemen, that the deficit that we have indicated is so great that there are no changes or expediencies that can be devised that are going to erase it or do away with the necessity of renewing this procurement device. Voluntary procurement, as you know, is almost non-existent today for a wide variety of reasons.

I might say that in our conferences and discussions the subject that has come up most frequently has been the care of non-military people, primarily dependents of military personnel. Since it has come up so much, we made a careful study to determine just how expensive this was in terms of our total professional workload. This subject is of great importance to the Department of Defense as a whole, obviously so, especially in the field of procurement. However, we feel it is a completely separate subject that ought to be taken up by Congress entirely apart from Public Law 779. But let us look at the next slide. That will give you an idea of our total workload that stems from this source.

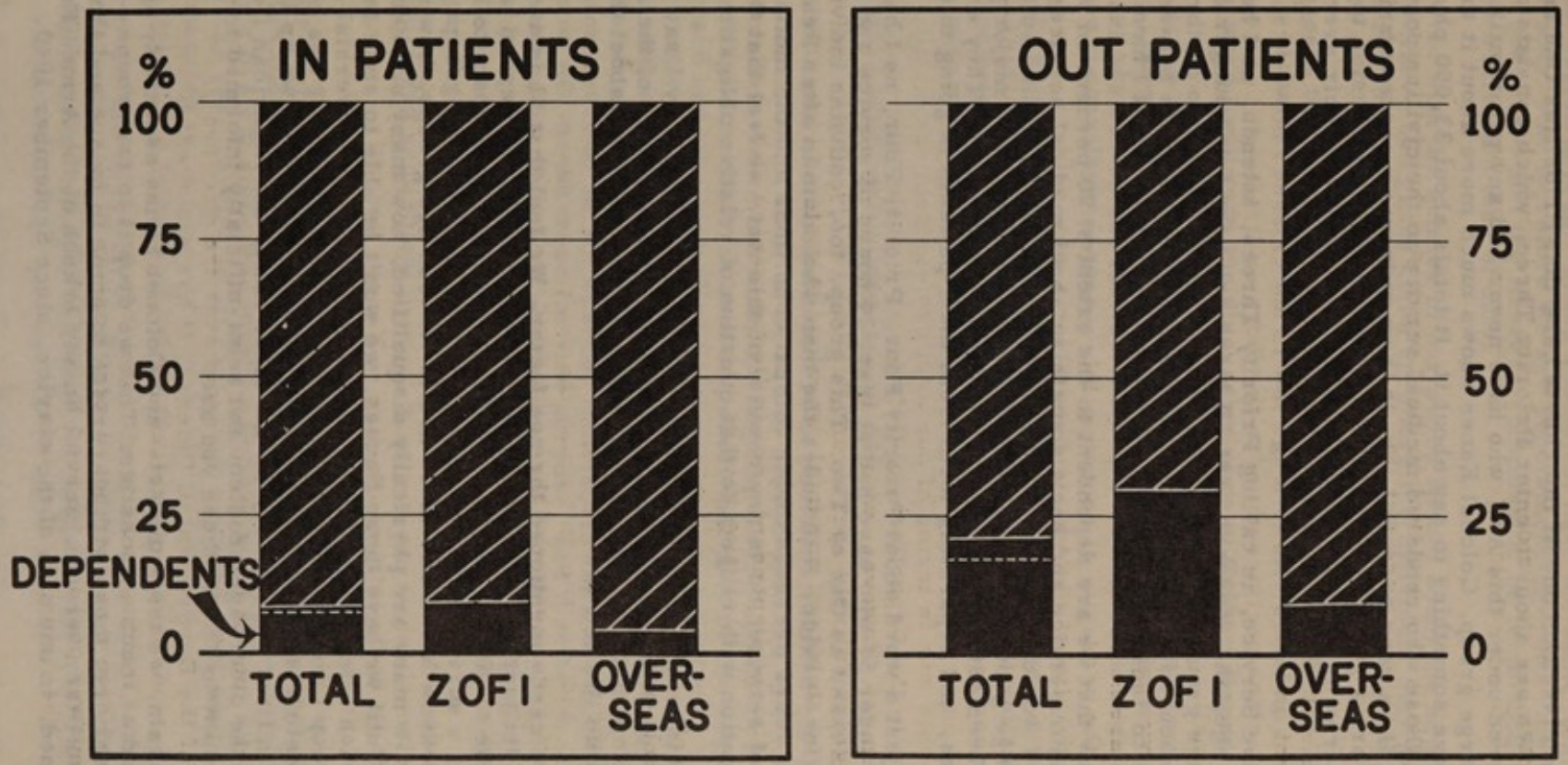
(Next slide)--Dependent Care in Department of Defense Medical Treatment Facilities (See p. 51)

This column in the left half of the slide represents the inpatients. Actually 8 percent of the inpatients are dependents. And that is overseas as well as in the United States. Our outpatient care is indicated at the right. As you can see, dependents make up approximately 21 percent of the total receiving outpatient care. Now, you could discount these percentages completely, and you wouldn't erase the deficit you saw on the previous slide. And we still feel--in fact even those who have criticized our policy on dependent care have always modified their remarks to the extent that--yes, they felt it should be given in overseas stations and in isolated areas in the United States where civilian facilities were not available.

We made a study in the Army Medical Service and found if we eliminated dependent care in metropolitan areas our total savings would be only 175 physicians. I might say, too, that even if we had a total cease-fire in Korea, the entire savings, or reduction, in our Armed Forces requirement would be somewhere between 600 and 700 physicians, and that would represent largely the discontinuance of the care of battle casualties and the reduced staffing of certain of the units that we could accomplish with a total cease-fire.

Now let's look at the Act and consider what we need for the future. First I might say that Public Law 779, as it has operated over the past two years, has adapted itself ideally to the needs of the Department of Defense. It has provided us young physicians. They have come to us with various levels of professional training, some on the level of the general practitioner with no formal training, others with one, two or three years of a residency; some board-qualified and even a number board-certified. And I may say that this is the type of professional manpower pool that we need to conduct the many varied types of world-wide medical activities in the Armed Forces today.

DEPENDENT CARE IN D OF D MEDICAL TREATMENT FACILITIES



You have seen on one of my charts here that Priorities One and Two are just about exhausted. We are about to enter Priority Three, which consists of those physicians under 51, registered under this Act, who have never had any prior military service in any capacity. This is a large group. Colonel Eanes knows much more about it than I do, and he will probably have something to say about it. It totals about 33,000 physicians. The group consists of those who rendered medical service to the civilian population largely during World War II, a very essential job. It is an extremely controversial group, because, may I say, there are a great many veterans in the medical profession today. The age of this group concerns us a great deal. Colonel Eanes believes their average age is somewhere around 45.

Selective Service, in calling Priority Threes, intends, as I have been told, to bring them in by age, the youngest first. If there are very few younger ones, we will soon be in the older-age group. And from there on out for the next two or three years no physicians would be procured for the Armed Forces except individuals between 45 and 51 years of age--in addition to those coming out of their internships, that I have indicated.

You saw that we are dependent to the extent of 70 percent on this Act. Those of you who have had prior service and know something about medical services can appreciate the difficulties I would experience as Chief of Personnel in finding suitable assignments for this older-age group. We think they are going to constitute major public relations problems. They have been out of medical schools for 20 or 25 years. They are firmly rooted in their communities, and separating them from their patients is going to be a difficult task.

Next, just a word about Priority Four. Priority Four, as I have said, includes all those physicians under 51 who have had at least 24 hours of service and who would not otherwise have been classed as One or Two. This group, too, contains individuals with widely varying obligations for service. It includes the man who came in after Pearl Harbor and served four or five years overseas under combat conditions and the individual who may have only two weeks of service. So in any rewrite of this Act, we feel that this group should be given a lot of attention with respect to that question of relative obligation for service.

Now, this brings us up to some of our thinking--and may I say that this is not official Department of Defense, but it does represent the viewpoint of the Armed Forces Medical Policy Council that has been studying this whole problem--about the changes that ought to be written into the new law.

I have already mentioned the age factor. We feel that 51 is an unrealistic age. Now, I don't know yet just what age would be appropriate. It will depend largely upon what Colonel Eanes is able to give us in the way of information with respect to Priorities Three and Four. He is taking a survey of selective services of both of these groups at the present time so that we will know how many there are in various age groups, how many are physically qualified, how many are physically disqualified, how many are essential, how many are available. Until we have those figures, we won't be able to state that we want the age at such-and-such a level. This, also, is an extremely controversial aspect, and it depends upon the group I am talking to as to what they recommend. I was before the Southern Surgical meeting in Miami Tuesday and they recommended we up the age to 55 and call the older ones in first. (Laughter) On the other hand, the American Dental Association has recognized the older-age problem and semi-officially informed me that they would be very happy to drop it to 45. So there you are.

Now, again, we think the Act--and Colonel Eanes especially agrees to this--ought to be simplified as much as possible. That we drop it to two groups--those with no service and those with service; those with no service to come in by age and those with service to come in by total military service, service in any branch of the Armed Forces, enlisted or commissioned, in any arm of the service, since September 1940.

We believe that as special registrants this group should not have the same Reserve obligations as regular registrants. And therefore we are recommending--this committee that has been working on this question--that the Reserve commission be terminated at the time the individual is separated after his tour of duty.

We also believe that service with the armies of our allies should count the same as service in our own armies. We have had cases come up where the individual may have had three years in the Canadian Army during World War II. As the law is now written he has to come in as if he didn't have one day of service.

Those, in general, represent the major changes that we would like to effect. There are many minor ones that are of a technical nature that I shan't go into this morning.

Now, with just one more word I will turn the discussion over to Colonel Eanes.

I am concerned with the group that are in double jeopardy--the ones registered under the Regular Draft Act and the "Doctor Draft" that will, within the next few years, numerically meet the requirement for physicians for the entire Armed Forces. It is a group that is very small now but becomes increasingly larger.

Ladies and gentlemen, this group constitutes just as much of an assignment problem to me as the older-age group of Threes. If I had to take all of them immediately following their internships--and I don't need to belabor that point to this group--they would, of course, provide us with none of our specialty requirements.

Next slide, please.

(Next slide)--Army Medical Corps Specialists (See p. 54)

This slide gives us, for the Army alone, the numbers of positions counted up, position by position, that require specialization (3,452). If we had to depend upon the interns, the only source of getting our specialists would be from the Regular Corps and career Reservists, a total of 1,908. But you would first have to deduct that part of the Regular Corps that is assigned to staff command and administrative positions and you would have to deduct the residents; that would leave only 1,215 Regular Army and career Reserve specialists to apply against the Army specialist requirement of 3,452. You could well imagine the deterioration in the medical services that would take place under those conditions. So we feel that eventually some system must be set up whereby individuals finishing their internship who can secure residencies will be deferred for that purpose, and then by the normal attrition that takes place in residencies, they will be fed back to us, some with one, some with two, and some with three years of a residency. There will then be available to the Armed Forces, from that time on out, a group that will approximate very, very closely that which we are now getting in Priority One.

Thank you very much, ladies and gentlemen.

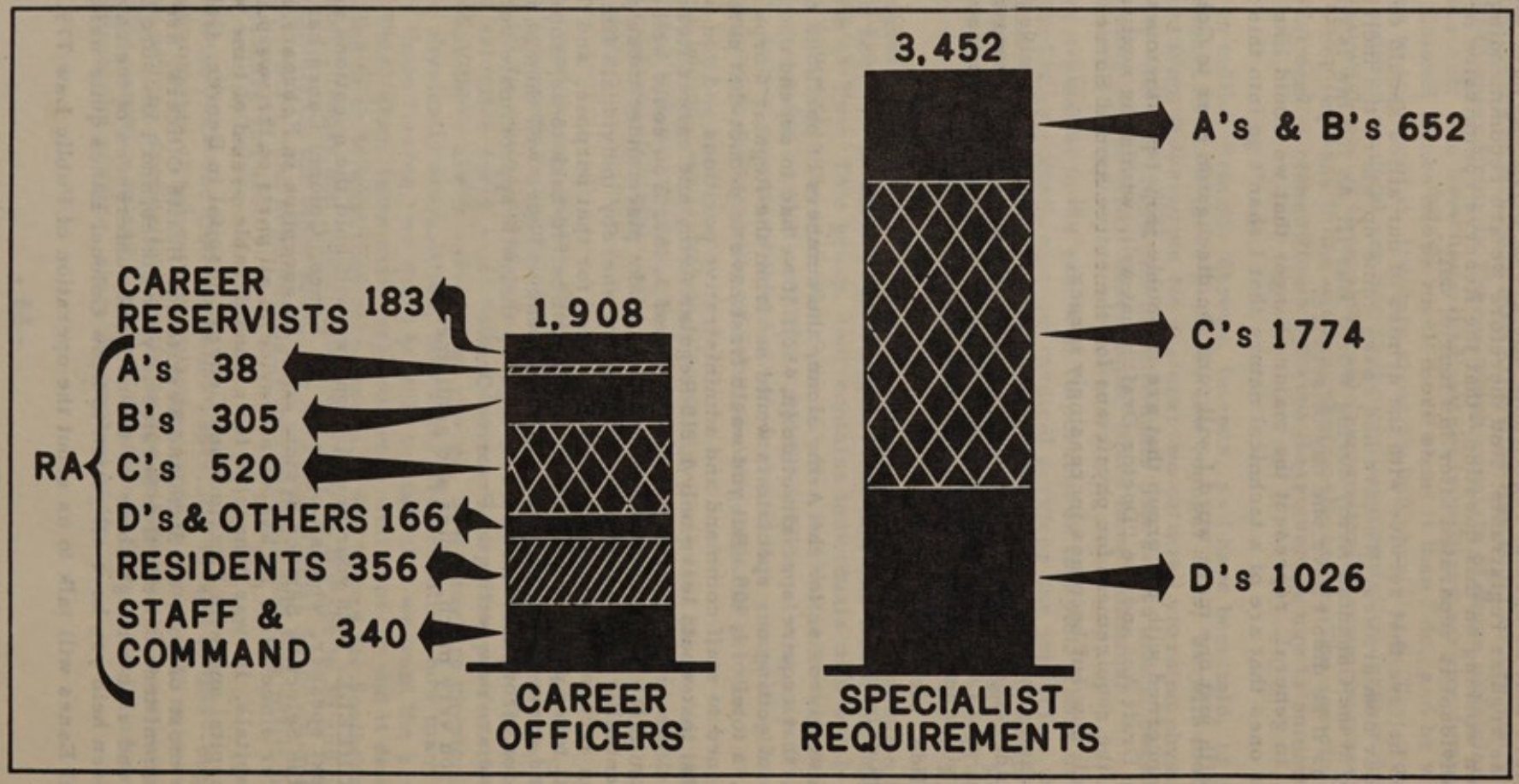
. . . . .

DR. SCHEELE: With your permission, we will hold the questions and discussion until after the next speaker, who is Colonel R. N. Eanes. Colonel Eanes has been Chief Medical Officer of the Selective Service System since its inception in February 1941. A Regular Army Officer since 1920, he has seen service in all parts of the world, principally in general hospitals. He was connected for a considerable period of time with Walter Reed General Hospital and with Fitzsimmons General Hospital in Denver, Colorado.

I think most of you, as State and Territorial Health Officers, are on the Medical advisory committees to Selective Service in your States, and I am sure that through correspondence and also through some of the national conferences of the advisory committees that have been held you have all gotten to know Colonel Eanes quite well.

Colonel Eanes will talk to us about the operation of Public Law 779.

ARMY MEDICAL CORPS SPECIALISTS



OPERATION OF PUBLIC LAW 779

Colonel R. H. Eanes
Selective Service System

Dr. Scheele, Ladies and Gentlemen of the Conference: It is opportune that I can appear before you this morning, because decisions which are of extreme importance are being made at this time with reference to our passage from Priorities One and Two to Priority Three of the doctor registrants. I cannot tell you the final word on all of them, but I will go as far as I can.

The problems presented in the operation of Public Law 779 are so weighty that I am certain Dr. Scheele could not afford to allow or allocate sufficient time to go into every detail. It would take too long. I purposely have not prepared a paper. I prefer to skim over, to show you some of the things that are happening, to refresh your minds. I know that many of you, as Dr. Scheele just stated, are members of the State advisory groups and as such are familiar with the general principles and policies of the operation of Public Law 779.

To go back just a moment, you will recall that along in 1949 and 1950 the armed forces began to call the professions' attention to the fact that there was a prospective shortage of physicians and dentists in the armed forces; that it seemed as though they were going to be unable to meet an emergency.

We know that the professional societies did the best they could. They attempted in every way to assist the armed forces in supplying their needs. This failed, and the crisis came in June of 1950. It became necessary that the armed forces immediately appear before the Congress and present their problem. This resulted in Public Law 779 which was approved on September 9, 1950.

I need not go into the question of registration. We started as soon as possible, October 16 being the first registration, for Priorities One and Two. Colonel Glattly has already related to you, to refresh your minds, those who constitute Priorities One and Two, Three and Four.

But as a result of the registration--and registration is still going on in all of these priorities--there have been registered 11,872 physicians in Priority One and 2,792 in Priority Two. I am not going to give you the figures on dentistry. I know that figures don't stay with you well, and we have got to get along and not take too much time.

As a result of the President's proclamation, the registration for Priorities Three and Four was held on January 15, 1951. As of October 31, 1952, there were 33,046 Priority Three registrations, and 51,669 Priority Four registrations. The figures for November 30 are now being received.

As the result of this operation, 11 calls have been placed against the Selective Service System. We are actually presenting the 9th call in the last week of this month. The 10th is in January and the 11th is for February.

I cannot tell you how many men have received commissions as the result of the operation of Public Law 779. In setting up the regulations for Public Law 779 we purposely made them as liberal as possible, feeling that it was the intent of Congress that these professional men should be commissioned to perform their professional services in the armed forces. We have given each and every one of them every opportunity possible to be commissioned. We have not followed them too closely until after an order for induction was placed.

In our Regulations men who applied for and accepted commissions are classified in I-D. This arrangement was made before any call was placed. This classification indicates they have been commissioned and are a part of the armed forces. They are not subject to further processing by Selective Service. This procedure is quite different from the provisions under the general regulations, for we are forbidden to give a regular registrant any consideration because of a reserve status except under very definitely described circumstances. The Congress in 1948 forbade it. Subsequently certain liberalization was made for men who have already joined the armed forces and accepted a specific obligation. This refers particularly to the ROTC students.

The point is, that we did attempt to encourage men to apply voluntarily for commissions. Quite a few did, so many in fact, that we did not get down to really placing calls for men until this year. When the calls come to us they are for definite numbers and by professions. We set up an arrangement whereby a man who had come up in Priority One or Two, or in dentistry in Priority Three, and had an order for induction placed against him would have to accept a commission or be inducted. This was done with an "Order for Induction" which is a serious thing. It is a real order, supported by the laws and regulations of the United States, and a man must comply. We provided under these special regulations that if at that time a commission was offered, and he accepted that commission prior to the date of the Order for Induction, we considered the Order for Induction as having been satisfied, and the Order was cancelled.

This has worked very well, though in spite of it--and I don't know why this had to happen--about ten physicians have been actually inducted, also about fifteen dentists. One or two of the dentists were inducted as regular registrants. That, too, was not necessary. Any of them who properly applied for a commission could have received one, for ample provision was made for them to apply. Men who are called are inducted unless they accept a commission voluntarily.

When we looked at our figures, and see Colonel Glattly's--and his are imposing--we felt that we had ample men to supply all the needs of the armed forces. But many things have happened, and some of our predictions have not materialized. Colonel Glattly has told you that he has revised his charts several times, and he is going to revise them several times again. They are becoming obsolete at the present moment. I am not criticizing his charts. I use them sometimes because I have nothing anywhere near so good. I merely call your attention to the fact that circumstances and figures are never constant.

The general philosophy and principles of deferment apply alike to the regular registrant and the special physician registrant. They are very simple, as laid down in The Act by Congress. Every American citizen required to register by the Congress is liable for service until he establishes his essentiality, in a civilian capacity, in the maintenance of the national health, safety or interest. That essentiality may be established only upon the status of the individual; there cannot be group deferments. There is an exception, that being for ministers of the Gospel and students of the ministry. There are quite a few physicians and dentists who are properly ordained ministers, missionaries and the like. They are exempt from service under the general, as well as the special, Provisions of the Act.

Men practicing medicine, or who are teachers of medicine, may be deferred, and the same applies to dentistry, if they can establish that they are doing a full-time job, a job necessary to the maintenance of the national health, safety or interest, and that they may not or cannot be replaced.

Since the beginning of the Selective Service System in our present times, the Selective Service System has never written anything specifically on the deferments of interns, though it has adhered to the policy that interns, both in medicine and dentistry, should be deferred during the first year of internship. We have maintained all along that any additional post-graduate training should be done after a man has served in the armed forces and satisfied his liability, and we have never recommended deferment of residents as a group.

There are residents who in some types of hospitals are necessary to the operation of the hospital, and there are residents who have a brief time remaining to complete their residency. Regulations amply provide for handling both of these types when they come up; but, to repeat, we do not recommend the deferment of residents in our hospitals as a group. At the present moment, for every man selected for the armed forces one is being released; and we feel that residencies belong to those ex-servicemen who care for them.

Practically all men in Priorities One and Two have been examined, in spite of figures to the contrary. The figures are misleading. For a large number of special registrants who have been examined, the Army has not been able to satisfy itself as to their acceptability or non-acceptability. This indecision often has not been reported to us.

This is the situation today in the Selective Service System. We have a call for 460 physicians and 204 dentists for the month of December, and we do not find available and acceptable in Priorities One and Two enough men to fill this call. Why don't we have them? We had, as I told you, 11,872 physicians in Priority One, with figures comparable in dentistry. Four thousand six hundred sixty-three are on active duty, with 2,146 commissioned but shown as not being on active duty. Men classified in I-D are out of our consideration. In Priority One alone there are 1,050 physicians deferred. We do not believe that that is as it should be. Most interns are veterans and few of them come in this figure. They are regular registrants and grouped as such or they are in Priority Four. We believe that there are nowhere near that number of Priority One physicians practicing medicine in isolated areas where they are necessary for the maintenance of the national health, safety, or interest. We are very sensitive about this condition because we do not want to be accused of depriving any area of needed professional services.

Incidentally, there are 17 ministers who are physicians in Priority One. I have already informed you that ministers are exempt.

There are 2,476 physically disqualified in Priority One. That represents about 22 percent of all Priority Ones. Priority Ones were not 4-F during World War II; the majority of them were ASTP or V-12 and were actually in the service. Now we find 22 percent not qualified physically or mentally. You must recall they are being examined on a very liberal standard; but even so, we feel that this group must be reviewed.

We turn a moment to the 1,050 who are deferred, being essential to the maintenance of the national health, safety, or interest.

You gentlemen are largely members of advisory groups. The responsibility for those deferments rests upon the Selective Service System. They do not rest upon you, but you are privileged under the Law and under our Regulations to present a recommendation concerning the essentiality of these physicians. General Hershey will ask the state directors to review these II-A deferments to see that we bring the number down to the minimum. I request you advisory committee members to have your people review all so classified to make certain they are actually necessary in the maintenance of the national health, safety, or interest. Let us be sure that no others are deferred.

We ran out of Ones and Twos in dentistry much sooner than was expected, and we had to go to Priority Three. Priority Threes are limited at present to those not yet 36 years of age. Through December, there are not enough available and acceptable dentists in Priorities One and Two and Priority Three under 36 to meet the call. We will fall short.

The January call is for 544 physicians, 383 dentists and 18 veterinarians. The veterinarians present no problem whatsoever.

We cannot fill that call for January from Priorities One and Two physicians or from Priorities One and Two dentists and dentists of Priority Three who have not attained their 36th birthday. What shall we do about the January call? The call went out by telegram yesterday to the 56 state directors--no Priority Three physicians, and no Priority Three dentists beyond the age of 36, included in it. General Hershey has made an administrative determination that before we go into Priority Three physicians, or advance the age in Priority Three dentists, we must clear up Priorities One and Two.

For February we have an additional call of 536 physicians and 286 dentists, which we haven't even considered yet.

Last week a State Directors Conference convened in the city of Washington. It was my intention, through conversation with the 56 Directors, to find out how they were getting along in their respective States. Unfortunately, I was grounded in Denver arriving back just before the conference closed. I had but a brief opportunity to discuss this operation with them first hand.

The State Director of California reported that in the month of October, 80-some percent of those in Priority One and Two, but mostly in Priority Three, physicians and dentists had been physically disqualified. In the month of November, 70-some percent were so disqualified. We are aware that Priority Three is made up in part of those deferred because of physical reasons during World War II and were able to continue the study of medicine--and of older men. We had expected the rejection rate to be high in that group, but the above figures are certainly not realistic. One of the principal causes for rejection is asthma. It seems any one can get a certificate affirming he has had asthma at some time or another. Unfortunately, Army Regulations state that if a man presents evidence he has had asthma since 12 years of age, he is not acceptable physically. I don't believe you physicians subscribe to that.

I wish to speak again of another Priority Three group, particularly of Colonel Glattly's chart of the estimated Medical Corps members required by Department of Defense, projected through fiscal year 1955. (Note chart for this requirement.) He showed dependence to some extent upon the Priority Three regular registrants. Being young men, just out of school, it looks like they should be immediately available for service. We were liberal in our regulations concerning the general registrants. A man who is a father is deferred by reason of dependency, even from the date of known conception. These young doctors, as they graduate from medicine, have a situation quite different from that which we had when we went to medical school. They have wives. They were quite smart and before they finished with their internship, a little one appeared on the scene. Result--the father is deferred as a regular registrant because of that little one.

Something must be done about them. The solution may be near. Any man who acquires dependency of a child while being deferred for another specific reason will not be given a 3-A, dependency classification. That will upset the plans of some men. That is why Colonel Glattly cannot depend on Column 1 which represents 3,191 young physicians, a part of whom are liable as regular registrants, until we actually go into Priority Three. The Director of Selective Service has determined we will not go into that Priority during December and January. Before we get to next July, to the men that Colonel Glattly is putting much dependence upon, I am certain these young fathers will become available. To reiterate, though he depends partly on Priority Three men in February, available Priorities One and Two men must be practically exhausted before General Hershey will feel justified in dipping into Priority Three.

Colonel Glattly showed you the Department of Defense continued Need for Compulsory Procurement of Medical Corps Officers. Those graduating who are regular registrants will remain liable until their 35th birthday because they were enjoying a deferment for the study of medicine, or for a dependent when they attained the age of 26. As time goes on, they will become sufficient in number to meet the needs of the Services.

We are, at the request of the Department of Defense and the National Advisory Committee of the Health Resources Advisory Committee, canvassing our local boards to determine the exact age of each Priority Three man and how many we have in each age group. In Priority Four we are making a canvass as to age and length of service by months.

We are not classifying Priority Four. We haven't sent out a questionnaire, and it is going to be a long time before we will. We have for some time been in the classification of Priority Three, and have received many protests; but even so, when we examine Colonel Glattly's and our own figures we are convinced that we were too slow in going into Priority Three classification.

It has been necessary for Colonel Glattly to communicate with all six armies to expedite the examination and the reporting on Priority Three men so that we may catch up. At the present moment we do not know how many of these men are available and acceptable. You know that it is the responsibility of the armed forces to determine acceptability.

Dr. Scheele, I think that covers in a general way the things that have been advanced, and if there are any questions I shall be delighted to answer them.

. . . . .

DR. SCHEELE: The meeting is open now for any questions or discussion.

QUESTION: I wish to ask a question. It was not clear to me as to whether recommendations for revision of the present Doctor Draft Law will be submitted to the next session of the Congress.

COLONEL GLATTLY: Yes, they will be. The Department of Defense is presently working on a proposed draft that will probably be introduced in January.

QUESTION: You don't know exactly at this time what the recommendations for revisions will be?

COLONEL GLATTLY: I mentioned certain areas in which we are planning changes. For instance, in age - we will not be able to come up with a recommended figure on age until Colonel Eanes here has available to him the inventories on Priorities Three and Four.

COLONEL EANES: I might say, there is no significant difference in recommendations of the Selective Service System and those of the Department of Defense. We are so close together, we don't even discuss differences in our planning conferences.

QUESTION: Colonel, has there been any consideration of changing the position of Groups Three and Four? In our advisory committee frequently it appears that they are misplaced. Frequently it seems that some in Group Four should have gone before Group Three was called.

COLONEL EANES: In our present thinking, both in the Department of Defense and the Selective Service System, we do not expect to recommend a reversal of Priorities Three and Four. To all practical purposes, Priority One and Priority Two, as I have already told you, are going to be out of the way in a short time - before July 1.

COLONEL EANES: It is our thinking that Priority Three should go first - we should finish Priority Three. I believe that also is the thinking of all veterans' organizations in the United States. In fact, they generally clamored for a reversal of Three and Two. But we had no alternative in that.

QUESTION: That is what I really meant.

COLONEL EANES: I suspected that is what you might have meant. For all practical purposes it is going to be out of the way, and the remainder will be insignificant.

QUESTION: On the last chart, (Department of Defense Need for Compulsory Procurement of Medical Officers) where it read in the cross-hatched area "On Board Strength," I didn't understand exactly what the resource of medical officers was in that area.

COLONEL GLATTLY: Well, we divided that total cross-hatched area into two parts, to show what would happen if the law were not renewed July 1 of 1953, and what would happen if it were extended until July 1, 1955.

In the event that the Act were not renewed at all, then the cross-hatched area and the solid deficit area would represent the deficit. If the Act were renewed for just two years, then the remaining deficit would be represented by the solid deficit area only.

DR. SCHEELE: In view of the fact that time is running out on us here and you have an additional program this morning as well as some executive sessions, maybe we will just allow Dr. Bierring to ask a question and then possibly Colonel Eanes and Colonel Glattly will be glad to stay here at the front of the room and talk to you individually.

DR. BIERRING: I did not rise for the purpose of asking a question, but I thought something might be said about the clear presentations we have had this morning by Colonel Glattly and Colonel Eanes regarding the operation of Public Law 779, and recognize the difficulties they have had in adjusting these various points in connection with this operation, perhaps in relation to the various professions involved as well as to the Selective Service requirements. I think we have to express our high commendation for the manner in which they have tried to serve both the professions and the needs of the Services. The way they have managed not only to keep the various professions reasonably well satisfied, but also to meet the needs, is rather remarkable. It means something to interrupt a career, in the period of training in post-graduate work as well as in the professional activities. I believe whenever possible they have always been very considerate in giving deferment, even up to the limit of six months, if a residency was near completion or a practice had been well established in a community.

We have been most fortunate in having men who have directed the personnel divisions of the Services as well as fulfilled the requirements of the Selective Service Law. We ought, in some way, express our appreciation to Colonel Glattly and Colonel Eanes for appearing before us and clarifying so much of this rather difficult problem. Therefore, I should like to present a motion of recognition of their contribution to our program this morning.

DR. SCHEELE: Thank you, Dr. Bierring. I know you are echoing the opinion of the folks in the Public Health Service who have watched this program operate and who have also been recipients, in a small way at least, of some of the results of the program.

We might have our second and vote on that motion in the form of applause. (Applause).

We will now have a short break, after which Dr. Burney will reconvene the Association.

(Whereupon, at 11:25 o'clock a.m. a recess was taken.)

DR. BURNEY: Our first speaker this afternoon is Dr. Hyde, Director of the Division of Health and Sanitation of the Institute of Inter-American Affairs, a position he has held since 1950. From 1941 until that time, he was a medical officer with the Public Health Service. During the war he was assigned to duty with the Office of Civilian Defense, and later served in three important foreign posts. Following that, Dr. Hyde was Assistant Chief of the Division of International Health of the Public Health Service, Health Advisor to the Division of United Nations Economic and Social Affairs of the Department of State, and has served as the United States Representative on both the Executive Board of the World Health Organization and the Executive Committee of the Pan American Sanitary Organization. Prior to joining the Public Health Service in 1941, he engaged in the practice of internal medicine in Syracuse, New York, for five years. Dr. Hyde will speak to us on "Staffing of International Programs". Dr. Hyde.

STAFFING OF INTERNATIONAL PROGRAMS

H. van Zile Hyde, M.D.
Department of State

The subject that I would like to discuss with you is somewhat broader than the title would suggest. As many of you know, we have for some time been seeking ways whereby we might bring the full force of American public health leadership to bear upon the problems of health abroad. Leadership in public health in this country is rested to a very large degree in the State and local health departments. You are leaders and you are the bosses and leaders of leaders. We want to know how we can avail ourselves of your leadership and influence in tackling international health problems.

It is most gratifying to know that, at the same time, you are searching for ways whereby you may extend your talents to the international program. We need to seek, and find the ways whereby you and your services can be part and parcel of the international movement.

There is no question as to your full recognition of the importance of public health in the stabilization of world peace. You are acutely aware of this. You have done much to draw this to the attention of the people of the country, and to officialdom at all levels. The inclusion of this subject on the agenda of this session, which by the way was done at the initiative of the Association, not of the Public Health Service, and the adoption yesterday of the resolution on international health give full evidence of your desire to play an active and leading role in the international health program.

Your resolution constitutes a clear recognition of the fact that from now on the United States is inextricably involved in the health problems of the world. It further recognizes the fact that this is a phase of public health which is not exclusively a Federal responsibility--not solely a responsibility of the Public Health Service--nor of the Department of State or any other Federal agency. You have given clear recognition to the fact that American health leaders, at all levels, must from now on encompass a world responsibility while discharging their domestic responsibilities.

Your resolution will be encouraging not only to those of us in the Federal agencies concerned with international health, but also to the World Health Organization, the Pan American Sanitary Bureau, and, more particularly, to those countries that need your leadership and assistance in improving their health. It will serve as a beacon to them in searching the way out of the morass of ill health.

The Public Health Service, recognizing that the international phase of public health is a permanent responsibility with work-a-day aspects, is transferring the Division of International Health to the Bureau of State Services. Through this move the Service hopes to integrate more closely and bring into proper balance the two phases of its total public health responsibility. It is hoped also that this move will strengthen the intimacy of the relationship of the Service to the State health officers in discharging their international responsibility. The transfer will provide for full utilization in international work of the regional offices, which have thus far been concerned almost exclusively with the domestic phase of the total health problem. This move, which will be made in the relatively near future, will bring the State health officer in much more intimate contact with the international scene than has heretofore been possible.

How do you mobilize your strength in this program? How do you bring it fully to bear on the international problem? We need to seek new ways. We need to seek them together. We have discussed the problem with a number of you, and, in every case we have found enthusiasm

and interest. The only reservations you have expressed are those concerning your ability to contribute as largely as you would wish.

There are certain underlying principles governing the program that should be understood.

1. It is truly a joint endeavor with each country, not a unilateral effort.

2. The specific content of each country's program is determined jointly with the Ministry of Health in the country concerned. It is not dictated from Washington nor by the Americans in the field.

3. The program can be influenced most effectively in the field by field visits when the annual program is being developed. It would be brash to attempt to mold or veto programs at great distances particularly when they are to be carried out in a foreign setting.

4. The U.S. is furnishing leadership, not the mass of workers. The program requires, therefore, quality, not quantity--competent, experienced public health leaders to give direction to program development and to train and direct indigenous workers.

   In the 18 countries in Latin America, where the program is most advanced, there are fewer than 100 American technicians directing programs involving over 6000 native personnel. In the Near East and African and Asian regions there are now in the field of health and sanitation 95 technicians under an authorized budget providing for 158 positions. Although some increase of the authorized budget might be forthcoming, it is not expected that the number of personnel required will skyrocket.

   The object of the program is, of course, to build strong, permanent, self-supporting indigenous national and local health services. It is necessary first to create widespread public demand for such services--a demand sufficiently strong and clear to constitute effective political pressure. Such a demand can be generated through sufficiently widespread, successful demonstrations of effective health services. It is necessary, at the same time, to train native technicians, professional and sub-professional, and to develop true public health leadership within the country. The program is, thus, basically one of demonstrations and training. It is a program that requires competent experienced leadership abroad working under the stimulation and broad guidance of the best we have here at home.

In seeking means for full participation in this program an important pioneering step has recently been taken in the signing of a contract between the Technical Cooperation Administration of the Department of State and the Commonwealth of Massachusetts. This contract establishes the principle of cooperation and sets up a working method that is already providing action. It is desirable to consider it for a moment because of the principles inherent in it.

The contract establishes a special relationship between the Department of Public Health of the Commonwealth of Massachusetts and the Technical Cooperation Administration, with particular reference to the Point 4 health program in Pakistan. The contract, in its preamble, recognizes the fact that the personnel and facilities of the Department of Public Health of Massachusetts are particularly well suited for participation in the activities contemplated under the program for the improvement of public health and sanitation in a relatively underdeveloped country. The Commonwealth on its side recognizes, in the preamble, that its personnel under such an arrangement will gain invaluable training and experience in work abroad.

Article I of the contract defines the functions of the Department of Public Health of the Commonwealth as follows: (1) To make available the ability and services of the Commissioner of Public Health as Chief Consultant to the Government of Pakistan and to the Technical

Cooperation Administration in the development of cooperative programs of public health in Pakistan. (2) To make available the abilities and services of such specialized personnel of the Department of Public Health as the Commissioner may consider advisable, who may serve as additional consultants. (3) To be responsible in cooperation with the appropriate officials of the Government of Pakistan or other participating countries and the Directors of U.S. Technical Cooperation in such countries for the planning of cooperative programs for the development of public health. (4) To endeavor to provide, as expeditiously as is practical, technicians to perform services as the needs of the cooperative public health and sanitation programs in Pakistan or other participating countries require and as requested by the Technical Cooperation Administration. (5) To assume responsibility for participating in the selection of candidates for Technical Cooperation Administration grants for training.

Certain funds are transferred to the Commonwealth of Massachusetts in order to enable it to carry out these functions.

It is important to notice that this contract sets up a partnership between the Technical Cooperation Administration and the Commonwealth of Massachusetts, Department of Public Health--a partnership dedicated to assisting a specific country through a cooperative program. The State will have a major voice in the form that such a program might take. It will give intellectual leadership, stimulation and direction. Staffing will be only a part of the job. Under such a contract State personnel can be assigned to foreign duty without loss of rights within the State service. Such personnel can continue to grow under the leadership, direction, and observation of the State Commissioner of Health.

The contract is not so rigid as to exclude other methods of employment. Particularly, when it is advantageous to do so, the personnel may be commissioned in the Reserve Corps of the Public Health Service. Whether in the employ of the State or commissioned in the Public Health Service, personnel when on assignment to the foreign country will work as an integral part of the Point 4 Mission to the country, receiving technical stimulation, guidance, and leadership from the State Health Officer in close conjunction with the TCA and the Division of International Health of the Public Health Service.

A contract such as that which has been entered into with Massachusetts may be applicable in the case of other States desiring to participate in this program. In some States quite a different pattern might be required. It has been suggested that in certain States it might be desirable to establish a new, separate entity of government under the State health officer. In a number of States specific legislation may be required in order to provide for leave of absence or to encompass service abroad within the framework of State service. In the "cold war" in which we are now engaged it is appropriate that the equivalent of military leave be given for service in Point 4, which is indeed the front line in the "cold war"

It is not possible at this meeting to explore the various relationships of the States to the Point 4 program. The matter needs to be explored on a State-by-State basis because of the variations in State legislation and resources available.

The interest shown by many of you now and earlier, and particularly the adoption of the resolution yesterday, would seem to constitute an invitation for the Technical Cooperation Administration and the Public Health Service to explore with each of you individually your degree of interest, the extent of resources that you might mobilize, and the way in which each of you might play a part in this total program. You have indeed shown your good will and your interest. The burden now lies with us to approach you with intelligent, constructive proposals designed to strengthen your own services and programs while at the same time enabling you to play an active role and make a solid contribution to the international phase of the total health program.

I assure you that the TCA and the Public Health Service will jointly accept this invitation and, as rapidly as possible, take these matters up with you on a State-by-State basis to determine how we may, working together, make a total American effort in international health.

RECOMMENDATIONS

CONFERENCE OF

THE SURGEON GENERAL OF THE PUBLIC HEALTH SERVICE

AND

THE CHIEF OF THE CHILDREN'S BUREAU

WITH

THE STATE AND TERRITORIAL HEALTH OFFICERS

STATE MENTAL HEALTH AUTHORITIES

AND

REPRESENTATIVES OF STATE HOSPITAL SURVEY AND

CONSTRUCTION AGENCIES

December 11, 1952

Environmental Sanitation Committee

Chairman, Wilson T. Sowder, M. D., Florida
Vice Chairman, G. J. Van Heuvelen, M. D., South Dakota

Members

John T. Herron, M. D.	Arkansas
L. J. Peterson, M. S. P. H.	Idaho
Grady F. Mathews, M. D.	Oklahoma
Russell E. Teague, M. D.	Pennsylvania
George W. Cox, M. D*	Texas

Consultants

Public Health Service

Mr. Mark D. Hollis (Liaison)
Mr. Leonard M. Board
Mr. Vernon G. McKenzie
Mr. Carl E. Schwob
Mr. M. Allen Pond
Mr. Chris A. Hansen

The Committee's recommendations:

1. Uniformity in sanitary laws, ordinances, rules, and regulations

That the Public Health Service and the various State and Territorial departments of health continue their efforts to promote more uniformity throughout the nation in sanitary laws, ordinances, rules and regulations, including milk and food sanitation. While it is recognized that many differences in existing laws, ordinances, rules and regulations are due to regional differences in problems, there are some differences which have no sound basis.

2. College training facilities and educational standards

That the various State health departments, in cooperation with the Public Health Service and other agencies and organizations concerned, go on record favoring better and more plentiful college training facilities; and higher educational standards for the employment of sanitarians.

3. Raw garbage

That the Conference urge State and Territorial health departments to cooperate fully with the appropriate agencies in the several States and Territories to prevent the feeding of raw garbage to swine.

The Conference further requests the Public Health Service to continue research on control measures and to provide technical consultation to State health departments in furthering their role in this program.

4. Indices for evaluating sanitation programs

That the Public Health Service develop indices suitable for the evaluation of overall environmental sanitation programs.

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*Absent

5. Processing of poultry

That the States strengthen their State and local programs for controlling the hazards associated with the processing of poultry, including but not limited to such items as inspection for wholesomeness, and sanitation in storage, transportation, and retail sales; and, that the Public Health Service continue to apprise the State and Territorial enforcement agencies concerning progressive codes for conducting effective poultry inspection programs.

Federal Relations Committee

Chairman, Harold M. Erickson, M. D., Oregon
Vice Chairman, Herman E. Hilleboe, M. D., New York

Members

Clarence G. Salsbury, M. D.	Arizona	Daniel J. Hurley, M. D.	Nevada
C. L. Wilbar, Jr., M. D.	Hawaii	Russell O. Saxvik, M. D.	North Dakota
Felix J. Underwood, M. D.*	Mississippi	R. B. Aiken, M. D.	Vermont
(Dr. J. A. Milne represented	Mississippi)	A. J. Chesley, M. D.	Minnesota

Consultants

Public Health Service	Children's Bureau
Dr. Jack C. Haldeman (Liaison)	Dr. Katherine Bain
Dr. David E. Price	Mr. John C. McDougall
Dr. Aaron W. Christensen	Dr. Arthur J. Lesser
Dr. Raymond F. Kaiser	Mrs. Elizabeth H. Ross
Mr. Sam A. Kimble	

The Committee's recommendations:

1. Amendments to Public Health Service regulations

That the amendments to Part 51 of the Public Health Service regulations, as proposed, be adopted.

2. Revision of State health plan document

That the trial period of the new joint Public Health Service--Children's Bureau State plan document be continued, as amended, in ten additional States and that its optional use be encouraged in other States. Further, it is recommended that a report from each health officer from the State in which the plan is used be furnished the Chairman of the Records and Reports Subcommittee of the Federal Relations Committee prior to the next annual meeting.

3. Categorical grant expenditures

That Public Health Service regulation 51.6 and Children's Bureau regulation 200.18, pertaining to validation of categorical grants, be repealed before July 1, 1953.

4. Consultation and assistance to States

That the Public Health Service and the Children's Bureau evaluate the present consultative services including the program review provided through regional offices.

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*Absent

5. Time limit on equipment

That the Public Health Service and the Children's Bureau be requested to administratively establish a time limit on the accountability of equipment purchased with grant-in-aid funds.

6. Progress report of Joint Committee on Public Health Service--Children's Bureau Records and Reports

That the report of the Joint Committee on Public Health Service--Children's Bureau Records and Reports be accepted with thanks, be approved as amended, and that the Committee be continued.

7. Use of grant funds in defense impact areas

That the Public Health Service continue its attempt to secure additional funds for the provision of public health services in defense impact areas, because of the additional burden placed upon public health services in these areas.

8. Audits

That the Federal Security Agency be urged to keep all Federal audits of State grants-in-aid current.

Hospital Committee

Chairman, Wilton L. Halverson, M. D., California
Vice Chairman, John J. Bourke, M. D., New York

Members

Walter E. Keyes	Florida	Foster L. Fowler	Mississippi
Roland R. Cross, M. D.	Illinois	Sanford Bates*	New Jersey
Walter L. Bierring, M. D.	Iowa	(E. A. Mooney represented	New Jersey)
Claude Harrison*	Louisiana	John A. Ferrell, M. D.	North Carolina
(E. R. Anderson represented	Louisiana)	Mack I. Shanholtz, M. D.	Virginia
Robert H. Riley, M. D.	Maryland		

Consultants

Public Health Service

Dr. John W. Cronin (Liaison)
Dr. Vane M. Hoge
Mr. Douglas N. West
Dr. John R. McGibony

Children's Bureau

Miss Mildred Walker
Miss Ruth Doran*

The Hospital Committee submits the following report for Conference action. It is recommended by the Conference of State Hospital Authorities:

1. Determination of need for hospital and health facilities

That a committee be appointed by the Surgeon General to include representatives of the American Hospital Association, the American Medical Association, the Association of State and Territorial Health Officers, and other interested groups, to work with the U. S. Public

*Absent

Health Service and the Federal Hospital Council in studying factors which should be re-examined as they relate to bed need ratios specified in the Federal Act, in the light of changing conditions of medical practice, length of patient stay, and other elements affecting need for hospitals and health facilities.

Further, that consideration be given to a policy of authorizing States, with approval of the Surgeon General, to experiment in the development of bed need ratios.

2. Distribution of Federal funds to States

That the U. S. Public Health Service re-study the basis on which Federal funds are allocated to States in anticipation of extension of the program beyond 1955, with particular reference to:

(1) Upward revision of the present State minimum allotment of $200,000 per annum.

(2) Amendment of Section 631(g) to require promulgation annually rather than bi-annually of States' allotment percentages.

3. Appraisal of facilities assisted under the Hospital Survey and Construction Act.

That the State Agencies and the Surgeon General place continuing emphasis on the appraisal of hospitals constructed under the program which have operated for one year or more to determine adequacy of community service they are providing, deficiencies in their physical plant, and their financial and operating success.

The Committee expresses appreciation of the preliminary report prepared by the U. S. Public Health Service, and requests that this report be made available to the members of the Conference.

4. Bed capacity of existing hospitals

That the United States Public Health Service be respectfully requested in cooperation with the official State hospital agencies, the American Hospital Association, the American Medical Association, the American College of Surgeons, the Association of Hospital Planning Agencies, and other interested agencies to develop uniform standards for measuring the bed capacity of hospitals.

5. Coordination of hospital and health facilities, services and resources

That the U. S. Public Health Service in conjunction with official State hospital agencies, health departments, medical and hospital associations, universities, medical schools, and other voluntary and official agencies, undertake studies to determine methods and means for the development of systems and patterns of coordination and regionalization of hospital and health facilities, services and resources, and that sufficient funds be made available, under existing authority, to make such studies possible. It is further recommended that State hospital agencies give impetus to the program.

6. Psychiatric facilities in general hospitals

That it reaffirm its stand that the facilities be available in all general hospitals for at least temporary care of mental patients.

Further, that the State agencies administering the Hill-Burton program place greater emphasis on meeting the needs for services for the mentally ill in general hospitals.

7. Hospital census of 1953

That the State hospital authorities and Association of Hospital Planning Agencies accept the invitation of the Bureau of Census to membership on the Committee to consider the proposal of a plan for a hospital census for 1953.

Infectious Diseases Committee

Chairman, Bruce Underwood, M. D., Kentucky
Vice Chairman, Franklin D. Yoder, M. D., Wyoming

Members

D. G. Gill, M. D.	Alabama
T. F. Sellers, M. D.	Georgia
E. A. Rogers, M. D.	Nebraska
Ben F. Wyman, M. D.	South Carolina
Roy A. Anduze, M. D.*	Virgin Islands

Consultants

Public Health Service

Dr. Justin Andrews
Dr. Dorland Davis
Dr. Theodore J. Bauer
Dr. Robt. J. Anderson
Dr. C. C. Dauer
Dr. James H. Steele

Children's Bureau

Dr. John M. Saunders

The Committee's recommendations:

1. A standardized agglutination test for brucellosis in human medicine

It is recommended that the Public Health Service secure the cooperation of the U. S. Bureau of Animal Industry in making the Bureau of Animal Industry brucella antigen for the agglutination test available for use in the diagnosis of human infection, and in developing appropriate means for its distribution. And be it further recommended that standard procedures be established for the interpretation of the results of the test as well as recommendations for its use.

2. Animal diseases spread to man

It is recommended that the Surgeon General of the Public Health Service take steps to coordinate the activities, at a national level, of all groups interested in veterinary public health to the end that there may be a better control of animal diseases which may be spread to man.

3. Antigens for serologic tests for syphilis

It is recommended that the Surgeon General of the Public Health Service be requested to reinvestigate the preparation, standardization, and control of antigens for serologic tests for syphilis and to ascertain what means may be employed for improving or stabilizing the quality of such antigens as may be distributed in this country.

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*Absent

4. Malaria

It is recommended that the malaria surveillance program, now being carried on by the Public Health Service and the several States and Territories, be commended and continued.

5. Psittacosis

It is recommended that the Surgeon General of the Public Health Service continue to study the entire problem of psittacosis in humans and the reservoirs of infection for this disease.

6. Rabies control

It is recommended that the Surgeon General of the Public Health Service stimulate efforts to obtain an improved rabies vaccine for human use. Be it further recommended that he ensure that work be continued to determine the effectiveness of vaccines for animal use.

7. Smallpox surveillance

It is recommended that accurate and detailed information on each officially reported case of smallpox be published in Epidemic Reports Section of the Weekly Morbidity and Mortality Report of the National Office of Vital Statistics.

8. Non-resident tuberculosis

It is recommended:

(a) That the States make every effort to take care of tuberculosis cases where they are found without regard to legal residence or settlement;

(b) That efforts be made to establish reciprocal agreements between the States for reimbursement for the care of tuberculosis patients;

(c) That the Surgeon General of the Public Health Service give consideration to the problem of cases of tuberculosis occurring outside the State of residence.

9. Encephalitis

It is recommended:

(a) That narrative epidemic reports for encephalitis be submitted by States to the National Office of Vital Statistics;

(b) That annual reports from States to N. O. V. S. indicate the cases as of primary or secondary origin.

10. Botulinus antitoxin

It is recommended that the Public Health Service take proper steps to alleviate the present shortage of botulinus antitoxin available for human use.

Maternal and Child Health Committee

Chairman, S. J. Phillips, M. D., Louisiana
Vice Chairman, G. D. Carlyle Thompson, M. D. Montana

Members

F. I. Hudson, M. D.	Delaware
Thomas R. Hood, M. D.	Kansas
Dean H. Fisher, M. D.	Maine
Albert E. Heustis, M. D.	Michigan
James R. Amos, M. D.	Missouri
Edward A. McLaughlin, M. D.	Rhode Island

Consultants

Public Health Service	Children's Bureau
Dr. Thomas L. Hagan	Dr. Lucille J. Marsh (Liaison)
Dr. C. Mayhew Derryberry	Dr. John T. Fulton
Dr. Halbert L. Dunn	Miss Ruth Taylor
	Miss Helen Stacey

The Committee's recommendations:

1. Convalescent care of adolescent children

That the State and Territorial Health Officers Association direct the attention of the Children's Bureau, National Institute of Mental Health, and other interested health agencies to the need for increased attention to the physical and mental health problems of adolescents.

2. Maternal and child health care in Federal hospitals

That the Public Health Service and the Children's Bureau work cooperatively with the Department of Defense and the Indian Service of the Department of the Interior toward the adoption of established standards of nursery and maternity care in all Federally operated hospitals.

Mental Health Committee

Chairman, J. W. R. Norton, M. D., North Carolina
Vice Chairman, Joseph E. Barrett, M. D., Virginia

Members

Frank F. Tallman, M. D.	California
Stanley H. Osborn, M. D.*	Connecticut
(Dr. E. J. Marsh represented Connecticut)	
M. A. Tarumianz, M. D.*	Delaware
Daniel L. Seckinger, M. D.	District of Columbia
Fred K. Hoehler*	Illinois
Juul C. Nielsen, M. D.*	Indiana
Wilbur Miller, M. D.	Iowa
Edward D. Grant*	Louisiana
(Mr. E. R. Rogillio represented Louisiana)	
Jack R. Ewalt, M. D.*	Massachusetts
(Dr. Peter B. Hagopian represented Massachusetts)	

*Absent

Charles F. Wagg	Michigan
Jarle Leirfallom*	Minnesota
(Mrs. Constance Carlgren represented Minnesota)	
R. J. Spratt, M. D.*	Montana
Anna L. Philbrook, M. D.	New Hampshire
Newton J. T. Bigelow, M. D.*	New York
(Dr. R. C. Hunt represented New York)	
John L. Lamneck*	Ohio
William C. Brown	Pennsylvania
Edward P. Reidy*	Rhode Island
W. P. Beckman, M. D.	South Carolina
John W. Tramburg*	Wisconsin

Consultants

Public Health Service

Dr. James V. Lowry (Liaison)
Dr. Curtis G. Southard
Mrs. Alice Spillane
Dr. Paul Stevenson

Children's Bureau

Miss Doris Siegel
Dr. Harold E. Mann*

Johns Hopkins University

Dr. Paul Lemkau

The Committee's recommendations:

1. Alcoholism

That the appropriate State and Territorial agencies develop programs directed toward the problem of alcoholism and coordinate such programs with the activities of other State and local organizations. Further, that the Public Health Service provide increased support for training institutes and meetings for the exchange of scientific and program information on alcoholism.

2. Annual statistics on psychiatric outpatient facilities

That methods be developed for obtaining statistics on the preventive activities, care, and treatment provided in psychiatric outpatient facilities and, when such methods are developed, information be compiled on an annual basis, and we wish to commend the work already begun on this.

3. Mental health education for the general public

That mental health programs should include mental health education activities for the general public both directly and through the education of special groups such as physicians and teachers.

4. Rehabilitation services

That State and Territorial health departments, hospital survey and construction agencies, and mental health agencies use their resources to encourage the planning and development of adequate services and facilities for community-wide rehabilitation programs;

*Absent

That such action be taken in cooperation with State and local rehabilitation agencies, hospitals, private physicians, and other community agencies and resources;

That such action be directed toward:

(a) The development of rehabilitation services in general, chronic disease, tuberculosis, and mental hospitals;

(b) The establishment of pilot studies or demonstration projects to develop and improve techniques for the physical and emotional rehabilitation and readjustment of disabled persons;

(c) The incorporation of rehabilitation principles and methods in all training and refresher courses for professional health personnel;

(d) The improvement and extension of coordinated planning and action of all available community resources.

5. Increased State funds for mental health

That increased funds be made available to the States and Territories in order to meet the needs of program development.

6. Training and training programs

That there be increased emphasis on:

(a) Further development of activities to train mental health personnel in the field of public health and of public health personnel in mental health;

(b) Training to facilitate recruitment of mental health personnel; and

(c) Training schools for mental health personnel.

Special Health and Medical Service Committee

Chairman, J. A. Kahl, M. D., Washington
Vice Chairman, C. Earl Albrecht, M. D., Alaska

Members

John Samuel Wheeler,* M.D. (Dr. L. G. Jacques represented New Hampshire)	New Hampshire
James R. Scott, M. D.	New Mexico
Juan A. Pons, M. D.*	Puerto Rico
George A. Spendlove, M. D.	Utah

Consultants

Public Health Service

Dr. J. O. Dean (Liaison)
Dr. John W. Knutson
Dr. Arnold B. Kurlander
Dr. Seward E. Miller*
(Dr. Dale Cameron represented Dr. Miller)
Dr. C. J. Van Slyke*

Children's Bureau

Dr. Betty Huse
Miss Edith Baker
Miss Clara Arrington
Miss Marjorie Heseltine*

*Absent

The Committee's recommendations:

1. Migratory labor

That the Public Health Service and the Children's Bureau continue to explore with other departments of the Federal government, State health departments, and other groups concerned with this problem to determine the responsibilities of Federal, State, and local government in improving the health status of migrant workers and their families.

2. The aging population

That the Public Health Service, in cooperation with other interested groups, study the needs of our aging population, particularly in respect to chronic disease hospitals, nursing home service, and general medical care, including home care.

Further, that the various States be provided with information concerning standards for institutions needed, including equipment, staff, and program organization.

3. Chronic disease program

That the State and Territorial health officers request the Public Health Service and other interested agencies to continue to study the community planning and the community organization structures for such chronic disease programs for adults as cancer, heart disease, diabetes, and weight control, and make recommendations to the respective States concerning such program development and organization.

Further, that the Public Health Service evaluate the usefulness, the tests included, and the costs of multiple screening in the chronic disease program.

4. Radiological health

That the State and Territorial Health Officers Association, recognizing the need for proper protection against ionizing radiation, urge further study in the field of radiological health activities so that the States may be advised as to the type of program recommended to provide necessary individual and community protection against ionizing radiation.

SUBJECT INDEX FOR COMMITTEE RECOMMENDATIONS

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