The Health Bulletin

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Tooth decay can be drastically reduced by adding a trace of fluoride to public drinking water—that has been proved. Yet a small but zealous band of opponents has managed to deny 40,000,000 children the benefits of this safe, simple protection.
What's holding up fluoridation?


For more than ten years now, every community in the United States has had the means to give lifelong protection to its younger citizens against a universal, costly, painful and disfiguring health problem—tooth decay.

For that period, the scientific world has been in agreement that adding a trace of fluoride to public drinking water (one part fluoride to 1,000,000 gallons of water) positively reduces tooth decay by as much as two-thirds; that at a cost of only about a dime a year per person it is economically feasible; and that it is absolutely safe.

These facts have been proved beyond scientific dispute by more than 30 years of careful, objective evaluation of evidence collected from all over the world—proved, that is, everywhere except in the public mind.

After ten years of certainty, only 2,000 communities with a total population of 38,000,000—out of a possible 20,000 communities with more than 125,000,000 in population—have accepted fluoridation of the water supply. (Another 7,000,000 persons live in areas where the water supply naturally contains protective amounts of fluoride.)

After ten years, in city after city across the country, parents, doctors and public health officials interested in bringing better teeth to tomorrow's adults are being stymied in their efforts to get fluoridation programs adopted.

This failure to accept fluoridation is costing dearly. For example:

► More than 97,000,000 people in the nation have decayed teeth requiring treatment, and another 21,000,000 have lost all of their teeth.

► The average high school graduate has ten teeth attacked by decay.

► The national dental bill, even though a third of the population never goes to a dentist, totals around 2.4 billion dollars annually, or an average of $44 per family.

Of course, fluoridation cannot eliminate all dental bills or all dental ills. Nor can it remove the necessity for such additional dental health practices as good diet, conscientious brushing and regular visits to the dentist. It has been repeatedly proved, however, that drink-

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GIVE ME A CHANCE TO HAVE SOUND TEETH
Grandma Says It's Time To Start
What's Holding Up

(Continued from page 2)

ing fluoridated water through childhood can reduce tooth decay by as much as 65% and that this benefit lasts throughout life.

Why, then, with so much to gain, don't more cities institute fluoridation programs? Why do citizens so frequently vote against fluoridation when they have a choice in a referendum? Why should there be so much controversy over putting into practice a medical fact? Who opposes fluoridation—and why?

The uproar—what it's all about

Fluoride is a natural substance that is found in varying amounts in all drinking water and in many foods. It would be next to impossible to live without ingesting some fluoride, but it appears naturally in such small amounts that most people get very little.

In late 1930 it was discovered that in communities where the fluoride content of water was high, tooth decay was astonishingly low. Unfortunately, only a few areas had enough natural fluoride in their drinking supply to do the trick. In 1945, after 15 years of intensive study, it was decided to add sufficient fluoride to the drinking water of several cities (the first were Grand Rapids, Mich., Newburgh, N. Y., and Brantford, Ontario) to bring the level of the chemical up to one part per million gallons (1 ppm).

By 1951 and 1952 it has become apparent that the plan worked even better than anyone had dared hope. Tooth decay did decrease in fluoridated cities. In Grand Rapids, for instance, these were the results:

• 65% less tooth decay in children who drank fluoridated water from birth;
• 45% less decay in children who were 5 or 6 years old when the program started;
• 20% less decay in those who were teen-agers.

Endorsements of fluoridation for all cities from a public health measure began coming from the cautious scientists. By now every major scientific group with any interest in the subject has added its approval—the U. S. Public Health Service, the National Institute of Dental Research, the American Medical Association, the American Dental Association, the American Academy of Pediatrics, the American Association of Public Health Dentists, the American Public Health Association, the American Association for the Advancement of Science, the National Academy of Sciences-National Research Council, the American Cancer Society, the American Pharmaceutical Association and scores of others.

Non-scientific groups have also supported the movement. The National Congress of Parents and Teachers, the American Legion, many chambers of commerce, the AFL-CIO, the Child Study...
Association of America and the U. S. Junior Chamber of Commerce are among them. Individuals from Dr. Benjamin Spock, the famous pediatrician, to Dr. Louis I. Dublin, one of the nation's leading statisticians, have urged communities to go ahead with the program.

At first, the idea spread rapidly, and towns and cities all over the country began the work of insuring stronger teeth for their children. Two-thirds of all the big metropolitan areas have fluoridated water. Among them are Chicago, Baltimore, Philadelphia, St. Louis, San Francisco, Pittsburgh, Milwaukee, Houston, Buffalo and Minneapolis. The U. S. Congress, which twice has heard antifluoridationists speak their piece in formal hearings, some years back quietly fluoridated the water of the city it governs, Washington, D. C.

For the last eight years or so, however, fluoridation has been steadily losing ground to the strident objections of a small but highly persuasive group of opponents. In elections in the fall of 1960, for instance, citizens of 35 municipalities voted on fluoridation referendums. In 29 of these 35 towns and cities, they voted the proposal down. In a number of communities that have had fluoridated water supplies for some time, opponents have succeeded in getting programs stopped.

Wherever the issue comes up these days, there is bitterness, name calling, smears, hate campaigns, wild charges and counter charges, distortions and outright lies. Before it is all over, there is likely to be rancor between friends and neighbors, division within civic and social clubs, professional organizations, even scientific groups.

The movement to put fluoridation into a town may start with a favorable report and a recommendation to the city government by its local public health director. It may (and very often does) begin with a request to the city fathers from the PTA. The Junior Chamber of Commerce may be the instigator or the Rotary Club or an American Legion post.

No matter who starts the movement, the deluge is soon on. Any local opposition is instantly reinforced by help from outside the city. The governing body is pressured to kill the whole idea. If that maneuver fails, it is practically forced to put the issue to a vote of the people although most governments have the power to decide public health matters just as they have the power to establish fire departments. When an election is called, an acrimonious campaign is bound to ensue, and through a combination of factors the opposition all too often wins.

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LET'S SAVE OUR CHILDREN'S TEETH

BY ARTHUR S. FLEMMING

Contributing Editor of Good Housekeeping
Former Secretary of Health, Education and Welfare

Dental decay can be prevented by fluoridated water drunk from infancy. But a militant and misguided minority contrives to fight this forward progress

Arthur S. Flemming, now president of the University of Oregon, has, since 1939, served in the administration of three American Presidents — Roosevelt, Truman and Eisenhower. From 1958 to 1960 he was Mr. Eisenhower's Secretary of Health, Education and Welfare. Once an editor and newspaperman, he is also former president of Ohio Wesleyan University. He is the father of five children including one pair of twins.

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Let’s Save Our Children’s Teeth

Millions of our nation’s children are being needlessly denied the benefits—now and in later years—of healthy teeth.

No more tragic—or inexcusable—situation was called to my attention during the two and a half years I served as Secretary of Health, Education and Welfare.

Dental decay is the most prevalent of all diseases. It is a heavy national burden—painful, disfiguring and costly. More than 97 million people in the United States have decayed teeth requiring treatment. The average person has ten teeth attacked by decay by age 18. More than 21 million persons have lost all of their teeth. Family dental bills total $2.4 billion annually, in spite of the fact that only 40 percent of the population seek dental treatment.

It isn’t necessary for the nation to carry this heavy burden. Most dental decay can be prevented. More than 30 years of scientific research has proved that fluoridated water, drunk from infancy, prevents two of every three cavities in children’s teeth and, moreover, that it continues to be effective through life.

This same research has proved beyond question that fluoridation, namely, the controlled addition of fluoride to water supplies, is completely safe.

As of January 31st of this year, 1,698 communities, with a combined population of 38.5 million people, were using water to which there had been added small amounts of fluoride—a chemical compound formed by the combining of the element fluorine with another element, such as sodium or calcium. In addition, seven million people in 1,903 communities drink naturally fluoridated water. And so, children in just under 4,000 communities are being provided with the benefits of one of our major break-throughs in the field of dental health.

Children in approximately 14,000 communities using central water supplies are being denied these benefits.

Since 1952, when 378 communities adopted fluoridation, the number giving their approval to this dental-health measure has declined annually, until in 1960 only 90 communities approved its initiation. The voters in 22 communities voted on the issue on November 8, 1960. Only six voted affirmatively, and (Continued on page 14)

The school dentist finds fewer cavities in the teeth of children who have had the benefits of fluoridation.
What's Holding Up
(Continued from page 5)

Who the opponents are

Ten or fifteen years ago, there was some genuine disagreement among scientists about whether fluoridation was absolutely safe, whether it would actually work, whether alternative methods of putting fluoride into the diet might be better. Now the evidence is in, and these questions are no longer disputed except by a few die-hard physicians and dentists and by a loud group of laymen who are confirmed "aginners." The dissenters have been classified in this manner:

1. Professional hatemongers who see fluoridation as an evil and subversive plot conceived by such diverse culprits as the Public Health Service, the American Medical (or Dental) Association, the Jews, the United Nations, the politicians, the Communists or "the Capitalists" to weaken people's minds and destroy their reasoning power.

2. Health-food enthusiasts and people dedicated to drugless therapy. Sellers of "nature" foods and pills, such as the Rev. Andrew G. Rosenberger of Boston, Dr. Royal Lee of Milwaukee and E. H. Bronner of Los Angeles are in the group. So are the writers of books and publishers of magazines and pamphlets on "natural" diet, such as J. I. Rodale of Emmaus, Pa., (who is best known for espousing organic gardening) and Dr. C. T. Betts of Toledo, Ohio, (who has spent a lifetime trying to convince people that aluminum cookware causes cancer). Included also are many chiropractors and naturopaths. Finally, there are people like the Christian Scientists who sincerely think that fluoridation of drinking water is medication and therefore runs counter to their religious beliefs.

A good many of the groups to which these people belong are (or have been) against other public health measures, such as chlorination of water, all immunization and vaccination, pasteurization of milk.

3. Physicians and dentists who may have any one of a number of reasons for opposing fluoridation. Some still honestly disagree with the overwhelming weight of fact and judgments of their colleagues. Some jump on the antifluoridation bandwagon in order to gain notoriety. Some dislike the organizations favoring fluoridation and use the issue to bludgeon their "enemies." Some see the "socialized medicine" bugaboo in the measure even though their professional organizations do not.

Probably the best known of the professional men—persons who are cited by antifluoridationists as authorities and sometimes travel for the cause—

Dr. E. A. Pearson, Jr., director of the Oral Hygiene Division of the State Board of Health, is seen on a visit to a third grade to stress good dental health practices.
are these: Dr. Leo Spira, who is convinced fluorides cause chronic poisoning; Dr. Frederick B. Exner, a prominent radiologist of Seattle, and Dr. George L. Waldott, an allergist of Detroit (these two physicians coauthored the book that is the bible of the opposition); Dr. Paul Manning, a dentist from Springfield, Mass.; and Dr. A. B. MacWhinnie of Seattle, also a dentist.

4. The rugged individualists, who see fluoridation as an invasion of the individual's rights. The archconservative John Birch Society is said to take credit for defeating fluoridation in Council Bluffs, La., and Alameda, Cal.

What they say

"Fluoridation," stated the writer of a letter to one town's newspaper during a referendum battle, "is unpleasant, unnecessary, unscriptural, unnatural, unscientific, unconstitutional, unlicensed, unlawful, unprofitable, unhealthful, unjustifiable and unpardonable!"

Which pretty well sums up the position of those who oppose fluoridation.

Last year the University of Michigan's School of Public Health published a list of antifluoridationist objections and an appraisal of their validity. The objections, printed in index form, filled five oversized pages.

A major objection has always been that fluoride is a poison. It is a poison—in the same sense that table-salt (chloride) is a poison. Taken in excessive amounts, either could cause illness or death. Most foods and water contain, however, some fluoride, and it is considered a nutrient like phosphorous and calcium. Some 7,000,000 persons have drunk fluoride (often in quite high amounts) with their untreated water all their lives, but studies of thousands of them show no adverse cumulative effect on general health.

Yet, the Michigan survey found that opponents to fluoridation have cited more than 100 different disorders supposedly caused in human beings or animals by fluoride. The ailments included cancer (the American Cancer Society says that there is no evidence of any relation between fluoride and cancer), ulcers, diarrhea, constipation, liver disease, kidney troubles, tuberculosis, sinusitis, heart disease, leukemia, hemophilia, neuroses, psychoses, stammering, loss of memory, nail biting, poliomyelitis, multiple sclerosis, cataracts, glaucoma, color blindness, goiter, diabetes, sterility, acne, boils, athlete's foot, baldness, brittle nails, brittle bones, arthritis, rickets, poor posture, flat feet, increased tooth decay, periodontal disease, malocclusion, abortions, stillbirths, prematurity of birth, tonsillitis, left-handedness, loss of hearing and allergic manifestations.

The only disorder that can, according to all present medical knowledge, be caused by ingesting fluoridated water is the mottling of teeth. This happens in communities where water naturally contains too much fluoride; it never happens where the fluoride content is

Let's get a drink of water—Daddy says it's fluoridated now.
controlled, as it is in all city fluoridation programs at 0.7 to 1.2 parts per million.

In addition to specific diseases the survey found 46 other objections involving fluoride's toxicity. They range from the possibility that there may be important variations in individual tolerances to fluoride to such outrageous assertions as the charge that the grade of fluoride used in water contains arsenic.

Other objections are that commercial activities like ice-manufacturing, food-processing and beer-making are adversely affected when fluoridated water is used (there are no such problems); that fluoridation is too expensive and is wasteful because only a small proportion of a city's water is used for drinking (on the contrary, doing without fluoridation is expensive, and separate water systems for treated and untreated water would be the wasteful procedure); that adding fluoride is a big problem to engineers at the water works (it is no more of a problem than adding chlorine); that the value and safety of fluoridation has not been proved (no other proposed public health measure ever has had such soundproof or such widespread approval by scientists).

The supreme courts of numerous states have passed on the legality of fluoridation, and the U. S. Supreme Court has refused to review their decisions. Still the opponents often claim interference with human rights. A favorite ground is that fluoridation constitutes compulsory medication. Actually, proponents reply, fluoride is a normal constituent of food, and adding it to the water supply in correct amounts is no more medication than adding nutrients to white flour. Besides, it's a preventive, not a curative, measure.

If all else falls on deaf ears, the antifluoridationists claim that better ways of administering fluoride exist, such as the use of fluoride tablets (which would cost about $2.50 a year per child and are tedious to use) or the application of fluoride directly to the teeth (which costs about $20 for each series of treatments and reduces decay only 40%).

A host of other objections are encountered—many of them the sort that are hard to answer in nontechnical language. The net result is to confuse, befuddle and cast doubt and fear in the minds of the electorate, which is likely to be somewhat apathetic about tooth ills at best.

I. D. Bartlett, chief chemist, Public Utilities Department, City of Raleigh, is shown taking a daily sample of water for analysis to determine the fluoride content.
If it happens in your town

In too many places in the past, proponents of fluoridation have been helpless to counter effectively the attacks of the opposition. Local dental societies and individual dentists and physicians have been less than forward because of their fear of "mixing in politics." Ammunition, such as pamphlets to distribute, has been scanty.

These things are still true, unfortunately, but there is beginning to be more hope. Particularly, dentists are being urged by their professional association to stand up and fight. The American Dental Association is becoming more and more active in preparing and distributing information to local groups. In addition, most state public health services will help organize fluoridation programs in communities, and the U. S. Public Health Service will provide written material.

If fluoridation fight is in the offing in your community and you are involved, remember that all the proponents in town must be mustered into the fray, their backs stiffened and their luke-warmness heated.

You can expect an arduous, hard-hitting, no-holds-barred campaign. There is nothing polite about most battles for fluoridation, but most people who think about it figure their children's and grandchildren's teeth are worth the struggle.

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**Status of Fluoridation In North Carolina**

**Fluoridated**

36 towns with population of 1,005,418.

**Natural Fluoride Content**

17 towns with population of 36,142.

North Carolina has a total population of 4,556,155. Of this number 1,801,921 persons (39.5%) are in urban communities and 2,754,234 persons (60.5%) are rural. Percentage-wise, 57.8% of the urban population is drinking fluoridated water.

In 1961 three towns were added to the growing list of towns which are fluoridating their public water supplies.

Towns currently working toward fluoridation are: Chapel Hill, Mt. Pleasant, Burlington, Cornelius, Elizabethtown, Graham, Jackson ville, Morganton, Leaksville, Marshall, North Wilkesboro, Rutherfordton, Tryon, Troy, and others.

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W. J. Stevenson, district engineer of the State Board of Health, is shown with P. G. Lankford, chief operator, Public Utilities Department, City of Raleigh, checking the settings to make sure the machine is applying the correct amount of sodium fluoride to the water leaving the plant. Constant supervision is maintained.
These Towns Could Fluoridate

Towns with Water Sources and Treatment Facilities Suitable for IMMEDIATE Installation of Fluoridation Equipment

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The towns listed above have (1) Filtration facilities, (2) Laboratory facilities, and (3) Acceptable personnel to immediately fluoridate their public water supply. Other towns across the State could improve their facilities and fluoridate their water supply also. Many towns not on this list are making progress toward fluoridation.
Children learn good dental health practices from Little Jack and his Puppet Show. It takes about three years for the show to visit all the elementary schools in the State. Presenting the show this year are (in the bottom picture) Melissa Bassler (left) and Alice Pohl, both of Raleigh.
Let's Save
(Continued from page 7)

16 turned it down.

There are two reasons for this discouraging trend.

First, far too many citizens are refusing to take time to become acquainted with the facts.

Second, as a result, positive action in one community after another is being blocked by those who appeal primarily to the fears and prejudices of an uninformed electorate. This is not true of those who oppose fluoridation as a matter of principle—a principle that is oftentimes related to their religious beliefs. I respect the views of such persons, even though I cannot agree with them. I do not respect, however, the views of those who, whatever their motivation, distort facts and arouse fears and by so doing help to undermine the nation's health.

The situation calls for crusaders in the 14,000 communities where children are denied the benefits of healthy teeth.

These crusaders must first of all become acquainted with the facts that make fluoridation a "must."

—They must know that the American Dental Association, the American Medical Association, the United States Public Health Service, the American Association for the Advancement of Science—and virtually all other scientific and professional organizations that have probed into the matter—have recommended fluoridation of water supplies.

—They must know that the protection afforded by fluoridation costs only a few cents per person per year.

—They must know that controlled fluoridation does not mean adding a foreign substance to water. All water contains some fluoride. Fluoridation of water simply means

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THE HEALTH BULLETIN

January, 1962
controlling the amount of fluoride in a public water supply.

-They must know that even water containing as much as eight times the amount of fluoride recommended for the prevention of tooth decay does not injure a person's health. My opposition to adding substances to food or water that may prove to be injurious to health is well known. In this instance, however, I am convinced, after becoming acquainted with the relevant evidence, that fluoride in water in small amounts, rather than being injurious to health, is needed to prevent disease.

-They must know that one city after another can point to dramatic results following the fluoridation of their water supplies. Newburgh, New York, after fifteen years of fluoridation, reports that their children have about 60 percent fewer cavities than children without fluoride in the neighboring city of Kingston, my home town. The Public Health Director of Grand Rapids, Michigan, states that 15 years' experience in fluoridating water has led to the conclusion that children have considerably fewer cavities and fewer extractions, and their teeth are firmer and more attractive. The mayor of Philadelphia reports that "after just four years of fluoridation, our six-year-olds have 50 percent fewer cavities and 43 percent fewer extractions." In Washington, D.C., after eight years of fluoridation, the Health Department, on the basis of 9,820,403 examinations, has found that tooth troubles in children have been reduced by as much as 60 percent.

Crusaders for fluoridation must also take time to know their opposition.

-They must leave no stone unturned to determine whether those who oppose fluoridation are really experts. At times they will discover that such persons have no professional competency. They will also discover that these are persons who have been in trouble with the Food and Drug Administration because of their willingness to place economic interests ahead of health interests.

-They must determine whether the opponents belong to that group of persons who continually try to discredit medical science and legitimate public health progress.

-They must demand proof for unsupported charges that scientists and public officials have been "bought" by those who manufacture the chemicals and machinery used in the fluoridation process, that it is a step in the direction of socialization, and that it is "mass murder."

Those who are willing to enlist in such a crusade will reap gratification from the knowledge that positive steps have been taken to provide children with healthy teeth—now and in later years—and that they have helped to prevent needless pain, disfigurement and ill health.

Fluoridation of water supplies provides us with a real test. An informed and aroused citizenry can see to it that the test is met successfully. They can make sure that forward progress in the health field is not blocked by a misguided but militant minority. They can open up new horizons of health and happiness for millions of children.
N. C. Junior Chamber Favorable

The Board of Directors of the North Carolina Junior Chamber of Commerce passed a resolution favoring fluoridation of public water supplies in every North Carolina community, and urging their local chapters to promote this modern means of dental health. More power to this fine civic group, and to the N. C. Parent-Teachers Association and other interested citizens sponsoring fluoridation across the state.

What date will your town fluoridate?

Will they see your name on the list of persons helping your town to get fluoridation?

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DATES AND EVENTS

Feb. 16-17, 1962—N. C. Assn. for Mental Health, Jack Tar Hotel, Durham.
April 24-26—N. C. Assn. of Nursing Homes and Homes for the Aged, Battery Park Hotel, Asheville.
April 24-25—N. C. Tuberculosis Assn., Jack Tar Hotel, Durham.
April 29 - May 1—N. C. Conference for Social Service, Hotel Sir Walter, Raleigh.
May 3-21—15th World Health Assembly, Geneva, Switzerland.
Every Saturday—State Board of Health Radio Program over WPTF (Raleigh) 7:30 P.M.
Perspective in Public Health

Service totaling 190 years was represented by six retired members of the Buncombe County Health Department recently as they gathered to receive Merit Awards in recognition of their achievements. Coke Candler (right) chairman of the County Board of Commissioners, presented the awards to (left to right): Dr. Margery J. Lord, 31 years; Henry O. Bealmeare, 27 years; Mrs. Maude Morgan, 33 years; Miss Mae McFee, 42 years; Mrs. Roberta Hyatt, 17 years; and Chester C. Demaree, 40 years. Dr. H. W. Stevens (rear), County Health Director, presided over the dual-purpose occasion. In addition to the awards, the retirement of Demaree was celebrated with a big cake. He also received several gifts from the department staff. Dr. Stevens’ comment was “I am very proud of my Public Health retired group with their 190 years of unselfish service to the citizens of Buncombe County. You never replace a man like Chester Demaree, you have to grow them.”
Prevention of Heart Disease

Talk given by Lewis Lunsford Jr., M.D., Asheville, N. C.
at Western N. C. Public Health Association, May 19, 1961

I have chosen several types of heart disease which are fairly common and in which prevention has been shown to be either practical and effective or of current interest to the general public.

The first type of heart disease that I would like to discuss is rheumatic heart disease. This, in my opinion, continues to be the golden opportunity for preventive medicine. Yet a large percentage of these patients are still not adequately treated.

Unlike most types of heart disease, rheumatic heart disease occurs in children and young adults and frequently handicaps them for the rest of their lives. Although statistics vary, I would like for you to consider these facts. Acute rheumatic fever occurs in from 1 to 3 people for every 1,000 in the general population. There are estimated to be 1,000,000 cases of rheumatic fever in the U.S. today. It is one of the most common of medical deaths in the age group between 5 and 19 years. And this type of heart disease can be prevented to a large extent.

As you know, acute rheumatic fever results from a sensitivity reaction to an infection caused by the beta hemolytic streptococcus. This infection is usually a streptococcal pharyngitis or "strep throat", but may be manifested as scarlet fever or some other form of hemolytic streptococcus infection. It is estimated that for every 100 children who have a hemolytic streptococcus infection, 3 will develop acute rheumatic fever. Although the joints are primarily involved in acute rheumatic fever, about 50% of the cases have some degree of heart damage and these patients have heart disease. The amount of heart damage that results from the first attack of rheumatic fever is usually not very great, but these patients are unusually susceptible to recurrent attacks of rheumatic fever. These attacks are triggered off by recurrent infections due to the hemolytic streptococcus. About 25% of children who have had rheumatic fever will develop a recurrence with each streptococcal infection. It is during these recurrent attacks of rheumatic fever that further heart damage occurs until some of these patients become cardiac cripples and completely incapacitated at an early age in life.

Now, what can be done to prevent this chain reaction of streptococcal infection leading to acute rheumatic fever and finally to rheumatic heart disease?

It is very difficult to prevent the first episode of rheumatic fever in most patients because the symptoms of the streptococcal infection may be so mild that they do not seek medical aid. However, once rheumatic fever develops, we know that that patient is prone to recurrent attacks. These can be pre-

(Continued on page 5)
Miss Carole Maxey (center), daughter of Mrs. Ann Painter, Nutrition Consultant, Guilford County Health Department, is shown upon receiving the title of "Miss Piedmont" during the Piedmont Festival. With Carole are: Miss America, Maria Beale Fletcher (right), and Miss North Carolina, Susan Kay Woodall.
Health Briefs

The North Carolina Legislature enacted legislation setting up the State Board of Health, February 12, 1877.

Plans for a Southeastern Conference on Aging, the first of four regional meetings initiated by the Joint Council to Improve the Health Care of the Aged, have been made by Heart Services of Charlotte in cooperation with the N.C. Medical Society and the American Medical Society. This conference will be held April 12-15 at the Hotel Charlotte, Charlotte, N. C.

George W. Dowdy, Chairman of the Greater Charlotte Occupational Health Council, will direct a group of 22 medical and business leaders scheduled as speakers and panelists at Charlotte’s Sixth Occupational Health Conference on March 29. The theme of the conference is “Health Maintenance for Greater Efficiency.”

E. B. Crawford, Jr., of N.C. Memorial Hospital of the University of North Carolina was inducted as a fellow in the American College of Hospital Administrators Sunday, September 24, at Atlantic City, N. J. He is married and is the father of three children. Crawford is the son of E. B. Crawford, Sr., who heads North Carolina’s Hospital Saving Association.

Surgeon General Luther L. Terry of the Public Health Service has announced that field trials for two types of measles vaccine have been started in some 5,000 children. The studies are being conducted by local health departments, in cooperation with the Service’s Communicable Disease Center, in DeKalb County, Georgia; Cincinnati, Ohio; Seattle, Washington; and in Rochester and Buffalo, New York.

A postgraduate course in obstetrics and pediatrics will be held March 13-15, 1962 at the Bowman Gray School of Medicine in Winston-Salem. The course is supported by the State Board of Health.

Two four-week summer courses will be sponsored by the U.N.C. School of Nursing in cooperation with the Extension Division of the University. “Nursing Care of the Patient With Long Term Illness” will be given June 11-July 6, 1962. “Psychiatric Nursing” will be offered June 11-July 7, 1962. Application for enrollment and further information may be obtained by writing the Extension Division, University of North Carolina, Chapel Hill, N. C.

A one-day institute on psychiatric nursing will be offered at the U.N.C. School of Nursing, May 9, 1962. This institute should be of interest to psychiatric and public health nurses, and all other nurses who work with emotionally ill persons.

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Editor—Edwin S. Preston, M.A., LL.D.
Vol. 77 February No. 2
February, 1962
HEART DISEASE
(Continued from page 2)
vented by simple, practical measures that are almost 100% effective.

The most important of these is the daily prophylactic administration of sulfa drugs or penicillin. These drugs will prevent streptococcal infections. The sulfa drugs or penicillin can be given orally in small doses twice a day, or if preferred, a long acting penicillin can be given intramuscularly every 3 to 4 weeks. Sulfa drugs are usually preferred for this aspect of prevention because they are both safe and less expensive than penicillin. This program should be continued until the patient is at least 30 years old and some authorities have recommended that it be continued indefinitely. Streptococcal infections will occasionally develop in persons on maintenance antibiotics. This, however, is usually due to failure to take the drug each day.

Therefore the second step in prevention of rheumatic fever is the prompt and adequate use of penicillin for streptococcal infections, principally sore throats. Although sulfa drugs are effective in prevention of streptococcal infections, they are of no value in treating these infections once they have become established and should not be used.

And finally it has been shown that most cases of rheumatic fever develop in the lower economic groups, especially those living in crowded environments such as slum areas in cities. Therefore every effort should be made to improve the living conditions of patients with a history of rheumatic fever as a means of preventing recurrent attacks. A well balanced diet is also important in this regard as studies have shown that children on a deficient diet are more susceptible to streptococcal infections. By these measures the incidence of severe rheumatic heart disease can be significantly decreased.

While we are on the subject of heart disease related to infection, I would like to mention another type of heart disease that isn't as common as rheumatic heart disease but is important in that it can sometimes be prevented by rather simple measures. I am referring to the congenital heart defects that are caused by German measles occurring during the first 3 months of pregnancy. Although not all congenital heart disease is caused by an infection of this virus, a significant percentage is. During the first 3 months of pregnancy, while the baby's heart is in the state of development, the mother should be careful to avoid contact with any suspected case of German measles. It is only during the first 3 months of pregnancy that German measles will cause congenital heart defects because after this the baby's heart has completely developed and is no longer affected by the virus of German measles. If the mother inadvertently becomes exposed during the first 3 months of pregnancy, then she should receive Gamma Globulin injections in an attempt to prevent contacting the infection. Also from this standpoint, it would be unwise to prevent female children from having German measles in childhood. This is due to the fact that an attack of German measles usually confers permanent immunity so that the possibility of developing German measles during pregnancy later on in life would be almost eliminated.

The discovery that Gamma Globulin will often prevent German measles, if given soon after exposure, has been a big help in preventing this type of heart disease.

I have left the most common type of heart disease until last because the prevention of arteriosclerotic heart dis-

February, 1962
THE HEALTH BULLETIN
ease, or that type caused by arteriosclerosis is much more difficult than rheumatic heart disease or the congenital heart disease that we have just discussed.

Now first of all, what is arteriosclerosis and how does it cause arteriosclerotic heart disease?

Arteriosclerotic is a degeneration of the lining of the arteries of the body with the deposition of fats and cholesterol in the damaged areas. These deposits form plaques in the inside of the vessel and gradually narrow the lumen, thus decreasing the amount of blood the vessel will carry. This process starts in the first year of life and gradually progresses throughout life in everyone. Although the process develops more rapidly in some people than in others. This narrowing of arteries throughout the body decreases the blood supply to many organs including the heart. When the blood supply to the heart is decreased below a certain level, then symptoms of heart damage or heart failure occur. This then is arteriosclerotic heart disease.

Now that we know what we are dealing with, can we prevent it? This is difficult for several reasons. First, the cause of arteriosclerosis is not completely understood. Although we understand what damage is done to the arteries, as I have just outlined, we don't know why this occurs and why it progresses more rapidly in certain people. This obviously makes prevention somewhat difficult. As all of you know, there is a definite relation between this type of heart disease and the amount of fats and cholesterol in the blood of most patients. Exceptions to this do occur, and some patients with severe arteriosclerotic heart disease and advanced arteriosclerosis have normal amounts of fats and cholesterol. Other patients with high cholesterol levels may have only slight involvement of their arteries. The real question is, does an increase in fats and cholesterol itself cause arteriosclerosis, or is some as yet unknown factor responsible for both the arteriosclerosis and the elevation of fats and cholesterol in the blood? At present the weight of evidence seems to indicate that an elevated cholesterol accentuates the development of arteriosclerosis although some experimental studies do not support this concept.

The second unanswered question is, can the serum cholesterol be lowered for a long period of time by the use of diet and drugs. Up until recently the available drugs were effective for only some months and the level of cholesterol would then gradually return to the pretreatment level in spite of continued treatment. Also many of the drugs now used have disagreeable side effects or other disadvantages that makes prolonged administration impractical. Several of the newer drugs appear to be more promising in this respect, but further evaluation is necessary before their true value can be determined. And the third and most important unknown in this problem is, will lowering the serum cholesterol delay or prevent the development of arteriosclerosis and arteriosclerotic heart disease. Obviously this point is most crucial in any program set up to prevent this type of heart disease by lowering serum cholesterol. Because of the slow development of arteriosclerosis these patients have to be followed for long periods of time before it can be determined whether treatment has beneficial effect. So far, adequate follow up studies are not available.

Many doctors however advise a diet that is low in saturated fats and cholesterol and high in unsaturated fatty acids with or without the use of drugs in an attempt to lower the serum cholesterol.

(Continued on page 10)
HEY DAGOOGWOOD HOW COME YOU HAVE SUCH A HAPPY FAMILY?

WELL, IT ISN'T EASY, HERB—HAPPINESS IS SOMETHING WE HAVE TO WORK FOR—WE ALL TRY TO UNDERSTAND EACH OTHER.

IT'S IMPORTANT TO UNDERSTAND YOURSELF, TOO—WE ALL HELP TO MAKE OUR OWN HAPPINESS—AND EACH OTHER'S, BUT OF COURSE NO ONE CAN BE HAPPY ALL THE TIME.

HELPING EACH OTHER COUNTS EVEN MORE WHEN WE'RE UNHAPPY.

DON'T FORGET, COOKIE, IF YOU UNDERSTAND PEOPLE IT MAKES A BIG DIFFERENCE OUTSIDE THE FAMILY TOO. IT HELPS IN EVERYTHING YOU DO.

COME ON, BLONDIE—WHY DON'T YOU SHARE YOUR SECRET WITH YOUR FRIENDS?

IT'S NOT THAT SIMPLE, TOOTSIE—THERE IS NO MAGIC FORMULA—BUT THERE ARE A FEW THINGS EVERYONE SHOULD KNOW....
MY MY—AREN'T YOU THE GROUCHY ONE!

GRR—THE BOSS HAS BEEN ON MY BACK ALL DAY!

YOU OUGHT TO KNOW BETTER THAN TO LET YOUR FEELINGS RUIN YOUR APPETITE—RELAX—DINNER'S READY!

AND YOU STOP PICKING ON ME, TOO!

THEY CAN EAT ALONE FOR ALL I CARE!

DAD, I NEED A DOLLAR...

DADDY...

SCRAM! BEAT IT! GET LOST!

GR-R
There are loose boards in the fence—take it out on them?

Yeah, dear! I got it out of my system.

Feel better?

BANG

BANG

You see, when humans get angry they can't always fight back, but it only makes things worse if they take it out on someone else!

Mr. Dithers was mean to Dagwood, so Dagwood was mean to his family—and everybody was miserable!

It always causes trouble to make someone a scapegoat!
This is done in the hope that the development of arteriosclerosis will be delayed.

The next aspect of prevention that I would like to discuss is the use of anticoagulants. This differs somewhat from the above measures in that it is used only after symptoms of heart disease appear. Anticoagulants tend to prevent the blood from clotting. This is beneficial because much of the mortality of arteriosclerotic heart disease is due to clots that form in the arteries of the heart that have become narrowed by arteriosclerosis. Anticoagulants tend to prevent these clots and thus help to maintain an adequate blood supply to the heart.

Numerous studies have shown that anticoagulants do in fact prolong the life and good health of patients with arteriosclerotic heart disease to a great extent. However, there is some risk involved in their use since they not only prevent blood from clotting in the arteries of the heart but also in all blood vessels throughout the body thus creating a sort of bleeding tendency. Numerous deaths have occurred in patients on anticoagulants due to uncontrolled hemorrhage, either spontaneous or following injury. However, if used wisely and under supervision, their benefits far out weigh their dangers.

Now what constitutes wise usage and adequate supervision. First the patient should be intelligent enough to follow the prescribed dosage schedule, since this must be individualized with each patient according to the results of a blood clotting test called a prothrombin time. This may sound ridiculous but I have been surprised at the number of patients who are unable to follow a simple program of alternating 1 tablet with 1/2 tablet each day. Under these circumstances it is impossible to maintain the blood clotting within a safe range and the drug should be discontinued.

Next it is necessary that the patient be able to have a prothrombin time at regular intervals at a reliable laboratory. It is necessary that these tests be done by a capable technician since it is not a simple test to perform.

And finally the patient must be immediately available by telephone so that he may be contacted promptly should it be necessary to change the dosage of the anticoagulant as determined by his prothrombin time. Also if spontaneous bleeding occurs he should be able to contact his physician without delay.

These requirements limit somewhat the use of anticoagulants in the prevention of arteriosclerotic heart disease.

Next I would like to make a few remarks about the value of exercise in prolonging the life of patients with arteriosclerotic heart disease. The main value of exercise is probably in increasing the size and number of blood vessels that supply the heart with blood. Thus, even though the arteries are narrowing by arteriosclerosis, the increase in size and number of arteries allow a sufficient blood supply to the heart.

Dr. Paul Dudley White, who obtained some national prominence even before he was President Eisenhower's physician during his heart attack several years ago, is responsible for bringing before the general public the value of exercise in prolonging life in patients with this type of heart disease. Through his efforts many large cities have constructed bicycle paths through their parks for this purpose. The exercise should not include strenuous exertion. Walking and bicycle riding are good examples of the type of exercise that is recommended.
And so it can be seen that prevention of arteriosclerosis and arteriosclerotic heart disease is not a simple matter at this time. Authorities disagree on the relative importance of each of the above measures and only time will give us the answers.

I have tried to present the current thinking on the preventive aspects of several of the more common types of heart disease. Some of these measures I have discussed are simple and convenient. Some involve a great deal of cooperation on the part of both the patient and the physician. Some have been proving effective beyond any doubt while others are only of questionable value. But as the saying goes "An ounce of prevention is worth a pound of cure."

'Twixt Cup and Lip

On April 10, 1961, Governor John A. Volpe, of Massachusetts, signed into law Chapter 340, Acts of 1961, "An act providing that in prosecutions for operating a motor vehicle while under the influence of intoxicating liquor, evidence of the percentage of alcohol in the blood of the defendant shall be admissible and create certain presumptions."

These presumptions are: "If such evidence is that such percentage was five one hundredths (0.05) or less, there shall be a presumption that such defendant was not under the influence of intoxicating liquor; if such evidence is that such percentage was more than five one hundredths but less than fifteen one hundredths (0.15), there shall be no presumption; and if such evidence is that such percentage was fifteen one hundredths or more, there shall be presumption that such defendant was under the influence of intoxicating liquor."

Under Chapter 340, a chemical test or analysis of breath to determine the percentage, by weight, of alcohol in the defendant’s blood at the time of the alleged offense may be “made by or at the direction of a police officer” only with the consent of the defendant. The defendant is afforded a reasonable opportunity to have another such test or analysis made by a person or physician selected by himself.

"Blood shall not be withdrawn from any such defendant for the purpose of any such test or analysis except by a physician." Evidence that the defendant failed or refused to consent to such test or analysis cannot be admitted against him in any civil or criminal proceeding.

Recognizing the appalling and agonizing fact that the automobile is a leading killer, and well aware that its toll can be prevented by intelligent legislation and by education of the general public to break down an apparent apathy, the medical profession has joined with safety councils and bar associations to fight this menace directly and practically. To the zealous workers for highway safety, the democratic process may at times appear as an annoying roadblock, preventing immediate and obvious solutions to tragic slaughter. The democratic process, however, prevents rash and police-state action and protects legal rights of an individual — rights that may at times seem to include the right to self-destruction behind a steering wheel.

Since 1957, the Massachusetts Medical Society’s Committee on the Prevention of Traffic Accidents has been wrestling with the problem of highway deaths and what preventive steps the medical profession can initiate, adopt or support.

Studies of surveys conducted here and abroad have demonstrated to the Committee, as well as to all actively
concerned with and involved in solving the problem, that the drinking driver may well be responsible for the majority of fatal accidents. If he is, the principal attack is obvious: the State and interested organizations must concentrate on removing the hazard of the drinking driver under due process of the law and through education. Promotion of installation and use of seat belts, annual physical examinations of licensees and reporting by physicians of persons with physical conditions that may hamper their driving ability—important as they are—appear secondary in importance to a solution that can solve half the problem directly and effectively. Chapter 340, strongly supported by the Massachusetts Medical Society, is a step in the right direction, and its immediate state-wide implementation is urged.

It is suggested, too, that the Legislature consider revision of the law, to provide, as do 9 out of 35 states with similar statutes, an “Implied Consent Provision.” Under this provision, a person by obtaining a license to operate a motor vehicle implies his consent to be tested should he be arrested for operating under the influence.

Judge Lawrence G. Brooks, presiding justice of the First District Court of Eastern Middlesex, in discussing Chapter 340 in the September, 1961, issue of the Boston Bar Journal refers to a ten-year study by Dr. S. R. Gerber that found the greatest number of killers at the wheel to be the so-called moderate drinkers.

This is a lesson to all of us—that we pay more than lip service to the injunction not to mix alcohol with gasoline, remembering that no man is a safe judge of his own condition when it comes to alcohol. Let us not forget the lament of Cassio after “one cup” too many—“O that men should put an enemy in their mouths to steal away their brains!”

RESOLUTION DEDICATING REDECORATED STATE BOARD OF HEALTH AUDITORIUM
HONORING JOHN H. HAMILTON, M. D.

In 1933 Dr. John Homer Hamilton became the second Director of the North Carolina State Laboratory of Hygiene. In 1942 he became Editor of The Health Bulletin and in 1951 was named Assistant State Health Director. He served in these relationships until his retirement April 30, 1960. Dr. Hamilton came to North Carolina in 1920 as New Hanover County Health Officer. In 1931 he came to the State Board of Health as Director of the Division of County Health Work and Epidemiology.

Prior to these North Carolina responsibilities, Dr. Hamilton served as Associate State Director, International Health Division, Rockefeller Foundation; as Associate Professor of Preventive Medicine and Assistant Director, State Public Health Laboratory, University of Iowa; and as Associate Bacteriologist, Division of Laboratories and Research, New York State Department of Health.

Dr. Hamilton is a native of Missouri. He received his undergraduate degree from Oklahoma Agricultural and Mechanical College, now Oklahoma State College. He is a graduate of the Harvard School of Medicine.

Concurrent with his work in public health Dr. Hamilton has held office in professional associations and been affiliated with various medical, public health and cultural organizations. His outstanding leadership in promoting the interests of the State Board of Health through building up the Laboratory Division and his contributions to the program and staff in other relationships are recognized with deep appreciation.

As an expression of this appreciation the State Board of Health formally dedicates the newly redecorated and refurnished Auditorium of the State Board of Health in the Laboratory Division in honor of Dr. Hamilton. Hereafter, by action of the State Board, this Auditorium shall be designated as the “John Homer Hamilton Auditorium”.

This designation seeks not only to recognize Dr. Hamilton’s leadership, patience, wisdom and kindness, but also serves to challenge and stimulate these same characteristics of dedication and unselfish service in the lives of all who serve in any capacity in public health in North Carolina.
September 29, 1961

J. W. R. Norton, M.D.                      Charles R. Bugg, M.D.
State Health Director                       President
Careers In Health Professions

Medicine (above) and Physical Therapy
Health careers were emphasized at a two day meeting in Winston-Salem, January 26-27. High school students from over the State were invited to attend this meeting. A unique campaign to end critical shortages of professional health personnel was initiated during this meeting with the formation of the Association of Health Career Clubs. Fourteen professional health organizations presented exhibits and personnel to familiarize the delegates with opportunities in the health field.

Dentistry (below) and Nursing
Dates and Events

April 13-15—Southeastern Conference on Aging, Hotel Charlotte, Charlotte.
April 12-13—Carolinas-Virginias Hospital Conference, Hotel Roanoke, Roanoke, Va.
April 24-26—N. C. Assn. of Nursing Homes and Homes for the Aged, Battery Park Hotel, Asheville.
April 24-25—N. C. Tuberculosis Assn., Jack Tar Hotel, Durham.
Every Saturday—State Board of Health Radio Program over WPTF (Raleigh) 7:30 P.M.

The Medical Society of the State of North Carolina has approved at the State level the recently announced Blue Shield National program for prepaid medical care coverage for the aged, according to an announcement by Dr. Claude B. Squires of Charlotte, President of the Medical Society. This action makes North Carolina one of the first states to sanction implementation of the national voluntary program extending provisions of surgical and medical care benefits for persons 65 and over.

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The President has designated the third week of March as National Poison Prevention Week. This year's observance will be March 18-24. This nationwide campaign to reduce accidental ingestions among young children is being sponsored by representatives of the medical and allied professions, industries and government and has been approved by the Advertising Council. These organizations feel that the public should be aware of a problem that involves approximately one-half million accidental ingestions and 456 needless deaths a year in children under 5 years of age. This number represents 5 times the number of deaths in this age group from polio and more than 7 times the figure due to nephrosis.
Learning to Trust


March 1962

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THE HEALTH BULLETIN
The Official Publication Of The North Carolina State Board of Health
To meet emergency conditions caused by the March storm on the East Coast, two engineers and seven sanitarians of the State Board of Health were assigned to Dare County to assist the local officials and citizens in clean-up work. Beginning their work on Sunday, March 11, particular attention was given to water supplies and checking food-handling and lodging places in an effort to get them open for business as rapidly as possible. Water samples were collected from private and public places and forwarded to the State Laboratory for analysis. Field test kits were prepared by Dr. Lynn Maddry of the Laboratory Division and transported to Manteo for use by staff in making quick chloride determinations. Reports indicate that progress is being made in cleaning up some of the hotels, motels and restaurants. Drinking water is being made available in paper cartons through the courtesy of the Maola Milk Company of New Bern. Daily reports are received from the personnel assigned to the area and plans are for them to stay as long as necessary in an effort to get the clean-up operation finished as rapidly as possible. Plans are underway by local officials of Kill Devil Hill and Nags Head to obtain financing for central water supplies for these communities.

Dr. Albert Schweitzer, Nobel Peace Prize Winner and world famous medical missionary, states: "It's not enough merely to exist. It's not enough to say, 'I'm earning enough to live and to support my family. I do my work well. I'm a good father. I'm a good husband. I'm a good churchgoer."

"That's all very well. But you must do something more. Seek always to do some good, somewhere. Every man has to seek his own way to make his own self more noble and to realize his own true worth.

"You must give some time to your fellow man. Even if it's a little thing, do something for those who have need of a man's help, something for which you get no pay but the privilege of doing it. For remember, you don't live in a world all your own, your brothers are here, too."

The Southern Branch of the American Public Health Association meets at the Hotel Roanoke, Roanoke, Virginia, on May 2, 3, and 4, 1962. Dr. H. W. Stevens, Health Director of Buncombe County, is President-elect. Dr. J. W. R. Norton, State Health Director, is a past president of the Southern Branch. Health personnel, desiring to attend should immediately make reservations at the Hotel Roanoke, Roanoke, Virginia.

Two leaders in the National Health Forum discussions—Chairman L. Holland Whitney, M.D., (left) Medical Director, American Telephone and Telegraph Company, and Oscar A. Sander, M.D., Consultant, Occupational Diseases of the Chest, Milwaukee, Wis.
Assault on the Impossible

Accident Prevention is Possible

by Harry T. Sealy, Vice-President Operations, Cleveland Electric Illuminating Co.

Keynote address on Accident Prevention at the 1962 Health Forum held in Cleveland, Ohio. Delivered March 20, 1962.

Civilization, it has been said, is the story of man's assault on the impossible.

Nowhere is this more true than in the fields of health and medicine.

For hundreds of centuries smallpox ravaged the human race. Men believed it was impossible to escape from it, so they resigned themselves to die under it. Then in 1796 an English country doctor named Edward Jenner came along, inoculated a patient with cowpox vaccine—and the impossible collapsed. Mankind took a step forward, freed from one of its great plagues.

Pain was once an impossible frontier; men had always suffered pain, men always would. Then in the 1840's the Americans—Morton, Jackson, Wells, and Long—pushed through that frontier with anesthetics. And the human race advanced again, freed from the burden of unnecessary suffering.

From the dawn of history men attributed disease to God, to demons, and to vapors in the air. Conquest of disease, therefore, was held to be impossible. But Pasteur and Koch evolved the daring, new science of bacteriology—and the impossible went down before them.

Men believed nothing could be done about diphtheria and tetanus—but Kitasato and Behring proved it could.

Men believed nothing could be done about venereal disease—but Paul Ehrlich believed it could.

Men believed nothing could be done about diabetes—but Banting and Best developed insulin from the pancreas of sheep and oxen.

Down through the centuries, one by one, the impossible plagues of mankind have been brought under control; smallpox, cholera, typhus, malaria, the list can go on and on. And in each case, the impossible has yielded to the faith of the few. And mankind has advanced because of it.

Today we are here to discuss one of the few remaining plagues which, as usual, a great share of mankind believes impossible to solve.

Accidents!

And this is a plague.

In terms of injury and mortality, it surpasses annually many of the great plagues of the past. It is more virulent because, unlike epidemics which flare and then subside after running their course, accidents never subside.

It is more difficult to come to grips with because, basically, people aren't really concerned about accidents until they themselves are involved, or someone close to them.

We are concerned, however. That is why we're here.

However impossible it may seem—accident prevention is a very real challenge to those of us in this room. We have made some progress, true; but much more remains to be done. Therefore, I believe, our job is to accept this challenge—and to carry on, as others have done, the assault on the impossible.
I would like to discuss this challenge in terms of three things:
-the need for accident prevention,
-attitudes which hinder accident prevention programs, and
-an approach to accident prevention.

First, the need for accident prevention.
I could deluge you with statistics at this point. They're available in abundance, and they're incredibly shocking. I will cite only a few, however, the latest published by the National Safety Council.

How many were killed in accidents in a year? 93,000.
How many suffered disabling injuries? 9,400,000.
How much did this cost—and by cost, we include everything from wage losses to claim settlements to medical bills to property damage? It is estimated at over thirteen billion dollars! Not over a period of time, but for only one year.

Accidents today, here in America, are the leading cause of death among all persons from one to thirty-six. Among all ages—accidents are the fourth leading cause of death, surpassed only by heart disease, cancer and vascular disease. As for injuries, non-disabling as well as serious, 45 million persons are affected annually.

These are impressive statistics. Of themselves, they almost sell the need for accident prevention programs. Almost, but not quite. For they merely suggest the problem. We need to look behind them to understand the nature of the problem itself.

Accidents are a plague. They must be attacked as a plague. Not only because of deaths and injuries caused but for other reasons as well.

Accidents cost the worker in dollars and cents. He loses wages. He has to pay medical and hospital bills, not only for himself, but for injured members of his family as well. Wage losses cost him over 5 billion dollars in 1960. Medical fees and hospital expenses, another billion.

Accidents place an unnecessary burden on overcrowded hospitals. If you take the long view on this you can say dollars spent for the care of accident victims, every hospital bed filled every hour of a doctor's time meant dollars, beds, and important hours denied people seriously ill of a disease.

Accidents place unnecessary burdens on families. When a person is invalidated by an accident, someone has to support him and pay for costly medical care. The family usually undertakes this responsibility—and in most cases it's undertaken willingly. Nevertheless it often places an intolerable burden on the wage earner, and the entire family pays in some manner.

Accidents affect corporate profits. They decrease corporate earnings, and lower the dividends paid to stockhold...
rs. By how much? We don’t know.

To begin with, there is no neat, well-packed approach to this problem. Many millions of dollars in sales are required to pay industry’s costs of work accidents—money that could be profits for industries and their stockholders. In fact, during times of high competition and low profit margins, effective safety programs may contribute more to profits than industry’s best salesmen.

**Accidents increase taxes.** Here in Cuyahoga County, for example, we paid a total of $421/2 million dollars in health and welfare taxes in 1960. Accidents contributed heavily to this welfare burden—just as they do in all communities. Wherever accidents create unpayable bills, halt income and create dependency—people pay higher community taxes.

**Accidents affect the productive capacity of the community.** They limit the amount of goods and service an area can produce and deliver. As the greatest single cause of loss-of-productive-years-of-life, they tend, over a long period of time, to lower our standard of living.

In terms of hard dollars, all of us pay for accidents whether we’re involved in them or not. We pay through higher insurance rates. We pay through increased need for hospital space. We pay through the increased price of goods and services we buy; after all, a manufacturer has to include the cost of accidents in his operation in setting the price of his produce.

Accidents kill, they maim, they wreak hardship, they cost billions of dollars annually.

The needs for accident prevention are self evident.

We have, through a variety of programs, done much toward meeting these needs.

The question is: why aren’t we more successful? Why do the best designed, best organized prevention programs so often fall short of their goals?

The answer is people—you and I—attitudes which exist even in an audience as sophisticated as this. Before we can ever do the job we must do in the realm of accident prevention—we must be aware of these attitudes and design our programs to break through the barrier they represent.

III

The most dangerous attitude, because it is the most instinctive, is expressed in five simple words: “It can’t happen to me.” In itself there is nothing wrong with this attitude. Indeed, without it man would have made little progress upward from the caves. He would never have ventured beyond coastlines unless he had believed in his heart: nothing can happen to me. He would never have lifted a plane off the ground, built the arch of a cathedral, climbed a mountain, inoculated himself with plague germs unless he had felt: nothing can happen...
to me. It is the attitude that, in wartime, enables men to take an impossi­
bable beachhead; the attitude which helped Shepherd, Grissom and Glenn
into space. This attitude, per se, is probably one of the healthiest attitudes
of the human race.

However, when related to the prob­
lem of accidents—it is a killer.

By giving us a sense of false se­
curity—of being invulnerable to the
things that happen to others—it creates
carelessness and sets the stage for
tragedy. What can we do about it? I
don't know. The answer may properly
belong in the field of the psychiatrist.
I only know that the attitude exists,
that it represents a major bloc to effec­
tive accident prevention programs, and
that serious research must be done in
it before we can accomplish what we
should.

A second dangerous attitude among
many is that "Accidents are the acts
of God." This is ridiculous; both theo­
logically and realistically. If you be­
lieve in God, then you believe in a
God of love, not of deliberate cruelty;
if you don't believe in God, then you
don't have any particular trouble with
this premise. The question, however, is
not a theological one. It is a practical
one: "Are accidents inevitable, unpre­
dictable and beyond man's power to
control?" The answer is an emphatic
NO! Industry has proven this. All ac­
cidents have an Achilles heel. Our job
is to find it.

Another attitude involves pure fatal­
ism. "People are people; you can't
change them. And since people cause
accidents, accidents can't be prevent­
ed." The assumption is false; just as

William J. Johnson, General Manager,
National Safety Council and a leader
of the Accident Prevention Section of
the National Forum.

fatalism, in general, is a false phil­
osophy, a denial of man's innate ability
to better his condition. Fatalism is sur­
render—and in this field of accident
prevention we are not considering sur­
render. The falseness of this attitude is
demonstrated best by the fact that peo­
ple have been changed, and accidents
have been reduced through intelligent
prevention programs. The statistics are
there to prove it.

A fourth negative attitude is found
usually among the hairy chested ad­
vo cates of the strenuous and challeng­
ing life. They complain that accident
prevention is aimed at taking the risk
out of everything; some of them theo­
rize that if we prevent accidents and
the risks that surround them, children
will become helpless, dependent and
fearful. This is a legitimate attitude;
possibly it's true; possibly it's also a
little silly. We can never take the risk
out of things: we can only train peo­
ples better to do what they have to do,
or wish to do, before they assume the
risks. We must do everything in our
power to reduce the number of deaths
and injuries through intelligent train­
ing programs.

The final negative attitude we must
consider is this: "Preventing accidents
is someone else's business, not mine." All of us have the feeling, I think, that safety is the responsibility of national councils and agencies and units of government. It's their business. They're supposed to be doing something about it. The truth of the matter is—and we all know it—accident prevention is strictly the business of the individual, your business and mine. The National Safety Council can't keep us from falling over a chair—the municipal traffic safety league can't make safe drivers out of us. Others can acquaint us with the types of danger that exist; they can teach us how to avoid them if we want to be taught. But only we can take the necessary action. Accident prevention, therefore, is the business of the individual. And he must be made to realize this before any kind of training can be effective.

So far we have explored the need for accident prevention—and some of the negative attitudes which make accident prevention a major problem.

How then can we approach it?

To begin with, there is no neat, well packaged approach to this problem. Every person, every machine, every job, every environment small and large has its own accident potential. Accident prevention, therefore, is a highly complex thing involving many, rather than few elements. Programs therefore, must be tailored to meet specific needs.

Industry as a whole recognized this. Every plant of substance has a safety director and a safety program; every plant takes accident prevention very seriously. Therefore, what I have to say, represents only one approach to the problem—that of my particular Company. It can be accepted, however, as representative of the kind of programs industry as a whole is working on.

First, my Company. Most people know us, the Illuminating Company. Our full name is The Cleveland Electric Illuminating Company. You can understand why we telescope into initials wherever possible. Our product is electric power. We supply it to more than a half-million customers in a 1700 square mile area. Some 4,000 employees help us do this. There are, in the United States more than 370 investor-owned electric utilities. In terms of electric output—CEI ranks twenty-third. This will give you an idea of our size and scope of operations. My specific job with the Company is Vice President—Operations. As such, about 70% of all the employees are within my area of responsibility and practically all of the safety operation. As for the type of accidents we are faced with, there is the broad spectrum of mishaps which occur in any business where men and equipment meet. There are also accidents somewhat peculiar to our operation: namely those involving climbing, working aloft and handling hot wire.

As you can imagine, the accident potential in any electric utility company is very great. However, only 2% of
our accidents are electrically related indicating that 98% of our safety programs are the same as other industries. That is why, over the years, our industry has spent millions of dollars trying to lower it. At The Illuminating Company we went about it in this manner.—

First of all, we set up objectives. This is necessary when you’re dealing with a problem as vast and nebulous as accident prevention. You need to define—on paper—what you hope to accomplish and how you plan to go about it. There is a wise old adage that says nothing is thought out until it is written out. In our case we started with the basic premise that accident prevention is part of every employee's job. We have the right, we believe, to expect all work to be planned and carried out in a safe manner so that accidents will not occur. But we also have the responsibility of so indoctrinating our people in safety principles and tech-

One of the recorders for a National Health Forum session gets his notes in order—John N. Carr, Manager, Occupational Safety Department, Greater Cleveland Safety Council.

...niques that they will be able to do their work safely. Safety is a two-way street. The Company has to do its part—fact, more than its part—if it hopes to reach any goals.

Accidents, therefore, are considered as errors which can be prevented. They are also considered as a measure of job performance for either an individual or group. To prevent these errors—which is our number one objective—we set up an organization: simple, but with clearly defined responsibilities. There is the staff element whose responsibility is to develop a safety program. Staff provides the background materials for decision making and action taking; Line—the supervisors working directly with the employees—makes the decisions and takes the action.

Of the two, Line is the more important—so important, in fact, that it’s the key to our entire safety program. To the supervisor is delegated full responsibility and authority for the prevention of accidents. Staff plans and the Line implements.

We set up, therefore, the objectives of an accident prevention program.

We create an organization to develop such a program.

Now—what elements go into it? (Continued on page 12)

Nettie Day, Chief of the Accident Prevention Section of the State Board of Health, was a charming participant at the banquet during the National Health Forum. With her is seen Grace Mattis, Nursing Consultant, Division of Accident Prevention of U. S. Public Health Service.
This page and the two following pages are reprinted from the 16-page booklet, "Dennis the Menace Takes a Poke at Poison", prepared in cooperation with the Food and Drug Administration and the Public Health Service, U. S. Department of Health, Education and Welfare. Copyright 1961 by the Hall Syndicate, Inc.

March, 1962

THE HEALTH BULLETIN
HI, FOLKS! Don't let it scare ya, but this is a book about poisonous!

It's for all Moms 'n Dads who've got kids like me... but wanna keep 'em anyway!

Poisoning can be terrible! Our neighbor, Mr. Wilson, thinks I'm terrible, so I guess I'm poison to him.

Anyhow... you read this book an' it may keep ya from gettin' awful sick!
Look at these headlines! ACCIDENTS! ACCIDENTS! the paper's full of stories about them!

I hate to look at a newspaper. The pity of it is that so many accidents happen to children.

OOPS! I'M FALLIN'!

It's the parents' fault. They don't warn their children to look out for everyday dangers.

ROWF!

DENNIS!

I'm not hurt. Mom, just my bones shook up. Ruff's, too!

DENNIS! WHAT ON EARTH WERE YOU UP TO?

I was almost up to the medicine cabinet, but that ol' stool slipped!

March, 1962

THE HEALTH BULLETIN
Assault on the Impossible
(Continued from page 8)

First—we establish goals. People need to know what is expected of them—they need to know how good they should be. So we tell them. We define what is expected. Definition clears the air and lets everyone know where he stands.

Second—we set up a training and communications program to help reach these goals. Training involves a number of approaches. The purpose is not merely to plead for safety, but to point out, specifically, where in the company’s operation, danger exists and how to avoid it. For example, in training we deal with such subjects as the handling of ladders, molten materials, scaffolding, tools, respirators, hot wire as well as first aid procedures. This is necessary as a starting point toward accident prevention. But only as a starting point.

The heart of our training program is personal instruction by—or under the direction of the supervisor. On the job, a man is given individual coaching on safe work methods. In addition, supervisors and their men get together periodically for safety discussion. The first method is that of the rifle; the second, that of the shotgun. Between the two we manage to pump a great deal of safety consciousness into some otherwise careless people. If we miss with both of these—we often hit with a new procedure which is becoming popular: that of informal evening sessions where the men and their wives get together to discuss accident prevention and actually learn and practice such things as resuscitation techniques including external heart massage. I might add that the attendance at these after-hour programs has been very gratifying, proving that wives and families are safety conscious. While these are held on Company property, they are on the employee’s own time.
The value of such training is exemplified by an incident in January of this year involving two of our service installers. They were working on the outside of a house installing a service line. They heard a scream from inside. They rushed in, found a woman holding her unconscious three-year-old son. While the one performed external heart massage on the boy, the other used mouth-to-mouth breathing, both of which they had learned as part of their training in resuscitation methods. The police arrived and took the boy to the hospital where he was treated and then released. Prompt action by our installers was credited with saving his life.

In order to train more of our employees in such techniques, we became the first Company in this area to acquire a girl named Resusci-Anne. Anne is a life-size rubber doll—or perhaps the word is mannequin. She's equipped with inflatable lungs and a heart. Her job is to help us train our people in the major resuscitation techniques—direct breathing and external heart massage. Anne, of course, is the subject of a certain amount of boisterous humor—but there's nothing funny about the problem she's designed to cope with. Nor in her effectiveness as a training aid. I understand that Resusci-Anne is on display here and will be used at one of the sessions.

Traffic safety is another area which receives an unusual amount of emphasis at CEI. I say unusual, because most companies take driver ability pretty much for granted; it is also an area, they feel, which is pretty much the responsibility of the individual driver. Our policy is that while a driver is operating one of our vehicles on the job, we're responsible for him. If we can also help better his driving habits off the job—so much the better. To this end we require that every employee, before he drives a Company car, takes and passes a test given by the Automobile Club—even though he already has a driver's license. His supervisor scans the results of the test and if in his opinion, the employee needs brushing up, he is given a training and refresher course. We also retest and retrain our drivers from time to time—and give special recognition to those who by performance become "expert" drivers.

Our overall training program, therefore, involves on-the-job coaching, group discussions, family get-togethers, driver training, and studying first-aid and resuscitation techniques by actually practicing them. Supervisors bird-dog the entire process. They observe employees work methods, offer corrective action or praise, work at eliminating unsafe conditions before accidents occur and, above all else, set a good habit and attitude example themselves.

Communication is an important part of the training program. And by communication, I mean an atmosphere of idea exchange. From staff, through line to the men. And from the men back up to staff. We try to keep the channels open; we feel the boys in the power plants and out on the lines can help us as much as we can help them in achieving a high safety level. In addition to the open exchange of ideas, we utilize such communication media as films, leaflet handouts, posters and display material.

This training and communication program has value—but it doesn't have real value until we add one more step to the process. That is—evaluation. Every company needs to set up standards of measurement to know just how well, or how badly it is doing with a given program. It needs to know what things are happening—and why they are happening in order to prevent them from happening in the future.
To this end we require from our supervisors thorough investigation and detailed reports of all accidents and with staff assistance, an analysis of the reports to determine measures to prevent such accidents in the future.

As a stimulus toward reaching our goals, we have a system of contests and awards. Recognition, for example, for the lowest lost-time injury rate among operating departments, for the greatest reduction in partially disabling injury rate, and for traffic safety improvements.

We not only award, however, we also spank. Discipline of some kind has to be built into any program involving people. Hence, in flagrant safety violation cases, we've given men time off without pay. Not only the men in question, but sometimes their supervisors. And in most cases of this nature, we get no complaint from the union. They realize what we're trying to do and give their support.

Thus, to recap—our accident prevention program begins with a setting up of policy and objectives. We have a staff-line type of organization with clearly defined responsibilities to meet these objectives. We train, we keep open channels of communication, we give recognition and, when necessary, we discipline.

What are the results? Considerable improvement. Not to the extent we're shooting for—but a good start.

Back in 1948 before our accident prevention program shifted into gear, we had a frequency rate of 23.26 lost-time injuries per million man hours of work.

Today that frequency is down to four.

Our injury frequency rate has been better than the national average for our industry every year since 1950.

We have had many stretches of over a million man hours worked without any lost-time injuries; our best record to date is 3 million-plus man hours.

The record for the electric utility industry, incidentally, is 5 million-plus hours, held by the Texas Power and Light Company.

So accident prevention is possible. It can be designed into a working program and made effective.

What we try to do at the Illuminating Company is carry the whole thing one step further.

We want our people to become as safety-conscious off the job as well as on. Our current program, therefore, is pegged to the concept: "Safety—Everywhere All The Time." There is good reason for this.

When we compare the number of off-the-job lost-time cases, with those occurring on the job, we find that our employees are about four times safer on the job. This is consistent with the latest figures of the National Safety Council. In 1960, accidents at work killed 13,800 persons; away from work, 29,200. At work, 1 million, 950 thousand workers were injured; away from work, 2 million, 250 thousand. Off-job safety is an area that is yet relatively unexplored.

Because of its effect on industrial production, industry, I believe, has the largest stake in exploring it. That's why this has become part of our overall safety policy at CEI—and why, at present, we're giving it special attention.

We are, in this connection, cooperating with Cleveland's unique "Blueprint for Life" campaign. This is a massive, community-wide action program to cut the toll from all types of accidents and fires in Cleveland and Cuyahoga County. Unlike most campaigns which are largely pleas and preachments, this one has a realistic goal and a time limit. It is trying to cut the toll by 100 deaths...
and 12,000 disabling injuries during the 12 months period between Labor Day 1961 and Labor Day 1962. And the best efforts of many people and many Cleveland industries are going into it. To date we are close to being on target.

Now, having said all these things about CEI and its accident prevention program—let me repeat again: This is the program of only one company, designed to meet its particular needs. Practically all major companies have similar programs, designed to their needs. What I have said therefore, should be considered only as illustrative of an important fact: namely, that industry is deeply concerned about our national accident toll today—and that we’re doing everything in our power to lower it.

In closing—we might look at the picture from a kind of ethical perspective.

Today—we live in a world of scientific and technological advances. They’re exploding so rapidly, on so many different fronts, there are so many breakthroughs weekly, sometimes daily, that it is difficult to keep abreast of them. One of the costs of these new advances is new dangers.

We try to combat them, of course. We design safety factors into machines, plants, whole environments. But accidents still happen—in spite of everything we do. What is the answer? We do one of two things. We can say: “this is the price of technology—we can’t expect to achieve, we can’t expect to throw our productive machine into full scale competition with the communist world—without some sacrifice of life and limb.” We can adopt this philosophy—which is the easy one. Or we can repudiate and take on what appears to some to be the impossible challenge of accident prevention.

We must, I believe, repudiate it. Ethically we can do nothing else, for we belong to that great tradition of western civilization which holds that life is to be revered, and every man possesses innate worth and dignity. Any philosophy which accepts death and injury as the price of achievement is repugnant to us.

We are therefore committed to doing everything possible, in our respective fields of endeavor, to control and prevent accidents. It’s as simple as that.

As for the impossible—well, we’re here today with the civilization we have because, down through the centuries, men have dared to assault the impossible.

The least we can do—in facing the problem before us—is to carry on that tradition.

**Health Briefs**

The N. C. Heart Association Annual Meeting and Scientific Sessions will be held on May 24, 1962 at the Sir Walter Hotel in Raleigh. Speakers at the scientific sessions will include Dr. Arthur C. Guyton, chairman of the Department of Physiology and Biophysics at the University of Mississippi; Dr. Arthur Grollman of the Department of Experimental Medicine at the University of Texas in Dallas; Dr. Oscar Creech, Jr. of the Department of Surgery at Tulane University; and Dr. Gene H. Stollerman, Associate Professor of Medicine at Northwestern University in Chicago.

The N. C. Conference for Social Service meets in Raleigh at the Sir Walter Hotel, April 29-May 1, celebrating its fiftieth anniversary. Emphases in five principal areas will include: economic opportunity, education, health, housing and community development, and welfare. Another feature of the program will be a banquet on the evening of April 30 at which Governor Sanford will make the major address. These sessions are open to the public and all interested persons are invited.
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DATES AND EVENTS

April 12-13 — Carolinas-Virginias Hospital Conference, Hotel Roanoke, Roanoke, Va.
April 13-15 — Southeastern Conference on Aging, Hotel Charlotte, Charlotte.
April 24-26 — N. C. Assn. of Nursing Homes and Homes for the Aged, Battery Park Hotel, Asheville.
April 24-25 — N. C. Tuberculosis Assn., Jack Tar Hotel, Durham.
May 2-4 — Southern Branch, APHA, annual meeting, Hotel Roanoke, Roanoke, Va.

Dr. H. William Bardenwerper of Milwaukee, Wisconsin, recommends routine active immunization against tetanus in an article in the March issue of the Journal of the American Medical Association. Tetanus, also called lockjaw, is an infectious disease, often fatal, which is caused by a germ which invades the body primarily through wounds. The germ produces a poison, or toxin, which causes muscle spasms, particularly those of the neck and lower jaw.

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The Public Health Service has awarded the Esso Research and Engineering Company, Linden, New Jersey, a $49,820 contract to study new ways of keeping detergents and other chemicals out of water supplies and waterways. The contract is part of the Public Health Service's long-term Advanced Waste Treatment Project, designed to develop practical means of accomplishing complete removal of municipal and industrial wastes.

The Southern Regional Education Board has announced a grant of $151,160.00 from the W. K. Kellogg Foundation for a five-year project to advance nursing education and research in the South. Miss Helen C. Belcher, formerly Nurse Consultant with the Public Health Service, has joined the staff of SREB to help develop this project.
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LEADERS IN REGIONAL CONFERENCE ON AGING

Sponsored by the American Medical Association's Council on Medical Service, Committee on Aging, a Regional Conference on Aging was held in Charlotte, April 13-14. Intended to emphasize extension of life and enrichment of living, the Conference was well attended from several southeastern states. Leaders shown below, from the left, are: Frederick W. Swartz, M.D., Lansing, Mich., chairman, AMA Committee on Aging; John R. Kernodle, M.D., Burlington, chairman, Committee on Chronic Illness of Medical Society of N. C. and the Society's newly elected president; and J. W. R. Norton, M.D., State Health Director. (See also pictures on pages 2, 3 and 4.)
Scenes from Regional Conference on Aging Held in Charlotte in April

Mrs. Edith B. Chance, R.N., operator of the Whispering Pines Nursing Home of Fayetteville, is seen in conference with Albert Haskins, Raleigh, an architect interested and experienced in nursing home construction. Mrs. Chance is the newly elected president of the N. C. Association of Nursing Homes and Homes for the Aged.

Robert Root of the news department of the American Medical Association (left) conferring with Don Seaver, special writer of the Charlotte Observer and Richard Nelson, (right) field representative of the American Medical Association.

Mental health leaders attended the regional meeting on aging. From the left, Scotty Mozingo, Raleigh, field representative, N. C. Mental Health Association; Dr. Irene McFarland, Wilson, President of the Association; Dr. Dewey Dorsett, Charlotte; and H. J. Hickey, Charlotte, the Association's immediate past president.
Home Nursing — A Community Challenge

by Lucile Petry Leone

Far from being new, the concept of nursing the sick in their homes is as old as Christianity. Phoebe, the Grecian lady, is famed for taking St. Paul’s epistle to the Romans. She also performed deaconess service, and for this work has been accorded the honorable title of the first visiting nurse. 1

Here at home and in modern times, secular visiting nurse societies were established in the last quarter of the 19th century in New York, Boston, Philadelphia, and Chicago. 2

Today the mounting demands for nursing service compel us to develop and expand out-of-hospital means of caring for many who are not acutely ill. Nursing care of the sick at home is the great community challenge.

Medical science has assured a longer life span, but we have not provided adequate nursing services for people who have incurred the disabilities of age, chronic disease, and crippling accident. New drugs have made it possible for many patients with tuberculosis, diabetes and mental disease to remain with their families, but only if they adhere to a prescribed medical regimen which often requires the supervision of a nurse.

Twenty years ago the Conference of State and Territorial Health Officers recognized nursing for the sick at home as an “urgent need.” Yet, as a recent U. S. Public Health Service study established, close to one-third of the cities of 25,000 population and over are without organized home nursing care. Except for certain New England communities, most cities of less than 25,000 have no home nursing service at all. 3 In 1960 only 248 local official agencies reported home nursing on a continuing basis. 4

And yet, home nursing brings health to people and the leavens of economic solvency and spiritual wholeness to the community. It postpones the time when hospital facilities must be provided and sometimes shortens hospital stay.

Home nursing has been a boon in communities where it has been tried.

In Detroit the Visiting Nurse Associa-


Mrs. Mary K. Kneelder (center foreground), Chief of the State Board’s Public Health Nursing Section, was one of the interested listeners at the Regional Conference on Aging.
Howard I. Wells, Jr., (left), Chicago, Ill., Executive Secretary of the Joint Council to Improve the Health Care of the Aged, counsels with Louis L. Amato, M.D., Fort Lauderdale, Fla. and George W. Karelas, M.D., of the Medical Rotunda, Newberry, Fla., at the Regional Conference on Aging.

A new Public Health Service film "Care at Home,"7/ demonstrates the benefits of home nursing to patients in the Pittsburgh, Pennsylvania area. Well depicted is the pride of each independent, spirited, participating member of the community who, but for skilled nursing care at home, might have become more "patient" than "person." In institutional surroundings we take care to remember that a patient is a person. But at home the patient is a person. The life stream is a life-giving stream.

"Care at Home" presents, among others, a housewife who has had a leg amputation. With continuity of nursing care teaching, which includes rules of self-care, she is confidently looking forward to her new leg. From her wheelchair she bakes her pies and cakes. She may be somewhat inconvenienced, but she is very much the manager of her home. She is far from helpless, not in the least dependent.

In Denver there was almost 100 percent agreement among patients who

(Continued on page 10)

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Vol. 77 April No. 4
The Person County Home Care Demonstration was one of the nation's first, if not the first, rural programs of services in the home for the long-term or potentially long-term ill patient. Also it was a test to determine the feasibility of home care in a rural area. It was an attempt on the part of the local health department, the local medical society, and the county to meet the health needs of the long-term ill in Person County, North Carolina. We did not do a survey to determine the needs; we knew we had a problem.

Person County, North Carolina, is one of five counties that makes up the District Health Department of which I am Director. This county is located in northcentral North Carolina, covers an area of twenty miles square and has one town centrally located with a population of 5,144. The population of the county is 26,314 of whom about 40% is non-white. Person County is primarily rural with chief income derived from farm products (tobacco) with a few small manufacturing companies located around the town of Roxboro. The 1960 census reports that approximately 50% of the homes are occupied by renters.

At the present time Person County has 12 practicing physicians, two are surgeons, one an internist, and 9 general practitioners. Two of these general practitioners are over 70 years of age and two are non-white. There is a good 60 bed hospital (Hill-Burton constructed). The Health Department is housed in a new building (Hill-Burton constructed). Within fifty miles of Roxboro, there are three large medical centers. Working relationships within the county have been cooperative and harmonious.

This home care project was a direct result of Person County, local, state and national medical societies, state and federal public health services recognition of the problems related to chronic illness. Everyone realized that the pattern of disease was changing, but were reluctant to do something about it. This appreciation of the need resulted from experience over the years with tuberculosis, venereal diseases and the other public health problems.

Since 1944, the Health Department had assumed the major responsibility for the treatment of tuberculosis and venereal diseases within this county. This was at the request of the local medical society and the county officials. By keeping the public informed of the problems and the needs of the people in the county and the work being done, it was not difficult to secure the local support needed for the development of the home care project.

In cooperation with the Person County Medical Society, in consultation with the State Board of Health and the Public Health Service, a tentative project was prepared and submitted through channels. Before the final project was prepared and submitted it was discussed with the county medical society in detail and "Policy and Procedures..."
Statements" were developed that related to every phase of the anticipated program. The medical society agreed without reservations to provide medical care and supervision for all persons residing within the county who were referred to and carried by the project.

After approval of the project, plans were made and the program became a reality. The first patient was referred and admitted on December 8, 1958. Home care including rehabilitation services was provided through the cooperative efforts of the local health department, the county medical society and other county agencies together with interested citizens and groups.

At this point I should state that this small rural county does not have voluntary agencies with paid personnel, and the only official agencies within the county are the health and welfare departments. The voluntary agencies are as stated—voluntary and with very limited funds. Doubt exists in the minds of many as to the practicality and advisability of attempting to organize an agency that could collect fees and serve as a sponsor of a project within this county.

This home care demonstration received financial support from the Public Health Service and the North Carolina State Board of Health and the county.

Even though official health agencies are interested and concerned with the care of the sick, their work has been limited in the main to direct services on a teaching and demonstration basis only. It was a departure from the accepted public health program when we undertook to embark on this expanded program which included services not ordinarily available in rural areas or in small hospitals. This expanded service was basically medical, social service, physical therapy and expanded nursing services. To provide these services it was necessary that the health department modify their old accepted routine-type public health programs so as to make time available. We did not at any time provide medical services for persons on the project. In the beginning it was agreed that the doctor-patient relationship would remain in effect at all times. The health department would provide services available through the staff and no fees would be charged and race nor social status would be considered. Before the project, the ratio of nurses to population was 1 to 6,500, and with the project, 1 to 4,400. It was difficult for us to recruit and retain qualified workers.

We endeavored to integrate this program into the overall program of the health department and the other agencies providing health services in the community. Plans were made for the securing of medicines, sick room supplies, orthopedic equipment, and transportation for those persons needing it. Also arrangements were made for occupational therapy, nutritional counseling and health education on a consultant basis from the State Board of Health. The county hospital agreed to admit for short periods of time any person needing special diagnostic tests and x-rays. Every community resource was utilized through the coordination and efforts of the health department.

The public was kept informed of the activities going on and the needs that existed. During the chronic disease program as well as with all other special programs, every opportunity was taken to speak before lay groups, prepare news releases and spot announcements for the local radio station. Immediately after receiving the unqualified endorsement of the chronic disease program and the pledge of support of the county medical society, lay committees were organized. These committees were:

1. Health Education
2. Procurement and Supply.
3. Vocational Rehabilitation.
4. Social Service.
5. Chaplain and Recreation.

I assure you that these committees were active because they were made up of interested, dedicated, enthusiastic citizens of the county. Each of you know the value of such support. As a further aid to the operation and evaluation of the project, an Advisory and Technical Committee made up of representatives from the local and state medical societies, local and state welfare associations, state nurses association, State Board of Health and University of North Carolina School of Public Health was organized.

All beneficial results to the individual patient in this program have been an accomplishment of a concerted “team effort”. The health team teaches and provides services as ordered by the attending physician. The patient and his family are taught the proper care of his illness through the actual services offered. Thus, the private physician and this team work as an effective unit toward the achievement of maximum recovery and physical independence of the patient.

It has been our feeling that the majority of people wish to remain at home or in the community where they have lived most of their lives and secure treatment from their friends.

You might ask what were our aims and/or our anticipated results. I will list the major ones.

1. To provide information about the cost of home care in a rural area.
2. To shorten the period of hospital stay for patients with long-term illness.
3. To extend into the home services ordinarily restricted to hospitals.
4. To reduce the number of people disabled by chronic conditions.
5. To effect a reduction of cost to the county for hospital and welfare care for persons with long-term illness.
6. To provide adequate medical care to the people of Person County.

In the beginning it was agreed that all patients carried on the project would be under the supervision of a local physician who would refer the patient to the project and continue the medical direction throughout their care. After referrals representatives of each of the health disciplines would visit the patient in the local hospital or at home and evaluate the patient together with the home setting as to what could be done by them for this particular case. After these first visits an admission conference was scheduled, with the doctor in charge of the case presiding. The group or team decided whether the patient would be admitted to the project and what services would be provided, and the physician in charge would give written orders. Periodic review conferences were scheduled where progress, prognosis and disposition of the patient was decided. At all times, adequate and sufficient records were kept and a system of transfer of information between doctor and health team was worked out.

During the two and one quarter years of project operation, 96 patients were admitted (one patient was re-admitted). Twenty-one patients were discharged (including the one re-admission), 11 died and 65 cases were brought forward for services as of January 1, 1961. During all the project, 6 persons were referred that were not admitted because at that time we had as our goal restoration to self-help and/or self support. It wasn’t until later that this aim was modified. The age range of patients admitted was 4 years to 87 years. Of the total 75% were age 55 or over and 47% were 65 and older. The number of male and female admissions was approximately the same with 46% male and 54% female. The breakdown for white and non-white was more remarkable in that 81% were white while 19% were non-white.

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This may be due to the reluctance of non-whites in our area to obligate themselves to long time medical care and their receipt of more services from out of county medical centers.

All the deaths occurred in patients 55 years and older. More of the deaths occurred in male patients. Deaths were much higher in the non-white group. Of the patients continuing service after January 1, 1961, 65 were white and 9 were non-white.

Our staff was not charged with determining the socio-economic status of patients since there was no fee for service. However, we divided the patients as 53% in the high and middle income brackets of the community while 47% were in the low income group and 29% of the total received public assistance grants from the Welfare Department. Nine of the 11 deaths occurred in the lower income group.

The majority of all patients admitted had a primary diagnosis of stroke (29%) or arthritis (26%) with 32% having a diagnosis of fractures and injuries and 12% with other diagnoses. As you would expect, the highest mortality rate and the lowest discharge rate was experienced by stroke patients. Seventy-two percent of the deaths occurred in patients with strokes. An encouraging fact is that five patients with strokes were discharged, four after receiving maximum benefits under the project and one moved out of the county. Very few, if any, patients had only one diagnosed condition.

On January 1, 1961, we did not have one who can't be cared for at home. I could give you figures about patients and patient days by diagnosis, deaths and discharges, patients carried forward, service contacts for all diagnoses, phases of patient care by diagnosis, etc., but I feel certain that you know generally what these might be.

Because there is very little uniform cost accounting and reporting, there is a wide variation in cost element reported by the various programs throughout the country. Despite the imperfections of cost measurement, operational expense per patient day on the home care program was considerably lower than for the general hospital. In Person County the cost of hospitalization for any patient for one day is $17.91. The average expenditures per home care patient per day was $1.38. However, one must consider that this latter is a cost to the project and does not include the cost of ward service, room, board, care, etc. assumed by household members.

During 1960, it was determined that 87% of the expenditures was for salaries and 51% was charged to administration and 49% to health services. Estimates based on phases of care categories gives patient day cost of $1.55 for homebound, $1.63 for combined, $.48 for maintenance and $1.59 for extended care category. Let me refine for you phases of care:

1. Homebound care—patient homebound, but could be taken to physical therapy room in hospital.
2. Combined care—ambulatory patient.
3. Maintenance Care—patient classified as status quo.
4. Extended Care—when the patient although hospitalized was receiving program services.

Further analysis shows 4,235 hours expended by all personnel with expense per hour of $6.01. 3,655 units of service provided with expense of $6.96 per unit and units per hour of .868.

It has been found that home care can serve to reduce the number of patients in the hospital and concomitant amount of time required of hospital personnel. Periodic nursing care under a home care program is less expensive than around the clock service in the hospital. Welfare expenditures decrease when the indigent leaves the hospital.
There are many intangible values to be considered in home care costs, such as elimination of depressive states caused by endless hospitalization, preservation of family structure, reduction of family's financial stress by home care, permitting families the opportunity for caring for their own sick.

At this point, I'd better state a few of the problems we encountered.

1. No pattern to go by. This was the first home care program attempted in a rural area. We had to learn to do by doing. There were programs in metropolitan areas, but these were not applicable to a rural area.
2. The recruitment of qualified personnel.
3. The change of personnel during the project.
4. The adjustment to working with new disciplines in rural public health.
5. The breakdown of communications at times between local, state and federal personnel, and at the present time.
6. The securing of money to continue the program.

You might ask what are the results of the program. This program has a special impact on the health department. It has served as a real stimulant, has increased the staff's awareness and understanding of complex problems which are inevitably imposed upon patients, their families and the community by long-term illness.

Increasing efficiency in service to persons with long-term illness has been evident. There is a better understanding of the team approach and the contribution all team members have to make to total patient care.

We have developed even better relations with appropriating bodies in our county.

This project has been very useful in revealing maternal, infant, preschool, venereal disease, and tuberculosis cases existing in home care families. It has been a total family unit care rather than individual care.

I will state the patients and their families have been enthusiastic and appreciative of services made available by our project. Since over 50% of the patients were from the upper income brackets of the community, it is remarkable that there existed no feeling of stigma in receiving free service from this public agency. There has been an extension of services to socio-economic groups never served by the health department and also an increased utilization of the total health program by the community as a whole. As a result, general knowledge of the total public health program has increased.

Through mass communications such as talks to various groups, visual aids, newspaper, radio publicity and dissemination of reading materials, the people have become more aware of the problems of long-term illness and what can be done about them as well as the preventive aspects of chronic disease. At the writing of this report there is no information that an individual with long-term illness is without medical supervision. Now a stroke patient is referred within 48 hours. Similarly there are no patients in the local hospital whose needs might be met by care in their homes. The above statements could not have been made prior to the advent of this project.

The program was greatly aided and supported by the lay people in Person County. They gave willingly and creatively of their time, material goods and their talents. Example are:

1. Building and equipping the physical therapy treatment room in the local hospital through individual and civic contributions.
2. The county commissioners each year increased the local appropriations for the total and special public health programs.

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Although the demonstration project ended on June 30, 1961, the program was continued in Person County. The service and educational aspects are not radically changed or reduced since the program no longer operates as a project. The medical social worker who had been serving as coordinator was not continued, and the Health director, assistant health director and assistant supervising nurse assumed the responsibility for project coordination. Limited social service has been provided by the public health nurses with assistance from the county welfare department and state consultants. The physical therapist reduced his time of direct service to patients so as to provide consultative and service work in two adjoining or additional counties of the local health district. The operational policies and procedures remained essentially the same. Referral and admission procedures, review and discharge conferences were continued. Our project demonstrated its value in improving the care of the long-term ill and disabled persons in their homes. These services involved several types of care which in a sense may be comparable to progressive patient care. This was and is a practical approach to meeting the needs and is applicable to a rural community.

The importance of public relations in the development of health and welfare services for the American people will be spotlighted during the 1962 Public Relations Institute of the National Public Relations Council of Health and Welfare Services, Inc., to be held in New York City June 3-5 at the Hotel Commodore.

The N. C. Tuberculosis Association held a most successful annual convention at the Jack Tar Hotel, Durham, in April. Some 200 delegates attended.

Home Nursing—by Leone

(Continued from page 4)

had responded to questionnaires on satisfaction with home care that this service had met their nursing needs. They said that, in the event of future hospitalization, they would again choose early discharge, provided they could have nursing care continued at home.8/

Home nursing is preventive as well as restorative.9/ Not only is home care often an alternative for hospitalization, it may be the alternative for regression, for hollow waiting, for the sad old pattern of illness, partial recovery, and ensuing decay. How often in the past and even in the present a stroke patient goes to the hospital; returns home improved; and then lapses into invalidism for the rest of his life. It does not have to be that way with coordinated home care, which either continues the care begun by the physician in the hospital or makes hospitalization unnecessary in the first place. However, we can not expect that a patient be the coordinator of his own health services.

Nursing is an essential part of any home care plan because the therapy prescribed by the physician often can reach the patient only if a skilled health worker applies it and teaches the patient to participate in it.

Nursing is an essential part of any home care plan also because a patient needs to sense a unity in a therapeutic regimen. For the patient, nursing at home may be likened to a class "promotion" rather than a transfer to a completely new or foreign school system. It is an established principle in education that effective teaching leads the student from the familiar to the unfamiliar. Patients who need teaching to get well or reeducation to accept their limitations are more responsive to instruction in the familiar setting of home.

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The nurse also makes an important contribution to medical education for home care. A public health nurse at North Carolina uses the home care program at North Carolina Memorial Hospital to teach advanced medical students how to care for long-term patients at home.

I wish the philosophy of North Carolina Memorial Hospital’s coordinated home care program were more universal because it honors home care as a human need, a need of all the infirm, not solely of a specific socio-economic group. “Having enough money to pay one’s physician’s fees and hospital bills doesn’t necessarily preclude the need for nursing follow-up at home. Why should those who pay the taxes be denied the service...”

Individual health is indeed a public concern. In our Nation of 180,000,000 people, 15,000,000 are 65 and over. Three-fourths of the people in this age group have one or more chronic conditions. 2½ million are limited in mobility.

U. S. Public Health Service programs, therefore, are strongly focused on that most important comprehensive health goal, nursing care of the sick at home.

Consultation from the Service is available to States and communities which desire to develop and expand their resources for nursing care of the sick.

It is recognized that small health agencies which are authorized by communities to provide home nursing will have to fix a fee for their services. The Division of Nursing of the Public Health Service has therefore developed, in cooperation with the National League for Nursing, a simple method to help small agencies determine their expenditures for nursing care. The National League for Nursing also has recently published “Criteria for Evaluating the Administration of a Public Health Nursing Service,” which is useful to agencies planning to include home care among their insurance benefits.

The Division of Nursing has also devised a method to help local agencies study, measure, and document the progress of patients receiving out-of-hospital nursing service.

Under the Community Health Services and Facilities Act, which the President signed into law in October 1961, the Public Health Service is authorized to make project grants to public or non-profit agencies for new or improved methods of providing out-of-hospital care. Home health services include homemaker services, physical and occupational therapy, nutritional and social services, and nursing care. The Division of Nursing has major responsibility for review of projects for the improvement of the nursing aspects of home care.

The Division of Nursing this year for the first time has had a limited amount of funds to support training in rehabilitation nursing. Contracts have been let to several non-profit institutions in various parts of the country to train public health nurses for work with long-term patients. One such grant was made to a hospital in California to teach rehabilitation techniques to 100 staff nurses from several western States. The outstanding rehabilitation program of this hospital has enabled even patients requiring mechanical respirators indefinitely to remain at home with their families.

Through the Professional Nurse Traineeship Program, also administered by the Division of Nursing, nurses in teaching, supervisory, or administrative jobs have received intensive instruction to improve their skills in rehabilitation and the day-to-day care of long-term patients.

The garments of legend and of song are marvelously adorned with thoughts of home. The wonder of the Ulysses
story is that after 10 years he saw his homeland. Modern poetry and music pay homage to man's yearning for home with "Oh, to be in England" and "Way down upon the Swanee River." Daily strong men and well seek the roadways and airways to reach the one place they hold most dear.

Out-of-hospital care, medically prescribed, community-sponsored, and woven together by nursing, will assure to the weak, as well as the strong, the healing grace of home.

Footnotes
6/ Proceedings of Workshop on Home Care Services, conducted April 1960 in Chicago, Illinois, under the joint sponsorship of American Hospital Association, American Medical Association, Blue Cross Commission, Blue Shield Medical Care Plans, U. S. Public Health Service.
7/ Care at Home, 16mm black and white film, 20 minutes, produced by WOED-TV, Pittsburgh, Pa., for the U. S. Public Health Service, 1962.
8/ Home Nursing Care Program, Pilot Study, April 1960, Denver, Colorado, Report of study sponsored by Rose Memorial Hospital, Colorado Blue Cross, Denver Visiting Nurse Service and Tri-County Visiting Nurse Service.
9/ An After-care Program for Patients Discharged from Mental Hospital, David M. Grayson and Winifred M. Lanahan, Nursing Outlook, September 1961.
10/ Nursing's Contribution to Medical Education, Shirley E. Callahan, Nursing Outlook, September 1961.

A Conference on Health Careers will be held May 22 in Winston-Salem under the sponsorship of the North Carolina Health Council.

In announcing this one-day meeting, Mrs. Marie B. Noell, Raleigh, President of the Council, stated that its purpose is "to give help to all persons concerned with recruitment of health personnel". The conference theme is "Personal for Progress—Meeting Our Growing Health Needs".

George Griffenhagen, Washington, D. C., Director of the Division of Communications of the American Pharmaceutical Association, will be the keynote speaker. His subject will be "The Challenge Ahead".

Mrs. Lula Belle Rich of the State Board of Health has served as Program Chairman for this special conference.

The Health Careers Conference is one of the activities of the N. C. Health Council in which some sixty health related organizations and agencies in the State have membership.

A series of seminars on hepatitis sponsored by the U. S. Public Health Service, Communicable Disease Center and the States' Public Health Associations, has been launched to help State and local health officials tighten their control over the spread of this disease. Hepatitis now ranks third among the communicable diseases reported to the Public Health Service and is exceeded only by measles and streptococcal infections. The seminars will be held in ten States and the Commonwealth of Puerto Rico between March and July.
Community Mental Health Workshop to be Held in June

The Seventh Annual Workshop in Community Mental Health will be held June 11-21, once more at the Pisgah View Ranch near Asheville, according to an announcement by Dr. Robert M. Fink, Consultant, Mental Health Section, State Board of Health.

The workshop is designed to bring together persons who work in community mental health programs for the purpose of discussing community mental health needs and how they can be met.

An outstanding staff of national, regional and state personnel has been secured. Among these are: Eleanor Collard, Mental Health Nurse Consultant, Public Health Service, Charlottesville, Va.; E. H. Ellinwood, M.D., Director of Public Health, Guilford County, Greensboro, N. C.; Berton Kaplan, M.A., Instructor, Sociology in Mental Health, School of Public Health, University of North Carolina, Chapel Hill, N. C.; Virgil Shoop, M.S.W., Psychiatric Social Work Consultant, Public Health Service, Kansas City, Mo.; and Marvin Taves, Ph.D., Chairman, Department of Rural Sociology, University of Minnesota, St. Paul, Minn.

Write to Dr. Fink for costs and further information.

Chester Cogburn, owner of Pisgah View Ranch and Mrs. Cogburn who will furnish the good food and mountain setting for the Seventh Annual Workshop in Community Mental Health. Chester's literary flavored breakfast greetings beggar description.

Dr. Luther L. Terry, Surgeon General of the Public Health Service, has established a new Division of Community Health Services to be a focal point in the Service's work on problems in the fields of public health and medical care administration.

Accident Prevention — The Role of Physicians and Public Health Workers is the name of the new accident prevention textbook prepared under the direction of the Program Area Committee on Accident Prevention and authorized for publication by the Technical Development Board of the American Public Health Association. Emphasis is placed on the human factors plus the specific types of accident prevention activities in which public health workers and physicians can engage. The State Board of Health library has two copies of the book available on free loan to public health workers, physicians and others interested in accident prevention.
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NCPHA Scholarship Offered

The scholarship offered by the North Carolina Public Health Association is available for the 1962-63 academic year and applications are now being accepted. There is no age or experience limit for this scholarship, and it may be awarded for study in any public health field. Eligibility is based on eligibility for admission to the University of North Carolina School of Public Health at in-state resident tuition fees.

Because of the lack of age and experience requirements, this scholarship should be of particular interest to those who, because of age or length of experience in public health, are not eligible for federal traineeships. The scholarship pays in-state tuition and fees for one academic year.

Applications must be made on prescribed forms, which may be obtained from Dr. William P. Richardson, School of Medicine, University of North Carolina, Chapel Hill, North Carolina, and must be returned to him by June 1, 1962.

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Effectiveness Rests At The Local Level

Regulations issued by the State Board of Health for assuring sanitary conditions in migrant labor camps in North Carolina are commendable, but county health departments throughout the state will determine through their enforcement of the regulations how effective they are.

Conditions in these labor camps have become a matter of grave concern in recent years, and there is ample proof that many such camps have been far below what might be considered standard or even reasonable. Efforts by the state to up-grade living conditions for migrant farm workers should not end with issuing a set of regulations.

We are confident most of the county health departments will endeavor to see that the regulations are met, but in many counties health departments are understaffed. Demands upon the time of their employes already have them spread too thin for the jobs they are supposed to be doing. It is not unlikely that the counties which have most of the migrant labor camps will also be the same counties which have limited staffs to take on the additional chore of seeing that the camps are operated in accordance with the state regulations.

If the new program is to be effective, the state might well consider having a stand-by group of its own workers to give assistance to county health departments where checking on the migrant labor camps imposes still another burden on an already overloaded department staff. —Editorial in Greenville Reflector.

Rabies Control Outlook for North Carolina

During 1961 there were 14 laboratory-confirmed cases of animal rabies in North Carolina (4 dog, 9 fox, 1 cow). This is the lowest number ever recorded in the state. Nine cases were reported from Alleghany, four from Surry and one from Wilkes. The number of human antirabic treatments dispensed by the State Board of Health Laboratory Division to private physicians and health directors also hit a new low in 1961 of 105 complete treatments.

Control programs were strengthened in several counties during 1961, however, many counties are still without organized stray dog control and have only a small percentage of the dog population adequately immunized. It is hoped that 1962 will bring continued improvement in this public health problem. Complacency and apathy may become our biggest problem. It is indeed encouraging that we have not had a single case of laboratory-confirmed animal rabies in North Carolina since October 1, 1961 and we have not had a human death from rabies since 1954.

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DATES AND EVENTS

May 6-9—Annual meeting Medical Society of the State of N. C., Raleigh
May 9—Conjoint Session, State Board of Health and Medical Society of the State of N. C., Raleigh
May 24—Annual Meeting N. C. Heart Association, Raleigh.
May 25—Heart Seminar, Burke County Health Department, Morganton.
June 6-8—N. C. Hospital Association, Chapel Hill.
June 7-9—Eastern Affiliate N. C. Public Health Association, Annual Meeting, Nags Head.
June 18-22—Annual Educational Conference, National Association of Sanitarians, Cincinnati, Ohio.
Every Saturday—State Board of Health Radio Program over WPTF (Raleigh) 7:30 P.M.

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Rabies Control Outlook for North Carolina 15

Under our existing legislation all children entering school for the fall term, 1962, must show evidence of immunization against smallpox, tetanus, diphtheria, whooping cough, and poliomyelitis. Such evidence must be shown in the form of a certificate furnished by a licensed physician or health department.
SOUTHERN BRANCH APHA LEADERSHIP

H. W. Stevens, M.D., (center) of Asheville, N. C., the newly elected president of the Southern Branch of the American Public Health Association, is flanked by Elizabeth Holley, Chapel Hill, program chairman for the Roanoke, Va., meeting in May and now the First Vice-president; and M. L. McDonald, Dallas, Texas, retiring president of the body.
ASHEVILLE—Ida Reid Cohen and Bernard M. Gibson were among the delegates from the Buncombe County Health Department at the annual Southern Branch meeting.

PREPARATION—Retiring President M. L. McDonald, Dallas, Texas, of the Southern Branch APHA prepares his material for the Banquet session in Roanoke while Helen Hood, Salem, of the Roanoke County Health Department looks after delegates asking for information.

CENTER OF ATTRACTION—These attractive Pages at the Annual Meeting of the Southern Branch of APHA held in Roanoke, Va., are seen enjoying the witticisms of J. M. Jarrett, director of the Sanitary Engineering Division of the State Board. These Pages who served so well during the meeting are from Roanoke Memorial Hospital. From the left, they are: Padche Buchanan, Saltville, Va.; Betty Combs, Grundy, Va.; Barbara Littell, Staunton, Va.; and Peggy Smith, Vinton, Va.

When the Southern Branch APHA Met in Roanoke, Va.
A Proposal

WHEREAS, the Southern Branch of the American Public Health Association, assembled in Roanoke, Virginia, this May 4, 1962, recognizes that the many plans proposed by the various organizations and in Congress have all lacked adequate study, did not recognize medical care needs of the public including the aged, nor the resources to meet those needs,

THEREFORE, BE IT RESOLVED, that this Association urge the American Medical Association, the American Heart Association and the American Public Health Association to promptly convene a joint study group to prepare and suggest, after adequate study, a positive and comprehensive plan for the medical care of the public; a plan which would take into account the particular medical needs in various groups of the citizenry of the United States, and the efficient utilization of both public and private resources to meet such medical needs; such plan to be presented to the Congress of the United States after widespread publicity and study by appropriate and interested bodies.

SECTION MEETINGS — Paul C. Watt, Washington, D. C., is seen addressing the Sanitation Section of the Southern Branch meeting. This was one of ten Section Meetings during the three-day convention.
Progress in Control of Poliomyelitis, Measles and Infectious Hepatitis

by Jacob Koomen Jr., M.D., Assistant State Health Director

In the report of the North Carolina State Board of Health to the Conjoint Session of 1962 it seems appropriate to discuss poliomyelitis, measles and infectious hepatitis in view of the current progress made in control.

Poliomyelitis, a dread disease of the present century and the latter portion of the nineteenth century, is now near control. With the immunizing agents at hand for immunization, eradication can be considered.

Measles, appearing in epidemics every two to three years, ranks high as a cause of morbidity, affecting almost exclusively children of school and preschool age. Until recently no agent for active immunization was available. Experimental studies now in progress point the way to control of this disease.

The third disease to be discussed, infectious hepatitis, though known since ancient times, has only relatively recently become a clinical and public health problem of great magnitude. Much remains to be learned in the clinical, laboratory and epidemiological aspects of this disease before control can be expected. It is to be anticipated that some of these aspects will be elucidated in the near future.

Poliomyelitis

Table I presents data relative to numbers of cases of paralytic status of poliomyelitis in North Carolina for the period 1955-1961. Prior to 1955 paralytic and nonparalytic cases were not distinguished or were incompletely distinguished. In 1955 an extensive poliomyelitis surveillance program was initiated in cooperation with the Communicable Disease Center. From that date information relative to immunization status, results of virus isolation studies and paralytic status are complete.

By the standards of the present day relatively large numbers of cases of paralytic disease were seen in 1955 and 1956. Two years in which few cases were seen followed. In 1959 a severe epidemic occurred. Two hundred and seventy paralytic cases were reported.

Several features of the 1959 outbreak are worthy of mention. Disease was not evenly distributed over the State but occurred in rather sharply
TABLE I
Cases of Paralytic Poliomyelitis and Incidence per 100,000 Population
North Carolina
1955-1961

<table>
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<th>Year</th>
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<tr>
<td>1961</td>
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TABLE II
Paralytic Poliomyelitis Case Distribution by Age and Salk Vaccination Status
North Carolina
1961

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<tr>
<td>Total</td>
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</table>

circumscribed, localized outbreaks. Incidence of the disease corresponded closely with failure to receive an adequate course or indeed any Salk poliomyelitis vaccine. In some outbreaks the non-white population showed a greater incidence of disease than the white, a phenomenon observed for the first time and in keeping with the lower incidence of adequate immunization to poliomyelitis. Three of 4 military installations reported outbreaks among personnel and their dependents.

The two years that followed, 1960 and 1961, showed a sharp reduction in paralytic cases.

Last year only 9 paralytic cases were reported. The 9 cases reflect, it is believed, the lowest incidence of paralytic disease seen in North Carolina since poliomyelitis became a disease of importance.

Table II shows numbers of cases by age and vaccination status for 1961. Four received no vaccine. Four patients had received 1 or 2 doses of vaccine. As in prior experience the largest number of individuals were seen in the 0 to 4 age range. Data obtained nationally and in North Carolina indicates that the 0 to 4 age group is among the most poorly immunized, while those in the school age group are among the best immunized.

While certain irregular cyclic events occur in poliomyelitis reflecting high and low incidence, the great progress in control is largely attributable to the widespread use of Salk vaccine. Failure to achieve full immunization, especially in the 0 to 4 age group generally and in certain non-white groups were reflected in the occurrence of cases in that age range. Seven years of Salk formalin-inactivated vaccine usage have amply demonstrated its effectiveness in May, 1962

THE HEALTH BULLETIN 5
control of this important disease. The merits of the vaccine, and its advantages are well known to each of you and will, therefore, not be discussed further.

With the announcements in the summer of 1961 that types I and II of Sabin oral live vaccine had been licensed for use and the subsequent licensure of type III in spring of 1962, another important immunizing agent to poliomyelitis became available.

This vaccine, its efficacy well demonstrated in the United States and abroad, offers certain advantages over formalin-inactivated poliomyelitis vaccine.

Large numbers of individuals can be easily immunized in the field because syringes and needles are not required. This eliminates the need for many time consuming procedures and sterilization equipment.

The vaccine is pleasant to take. It is hoped that many who rejected Salk vaccine because of the necessity for injection will accept Sabin oral vaccine.

Protection to poliomyelitis for the specific type follows quickly the taking of oral vaccine. Since oral vaccine administration is believed to follow the natural route of infection, local immunity of the intestinal tract is achieved, preventing subsequent natural infections and transmission of poliomyelitis viruses of the wild strains to other individuals.

The vaccine is low in price, not only in its initial cost but as indicated above, because the cost of injection is saved.

It remains to be determined whether oral vaccine will produce life-long immunity, but such is a possibility.

Both vaccines will in the future have a useful role in the prevention of disease. The role of each remains presently to be determined.

Certainly with the “poliomyelitis season” about to begin this is no time to abandon Salk vaccine. This is the time to urge its vigorous use to reach those in the susceptible groups who have not been immunized and to reinforce when necessary the immunization of those previously immunized. Fall, winter and spring are the recommended times to use Sabin vaccine—the times when little interference to infection may be anticipated from the other enterovirus which may prevent “take” of the vaccine.

Present schedules require that type I oral poliomyelitis vaccine be given first. Six weeks thereafter, type III is to be administered and six weeks later, type II follows. In this way protection can be achieved to the three types of poliomyelitis virus. With achievement of immunization of all in the susceptible age groups by means of Salk vaccine or of a sufficient number to prevent circulation of wild strains of poliovirus by Sabin vaccine, it may be expected that poliomyelitis will diminish further and perhaps disappear as an important clinical and public health problem.
MEASLES

Measles remains an important childhood disease. Most adults have contracted infection as children—approximately 90% of our population has suffered from measles at the time the age of 12 is reached. Many physicians have accepted measles as a necessity of childhood, as a relatively mild disease and as one from which few sequelae might be expected. That encephalitis and death did occur was known to all however, but the picture of a mild disease dominated the thinking of many workers in the communicable disease field. One to five thousand cases of measles were reported each year in North Carolina. This did not reflect the true numbers of cases since many were not seen by physicians and therefore not reported. One measure of the severity of the disease is shown in the death toll. Last year (1961) 23 individuals died of measles. Only one patient died of acute poliomyelitis.

Some protection against this disease, once exposure was known to have occurred, was available. Gamma globulin supplied to us through the generosity of the American Red Cross has long been useful in modifying or preventing measles. Active immunization became a possibility only after adaptation of measles virus to tissue culture. Here, as in the poliomyelitis field, we must express our thanks to Dr. John F. Enders and his associates for isolation and cultivation of this agent. Following adaptation of the virus to chick cells and demonstration of attenuation in 1957, the possibility of immunization trials occurred. After appropriate study, it was determined that the inoculation of attenuated virus produced antibody in a high proportion of previously antibody negative individuals. The attenuated agent produces, following a subcutaneous or intramuscular injection, fever of about 1-3 days duration in a high proportion of those inoculated. About 45% of the inoculated individuals develop a pink, macular, non-itching, discreet rash usually limited to the upper trunk, neck and face. While rash and fever are the two major features seen following inoculation very few children display irritability, loss of appetite, cough, conjunctivitis, inflammation of the upper respiratory tree, and abdominal discomfort. Approximately 95% of the children receiving a single dose of the protective vaccine will demonstrate antibody. Field trials indicate a high degree of protection under conditions of natural exposure. The principal drawback to the use of this vaccine is that clinical illness is produced. The illness, however, is one of unusual mildness. Most children are not sufficiently ill to require bedrest.

LOCAL ARRANGEMENTS—Margaret M. Glendy, M.D., director of the Roanoke City Health Department, who was in charge of Local Arrangements. They never have been done better, so many veteran delegates said.

May, 1962
In an effort to avoid illness following inoculation, three approaches are being tried. One of these combines the use of gamma globulin, so effective in naturally occurring measles, to prevent symptoms, and another involves use of formalin-killed vaccine.

The scarcity and cost of gamma globulin are certain to limit the usefulness of this approach to measles immunization. Some trials using formalin-inactivated vaccine indicate great promise for this type of vaccine. A third approach involves injection of killed-vaccine followed by inoculation of living vaccine in the expectation of producing a solid, long lasting immunity without significant clinical illness. There is now within grasp a measles vaccine promising control.

**INFECTIOUS HEPATITIS**

Infectious hepatitis was made a reportable disease in North Carolina in 1952. This is about the time most states first made infectious hepatitis reportable. Two epidemic periods have been seen. The first occurred in 1953. North Carolina and the United States are now in the midst of the second epidemic which began in 1960, continued to a high level in 1961 and will, in 1962, perhaps equal or exceed the peak seen in 1961. While a considerable amount of new data are being added in the epidemiological studies of infectious hepatitis, much remains to be learned. This year two outbreaks of hepatitis traceable to oysters and clams were studied in this country. A small number of water-borne outbreaks of this disease also attracted attention. Several small outbreaks related to contact with chimpanzees were reported.

The bulk of the disease, it is believed, is related to close person to person contact with a high proportion of the recognized illness occurring in the school-age group. In the pre-school age group, infectious hepatitis occurs but is often of mild form, often without jaundice. Approximately 25% of the reported cases of infectious hepatitis recorded in North Carolina occur in adults and like poliomyelitis when seen in the adult years, tends to be a severe disease.

Commonly case incidence is highest in winter and late spring. However, in epidemic years the incidence tends to be high in each month of the year and the decline in cases expected during the summer months is not seen. Attack rates are approximately equal for both sexes though males slightly outnumber females. It may be postulated from the excellent protection conferred by use of gamma globulin and the relatively low attack rate among adults that most adults, 1.2 contributors to gamma globulin pools, are immune.

Until recently man has served as the only experimental animal. Data to date on the nature of the agent has been derived almost exclusively from experiments in volunteers or epidemiological observations. Some information previously referred to is of interest here. In particular, the frequency with which the disease was transferred in this past year from chimpanzees to veterinarians and others associated in their care. It seems clear that the chimpanzee can serve as a natural host for the virus. Tissue culture, so useful in isolation of the many viruses adapted to man and to animal, has to now proved unsuccessful in the eyes of many observers in bringing to light the virus of this disease. From time to time reports in the literature indicate isolation of this agent.

A portion of the Annual Meeting (1961) of the Public Health Association was devoted to presentation of data concerning isolations of agents from cases of infectious hepatitis. As pointed out earlier, while an agent or agents may have been isolated, many observ-
ers believe this area requires further study before acceptance of the data. Following the isolation of the agent and reproduction in tissue culture, it may be anticipated that a vaccine will be produced for field trial use and, if successful in disease prevention, will subsequently bring about broad scale usage in our population. Data acquired from the use of gamma globulin would indicate that a vaccine which induces antibody formation would thereby confer a protection. Such a vaccine would be most important in control since in this past year 2194 cases were reported in North Carolina, attesting to the epidemic level and attesting to the high morbidity importance of the disease since infectious hepatitis perhaps, as few acute communicable diseases, produces long periods of disability and some deaths. It has recently been reported that progress is being made in growing liver tissue in tissue culture. In prior attempts to cultivate liver tissue the usual end result was connective tissue. If it is true that liver cells have been reproduced in regular cell lines, there is offered the hope that the virus can be grown therein. This would give us appropriate laboratory media for isolation of the agent and a direct approach towards correctness of diagnosis, epidemiological follow-up, and above all, possibly permit production of a vaccine.

The three diseases, poliomyelitis, measles and infectious hepatitis, have been reviewed in the light of recent development in control. As has been noted, within our grasp is elimination, that is, eradication of the disease poliomyelitis. Coming within reach is the possibility of the control of measles and possibly its eradication as well. In the case of infectious hepatitis, we are much less far advanced but beginning steps are being made. It may be hoped that within the next decade sufficient information will be at hand to control this important cause of morbidity as well.

(Citations of sources may be had upon request.)

BARBARA MORGAN of Asheville, the 1961 N. C. Dairy Princess, who reigns during June, designated as National Dairy Month.

June Is Dairy Month

This year marks the 26th anniversary of the nationwide celebration of Dairy Month. This industry makes a mighty contribution to the economy of North Carolina and of the nation. As one of the basic foods, milk and milk products, comprise a major element in the food supply of the individual and the family.

The choice of Miss Barbara Morgan of Asheville as the 1961 North Carolina Dairy Princess makes it so she will reign throughout the month of June this year. A contest will be held among the 12 districts of the State to choose the 1962 N. C. Dairy Princess. Held in Asheville July 11-12 at the Grove Park Inn, this event will be in conjunction with the Summer Meeting of the N. C. Dairy Products Association.
RESIDENT LIVE BIRTHS, INFANT DEATHS, AND MATERNAL DEATHS WITH RATES:

NORTH CAROLINA AND EACH COUNTY, 1961*

(Infant mortality rates per 1,000 live births. Maternal mortality rates per 10,000 live births.)

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<th>Area</th>
<th>Live Births Number</th>
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<th>Infant Deaths Rate</th>
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*Data are provisional and include receipts through January 1962 for 1961 occurrences.

Source: Public Health Statistics Section

4-5-62

May, 1962

THE HEALTH BULLETIN 11
A Guide for the Family of the Alcoholic

By Joseph L. Kellermann, Director
Charlotte Council on Alcoholism

INDIVIDUALS may be capable of assisting alcoholics outside the family yet become confused, upset and destructive when a member of their own family begins drinking compulsively. The "next of kin" may need more assistance and counseling in launching an effective recovery program. Alcoholism produces tremendous emotional upset within the family.

From the very outset I want persons reading this article to understand that there is some guide or direction available in dealing with alcoholism problems. The question that is asked over and over again by persons coming to our office is, "What can I do?" Perhaps it is even better to start off by giving answers as to what one should not do. It has been my experience that wives make so many mistakes, and family members also make so many horrible mistakes, that it is almost impossible for the alcoholic to recover until the family at least can avoid putting handicaps and obstacles in the way of recovery.—The Author

Wives may find themselves blamed for everything wrong in a marriage and may begin to feel this may be true. Yet alcoholism is an illness. The wife does not cause it as she would not cause diabetes. She cannot be held responsible for the existence of alcoholism but she can take steps which may lead to early recovery. This, to a degree, is true of all members of the family, especially the one person upon whom the alcoholic ultimately depends.

The best initial help for any person involved in alcoholism is to seek help for himself. This may not result in recovery but this person then is far less likely to play into the progressive pattern of the illness. No action can guarantee recovery but it materially changes the odds.

The problem is not the bottle but the person, but recovery does not begin until the alcoholic is able to break away from the bottle. No one can do for the alcoholic what must be done by the alcoholic. Recovery begins when the alcoholic by volition surrenders the bottle.

It is appalling how well the alcoholic controls the family. The alcoholic drinks and the family cries, pleads, begs, prays, threatens, curses or freezes into silence. It also covers up, protects, shields, and suffers because of shame. All this preserves the omnipotent neurosis of the alcoholic who has two effective weapons used against the family. The family must defend against these weapons or become virtual slaves of the illness, thereby creating for themselves emotional illness.

The Alcoholic's Weapons

The first weapon is the projection of the self-image in the form of extreme hostility, thereby making the family angry. If the family member becomes angry and lashes back all possibility of help is destroyed, the self-image is confirmed, and the alcoholic justifies former drinking and now has a perfect reason to get drunk again.
The second weapon, a defensive one, is the ability to arouse anxiety on the part of the family which compels the family to do for the alcoholic what must be done by the alcoholic if the disease is to be arrested.

A "bad check" is a good example of this principle. The family gets over-anxious, redeems the check, berates the alcoholic for writing it but condones the action by a removal of the consequences. Result: More drinking, more checks, and more important—the alcoholic's guilt is increased because he can never redeem a check redeemed by others who themselves are escaping from reality and pain by taking up the check. Each is the counterpart of the other. The alcoholic can not mature and face reality if the family removes it because of their own anxiety.

Anger and anxiety must be understood and eliminated within the family or it contributes to the progress of the disease. For this reason and many others the family should seek counsel outside the circle of relatives, friends, and neighbors.

Love and Compassion

A serious failure in approaching the alcoholic stems from the inability to understand the meaning of love. "If you loved me you would not drink" is just as irrational as stating "If you loved me you would not have tuberculosis." Alcoholism is an illness. A disease is a condition, not an act. Drinking excessively is a symptom of the disease. As an anesthetic alcohol relieves the "pain" of the illness alcoholism. But drinking increases the anxiety, tension and resentment of the family. When the alcoholic soberes up there is no desire to suffer the painful consequences of drinking so the family is used to remove the painful consequences just as the alcohol was used to remove the initial pain.

Three primary dimensions of love are justice, discipline and compassion. Without these love cannot exist. If the family tolerates repeated injustice love is destroyed. If discipline is not exercised by the family the alcoholic is not likely to learn it. Compassion is to bear with or suffer with a person but not to suffer because of the person who refuses to suffer by using alcohol to remove primary pain and uses the

This article is offered as a suggested "guide" for the family seeking help in an effort to deal more adequately with an alcoholic. The basic problem is gaining valid knowledge and achieving the emotional maturity and courage to use it.

family to remove the painful consequences of drinking. To preserve justice, and as an act of self-discipline, the family must learn not to suffer when drinking is in progress nor to remove the consequences. In this way compassion is achieved by sharing the suffering of the alcoholic, not by becoming the abortive means of escape for the alcoholic.

How Love is Destroyed

If the family suffers when the alcoholic drinks and pays the full price of the consequences then justice is aborted, discipline is avoided and compassion is evaded. Gradually fear takes over human emotions and fear is the opposite of love. Recovery for the family begins when they understand that love does not require the acceptance of injustice or the avoidance of discipline, and above all that compassion exists only when one suffers with another person—not by removing the pain of another.

This is why family members need help if alcoholism is to be arrested. The gross ignorance of the nature of the
disease and failure to understand the meaning of love allow the family to become destructive emotionally rather than creative in their interaction with the alcoholic.

Knowledge of the nature of alcoholism and the courage to live by this knowledge is essential if fear is not to replace love in the family of the alcoholic.

Before leaving this area of discussion it must be mentioned that there are wives and husbands who need an alcoholic spouse to gratify their needs. Masochism is the neurotic need to suffer in order to find a sense of worth in life. Sadism is the need to inflict pain. Some individuals have a tremendous need to control another person.

All three of these neuroses are well met if the spouse is an alcoholic. Parents and other family members can exercise these neuroses in interaction with the alcoholic as well as the spouse. These illnesses are just as serious as alcoholism and need intensive treatment or else sheer destruction results when any of these three neuroses unleash their impact upon the alcoholic.

There is little chance of recovery as long as the alcoholic uses the family or the family uses the alcoholic to meet real neurotic needs. It is well-nigh impossible for the alcoholic to recover if the family does not change also. If the family makes genuine recovery and stops reacting destructively with the alcoholic then chances of recovery are greatly increased.

Long-range Sobriety
It is impossible to keep the bottle away from the alcoholic or the alcoholic away from the bottle. Any battle won in this way today will be refought tomorrow. Winning the war against the disease is the goal.

The best known motivating force works as follows: The pain of the consequences of drinking must become more powerful than the pleasure of alcoholic escape before the patient is ready to stop drinking. To accomplish

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In the long run, by the exercise of discipline in compassion, the family will be able to give the alcoholic greater joy in sobriety while allowing the consequences to become painful in themselves. The average family removes the painful consequences, suffers intensely in this process, and then emotionally and otherwise inflicts pain upon the alcoholic during sobriety.

Recovery from any serious illness often entails a relapse. If the alcoholic drinks again and the family does not panic this “slip” may become a reinforcement to the idea that recovery depends upon voluntary abstinence on a permanent basis.

In the process of recovery the alcoholic may become as compulsively engrossed in treatment as he was in drinking. This is especially true if Alcoholics Anonymous is discovered and enjoyed. The wise spouse joins the alcoholic partner by attending Al-Anon and going to open A.A. meetings regularly. In fact, Al-Anon for members of the family are as helpful for the spouse as A.A. is for the alcoholic and is recommended for family members whether or not the alcoholic attends A.A.

The only logical means of speeding up the recovery process is active therapy for the non-alcoholic member or members of the family.

Begin With Self

Rules of thumb in seeking help for self are as follows:

1. Learn all the facts and put them to work in your life. Don’t start with the alcoholic.
2. Attend A.A. and Al-Anon meetings. If available, go to an Alcoholism Information Center, Mental Health Clinic, competent counselor or minister who is experienced in this field.
3. Remember you are emotionally involved. A change of attitude will help.
4. Encourage and cooperate in all beneficial activities of the alcoholic.
5. Love cannot exist without justice, discipline and compassion. To give or accept it without these qualities is to destroy it eventually.

Important Don’ts

It is easier to find a list of don’ts and these are as important as the do’s.

1. Don’t allow the alcoholic to lie to you thereby encouraging the process as a means of avoiding pain.
2. Don’t let the alcoholic outsmart you, thereby avoiding responsibility and losing respect at the same time.
3. Don’t let the alcoholic exploit or take advantage of you, thus making you an accomplice in the process.
4. Don’t lecture, moralize, scold, praise or blame, threaten and not do it, argue when drunk or sober, pour out liquor, or cover up the consequences of drinking.
5. Don’t accept promises, for this is a method of postponing pain. In the same way, don’t switch arguments.
6. Don’t lose your temper and thereby destroy yourself and the possibility of help.
7. Don’t allow your anxiety to compel you to do what the alcoholic must do for himself.
8. Don’t follow this article as a rule book but only as a “guide.” If at all possible seek the professional help which you may need, possibly more than the alcoholic.
9. Above all, don’t put off facing the reality that alcoholism is a progressive illness that gets increasingly worse as drinking continues.

Start now to learn, to understand, and to plan for recovery. To do nothing is a choice and the worst choice you can make.

The above is a condensation by the author of a booklet, “A Guide for the Family of the Alcoholic.”
DATES AND EVENTS

June 4-22—Trudeau School of Tuberculosis, Saranac Lake, N. Y.

June 7-9—Eastern Affiliate N. C. Public Health Association, Annual Meeting, Nags Head.

June 11-July 6—Summer Course, "Nursing Care of the Patient with Long Term Illness", U.N.C. School of Nursing, Chapel Hill.

June 11-July 7—Summer Course, "Psychiatric Nursing", U.N.C. School of Nursing, Chapel Hill.

June 18-22—Annual Educational Conference, National Association of Sanitarians, Cincinnati, Ohio.


Every Saturday—State Board of Health Radio Program over WPTF (Raleigh) 7:30 P.M.

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Dr. J. W. Roy Norton was given the first Award of Merit at the Southern Branch of the American Public Health Association which met in Roanoke, Va. in May. M. L. McDonald, president of the body, stated in presenting this award that it was given "for outstanding contribution and meritorious service in the field of public health and preventive medicine."
AN EDITORIAL GALAXY—Rarely do editors get their pictures taken singly. Even rarer is this picture of a group taken during the 89th Annual Forum of the National Conference on Social Welfare held in New York City May 27- June 1, 1962. Participating in a panel discussion on the subject, "Writing for Professional Journals", were five distinguished editors of widely known national journals. Seen in the picture, from left, are: (seated) Kathryn Close, Washington, D. C., Editor, CHILDREN, Children's Bureau, Department of Health, Education and Welfare; Cora Kasius, New York City, Editor, SOCIAL CASEWORK, Family Service Association of America; Rachel B. Marks, University of Chicago, Editor, SOCIAL SERVICE REVIEW; (Standing) Alice Ullmann, New York City, Social Work Coordinator of Comprehensive Care and Teaching Program, New York Hospital, Cornell Medical College, discussion leader for the session; George Rosen, M.D., New York City, Editor, AMERICAN JOURNAL OF PUBLIC HEALTH, Columbia University School of Public Health; Mrs. Beatrice Saunders, New York City, Managing Editor, SOCIAL WORK, National Association of Social Workers; and Susanne A. Kohut, New York City, Associate Director, Social Service Department, St. Vincents Hospital, and chairman of the Medical Social Work Section of the NASW which planned this and several related section meetings of the Annual Forum. (See pp. 13-15.)
AN HONOR FOR A NOBLEMAN
By conferring the honorary degree of Doctor of Laws upon Dr. Fred T. Foard, M.D., during this June Commencement, the University of North Carolina not only honored a man who in that institution's judgment deserved such recognition, but took action applauded by all Dr. Foard's associates in the State Board of Health. Here we have in North Carolina a true nobleman and we are proud of him.

A Special Week on Aging will be observed in North Carolina July 15-21, sponsored by the Governor's Coordinating Committee on Aging. During this week the many services given by Local Health Departments and by the State Board of Health and by other governmental and private organizations and agencies will be called to the attention of the public. In addition, honor will be paid to these older senior citizens by many governmental units and private organizations.

Tetanus immunization campaigns are going on over the State under the auspices of the Medical Society with the cooperation of the local health departments and other agencies.

Health Departments are cautioning local homemakers to be especially careful in the management of their families' food supplies during the summer. Protection of foods against infection and then proper storage after preparation are of prime importance. The most common foods transmitting food poisoning are: custard-filled pastries, processed meats (especially pork and fowl), and unpasteurized milk and milk products.

AT WORK—On a recent visit to Gastonia to confer with the staff of the Gaston County Health Department, the Editor's host was the Local Health Director, B. M. Drake, M.D. He is seen here in his office catching up on his correspondence with the help of Mrs. Gloria Dalton. Dr. Drake is president of the N. C. Public Health Association.
Scenes from Health Careers Conference

Meeting held in Winston-Salem under sponsorship of N. C. Health Council.

YOUTH SPEAKS—Nancy Carr, President of N. C. Health Careers Clubs, told of the interesting meeting of these clubs some weeks earlier. Mrs. Marie B. Noell, President of the N. C. Health Council is shown as presiding officer of the Health Careers Conference.

SYMPOSIUM—"Some Present Programs in Health Career Information" was the subject of a major panel discussion at the Health Careers Conference in Winston-Salem. Seen, from the left, are: Mrs. Cynthia N. Warren, Richmond, Va., Assistant Director, Virginia Council on Health and Medical Care; N. C. Liske, Siler City, Administrator, Chatham Memorial Hospital; Mrs. Charles F. Tillinghast, Asheville, Executive Secretary, Health Careers for Western North Carolina, Inc.; Reuben Graham, Winston-Salem, Assistant Administrator, North Carolina Baptist Hospital; R. E. Coker, Jr., M.D., Chapel Hill, Panel Moderator and Professor of Public Health Administration, School of Public Health, University of North Carolina; and Mrs. Marie Noell, Raleigh, President of the N. C. Health Council which sponsored the Conference.
CAREERS CONFERENCE LEADERS—Most helpful in many ways in making the Health Careers Conference a success were these, from the left: Courtland H. Davis, Jr., M.D., Winston-Salem, Associate Professor, Neurosurgery, Bowman Gray School of Medicine, who gave an outstanding summary of the day’s deliberations; George P. Harris, Charlotte, Director of Field Services, Duke Endowment, who served on the program committee and contributed in other ways; and Francis W. Mulcahy, Executive Director, Goodwill Industries Rehabilitation Center and host to the Conference.

Typhoid immunization is urged by Dr. Isa Grant, Wake County Health Director. While not a major threat in this county, such protection is needed by persons who visit in places where there is no approved water supply, families who camp out, persons who handle food, and those who swim in private lakes or ponds. Immunization is easy—a shot a week for three weeks and then an annual booster.

Safety supervision at public swimming pools is needed, according to Dr. Maurice Kamp, director of the Charlotte-Mecklenburg Health Department. Motel owners and swimming pool equipment firms discussed this need at a recent meeting called after a drowning and a near drowning in a local motel pool.

SECOND ROW VIEW—A second row view of one of the panel discussions during the Health Careers Conference held recently at Winston-Salem under the sponsorship of the N. C. Health Council.

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INFORMAL BUT STILL BUSINESS—Lunch hour fellowship during the one-day Health Careers Conference at Winston-Salem permitted informal continuation of discussions begun on the more formal program. Seen here are, from the left: Ella Stephens Barrett, Supervisor, Guidance Service; and Nile F. Hunt, Director, Division of Instructional Services—both of the State Department of Public Instruction; and Mrs. Lula Belle Rich, Chief, Health Education Section, State Board of Health.

SCHOOL AND COLLEGE GUIDANCE—Services in these areas were discussed by a panel led by Nile F. Hunt (left), Raleigh, Director, Division of Instructional Services, State Department of Public Instruction; with H. F. Forsyth, M.D., Winston-Salem, Director, Department of Orthopedics, Bowman Gray School of Medicine, presiding.

June, 1962
COUNTY CAREER INFORMATION—
N. C. Liske, Siler City, Administrator, Chatham Memorial Hospital, told the Health Careers Conference about health career information being given out in his community. Listening are: fellow panel member, Reuben Graham, (left) Winston-Salem, Assistant Administrator, N. C. Baptist Hospital; and panel moderator, R. E. Coker, Jr., M.D., Chapel Hill, Professor, Public Health Administration, School of Public Health, University of North Carolina.

PARTICIPANTS—Some who participated in the one-day conference on Health Careers which was held in Winston-Salem recently under the sponsorship of the N. C. Health Council.

HIGH LEVEL CONVERSATION—Mrs. Cynthia N. Warren, Richmond, Va., Assistant Director, Virginia Council on Health and Medical Care, converses with R. E. Coker, Jr., M.D., Chapel Hill, Professor at the School of Public Health of UNC, just prior to the panel discussion on Health Careers in which both took part.

June, 1962
National Physicians Polled On Kennedy Health Care Plan

More than 30,000 physicians, ballot­ing in a national poll on health care for the aged, turned thumbs down on the administration's King-Anderson bill and gave 2-1 support for the Kerr-Mills Act over all other proposed health care bills combined. The poll was conducted by Modern Medicine, national medical journal, and results are published in its June 11 issue.

Cutting in large measure across political and geographic lines, the doctors gave the Kennedy-backed plan less than 10 per cent of the vote and rolled up a majority of 62 per cent for Kerr-Mills. Running far behind in second place was the Bow bill with 17 per cent. The King-Anderson bill was third.

Kerr-Mills, now in effect, provides medical care to the near-needy aged through federal matching grants to states. The Bow bill would provide medical and hospital care by subsidizing voluntary health insurance premiums through federal income tax credits. The King-Anderson bill is linked to Social Security and would cover some institutional and home services.

Also included in the poll was the Javits bill, which would pay for some institutional and home services or, optionally, for part of private insurance premiums out of payroll taxes for Social Security and from general revenue. It was supported by four per cent of the doctors. Slightly more than seven per cent voted "no preference or against all such legislation."

North Carolina is not one of the 26 states which has implemented the Kerr-Mills federal legislation.

Some Facts About the MEDICARE Proposals

On the following five pages facts about federal legislative proposals seeking to provide health care for the aged are given in brief objective summary. Not all persons taking positive positions in this controversy have had the opportunity or taken the time to consider these various proposals in as much perspective as this summary provides. The summaries were prepared by the Washington staff of the national medical journal, Modern Medicine, and published in the April 30 issue as a special insert. We acknowledge with appreciation this material and the contribution thus made to a better understanding of the whole issue. Editor's Note.
### Special report

#### Comparison chart of the major health plans

<table>
<thead>
<tr>
<th>Kerr-Mills</th>
<th>King-Anderson</th>
<th>Eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aged persons on public welfare rolls; also low income persons unable to pay medical bills</td>
<td>All over 65 years of age eligible for Social Security or Railroad Retirement Act benefits</td>
<td></td>
</tr>
<tr>
<td>Broad range among states; can include hospital, physician, drugs.</td>
<td>Limit on hospital, nursing home care; covers physician services and drugs furnished by hospital; home health services.</td>
<td>Benefits</td>
</tr>
<tr>
<td>U.S. pays 50 to 80% of costs for care, 50% of administration.</td>
<td>Through an increase in social security payroll and self-employment payments</td>
<td>Financing</td>
</tr>
<tr>
<td>By states of which 26 are now participating</td>
<td>Secretary of Health, Education, and Welfare Department to set standards; could permit states to check on institutions</td>
<td>Administration</td>
</tr>
</tbody>
</table>

### Other plans in Congress

H.R. 10512, by a physician, Rep. Edwin R. Durno (R., Ore.), would establish a commission to seek a single, simplified, nationwide voluntary insurance plan for the aged, financed by ability to pay (as measured by tax returns), supplemented by state and federal money. H.R. 11405, by Rep. August E. Johansen (R., Mich.), would allow tax credits to buyers of paid-up health insurance that becomes effective at age 65. Tax credits would go to aged persons who buy policies or those who buy insurance for them.

H.R. 7756, by a surgeon, Rep. Durward Hall (R., Mo.), would expand income tax deductions for medical care expenses by the aged or their patrons and

*Modern Medicine, April 30, 1962*
<table>
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<th></th>
<th>Javits</th>
<th>Bow</th>
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<tbody>
<tr>
<td><strong>Eligibility</strong></td>
<td>Those 65 or older with net incomes of under $3,000 ($4,500 per couple)</td>
<td>Every person 65 years of age or older regardless of income or resources</td>
</tr>
<tr>
<td><strong>Benefits</strong></td>
<td>Choice of 3 plans, including catastrophic; limited hospital, physician, nursing home care</td>
<td>Per day limit on hospital, convalescent home charges; covers services of physicians, surgeons</td>
</tr>
<tr>
<td><strong>Financing</strong></td>
<td>Increase in Social Security taxes; general revenue to pay for those not receiving social security</td>
<td>Deduct $125 from income tax ($250 for couple) to pay health insurance premiums</td>
</tr>
<tr>
<td><strong>Administration</strong></td>
<td>By states, or by HEW Secretary in absence of agreement with states</td>
<td>United States Treasury Department</td>
</tr>
</tbody>
</table>

It would allow those with no taxable income but heavy expenses in a given year to apply for refunds on previous returns or credits on future returns. By extending tax deductions, H.R. 10117, by Rep. Thomas B. Curtis (R., Mo.), would encourage pension plans to add health insurance benefits for retirees.

S. 65, by Sen. Pat McNamara (D., Mich.), is in the King-Anderson pattern but attempts to cover all the aged. Benefits for OAA recipients and some other aged persons would be financed out of general revenue. Benefits are somewhat greater than King-Anderson, with no deductibles. Estimated cost: $1.1 billion reaching $1.5 billion later.

*Modern Medicine, April 30, 1962*
Kerr-Mills
(Passed in 1960)

A part of Public Law 86-778 of 1960 known as Medical Aid to the Aged (MAA), this is a system of federal matching grants to states to provide medical care to the near-needy aged. Federal grants to state-administered Old Age Assistance systems provide for welfare cases, while MAA helps those who are otherwise self-supporting but who are unable to pay medical bills. Payments are at an annual rate of $164 million and soon will reach $215 million.

Eligibility: If his state participates, a person 65 years or older may receive MAA help, generally after showing inadequate income. Need tests vary but usually exclude individuals with yearly incomes of more than $1,200 or $1,500 with higher limits for couples. Some states exclude persons with personal property valued at more than $2,500.

Benefits: States may use MAA money in such major categories as hospitalization, nursing home care, physicians' services, prescription drugs, and dental care. However, states must provide at least one institutional and one noninstitutional type of benefit. Standards and payments vary from state to state.

Administration: As of early April, 26 states and territories had MAA systems in effect. During the first year ending last October, 21 states had MAA systems, and 6 provided some care in the major categories. All 21 provide hospital care. MAA payments in 16 states in October totaled $13.7 million to assist 66,000 persons, 90% of whom were in New York, Massachusetts, West Virginia, Maryland, and Michigan. Among states with 50 or more participants, average payments ranged from $16.63 in Maryland to $325.28 in Washington.

Financing: Depending on a state's per capita income, the federal government appropriates from general tax revenue 50 to 80% of costs of care and pays 50% of administration. What a state is willing to spend on medical care of the aged determines the amount of federal aid.

Modern Medicine, April 30, 1962
The administration social security plan would pay for some institutional and home services but not private doctor fees. Administration estimate of first-year cost: $1.25 billion.

Eligibility: Anyone 65 years or older who is eligible for benefits under the Social Security and Railroad Retirement acts, about 14.9 million persons.

Benefits: 150 units of service per illness period, a unit equalling 1 hospital day or 2 nursing home days, with maximums of ninety hospital days and one hundred eighty nursing home days. At least ninety days must elapse between periods of covered care before benefits resume. Payments would cover: [1] inpatient hospital services, the patient paying $10 a day up to nine days but at least $20; services are those customarily furnished, including pathology, radiology, physical medicine, anesthesiology, and those provided by an intern or resident under an approved teaching course; [2] skilled nursing home services upon transfer from a hospital; [3] drugs, biologicals, supplies, and equipment customarily furnished in a hospital or skilled nursing home; [4] outpatient hospital diagnostic services, subject to a $20 deductible for each study; and [5] home health services up to 240 visits a year, including intermittent nursing care and part-time homemaker help.

Administration: The HEW secretary would set standards to assure health, safety, and quality of care but could delegate authority to a state agency for enforcement. Reimbursement would generally follow the Blue Cross basis of reasonable cost. A physician would certify need for services. After thirty consecutive days a utilization committee of the institution must certify existence of need and that services were furnished.

Financing: A Federal Social Insurance Trust Fund would be maintained through an increase in Social Security taxes of 0.25% on employers and on employees (with 0.375% for self-employed persons) on an earnings base of $5,000 or $5,200 a year.
Special report

Bow bill
(H.R. 10981)

This would provide medical and hospital care by subsidizing voluntary health insurance premiums through federal income tax credits. Tentative estimate of cost is $1.6 billion.

Eligibility: Everyone 65 years or older, regardless of income; anyone who pays premiums for an aged dependent or retired employee could claim tax credit.

Benefits: Approved insurance, guaranteed renewable, would have to conform to 1 of 2 plans. Plan A policies would provide [1] $12 a day for hospital room and board, $1,080 annual maximum; [2] $120 a year for hospital ancillary charges; [3] $6 per day for convalescent care up to $186 total for all confinement; and [4] surgical charges according to a fee schedule with a $300 maximum.

Plan B policies would cover payment of at least 75% of the following costs, after deductibles of either $100 with a $5,000 lifetime maximum or $200 with a $10,000 maximum: [1] inpatient hospital care at semi-private-room rates and full ancillaries; [2] convalescent care, room and board up to $6 a day, with an annual top of $540; [3] surgical charges according to a fee schedule with a $300 top; [4] most physicians' services at $5 a call; [5] registered nurse service up to $16 a day with $480 annual top; [6] prescribed drugs, rental equipment, and anesthetics; [7] diagnostic x-ray and other tests; and [8] radiation treatment.

Administration: By the United States Treasury Department through private insurance plans.

Financing: Persons with a tax liability of at least $125 ($250 per couple) would deduct this amount from federal income tax to pay for insurance premiums. Those with smaller or no tax liability would receive medical care insurance certificates for the difference between tax liability and $125 or $250. To claim credit, tax returns would show evidence from an insurer that a policy meeting Bow bill standards had been issued. A person qualifying as a near relative could pay an aged person's premium and take the deduction.

Modern Medicine, April 30, 1962
89th Annual Forum of National Conference on Social Welfare Provides Community Setting For Public Health

On this and following pages are shown scenes from the 89th Annual Forum of the National Conference on Social Welfare. This meeting, held in New York, included 86 specific conferences and panel discussions on Health and Medical Care, Mental Health and Aging among a total of 233 meetings covering such other subjects as: Children, Youth, City and Urban Concerns, National and International related subjects, Neighborhood and State areas of discussion, Corrections, Discrimination, Family Life, Governmental Services, and Volunteers.

THE MASS MEDIA AND FIFTY MILLION FAMILIES—A scintillating panel at the National Forum on Social Welfare discussed this area and brought much observation and experience to bear on the subject. From the left, the panel members were: Otto Preminger, Producer of Motion Pictures, among them being the recent picture, EXODUS; Bennett Cerf, President of the publishing company, RANDOM HOUSE, and panelist on the television program, WHAT'S MY LINE; George D. Hecht, publisher of PARENT'S MAGAZINE; Irving Gitlin, Executive Producer, NATIONAL BROADCASTING COMPANY; Robert L. Shayon, television Reviewer, THE SATURDAY REVIEW; and Arthur L. Mayer, Writer and Importer, Motion Pictures. Panel Moderator was Leonard W. Mayo, Chairman, President's Panel on Mental Retardation.
NEW PRESIDENT—Seen in a characteristic pose, Sanford Solender, in New York City, the new president of the National Conference on Social Welfare, is the Executive Vice-President, National Jewish Welfare Board.

MEMBERS OF THE NORTH CAROLINA STATE BOARD OF HEALTH
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John R. Bender, M. D., Vice-President .............................................. Winston-Salem
Ben W. Dawsey, D. V. M. ................................................................. Gastonia
Glenn L. Hooper, D. D. S. ............................................................... Dunn
Lenox D. Baker, M. D. ........................................................................ Durham
Roger W. Morrison, M. D. ............................................................... Asheville
Jasper C. Jackson, PH. G. ................................................................. Lumberton
Oscar S. Goodwin, M. D. ................................................................. Apex
D. T. Redfearn, B. S. ................................................................. Wadesboro

EXECUTIVE STAFF
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Jacob Koomen, Jr., M. D., M. P. H. .................................................. Assistant State Health Director
J. M. Jarrett, B. S. ..................................................................... Director, Sanitary Engineering Division
Fred T. Foard, M. D. ................................................................. Director, Epidemiology Division
Robert D. Higgins, M. D., M. P. H. .................................................. Director, Local Health Division
E. A. Pearson, Jr., D. D. S., M. P. H. .................................................. Director, Oral Hygiene Division
Lynn G. Maddry, Ph. D., M. S. P. H. .................................................. Acting Director, Laboratory Division
Charles L. Harper, M. S. P. H. ......................................................... Director, Administrative Services
James F. Donnelly, M. D. ............................................................ Director, Personal Health
RED CROSS LUNCHEON—General Alfred M. Gruenther, president of the American National Red Cross, was the speaker at a special luncheon held during the 89th Annual Forum of the National Conference on Social Welfare. Presiding was Margaret Hickey, Public Affairs Editor of The Ladies' Home Journal and Assistant to the Chairman, Roland Harriman, of the American National Red Cross.

SECRETARY ABRAHAM RIBICOFF—one of the principal speakers at the 89th Annual Forum of the National Conference on Social Welfare.

AGING—Eight section meetings during the 89th Annual Forum of the National Conference on Social Welfare were concerned with the problems of Aging. Leaders in one of these sessions are seen here. From the left, they are: James R. Dumpson, Commissioner, Department of Welfare, New York City; Charles I. Schottland, Waltham, Mass., Dean, Florence Heller Graduate School for Advanced Studies in Social Welfare, Brandeis University; and Jay L. Roney, Chicago, Ill., Director, Special Project on Aging of APWA.
DATES AND EVENTS

June 30-July 7—5th International Conference of the International Union for Health Education of the Public, Philadelphia, Pa.

July 5-6—Annual Meeting, Western District, N. C. Public Health Association, Blowing Rock.

July 11-16—Dairy Products Association meeting (Dairy Princess Finals) Grove Park Inn, Asheville.

July 15-21—Observance of Special Week on the Aging.

August 19-22—Institute-Problems in Tuberculosis Control, Lake Junaluska.


October 22-24—National Rehabilitation Association National Conference, Detroit, Michigan.


Every Saturday—State Board of Health Radio Program over WPTF (Raleigh) 7:30 P. M.

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Free shots for those who can afford to pay for them will not be given in the future by the Charlotte-Mecklenburg Health Department.

Dr. O. L. Ader, director of the Durham County Health Department, has criticized the proposed King-Anderson medicare bill endorsed by the Kennedy administration because the bill "does not provide medical care for those who really need it—the medically indigent."
PRESRIPTION FOR BECOMING MISS NORTH CAROLINA 1962—
Be the daughter of a doctor, a general practitioner.
And be Miss Janice Elizabeth Barron of Morganton.
A sleeping pill, widely used in some foreign countries but banned for all but investigative use in the United States, has been blamed for the fact that some three to five thousand babies have been born with malformations or even total absence of legs and arms. The drug, Thalidomide, has been marketed under various trade names in Western Europe (except France), Britain, Brazil, Japan, and Canada. The drug had been used as a sleeping pill and for the alleviation of morning sickness in early pregnancy. Some months ago, physicians were warned that research had proved that this drug, when used by women in the early months of pregnancy, prevented the proper formation of the limbs of the unborn child. Fortunately, the U. S. Food and Drug Administration had not considered the drug as proved safe and had not permitted it to be placed upon the drug market here. Further investigation is going on here and in other countries and the drug has been withdrawn from the market.

GERMAN MEASLES VIRUS FOUND

The Public Health Service announced recently the discovery of the virus which causes German measles (rubella), by scientists at the Service's National Institute of Neurological Disease and Blindness (NINDB). The new virus appears to be unrelated to any yet identified.

German measles is known to lead to severe fetal damage during pregnancy. According to recent reports, birth defects occur in some 50 percent of live-born babies whose mothers had rubella during the first month of pregnancy and in about 20 percent of infants if infection occurred during the first three months.

Anthony J. Celebrezze, the new Secretary of Health, Education and Welfare, comes from Cleveland, Ohio. He is Italian-born. His reputation for getting things done and a non-political philosophy may be the reason voters have returned him five times as mayor of that city.

Medical Care—Its Place in Public Health

This is the title of the publication in booklet form of the papers delivered at the recent 30th Annual meeting of the Southern Branch of the American Public Health Association in Roanoke, Va., in May of this year. Containing all the major addresses, this 86 page mimeographed and bound book may be secured for one dollar ($1) a copy from Regional Office, Southern Branch, American Public Health Association, P. O. Box 2591, Birmingham 2, Alabama.
SOME JOINT RESPONSIBILITIES OF PRIVATE MEDICAL PRACTICE AND PUBLIC HEALTH IN NORTH CAROLINA

By J. W. R. NORTON, M.D., F.A.C.P., Raleigh State Health Director

THIS opportunity to discuss mutual responsibilities and challenges with representatives of the Old North State Medical, Pharmaceutical and Dental Societies and to offer congratulations and felicitations on your Diamond Anniversary is most welcome to me. Your professions promoted and have sustained and supported our State and local health services, serving the State since 1877 and since 1949, all our one hundred counties.

So far as I know no other state has, by legal requirement, a representative of each of your professions on its State, and on each local, Board of Health. No other state, and no other agency in this State, has developed similar local autonomy and support, or been more responsive to competent professional guidance.

You constitute our staunchest bulwark against overcentralization of power and for local responsibility and freedom.

Since most of you are already familiar with the health services which we work together in providing, it seems appropriate to use our short time now in discussing some of our more general problems associated with our joint efforts toward health promotion for all the people in our State.

Recognition of Teamwork Needed

In too many instances in a few states private fee-for-service medical doctors have looked on all those not in their particular group as interfering "third parties" in medical and health care. Fortunately for us in North Carolina there has been fuller recognition of the need for teamwork in the increasingly complex problems, not only of private practice, but of teaching, services in hospitals for veterans and for those with tuberculosis or mental disorders, research, and public health as these latter supplement rather than supplant private practice.

There has never been a time of greater need for all in curative and preventive services—private, official and voluntary—to understand each other and work together toward more effective, economical, and efficient promotion of health for all our people.

There has been too little joint action and too much fault-finding by each particular group with the others.

The public has taken up the fault-finding and increasingly we hear criticism of medical, dental, and pharmaceutical services and costs. We shall, as doctors and pharmacists, hang to-

*Address delivered before the Luncheon Session, Old North State Medical, Dental and Pharmaceutical Societies, Greensboro, June 13, 1962.

July, 1962

THE HEALTH BULLETIN
gether in unselfish joint action, or paraphrasing further, we shall undoubtedly hang separately.

Our North Carolina State Board of Health and our local health boards have more opportunity to plan and determine policy under medical and allied professional guidance than any of the other twenty-odd State agencies receiving State medical and health care funds, and yet we have had some in our own professional groups favoring some of the other agencies which ignore or even run counter to what most doctors know would be best.

Our public health organizational setup is also the most decentralized, with greater local autonomy and we have emphasized provision of services to those most in need and least able to pay for them. While control of communicable diseases has been our principal activity there have been increasing areas of joint planning to prevent disablement from any illness or injury.

It would be impossible to enumerate all the preventive services supplementing private practice. We have passed out copies of our organization chart and you are on our Health Bulletin mailing list. Please keep in close touch with members of your local health staff and ask yourself whether you are supported and your practice made more attractive and effective for you and your patients by your health department. What changes should be made, by addition, modification or subtraction? We welcome your suggestions to us and to your local Boards of Health and Commissioners.

Helpful Suggestions Invited

We always need practical long-range suggestions on how best to meet needs in our changing environment. Your patients may have excellent ideas which you may be able to pass along. For instance, the following quotation may be familiar to some of you:

“We believe that the conditions of perfect health, either public or personal, are seldom or never attained, though attainable—that the average length of human life may be very much extended, and its physical powers greatly augmented;—that in every year within this Commonwealth thousands of lives are lost which might have been saved— that tens of thousands of cases of sickness occur, which might have been prevented— that a vast amount of unnecessarily impaired health and physical debility exists among those not actually confined by sickness; — that these preventable evils require an enormous expenditure and loss of money, and impose upon the people unnumbered and immeasurable calamities, pecuniary, social, physical, mental, and moral, which might be avoided;— that means exist, within our reach, for their mitigation or removal; and that measures for prevention, will effect infinitely more than remedies for the cure of disease.”

(Continued on page 10)
Outbreaks of Asian flu are thought to be due in the United States again next Fall and Winter. Health authorities are urging the susceptible population to be vaccinated. The susceptible groups include all persons over 45 years of age, and those who suffer from chronic debilitating diseases, and for pregnant women.

The American Cancer Society has distributed the following statement describing Anticancergen Z-50: "After careful study of the literature and other information available to it, the American Cancer Society has found no evidence that treatment with Anticancergen Z-50 results in any objective benefit in the treatment of cancer, or that diagnosis by means of the Zuccala Lytic Test is a reliable method of detecting cancer in human beings."

Lenox D. Baker, M.D., of Duke University, Durham, has been named president-elect of the American Orthopaedic Association. Dr. Baker, a long time leader in the battle against cerebral palsy and other crippling diseases, was instrumental in establishing the N. C. Cerebral Palsy Hospital in Durham. He is medical director of that hospital in addition to his clinical and teaching duties as professor of orthopaedic surgery at Duke. He is the public member of the State Board of Health.

"Urban Planning for Environmental Health" will be the subject of a three-day meeting in the Institute of Government at Chapel Hill Sept. 12-14. This conference is sponsored by the Sanitary Engineering Division of the State Board of Health, the U. S. Public Health Service, the Institute of Government, and eight state agencies and associations directly concerned with public health and government. The growing and expanding urban areas and their peculiar problems will be the main focus of the conference.
Leaders in the Eastern N. C. Public Health Association which held its annual meeting recently are shown (from the left): Joe Campbell, M.D. of Wilson, the retiring president who has done an excellent job; E. L. Kilpatrick, Sanitarian in Pitt County, the new president; and Q. E. Cooke, M.D. of Hertford-Gates County, the president-elect.

Mrs. J. W. R. Norton snatches a moment of quiet reading between sessions at the Eastern N. C. Public Health Association at Nags Head.
BIG FISH—These large sail fish are caught on the eastern coast of N. C. and are mounted. This picture was taken at the Carolina Hotel in Nags Head during the annual meeting of the Eastern N. C. Public Health Association.

From a historical display, and with the acquiescence of Dr. Campbell, Mrs. Joe Campbell is considering a choice of weapons during the Eastern N. C. Public Health Association's annual meeting.

Mr. Merit System meets Mr. Retirement. Claude E. Caldwell (left) Supervisor of the Merit System, and Nathan H. Yelton, Executive Secretary of the Teachers and State Employees Retirement System, converse between sessions at the recent meeting of the Eastern N. C. Public Health Association.
Western N. C. Public Health Association officers elected recently at the group's meeting in Blowing Rock were (from the left): Jack Cobb, sanitarian of the Alleghany-Ashe-Watauga District, president; Mrs. Virginia Haire, public health nurse of the Rutherford-Polk District, vice-president; and Claudine Monteith of the Buncombe County Health Department, secretary-treasurer.

Western N. C.
Public Health Association
Convenes at
Blowing Rock

A panel discussing the subject "Health Programs to Match Our Mountains" was a feature of the morning session on the second day during the annual meeting of the Western N. C. Public Health Association in Blowing Rock. Moderated by Dr. J. W. R. Nortont, State Health Director, the panel is shown (from the left): Jack Cobb, Sanitarian of the Alleghany-Ashe-Watauga District and the newly elected president of the Association; John Faulkner, Regional Engineer of the U. S. Public Health Service, Charlottesville; Jacob Koonen, Jr., M.D., Assistant State Health Director; Margaret Dolan, R.N., Professor UNC School of Public Health; Roddy N. Ligon, Jr., Assistant Director, UNC Institute of Government; Dr. Nortonton; and Herman J. Sisk, Director of Area E, Civil Defense.
Food was one of the attractions at the annual meeting of the Western N. C. Public Health Association at Mayview Manor in Blowing Rock. Anyone suffering from indecision could be forgiven as he went down the smorgasbord line. Seen in these pictures are Charles L. Harper, Dr. Robert Higgins and Mr. I. A. McCary.

The youngest delegates attending the annual meeting of the Western N. C. Public Health Association at Blowing Rock were the two granddaughters of Dr. and Mrs. J. W. R. Norton. They are seen here with Mrs. Norton (left) and their mother, Mrs. H. J. Dickman. Little Miss Carolyn is in the middle, and little Miss Lisa is at the right.
JOINT RESPONSIBILITIES
(Continued from page 4)
This is from Lemuel Shattuck, a Boston bookseller and it was written in 1850. After 112 years we still have preventable illnesses and injuries, premature death, and non-effectiveness. We should be willing to work just as hard toward full peace-time manpower effectiveness as we do so readily in time of war.

The scattering of tax support for medical and health care makes medical guidance increasingly difficult. Have you talked with your State and National legislators about it? Dr. Leona Baumgartner, Health Commissioner of New York City, has aptly commented: "American health services today are indeed a many-splintered thing". Nurse Marion V. Sheahan in her APHA presidential address last November commented:

"The task before us in these next decades is to bring the seemingly separated segments of comprehensive medical care together through an organization of resources to the end they are readily available to people. Medical care encompasses health preservation, prevention of disease, diagnosis and treatment, and rehabilitation. It is at the community level where the service must be provided. Such leadership is needed now to bear on the problem of pulling the fragments together to provide the kind of health services needed to make the facilities as available as possible to the people who need them".

The canny Scot, Dr. James M. McKintosh, last year before the Canadian Public Health Association, took a look ahead too:

"What are likely to be of chief concerns in the future? On the stricter side of medical care, we should be continually alert about three groups: (a) the conditions which cut off life in its prime; (b) the disasters which curtail life in the richness of its experience; (c) the conditions and disabilities that limit the fullness of life and health through mental or physical disability".

Our job then as we think and plan and work jointly is to be as keenly and responsibly conscious of the necessity for total disability prevention among our entire community as a battle commander is for his assigned fighting force. It is not enough to concentrate alone on this or that sickness or injury as affecting a part of an isolated individual. Any disabled person not only is unable to pull his share but may require the shunting of energy of one or more effective from the constructive goals. Not until every individual is constantly moving toward the optimum in capacity and motivation can we feel that all our joint efforts are operating effectively.

Much progress has been made and we must be grateful to the pioneers who have given their full measure of devotion. Their dedicated contributions to medical and health progress should be seen not as a height from which we can stand and boast but as a point of running start toward further reduction in disability and promotion of optimum health.

We realize that we must exert continuing pressure to hold our gains against the communicable diseases. What we have learned in controlling bacterial diseases is helping in our advances against the viruses.

We must shift our limited personnel with the changing of the leading cripplers and killers—particularly those against which we seem to be losing ground: cardiovascular—renal diseases, cancer, accidents, arthritis, mental and emotional disorders.

We even have an epidemiology of plenty problem in our softness, overeating, alcoholism, and recklessness.

Poverty and Ignorance Contribute to Disability

Poverty and ignorance are recognized contributors to physical and mental disability. These are complicated by an
even more widespread increase in individual and family irresponsibility. Long accepted duties are shirked, laziness is condoned, and an attempt is made to reverse the old order of achieve and then receive. Individuals and families fail to do their part and then too many others join them in blaming teachers, doctors, druggists, hospitals, or the community.

In medical care, both curative and preventive, there is an increasing need for understanding and active intelligent participation by the patient—a larger proportion of treatment is with rather than for the individual patient or the community.

A serious and difficult problem is the maldistribution of medical and health services. Employment opportunities and educational advantages, referred to above in reference to their lack resulting in poverty and ignorance, are basic supporting essentials.

Rates of early school dropouts, poor housing with insanitation and crowding, illegitimacy, venereal diseases, wastage of mothers and babies, homicide, lack of family planning, and accidents are largely predictable when one knows a few non-medical facts about a group. Many of these are controllable to a considerable extent.

Two of the sixteen college students who are serving a Summer Internship in various departments of State government are with the State Board of Health. These young men are observing and participating in the varied activities of the State Board and the local health departments. Shown during their ten-week schedule, with Jacob Koomen, Jr. (center) M.D., Assistant State Health Director, are Charles K. Scott (left), Haw River, a medical student at UNC; and William P. Brandon, Hickory, who is majoring in philosophy at Johns Hopkins University.

Correction of the maldistribution of physicians in the State is probably much less complicated than correction of a variation of several hundred per cent in the rates of infant and maternal mortality, illegitimacy, or venereal diseases. Are such problems worthy of our medical interest, concern and intelligent effort? What are our best approaches? To whom should they be of special concern and what are their priority rankings? Since doctors know these problems most intimately in their daily work, can they afford to be negligent in providing leadership toward correction? Neglecting a primary duty under an excuse of "too busy" gives relatively uninformed busybodies a chance to move in and take over.

**Traffic Collision Problem Deserves Attention**

A good example of a problem deserving our concentrated work is that of the leading killer to age 35. I refer to traffic collisions and I have passed along to you a leaflet on this problem. They are not really accidents in the usually accepted usage since practically all are preventable. Recklessness and negligence are not accidental.

With less effort and expense than it has taken to eliminate typhoid equally effective control could be attained. Better engineered highways, safe cars, driver training, courts promoting safety rather than mere money-changing—these would each help, but the driver is the key to reduction in this intoler-
able destruction of property, limbs, and lives.

Legislative proposals have been aimed at safety but some have wondered if the traffic case fees may have influenced the votes of the lawyer-dominated legislatures.

Have you considered these broken limbs and lives of concern such as your forerunners a generation ago looked on typhoid and diphtheria? They did something about it.

Must you wait till you are called on to repair the broken limbs or pronounce the victims dead?

Can the public depend on you for active as well as passive medical guidance?

Do you set an example by using seat belts?

What have you done to reduce your community's annual part in North Carolina's tragic and intolerable loss: 1254 deaths, 34,438 injured, 60,844 collisions, $207 million economic loss from hospital and funeral expenses, property damage, loss of income, lawsuits and rehabilitation (1961 figures)? Are not such medical leadership activities among those which will convince the public that we as physicians are earning and deserve recognition as leaders in medical and health matters?

Our PTA leaders are pointing toward some good traffic safety legislative actions and it seems we doctors could at least backstand them since we have not led them:

1. Enactment of laws which will endeavor to eliminate driving by persons who are mentally and emotionally unfit to operate motor vehicles.
2. Enactment of laws to provide chemical tests as a means of determining intoxication of drivers.
3. Periodic inspection of motor vehicles on a mandatory basis.

4. Regulation of number of children riding in public and private conveyances to and from schools and the strict enforcement of such legislation.
5. Uniform system of courts.

You will note that I have not tried to catalogue State and local health department services in detail. You are familiar with our continuing environmental health services, our public health nursing, public health statistics, laboratory tests and distribution of biologics, school health work, maternal and infant and other clinics, oral hygiene, communicable and chronic (including mental) disease control, nutrition and general health education.

You keep up, as I try to do, with the best use of our available preventive agents as well as the changing therapeutic armamentarium. Along with you, I am grateful for the progress achieved through our joint efforts against the external hazards. We are on the threshold of more: perhaps measles, cancer, hepatitis, and even the common cold.

As Jonas Salk said on May 27 in Toronto before the Canadian Public Health Association: "Man is his own worst enemy.—When the casual effect of infectious agents and environment factors in disease were recognized, man was able to revolutionize his ecological state. The recognition of the role of man as a noxious influence has not yet brought about a dramatic effect.—Man possesses a sense with which to anticipate the order of things and to sense what will fit. It would seem to be possible to arrive at the state where the respect of man for other men will make life and health synonymous, and the struggle to the death between men will be replaced by the zest to contribute and to create."
It seems that making the fruits of medical and health progress accessible to all as a necessary forerunner of progress toward peace is worthy of the best we can invest in joint responsible effort.

The impossible—the intolerable—has yielded to the faith, courage and daring of the few—plague, typhus, smallpox, cholera, pain, malaria, and the intestinal—respiratory—environmental diseases. The presently impossible—ineligible problems of enormous crippling and killing from traffic and home and farm accidents and mental-emotional disorders should have our preventive efforts combined against them. Our faith, courage and daring should bring about similar success.

Even with our enormous and rapid worldwide travel we have kept the former communicable plagues under control. For instance, no quarantinable disease in which secondary cases occurred has been introduced from abroad since 1947.

We prefer to be optimistic. We enjoy bringing good news. It is easier to say we have come half-way than we have half-way yet to go. We share pride in achievement. Success cheers and gives determination to achieve new advances. After each day we measure how far we have come—and gain courage to push on along the far road we have yet to go.

The darkness and difficulties are more formidable for those who have progressed least—who have farther yet to go. The struggle for survival and meeting the needs of today leave little for investment in tomorrow's progress. The heavy load of today too often leads to stumbling, faltering, frustration, and drifting. Even with tired and aching muscles one must have the determination to analyze and plan and the spirit "to sail beyond the sunset and the baths of all the western stars."

Beyond the urgency for food, clothing, and shelter, better health, education, and relief from poverty, how can we as physicians, pharmacists and dentists remove the barriers to individual and family motivation? Every human being deserves a chance to pursue happiness—to live beyond mere survival—to find purpose, creativity, and emotional satisfaction.

Environmental Hazards Continue

Environmental hazards continue with us and in some areas have increased with our crowded, intensive type of living. We continue to pollute the soil, water, and air. In addition to our traditional intestinal and industrial wastes we are adding to our environment detergents, new pesticides, gases, fumes, dusts, and even radioactive waste products.

Family Standard of Living Affects Health

The members of your three Societies realize more keenly than I the effect of the family standard of living on health. You deal daily with the deserving and the undeserving poor. You know life is too complicated to divide the haves and the have-nots into the hids and the did-nots.

Thomas Gladwin in his "The Anthropologist's View of Poverty" causes some of us to recall our childhood and the depression of the early thirties. He reminds us of the shifting values placed on the three broad principles: right of private property; equality of opportunity for all men; and the dignity and worth of the individual.

Universal poverty has become a minority problem and the decrease in the number of deserving poor has outrun the general reduction.

The hard core not only tends to be self-perpetuating but to spread its characteristics: multiplicity of problems; chronicity of need; resistance to treatment; and handicapping attitudes. These
are segmental human characteristics not related to climate, color of skin, or place of residence.

Those of us who have been motivated to overcome obstacles and handicaps as individuals and families respect those who are trying, and we enjoy and prefer working with them.

We find it difficult to understand those who individually or collectively refuse to accept responsibility in working toward change, in planning a better future and giving up something today in return for a better tomorrow.

We believe one can work hard and through choice of career, education, dedication and conscience earn respect and success and that at least a secondary place is taken by chronic fault finding toward, and making demands on, others and the government.

It is frustrating and sometimes seems hopelessly futile to form a team with those whose goals we share but who expect something for nothing or believe that through socialization the government can be all things to all people.

Those of us in the health professions do have a direct and vital responsibility that we welcome, namely, that of preventing, diagnosing, treating and rehabilitating illnesses and injuries, avoiding premature death, and of promoting optimum health and happiness, not just on call of a few private patients but for all our neighbors as the Bible defines them.

These fundamental services are a necessity, incidentally in recovering our waning professional prestige, primarily as part of our responsibility in assuring to every human being his best opportunity for usefulness and happiness.

The Forsyth County Health Department will begin using oral polio vaccine this fall.

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W. S. McKimmon of the Sanitary Engineering Division received the George Warren Fuller Award at the 82nd annual conference of the American Water Works Association at its meeting in Philadelphia in June. Mr. McKimmon is Chief of the Engineering Section of the Sanitary Engineering Division of the State Board of Health, and has been with the Division since 1933.

Full support of the five point legislative program presented by the Governor’s Coordinating Committee on Traffic Safety was voted by the State Board of Health in its July meeting. In addition, the State Board commended consideration of this legislative program to other major health related organizations in the State.

The legislative program includes the following:

1. Additional highway patrolmen.
2. Chemical tests for intoxication plus an improved definition of what constitutes driving while under the influence.
3. Additional traffic engineers.
4. Special licenses for teenagers.
5. An improved court system.

The Department of Health, Education, and Welfare supports legislation to strike the “separate but equal” clause from the Hospital and Medical Facilities Construction Act. The Department watched the progress of the lawsuit in North Carolina attacking the constitutionality of the present hospital construction provisions. The Federal Government has intervened in the suit on the side of the plaintiffs. The Federal Hospital Council agreed, however, that the authority of hospital boards of trustees to make decisions regarding staff privileges should not be impaired or diluted.

After the Fall of 1962, the School of Public Health of the University of North Carolina will admit no new students to the undergraduate program leading to the Bachelor of Science degree in Public Health Nursing. The School plans to strengthen and enlarge its graduate program, according to Margaret B. Dolan, Professor of Public Health Nursing.

The Alleghany-Ashe-Watauga health district has appointed Dr. Mary Michal health director for the area, a post which she previously held from 1950 to 1959. She has assumed her duties at the local health center, according to the health department.

Fifty-three waitresses, cashiers and managers from local restaurants received certificates recently for completion of a 10-hour North Carolina Travel Host School course held at Buck’s Restaurant in Asheville.

Miss Lillian Capehart Harrell was recently honored for her 20 years of service in the Bertie County Health Department as senior public health nurse.

“It’s a wise child who knows his own father,” but it’s a wise child who also knows his family doctor.
DATES AND EVENTS

August 19-21—Institute-Problems in Tuberculosis Control, Lake Junaluska.


September 6-8—N. C. State Employees Convention, Durham.

September 7-8—N. C. Hotel Association, Clemmons.

September 16-17—N. C. Dental Society, Charlotte.

September 17-20—64th Annual Meeting of the American Hospital Assn., Chicago, Ill.

September 19-21—Southern Tuberculosis Conference, Asheville.


October 15-19—American Public Health Association, 80th Annual Meeting, Miami Beach, Fla.

October 21-23—Annual Conference of the N. C. Family Life Council, Raleigh.


October 23-26—60th Annual State Nurses Convention, Jack Tar, Durham.


Every Saturday—State Board of Health Radio Program over WPTF (Raleigh) 7:30 P.M.

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DR. FRANCES KELSEY, Pharmacologist of the Food and Drug Administration, whose intuitive and careful insistence on further information about the drug Thalidomide saved the United States from the tragic impact of having many deformed babies born, a result of its use experienced in Canada and several European countries. Dr. Kelsey, a Canadian-born practicing physician who has taught pharmacology, came with the Food and Drug Administration in September 1960 and had as her first major assignment the evaluation for licensed sale of Thalidomide under the trade name "Kevadon". Unconvinced by data submitted on the drug's use on animals and concerned about slight indications of side effects caused by its use, Dr. Kelsey insisted on further information and experimentation. During the period of such further investigation the reports of birth malformation attributed to the drug's use began to come in from countries in which the drug had already been approved. Dr. Kelsey received the President's Award for Distinguished Civilian Service in acknowledgement of her contribution.
Mosquitoes will have little chance in Rocky Mount if the plans announced by the city's Vector Control officials take effect. They are asking citizens to help in these ways: check the premises for water holding containers, such as old buckets, stopped up gutters, boats with water inside, and small drainage ditches which can be unstopped.

A Mental Health Clinic Site was recommended recently in Winston-Salem by the City-County Planning Board. It is a site just south of the proposed new health-welfare site.

High Point is planning a clean-up based upon recommendations in a survey made by county sanitarians earlier this year. Clean-up of vacant lots, garbage disposals, malfunctioning septic tanks and other problem areas will be included.

Two Johnston County Midwives retired recently after having delivered "over one thousand" babies each. "Retirement certificates" were presented to these two by Miss Janie Johnston, supervising public health nurse for the county. Although both of the women are members of the Negro race, they recall delivering many hundreds of white babies over the years. The midwives are: Mrs. Maggie Mitchiner, 75, of Route 3, Smithfield; and Mrs. Mittie Davis, 74, of Smithfield. Both had served as midwives since 1938.

One of the primary projects of a new Poison Control Center set up at Memorial Mission Hospital in Asheville will be the keeping of a complete reference file on information which is not printed on the labels of many trade products—ingredients that could be harmful to children. Examining one of the reference files here are Dr. Mary Helen McConnell, director of the center; Mrs. Louise Laney, supervisor of the hospital emergency department; and Murray J. Small, assistant administrator of the hospital. The files contain not only ingredients of such products as bleaches, waxes and furniture polish, but symptoms and suggested antidotes as well.
Davidson County's mental health program will be expanded presently when a case worker in the field will be on duty in the county. The case worker will be a member of the staff of the High Point Mental Health Center and will be available at the County Building in Thomasville.

John D. Faulkner has been named Associate Regional Health Director for Environmental Health Services to Region III, which includes North Carolina. Mr. Faulkner served for several years as an engineer with the North Carolina State Board of Health, and contributed greatly in the advancement of environmental health. Mr. Callis H. Atkings, whom he replaces, was selected by the Surgeon General to serve as Chief Sanitary Engineering Officer for the United States Public Health Service. Mr. Atkings is a native North Carolinian and also a former employee of the State Board of Health.

Control of Pollution for residential lots on the Catawba river reservoir, mosquito control, sewage and refuse disposal were among the subjects discussed at a recent meeting held at the Iredell County Health Department. J. S. Ameen, sanitary engineer with the State Board of Health, presided. County health officials attended.

How a mother can help to keep her child well is the subject of a new booklet published by the N. C. Conference for Social Service and available in quantity without charge. The booklet, entitled, "For My Mother—How To Keep Me Well", was prepared by the Health Committee of the Conference in collaboration with the Maternal and Child Health Section of the N. C. State Board of Health. This colorful and attractive booklet is illustrated and covers many helpful aspects of the health of children. The Conference address is Post Office Box 532, Raleigh, N. C.

It's a good idea to require maids and other domestic servants employed in the home to have a health card. These cards are granted without cost by local health departments after screening tests. It is recommended that a personal physician provide information concerning the general condition of the person if possible as a basis for the further health department service in this matter.

Brunswick County fishing interests are reported to have vigorously opposed a lagoon-type sewage disposal system for Southport at a hearing conducted recently by the State Stream Sanitation Committee. A comparatively inexpensive plan to dispose of sewage directly into the ocean was suggested.

The Nursing Home Section staff is seen in the accompanying picture. From the left, are: J. Lee Higgins, Sanitary Engineering Consultant; Shirley Callahan, Nursing Consultant; W. Gordon Poole, Chief; Mrs. Elizabeth Kelly, Dietary Consultant; and Routh Dixon, Physical Therapy Consultant.

August, 1962
A portrait of the late Dr. George Marion Cooper, a Sampson County native who became state health officer and a public health pioneer, has been presented to the Sampson County Memorial Hospital in Clinton by the Women’s Auxiliary of the Sampson County Medical Society. Dr. Cooper served with the State Board of Health for 35 years until his death in 1950. The new building of the State Board of Health is named in Dr. Cooper’s honor.

Awards of Merit were given to two films produced by the Public Health Service. The awards from the National Committee on Films for Safety were given to “When Sally Fell,” depicting the effects of an easily avoidable home accident, and “Look Alive,” showing how a vehicle-pedestrian accident occurs and how it affects the mental and physical outlook of both the driver and the pedestrian.

A five-year research project will be carried on by UNC School of Nursing as a result of a U. S. Public Service grant. The project is designed to develop a plan for selected learning experiences which will prepare a registered nurse to function more effectively as a public health nurse.

A new book, entitled CURRENT MEDICAL TERMINOLOGY (CMT) has been published by the American Medical Association with the purpose of eliminating conflicting terms used in designating diseases and conditions to which medical science has given names. For the first time, according to an AMA spokesman, significant diseases have been catalogued in dictionary form along with their synonyms, causes, symptoms, possible complications, usual findings and tests. Putting this information on magnetic tape fed into an electronic computer from which pages are printed makes it possible to keep this information current.

Headache victims in the United States spend an estimated $300 million each year on “remedies,” according to a new brochure recently released by the U. S. Public Health Service. This publication entitled, “Headache—Hope Through Research,” explains some of the causes and types of headaches and reviews the latest treatments known to medical science. Single copies may be obtained free from the Public Health Service.

A new Department of Hospital Administration has been set up in the School of Medicine of the University of North Carolina. Dr. Robert R. Cadmus will become chairman of the new Department. Eugene B. Crawford, Jr. will succeed Dr. Cadmus as director of the N. C. Memorial Hospital.
Preparation for a New Health Problem

THERE is need for local health departments to review critically their administrative organizations in order to prepare themselves to meet the newly emerging environmental health problems. Such review, with attention to evaluation and planning of programs, will in many instances point up the need for changes in both organization and administrative policies.

Too many local departments have become so involved with old or traditional programs and activities that they cannot find the time or personnel to consider properly the new problems of an environmental nature.

Provision should be made for better training and more training of personnel to recognize and cope with these newer developments. Scheduling of planned inservice training on a regular basis would do much to bring about a better appreciation of the ever changing local needs and the means of meeting them.

Health educators should be used to a greater extent in helping to plan and formulate environmental health programs. Sanitarians and health educators have not to the fullest possible extent presented to the citizens, in a manner to obtain maximum support, information about needs, programs and activities.

In addition, all available community resources should be known and studies integrated to help people live healthily and happily. The "good old days" and ways must give way in considering present and future environmental health programs.

Organizational changes should be effected to incorporate more consideration of, and activity in, occupational health programs. Here again health education is needed to bring information about radiation and air pollution problems and hazards to those concerned.

Organizational changes to afford more education and training of food service workers are necessary. Faulty and incomplete training methods of the past need revision if we are to have our efforts rewarded. Continuing programs, as opposed to present intermittent programs, are certainly indicated and should be more inclusive than those now given.

In summary, what health departments need to do is to develop greater awareness of new environmental health problems as they arise; study and revise their programs and assignments of personnel to give these new needs the attention they require; and greatly expand their educational efforts in all areas, for their personnel, for industry and for the public.—by J. W. R. Norton, M.D., State Health Director.

Taken from the May 1961 HEALTH OFFICERS NEWS DIGEST.

August, 1962 THE HEALTH BULLETIN 5
THE EXECUTIVE'S ANXIOUS AGE

BY HARRY LEVINSON

Although most men in their middle 40's have come to terms with life, for some it is a painful period, a mental change of life, upsetting personal relations and business careers. The author, head of the Menninger Foundation's industrial mental health division, diagnoses the disease and tells how managers can help subordinates identify the symptoms.
Until a man reaches middle age, he sees his future ahead of him. When he becomes 45, he knows that in all likelihood he has fewer years ahead of him than behind. If he has not already reached the pinnacles to which he aspired at 21, the probabilities of reaching them grow less with increasing years. Usually, he has to settle for achievements which may be commendable in themselves but invariably fall below his aspirations. Most men must accept the fact that they will remain in much the same position as they find themselves at middle age. They will have to come to live with the feeling that “This is it.”

It is true, of course, that for many men mid-life is a period of golden years. These men will be well established in their careers or businesses. The early years of struggle will be only memories. They will be able to look upon their achievements with pride and satisfaction. Some will have established themselves so well financially that their mortgages have been paid off and their financial responsibilities to their children have been met. Many men will glow inwardly as their children go off to college or career, satisfied with the job they have done as fathers, and basking in the reflected glory of their children’s achievements. Often, such men will now turn their attention to public service; some will begin to travel or to undertake long-postponed activities. Those who have been wise enough to work at their marriages all along will find new romance in their relationships with their wives.

Yet other men find this period particularly painful. For such men there is no question that the middle-age transition period is a “change of life,” even though there is no radical biochemical change as there is in women.

A man in this group, even if he is in good health, winces as he reads in the
sports columns that men in their 30's are regarded as old men among athletes. It is he who is being urged each winter to be cautious about shoveling snow lest he have a coronary. He also begins to experience a psychological desertion. Despite his pride and pleasure in his children's activities, they either are about to leave the family circle or have already left. They have their own adult lives to live and their own families to rear.

Taken together, these changes make it apparent for a man in this group that he is not what he used to be and that his course is inevitably a downward one.

This crisis of mid-life is a serious, often painful problem—to the men who are afflicted, to their families, and to their business associates and managers. It creates, in turn, other problems for managers because they are responsible for the performance of the men whose work they must supervise. A wise superior, anticipating some of these problems, may help a subordinate identify them in time.

For example, some highly successful men decide early in their careers that they will pursue their business goals single-mindedly. They work hard achieving success, with the fantasy that once they have attained it they will then indulge themselves in the pleasures they passed by along the way. For them, the attainment of their goal often becomes a disillusioning experience when they discover that what they have attained is only a hollow shell.

A man who, in his late 40's, owned three sizable companies is a case in point. He was the son of poor farm parents, had managed to get through high school, and then went to work in the oil fields. The small company he worked for became highly successful, and he became its president at an early age. He expanded his holdings, bought the controlling interest in a bank, later added a medium-sized manufacturing company. Meanwhile, he had married, and his two children were now away in school. He had determined early that he would make a success of himself, and when he had achieved his success, he would then take time to enjoy himself and make up for his many sacrifices. Now he had success, but he could find no pleasure: He didn't really know his children; his wife had her own interests; he didn't know how to go about enjoying himself. As he looked back on his life, his achievements were, in his eyes, for nothing. The world saw him as a success; he saw himself as a failure.

**Middle-Age Threats**

The middle-aged man begins to be more aware of death; up to this point it had been relatively easy to forget about the inevitable. In his early adult years, a man felt that death, barring accidents, was a long way off. He was familiar with happy events: He recognized the names of his friends in engagement, wedding and birth announcements in the local newspaper. In middle age, he begins to recognize more frequently the names in the obituary column, and to shake his head over the premature death of some of his friends.

His circle of friends narrows as he grows older. Along the way, his interests have narrowed. He tends to see those people less frequently who do not share his interests. By middle age, he feels himself most comfortable with a few old friends. His circle of friends becomes even smaller as death decreases their number. Yet he may be only dimly aware of this constriction, for he still sees many familiar faces.

Middle age is for many men, then, an acute psychological loss period. The losses are made even more painful by the recognition that there are
aggressive rivals who threaten to de-throne them. In almost any field, younger men bring new skills and techniques which will ultimately displace the old. The older men fear to lose their self-respect if they admit what they have been doing is no longer adequate. To accept the newer ways, for some, is to make that admission. If they do change, they admit the younger men are right. If they fail to change, they run the risk of seeing younger men move rapidly ahead of them. Rapid technical changes may even make their experience of limited value. They are stimulated to defensive competition at the very time when, in their careers, competition would seem to offer the least rewards in the form of advancement, and when they are already coping with severe psychological stresses.

Some withdraw from the competition. These are the men who have reached a plateau. "We can't do anything to budge our middle-aged engineers," said the president of an engineering firm. "I don't know what gets into them, but they seem to stop at dead center." A college president made the same complaint about his faculty. "We give them early promotions to encourage them to produce," he said, "but it doesn't seem to do any good. They coast along comfortably in ruts, and you can't force a man to be creative." Like a wounded animal who seeks the protection of its cave, a man in such a position may well build a psychological cocoon around himself. Others become hostile to possible competitors as well as to superiors. They may refuse to train younger men in ways which are difficult to see. They may use the younger men as flunkies, or criticize them harshly, all in the name of giving them good training. Hostility to the superior is more often expressed passively in the failure to do what they are capable of doing.

The multiple psychological losses which combine to make some men feel that they are less manly than before may lead to impulsive behavior. Extra-marital affairs which occur for the first time during this period may be viewed as efforts to hold on to one's masculinity, and to regain the youthful experience of romance and excitement. Such affairs are seldom psychologically rewarding. Instead, they often add a burden of guilt to other already pressing psychological problems.

The feeling of being less manly reawakens old conflicts about being dependent. Given the long period of dependency on parents in our culture, everyone struggles with the wish to become independent versus the pleasures of remaining dependent. This is particularly the struggle of the adolescent. When one becomes an adult he asserts his independence, but few of us can altogether give up our wishes to be dependent. When one feels less an adult, his dependent wishes come more to the surface. But, since he is in fact physically an adult, it is difficult for him to face the existence of such wishes.

Alcoholism is one way of handling the conflict about dependency wishes. The alcoholic makes the same use of the bottle as does the infant. He organizes his life around it, and when he is drunk he is completely dependent on other people. Most men who have drinking problems, and 2 percent of the male population does, fall in the 35-55 age range.

Some men, particularly those who have lost important sources of affection, or who are severely disappointed in themselves, may become depressed. Depression in response to these change-of-life stresses, called involutional melancholia, is quite common. It is marked by sleeping difficulties, loss of appetite and weight, irritability, feeling of uselessness and futility ("Life is really
over for me,"), and fears of death. Like other forms of depression, it responds well to treatment.

How to Cope with Losses

If the male menopause is primarily a psychological loss experience, the most obvious way to counteract it is to replace the lost gratifications with new ones. Hopefully, a man will begin the replacement process before the losses occur. There are four kinds which must be replaced. All the experiences we have considered so far would fall under one or another of these categories, sometimes in more than one.

• Loss of outlets for the discharge of aggressive energy. Changes in physical abilities, sexual activities, competition for advancement, and diminishing social activities all alter the ways in which aggressive energy can be discharged. When such activities are lessened, some avenues for the constructive use of aggressive energy are cut off.

• Loss of sources of affection and of persons to whom to give affection. With the departure of children, sometimes a decrease in sexual activity, a narrowing circle of friends and loss of particular friends through death, there are fewer ways of obtaining love, support and esteem. Equally important, there are fewer targets for one's own feelings of affection.

• Loss of adult identity. With the tendency to feel himself to be less a man than he was, with the reawakening of dependency conflicts, and with the depreciation of the sense of usefulness, his image of himself is somewhat shaken. It is at this point he often asks what he has for all his efforts, and wonders if he has taken the right life path.

• Loss of adventure in living. The feeling of having settled into a niche or rut implies repetitive dullness or boredom. At 21, the world holds promise of romance, excitement and stimulating new experiences as an adult. In middle age, there is often the feeling that there is nothing new under the sun. While it is perfectly acceptable for the young man to be a dreamer, to call a middle-age man a dreamer is to criticize him. He is supposed to live in the hard, real world.

Avenues of Replacement

Replacement of these losses is not necessarily a complex task, but it also should not be viewed as a very simple one, because the replacements must fit the personality and preferences of the person. Whether any specific activity will satisfy any given person, only he can tell. We can specify only the general directions in which replacements may be sought.

1. Find new avenues for discharging aggression in ways comfortable for you. At least one avenue should be physical activity—sports, gardening, walking—something in which the large muscles are used. Another avenue should be hobbies or career activities, actively pursued. The vice president of one of the major divisions of a steel company has become an authority on Japanese prints. A 55-year-old dentist of my acquaintance bought a drugstore with a small down payment and now devotes a part of his time to each interest.

A third avenue should be in public service, help to voluntary health or social service agencies, to the church, or in political activity. There is a desperate need in all areas of public service for people who are willing to lend a hand.

2. Find new friends. Deliberately seeking out other people, learning
about them and establishing friendly relationships with those whom one likes, serves both parties alike. It is not easy for many people to seek out friends, yet loneliness is such a common experience that it has become a major theme for novelists and playwrights. Often, when someone takes the initiative he finds that the other person wanted very much to establish a social relationship but simply did not know how to begin.

A specific activity in this direction should be volunteer service on a personal basis in a hospital or some other institutional setting—a boys’ club, USO, a rehabilitation center. These are places where people need most of all personal relationships with other people. There it makes no difference where one is in the social or business hierarchy. He is important to another human being because he can give affection. This kind of psychological transfusion is no less important to some people than a blood transfusion would be to others. And what’s more, such an activity requires of a person that he be at the appointed place at a given time. Nothing demonstrates the usefulness of a person more than the demand that he must live up to his promise to appear because another person is depending on him.

Animals can be friends, too. Our culture doesn’t permit men to display their affection for other men as they might in Italy or Spain. And only in limited ways does it permit men to demonstrate affection publicly for women. But it does permit a man to be lavish in his affection for his pets. Animals, like children, thrive on affection and return it.

3. Find new adventure. Renew the feelings of romance and excitement, but don’t run after them, because they can be lost in the chase. Travel leisurely, particularly with friends. See new things, different things, because they interest you. A friend who learned Spanish in night school took several trips to South America. But he passed up all the churches, night life and organized tours. He was a simple man with simple interests, so he went from one small town to another, talking to ordinary people as he went. They were as curious about him as he was about them. Since he could speak their language, frequently he was invited to their homes. A by-product of this quite ordinary activity was a new kind of adventure at home: Service clubs wanted to hear how other people really thought and felt. As a result of his lectures, the man developed a new circle of friends in his own community.

New Stimulation

One of the most readily available ways of finding new stimulation is in adult education courses. Not enough businessmen take advantage of these courses, although their participation is increasing. They cover almost every conceivable subject; in many ways they are ideal for the middle-aged man. He may select a topic new to him, or refresh his knowledge on familiar subjects. The other participants will include people of his own age range. In this activity it will make no difference what his position is, or how much money he has. The methods of teaching adult education classes are most likely to fit the needs of the people who participate, rather than preconceived formal goals. As a result, such classes usually are practical and down-to-earth. In smaller communities where there may be fewer facilities for adult education, a man may take advantage of correspondence courses. If he invites friends to share such courses with him, so much the better.

One way of finding adventure is to do something you always wanted to do. Almost everyone has some dream
to fulfill, some ungratified wish. Free of some of the responsibilities of parenthood, and still a long way from retirement, middle age is the time to do it. And you needn't be concerned about justifying what you want to do to your neighbors. It's your life, not theirs, and your dream.

The man who anticipates some of his possible psychological losses and takes steps to do something about them actually does himself two good turns. Not only does he alleviate much of the pain of the middle-age period, but he also avoids even more painful experiences later on. The methods he evolves for coping with the change of life are also his preparation for retirement.

The team approach is now possible in the work of the Nursing Home Section of the State Board of Health. Now with a completed staff under the direction of Gordon Poole, Chief of the Section, this unit assists nursing home operators to improve patient care for nursing homes which the State Board licenses under State law.

The impact of smoking upon health will be studied by an expert committee to be set up soon by Surgeon General Luther L. Terry of the Public Health Service. The Surgeon General conferred with representatives of several Federal agencies, non-governmental professional groups, health organizations and the tobacco industry in laying the ground work for establishment of the expert committee and setting forth basic plans for its methods of operation.

A recommendation made by a group of consultants to the Children's Bureau at a recent conference is to the effect that legal machinery should be established in all States to make it mandatory for physicians and certain hospital administrative personnel to report cases of suspected physical abuse of children by adults.

The 90th annual meeting of the American Public Health Association, and the first held in the South in 25 years, is scheduled for Miami Beach, Fla., October 15-19. Registration, exhibits and press headquarters will be in the Hotel Fontainebleau. Dr. Berwyn F. Mat­tison is executive director of the Association. Dr. Charles Glen King of New York, is president. Dr. J. W. R. Norton, North Carolina's State Health Director, is president-elect.

**BEFTER COMMUNICATIONS FOR BETTER HEALTH,** published by the National Health Council, brings together and relates the major communications problems in the health enterprise and what is being done or could be done to solve them. This book is based on the 1961 National Health Forum. It is distributed by Columbia University Press at $5.00.

A travel grant has been made by the Easter Seal Research Foundation to Charles H. Frantz, M.D., orthopedic consultant to the Michigan Crippled Children Commission in Grand Rapids. Dr. Frantz is an outstanding expert in the treatment of children with congenital abnormalities or deformities of limbs. He will go to Germany to help in solving the critical problem created by the recent births of four to five thousand children as a result of the use of the drug thalidomide by the mothers.

A recommendation by the Wake County Grand Jury that the State Health agencies present a report showing the standing of the Wake County Home in relation to privately operated nursing homes was referred to the County Commissioners. Judge Raymond Mallard of the Superior Court said that this was a political realm and beyond the authority of the Grand Jury. Conditions at the County Home had been reported as "substandard".
If You Had Attended a Meeting of the State Board of Health

by the Editor

I wish you had been able to sit in on the meeting of the State Board of Health held in Raleigh recently. I believe you would have been interested and that you would have left the meeting with new appreciation of the way in which this State Board seeks to guard the health of the State's citizens.

Dr. Charles Bugg of Raleigh presided as president of the Board. Dr. Bugg is a leading pediatrician of this city and he is serving his second term as president.

This was the meeting for the discussion of the final draft of the budget of the State Board of Health for the two-year period beginning next July. A great deal of work has gone into the preparation of this draft of the budget proposals over the past months. The section chiefs and the division directors have considered needs and priorities and made recommendations. Dr. J. W. R. Norton, the State Health Director, and the budget staff have reviewed these recommendations.

The proposed budget for the continuation of present programs at their present levels was discussed with the budget bureau of State Government. A tentative budget for this was approved. That is what is called the "A" budget.

The real concern of this meeting of the State Board was to consider proposals in what is called the "B" budget. This is for new projects or advances in health programs which are already in operation.

Dr. Jacob Koomen, Jr., the Assistant State Health Director, presented these proposals with the help of Mr. Charles Harper, director of the division of administrative services, and Mr. William Parrish, the Board's Budget Officer. The Board members had received budget information in advance and some phases had already been considered.

The largest increases in these proposed "B" budget requests were for local health department work and for strengthening mental health programs throughout the State. Cancer control and occupational health were also in the list of priorities.

Dr. Koomen reviewed with the State Board each of the items in the budget and he and other staff members responded to questions and gave additional information as requested. After the nearly two hours of discussion the Board voted unanimously and enthusiastically to recommend this budget for the consideration of the Advisory Budget Commission and the General Assembly.

The Advisory Budget Commission will consider the requests in the "B" budget of the State Board of Health at a specially scheduled hearing sometime in September. This Commission will review the "A" budget for continued operation at the present levels but, since this has been tentatively approved by the budget bureau, may not make much change in it.

In a discussion about money, it is interesting that the discussion in the State Board concerned itself with the best ways to meet those needs, and with a concern for making the dollars
bring in the best return in health protection for the State's citizens. This was one time when any person listening would have been impressed with the sincere concern of both staff and board members alike.

I have not mentioned any amounts, nor the total of the budget. This was intentional. Cold figures, especially when divided by 100 counties, or by nearly four and a half million people in this state, mean little. But the benefits from these expenditures—in lives saved—in illnesses lessened—in diseases prevented—these are the real facts.

Some of this type of budget results were reviewed with the State Board of Health at their meeting. The epidemic of infectious hepatitis seems on the wane. Only one case of paralytic polio has been noted in North Carolina thus far this year, compared with 257 in 1959. Research projects in a number of needed areas are being carried on.

In other actions during the meeting, the State Board of Health put its full support behind the efforts of Governor Sanford and the Governor's Co-ordinating Committee on strengthening safety precautions on the highways.

Dr. James F. Donnelly gave the State Board a report on the dangers from the drug, thalidomide, which has been causing malformations of newborn infants in some foreign countries, but which fortunately was not licensed to be sold in the United States.

Boundary lines of the Haw River Sanitary District were extended by action of the Board after a careful review of the facts presented by the engineering staff. The City of Wilson was authorized to permit controlled fishing and hunting from controlled blinds on the Wiggins Mill Reservoir. These were the sort of subjects you would have heard discussed if you had attended the regular meeting of the State Board of Health this past week. And you could have attended for these meetings are all announced in the press in advance, and any citizen may come and see and hear for himself.

MEMBERS OF THE NORTH CAROLINA STATE BOARD OF HEALTH

Charles R. Bugg, M. D., President ................................................................. Raleigh
John R. Bender, M. D., Vice-President ......................................................... Winston-Salem
Ben W. Dawsey, D. V. M. ................................................................. Gastonia
Glenn L. Hooper, D. D. S. ................................................................. Dunn
Lenox D. Baker, M. D. ................................................................. Durham
Roger W. Morrison, M. D. ................................................................. Asheville
Jasper C. Jackson, PH. G. ................................................................. Lumberton
Oscar S. Goodwin, M. D. ......................................................... Apex
D. T. Redfearn, B. S. ................................................................. Wadesboro

EXECUTIVE STAFF

J. W. R. Norton, M. D., M. P. H. ................................................................. State Health Director
Jacob Koozen, Jr., M. D., M. P. H. ................................................................. Assistant State Health Director
J. M. Jarrett, B. S. ................................................................. Director, Sanitary Engineering Division
Fred T. Foard, M. D. ................................................................. Director, Epidemiology Division
Robert D. Higgins, M. D., M. P. H. ................................................................. Director, Local Health Division
E. A. Pearson, Jr., D. D. S., M. P. H. ................................................................. Director, Oral Hygiene Division
Lynn G. Maddry, Ph. D., M. S. P. H. ................................................................. Acting Director, Laboratory Division
Charles L. Harper, M. S. P. H. ................................................................. Director, Administrative Services
James F. Donnelly, M. D. ................................................................. Director, Personal Health
Survey Gives Figures On Health Personnel Lack

A survey conducted by The Duke Endowment at the request of the North Carolina Health Council gives concrete figures on health personnel shortages for North Carolina.

It comes as no surprise that the greatest lack in the 114 hospitals responding to the questionnaire is professional nurses. Six hundred forty-nine more are needed by these 114 hospitals to give the kind of care they'd like to give. Projecting this figure to include the hospitals which did not reply as well as private duty, public health and occupational health nurses brings the estimated total additional R.N.'s needed in the state today to 2,106.

Other personnel shortages as listed by these hospitals are: Licensed Practical Nurses—269; Registered Medical Technologists—114; Interns—78; Registered X-ray Technicians—60; Registered Dietitians—55; Resident Physicians—39; Operating Room Technicians—38; Nurse Anesthetists—31, and the same number of Registered Pharmacists; Physical Therapists—29; Medical Social Workers—25, and an equal number of pathologists; and additional personnel in other health fields related to hospital duties.

Dr. M. B. Bethel of the School of Public Health of UNC, a member of the Editorial Board of The Health Bulletin, and a member of the executive committee of the N. C. Health Council, has joined the staff of the American Medical Association with headquarters in Chicago, Ill. He will be missed in his many helpful relationships in North Carolina.

August, 1962

Increased Help for Nursing Home Care

The State Board of Public Welfare has recently adopted two additional policies which give increased flexibility in planning for the special health needs of indigent elder citizens of this State.

One policy makes possible payment from public funds for care of elderly needy persons in licensed nursing homes, who go into a nursing home directly from their own homes upon the advice of their personal physicians. This supplements the long-established program for the financing of nursing home care following hospitalization, developed to relieve the pressure on hospital beds.

The second policy provides for an item in the money grant of the needy older person when the physician by written order recommends visiting nurse service from either a registered nurse or a licensed practical nurse.

Through the cooperation of Dr. J. W. R. Norton, State Health Director, and Mrs. Marie Noell of the State Nurses Association, registers of qualified and available nurses will be maintained in the local health departments.

While only 47,000 of the 335,000 persons 65 years of age and over in North Carolina receive old age assistance, these increased resources for this relatively small proportion are none the less important in the total picture of services to the aged.

"Better Communication for Better Health", the printed report of the 1961 National Health Forum held in New York, is now available at $5.00 from the Columbia University Press, 2950 Broadway, New York 27, New York.
DATES AND EVENTS

September 19-21—Southern Tuberculosis Conference, Asheville.


October 15-19—American Public Health Association, 80th Annual Meeting, Miami Beach, Fla.

October 21-23—Annual Conference of the N. C. Family Life Council, Raleigh.


October 23-26—60th Annual State Nurses Convention, Jack Tar, Durham.


Every Saturday—State Board of Health Radio Program over WPTF (Raleigh) 7:30 P.M.

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The Governor's advisory committee on migrant labor has gone on record in what the Raleigh News and Observer terms "a mild approach" in support of federal legislation aimed at dealing with migrant labor problems on an interstate basis. The measures proposed in the legislation would provide: (1) Registration of farm labor contractors; (2) grants to states to extend public health services to migrant laborers and their families; (3) matching federal funds to provide schooling for migrant adults and children; and (4) creation of a national council on migrant labor to advise the President and Congress.
A distinguished group at the annual meeting of the National Council on Family Relations is seen in this picture. Shown here are (from the left) Wallace C. Fulton, the newly elected president of the Council; Dr. Mildred Morgan of Black Mountain, a past president of the Council; Dr. Edward Staples, Nashville, Tenn., president of the Southeastern Council on Family Relations; Mrs. J. Leonard Middleton, Raleigh, president of the N. C. Family Life Council; Blaine Porter, newly elected president-elect of the National Council; and Dr. David R. Mace, retiring president of the Council. All except Mr. Porter will be on the program of the forthcoming annual conference of the N. C. Family Life Council meeting jointly with the Southeastern Council in Raleigh, October 21-23. (See pages 8 and 9)
MORE than 6,000 public health practitioners—the men and women responsible for protecting and maintaining community health in the Americas—will attend the American Public Health Association’s annual meeting at the Fontainebleau Hotel in Miami Beach October 15-19.

This will be the 90th annual meeting of the Association. It has grown from a handful of physicians and engineers, concerned with the control of communicable diseases and basic sanitation, to one of the world’s major professional societies with 13,000 members—physicians, nurses, dentists, engineers, veterinarians, statisticians, nutritionists, social workers, health educators, laboratory scientists and others—concerned with a complex variety of factors affecting people’s health, from smoking to radioactive fallout to highway accidents to substandard housing.

Meeting with the Association will be more than 60 related organizations—alumni groups of schools of public health, voluntary health organizations and associations representing specialties within public health.

An opening general session on October 15 will feature a symposium on The Role of Health Today in Social and Economic Development. Participating will be Mark Perlman, Ph.D., associate professor of political economy, Johns Hopkins University; George Bugbee, director of the health Information Foundation, Chicago; A. M. Payne, chairman of the department of epidemiology and public health, Yale University School of Medicine; and J. George Harrar, Ph.D., president of the Rockefeller Foundation, New York. Presiding will be Charles Glen King, Ph.D., president of the Nutrition Foundation, New York, and president of the Association.

Highlights of Monday afternoon’s scientific program will be sessions on food protection for the future; current problems in infectious disease, including reports on measles vaccine experience in five U.S. communities, current status of venereal disease in New York City, and recent influenza epidemics; epidemiology of cancer, including a study of familial aggregation of lung cancer and epidemiologic studies of leukemia in childhood, cancer of the colon and breast cancer; various aspects of infant and perinatal mortality and morbidity, including a projection of further reduction in infant mortality in this country based on international trends and a report on the effect of prenatal care on the course and outcome of pregnancy; reports on a public health approach to nursing home care and on studies of local health services, including plans of the National Commission on Community Health Services; trends in school health services; a session on medical care and the health of the nation, including a discussion of the APHA’s policy statement on medical care; reports on four public health programs for the treatment of alcoholism; a session on public health oriented studies on social problems and social action; discussion of practical methods for occupational health, including epidemiologic study of nonoccupational diseases in industry and of occupational bladder cancer and a report on the cardiac and work, and a session on public health problems in the space race.

(Continued on page 10)
A reporter, hopefully, is always learning something. I was shocked, a few weeks ago, to learn of the deplorable condition of American teeth. The U.S. Public Health Service furnished statistics to support the charge that we are rapidly becoming a nation of dental cripples. I reported on this situation on July 12, adding the comment, endorsed by leading dentists, physicians, the American Dental Association, the American Medical Association and public health experts here and abroad, that one obvious, easy, proved and inexpensive remedy was the fluoridation of drinking water.

It was then that I learned something else: the passionate fervor, stubborn potency and staggering misinformation of the anti-fluoridation lobby. Listeners from coast to coast wrote to inform me that, whether or not I had holes in my teeth, I obviously had holes in my head. Their letters were undeniably sincere but strikingly similar in theme, as though most of them had got their information from the same sources—which is very possibly the case.

Fluoride is a deadly cumulative poison, wrote a health food merchant of Portland, Oregon. Fluoridation is "a pretty serious step away from democracy," warned a man from Saugerties, New York. A dentist of Red Bluff, California, declared "fluoridation of drinking water is one of the most insidious 'rackets' to date." The "aluminum trust," he charged, is behind the idea as a method to dispose of aluminum by-products. Implying a conspiracy against the critics of fluoridation by scheming bureaucrats, a lady in Sherman Oaks, California, wrote that "as long as minority opinions can be silenced, they will remain unheard and minority opinions."

The opinions of the anti-fluoridationists are not unheard. Though seldom clear, they have come through loud enough to defeat fluoridation in community after community. They are given some credit for blocking it here in New York City. The U.S. government, the University of Michigan, other public and private institutions and individuals have spent large sums of money and incalculable man-hours in examining their claims and have found them, almost without exception, to be baseless or grossly misleading. We pretend to be the best informed country in the world. But one of the ironic paradoxes of the age is that despite the availability of facts to disprove the charges against fluoridation, the public is so ignorant of them that the opposition has succeeded in bringing almost to a complete standstill the expansion of this method as an aid to dental hygiene.

This is not to say that fluoridation is faultless, that it is the answer to every dental problem or that every hamlet in the land needs it. Undoubtedly exaggerated claims have been made for it. Very likely public health officials have been inept and/or impatient on occasion in trying to meet a community's resistance to the process. But if one accepts the case of the opposition, then one must believe that the most responsible spokesmen of the
medical and dental professions and the leading public health experts of the country are either idiots or criminals or both. This is just a little too sweeping to make sense.

Fluoride in water can cause the mottling of teeth. But this happens where water naturally contains too much fluoride. It does not happen in city water systems where fluoridation is controlled. Fluoride is a poison—in the same sense that sodium chloride, table salt, is poisonous if taken to excess. The aluminum industry has not bamboozled or corrupted health officials to provide a market for its slag. The fluoride used in water systems does not come from aluminum by-products and the quantity required is too infinitesimal to make its market important. These and other facts negating the opposition to fluoridation are available to anybody who wants them—in the office of the Surgeon General of the United States.

Some citizens who wrote me castigated the author ites for not concentrating on cleaning up the nation’s diet, instead of tinkering with its water supply. As I reported on July 12, such experiments have repeatedly failed. A lady in Minneapolis furnished fresh proof of failure: some Minneapolis schools tried to withdraw “empty calorie” sweets from lunchroom counters. Students simply loaded up on candy at the corner drug store. In Chicago two high schools lost more than $50,000 in unbought meals when raisins and fresh fruit were substituted for candy, pop and caramel apples so officials gave up and put the sweet stuff back on the menus.

The luckless cause of fluoridation has received impressive support from a reliable source—the conservative British government. In a special 50-page pamphlet which the U. S. Public Health Service has just received, the British Ministry of Health reported the follow-
TENTATIVE PROGRAM
NORTH CAROLINA PUBLIC HEALTH ASSOCIATION
HOTEL SIR WALTER
RALEIGH, N. C.
SEPTEMBER 26 - 27 - 28 - 1962

SEPTEMBER 26, WEDNESDAY
1:00 p.m. N. C. P. H. A. Executive Board Luncheon
3:00-10:00 p.m. Pre-Registration Lobby, Sir Walter
(N. C. Academy of Preventive Medicine and Health)

SEPTEMBER 27, THURSDAY
8:30 a.m. Registration Lobby, Sir Walter
FIRST GENERAL SESSION: Dr. B. M. Drake
10:00 a.m. Invocation Rev. Lynnwood White Memorial Presbyterian Church, Raleigh, N. C.
Welcome Honorable W. G. Enloe Mayor of Raleigh
Response Mrs. Betty P. Keziah President-Elect
Introduction of Guests Dr. J. W. Roy Norton State Health Director
“Communications for What?” Dr. David Phillips
Head, Dept. of Speech University of Connecticut Storrs, Conn.

SEPTEMBER 27, THURSDAY
SECOND GENERAL SESSION:
1:30 p.m. “Infectious Hepatitis” Dr. Jacob Koomen
Assistant State Health Director
Break
“Radiation—How it Affects Public Health”
3:30 p.m. Adjournment
Sanitarians will hold their Section Meeting at 3:45 p.m.
4:30- 6:00 p.m. Open House, A. C. Bulla Health Center

THIRD GENERAL SESSION:
8:00 p.m. Banquet
Awards
Introduction Dr. J. W. Roy Norton
Address Governor Terry Sanford

(Continued on page 6)
SEPTEMBER 28, FRIDAY
FOURTH GENERAL SESSION: 9:00 a.m. - 11:45 a.m.
9:00 a.m.  Message from Medical Society
Dr. Jacob Koomen, Jr.
9:15 a.m.  New Legislation
Dr. B. M. Drake
9:45 a.m.  President’s Address
Dr. Charles Cameron
10:30 a.m.  Break

10:45 a.m.  “Accident Prevention”
Dr. Charles Cameron
Panel
Professor Public Health Administration UNC

11:45 a.m.  Dismiss General Session
Section Meetings will follow the Adjournment of
Friday Morning Session according to Section
Announcements.

— Adjournment in late afternoon —

4-H State Health Pageant
by Larry Horne,
Route 2, Laurinburg

The highlight of State 4-H Club Week came as David Sanderson of R.F.D. No. 2, Burgaw, and Ida Carolyn Kidd of Highfalls were crowned the 1962 4-H Health King and Queen in the Reynolds Coliseum at North Carolina State College on July 27.

Miss Betty Jean Crews of Henderson and Ronald Boyd Outen of Monroe were the runners-up.

These outstanding 4-H’ers were chosen out of approximately 200 4-H’ers in the health pageant for having the most outstanding records of improving the health of themselves, their family, and that of their community. These 4-H’ers distributed pamphlets, and gave demonstrations and exhibits to stress the importance of improving health in the state. David and Carolyn both will receive an all expense paid trip to Chicago to National 4-H Club Week and a chance to compete for $400.00 scholarships to be given to six national health winners.

Sponsor of the Pageant was the Medical Society of the State of North Carolina, and Dr. Fleming Fuller was in charge of the coronation.

A salute to the 4-H Health program!

The State Health Education staff gave their newest member an introduction to North Carolina recently. Seen extolling the virtues of North Carolina is Mrs. Lula Belle Rich, chief of the Health Education Section. The newest staff member (second from the right) is Barbara L. Kahn, an exceptionally well-qualified health educator who will serve in the central counties. The other two members of the staff of this section are: Grace Daniel and Eddie Brown.

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The Age of Challenge
By George Moore, M.D., M.P.H.

"It is only in an order to things in which there will be no longer classes or class antagonism that social evolutions will cease to be political revolutions. Until then, on the eve of each general reconstruction of society, the last word of social science will ever be: Combat or death; bloody struggle or extinction." — Marx's Poverty of Philosophy.

If we as Americans have ever faced a challenge as formidable, then we have not known it. A billion or so of the earth's inhabitants are now dominated by Marxist philosophies. The forces of communism are dedicated to overthrowing our concept of freedom and if we fall, by enslavement or death, the world is insured as a totalitarian state in the image of Lenin.

It is quite obvious that we must make up our minds now about what needs to be done to safeguard our democracy. This is not a time either for indecision or wishful thinking. This is a time for all Americans, rich or poor, whatever our capabilities, creed, race or occupation to begin "to hang together or else be individually hanged."

We must come to grips with hard reality and realize that we can preserve our Nation and hopefully-world democracy by bending our energies in three directions.

First, we must continue our efforts in diplomacy and foreign relations. As long as we can maintain an open conference table, there is the hope that the world may yet reach an understanding of peace as free men know it.

Second, we must understand that if others will not mutually cooperate with us, then we must be prepared to fight. Our military strength should be second to none to prove our right in living the way we choose.

Third, we must prepare to defend our homes, our towns and individual freedoms by engaging in those emergency activities and measures which may be invoked in case of attack. Civil Defense is as important to us as world diplomacy and military strength for this is our proof of determination and will to resist.

For those who state that "they are willing to take their chances above ground," or "they don't want to live afterwards," or "the building of fallout shelters admits the possibility of war," I would like to offer one or two thoughts.

Most fatalities from a nuclear war will result from radiation sickness which is not a very pleasant way to die. Such sickness may be delayed in effect, is long lasting and is completely degrading to human dignity. Death is slow, agonizing and painful. Most will vomit incessantly and suffer continuous bloody diarrhea for days. Survivors of radiation sickness will require months to heal, regrow hair and feel strong again. Most who have good fallout shelters can be spared these horrors and face the challenge of rehabilitation and recovery with strength of mind and body.

After a nuclear war, we may find ourselves living in an extremely harsh frontier world but our forefathers faced a world of cold, hunger, drought, fires, Indians and diseases and accepted its reality without hesitation. We can do the same.

(Continued on page 12)
Dr. and Mrs. David R. Mace were enjoyable in fellowship during the week. Dr. Mace, a noted authority and author in the field of Family Relations, presided as president of the National Council.

This modernistic auditorium of the University of Connecticut located at Storrs housed the General Sessions of the National Council on Family Relations.

National Council On Family Relations Meets In Connecticut

Many families from across the country attended the annual meeting of the National Council on Family Relations held in Connecticut. Here are the parts of some of the North Carolina families which could be located at any one time on that spacious lake-centered campus of the University. The group includes: the Rev. and Mrs. William E. Bobbitt, Jr., Charlotte; Mr. and Mrs. James H. Banbury, Charlotte, and their three children—Rosalind, Jimbo and Bruce; and J. Leonard Middleton, Raleigh, and the Middleton children—Marilyn and Jacilyn.
Part of North Carolina’s banner delegation seen at the National Council on Family Relations meeting in Storrs, Conn. (From the left) Kate Garner, Greensboro, secretary of the N. C. Family Life Council; Dr. Mildred Morgan, Black Mountain, co-chairman of the program committee for the forthcoming annual conference of the N. C. Council; Dr. Dan Hobbs, Greensboro; Frances Jordan, Raleigh, Family Life Specialist, N. C. Agriculture Extension Service; and Mrs. J. Leonard Middleton, Raleigh, president of the N. C. Family Life Council.

Mrs. Sylvia Aho, instructor in Home Management in the Department of Home Economics of the University of Connecticut, shows clothing designed especially for children with various handicaps.

One among the many emphases during the annual meeting of the National Council on Family Relations was upon especially designed homes, equipment and clothing for the handicapped. Inspecting this kitchen designed especially for the handicapped mother in a wheelchair, are Frances Jordan, Raleigh, Family Relations Specialist of the N. C. Agriculture Extension Service, and Dr. Ruth Hoeflin, associate director of the School of Home Economics of Kansas State University and the incoming secretary of the National Council.
APHA Annual Meeting

(Continued from page 2)

A general session Tuesday evening will feature addresses by the Association's president, Charles Glen King, Ph.D., executive director of the Nutrition Foundation, New York, and the Honorable Fowler Hamilton, administrator of the Agency for International Development, and presentation of the annual Sedgwick Memorial Medal for distinguished service to public health.

On Thursday evening, the Bronfman Prizes for Public Health Achievement for 1962 will be presented at a general session which will also feature the second annual Bronfman Lecture. The sessions will conclude with a symposium Friday morning on new developments in nutrition. Participants will be Nevin S. Scrimshaw, M.D., professor of nutrition and head of the department of nutrition, food science and technology, Massachusetts Institute of Technology; William J. Darby, M.D., professor and head of the department of biochemistry, Vanderbilt University; Frederick J. Stare, M.D., professor of nutrition, Harvard University, School of Public Health; and Joaquin Cravioto, M.D., assistant director, Institute of Nutrition of Central America and Panama, Guatemala City. Summarizer will be William H. Sabrell, Jr., M.D., professor of nutrition, Institute of Nutritional Sciences, Columbia University.

Tuesday morning's scientific program will include sessions on epidemiological research in periodontal disease; an exploration of environmental health—present and future; a symposium on hepatitis, including reports on a physician-related outbreak of the disease and on efficacy of varied doses of gamma globulin during an epidemic; epidemiologic studies of mental disease; care of handicapped children; progress and research in school health; temperature control in food sanitation; medical education and community needs; community organization for local health services; recent toxicological problems; reports on new health education programs; making public health nursing service more effective, and statistical methodology.

Tuesday afternoon's sessions will cover international cooperative studies in virology; cooperation among voluntary health agencies; components of environmental health management; the local health department and occupational health; problems with rare diseases and small populations, including observations on epidemiology of male breast cancer; program research and its effect on public health administration; water and sewage; rapid diagnostic virology; various aspects of maternal and child health, including adjustments of parents to the first baby and a proposal for a research project on hereditary diseases; epidemiologic study of behavior deviations; statistical studies on mental health services; prevention of disability, and health and the Alliance for Progress.

Wednesday morning's scientific sessions will include discussions of social science in public health; an up-to-date report on radiation; practical experiences with use of instrumentation in environmental health; respiratory symptoms, lung function and smoking habits in a total community, the cigarette arsenic-lung cancer hypothesis, and relationship between physical activity and reported mortality from coronary heart disease; community and school services for special needs of children; methods of evaluating public health programs; laboratory studies, including comparison of the immunogenicity of inactivated, attenuated, and combined killed and live measles vaccines; home care programs—the possible need for standardization and accreditation; study of
thinking practices; changing public opinion toward cancer, and public health tutoring and mental health services.

Wednesday afternoon's topics will include dental programs in South America; community health services for the chronically ill and aged; research and research needs in school nursing; personnel problems in public health; experience in overcoming barriers to prepaid group practice; health planning for community survival; research in environmental health; a forum on eradication of disease and hunger—objectives of the Alliance for Progress; anthropod-borne virus infections; workmen's compensation and rehabilitation, and smoking and health factors, including a special report by the American Cancer Society on teen-age smoking programs.

Wednesday evening's sessions will include the annual banquet of the American School Health Association, to be addressed by Berwyn F. Mattison, M.D., executive director of the American Public Health Association; a session of the Conference of Public Health Veterinarians on epidemiology of salmonellosis; a program of the National Association of Poison Control Centers on experiences with labeling under present Federal regulations, and reports on vital statistics in public health.

Thursday morning's scientific program will cover use of the child's social environment as a health developing and therapeutic tool; health needs in school athletic programs; pros and cons of scientific decision making; voluntary health programs in medical care planning; the responsibility of health departments for environmental health programs; a round-up of present knowledge on rabies and chronic respiratory diseases, an emerging health problem.

Thursday afternoon's program includes discussions of behavioral science and public health; developments in epidemiologic and public health statistics outside the U.S.; combatting health misinformation; design of facilities with environmental health significance; epidemiologic studies of neurological disorders; health instruction in schools; medical care services available for the aging; food chemistry and food additives; microbial surface contamination; new roles for nurses in maternal and child health; research on patterns of psychiatric care, and needs of patients beyond hospital care.

Registration will be open to persons professionally interested in public health, including non-members of the Association. In addition to the scientific discussions, scientific and technical exhibits are being planned.

A post-convention trip to Puerto Rico and St. Thomas will include scientific sessions on medical and health activities of the Puerto Rico Nuclear Center and on Puerto Rico's health and welfare program.

The American Public Health Association has headquarters at 1790 Broadway, New York 17. Berwyn F. Mattison, M.D., is executive director.

Special Grant Received by National Council on the Aging

The National Council on the Aging has received a special grant from The Baumritter Corporation, Garson Meyer, president of The Council announced here today.

The grant will be used to sponsor an Institute on furniture requirements for older persons, the first in a series of consumer institutes on the special needs of the elderly.

The furniture Institute is scheduled for November.

In accepting Baumritter's initial grant, Mr. Meyer praised the Corporation for its pioneering effort.
The Age of Challenge
(Continued from page 7)

It is apparent that the major difference between our forefathers and men today is the resolution to accept reality and succeed. These remarks although brutal are necessary to relate. Not enough of us have accepted the true cause of Civil Defense.

For the most part, public apathy, skepticism and confusion have been reflected in the performance of many Civil Defense agencies. In acknowledgement of this state of affairs, President Kennedy, on May 25, 1961, in a congressional address, outlined those actions considered necessary to strengthen the Nation's civil defense capability.

In an Executive Order, dated July 20, 1961, President Kennedy assigned (1) major responsibilities in civil defense operations to the Department of Defense, and (2) coordination of the total civil defense program to the Office of Civil and Defense Mobilization (reconstituted as the Office of Emergency Planning).

On August 14, 1961, a second Executive Order assigned responsibility to the Department of Health, Education and Welfare for civil defense stockpiling of medical supplies and equipment.

On February 17, 1962, executive orders were issued assigning civil defense preparedness functions to nine different Federal agencies. These orders delegate emergency responsibilities for those programs which are related to the peacetime activities of each agency. One of these orders assigned the planning and development of preparedness programs covering health services, health manpower, and health resources to the Department of Health, Education and Welfare. These responsibilities have been redelegated to the Public Health Service.

Each Executive Order reaffirms the role of OEP (Office of Emergency Planning): "To advise and assist the President in determining policy for, planning, directing and coordinating...the total civil defense program." OEP has now defined the new National civil defense program in a recent document entitled "The Comprehensive Program for Survival of Government and Management of Resources." As this article is being written, OEP area personnel are meeting with State officials to explain the new program and gain their active support in the implementation of similar programs at State and local levels.

Through OEP's consistent and firm program at the Federal level, purposeful effort is being realized. OEP is prepared to offer guidance and assistance to State governments, and through them to local governments and individuals. Every individual will eventually realize his responsibility toward the implementation of an action program.

Health and medical personnel will assert increased leadership in the health and medical field and find more active support from others. The organization to coordinate the total Emergency Health and Medical Preparedness Program will be provided by government through its official health agencies. Health directors, supported by the medical profession and allied health and medical groups, will assume this obligation for their communities so that each individual will be given the greatest opportunity for survival.

My remaining remarks are dedicated to a brief review of Federal and State health preparedness programs which emerge as beacon lights for definitive civil defense action. It is hoped that you may follow these guidelines and find your best course to preparedness.
Medical Self-Help Training Program

Following a mass attack on this country, American families may be deprived of a physician's services, due either to isolation within their own homes or shelters, or to a medical care demand so overwhelming that physicians will be hard-pressed to care for all who need help. The purpose of the Medical Self-Help Training Program is to teach people to help themselves when professional medical help may not be available for days, weeks, or longer.

Medical Self-Help Training Kits have been developed which contain educational items necessary for both students and instructors: instructor lesson guides, student handout materials, projector slides, screen, examination booklets, etc. The course consists of twelve lessons: Radioactive Fallout and Shelter; Hygiene, Sanitation and Vermin Control; Food and Water; Shock; Bleeding and Bandaging; Artificial Respiration; Fractures and Splinting; Transportation of the Injured; Burns; Nursing Care of the Sick and Injured; Infant and Child Care; and Emergency Childbirth.

Public Health agencies and private medicine should assume primary leadership in furnishing the operational guidance, program direction, coordination and supervision for the implementation of this program.

Civil Defense Emergency Hospital Prepositioning and Expansion Program

The CDEH is a completely functional 200-bed general hospital designed to be set up in an existing structure, such as a church, school, community center, or large motel. It contains provisions for the following departments: laboratory, pharmacy, X-ray, surgery, shock, treatment and holding wards, sorting or triage areas, and medical and surgical supplies. Provisions are also included for records, emergency power, and an emergency water supply. As of this date, 1,932 hospitals are prepositioned throughout the nation. Within the next 12-18 months an additional 750 hospitals will be prepositioned. Back-up supplies for all CDEH's will be increased to 20 days.

A program of this magnitude requires the active cooperation of community health and medical personnel. Additional adequate storage space must be located, custodial care provided, and orientation and training offered in the use of the CDEH. Above all, CDEH'S must fit into the community health plan.

The Public Health Service through each State Department of Health has made training guides and visual aids available on CDEH utilization. A complete CDEH training manual is in draft form at this time and should be distributed within the coming months.

3. Training

There are other types of training for physicians, health workers, and allied health and medical personnel which would also contribute directly to total community preparedness: Expanded Function Training for Allied Health Professionals, In-Service Disaster Training for Health Workers, and Austere Medical Care Techniques.

Expanded Function Training should be taught by physicians. A local medical society could organize courses for allied health professionals following the guidelines outlined in the AMA Report on National Emergency Medical Care published in 1959. A physician's ability to provide care in an emergency would be greatly increased through this type of team training.
A State baseline course, The Local Health Department in Emergencies, has been developed to teach public health workers modern weapon effects and methods of protection, preparation, and recovery. A continuum course for environmental health workers, "Expanding Sanitation Services in a Disaster," has been developed and is now being offered in several States. Similar courses for nurses and other health disciplines are being prepared.

The purpose of these training activities is obvious. Regardless of resources, supplies, materials and facilities, we will not be able to achieve full potential in a serious emergency unless health and medical personnel are prepared through orientation and training to use austere techniques, utilize allied health professionals effectively and learn methods of improvisation.

4. Planning for Emergency Health Services

Basic guidelines for the preparation of local emergency health and medical plans are contained in the health and medical annex to the State Operational Survival Plan.

Guidelines for the development of hospital plans have been prepared by The American Hospital Association in a publication entitled, "Principles of Disaster Planning in Hospitals." A descriptive guide, "Hospital Disaster Planning—Community and CDEH," is a part of the CDEH Training Manual and will provide excellent suggestions for CDEH plans.

Inventories of health resources, manpower, supplies and materials, and facilities can be instituted immediately in each community to determine the extent of current resources as well as requirements for additional stockpiling.

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Once plans have been developed, information should be disseminated to the public and health and medical personnel can then undertake training exercises to review and test concepts.

In conclusion, the role of organized medicine and public health in Civil Defense is thus manifest. Many of the same programs and services provided in peacetime apply to disaster. All that is needed is preparation for expected magnitudes. There is no substitute for trained people and our available manpower in medicine and health must prepare themselves psychologically and physically. Shelters must be built in order that we may be able to help others hurt by disaster. The more who survive a nuclear holocaust, the more assurance of early rehabilitation, victory and safeguarding ourselves and our children in this age of challenge.

We can neither be pessimists nor fatalists.

War is not necessary and as long as we can maintain this uneasy peace, the more hope we have of eventual world peace.

Civil Defense protection is a vital part of our heritage.

There is something each of us can do—and for the remainder, we will trust in God.

November 12 - 16 — A short term course for nurses in “Principles and Problems in Administration” will be given at the School of Nursing under the Professional Nurse Traineeship Program. Faculty: Richard P. Calhoon, professor of personnel management, School of Business Administration, University of North Carolina; Mrs. Mary King Kneedler, R.N., B.S.-PHN, M.A.; assisted by faculty members of the University of North Carolina School of Nursing.

She Did So Much For So Many
Excerpt from editorial in the Wilson Daily Times, Friday, July 6, 1962.

Life is not reckoned by the number of days that you live but how well you use the few years allotted to you, for the benefit of your loved ones and your fellow men.

Dr. Irene McCain McFarland only lived in Wilson for five short years but so well was she identified with the worth while things of life, that you think of her as always being part and parcel of the community. And what she stood for will last as long as time.

She was so young to die, she did so much for so many, and there was so much left for her to do, were some of the expressions you heard, over and over again, as the message of her death shocked the community. She died in her sleep early Wednesday morning at the age of 38.

Strong, the picture of health, always smiling, and endowed with exceptional ability and a driving purpose, she went about life as though she had much to do and no time could be wasted. She was right. And when you think back on the lives she touched, the causes she furthered, the example she left, you are eternally grateful.

Dr. McFarland knew how to inspire others, she was endowed with exceptional executive ability and many talents. Psychiatry was her specialty and shortly after coming here she began to point out the need for a Mental Health Association. This soon became a reality. The logical sequence is a Mental Health Clinic and this followed after much hard work on her part and with the help of many others.

Now the Wilson Mental Health Association is recognized over the state, as an example to follow, and the Mental Health Clinic is enlarging its scope of service.
DATES AND EVENTS

October 2-3—Congress on Occupational Health, Boston, Mass.
October 4-6—AMA National Congress on Mental Illness and Health (First) Chicago, Ill.
October 9-12—American Dietetic Association, Miami Beach, Fla.
October 10-12—Association of State and Territorial Health Officers, Washington, D. C.
October 12-13—American Medical Writers Association, Washington, D. C.
October 15-19—American Public Health Association, 80th Annual Meeting, Miami Beach, Fla.
October 15-19—Association of Business Management in Public Health, Miami, Fla.
October 15-19—Association of Schools of Public Health, Miami, Fla.
October 19-21—Fourth National Conference on Family Life of the Methodist Church, Chicago, Ill.
October 21-23—Annual Conference of the N. C. Family Life Council, Raleigh.
October 23-26—60th Annual State Nurses Convention, Jack Tar, Durham.
Oct. 29-Nov. 1—American Association of Public Health Dentists, Miami Beach, Fla.
November 14-17—National Association for Mental Health, St. Louis, Mo.

Every Saturday—State Board of Health Radio Program over WPTF (Raleigh) 7:30 P.M.

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During the 90th Annual Meeting of the American Public Health Association in Miami in October, J. W. Roy Norton, M.D., M.P.H., North Carolina's State Health Director, becomes President of this, the largest public health body in the world. (See pictures and story on pages 2 and 3 and following.)
The new APHA President, Dr. Norton (right) with the association's executive director, Berwyn F. Mattison, M. D.
The in-coming president of the American Public Health Association, J. W. Roy Norton of North Carolina, is no back-yard chef—nor is he called upon to be the chief cook when he and his friends go on a fishing trip or hunting safari.

But—“Roy Norton is the most cheerful, willing and uncomplaining fish cleaner, bottle washer and general cleaner-upper any fishing companions ever had.” The consistent testimony of many friends bears this out.

“One time our fishing crowd caught 140 spot,” one man said, “and Roy cleaned every one of them cheerfully and without a lick of help from any of the rest of our lazy crowd.”

Growing up with six sisters in a Scotland County farm family in the Sandhills section of North Carolina, Roy and his brother, Maurice, had little reason to learn any of the culinary arts. And now, with a wife and two daughters, Roy and his son just enjoy the fruits of their labors.

But a more appreciative partaker of good food could hardly be found. He loves country ham. Even today, any public health trip near where North Carolina’s justly famous country hams are produced means a stop.

Early days on the Farm

Those early days in the farm home near Laurinburg made contributions in self-respect, ambition, purpose, vision and in an appreciation of the worth of other people. His parents, Lafayette and Lola Josephine (Reynolds) Norton, were examples of the philosophy of personal responsibility and shared in community problems and progress. Today, Roy’s widowed mother, now 88, still manages the farm with a keen mind and an amazing awareness of what’s going on in the world, nationally as well as locally, even including the world of sports.

Few may have heard of the triple play of 1915 on the baseball field of Snead’s Grove School in Scotland County but Roy was a participant in that play. It was the first triple play he had ever seen. With a man on first and one on second and nobody out, the opposing batter hit a hard line drive to Ernest Morgan on second. Ernest touched second and shot the ball to Roy at first base, to retire the side with that one triple play. A lifetime of interest in baseball and other sports was born.

Those high school days, the college athletics at what is now Duke Uni-
versity and later semi-pro baseball made their contributions of self-discipline and respect for a good physical condition. Service in the first World War, from private to second lieutenant in the Field Artillery, and as a colonel in the Medical Corps of World War II, left unmistakable marks in the erect, quick moving, purposeful and direct public health leader of 1962, the State Health Director of North Carolina.

He Almost Missed College

After high school, Roy almost missed college. Like many boys, the attractions of job opportunities after high school were strong. His parents, the school principal and the county superintendent of schools urged him to enter Trinity College (now Duke University.) He began his college work, but World War I interrupted these college days after his Sophomore year. Upon his return from service, the same job temptations were finally set aside on a trial basis as his father urged him to try it “for a few months only.” He continued to graduation with an A.B. degree and law study under Dr. S. F. Modecai. He then entered the Medical School of the University of North Carolina and after two years transferred to Vanderbilt University, receiving his M.D. degree in 1928.

While Roy was completing his medical education in Nashville, Tennessee, fate guided a vibrant and charming young lady from Mississippi, Jaunita Harris Ferguson, to Peabody College in that city. There she finished studies in Home Economics and graduate work in 1928, a week before Roy received his M.D. from Vanderbilt. They had been married a few weeks earlier on Easter to celebrate the 25th wedding anniversary of Jaunita’s parents.

Jaunita is from Jackson, Mississippi, where she received a B.S. degree from Belhaven College in 1925. She then went to Northwestern University at Evanston, Illinois, for Public School Music and to the Renshaw School of Speech, Washington, D. C., 1926.

A Focus on Public Health

Roy’s attention became focused on public health first under Dr. D. A. MacPherson in the immunology course at Chapel Hill.

Public health entered Roy’s life-plans in 1931 when he was back in Raleigh for a visit during his tenure as chief of the Medical Department of the Holt-Krock Clinic at Fort Smith, Arkansas. Edwin Gill, then Secretary to Governor Max Gardner and now Treasurer of the State of North Carolina, got him in touch with Dr. James M. Parrott, then State Health Officer. Dr. Parrott recommended Roy as City Health Superintendent of Rocky Mount, N. C. and for four years this local health work gave him experience in the solid groundwork of public health. A Rockefeller Foundation fellowship to Harvard under the
sponsorship of Dr. John A. Ferrell (a former APHA President) resulted in a Master of Public Health degree in 1936. A prophetic note could be heard in Dr. Parrott's comment as he came back to his office after his first meeting with Roy Norton. He told an associate, Dr. J. H. Hamilton, "I have just met one of the most personable young men I have ever known. He is to be Health Officer at Rocky Mount, but I blame myself for not bringing him here to the State Board of Health instead."

The Army Makes its Contribution

Roy Norton loves the Army. To know this fact helps a person know the man. When he engaged in the summer activities of a Reserve Officer, he was all military. He did not consider it, as some do, an easy two weeks of release from the job back home. He was a soldier when he put on his uniform.

Even having the flagship he was on in World War II torpedoed and sunk beneath him did not dim his enthusiasm for the military. He has the conviction that the United States needs to maintain a strong defense and that there is a real place and function for a strong reserve.

It was about 2:30 A.M. on a bright moonlight morning when the flagship of the troop convoy from Britain to North Africa was torpedoed and set afire. "We were short of life-boats and rafts," Dr. Norton said in telling about the incident. "We were about 75 miles off of Oran, headed for Algiers. It looked for a time as though we would have to swim for it. However, a destroyer came alongside and we threw landing nets over the side and scrambled over onto the deck of the destroyer. We lost about 150 men and were fortunate not to have lost more. But we lost none of the first contingent of WAAC's sent overseas."

Roy Norton has had generous opportunity to view military operations. He served as Medical Inspector at Fort Bragg, Assistant Chief of Preventive Medicine in the European Theatre, Deputy Chief of Hygiene in the Allied Force Headquarters, Medical Inspector of the Seventh Army, Director of Epidemiology for the Army, and Chief of Preventive Medicine for the Ninth Service Command (eight Western states, Headquarters in Salt Lake City, Utah.) He was awarded battle stars in the Tunisian and Sicilian Campaigns and also the Army Commendation Citation for service as Army Epidemiology Chief.

At present, the Nordons are a service family. Roy proudly states: "All my sons are in the service now." Two of these are sons-in-law, however, the husbands of his daughters, Geraldine, whose husband is Lt. Cmdr. Charles F. Aquadro, a regular in Navy nuclear submarine service; and Jean, whose husband is Captain H. J. Dickman, a pilot in regular Air Force, now in Viet Nam. His son, Lafayette Ferguson ("Ferg") is also in military service flying jets for the Navy and may continue in it when his required five-year tour is ended.

Sports and Hunting Are Avocations

Throughout his school and college career, Ferg carried on his father's interest in athletics to the delight of both parents. His Dad says, "We planned our vacations according to the Little League, Pony League and American Legion baseball schedules. And we did the same throughout Ferg's high school and college days."

When Ferg played in the baseball schedule of the University of North Carolina, it took something really important to keep Roy and Jaunita Norton from the cheering section. He played third base and was co-captain in his Senior year.

Ferg also reflects the hunting and fishing interests of his Dad. They love
to hunt together during vacations.

Roy Norton is an ardent dove hunter. That probably is his favorite kind of hunting. When the dove season opens, about the first week in September, some hunting time must be found somehow. Bird hunting, duck hunting, deer hunting, and even bear hunting have their occasional place in the brief opportunities between the pressure periods of major public health administration responsibilities and the work of national public health committees. His remarkable sense of direction, attested to by his hunting friends, seems to carry over into the guidance and counsel he gives in public health.

**When He Walks, He Moves**

Whenever it is necessary to walk somewhere, this man Roy Norton changes his geographical location rapidly by the vigorous use of his pedal extremities—by fast walking, that is. Friends advise others to sit with him, to dine with him, to talk with him—but warn them not to try to walk with him. When it becomes necessary for several of his friends to walk some distance with him, they some times conspire against him and put two of their number just ahead of him to block and slow the pace sufficiently to permit conversation.

Recently the Norton house caught fire in mid-morning when both Dr. and Mrs. Norton were elsewhere in the city. Roy’s office sent two men and a secretary to try to intercept him as he was transacting business at several downtown offices. The men did not locate him, but the secretary cruising along in her Alfa Romeo came alongside him, saying, “Dr. Norton, I’ve come to take you to the fire.” Roy broke into that broad engaging smile of his, laughed and thanked her and kept on walking, thinking she was merely referring to the old saying, “Where’s the fire?” because of his fast walking. Before he got out of hearing the secretary called out, “But Dr. Norton, it’s *your* house that’s on fire!” Only then did he realize that her mention of a fire was not just another jibe at his fast walking pace.

**Concentration Moves Mountains of Work**

One outstanding characteristic permits Roy Norton to engage wholeheartedly in activities which release the tensions of major administrative responsibility. When he is engaged in public health work he puts every ounce of his energy and concentration in the concern of the moment. He permits himself no relaxed dealing with the work to be done. His battle plan is—attack, attack until the enemy of work to be done is conquered. He makes swift decisions and takes decisive action based upon his own experience and judgment, but also willingly accepting and respecting the counsel of competent associates who have something to contribute.

**Has Faith in Associates**

In dealing with friends and associates, Roy Norton practices a motto which hangs upon the wall of his office behind his green upholstered chair. It is a motto he has had for so many years he has even forgotten the source from which it came. It is the basic philosophy of human relations which he testifies has helped him as a teacher, as a school principal, as baseball and basketball coach, as public health administrator and as college professor.

“The spirit of this motto fits in with the way I like to think about the people I work with,” he says.

The motto, by Bernard Haldane, reads, “If you want to get the best out
of a man, you must look for the best that is in him.”

Whether it has been the considerate and expectant spirit alive in this motto, or a well-trained public health worker in action, or a dedicated purpose, or the application of wisdom born of wide experience, or a combination of these and other factors—whatever the cause, Roy Norton has done things in public health and has gone places. As the incoming president of the American Public Health Association, taking office at Miami Beach in October, he will have reached the titular pinnacle of the organized public health work of the nation.

Has Served In All Public Health Places

He has reached this pinnacle by service at nearly every stage of public health work. He believes in stressing the team approach in public health and has himself occupied either officially or defacto every place on the team.

Starting from the hand to hand confrontation with public health problems in the local health department, he has served as Assistant Division Director of the N. C. State Board of Health, Professor of Public Health Administration of the University of North Carolina, Chief Health Officer of the Tennessee Valley Authority and, since July of 1948, North Carolina’s State Health Director.

In the larger areas of public health, Roy Norton has participated for years in the Council and committee activities of the American Public Health Association; as committee chairman and later president of the Southern Branch APHA; president of the State and Territorial Health Officer’s Association; chairman of the public health section of the Southern Medical Association; treasurer of the International Society of Medical Health Officers; president of the N. C. Conference for Social Service; president of the Harvard Public Health Alumni Association; Consultant of the National Mental Health Institute and Surgeon General’s Committee on Mental Health Activities, U.S.P.H.S.; and member of the board of directors of the National Citizens Committee for the World Health Organization.

He has been the recipient of numerous awards, among them: Distinguished Service Award from the School of Medicine of the University of North Carolina, McCormack Award of the State and Territorial Health Officers Association, Lasker Foundation Award of the Planned Parenthood Association, Reynolds Medal from the N. C. Public Health Association, the Scientific Exhibit Award from the Medical Society of the State of North Carolina, and the First Award of Merit, Southern Branch, APHA.

Philosophy Based on Personal Responsibility

As an author and co-author of many articles and publications, Roy Norton has set forth a philosophy of public health focused on personal responsibility.

“In public health we must motivate people to do for themselves all that they can do,” he has said. “Parents should feel a personal responsibility for their children, and the other members of the family for the old people. We should encourage people more and more to feel a responsibility to work with us instead of expecting us to do things for them. We are entering an era of health care in which people must do for themselves, as they must do in dealing with cancer, mental and emotional problems, heart disease, motor vehicle accidents, and even in that old original program of public health—saving babies and mothers.”

A hint of Roy’s personal philosophy of life is given in his “homing” instinct and his long look ahead.

Roy loves his home county and the (Continued on page 15)
The North Carolina Public Health Association Met in Raleigh

Pictorial Report

NEW OFFICERS
President: Mrs. Betty Potts Keziah Charlotte
Pres-Elec: Martin P. Hines, D.V.M. Raleigh
Vice-Pres.: Robert W. Brown Asheville
Secretary: Dr. Rosemary Kent Chapel Hill
Treasurer: Mrs. Corrina Sutton Raleigh
Past Pres.: B. M. Drake, M.D. Gastonia
Number Registered for Meeting: 815

AWARDS:
Mrs. Bertha Paschall
Pender County Health Department
The Carl V. Reynolds award for her work in fire and accident prevention.

Dr. Hugh A. Matthews Canton
The Distinguished Service Award for 1962. Cited for organizational work in community.

Walter C. Lackey, Sanitarian Murfreesboro
Citation of Merit, for work in disease control following the March storm on the Dare County coast.

Lemuel B. McMahan Burlington
Citation of Merit, for community organizational work.

The outgoing and incoming presidents of NCPHA stand ready to greet guests at the reception in the Governor's suite during the Association's Annual Meeting. B. M. Drake, M.D., Gastonia, retiring president; and Mrs. Betty Potts Keziah, Charlotte, incoming president.
SECTION OFFICERS:

Health Director's Section:
Chairman: Dr. Joe Weaver, Granville County Health Department
Chairman-Elect: Dr. Joe Bain, Wayne County Health Department

Mental Health Section:
Chairman: Mrs. Mary Dorst, Asheville
Vice-Chairman: Dr. Robert Fincher, High Point
Secretary-Treasurer: Mary VanNess, Greensboro

Nurses' Section:
Chairman: Martha Parton, High Point
Vice-Chairman: Mrs. Frankie Booker, Rocky Mount
Secretary-Treasurer: Mrs. Frances Hutchinson, Winston-Salem

Secretarial and Statistical Section:
Chairman: Faye Flack, New Hanover County Health Department
Vice-Chairman: Margaret Neal, Wilson County Health Department
Secretary-Treasurer: Valera Cobb, Raleigh
Historian: Virginia Bellamy, Brunswick County Health Department

Nutrition Section:
Chairman:
Vice-Chairman:
Secretary-Treasurer:
To be elected through the mail.

The vice-president Robert W. Brown efficiently stands ready to serve during the Association year.

October, 1962 THE HEALTH BULLETIN
More efficient registration desks and personnel could hardly be found.

The president-elect of NCPHA, Dr. Martin Hines (right) discusses matters of importance with Dr. William Happer, Health Director for Caldwell County.

SECTION OFFICERS

Health Education Section:
Chairman: L. V. McMahan, Burlington
Vice-Chairman: Marshall Abee, Winston-Salem
Secretary-Treasurer: Norman Gaskill, Raleigh

Venereal Disease Section:
Chairman: Louis Doniferio, District Epidemiologist, Durham
Vice-Chairman: Joe Montez, District Epidemiologist, Fayetteville
Secretary-Treasurer: Ben Shaw, Epidemiologist, Durham

Laboratory Section:
Chairman: Mrs. Katie C. Daniels, Raleigh
Vice-Chairman: Bryan Reep, Raleigh
Secretary-Treasurer: Sidney Lyles, Gastonia Health Department

Dental Health Section:
Chairman: Dr. George Dudney, Raleigh
Vice-Chairman: Dr. H. C. Jont, Winston-Salem
Secretary-Treasurer: Miss Sylvia Verdery, Raleigh

Sanitation Section:
Chairman: Lewis Caton, Fayetteville
Vice-Chairman: Owen Braughler, Greensboro
Secretary-Treasurer: Bob Sandford, Richmond County Health Depart-
Governor Sanford seems pleased to have his picture taken with the new president of NCPHA, Mrs. Betty Potts Keziah of Charlotte.

Part of the charming and efficient registration personnel for the 51st Annual Meeting of the NCPHA in Raleigh. From the left these are: Miss Carolyn Buffaloe, Garner; Mrs. Valera Cobb, Raleigh; Mrs. Katherene Massey, Raleigh; Mrs. Elaine Mansfield, Chapel Hill.
B. M. Drake, M.D., retiring president of NCPHA, was host to the program dignitaries during the annual session. He is seen with Governor Terry Sanford who delivered the address at Thursday evening's banquet session.

Dr. Charles R. Bugg, Raleigh, president of the State Board of Health, lights up as he prepares to listen to Governor Sanford's banquet address.

Jacob Shuford, M.D. (left) Hickory, vice-president of the Medical Society of the State of North Carolina, brought a message from this Society at the final general session of the NCPHA meeting. With him is C. M. Cameron, Jr., M.D., Chapel Hill, Professor of Public Health Administration, School of Public Health, UNC.

Mrs. Scottie McConnell of the Public Health Administration Department of the School of Public Health UNC, enjoys a coffee hour with others of the record-breaking 815 persons registered.
A distinguished threesome enjoyed fellowship during a social hour. From left: Governor Terry Sanford, Emil E. Palmquist, M.D., Charlottesville, Va., Regional Health Director, USPHS; and J. W. R. Norton, M.D., N. C. State Health Director.

Hugh A. Matthews, M.D., Canton, received the Distinguished Service Award for 1962 for his organizational health work in his community. He is seen at the banquet with Mrs. Annette Boutwell, Raleigh, Health Educator with the Medical Society for the State of North Carolina.

October, 1962

THE HEALTH BULLETIN
H. W. Stevens, M.D., Asheville, Buncombe County Health Director and President of Southern Branch APHA, is seen laden down as he and Mrs. Stevens prepare to leave for their mountain home.

Dr. and Mrs. B. M. Drake have a parting word with C. Scott Venable, Raleigh, before leaving for Gastonia.

Henry J. L. Rechen, of the Division of Radiological Health, HEW, Washington, D. C. (left), is shown with President B. M. Drake, M.D., Gastonia, and W. L. Wilson, M.D., who heads the Radiological Health Program of the State Board of Health.
Roy Norton — The Man
(Continued from page 7)

people thereof. "His smile broadens and his pace quickens," as one friend said, "as soon as he gets within 50 miles of Laurinburg." Eleven years ago he and his brother fulfilled a long held desire by buying a farm near their old home place. Roy has taken great delight in developing his part, a 260 acre tract, with a seven-acre lake and other recreation areas "for the pleasures of the grandchildren", as Roy says.

The Norton's have three granddaughters: Jeana Lauren Aquadro, Carolyn Jean Dickman and Lisabeth Anita Dickman and will welcome an heir from Ferg and Sharon Cates Norton about Thanksgiving.

A feature which makes the location of Roy's farm even more attractive and promises to be of some importance in the future is the recent location of the all-new St. Andrews College in a campus only a few hundred yards away.

"Jaunita and I enjoy going there from time to time and digging in the earth," he says. "Sometime we will retire there, I expect. I think it is good for a person to make plans and encourage his interests long before retirement days come. The good college library and able faculty members nearby will be stimulating and their concerts, conferences and other cultural interests will continue to help make life worth living for both of us."

Secretary
Celebrezze to Address Annual Meeting on Aging

U.S. Secretary of Health, Education, and Welfare Anthony J. Celebrezze will make his first scheduled New York address as Secretary during the twelfth annual meeting of The National Council on the Aging, October 23 at the Hotel Commodore.

Mr. Celebrezze will speak before a luncheon meeting of a conference of national, voluntary organizations concerned with the problems of older persons.

MEMBERS OF THE NORTH CAROLINA STATE BOARD OF HEALTH

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<td>Director, Administrative Services</td>
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<td>Director, Personal Health</td>
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DATES AND EVENTS

October 15-19—American Public Health Association, 90th Annual Meeting, Miami Beach, Fla.

October 15-19—Association of Business Management in Public Health, Miami, Fla.

October 15-19—Association of Schools of Public Health, Miami, Fla.

October 19-21—Fourth National Conference on Family Life of the Methodist Church, Chicago, Ill.

October 21-23—Annual Conference of the N. C. Family Life Council meeting jointly with Southeastern Council on Family Relations, Hotel Sir Walter, Raleigh.


October 23-26—60th Annual State Nurses Convention, Jack Tar, Durham.


Oct. 29-Nov. 1—American Association of Public Health Dentists, Miami Beach, Fla.


November 14-17—National Association for Mental Health, St. Louis, Mo.


Every Saturday—State Board of Health Radio Program over WPTF (Raleigh) 7:30 P.M.

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Credits — Line drawings taken from Health Officers News Digest. Photo bottom of page 11, Raleigh Times.
Christmas Seal Campaign Helps Support Tuberculosis Control

Mrs. Jacqueline Kennedy, First Lady of the Land, has accepted the National Tuberculosis Association's invitation to serve as 1962 National Honorary Christmas Seal Chairman. North Carolina's First Lady, Mrs. Terry Sanford, received the first seals from Luther Barnhardt, former Lieutenant Governor and the N. C. Tuberculosis Association's 1962 State Christmas Seal Chairman.

The continuous and major public health contributions to tuberculosis control by the State Board of Health, the local health departments and the United States Public Health Service are recounted in two articles in this issue. (Pages 3 and 10.)

November, 1962
Sanitation Regulations on Vending Machines have been revised and are now available upon request in printed form from the Sanitary Engineering Division of the State Board of Health. Effective January 1, 1963, these regulations apply to machines dispensing "unit serving of food or beverage" upon the insertion of coins or tokens. Carbonated beverage vending machines are exempted.

The 1962 migrant health legislation authorizes the Public Health Service to make project grants to pay part of the cost of family health service clinics and other projects to improve health conditions and services for domestic migratory farmworkers and their families. Public agencies and nonprofit private organizations are eligible to apply for grants.

President John F. Kennedy officially launched the 1962 Christmas Seal Campaign at the White House as he received the first sheets of these seals from little Ann Marie FitzGerald of Cleveland, Ohio, who is "Miss Christmas Seal" of 1962 and is a recovered TB patient. On the right is William J. Martin of Quincy, Mass., president of the National Tuberculosis Association, which sponsors the annual Seal campaign. The President presented Ann Marie with a charm bracelet from Mrs. Kennedy who is National Honorary Christmas Seal Chairman for 1962.
The Halifax County Crash TB Program In Action

Robert F. Young, M.D.
Health Director, Halifax County

LIVING in a power conscious age with super charged motors, four-barrelled carburetors, fuel injection systems, scratch offs, screeching stops, Jets and rockets, it is only natural in these days to think in terms of speed. Therefore, when the first news of the recommendations of the Arden House Conference flashed our way, we promptly began to plan a Crash Program in Tuberculosis Control within a limited area of our county. High octane fuel was taken aboard when the Public Health Service agreed to finance a substantial portion of the program. Our motor became super charged when the North Carolina Sanatorium System agreed to provide a staff physician for a weekly chest clinic and when the State Board of Health, the local and state Tuberculosis Associations, the Halifax County Medical Society, and local groups of volunteers also joined our forces, providing personnel, equipment and supplies.

Since statistical studies had indicated for years that an unusual number of tuberculosis cases had concentrated within a certain small community within Halifax County, an all out attack was planned and directed at this area which includes four townships and portions of two others and approximately 12,000 citizens. What a break—to find this disease holed up, at least for the present, in a limited and well defined area.

We feel that too much emphasis cannot be placed on maintaining a specific and current evaluation of tuberculosis within each jurisdiction in order to be certain that the maximum effort in case finding is directed at its strongest concentration. In recent years, even within our high incidence area, we have found it necessary to run what we call a zone control on this problem.

It has been interesting to us in studying detailed statistics on tuberculosis that the disease not only shifts from one general area to another over a period of years, but also changes its position within a high incidence area, both geographically and within segments of the population. Having this specific information enables us to relate the problem to certain communities and groups, and, thereby, to secure better cooperation among the citizens affected because they can see exactly how tuberculosis affects them. In other words, it is becoming more and more urgent that we personalize this problem so that program planning becomes more a matter of "cutting the cloth to fit the pattern".

With funds provided by the Public Health Service, we have assigned two veteran public health nurses, full-time,
to this problem area where they have no other responsibilities whatsoever except tuberculosis control—no clinics, no home visiting for other services, etc., and no other assignments to pull them away hurriedly from this area. If necessary, they can spend the entire day rocking on the porch with an elderly person trying to persuade him to have a chest x-ray examination or trying to learn some of the sociological reasons for a hard core of people stubbornly resisting tuberculosis control procedures.

We still rely heavily on the Selective Chest X-ray Survey conducted in cooperation with the State Board of Health and State Sanatorium System, with seven consecutive surveys having been held in this limited area since 1957. Actually, we have had three surveys within the past twelve months in this area. The number of active cases per 1,000 x-ray films has declined from 2.7 in 1957 to .3 per 1,000 in 1961. The last survey just completed was a little unique in that it was scheduled fast on the heels of a survey held in December. The controls we ran on the December Survey indicated a poor response in a high incidence zone within the Project Area and we, therefore, capitalized on this situation to swing public opinion behind what we called an Emergency Survey.

In connection with the Emergency Survey, an interesting project was conducted by members of the Civic League, white and negro Home Demonstration Clubs and other lay leaders from the community and schools. We are referring to this exciting project hereinafter as the Purloined Project because it should have been reported directly by these dedicated people who made such an important contribution to our Tuberculosis Control Program. Again—What a Break—to find an aroused group of volunteers willing to risk the wrath of their neighbors and fellow citizens in the area in order to get everyone x-rayed over fifteen years of age. In order to soothe my feeling of guilt and to give credit where credit is due, I will quote directly from a report on this project prepared by Mrs. Wade Dickens, Jr., President of the Civic League, who wrote—

"Over a period of years, the Scotland Neck Civic League has maintained a continued interest in the tuberculosis Control Program as applied to our own community. We have served as hostesses to encourage people on the street to take advantage of free x-rays when the mobile unit was here, and have recently completed an intensive house-to-house canvass or census to determine the "x-ray status" of every adult over fifteen years of age within the limits of our township."

The Health Bulletin
First Published—April 1886
The official publication of the North Carolina State Board of Health, 608 Cooper Memorial Health Bldg., 225 N. McDowell St., Raleigh, N. C.—Published monthly.—Second Class Postage paid at Raleigh, N. C.—Sent free upon request.

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Editor—Edwin S. Preston, M.A., LL.D.

Vol. 77 November, 1962 No. 41

THE HEALTH BULLETIN
November, 1962
"If nothing but education has been the result of this survey, it has been worthwhile. The Civic League is a group of young women approximately 20 to 35 years of age. Almost all have small children, and little or no household help. The purpose of this group, as stated in the constitution, is "the civic, intellectual, social, philanthropic, and domestic betterment of the community of Scotland Neck. Originally it was a Junior Womans' Club, but the demands outside the community on a state and national level were such that there was little time or money left for more urgent local activities. For this reason, the group left the national organization and became an independent group dedicated to local service. We felt that our services to the health of our community in performing this census were part of our reason for being. We were glad we could do it, for it has been a rewarding experience to all of us. We have learned much."

"The area included was too large for our group to handle by itself, so the Scotland Neck Home Demonstration Club was asked to help with this phase of the program. In addition, the Public Health nurses covered the outlying areas, and a negro group conducted a similar study among the negro population."

"The forms for use as questionnaires were prepared by the Health Department. We found them to be quite satisfactory, though some minor changes might have aided in making them easier to use, and more readily understandable to the tabulators."

"Using a detailed map of Scotland Neck, the town was divided by blocks, rather than streets, into work units for one person or a team of two, depending on the area. By dividing it in this manner there was less chance of skipping a corner house or one set apart from a main group. The seventeen units comprise the area covered by the Civic League. It took in areas representative of all income levels in the community."

"Each area had from 20 - 30 houses. The areas were numbered, as were the teams for ease of reference. It was much easier to tally results from "Team No. 5", "Area No. 17" than to describe the area and use

Dr. J. W. Roy Norton (right), North Carolina's state health director, received a certificate of appreciation recently awarded to the State Board of Health for its role during the past three years in collecting information on the problem of air pollution. Presenting the award is Arthur C. Stern of Washington, D. C., assistant chief of the Division of Air Pollution of the Department of Health, Education and Welfare. J. M. Jarrett (center) of Raleigh, director of the State Board's Division of Sanitary Engineering, is in charge of the state's program to combat air pollution.

November, 1962
names of team members each time."

"Each team was provided with adequate supplies of each of the three forms to be used, along with a page of instructions. These were kept as simple as possible, without sacrificing detail. Apparently they were adequate, for there were relatively few questions from workers."

"Material was distributed so as to give the workers about two weeks to complete their assignments. Bad weather and "flu" slowed us down, so that the work was nearly a week late in completion."

"As is always true when you are working with people, the human interest reports of some of the workers were interesting and in some cases enlightening."

"One man tried to keep his daughter from giving the information because it would mean "nothing but trouble" for all of them. He was not even a resident of the area."

"In another case a man who had been x-rayed during the December survey reported that his wife had not and probably would not go. A follow-up visit to the wife gave us the information that if we thought it necessary, she would go."

"On several occasions elderly people reported that they didn't think it necessary now - - couldn't possibly have T.B. after all these years."

"Over and over the same comment about too much x-ray not being good for you was given as an excuse for not going."

"Many were chagrined to have to say "no" to the interviewers. It was one of those things that had just been overlooked."

"One man reported that he didn't remember having an x-ray in December, but he had received a card saying he was alright, so he guessed maybe he did. Just absent-minded!"

"I do not pretend to know the answer any more than the next one, but I conclude this report with the hope that what we have done has contributed something to the eventual 'decline and fall' of tuberculosis as a menace to the health of our community, and most particularly to our children."

By dividing the High Incidence Zone into quadrants, specific information was determined as to the x-ray population and the percentage of citizens who failed to have an x-ray during our December Chest X-ray Survey. Also, the number of citizens 65 years of age and older, together with the percentage that failed to report for x-ray was determined. These volunteers used a Census Form to gather this information and left a written appointment for the Emergency Survey for persons not x-rayed in our last survey. For those who were stubborn or who seemed unwilling to any degree to have an x-ray, a special "summons" form was used. Since this form happened to be colored green, it became known as the "Parris Green Form". We were gratified to note after the census that there were only 54 citizens in the area who deserved this form."

A very important bit of information revealed by this census was that there were 1,094 fewer citizens fifteen years of age and older than the factor of 62.7 used by the State Board of Health to determine this data would indicate. Thus, our population, particularly in this section of the county, is much younger than the average throughout the state and particularly when compared with other sections of the country.

When the State Board of Health mobile x-ray unit completed the Emer-
gency Survey in March of this year, and the total x-rayed had been added to the December total, we found, much to our delight, that 98 per cent of the x-rayed population in the High Incidence Zone had been examined. The quadrant with the greatest x-ray population reached 99 per cent.

With further reference to x-ray examinations, we hold a Chest Clinic every Friday at our Health Center in Halifax, with Dr. Harry Brooks from Eastern State Sanatorium being in charge every other Friday. Since we have noted a gradual decline in the number of new cases of tuberculosis found among family contacts, we have been on the look out for more profitable sources of new cases and, so far, have found two worthy of mention. First, chest x-ray examination of all patients who have a recent history of influenza, pneumonia, or pleurisy, since we have found it not uncommon to discover active tuberculosis among these patients. Second, suspects referred to us by the general public in the Project area. During one recent twelve months period, we found half as many new active cases of tuberculosis among these suspects as among family contacts of new cases. We have learned to pay a lot of respect for these requests and to schedule these patients as promptly as possible.

At the beginning of this Crash Program, we re-evaluated all of our closed cases from the Project Area and found one case that had reactivated and was in need of treatment. Out of 106 closed cases pulled from our inactive file, we found that 39 had died, 30 had moved out of the county, and two had failed to report for examination, leaving 35 for actual examination.

In order to maintain a check on our infection status, we tuberculin tested all of the school children, both white and negro, in the Project Area at the beginning of the program and are routinely testing the first and ninth grade students annually.

We feel that our case finding program has been benefitted by a conference with Dr. Ralph Patrick, Anthropologist, North Carolina School of Public Health, by which we gained a better insight of how to reach the hard-to-reach. We have not only learned better how to interpret and understand the attitudes of some of these resistant people—in the project area—but also we have learned more about ourselves—with our middle class slant on things in general. Obviously, the deeper we dig into these strongholds of the "hard-to-reach", the sooner we will be able to break the strangle hold.

Civil Defense Deputy assigned to North Carolina—The United States Public Health Service has assigned Samuel J. Hawkins to North Carolina as a full-time Deputy in Civil Defense to the State Health Director. Seen discussing Civil Defense matters with Charles B. Kendall, M.D., who has headed up this emphasis in the State Board of Health as the Deputy in Civil Defense to the State Health Director, are the following: (from the left) Charles L. Harper, Director of Administrative Services; Hawkins; Kendall; and Donald G. Lederman, program representative for Health Mobilization on the staff of the Regional Health Director.
of tuberculosis in this area. Our two full-time public health nurses in this program have also gained valuable information which we believe will be of value to us in our “mopping up operations.”

I thought it would be interesting for you to hear first hand from these nurses as we quote from their narratives. One public health nurse wrote:

“In the Project Area, I asked for and received invitations to PTA groups, the Women’s Club, Lion’s Club, Civic League, Jaycees and Business and Professional Women’s Club. At each organization, a plea for cooperation with the Special Project was coupled with facts and figures. These meetings, with the aid of newspaper articles and private interviews with key people in the community, helped to disseminate the information that the health department recognized a problem in tuberculosis existed in the area. Such knowledge helped those concerned to become active and when results of the Tuberculin Testing became known, “our” problem became “my” problem to quite a few families who had thought “it can’t happen to us”.

“Having all my time free for working only with tuberculosis has given me more time to talk to my patients—or rather to listen to them. It has been like a game of “cops and robbers” with my role as a “private detective” ferreting out old cases and contacts who have long since disappeared from the scene. However, their influence lingers on in the positive reactors and the fresh cases we are finding in the special project.”

Our second public health nurse related:

“Although the program had received wide publicity, there were several families who did not understand what was being conducted. Some of the families knew me and I was received cordially. There were sections, however, where I was not well known and on visits to this area, my first job was to get acquainted and establish rapport. This took considerable time as I almost always had to listen as they described their many problems.”

“I usually began my interview by introducing myself, and when I would explain that the Special Tuberculosis Program was sponsored by the Federal Government, they would look at me in amazement, asking if the program had anything to do with income tax or Social Security. This, of course, provided a wonderful opportunity to describe the program further. Most of the time, the family had their x-ray survey cards on hand to prove they had been x-rayed.”

“On one visit to a family of Jehovah Witnesses, I was forced to spend three hours listening to Biblical interpretations, while vainly striving to discuss the purpose of my visit. A few days later, however, I was pleasantly surprised when several persons from this particular farm reported to the health center for x-ray examinations.”

“At times, it seems that tuberculosis suspects were unusually resourceful in inventing excuses. Typical remarks were:

“I got that same test when I took my x-ray downtown.”

“My doctor told me not to take a shot from anyone.”

“One person intimated that she knew of a man that took the shot and got tuberculosis. Some of the positive reactors contended that the test was completely gone the day before and they scratched it in their
sleep. Now, look at it! They do not believe this, but they hope we will. On the other hand, several stated that they would welcome the chance to go to Eastern North Carolina Sanatorium for a rest.

"Somehow the knowledge that the project was sponsored by the Federal Government seemed reassuring to many. Most people felt that what the government offered must be good."

"Public health nursing home visits do not always take place in the home. I have tuberculin tested just as many on tobacco plant beds, stores, barber shops and on country roads. There were just a few who wanted to be secretive about the test, while others made no effort to conceal the fact that they were being tuberculin tested. Some were helpful by informing us of others who had not been tested. Whenever possible, I tried to follow up these leads given me by these people."

In connection with our case finding activities, we have found it advantageous to maintain a constant patrol of a new patient or suspect from our first contact with him until he is finally admitted to a sanatorium or other disposition is completed. The pressure of public opinion brought about by the educational impact of 12 Chest X-ray Surveys since 1946, together with a thorough and sympathetic conditioning of the patient and his family by our public health nurses regarding sanatorium life, have combined to make it possible to get our patients admitted to a sanatorium within a week of their diagnosis. A currently maintained Case Register and a Patient Log Book are two devices we consider indispensable.

What have been the results, if any? Well, we will simply quote from our statistics for the past five years. In the Project Area, during the past five years, the total number of cases declined 48 per cent as compared with a 14 per cent increase in the rest of Halifax County exclusive of the Project Area. Within the Project Area, the number of negro cases dropped 58 per cent, while the number of white cases remained the same during this period of time. In 1957, in the Project Area, white cases made up 17 per cent of the total, while in 1961, they constituted 33 1/3 per cent of the total cases. Therefore, the negro cases declined from 83 per cent of the total in the Project Area in 1957 to 66 2/3 per cent in 1961. In the rest of the county, the percentage of negro cases had increased from 64 per cent in 1957 to 70 per cent of the total in 1961, with this latter trend being more typical of the localization of tuberculosis within lower economic groups throughout the county.

While we are not claiming credit for the considerable decrease in cases in the Project Area, we are hopeful that a trend for the better is being established.

Simon A. McNeely, Director of Federal-State Relations, President's Council on Youth Fitness, who will be one of the featured speakers at the 13th Annual Meeting of the N. C. Health Council to be held at Hotel Sir Walter, Raleigh, on Thursday, December 11. Convening at 10 A.M. the meeting includes several Symposium groups, a Luncheon session and will close at 4 P.M. with a business session. Over sixty health related member agencies and organizations in the State are expected to be represented. Mrs. Marie Noel is president.
The Sanatorium Movement

The “Sanatorium Movement” in North Carolina makes interesting reading, and it may be said that efforts towards tuberculosis control began with this movement. The mountains of the State are particularly suited for tuberculosis sanatoria fulfilling all the then known concepts of treatment. History records that the Indians set aside the region around Asheville as a neutral ground to which they brought their sick, and as early as 1800 the white man began to take advantage of this beautiful area. According to Dr. Gaillard S. Tennent, Charlotte Medical Journal 1906, Dr. F. C. Hardy, born in 1802, was the first consumptive to come to Asheville. Dr. Tennant reported, “he came in 1821 with only one lung, but he lived 61 years more.”

In 1897 a paper was read at the 45th annual meeting of the American Medical Association in Philadelphia, which stated that, “for the past 30 years or more, the plateau of Western North Carolina, of which Asheville is the center, has been the mecca toward which faces of many of our afflicted have been turned.”

In 1871 two physicians by the name of Gatchell established a sanatorium at Forest Hill, then just south of Asheville city limits. After some time the project was discontinued but later revived by one of them, Dr. H. F. Gatchell, at the northeastern corner of Haywood and College streets. The institution was called “The Villa.” Dr. Gatchell had been a professor in the Hahnemann Medical School in Chicago for some years. “The Villa” was the first sanatorium for tuberculosis ever started in North Carolina and preceded Dr. Trudeau’s “Little Red” at Saranac Lake in New York by 13 years.

In 1875 Dr. Joseph William Gleitsmann, a German by birth and a graduate of the University of Wurzburg, the home of Roentgen, came to Asheville from Baltimore and on June 1, 1875, opened the “Mountain Sanatorium for Pulmonary Diseases” at the old Carolina House which stood opposite the old Gluder place on North Main Street, now Broadway. Dr. Gleitsmann received patients from the entire east coast, and he states in his report that the greatest number were sent by Dr. A. L. Loomis of New York, who nine years later, sent his patients to Dr. Trudeau in Saranac. Dr. Gleitsmann operated his sanatorium for six years.

By 1891 there were a number of sanatoria in the City. One of these was the “Winyah” founded in 1886 and operated by Dr. Karl von Ruck. About World War I time private sanatoria began to decrease in number due to Federal, State and County sanatorium construction.

It is interesting to note that the sanatorium movement in North Carolina gained National attention and actually pre-dated Saranac. Treatment in Asheville was as effective as in any of the western tuberculosis centers and undoubtedly many lives were saved without taking the long journey to New Mexico or Arizona.

*Notes on the Sanatorium Movement from “History of the North Carolina Tuberculosis Association—1953” by Latham L. Miller
Although tuberculosis from the earliest times in the State was recognized to be the most fatal disease, and is now the most fatal of the contagious diseases, yet it was only in 1904 that the tuberculosis problem was brought forcibly to the attention of the public by Dr. Richard H. Lewis, a Raleigh Ophthalmologist, and then the State Health Officer. His annual report to the State Medical Society concerning the high prevalence of tuberculosis resulted in the society adopting a resolution asking that every member of the society and every physician in the State use every effort, professional and personal to promote the fight against tuberculosis. Dr. Lewis prepared a six page pamphlet on the “Causes and Prevention of Consumption” and 80,000 of these pamphlets were distributed. The North Carolina Tuberculosis Association was organized in 1905 and this organization has taken a prominent part in the fight against tuberculosis.

The announcement of Dr. Lewis in 1904 thoroughly aroused the medical profession as well as citizens of the State to the tuberculosis hazard and plans were made to establish a State Sanatorium for the treatment of tuberculosis. Incidentally at the time the approximate prevalence of tuberculosis was not known in the State as North Carolina was not in the National Registration area. The State sanatorium at what is now McCain was opened in 1908 with 32 beds. North Carolina became a member of the National Registration area in 1914, and in that year there were 3260 deaths reported from tuberculosis; in 1915 3710. At that time the number of active cases were believed to be ten times the number of deaths and it is safe to say, that, when the 32 bed State Sanatorium was opened, there were at least 35,000 active cases in the State and this is a conservative estimate.

Later three additional sanatoria were opened; namely, at Black Mountain, Wilson, and Chapel Hill. Counties also erected their own Sanatoria and at one time there were over 800 county beds. County beds have now been closed and all tuberculosis patients applying to the State Sanatoria System are hospitalized in one of the four sanatorias.

At this time the Sanatorium System has available over 1500 beds and of these over 1200 are occupied. There are sufficient beds to accommodate all applicants for admission and delays in admission are rare. The outpatient service of the Sanatorium System is extensive and the tabulation below shows the general status of inpatients, outpatients and total outpatients served 1951-52; 1959-60; 1960-61 and the first seven months of 1961-62.

<table>
<thead>
<tr>
<th></th>
<th>Current Year (1961-62)*</th>
<th>One Year Ago (1960-61)</th>
<th>Two Years Ago (1959-60)</th>
<th>Ten Years Ago (1951-52)</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL INPATIENTS SERVED</td>
<td>4,100</td>
<td>4,073</td>
<td>4,016</td>
<td>2,344</td>
</tr>
<tr>
<td>AVERAGE INPATIENT CENSUS</td>
<td>1,180</td>
<td>1,179</td>
<td>1,220</td>
<td>1,162</td>
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<tr>
<td>INPATIENTS CENSUS AT END OF YEAR</td>
<td>1,180</td>
<td>1,192</td>
<td>1,181</td>
<td>1,171</td>
</tr>
<tr>
<td>TOTAL OUTPATIENTS SERVED</td>
<td>10,700</td>
<td>9,237</td>
<td>9,832</td>
<td>5,951</td>
</tr>
</tbody>
</table>

* A projection of statistics for the first seven months of the current year (1961-62).

From this table, it will be seen that the total number of outpatients served has increased by over 44% since the fiscal year 1951-1952.

November, 1962
The tuberculosis situation in North Carolina as to deaths and new active cases compared to the United States is shown in the following tabulation:

### NORTH CAROLINA

New active case rate percentage decline 9 year period 1952-1961—37.0
10 year period — - 46.1
Average annual per cent decline per year 9 year period—4.92
10 year period — - 5.87
Per cent decrease in death rate 1951-1961 — - 75.0

### UNITED STATES

New active case rate percentage decline 9 year period 1952-1961—46.7
Average annual per cent decline per year 9 year period—6.72
Per cent decrease in death rate 1951-1961—71.6

#### TUBERCULOSIS SITUATION IN NORTH CAROLINA AS COMPARED TO THE UNITED STATES

9 Year Period 1952-1961 Active Cases; 10 Year Period Deaths; 1916 Deaths Only; Also Active Cases North Carolina 1951

<table>
<thead>
<tr>
<th>Year</th>
<th>Cases</th>
<th>Rate</th>
<th>Decline</th>
<th>Deaths</th>
<th>Rate</th>
<th>Decline</th>
</tr>
</thead>
<tbody>
<tr>
<td>1916</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>3,577</td>
<td>142.3</td>
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</tr>
<tr>
<td>1951</td>
<td>1,834</td>
<td>44.5</td>
<td>---</td>
<td>627</td>
<td>15.2</td>
<td>18.7</td>
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<tr>
<td>1952</td>
<td>1,591</td>
<td>38.1</td>
<td>14.4</td>
<td>548</td>
<td>13.1</td>
<td>13.8</td>
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<tr>
<td>1953</td>
<td>1,513</td>
<td>35.8</td>
<td>6.0</td>
<td>408</td>
<td>9.7</td>
<td>26.1</td>
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<tr>
<td>1954</td>
<td>1,567</td>
<td>36.7</td>
<td>+2.5</td>
<td>316</td>
<td>7.4</td>
<td>23.7</td>
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<tr>
<td>1955</td>
<td>1,479</td>
<td>34.2</td>
<td>6.8</td>
<td>261</td>
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<td>18.9</td>
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<td>1,389</td>
<td>31.8</td>
<td>7.0</td>
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<td>6.1</td>
<td>+1.7</td>
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<td>1,273</td>
<td>28.8</td>
<td>9.4</td>
<td>222</td>
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<td>18.0</td>
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<td>1,267</td>
<td>28.4</td>
<td>1.4</td>
<td>227</td>
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<td>+2.0</td>
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<td>1959</td>
<td>1,181</td>
<td>26.1</td>
<td>8.1</td>
<td>211</td>
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<td>7.8</td>
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<td>1960</td>
<td>1,175</td>
<td>25.8</td>
<td>1.1</td>
<td>192</td>
<td>4.2</td>
<td>10.6</td>
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<td>1961</td>
<td>1,106</td>
<td>24.0</td>
<td>7.0</td>
<td>174</td>
<td>3.8</td>
<td>9.5</td>
</tr>
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</table>

* + Increase
  - Decrease

12 THE HEALTH BULLETIN November, 1962
COMMENT

It has been recommended by the Arden House Conference on Tuberculosis, sponsored by the National Tuberculosis Association and the U.S. Public Health Service Tuberculosis Program, that for all communities the goal towards control should be an average annual decline of at least 10% in their new active case rates for the next ten years, and the goal for the nation a new active case rate by 1970 of not more than 10 per 100,000 population.

From the table it will be seen that for the period 1952-1961 there has been only one decline of 10% in North Carolina; namely, 1952, and for the period 1953-1961 the decline did not reach 10% for any one year. In 1954 there was an increase in new active cases.

For the nation as a whole during the period 1953-1961 there has been a decline of 10% twice; namely, 1956 and 1959.

The average annual per cent decline for North Carolina for the 9 year period 1952-1961 was 4.92, and for the United States during a similar period the average was 6.72.

From a study of this table it appears that the annual average rate of decline in both North Carolina and the United States is quite slow by suggested Arden House Standards and seldom approaches the goal of an annual per cent decline of 10.

The active cases at home and cases at home on drugs are continual problems in control. This tabulation shows the number of these types of cases for the years 1958-1961 inclusive:

<table>
<thead>
<tr>
<th>Year</th>
<th>Active At Home</th>
<th>Home on Drugs</th>
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</thead>
<tbody>
<tr>
<td>1958</td>
<td>848</td>
<td>2,551</td>
</tr>
<tr>
<td>1959</td>
<td>891</td>
<td>2,928</td>
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<tr>
<td>1960</td>
<td>869</td>
<td>3,212</td>
</tr>
<tr>
<td>1961</td>
<td>821</td>
<td>2,863</td>
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</tbody>
</table>

*From Annual County Reports

TUBERCULOSIS SITUATION IN NORTH CAROLINA AS COMPARED TO THE UNITED STATES

9 Year Period 1952-1961 Active Cases; 10 Year Period Deaths; 1916 Deaths Only; Also Active Cases North Carolina 1951

**United States**

<table>
<thead>
<tr>
<th>Year</th>
<th>Cases</th>
<th>Rate</th>
<th>Decline</th>
<th>Deaths</th>
<th>Rate</th>
<th>% Decline</th>
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<tbody>
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<td>101,396</td>
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* + Increase—decrease
** Active cases for United States not available for 1951

November, 1962

THE HEALTH BULLETIN
The Tuberculosis Public Health Nursing Services are Shown in this Table:

<table>
<thead>
<tr>
<th>Year</th>
<th>1957</th>
<th>1958</th>
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<th>1960</th>
<th>1961</th>
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</thead>
<tbody>
<tr>
<td>1. Total number of diagnosed tuberculosis cases visited during the year.</td>
<td>7,309</td>
<td>7,959</td>
<td>7,677</td>
<td>6,626</td>
<td>7,512</td>
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<td>2. Total number of visits made to diagnosed tuberculosis cases during the year.</td>
<td>29,029</td>
<td>28,700</td>
<td>29,214</td>
<td>26,484</td>
<td>26,576</td>
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<td>3. Total number of visits for tuberculosis (to or in behalf of cases, suspects, and contacts) during the year.</td>
<td>75,447</td>
<td>76,865</td>
<td>76,685</td>
<td>72,073</td>
<td>74,100</td>
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</table>

A study of the ACTIVE AT HOME cases from 1958 to 1961 shows that these cases have ranged from a low of 821 in 1961 to 891 in 1959. There are differences from year to year but from 1958 to and including 1961 there have been over 800 of these cases at home and this type case is a distinct public health problem.

The diagnosed cases visited at home with the exception of 1960 have been over 7,000. Nursing visits to tuberculosis during the period 1957-1961 have ranged from a low of 72,073 in 1960 to over 76,000 in 1958 and 1959 and in 1961 visits were over 74,000.

The nursing problem has changed little during the past 5 years.

GENERAL COMMENT

The general tuberculosis situation throughout Continental United States and North Carolina has been steadily improving. The improvement however has distinctly slowed in North Carolina as compared to Continental United States. It is true that this State shows a better record than many states east of the Mississippi River but the overall picture as compared to Continental United States is not impressive.

The number of active cases at home shows little improvement. This type case cannot be compelled to remain in hospital until the disease is inactive and such a case is always a public health hazard regardless of home conditions. There must be constant medical supervision and examination of contacts, for contact to the recent active case is the source of most of the new active cases.

The Public Health Service has been engaged since 1956 in a series of large-scale trials of the prophylactic use of isoniazid among contacts of recently diagnosed tuberculosis cases. More than 50,000 persons participated in the trials, and it was found that isoniazid reduced the incidence of tuberculosis in household contacts by about 80% during the year in which it was administered. Further observation, however, will be required to determine whether taking the drug for one year gives protection in the following years. The treatment of known active cases has first call and the place of isoniazid prophylaxis among contacts during the year after diagnosis of the first case should receive consideration.

GOALS AND STANDARDS for eliminating tuberculosis, which is a statement by a Committee appointed by the U. S. Public Health Service, have already been distributed to each health department. All of the six PROGRAM PERFORMANCE STANDARDS are im-
important and the management of close contacts to newly discovered active cases and tuberculin testing programs need particular consideration.

In SUMMARY, the tuberculosis situation in North Carolina has improved, but the situation remains a serious threat with over a thousand new active, highly contagious cases a year and during the past ten years over 13,000 such cases. There must be no complacency for there have also been within the past two years, what might be termed epidemics, in two separate communities. There must be no relaxation in our efforts to control this disease.

A Chapel Hill citizens group has been granted permission to enter a fluoridation suit as "a friend of the court" to expedite action in a suit pending for more than two years in Orange County Superior Court. The suit was brought originally by a Chapel Hill resident to prevent fluoridation of Chapel Hill's water supply which is furnished through facilities owned by the University of North Carolina.

Mrs. Margaret P. Copeland, Supervisor in the Public Health Statistics Section of the State Board of Health, was presented certificates of merit recently for her outstanding service to the recruiting groups of the Army and the Air Force. Mrs. Copeland was praised for service "beyond her normal duty" in providing vital statistics on service applicants thereby making an outstanding contribution to the peace. In accepting the awards Mrs. Copeland shared the honor with co-workers. Dr. Norton expressed appreciation to the Army and Air Force for their recognition of the work of the Section.

Air Pollution will be the subject of a national conference to be held in Washington, D.C., December 10-12 under the sponsorship of the Public Health Service, Conference at Sheraton-Park Hotel.

A series of studies to reveal North Carolina's needs and resources for the management of patients with neurological and sensory diseases is being carried on with funds made available by the State Board of Health to staff members of the UNC School of Public Health.

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DATES AND EVENTS

November 14-17—National Association for Mental Health, St., Louis, Mo.

November 25-28—N. C. Farm Bureau Federation Convention, Asheville.

Nov. 27-Dec. 1—Eleventh Annual Workshop Association of Rehabilitation Centers, Boston, Mass.

December 7-8—Association for Research in Nervous and Mental Disease, New York.

December 10-12—National Conference on Air Pollution sponsored by U. S. Public Health Service, Sheraton-Park Hotel, Washington, D. C.


December 26-31—World Medical Association 15th General Assembly, Israel.

March 12-15—American Mosquito Control Association, Atlantic City.


April 28-May 4—Mental Health Week in Canada and the U. S.


Every Saturday—State Board of Health Radio Program over WPTF (Raleigh) 7:30 P.M.

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Governor Terry Sanford Reviews Progress in Public Health

In an inspiring and statesmanlike address before the Banquet session of the Annual Meeting of the N. C. Public Health Association, Governor Sanford reviewed the State's progress in Public Health. He commended the State's leadership for the accomplishments of the past decades and pointed up the health needs which challenge North Carolina to advance in the years ahead. (See address beginning on page 11.)

December, 1962
When the man came into my office it was easy to see that he was in distress. Certainly he was in low spirits. With a sad, forced smile as he slouched into a chair, he apologetically admitted that he was in his sixty-first year, the one explanation why a large corporation had turned him down for a job.

"You know our rule," he was informed: "We never employ a man over sixty." The handsome man with a brilliant mind turned out to be an inventor with a flair for electronics. In apparent ill health from sluggish habits, overeating, excessive smoking and no exercise, the refusal of a hoped-for job seemed to be the final straw. It was certainly a situation where a fellow needed a friend.

The course of action to recapture lost strength and enthusiasm necessitated a thorough job of overhauling. I prescribed a health-building program directed to weight reduction, toning up flabby muscles, regular rest periods and recreation. In two months, he was a transformed person. He had lost 15 pounds, he had built up strength by exercise and deep-breathing exercises and his mind was more alert and responsive. The company that had turned him down, upon hearing of his inventive talents, offered him a "special assignment" which he refused. "I've borrowed money and I'm starting my own company," he told them. The following year, success was in the making. Now an established career man of sixty-three, he has a plan of development which, in his words, "will take me twenty years to complete."

An attractive woman came into my office with a digestive problem. When I asked her age, she replied: "How old do you think I am?" This is a delicate point for a physician to handle, since it is so easy to say the wrong thing, even though an experienced physician should be capable of estimating the age of young or old within a few years. The wise doctor, however, will be prompt to admit pitfalls.

"I'll guess your age is, say, fifty-five or sixty," I answered, for this poised, beautifully dressed woman, with a neat waistline and a trim appearance had just about what a woman at her prime really ought to have.

"My next birthday I'll be seventy-six," she replied with a smile.

Reprinted by Permission of Woman's Day Magazine, a Fawcett publication.
How old is old? You've seen many persons who give an impression of being old all their lives. But you've also seen men and women at the summit of their years (beginning in the sixties) who become more, much more, attractive as time speeds by. In order to live to the hilt, preserving the health of the body and the activity of the mind, it is necessary to be highly motivated. It's an attitude, a state of mind. It reflects self-respect and a wholesome pride in one's posture, stature, grooming and outgoing individuality. This is a real challenge to each person, young and adult. A most wise rabbi once observed: "Youth is not a time of life, it is a state of mind . . . nobody grows old merely by living a number of years. People grow old by deserting their ideals."

Is it natural to grow old?
Aging, medically speaking, is the change which occurs in the cells and organs of the body as life continues. It begins with conception, strictly speaking, and continues through childhood, adolescence and adult life. The body attains full physical vitality and size at about twenty-five years. If muscles, bones and joints are kept active and excess weight is avoided, the physical body could last easily one hundred years. That is, it can last that long if there is the will to live, to be part of life and the world. The human body has an amazing built-in, self-recharging mechanism. This remarkable power heals broken bones, diseased hearts, injured minds and depressed spirits, if we only give ourselves the chance. It is as if we have been given a precious instrument (which the body is, indeed) and we punish it, overload it, ignoring the simplest rules of good hygiene and care. Life has an upward thrust at all ages. To grow older may be a downward experience if we do not consciously elect to make the most of the divine gift of life. To be conscious of the opportunity to grow each new day; this, together with good living habits, is the secret that helps us master and overcome the ailments of the body as we grow older.

Modern science is controlling and eliminating many of the diseases and disorders which in the past were common killers. For instance, diphtheria, smallpox, typhoid fever and nutritional deficiencies are now seldom seen, compared to the past. Science is adding years to life. It is our unique opportunity to add life to these years, to give them meaning and fullness.

Can modern medicine cure old age?
Modern medicine is now turning its attention to the complex problems of aging. The studies done by such organizations as the American Geriatrics Society, the National Health Council, the White House Conference on Aging, show that as a nation, we are becoming more and more aware of the problems of the aged. Among the subjects studied by modern medicine as of particular importance to the health and well-being of older people are nutrition, the condition of the heart and of the blood vessels, the importance of...
avoiding anemia, and the establishment of good physical and mental habits.

As long as we, as a nation, are sickness oriented, instead of being health oriented, we will continue to be victims of avoidable serious diseases. Why don’t we initiate an aggressive nationwide program to Keep People Healthy? We know enough about nutrition from infancy to the older years, we know about the mechanism of the basic tissues and organs to establish programs that will keep us fit. And we are working on the problems of controlling these common killers such as the breakdown of the vascular system (heart diseases), cancer, arthritis and rheumatism. Therefore, let us as a nation become health oriented. This will require a new and more wholesome positive approach.

And let us start with keeping our youth fit if we want to have our older citizens fit. A soft life has made our youth flabby and weak. Let us learn from the physical-fitness programs of the Swedes, Norwegians and Russians that keep their young people fit and strong.

There are no pills available to guarantee a long and healthy life. A physician can advise on healthy practices that will help patients avoid many of the nuisances that cause so much sickness and, too often, death. But the futile search for the Fountain of Youth should be abandoned. To resort to strong stimulants is to invite the breakdown of vital organs.

A vast amount of misinformation is flooding us in the form of literature, nostrums and generally false advice. Suggestive recommendations imply that sluggish body actions, weakness and boredom are due to inadequate amounts and kinds of foods such as starches, proteins, vitamins and minerals, that cause poor blood. These recommendations are pernicious, especially since an individual may have an organic lesion such as a tumor or a blood condition, both of which require medical care by a reputable doctor. Doctoring oneself, especially in the case of persistent weakness, can be disastrous. A prompt visit to the family physician is the safest policy; delay may be fatal.

During the last few years, there have also been reports of “wonder cures” from Russia, Rumania and Switzerland that have “delayed old age” with injections of procaine, vitamins and animal cells. None of these cures has been verified by competent scientists. Scientific medicine, and this is the only valid kind, has very strict rules. If a physician claims results from the use of a particular chemical or procedure, the same results should be forthcoming when another doctor uses the recommended method. When this is not the case, the method cannot be safely recommended.

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Editor—Edwin S. Preston, M.A., LL.D.
Vol. 77 December, 1962 No. 12
None of the foreign "cures for aging" has stood up to the exacting tests of American medicine.

**What are hospitals doing for the aged?**

Many hospitals have now organized study groups to investigate the problems of old age. Among them are the Center for Studies of Aging at Duke University in Durham, N. C.; the Gerontologic Research Center in the Baltimore City Hospital; the Einstein Medical Center in New York City; Western Reserve University in Cleveland and The Lankenau Hospital in Philadelphia.

At The Lankenau Hospital, a number of exciting and illuminating studies are underway in the research laboratories. They include studies on the action of the heart and lungs in individuals of different ages both at work and at rest; on the physical fitness of young and old adults; on new approaches to arteriosclerosis (a form of "hardening" of the arteries, one of the diseases of old age); on the evaluation of the total-performance capacity of the older individual, including his capacity for strenuous exercise; and on the motivation of older people, since a person's motivation determines the kind of life he will lead in later years. Eventually, this highly significant information may lead to a reliable biological index of aging, that is, a way to indicate the physiological age of a person or his work capacity rather than tabulating him merely by the number of years he has lived.

Furthermore, as a routine service to the community, The Lankenau Hospital has established a health-education program. This program, the first of its kind in the world, is under the supervision of Mr. Morris Barrett and his staff; young and old from near and far come for instruction in many areas of health maintenance that will benefit them not only now, but through their later years. The hospital even has a health museum, to make instruction more graphic and immediate.

In the hospital's research clinic, individuals are studied from several aspects in order to better enable them to attain a healthy old age. This is not alone an individual problem; it is also a family responsibility. And where the young learn from the old, and the old learn from the young, a healthy family atmosphere is the result. All members are benefited, and illness, disease and depression are held down.

**Is geriatrics a specialty?**

"Be your age, don't be an old fool," the doctor replied when an eighty-one-year-old complained of a painful right knee. "But the left knee is just as old and it's fine," Uncle John spiritedly replied. "Please fix this right knee so I can go to the square dance this evening." The young-old man was ahead of his old-young physician in the appreciation of life's possibilities.

Throughout the nation, concerned families are beseeching their doctors to find ways to assist their ailing old parents. To conclude that nothing can be done is a sore injustice to the unfortunate elderly. It isn't true that "nothing can be done at your age," and the family physician should be willing to probe beyond the actual age in years of his patient. There are many reserves to be used, and the physician can often help to reawaken dormant interests.

There are no mysterious skills required of the professional man who wants to be a friend and adviser to an old person. But first of all, he must have an affectionate interest and a generous respect for aging patients, for often, only a changed approach will turn defeat into a new grasp of life for the patient. And a sense of humor on the part of the physician and an appreciation of what is fit and right, matter greatly.
Ways to creative aging

There are ten basic needs for older men and women, given here in their general outlines. The details of these needs cannot be put down in one general prescription. They must be adapted to the needs of each individual, and supervised. Only the physician who knows his patient can decide on the specific paths to follow.

The very first need is a balanced diet. There are certain foods, which, in my opinion, should have priority. Honey, applesauce, prunes, fresh-fruit juices, milk and eggs at regular intervals, fresh vegetables, lean meats, white fish, broiled fowl: these basic foods furnish a supply of energy for the body’s activities. Older individuals should avoid heavy meals at all times, since such overindulgence, frequently repeated, may cause a strain on the heart. The unsaturated foods, particularly corn oil, are now being recommended by a great many nutritional authorities. But it should be kept in mind that super-nutrition does not create a superman.

The second need is the complete elimination of waste products. The bowels, kidneys, skin and lungs need be kept clear of accumulated body residue. I prescribe deep breathing at frequent intervals during the day to maintain satisfactory functioning of the lungs and the circulation.

The third need is complete rest of body and mind. It is not true that every person should retire at a given hour to sleep for six or more hours. For individuals have different rhythmic patterns of rest. Some sleep longer with no break, while others require frequent shorter periods of sleep, from two to four hours with periods of wakefulness in between. If the public understood this, a huge amount of unnecessary sedatives could be eliminated.

The fourth need is recreation. To have periodic intervals away from serious endeavor is exceedingly important and refreshing. Need for the quiet hour gives the opportunity for creative thinking.

Another need is the sense of humor, which is the balance wheel of modern living. It is the best antidote for nervous tension. A pleasant smile and a happy heart “doeth good like a medicine.”

The sixth basic need is the control of the emotions of anger, hate and jealousy; for high tension leads to personal ineffectiveness. The fires of anger are frequently forerunners of high blood pressure and stroke.

The seventh need is companionship. In times of joy and sorrow the support of family and friends is absolutely necessary.

The eighth and one of the most important needs of all is the maintenance of a sense of pride in one’s job. Whatever the work, there is a value in high performance and accomplishment that adds to an individual’s stature and gives his life dignity. The unhealthy attitude of “getting more and more for doing less and less” can do great harm to the individual.

The ninth is participation in community affairs. Senior citizens are uniquely equipped to add to the vitality of community life.

The final need for each individual, young and old, is to keep growing in knowledge and experience in whatever field one’s work is found. All scientific studies have emphasized the importance of having true zest for living. The longer a person can grow, the more wonderful his life will be.

Blueprint for living 100 healthy years

All available evidence indicates that a great many people now alive are going to live far beyond the Biblical promise of three score years and ten
If, as experiments have established, the life span of animals can be doubled, a substantial extension of the human life span is a reasonable expectation. Thus we must begin to think in terms of the likelihood that today's children and a goodly percentage of their parents are going to live into their eighties and nineties, and that the time will come soon when a 100th-birthday celebration will be of interest solely to the celebrant and his family and friends.

Using as a basis a round century of life, give or take a few years, future man may well divide his life into three "trimesters" of roughly 30 years each.

In the first trimester of his life, he will spend most of his time in education. The early part of his education should include a substantial amount of training, in simple terms, in how his body grows and how he must care for it to maintain lifelong good health. The growing child must receive instruction in personal and social development. This type of basic teaching, given so that the child understands the necessity of its practice, will provide the basis for a mature life of physical and emotional health. Once having absorbed this training, along with the normal fundamentals of learning, the person will be ready in the later years of the first trimester for training in a career, as it is the custom today.

The second trimester, the years between 30 and 60, should show little change from life as we know it today. It will contain for men the establishment of themselves in a career, as well as raising a family, with emphasis on attaining a financial state that will make the family self-sustaining for an extended life span. For women too, the family will be the principal center of interest in this period. The chief change for all in the management of this period of life should be in the change of attitude toward the critical milestone of life: arriving at the age of 60 or 65. Today society, with the approval of government, industry, labor and the professions, writes off a man or woman at this age with the dreaded terms of "retired" or "emeritus." Instead, it is proposed, the retirement period as such must be written off or pushed up to at least 85 or 90. Instead of retiring at 60, 65, or 70, the person should then enter into a second career. This can be one of many kinds. Preparations for it must have been laid during the second trimester, not only by men, but, it is to be hoped, by women also.

The third trimester, the years from 60 on, should represent the harvest years. This should be a period of continued growth and development built on a solid program of growth in the earlier years, an increase in knowledge, understanding and, let us hope, wisdom. Especially it should include a longer participation in community affairs.

With retirement at 85 or 90 years of age, the years beyond will be years of moderate recession, a final letdown in the rhythm of a long, vigorous and useful life. The close of such a life should bring with it a sense of completion, of prestige honestly won and successfully retained.

Whether such a plan can become a reality depends upon successful interaction between the individual, the family and the community. If today's barriers to such a goal remain in place, the later years of millions of persons are sure to be little more than a prolongation of discomfort, distress and deterioration. If these barriers can be removed, the way will open to a life richer in meaning and fulfillment than man has ever contemplated.

December, 1962 THE HEALTH BULLETIN
National Family Life leaders appeared on a panel program over WPTF (Raleigh) during the recent State and Regional Family Life Conference. Shown in the picture from the left are: Dr. David R. Mace, Madison, N. J., noted author and immediate past president of the National Council on Family Relations; Wallace C. Fulton, New York, president of the National Council; Mrs. Mildred I. Morgan (back to camera), Black Mountain, family life consultant and a former president of the National Council; Dr. Emily H. Mudd, Philadelphia, Pa., Director, Marriage Guidance Council; and Mrs. William Pressly, Raleigh, moderator of the panel.

A luncheon was a feature of the State and Regional Family Life Conference. Seen in the picture are: James H. Banbury (at end of table) Charlotte; and (counter clockwise) Dr. George Douglas, Greenville; Mrs. Banbury; and (across the table) Mrs. Douglas and Mrs. Henrietta Jeffries, Greensboro.
Mrs. J. Leonard Middleton, Raleigh, who will lead the N. C. Family Life Council through the second year of her two-year term.

At the Family Life luncheon—Mrs. Mildred I. Morgan, Black Mountain; Joe S. Babb, Raleigh; and Dr. William Morgan, Black Mountain.

Wallace C. Fulton, New York, president of the National Council on Family Relations, received characteristically good Southern service at the Family Life luncheon held in the beautiful ballroom of the Sir Walter Hotel.

Luncheon conversations at the Family Life Conference looked interesting. Here from the left are: Dr. David R. Mace, Madison, N. J.; Mrs. Ethel Nash, Chapel Hill; and Judge Mason B. Thomas, Raleigh, Judge of the Juvenile and Domestic Relations Court of Wake County.
Mrs. Marie Noell, president of the N. C. Health Council, is seen in conversation with Simon A. McNeely of Washington, D. C., one of the principal speakers at the recent most successful annual meeting of the Council. Mr. McNeely is Director of Federal-State Relations for the President's Council on Youth Fitness.

1963 North Carolina State March of Dimes Chairman, Mr. Wendell H. Eysenbach, Winston-Salem, N. C., is pictured with Jimmy Boggess, S, Coy, Arkansas, 1963 National March of Dimes Poster Boy, a birth defects victim. The 25th Anniversary Campaign will be held January 2-31, 1963 using the theme “Give for the Life of a Child” and will raise funds for aid to victims of birth defects, arthritis and polio and for research into these crippling diseases.

December, 1962
Address by Governor Terry Sanford
At 1962 Annual Meeting of North Carolina Public Health Association

LAST year the North Carolina Public Health Association observed its Golden Anniversary Session in Greensboro.

That anniversary of the organization of your Association served a highly useful purpose as well as bringing to light many interesting facts to show the progress and contrasts in the public health programs during five decades. That significant occasion was useful to you and to others of us who have concern for the good health of the citizens of our State. The anniversary provided a check list of needed progress toward the ideal of fully adequate health services for all, inviting the attention and cooperation of all health and health related professions in voluntary organizations and marshalling the health services in our State and local governments.

That anniversary, celebrated also the establishment of the Guilford County Health Department, one of the first county health units in the nation. North Carolina not only has a strong State Board of Health with one of the best staffs in the country, but this State has left with local governmental units the responsibility and authority to deal as wisely as they are able with the health problems close at home. No other State in the nation has reserved more autonomy for local county governmental units. Medical and other health related professions are represented on the local boards of health as well as upon the State Board. This is as it should be.

Citizens' Health is Greatest Asset

The health of the citizens of our State is one of the greatest assets contributing to the citizen's well-being and to the State's economic prosperity. Whatever your organization can do, what you as individuals can do, and all that others of us can do to improve the health services of our State contribute to the over-all development of North Carolina.

Progress has been made—commendable progress. Even a brief review of this State's progress in health affairs gives us encouragement. There is much to be done but like the lightning bug we can take pleasure in turning the light on where we have been, even though the future may be clouded with new and difficult problems. An appreciation of the pioneering efforts of past leaders may brighten our insight in program planning for the future.

We have passed through the trying days of campaigns for the eradication of hookworm, a Swat-the-Fly campaign, and the piece-work plans for the compensation of local health directors.

They tell me that in Guilford County some 50 years ago the County Commissioners voted to get a horse for the use of the County Health Director, provided he would share it half-time with the Fire Chief. In equipment and in trained personnel for health services, North Carolina has made great progress in these past decades.

December, 1962

THE HEALTH BULLETIN
These Years Have Seen Progress

Measured by whatever standards—longevity, unnecessary deaths, preventable illnesses—these years have seen progress unparalleled in the history of the health of man.

No single group can or would take exclusive credit for this progress—for (1) the tremendous increase in life span, (2) the fall in the sickness and death rates from communicable diseases, (3) the dramatic reduction in infant, neonatal, and maternal mortality, and (4) the reduction in disablement and deaths from preventable diseases such as hookworm, malaria, smallpox, diphtheria, whooping cough, and polio. But this progress has occurred concurrently with your efforts and activity aimed at control through community action, and only through modifying the environment or the reaction to the environment.

Ours was one of the first, if not the first, State to develop county health departments. Certainly in Robeson County we were the first State to develop a health department for a strictly rural county.

Health Progress Has Been Harmonious

North Carolina’s progress in health has been uniquely marked by the harmonious cooperation and encouragement of the health professions, voluntary organizations, the officials of State government, civic groups, and the private citizen. All the way back to 1877 when the Medical Society of the State of North Carolina sponsored the establishment of the State Board of Health, there has been a most helpful and cordial relationship focused upon a constant concern for the improvement of the health of the citizens of the State.

Health Services Undergird Many Other Programs

Health services affect all the State’s citizens. The professions represented in your organization and in the State and local health departments cooperate with and provide services for many other voluntary lay organizations and State departments. Your preventive health efforts undergird the medical profession and the hospitals. The public health dentists help the dental profession stress good dental health. Food processors, the dairy council, restaurant, hotel and motel operators—all are aided by the work of your sanitarians. The approach of the Travel Council for tourist trade is aided by the standards maintained through the work of the health departments. The fishing industry and many many more aspects of the economic life of our State are aided and the State’s economy thus strengthened as you do the work for which you are responsible.

North Carolina in 1937 was the first State to initiate a program of the planned parenthood association. This State has been among the first in immunization programs for typhoid. We were the first in the nation to make certain immunizations a requirement—including that of polio. We have the good fortune of having, in the School of Public Health of the University of North Carolina, one of 10 such regional schools in the nation.

State First in Crash Injury Program

By beginning in September 1953 this State’s cooperation in the Cornell University Crash Injury Program, North Carolina became the first state in the nation to move in an area of great personal concern to me as Governor. We must all do what we can—as individuals and as members of such organizations as this—to cut down on this crippling and killing on the highways.

We were among the earliest states to set up an organized cancer detection program.
In recent years North Carolina has made great and satisfying progress in community mental health programs—programs seeking to deal helpfully and with a preventive purpose with persons who are mentally or emotionally disturbed. This has resulted in keeping many persons from needing full-time institutional care in one of our mental hospitals. We also have followed up the persons released from the mental hospitals seeking to prevent their need to return, in keeping with the successful pattern followed by local health departments for many years with our tuberculosis hospitals.

Our State was among the pioneers in the program of oral hygiene with the public schools, beginning in 1929. At one time North Carolina alone employed over half of the public health dentists in the nation.

The Medical Society and the State Board of Health have cooperated in promoting polio immunization by the Salk vaccine. Our State's record of four paralytic cases thus far this year attests the effectiveness of these dedicated labors. Preparations have been made to continue this good work through the use of the newer Sabin oral vaccine. Temporarily this program has been deferred. When questions recently raised concerning the safety of Type III have been cleared, further progress is expected to be resumed. Meantime, we will continue vigorously with promotion of the use of the Salk vaccine.

The plans for suicide prevention services in North Carolina have put a spotlight on this twelfth most prevalent cause of death—with nearly 500 suicides each year. The increased emphasis on radiological health brings into focus one of the most recent health areas needing attention. North Carolina is moving forward towards adequate support of this program.

In areas of health care in which your organization is interested along with every other organization and citizen of the State, there has been significant achievement.

This State is fortunate in having three outstanding medical schools. These schools produce well-qualified physicians and surgeons and make an important contribution in medical research. Their location in our State does a great deal to keep high the quality of medical practice and health care.

The building of many new community hospitals has put these facilities within the reach of every citizen. You know first hand of the improvements that have been made in the buildings housing the local health departments across the State.

Perhaps we have overpublicized the progress we have made. With all the progress made in health services, it would not be remarkable for the public to wonder how we could still have problems and needs. After seeing the accomplishments formerly thought to be impossible, the public tends to overlook the difficulties that first had to be overcome. In recent decades our success in postponing disability and death has been most gratifying.

Priorities Must Shift With Changing Needs

In thus learning prevention—epidemiology if you please—with regard to the more acute diseases much can now be used in the more chronic and the non-communicable fields. Priorities must shift with changing needs. We have good reason to make the necessary investment of trained talent and money toward controlling the leading cripplers and killers of today: heart and blood vessel diseases, cancer, accidents, mental disorders—to name only a few. We must have increasing motivation for individual and family understanding and
participation as we seek to solve these present problems. Only when all our citizens enjoy physical and mental health in their fullest possibilities can we as a State be satisfied.

This year is the 85th year since the founding of the State Board of Health. This year would be a good year to take inventory, to analyze and appraise, and courageously to plan for the future. Our most urgent need is for public understanding, the strengthening of local responsibility, and the honest determination of each citizen to support those programs which improve health care in the State.

Bewitched, Bothered and Professional

WITCH DOCTORING is becoming subject to civilized professionalization. A well-known South African witch doctor, appalled by the ignorance of his colleagues, has proposed a 5-year university course for practitioners. “We must get rid of quacks,” he says. And witch-doctors in Nyasaland have formed their own union complete with constitution and disciplinary code of conduct.

More Medical Schools

Two medical schools were added to the list of accredited institutions during the past year, bringing the total to 87, according to the annual report on medical education of the American Medical Association.

The new additions are the University of Kentucky College of Medicine, Lexington, and the California College of Medicine, Los Angeles, formerly the College of Osteopathic Physicians and Surgeons.

Approval is granted by the AMA and the Association of American Medical Colleges. There are now no unapproved medical schools in the nation.

The 1961-62 report, prepared by the AMA Council on Medical Education and Hospitals, said “10 or 12” new medical schools are currently being planned.

Five universities — Brown, Rutgers, Connecticut, New Mexico and Texas— are proceeding with plans announced last year to establish two or four-year medical schools, the report said.
**"Jet" Flu Shot**

Donna Hipp, an 11th grader at Broughton High in Raleigh, got a Flu shot with the new hypospray jet injector gun which was used in the initial part of the Cooperative Influenza Vaccine Field Trial being conducted in two schools in North Carolina and in certain schools in four other states, including Alaska. Dr. George Magnus Johnson, Epidemic Intelligence Officer assigned to the State Board of Health by the U.S. Public Health Service, is giving the first of the two shots each student received. A follow up through the expected Flu epidemic this winter is a continuing part of the total plan. Enloe High School of Raleigh was the other of the two North Carolina schools participating. Donna is the daughter of Raleigh attorney Ed. B. Hipp and Mrs. Hipp.
DATES AND EVENTS

1963

January 9-11—State and Territorial Mental Health Authorities Conference, Washington, D. C.

January 17—Area Conference on Home Care Services, N. C. Wesley Methodist Church, High Point.

January 26—State Medical Society's Annual Officer's Conference, Pinehurst.

February 13—S. E. Area Conference on Aging, Recreation Center, Lumberton.

February 21—Wayne County Mental Health Association and the State Medical Society sponsored county conference of Mental Health, Goldsboro.

March 5-6—American Association of Retired Persons Area Conference, Jack Tar Durham Hotel, Durham.

March 7-8—North Carolina Mental Health Association, Annual Meeting and Leadership Conference, Hotel Sir Walter, Raleigh.

March 12-15—American Mosquito Control Association, Atlantic City.

March 13-14—Seventh Annual Conference on Occupational Health, Barringer Hotel, Charlotte.


March 29-30—N. C. Physical Therapy State Meeting, Duke University Medical Center, Durham.

April 5-6—North Carolina Society of X-Ray Technicians, Washington, N. C.


May 8-10—Southern Branch APHA, Biloxi, Miss.


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