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The New State Legislative Building

Souvenir Edition

Rotunda Between House and Senate
The spacious red-carpeted stairway just inside the front doors which leads from the first floor to the third floor on which the Balcony entrances to the two legislative halls are located.
Senator Clarence Stone of Rockingham County and Representative Clifton Blue of Moore County will preside over the Senate and House in the 1963 General Assembly.

The Laboratory Division of the State Board of Health has been invited by the Public Health Service to participate in a pilot project to test the applicability of the fluorescence inhibition test in State laboratories. If results are favorable, this will assure our laboratory a head start in establishing this test as a service in this area. Dr. Lynn G. Maddry, Acting Director of the Laboratory Division, considers this a distinct honor.

The Conjoint Session of the State Board of Health and the Medical Society is scheduled for 9:00 A.M., Wednesday, May 8, in Asheville.

A three-month, tuition free course for the training of dental assistants will begin June 6 at the University of North Carolina School of Dentistry, open to any high school graduate between the ages of 18 and 40 with a knowledge of typing.
THE NEW STATE LEGISLATIVE BUILDING

- Third permanent home of the General Assembly.
- Three stories, with basement, includes 206,000 square feet.
- On two-block site astride Halifax Street, one block north of Capitol Square.
- Designed by Edward Durell Stone of New York, in association with Holloway-Reeves of Raleigh.
- Total cost, $6,200,000.
- Built by Rea Construction Company of Charlotte.
- Work began in December, 1960, was finished in mid-December, 1962.
- First session of the General Assembly met in the State House on Wednesday, February 6.

The Legislative Building alive with lights on a February evening.
Governor Terry Sanford delivers his State of the State message to the joint session.

Senate members take the oath of office.
Research Coordinator Appointed

A Coordinator of Research for the State and local health department staffs has been named by J. W. R. Norton, M.D., State Health Director.

Accepting appointment to undertake this assignment is John T. Hughes, B.S., D.D.S., M.P.H. Dr. Hughes will serve in this newly created position in addition to his present assignment as Assistant Director of the Division of Oral Hygiene.

Dr. Hughes is a native of Pittsboro, did his undergraduate work at Wake Forest College, and received his D.D.S. Degree at Baltimore College of Dental Surgery—University of Maryland Dental School. The Master of Public Health Degree was conferred by the School of Public Health of the University of North Carolina.

In making announcement of the appointment of Dr. Hughes as Coordinator of Research, Dr. Norton said, “We have felt for a long time the urgent need of having a qualified person to stimulate and coordinate public health research. A considerable amount of funds are accessible, particularly from the National Institutes of Health, for this type of work and we feel that Dr. Hughes has a special interest in this area and that we can expect from him a most worthwhile accomplishment.”

The House Chamber shortly before that body was called to order.
The Forty-eighth Session of the Trudeau School of Tuberculosis and Other Pulmonary Diseases, established in 1916, will be held in Saranac Lake, N. Y. from June 3rd to 21st, 1963. This annual, unique postgraduate course for physicians, conducted under the auspices of the Trudeau Foundation and supported by the Lillia Babbitt Hyde Foundation, provides outstanding instruction in the field of chest diseases at a minimal tuition of $100 for a three weeks session. Attendance at the Trudeau School carries with it a thorough review for specialization in pulmonary diseases or for work in public health involving tuberculosis.

The retirement of Dr. Curtis Southard as Chief of the Community Services Branch of the Public Health Service's National Institute of Mental Health has been announced by Dr. Robert H. Felix, Director of the Institute.

A native of North Carolina, Dr. Southard joined the Public Health Service in 1939.

He was recently selected as a famous son of his native State and presented the Tar Heel award by the Governor of North Carolina.

All full-time local health departments in the United States have been invited to submit entries for the 1963 National Samuel J. Crumbine Awards.
An indoor garden in the new Legislative Building.
Legislation Sponsored by the State Board of Health

The State Board of Health plans to sponsor bills in the following areas during the 1963 General Assembly.

1. **Air Pollution**—A bill which would designate the State Board of Health as the State agency to encourage and conduct studies and research on air pollution, to elicit the cooperation of all pollution sources to this end and to administer funds from Federal, State and other sources made available for this purpose.

2. **Swimming Pool Minimum Design and Sanitation Standards**—This bill confines itself to the sanitary engineering aspects of swimming pool construction and operation.

3. **Death Certificate Regulations**—A bill to improve the speed of processing of death certificates and to clarify the official responsibility for prompt completion of the certification process. This bill was worked out in conference with all interested State-wide associations and agencies.

4. **Fees for Certain Home Care Services Provided by Local Health Departments**—This bill is enabling legislation which permits local health departments to establish a fee scale for certain home care services, such as home nursing and physical therapy. Fees would be charged where resources were available from the individual himself or as in the case of a welfare recipient, from other sources. Referral for these services would be made by the patient’s personal physician.

In addition, the State Board of Health will support other legislation appropriate to our concern in health matters as sponsored by other agencies and organizations.
Looking down on the Main Rotunda.
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.
Implementing the Kerr-Mills Law in North Carolina

Implementing legislation to permit North Carolina to take advantage of the provisions of the Federal Kerr-Mills law was presented early in the 1963 session of the General Assembly. In the Senate a bill was introduced by Senator John R. Jordan of Wake County, chairman of a special committee appointed by the Governor, and in the House by another committee member, Representative Rachel Davis, M.D., of Lenoir County. This initial legislation seeks to make legal the general application of the provisions of the Kerr-Mills law in this State.

Subsequent bills to be presented are expected to specify the needed appropriations of State money to provide certain ones of the services available under the Federal Act. The more services to be made available in North Carolina under the law and the eligibility requirements of recipients will determine the amount of State money needed. Approximately $750,000 of State money, matched by $750,000 of county money, is expected to bring in $4,500,000 of Federal money. Eligibility requirements for the medically indigent recipients would be set by the State Board of Public Welfare.

Present indications are that the services which may be asked for in subsequent appropriation requests will include: (1) diagnostic services in physicians offices; (2) prescription drugs; (3) dental care; and (4) home nursing care.

The N. C. Hospital Association is at least one group which feels that appropriations for the payment of the full cost of hospitalization for Public Assistance cases should be made before there should be any extension of services in other areas.

Other viewpoints are expected to be heard, including health professions whose services are available under the Federal law but which are not chosen to be included in the particular package which is presented to the General Assembly to finance in this State. Because of some transfers expected to be made in other funds if the Kerr-Mills law is implemented in this State, the net effect of the law here may be to provide some non-institutional care for a segment of medically indigent persons over 65 years of age.

January, 1963
The roof-top domes and tree plantings atop the new Legislative Building.

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. Dawson, 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.D. .............................................................. 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 Koonen, 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

THE HEALTH BULLETIN
January, 1963
Joint Meeting on Occupational Health
Set for Charlotte in March

The Honorable Terry Sanford, Governor of North Carolina, will address the opening session of the Seventh Conference on Occupational Health, a joint venture, set for March 13 and 14 at the Hotel Barringer in Charlotte.

Fred E. Henderson of Winston-Salem, retired Western Electric executive, heads the Governor's Council on Occupational Health. George W. Dowdy, executive vice-president and general manager of Belk's, is chairman of the Greater Charlotte Council. Both groups were organized early in 1957 and have held conferences annually since that time. For the first time this year, they are meeting jointly.

The Conference will begin with a reception honoring Governor Sanford at six o'clock on Wednesday evening, March 13. At the banquet immediately following, the Governor will speak on "North Carolina Safeguards the Health of Her Workers."

Benny Goodman, M.D. of Hickory is chairman of the planning committee for the Seventh Annual Conference. Dr. Goodman is president-elect of the Carolinas Industrial Medical Association. He combines private practice as a family physician with part-time industrial practice for the General Electric plant at Hickory.

The conference registration fee is $10.00; for Wednesday only $6.00, Thursday only $5.00. Advance registrations should be sent to Occupational Health Council, 526 Charlottetown Mall, Charlotte, N. C.
DATING AND EVENTS

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, Baringer Hotel, Charlotte.

March 18-21—National Health Council—National Health Forum, Mayflower Hotel, Washington, D. C.


March 29-30—N. C. Physical Therapy State Meeting, Duke University Medical Center, Durham.

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Picture credits—Photographic staff of Raleigh News and Observer.

The Great Seal of North Carolina inset on the broad front steps of the Legislative Building.
Souvenir Edition

The New State Legislative Building

Rotunda Between House and Senate
The spacious red-carpeted stairway just inside the front doors which leads from the first floor to the third floor on which the Balcony entrances to the two legislative halls are located.
Senator Clarence Stone of Rockingham County and Representative Clifton Blue of Moore County will preside over the Senate and House in the 1963 General Assembly.

**THIS SPECIAL ISSUE**—The unusual and continuing demand for additional copies of the January issue of The Health Bulletin has far exceeded expectations. Reprinting extra copies after the magazine is once through its regular run and off the press is more expensive than to print extra copies while the presses are still running. This may explain the unique character of this February issue which has some new features but includes once again some of the most pictorial photographs taken thus far in black and white of the new State Legislative Building. Among the new features added in this issue are floor plans of the building which can be used as guides to help visitors find their way in this beautiful and well-arranged but immense edifice.

Extra copies of this issue have been printed and are available upon request to The Health Bulletin, P. O. Box 2091, Raleigh, N. C.
THE NEW STATE LEGISLATIVE BUILDING

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- Total cost, $6,200,000.
- Built by Rea Construction Company of Charlotte.
- Work began in December, 1960, was finished in mid-December, 1962.
- First session of the General Assembly met in the State House on Wednesday, February 6.

The 1963 General Assembly named the following legislators as members of the Commission to be responsible for the operation of the State Legislative Building: Representative H. Clifton Blue, chairman; Senator Clarence Stone; Senator Tom White; Senator Staton Williams; Representative George Uzzell; and Representative I. C. Crawford.

The Legislative Building alive with lights on a February evening.
Governor Terry Sanford delivers his State of the State message to the joint session.

Senate members take the oath of office.

The House Chamber shortly after that body was called to order.

A view along the Salisbury Street side of the new Legislative Building.
An indoor garden in the new Legislative Building.
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5. **Regulations Governing the Sanitation of Agricultural Labor Camps**—This bill is essentially the same as the one introduced in 1961 but has named an Advisory Committee which includes representatives from major areas using migrant labor. The bill has been worked out by the Governor’s Committee on Agricultural Migrants and the State Board of Health.

In addition, the State Board of Health will support other legislation appropriate to our concern in health matters as sponsored by other agencies and organizations.
Looking down on the Main Rotunda.
Floor Plans
North Carolina State Legislative Building – First Floor
Floor Plans

North Carolina State Legislative Building — Second Floor

February, 1963
THE HEALTH BULLETIN
Floor Plans

North Carolina State Legislative Building - Third Floor and Area Map

Third Floor

Area Map
A view of the new Legislative Building from the Salisbury and Jones Street corner.

**TRAVEL FOR HEALTH**—Frequently the Editor of The Health Bulletin receives notices of travel opportunities—for health, for fellowship, for pleasure, for educational enrichment—and since he cannot go, maybe you can—write us and say what you are interested in doing with congenial friends and where you want to go. We may be able to make a good suggestion.

### MEMBERS OF THE NORTH CAROLINA STATE BOARD OF HEALTH

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February, 1963 THE HEALTH BULLETIN 15
Dates and Events

March 13-14—Seventh Annual Conference on Occupational Health, Barringer Hotel, Charlotte.
March 18-21—National Health Council—National Health Forum, Mayflower Hotel, Washington, D.C.
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.
April 28-May 4—Mental Health Week—Canada and the United States.
May 8-10—Southern Branch APHA, Biloxi, Miss.

Contents

Picture credits—Photographic staff of Raleigh News and Observer. Picture on page 5 by UPI Photographer, Joe Holloway.

The Great Seal of North Carolina inset on the broad front steps of the Legislative Building.
Dr. Carl V. Reynolds, medical pioneer in the mountains and State Health Officer for 14 years, died March 3, 1963 in his adopted home of Altadena, California. Dr. Reynolds, 90, had been making his home with a daughter, Mrs. Alyne Johnston (Randolph R.) Ball Jr., since his retirement as N. C. State Health Officer in 1948. (See editorial tribute on page 15.) This picture is taken from a portrait painted by Miss Mary Tillery of the Division of Oral Hygiene of the State Board of Health.
Dr. E. G. McGavran, dean of the School of Public Health of the University of North Carolina, which is formally dedicated April 6 and 7.
Dedication Ceremonies of School of Public Health

Governor Terry Sanford; Deputy Surgeon General David E. Price; U. N. mediator, and former Consolidated University President, Dr. Frank P. Graham, and Dr. Abel Wolman of Johns Hopkins University, head a distinguished roster of speakers for ceremonies dedicating the University of North Carolina's new School of Public Health Building, April 6 and 7.

The new facility, completed and occupied in the fall of 1962, represents $1,816,000 in new construction and, combined with a previously existing unit, gives the UNC School of Public Health a two-million dollar building, with 120,000 square feet of space.

Dr. E. G. McGavran, dean of the School, will preside at the two-day celebration. In Chapel Hill to commemorate the official opening of the building will be educators and administrators from the nation's public health schools and from national and international health organizations.

Keynoters for the event are Dr. Graham and Dr. Wolman, professor and director, Department of Sanitary Engineering, Johns Hopkins University School of Public Health and a former president of the American Public Health Association.

Twenty outstanding authorities in the field of public health will participate in a four-part discussion, Saturday afternoon, April 6, on "Schools of Public Health—Past, Present, and Future." Head ing the discussion will be Dr. John Wright, former head of the UNC Department of Public Health Administration and current director of the School's program in continued education service; Mr. Emil Chanlett, professor of sanitary
Dr. Wolman will talk at the First General Session, Saturday, at 10 a.m., on “Trends and Challenges in Public Health.” Dr. Graham’s talk, at 8:30 p.m. Saturday, will be on “The University’s Role in World Education.” Both talks will be in UNC’s Hill Hall auditorium.

Dedication ceremonies will begin Sunday morning, with a special memorial honoring the late Dr. Milton J. Rosenau, former director and dean (1936 to his death in 1946) of the School of Public Health, and founder of the world’s first such facility, the Harvard University School of Public Health.

UNC Chancellor William B. Aycock and Dr. David E. Price, Deputy Surgeon General, will make opening addresses at the building dedication Sunday afternoon at 2 p.m. Governor Sanford will make the dedication talk and will present the dedication plaque to Dean McGavran.

Following these ceremonies, the new building will be open for tours.

“Miss Lucy” Honored

A legend in health education circles, a woman whose tireless efforts have been noted and appreciated around the world, was honored in November when the North Carolina Association of Health Educators presented a portrait of “Miss Lucy”—Dr. Lucy Shield Morgan—to the University of North Carolina School of Public Health.

The gift of “Miss Lucy’s” portrait was formally made by Mrs. Lula Belle H. Rich of Raleigh, executive committee member and co-chairman of the portrait committee of the N. C. Association. Mrs. Rich is chief of the Health Education Section of the State Board of Health.

Mrs. Rich said: “Dr. Morgan’s professional life has been devoted to education, first as a public school teacher in North Carolina, Tennessee, and Texas, and then in the field of health education... The largest single portion of Dr. Morgan’s career has been spent here at the School of Public Health of the University of North Carolina. She was first assigned to this state by the Public Health Service in 1941. Her work in Fayetteville has become almost legendary in health education circles.”

Dr. Morgan, who came to UNC in 1942 to organize a Department of Education set “a new force abroad in the land:” a group of eager, aggressive, capable health educators.

“Since hearing Dr. Morgan’s own account of her recent tour of duty with the World Health Organization,” Mrs. Rich said, “we are particularly aware at this moment of the impact of her students on the world scene.”
Health Services and the Migrant

Who Are the Migratory Workers?

So far, few machines have been invented to replace human beings in gardens and orchards at harvest time. Until more such machines are invented, the cultivation and harvest of much of America’s giant farm crop will depend on the availability of migratory workers. "It still takes judgement and deft human hands to pick the perfect berry, leaving imperfect or overripe ones to be harvested later."

Each spring, as crops ripen and hands are needed, nearly a million migratory workers take their belongings and their children and travel with the harvest. Close to 500,000 of these mobile persons are under 18 years of age. Many work long hours in the fields. Children over 9 are usually considered working hands, an additional source of income to the family.

"Some of these families have contracts with growers for specific work at specified localities; others are on their own, uncertain of their ultimate destination or whether they will find work, gambling against time, weather and crops." Some may travel only a few hundred miles but others have no home at all and travel 12 months a year.

There are three cultural groups of migrants and three basic routes of migration. Southern Negroes work their way up the eastern seaboard from Florida to New York and sometimes into New England; some of them filter into the Great Lakes states. In recent years, Spanish-speaking Americans have entered this stream.

Many of them are recruited by agricultural associations or large growers to work as part of a crew. Crew leaders or labor contractors usually act as middlemen, negotiating working and living arrangements for a crew. Most of them are honest, but because of the lack of regulation of this operation, the migrant is often the victim of an unscrupulous middleman.

A new amendment to Title III of the Public Health Service Act may pave the way toward a solution of the migratory workers' health problems. This concrete national action to meet the need for migrant health services authorizes a maximum federal appropriation of $3,000,000 for the fiscal year ending in June 1963 and for each of the two succeeding years. Primary emphasis is placed on grants for the establishment of health clinics for migrant families.

Another stream, largest of the three, originates in South Texas. These migrants of Mexican descent usually travel in extended family groups. The majority work as far north as the Great Lakes states and then migrate back to the cotton fields of west Texas. Some Anglo Americans from the south central states work into this stream.

The third stream, including many Spanish-speaking Americans, works mainly in California, some moving as far up the west coast as Washington and Oregon. American Indians frequently work in central and western states.

Health and Nonresidence

Wherever migrants are, health problems may be found, problems that affect

"Article and illustrations reprinted with permission from Currents in Public Health, Vol. 3, No. 2, Ross Laboratories, Columbus, Ohio, 1963."
both the migrant and the communities that attract him.\textsuperscript{1,2} The mobile status of migrants means that no single community or state has the sole responsibility and none alone can plan for the continuity essential for effective health services.\textsuperscript{2} It is estimated that all states but two have areas where migrant labor is needed sometime during the year.\textsuperscript{3}

Many times the workers migrate into counties or states where they must live months or years before they can be legal residents. As nonresidents they may be ineligible for health care, according to existing laws.\textsuperscript{2}

Some of the communities where migrants work are isolated and thinly populated and their health services even for permanent residents are likely to be deficient.\textsuperscript{5}

In other areas, the public has been reluctant to provide for health care of the migrant. Often, health services are instituted only after an epidemic or disaster among migrants has adversely affected permanent residents.\textsuperscript{2}

Constructive efforts to provide health care have been successful in some areas but have little relationship to efforts being made elsewhere.\textsuperscript{2} "One community may include [the migrant] in a local immunization program. A health record may be carried by his family to the next community. But the next place may be unprepared to follow through."\textsuperscript{3} And often, the migrant's ignorance about health services and their purpose prevents him from utilizing those that are available to him.\textsuperscript{2,4}

In fact, the migrant does not have the protection provided to noncitizen migrants who come each year from Mexico and the British West Indies to work the crops. "Contracts for the extraterritorial workers provide some health insurance, workmen's compensation, minimum standards in transportation and housing, and work guarantees."\textsuperscript{2} These nationals have to return to their countries when the contracted term ends, but they do have health protection.

(Continued on page 10)
Migratory Workers in North Carolina

According to the Employment Security Commission, the total number of migratory laborers used in North Carolina in 1962 was 12,153. This included 1,988 migrant workers who are residents of North Carolina.

They were distributed throughout the migrant belt in various areas. These areas are: Albemarle Section, which would include Currituck, Camden, Pasquotank, etc.; Washington area, which would include Pamlico, Martin, and Beaufort area; the Wilmington area, the Mount Olive area, the Winston-Salem area and the Hendersonville area.

The kind of crops harvested consisted of Irish potatoes, sweet potatoes, beans, corn, cucumbers, watermelons, tobacco, blueberries, mixed vegetables, and apples.

The legal responsibility with regard to housing and sanitation of camps, where there is such legal responsibility, is in the hands of the local health departments. Some have adopted local ordinances. The enforcement of these local ordinances has been very lax in most instances.

The only State Law we have, which is enforced primarily by the local health departments, is the one relating to safe disposal of human wastes. We have spent considerable time in recent years working with the employers of migrant labor, particularly those having housing facilities, to provide protected water supplies, safe sewage disposal, garbage control, and minimum housing facilities. The local health departments have cooperated with us and some progress has been made. The standards, under which we have been operating, have been minimum standards applied on a voluntary basis.

The needs include the provision of legal authority to establish State-wide standards in order that facilities would be provided at all places where migrants are housed and would provide a base on which we could conduct our program. The absence of any State-wide standards makes it difficult to develop an effective program and secure reasonable enforcement and results.
Migrants on the Road

Migrant laborers, their families and their "worldly goods" on the way to the next job harvesting the crops.
Health Services and the Migrant  
(Continued from page 7)
while here to an extent unheard of for the average migratory worker citizen.  

Problems Related to Health  

Cultural difference—For the migrant, problems of nonmembership in a community are compounded by his position in the lowest socioeconomic level and, usually, in a minority group. He may be Negro, Indian, Anglo, Texas native of Mexican extraction, Oriental, Filipino or Puerto Rican. "The wide gap that exists between these cultures and those in most American communities makes outsiders of the migrant worker and child, with few exceptions."  

Education—Experience has shown that an effective way of altering family health practices is through educating the children. "But the education of the migrant worker's child is impeded by his migrancy and his isolation in camps far from schools, libraries, clinics, hospitals, and other community services." His education may also be impeded by his working in the fields with his parents, if not during school hours, often after school hours. Unpublished Bureau of Labor Standards tabulations showed that in July, 1957 an estimated 457,000 children 10 to 15 years old—many migrants—did paid agricultural work.  

The average migrant obtains no more than a fifth grade education. When school attendance is so often interrupted, children must adjust to new texts, methods of teaching and classroom situation in each school entered. "Studies in Oregon, Colorado, California and other states indicate the consequence—the majority of migrant children are behind their proper grade level for their age by the time they are 10 years old. When they reach their teens, their over-size in comparison with other pupils of the same grade is embarrassing and school attendance becomes a painful experience to be avoided as quickly as the legal age for leaving school is reached."  

Income and Housing—Migrants suffer from "the insecurity that goes along with unpredictable and unusually low incomes. The average migrant worker earned $859 in 1957,"  

Families usually live near the work site in overcrowded, poorly constructed housing facilities. Toilet facilities often provide for neither decency nor essential sanitation. "Whole families frequently live, cook, and sleep in one room. Such housing can rob everyone in the family of self-respect."  

Status in community—Migrants soon become familiar with the signs, "Migrants Not Admitted," often found in windows of restaurants, shops and theaters. Forbidden to play in community playgrounds or to swim in community pools, children and teenagers are chief victims of loneliness and lack of community roots. Deprived in this manner of any sense of belonging and prevented from participating in community affairs during his short stay, it is no wonder the migrant neither expects nor attempts to utilize such health services as may be available to him.  

Health of Migrant Families  

Public health and crippled children's clinics may be open to the migrant, but he may be unaware of them or shy about requesting health assistance. Or clinics may be scheduled at times and places inaccessible to a family with no transportation available and a pressing need for both parents to work long hours each day to earn as much as possible during short crop seasons. "The purchase of medical care may cause the family severe deprivation, since the community public welfare resources to assist low income residents are not generally available to transients, including members of migrant families."  

THE HEALTH BULLETIN  

March, 1963
Migrants generally “share the health problems of other families handicapped by poverty, minority group status, lack of knowledge, and geographic or social isolation. Poor nutrition, diarrheal disease, impetigo, respiratory infections, and other ailments are often reported. A study of migrant health in a western state in 1950 found that the infant mortality rate among migrants was nearly twice that for the state, and that more than a third of the births in a five year period were not attended by a physician. . . . The mental health hazards of migrant living are usually unrecognized.” But diarrheal and nutritional diseases are the natural outcomes of poor sanitation and living conditions. Poor diets are the natural result of low purchasing power, lack of adequate food, poor cooking and storage facilities and lack of understanding of nutritional requirements. Alcoholism and occasional outbreaks of violence in camps may be looked upon as reflecting low moral standards or lawlessness. But they may indicate, instead, emotional problems related to the tensions of migrant living. 6

What the migrant believes—Because migrants often differ from other residents in attitudes and customs and because there may be a language barrier, the efforts of local health workers may founder on misunderstanding. 3

For example, in one state, it was found that Spanish translations of standard teaching materials were of little value to Mexican migrants from Texas. Education about the basic seven food groups meant little to women who worked in fields from dawn to dark. They needed help, but from health workers who understood that they had little money, little time, no refrigeration and the most meager cooking equipment. 4

Better methods of measuring the medical needs of migrant children are needed as well as methods of evaluating the steps in improving their health status. “The need for coupling social with medical research is fairly obvious. . . . Domestic farm migrants in some respects present medical problems of 50 years ago,” Johnston states. 5

It has been found that the migrants’ concepts of immunization are often vague and erroneous. One group of health workers found that “diarrhea, intestinal parasites, and copious nasal discharges were so common among them (migrants) that they considered such conditions normal. They had little insight into a continuing need for x-ray follow-up and medication in tuberculosis; flies and mosquitoes were pests, not carriers of disease. It is obvious that health workers will be frustrated in their attempts to change health care practices of these people, before they have an accurate knowledge of their concepts on health and disease, and of course of the ones that may be altered for their benefit.” Experience has shown the need for flexibility and adaptability in the health workers who serve migrants. 4

What Some Agencies Have Done

Florida project — The health center staff in Belle Glade, Palm Beach County, saw about 6000 migrants during a recent two-year period. 9 A team approach to health problems of the migrants is used. A liaison worker, a member of the Negro community known to the migrants, “transmits health information to migrants in their cultural terms, and aids the staff in the interpretation of their reactions. The invaluable contribution of this worker suggests that selected leaders among migrant groups could be developed as intermediary persons who would be most effective in securing changes in health care practices among their people. 4,9

As a direct result of this program,
many generalizations formerly held by health workers about health care for migrants were changed. It was found that the migrant tended to neglect health problems because he was unfamiliar with local resources and because he did not fully understand their purpose. But when known principles of health education were adapted to him in terms he understood, his attitudes began to change.

Maternity care — Expectant mothers attended a prenatal clinic conducted by public health nurses. After laboratory tests were performed and patients were counselled, the migrant women were offered prenatal care in a doctor's office and hospital delivery at a reduced fee. Special arrangements were also made to permit them to stay in hospitals for two days at reduced rates. Some appeared to appreciate private care; they later went to a private physician and paid the regular fee instead of returning to the clinic. When advice was offered in familiar terms, they began to learn to budget their very limited incomes.9,10

Well-baby conferences were conducted at traditional once-weekly immunization clinics. "Services in addition to immunization included weighing and measuring the children and inspecting them for gross defects. Nursing conferences regarding formula preparation and the addition of solid foods were held with mothers who brought children under one year of age."10

Many diseases were found among supposedly well families, including hypertension, brain or abdominal tumors, uterine cancer, cardiac abnormalities, anemias, diabetes and nutritional deficiency diseases. "Gross dental decay was seen in about 95 percent of adults and 75 percent of children. General status of health in the children was better than would be expected in such a group. The pediatrician attributed this to high fetal loss, high infant death rates, and deaths in young children that might have been prevented by medical care. Apparently children in this well-family clinic had managed to become part of the 'survival of the fittest' group."4,9

Invitations to the clinics became status symbols among the Florida project group. Families heard about the clinics and began requesting appointments.10

California clinics — Migrants working on Fresno County's isolated cotton ranches obtain health care at the Westside Clinics.4,6 The clinics open after the day's work is done and they do not close until the last patient is seen—sometimes as late as 2:30 a.m. They are staffed by volunteer physicians, resident physicians from the county hospital, public health nurses and citizen members of the Fresno County Rural Health and Education committee.

After this community group opened the clinics, a dramatic decline in the infant mortality rate and a noticeable decrease in the number of county hospital bed patients from this group were seen. The clinics are part of the county health services.

During the first three months they were open, only 85 migrants sought medical services. "Eight years later, in 1959, 1,333 came in those same three months and a total of 600 clinic visits were made that year. Of 330 mothers given prenatal care, 214 visited the clinic before the sixth month of pregnancy. An average of 1,200 to 1,400 children in Fresno county are seen at the 20 child health conferences held each month. Parents receive education in preventive medicine and accident prevention is stressed. Immunizations are given, and children who are ill are referred to their private physicians, county hospitals, Westside clinics or other indicated children's services."4,5

Although there has been a significant

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increase in the county’s child population since the clinics opened, infant mortality has decreased about 22%. The number of diarrheal deaths has dropped. Among children there has been a general decline in all reportable diseases except tuberculosis. Staff members have noted a change in the types of families seen at the clinics; they seem to migrate less. Better standards of hygiene and living are seen in home visits.

Implications—The existence of these health services shows that a coordinated, community effort offers one practical approach to improved health education and care for mobile or isolated groups.

Henderson suggests that a central directory be formulated to list available services on a nationwide basis. This might facilitate referrals for the migrant workers seen by health agencies. Attempts have been made to design health records that migrants could carry with them. Crew leaders have been helpful in persuading workers to carry these, but with limited success. As a rule, the migrant won’t carry anything larger than a wallet-sized card.

The Road Ahead

Jessup states, “It seems to me that our greatest hope for the solution of the problems of migrant families in the future lies in the growing recognition of the need for interagency and interstate planning. We in the state and the local public health agencies are deeply interested and want to do our part, but we have no way as individual agencies to assure continuity of the basic services that migrant families need wherever they live temporarily, nor as health agencies have we the mechanism of the employment service for scheduling workers and for predicting the number and characteristics of the migrant population for which plans need to be made at particular places and particular times. Many aspects of our state and local health task rely on the efforts of other states and localities and other groups, including the employment service, the employers, and the migrant families themselves.”

The coordination needed between agencies may ultimately result from the establishment of projects under the new legislation. The 1962 migrant health bill authorized two mechanisms “through which a solution to the migrant health problem can be approached:

1. By granting funds through the Public Health Service to pay part of the costs of projects submitted by public or other nonprofit agencies.

2. By expanding technical assistance of the Public Health Service, placing emphasis on encouragement and cooperation in intrastate or interstate programs to improve health services or otherwise improve migrant’s health conditions.”

Primary emphasis will be placed on family health service clinics. Grants will cover part of the cost of establishing and operating these clinics and of consultation from the Public Health Service. Field staff will help states, local communities, and private nonprofit organizations coordinate migrants’ health services. No specific State or local cash matching is required, but the amount expended by States, communities, and nonprofit organizations is expected to exceed the Federal grants. Responsibility for planning and conducting programs will remain with States and local communities.

It is inevitable that migrants will continue to have health problems and that their problems will continue to constitute problems for the communities and states where they temporarily reside. The new Federal legislation may put an end to the problems that arise because of the migrant’s inability to
meet local and state residence requirements. But the integration of health activities on an interstate level will not be easy to achieve. "Only to the extent that the dynamics of the migrant's life are recognized and understood" can health personnel begin to meet the health needs of those in our population who "follow the sun."12

References:

Shepnen Mason Thomas of Sylva, N. C. was one of the winners of a 1963 Morehead Scholarship. Stephen is the son of Mr. and Mrs. C. B. Thomas of Sylva. "Charlie," as he is known to his many associates in public health, is Sanitarian Supervisor with the Jackson-Macon-Swain District Health Department.
Carl V. Reynolds—Public Health Pioneer
June 13, 1872 - March 3, 1963

Sixty years ago Carl V. Reynolds, M.D., received his first appointment as Asheville's City Health Officer. That term and his second (1914-1923) had this result for Asheville: that through his influence and leadership public health here advanced more rapidly, by the span of at least one generation, than it probably would otherwise have done.

Not only this—his work in Asheville as a sanitarian led to his election as President of the North Carolina State Board of Health, and later to his election as State Health Officer.

In this latter post, Dr. Reynolds carried farther his Asheville program for control of venereal diseases, this program antedating by some months the Federal Government's program organized just prior to World War II.

Dr. Reynolds was once described as "a kinetic" health officer—or one who is always giving motion and action to ideas of preventive medicine.

Thus in 1942 the North Carolina Health State Officer established in Raleigh the Venereal Disease Educational Institute. The educational techniques of this institution spread to other states. And the Asheville and Buncombe County physician and sanitarian was given national recognition and honors.

Instrumental in founding the School of Public Health at the University of North Carolina at Chapel Hill, Dr. Reynolds was a faculty member of the School in 1935. Later the University conferred on him the honorary degree of LL.D.

What he did for public health in Asheville long ago became a routine phase of municipal life; they were pioneer reforms in other days. With the support of the city's first Commission Government, the Reynolds list of health measures includes these city ordinances:

—For the wrapping of hitherto unwrapped bread on sale.
—For a campaign against the house fly, credited as the first in the world.
—Vaccination of all school children.
—Tuberculosis testing of cows and the city's first milk law, in the drafting of which Dr. Charles L. Minor collaborated.

Retiring in 1948, Dr. Reynolds made Altadena, California, his adopted home. His life's work lengthened the lives of men and women; it saved and still saves the lives of many, many thousands of children.

His accomplishments in the field of public health are by no means the only reasons why those who knew him will cherish his memory. Dr. Reynolds had a kindliness of mind and heart, though he was properly strict in law enforcement. He had a sincere graciousness that made it easy for those around him to work with him, and his personality also brought him close friends and admirers among the general public.

Editorial March 10, 1963 in the Asheville Citizen-Times
Nurses' Writing Contest

All registered professional nurses are invited to enter the Nurses' Writing Contest now being co-sponsored by the American Nurses' Association, the National League for Nursing, and The Reader's Digest. April 30 is deadline.

The theme of the contest is "What Nursing Means to Me."

Just tell your own personal story of why you became a nurse, what dramatic, inspirational, and amusing things have happened to you on your job, and why you would encourage young people to select nursing as a profession.

A new catalog of Occupational Health Films and Filmstrips has just been released by the Division of Occupational Health, U. S. Public Health Service.

Designed to help industrial nurses, health educators, and others interested in using occupational health films and filmstrips as aids in protecting and improving the health of workers, this booklet was compiled to provide a current ready reference to selected occupational health films and filmstrips. Film descriptions are based on available information rather than staff evaluation.

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DATES AND EVENTS

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Printed by The Graphic Press, Raleigh, N. C.
Health Leaders Confer

Dr. Milton S. Eisenhower (right), president of the National Health Council is seen conferring with Dr. J. W. R. Norton, North Carolina's State Health Director, after one of the sessions of the 1963 National Health Forum held in Washington, D. C., in recent weeks. Dr. Eisenhower is president of Johns Hopkins University.
Today, we know more about the human body than ever before, thanks to a new alliance of biology, chemistry and physics. This knowledge illuminates, for example, the body's strategy in fighting disease, the "memories" of individual cells, the influence of physical sickness on mental attitudes. The author, Board Chairman of the Salk Institute for Biological Studies, outlines some of the implications for man's future.

One hundred and thirty-four years ago, a German chemist reported that he had synthesized a substance with a rather simple formula: \( \text{H}_2\text{NCONH}_2 \).

This does not seem to be a very impressive accomplishment—without further explanation. Chemists are forever putting things together to form other things, and nowadays they can make exceedingly complicated things, like rubber or quinine or plastics.

But the substance Friedrich Wohler synthesized was urea, the chief solid constituent of urine. Up to that time, it had been supposed by man that there was some mystical power, some "vital force" that enabled living organisms to produce within their bodies substances which were characteristic of and necessary to "life." Chemists were not supposed to be able to make these substances using inorganic materials and the ordinary equipment on the laboratory table.

Indeed, in the 18th and 19th centuries, many scientists considered that the phenomena characteristic of the living body are not governed by physical and chemical laws, but rather, by laws of a wholly different kind—those of "the sensitive soul." If that had been the case, then chemistry — and all the rest of physical science — could have been of only limited usefulness in the exploration of the problems presented by living creatures. For then biology and medicine would have had to say to the physical sciences, "thus far but no further."

(Continued on page 4)
The New Biology
(Continued from page 2)

It is unnecessarily foolish to suppose that the physical sciences will never encounter any aspect of living organisms with which they cannot deal. Nearly everyone—including physical scientists—believes there is more to a man than physics and chemistry and mathematics can reveal. But there is nevertheless this vital fact concerning a living organism or its parts: We have been able, to date, to find useful and relevant answers to any question asked in scientific terms.

Indeed, we have come a long way. Step by step, the tools and methods of chemistry and physics have proceeded to demonstrate their capacity to deal with detailed aspects of the structure and functioning of living organisms. Step by step, we are discovering the detailed physico-chemical causes for diseases.

Deficiencies in copper, cobalt or iron—all metals and about as inorganic as you can imagine—can cause anemia.

A definite chemical substance, thalidomide, has only recently been shown to interfere in a profound and tragic way with the proper development of human embryos.

The case of sickle cell anemia is a particularly striking one. Part of the red blood cells of those who have this disease, instead of being roughly spherical as is normal, have the bent shape of a sickle. If the physical chemist splits, into its component peptides, the hemoglobin molecules in these abnormal blood cells, he finds that one of these peptides is abnormal. When this abnormal peptide is split into the nine amino acids that compose it, eight of the nine turn out to be proper. But one single amino acid in this one peptide is wrong: It is valine when it should be glutamic acid.

In terms of the physicochemical analysis of biological problems, how can anything be more dramatically convincing than looking at the tragic sight of a fatally sick child, and realizing that this is caused not by some mysterious and evil spell, but by the specific fact child's blood has two more hydrogen atoms and two fewer oxygen atoms than it should have!

The conquest of physics and chemistry has extended not only to the diseases which are characterized by recognizable physical disorder or abnormality, but also to those more subtle phenomena connected with behavior and that the hemoglobin molecule in the with normal and abnormal nervous and mental states.

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Editor—Edwin S. Preston, M.A., LL.D.
The new biology will probably give older people a longer lease on life, as well as give youngsters the promise of better health throughout their lifetimes.

Thus a deficiency of a single amino acid, lysine, is known to cause a serious psychic disorder, pseudo-schizophrenia. As another example, a disastrous gene mutation results in the absence of an enzyme which enables the body to oxidize phenylalanine properly. This biochemical fault has the tragic result of causing a severe mental abnormality, the individuals' being Mongolian idiots with intelligence quotients usually less than 10.

**Manganese and Mother Love**

Perhaps most striking of all is the fact that the absence of the metal manganese from the diet of a female pigeon or rat results in the fact that the animal completely loses her “mother instinct.” She will not feed her young, smothers them in the nest, etc. How would a vitalist face the fact that “mother love” is under the control of a metal!

All this certainly does not mean that biology has been totally swallowed up by the physical sciences. There are large and important areas of biology which have not been extensively invaded by physical techniques. The systematist continues to be an essential servant to biological progress. Experiments with organ systems and with intact animals continue to be essential. Although these experimental procedures are vastly assisted by all sorts of physical devices, by the measuring methods of the physical sciences, and by the power of mathematics to aid in the planning and in the interpretation of research, these experiments continue to be essentially biological in nature.

It is mainly when investigation and analysis get very fine-scaled, down to the submicroscopic dimension of molecules and even atoms, that biology coalesces so completely with chemistry and physics. These studies, now very generally labeled “molecular biology,” constitute the new biology. This is the level at which genetics, cytology, cellular biochemistry, immunology, cellular physiology, organic and physical and biochemistry, quantum dynamics, electron diffraction, electron microscopy, information theory, and indeed, mathematics and electronic computers are all inextricably interrelated. They are so interdependent, in fact, so heavily overlapping, that it is as hard to disentangle them as it would be to decide whether a virus is a biological organism or a crystalline chemical.

If biology has gained power and insight through this fruitful union with the physical sciences, what may we expect in the way of future developments—over the next 5, 10, 25 years?

Prophecy in science is both dangerous and presumptuous—particularly so inasmuch as one of the most charming and stimulating facts about science is the unpredictability of the range and nature of usefulness of a new scientific idea. But one can nevertheless sense, along certain directions, a vigor of attack and an intellectual momentum of movement that make it most tempting to risk some guesses.

I am not a biologist, although I have spent some thirty years in rather intimate administrative relation to biological research in this country and abroad. Because I was not originally trained as a biologist, and because I lack direct laboratory experience in that field, I should emphasize that in the following remarks about probable future developments, I am an amateur motivated by hope, courage and innocence—rather than a professional who would be restrained by caution and detailed knowledge of difficulties.

If you examine the natural history
of the development of any branch of science you always find periods characterized by a tremendous amount of highly competent and absolutely essential labor devoted to cleaning up details, to pushing out little feelers here and there, to applying the existing theories to numerous problems previously identified.

On the other hand, you will occasionally find a period in the history of development of a science, when truly explosive new ideas appear. John Pfeiffer emphasizes just this point and illustrate it with the magnificent story of the DNA genetic code ("What Everyone Should Know About DNA," THINK, October 1962).

Biology, without any doubt, is in one of these exhilarating periods of explosive new ideas. For just that reason prophecy is, at this moment, as attractive as it is difficult. An essential characteristic of a great new idea is that it is new. But science, unlike many other important fields of human activity, is an accumulative enterprise. The future depends on the past, rather more solidly and hence rather more predictably, than would be true in other fields. So perhaps some directions, at least, of progress can be anticipated.

There is good reason to hope that the present biological battery of ideas and experimental techniques (the two always go hand in hand, one helping the other) is capable of successful assault on a wide variety of important problems concerning living things. If we think of the analogy of a key, we have good reason to believe that we are not, at present, concerned with fashioning one key for the pantry, one for the cupboard, one for the tool shed, etc. We are concerned with the design of a very few master keys which will unlock many mysteries.

The Body’s Intelligence System

In the proud history of medicine’s advance, it has in the past been necessary to study diseases one at a time. This may very well not be the case in the future. Let me illustrate.

We have long known that certain cells within the body, namely the cells called lymphocytes, possess the ability to cause the manufacture of “antibodies”—substances that resist and repel the invasion, into the body, of a “foreign” protein. The foreign protein in question may be associated with bacteria or viruses which would cause a disease; and the antibody response may thus furnish immunity against the disease. This is the fortunate phenomenon we all utilize when we have “shots” to protect us from diphtheria, flu, yellow fever, polio.

The body has this extraordinary capacity to recognize itself—to distinguish, relative to any substance, whether it is “self” (hence welcome) or “non-self” (hence to be repulsed).

In addition to this capacity, the body also has an intelligence system that examines cells: Are they proper and ordinary cells of “self,” or are they strange cells? And strange cells may arise in two ways: by invasion (a surgeon attempting to graft skin or even an organ from another person), or because certain previously normal “self” cells have changed character and have become abnormal rebels (when once-normal cells become cancer cells).

Vigilant Spies and Foreign Cells

Until very recently, we knew little indeed about this whole process. We did not understand the role of the thymus gland in producing the lymphocytes. Some of them are ever vigilant spies on the watch for foreign chemicals, others are on the lookout for foreign cells.

All of this story is now rapidly unrolling. It is certainly too early to say that it will lead to a wholly new mass attack on disease (as contrasted with...
individual battles with individual diseases). It is too early to guess what this may mean for cancer research. It is too early to be confident that this will lead to the possibility of all types of grafts and of organ transplants from one individual to another. But certainly we stand on a new hill from which we can now see country never dreamed of before.

The business of “self” and “non-self” is utterly fascinating. As I write these words, my wife is putting lunch on the table. Presently, I will eat some of the food, taking a bite, so to speak, out of the external physical universe that is utterly alien to my body. Within a day or two, part of this food will have been discarded—but the rest of it will have become an integral and accepted part of me.

Before the modern concept of “information” and the way in which, whatever its character, it can be reduced to elementary “bits” (which can be represented by zeros and ones, or by dots and blanks, white and black spots, by states of magnetism or of non-magnetism, or by current or non-current), one could really not imagine how complex and large amounts of information could be coded onto molecular aggregates. One could not imagine how a cell of his own body could approach a bit of chemical, or another cell, and say, in effect, “Friend or foe?” All of these exciting ideas are now falling into place, producing a pattern of understanding that is opening up wholly new possibilities.

In this same general field of human disorders, we can reasonably expect other great advances. Not only should we be able to conquer many of the diseases of early and mature life (perhaps even by some procedure which prevents many of them at one stroke), we should also be able to deal much more successfully with the degenerative diseases of later life. Evidence is accumulating that the process of aging may well be caused by a steady decrease in the body’s capacity to resist damage. If so, then a deeper knowledge of the mechanisms of resistance might well lead to a substantial increase not just in length of life, but in the length of vigorous, useful, happy life.

One of the most basic and most mysterious problems of biology is that of the differentiation which occurs as growth and development proceed. The single original fertilized cell divides, divides, divides, until there are at least 1,000 times as many cells in a man’s body as there are human beings on earth. How can it be that, in this process, certain cells “know” that they must develop into muscle cells, or nerve cells, or blood-cells, or any of the other precisely specialized types?

We have had, up to now, really very little insight into how this happens. Indeed, it almost forced one back to the old vitalist view when he tried to think how this could happen. But now we realize that, precisely and readably stored in the genetic code of the original cell, there are as many “bits” of information as are contained in some fifty different 24-volume sets similar to the Encyclopaedia Britannica. We realize that the physicochemical complexity of the cell is quite adequate to its task. In addition, it has recently been suggested, the film of molecules on the cells’ surface may form an additional hereditary system, independent of the nucleic acids of the genes, in which orders to govern development are stored as is the information stored in the memory organ of an electronic computer.

These become thingable problems once we have gained the modern view that “the very basis of biological order, of specificity and diversity, is a sequence of a few small molecules,” as André Lwoff of the Pasteur Institute has
pointed out.

The Case of the Learned Worms

The new techniques and insights lead into unexpected realms. The capacities to learn and to remember are of the clearest importance. Researchers at the University of Michigan have uncovered evidence that the process of learning causes actual chemical changes in the organism. Suppose worms, through repeated trials, have learned to respond to a light stimulus. If these learned worms are eaten by worms which have not had this schooling (it's an unpleasant fact, but these worms are cannibalistic), then it turns out that the particular unschooled worms learn to respond to the light stimulus several times more rapidly than do other unschooled worms which have not had the advantage of the scholarly diet!

A Swedish researcher has, in work obviously related to this, shown that when something has been stored in the memory of an organism, this appears to cause an alteration in the nucleic acid structure of its DNA.

Finally, it should be mentioned, but with caution, that we do, in fact, seem to be getting closer and closer to an understanding of the character of the process which permits certain configurations of molecules to be recognized as "alive." The most ancient life of which we know is that of certain algae, stored in rocks about two thousand million years ago. But the mind of man is not content to stop with that fact and that epoch, nor will it be content to be restricted to this planet.

We must and will drive on. If there are, in fact, fossils in meteorites coming from outer space, if protein-like macromolecules with the degree of complexity necessary for life can be produced under suitable conditions from inorganic chemicals, then we must know this. We can rest assured that the dignity of man will be thus enhanced rather than debased. For it is, after all, his brain which is meeting the challenge.

FLUORIDATION STATUS

January 1, 1963

42 towns adding fluoride to municipal water supplies.
17 towns with natural fluoride at optimal level.

Population of fluoridated supplies .......................... 1,163,740
Population of natural fluoride supplies ....................... 36,142

Total population served ........................................ 1,199,882

66.5% of urban population drinking water containing optimal amount of fluoride.

Three towns joined the ranks in 1962.

North Wilkesboro
Durham
New Bern

Burlington, Roxboro and Spray began fluoridation in 1963.
### Dates of Fluoridation of Cities and Natural Fluoridation

<table>
<thead>
<tr>
<th>No.</th>
<th>City</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Charlotte</td>
<td>4/25/49</td>
</tr>
<tr>
<td>2.</td>
<td>Winston-Salem</td>
<td>10/11/51</td>
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<tr>
<td>3.</td>
<td>Concord</td>
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<tr>
<td>4.</td>
<td>Salisbury</td>
<td>7/24/52</td>
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<tr>
<td>5.</td>
<td>Fayetteville</td>
<td>10/1/52</td>
</tr>
<tr>
<td>6.</td>
<td>Roanoke Rapids</td>
<td>11/18/52</td>
</tr>
<tr>
<td>7.</td>
<td>Lenoir</td>
<td>11/24/52</td>
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<tr>
<td>8.</td>
<td>Southern Pines</td>
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<td>9.</td>
<td>Rocky Mount</td>
<td>12/1/52</td>
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<td>Rockingham</td>
<td>12/19/52</td>
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<td>High Point</td>
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<td>Hickory</td>
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<td>Dunn</td>
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<td>9/16/54</td>
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<td>Sanford</td>
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<td>North Wilkesboro</td>
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<td>38.</td>
<td>Durham</td>
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<tr>
<td>40.</td>
<td>Burlington</td>
<td>1/16/63</td>
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<tr>
<td>41.</td>
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<td>3/14/63</td>
</tr>
<tr>
<td>42.</td>
<td>Spray</td>
<td>3/15/63</td>
</tr>
</tbody>
</table>

### Natural

- Ayden
- Bailey
- Belhaven
- Edenton
- Farmville
- Hamilton
- Littleton
- Plymouth
- Powellsville

### These Towns Could Fluoridate Water Supply NOW

- Alamance — Graham, Mebane; Anson — Wadesboro; Buncombe — Asheville; Burke — Drexel, Morganton, Valdese; Cabarrus — Mt. Pleasant; Caswell — Vance; Chatham — Siler City; Cleveland — Kings Mountain; Davidson — Denton; Davie — Mocksville; Durham: Forsyth — Kernersville; Gaston — Belmont; Bessemer City, Gastonia, Mt. Holly, Stanley; Granville — Creedmoor, Oxford; Guilford — Greensboro, Jamestown; Iredell — Statesville; Montgomery — Biscoe, Mt. Gilead; Moore — Robbins; Orange — Chapel Hill; Person — Roxboro; Polk — Tryon; Randolph — Asheboro, Ramseur, Randleman; Richmond — Hamlet; Rockingham — Leakesville, Spray; Rowan — Landis Rutherford — Forest City, Spindale; Stanly — Norwood; Surry — Elkin; Union — Monroe; Vance — Henderson; Wake — Apex; Warren — Warrenton; Watauga — Blowing Rock; and Wilkes.
One of the most stimulating and vigorously controversial books of the past year was a dramatic indictment of widespread, indiscriminate use of pesticides. The book is "Silent Spring." The author, Rachel Carson, appears to be able to remain calm amidst the storm of controversy her book brought about.

Rachel Carson does not intend to become a lecture hall crusader against the use of the poisonous pesticides she wrote about in her sobering book. She is a biologist who first won fame with books about the sea and shore. It was only to "put the facts on record" so the public could make its own decision, she says, that she undertook a four-and-a-half year project to warn about "Poisonous and biologically potent chemicals" she reports have been put indiscriminately into the hands of persons wholly ignorant of their potential harm.

A letter from a friend who experienced a community DDT treatment for mosquitoes and feared she would be caught in another widespread campaign against the gypsy moth got Miss Carson interested in the pesticide problem.

Miss Carson hopes her efforts will have some good results for fellow human beings and the world of nature that has been her abiding love since childhood. "We simply have to wait and see."

Meanwhile the controversy goes on—and responsible scientists in many disciplines take strong issue with the book. They say it is dramatic and well written—but selects glaring examples which are not representative of the proper use of the agricultural chemicals being used to control pests which damage or destroy food crops.
fessional journalist—not a scientist in the field of her discussion—and misses the very essence of science in not being objective either in citing the evidence or in its interpretation.

"The net effect is a stimulus to the anti-scientists—those in each generation who would block such steps forward as the development of vaccines, techniques of transfusion, experimentation with animals to advance surgery, and the control of malaria, tooth decay and typhus; and who seek to nullify the dedicated efforts of those who work to make us less subject to the whims of a hostile environment.

"I do not believe, as Miss Carson asserts in her story, that man, in the use of agricultural chemicals—essential to producing an adequate food supply—is in dire danger of irreversibly polluting his environment, poisoning his fellow man, and damaging the heredity of the human race.

"Our food has never been better or safer, our health and life span never more favorable, and never before has science done so much to improve standards of living in the sense of citizenship goals."

These are the views of C. G. King, President of the Nutrition Foundation, on the controversial book, "Silent Spring," by Rachel Carson.

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Health and Safety Tips

Sometimes it’s “household knee.” Or “policeman’s heel.”

By any other name it’s still bursitis, and it is one of mankind’s more painful and disabling ailments.

Bursitis means inflammation of a lubricating sac about a joint. The sac, called a bursa, is sort of like a collapsed balloon with some fluid inside. It is located at various places in the body where joints or tissues touch and rub, and without cushioning there would be friction.

Bursitis can hit at many points in the body, but most often occurs in the shoulder, elbow or knee, says a recent publication of the American Academy of Orthopedic Surgeons.

In almost every case bursitis follows unaccustomed strain or overuse of an extremity. By taking a little time to work up to your physical condition, and especially by working up the muscles that you plan to use in any repetitious motion outside your normal activity (strengthening your wrist and arm before you start painting your house, for instance), you can probably keep clear of this common and painful disease.

If you get bursitis, no one need urge that you see a doctor. The pain is so acute that you will be the first to seek relief.

In recent years science has learned much more about bursitis and there is much your doctor can do to relieve the pain and promote healing. One of the mainstays in treatment is aspirin. The newer cortisone-type drugs have been used with some success, and heat treatments and X-ray also have their place in bursitis therapy. In extreme cases surgery may be required. A treatment long used in this painful ailment is complete rest in bed. Anything that will lessen the chance of the afflicted joint being moved will ease the pain and speed healing.

Like any other bearings, your bursae stay trouble-free much longer if you warm them up slowly and let them get fully lubricated before your race your motor.
Membership Facts About the North Carolina Public Health Association

by Robert P. Lacey, M.D.
Chairman Membership Committee

NUMBER AND PERCENT MEMBERSHIP BY SECTION FOR LOCAL, STATE AND OTHER ORGANIZATIONS

<table>
<thead>
<tr>
<th>Section</th>
<th>Local Employees</th>
<th>State Employees</th>
<th>Other*</th>
<th>Total No. by Section</th>
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<td></td>
<td>No.</td>
<td>Joined</td>
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<td>1212</td>
<td>84.3</td>
<td>387</td>
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* Active members not employed by the State Board of Health or local health departments but work in related health fields.

MEMBERSHIP BY TYPE

Active Members ___________________________ 1531
Sustaining Members _________________________ 6
Honorary Members _________________________ 19
PERCENT MEMBERSHIP BY COUNTY

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<th>County</th>
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<tr>
<td>Burke</td>
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<tr>
<td>Camden-Chowan-Pasquotank-</td>
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<tr>
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<td>Beaufort</td>
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April, 1963

THE HEALTH BULLETIN 13
Duke’s Poison Control Center

Duke Hospital's Poison Control Center handled a record number of 547 cases during the past year.

The annual report of the Center for a 12-month period that ended Oct. 31 lists 195 poisoning cases caused by internal medications; 170 by household products; 91 by pesticides and insecticides; and 91 by other agents that include plants, cosmetics and shaving products.

Dr. Jay M. Arena, Duke pediatrician who heads the Poison Control Center, said that this year's total marks an increase of 183 cases over the previous record number of 364 managed by the Center during 1960-61.

He attributed the jump to increasing numbers of young children who form the group most vulnerable to accidental poisoning; to the growing number of drugs and household products available to the public; and to increased use of services offered by the Poison Control Center.

Dr. Arena predicted that accidental poisoning hazards will continue to increase as the nation's population increases and more potentially harmful products are put on the market.

On the positive side, he stated that architects and others concerned with home planning are becoming more concerned about safety features such as medicine cabinets with doors that are difficult for youngsters to open. Safety caps for medicine bottles are being used increasingly, he said, noting, however, that no such device can be totally effective.

Emphasizing the need for educating parents in the prevention of poisoning, Dr. Arena said that “many homes, where both parents work, are poorly supervised in this respect.”

He said that parents should give medicine to their children “in a matter of fact way” and never try to make a game out of it or suggest that drugs are candy. Also, parents on continuous medication should take their drugs in privacy and never before small children.

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Medical Self-Help Training

A program to prepare the civilian to meet his own health needs when deprived of the services of a physician in a national emergency was introduced to health, civil defense, and education leaders in late 1961; and to the general public in 1962. Entitled "Medical Self-Help Training," the program was developed by the Division in cooperation with the Office of Civil Defense of the Department of Defense and the American Medical Association's Council on National Security. It began as a research project started in 1959, to determine what an individual needs to know in order to survive and how this knowledge could best be presented to him.

Following extensive research by physicians, scientists, and environmental health specialists, and subsequent review by additional experts in the respective fields, program materials were developed and field tested in early 1961 and their production undertaken. Several such classes have been conducted among the staff of the State Board of Health.

The Medical Self-Help Training Program consists of two parts: One, a reference manual, Family Guide—Emergency Health Care, which serves as a resource document; and two, a formal training course to be given under medical supervision. The Medical Self-Help Training Course is based on the survival and health care principles contained in the Family Guide and is divided into 12 lesson subjects to be taught in 16 classroom hours: Radioactive Fallout and Shelter; Hygiene, Sanitation and Vermin Control; Water and Food; 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.

To make the conduct of the course as simple and as standardized as possible, a training kit has been produced which contains everything an instructor needs to teach a course: an instructor's guide, complete lesson texts, filmstrips, a projector and screen, examination forms, graduation certificates, and student handbooks. All materials are packaged in a compact fiberboard box.

The program was inaugurated by three national workshops held in different areas of the United States and attended by State leaders from the various health departments, civil defense and education offices, and State medical societies, and representatives of appropriate national medical, health and civil defense organizations. Program administration was accepted by the various States as a cooperative venture of the three State agencies and the medical society, and all implementation is being done under State aegis.

A total of 5,000 training kits were allocated to States in February and March, 1962, and training was instituted on a comprehensive survey and analysis basis to permit evaluation of the training material, methods of instruction and methods of implementation. Following this initial phase, necessary modifications will be made and an expanded program launched with the objective of training at least one member of each family in the United States.

In general, Medical Self-Help Training includes the basic information and skills a person needs to preserve life and health when medical and nursing care and public health protective measures are not available. It is supported by all governmental and private organizations with responsibilities in emergency activities, including the American National Red Cross.
DATES AND EVENTS

May—World Health Assembly, Geneva, Switzerland.
May 13-17—National League for Nursing (Biennial Convention) Atlantic City.
May 23—N. C. Heart Association, 14th Annual Scientific Sessions (co-sponsored by the N. C. Academy of General Practice,) Jack Tar Hotel, Durham.
June 9-13—Air Pollution Control Association, Pittsburgh.
June 16-20—American Medical Association (Annual Meeting)—Atlantic City.
July 24-25—Area 1 of American Association of Retired Persons Conference—Sheraton-Biltmore Hotel, Providence, Rhode Island.
August—Pan American Health Organization—Washington, D. C.

The 14th Annual Meeting and Scientific Sessions of the North Carolina Heart Association (co-sponsored by the North Carolina Academy of General Practice) will be held at the Jack Tar Durham, on May 23, 1963, from 8:30 a.m. to 5:00 p.m.
How Much Health Is There in "Health" Foods?

See Page 2

What We Know About Preventing Heart Attacks

See Page 8
How Much Health Is There in "Health" Foods?

Unscrupulous promoters, exploiting age-old fears and superstitions, are taking millions from a gullible public. Here are five fallacies they spread, and the scientific facts that refute them.

From the May 1963 issue of The Reader's Digest.
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Last year, more than ten million Americans, afraid that our staple foods are unhealthful, nutritionally deficient, and contaminated by deadly poisons, spent over a billion dollars on "health" foods.

Encouraged by self-styled "authorities" on nutrition, these people bypassed the grocery and supermarket and sought their "miracle" foods, "organically grown" vegetables and fruits, and other "natural" food products from "health food" stores and mail-order houses. The trend was pushed still further by at least 50,000 door-to-door salesmen of food supplements who were trained to talk like dietary experts. The resulting demand for these special foods-for-health forced many supermarkets and department stores to stock them.

Through the ages all sorts of queer beliefs, superstitions and fallacies have clustered about the foods we eat—and the foods we avoid. The difference today is that such prejudices are exploited by high-powered marketing and promotion techniques. Most "food faddists" are well-meaning people; they really believe that vigorous health lies in such things as brewer's yeast, raw sugar, seaweed, yogurt, blackstrap molasses. But many dishonest promoters deliberately spread falsehoods in order to sell their special foods and supplements.

"It is not true that the American food supply is deficient in vitamins, minerals and other essential nutrients," says the U.S. Food and Drug Administration. "This is the 'big lie' of nutrition quackery, the theme song of a persistent propaganda campaign to undermine public confidence in the nutritional adequacy of our staple foods. The truth

By Ronald M. Deutsch
is that the American food supply is unsurpassed throughout the world in both quantity and nutritional value."

The American Medical Association's Council on Foods and Nutrition adds tersely: "The health-food business is a waste of time and money."

"Many families," says Dr. Fredrick J. Stare, chairman of the Department of Nutrition of the Harvard School of Public Health, "throw away hard-earned money on useless products instead of buying wholesome, nutritious food at the grocery store for less money."

But the problem has a more serious aspect. "There are times," says Dr. Stare, "when persons with real health problems rely on products of nutritional quackery rather than on sound medical treatment. There are times when people actually create or contribute to their dietary deficiencies by abandoning their normal diets and turning to so-called health foods."

Says the Arthritis and Rheumatism Foundation: "Arthritis sufferers form one of the biggest targets for nutritional nonsense, and a large part of the 250 million dollars spent annually for worthless arthritis nostrums goes for 'health foods.'"

Cancer is "treated" with such things as grapes, red cabbage, vegetable juices. For several years the American Cancer Society has been warning the public to avoid a popular "dietary treatment" consisting of liver, vitamins, fruit juices, fresh vegetables (which, the advocates claim, must not be prepared in aluminum utensils), plus frequent coffee enemas.

Reminiscent of the old-time patent-medicine man, food quacks recommend their products for respiratory diseases, multiple sclerosis, cerebral palsy, tooth decay, graying hair and sexual frigidity. Garlic pills are sold for "sexual potency" and for the treatment of high blood pressure, wheat-germ oil and vitamin E for heart disease.

The promoters often rely on one of the oldest tricks of quackery—the testimonial. ("Vegetable protein cured my trouble. It can help you.") These testimonials are not always fakes. The man who was "cured" probably never had the disease in the first place; he simply made his own diagnosis. Or he may have had a condition which cured itself.

Here are five common fallacies, exploited by food faddists, together with some scientific facts which negate their claims.

Much American soil is deficient in nutrients; food grown in such soil lacks qualities needed for health.

When soils are worn out only the yield is affected. On poor soil the farmer will, for example, get fewer carrots, and each carrot may be smaller. But, ounce for ounce, the carrots will be every bit as nutritious as any others!

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As for chemical fertilizers that the faddists deplore: iron is iron, nitrogen is nitrogen, whether present in the soil or added as fertilizer. These natural chemicals make crops more bountiful.

Says the U.S. Department of Health, Education and Welfare: "There is no scientific basis for the theory that crops grown on poor soil, or with the help of chemical fertilizers, are nutritionally inferior in any way."

Foods are robbed of essential nutrients by over-processing.

"Modern processing methods preserve nutritional values or restore them to foods," says the Food and Drug Administration. "Americans have to go out of their way to avoid being well nourished."

Faddists claim that bread is impoverished when the bran and wheat-germ are removed in milling the flour. Bran, the largely indigestible wheat hull, makes bread coarse. The soft, oily wheat germ gives it a flavor and color which many consumers do not want.

What is lost? Some B vitamins, which are replaced, and some protein, which is abundant elsewhere in the American diet. "Whole-wheat flour," says Dr. Stare of Harvard, "has not been proved superior to enriched, refined flour for the nutrition of man. It is not necessary in the average American diet today."

Some faddists demand flour ground on stone—they say the mild heat of steel-grinding destroys certain enzymes in wheat. True—but the enzymes are of no nutritional importance, and the heat of baking is so much higher that to get those enzymes the faddists would have to eat their flour raw.

Some insist on "raw" sugar instead of the refined form. Says Dr. Cora Miller of the Greater Los Angeles Nutrition Council: "The only thing of importance that white sugar lacks and raw sugar contains is dirt."

They say that raw milk is essential, because pasteurization destroys some vitamin C. They overlook the fact that milk is naturally a negligible source of vitamin C, which we should get from fruits (chiefly citrus) and vegetables in a balanced diet. Loss of some vitamin C through pasteurization is a minuscule price to pay for protection against the serious diseases raw milk can carry.

Poisons are being added to our food—through agricultural sprays, preservatives, and certain aluminum cooking utensils.

The use of agricultural sprays that enable the farmer to control insects, weeds and plant diseases is controlled by law. No spray may be used in such a way that harmful residue appears on the plant. In case of accidental contamination, the offending crop must be destroyed.

Such contamination is uncommon, but when it does occur it is highly publicized. (Witness the cranberry scare a few years ago. The danger proved negligible; yet the nation was alerted and shipments were seized.) Says Commissioner George Larrick of the Food and Drug Administration: "There is no evidence that the use of insecticides is causing Americans to become ill as a result of eating food."

Many faddists fear the chemicals that are added to foods—to prevent deterioration or spoilage, for example. Some of the commonly used additives were found to be harmless 70 years ago, and have been used safely ever since. The safety of new additives has to be proved to the satisfaction of the Food and Drug Administration before they can be used.

As for the myth that aluminum cooking utensils "poison" food, the American Medical Association says: "Though there are a few who make it a profitable business to keep this prejudice
alive, it has been proved over and over that there is no harm in aluminum."

Most diseases, including cancer and arthritis, are caused by poor nutrition, and can be prevented or cured by diet. Medical authorities are unanimous in denouncing this as untrue and harmful to the nation's health. "There are some diseases that are caused by dietary deficiencies," says the U. S. Department of Health, Education and Welfare, "but these are rarely encountered in the United States." The reason why they are rare is attributable not to the consumption of specific "health foods" but to the balanced diet of a variety of staple foods—meat, fish, fruits, vegetables and cereals—which has become the American standard.

Discussion of Common Food Fallacies
Continued

Doctors are convinced that only nutritional deficiencies can be cured by diet, and these deficiencies play no part in such diseases as cancer and arthritis. Clinical nutrition, when it is needed, "is a medical specialty," warns Dr. Robert E. Olson of the University of Pittsburgh Graduate School of Public Health. "It should be practiced by physicians and allied professional personnel, rather than by high-pressure salesmen."

The United States is a less healthy nation than it used to be; we must go back to the "natural" foods eaten years ago.

At the turn of the century, there was virtually no science of nutrition. Even the vitamins were unknown. Fruits and vegetables were available in short seasons. Proteins were costly, hence far less widely consumed; fats and starches were the principal staples in the diet. Life expectancy was 47 years.

Today life expectancy is 70. Many deadly diseases have been conquered. True, there is more cancer, more arthritis, more heart disease. But medical authorities maintain that this is because more of us are living longer; hence we have increased our chances of getting them.

Today, American children grow an average of two to three inches taller, and reach their full growth five years sooner than they did a half century ago. Better nutrition—in the form of well-balanced diet—has played a key role in this story. It is foolish to talk of turning back.

Nevertheless, that is what the food faddists seem to advocate. And, with their noisy advocacy of the raw, natural, primitively processed foodstuffs that were common when Grandfather was a boy, the "health food" business is booming. The federal agencies despite increased enforcement budgets, are unable to cope with the growing problem. Says FDA Commissioner Larrick: "Keeping track of sales arguments used in the privacy of the home by 50,000 doorto-door canvassers is too much for the few inspectors who are available for this duty."

What is the solution? Medical and government authorities believe it lies in educating the consumer to guard against food nonsense. This education can be short and sweet. The A.M.A.'s Council on Food and Nutrition sums it up in a simple statement, with which every responsible physician and nutritionist agrees: "There are no health foods."
June 5, 1963

Editor
The Health Bulletin
North Carolina State Board of Health
608 Cooper Memorial Health Building
225 N. McDowell Street
Raleigh, North Carolina

Dear Sir:

Your comment on the book "Silent Spring" by Rachael Carson in THE HEALTH BULLETIN, April 1963, p. 10, was noted with some concern. By the use of the very extensive quotation from C. G. King, President of the Nutrition Foundation and Past President of the American Public Health Association, and calling him "one of the most responsible and objective critics of the indictments," in Miss Carson's book you have essentially given him the last word in this controversial problem. However, we wish to disagree in very strong terms with this implication.

Members of the American Public Health Association received, by virtue of being on the APHA mailing list, the considerable literature package from the Nutrition Foundation in rebuttal to "Silent Spring." However, this material can be described as presenting "almost solely selected information," to use King's own phrases, and glosses over the known facts of the considerable misuse of large-scale insecticide applications. The point that we wish to stress is that the large-scale use of pesticides is a new phenomenon and it must be studied and carefully regulated before it can be shown that there is no harm in their use and no substantial accumulation in humans or animals.

The recent report of the Presidential Science Advisory Committee on the use of pesticides stresses in no uncertain terms the need to use these materials with the greatest of care to avoid their accumulation in the environment as well as in man and other living organisms. The use of pesticides in modern agriculture has brought about a revolution in the quality control of crops from which we all benefit. However, we must initiate research which will help identify the optimum methods and amounts of application so as to protect the health of the public. Damage done to health by the pesticides in chronic exposure may very well be hidden in the normal illnesses to which individuals are prone. Extensive toxicological and epidemiological research needs to be initiated in this area.

Very truly yours,

Daniel A. Okun
Head

Charles M. Weiss
Professor of Sanitary Science
What We Know About Preventing Heart Attacks

by Jeremiah Stamler, M.D.

The author, a physician, university professor and director of a research group for the Chicago Board of Health, reports the known facts about heart attacks. At the same time, he lists the simple precautions (diet, weight control, exercise) which could, medical surveys reveal, reduce the heavy toll.

As most adult Americans are painfully aware, from intimate experience with their families, friends and associates, diseases of the heart and blood vessels are responsible for an absolute majority of all deaths in the United States.

Among the several cardiovascular ailments, one takes precedence as the No. 1 killer: arteriosclerotic heart disease (heart attack, coronary disease). It alone is responsible for almost thirty percent of all deaths. In white males in the 45-54 age group, it causes more than one third of all deaths.

The underlying disease process responsible for heart attack is severe atherosclerosis or hardening of the main arteries supplying the heart muscle. Severe atherosclerosis produces extensive narrowing of these coronary arteries and leads to a major complication, that is, thrombosis, or clot formation, resulting in complete block of blood flow and death of heart muscle (myocardial infarction). The essence of the heart attack problem, therefore, is severe atherosclerosis.

Since World War II, we have made major research advances toward the possibility of preventing heart attacks, at least in middle age. In this discussion, we shall review the immediate achievements signaling a possible breakthrough against this dread disease, and present a report on investigations currently in progress.

Five years ago, our research group began an intensive long-term study of cardiovascular diseases in the labor force of one large Chicago corporation, the Peoples Gas Light & Coke Company. Extensive data on the men, age 40 to 59, was collected and analyzed for 1958, and the findings further clarify the situation in our country today.

Almost one third of the middle-aged men were found to have one or more detectable abnormalities in the cardiovascular system: disease in blood vessels, hypertensive heart disease, arteriosclerotic coronary heart disease. In the population of employed middle-aged Americans, two separate but interrelated processes—high blood pressure
hypertension) and hardening of the arteries (arteriosclerosis, atherosclerosis)—are the major cardiovascular problems today.

The foregoing findings present a "still picture" of the disease situation in a population at a given point in time. For both practical and research reasons, it is at least as important to get a "moving picture"—an analysis of the rate of development of new disease over a period of time in persons originally healthy.

We therefore studied another group of men, age 50 to 59, who had had no history of heart attack up to 1954, and observed them for the next four years. Our findings closely paralleled results obtained by the Du Point Company, the Western Electric Company in Chicago, and other industries, in community studies in Los Angeles, Albany, Minneapolis and Framingham, Massachusetts. The four-year incidence rate of new coronary disease in the middle-aged men employed by the gas company was in the order of 60 per 1,000, or 15 per 1,000 per year.

The Victims: One Out of Every Five

Using arithmetic, then, we can say: The average, presently healthy, middle-aged American male, free of clinical coronary disease (as far as present diagnostic methods can reveal), has about one chance in five of developing this disease in middle age, that is, before age 65. It is, indeed, a high average risk.

The incidence rate of about sixty per thousand in four years is fairly uniformly experienced by all subgroups in our middle-aged urban male population: by Negro and white men, indoor and outdoor workers, men doing sedentary, light or medium activity work, and by white and blue-collar workers (with a statistical hint that the blue-collar, semiskilled, unskilled and service workers may be a little better off, but not remarkably so). Contrary to earlier misconceptions, the recent studies have yielded solid, consistent data showing that the toll exacted by coronary disease falls heavily upon all middle-aged American males, regardless of the kind of work they do, their income, scale of living, ancestry.

The disease, then, is by no means confined to the managerial, executive, supervisory groups. It is "epidemic," to use Dr. Paul Dudley White's term, throughout our middle-aged population.

A further important characteristic of the disease is represented in data recently presented at the Fourth World Cardiological Congress in Mexico City. The findings were accumulated during several years of follow-up by the Public Health Service Study of more than 5,000 men and women in Framingham, Massachusetts. They document a particularly pernicious aspect of the coronary disease problem. (Our study of the Gas Company men from 1954 through 1957 yielded like findings.) In the 5,000 Framingham men and women, originally free of coronary disease, 242 developed it over the years. Of the 242, 83 (34 percent) died within three weeks of becoming ill; 46 (19 percent) experienced sudden death within one hour, that is, before any medical care could be given.

Objective: Prevent the First Attack

These facts deserve emphasis because they compel an important conclusion in view of the high rate of sudden death: If effective progress is to be made against this disease, if a real breakthrough is to be achieved, at least in middle age as a first objective, the focus of our effort must be on primary prevention. That is, the prevention of the first attack!

As important as it is to improve treatment of the acute attack (for those surviving long enough to receive it), as
important as it is to improve long-term therapy—and the importance here cannot be overestimated—major emphasis must be on primary prevention. Our cardinal problem, therefore, is: How much do we know about primary prevention?

One of the remarkable achievements of recent research is the identification of risk factors in developing severe heart disease. And based on this is the development of techniques to detect susceptible individuals before they become sick.

It is an axiom of preventive medicine that in order to develop truly effective primary prevention programs, it is essential to focus the effort on the susceptibles. In polio, for example, children and pregnant women are susceptible. Therefore, while an effort is made to immunize the entire population, particular attention is devoted to inoculating the susceptibles.

One of the major advances in the field of atherosclerotic coronary disease in recent years is the recognition that people vary markedly in their susceptibility to it. The average risk of the average American male (one chance in five of a heart attack in middle age) is, like many averages, an abstraction of only limited meaning. It is an average of very different risks, for there are those who have as high as one chance in two, or two chances in three or worse, of developing coronary disease before age 65. At the other end of the distribution, there are more fortunate individuals with a risk of only one in 20, one in 30, or one in 40.

Can we identify susceptible individuals before they develop overt clinical disease? The answer is "Yes."

Susceptibles and Risk Factors

The first point worth emphasizing is the remarkably greater susceptibility of men compared to women, particularly prior to age 45, that is, before the onset of menopause in women. Middle-aged women are in general highly resistant to the disease. This resistance is the single main factor accounting for the six-year greater life expectancy of women and for the fact that there are more women than men in the United States, and that early widowhood is a major social problem.

In the Framingham study, there were no heart attacks in women under age 40, whereas there were 21 per 1,000 in men. The contrast was similar for the age group 40 to 49. This sex differential began to lessen only in the age group 50 to 59, and gradually decreased thereafter.

First of all, therefore, in the evaluation of risk, it is essential to recognize that men are generally more susceptible than women. This fact, however, should not be exaggerated, since women after the menopause develop an increasing coronary proneness.

The relationship between three key variables—blood pressure, weight and serum cholesterol—and coronary proneness is illustrated in the Framingham study. Men with elevated blood pressure developed six times as many heart attacks as men with normal blood pressure. Overweight men developed two times as many heart attacks as men who were not grossly overweight. Men with high serum cholesterol levels developed six times as many heart attacks as men with lower levels. Those normal with respect to all three variables had only 10 heart attacks per 1,000 in four years, a risk of about one in 20 developing coronary disease before age 65. Those with two or three of these abnormalities had 143 attacks per 1,000 in four years, a risk of about one chance in two of developing heart attack in middle age. These can be designated our high-risk men. The difference between the two groups is 14-fold.
Another important risk factor is revealed in the Framingham and Albany studies, involving several thousand men during six- and eight-year periods. The findings showed a more than sixfold difference in fatality rate from myocardial infarction in cigarette smokers vs. non-cigarette smokers. They also showed a difference in rate of all heart attacks (fatal and non-fatal) that was more than threefold.

Up to this point, consideration has been given to findings that are not direct measurements of the status of the heart or coronary arteries per se. Rather, they are measurements of physiological variables (blood pressure, weight, serum cholesterol) known to influence the development of hardening of the arteries or atherosclerosis. These variables are therefore properly designated as coronary risk factors. Other coronary risk factors include: diabetes, thyroid disease, kidney abnormalities, lack of exercise, and a history of blood vessel disease (atherosclerosis, hypertension) occurring prematurely (before age 60) in members of the family.

Medicine has also increased its knowledge in another area of vital importance for predicting risk. It has been definitely shown that certain abnormalities revealed by the electrocardiogram (frequently found during routine examination of presumably healthy people) also portend an increased likelihood of developing heart attacks during the ensuing years. The electrocardiogram is therefore an invaluable means of detecting persons with coronary disease before they have become clinically ill.

In the Framingham study, an assessment was made of the relationship of three measurements—the electrocardiogram, blood pressure and serum cholesterol—and risk of developing coronary disease. Those men normal with respect to all three experienced very few heart attacks in later years. Those with one abnormality experienced a 12-times higher attack rate; those with two abnormalities a 20-times higher rate; and those with all three abnormalities experienced a 33-times higher rate!

These statistics illustrate with a vengeance the value of these measurements in detecting coronary-prone persons—and the challenge such persons present to preventive medicine.

How Many Are Coronary-Prone?

The next relevant question: How frequently are coronary-prone persons encountered in our population? Our studies at Peoples Gas yielded highly significant data on this matter. Again, the data typifies the general situation prevailing throughout our country.

Over 500 men per 1,000 (more than fifty percent) were found to be overweight, 284 per 1,000 markedly overweight; 283 per thousand had a high serum cholesterol level; 103 per 1,000 had frank high blood pressure; more than 400 per 1,000 were heavy smokers; 175 per 1,000 had a positive family history of premature blood vessel disease.

The next logical step is a relatively simple one: Something can be done about most of these abnormalities. Even with respect to family history, there is no reason for fatalistic hopelessness. For it is now known that to a large degree a family tendency to premature coronary disease results from familial tendencies to high serum cholesterol, to obesity, to high blood pressure, to diabetes. And it is quite possible for contemporary medicine to treat every one of these abnormalities, if they are recognized early. It is possible, therefore, to intervene and attempt to head off both coronary disease and the effects of family background.

In any case, the coronary risk factors are often present without a positive
family history and can be treated. High blood pressure can be successfully treated by diet and drugs, particularly when detected early, before hypertension is severe and serious organ damage has developed. Obesity can also be treated by reliable, professional methods, although long-term control is a tough problem. Heavy smoking can also be eliminated (another tough problem). We now know that high serum cholesterol can be lowered in most cases by dietary means entirely compatible with the pleasure of good eating. Diabetes can also be controlled, like other risk factors.

It is a simple logical conclusion that if these abnormalities make for increased likelihood of heart attacks, and they can be detected before attacks occur, and can consequently be corrected and controlled, then the possibility arises of preventing heart attacks.

How valid is this logical possibility? At present, we must give an interim answer. Several sets of data are very encouraging. They show, for example, that heavy cigarette smokers who quit before they become ill will lessen their coronary proneness down toward the non-cigarette smoker's level. This is a very encouraging fact.

Life insurance data are also available, indicating that obese men who reduce and stay reduced (in order to be rated at standard rates by insurance companies) also have a subsequent mortality experience like that of men who are not overweight. In studies over the last 5-to-10 years, the new hypertension drugs show that control of high blood pressure leads to fewer heart attacks, heart failures, strokes and kidney failures—complications that produce illness and premature deaths in hypertensives.

While it is a debatable question, there is evidence indicating that well controlled diabetics suffer significantly less from the major complications of diabetes (heart attacks, heart failure, strokes and other vascular complications) than do poorly controlled diabetics.

Finally, there is a considerable accumulation of data collected in central Europe after World War I, and in the occupied countries during World War II, indicating that the changes in diet, exercise and smoking which came from wartime conditions were associated with significant declines in mortality rates from heart attacks.

All these intriguing pieces of information support the logical conclusion that treatment of coronary risk factors may be effective in preventing the disease.

When the American Heart Association arrived at the conclusion, a few years ago, that available data warranted a statement on diet, heart attacks and strokes, they issued such a statement to the profession and the public. It was carefully formulated so as to be neither too negative nor too positive. This statement emphasized the possibility of prevention—not the certainty at this juncture, because the available data are not comprehensive enough to warrant our speaking about the certainty of prevention.

**Mass Field Trials for Prevention**

In order to clarify the current situation, an analogy is useful since it has considerable validity. The problem of preventive approaches to coronary disease stands today at the point where polio research stood in 1953. By that time, researchers had shown that a vaccine could be safely given. "All" that had to be done was a mass field trial to test whether such a vaccine did protect children in the mass. The results are history.

Similar mass field trials are now needed to test the ability to achieve
effective primary prevention of heart attacks by nutritional, hygienic and pharmacologic means. The trials needed are essentially similar in basic principles to those needed for polio. However, specific features of atherosclerotic disease put a special stamp on the field trials against coronary disease:

The preventive measures are not vaccines, rather changes in living habits. The subjects are not children, rather middle-aged men.

The period of follow-up is not one summer, rather four to five years.

These concrete aspects create unique problems for mass field trials on coronary disease.

Since 1957, pilot studies have been in progress. Ours in Chicago was one of the first. We were very happy to work closely with medical departments in industry, not only with Peoples Gas, but also with Standard Oil, Union Carbide and the Sun Times-Daily News. By now, considerable experience has been accumulated in Chicago, New York, Cleveland, Los Angeles and elsewhere.

Our Coronary Prevention Evaluation Program works long-term with high-risk men in the 40-59 age group. It strives to correct, and keep corrected (the decisive challenge), five abnormalities making for coronary proneness: overweight, high serum cholesterol, high blood pressure, heavy cigarette smoking and lack of exercise. Our research physicians and nutritionists work closely with the men and their wives to effect a permanent change in living habits. Short-lived efforts (the frequent American pattern of going on a diet, then going off) are futile. A sustained correction—for years—must be achieved if anything is to be accomplished.

The dietary approaches required to attain these goals have been worked out in great detail. In the language of nutrition, they involve diets moderate in total calories, total fats, polyunsaturated fatty acids and carbohydrates; low in saturated fatty acids and cholesterol; and high in all essential nutrients (proteins, amino acids, vitamins, minerals). In terms of foodstuffs this means: Eat more low-fat dairy products...
(skim milk, buttermilk, cottage cheese); more lean cuts of meat and poultry and moderate meat portions (four to six ounces, not 12 to 16); more seafood; more fruit desserts; more green and yellow vegetables. This also means: Eat less cream, cheeses, butter; fewer fat cuts of meat; fewer cakes, pies and cookies. It means moderation with potatoes, rice, spaghetti and breads; with jellies, jams and honey—and alcoholic beverages.

Pages and pages of delightful recipes are available to convince even the most skeptical that pleasure lies ahead for those who follow this way of good hope for prevention of heart attacks. Indeed, one of the major lessons of research experience to date is that one of the pleasures of the good life—good eating—can and should remain with us as we make the effort to end the contemporary epidemic of premature heart attacks.

Based on positive experiences in Chicago, New York, Los Angeles, Cleveland and elsewhere, a national cooperative study has been organized to explore further the feasibility of mass field trials. The first studies along this line were recently launched. Grants were awarded for this purpose by the National Heart Institute; close cooperation and support are coming from the American Heart Association and its affiliates; and work is proceeding in Chicago, Baltimore, Boston, Minneapolis and Oakland in this cooperative undertaking. A decade of hard work still lies ahead to complete the overall job.

This, then, is a progress report, a report of significant advances by many investigators whose intensive efforts have been made possible by steadily increasing research support from the Heart Association and the National Heart Institute of the U. S. Public Health Service, that is, support from the American people in the form of their voluntary contributions and tax dollars.

But major research work remains to be done still, and with it some key questions arise: What to do in the interim? What should medicine do? What should industry do? What should the public generally do?

Many signs point to the possibility of preventing heart attacks, but at the same time knowledge giving certainty is not yet in hand. And therefore the problem of an interim approach arises.

Two alternatives are possible. One might be called a more conservative alternative, and goes something like this: “All the new research information is very interesting and nice. It’s good to see the research fellows making progress. We wish them luck. Admittedly, though, they haven’t all the answers yet. In the meantime, therefore, we’ll just wait and see.”

The other approach is: “The facts point very strongly in certain directions. They indicate the possibility of prevention. Moreover, and this is very important, they indicate that this possibility can be achieved pleasantly and—even more important—safely, because the procedures involved (nutritional, hygienic and pharmacologic) entail minimal risks.” It would seem, then, that a sound interim approach (particularly for the higher risk individuals) would be to attempt to take advantage of prevention possibilities.

What does this means for industry?

First, it would seem to mean a major undertaking on the part of industry to cooperate in the effort to assess risk and detect susceptible persons.

Second, it would seem to mean continued and expanded close cooperation between industry and medicine in developing prevention programs.

Over the Hump?

What, then, are the possibilities for the years ahead? There is reason for cautious optimism. From 1920 until
the late 1940’s, the total death rate from all disease of the cardiovascular system went up steadily for white men, age 45-54, in the United States. In the late 1940’s, the death rate stopped rising for the first time in over 30 years. Then, in the early 1950’s, it began to dip, and from 1950 to 1959 a phenomenon occurred that has been overlooked and unheralded: an actual decline, modest but definite, in mortality from the cardiovascular-renal diseases, for all sex-race groups. The toll is still great, but it is possible that we are now over the hump.

In 1917, Chicago—to cite one example—experienced 1,216 deaths from diphtheria, many of them from diphtheritic heart disease. Who would have predicted then that in a few years this disease would be virtually eliminated?

In 1920, when rheumatic heart disease was a major scourge in the U. S., who would have predicted that the death rate in children, teenagers and young adults would be cut so drastically that by 1959 it would fall to 10 percent of the 1920 figure?

These may well be portents of what lies ahead as a result of the mounting research efforts to prevent premature sickness, disability and death from high blood pressure and hardening of the arteries.
THE 1963 General Assembly dealt with a number of matters concerning responsibilities of the State Board of Health as well as with other health related matters.

All five bills in the legislative program sponsored by the State Board of Health were enacted. These included legislation in the following areas: air hygiene; the sanitary construction and operation of public swimming pools; improving death certificate procedures; migrant labor camp sanitation; and authority for local health departments to collect fees for certain services.

These acts and other legislation of interest are given in summary on the following pages.

SENATE BILL 100 — AN ACT RELATING TO REPORTING CANCER CASES TO THE STATE BOARD OF HEALTH.

All pathologists in the State are required to report to the State Board of Health all cancer cases which they diagnose. These cases will be reported directly to the Office of Vital Statistics, rather than through the local health departments. G. S. 130-184, a prior law which requires the reporting of cancer by all physicians through the local health departments, was not repealed by the new law. Effective July 1, 1963.

SB 146 — AN ACT TO AMEND CHAPTER 130 OF THE GENERAL STATUTES SO AS TO AUTHORIZE THE ESTABLISHMENT OF A STATE AIR HYGIENE PROGRAM BY THE STATE BOARD OF HEALTH.

(Original Bill sponsored by the State Board of Health.) This act authorizes and empowers the State Board of Health to create a State Air Hygiene Service. This Service is authorized to advise, consult and cooperate with other State agencies, local governmental units, industries, the Federal Government and other interested groups on problems relating to air pollution. The personnel of this Department will collect information relative to air pollution, prevention and control, as well as initiate, supervise and encourage research and studies of air quality, methods of examination and appraisal. They will also develop procedures and standards of State-wide application with special emphasis on the effect of air contaminants. Local agencies will be encouraged to handle air pollution problems to the maximum extent permitted by their resources. However, technical assistance will be provided by the State Air Hygiene Service to local and regional air pollution programs. The Act provides for persons engaged in operations that may result or contribute to air pollution to supply to the Air Hygiene Service certain requested information when available concerning the pollution, such as composition of effluent, sources of emission and rate of discharge. Effective July 1, 1963.

The Act creates a new Department of Mental Health and was effective upon ratification. The Act provides for four major divisions: Hospitals, Mental Retardation, Community Mental Health Services and Business Administration. State Board of Health programs in mental retardation are not directly affected by the Act. It stipulates that County Commissioners, city councils, combinations of these or private agencies may establish mental health clinics under certain conditions. The State Department of Mental Health will deal with these clinics as a part of the state program. The State Board of Health will, of course, cooperate with the new Department of Mental Health and all of its facilities. We are sure that each local health department will do the same. Effective upon ratification June 24, but practical effective date July 1, 1963.

SB 208 — AN ACT TO APPROPRIATE FUNDS FOR THE TREATMENT OF CHILDREN SUFFERING FROM CYSTIC FIBROSIS AND OTHER ERRORS OF METABOLISM.

This Act carries an appropriation of $25,000 for the biennium to provide medical services for children with cystic fibrosis and related diseases. It will enable the State Board of Health to provide complete medical services for 20-40% of the children with cystic fibrosis who are in need of financial support—approximately 40 children. The program will develop interest in cystic fibrosis and encourage research. Effective upon ratification June 24, 1963.

SB 265 — AN ACT TO REVISE CERTAIN SECTIONS OF THE VITAL STATISTICS LAWS OF NORTH CAROLINA.

(Original Bill sponsored by the State Board of Health.) Several amendments to the Vital Statistics Laws were enacted, among which was a provision requiring the attending physician to make the medical certification on a death certificate before burial or within 72 hours. This is the same limitation that is placed on the funeral director for filing a completed death certificate. The charge for violation of the Vital Statistics Law in regard to the filing of death certificates and obtaining a bureau-transit permit was changed from a felony to a misdemeanor. The former felony provision proved to be impractical from the standpoint of obtaining a conviction. Also included was a provision authorizing the State Board of Embalmers and Funeral Directors to revoke the license of any funeral director who violates this Act. In addition to the amendments sponsored by the State Board of Health, the Legislature amended G. S. 130-69 to require the local registrar to file copies of birth and death certificates with the Register of Deeds within seven days. Effective upon ratification May 22, 1963.

SB 384 — AN ACT TO PROVIDE A PROGRAM TO DEAL WITH THE PROBLEM OF MENTAL RETARDATION IN THIS STATE AND TO MAKE APPROPRIATIONS THEREFOR.

This Act permits the establishment of three regional centers for diagnosis, evaluation and rehabilitation of mentally retarded children during the next two years. (A total of six eventually.) It permits the development of additional diagnostic services at county levels by providing funds for public health nurses

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and for physician services. The Act permits development of a medical team at
the State level to be concerned solely with the retarded child. These provisions
will permit: the evaluation of an additional 900 children a year with, or suspected
of, mental retardation; the screening of 3,000 to 5,000 additional children for
mental retardation and other disorders; the development of services—health, wel-
fare and education—for retarded children; and the development of a better un-
derstanding of the retarded child. Effective upon ratification June 12, 1963.

SB 420 — AN ACT RELATING TO THE AUTHORITY OF LOCAL BOARDS OF HEALTH
TO ACCEPT FEES.

(Original Bill sponsored by the State Board of Health.) Local departments of
public health are concerned with establishing public health services for the
population at large. Although not all health services are rendered directly by
health departments, they nevertheless are concerned that services are available.
A recent trend has been the extension of public health nursing services and physi-
cal therapy services to individuals in need of bedside nursing and physical
therapy because of chronic illness. Where such services can be made available,
the individuals can be cared for in their homes rather than having to be hospital-
ized. This need exists not only for persons with low incomes, but for all seg-
ments of the population. Since practically no county in North Carolina has private
facilities through which these services can be received, the function logically was
assumed by a number of local health departments. This legislation will permit
county health departments to render services to persons in need of the services,
and to collect the cost of such services from those able to pay, or from agencies
authorized to pay such costs for others. At the present time, only about one-fourth
of all North Carolina counties are providing the special services referred to above.
Effective upon ratification June 21, 1963.

SB 530 — AN ACT AMENDING CHAPTER 104C OF THE GENERAL STATUTES, RE-
LATING TO ATOMIC ENERGY RADIOACTIVITY AND IONIZING RADIATION.

This Act authorizes a State-United States Atomic Energy Commission agree-
ment whereby the State Board of Health is to license and regulate the uses of
certain radioactive materials in a manner designed by Federal law and State law to
protect public health and safety from significant radiation hazards in North Caro-
HB 9 — AN ACT TO REQUIRE SEAT SAFETY BELTS FOR ALL NEW MOTOR VEHICLES REGISTERED IN NORTH CAROLINA AND MANUFACTURED, ASSEMBLED OR SOLD AFTER JANUARY 1, 1964.

This Act improves traffic safety factors by requiring that every new motor vehicle registered in this State after January 1, 1964 shall at the time of registration be equipped with at least two sets of seat safety belts for the front seat. Effective January 1, 1964.

HB 34 — AN ACT TO AMEND CHAPTER 131, ARTICLE 13A, OF THE GENERAL STATUTES SO AS TO ELIMINATE DUPLICATION OF CERTAIN SUPERVISORY ACTIVITIES OF DIFFERENT STATE AGENCIES BY EXEMPTING X-RAY FACILITIES OF CERTAIN HOSPITALS FROM THE PROVISIONS OF CHAPTER 104C OF THE GENERAL STATUTES.

This Act makes the Medical Care Commission responsible for regulating some 200 (mostly hospital) x-ray facilities licensed by the Commission (GS 131-126.) The effective radiation protection program for which the State Board of Health has been responsible since 1959 will now depend under this Act upon assurance of State standards of personal protection kept consistently uniform by the Commission for some 700 to 800 x-ray machines, and similar standards maintained by the State Board of Health for some 2,000 other x-ray machines and all radioactive materials in North Carolina. No inconsistent local regulations are permitted. Effective upon ratification March 19, 1963.

HB 291 — AN ACT AUTHORIZING THE STATE BOARD OF HEALTH TO ESTABLISH RECOMMENDED MINIMUM STANDARDS FOR THE DESIGN, CONSTRUCTION, OPERATION AND MAINTENANCE OF PUBLIC SWIMMING POOLS.

(Original Bill sponsored by the State Board of Health.) The provisions of this Act authorize, empower and direct the State Board of Health to prepare standards relative to the design, construction, maintenance and operation of public swimming pools. In general, these standards pertain to the sanitary aspects of the pool, bathhouse and operating equipment. They are to be made available to the local health departments upon request, and may be used by them as a guide in preparing swimming pool regulations. Residential pools, lakes, ponds and other natural bathing places are exempt from the provisions of this Act. It is believed that the preparation and use of these standards will be of distinct benefit to contractors, architects and engineers in the design and construction of pools since until now there have been no official standards which these professional groups could follow. Effective January 1, 1964.

HB 446 — AN ACT TO AMEND THE WORKMEN’S COMPENSATION ACT TO PROVIDE COMPENSATION FOR DISABILITY OR DEATH RESULTING FROM EXPOSURE TO RADIOACTIVE MATERIALS.

This Act now will provide for employees’ compensation for job-caused injury or disease from all forms of ionizing radiation (previously only radium and x-ray.) Hence uniform State regulations over some 281 AEC licenses outside North Carolina is as significant as the 188 intra-state licenses to local employers and their employees' personal health, especially if radioactive materials may be added to other exposures to one or more of the hundreds of x-ray machines. Effective upon ratification May 24, 1963.
HB 461 — AN ACT REGULATING THE SANITATION OF AGRICULTURAL LABOR CAMPS.

(Original Bill sponsored by the State Board of Health.) In accordance with the provisions of this Act, no person may operate an agricultural labor camp for ten or more seasonal or temporary workers without first obtaining a permit from the local health department having jurisdiction over the area in which the camp is located. Such permits are valid for a period of one year. The sanitary requirements as provided for pertain to the sanitation of the camp area in general, water supply, garbage and sewage disposal, bathing facilities, adequacy of shelter, lighting, ventilation and sanitary food facilities, where central feeding facilities are provided and operated for pay. The State Board of Health or its duly authorized representative is responsible for the enforcement of this Act. In addition to the foregoing provision, certain duties and responsibilities are described for the Crew Leader and camp occupants and employees. This legislation will, for the first time, establish legal minimum requirements for the construction and operation of these camps, and while not incorporating all needed provisions, it is a beginning. Effective January 1, 1964.

HB 527 — AN ACT TO AMEND CHAPTER 20 OF THE GENERAL STATUTES OF NORTH CAROLINA TO PROVIDE FOR BREATH TESTS FOR INTOXICATION IN CRIMINAL CASES INVOLVING DRUNKEN DRIVING.

The State Board of Health is responsible for approving methods for analyzing the person's breath and setting standards of qualification and issuing permits to individuals qualified to administer the test. Effective January 1, 1964.

HB 606 — AN ACT TO AMEND G.S. 153-9, SO AS TO GIVE BOARDS OF COUNTY COMMISSIONERS CERTAIN REGULATORY POWERS.

Many police powers are granted to Boards of County Commissioners by this Act. However, the authority of local Boards of Health to adopt rules and regulations for the protection and promotion of public health is specifically exempt from the provisions of this Act. A number of counties are exempt. This Act does not apply to the following counties: Alamance, Alexander, Alleghany, Ashe, Avery, Burke; Caldwell, Carteret, Catawba, Chatham, Cherokee, Clay, Craven, Duplin, Gaston, Graham, Guilford, Harnett, Hoke, Iredell, Jackson, Johnston, Jones, Lee, Lincoln, Macon, Madison, Onslow, Pamlico, Pasquotank, Pender, Pitt, Polk, Randolph, Rowan, Scotland, Stokes, Surry, Swain, Transylvania, Vance, Warren, Watauga, Wilkes, Wilson and Yancey. Effective upon ratification June 24, 1963.

HB 672—AN ACT TO AMEND G. S. 51-18, RELATING TO THE FILING OF MARRIAGE LICENSE RETURNS.

This Act merely substitutes two instead of three witnesses to a marriage, thus simplifying the procedure. Effective upon ratification May 15, 1963.

HB 797—AN ACT TO CREATE A COUNCIL ON MENTAL RETARDATION.

Council making permanent the previous body and will develop interest in and a program for mental retardation for the State of North Carolina. Effective July 1, 1963.
HB 811—AN ACT TO AMEND G. S. 130-9 (e) RELATING TO THE LICENSING OF NURSING HOMES AND BOARDING HOMES FOR THE AGED AND INFIRM.

Two amendments to the Nursing Home Licensing Act were made by the 1963 General Assembly. The first amendment permits the establishment of combined nursing home and boarding home operations in separate areas of the same building or in adjacent buildings. The State Board of Health is assigned the sole licensing responsibility for both the nursing homes and the combination homes. The State Board of Public Welfare will retain responsibility for licensing homes providing boarding home care only. The second amendment assigns to the State Board of Health the responsibility for establishing a method for a medical evaluation of the residents of the homes for the aged and infirm. (This method is being developed in consultation with the Medical Society of the State of North Carolina and the State Board of Public Welfare. Medical examination will be left in the hands of the practicing physicians. Review of the medical evaluation reports and the maintenance of standards will be the responsibility of the licensing agency.)

Effective upon ratification June 12, 1963.

HB 890—AN ACT TO PROTECT CHILDREN BORN OUT OF WEDLOCK.

This Act requires the State Office of Vital Statistics to forward to the local health directors copies of resident illegitimate births “when it appears from the birth certificates” that the mother has previously given birth to two or more illegitimate children. It also provides that “any local official” who obtains any information concerning a child born to a woman by a father other than her husband shall report the same to the local health director, provided the woman has previously given birth to two or more children out of wedlock. Upon receipt of this information, the local health director is to notify the mother by registered or certified mail that she is to report to the county welfare director within 15 days. A copy of the letter shall be sent to the welfare director. Effective July 1, 1963.

HB 1114—AN ACT TO AUTHORIZE THE GOVERNING AUTHORITY OF THE CITY OF BURLINGTON IN ITS DISCRETION TO SUBMIT TO THE PEOPLE OF THE MUNICIPALITY THE QUESTION OF WHETHER OR NOT THE PROCESS OF FLUORIDATION SHOULD BE UTILIZED IN THE MUNICIPAL WATER SUPPLY.

This Act is of local application to the City of Burlington only and authorizes City officials to conduct a referendum on the question of fluoridation of the City water supply.

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THE HEALTH BULLETIN
Health Legislation In Brief

Bills and resolutions enacted by the 1963 General Assembly in the health field are listed below by number and short title. After each is the date of the final action taken by the General Assembly. The chapter number under which a ratified bill or resolution will appear in the 1963 Session Laws is indicated in parentheses at the end of the entry.

I. ACTS SPONSORED BY THE STATE BOARD OF HEALTH

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II. ACTS AFFECTING RESPONSIBILITIES OF THE STATE BOARD OF HEALTH

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<td>HB 446</td>
<td>To provide Workmen's Compensation for disability or death resulting from exposure to radioactive materials.</td>
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<td>HB 672</td>
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<td>HB 811</td>
<td>Relating to licensing of nursing and boarding homes for the aged.</td>
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III. OTHER HEALTH RELATED ACTS

SB 8 Medical assistance to aged. Ratified—May 29. (Ch. 599)
SB 83 Authorizing sterilization. Ratified—May 29. (Ch. 600)
SR 102 Continuing N. C. Cancer Commission. Ratified—April 23. (R 49)
SR 131 To study establishing a Medical Center in Charlotte. Ratified—May 1. (R 53)
SB 145 (Franklin) Fluoridation opinion election. Ratified—April 9. (Ch. 165)
SR 189 Encouraging schools of nursing. Ratified—May 22. (R 67)
SB 271 Nursing student loan condition. Ratified—May 22. (Ch. 493)
SB 364 Toilet facilities. Ratified—June 24. (Ch. 1114)
SB 409 Stream Sanitation. Ratified June 21. (Ch. 1087)
SB 423 Appropriations for medical assistance for aged. Ratified—June 24. (Ch. 1122)
SB 485 Nurses scholarship fund—anesthesia. Ratified—June 26. (Ch. 1246)
SB 511 Milk license regulation. Ratified—June 11. (Ch. 797)
SB 522 (Harnett) Dog warden. Ratified—June 4. (Ch. 664)
SB 546 Medical care personnel appropriations. Ratified—June 20. (Ch. 1045)
SB 549 Alcoholic rehabilitation appropriations. Ratified—June 19. (Ch. 991)
SB 562 Oleomargarine licenses. Ratified—June 24. (Ch. 1135)
SB 608 State employees incentive award. Ratified—June 20. (Ch. 1047)
SB 609 Hourly basis state employees. Ratified—June 18. (Ch. 958)
SB 613 Dairy research appropriation. Ratified June 18. (Ch. 960)
SB 623 Increase mileage allowance for State employees from 7¢ to 8¢ per mile. Ratified—June 20. (Ch. 1049)
SB 624 (Halifax) Water well contractors. Ratified—June 13. (Ch. 906)
SB 647 Maximum hours—state employees. Ratified—June 25. (Ch. 1177)
SB 666 State salaries. Ratified—June 25. (Ch. 1178)
HB 9 Requiring seat safety belts on all ’64 new cars. Ratified—April 25. Effective—January 1, 1964. (Ch. 285)
HB 46 65 MPH speed limit. Ratified—April 2. (Ch. 134)
HB 338 (Wake) Water and sewer lines. Ratified—May 1. (Ch. 315)
HB 347 (Avery) Well contractor’s license. Ratified—April 9. (Ch. 179)
HB 416 (Nash) Water well contractors. Ratified—April 19. (Ch. 250)
HB 458 (Buncombe) Water well contractors exemption. Ratified—April 23. (Ch. 272)
HB 459 Mental patient admissions. Ratified—May 17. (Ch. 451)
HB 471 Election of members of local Board of Health. Ratified—May 7. (Ch. 359)
HR 474 Creating Governor’s Committee on Traffic Safety. Ratified—May 17. (R 64)
HB 497 (Burke and McDowell) Lake James sanitation. Ratified—June 13. (Ch. 912)
HB 533 Election and terms of office of Sanitary District Boards. Ratified—June 3. (Ch. 664)
HB 549 Elimination of the nomination of a member of the Medical Care Commission by the N. C. Dental Society. Ratified—May 1. (Ch. 325)
HB 550 Eliminate the provision for a representative of the Dental Society of the State of N. C. as a member of the Mental Health Council. Ratified—May 1. (Ch. 326)

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HB 554  Medical care of the indigent sick and afflicted poor. Ratified—May 22. (Ch. 505)
HB 609  Appointment of District Board members for Metropolitan Sewerage Districts. Ratified—May 21. (Ch. 471)
HB 615  Dissolution of Sanitary Districts. Ratified—May 22. (Ch. 512)
HB 651  (Catawba) Water well contractors. Ratified—May 24. (Ch. 557)
HB 683  (Orange) Water well contractors. Ratified—May 23. (Ch. 545)
HB 710  Commitments to general hospitals. Ratified—June 11. (Ch. 813)
HB 732  Dead animals on highway. Ratified—May 22. (Ch. 520)
HB 786  To create Medical Advisory Council to the State Board of Mental Health. Ratified—June 4. (Ch. 668)
HB 797  To create a Council on Mental Retardation. Ratified—June 4. Effective—July 1, 1963. (Ch. 669)
HB 838  Sanitary district tax valuations. Ratified—June 26. (Ch. 1226)
HB 839  Sanitary district facilities bonds. Ratified—June 26. (Ch. 1247)
HB 871  Chiropractors' license. Ratified—May 31. (Ch. 646)
HB 874  (Jackson) Water well contractors. Ratified—May 28. (Ch. 597)
HB 889  Adoption of illegitimates. Ratified—June 26. (Ch. 1258)
HB 1026  (Cumberland) Water well contractors. Ratified—June 4. (Ch. 682)
HB 1035  Drainage district powers. Ratified—June 7. (Ch. 767)
HB 1038  Local bill applying to Guilford County. Ratified—June 6. (Ch. 768)
HB 1091  (Davidson) Water well contractors. Ratified—June 6. (Ch. 741)
HB 1114  Relating to question of fluoridation referendum in the City of Burlington. Ratified—June 11. (Ch. 828)
HB 1165  Medical technician scholarships. Ratified—June 25. (Ch. 1185)
HB 1209  (Lee, Stokes and Union) Water well contractors. Ratified—June 12. (Ch. 879)
HB 1257  (New Hanover) Kure Beach sewerage assessment. Ratified—June 18. (Ch. 972)
HB 1268  (Carteret) Sewerage to annexed areas. Ratified—June 25. (Ch. 1189)
HB 1316  Sewage disposal contracts. Ratified—June 26. (Ch. 1232)
HB 1337  Podiatry licensing requirement. Ratified—June 25. (Ch. 1195)

State Board of Health Budget

For the 1963-65 biennium, the Legislature approved increases in the Department's budget totaling $1,265,724 or 16.6% above the $7,636,616 appropriated for the 1961-63 biennium. The significant increases for expanded services were limited to a small number of programs, including Services for Mentally Retarded Children ($354,000), Cystic Fibrosis ($24,000), Salt Marsh Mosquito Control ($268,000), and Venereal Disease Control ($24,000). Other increases were spread over all programs, and for the most part, were for recurring obligations, such as regular salary increments. A substantial amount ($576,000) requested for Aid to Counties was recommended by the Advisory Budget Commission but was not appropriated by the General Assembly.
Authority to Accept Fees

SENATE BILL 420 — AN ACT RELATING TO THE AUTHORITY OF LOCAL BOARDS OF HEALTH TO ACCEPT FEES.

The General Assembly of North Carolina do enact:

Section 1. G.S. 130-17 is amended by adding a new subsection thereto to be designated subsection (e), and to read as follows:

“(e) The local boards of health are hereby authorized to enter into contracts with the Veterans’ Administration or any other governmental or private agency, or with any person, whereby the local board of health agrees to render services to or for such agency or person in exchange for a fee to cover the cost of rendering such service. This authority is to be limited to services voluntarily rendered and voluntarily received, and shall not apply to services required by statute, regulation, or ordinance to be rendered or received. The fees to be charged under the authority of this subsection are to be based upon a plan recommended by the local health director and approved by the local board of health and the State Health Director, and in no event is the fee charged to exceed the cost to the health department of rendering the service.

“The fees collected under the authority of this subsection are to be deposited to the account of the health department so that they may be expended for public health purposes in accordance with the provisions of the County Fiscal Control Act. No individual employee is to receive any compensation over and above his regular salary as a result of rendering services for which a fee is charged.”

Sec. 2. All laws and clauses of laws in conflict with the provisions of this Act are hereby repealed.

Sec. 3. This Act shall be in full force and effect from and after its ratification.

In the General Assembly read three times and ratified, this the 21st day of June, 1963.

T. Clarence Stone
President of the Senate.
H. Clifton Blue
Speaker of the House of Representatives.

Examined and found correct,
Robert B. Morgan
For Committee.

June, 1963
The Conflict Between Progress and Safety

An editorial by René Dubos

The expectancy of life at birth has been steadily increasing in all countries of Western civilization; it now exceeds 70 years in the United States. Unfortunately, the public health significance of this achievement is marred by the fact that most of the increase comes from the control of mortality during infancy and early adulthood, whereas life expectancy beyond the age of 45 has not changed much during recent decades. From this point of view, the health record in the United States is not good, poorer in fact than in several other less prosperous parts of the world. As is well known, the high death rates during late adulthood in our communities reflect the increasing prevalence of chronic and degenerative diseases. There are good reasons to believe, furthermore, that this change in the pattern of disease is in some obscure but certain way related to the living conditions now prevailing in most of the Western world and particularly in the United States.

The general public has long been aware of the fact that some factors of the modern environment are creating disease problems which become manifest chiefly during adulthood and the later years of life. However, this awareness is derived chiefly from statistical evidence, and consequently it is not sufficient to motivate social action. Whether we like it or not, emotional upheavals are still the most effective stimuli for mobilizing public opinion and for generating effective legislation. The hasty legislative action which followed the accidents associated with the use of thalidomide provides convincing even though disturbing evidence that emotional appeal has far more power than deliberate approach based on knowledge and common sense when it comes to moving the wheels of Government and Congress. In view of this fact, the tremendous popular impact of the articles by Rachel Carson in the New Yorker and of her book, Silent Spring, cannot help being of importance for organizations concerned with medicine and public health.

The public success of Rachel Carson's book is explained in large part by the obvious relevance of her theme to human life, and, needless to say, by the superlative quality of her writing. The fact is, however, that other authors have also written well on the same theme for the general public and yet have failed to attract attention. For example, Lewis Herber published early in 1962, several months before the appearance of Rachel Carson's book, an excellent semipopular account of the dangers created by Our Synthetic Environment. Herber's account is clearly accurately, and interestingly written, presents all the facts reported in Silent Spring, and covers a much wider ground. Nevertheless, very few persons

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have heard of *Our Synthetic Environment*, and the only notice of it that I have seen is a short but favorable review in *Scientific American*.

Miss Carson's fame as a writer contributed greatly, of course, to the immediate success of her last book but does not explain it entirely. What captured public attention was the inspired idea of relating the problems of toxicity to man's love for bird song in the spring. The public was moved not so much by the display of scientific knowledge as by an arresting image. Public interest was not caught by fear of poison—all of us have become inured to this threat—but by the poetical and graphic evocation of a small town where the birds have ceased to sing. It is immaterial that the account is fictitious. What matters is that the literary trick did identify insecticides and weed killers with the image of a lifeless spring.

While it was a stroke of genius to associate the use of chemicals in agriculture with the end of bird song, the emotional appeal of this approach is not suitable for presenting in all its complexity the manner in which chemical pollution is becoming such a disturbing feature of technological societies. Insecticides and herbicides do create health dangers, but these are not greater than the dangers posed by air pollution, by the chemical contamination of drinking water, by the indiscriminate use of antimicrobial drugs, stimulants, tranquilizers, by the constant bombardment of stimuli, whether these be derived from news broadcasts, flashing neon lights, or background music. The problem is not to protect man from exposure to a few poisonous substances but rather to consider, as a whole, the dangers to health that are created by the innumerable products and techniques of modern technology.

It must be said in fairness that Rachel Carson in *Silent Spring*, as well as Lewis Herber in *Our Synthetic Environment*, tries to formulate the problem of chemical pollution in a general manner by emphasizing that man is creating grave dangers whenever he upsets the balance of nature. In reality, however, every ecologist knows that the expression "balance of nature" is not as meaningful as appears at first sight. Nature is never in a static equilibrium, because the interrelationships between the biological and physical forces are forever changing. Man, furthermore, placed himself out of nature when he began to live in complex societies, and he has been changing nature ever since. The real issue, therefore, is not to avoid changing biological relationships in nature but rather to control the change in such a manner that the over-all result is profitable to man.

Needless to say, ecologists, students of natural resources, physicians, and public health officers have long recognized that technological innovations create dangers for human health. The two books, *Our Synthetic Environment* and *Silent Spring*, are the popular expressions of an intellectual attitude which has stimulated much scientific work during recent years. Two examples will suffice to illustrate the awareness of the scientific community and the earnestness with which it tries to deal with the problem objectively. The first example is the publication of a new periodical, *Residue Reviews*,6 which is specifically devoted to the chemical and biological questions posed by the presence of chemicals in animal feeds, transformed food products, etc. The very existence of such a journal constitutes obvious evidence of scientific awareness. The second example is the article by Wolfe et al. in the present issue of this journal reporting experiments to determine the dangers involved in the use of insecticides during agricultural operations.

In addition to providing technical details, the article by Wolfe et al. brings
into sharp relief some of the most preplexing aspects of the public health dangers associated with the use of insecticides. The findings reported by these authors show that the usual practice of dusting potato crops with endrin involves an exposure of the worker which does not exceed 1.8% of a toxic dose; likewise windfall apples in orchards sprayed for mouse control carry an amount of residue so small that a child would have to eat more than 300 apples to ingest a lethal dose of poison. Stated in these terms, the facts are very reassuring. They become much more alarming, however, when it is realized that endrin, dieldrin, and other chlorinated hydrocarbons accumulate in fatty tissue and, therefore, can have a cumulative toxicity not revealed by acute toxicity tests. While a boy will not eat 300 windfall apples at one sitting, who knows how many he might eat in a season!

The findings reported by Wolfe et al. and those of other workers in the field emphasize the difficulties involved in formulating adequate safety criteria and also in devising tests for the measurement of toxicity. One type of difficulty comes from the fact that many toxic potentialities become expressed only under special conditions, as illustrated by the case of thalidomide. Another difficulty is that many toxic effects are extremely delayed in their manifestations, either because they are cumulative, or because they set in motion physiological or genetic disturbances which become apparent only after many years, or even in succeeding generations. There is clearly an urgent need for the development of new kinds of techniques and of facilities to make possible that toxicological analyses be carried out under a very wide range of conditions and over prolonged periods of time. The scientific effort required to bring such a program into existence will be very expensive financially and will demand many more trained personnel than are presently available.

For the time being, we must accept as a fact that it is impossible to detect beforehand all the potential dangers of new technological developments. No legislation or administrative regulation can cope with this problem, because the scient-

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J. M. Jarrett, B. S. ................................................................. Director, Sanitary Engineering Division
Fred T. Foard, M. D. ................................................................. Director, Epidemiology Division
Robert D. Higgin, 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. Maddy, 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
tific background is far too inadequate. It must be recognized, furthermore, that to exact a certificate of absolute safety before licensing a new process or a new product would completely paralyze technological progress.

It is almost certain that any substance possessing biological activity will also prove to have some toxic properties. Each one of the drugs introduced into the practice of medicine during the past 20 years—from penicillin to cortisone or the tranquilizers—is now known to be capable of causing severe toxic reactions under certain circumstances; this is true even of acetylsalicylic acid (aspirin). Thus, the problem is not to rule out of use substances which are potentially toxic but rather to use educated judgment in weighing advantages against dangers. The case of isoniazid illustrates well the need for common sense as opposed to sweeping regulations. It has been known for many years that isoniazid causes neurological symptoms in a certain percentage of human beings, and it was reported last year that it can elicit cancers in several strains of mice. On the other hand, isoniazid is an indispensable drug for the control of tuberculosis. Clearly, therefore, it must be used extensively despite its potential dangers. And a similar case could be made for many other substances which have become essential in medicine, industry, or agriculture, even though they present some danger for human health.

All technological innovations, whether concerned with industrial, agricultural, or medical practices, are bound to upset the balance of nature. In fact, to achieve mastery over nature is synonymous with disturbing the order of nature. Technological progress necessarily involves dangers, and these cannot always be foreseen. Thoughtful men are of course concerned with safety, but on the other hand, vigorous societies are always willing to take risks for the sake of technological development. In consequence, it is probably useful now and then to overstate the dangers of technological innovations lest there be no control of them. In this respect books such as Our Synthetic Environment and Silent Spring serve as necessary social role, even though they present an unbalanced picture of the problem posed by the use of chemicals in modern life. Half a century ago the popular emotion aroused by Upton Sinclair’s novel The Jungle compelled Congress to give adequate authority to the Food and Drug Administration. It may turn out that the fictional description of a birdless midwestern town will play a similar role with regard to the problem of environmental pollution in our society. It will also spur the reach for better scientific knowledge of the biological effects of chemicals and thereby help technologists control natural forces more intelligently without poisoning thereby either human beings or the birds which enliven the spring.

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### BABIES ON TV

Memphis, Tenn.—The new maternity wing at Baptist Memorial Hospital is some distance from nurseries, but mothers can see their infants whenever they want by turning a dial. A closed circuit TV hookup provides constant surveillance of the babies as well as of relatives and friends who come to admire new arrivals. Telephones near each camera can be used by visitors who wish to talk to the mother who is watching them on the TV screen in her hospital room.

Ronald Boyd Outen of Monroe and Betty Jean Crews of Henderson, the 4-H King and Queen crowned during State 4-H Club Week. (See story on page 9.)
The Author

Scottish journalist and author Ritchie Calder has long been associated with science and the United Nations; this article was reprinted from February, 1963, issue of The UNESCO Courier. A former newspaperman, and radio and television broadcaster, former chairman of the Association of British Science Writers, author of many books, he has advised or headed various United Nations commissions. His home is in Belmont, England.

New Harvests For the Hungry
by Ritchie Calder

In A CONGO MARKET, street vendors were selling fat, black, hairy, wriggling caterpillars, four inches long. These were not live bait for anglers but food for human consumption. One shuddered and thought of the dreadful privations which could reduce people to such straits. But this was not the Hunger Belt of the Congo and those caterpillars were not starvation rations but, for Africans, delicacies like shrimps, escargots, or frogs' legs.

In West Africa, ambitious attempts to set up poultry farms have been expensive failures because of the local microorganisms. In any event, the feast-day delicacy of the local Africans is not the Christmas or Thanksgiving turkey, but the giant snail. This represents about half a pound of nutriment and is as appetizing as the Californian mollusk, abalone, an expensive dish on the American menus.

2 THE HEALTH BULLETIN July, 1963
NEW HARVESTS FOR THE HUNGRY

Much of the world's food potential is as yet untapped.

by Ritchie Calder

In the Arabian deserts the wandering Bedouins eat fried locusts. The locust has been the plague of settled cultivations since Biblical times. The insect is just a winged stomach and consumes its own weight of growing crops in a day. Since a swarm of locusts can weigh thousands of tons, this consumption is devastating.

But desert wanderers do not concern themselves about what happens to crops hundreds of miles away. To them a locust is human food. So much so that when locust-control officers went into the Empty Quarter of Arabia to stop the locusts before they took off to wreak destruction in the Soviet Union, Iran, Pakistan, and the Middle East, they had to take sacks of Maria Theresa dollars. They had to have those coins of 200 years ago fresh-minted as the only currency the desert tribes
would recognize. They had to bribe them to allow the killing of the locusts.

In Scotland, when I was young, we youngsters used to sneak into the back streets to buy and eat hunks of seaweed, which to us was as desirable as the candy floss of a more affluent generation. We had to do it furtively because it was vulgar, but years later I paid a dollar in a luxury restaurant for a dish which was only a fancy version of that selfsame seaweed.

Those are examples of what is really meant by saying "One man's meat is another man's poison." In rare cases the expression may be true; there are food allergies by which otherwise innocent edibles like strawberries, or eggs, or chocolates can have serious and even fatal effects on some individuals. Mostly, however, our likes and dislikes are dictated by habits or by imagination (or the lack of it) or by taboos, and our reactions are not biochemical but psychological.

They are nonetheless real because of that. Even in a famine, religious vegetarians will die rather than eat meat, as also will rice eaters rather than eat wheat. A world-eminent free-thinking professor, a long way removed from the sacred sanitary laws of the Leviticus, can never force himself to eat ham or pork; his stomach refuses to break the rules of his upbringing.

One of the most appetizing and worth-while fish is mackerel, but the fishermen of my part of the world who catch mackerel and sell them will never eat them because (quite unjustly) they are supposed to feed on the corpses of seamen. In Thailand, pretty well off for food, mothers harm themselves, their unborn infants, and their suckling children by barring a whole range of fruits and vegetables because they are fetish symbols—but no part of their Buddhist religion.

Another food discriminator is snob-bery. No one will eat something called "dogfish" (Squalus acanthias), but call it "rock salmon" on the menu and everyone is happy.

None of us would really enjoy the notion of eating reptiles, but the great feature of the Lord Mayor of London's banquet is real turtle soup and a turtle is, of course, a reptile. Similarly, we recoil from an egg which is "off," but when we have a Chinese meal we will eat addled turtle eggs and "bird's-nest soup," which is bird spittle—mucilage (and perfectly good protein) secreted from the salivary glands of swifts. Kangaroo tails are served in the British House of Lords. Crocodile tails are delicacies to Africans, just as the palms of the polar-bear paws are to the Eskimos. Shark's fins are shipped to the Chinese, but the food-thrifty Japanese eat shark meat and get rich vitamins from shark's liver.
Off Peru, an oceanographic expedition sponsored by the Peruvian Government and the United Nations Special Fund takes plankton samples from the water. In recent years Peru has multiplied her fishing industry 15 times; Peru is now one of the five leading fishing nations of the world. A purpose of the marine study is to determine how far the exploitation of these reserves may be carried without risk of exhausting them. Immense numbers of anchovy supply Peru's booming production of fishmeal.
When oysters in the days of Charles Dickens were the food of the poor of London, the rich did not eat them. Now the rich eat them and the poor cannot afford them. In expensive Western stores, one can buy bottled ants and silkworm conserves — made of the cocoons, once the silk has been unwrapped.

One can buy jars of manna, from the Biblical wilderness. It may not be the manna of the Exodus, but it is the saccharin excretion of an aphis which drinks the dew on the tamarisks of the Sinai and the Negev. The excretion dries like sugary snowflakes and drifts over the desert.

Where and when food is abundant, taste can afford to be selective. In the land of feasts and famine, among the Eskimos, if the caribou kill is high, they will feast off the tongues and throw the meat to dogs. Come the famine, and they will ration the offal and split the bone for the marrow.

But there is another kind of waste: Where people like things (giant snails, for instance) which seem a bit eccentric, why should we try to impose conventional foods upon them? These may be the new foods. With all his science, modern man has not been very enterprising. Practically every food animal we know was domesticated in prehistoric times. Of course, we have improved the breeds and the yields until a farm animal has become an agrofactory, but we have not much extended the range.

Why not domesticate the sea cow, the manatee, or its kin the dugong? The manatee is a substantial creature in terms of sea-cow sirloins, because it can grow as much as 25 feet in length. It is oceanic, but it favors estuaries and might be coaxed or adapted to the fresh-water environment of the great rivers. It has one special virtue: it is the one creature, it seems, which is prepared to feed off the water hyacinth. If this seems to put it in the category of the famous Ferdinand the Bull, which preferred flowers to fighting, it should be explained that the wild hyacinth, with its delicate blue blossom bobbing on the waters, is no choice bouquet. This is one of the world's scourges.

In the South American rivers where the water hyacinth belongs, it is quite well behaved, but when it has been introduced by design (how nice to have it in our pool!) or by accident (in ship's bilges) into Africa or Asia, it has become a plague. It chokes the great rivers, blocking the channels and smothering dams. It cannot be got rid of by weed killers because they would imperil the fish or the useful plant life. It has to be cut and dredged out by physical effort. But the manatee loves it and could process the pest into excellent meat and oil.

Then there is the hippopotamus. We call it "the river horse," but it is a pachydermatous, nonruminating, artiodactyl ungulate—in other words, underneath the two-inch-thick rind of its 14-foot bulk, there are three tons of excellent pig meat. A rasher of hippo would provide a meal for a family.

If you can't lick 'em, join 'em! If you cannot domesticate wild animals, conserve them. That is a good thing in itself because the world is in danger of losing its noble animals by stupid destruction. But conservation has other commendations. Protected animals multiply beyond the resources of their natural habitat, and in the interests of their kind they have to be culled—selectively killed, just as the sensible cutting of trees improves a forest. In Africa this would preserve the species for posterity and protein for the people.

Conservation as against domestication has other values. The increase of flocks and herds on savannah ranges...
(as in East Africa) can destroy the herbiage and start erosion into desert. Cattle and sheep are grazers; they eat only from the ground but they crop everything close. Nature has budgeted more intelligently. There are the rooting animals, like the wart hog, which get their food below the surface and the many types of deer and antelopes which graze but are non-competitive in the many types of plants they eat. There are the browsing animals which dine off shrubs and bushes and there are the giraffes and elephants which can help themselves from the trees. It is self-service on four floors! No biotechnical efficiency expert could improve on that.

Where we have been least effective in our harvesting of food is in terms of the sea. Seven-tenths of our planet is covered by oceans. Davy Jones's locker is a vast food hamper. The nutrient material produced annually by the sea amounts to 100 billion tons, of which only 30 million tons, the world over, are recovered as edible fish. This contrasts with the billion tons of vegetable produce, and 100 million tons of animal protein, farmed from the land surface.

Since the early Chinese, and through the medieval monasteries with their carp ponds, we have had inland fish farms (still not enough), but as far as the sea is concerned we are still at the caveman stage of hunting our sea food. We have not domesticated the sea creatures nor husbanded nor harvested the sea pastures.

The idea of sea ranching—"The Riders of the Purple Kelp"—is not in the least absurd. We could herd the sea creatures. (We might even train the in-

Indonesia encourages fish ponds (below) to increase people's protein intake. Philippine farmers raise fish in flooded rice fields.
telligent dolphins to be the collie dogs of the oceans.) Sir Alister Hardy, the distinguished marine biologist, once conjured up, in a scientific assembly, the vision of frogmen "riding the fences" of the sea ranches, driving the submarine tractors, harrowing the starfish (which are the marine pests, eating four times as much food as the edible fish), and plowing up the bottom of the sea.

But one does not need to be that fanciful. The herding could be done by electrical devices. The harrowing could be done by mechanical drags which would comb out the starfish and recover them as poultry food.

The ocean floor could be plowed by remote-controlled tractors. Why plow? Because the bottom of the sea is a great compost heap. It contains stagnant nutrients in abundance—so much so that the idea of artificial fertilizers for the sea, which has engaged a lot of thought, is redundant. All that is needed is to stir the nutrients so that they circulate in the layers where grow the submarine vegetation and the plankton which are the diet of the edible fish.

This would encourage sea pastures for other purposes as well. The Japanese, industriously searching for means of feeding their multiplying population, have already discovered uses for some 10,000 different kinds of seaweed. Some of it is used as fertilizers for land crops, producing food at one remove, but many of them have been processed for direct human consumption. They can be attractively packaged (like breakfast cereals) and if one does not mind "cornflakes" colored green with a flavor of iodine, or black "potato crisps" with the salt built in, substitutes from seaweed are palatable and nutritious.

We could have sea farming in fiords and enclosed sea basins. The trouble is that one cannot clip the wings of fish as one clips the wings of poultry to prevent them from migrating, but it should be possible to fence some of those inlets. Just as a single wire with a harmless charge of electricity will discourage land animals from straying, an electric current beamed across the exit would discourage the fish from leaving. They would remain to multiply and grow.

There are also floating pastures of minute plant plankton and swarms of animal plankton. So far we have found no effective way of harvesting this suspended vegetation and animal material. We might, however, study the whale, which swims along gobbling plankton, squeezing out water, and converting the material into 70 tons of meat, bone, and blubber. Perhaps we could devise a mechanical, atom-propelled "whale" as our combine harvester of the sea!

Now we come back to likes and dislikes: Who would choose to eat plankton? But we can give all such things, whether the wasted sustenance of the sea or the waste proteins of the land, a gastronomical anonymity. When we eat meringues and some kinds of ice cream, we never recognize them as algenates, extracted from seaweed. Fish-fingers beautifully packaged out of the deep-freeze may be fish from which one would recoil if one saw it on a fishmonger's slab.

Deep-seated objections, like religious taboos, are more difficult to overcome. The Indians who prefer a vegetarian diet would be better off with meat protein, but there is no need to offend their religious convictions nor to convert them to meat. At the Food Research Institute in Mysore, they have produced a multipurpose food. Ten teaspoonsful has the nutritive value of one-quarter of a pound of meat, a baked potato, a dish of lentils, and a
Dr. John Rhodes Crowns
King and Queen of Health

By Larry Horne

Dr. John S. Rhodes of Raleigh, president of the Medical Society of North Carolina, crowned Betty Jean Crews of Henderson and Ronald Boyd Outen of Monroe, 4-H Queen and King at State 4-H Club Week in Raleigh, July 26th.

Betty Jean has been very active in her county and has worked with many of the young 4-H'ers in their health projects.

Ronald works at a hospital pharmacy, and has distributed many health booklets to his fellow 4-H'ers. He also sponsored diabetic tests with all the county home demonstration club members.

Both Ronald and Betty will receive all-expense paid trips to Chicago for National 4-H Club Week because of their outstanding work in the health project.

They were chosen out of approximately 170 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.

Larry Horne is a 4-H Club member living at R.F.D. No. 2, Laurinburg.

The Family Service Association of America will present a variety of awards to magazines, newspapers, wire services, and/or radio and television programs at the Association's Biennial Conference on family life in San Francisco, November 13-16, 1963. Writers of particular articles and/or shows which are selected will also receive an award.

The deadline for submission of suitable material is September 1, 1963. The material must have appeared during the two-year period between October 1, 1961 and September 1, 1963.
The President's Council on Aging

The President's Council on Aging in its first annual report entitled "The Older American" gives a brief portrayal of the situation of nearly 18 million people over 65. The Council underscored:

—The individuality of each older American—his hope, aspirations, and capacities.
—The importance of enabling older Americans to live in maximum independence.
—The importance—to them and to society—of their social and community participation rather than rejection and isolation because of age.
—The need for special assistance for older Americans who are dependent or otherwise at a disadvantage.

This and the following pages present some comment and pictorial excerpts from this report. If you wish a copy of the full report, write to the President's Council on Aging, Washington 25, D. C.
18 million faces

Listen to the Older American, and he will tell you who he is. In 18 million ways he will tell you, for each Older American has a distinctly personal story to tell.

The stories are also the story of our Nation’s history, for that is no more and no less than the history of our people as they went about their business.

The faces of older Americans represent democracy and freedom ripened into the golden fruit of wisdom and knowledge. The lines in their faces were formed by frowns and smiles, triumph and defeat, by progress as well as problems. This is the Older American.
The Older American Needs a Place In the Community

Communities are not made just of brick and mortar, of concrete and sand, of board and nail. Communities are made of people needing each other.

The Older American knows this better than most—he made your community. He asks only that he may continue to be part of it—not just a cipher among the brick and the concrete and the board but a person among the people. His voice is needed in community affairs, and he wants to speak. There are jobs to be done in the community, and he is ready to volunteer his services. There are schools in the community, and he wants to learn.

The Older American wants to be an active part of his community, a contributing, participating, sharing partner. He will willingly accept no less. He will ask no more.
The Older American is different in one respect from all other Americans. He is older. He has more years behind him. He may have special needs because of these years. So may we all when the years of our life accumulate.

Thus, when age makes its unavoidable demands on our bodies, we may need help from our neighbors. If we can no longer live alone, we may want a specialized home but one that is a home, not just an institution. Or we may want to stay in our own house and hope that others will continue to make our house a home. Again, the Older American, despite his age, wants to live like the rest of us—in a home—his own home if possible, if not, a place that he can call home. Is this asking too much? To live at home?
Laboratory Receives Tuberculosis Testing Grant

A two-year grant of $61,000 has been given the Laboratory Division of the State Board of Health to permit the staff to culture all tuberculosis specimens. In announcing the receipt of this grant, Dr. J. W. R. Norton, State Health Director, expressed gratification that this phase of the Laboratory program could be made more helpful to the citizens of the State.

Dr. Lynn G. Maddry, who directs the Laboratory Division, stated that this grant which comes from the Tuberculosis Control Section of the United States Public Health Service has as its purpose improving the Laboratory diagnostic services.

Over 15,000 specimens are received each year for tuberculosis examination. Due to a lack of personnel, only a minimum amount of testing has been possible. Acid-fast staining is done on all specimens, but cultures are done only upon request and amount to some 8,000 per year. This new grant will permit cultures to be done on all specimens. In addition, sensitivity testing which has not been possible thus far will be begun.

The Laboratory Division which has been in existence for fifty-four years has examined specimens for tuberculosis organisms during most of this time. In preparation for this new project, a portion of the Laboratory has been renovated and additional equipment secured. Personnel is now being recruited. This new project is expected to permit the State Board of Health to render additional service in health throughout the State. Though the grant is expected to be for only two years, it is hoped that the value of the service will justify continuance through State appropriations.
National Council on the Aging Receives Grant

The Ford Foundation has awarded a $300,000 grant to The National Council on the Aging for a five-year program on the employment and retirement problems of older workers, Council President Garson Meyer has announced.

The employment and retirement program will include field services, consultation, conferences and publications in such areas as automation, training and retraining older workers, pensions and income maintenance, preparation and criteria for retirement.

In announcing receipt of the grant, Mr. Meyer explained that The National Council on the Aging "sees all these areas of interest as part of a program for helping maintain employment for middle-aged workers, at least until retirement benefits are available; for considering criteria for determining retirement policies most advantageous to employer and employee; for helping develop attitudes by which persons may make the most of retirement years through satisfactions other than those derived from work; and for emphasizing the need to maintain adequate standards of living during retirement."

The program will be supervised by The Council's Advisory Committee on Employment and Retirement, headed by Edwin F. Shelley, vice-president of U. S. Industries, Inc.

The National Council on the Aging is a non-profit organization serving as a central, national resource for information, consultation, planning and materials on aging. In addition to employment and retirement, The Council operates programs in health, housing, institutional care, social services, education, recreation and community planning.

President Garson Meyer of the National Council on the Aging

Grants Made For Migrants

Thirty-five grants totalling $1,305,690 have been awarded to support projects to improve health conditions and services for domestic agricultural migrants.

These are the first grants to be awarded under the Migrant Health Program authorized by an act of Congress approved by the President on September 25, 1962. The projects represent the beginning of a three-year program.

The projects in North Carolina include the following: Carteret County Migrant Committee for medical examinations, immunizations, health education, clinics; Henderson County Migrant Committee for family health service clinics, health education and sanitation; and the State Board of Health for sanitation.

July, 1963

THE HEALTH BULLETIN
DATES AND EVENTS

September 6-7—N. C. State Employees Association Convention, Jack Tar Durham.

September 9-10—Fourth District Dental Society Convention, Raleigh.

September 14—N. C. Mental Health Association State Board Meeting, Fayetteville.

September 16—American Medical Association, Atlantic City, N. J.

September 19-21—Mental Health Conference, Lake Logan, N. C.


September 20-21—N. C. Association for Retarded Children, Inc.—Annual Convention, Jack Tar Durham.

September 24-27—American Public Welfare Association, Southeastern Regional Meeting, Asheville.

September 25-26—Congress on Occupational Health, San Francisco.

September 26-27—N. C. Public Health Association Annual Convention, New Queen Charlotte Hotel, Charlotte.

September 26-28—N. C. State Highway Employees Association Convention, Durham.

September 29-October 2—N. C. Motor Carriers Association Convention, Pinehurst.

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Medical Officer Assigned to State Board of Health

The Communicable Disease Center of the U. S. Public Health Service in Atlanta has again detailed a medical officer to the State Board of Health to assist in investigating the source of communicable disease outbreaks.

Fred T. Foard, M.D., Director of the Division of Epidemiology, has announced the coming of Dr. Ronald H. Levine as Epidemic Intelligence Service Officer. He succeeds Dr. George M. Johnson who completed a two-year assignment in this State last month.

Dr. Levine's services will be available to local health departments to investigate or to assist in investigating the source of communicable disease outbreaks, including those due to food poisoning, and to institute control measures.

Dr. Levine is a native of New York State. He is a graduate of Union College at Schenectady, New York, and the Downstate Medical Center in Brooklyn, New York. He served as a straight pediatric intern at the Municipal Hospital, Brooklyn, in 1959-60 and subsequently as a pediatric resident at New York Hospital. During the past year, he has served as Chief Resident in Pediatrics. He has recently completed the usual course of training for Epidemic Intelligence Service Officers at the Communicable Disease Center in Atlanta. He comes to North Carolina highly recommended by the U. S. Public Health Service and is well qualified to serve as medical officer in the communicable disease control field.

Oral Hygiene Division Awarded Grant

The North Carolina State Board of Health—Division of Oral Hygiene, has been awarded a grant from the U. S. Public Health Service to conduct a Community Cancer Demonstration Project.

The project, according to Dr. E. A. Pearson, Jr., Director of the Division of Oral Hygiene, is one of providing continuing education in oral cancer detection to practicing dentists in North Carolina.

In cooperation with the University of North Carolina, School of Dentistry, Departments of Oral Pathology and Oral Diagnosis; and the North Carolina Society of Pathologists, teaching teams are being selected to conduct seminars to provide the dentists with the latest techniques and methods in early detection of oral malignancies.

In 1961, 130 deaths in North Carolina were caused by cancer of the buccal cavity and pharynx, facial skin, lips, and jaw bone. This area is easily examined and all dentists have the opportunity to find many malignant lesions at a stage when the outlook for successful therapy is most promising. Cancer detection should be a vital part of a complete oral examination, and this is a part of the scope of this program, said Dr. Pearson.

During the course of the three-year project, the teaching teams will have conducted 35 seminars for the Dental profession and will have traveled the entire state.

You have been most kind in the use of your films for which I am truly grateful. Brenizer L. Price, Principal, Tarboro High School, Tarboro.
Rabies Found In Bats In North Carolina

On July 20, 1963, an 18-month-old girl from Rowan County was bitten by a bat on the palm of her hand while in the family car parked under a tree. An older sister was seated in the car when the bat flew in and bit the baby girl on the hand. The sister pulled the bat off the child and threw it to the floor-board where it died.

On July 22, 1963, the State Board of Health Laboratory demonstrated Negri bodies, diagnostic of rabies, by both direct microscopic and fluorescent antibody technique. The child is receiving duck embryo vaccine.

On July 22, 1963, from Rowan County was bitten by a bat on the palm of her hand while in the family car parked under a tree. An older sister was seated in the car when the bat flew in and bit the baby girl on the hand. The sister pulled the bat off the child and threw it to the floor-board where it died.

On July 22, 1963, the State Board of Health Laboratory demonstrated Negri bodies, diagnostic of rabies, by both direct microscopic and fluorescent antibody technique. The child is receiving duck embryo vaccine.

This bat was identified as a red bat (Lasiurus borealis) which usually winters further south. In the summer it is solitary and roosts in trees, shrubs or near the ground. It flies early in the evening and hunts along water-courses.

On July 26, 1963, Dr. M. K. Holler, Rowan County Health Director, submitted a bat to the State Laboratory that was captured alive approximately one and one-half miles from the area where the rabid bat was captured. This bat gained entrance to a home and was found hanging to a drape in a dark area of the house. All occupants of the house were examined and questioned regarding possible bites but none could be found. No Negri bodies could be demonstrated in this bat as it was not satisfactory for examination.

On August 9 several bats flew in the dormitory window at the Murdock School in Butner, North Carolina. Dr. Dorothy Shearin, staff physician, reported that four teenage children were bitten on the hands and arms, but only one bat was captured. This bat was negative on direct microscopic examination but positive by fluorescent antibody technique. All of these children are receiving hyperimmune serum and 16 doses of duck embryo vaccine.

On August 14, 1963, Dr. Robert Lacey, Forsyth County Assistant Health Director, reported that a bat was found in bed with a child. There was a small mark on the child which was difficult to identify as a bite wound. This bat was negative on direct microscopic and fluorescent antibody tests. The child is receiving serum and 16 doses of duck embryo vaccine.

On August 15, 1963, a Durham, North Carolina woman noticed a bat flying at the base of a tree. Having read of the Butner incident in the papers, she called the county dog warden who captured the bat and submitted it to the
State Laboratory. The bat was positive on direct microscopic examination and fluorescent antibody test.

On August 15, a child from Monroe, North Carolina was bitten on the lip by a bat. This bat was found in bed with the child, but was negative on direct microscopic and fluorescent antibody tests.

The first identification of rabies in insectivorous bats in the United States occurred in 1953 when a yellow bat attacked and bit, without provocation, a seven-year-old Florida boy in daylight. Seven other isolations in the United States were made in 1953. Since this incident, rabies virus has been isolated from several hundred bats in 40 states.

In 1961 isolations were made from 186 bats and from 157 in 1962. These isolations were from five species of tree living or solitary bats and twenty species of colonial or cave dwelling bats.

Since 1951 six cases of human rabies have been attributed to insectivorous bats, and a large percentage of the isolations of virus from bats have been reported as episodes involving the biting of human beings.

Persons should be warned not to pick up or handle sick or strangely behaving bats. Bats do not normally perch on porches or other such places. One should never try to administer to what appears to be a wounded or crippled bat. It would not be there if it were healthy and normal. Children should be warned of this danger.

Any person bitten by a bat should receive prophylactic anti-rabies treatment. Every effort should be made to capture the bat and submit it for laboratory examination.

Anti-rabies treatment, however, should be started promptly without awaiting results of laboratory tests because experience in California and other states reveals that only about 50% of rabid bats show Negri bodies on direct microscopic examination of brain smears and laboratory diagnosis by mouse inoculation tests may take longer than the incubation period of the disease in man.

The North Carolina State Board of Health Laboratory employs the fluorescent antibody test along with direct microscopic and mouse tests on all cases where humans have been exposed.

The maximum survival time for insectivorous bats with naturally acquired rabies is not known. There is strong evidence that some species of insectivorous bats may be capable of becoming asymptomatic carriers. For this reason the apparent health of the living animal cannot be used as an indication of freedom from infection.
ANNUAL MEETING
N. C. Public Health Association
CHARLOTTE
Queen Charlotte Hotel
September 25-27, 1963

Wednesday, September 25

N.C.P.H.A.
10:00 a.m. - 8:00 p.m. Registration
1:00 p.m. N.C.P.H.A. Executive Board Luncheon
Kuester Room

Wednesday

NORTH CAROLINA ACADEMY OF PREVENTIVE MEDICINE AND PUBLIC HEALTH
3:00 p.m. Business Session
Tryon Room
Academy Members
3:30 p.m. First Scientific Session
Kuester Room
Members and Guests
5:30 p.m. Social Hour
Kuester Room and Balcony
Members and Guests
6:30 p.m. Academy Dinner
Kuester Room and Balcony
Members and Guests
8:00 p.m. Second Scientific Session
Chelsea Room
All public health workers invited

THURSDAY, SEPTEMBER 26, 1963

8:00 a.m. Registration
Lobby
9:00 a.m. First General Session
Ballroom
1:30 p.m. Second General Session
Ballroom
4:00 p.m. Sanitation Section Meeting
Chelsea Room
4:00 p.m. Executive Committee Meeting, Western North Carolina Public Health Association
Parlor A
6:30-7:30 p.m. Health Education Section
Social Hour
Tryon Room
8:00 p.m. Third General Session
Banquet
Ballroom

FRIDAY, SEPTEMBER 27, 1963

8:00 a.m. Registration
Lobby
9:00 a.m. Fourth General Session
Ballroom
12:00 noon Nutrition Section Luncheon
Tryon Room
12:00-1:30 p.m. Nurses' Section Luncheon and Business Meeting
Chelsea Room

August, 1963
12:30 p.m. Laboratory Section
Buffet Luncheon and Section Meeting
Manger Inn, 621 North Tryon Street, Piedmont Room
(across from Sears, for transportation meet in hotel lobby at 12:00 noon)

1:00 p.m. Dental Health Section
Parlor A
1:00 p.m. Sanitation Section
Ballroom
1:00 p.m. Secretarial and Statistical Section—Luncheon and Business Meeting
Sheraton-Barringer Motor Inn—Terrace Room

2:00 p.m. Mental Health and Nurses' Sections—Joint Meeting
Chelsea Room
2:00 p.m. Nutrition and Health Education Sections
Joint Meeting
Tryon Room
2:00 p.m. Venereal Disease Section
Parlor E
2:00 p.m. Health Directors Section
Chinese Room
3:00 p.m. Mental Health Section
Business Session
Room 327
3:30 p.m. Health Education Section
Business Session
Tryon Room

Exhibits Kuester Room

**Dressler Will Address Seminar**

Dr. Sidney H. Dressler, Special Assistant Chief, Tuberculosis Branch, Communicable Disease Center, U. S. Public Health Service, Atlanta, Georgia, will address a seminar on tuberculosis, September 26, at the Fifty-Second Annual Meeting of the North Carolina Public Health Association in Charlotte.

Seminar hours are from 1:30 P.M. until 3:50 P.M. in the ballroom, Queen Charlotte Hotel.

Dr. Dressler will give an illustrated presentation on the problem of tuberculosis as it exists in the United States and some of the latest principles of control leading to eradication.

Tuberculosis is a major health problem. In the nation, over 50,000 new active cases were reported in 1961 and nearly 10,000 people died of the disease during the same year.

Much research has recently been done in tuberculosis epidemiology, therapy, and laboratory studies. This knowledge must be made available to public health workers and other professional people in the tuberculosis field in order to close the gap between research findings and their application to the program.

Dr. Dressler is a native of Brooklyn, New York. He received his M.D. from the University of Berlin in 1938 and served as a Medical Officer in the Army of the United States from 1942 until 1946. He joined the staff of the National Jewish Hospital in Denver, Colorado, during 1946 and served as Assistant Clinical Professor of Medicine at the University of Colorado School of Medicine, as an Attending Physician at Denver General Hospital, and was president of the Denver Tuberculosis Society.

Dr. Dressler joined the Tuberculosis Branch of the Public Health Service in 1961. He is a Fellow of the American College of Chest Physicians, a member of the American Medical Association, and a member of the American Thoracic Society.
Since 1850, the average length of life in the United States has increased about 29 years. According to mortality conditions in 1850, the expectation of life at birth was approximately 41 years. By 1962, the figure had risen to about 70 years.

The improvement in longevity has been much more rapid in the period since 1900 than in the preceding 50 years, despite the very limited gains made during the past decade. The table on page 2 gives the details through 1960, the latest year for which data are available by sex and age. Among white males, the increase in expectation of life at birth was about eight years from 1850 to 1900-02 and about 19 years in the following six decades. The gain for white females was the same as that for white males prior to 1900-02, and was as much as 23 years in the subsequent period.

As a result of these trends, the difference in longevity between the sexes has widened. In 1850, the average length of life among white females exceeded that for white males by only 2½ years. In 1900-02 the difference was nearly three years, and by 1960 it had increased to more than 6½ years, the expectation of life at birth being 74.1 years for white females and 67.4 years for white males.

The largest gains in expectation of life have been recorded in childhood and early adult life; some progress has also been made at the older ages. In the past half century, the expectation of life at age 45 has increased 3½ years among white men and seven years among white women; at age 65 the corresponding gains have been 1½ and four years. As a consequence, the men at age 65 can now look forward to 13 additional years of life, on the average, while the women still have an average of 16 years ahead of them.

Mortality among white females prior to midlife has dropped to very low levels. Their death rate currently is less than 1 per 1,000 in the range of ages from 2 through 32 years, and remains under 2 per 1,000 through age 40. Among white males, death rates under 1 per 1,000 are experienced at ages 3 through 15 and are under 2 per 1,000 through age 34.
Since 1900-02 the expectation of life at birth among nonwhite persons has increased 31.3 years for females and 28.6 years for males. With the more rapid progress among nonwhites than among whites, the difference in longevity between them has been reduced. Nevertheless, the expectation of life at birth for nonwhites is still considerably below that for the white population—by 6.3 years among males and 7.8 years among females.

Since 1954, only a half year has been added to the average length of life in the United States, and it appears that the future will bring relatively small further gains. The marked advances of earlier decades resulted largely from a sharp rise in living standards and outstanding successes in controlling tuberculosis, pneumonia, the communicable diseases of childhood, and many other infectious diseases. Some additional gains in longevity will undoubtedly be made through further reductions in the death rate from infectious disease and from some other causes. However, the total mortality is already so low in childhood and early adult life that further decreases in death rates at these ages would add comparatively little to the average length of life in the United States. For example, if all deaths in the first 25 years of life could be prevented, the expectation of life at birth would be increased only three years. In fact, if no deaths whatever were to occur before age 50, the average lifetime would be increased 5½ years, or by only one fourth the gain since the turn of the century. Future progress in longevity will depend largely on the magnitude of the reductions in mortality from the chronic and degenerative diseases.

(From July 1963 Statistical Bulletin of the Metropolitan Life Insurance Company.)

I am a teacher of courses in psychology and education in a teacher training institution. We have used your films often and would like to express our thanks for the opportunity of their use and for the efficient service you have rendered in providing them.

Joseph R. Ellis, Appalachian State Teachers College, Boone.

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8 THE HEALTH BULLETIN August, 1963
Five-County District Undertakes Cervical Cancer Project

O. David Garvin, M.D., M.P.H.

The District Health Department in cooperation with the Public Health Service, the State Board of Health, the Pathology Department of the University of North Carolina and the doctors practicing in Orange, Person, Caswell, Chatham and Lee Counties embarked upon a three year Cervical Cancer Demonstration Project on July 1, 1962. A grant was received from the Cancer Control Program, Division of Chronic Diseases, Public Health Service, which financed most of the project.

Need. It was determined by the local physicians, local welfare departments, health department, county commissioners, civic groups, and interested individuals that a need existed for the establishment and operation of a community program for the early detection of cervical cancer among medically indigent in a basically rural population.

The project's purposes are:
1. To establish in a rural area high quality programs to detect and control cervical cancer.
2. To maintain top quality performance in program.
3. To demonstrate how counties with widely dispersed population and limited health resources within the area can be organized in a cooperative effort to solve the problem of cervical cancer.

This is the first screening project undertaken in a rural area. It was estimated that approximately 50% of all females over age 15 years could utilize this project's services.

The District Health Department serves five counties in north central North Carolina, had a 1960 population of 142,022 of which 108,194 were classified as rural residents. These counties encompass a land area of 2,205 square miles. There are three county hospitals and North Carolina Memorial State Hospital in the area with Duke Medical complex near by. The distribution of practicing physicians varies from one in Caswell County to twenty-one in Lee.

Initiation and development of project. Much time in the early phases of project application preparation was spent in meetings with physicians both at medical society meetings and individually in an effort to orient them to the project proposal and get their endorsement and cooperation. Each county medical society and each doctor gave their wholehearted approval to the project. A contractual agreement was made with the Pathology Department of the University of North Carolina Medical School to interpret all Pap slides submitted on the project. Members of the Pathology and Ob-Gyn Departments at the University of North
Carolina Medical School met with county medical societies one or more times to fully explain the procedure for taking, preparing, submitting and interpreting reports on Pap Smears. From the beginning the entire project has been designated as a private physician program even though smears are made in all Health Department clinics (maternity, welfare and general). The physician was furnished necessary supplies and equipment. The physician was asked to judge whether or not his patient would qualify as "medically indigent". The project assumes all expenses associated with preparing, shipping and interpreting of slides. No provision is made for professional fees.

The planning phase of the program or project lasted from July 19 to September 1962. This delay was necessitated by need for the Pathology Department at the University of North Carolina to add and train personnel as well as our need for time to accumulate and distribute supplies and records. The first smears were accepted on September 8. The Health Department staff has been increased by the addition of a Public Health Service program representative and a Health Educator.

Information was disseminated to the public through the facilities of local newspapers and radio stations, urging all women to visit their private physician for physical examination and Pap test. Letters were devised to inform ex-Health Department maternity patients and others of this service. Local welfare departments were contacted to mail to all welfare recipients notice of the availability of this test. Local county organizations (home demonstration clubs, church groups, etc.) were contacted and the project explained. A district-wide educational program was and is under way. Mass media is being used as a constant reminder, but the real effort is being made to reach all women in the community and not necessarily those in the target group.

A district tumor board was organized with representatives from the North Carolina Memorial Hospital, Ob-Gyn service, x-ray department, surgery department, pathology department along with a general surgeon from Siler City to review, study, evaluate and make recommendations on all patients needing and/or receiving treatment for positive Pap smears and positive biopsy reports.

Our goals were simple: (1) to make Pap smear available to all those women who normally, because of medical indigency, did not have the test routinely, (2) to keep foremost in the minds of the physicians the importance and benefits of routine cytological screening of all females.

Results first year.

Even though the project was approved for July 1, 1962, the program did not officially get under way until September, 1962. During the span of time from September 1962 to June 30, 1963, 80% of all Pap specimens originated in the office of practicing physicians in the district.

As of June 30, 1963, total of 1,259 (876 white, 343 non-white) (3,000 planned for in first year) specimens were submitted. Of this number, 32 (16 white and 16 non-white) had suspicious (Class III) or positive (Class IV) cytological findings. Of the 32, 14 (10 white and 4 non-white) patients have had surgery and pathological confirmation of cervical cancer. Two of the 14 were classified as invasive carcinoma of the cervix and 12 as cancer-in-situ. Of the remaining 18 (6 white, 12 non-white), four (1 white, 3 non-white) have been reexamined and classed as negative (Class II reports) and 14 (5 white, 9 non-white) are under diagnostic follow-up.
The majority of the in-situ diagnoses were asymptomatic on the initial examination. These results indicate the importance of the Pap smear as a routine procedure in the detection of early cervical cancer.

The age grouping of the first years activity shows:

<table>
<thead>
<tr>
<th>AGE</th>
<th>NEGATIVE (Class I &amp; II)</th>
<th>SUSPICIOUS (Class III)</th>
<th>POSITIVE (Class IV)</th>
<th>UNSATISFACTORY</th>
<th>TOTAL</th>
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<tr>
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<td>403</td>
<td>10</td>
<td>1</td>
<td>4</td>
<td>418</td>
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<tr>
<td>30-44</td>
<td>472</td>
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<td>7</td>
<td>5</td>
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<td>3</td>
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<td>3</td>
<td>7</td>
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<td>2</td>
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<td>1216</td>
<td>16</td>
<td>16</td>
<td>21</td>
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</table>

Race Distribution

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<th></th>
<th>Suspicious—Pos. Class III &amp; IV</th>
<th>DISPOSITION</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Treated</td>
<td>Neg.</td>
</tr>
<tr>
<td>White</td>
<td>876</td>
<td>16</td>
</tr>
<tr>
<td>Non-white</td>
<td>393</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>1269</td>
<td>32</td>
</tr>
</tbody>
</table>

Short Course Planned In Nursing Home Care

The School of Public Health, University of North Carolina, is planning a short course entitled "The Public Health Team Approach to Better Patient Care in Nursing Homes (Through the Improvement of the Environment.)" This short course will be offered October 14-18, 1963 and is sponsored by the Departments of Public Health Nursing, Public Health Administration and Environmental Sciences and Engineering. The course is planned for public health physicians, public health nurses, sanitarians, nutritionists, physical therapists and other personnel who are employed in health agencies working with nursing homes. Course content will include such areas as: philosophy and trends, legal aspects, health and medical care needs of the patients, the physical plant and the emotional and social environment. A second short course will be offered for the same trainees in May, 1964. Faculty of the University of North Carolina and guest instructors will participate in these courses.

Funds have been obtained from the Public Health Service Traineeship Program to provide registration fees and stipends of $12.00 per day for a limited number of trainees. There will be available to state and local public health personnel who are concerned with working with nursing homes and preference will be given to teams of public health workers from the same agency. It is expected that the trainees attending the first course will plan to attend the follow-up course which will be held in May, 1964. Traineeship funds will be available for the second course also. Travel expenses must be covered by the individual or the employing agency.

Application forms may be obtained by writing to: Miss Elizabeth S. Holley, Associate Professor, School of Public Health, Drawer 229, Chapel Hill, North Carolina. Deadline for receiving applications is September 20, 1963. Late applications may be considered.

August, 1963

THE HEALTH BULLETIN
DATES AND EVENTS

September 19-21 — Mental Health in Business and Industry — conference for top management, Lake Logan.


September 20-21 — N. C. Association for Retarded Children, Inc. — Annual Convention, Jack Tar Hotel, Durham.

September 24-27 — American Public Welfare Association, Southeastern Regional Meeting, Asheville.

September 26-27 — North Carolina Public Health Association Annual Convention, New Queen Charlotte Hotel, Charlotte.

September 26-28 — N. C. State Highway Employees Association Convention, Durham.

September 29 - October 2 — N. C. Motor Carriers Association Convention, 34th Annual, Pinehurst.

October 4-5 — N. C. Mental Health Association Leadership Conference, Charlotte.

October 5-10 — American Academy of Pediatrics, Annual Conference, Palmer House, Chicago.

October 7-9 — National Rehabilitation Association, National Conference, Carillon Hotel, Miami.


October 15-18 — American Dietetic Association, Philadelphia.

October 17-24 — American Occupational Therapy Association, St. Louis.

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Our Cover

"The Physician and the Child"

Child Health to Be Stressed in October

Starting with Child Health Day on October 1, the emphasis during the month will call attention to programs of health for children. The Children’s Bureau considers this an occasion to re-examine and re-state some important goals. This year’s emphasis is centered on ways to help give babies a good start in life. Among these are:

- A preventive health program to assure optimum health for all girls and women during their child-bearing years.
- Adequate prenatal care for all expectant mothers, with consultation from obstetricians and other specialists.
- Hospitalization for women with complications of pregnancy, and for premature or other infants in need of specialized care.
- More adequate provision for the purchase of maternity care by health departments for women in low-income families.
- Home care from medical and nursing personnel when hospitalization for delivery must be brief.
Graduate students from the School of Public Health at the University of North Carolina visited the State Board of Health recently. These and others who participated in the Conference are shown in the accompanying picture. They are (left to right) front row—Miss Barbara Kahn, Health Educator, State Board of Health; Mrs. Mabel Zaffar, Pakistan; Mrs. Kazuko Okuno, Tokyo, Japan; Mrs. Raul J. Bustillos, Caracas, Venezuela; Miss Rita Hsiang-Ming Chen, Atlanta, Georgia; Miss Helen Guha, Calcutta, India; Mrs. Prabha Limprasutr, Bangkok, Thailand; Dr. Saranya Reddy, Geneva, Switzerland; Miss Elizabeth Holley, Associate Professor, Public Health Nursing, School of Public Health, UNC; back row—Mr. Raul J. Bustillos, Caracas, Venezuela; Dr. Mohammad Anwar Khan; Mr. Roberto Augusto Martinez, Caracas, Venezuela; Dr. Kamil Yousif Hamati, Zerka, Jordan; Mr. Luis Nava, Carrboro, North Carolina; Mr. Muhammad Rafique Mian, Pakistan; Mr. Robert Ta-Chung Cheng, Taiwan, Free China; Dr. Felix Jose Gruber, Caracas, Venezuela; Mr. Nagaharu Okuno, Tokyo, Japan; Dr. H. B. Walker, Associate Professor, Public Health Education, Chairman of the Foreign Students Committee; Mr. Unis Ali Hijazi, Jerusalem, Jordan; Dr. Jacob Koomen, Assistant State Health Director; and Dr. Andreas Markides, Nicosia, Cyprus.
"10 Little Goblins" is the newest in the popular "10 Little . . ." series on safety. This is issued as a special Halloween safety leaflet and is in the Halloween colors of orange and black. Prices are on a sliding scale ranging from 8¢ each for 100 to 400 copies, down to 3¢ each for as many as 5,000. This and the other leaflets on safety are available from IMAGINATION, INC., 4032 Maryland Avenue North, Minneapolis 27, Minnesota.
National Council On Family
Relations Meets In Denver

By Mrs. J. Leonard Middleton

A dozen North Carolinians journeyed to the mile-high city of Denver, Colo. to participate in the 25th Annual Meeting of the National Council on Family Relations at the University of Denver, August 20-23rd.

They were: Dr. Mildred I. Morgan, Black Mountain; Mrs. J. Leonard Middleton, President of the NORTH CAROLINA FAMILY LIFE COUNCIL, and daughter, Marilyn; Miss Frances Jordan, Family Relations Specialist, Raleigh; Dr. and Mrs. Joseph S. Himes, Durham; Dr. and Mrs. Daniel F. Hobbs, Jr. and two children, Greensboro; and Mr. and Mrs. James H. Banbury, Charlotte. Doctors Morgan and Hobbs and Mesdames Middleton and Banbury appeared on the program of the Conference.

"THE AMERICAN FAMILY AND THE NATIONAL COUNCIL ON FAMILY RELATIONS—RETROSPECT AND PROSPECT" was the Conference theme. The main features of the program were three Plenary Sessions, an Annual Banquet, four section meetings on Counseling, Education, Research, and Special Emphasis, a barbecue, sight-seeing tours, and a Pre-Conference Special Seminar on Affiliated Groups.

Dr. Evelyn Duvall, Chicago, Illinois, charter member and former Executive Secretary of the Council, opened the Conference with her address entitled: "American Families and National Council on Family Relations—since 1938". She sketched family life in America during the last twenty-five years and outlined the history of the Council from its conception on April 21, 1938 to its current membership of approximately 3,000. She proposed a United States Department of Family Life with its Secretary a member of the President's Cabinet, and reported on the proposal for a World Family Year, probably in 1965, sponsored possibly by the International Union of Family Organizations.

Dr. Reuben Hill, formerly of the University of North Carolina at Chapel Hill,
and now of the University of Minnesota, spoke on "The American Family of the Future". He delineated four methods for projecting the American Family into the future: 1. Extrapolation of current trends in the family, 2. studying three generations of American Families, 3. impact of current inventions on the family, 4. inferences from writings and Researches of Family Specialists. He stated: "I should say, therefore, that my point of view is less one of despair about the contemporary family and more one of admiration and respect for its flexibility, its resilience, and its capacity for survival and growth...". Dr. Hill received the Ernest W. Burgess Award for Family Research at the conclusion of his speech.

Dr. Jessie Bernard of Pennsylvania State University spoke on "Charting the Course of the American Family and National Council on Family Relations". She suggested there is an increasing (and revolutionary) emphasis in our textbooks on companionship in marriage. This is still a luxury item but increasingly it will become incorporated as a standard requirement for a good marriage she stated. She further suggested that the great developmental task of the next 25 years will be the acculturation of the Negro, and we cannot escape a continual discussion of values.

As the Banquet honored the Past Presidents of the Council, President Wallace C. Fulton of New York City spoke on "The American Family and Time". He theorized: "The value of time tends to be judged in terms of its use. Therefore, it seems to me that it is imperative that we learn more about men's use of time in order to meet more realistically our educational and counseling responsibilities in the family life field...". "...our major concern lies with time as a phenomenon in social science, and, in particular, as a resource for individual and family use."

Dr. Blaine R. Porter of Brigham Young University was elected President and Dr. Clark Vincent of Bethesda, Maryland is the President-Elect. The next Annual Meeting of the Council will be October 9, 10, 11, 1964 at the Beauville Hotel, Miami Beach, Fla.
On the
Next Two Pages

The Prize Picture
Entitled

"The Patient's Heart Has Stopped
But He Is Still Alive"

Photo Courtesy
of the
B. F. Goodrich Company
W. Wright Langley, Jr., Director of North Carolina's Health Careers Project, is shown as he pointed out features of the Medical Records Librarian exhibit, one of nineteen exhibits presenting Health Careers at a recent conference in Durham. Students shown are: Miss Cathy Cordyack (left), Durham; and Miss Glenda Brown, Greensboro.
Health Careers Coordinators shown in these pictures serve in the six districts of the N. C. Health Careers Project, sponsored by Health Careers for North Carolina. This project is supported over a three-year period by a total of some $84,000 per year contributed by member hospitals of N. C. Hospital Association and generous amounts from the following foundations and organizations: The Duke Endowment; Z. Smith Reynolds Foundation; R. J. Reynolds Tobacco Company; Liggett and Myers Tobacco Company; Hospital Care Association; Hospital Saving Association; N. C. League for Nursing and the Medical Society of the State of North Carolina. Directed by W. Wright Langley, Jr. this Project seeks to enlist personnel for a wide variety of health careers. The North Carolina Health Council furnishes an Advisory Committee to the sponsoring organization. Coordinators shown are (left to right) top row—District V, Julian LeRoy Sessoms, Elizabethtown; District III, Miss LoRayne Dinguess, Charlotte; District VI, Charles B. Conklin, Greenville; bottom row—District I, Mrs. C. F. Tillinghast, Asheville; District II, Earl Hartsell, Jr., Winston-Salem; and District IV, Mrs. E. C. Peele, Raleigh.
Wake County Observes Community Health Day

By Phil Buchen, M.S.P.H.

Last year on Tuesday, September 18, the Wake County Health Department was bursting at its seams with people and activity. All day long and up into the evening (10 p.m. to be exact) there was a steady flow of traffic as people arrived and departed from the building. In addition to two well-attended clinics, the main attraction at the health department was Community Health Day.

For some time the seemingly ever present problem of how to interpret to the public the community's vast health program had been in the minds of many of Wake County's health leaders. With the formation of the Health Affairs Roundtable (An organization of voluntary membership comprised of about twenty health and related organizations in Wake County) last Spring, and the close association which the organization began to foster between health agency representatives, it was soon realized that the problem could begin to be met with unity and sincerity of purpose. There also comes a time during growth and development when an organization needs to participate in some type of activity that will not only benefit others but also itself. Community Health Day was the first cooperative educational venture of the Health Affairs Roundtable, and represented the initial step in its maturation.

The idea to plan an informative day where the public could meet with its health workers and learn of the many and varied health services available came from Mrs. V. B. Benson, Health Affairs Committee Chairman of the Raleigh Woman's Club and Roundtable member. The idea, having received prior support from the County's Health Director, Dr. Isa Grant, to hold the project in the health department, was presented to the Roundtable for their participation.

To develop further ideas and suggestions, a planning committee was formed which included members from the project's co-sponsors: Mrs. Julia Snyder, health educator of the Wake County Health Department; Mrs. Benson; and Mrs. Sara Casper representing the Health Affairs Roundtable.

It was first considered to open Community Health Day to the general public, but after some deliberation it was agreed that small groups of selected guests would yield the best results in an educational endeavor, and prevent things from becoming too unwieldy. It was most important that a degree of success be mutually recognized, regardless of the project's scope, in that first cooperative effort.

Plans were made and Community Health Day began to take shape.
written invitations were mailed to community leaders in government, civic affairs, women's clubs, schools, and professional organizations. One person who participated in the planning remarked that it would be fortunate if a hundred came, but as it turned out about 200 acknowledged their invitations in the affirmative and attended.

Each person invited was given a specific hour to attend (including an alternate hour). The day was divided into eight one-hour sessions and it was estimated that there were about twenty-five guests to a session.

As the guests arrived to each session, they were greeted and registered by volunteer members of the Women's Club and directed to the health department library. There they enjoyed a cup of coffee and listened to two informal discussions. The discussions set the theme of the day in motion—"focus on Total Health".

The first presentation was given by the president of the Health Affairs Roundtable, Mr. Charles Schuch of the Wake County Cerebral Palsy and Rehabilitation Center, who discussed the organization's purposes and objectives. The second discussion briefly outlined the services, functions and legal responsibilities of the health department; some of the community's current health problems; and an explanation of why and how the community is given a periodical physical examination by the health department. That discussion was led by a different staff member at each session. While the guests were in the library, they were given a pamphlet (homemade) which kept pace with the day's theme. The meeting in the library was about thirty minutes in duration. The guests were then divided into small groups for a tour of the building. Each health department section had a staff member stationed in their respective offices with visual aids to assist them in their summary of their responsibilities and to answer any questions that arise. The tours terminated in the public health nurses' large office. This room was temporarily converted for the day to house all of the Roundtable member agencies. Each organization representative had a desk from which they displayed and distributed informational materials. It was in this setting that the Roundtable members met and talked with many of the guests. The guests were given an opportunity to visit with as many agency representatives as they desired. This gave the Roundtable members the occasion to impart, on a person-to-person basis, information regarding their own specific organization.

Perhaps it is premature to attempt an evaluation of the learning experiences inherent in the day's proceedings. However, in retrospect certain observations and remarks made by the participants and visitors suggest that the project stimulated an increased appreciation and awareness for the community's health program. A sincere interest was evident from the numerous queries received from the visitors as they talked with staff members and Roundtable representatives. The milk sanitarian remarked that he had never been flooded with so many questions in one day, and several home demonstration club presidents stated that they never realized the scope of what was being done to secure and maintain an optimum standard of health in the community. Suggestions were received in the mail that the project be expanded and made an annual affair. It was also suggested that information regarding Community Health Day be made available to other health departments and community groups.

Certainly the project could not have been undertaken without the excellent cooperation demonstrated between the three organizations involved.

September, 1963 THE HEALTH BULLETIN 13
Unit: Nursing Home Council

**Director Named**

Henry A. Holle, M.D., former Texas state commissioner of health, was named executive director of the National Council for the Accreditation of Nursing Homes.

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**MEMBERS OF THE NORTH CAROLINA STATE BOARD OF HEALTH**

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<td>James F. Donnelly, M.D.</td>
<td>Director, Personal Health</td>
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**DR. WINGATE JOHNSON, VETERAN PHYSICIAN, TEACHER SUCCUMBS**

Dr. Wingate M. Johnson, 78, editor of the North Carolina Medical Journal since its founding in 1940, died of a heart attack in Winston-Salem on September 12.

Johnson, one of the oldest practicing physicians in the state, was a former president of the American Geriatric Society and was considered one of the nation's outstanding authorities on diseases of older people (geriatrics).

A native of Riverton, Dr. Johnson started his medical practice in Winston-Salem in 1909.

He was a trustee of Wake Forest College from 1920 until 1940.

Surviving in addition to his wife, son, Dr. Livingston Johnson of Shelby, and daughter, Mrs. Edward Jackson of Durham, are three sisters, Dr. Mary Lynch Johnson of the Meredith College faculty, and Mrs. Foy J. Farmer, both of Raleigh, and Mrs. Elbert N. Johnson of Wagram.
NEW DEAN FOR UNC SCHOOL OF PUBLIC HEALTH

Dr. William Fred Mayes, a distinguished teacher and public servant in public health, has been named the new Dean of the University of North Carolina School of Public Health.

Dr. Mayes' appointment was effective August 1 and was announced by UNC Chancellor William B. Aycock. He will succeed Dr. E. G. McGavran, Dean since 1947, who retires this year and will accept a post with the Ford Foundation in India.

Dr. Mayes is the first new dean to be appointed in the University's Division of Health Affairs—including schools of Pharmacy, Medicine, Dentistry, Nursing and Public Health—since the Division's establishment in 1950. He comes to UNC from Washington, where he served as Chief of the Office of Research Grants in the Bureau of State Services of the Public Health Service.

Dr. Mayes, born in Missouri in 1908, was educated at the University of Kansas, where he received the B. S. degree in 1936 and the M.D. degree in 1938.

Dr. Mayes began his career in public health practice in 1941, as local health officer in a four-county rural district of Kansas. In 1942 he was Maternal and Child Health Director of the Kansas State Department of Health and in 1943 was Regional Medical Consultant in Atlanta, Ga., to the U. S. Children's Bureau.

Dr. Mayes was Chief Health Advisor to the U. S. Technical Operations Mission to Pakistan from 1953 to 1955. In 1955 he returned to Harvard's Public Health School as an associate professor, serving as acting head of the Department of Public Health Practice there from 1956 to 1957.

In 1957, he became assistant chief of the Division of General Health Services of the Public Health Service, and in 1961 he assumed his present duties.
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DATES AND EVENTS 1963

October 4-5—N. C. Mental Health Association Leadership Conference, Charlotte.
October 5-10—American Academy of Pediatrics, Annual Conference, Palmer House, Chicago, Ill.
October 7-9 — National Rehabilitation Association, National Conference, Carillon Hotel, Miami, Fla.

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October 17-24—American Occupational Therapy Association, St. Louis, Mo.
October 21-24—American Association of Medical Record Librarians, Chicago, Illinois.
October 24-26—N. C. Library Association, Jack Tar Hotel, Durham.
October 25-26—N. C. Society for Crippled Children and Adults—Annual Meeting Battery Park Hotel, Asheville.
October 25-27—36th Annual Scientific Sessions, American Heart Association, Biltmore Hotel, Los Angeles, California.
October 28-Nov. 1 — National Safety Council, Chicago, Ill.
TWO GREAT PUBLIC HEALTH LEADERS CONFER

During the Annual Meeting in Charlotte, Dr. J. W. R. Norton (right), fifth State Health Director for North Carolina and President of the American Public Health Association, visited with Dr. Watson S. Rankin, North Carolina’s first full-time State Health Director. This memorable conversation took place in the well-appointed study which Dr. Rankin has in his home on the beautiful grounds of the Methodist Retirement Home just outside of Charlotte. Dr. Rankin, now 85, was one of the founders of the organization which became the present North Carolina Public Health Association.

October, 1963
Chairman of Local Arrangements for the Annual Meeting was the Mecklenburg Charlotte local health director, Dr. Maurice Kamp (left). He is shown in conversation with Dr. Jacob Koomen, Jr., Assistant State Health Director. Dr. Kamp and his staff and others from Charlotte did a splendid job of arrangement and entertainment.

North Carolina’s Public Health Association Meets In Charlotte

Registration personnel for the Annual NCPHA Meeting in Charlotte were most efficient, hard working, pleasant and helpful. Most of this group are shown in this picture. From the left, these are (seated) Jessie Pate, Harold Sauls, Valeria Cobb and Clara Tessenear; (standing) Katherine Massey, Geneva Goodwin, Lorraine Ives, Doris Philyaw, Elise Powers, Bonnie Ray (all of Raleigh), and Pat Campbell of Charlotte.
Legislative Aspects of North Carolina's Health Program

by State Senator John R. Jordan

It is perhaps an over-simplification to say that the progress and well-being of North Carolina depends primarily upon the health of its people, but the point I wish to make is best illustrated by the vision of North Carolina-born Walter Hines Page and the eradication of the hookworm in this State and in the South.

In 1906 Page was a member of President Theodore Roosevelt's special commission investigating social and economic conditions in the South. The sanitarian for the commission was another North Carolinian, Dr. Charles W. Stiles, a distinguished zoologist. Stiles had for many years maintained that much of the mental and physical sluggishness which prevailed in the rural South was because of a hitherto unclassified species of parasite popularly known as the hookworm.

The pathological effects of this creature had long been known; it localized in the intestines, there secreted a poison that destroyed the red blood corpuscles, and reduced its victims to a deplorable state of anemia, making them constantly ill, listless, mentally dull—in a sense, useless units of society. Dr. Stiles' theory had been laughed off for the years, but he finally convinced Page that it was the hookworm which was draining away the strength of the South and Page in turn talked John D. Rockefeller into contributing one million dollars for an investigation.

The rest is familiar history: Dr. W. S. Rankin of Mooresville and Dr. John A. Ferrell of Duplin conducted the study and campaign which proved Dr. Stiles' theory, eradicated hookworm and liberated a third of the population of this State to a happier, fuller life. The pages of history contain no more dramatic illustration of what an intelligent awareness of health can do for the economic and social well-being of a people.

As those who interest themselves in the public health of North Carolina,
you, more than any others, are acutely aware of both the heavy responsibilities and the tremendous opportunities which attend your endeavors today.

Just a few years ago, both the opportunities and the responsibilities were much fewer. Then public health practice was in the large oriented to communicable disease epidemiology.

Public health nurses taught families the care of communicable diseases in the home, made investigations in syphilis cases, and attempted to convince tuberculosis patients they were hazards to their families and should accept hospitalization.

The main concerns of the Health Department were water and milk sanitation, maternal and child care, and the control of communicable diseases of which syphilis, tuberculosis and poliomyelitis were the most prevalent; but public health has achieved such brilliant successes in preventing infants from dying or diarrheal diseases, in preventing mothers from dying in childbirth, in preventing children and young adults from dying of diphtheria, whooping cough, typhoid fever and tuberculosis, that today more and more people reach the ages at which illness and accident rates are very high.

Thus, for the population as a whole, the amount of morbidity now is considerably greater than in the days when the population was relatively young. We then have a population which is older, sicker and has more chronic diseases and disabilities than its predecessors. This is the core of the challenge for public health today.

It is against this background that we review the accomplishments and the failures of the 1963 General Assembly in the field of health. Adjournment of a long and controversial session came on June 26—4 months, 20 days, 5 hours and 2 minutes after the opening session on February 6. (And it seemed even longer). Actually, this General Assembly probably considered more health legislation than any one in recent years.

I would like to first discuss the most widely-publicized of the health bills, Senate Bill 8, which I introduced myself and which implemented in North Carolina a broad based program of medical aid for the aged and others. The total medical aid program in North Carolina may be summarized as follows:

1. Hospitalization for the medically indigent and for the totally indigent including those receiving old age assistance, those receiving aid to the totally and permanently disabled and those receiving aid to dependent children benefits.

2. Out-patient care for the medically indigent and for the totally indigent in all three categories named above.

3. Drugs for the medically indigent.

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Editor—Edwin S. Preston, M.A., LL.D.
Vol. 78 October, 1963 No. 10
on a vendor payment basis and authorization to implement a vendor payment program for drugs for the totally indigent in the three categories named above.

4. Dental care for the medically indigent and for the totally indigent in the old age assistance category only. (Dependant children of school age receive dental care through the Public Health Program as it is now constituted).

The State Board of Health enjoyed an unusually successful legislative program, and all five measures sponsored by it were adopted. Among them were:

1. The establishment of a State Air Hygiene Service under the State Board of Health. This agency is authorized to advise, consult and cooperate with other State agencies, local governmental units, industries, the Federal government, and other interested groups on problems relating to air pollution.

2. The State Board of Health was authorized to establish recommended minimum standards for the design, construction, operation and maintenance of public swimming pools. This is much needed legislation in that there are no official standards to guide contractors, architects and engineers in the design and construction of pools. The private swimming pool is, of course, becoming more and more commonplace in our society.

3. Improved procedures for handling vital statistics. Among these much needed amendments was a provision requiring the attending physician to

Presiding at the Banquet must not be a very worrisome job. Here is Mrs. Betty Poits Keziah, retiring president, with Martin P. Hines, the incoming president, during the dessert and coffee course of the banquet over which Mrs. Keziah presided.
make the medical certification on a death certificate before burial or within 72 hours. Also included was a provision authorizing the State Board of Embalmers and Funeral Directors to revoke the license of any funeral director who violates the provisions of the North Carolina Vital Statistics Law.

4. The General Assembly, again on the recommendation of the State Board of Health, turned its attention to the problems of migrant labor and authorized the maintenance of agriculture labor camps only upon obtaining permission from the local health department having jurisdiction over the particular area. The State Board of Health is made responsible for enforcement of this act.

5. The General Assembly authorized local boards of health to accept fees for public health nursing services and physical therapy services to individuals in need of bedside nursing and physical therapy because of chronic illness. At the present time, only about one-fourth of all North Carolina counties are providing these special services and it is felt that the new legislation on the subject will encourage broader participation.

Mental health was a matter of considerable legislative concern, and Senate Bill 182 created a State Department of Mental Health. Certain powers previously vested in the State Board of Health and the State Hospitals Board of Control were transferred to the new...
agency, and local mental health clinics were authorized under prescribed conditions.

Senate Bill 384 provides for the establishment of three regional centers for diagnosis, evaluation and rehabilitation of mentally retarded children during the next two years. It is anticipated that an additional 900 children will be evaluated each year, and 3,000 to 5,000 additional children will be screened for mental retardation. State Board of Health programs in mental retardation are not affected by the legislation creating a new Department of Mental Health.

House Bill 797 created a Council on Mental Retardation making permanent the previous committee in the hope that such will develop interest in a continuing program for mental retardation in the State.

The acute shortage of nurses was recognized by the General Assembly and a program of scholarship for nurse anesthetists was authorized as was a program of scholarships for medical technicians. The existing Student Nurse Loan program was amended so as to eliminate geographical restrictions in the hope of encouraging fuller participation.

Two men distinguished for long and outstanding service in public health were given Watson S. Rankin Awards at the Banquet Session. From the left those shown are Dr. E. R. Hardin for forty-four years health director in Robeson County; Dr. Bernard G. Greenberg of the UNC School of Public Health, Chairman of the Awards Committee; and Dr. A. H. Elliot presently health director in Brunswick County and formerly a Division Director of the State Board of Health and service in other public health responsibilities.

Public health officials in North Carolina who have pioneered in so many public health areas—for instance, North Carolina was the first state in the nation to enact compulsory immunization against poliomyelitis—came forward this year in support of a health problem from a source other than disease, to wit, accidents. The State Board of Health endorsed the entire program of the Governor's Co-ordinating Committee on Traffic Safety and that program, with one exception, was enacted.

You will be particularly interested in House Bill 527 providing for breath tests for intoxication, because the State Board of Health has been assigned the responsibility for improving methods for analyzing a person's breath and setting standards for qualification to individuals to administer the tests.

Senate Bill 83, known as the Sterilization Law, provides that a physician licensed by the State, in consultation with at least one other physician so licensed, may legally perform sterilizations for social and economic reasons under certain provisions. Many thoughtful legal scholars feel that such was the law all along but that this legislation has at last codified it.

Other health legislation included an
act to continue the North Carolina Cancer Commission, an act to encourage development of additional schools of nursing, an act to make permanent the Governor's Co-ordinating Committee on Traffic Safety, and perhaps one of the kindest acts of the General Assembly of 1963 was Senate Bill 208 appropriating funds for the treatment of children suffering from cystic fibrosis and other errors of metabolism.

Difficult to understand was the failure of the General Assembly to appropriate an additional $576,000 for aid to county health programs which increase had already been approved and recommended by the Advisory Budget Commission. Such is to be "penny wise and pound foolish." This legislative omission was perhaps prompted by the fact that Federal matching funds for health programs are not available at the same high ratio of Federal funds for welfare purposes. Such a basis for legislative decisions defeats both logic and efficiency.

While you have done so much, much remains to be done. While most communicable disease is under control, trends in the past two or three years show increases in North Carolina in both venereal disease and tuberculosis.

Further planning to avoid traffic deaths and home and farm accidents is a necessity, and, of course, increased bedside care needs will multiply the burdens of the public health nurse. May I parenthetically take this opportunity to thank the public health nurses of North Carolina for the pioneer work you have already done in this field.

As already indicated, in spite of all that has been done for the health of North Carolina, much remains to be done. While we would welcome the vision and leadership of another Walter Hines Page, today—unlike in Page's day

Participating in the Sessions of the Annual Meeting was Dr. Emil Palmquist (left) Charlottesville, Va. With him are shown Dr. Isa Grant, the new President-Elect and now local health director in the district which includes Pasquotank—Perquimans—Camden and Chowan; and Roddey M. Ligon, Assistant Director of the UNC Institute of Government.

A visitor from Kentucky, Dr. Russell Teague (right), State Health Commissioner, told the delegates about the Medical Care Program in his state. With him are shown from the left Dr. Martin P. Hines, newly elected President; Dr. J. W. R. Norton, State Health Director and President of the American Public Health Association; and Dr. John S. Rhodes, President of the Medical Society of the State of North Carolina. Dr. Rhodes brought a message from the Medical Society.
we can already identify our health needs. North Carolina's distinguished State Health Director.

Dr. Roy Norton, has recently enumerated these health needs: The increasing industrialization of North Carolina has revealed our inadequate facilities for occupational health services. More adequate protection of private water supplies is needed. Effective safeguards against certain infections occurring in nursing homes and hospitals are needed. Alcoholism continues to be a major threat. Research on chronic diseases must be expanded.

North Carolina's new program of medical aid for the aged will have to be constantly re-evaluated in the light of experience. Additional health personnel and greater financial support for health programs should be given a higher budgetary priority. The increasing cost of medical care and hospitalization must be given more deliberate attention than it has received to date. We suffer from serious shortages of doctors, dentists and nurses; North Carolina stands 39th in ratio of physicians to population and 42nd as to dentists.

As Dr. Norton has said, "The State as a whole prospers when, through good adult health, individuals and families and the communities prosper in ways that permit profitable and productive work."

In the field of public health you may justifiably look to public funds and public legislation for support in meeting the problems we have mentioned. But legislation alone will not do the job. At times even the best intended legislation misses its mark. Consider this Act passed by the British Parliament in 1770:

"All women of whatever age, rank, profession or degree, whether virgins, maids or widows, that shall impose upon, seduce, and betray into matrimony any of his Majesty's sub-
jects by scents, paints, cosmetics, washes, artificial teeth, false hair, Spanish wool, iron staves, hoops, high-heeled shoes, bolstered hips, or padded bosoms shall incur the penalty of the law enforced against witchcraft and the like misdemeanors and that marriage, upon conviction, shall stand null and void."

(Now, you and I know how much good that legislation did!)

In this age of the new biology, the health of the men, women and children of North Carolina rests now, as in the past, in your hands. Legislation can but give you the tools—tools which it must be admitted too often are too little and too late. And so, as a Legislator, and as a citizen, I salute you for your dedication, for your patience and for your unselfish service to your fellow man.
Informal after-session conferences could be seen on every hand during the days of the Annual Meeting. Here are shown from the left: J. S. Canady, Fayetteville, District Sanitarian; W. C. Lackey, Murfreesboro, District Sanitarian; and Dr. Martin P. Hines, newly elected president of the Association.

Asheville and Winston-Salem sent their most able and charming representatives to the Meeting. Here are Mrs. H. W. Stevens (center), Asheville, wife of Buncombe County's health director; Dr. and Mrs. Robert P. Locey, Winston-Salem. Dr. Locey is the Forsyth County health director.

Chatting with friends during the time in Charlotte appeared to be an enjoyable occupation. Here are Mrs. Joseph L. Campbell (left), Wilson, wife of the local health director; and Mrs. J. W. R. Norton, wife of the State Health Director.
Dr. Albert S. Edwards (right), Raleigh, minister of the First Presbyterian Church, was the delightful after-dinner speaker at the Banquet Session stressing the encouraging progress made in health matters. With him at the head table are shown Dr. Martin P. Hines, newly elected President, and Mrs. Corrina Sutton, Raleigh, treasurer of the Association.

At the Banquet During Annual Session

This distinguished foursome at the head table during the Banquet received much merited and interested attention. From the left these are Dr. J. W. R. Norton, State Health Director and President of the American Public Health Association; Mrs. Norton; Dr. William Fred Mayes, new Dean of the UNC School of Public Health; and Mrs. Mayes.
New Officers Elected at Annual NCPHA Meeting Held in Charlotte

Number Registered for Meeting: 745

NEW OFFICERS:
President: Martin P. Hines, D.V.M., Raleigh
Pres-Elec: Dr. Isa Grant, Elizabeth City
Vice-Pres: Dr. Robert P. Locey, Winston-Salem
Secretary: Lucy Lopp, High Point
Treasurer: Mrs. Corrina Sutton, Raleigh
Past Pres.: Mrs. Betty Potts Keziah, Charlotte

SECTION OFFICERS:
Health Director's Section:
Chairman: Dr. Robert P. Locey, Winston-Salem
Vice-Ch.: Dr. Melvin F. Eyerman, Lillington
Sec-Trea.: Dr. Carl Hammer, Goldsboro

Mental Health Section:
Chairman: Mrs. Mary T. Dorst, Asheville
Vice-Ch.: Dr. Robert Fincher, High Point
Sec-Trea: Mrs. Mary J. Blair, High Point

Nurses' Section:
Chairman: Mrs. Frankie Booker, Rocky Mount
Vice-Ch.: Mrs. Maude K. Eaker, Gastonia
Sec-Trea: Mrs. Martian H. Bass, High Point

Secretarial and Statistical Section:
Chairman: Mrs. Berta Ellis, Durham County

Vice-Ch.: Mrs. Virginia Preddy, Granville County
Sec-Trea: Mrs. Betty Neal, Halifax County

Nutrition Section:
Chairman: Asenath Cooke, Greensboro
Vice-Ch.: Mrs. Elaine M. Mansfield, Durham
Sec-Trea: Mrs. Elizabeth Byars, Charlotte

Health Education Section:
Chairman: Marshall Abee, Winston-Salem
Vice-Ch.: Jay Lloyd Allen, Asheville
Sec-Trea: Hiawatha B. Walker, Ph.D., Chapel Hill

Venereal Disease Section:
Chairman: Edward Foster, Pitt County
Vice-Ch.: Maxim Demchak, Charlotte
Sec-Trea: Jerry Jackson, Charlotte

Laboratory Section:
Chairman: Bryan Reep, Raleigh
Vice-Ch.: Mrs. Norma B. Carroll, Raleigh
Sec-Trea: Mrs. Alice T. Ashton, Raleigh

Dental Health Section:
Chairman: Dr. T. H. Harris, Raleigh
Vice-Ch.: Dr. Paul Sanders, Raleigh
Sec-Trea: Sylvia Verdery, Raleigh

Sanitation Section:
Chairman: Owen R. Braughler, Greensboro
Vice-Ch.: W. M. Haislip, Gastonia
Sec-Trea: Bob C. Sandford, Rockingham
The Carl V. Reynolds Award: Given to an individual for outstanding contributions to public health in North Carolina during the past year for meritorious service above and beyond the call of duty. This award presented to Dr. Edward G. McGavran, UNC School of Public Health.

The Watson S. Rankin Award: Given to an individual in recognition of outstanding contributions to public health in North Carolina over a period of several years. Awards presented to Dr. Avon Hall Elliot, Health Director of Brunswick County and Dr. Eugene R. Hardin, Health Director of Robeson County.

The Merit Award: Given to a local health department or group for outstanding contributions or activities during the past year. Presented to the Guilford County Health Department.

The Merit Citation: Given to an individual for outstanding contribution in working with a special project during the past year. Awards presented to Lewis H. Caton, Sanitarian Supervisor, Cumberland County Health Department and to Dr. Sarah Taylor Morrow, Guilford County Health Department.

The Distinguished Service Citation: This award given to recognize individuals in other organizations or professions who have made significant contributions to public health in North Carolina. This year presented to former State Senator O. Arthur Kirkman, High Point.

Local health directors and others hear a discussion of new health legislation.
School Dental Health Education
By W. C. Byrd, Health Educator
Buncombe County Health Department

In many communities in North Carolina, efforts are being made by dental societies, health departments and public school people to pool their resources for a concentrated attack on dental problems through special educational efforts in the public schools. In several instances, the public health director or another staff person has taken the initiative in bringing about cooperative dental health education programs by using public health statistics to impress upon the school people and dental societies the magnitude of the problem of poor oral hygiene in young school children.

In most instances, the school people are impressed with the fact that much decay and periodontal disease could be prevented by educating young children about proper toothbrushing, diet, and the importance of regular visits to their dentists. Dental society members are usually enthusiastic about any program to help children and many have volunteered to give their time to help conduct instructional seminars for teachers and even to visit schools and do dental inspections of children involved in these special programs.

One of the first comprehensive dental health education programs in North Carolina started in Asheville in 1961, with the cooperation of the Buncombe County Dental Society, the Asheville City Schools, the Buncombe County Schools and the Buncombe County Board of Health. This group developed a program designed to provide teachers of selected grades with dental health facts and materials through seminars for the teachers. The teachers, in turn, were expected to do a comprehensive dental health unit in their class-

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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

THE HEALTH BULLETIN
October, 1963
rooms. Dental society personnel helped conduct the teacher seminars and did dental inspections in the classrooms. The cooperative spirit and effort in Asheville has placed the health of children above any jealousies or so-called "ethical" questions and has resulted in a solid program that has benefited all.

In addition to various educational materials from the American Dental Association and the state Division of Oral Hygiene, the Asheville group obtained various educational materials from Procter and Gamble Company. These included posters showing tooth anatomy, the decay process, and a proper toothbrushing method. Also, an educational kit was used which contained a toothbrush, a tube of Crest and two dye tablets. The dye tablets, or "disclosure tablets", were used to reveal improperly cleaned surface of children's teeth in classroom demonstrations.

The Asheville project started in the third grades in February of 1962, was repeated at that grade level in the fall of 1962, and added the fifth grade in the spring of 1963. Plans are complete for a program in the second grades this fall.

In 1962 and in 1963, thorough evaluations were made of their dental health education programs and the survey findings reflect enthusiasm and satisfaction on the part of all participants, especially the school teachers, who are the most important persons involved.

By virtue of agreements made by the participating groups in Asheville, there has been no publicity about their program except as was approved and released by their Health Department. This has been limited to local publicity, correspondence, printed evaluations, and word of mouth. However, this is a program that could be carried out beneficially anywhere in our state. The school children need this instruction and health departments and dental groups can certainly give a big helping hand to our colleagues in the public schools as has been done in Buncombe County. For this reason, we pass on to you this brief description, hoping that it might benefit you and your community.

RESULTS OF THE FIRST YEAR DENTAL SURVEY (1961) OF CHILDREN IN ASHEVILLE AND BUNCOMBE COUNTY

By Dr. D. W. Dudley

Total number children examined _4836
Total number needing no treatment ___________2415
Total number needing treatment ___________2421

492% need no treatment
501% need treatment

Third Grade:
Number children examined ______ 792
Number needing no treatment ____ 469
Number needing treatment ______ 323

59% need no treatment
41% need treatment

Fifth Grade:
Number children examined ______ 849
Number needing no treatment ___ 441
Number needing treatment ____ 408

52% need no treatment
48% need treatment

Seventh Grade:
Number children examined __ __ _ 1277
Number needing no treatment ___ 652
Number needing treatment _____ 623

51% need no treatment
49% need treatment

Ninth Grade:
Number children examined _____ 1918
Number needing no treatment ____ 853
Number needing treatment ____ 1065

441/2% need no treatment
551/2% need treatment
If you do NOT wish to continue receiving The Health Bulletin, please check here □ and return this page to the address above.

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DATES AND EVENTS

November 2-3—Annual Meeting of N. C. Division of the American Cancer Society, Hotel Sir Walter, Raleigh, Public invited.
November 8—N. C. Dietetic Association Fall Meeting — Carolina Inn, Chapel Hill.
November 8-9 — Gerontological Society, Sheraton-Plaza Hotel, Boston, Mass.
November 10-16 — National Children's Book Week.
November 11 -15 — American Public Health Association, Municipal Audito-rium, Kansas City, Mo.
November 13-15—American Association of Homes for the Aging, Dallas, Tex.
November 15-16 — District Health Careers Congress, Asheville, Battery Park Hotel.
November 20-23—National Association for Mental Health, Annual Meeting and Mental Health Assembly, Sheraton-Park Hotel, Washington, D. C.
November 22-25 — Annual Convention of the National Society for Crippled Children and Adults, Palmer House, Chicago, Ill.

December 3-7—Association of Rehabilitation Centers Annual Workshop, Congress Hotel, Chicago, Ill.
First week in December—Conference of National Council on Aging, Boston, Mass.

December 4-7—American Public Welfare Association (Biennial Round Table Conference), Statler - Hilton Hotel, Washington, D. C.

December 6-7—Association for Research in Nervous and Mental Diseases, Hotel Roosevelt, New York, N. Y.

December 26-31—World Medical Association, 17th General Assembly, Helsinki, Finland.

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LEADERS AT AUDITORIUM DEDICATION

These were among the leaders honoring Dr. John H. Hamilton (center) upon the dedication of the auditorium of the State Board of Health in his name. Standing in front of the bronze plaque with Dr. Hamilton are Dr. Jacob Koomen Jr., (left) Assistant State Health Director, and Dr. J. W. R. Norton, State Health Director and President of the American Public Health Association. (See pages 2, 3 and 4.)

November, 1963
Auditorium Dedicated

The auditorium of the Laboratory Division of the State Board of Health — newly redecorated and attractively refurnished — was dedicated in November as the John Homer Hamilton Auditorium.

A large assembly of friends and public health personnel gathered for a special meeting of the North Carolina Public Health Academy to honor Dr. Hamilton. Dr. and Mrs. Hamilton were present for the program and for the unveiling of the appropriate bronze plaque.

Dr. John R. Bender, physician of Winston-Salem and Vice-President of the State Board of Health, made the principal address.

Dr. Lynn G. Maddry, acting director of the Laboratory Division, gave an appropriate tribute, and unveiled the bronze plaque.
Tribute to Dr. John H. Hamilton
by John R. Bender, M.D.
Vice President of the State Board of Health

Dr. Koomen; Dr. Norton — Ladies and Gentlemen:

Many introductions have been given, many eulogies written and many laudable comments made concerning (Dr.) John Homer Hamilton. And a voluminous treatise, yet to be given would not portray the entirety of his achievements or the benevolence of his humanitarian character. I will make no attempt therefore to proffer a laudation in his presence or on his behalf. But I would be derelict in my duty on behalf of the State Board of Health and personally negligent to those grateful emotions which arise within me if I did not express to Dr. Norton and to you, the members of the staff and the N. C. Public Health Team of the State Health Department of which Dr. Hamilton was for so long a member and all of whom he so dearly loved, my deep and sincere appreciation for the opportunity to attend this meeting — and my gratitude in having this honor as a representative of the State Board of Health, to pay tribute to a personal friend and an esteemed colleague.

My association with Dr. Hamilton — extends back over a period of 14 years — and during this period of time I have marveled at his judgment and the effective dispassion with which he presented his position — regardless of the issue. His freedom from personal bias and mundane motives — gained him the unselfish admiration of the members of the State Board of Health.

Dr. Hamilton’s career in North Carolina as a public health physician is the more remarkable when we consider that he was born in Missouri, reared in Oklahoma, taught public school in Kansas; and came to this state — of his own choosing — by way of Pennsylvania. And we will be ever grateful to him for the choice he made 43 years ago; when he chose to end his journeying and settle in the Tar Heel State.

Dr. Hamilton — brought to the banks of the Cape Fear and the Atlantic Seaboard the intellectual curiosity befitting a native of the “show-me” state of Missouri; the enduring stamina and strong physique of a frontiersman of the western plains of Kansas; the sagacious courage common to a denizen of the Oklahoma Territory; the analytical mind of a research fellow of the Rockefeller Foundation, the cultural background of a professor of chemistry at Penn State and the clinical acumen of a Harvard Medical Graduate. This composite young physician was worthy and well qualified, to take over the directorship of the Laboratory of Hygiene in 1933 and in 1951 to assume the duties of Assistant State Health Officer. Both of these positions he held concurrently until retirement in 1960.

Dr. Hamilton discharged the duties of these separate departments with outstanding service to this State; with intellectual perspicacity to the departments, honor to the medical profession and international acclaim to the N. C. State Health Department, and the State Board of Health. Therefore it is befitting the integrity of this outstanding humanitarian — “who has devoted a lifetime to the ministry of public health”— that we should assemble here today; in this room — of which his is a legendary part and which his presence halos — to unveil this plaque and dedicate this auditorium, which “honors the dedicated service to public health of John Homer Hamilton, M.D.—"
Dr. Robert B. House, Ex-chancellor and University Professor Emeritus of the University of North Carolina at Chapel Hill has agreed to serve as honorary Chairman for the 1963 Christmas Seal Campaign in North Carolina. Dr. House is presently a member of the faculty of the Classics Department in the evening college at the University.

In making the announcement, John P. Kennedy, Jr., of Charlotte, President of the North Carolina Tuberculosis Association, commented, "The North Carolina Tuberculosis Association was honored by Dr. House's acceptance of the chairmanship. He in some way has touched, directly or indirectly, so many lives in North Carolina."

A native of Halifax County, Dr. House was graduated from the University of North Carolina in 1916 and from Harvard with a Master's Degree in 1917. Catawba College (1939) and Bowdoin College (1948) have conferred upon him the honorary Degree of Doctor of Laws.

Dr. House was appointed as Executive Secretary of the University of North Carolina in 1926. After serving as right-hand man to two University of North Carolina Presidents, he was elected Dean of Administration in 1934 and Chancellor of the University in 1945.

He was a leader in organizing the Citizens' Library Movement in North Carolina, the State Fine Arts Society and the Department of Art of the University of North Carolina at Chapel Hill.

"The participation of Dr. House in the campaign will help draw the attention of the state once more to the significance of the Christmas Seal in the fight against tuberculosis, emphysema and other lung-crippling diseases," Kennedy stated. "The great work of our Association depends entirely on the use of the Christmas Seal. We are grateful to Dr. House for his participation in this campaign."

Dr. House is married to the former Hattie Palmer of Warrenton and they have one daughter, Mrs. William S. Stewart of Chapel Hill.
Ann Landers Serves As National Honorary Chairman Of Christmas Seal Campaign

A mother who was disturbed that her son might not achieve recognition in his chosen career wrote recently to a famous newspaper columnist for advice.

The reply came back, "Don't worry about your boy. If he has what it takes, the world will take what he has."

Ann Landers, the columnist, was writing from personal experience.

In 1955 she was a housewife who had never seen the inside of a newspaper office. Today she is America's leading human relations columnist. Each day her words are awaited by some 50 million readers of 537 newspapers.

Her parent newspaper is the Chicago Sun-Times, and her column is distributed through Publishers Newspaper Syndicate, one of the largest newspaper syndicates in the United States. Both are divisions of Field Enterprises, Inc., which also publishes the World Book Encyclopedia.

In private life Ann Landers is Mrs. Jules Lederer, happily married for more than 24 years. Her husband is the president of a coast-to-coast car rental company, Budget Rent-A-Car. They are the parents of a daughter, Margo, married in 1962, who is also a mother.

Miss Landers is a petite woman (5'2", 108 pounds) with a dancer's figure, a ready smile, and a flair for clothes. Her appearance gives no hint of her intense dedication to her job and her awesome capacity for work.

She has the arduous task of producing seven columns for syndication each week, requiring the completion of dozens of associated tasks.

She receives and answers an average of 20,000 letters a month from readers, many asking how to solve problems arising from long and serious illnesses such as TB and other respiratory diseases. She is assisted by eight secretaries in sending a personal reply to each person who writes to her.

Miss Landers spends much time conferring with leading doctors, lawyers, and clergymen of every faith to get the best answers to particularly knotty problems.
Dear Ann Landers:

I have a problem.

We want to do a good job of promoting the Christmas Seal Campaign through the pages of The Health Bulletin, the official monthly publication of the North Carolina State Board of Health. This publication goes to 47,000 persons in North Carolina and some in every other state and some foreign countries.

My problem is that I have your picture and a biographical sketch, both of which I plan to use, but I do not have any answering letter from Ann Landers to complete what I consider to be the necessary material to properly present a columnist of your renown.

Busy as you are, could you write a few lines to tell me why you are interested enough in the Christmas Seal Campaign to agree to serve as National Honorary Chairman.

This is not the usual problem that comes to your attention, but this just happens to be mine.

Edwin S. Preston, Editor
The Health Bulletin

Why Are You Interested in the Christmas Seal Campaign?

Dear Editor:

I accepted the responsibility of the Honorary Chairman of the National Christmas Seal Campaign because I am deeply interested in human beings and their problems, be they emotional or physical.

My participation is a small contribution toward an excellent cause — and I happily add it is enormously rewarding.

Sincerely,

Ann Landers

November, 1963

THE HEALTH BULLETIN
Christmas Seals at Work in North Carolina

By C. Scott Venable, Executive Director
North Carolina Tuberculosis Association

At this season of the year the attention of the people throughout the nation is directed toward the fund-raising aspect of the voluntary tuberculosis association's program.

Here in North Carolina we have been privileged to report a yearly increase in funds, with minor exceptions, since the beginning of the Christmas Seal Campaign in the State—$3,960 in 1912 to $566,770 in 1962.

Our primary objective through the years has been to conduct an educational campaign for the prevention of tuberculosis and for the promotion of health. While the objective has remained more or less constant, the emphasis has shifted and the methods have varied.

When tuberculosis was rampant and treatment facilities grossly inadequate, our program was directed toward getting more appropriations for sanatorium beds and competent sanatorium staff. In the early 20's health education was the keynote with much emphasis being placed on the health of the children in the state.

During the next decade the Association waged an aggressive diagnosis campaign which was a forerunner to the promotion of mass X-ray surveys. Attention was later directed to hospital admission X-rays.

As pioneers we have demonstrated in the fields of education, treatment, nursing, case detection, rehabilitation and research. In short, ours has been the task of helping the official agency get support for doing a more comprehensive and effective job.

In recent years in an attempt to speed up TB eradication the TB Association has concerned itself with other respiratory diseases. Program expansion into other respiratory diseases and a simultaneous effort to eradicate tuberculosis will require not only continuous and unrelenting education and information, but increased funds to accomplish our objectives.
Tuberculosis In North Carolina

By William A. Smith, M.D.

N. C. State Board of Health

I. GENERAL

During the past year there has been no let-up in efforts by counties and other agencies in the control and eradication of tuberculosis. Among the highlights of these endeavors is the work of the GOVERNOR’S ADVISORY COMMITTEE. The work of the Committee included a thorough study of the disease in North Carolina with appropriate recommendations. Major portions of the REPORT with pertinent recommendations are included in this bulletin.

In addition to the findings and recommendations of the GOVERNOR’S ADVISORY COMMITTEE there is also included in the bulletin in Paragraph II, GOALS AND STANDARDS FOR ELIMINATING TUBERCULOSIS. This is a statement of a committee appointed by the U. S. Public Health Service and the statement is a result of the Arden House Conference. The membership of the conference consisted of outstanding tuberculosis specialists who met in Arden House, Harriman, New York, in late 1959. This meeting was sponsored by the U.S. Public Health Service and the National Tuberculosis Association, and the object of the meeting was to "define the major gaps in present practices and to suggest the action needed".

Activities relating to Tuberculosis Control during the year by the Tuberculosis Control Section consisted of conducting chest x-ray surveys in 43 counties and x-raying over 200,000 persons. The Section also interpreted almost 30,000 miniature films for county health departments. Other case detection measures throughout the state consisted of tuberculin testing projects by counties in which over 100,000 persons, principally school children were tested. This is an increase of almost 50,000 tests since 1956.

During the year county chest clinics have increased. At this time 78 counties are served by a regularly scheduled clinic located either in the health department or the health district or a nearby out-patient clinic of one of the state sanatoriums. Six counties are furnished with consultant tuberculosis services by the local health department district by permission of the local medical society; two cities have chest clinics in addition to the local county clinic and there is a clinic on the Cherokee Indian Reservation. Seventeen counties do not have available a nearby clinic and use the out-patient department of the nearest state sanatorium.

The state sanatorium system has available sufficient beds to hospitalize...
without delay tuberculosis and other chronic respiratory disease.

In addition to state agencies concerned with Tuberculosis Control there is the North Carolina State Tuberculosis Association, which was organized in 1906. This Association has always proved invaluable in tuberculosis education and through local affiliates, has furnished in many cases funds for purchasing supplies to be used in chest clinics and also in financing tuberculosis surveys.

II. GOALS AND STANDARDS FOR ELIMINATING TUBERCULOSIS: Statement of a Committee Appointed by the United States Public Health Service.

These GOALS and STANDARDS are published in this Bulletin for the purpose of informing all persons interested in tuberculosis control of the GOALS to be reached and the STANDARDS to be followed in tuberculosis eradication.

Intermediate Goals
a. GOAL: For the nation a new active case rate by 1970 of not more than 10 active cases per 100,000 population. COMMENT The new active case rate per 100,000 population in North Carolina for the year 1962 was 28.4.

b. GOAL: For the community, control of the spread of the infection to the point where not more than one per cent of the 14 year olds react to tuberculin.

COMMENT. In the Pamlico County tuberculin testing project, which was a very thorough project, the per cent reactors in the 10-14 year old group, white children was 9.6% and negro children 10.2%; in the central part of the State among 8th grade negro children (probably 13 year olds) 6.7% were reactors and the same grade white children 2.87% were reactors. The rate, then must decrease to 1% from the above figures before a high degree of success in controlling the disease is obtained, and that figure in the next 7 years.

PROGRAM PERFORMANCE STANDARDS
CASE DETECTION
1. All persons with an x-ray reading of tuberculosis or suspected tuberculosis, who are not known to be under current supervision, should be referred for diagnosis, and a definite diagnosis should be made and reported.

STANDARD: The Health Department should obtain a satisfactory report on at least 75 per cent of the referred tuberculosis suspects within six months after the end of the initial screening operations.

2. In tuberculin testing programs, all newly discovered tuberculin reactors need a chest x-ray examination.

STANDARD: Within two months of the end of a tuberculin survey, at least 90 percent of the tuberculin reactors should receive a chest x-ray examination.

3. All close contacts to newly discovered active cases need to be examined promptly, either by a tuberculin test followed by a chest x-ray for reactors or by an x-ray initially.

STANDARD: Such examinations should be accomplished for 90 per cent of the close contacts of the new active cases reported during a calendar year, by January 31 of the following year.

4. The conversion of patients' bacteriological status from positive to negative as soon as possible after diagnosis is of primary importance in tuberculosis control.

STANDARD: At least 75 per cent of the newly reported active cases with positive bacteriological findings should have converted to a negative bacteriological status within six months from the date of the new case report.

5. All patients with active tuberculosis need to be under treatment.

STANDARD: At any given time, at least 90 per cent of all the known
active cases should be in the hospital or under drug treatment elsewhere.

6. All patients who have active disease need periodic bacteriological examinations.

STANDARD: At any given time, at least 80 per cent of all cases at home with active disease at last report should have had a bacteriological examination within the preceding six months.

III. HIGHLIGHTS OF THE GOVERNOR'S ADVISORY COMMITTEE ON TUBERCULOSIS

This Committee was organized in 1961 and submitted their report in early 1963. The report has been sent to all health departments in the state and pertinent recommendations and findings are herewith noted:

DIAGNOSTIC-TREATMENT. CHEST CLINICS

RECOMMENDATIONS:

a. That Diagnostic-Treatment Chest Clinics in local health departments be expanded to include the entire state, with priority being given to 13 counties clustered in the Northeastern part of the state.

b. That all Chest Clinics, including those operated by private physicians, utilize available laboratory facilities in order to determine the bacteriological status of all known cases and suspects of pulmonary tuberculosis.

CASE DETECTION

RECOMMENDATIONS:

a. That all case detection activities be based on current known epidemiology of tuberculosis with emphasis on the high incidence groups revealed by statistical studies, and with further emphasis on prisons, nursing homes, homes for the aged, public and private child caring institutions, alcoholics, migrant laborers, recipients of any welfare assistance, mental patients, etc.

b. That a chest x-ray examination be made of all individuals with a recent history of pneumonia, influenza and pleurisy or a history of chronic pulmonary disease.

c. That all new incoming patients to hospitals and clinics have an x-ray of their chests because this has been known to yield a high incidence of tuberculosis and other diseases of the lungs and heart.

d. That personnel of hospitals and clinics who come into contact with patients should have an x-ray of their chests once a year.

TUBERCULIN TESTING

RECOMMENDATIONS:

1. Referring to School Children—
   a. That an intermediate dose of 5 TU (0.0001 MGS) of PPD be used for school surveys, and that the reaction of 5MM induration or more, between 48 and 72 hours, should be read as positive.

b. That when skin testing is first introduced into a school, ideally all grades should be tested, followed by yearly testing of the first and ninth grades.

2. Referring to State Institutions—
   That the tuberculin test be required for the admission of children to state institutions such as mental and corrective schools, and those with a positive reaction be given a chest x-ray.

3. Referring to Contacts—
   That a chest x-ray and tuberculin test be done promptly on all contacts of newly found cases of tuberculosis, and if the tuberculin test is negative it should be repeated in three months.

4. Referring to practicing physicians—
   That the Tine Test be used as a screening test to identify reactors to tuberculin, and if positive, to be followed by a Mantoux Intradermal Test and chest x-ray.
DRUG RESISTANCE
RECOMMENDATIONS:
  a. That every new and relapsing case of tuberculosis should have a culture made for tubercle bacilli and if positive should be assayed for sensitivity to the drugs.
  b. If facilities are not made available locally, cultures should be sent to the laboratory of one of the state tuberculosis hospitals.

CENTRAL CASE REGISTER
RECOMMENDATION:
That a central case register be established and maintained in the N. C. State Board of Health which should contain the names, addresses and current status of all known active and inactive cases of tuberculosis in the State of North Carolina; and those in charge of the registry should have the responsibility and authority to obtain information regarding the status of all registrants at least once yearly.

PUBLIC HEALTH NURSING
RECOMMENDATION:
That additional public health nursing service be made available especially in high incidence counties.

PROCUREMENT AND DISTRIBUTION OF DRUGS
RECOMMENDATION:
That the General Assembly of North Carolina be requested to appropriate to the N. C. State Board of Public Welfare necessary funds to purchase drugs for indigent and medically indigent tuberculosis out patients; and that the N. C. State Board of Public Welfare be requested to establish the necessary machinery.

DVR COUNSELING
RECOMMENDATION:
That every TB patient be evaluated by the appropriate counselor of the Division of Vocational Rehabilitation to determine his needs for rehabilitation services.

DISCHARGE OF HOSPITALIZED PATIENTS
RECOMMENDATION:
That the State Tuberculosis Hospitals adopt a uniform system of reporting expected discharge of patients to health and welfare departments, this report to constitute an application for aid for indigent patients who should be discharged during the last 10 days of the month if possible.

BCG VACCINATION
RECOMMENDATIONS:
  a. That until a newer and better vaccine is made available, BCG vaccination should be used in two susceptible groups—(1) Nurses, medical students and attendants in hospitals and (2) tuberculin negative children in families in certain specific instances where some other member of the family has active tuberculosis even though the infected individual has been removed from the home.
  b. That persons who are negative to tuberculin tests of both 5 TU and 100 TU and at risk of exposure be given BCG vaccination, especially if these persons may be exposed to tubercle bacilli which are resistant to isoniazid.

TREATMENT OF TUBERCULIN REACTORS
RECOMMENDATIONS:
  a. That persons of any age who are recent tuberculin converters be given isoniazid for 12 months, especially those whose reactions are 10 MM or more of induration.
  b. That isoniazid be given for twelve months to children under three years of age who are found to have a positive tuberculin.
  c. That recent tuberculosis converters with x-ray evidence of disease should be classified as active tuberculosis and be treated accordingly.
  d. That isoniazid not be given to contacts who are tuberculin negative where the contact has been broken.
HOSPITALIZATION OF PATIENTS WITH CHRONIC RESPIRATORY DISEASE

RESOLUTIONS:

a. Tuberculosis and other chronic respiratory diseases are becoming relatively more common in middle-aged and elderly individuals. This results in increasing difficulty in making the diagnosis of tuberculosis or determining that the individual has both tuberculosis and another chronic respiratory disease. Such a study may require several months of cultures, tests, and observations.

b. Inasmuch as there are very few existing facilities for these indigent long-term patients, the Advisory Committee recommends that indigents with chronic respiratory diseases, such as pulmonary fibrosis, silicosis, bronchiectasis, emphysema and other similar and allied respiratory diseases continue to be hospitalized in state sanatoriums.

c. It also urges tuberculosis associations to accelerate health education programs which include information on these respiratory diseases; and to participate, where feasible, in programs of rehabilitation, case detection and research in this area.

ADDITIONAL FACTS AND CONSIDERATIONS

1. LAWS REGARDING UNCOOPERATIVE TB PATIENTS

a. General Statutes 113-113 confers on the local health officer the power to order a person with tuberculosis in "an active stage or in a communicable form" to present himself at a designated time and place to undergo the required examination.

b. By General Statutes 130-3, "local health director" is given a definition sufficiently comprehensive to meet any local alternative for the office of county health officer.

2. DEATHS

In 1961, 174 North Carolinians died of tuberculosis. The death rate of 3.8 is divided thusly: White race, 3.2; non-white—5.3.

3. SIGNIFICANT POINTS REGARDING ALCOHOLISM AND TUBERCULOSIS

There were approximately 135 patients treated in state tuberculosis hospitals in 1960-1961 who were diagnosed as suffering with chronic alcoholism. As alcoholism increases in the general population an increase in the tuberculosis alcoholic census can be expected.

4. PUBLIC ASSISTANCE

There are perhaps 2,500 families and separate individuals in North Carolina who are receiving public assistance yearly because of tuberculosis.

The Formation of a Task Force On Tuberculosis

The formation of a Task Force on tuberculosis, to advise the Public Health Service on ways of stepping up nationwide tuberculosis control efforts, was announced by Surgeon General Luther L. Terry.

Dr. John D. Porterfield, Coordinator of Medical and Health Sciences at the University of California, will act as chairman of the new Task Force. Serving with Dr. Porterfield will be Dr. Joseph E. Cannon, Director of Health, Rhode Island Department of Health; Dr. Winthrop N. Davey, Professor of Internal Medicine, University of Michigan; Dr. Albert W. Dent, President, Dillard University; Mr. Benno E. Kuechle, Vice President, Employers Mutuals of Wausau, Wisconsin; Dr. Mark H. Lepper, Head of the Department of Preventive Medicine, University of Illinois College of Medicine; and Dr. Arthur B. Robins, Director of the Bureau of Tuberculosis, New York City Department of Health.
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N. C. FAMILY LIFE COUNCIL HOLDS ANNUAL CONFERENCE IN WINSTON-SALEM

Leaders in the 16th Annual Conference of the N. C. Family Life Council held in October are shown below. This meeting was one of the most successful held and centered on the theme, “Adolescents in American Society in the 1960’s”. From the left, those shown are: R. Winfred Tyndall, local activities chairman; Dr. Helen E. Buchanan, University of Tennessee, a featured speaker; Dr. Daniel F. Hobbs, Jr., Greensboro, program co-chairman; Dr. Dale B. Harris, Pennsylvania State University, also a featured speaker; Mrs. Elizabeth Middleton, Raleigh, Council president; Herbert Zerof, University of Pennsylvania, program co-chairman; and Mrs. Carolyn Russell, local arrangements chairman.
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DATES AND EVENTS

December 3-7—Association of Rehabilitation Centers Annual Workshop, Congress Hotel, Chicago, Ill.
First week in December—Conference of National Council on Aging, Boston, Mass.
December 4-7—American Public Welfare Association (Biennial Round Table Conference), Statler Hilton Hotel, Washington, D. C.
December 6-7—Association for Research in Nervous and Mental Diseases, Hotel Roosevelt, New York, N. Y.
December 26-31—World Medical Association, 17th General Assembly, Helsinki, Finland.

1964
February 15-20 — 13th Annual Meeting of the National Council on Aging, Edgewater Beach Hotel, Chicago.
March 5-6 — N. C. Mental Health Association Annual Meeting, Winston-Salem.
May 2-6 — Medical Society of the State of North Carolina Annual Meeting, Greensboro.
May 7-24 — 16th World Health Assembly, Geneva.
Dr. Charles R. Bugg

“Nearly forty years ago a brilliant young Virginia physician came to Raleigh to practice pediatrics. He brought with him the best training at Johns Hopkins University followed by residency in one of the finest children’s hospitals of the country. Most of all he brought gentleness, character and concern. It is not strange, therefore, that the death of Dr. Charles R. Bugg comes like a death in the family to this community which loved him.”

Dr. Charles R. Bugg, Raleigh pediatrician and president of the State Board of Health, died Wednesday, December 11.

He had been ill since early this year when he suffered a heart attack. Death came at 8:50 a.m. at Rex Hospital. He was 67.

In the medical profession, he was known as a pioneer in the pediatrics field. To thousands of Raleigh parents over a span of almost four decades, he was the tall, gentle man who doctored their children.

Dr. Bugg is survived by a son, Dr. Charles Bugg, who was in medical practice with his father; three sisters, Mrs. W. C. Duvall and Miss Virgilia Bugg, both of Farmville, Va., and Mrs. Lillian Pifer of Winchester, Va.; and two grandchildren.

Dr. Bugg had served as president of the State Board of Health since 1958. He was named to the Board by the Medical Society of the State of North Carolina in 1957.

A native of Farmville, Va., he came to Raleigh in 1925 to set up a practice in pediatrics with Dr. Aldert S. Root. Under the auspices of the Junior League of Raleigh, he and Dr. Root established and operated for many years the first pediatric clinic in Raleigh.

Dr. Bugg was one of the pioneers in establishing pediatrics as a medical specialty in this state. He also was a leader in efforts to bring about an effective program of immunization for children.

Dr. Bugg was a member of the staff of the old St. Agnes Hospital here. He also was on the staffs of Rex and Wake Memorial hospitals, and served as an instructor in pediatrics at the Duke University School of Medicine.

He was one of the leaders in the founding of the Hilltop Home for Retarded Children in Raleigh.

Dr. Bugg attended the public schools
at Farmville, Va. and Hampden-Sydney College, where he graduated in 1916 with honors, including Phi Beta Kappa membership.

He taught for a year in a private preparatory school before entering the Johns Hopkins School of Medicine. His medical education was interrupted by Army service in 1917-18.

His late wife, Virginia Lindsay Sylvester, was the daughter of the long-time president of the University of Maryland, Richard William Sylvester.

Commenting on Dr. Bugg's contribution to medicine and public health, Dr. J. W. R. Norton, State Health Director, said:

"Dr. Bugg has represented the people of North Carolina and the interest of public health in an outstanding way during his years as member and president of the State Board of Health. He has proved to be a person of highest integrity and of wise professional judgment in his consideration of health matters which have come before the State Board. Public health and the citizens of our state will continue to owe a great debt to Dr. Bugg for his dedicated and effective service."

An editorial by Jonathan Daniels in the Raleigh News and Observer caught up the spirit of the man and gave the community estimate of Dr. Bugg. The editorial said, in part:

"Numberless families in Raleigh can now recall Charlie Bugg coming like tenderness from the night to the bedside of a tossing, fevered child. And he brought not only science but reassurance, healing knowledge and the sympathetic heart. Rich and poor had his ministrations. His wide smile was as familiar in the drab halls of old St. Agnes Hospital as in the corridors of newer Rex. The only test in his practice was that a child—any child anywhere—needed help.

"And his concern ran far beyond the possibilities of his own practice. He was one of the leaders in the establishment and operation of the first free clinic for babies in Raleigh. He worked to help create a home for those often most pitiful of our children, the retarded. And in the last years of his life as president of the North Carolina State Board of Health his happy helpfulness extended to all his fellow citizens, man and child alike.

"He was the good doctor. He was the beloved doctor. And in all aspects of his mind and spirit, he was a beautiful man."
National Health Forum
To Be Held
In
Pittsburgh

National, regional and local leaders from the voluntary agencies, professional associations, government departments, industry and civic groups will meet in Pittsburgh, March 9-11, 1964 at the annual National Health Forum to discuss Health Needs in our Changing Environment, it was announced by Rome A. Betts, President of the National Health Council.

"Changes in our environment," Mr. Betts said, "have tended to multiply at an increasing rate in recent years. This promises to continue in the years to come. The purpose of the Forum is to explore the influence on health of modern technological developments. Representatives from all groups with responsibility or interest in these developments will be invited to discuss the strengths and weaknesses of present preventive measures, the steps that are needed to control the hazards from our environment, and who can best carry out these steps.

"Among the problems to be considered," Mr. Betts added, "are both the uses and abuses of our land, water and air resources. Urban congestion, the way chemical additives are influencing our food supply, air pollution, radiation, the adequacy of waste disposal practices and water supplies for future needs are some of the subjects to be discussed."

The annual National Health Forum is sponsored by the National Health Council to provide an opportunity for all elements in the health and social welfare fields to meet with those from related fields. It seeks to focus public and professional attention on a selected national health problem or important national health development. The 1964 Forum on Health Needs in our Changing Environment will be the twelfth in a series.
Toward Highway Safety
by Lenox D. Baker, M.D.

On previous occasions when Dr. Norton has suggested that I deliver an address before the Conjoint Meeting on Highway Accident Control, I asked to be excused. In December when he again asked me to do so, I thought the matter would have been settled by the following letter:

Dear Roy:

Thank you for asking us to speak before the Conjoint Session in Asheville on highway accidents. As you know, we begged off this privilege last year. To be frank, I cannot generate any enthusiasm about discussions of the problem, am not convinced that such discussions are of benefit, and do not go along with an educational program idea. Therefore, I should not be the one to do the job.

For what they might be worth, my reactions to the highway accident problem are as follows:

1. Have a rigid inspection program and get the jalopies off the highways.
2. Clear the highways of all trucks loaded in excess of what they can keep moving at a steady rate on hills and otherwise.
3. Stop giving drivers' licenses to morons.
4. Get all distracting lights well away from the highways, particularly those whose beams interfere with highway signs at night, and doubly so when the highways are wet and reflect the lights and signs.
5. Allow no highway commercial signs other than those parallel with the highway.
6. Get tough in regard to drivers' licenses.
7. Let all traffic violations carry a suspension of driver's license for a number of days equal to the dollar total of the fine levied. Let the suspension not only include the driver but the involved vehicle as well. In many instances this will mean cancelling drivers' licenses, if necessary, permanently.
8. Cut down on the number of access roads.
9. Add widening lanes to channel all turn-off traffic out of the main flow at least 100 yards before reaching a turn-off.
10. Convert many of the present STOP signs into YIELD signs, which can be done easily where lanes are provided for turn-offs. (This alone could in the main, relieve us of the overplayed, dramatized whiplash comedy of errors.)
11. Inform someone in the Traffic Department that approximately 5 percent of all males are color-blind and make it mandatory that all green
GO lights are aquamarine with no yellow.

12. Acquaint some of the professional workers in the safety program with the fact that yellow attracts attention quicker than any other color. (With this a known fact, the safety people are changing former yellow and black STOP signs to red and white. A color-blind driver does not necessarily see the red sign.)

13. Allow no commercial signs along the highway to use any color, particularly in lighted signs, that is used for traffic signals.

You probably think, well, he's written a paper. But this is a "get tough" approach, and no one would like it and it would only meet criticism.

It should be pointed out that if an automobile will travel 100 miles an hour, someone, as long as his gonads are functioning, will drive it that fast. Unfortunately when I reached 50 years of age I found that I had dropped down to 50 miles an hour. Now that I have reached 60 I find that I am driving about 40 miles an hour. Presumably I shall continue to deduct one mile per hour for each year of age and eventually shall be going about 25 miles an hour. Presumably I shall continue to deduct one mile per hour for each year of age and eventually shall be going about 25 miles an hour and shall be causing more accidents than we have doctors to treat the patients.

Which reminds me, the man driving too slowly is a more reckless driver than the man driving too rapidly; so treat them alike and fine one just as quickly as you fine the other. These slow drivers fall in the category of accident-causers as much as the drivers described as follows: "I don't mind the urban drivers; I can even cope with the suburban drivers. But oh, those bourbon drivers!"

Someone else described one of the major traffic hazards as follows: "Driving with one hand, heading down a church aisle. The question is, will he walk or will he be carried?"

Please pardon the long harangue but I wanted to get the subject off my chest. Also, I enjoy discussing such matters with you as you always straighten out any errors.

As ever yours,

(Signed) Lenox

As a result of the above letter, Roy came to the office and said that since a paper had been written, why not read it. He handed the letter back and asked that it be expanded a bit. I was reluctant to do so as the letter took a negative approach and was too critical. Nevertheless, I am most appreciative of the privilege of addressing a Conjoint Meeting of the Medical Society and the Board of Health of the State of North Carolina. It was not until after I got into the mess that that still little voice asked me, What is highway safety? What is it all about anyway? When this happens, you stop to think—and you are lost.

Are Highway Safety Programs Feasible?

Highway safety—certainly the words have a fine, almost fervid ring that invokes pictures of the grim reaper hovering around every curve and corner, distraught patrolmen ready to pounce, pompous safety directors, and apprehensive mothers, all working like angry farmers tearing weeds out of gardens and flinging them on to a trash pile.

There are other less dramatic but equally important implications in the program. In the first place, when we urge our profession and those working with us to embark on a program of highway safety, we imply that we either already know how to do it and what the problem is, or that we can learn in a reasonably short period of
time. Secondly, we imply—and indeed it has become fashionable to say implicitly—that highway safety is not only a possible but a feasible goal. By feasible we mean we can do it with finances and approaches which lie more or less readily at hand. Thirdly, we imply that we know enough about what we are doing to be at least reasonably sure that our efforts will not have unexpected side effects, with the incidental eradication of good as well as correction of evil—such as wide, one-way boulevards encouraging more speed; safety belts giving a false feeling of security; wider brake bands and more tire traction surface, telling us, Faster, faster—we will save you.

Finally, the constant emphasis by Madison Avenue public relations approaches may give us the feeling that after the last project has been completed and the PR man has presented his bill, we shall have a nice neat formula that will just loft us through life with safety for all and the least possible effort on our part. Of course, none of this is true, but some people, in thinking of highway safety, imply that it is possible. Indeed, most of the arguments put forward for adopting safety programs have been based on such concepts. I do not intend to take the negative approach, since it is hard to prove a negative proposition in this age in which so many unproved safety miracles are being described.

The Futility of Fear Propaganda

As we discuss the problem, we should remember that all doctors should have, as their major concern, the good health of their patients and the public. Therefore, the highway safety program is of major concern to our profession. This does not mean that we should approach the matter according to some stereotyped formula. For many years, the public has been bombarded with fear propaganda and highway toll statistics. Within the past ten days the Associated Press released statistics for the month of March, 1963. Many of us probably read them. I doubt that there is a man in this audience who could quote the figures with any degree of accuracy. In spite of the fear campaign and the frequent repetition of astronomical figures, little or nothing has been accomplished, and in my opinion such efforts will continue to be fruitless. Man simply will not accept the fact that what happens to somebody else can happen to him, and the number of people killed on the highways in California, especially on the Los Angeles Freeway, is of little real concern to any of us.

In the midst of all this ineffective publicity, the truth as to the causes of accidents is hard to ascertain. Basically, one of the main causes undoubtedly is human error, due to many factors in man's makeup—irresponsibility, daydreaming, fatigue, slow reactions, native stupidity, inexperience, inability to judge speed and distance, and the too frequent mixing of the highway boilermaker cocktail—whisky chased by gasoline.

Propaganda is not likely to affect any of these human factors; rigidly enforced rules in regard to driver's license—which gives one a privilege and not a right—can partly control them.

Other factors are the speed and the fascination of the modern automobile which almost invite you to challenge the speedometer. The third villain is the inadequately constructed and engineered highways and crossroads. This is particularly true in our cities where almost every corner is a blind one.

Publicizing the fact that the U. S. motorists set a new record for highway slaughters in 1962—41,000 dead—will not eliminate any of these major contributors to our death rate, and the fact that the year's death toll was greater...
than the number of Americans killed in action in the American Revolution, the War of 1812, the Spanish-American War and the Korean War put together, produces only boring table conversation. If you are interested in more recent statistics, during the month of March, 1963, 3,120 lives were lost on the highways, making a total of 8,460 for the first quarter of 1963. In addition, 300,000 people were injured sufficiently to be disabled beyond the day of the accident.

**Medicine's Field of Responsibility**

But I am not here to discuss statistics, and I doubt that it is the medical profession's responsibility to be concerned with such reports nor with the speed of the automobile nor with the construction of highways. If members of society are to make any contributions toward either cutting down on the number of accidents or lessening the mortality and morbidity resulting from them, we each should stay in our own field, tend to our own knitting, and make our contributions as best we can.

If medicine agrees on such an approach, our duties will be confined to proper organization of our personnel, equipment, and services in our hospital emergency rooms to render the best possible care to any and all victims brought to us from the highways.

The American College of Surgeons has long had a great interest in this phase of the problem. Just how each hospital, community, or county is to prepare for the handling of accident victims will have to depend entirely on the facilities and personnel available. The American College of Surgeons has outlined adequate programs and organized to meet the needs according to the circumstances. In the light of new knowledge and experience, the details for each program and the recommendations are constantly being changed. At the moment it appears that the most practical approach to the problem is a cartwheel-like organization, with the large teaching hospital as the axis and the other institutions in each area located about the periphery. This arrangement allows the small, wayside, one-man clinic to have access to community services nearby to which the physician may refer those cases beyond his control, and likewise each hospital along the way to have means of communicating with each of the larger institutions according to need and methods of quick referral involving a minimum of red tape.

At each station it is felt that the team approach, with everyone knowing his duties, is the best approach. Such organization tends to break down rapidly. It requires leadership. Whether medicine has the interest, the know-how, and the leadership to keep such a program going might be questioned. Certainly we can't do it alone. But if each of us will contribute according to our abilities, will be willing to serve on committees, and attend staff conferences for discussion of the various cases that have been seen each month, undoubtedly we can improve our part of the battle against the highway toll. In this approach I believe medicine has been doing and is willing to do its job, never perfectly but certainly willingly.

**Interest in Other Fields**

The courts

Perhaps it behooves us to be self-critical and to learn our own lines and speak them well. Nevertheless, in the overall show, perhaps we should keep an eye and ear directed somewhat to other fields. When members of the General Assembly argue against air surveillance for control of speed because the public doesn't like to get caught in that fashion, when they think the whammy should be discontinued because it is sneaky, and when they question the use of unmarked automo...
biles for highway patrolling, we might question whether they are not putting their constituents' wishes on a more important pedestal than they are their constituents' lives.

The Metro Police in Dade County, Florida, using 30 unmarked squad cars, halted 100 violators in one eight-hour period. In the same county, of 131 adults killed in automobile accidents in greater Miami in 1962, 43 percent had been drinking. But even more revealing, of the pedestrians injured in traffic accidents, 70 percent had been drinking. This was not an unusual finding. A similar study conducted over a period of six years showed that 58.6 percent of 768 fatal victims tested had been drinking. The figures included no children and only adults brought in within 24 hours after the accident.

Now where did the police, or perhaps we should say where did the courts, come into the picture? Of the 131 fatal accidents, there were only 17 instances of drinking listed by the police as a contributing circumstance. Actual charges of driving while intoxicated were made against only 10 drivers. Only 3 pedestrians were officially listed as drinking. So perhaps our courts also have responsibilities. But it is not our business to criticize the police nor the courts. Nevertheless, as citizens we should keep looking.

Whether something should be done concerning the speed of our present-day cars is another matter in need of consideration, but not at this time.

Highway engineering

The last factor has to do with the safety of the highways themselves, and as a driver of an automobile who is constantly attending clinics and meetings in this state, I have one suggestion for each of you. On the road which you use most frequently, count the engineering errors and the needs for better construction over any mile or 5 miles you might travel routinely.

Going and coming from our house to the hospital where I work, a distance of 5 miles, one can count 62 needed corrections that would make that 5-mile strip of road safer on which to drive, and this road is not old in the true sense of the word. What are some of these errors? Blind corners, blind curves, blind hills, incorrectly banked curves, not a single strip of road for safe passing in the entire 5 miles. There is a double curve in this 5-mile stretch that has a blind street coming in at a 75 degree angle. Both corners are blind, both curves are banked the wrong way, and both have too great an angle for safe driving at a moderate speed—that is, a speed within the limit shown on the highway markers. Fifty-one accidents have occurred on this double curve.

Now what has our Highway Department done to correct this matter? Not one thing. The only correction in the way of protection that has occurred was made by an electric power company. These accidents have resulted in innumerable property damage to one of their power poles. Did they move the pole? No. Did they paint it a bright yellow? No. To protect their property they surrounded the main pole with other poles that stand about 6 feet out of the ground. Incidentally, these 51 accidents have led to innumerable hospitalizations, fractures, head injuries, amputations, paraplegia, hemiplegia, cerebral damage, and 3 deaths.

Summary and Conclusion

Maybe some of us could contribute something to the program if we were willing to serve on our Board of County Commissioners and on other bodies interested in the welfare of our citizens. This slaughter will not be stopped by publicity and propaganda nor boring statistics such as I have quoted. I believe it can be said categorically that
the slaughter will not be stopped. There is a possibility of lessening the damage by better law enforcement, better highway construction, and possibly by some control of the speed of the automobiles being manufactured, and, again back to our own cooking, by well organized trauma teams in our medical facilities. The latter is our job.

As stated at the beginning of this paper, I was reluctant to write it, as it is critical and will probably not meet with the approval of many of the powers that be. So why did I write it? Perhaps Dean Alfange answers that question for you:

I do not choose to be a common man. It is my right to be uncommon if I can. I seek opportunity—not security. I do not wish to be a kept citizen, humbled and dulled by having the State look after me. I want to take the calculated risk; to dream and to build to fail and to succeed. I refuse to barter incentive for a dole. I prefer the challenges of life to the guaranteed existence; the thrill of fulfillment to the stale calm of Utopia. I will not trade freedom for beneficence nor my dignity for a handout. It is my heritage to think and act for myself, and enjoy the benefit of my creations, and to face the world boldly and say, this I have done. All this is what it should mean to be an American.

Film Use Testimonials

I suppose that by now you think that all I do is use films! The schools and other organizations that I make the request for appreciate them and feel that the State Board of Health is rendering a worth while service to them. Caldwell County Health Department, Lenoir.

We certainly appreciate all the help you have given us this fall. Mrs. Elizabeth M. Jarratt, Box 817, Lenoir. As we approach another year the teaching of mental hygiene to college students who are to be teachers and nurses, we again call upon you for the very important contribution you have made to us through your films. Below I list the dates with the film desired for each period. Ethel M. Abernethy, Professor of Psychology, Queens College, Charlotte.

Thank you for your prompt consideration of former requests for films to our school. This is certainly a wonderful service that you render. We always feel so fortunate to be able to use it. Anne Pleasants White, Director of Education, Presbyterian Hospital School of Nursing, Charlotte.

I intended writing a note of thanks all last year, but didn’t, so may I do so now? Your films of last school year helped my class work so very much. I have besides my regular Home Economics classes a senior class of boys and girls on MARRIAGE AND FAMILY LIVING. Your films caused very good discussions and made the course very real to the students. Thank you so much for those films and the promptness of the service. Mrs. Laurin E. Leete, John Graham High School, Warrenton.

Never have I taught health as effectively as I have with the help of films. Our textbook, Working Together for Health has been used as a guide. From its pages I have selected the most important subjects, and from this list I have chosen films from your department. Mrs. W. J. Iverman, Elizabeth City Junior High School, Elizabeth City.

I would like to take this opportunity to express to you my appreciation for your having made possible one of the most profitable school years I have ever experienced last year through your film library. It is a very good medium for instruction in school. W. B. Parker, Henderson Junior High School, Henderson.
A pioneering guide to providing guardianship and protective services for older people has been published by NCOA Press of The National Council on the Aging.

Entitled Guardianship and Protective Services for Older People, the book is designed as a practical and thorough resource for all persons who are in any way professionally responsible for elderly people who cannot handle their own affairs. In addition, older people, their relatives and friends have, in this book, a clear, concise and easily readable picture of the factors involved in good planning for many eventualities occurring in the later years.

Guardianship and Protective Services for Older People considers the scope and nature of the help needed by a group of older persons defined as "those who, for one reason or another, cannot — without assistance — care for themselves or their assets or both." In detail, it answers the pressing questions of how social and financial planning can be used to help them; what kinds of services may be needed for them; what kinds of services may help those assisting them; and what is the real core of concern in providing older people with legal, social, health and financial services.

For the first time in one book, a reference is provided that correlates theory and experience and brings together information and guidelines for more effective co-operation among the various professions concerned with assisting older men and women who are unable to make decisions or care for themselves.

Guardianship and Protective Services for Older People (184 pages) may be obtained at $4.50 per copy from the Publications Office, The National Council on the Aging, 104 East 25 Street, New York 10.
The Human Christmas Tree

This Human Christmas Tree was the feature attraction at the Christmas Party of the North Carolina Public Health Academy held just before Christmas. Ed Burgess of the Oral Hygiene Division built the tree. Joseph Bouchard directed the group in carol singing. Appearing in this picture (from the left) are: (first row) Barbara Anderson; Margaret Pearce; Joe Bouchard, director; Sarah Hagwood; Charlotte Johnson; (second row) Thelma Holmes; Brenda Byrd; Doris Southall; Kathryn Surles; (third row) Arthur Danielson; Harold Sauls; Jim Hicks; (fourth row) Jimmy Mills; Glenn Flinchum; and (fifth row) Henry Woodard.
New legislation for housing low-income elderly families and adequate income for retired persons were called for at a National Council on the Aging conference held early in December at Boston’s Sheraton-Plaza Hotel.

Marie C. McGuire, Public Housing Administration commissioner, said that authorization under the 1961 Housing Act will soon be exhausted and that new legislation is required “if we are to meet in even greater measure the need we see tripling almost yearly.” She scored as “ridiculous” a recent National Association of Real Estate Boards’ resolution calling on Congress to eliminate further authorizations of new low-rent housing and demanding that the five billion dollar investment in public housing be sold to private interests or to the tenants who now occupy it.

Who, Commissioner McGuire asked, with an income of little more than $2,300—the median income of all residents in low-rent housing—can afford to buy the dwelling he now rents? Speaking at a housing session, she explained that the Federally-aided, low-rent program “pledges the solemn word of the United States Congress that its government will assist local housing authorities in meeting their communities’ housing needs for low-income people.”

Providing an adequate income for retired members has been the primary goal of the United Automobile Workers’ retirement program, said Charles E. Odell, director of the union’s older and retired workers department. Mr. Odell, who spoke at the conference’s employment and retirement session, urged that something be done “to provide prepaid hospitalization and medical insurance to retired workers and their dependents either under collectively bargained plans or through some form of national health insurance.” Health security, a basic objective of the UAW, has been extended into retirement, but the retired worker still bears half the cost of Blue Cross, Blue Shield and other types of protection out of his limited retirement income, he explained.

Pointing out that there has been no significant increase in social security benefits since 1955, although the cost of living has increased approximately ten per cent, Mr. Odell cited the union’s belief that “built-in cost-of-living adjustment in benefits under both social security and private pension plans is long over-due” and that a “portion of the monies set aside in both private and public pension and social security programs should be invested in economically and socially sound projects designed to meet the needs of the entire community.” He called the latter “one of the critical but unresolved issues discussed in collective bargaining over the years which deserves priority attention.” Mr. Odell serves as vice-president of The National Council on the Aging.

The conference was sponsored by The Council through its New England Regional Committee in cooperation with the Connecticut Commission on Services for Elderly Persons, Maine Committee.

The housing session was designed to discuss meeting the housing needs of the nearly 2,300,000 New Englanders 55 years of age and over. Commissioner McGuire pointed out that the plight of New England's half-million plus low-income elderly families is so massive that all the 550,000 low-rent public housing units in the United States, Puerto Rico and the Virgin Islands would barely meet their needs. She also explained that a low-rent program in eight northeastern states "added more than $78 million in new income during 12 months ending last June 30" and that this did not take into consideration money spent on materials, labor and services.

"The employer should not only provide pensions for our older people but must find a way to stimulate their minds and encourage their physical participation in community activities of a useful nature," Dr. George E. Spencer told a luncheon audience. Assistant Medical Director for New England Telephone and Telegraph Company, Dr. Spencer suggested that employers bring together employees interested in this type of activity with voluntary associations in the community looking for workers.

Dr. Spencer also stressed physical and mental health as an "important facet to retirement." By practicing preventive medicine and encouraging good health habits, he explained, the physician gives the employee a "good start on enjoying life after retirement."

The training and placement of older manpower was also discussed at the employment and retirement session. Use of the Manpower Development and Training Act as a tool for assisting in vocational training and job placement for unemployed older men and women was considered and a recent National Council on the Aging—Office
Manpower, Automation and Training joint project to retain older unemployed workers for jobs in competitive industry was described. The results of research into preparation and policies of retirement at Inland Steel were also presented.

In addition to the program of the Public Housing Administration, a session considered resources available through the Federal Housing Administration and the Farmers Home Administration for providing suitable housing for older people. The direct loan program of the Community Facilities Administration and state aids were also discussed. The experiences of a non-profit sponsor, public sponsor and private builder were related at a luncheon session and a round-table clinic offering answers and recommendations to specific problems in providing housing for older persons was conducted.

Communication and interpretation in the field of aging was the topic of a dinner meeting. William C. Fitch, executive director of the American Association of Retired Persons, said that "we have reached a point in time and experience where we should be able to discuss the later years objectively without the need to color them golden, silver or evergreen or try to sentimentalize on 'the best is yet to be.'" Our programs in aging "should have matured to a place where we do not feel compelled to segregate older Americans as Senior Citizens, Dean-Agers, Fossils or any other category that separates them from their rightful place as responsible, independent and useful individuals," he said.

Without a Pollyanna approach, he stressed, we can "emphasize wellness and the importance of living fully within the limitations age may impose." He cited the philosophy of the person working in rehabilitation as applicable to aging: "It is not so much what you have lost—it is what you do with what you have left that matters."

The National Council on the Aging is a non-profit organization serving as a central, national resource for information, consultation, planning and materials on aging. In addition to housing, employment and retirement, it operates programs in health, institutional care, social services, recreation education and community planning.

We wish to thank you so much for letting us use the film HELP WANTED. It covered thoroughly all the things we wanted to stress at the training meetings and it taught them so much better than we ever could have. Mrs. Dave Roberts, Asst. Home Agent, Pittsboro.

Your visual aids and the service your department extends to the schools of this State are to be commended. Thanks. Gus A. Constantine, Associate Professor of Education, Atlantic Christian College, Wilson.

We will have covered the county rather widely with this film by that time. We've had enthusiastic response to it and feel our efforts have been well rewarded. Thanks again for your assistance. Mrs. Elizabeth M. Jarratt, Exec. Sec. Caldwell County Heart Association, Lenoir.

All of the faculty of Lenoir Rhyne wish to thank you for your most helpful services. Clyde Deans, Assoc. Prof., Health Ed., Lenoir Rhyne College, Hickory.

The films that we get are quite helpful to our school groups, student nurses, community groups and to our staff and we do appreciate their use, and the cooperation of your staff in getting them to us. Mary Edith Finler, Cabarrus County Health Department, Concord.

December, 1963

THE HEALTH BULLETIN 15
DATES AND EVENTS


February 11-16 — 13th Annual Meeting of the National Council on the Aging, Edgewater Beach Hotel, Chicago.

March 6-7 — N. C. Mental Health Association Annual Meeting, Winston-Salem.


March 9-11 — N. C. Association of Nursing Homes, Annual Convention, Charlotte.

March 12 — N. C. World Affairs Conference, 10:00 a.m., Carroll Hall, UNC, Chapel Hill.


April 1-4 — Health Fair, Duke University, Durham.

April 1-3 — Three Days of Cardiology at Duke University Medical Center, Durham.

April 6-10 — American College of Physicians, Annual Meeting, Atlantic City, New Jersey.

April 8-10 — National Council on Alcoholism, New York, N. Y.

April 9-11 — AMA Conference on Mental Retardation, Aurora-Hilton Inn, N. Aurora, Ill.


April 22-24 — Southern Branch, APHA, Tampa, Fla.

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