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P R O C E E D I N G S

Fortieth Annual Conference

of the

UNITED STATES PUBLIC HEALTH SERVICE

with the

STATE AND TERRITORIAL HEALTH OFFICERS

March 25 - 26, 1942

Auditorium
Medical Society of the District of Columbia

Washington, D. C.

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WEDNESDAY MORNING SESSION
March 25, 1942

The Fortieth Annual Conference of the United States Public Health Service with the State and Territorial Health Officers, which was held March 25-26, 1942, in the auditorium of the Medical Society of the District of Columbia, Washington, D. C., convened at 9:40 a. m., Wednesday, March 25, Dr. Thomas Parran, Surgeon General, United States Public Health Service, presiding.

CHAIRMAN PARRAN: The conference will please be in order.

At the outset I would like to extend a special welcome to our colleagues, our allies, from Canada and also to the new State health officers who have been appointed since the last meeting.

In the eleven months since this Conference last met, many important events have occurred. The impact of war has been felt by every person in the country, and this impact in the future will be increasingly severe. Many major readjustments will have to be made. There will be added demands on everyone in the country, particularly upon the State and local health organizations.

It is gratifying to report that so far in this emergency there has been no significant increase in disease and death rates. There was a sharp rise in the prevalence of influenza last winter, but though it caused some concern it did not result in any considerable increase in the mortality rate. During the current winter the communicable disease rates have been lower than the median levels of the previous five-year period.

This good record has been maintained in spite of the major dislocations which have occurred as a result of mobilization and, later, of war. I know you feel that this is a real tribute to the efficiency of the public health organization in this country.

An exception to the currently favorable communicable disease situation, however, must be noted with regard to the venereal disease statistics. Through routine serological tests made on all selectees and volunteers, we have found many new cases of syphilis and gonorrhea, but too few of these cases have been brought under treatment. Generally speaking, the States with the highest rates as shown by selective service examination have had the least effective control organizations. While it is true that venereal disease rates in the armed forces are lower than in the last war, in my opinion they are not low enough. Somewhat disturbing is the increase in the rates of syphilis and gonorrhea in the Army between 1939 and 1941. As you know, very effective treatment measures have been developed against the venereal diseases, and this improvement should have been reflected in a lower incidence than we now have. One reason for the increase has been the growth of commercialized prostitution incident to mobilization for war. In many places the health agencies have not assumed leadership in persuading the police authorities to take firm repressive action. Moreover, we have been disappointed at the failure of many communities to seek aggressively to provide adequate quarantine and detention facilities for recalcitrant venereal disease patients. This matter is the subject of a letter which has just been sent to you, urging that you sponsor more aggressively than in the past facilities for the care of these patients.

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I should like to call your attention also to the substantial aid you are able to secure from the liaison officers of the Public Health Service who are assigned to each of the Army Corps Area headquarters. I urge you to make the fullest possible use of these officers in coordinating military and civilian venereal disease control efforts.

You will recall that at the Special Conference with the State health officers held in September 1940, a comprehensive program for the rehabilitation of physically disabled selectees was recommended. Unfortunately, this program is still in the planning and trial stage. Nothing substantial has been done to rehabilitate the very large number of men found by selective service examinations to be disabled. I hope that each of you in your own State will do what you can to speed this important work.

We shall need to give serious attention to personnel problems. I know how severe has been the impact of mobilization in depleting the ranks of State and local health agencies of their trained personnel. To meet this situation, as you know, a Procurement and Assignment Service has been established. This organization has as its primary purpose the securing of adequate numbers of officers for the Army and Navy, with the least possible disruption of essential civilian health and medical services. The detailed operation of the organization will be described to you later in our session by one of its representatives. A circular is now in the mails requesting all State health officers to list with the State Director of the Procurement and Assignment Service the names of the key personnel who cannot be spared from their present tasks.

In order to meet personnel problems, it has been necessary to alter the administration of the merit system in several ways. This obviously is necessary, in my opinion. In fact, as time goes on it will be necessary to make more and more changes with regard to diluting staffs, improvising methods, reducing the less essential activities, and using volunteer and other kinds of help which we can get to do the necessary jobs.

I have been concerned with the continued indisposition on the part of some States to look beyond the State boundaries for trained personnel. A communication recently received from an eminent teacher of public health says, "I look with the gravest concern upon the continued trend toward balkanizing public health in this country."

In an effort to help you with your personnel problems the Public Health Service has recruited more than 600 professional health workers. These persons have been assigned to various parts of the country in an attempt to meet the most urgent needs. I can say that in recruiting this personnel last autumn we scraped the bottom of the barrel rather clean. Nevertheless, in connection with a recent examination for the regular corps of the Public Health Service, we had applications from between 150 and 200 extremely well-qualified young doctors. These men have not had training in public health, but basically they are much better qualified than any previous group of applicants.

Our present funds do not, however, permit us to continue to employ additional reserve personnel for assignment in the States unless the States themselves see fit to transfer to their own pay rolls some of the persons whom we are now carrying. Many of the positions in which our personnel are serving are normally State or local positions which are vacant because of the war. I would ask your utmost

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cooperation in utilizing unexpended funds—funds which otherwise would lapse—to transfer these workers to the State pay rolls in order to enable us to recruit additional personnel and send them to you.

You are aware, I am sure, of the serious shortages of nurses, present and impending. In an effort to remedy this shortage, Congress has appropriated $1,800,000 which is this year being allotted by the Public Health Service to nursing schools in accordance with rather well established formulae to enable the nursing schools to increase the number of nurses in training. The cost has approximated $300 per student nurse per year. This program, however, will provide only a small proportion of the total number of nurses needed. It will be necessary also to recruit nurses' aides and less well trained personnel who can carry on some of the more routine nursing tasks.

Much of the time of the Public Health Service staff during the past year has been expended on the problem of community facilities. These facilities, provided in whole or in part by Federal funds, are not intended to make up for years of neglect on the part of the communities, but rather to meet the additional demands caused by the war.

The total number of water supply projects, sewer systems, hospitals, and health centers which had been approved by the President prior to March 16 was 536, at a total estimated cost of $122,000,000. The number of projects approved, however, is only about one-third of the total number requested. Sixteen hundred applications have been received asking for aid in connection with health and sanitation projects.

Moreover, because of the shortage of critical materials it is not possible to construct hospitals in accordance with previously accepted standards. Partly as a result of the unavailability of critical materials, a more functional type of construction is being utilized. This is a development which is therefore not without a certain element of benefit.

I have been concerned because, with the increased availability of Federal funds for certain purposes, the States seem to have a tendency to depend more and more on the Federal Government for aid. I think that more substantial State and local contributions are in order in many phases of public health. This is particularly true of industrial hygiene, a field in which a very large proportion of the cost is being met with Federal funds. Needless to say, this is one of the most important activities related to the war.

I regret to report that scarcity of relief labor makes it impossible to continue the WPA community sanitation projects during the ensuing year. Yet it is just as important to provide sanitary installations in many defense areas not suitable for sewer systems as it is to provide water and sewerage facilities for the more densely populated sections. A recent ruling by the Budget Bureau would make the operation of community sanitation projects extremely difficult if not impossible under the Community Facilities Act. Unless this ruling can be modified we may be forced to seek a special appropriation to carry on such projects in defense areas.

Those States which had malaria control programs last year are aware that they were not very successful, due largely to unavailability of WPA labor. During the ensuing year the Public Health Service will have a more direct responsibility

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in this work. The Service is now authorized to employ labor for the larvicidal program in defense areas and such ditching as the labor supply will permit. Pest-mosquito or salt-marsh mosquito control will not be carried out under this program. I ask your cooperation in the malaria control program now under way in the defense areas, and your interest and direct action in the non-defense areas where similar measures of control are needed.

Almost every year I bring up the question of unexpended State balances of title VI and Venereal Disease Control Act funds. Some of my colleagues have expressed an opinion that perhaps your fiscal control is not prompt enough to keep you aware of such balances. It is obvious that there are many urgent health needs which should be met, and if funds are available it has been inexplicable to us why the needs have not been met. I recognize that shortage of personnel is of growing concern. This accounts for some of the lag between the appropriation of Federal money and its utilization.

Another problem which has been of concern to many of us, perhaps to all of us, is that of more prompt provision for issuance of delayed birth certificates. This matter is of acute interest to the War Department and to the War Production Board. In fact, so serious is it that several bills have been introduced into Congress which would nationalize certain major aspects of the vital statistics function. This is a matter which I know will be of much concern to you as State health officers. For some reason, we have not been able to impress upon the fi authorities the need for additional funds to do this job. They have pointed ou the consideration which I have just mentioned, namely, that there are unexpend balances available in many States which could be diverted to this emergency task.

It is inevitable that war will bring you many additional problems. One problem which has been prominently before us is the organization of the Emergency Medical Service. As you know, the Public Health Service has cooperated with the Office of Civilian Defense from the beginning in the organization of the Emergency Medical Service. The administrative aspects of the work have been handled by the OCD, and matters of general medical policy and professional standing have been in the hands of the Public Health Service. Recently a joint arrangement or agreement has been made between the Office of Civilian Defense and the Federal Security Agency under which the various responsibilities of the Public Health Service and the Medical Division of the OCD have been clearly defined. Moreover, in order to meet emergencies arising from enemy action, the President has allotted to the Administrator of the Federal Security Agency some five million dollars, of which a half-million have been made available to the Public Health Service for payment of emergency medical and hospital bills incurred by persons affected by enemy action. Already some parts of this fund have been spent in connection with evacuees from Hawaii and Alaska, and on behalf of injured sailors and other persons on both coasts.

It has been necessary for the Public Health Service substantially to increase its reserve corps. We shall have two categories of reserve officers on inactive duty. With one of these you are familiar, that is, State or local health personnel who are given commissions with the understanding that they will be available for active duty in the event of an epidemic or other serious emergency. Another group of approximately 2,000 will be commissioned in the near future as an Emergency Medical Service reserve available to man emergency base hospitals and to take care of evacuees in reception areas. Dr. George Baehr, Chief Medical Officer of the Office of Civilian Defense, will discuss this problem in more detail with you.

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War will bring us many shortages. It is inevitable that there will be rationing of many things. Rationing on the food front may have to be extended. The advice of medical and health authorities will be an important factor in assuring that systems of rationing do not impair the health and strength of the population.

It is difficult to know what all of our problems during this next year will be. We need to keep an open mind and an effectual organization to meet emergencies as they develop. In fact, today the health agencies of the country face their supreme test, that of adapting themselves to a much broader purpose than that for which they were organized. This purpose is not only to help decide the national destiny, but, we may even say, to aid in shaping the future pattern of our human institutions. . . . (Applause)

Our next speaker is well-known to you. I need only say how very happy I am to have this opportunity to present to you a man who is active in our field in two important capacities. I believe he signs some mail with his right hand and other mail with his left hand. With his right hand he is Administrator of the Federal Security Agency, and with his left hand he is Director of the Office of Defense Health and Welfare Services.

I have the very great pleasure of presenting to you the Honorable Paul V. McNutt, who has taken as his topic, "Health Agencies—Their Responsibilities and Their Opportunities during the Present Crisis." . . . (Applause)

MR. McNUTT: Thank you very much, I hope the left hand knows what the right hand is doing.

Last year, when I spoke to this Conference, I said that the gravity of the world situation did not permit me to dwell on past accomplishments.

Today this is more emphatically so than it was then. We are now engaged in a "shooting war," and vigorous prosecution of this war must take precedence over everything else. I do not mean prosecution of the war along the civilian or home front, but wherever our troops, ships, or planes are striking at the enemy. In doing their part, health departments, like other civilian agencies, will have to give up personnel for service with the armed forces and on the field of actual combat. While the war is in progress there can be no thought of maintaining present organizations intact.

With such organizations as you can retain or recruit, you will have to discharge your responsibilities along the home front. These responsibilities are indeed numerous and grave. Many new duties are being imposed upon you. With your improvised forces, these duties can be fulfilled only by prodigious effort and possible curtailment of certain activities which are not indispensable to conduct of the war.

One problem which must be attacked immediately and vigorously is industrial hygiene. The world's attention is focussed on the combined man- and machine-power of the United States. On our ability to fabricate and deliver the materials of war are based democracy's best hopes and the enemies' darkest fears. Whatever impedes production diminishes both our hopes and their fears. Any factor which steals the worker's time or saps his energy threatens our national security and gives aid and comfort to the enemy.

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Sickness and disability are such factors. The time lost annually to industry through illness and disability is appalling. If this time were spent on the job instead of in the hospital or sickroom it would give us about 165,000 fighting tanks--40,000 more than the President has asked for during both the years 1942 and 1943. It would enable us to send down the ways more than 50 new super-dreadnoughts of the North Carolina class--a fleet large enough to protect our shores and also clear the sea lanes for any expeditionary forces we chose to dispatch.

The Government has appointed experts to put our supply system on a sound war-time basis. But supplies alone are not enough. Strong, healthy men and women are needed to transform materials into fighting assets. You are the experts to whom the Government looks for sound war-time management of our human resources. The Nation expects you to see that people are fit to take their places at their machines, on the assembly lines, on the farms, and do a faster and more efficient job than ever before. Your primary responsibility, therefore, is to transfer the largest possible proportion of this lost time from the debit to the credit side of the national ledger.

The development of industrial hygiene as a public health activity is one of the many advances in recent years to which you can point. But in view of present crucial needs not enough effort as yet is devoted to this activity. Considerably greater financial outlays must be made by the States themselves. Of the $1,006,0 budgeted for industrial hygiene purposes by State and local agencies during the fiscal year 1942, approximately 64 percent was contributed by the Federal Governm and only 36 percent was State and local funds. On this basis the States are not yet doing their share.

Money, however, is not all that is needed. Wisdom, initiative, and sustained effort will be required in greater measure than ever before. By the end of the year we expect 10,000,000 more persons to be engaged in war industry than there were at the end of 1941. Many of these new war workers will have to be drawn from the older age groups, the women of the country, and those whose physical condition leaves much to be desired. The time has come when we should launch a rehabilitation program in order to utilize the potential labor power of the physically handicapped. As the labor supply approaches the depletion point, the only way to step up production will be to increase the efficiency of the individual worker. Yet, longer hours and increased working speed will tax the workers' strength and resistance. Mental stresses and strains will become increasingly severe, especially if the months of struggle stretch into years. Nutrition--the primary factor in physical fitness--may be impaired in case America has to become the granary as well as the arsenal of democracy. To all these growing tasks and problems will be added those pertaining to extra-cantonment health and sanitation, large scale migration of workers, and the complicated duties of civilian defense.

The Public Health Service has rendered substantial aid to the States in supplying a mobile force of more than 600 emergency health and sanitation workers. These trouble-shooters have been sent into areas where needs are most urgent. But the over-all health task for the Nation will have to be done by State and local people. And, as the size and power of our combat forces grow, technical personnel for civilian functions are certain to be even further depleted.

How, then, are you going to manage? As Director of Defense Health and Welfare Services, I have naturally given this question the most serious attention.

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In all branches of the Federal Security Agency we have faced the same problem: to see how we can best aid in winning the war. With this end in view, it would seem that health departments have too limited a conception of their possible functions and activities.

The basic importance of health in practically all aspects of civil welfare is universally recognized. Accordingly, health agencies have been given broader legislative and statutory authority than almost any other branch of government. They have the right to make and enforce regulations, and to expend public funds. Again and again these rights have been upheld by judicial decisions. Nevertheless, many health departments continue to operate for the most part within the restricted sphere of duties bequeathed to them by tradition--imposition of quarantine, routine inspections, and advice on a broad, impersonal basis. Meanwhile the community may be sorely in need of the kind of additional help the health department is peculiarly equipped to give. Hospital facilities and medical care may be grossly inadequate. Faulty industrial hygiene may be robbing the workers of vitality and the country of needed goods. Sanitary codes may be hopelessly outmoded. Better housing may be the urgent health need. Organized vice may be impeding the military effort.

We must realize that business as usual is out. Inertia and solicitude for special interests cannot be tolerated in our health agencies today.

Failure to be more aggressive and to expand activities in conformity with needs cannot in many instances be attributed to lack of funds. Since passage of the Social Security Act in 1935, the Federal Government has been making substantial grants to the States in order to help them finance their health programs. As a result we now have a framework of organization which permits a very wide latitude of operations. Yet, the States for one reason or another fail to develop essential services while unexpended balances of funds accumulate on their books. Reluctance to undertake operating functions is especially inappropriate at this crucial time. What is needed today are operating agencies which will step in and do the most urgent jobs, regardless of tradition and custom.

The task of most immediate importance today may not, however, be the most important tomorrow. Circumstances and needs are constantly and rapidly changing. Under such conditions a high degree of adaptability is demanded.

Suppose a fleet of enemy bombers should one night elude our coastal patrols, appear over our cities, and unload their deadly cargoes on our homes, factories, and offices. Would your communities be prepared? Has your State Health department a clearly defined plan in the event of such a catastrophe? Do the health officers and their staffs know who would do what, and how? Who would man the first-aid stations? Who would organize the ambulance and hospital services? How would hospital bills be paid? Is there a blood bank with sufficient plasma? Are there facilities for the emergency treatment of water? These are questions which should be decided now. If they are not decided now, confusion, recrimination, and an awful sense of responsibility for lives needlessly lost may be the result.

The point I wish to make is this--in the development of the civilian defense program, the Office of Civilian Defense looks to existing agencies for actual operation. Have your State and local health departments come forward and assumed their rightful dynamic roles in the program?

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The part played by health agencies in the community facilities program has left much to be desired. The health departments were in a position to give material assistance to the Federal agencies in planning and implementing this program. Many of them, however, remained cautiously on the sidelines, while others showed themselves to be activated more by special pleading than by true civic needs. In some cases the Public Health Service has had to go contrary to State health department policy and recommendations in order to inject an element of reason into the facilities work.

Teamwork and cooperation are today nothing less than matters of national salvation. There is not time for each of us to work out his own problems in his own way. It is for this reason that the Office of Defense Health and Welfare Services has been established as a coordinating agency. We cannot place too much stress upon the necessity for constant and close cooperation between State health authorities and the regional offices of the Office of Defense Health and Welfare Services. State health agencies might well follow the example of the Public Health Service, whose cooperative relationships with other agencies have been developed to a remarkably high degree.

As an administrator, I hold no brief for the creation of new agencies for their own sake. I believe it is sound public administration to work through the fewest agencies possible. If, however, there is an urgent task to do, and no old-line agency is willing or prepared to do it, the only alternative is to set up a new agency. Behind the recent multiplication of governmental agencies is a long history of official complacency and neglected opportunity. I believe there are many lessons in this history which existing health agencies might well consider, and in the light of which they might reconstruct their basic philosophies.

It would appear that health departments are sometimes too easily discouraged when confronted by administrative difficulties. One problem now causing much trouble is inability to get personnel which meet merit-system requirements. I admit this has some vexing aspects, but I wonder just how far health departments have gone in trying to work out feasible plans for temporary relief in cooperation with their merit system administrative bodies.

Then there are legal stumbling blocks. Not infrequently a health agency wants to undertake a new activity, but finds itself faced with a defect in the law. This should not be an insurmountable obstacle, but in practice it is often regarded as such. We live in a democracy and are privileged to try to get rid of a bad law or pass a good one whenever we see fit. Frequently, however, we do not try, and if we do we do not try soon enough. The objectionable features of a law are often not discovered until the need for action is urgent. I believe every health department should periodically review the legal code and initiate revisions that seem desirable in the light of current or anticipated needs.

I would also have you consider in its broader aspects the implications of the increasing financial dependence of the States upon the Federal Government. The purpose of the Federal grants-in-aid is to encourage and assist the States to meet their problems, and to equalize burdens imposed by factors not always subject to State or local control. It was never the intention to relieve the States of their financial responsibilities, nor to extend assistance beyond the amounts which the States might reasonably be expected to meet. Nevertheless, there is an unfortunate tendency to let Uncle Sam shoulder as large a part of the load as possible.

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Such a policy is extremely short-sighted for two main reasons. First, it amounts to virtual abdication of State and local autonomy. The present emergency gives a broad national significance to the health problems of each individual State and community. Unless local authorities attack these problems aggressively, and unless they contribute materially to the cost of doing so, they are likely to find that certain essential activities will pass into the hands of those who assume the required initiative.

The second reason is even more important than the first. It is simply a matter of patriotism. At no time in history has the burden on the Federal Treasury even approached its present proportions. And never before has the manner in which Federal funds are expended been so replete with life-and-death significance in the most literal sense.

So far I have spoken mainly about the responsibilities of health agencies. But if the present crisis entails many added responsibilities it also presents some rare opportunities. Under the impetus of war many worthwhile and long overdue enterprises have been undertaken. Thanks largely to the Public Health Service emergency program, many communities are for the first time experiencing the benefits of full-time public health organization. Thus, the spade work--the most difficult part of the task--has been done, and the way is prepared for the States to carry on permanently. Likewise, the community facilities program is providing first-rate hospitals, health centers, and sanitary installations without which health departments have long been seriously handicapped. The war has aroused people to a new sense of civic duty which can be directed into many useful channels. A spirit of teamwork, unity, and self-sacrifice is manifest throughout the land. Consider the opportunity for health education presented, for example, by the 8,000 local civilian defense organizations with more than 5,000,000 volunteer members! These groups may not remain intact if they are to concern themselves solely with the effects of direct enemy action against their towns. If the air raids which had to be anticipated do not occur, will these organizations be permitted to waste away simply because their programs lack immediately applicable content? If so, health departments will have missed an unprecedented chance for instructing the public and enlisting its support.

I am not unmindful of the great advances in public health achieved in recent years, nor of the truly splendid work the official health agencies have done in bringing about these advances. It is precisely because of the effective work you and your predecessors have done that many of the traditional public health problems are no longer of primary concern.

But today new problems have arisen. Upon the way you accept and meet their challenge depends the strength and staying power of America's fighting, toiling millions. You must not let them down.

The struggle into which we are now plunged can have but one of two endings. Either we will join those unfortunate countries who have already been beaten, humiliated, and brutalized or we will continue to hold our heads high in a world of free men and self-governing nations.

Today the decision rests with us--of that I am sure. Tomorrow the power to decide may have passed out of our hands.

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When you go back to your home States, I urge you to review your health programs carefully. Weigh every shortcoming and ask yourselves how it affects the progress of the war. Analyze every deficiency and ask what implications it holds for the future of the country you love.

Then, together with your lieutenants, put your commands on a war footing. Map out a strategy of attack and clear the decks for action.

Then, when your course is charted, let Farragut's order be your watchword: "Full speed ahead and damn the torpedoes!"

CHAIRMAN PARRAN: Governor McNutt, I am sure that every person here joins me in extending sincere thanks for this very challenging message.

MR. McNUTT: Thank you very much, Dr. Parran. I enjoyed being here.

CHAIRMAN PARRAN: Next on the program is a brief discussion of the "Status of Legislation and Appropriations," by Dr. E. R. Coffey, Assistant Surgeon General, Division of Sanitary Reports and Statistics. Dr. Coffey.

DR. E. R. COFFEY: I shall endeavor to present a brief survey of the bills and joint resolutions of the 77th Congress which have either been passed or are pending, and which are of interest to you officially as health administrators.

In this Congress, to date, approximately 9,650 bills and joint resolutions have been introduced, of which number approximately 100 may be said to pertain to public health. Incidentally, it may be noted that almost as many bills classified as being of a public health nature have been introduced so far in the present Congress as were introduced in the entire 76th Congress. Included in the approximation of 100 health bills for the present Congress, however, are many bills which deal indirectly with national health problems, and no effort has been made to include such bills in this presentation. Only those bills which bear directly upon national and State health problems have been selected.

Mention should perhaps first be made of HR 2475, introduced by Mr. May of Kentucky. This bill was approved on July 11, 1941, becoming Public Law 163. It prohibits prostitution within such reasonable distance of military and naval establishments as the Secretaries of War and Navy shall determine.

Another bill which has become law and which is of immediate interest in connection with the war effort is HR 4545, introduced by Mr. Lanham of Texas. This bill was approved and became Public Law 137, on June 28, 1941. By its terms Congress authorized the expenditure of $150,000,000 to remedy acute shortages of community facilities necessary to the welfare of national defense workers in localities where the President finds such acute shortages exist or impend. The administration of the act rests with the Federal Works Administrator. To make the authorization effective Congress appropriated $150,000,000 by Public Law 150, approved July 3, 1941. This was followed by another appropriation of the same amount made by Public Law 371, approved December 23, 1941.

Several bills were introduced with a view to the control of tuberculosis. HR 3492, HR 3968 and S 195, introduced, respectively, by Mr. Kilday of Texas, Mr. Houston of Kansas, and Senator Murray of Montana, are similar bills which authorize

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appropriations for the purpose of assisting States and other political subdivisions to combat tuberculosis. Allotments of funds are provided for, and a Division of Tuberculosis Control would be established in the Public Health Service. HR 3463, introduced by Mr. Voorhis of California, also would assist States and other political entities in combating tuberculosis by authorizing appropriations for grants-in-aid and for loans to be used in providing adequate hospital facilities. Additional duties would be imposed upon the Public Health Service, a National Tuberculosis Center would be established in the National Institute of Health, and a National Advisory Tuberculosis Council would be instituted. The purpose of HR 70, introduced by Mr. Elliott of California, is to provide for the prevention, treatment, and control of tuberculosis among migrants through assistance to States and local subdivisions, and through investigations and demonstrations.

SJRes. 104, introduced by Senator Langer of North Dakota, and passed by the Senate on August 21, 1941, is concerned with encephalitis and establishes an Encephalitis Control Board, the chairman of which is the Surgeon General of the Public Health Service. The Board is authorized to study the causes of encephalitis and is given certain powers relative to quarantine, examination of patients, and autopsies. Necessary annual appropriations are authorized and an appropriation of $3,000,000 is made.

Mrs. Rogers of Massachusetts introduced HR 1007 which would amend the National Cancer Institute Act so as to provide assistance to States and local subdivisions in extending and improving measures for the diagnosis, treatment, and control of cancer. Appropriations are authorized and out of these appropriations sums would be granted to the States on the basis of certain specified factors. The appointment of two additional members of the National Advisory Cancer Council is also authorized.

S 194 would authorize and direct the Surgeon General of the Public Health Service to conduct, foster, and coordinate research relating to the cause, diagnosis, and treatment of dental diseases. This bill, which also authorized the necessary funds, was introduced by Senator Murray of Montana. It passed the Senate on May 23, 1941.

S 489, introduced by Senator Capper of Kansas, would add a new title XII to the Social Security Act, providing for health insurance under State plans approved by the Social Security Board.

Mr. Pfeifer of New York introduced HR 1791, which would establish a new executive department to be known as the Department of Health, headed by a Secretary of Health. The functions of the Public Health Service, among those of other agencies, would be transferred to this department.

Senator Reynolds of North Carolina has recently introduced a bill cited as the "Federal Birth Recording Act, 1942." This bill (S 2299) authorizes and directs the Director of the Census, upon payment of a filing fee, to issue a "certified birth record" to any person who has furnished proof of his birth within a State or the District of Columbia, when a proper application is accompanied by the fingerprint record of the person whose birth record is to be certified. In connection with the subject of birth records, at least seven other bills have been introduced. Mention may be made of two bills, HR 6534, introduced by Mr. Dickstein of New York, and S 2201, introduced by Senator Capper of Kansas. The first has reference to

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issuance of a certificate of citizenship to a person claiming to be a citizen by birth upon satisfactory proof of such fact to the Commissioner of Immigration. The second provides that proof of birth satisfactory to the governmental department or agency concerned may be accepted in lieu of the actual birth certificate when the latter is unobtainable.

Six bills with respect to water pollution control have been introduced, four in the House and two in the Senate. There are: HR 1110, introduced by Mr. Spence of Kentucky, HR 3778, introduced by Mr. Mundt of South Dakota, HR 4106, introduced by Mr. Weiss of Pennsylvania, HR 5676, introduced by Mrs. Smith of Maine, S. 1121, introduced by Senator Gillette of Iowa, and S 1913, introduced by Senators White and Brewster of Maine. While these bills may vary somewhat in detail, all of them would establish in the United States Public Health Service a Division of Water Pollution Control and would impose additional duties upon the Service in connection with the elimination or reduction of water pollution.

Two bills designed to promote the general welfare through the construction of needed hospitals are HR 584, introduced by Mr. Fulmer of South Carolina, and S 1230, introduced by Senator Brown of Michigan for himself and for Senator Wagner of New York and Senator George of Georgia. While these bills are not identical, both of them authorize appropriations of the Public Health Service and would establish a National Advisory Hospital Council, of which the Surgeon General would be chairman.

In the industrial hygiene field mention may be made of two bills, S 193 and S 509, both introduced by Senator Murray of Montana. S 193 authorizes appropriations to pay States having approved compensation plans and prevention plans relative to dust diseases. The bill would be administered by the Secretary of Labor. The other bill, S 509, also to be administered by the Secretary of Labor, provides for payments to States with approved plans for promoting the prevention and control of industrial conditions hazardous to the health of workers and thus affording more adequate protection to workers and their families from economic losses caused by disability or death resulting from occupational diseases.

Mr. Schwert of New York introduced HR 1074 which is cited as the "National Preparedness Act of 1941 for the Improvement of Physical and Social Fitness." Grants-in-aid to States are authorized, it being stated that the primary purpose of the bill is to assist in making adequate provisions through schools for physical education, instruction and guidance in healthful living, wider recreational use of school facilities, and the development of school camps. Duties in connection with the carrying out of the bill's provisions are imposed on the United States Commissioner of Education.

Another bill, S 797, introduced by Senator Walsh of Massachusetts, would create in the Federal Security Agency a National Physical Fitness Institute, to be headed by a director appointed by the President by and with the advice and consent of the Senate. The duties of the Institute would be to conduct research and prepare data with respect to conserving and increasing the physical fitness of the American people.

With regard to appropriations made to the Public Health Service, mention should be made of a number of enactments. Public Law 9, approved March 1, 1941, appropriates $525,000 for emergency health and sanitation activities in connection with defense. Public Law 146, approved July 1, 1941, contains in title II the 1942

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fiscal year appropriation act for the Service. The total amount appropriated under the heading "Public Health Service" is $35,480,700. Of this amount, $565,000 is for cancer work, $11,000,000 is for grants to States under title VI of the Social Security Act, and $6,250,000 is for venereal disease control work. In the total appropriation are also included, in connection with national defense, $1,235,000 for emergency health and sanitation activities and $1,200,000 for the cost of nurses' training courses. Public Law 150, approved July 3, 1941, appropriates an additional amount of $1,940,000 for emergency health and sanitation activities pertaining to defense, and Public Law 463, approved February 21, 1942, also provides additional amounts of $2,500,000 for venereal disease control work, $77,481 for disease and sanitation investigations, and, in connection with national defense, $1,295,000 for emergency health and sanitation activities and $600,000 for training of nurses.

CHAIRMAN PARRAN: Are there questions that you would like to ask Dr. Coffey regarding pending legislation? I called attention to the several bills which are pending in reference to vital statistics. Are there any questions regarding that, or does Dr. Coffey have anything to say on the status of such pending bills?

DR. COFFEY: Dr. Parran, the bills that seem to be of most concern to the State health officers at the present time are those which provide for delayed birth registration or proof of citizenship. During the past few days the State and Provincial health officers have given considerable time to discussion of that in committee, and I believe they are quite familiar with it.

DR. A. T. McCORMACK (Kentucky): I would like to ask Dr. Coffey to review the appropriations dealing with community sanitation.

DR. COFFEY: There is no legislation pending. Since it is at this time merely a question as to the advisability of seeking an appropriation to augment or to carry on the community sanitation programs in lieu of those which have been carried on in the past by the WPA, perhaps Dr. Mountin, who is more familiar with this subject, may answer the question.

DR. J. W. MOUNTIN (Assistant Surgeon General, States Relations Division): I did not hear the question in its entirety, but I believe it has to do with our present efforts to do something in the way of community sanitation. A few months ago we presented a request to the Federal Works Agency for a grant of approximately five million dollars to carry on a community sanitation program which would include work on privies, septic tanks, and small water supplies. That request was rejected by the Budget Bureau. We then asked for another hearing on the matter. We had that hearing less than a week ago but we have not as yet had a decision. That is the present status of the matter. An estimate has not yet been submitted to the Budget Bureau for transmittal to Congress. We wish to explore further the possibilities of doing the work through the Community Facilities Act. The Federal Works Agency is most sympathetic. We are quite hopeful that they may do it.

DR. EDWARD S. GODFREY, Jr. (New York): What do you mean by "small water supplies"?

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DR. MOUNTIN: Springs and perhaps individual wells; also wells which might serve a tourist camp or a small group of houses. In other words, something less than a village or municipal water supply.

DR. A. I. MILLER (Nebraska): Has the May Act been invoked?

DR. COFFEY: I think Dr. Parran or perhaps Dr. Vonderlehr can answer that.

CHAIRMAN PARRAN: I do not know of any areas in which the May Act has been invoked.

DR. C. F. McCLINTIC (West Virginia): I understand there is no possibility of invoking the May Act except in a cantonment. Is that correct?

CHAIRMAN PARRAN: The Act provides that within such reasonable distance of any military or naval cantonment or establishment of any type as may be determined by the Secretary of War or the Secretary of the Navy, prostitution, the aiding and abetting of prostitution, or the renting of houses for that purpose are declared to be unlawful. The first step in invoking the Act, therefore, is a formal designation of a specific area under the terms of the Act. Such formal designation has not yet been made. The threat of invoking the Act has been made in several places, with improvement, or at least temporary improvement, in most instances.

Are there any other questions? If not, we will pass to the next subject, "The role of State and Local Health Officers in Emergency Medical Service," by Dr. George Baehr, Chief Medical Officer of the Office of Civilian Defense.

Last year when I was in Great Britain, it was widely remarked that surgical skill and diagnostic acumen were not always a good test of administrative ability in connection with the emergency medical and hospital services in Great Britain. A notable exception to this statement was found, however, in the person of Sir James Fraser, who is the Chief of their Emergency Medical Service. We have found the same exception in this country. The Chief Medical Officer of the OCD is not only a distinguished internist, but one who is widely informed concerning public health and medical science. He is a member of the New York State Public Health Council and of the Technical Board of the City Board of Health, and Chairman of the Public Relations Committee of the New York Academy of Medicine. Dr. Baehr, will you come forward and discuss this topic? . . . (Applause)

DR. GEORGE BAEHR: Dr. Parran, Gentlemen: I had the privilege of addressing many in this audience at Atlantic City during the American Public Health Association meeting, and it is therefore unnecessary, except by brief reference, to cover the ground which we went over at that time. You know that the Medical Division of the Office of Civilian Defense is in a sense a branch of the Public Health Service. We have been detailed by the Surgeon General to the OCD to carry out the protection activities that have been assigned to the OCD by Executive order of the President.

The first and most important responsiblity of this division of the OCD is to formulate plans for an Emergency Medical Service. Previous to the issuance of the President's Executive order there had been some stimulation of the States by Federal agencies and this resulted in the setting up of State defense councils. Under those preliminary instructions there were lumped together under one division

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of the State Defense Council, activities having to do with health, welfare, recreation, nutrition, consumer, and related interests.

In setting up an Emergency Medical Service so as to concentrate upon those problems likely to arise in State and local communities as a result of direct enemy action, such as the care of the injured, it was necessary to split off from that heterogeneous agglomeration of functions a special section to concern itself with medical care.

In many States, the person who had the responsibility for the organization of the Emergency Medical Service was the State health officer. Unfortunately, although he is as a rule the best man for that responsibility, as the needs increased and as we approached nearer to war, it became obvious that he had to have a full-time Deputy Chief to carry out his instructions, as well as to travel throughout the State from community to community and assist localities in adopting the plans proposed by the Office of Civilian Defense and modified by the State Civilian Defense Council for adoption by local communities. In States where a Deputy Chief of Emergency Medical Service was not appointed, activities have lagged. In most communities in the coastal areas, which have been termed by the Board of Civilian Protection as the target areas of the United States, an Emergency Medical Service of more or less perfect organization has been developed.

As I travel about the country, I find that the deficiency which still exists in many communities is not due to the fact that people have failed to understand or have not tried to organize an Emergency Medical Service in accordance with the common pattern presented by the Medical Division of the Office of Civilian Defense with certain State and local modifications, but rather to two errors in thinking. I would like to point these out to you because it is through you that we must hope to influence the plans and preparations for action in our local communities. One error is that most people, even doctors, fail to appreciate the difference between the emergencies which we are facing and peacetime disasters. A peacetime disaster is usually a single incident. It takes no special organization to handle it other than the normal protection facilities of the community. In the event of need, all available facilities of a community--medical, health, fire fighting, and everything else--can be directed towards the one urgent problem without depriving the remainder of the community of any essential services for too long a time. But what we are facing now is something quite different. We are facing the possibility of multiple incidents occurring sometimes in large numbers over a period of hours or days at a time. Under such circumstances a degree of organization is required which is unnecessary in peacetime. A predetermined allocation of protection services is required for each section of a city which is governed by an overall central control within the communities, within counties, and within States, and which includes all protection services.

There has been an extraordinary lack of appreciation, perhaps a lack of understanding, of this essential need for central control on the part of many of our municipal authorities. Funds have not as yet been made available to create such a central control, nor has there been a proper districting of the area with each district under its own district control. This organization is absolutely essential if we are to use our protection services effectively.

Practically all the protection services from which we must create this emergency organization are on the local level--fire, police, public works,

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utilities, hospitals, health services, medical and nursing professions. The State authorities, like the Federal, are merely planning, stimulating, and organizing agencies. They provide relatively little compared with what the local community must provide for itself. Your influence in your State must be exerted directly on the State Defense Council if you are the State Chief of Emergency Medical Service, or through the State Chief of Emergency Medical Service if he is independent of the State health department. No matter how well the Emergency Medical Service in a community may seem to have been developed on paper, no matter how thoroughly the local medical and nursing professions have risen to the occasion and have volunteered their services on paper, the program will not work unless the central control is there. You must see to it that there is a local Chief of Emergency Medical Service in every locality who is competent to organize and also competent to direct the operation of the emergency medical facilities. This person must be prepared to give time in the event of air raids. He must be prepared to serve at the control center as the medical adjutant to the commander or controller of the control center. He is the one who disposes of the medical protection services under the direction of the control center during the critical hours of an air raid.

In each district, protection services should be adequate to meet the needs of that district under ordinary emergencies, but if extraordinary damage should occur it may be necessary to obtain help from adjacent districts, sometimes from districts far away. There can be no borrowing between districts directly; all borrowing must be controlled by a main center in charge of the interrelated activities of the various districts.

This control system, which is absolutely necessary for the operation of the various protection services, including the medical services, is not operating effectively today in many parts of the United States. To create it and make it operate requires funds--local funds. The cities and localities must provide these funds.

So much for the Emergency Medical Service in the field. Behind the field casualty services stand the hospitals. All field casualty services should be related to the hospitals. Either they must be organized as field units in the hospitals or, if there is no available resident staff, they may be organized outside the hospitals with doctors, nurses, and trained medical auxiliaries from the community. In this case, however, they should be related to hospitals so that there is discipline and central control, and so that when casualties are extricated from demolished buildings, they are cared for promptly by competent physicians and nurses, and then taken by ambulances as expeditiously as possible to the hospitals. Hospitals can exert a most important influence upon the type and quality of emergency medical care given at the site of the incidents. Burns and serious crushing or penetrating injuries predominate. The type of care given and the prevention of shock at the site of the incident will often determine whether or not the patient will survive. The field work must therefore be interrelated with the work in the hospitals. It is wrong to plan a field casualty service without relationship to a hospital.

All hospitals which receive casualties will become part of the Emergency Medical Service automatically, and will be known as casualty receiving hospitals. All local hospitals, whether voluntary or governmental, which receive casualties will be reimbursed at the per diem rate of $3.75 through funds made available by

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the President to the Federal Security Administrator and by him to the Emergency Medical Service through the Surgeon General of the Public Health Service.

Back of the casualty hospitals, in all States along our seaboards, emergency base hospitals must also be established. A great number will not be needed but they must be well planned and strategically located so as to serve as focal points to which casualties and other categories of the hospitalized populations may be evacuated to make room for fresh casualties in periods of great emergency. In other words, the emergency base hospitals should be so located that they can serve a number of urban casualties received in hospitals. They may have to take not only casualties, but other categories of the hospitalized sick whose evacuation may be ordered by the military authorities.

A study must therefore be made in each coastal State of the hospitals in the interior which can best serve in this manner. This work will require the services not only of the Chief of the Emergency Medical Service or his deputy, but above all of a full-time State hospital officer who knows the hospitals of his State and is prepared to serve the State Chief of Emergency Medical Service in this special capacity.

The emergency base hospitals, in accordance with the agreement between Mr. McNutt and Mr. Landis, will also be entitled to receive per diem reimbursement of $3.75 for each patient. In addition, it may be possible through Federal sources to provide structural alterations of not too extensive a character which may be necessary in order to make a hospital available for this special purpose.

Furthermore, it has been realized that in such an emergency base hospital, which may be located 50 or 100 or even more miles away from the urban communities which it is to serve, it will be necessary to have a full-time staff to supplement any existing staff in that locality. To provide such a staff, the Surgeon General is prepared to enroll in the reserve corps of the Public Health Service officers who represent the various clinical fields of medicine and surgery which might be needed in such base hospitals.

It is planned to concentrate first upon the enrollment and organization of small affiliated hospital units similar to the affiliated hospital units which the Army has organized for its own purposes as general military hospitals. But whereas the Army's affiliated general military hospitals have an officer personnel of fifty or fifty-five officers, these emergency medical affiliated units of hospitals will have an officer personnel of only fifteen. In that way they can serve as a balanced unit to form the nucleus of a professional staff which can be called into active duty by the Surgeon General when in an emergency he establishes such a base hospital in the rear.

In addition to the nucleus of an affiliated hospital unit, provision has been made for enrollment in the Public Health Service of reserve officers in the various specialities of medicine and surgery, who can be called into active service for assignment to such base hospitals in order to supplement the affiliated emergency medical unit. Provision has also been made for the designation of consultants who can be assigned to such base hospitals on a part-time basis. This is needed because some specialists, such as neurological surgeons, plastic surgeons ophthalmic surgeons, and so forth, might be required at the base, not on a full-time basis, but for one or two days a week, or whatever time may be necessary

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to carry out their functions there. These consultants would be paid a per diem rate, and would be able to spend the rest of the week in their own communities at their customary duties.

Officers commissioned in the reserve, when on full-time active duty, will have the pay, rank, and allowances equivalent to that of an officer in the armed forces.

All of this takes organization. There will be handling of funds on the local and State level, or at least the processing of vouchers for payment by the Public Health Service. A great deal of additional responsibility, will, therefore, devolve upon you who are Chiefs of Emergency Medical Service, or upon your deputies. It is necessary that some one in your organization be prepared to serve in a dual function for the State and for the Federal Government. In order to accomplish this and still leave the organization and operation of your hospitals and other emergency medical facilities in the hands of State and local authorities it is provided by the Surgeon General that commissions in the reserve of the Publi Health Service can be offered to the Chief of the Emergency Medical Service. If he is not full-time, he may be commissioned in the Public Health Service on an inactive status, and a deputy who is giving full time to this service may be called to active duty as a reserve officer in the Public Health Service. He will receive his pay, allowances, and travel from the Public Health Service and will be in uniform.

This is done not with any intent to usurp the functions of the States and localities. In accordance with the remarks made by the Administrator of the Federal Security Agency and by the Surgeon General today, it is most desirable that all facilities out of which the Emergency Medical Service is created, both on the local and State levels, remain as they are, and that they be operated and continue to be operated by the people who know how to operate them, who have operated them in peacetime, and who must operate them now in time of war for the benefit of their local citizens, their localities, and States.

What measure of assistance the Federal Government can give will be supplied through equipment which we hope will soon be available. We can promise you no delivery date, so it is necessary for you to do the best you can in providing equipment for the field casualty services and for the hospitals under your direction within your States and localities.

A matter which has troubled most communities is the need for blood plasma. Practically all of the production facilities of the commercial laboratories in the United States are now being employed to produce dried plasma or human serum albumin to meet the present and future needs of the Army and Navy, and all blood that can be processed at the present time must be directed into those channels. It is not essential, however, to have dried plasma or human albumin in every community which might be exposed to enemy action. Liquid and frozen plasma are fully adequate to meet local needs, and, therefore, since we cannot provide every community today with dried plasma or human albumin in the amounts which they may think they require for the protection of their people in the event of enemy action the following steps have been taken or will be taken during the next few days.

About 300 hospitals will be assisted in the establishment of blood and plasma banks. This will be done through the provision of technical assistance,

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the Surgeon General having appointed and assigned a national technical director for blood and plasma banks through the Medical Division of the Office of Civilian Defense. There will also be designated a number of regional consultants, experts in this field, who will be available to hospitals in your localities in the organization of such blood and plasma banks.

Furthermore, at our request, the Committee on Blood Substitutes of the Division of Medical Sciences of the National Research Council has prepared a technical manual for the guidance of institutions in the organization and operation of such plasma banks.

Finally, some funds will be available--not a great deal but adequate--to assist hospitals in setting up such banks. These funds can be used for the purchase of equipment and for the payment of certain technical personnel needed to begin the operation of a blood bank. The rules and regulations under which these funds will be available will be announced very soon, probably within the next week.

I might inform you that we shall expect institutions or hospitals which are helped in this manner to accumulate, in addition to their current, everyday needs of blood and plasma, a reserve of not less than one unit (which is 250 cc. of the plasma; about the amount that is obtained from a pint of blood) per hospital bed within the next two or three months. In this manner, at least 60,000 units of blood plasma will be accumulated within the next two or three months and held in reserve for use in the event of civilian or military casualties in those localities.

This plasma can be preserved either in the liquid state in accordance with the recommendations of the National Research Council or in the frozen state. It is readily realized that in the event of extraordinary emergencies these local supplies might ultimately prove to be inadequate, and lest there be any danger of exhaustion we are also setting up a second reserve of dried plasma which it is hoped will amount to about 50,000 units. This dried plasma or human albumin will be held in a number of depots in various parts of the country where it may be needed, and will be sent from there to any community which is under attack and which may be in danger of exhausting its own local supply.

In this brief time it is impossible for me to give you much detail. I have tried to cover only the broad aspects of this problem. Before you leave Washington there may be a great many questions that you might wish to ask.

Dr. Dean Clark, who is in charge of the new hospital section of the Medical Division of the Office of Civilian Defense, is here and will help me in answering any questions you may wish to ask concerning the hospitalization program of the OCD and of the Public Health Service. . . (Applause)

DR. WILLIAM B. GRAYSON (Arkansas): Dr. Baehr, may I ask if funds are now available to pay the $3.75 per diem?

CHAIRMAN PARRAN: Funds are now available for the $3.75 per diem payments for care of casualties in local hospitals, provided such casualties are caused by enemy action.

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DR. GRAYSON: Is the Public Health Service now recruiting personnel for hospital activities? Are they receiving such applications?

DR. BAEHR: Next week we expect to call into Washington all our regional medical officers so as to discuss with them the program of recruiting reserve officers for the Public Health Service who will be used in the Emergency Medical Service. We shall then be ready to announce to you how these reserve officers are to be recruited.

Our present intention is to concentrate primarily on hospitals and to do as the Army does, to invite hospitals to organize affiliated hospital units. We shall also be prepared to receive applications from specialists. Among specialists I would include pediatricians, obstetricians, and general practitioners, because from this pool of reserve officers will be drawn not only the supplementary personnel for the base hospitals, which may have to be manned, but also the physicians, the pediatricians, obstetricians, and others who might be required for service in reception areas into which civilian populations may have to be evacuated because of military necessity, as is the case at present on the West Coast. The details of the recruiting will be announced later.

DR. W. C. WILLIAMS (Tennessee): I should like to ask Dr. Baehr what is the procedure proposed for the immediate organization of the plasma and albumin banks. Who should assume the direct responsibility?

DR. BAEHR: The announcement will appear within the next week in all medical and hospital journals and will give sufficient information, I think, for hospitals to make direct application. They should clear with the State Chief of Emergency Medical Service, but because of the complexity of the relationship and the reports which will be required by the Public Health Service concerning the accumulation of blood plasma and certain technical details, we shall be obliged to adopt a more direct method of channeling our information back and forth between those hospitals and the special blood project section which has been established in the Medical Division of the OCD for this purpose. The applications, then, will come from the hospital to the Medical Division of OCD and will be cleared through the Surgeon General of the Public Health Service.

Hospitals must have two hundred beds; they must be approved by the American College of Surgeons and must be on the hospital registry of the American Medical Association; they must also have a pathologist who has a certificate from the American Board of Pathology, or its equivalent, so that we can be sure that the operation of the blood bank is in the proper technical hands. The hospital also will be required to conform to the technics recommended by the National Research Council so as to safeguard people who will receive the plasma into their veins. And there will be certain other rules under which blood banks will be expected to operate if they are to obtain financial assistance and technical help.

DR. WILLIAMS: What action should the State officer of Emergency Medical Service take in order to stimulate the establishment of these blood banks and albumin banks as outlined?

DR. BAEHR: The State officer can be helpful by aiding in choosing the hospitals which he thinks are so located that they ought to have a blood bank. He should pay particular attention to those communities in which either no blood

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banks or plasma banks exist or in which, in his opinion, the blood and plasma bank is inadequate. In many hospitals there are blood banks today, but there may be no plasma banks. Or, if there is a plasma bank it may be totally inadequate to meet special wartime needs.

DR. WALTER L. BIERRING (Iowa): May I ask what will be the relation of the serum centers which are now operating to the State departments of health, which are licensed by the Biologic Division of the National Institute of Health and which have facilities not only for preparing plasma, but for pooling serum in blood banks, and which are now preparing facilities for drying?

DR. BAEHR: Public health laboratories of the type Dr. Bierring has described will be invited to cooperate in the national program for production of dried plasma or human albumin. We are, however, limiting ourselves to a total production of 50,000 units of dried plasma because we do not believe that at the present time it is necessary or wise to attempt to accumulate more than that. The picture is changing, and before this year is over we may find that something else, perhaps human serum albumin, is cheaper to produce or more satisfactory. We may find that beef serum albumin, which is now being prepared free of globulin, might meet the need and prove to be safe.

In answer to Dr. Bierring, I should also like to say that we have agreed not to interfere with, nor to encourage any interference with, the blood collecting of the Red Cross for the armed forces. If rival blood collecting agencies are started on a wholesale scale, they will discourage the public from giving their blood in the generous way they are doing now. Therefore, if you wish to assist in the production of dried plasma, the blood must be obtainable through the Red Cross either by an expansion of one of their existing eighteen or nineteen blood collecting centers or by the establishment of a new blood collecting center in a location which will not interfere with the present Red Cross blood collecting program for the Army and Navy.

DR. BIERRING: Dr. Baehr, that seems the most satisfactory arrangement, because the Red Cross has chapters throughout the States. It cooperates nicely, not only in obtaining donors--there seems to be no difficulty in obtaining sufficien donors--but in the processing of the blood, which requires careful supervision.

DR. BAEHR: Ordinary hospital banks do not require a wholesale blood collecting agency. They get their blood at present by bleeding several donors for every recipient; instead of two donors, they can bleed four.

DR. DONALD G. EVANS (Washington): I have two questions. One pertains to the matter of assistants for the Emergency Medical Reserve. Must such assistants, in order to have a reserve commission, be of such physical soundness as to be eligible for service in the Army?

DR. BAEHR: No. The fact is that we cannot touch the pool of potential officers who might be needed now or in the future by the Army and Navy. Those commissioned in the Public Health Service reserve for the Emergency Medical Service should be physicians over forty-five years of age or those with physical defects which make them ineligible for military duty but which do not interfere with carrying out their professional functions. Also, women physicians are eligible for such commissions.

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DR. EVANS: In other words, I can take a retired Army officer if he is still able to work?

DR. BAEHR: It depends on how old he is.

DR. EVANS: He is very old.

DR. BAEHR: That would be possible. Would you wish to set the age limit at this moment, Dr. Parran?

CHAIRMAN PARRAN: For the Emergency Medical Reserve?

DR. BAEHR: Yes.

CHAIRMAN PARRAN: I would prefer not to set such a limit now. If we were to do so, we might have to raise it.

DR. EVANS: I would also like a clarification of a statement which you made during your presentation and which I don't think I caught. It was relative to the responsibility of someone acting as disbursing agent in connection with these funds? I am sorry I didn't get your statement.

DR. BAEHR: Since local hospitals and base hospitals will be reimbursed at the rate of $3.75 a day for the care of civilian casualties, and the base hospitals for the care of any individuals who might be moved out of urban hospitals to the base hospitals because of military necessity, it will be necessary for the State Chief of Emergency Medical Service, or his hospital officer in States provided with a hospital officer, to supervise the movement of people from the urban to the base hospitals and to approve the vouchers for payment. The vouchers will be routed by him to the regional medical officer and then to the Emergency Medical Section of the Public Health Service.

You will be instructed in more detail concerning this matter. Because of the Federal responsibility of the disbursing officer, it is considered desirable to invest him with a Federal title and office, in addition to the State title which he holds.

DR. GEORGE C. RUHLAND (District of Columbia): I should like to ask you where we might best turn to procure laboratory technicians and X-ray technicians for the civilian medical service. I am aware, of course, that for medical services it is necessary to go to the Procurement and Assignment Service, but I am not aware of any other agency to which one can go for technicians.

DR. BAEHR: I don't think such an agency has been set up. So far as the Emergency Medical Service is concerned at the present moment, we are undertaking to assist the base hospitals by the per diem reimbursement, by assuming the cost of certain minor structural alterations, and by supplementing the medical, the professional personnel. But nursing services and all other technical services of the hospital will be provided as at present, and the cost will be met by the contributions of the State or local agencies as well as by the per diem reimbursement of the Federal Government.

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DR. C. F. McCLINTIC (West Virginia): The other day I asked the State medical society to recommend a Deputy Chief of Emergency Medical Service, and the first question asked was, "What is the salary?" I wonder if that has been fixed.

DR. BAEHR: It is fixed at the salary, pay, rank, and allowance levels of the Army. The rank will depend upon the age, professional caliber, and background of the man, as in the Army.

DR. McCLINTIC: What would the rank be?

DR. BAEHR: For a State Chief of Emergency Medical Service it would be Surgeon of the Public Health Service, which would involve pay, rank, and allowances equivalent to those of a Major in the Army.

DR. McCLINTIC: Another difficulty we are having is in regard to the relationship of the Chief of the Emergency Medical Service with the State Coordinator. Our State Coordinator insists that all information which goes out, even correspondence, must be referred to his office. It is rather confusing for me to receive a communication, formulate a reply, and then send it over to the Coordinator to be mailed from his office.

DR. BAEHR: Such difficulties have arisen in some States and have not yet been resolved. It is impossible to resolve them under a plan such as that insisted on by your Coordinator.

DR. McCLINTIC: The Chief of the Emergency Medical Service should be able to act independently insofar as his relations with his assistants are concerned.

DR. BAEHR: Yes. In all cases involving general policy, communications should be sent out and signed by the coordinator. He is the head of the defense activities in the State. But with regard to technical details, he must give some authority to his Chief of Emergency Medical Service. Otherwise that officer cannot cooperate.

DR. BERTRAM P. BROWN (California): I would like to ask a question with regard to the equipment for casualty stations and for emergency base hospitals. How much Federal aid will we be able to have for those types of institutions?

DR. BAEHR: The one hundred million dollar bill was unfortunately delayed, and as a result materials are not at hand. They will be purchased by the medical department of the Army as rapidly as the Army can get them. But these demands cannot take precedence over the regular needs of the Army. The Army is now buying supplies for the military establishments and for our allies through the lend-lease provisions. When the civilian defense supplies are obtained they will be sent to the six OCD depots located in various parts of the country, from whence they will be distributed to the State property officer. For the field casualty services, provision has been made for field kits such as have been described in Medical Division Bulletin No. 2, and for hospital beds. But we are not now in position to say when you will get them. If you have not received them by this time I think it will be necessary for you to improvise with whatever is available in your community so as to be ready for action by tomorrow.

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As far as base hospitals are concerned, the situation is quite similar. In the bill there is provision for about 100,000 hospital beds and mattresses, about 15 percent of which are fracture beds, but not much else for a hospital. These beds will be held at the depots until the need becomes evident in the various localities, and then they will be distributed through the State property officer to the localities which he will designate. But, again, I can't tell you when you may expect to get them. It may be months. If you want to protect yourselves now, you will have to provide the best facilities you can out of your own resources.

DR. JOHN W. FERREE (Indiana): Do you contemplate any new statement regarding the relationship of the Emergency Medical Service to the American Red Cross, particularly in regard to disaster relief? We get quite a few inquiries regarding this which haven't been answered to our satisfaction. There is a feeling that it is unnecessary to duplicate services, and that duplication confuses the administrative setup.

DR. BAEHR: I am glad you brought up that subject, because I know it troubles many people in different parts of the country. The reason for the trouble is not a lack of understanding between Mr. Norman Davis, Chairman of the American Red Cross, and Mr. James M. Landis, Director of the Office of Civilian Defense; they understand their roles perfectly. Similar understanding does not always exist down the line in the local chapters. Local chapters, like local defense councils, are made up of all kinds of people with ideas of their own, who do not always follow the examples set at the State or regional or Federal levels.

The National office of the American Red Cross has agreed that in time of war all its units, whether disaster relief canteen services, or any other kind, shall come under the control of the commander of the civilian defense board, and that as such will be operated under the direction of the Chief of Emergency Medical Service. There is no question about this on the national level, but difficulties arise in communities largely because of equipment which the American Red Cross has assembled in many of its chapter storehouses, and which they have locked up and will not distribute to the casualty stations. Some local chapters accept suggestions that they store their equipment not in one central depot but in the casualty stations. That equipment must remain their property. They cannot give up title to it, because in case they need it somewhere else they must be able to take it away. I think it is possible to arrange with them that they divide their stores into many depots and store them in the casualty stations. But the property belongs to them and should be so labeled.

DR. P. E. BLACKERBY (Kentucky): Would the Officer of Civilian Defense be able to take over public buildings such as schools?

DR. BAEHR: He can only be authorized to do so by the civil authorities or by the military authorities. Until he gets such authorization from his superiors he can do nothing. If he wants to use a building he can do it only with the consent of the owner or owners, or at the direction of the civil authorities, or, in great emergency, at the direction of the military authorities. Of course, in the event of enemy bombing, no one will deny him the use of any structure.

DR. J. LYNN MAHAFFEY (New Jersey): Dr. Baehr, in New Jersey we have tremendous hotel space in such cities as Asbury Park, Atlantic City, Ocean City, and other seacoast towns. Such space might be sufficient to care for half a million

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injured people. I am wondering if this space might be used for a hospital in the event of bombing of Philadelphia or New York City.

DR. BAEHR: I believe that such space would be more readily available to meet the needs of the general population of your own very large urban communities, such as Newark. Northern New Jersey, is the center of one of the largest industrial empires in the world. Newark needs that type of resources behind it, more for the evacuation of civil populations than of the injured. It also needs it for the possible evacuation of chronic cases and convalescents from hospitals in order to make way for the reception of casualties, or for the evacuation of upper floors of hospitals.

All preparations for the evacuation of patients to institutions in the interior of the State must be made in collaboration with the State evacuation authorities, if and when they are set up, and with the local military authorities. This is necessary because your plans are only paper plans and cannot be put into operation unless lines of transport have been determined and are acceptable to those who may be obliged to use them for other purposes, such as the military or evacuation authorities.

DR. WILLIAM M. McKAY (Utah): Is it a hard and fast rule that only the Red Cross agencies shall be used in securing blood donors? In our State we already have a plan under way in which the Junior Chambers of Commerce has been very active. They have set up definite plans and have their organization already under way for the securing of blood.

DR. BAEHR: Is there a Red Cross collecting service in that area?

DR. McKAY: We have small chapters, but I think in many of our communities they would be totally inadequate in comparison with the service which would be rendered by the Junior Chambers of Commerce.

DR. BAEHR: If one of the eighteen or nineteen major collecting stations of the Red Cross is not operating in your area, then you are not interfering with the Red Cross collecting service and you can do what you please. What we meant by avoiding interference with the Red Cross program is interference with the public contributions for the military forces.

In this connection, I should point out that the military forces would make available to us whatever dried plasma they might have available in civil communities under enemy attack. Similarly, any stores of dried plasma or liquid plasma which we have accumulated with Public Health Service funds in any part of the United States would be made available to the military forces if their supplies ran short. We must realize, however, that it will take a great deal of material to supply the present needs of our military establishments, and we must not depend upon them too much.

DR. COURTNEY SMITH (Alaska): Inasmuch as Alaska has no hospitals of five or six hundred beds, are any special provisions being made to provide a plasma bank in Alaska?

DR. BAEHR: I think provisions must be made for regions such as Alaska through the establishment there of depots of dried plasma. Do you have blood banks in any of the hospitals at the present time?

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DR. SMITH: No, sir, we do not. We have considered a program of typing of all civilians, and we have been promised a supply of plasma from the Red Cross.

DR. BAEHR: I believe the Red Cross intends to establish a depot of dried plasma. Your current needs for whole blood can be met through the normal population as needed. If you have a group of small hospitals they might assist in the establishment of a blood bank in an area of exceptional danger. The reason for making a rule that participating hospitals should have about 200 or more beds is because there must be a turnover if a proper bank is to be operated, and unless you have that number of beds there isn't sufficient turnover. We know of some hospitals which are operating excellent blood banks although they have only 150 patients. That is because they are very active hospitals and require a great deal more blood than some 200- or 300-bed hospitals. Some special provision ought to be made to meet the situation in Alaska, and I think further discussion will result in some concrete plan which will probably satisfy you.

DR. GEORGE C. RUHLAND (District of Columbia): A matter has come to my attention which I believe might well be cleared. There is a popular misunderstanding with regard to the use of blood from Negroes; some persons fear disastrous consequences if it is mixed with the blood of white people. There is a serious prejudice regarding this in certain geographical areas, and it occurs to me that as a matter of popular health education it would be well worth while to have an article prepared which might clarify this situation.

DR. BAEHR: The suggestion is very well taken, Dr. Ruhland. People will take rabbit serum or horse serum but not certain types of human serum.

DR. DEAN CLARK: I would like to say one word about a new phase of the Emergency Medical Service program which is not directly connected with the Office of Civilian Defense but which at the moment is being undertaken by the Public Health Service under its grant of $500,000. That is, the immediate care of civilians affected by enemy action other than direct bombing or other activity against communities; I refer specifically to seamen and others from vessels sunk near our coasts, and to persons evacuated from Alaska, Hawaii, and other dangerous areas. I think most of you have received, or will have received by the time you get back, a series of bulletins on this program which provides funds for immediate temporary medical or hospital care of such persons.

The procedure for getting payment for service under these circumstances is somewhat different than in the case of the ordinary types of civilian casualties. In the first place, not only hospital care will be covered, but also physicians' and surgeons' services and burial costs. The reason for this is that in the case of civilian casualties due to direct bombing and other enemy action against communities, the persons affected will be mainly residents of the community, whereas in these other instances they are outsiders for whom the community has no direct local responsibility. Therefore, it is felt that surgeons, physicians, and hospitals must be reimbursed directly from Federal funds. The rates of reimbursement also will be somewhat different. In places where the Public Health Service has contracts with hospitals, the rates of payment will conform to the contract rates. In hospitals which have no contract the payment will be approximately at the base rate of $3.75 per day. Where prevailing rates are higher than that, the reimbursement rates may be a little higher.

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Vouchers for this type of service will be received directly in the Emergency Medical Section of the Public Health Service. I think the bulletin which you will get will clarify most of the details.

DR. C. F. McCLINTIC (West Virginia): May I ask what role or responsibility the Emergency Medical Service will have in evacuation?

DR. BAEHR: Its only responsibility in this field will be to assist in providing the necessary supplementary medical services. The evacuation of the people is being planned by an interdepartmental group representing the various agencies, Public Health Service, Federal Security Agency, Children's Bureau, OCD, and other agencies, and it will probably be necessary to set up on the State level some authority under which the movements will be carried out.

CHAIRMAN PARRAN: Is there other discussion?

Before closing the discussion I want to present to the audience the several assistants of Dr. Baehr who are here. Dr. W. Palmer Dearing... . (Applause)

DR. V. H. VOGEL. . . (Applause)

Dr. Leonard Scheele also is one of the staff of the Medical Divison of OCD, but he is on temporary detached duty in the western area where he is serving as a regional medical officer.

Are there any other questions?

DR. McCLINTIC: I move that a vote of thanks be extended to Dr. Baehr for his fine presentation and for the excellent information he has given us.

. . . The motion was seconded by Dr. A. T. McCormack, Kentucky, and unanimously carried . . .

CHAIRMAN PARRAN: I should like at this point to recognize the Assistant Administrator of the Federal Security Agency, Captain Watson Miller. Won't you come to the platform?

MR. WATSON B. MILLER: Thank you, General; I will not. I would like to say that I feel greatly privileged at being permitted the opportunity of joining a group like this. I thank you very much for the privilege of being here . . . (Applause)

CHAIRMAN PARRAN: Thank you, Captain Miller. We shall consider you as one of us, and we hope you will stay with us during the meeting.

Next on the program will be a discussion of committee arrangements by Dr. Mountin. The program this morning is relatively short, because we want the committees to be able to have a full afternoon for their deliberations, and as much of the evening as necessary.

. . . Dr. J. W. Mountin announced the committee meeting places . . .

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DR. W. C. WILLIAMS (Tennessee): The meeting of the Business Management Committee will be a joint meeting with the Committee on Records and Reports of the State and Provincial Health Officers and will be the last joint committee meeting of this session.

DR. MOUNTIN: Each State health officer is on some committee, so, if you misinterpret my remarks or have lost your schedule, remember that you all have some meeting to attend at the Old Naval Hospital. We hope that you will arrive there by 1:30.

Some State health officers are represented by their deputies. I have in mind Dr. Harper of Wisconsin, represented by Dr. Neupert. Dr. Neupert, will you act as Chairman of the Committee on Interstate and Foreign Quarantine in place of Dr. Harper? Are you representing Dr. Council, Dr. Smith? In such cases please consider your assignment the same as that originally given to your State or Territorial health officer.

During the last few years there has been a gradual transformation of these conferences from a scientific assembly into what might be called a business or action body. With that transformation, growing importance has become attached to the work of the committees. There are many items of a business character which, because of their number and complexity, cannot be listed on the program. We have, therefore, limited the general program to the discussion of a few topics of common interest to all, and the special aspects of subjects have been left to the committee meetings, where there is more time for discussion and deliberation. In that way, whatever you agree upon is the result of very careful consideration. We have, therefore, afforded a full afternoon for the committee meetings and for the preparation of your reports. Stenographic service will be available to those who want it.

We have allowed an entire half day for the discussion of the committee reports, so if some of you have activities or items which you wish to have brought before the conference, please get in touch with the chairman of the appropriate committee.

Another point I wish to make is that we have sent out to the committee chairmen a number of suggestions which represent the point of view of the Public Health Service. We have suggested to the chairmen that they take these matters up with their fellow State health officers, and that they solicit further suggestions from them.

You will notice some change in the names of the committees.

The Committee on Interstate and Foreign Quarantine has the same name as before.

The Committee on Hospitals and Medical Care has been changed to the Committee on Health Programs. The latter name is more comprehensive, and we expect that committee to consider the broad subject of the content of public health programs.

Dr. McCormack's committee formerly concerned itself for the most part with allocation formulae. We hope that in addition it will now take up the many other aspects of Federal-State relationships.

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The Committee on Venereal Disease Control is the same as formerly.

The Committee on Records and Reports has been changed to the Committee on Business Management. There is a business aspect to carrying on health affairs, quite apart from the technical aspect, and we would like to have that committee broaden its interests accordingly.

We wish that the Committee on Personnel would take up, in addition to qualifications, with which it formerly concerned itself, such items as the merit system, the content of courses in hygiene, and the various other aspects of recruiting, training, and certifying personnel.

Let me say, too, that we hope these committees will perform a year-round function, that they will not merely be groups which meet and draw up resolutions to be adopted or rejected by the Conference.

I do not like to pick out certain committees and to hold them up as examples, but I fear that I must. I especially wish to commend the Committee on Personnel under the chairmanship of Dr. Bierring. He, in collaboration with his consultant, Mr. Gordon H. Seger, has done a marvelous job. They have worked throughout the year, and they have coordinated their efforts with the corresponding committee of the State and Provincial Health Officers, with the corresponding committee of the American Public Health Association, and with other professional and certifying groups such as the associations of clinical pathologists, medical social workers, and others.

Dr. Williams' Committee on Records and Reports has done a splendid job in collaboration with Mr. Siepert and Dr. Derryberry of our staff. They also worked throughout the year. I am hoping that the other committees will do the same.

We are attempting now to facilitate your work by designating one of our consultants as a recording consultant who will be more or less a secretary to your committee, and we hope that you will use that individual. We tried to select somebody who will take instructions, who will go to work, and who will do things the way you think they ought to be done.

Before I relinquish the floor, Dr. Underwood has an announcement.

DR. FELIX J. UNDERWOOD (Mississippi): Mr. Chairman, the Committee on Maternal and Child Health will meet at the Children's Bureau, Room 7129, at 7:30 this evening.

CHAIRMAN PARRAN: Are there other matters to come before the Conference this morning? If not, we will adjourn to meet in separate committee rooms this afternoon.

. . . The conference adjourned at 11:50 a. m. . . .

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THURSDAY MORNING SESSION

March 26, 1942

The meeting convened at 9:30 a. m., Dr. W. F. Draper, Assistant to the Surgeon General, United States Public Health Service, presiding.

CHAIRMAN DRAPER: The first discussion on the program this morning will be opened by Dr. Mountin on the subject, "Are We Meeting the Crisis?" . . . (Applause)

DR. MOUNTIN: Inasmuch as all previous speakers opened and closed their remarks with references to the current emergency, I presume everyone here knows we are at war. And I presume everyone is convinced that he should do something about it. As a matter of fact, we have had numerous suggestions as to what should be done.

It is my purpose merely to survey actual accomplishments--to recount what has been done in relation to the present crisis. The emergency was apparent when we met a year ago but it has only recently been forcefully brought home to us by the outbreak of war and the initial reverses of our armed forces.

Some of our public health accomplishments may not have emerged from the blueprint stage, but even such progress represents understanding of the problem and the intention to do something about it. In some instances I may be calling attention to problems which have already been solved, but if so the solutions have not yet been reported to us.

My remarks are designed to provoke discussion. Therefore I shall not be embarrassed if you call attention to omissions or misplaced emphasis. Please bear in mind that I am generalizing for the Nation.

When the President first declared a limited emergency the Public Health Service began a series of reconnaissance surveys in localities where military or industrial developments were contemplated or already under way. To date the Service has made a total of approximately 300 surveys, and additional ones are being conducted. First it was necessary to arrive at a clear understanding of the nature and extent of the problems which would be thrust upon these communities. Then we had to evaluate the resources available locally for meeting these problems. Finally, we had to determine the additional resources needed with regard to both health organization and physical facilities.

Because of the rapid expansion of the war effort, serious sanitary problems had already developed in some areas prior to the initial surveys. In other instances we made surveys in communities where the expected developments failed to occur. Such mistakes were inevitable because, for quite valid reasons, neither the war production organization nor the military authorities were disposed to release information about new installations until contracts had been let. Notwithstanding the errors in either direction, these surveys have been of inestimable value in program planning and in forestalling many serious situations which would otherwise have occurred.

Unfortunately, in a number of instances, the surveys were misconstrued as an attempt by the Public Health Service to assay its own tasks. This was not at all

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the purpose of the surveys. Rather, it was to evaluate the total problems of the communities--the problems which would have to be met by mobilization of all resources, including those of the communities themselves.

In accordance with accepted principles, the establishment of an effective local health organization was conceded to be the first objective wherever such organization was lacking. I am happy to report that for the Nation as a whole full-time local health service has been extended to 106 more counties than had such service on June 30, 1941. Most of the new health units have been developed in critical military or war-industry areas. Our field reports indicate that a full-time health organization of some sort is in operation in practically all of the major defense areas. Please note, I said, " . . . health organization of some sort." This may mean no more than a skeleton organization composed for the most part of our so-called "lend-lease personnel," with nothing more than a token contribution from the community. There are in addition a number of secondary defense areas where the number of troops or industrial workers is not large. In such localities a health department is also desirable, and it is our hope that effective health organizations may be extended to these areas during the coming year By and large, the extension of local health organization for meeting the current emergency has been a remarkable achievement, especially if contrasted with the period 1917-1918 when the job of providing health and sanitation services in industrial and extra-cantonment areas was very largely a direct function of the United States Public Health Service.

The reconnaissance surveys which I just mentioned revealed a striking need for certain physical facilities essential to health and sanitation. Particularly needed were hospitals, health centers, detention homes, and improvement or extension of water supplies and sewer systems. The data accumulated through the reconnaissance surveys furnished the most potent argument in favor of the Community Facilities Act, through which an initial appropriation of $150,000,000 for needed installations was made available by the Congress. This initial sum was later supplemented by a similar amount, bringing the total to $300,000,000.

As of March 21, 565 projects of importance from the standpoint of health and sanitation had been approved, involving an estimated total cost of more than $132,000,000. The administration of this Act has been unique in that the technical agencies of the Government having prior interest in the proposed facilities acted in an advisory capacity to the Federal Works Agency, under whose authority allotments are made. The Public Health Service is the certifying agency for all health and sanitation installations.

In this way a balance was achieved between facilities desired and those which could be provided under the terms of the Act and with the money available. Unfortunately, many communities regarded the Act as an opportunity to acquire facilities far beyond their needs. Others saw in it a chance to remedy situations brought about by long-standing community neglect. Even State and local health departments, I regret to say, often fail to understand that the purpose of the Act is to provide facilities the absence of which would interfere seriously with prosecution of the war.

Daily, as the war imposes new restrictions, and as materials and manpower become scarcer, we are compelled to revise our original recommendations. Hospitals can no longer be built in conformity with prevailing architectural plans. The

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impossibility of obtaining elevators, for example, makes it impossible to erect buildings of more than one or two storeys. As a result, many less imposing structures than were originally desired will have to be provided.

Lack of understanding of all the problems involved has resulted in other difficulties. The Public Health Service has been accused of compromising sound sanitary principles, for example, by allowing the discharge of untreated or partially treated sewage into streams that are already heavily polluted. I would ask you--what possible war-connected need can there be for a sewage treatment plant in a small town along the bank of a river when a few miles up the river a large city is pouring its untreated sewage into the stream?

For the health and sanitation projects as a whole, only about 30 percent of the cost is being met by the communities. Many of the communities are, however, in excellent financial condition. If they are to participate in this program at all their contribution should be generous. The Act was intended primarily to help small communities who were overwhelmed by the problems growing out of the war program and who did not have the resources to meet the situation.

Aside from meeting the problems resulting primarily from the war, the program will provide many communities with facilities which would otherwise not have been developed. It is to be hoped that in these communities, at least, the new facilities will make it possible for the health departments to get out of the basements and into decent accommodations. I am sorry to report that many health departments have requested annual operating grants of as little as $1,200 for health centers and have certified that without such grants the facilities could not be utilized.

More than a year ago it became apparent to the Public Health Service that the problem of personnel in State and local health organizations would become a serious one. Accordingly, an emergency health and sanitation appropriation was obtained which was very broad in its provisions. A substantial part of this amount was used to recruit and train physicians, engineers, nurses, and other technical personnel for assignment to State and local health departments. To date approximately 630 physicians, engineers, nurses, and other technical personnel have passed through our orientation course and have been given local assignments. Another class of about 75 persons will begin a training course on April 13 and will be available for assignment about the end of May.

I fear that you have not fully understood the limitations as well as the opportunities involved in the use of this personnel. In justifying the appropriation, we described to the Budget Bureau and Congress the problems, largely of Federal creation, which had been thrust upon the so-called war communities by military or industrial expansion. We pointed out the obligation which the Federal Government had in helping the communities to meet the situation. Because of this justification we cannot allow the use of these persons outside war-affected communities as long as they are on the Federal payroll. As I stated, by the end of May approximately 700 emergency health and sanitation personnel will be in the field. We had hoped that this number might be increased to about 1,000, but our current appropriation limits the number to approximate 700. According to the present outlook, there will be no more assignments after the April class is sent into the field. Since the beginning of the program it has been our hope that the State and local health departments would transfer the assignees to their pay rolls,

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thus creating vacancies in the Federal pay roll which could be used to recruit and train additional personnel. In other words, this was intended to be a sort of revolving fund. But unless the States take persons off the Federal pay roll it will not revolve, and from now on the program will be frozen at its present level.

I think I have heard all the reasons why these persons cannot be put on the State or local pay rolls, but perhaps a few more will be disclosed at this meeting. There is one excuse I hope very few or none of you will raise: that is, lack of funds. In title VI grants alone, there are substantial unexpended balances, and I am told that corresponding amounts are available in unexpended funds from the other grant-in-aid programs. Practically all communities are now benefitting financially from war-stimulated business. Sufficient time has elapsed to make necessary adjustment in municipal and State financial structures and to assume community obligations.

While on the subject of excuses, let no one mention staff vacancies--at least not until you have taken over our 700 emergency health and sanitation workers. I know this number will not be sufficient to meet all needs, but please stress that point later when those 700 persons have been absorbed by your organizations.

Extensive deferment for personnel has so far been a way of postponing the crisis, but like a lot of other things from girdles to gramophones I think deferment, except on a highly selective basis, is now out for the duration. There will, of course, be a number of persons who, because of physical disability, age, or other handicaps will not be suitable for military service. Many of these sincerely desire to make some sacrifice and to dedicate their personal services to the common cause. Our recruitment program has demonstrated that these persons can be utilized in ways that are extremely valuable.

In recent years we have talked much about raising the standard of public health personnel, and we have actually accomplished much toward this end. Now it is difficult to realize that we are simply not going to have in sufficient numbers the quality of personnel we should like to have. I have already done so much talking about this that I have been branded as a "dilutionist." But, frankly, to dilute our organizations is precisely what we will have to do. Such trained personnel as are available will have to extend the scope of their supervisory activities, while persons of lesser skills will have to do what was formerly done by more competent employees. I am not able to foresee the extent to which this process of dilution may have to be carried.

Let me point out that the Public Health Service emergency health and sanitation program is essentially a dilution process. There were many dire predictions of failure when this program was started, but, after weeding out the half dozen or so irresponsibles who would invariably be found among such a large number, we have emerged with a fairly workable group. At first I took rather seriously the claim of the health officers that these folks could not perform satisfactorily without further training. Accordingly, arrangements were made with the schools of public health to give them the necessary training. But lo and behold, when they were called for training an anguished cry arose from the health officers! Previously, these persons' services had been discounted, but now they were suddenly discovered to be indispensable to the health of the community. We were able to wrench away only about 25 engineers for training purposes, and then so much objection was raised that the entire plan had to be dropped as far as the others were concerned.

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So far we have been fortunate in that there have been no serious outbreaks of disease such as are usually associated with large-scale mobilization and migration. An epidemic of influenza threatened, but never materialized. Many epidemiologists predicted outbreaks of measles, meningitis, and respiratory infections, but for reasons which we are not able to ascertain they did not occur. They may still occur, however, and possibly in an explosive manner.

The venereal diseases have given the usual amount of trouble. It is true that present rates are distinctly lower than those during the first World War. But when we consider our improved therapeutic techniques they are not low enough. I shall not discuss the venereal disease problem because one of the Conference committees is to bring in a report on that subject this afternoon. Another reason why I cannot say much about it is that I am not intimately associated with the venereal disease control program, except insofar as the provision of detention homes under the Community Facilities Act is concerned. The failure of State and local authorities to obtain suitable sponsorship for such facilities has been a factor which has seriously hampered control activities.

It is casting reflection on no one to admit that malaria control during last summer was accomplished for the most part by dry weather. The difficulty arose from the fact that the program was designed to operate with relief labor, which could not be furnished. Another detrimental factor was the higher priority ratings given to other activities which local commanding officers considered more closely related to the war effort. I am glad to report that these obstacles have been recognized by the Budget Bureau, and that the Public Health Service now has available the sum of approximately $1,678,000 for direct operation of the malaria control program during the current fiscal year. We have justified before the Budget Bureau a request for $6,493,500 to be made available during the next fiscal year.

This program entails a number of principles which are somewhat new with regard to the relationships of our respective organizations, and I should like to elaborate a little on the scheme of operation. First, this money must be used only for the control of malaria-bearing mosquitoes in areas where the disease is known to be endemic. It cannot be used for the control of pest mosquitoes or even for the control of Anopheles mosquitoes where malaria is not endemic, unless there should be an actual outbreak of the disease. The Public Health Service is authorized under this appropriation to employ labor, purchase equipment, and, in brief, do all things necessary to the operation of the program. We expect to use relief labor wherever it is available, but operations will not be held up because relief labor cannot be had. Please understand that the Public Health Service does not contemplate taking over complete responsibility for malaria control even in defense areas. Generous support in terms of funds, personnel, and equipment is expected from both the States and the communities. We shall have to make use of your authority to enter upon property in order to make the program effective. The Public Health Service is merely relieved of the restrictions which interfered with operation of the program during the past season, and it has not been given responsibility for doing the whole job. Let me emphasize again that our malaria appropriation must be spent in defense areas, and that the problem of taking care of malaria in non-defense localities is a State and local job.

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The Public Health Service is deeply concerned about two endemic diseases, either of which presents distinct possibilities of explosive and serious outbreaks. These two diseases are plague and typhus fever. Plague is perhaps of limited and local importance at present, but the prospect of an outbreak of pneumonic plague in a military cantonment cannot be disregarded. Infected ground squirrels and infested burrows have been found on military reservations immediately adjacent to sites where soldiers pitch their tents during maneuvers.

For this reason the Public Health Service has transformed its plague investigation force into a control organization and has made more than $100,000 available from emergency funds for expansion of control activities. Working agreements to provide for more extensive rodent control are being effected with the Division of Predator and Rodent Control of the Fish and Wild Life Service. For some reasons which I cannot explain the States have, with one exception, not seen fit to engage extensively in field control measures.

Typhus fever, however, is more widespread than plague. It is now endemic throughout the South and seems to be spreading in other areas. Epidemiologists have not agreed as to whether it might not become epidemic if our population should become lousy. This is entirely possible if a lower standard of living and greater congestion should be forced upon us. There is, of course, good reason other than typhus control for reducing the rat population, namely, to diminish the depredation of our vital food supply.

The State of Georgia has pointed the way toward a reasonably effective and inexpensive method of control. Isolated communities in other States have been following this method, but as yet it has not been taken up on a State-wide basis throughout the typhus areas.

The Public Health Service now has a typhus control unit with headquarters in Savannah, Georgia. To date, it has operated as a function of the District Office at New Orleans, but very soon it will have independent status under the direction of Dr. Eskey, whom many of you know for his splendid work in the field of plague. It is true that his staff will be limited, but insofar as possible they will endeavor to act in an advisory capacity in the inauguration of local control programs.

Our experience in respect to the sanitation of individual premises through the improvement of water supplies and excreta disposal has been disappointing, largely for the same reasons which accounted for failure of the malaria control program. In addition to the shortage of relief labor, there have been administrative objections on the part of the WPA to the improvement of wells and other types of individual water supplies. We are now attempting to resolve some of these difficulties by developing a project within the scope of the Community Facilities Act. A program has been submitted to the Federal Works Agency calling for an allotment of slightly more than $5,000,000. If granted, this fund would enable the Public Health Service, in collaboration with State and local health authorities, to correct certain insanitary conditions in industrial communities and in areas of military concentration. This program provides only for defraying labor and equipment costs, and it is expected that the property owners will supply the materials. Actual working arrangements cannot be developed until the terms of the

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allotment are known. I anticipate, however, that the scheme may resemble the malaria control program already described, thus making necessary a close working relationship between our respective organizations in order that the authority vested in State and local health agencies may be utilized.

Generally speaking, I believe it is fair to say that performance in the field of law enforcement has not been all that it might be. It is recognized, of course, that law enforcement depends upon the enactment and carrying out of local ordinances. With this in mind, the Public Health Service very early prepared a series of sanitary codes which it was hoped communities might adopt either intact or in modified form where local codes were inadequate.

Yet, the mere enactment of ordinances is not enough. If ordinances are to have any meaning offenders must be brought to book. I have in mind one locality I visited where both the prosecuting attorney and the judge were most sympathetic, but they remarked dolefully that the court calendar was so full that it would take two years for a new case to come to trial. This was during the construction period of the Army camp there, so heaven only knows how far they are behind with their cases now. The district attorney may eventually prosecute the cases, but some of the culprits, I fear, will reach the undertaker first.

Of course, I realize that clearing court dockets is out of your jurisdiction, and I don't know what action to recommend. But some action is necessary and somebody has to take it. When confronted with the complacency often displayed in the face of such a situation, about all that is left to do is to suggest to Hitler and Hirohito that they postpone the war for a few years until our country can catch up with its legal work.

The most appreciable failure has characterized the emergency performance of one of the oldest of health department duties--vital statistics. The cause of this breakdown was the unprecedented demand for proof of citizenship, which is required for employment in war industry. Unfortunately, this rather simple requirement was made to involve the mechanism set up for birth registration, in spite of the fact that this mechanism was designed for another purpose. Now, because it did not prove adequate for the task, several types of proposed legislation have been presented to the Congress which, if enacted in present form, may eventually divest the health departments of their vital statistics function. Or, if they do not do that, they may seriously impair the validity and usefulness of vital statistics based on the certification of births.

In order to remedy this situation, certain changes in the basic law are needed in a few States. But the other States can solve their problem merely by simplifying and accelerating the process now in operation.

Thus far, in appraising past and future tasks I have seen fit to forestall a number of the excuses which I know will be forthcoming. It is therefore perhaps only fair that I should provide you with a few "outs" which will certainly be applicable in the future. Two problems which have not yet become distressingly acute, but which may be expected to become so, are transportation and supplies. It may seem strange that I, who have always maintained that health departments have been too mobile, should now be deploring the impending lack of transportation facilities. But such, indeed, is the pass to which we have come. I still believe,

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however, that health workers may derive some measure of profit from the necessity of stopping long enough in their daily rounds to render really tangible services.

The problem of supplies other than tires is also certain to be vexing. At this stage it is difficult to anticipate the extent to which these shortages will be hampering factors. Some time will be required by the agencies handling these problems to secure a complete inventory of present stocks, to estimate the probable needs of the war agencies, and to determine the extent to which substitutes may be used in place of materials we formerly regarded as indispensable. In any event, the outlook is not bright. I would make a special plea that you ascertain the State and local mechanisms which have been developed for handling various problems of this character. And I may say that we shall be much more interested in learning how you are meeting the situation than in being told the extent to which it is interfering with your work.

In closing, I should like to survey briefly some of the attitudes of mind which have been brought into sharp relief by recent events. These attitudes have long prevailed but only now do they begin to take on a really threatening aspect as far as our future welfare is concerned.

One of these attitudes is the fixation on the orthodox health program. It is well illustrated by a bulletin recently issued by a health department in an area which is today probably the most vulnerable part of the Nation. This bulletin, released about two months <u>after</u> Pearl Harbor, is substantially a plea for "each community to examine its sanitary inadequacies and take the necessary measures to correct them." A number of questions are presented to the communities for their consideration. The water supply--is it adequate? The sewerage facilities--are they adequate? The milk supply--is it adequate? And so on. There are two pages containing almost nothing but such questions. Ironically, the local health organizations to whom the questions were addressed are, for the most part, non-existent. Such local organizations as do exist in the region are hardly in a position to take remedial action even if they so desired. If anything is to be done it is manifestly up to the interrogator himself to do it. Therefore, the bulletin is actually nothing more than an exercise in self-appraisal.

This attitude might be termed the "let George do it" complex.

Any survey of attitudes quickly reveals another unfortunate circumstance--the stubborn persistence of a well-developed set of inhibitions. It is considered necessary--or at least discreet--to consult every vested interest before proceeding with any program. The medical society might object to this, the real estate interests to that. The organized exterminators might resent one measure, the dairy industry another. While such concern for special interests may at one time have been dictated by a certain amount of wisdom, this is no longer the case. Today such exquisite caution is no longer required. In these trying times even the vested interests are apt to be motivated by broader considerations than their own <u>immediate</u> welfare. They are actually looking for leadership--for some one who will show them how they may best contribute to the solution of the crisis which threatens us all.

If they are not looking for such leadership they should be--and they know it. For this reason, if for none other, they will be disposed to meet you half way in any proposal put forward for the common good.

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This second attitude might be called the "tread-softly-lest-you-step-on-somebody's toes" complex.

The third and last attitude to which I would call attention is a sort of psychological unpreparedness. It involves a state of mind so comfortably adjusted to one particular way of doing things that it scarcely recognizes a new problem when one arises. Even when blitzkriegs and sneak attacks are the enemies' stock-in-trade there is a disposition to do business at the old stand in the same old way--with an hour and a half off for lunch.

In public health as in clinical medicine, there are always new problems to challenge the practitioner. The physician who sees his patient through diphtheria and measles may expect to treat him some day for cancer or nephritis. In the meantime, however, the patient may need surgery or emergency treatment as the result of auto wreck. The situation with regard to public health is somewhat analogous. What might be termed the early ills of public health have by this time been brought under fairly effective control. The health officer no longer has to devote a great deal of time to them. Instead, his attention is being directed more and more to the chronic and malignant ailments, of which there are many. But at this particular moment society is sustaining some serious injuries in one of history's periodic smash-ups, and emergency measures are imperative. . . (Applause)

CHAIRMAN DRAPER: Dr. Mountin has covered a good deal of ground. There may be a number of points which you would like to take this opportunity to discuss with him or on which you would like to challenge him. The floor is open for general and free discussion.

DR. A. T. McCORMACK (Kentucky): My good friend, Dr. Mountin, not only knows more than any of the rest of us, but when you discuss things with him you are apt to get a sort of fixed complex on his side and to decide things along the lines of his thought. Each of us knows exactly what confronts him in his own jurisdiction. We do not, as Dr. Mountin does, have to decide matters here in Washington from the broad viewpoint of what would be done if conditions were ideal in every State.

In Kentucky there is a feeling of marked astonishment at the character and efficiency of the "lend-lease" personnel who have been sent to us. Not all of the men had previous preparation, but from their too short period of instruction here they have derived an attitude of wanting to help. They have come to us and have helped to a degree that is unbelievable, and they have added very greatly to our efficiency and effectiveness.

We would take over every one of them if we could, but there are two impediments which I wish Dr. Mountin would tell me how to overcome. In the first place, the Federal Government pays more than we do and they don't want to take the lower salaries fixed by our statutes. In the second place, if we take them, they stop wearing uniforms; and if they stop wearing uniforms they lose a good deal of prestige.

Our greatest practical difficulty has not been along the lines indicated by Dr. Mountin. We have been hampered, to a considerable degree, by the inability to find a name for sanitary engineering aides which would make them really useful under the leadership of our sanitary engineers. There are not enough sanitary

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engineers to go around. We know that perfectly well, and there are not going to be enough. The shortage is more serious in this field than in any other. We need sanitary inspectors as we need venereal disease follow-up workers; we have to have them, and I believe that the Public Health Service should enter wholeheartedly into the development of a program to obtain them. In the Service's own problem of environmental sanitation, both near war industries and around cantonments, the labor boss who is going to build privies and make wells need not be necessarily an engineer. An engineer, after having made the plans and written the blueprints, is frequently replaced by the boss of the gang--the engineer knows too much to boss labor, feels that he is doing a job that is beneath him, and consequently doesn't do anything. We believe that sanitary privies can be best built by sanitary specialists who habitually come in contact with the particular class of people who are affected. We believe we can make very much better progress that way.

The whole program is proceeding far better than we had any right to expect in view of the lethargy which affected all of us last year. We were interested more in some of the permanent problems than in the broader questions which had been forced upon us by what was then called the emergency. Now there is but one thing for us to do--just one: that is to follow the Commander-in-Chief of the armed forces of the United States completely. The President, great as are his abilities, can't give all the orders and instructions, and therefore certain responsibilities are deputized to the various agencies of Government. The Surgeon General of the Army, the Navy, and the Public Health Service are the three deputies with whom we come in closest contact.

During this period I would like to see us forget all of the prerogatives and all of the reservations that we have had in mind, forget the plans we had and the programs we would like to have, and follow the leadership of the Army and the Navy and the Public Health Service unquestioningly, as far as the law permits us to do so. And, as Dr. Mountin has so well said, we usually have at least two or three years before the law starts doing anything. If we go ahead with full steam and follow the leadership of the Service in those things for which we have the responsibility, we will get somewhere.

While I don't agree with all the things Dr. Mountin has said, I believe it is true that this war has given us an opportunity to make actual contact with vast numbers of people whom we have not reached before. Our local defense organizations are hungry for something to do. They are over-organized but have too little function, and if we can get them interested in the support of the local public health movement and get them to feel the responsibility that Dr. Mountin has so well said could be developed for local participation in the program, in both the ordinary program and in the extraordinary program now forced upon us, we will accomplish great things.

It is always a joy to have Dr. Mountin speak to us. He has the ability to say in his inimitable way things which we need to have said, and I feel very much as if I had had a mustard plaster put on that portion of my anatomy I use in sitting down, with a view to getting me to go forward because I would be too uncomfortable if I tried to remain static.

I hope, sir, that we will be able to do very much better work this year. I know we will do better work this year, because, my friends, you and I and those we

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are associated with are going to determine this year, possibly in the next few months, whether we are to continue to be free men. Whatever sacrifice is necessary for us to preserve our national freedom, our national form of government, and our national form of thought is too little for that great purpose. Dr. Mountin has presented a challenge which I hope we can rise and meet. I know we can, because we have to.

CHAIRMAN DRAPER: Thank you, Dr. McCormack. Is there any further discussion?

The plan which we put into operation to give the States assistance when the demand increased so rapidly was quite new and had a good many doubtful features connected with it. We got these young men and young women here to Washington and gave them in a brief period of time such essential instructions as we could. We were most hopeful that when they went out into the States they would be able to give you worth-while service. In the reports that we have received, they have done that, but not all of them could have been satisfactory, of course. I am sure that Dr. Mountin and all the rest of the people in the audience would be interested in any observations and comments you might care to make about your experiences with the "lease-lend" personnel. It would help us in knowing what to do in the future. If you will give us the benefit of your experience and knowledge in this connection, it may help us to help you more as time goes on. Is there any one who would like to say a few words in regard to the "lease-lend" personnel and his experience with it, either good or bad?

DR. A. T. McCORMACK (Kentucky): I would like to ask Dr. Mountin a question. Suppose we have a man who is receiving a salary from you of $3,400. Under our law we take him over for $3,000. Would it be possible under the "lease-lend" program to supplement that person's salary during the period of the war and let us take him over? We would be glad to do that.

DR. MOUNTIN: I haven't cleared that but I would say offhand that it might be possible. I think it is probably a good suggestion. There is only one difficulty. In the past we have had some trouble in supplementing salaries with title VI money over and above the fixed salary schedules of the States. It created a lot of dissatisfaction, and served more or less to separate the sheep from the goats—the sheep being title VI employees and the goats those paid exclusively with State funds. We finally had to reverse our previous attitude of liberality and ask that title VI money be budgeted on a straight State salary schedule basis. That is our reason for hesitancy in supplementing salaries, and not because we don't want to increase salaries.

DR. McCORMACK: You are absolutely right.

DR. MOUNTIN: I have some such fear if we follow your suggestion, but if you are willing to put up with all of the difficulties we might go part of the way with you.

I don't want to start stimulating questions if it isn't your desire to present problems, but, as Dr. Draper said, we sincerely would like to know what you do think about the "lend-lease" program which we have adopted. In the very beginning we sensed the fact that personnel would probably be a greater problem than money; in fact, this was brought home to us in a budget hearing the other day

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when we were told very frankly that man-power would probably be a greater problem in the future than money. The Budget Bureau said, "All the government agencies are coming and asking for more money, but we sometimes doubt if they can get the people and the supplies to spend even the money that we are giving them." Our facilities and resources for getting personnel were greater than yours, so we endeavored to meet the situation by recruiting people and assigning them to you so that they became, to all intents and purposes, workers on your staffs. Now, has this system been successful in the main? If there are exceptions I certainly would like to know them. You have not always been sufficiently critical. You may have felt you should endorse the program, and at times we have felt that you might be giving some of the people efficiency ratings higher than they deserve. We feel as though you were under the impression that you had to say they were all good, and that if you didn't you might not get any more. We want to purge our rolls of folks who are not good. We have gotten rid of a few drunks and dead-beats--about half a dozen--but perhaps there is still some inefficiency.

DR. W. C. WILLIAMS (Tennessee): I think the lack of comment is due more to the fact that these "lend-lease" employees or assignees have given more or less universally satisfactory service. With rare exception we have found that they have been most helpful to us.

I should like to make one comment which has come up in our discussions of plans for taking over these "lend-lease" employees. There is a definite hesitancy on their part because they will temporarily lose their Civil Service status, or at least their active Civil Service status. That was discussed in connection with the industrial hygiene employees or assignees, and it took some time to work out a satisfactory arrangement. I can understand why. It isn't only a matter of salary, because I think we can make the necessary adjustments. I can readily understand why an individual on active Civil Service status would hesitate to accept inactive Civil Service status, particularly if he thought there was definite unlikelihood of getting permanent status later on. This is one thing which I think should be definitely considered in any plan to take over personnel, and some solution should be worked out. In the main, I should say we are most pleased with the group of individuals who have been assigned to our State.

DR. MOUNTIN: In answer to your question, Dr. Williams, I may say that when we met with these groups we talked very frankly, and in our correspondence with them I think we have been most honest; or rather I believe Dr. Heller has been. He is such a good recruiter, though, that I sometimes wonder what sort of story he gives them. Whenever I have had the opportunity of talking to these recruits I have explained to them very carefully that they are part of an emergency health and sanitation program, that the appropriation out of which they are paid will certainly terminate when the President declares the emergency is over if the Congress doesn't terminate it sooner. I have told them that unless the scheme of health organization of this country is radically changed, which none of us hopes it will be, the Public Health Service will not continue to furnish them employment because we do not perform local services. We have urged them to put their best foot forward and to do everything to make a good impression on the State and local health officers, because if they have an interest in a future career in public health work that career will be with the State and the local health departments. We have endeavored to prepare them psychologically for any approach you might make.

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Please bear in mind that we are not trying to get out from under on this. We are perfectly willing to do what we are doing. If we get more money we will recruit more, but there certainly is a ceiling--right now there is a ceiling of 700 workers--and unless these persons are transferred to State and local pay rolls, our recruiting and training will be at an end about the first of May when the present class has finished the orientation course, except for the few who can be brought in from time to time to fill occasional vacancies which occur.

DR. W. C. WILLIAMS (Tennessee): The point you just made has not registered with many of the group; there is a definite impression of the possibility of a permanent Civil Service status.

DR. MOUNTIN: They might retain a permanent Civil Service status but they are certainly not going to have permanent employment in the Public Health Service. This is not because many of them are not of the proper caliber, but because the Service doesn't do a large volume of local work and therefore doesn't have a large staff.

DR. ROBERT H. RILEY (Maryland): I think one reason we haven't rushed in to take them over for State duty is because they are assigned to our States for defense purposes, and I don't believe we would get this personnel or that we would ask for them if it were not for the present situation. If you would allow us to use this personnel anywhere in the State, I would be very glad to take them over by some arrangement that would be satisfactory to the Public Health Service and to the State. But I have been distinctly informed that this personnel is available only in areas regarded by us as defense areas.

DR. MOUNTIN: That is right, so long as they are on the Federal pay roll, because the money was appropriated to enable the Public Health Service in behalf of the government to assist you in solving a problem which was largely of Federal creation, namely, the defense program. On the other hand, when they are taken over on your pay roll they become your employees and they are available for duty in any part of the State. That is the added advantage that would result from your taking them over.

DR. RILEY: I think that when the war is over we will take over some Federal personnel for general duty, but I believe it is a Federal responsibility to provide personnel to meet the emergency.

DR. MOUNTIN: I was concerned about the vacancies which are occurring in the State health department staffs for duty in other than defense areas. These vacancies remain unfilled allegedly because there are no people. My answer is that we have the people. If you take them over you will be filling vacancies in other than defense areas. You will enable us to keep on with the recruitment and training program.

The Chairman is getting uneasy because I am encroaching on Colonel Seeley's time.

DR. H. ALLEN MOYER (Michigan): The situation in the State of Michigan is that we are under Civil Service. The people who are sent into my State and are taken over come under Civil Service rules. I have tried to protect the State people that have been called into service by placing "lend-lease" men as acting assistants or acting directors of the divisions in which they are appointed. In

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that way, when this emergency is over I feel that the men who were there originally can be returned. If the new personnel are taken on under Civil Service in my State I am handicapped in replacing the men who were originally there.

DR. MOUNTIN: Couldn't you give them some sort of an exempt or emergency classification? Isn't there such a provision?

DR. MOYER: There is no such provision in the Civil Service regulations.

DR. MOUNTIN: Couldn't such a provision be incorporated?

DR. MOYER: Well, I don't know. We are having a struggle with the Civil Service in the State of Michigan today, and it is impossible at the present time to do anything in that line. That is my handicap.

DR. MOUNTIN: Please understand, we are not endeavoring to disgorge these people and to insist that you take them all over. I merely plead that wherever there is an opportunity to place them, or wherever you can make an opportunity, that you please do so. You will be adding to your own staffs, even though it be on an emergency basis; you will be clearing your rolls so that we can continue to recruit and to train more people to do more and more work for you.

CHAIRMAN DRAPER: Colonel Seeley is anxious to get back to his office, so with your permission we will pass on to the next paper. The Procurement and Assignment Service is a new and very important agency. I know that you have all heard a good deal about it, and I know that as time goes on you will hear a great deal more about it.

We are pleased to have Colonel Seeley, who is the Executive Officer of that Service, with us here this morning. Colonel Seeley will speak on "Procurement and Assignment of Physicians, Dentists, and Veterinarians.". . . (Applause)

LIEUTENANT COLONEL SAM F. SEELEY: Dr. Draper and Guests: I consider it a very fortunate time for me to be able to come and discuss with you the matter of personnel in this war-time emergency.

I wish first to emphasize one point, that the Procurement and Assignment Service, acting as it does, as the personnel office for every physician, dentist, and veterinarian in the country, has been set up by the medical profession itself to deal with the war-time emergency and to supply adequate numbers of qualified individuals in military and other services for the duration of the war, with the least possible jeopardy to the civil and industrial population.

I must go back, first, and tell you something of the history behind the war effort with reference to the utilization of these three professions. The farsightedness of the Surgeons General of the Army and Navy with reference to the joint rosters for the determination of the availability of medical people was the nidus for this development. Two years ago this spring, the Surgeon General of the Army and the Surgeon General of the Navy sent a representative to the American Medical Association meeting in New York and asked that a roster be drawn up of every licensed practitioner of medicine in the United States, in order that his professional status, age, school of graduation, specialty, and so forth might be made known so that these people could be allocated, assigned, or sought for military service in time of war.

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You all know what the American Medical Association did in that respect. With its own funds it organized a Medical Preparedness Committee of the A.M.A. The Committee sent a registration blank to every licensed practitioner in the United States, whether or not he was a member of the A.M.A. The information thus obtained was coded and put on a punch card system so that it would be available.

In addition to that, a Medical Preparedness Committee was set up in each State, as a committee within the State society to assist in the determination of the minimum needs of all cities and counties.

At the time the Procurement and Assignment Service was set up, out of 186,000 licensed physicians, the A.M.A. had received replies from 160,000. A skeleton card was prepared for each physician who did not reply, even though he might be retired or not engaged in the practice of medicine. In 2,008 out of the 3,070 counties in the United States, the numbers of physicians necessary to meet the minimal demands of the communities had been determined. The committee had also determined that 50.3 percent of the physicians who answered the questionnaires would be willing to serve in the armed forces in case of war. They had determined that there were 72,000 physicians in this country under the age of 45. Of these, 63 percent of the single and 48 percent of the married physicians within this age limit stated their willingness to volunteer in case of war.

The American Dental Association was approached by the Surgeon General of the Army in July 1940 in an endeavor to carry out a similar survey of some 71,000 dentists. This work was in progress, the questionnaires had gone out, some 80 percent had been answered, and the coding and carding was going on when the Procurement and Assignment Service was established.

The American Veterinary Medical Association had not been engaged in determining this information because the National Roster in Washington, D. C., which is conducted under the auspices of the National Resources Planning Board and the Civil Service Commission, had sent questionnaires and had very detailed information on some 8,000 veterinarians of the country.

To go back a little further in the defense effort of about two years ago, one of the original civilian defense committees set up under the office of the President was a Health and Medical Committee. This committee at that time had to do with a number of policies regarding not only medical matters in case of war, but also research and, in a measure, utilization of personnel, particularly with reference to the implications of the Selective Service Act on the maintenance of adequate numbers of graduates from medical schools. This committee was also concerned with the nursing situation, and with many other matters.

As activities expanded, it became apparent that this committee must separat some of its activities, and the Health and Medical Committee was placed under the Office of Defense Health and Welfare Services, which was organized on September 3, 1941, having previously been under Mr. McNutt as Federal Security Administrator. The Health and Medical Committee thereafter no longer concerned itself with research.

As you know, the National Academy of Sciences was set up in 1863 under President Lincoln to bring together the scientific minds of America to advise in

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matters of national import. The National Academy of Sciences had organized the National Research Council, and the work of this latter group was so valuable that President Wilson ordered that it be made a permanent section of the National Academy of Sciences. Early in 1940, the Surgeons General of the Army and Navy went to the National Academy of Sciences and asked the Medical Division to set up research committees which would aid in answering questions, determining new methods of treatment, and so forth in case of war. As a result, the Medical Division, under Dr. Lewis Weed, set up some thirty committees--committees in aviation medicine, chemical warfare, surgery, blood substitutes, and many others. To these committees were named the outstanding men of America in these respective sciences.

An over-all agency was recommended to deal with the medical and dental professions of the country in order that an equitable distribution might be obtained if many physicians and dentists had to be inducted for military service. As a result, the Subcommittee on Medical Education in March recommended to the parent committee that a central agency be set up to deal with personnel problems incident to drawing large numbers into the military service. The Health and Medical Committee accepted this resolution and in June took the resolution to the American Medical Association at its meeting in Ohio. Much effective work had been done by the Association at its own expense, and the Board of Trustees of the A.M.A. passed on this resolution and sent it back to the Health and Medical Committee with its recommendation. Mr. McNutt took this to the Cabinet, the Cabinet approved the idea in principle, and the President directed that there be set up such an agency and that this agency consider, if necessary, such legislative action as might be required to provide adequate medical, dental, and veterinary care for the armed forces. On October 22, 1941, the Health and Medical Committee called in consultants from all of the governmental agencies, the military agencies, the national associations of medicine, surgery, and so on, the dental representatives, and the chief of the Veterinary Division of the United States Army. These people consulted with the Health and Medical Committee and determined that such an agency should be set up. As a result of that meeting, a commission was formed, which, six days later, set up the Procurement and Assignment Service. When this commission deliberated, one thing became apparent: time was of the essence. Admiral McIntire, the Surgeon General of the Navy, made the statement that the organization should be set up immediately, and that he feared it would not be set up in time. We know now the reasons why Admiral McIntire felt the necessity for speed.

The commission, then, suggested the formation of a Procurement and Assignment Service along these lines: First, that it be set up in an already existing governmental agency in order that the legal, budgetary, fiscal and other departments of that agency might assist the organization in beginning its work with the greatest possible speed and greatest facility. The Office of Defense Health and Welfare Services had been set up by direction of the President on September 3 and was the obvious place for the new Service. The Health and Medical Committee and the Procurement and Assignment Service were to be parallel organizations under the same director, the Director of the Office of Defense Health and Welfare Services.

The other major consideration was that all organizations in the country which maintained rosters or had information relative not only to the age grouping, the school of graduation, licensure, the specialities of the profession, etc., should be asked to turn over to the Procurement and Assignment Service all of

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their roster information and make it readily available. As a result, the Board of Trustees of the A.M.A., the A.D.A. and the A.V.M.A. were approached, and they agreed to let us have in Washington a duplicate of all of the information existent at that time. As a result of that, the National Roster came into the picture, and now every punch card in the files of the American Medical Association has been duplicated and those of the American Dental Association are being duplicated.

This commission determined that the organization should have a directing board of civilian physicians who would advise in the various special fields of medicine, dentistry, and veterinary medicine. The directing board chosen included Dr. Frank H. Lahey of Boston, Chairman; Dr. James E. Paullin of Atlanta, Dr. Harvey B. Stone of Baltimore, Dr. Harold S. Diehl of Minneapolis, and Dr. C. Willard Camalier of Washington, D. C. Nine advisory committees were established under the directing board, including committees on medical education, hospitals, public health, Negro physicians, women physicians, veterinarians, industry, and so on.

It was further determined that this organization should have throughout the country properly chosen officials to advise concerning the availability of medical, dental, and veterinary personnel. For that reason, we asked the Association of American Medical Colleges to nominate nine men to represent medical education in the nine Army Corps Areas; we asked the American Hospital Association together with the Catholic Hospital Association to nominate nine men representing hospitals; we asked the American Medical Association to nominate such members as had acted as advisors to the Corps Area surgeons of the Army under the Medical Preparedness Committee. In each of the nine Corps Areas a committee was set up consisting of a Corps Area chairman, a man representing hospitals, one representing medical colleges, two widely known general practitioners of medicine to advise from the standpoint of civil practice, one dental educator, one general dentist, and one veterinarian.

In each State we asked that a man be nominated to act as State chairman for the Procurement and Assignment Service. This chairman would set up in his office the machinery necessary for the maintenance of a roster of every man in that State. Personnel under the age of 45 and essential in their present capacities would be so certified. Those available to replace younger men called to Service would be listed. If any man were listed as an indispensable key man who should not be replaced, the reasons for such listing were to be given.

The commission's recommendations were approved by the President on October 30 and the organization started functioning.

What was the status at the time of Pearl Harbor? The Army had a sufficient number of veterinarians with an adequate reserve to meet expanding needs for many months. The Army also had a sufficient number of dentists and a reserve large enough to meet needs for many months. The General Staff allotment of medical officers for the Army was limited to 12,938, and the Army was short approximately 1,500 medical officers. It was not short from the standpoint of giving adequate medical attention, but rather from the standpoint of having every organization filled up to war-time strength so that if they should be disseminated into the field, there would be adequate medical personnel. The Navy had a sufficient number of medical and dental officers; it had the full complement on duty and a reserve adequate to meet its needs for several weeks, but it was constantly recruiting and adding to the reserve list.

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The United States Civil Service Commission lists of professional personnel for the Vererans' Administration, the Children's Bureau, St. Elizabeth's Hospital, and many other agencies were a little short. The induction into the military service of a large number of persons had cut down the Civil Service recruiting program and a shortage was foreseen by spring.

The United States Public Health Service regular corps was, of course, adequate and up to full complement, but additions to the United States Public Health Service reserve corps were stimulated.

Therefore, after Pearl Harbor, the first and most important function of the Procurement and Assignment Service was to stimulate applications from a large number of men to fill the Army needs.

It is apparent to all of us, of course, that as a result of the World War there are a large number of men who are either in the reserve corps of the Army, in National Guard units, or in the regular Army, in the grades of Lieutenant Colonel or Colonel. In fact, there are so many of those people thoroughly qualified and ready to be called that the army does not have a shortage at this time in the Lieutenant Colonelcy or Colonelcy commissions. The shortage is in the younger age group. Therefore, the directing board asked that a notice be placed in the national and State medical journals in order to provide enough physicians, preferably under the age of 36, for the military service. Those who were immediately available, ready to go into service in the Army and Navy, were asked to send for application forms.

I regret that a little confusion arose some ten days later when it was stated that every physician in the United States should send in a form. This was contrary to the original idea, and some persons sent in forms with the idea that they would be called at a much later date. I am sure that you will be gratified to know that we received over 35,000 enrollments in the first eight weeks, and of those enrollments, 5,000 of the men under the age of 36 have been cleared through the Chicago office, with statements to the effect that they are graduates of approved schools, that their internship is satisfactory, that they are males, citizens, and that they meet the qualifications for a commission.

It was then possible for us, as a temporary expedient, to send out application blanks to those who desired Army service and to turn over to the Navy names of those who desired Naval service.

I am very happy to say that last week, for example, we cleared 1,000 physicians to the Army and Navy, not only with regard to schooling, internship, and so forth, but also with regard to availability with the least jeopardy to the civil and industrial population.

We have tried to carry out this program so that we could meet the emergency, and at the same time set up the organization so that it would function as we wanted it to function in the future. It is, of course, apparent to all of you that every man's status has changed since Pearl Harbor. There are some 2,000 changes of address listed in the United States each month, and keeping up this information requires a great deal of clerical work.

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Anticipating this, and also anticipating that every man's status should be made known simultaneously, the board has worked diligently on a short-form questionnaire to bring all existing information up to date. It has provided an enrollment form so that all physicians, dentists, and veterinarians may enroll with the Procurement and Assignment Service. The information we now have is on file in Washington. We have to ask certain questions which must be asked in time of war. We want to know if these persons can translate or speak various languages that might be of value. We want to know if they have traveled in countries to which our troops might be sent. I am happy to announce that the short-form questionnaire is coming off the press at the Government Printing Office today.

We simply ask the professions to enroll with the Procurement and Assignment Service, stating that they wish to make their services available to their country, and stating their first, second, third, or fourth preference for duty if we should feel obliged to ask them to become candidates for commissions. A man may specify, for example, the Army Medical Corps, the Naval Medical Corps, the United States Public Health Service, industrial medicine, private practice in his own community, or private practice in other communities.

When these forms are returned we anticipate that by analysis of the data we can determine not only the number of physicians who apparently meet the qualifications laid down by these various agencies, but also the number of persons who have voluntarily, either by first, second, third, or fourth preference, stated that they would be willing to go when the national need is made known to them.

These forms will be mailed to every individual physician, dentist, and veterinarian in the country, regardless of age, sex, color, licensure, whether or not he is retired from the active practice of medicine, or whether he is in an active reserve status in any of the governmental, military, or naval organizations.

When this information has been compiled on the National Roster, we will not have to depend on the temporary expedient we had to employ at the time of Pearl Harbor. We will then be able to fill a requisition made by any of the military agencies. The War Department, the Navy Department, the United States Public Health Service, and the Civil Service Commission all have agreed that they will not commission or employ a physician, dentist, or veterinarian until he has been cleared through our office from the standpoint of availability.

When the information is at hand, we shall know the age groupings, the schools of graduation, citizenship status, and other basic roster type of information. We shall also know what a man's preferences might be. There remains one item: is the man available and can he be spared by the community at this time or at a later date?

Let us use a concrete example of requisitions received in the office. Suppose that the Surgeon General of the Navy should notify the office that he desires the services of twenty orthopedic surgeons with specifications as follows: That they shall be male; that they shall be citizens, or, if naturalized, that they shall have been naturalized for a period of ten years; that they shall have been graduated from a school acceptable to the Navy Department; that they shall have had at least one year of internship in a hospital acceptable to the Navy Department; that they shall be classified as Grade 2 among the orthopedic specialists; to make it a little more complicated let us suppose that it is desirable that

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they speak Spanish fluently, and that they should preferably have had travel of a significant nature in South America or the South Seas. We phone to the National Roster and they pull the cards of all the people in the age group from 37 to 45, throw them in the hopper, start the machine, press the buttons which specify citizenship and the other stated requirements. Then, only the cards for those who are qualified will drop out of the machine. Every one of the 189,000 physicians can be processed in a maximum of six hours. The names will be made known to our office and we will clear immediately through the State chairman of our organization to determine whether or not at this time the man is certified as being essential. If he is not, his name is returned to the Navy. The Navy then notifies these men that the time has come for them to seek commissions.

Dr. Fishbein tells a story that is applicable here. He says that years ago Dr. William J. Mayo was showing him the punch card system which they had put into effect, and he pulled out the card of a man who had so many disorders that it seemed he must be in a bad way; he was shown to have alopecia, deviated septum, enlargement of the heart, dropsy, flat feet, and so forth. There were so many holes in the card that Dr. Mayo said they could put it on the player piano and have it play "Nearer My God to Thee."

Another thing I would like to tell you about is the rating of the specialists. It was very evident during the World War that many persons were assigned to tasks for which they were not, apparently, qualified. A large number of medical officers would report for duty at a camp. They would report to an officer and he would interview them with the idea of setting up his chiefs of service in the medical specialties. Any man could say he was a surgeon and the reason he said so might be because he hoped that the experience he would get during the war would make him a qualified surgeon by the time the war was over. This necessitated a great deal of retrenchment. In many instances, it necessitated graduate training and refresher courses.

The A.M.A. statistics show that one-third of all the physicians who answered the questionnaire stated that they were specialists.

The National Research Council committees were asked to assist in determining the relative standing of these men within their specialties. For example, one committee member who was President of the College of Physicians chose 360 physicians known to him and sent them the cards of all the men who said they were specialists in internal medicine. These 360 physicians, either on the basis of their own knowledge or by consultation with deans, teachers, or others whose opinion they could trust, graded all the cards from Grade 1 to Grade 4. Grade 1 representing the outstanding leaders; Grade 2, the men who without further professional training could go in and take a position as chief; Grade 3, the men who were qualified to act as assistants to a section chief in, let us say, gastroenterology or cardiology; Grade 4, the men who had spent most of their time in the specialty or who were in training, who did not qualify for Grades 1, 2, or 3, but whose services could be employed in that line of work.

In this way all of the specialties have been carefully analyzed, the people have been graded, and the work is constantly going on.

The third factor taken into consideration was a list of the diplomates of the American boards of medical specialties. There are now fifteen boards of medical specialties in the country. The diplomates of all of those boards have been named to the Procurement and Assignment Service, and the

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secretaries and other officers of these organizations have been asked to grade their men. The gradations will be placed on the punch cards and if the Surgeon General of the Navy should ask for ten orthopedic surgeons, Grade 2, that type of individual, and only that type, will be sorted out by the machine. In this way it is anticipated that we can put the round peg in the round hole and that we can give the Surgeon General the type of men he wants.

What is the status of this Procurement and Assignment Service with reference to public health activity? Dr. Reynolds, our Chairman, met with the officials of the United States Public Health Service and assisted in the initial questionnair which went out some three or four months ago for the purpose of determining those who were essential in their present capacities in public health agencies.

The Surgeon General of the United States Public Health Service has provided that those key men who should not be lost to the public health agencies might be commissioned as Reserve Officers of the United States Public Health Service, provided they meet the qualifications of the Public Health Service. Thus, these men would be set aside and would be utilized elsewhere only temporarily in case of a major catastrophe. To further this, we have asked the Surgeon General of the United States Public Health Service to call to the attention of all State public health officials the necessity of drawing up a list of persons who are now essential in public health activities, so that their names may be made known to our State chairmen locally. As soon as a man becomes essential he should be so designated. For example, there might be five men in a department, any three of whom are available for military service, but when those three go the other two remain as essential people. Their names should then be made known to the State chairman of the Procurement and Assignment Service.

The names of the State chairmen throughout the country are listed in the February 21 issue of the Journal of the American Medical Association. We ask our State chairmen to consult with all public health agencies in order that key men may be left behind. We ask that all such agencies make known to our State chairmen the names of all in their departments, listing all individuals in one of two categories, either essential at present or available when needed.

The Committee on Public Health of the Procurement and Assignment Service met yesterday and considered the criteria which the committee would suggest be used throughout the country in the formation of such a list. You may anticipate the arrival in the near future of a letter which will include those criteria.

The Surgeons General of the Army and Navy have told our office that as long as we meet their needs for personnel they will defer the men whom we certify to them for deferment. We of the Procurement and Assignment Service expect our State chairmen to keep these lists up to date. If you as an official state that a man is necessary at the present time and should not be taken into military service, and our State chairman agrees, he will withhold his name and carry him to us as an essential man. But this situation can prevail only so long as you and other officials of the State furnish to the State chairmen a sufficient number of individuals to meet the military demand.

The two factors with reference to the determination of availability which have made the Procurement and Assignment Service objective a bit difficult are (1) the present reserve officers, and (2) the provisions of the National Selective

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Service Act. Those officers who are reserve officers in the Army who have not been called to active duty but who are in good standing have all been notified this month that they must clarify their status by April 1. If they are in the reserve corps, they may be called to duty at the direction of the Secretary of War any time after April 1. Prior to April 1, they have the opportunity of tendering their resignations to the Adjutant General of the Army, who may or may not accept it. If a person is a key man in an agency and should remain there, and if it is believed necessary that he resign, supporting papers should be submitted by the employing agency when the case goes to the Adjutant General of the Army.

It is hoped that the situation will be entirely clarified. It is true that the man himself may be very reluctant to resign from the reserve corps at this time in view of the war. But it must be appreciated that as a reserve officer he is available for military service in time of war. That is the reason for his classification as a reserve officer in good standing.

With reference to Selective Service, Congress has stated that any man under the age of 45 is available for military service. No exception was made except in case of occupational deferments, that is, those who are put in Class 2B. Therefore, physicians, dentists, and veterinarians under the age of 45, the same as engineers, lawyers, and other professional people, should consider themselves available for military service at such time as the Selective Service System sees fit to put them into Class 1A.

Again, we have the assurance that, so long as we can meet the military needs, the advice of the Procurement and Assignment Service authority will be brought to the attention of the local boards, and they will be asked to defer the induction of physicians, dentists, and veterinarians in the capacity of privates.

The National Director of Selective Service, General Hershey, was not given the authority by Congress to tell the 6,500 local boards in the country not to induct certain individuals or certain classes of individuals. A local board is autonomous; it is the authoritative board which determines whether a man is available at the time he is classified. The local boards are willing, of course, to listen to reason. The National Director has authorized our State chairmen to act as consultants to all local boards within their respective areas, and the local boards have been asked to get their opinion when a man is brought up for classification.

I am happy to say that in 99 percent of the instances in which a chairman has asked that a man be deferred, and has given a justifiable reason for it, deferment has been granted. If the man, however, is determined to be available for duty by the local board and on advice of our State chairman, there is but one alternative -- the man should seek immediate application for a commission in order that he might enter the service in a commissioned capacity if he is qualified; otherwise he will be inducted in the capacity of a private.

In view of the fact that we are canvassing the entire profession, the local boards are granting deferments and we have asked that they wait until we have the roster available so that we can determine whether or not we are going to have enough physicians to meet the needs in localities other than the areas of the respective local boards. A local board may determine that a certain physician is available in its own community and that therefore he should go through

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the same processing as a lawyer who come up the same day. We of the Procurement and Assignment Service, however, know the needs not only of the military services but of the other services. If a man is essential to the other services, we ask the local boards to defer him.

It is obvious that sooner or later we must consider that any man under the age of 45 must be made available for military service. In a measure, this should apply regardless of his physical condition, because the Army has recently lowered the physical standards considerably, and there may be assignment for duty in a limited capacity in the interior. The former physical requirements were those governing regular Army appointments. During the defense program those physical standards were upheld because persons who went into reserve training and returned to civil life should be physically and professionally qualified to be called back at any time for a period of ten years. That accounts for the very high physical standards upheld not only by the induction boards for enlisted men but also by the boards for officers.

Since, however, the large majority of qualified officers must be in the field, and since we have a very large organization at home in the zone of the interior, the War Department has provided that a man with a physical handicap may serve in the zone of the interior. An officer may be commissioned for such service if he has a cork leg or a glass eye. Already, officers have been commissioned with amputated legs who have a satisfactory prosthesis. A man with 20/400 bilateral vision corrected to 20/20--20/40 can now serve. A man with one glass eye and with a vision of 20/100 in the other eye, may get in if it is corrected to 20/20. Such men may serve in a limited capacity for duty in the zone of the interior.

For that reason, then, men under 45 should be considered available for military service regardless of physical condition, and a replacement should be obtained or anticipated for such a man. This replacement should be either a person over 45, a woman physician, or a man under 45 who has been definitely disqualified for military service.

It is apparent, then, that when we complete the record and have the roster type of information up to date, we will have the names of persons who are essential and who should be set aside so as not to jeopardize the civil and the industrial population.

On Thursday last, a consolidated report came to our office representing the requisitions of the Army and Navy for medical personnel. The Air Corps must have 2,600 physicians by July 1 and 600 physicians per month from then until the 31st of December. Adding the other medical department activities of the Army and the Navy, we must have a total of 42,000 physicians for the two armed services before December 31. The majority of those physicians should be under the age of 36, others may be between the ages of 37 and 54 if they are recognized as specialists in their fields, particularly in neuropsychiatry, ophthalmology, traumatic surgery, and ear, nose and throat.

This is a challenge to the medical profession. It demands that we get busy right now and pare minimal needs to the bone. On the first of April we must consider what our departments can get along with as of December 31 when 42,000 men will have gone. We must realize that this will put into military service the

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largest number of physicians who have ever entered military life in a single year in the history of our country. We must realize that at the end of the World War there were 31,500 physicians in the military service and that by the end of this year there will be over 42,000 physicians in the military service.

This program has been put into the hands of the medical profession itself. The profession has provided the roster of information, and it has provided the figures which indicate that needs can and will be met on a voluntary basis. Now is the time for those men who are prepared to go into the military service to make immediate application to the local Commandant if it is for the Navy, to the office of the Air Surgeon of the Army Air Force if it is for the Air Force, to the office of the Surgeon General if it is for duty in the Army medical department. Every one of the applicants will be cleared through our office by the State chairman from the standpoint of availability. Therefore, it is imperative that every man under the age of 45 who can now be made available or who in the near future will be made available must be so designated in the office of our State chairmen. We need your cooperation, and I believe you are aware and convinced of the fact that by this method we can set aside and hold for you the essential men.

This office, then, represents the personnel office for every physician, dentist, and veterinarian in the United States. It offers the opportunity of filling the needs of the military services on a voluntary basis. It offers the opportunity of the retention in civil and industrial life of the numbers necessary to care for the civil and industrial populations. It offers the opportunity to avoid legislative action against the medical, dental, and veterinary profession as a group--action which should not be, and which we hope never will be, necessary. In the past five days we have had our objectives laid down as a challenge to the medical profession, and I know that with your cooperation that challenge will be met. . . (Applause)

CHAIRMAN DRAPER: I know Colonel Seeley will be glad to answer any questions and to give any information you may request of him.

DR. STANLEY H. OSBORN (Connecticut): I would like to ask Colonel Seeley if any arrangements have been made anywhere or in the zone of the interior for women physicians.

CHAIRMAN DRAPER: Colonel Seeley will answer all the questions at once.

DR. R. L. CLEERE (Colorado): I would like to ask Colonel Seeley if any consideration has been given by the Procurement and Assignment Service to including public health engineers among the other personnel. Also, what basis is used for assigning rank to physicians who apply for commissions?

DR. JAMES A. HAYNE (South Carolina): I would like to ask what provision is made for retired medical reserve officers.

DR. THOMAS PARRAN: I suggest that since Dr. Reynolds is the Chairman of the Public Health Committee, he may have a question or a statement concerning the work of the Public Health Committee.

CHAIRMAN DRAPER: We should be very glad to hear from Dr. Reynolds.

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DR. CARL V. REYNOLDS: Gentlemen, I haven't a thing to tell you other than what Colonel Seeley has told you. I can say, though, very frankly and honestly, that we are at the moment in the middle of a bad fix. A statement was prepared and would have been presented to this body this morning, but we understood that another statement would be prepared and sent out. Therefore, we waited to get most of the questions answered so that we could reduce the one statement to actual facts and keep you from becoming more confused than you are now.

As I understand it, the inclusion of engineers is a rather important question, and it can be done only if this organization will make a request to the President or through Governor McNutt. Personally, I believe that if it could be done it would be advantageous to us. If we could direct it through the present Procurement and Assignment Service committee it would save going through several bureaus and avoid many future difficulties.

DR. A. T. McCORMACK (Kentucky): Colonel Seeley, I would like you to answer a question that I know confronts all of us. In Kentucky approximately half of our 96 health officers are men under 45 and two-thirds of this group are under 36. They are qualified specialists in public health. There are no satisfactory replacements for them. The men who take their places are general practitioners who know nothing about the work. Now, should we prepare to put in such men? Incidentally, we had a number of men in the reserve corps who were graduates and specialists in public health, and not one of them has done anything that he is qualified to do since he has been in the Army. Isn't it a waste of qualified personnel to take them away from the jobs for which they are qualified?

DR. EDWARD A. McLAUGHLIN (Rhode Island): I would like to ask Colonel Seeley if a recommendation has been made to the State committees to have public health representation on the State committees.

COLONEL SEELEY: With reference to women physicians, it is estimated there are some 8,000 women physicians in this country. We are asking that they take over in civil capacities such duties as will relieve the male physician for military service where possible. This is particularly applicable in teaching institutions, in hospitals, and similar institutions. The Office of Civilian Defense has definite plans for women physicians in case it is necessary to move large numbers of women and children into the countryside, away from congested centers. The women are particularly apt in obstetrics and pediatrics, and it has been found that there is a very excellent place for them in that capacity. The problem of sanitary engineers, whose work is contributory and supplementary to the medical field, has been discussed many times. For example, we have canvassed to date all of the medical schools, all of the dental, and all of the veterinary schools, and we are in the process of canvassing all of the hospitals. The criteria to be used in the canvassing of all Public Health Departments will soon go out to all of you. In the medical schools, you find large numbers of men who have degrees as Masters or Doctors of Philosophy, degrees in bacteriology, pathology, physiology, and so on, and wherever possible it has been asked that the increased teaching responsibilities taken over by these men might make medical people available for commission in the Medical Corps. We feel justified, therefore, in assisting in any recommendation with reference to deferment, but it must be understood that the directive setting up the Procurement and Assignment Service dealt primarily only with physicians, dentists, and veterinarians. Our function is to maintain the rosters of those physicians, dentists, and veterinarians who

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are apparently qualified for military appointments, so that we may make those qualifications known to the military agencies. Therefore, the retention of lists in the State of these people, and these people only, facilitates the withdrawal only of those who can be spared at the time. It has not been suggested that the supplemental and special lists be handled by the Procurement and Assignment Service, and the load imposed upon the office this year has been so great that at this time we would be very reluctant to consider such a thing.

The nurses are asking whether a Procurement and Assignment type of service can be set up for them; other people are also asking. We feel that where sanitary engineers' duties are essential to State health departments, local boards have been and will continue to be sympathetic, and that an essential man may be so represented by his employing agency on Form 42-A of the local board, thus assisting in his deferment. Those sanitary engineers who can be spared, however, and who meet the requirements of the Sanitary Corps of the Army, may get appointments in that service. Those who cannot be spared should be retained, and proper representations should be made to the local induction board.

In order to avoid the induction of men who are essential, there are very definite steps to be taken. The employing agency submits the occupational deferment form. The man himself has a right to exercise his right of appeal within a period of ten days from the time he is put in Class 1-A. This is the constitutional right of the individual. If the local appeal board is unsympathetic, the man has the right to carry the appeal to the State director of the Selective Service System, or even to the National Director of the Selective Service System. The State and National Directors have the authority to take such claims directly to the office of the President, who has a board set up for that purpose. In the meantime, the man who is in a key position should be deferred, because the basic principle on which Selective Service operates is that the man is selected for the job and that those who are necessary to the civil community should be retained.

What rank may be expected? On October 27, last year, the War Department provided that an officer may be given an outright commission in any grade commensurate with his age and professional or military experience. Since February 1, promotions have been made not only by selection, but by appointments. Initial appointments may be made in any grade, but rarely above that of Captain.

Regarding the large number of older officers in the reserve, the National Guard, and the regular services, who are filling positions of the higher ranks, it should be recognized that a great number of officers have come into the military services and have qualified for higher rank, but because the higher ranks have been filled and because the reserve corps has a number of people who can be called in, these persons have been submerged or even held back. Furthermore, an initial appointment in, say, the grade of Lieutenant Colonel or Major cannot be given a civilian who is not a reserve officer unless the War Department can certify that there is not a man in the reserve now who is qualified for that position. In other words, preference is being and must be given to the man in the reserve corps who has been there for the purpose of being called when his services are needed in his grade. Preference cannot be given over the man who has come into the corps for a year and a half and for whom no vacancy exists, even though he may be qualified for a higher grade.

The General Staff makes an allotment. If the Army strength is 1,800,000, the maximum number of medical officers is 12,938. Of that number, only a certain

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proportion can be Majors, Colonels, and so forth. With the authority, however, to give outright appointments, the Surgeon General of the Army allows this statement: that men under 37 who are not specialists will be appointed as First Lieutenants; those under that age who are definitely qualified as specialists may anticipate a Captaincy; between the ages of 37 and 45, most certainly a Captaincy and possibly a Majority. But remember that the higher ranks are already filled, that there are people waiting to go into them, and that there are reserves ready to be given commissions.

It is interesting to note, too, that only in these departments can men get initial appointments. It was announced about two weeks ago that, except in rare instances, men would not be taken from civil life and given commissions as officers. Instead, ranking positions should be filled by men in the enlisted branches who were qualified, and who were recommended by their superiors for officers' candidate training schools. It was planned to commission 70,000 officers in the line of the Army by that method.

The National Selective Service System has made an exception. A civilian with several dependents may enlist with the view of going to the officers' candidate school and, if found qualified, be commissioned. If he is not found qualified, he may be discharged and sent back to civil life to await the convenience of the Government. Since members of the medical, dental, and veterinary professions have the opportunity of getting initial appointments, and since the initial pay of a married Lieutenant is over $3,100 a year, no real economic hardship is involved.

Men who might be qualified for the Sanitary Corps should apply to the office of the Surgeon General, as such appointments are made by that office and do not go through Procurement and Assignment. If a married man wants an Administrative Corps position he can enlist with a view of going to the officers' candidate school to get an M.A.C. commission, and if he fails he may ask to be separated from the service.

The Navy will not give initial appointments to men over the age of 50; the Army is not giving initial appointments to men over the age of 54. If a man is a reserve officer and in good active standing, he may be called to active duty up to the age of 60. In the Army, a reserve officer is automatically transferred to inactive reserve on reaching his sixtieth birthday. There is not a place for men over 60, and you can appreciate that large numbers of men under that age are awaiting orders and must be brought in as the Army expands.

Since the allotment was 12,938 medical officers for the Army in October and since the Army was short 1,500 medical officers, it was necessary that a commissioned officer of the Medical Department do whatever work had to be done. Had the Surgeon General had available to him 15,000 or 20,000 officers standing ready to be called in at any moment, then only specialists would have been given specialist's work. But as it is, a qualified orthopedic surgeon might be working in the dispensary and not at his specialty. That is another reason why the first requisition for the Army should be the non-specialist man in the lower age group. Feed the non-specialist younger Lieutenant and Captain in at the bottom so that the men who are now specialists but are not practicing their specialties can be relieved and put in the hospitals and other organizations where their special skill will be utilized.

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It must be recognized, however, that a battalion or a regiment may train for a year and be in battle only a few hours. But at that time it is required that adequately trained and expertly trained specialists be in those organizations so that larger numbers of men may be brought safely through the early stages of shock, hemorrhage, and so forth, and be saved for further treatment in the interior.

In war, the man who is a specialist and on field duty seldom practices his specialty except for perhaps a few hours a month or a year when his organization is in combat. Nevertheless, it is necessary that his fundamental, basic training as a physician be made available to the organization.

The obstetricians have asked, "What in the world would we do in the Army?" The answer is, they are physicians, they are basically trained, and they are needed.

As far as key public health officers over the age of 45 are concerned, you can see that the primary responsibility of Procurement and Assignment is to retain these men in their civil capacities.

We have the very fine cooperation of the Selective Service System, and we have asked that they accept the advice of Procurement and Assignment Service if a man is of draft age and should be retained at his civilian post. A dean of a school may have a man on the essential list, but the man may say, "I am going anyway. What are you going to do about it?" The man has the right to go into the military service. All that we ask is that the dean be given a few weeks in order to get a replacement for the man so that his loss from the agency will be less keenly felt. Any man who is going to volunteer is going to volunteer. We only ask that where a person is essential at that time, that the man and his employer settle it so that a replacement can be gotten and so that the work of the public health department or the school may continue.

Since there are 72,000 physicians under the age of 45, it is certain that we can meet military needs and still retain men in that age group who are in key positions.

A man who is a regular or reserve officer in the Coast and Geodetic Survey, in the Navy, or in the United States Public Health Service cannot be commissioned in the Army unless he has resigned his position with these organizations. Whether or not the Selective Service System is going to step in and draft such persons has not been determined. Nor has the status of the Civil Service Commission employees, or employees of other agencies such as the Veteran's Administration, Children's Bureau, Panama Canal, and others, been clarified. It has not been determined whether an employee of draft age in a governmental agency is deferred automatically. That is being discussed at the present time.

I trust I have answered your questions. We want to be of help. I feel that I am office boy for 179,000 physicians. If you don't get an answer to your correspondence, please be patient. We shall try to do things in a wholesale manner and we will send General Farran's office information. His office has warned State directors that they should start considering the necessity of drawing up lists of essential and available people. Dr. Reynolds' committee met yesterday, the criteria are being drawn up, and we shall disseminate them to you

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as soon as possible. We ask that all public health departments in States be given ample opportunity to set aside those who are essential. Let us hope that we will not have to have every man under 45 in the military service, and that we will not have to ask physicians over 45 and women physicians to assume the entire burden of maintaining civil and industrial health.

We can see this problem in its entire national aspect. We know the conditions. We know the demands of the military service, and they must be met first. We must win this war before we start worrying about what we are going to do about the situation later on. We have got to win the war first, and I know the Army and Navy will get the personnel to do it. . . (Applause)

DR. A. T. McCORMACK: Chairman Draper, I move, sir, that we express our appreciation to Colonel Seeley for this splendid presentation, and that we pledge him our unremitting and devoted allegiance to the success of the Procurement and Assignment Service. This is the first time in the history of any government in the world when the responsibility for its service to its people has been reposed in a profession. We can't let Colonel Seeley and Dr. Lahey down. We can't let the medical profession down and we can't decline the invitation of the President of the United States to do our job as it has to be done in the best interest of the people of the United States and for the purpose of preserving freedom.

. . . The motion was seconded . . .

CHAIRMAN DRAPER: Is there any discussion? If not, all those in favor will please indicate by saying "aye."

. . . The motion was carried unanimously . . .

Yesterday we had with us Captain Watson Miller, the Assistant Administrator of the Federal Security Agency, who was representing the Agency. Today we are honored by the presence of the Assistant to the Administrator, Miss Mary Switzer . . . (Applause)

DR. W. F. DRAPER: The reserve of the Public Health Service is authorized by the joint resolution of October 27, 1918, c. 196, 40 Stat. 1017, Title, 42, Section 18, United States Code, which reads as follows:

"That for the purpose of securing a reserve for duty in the Public Health Service in time of national emergency there shall be organized, under the direction of the Secretary of the Treasury, under such rules and regulations as the President shall prescribe, a reserve of the Public Health Service. The President alone shall be authorized to appoint and commission as officers in the said reserve such citizens as, upon examination prescribed by the President, shall be found physically, mentally, and morally qualified to hold such commissions, and said commissions shall be in force for a period of five years, unless sooner terminated in the discretion of the President, but commission in said reserve shall not exempt the holder from military or naval service: PROVIDED, That the officers commissioned under this section, none of whom shall have rank above that of assistant surgeon general, shall be distributed in the several grades in the same proportion as obtained on October 27, 1918, among the commissioned medical officers of the United States Public Health Service and shall at all times be subject to call to active duty by the Surgeon General and when on such active duty

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shall receive the same pay and allowances as are now provided by law and regulation for the commissioned medical officers in the said regular commissioned medical corps."

As of January 1, 1942, the reserve numbered 508 officers, nearly all of whom were between the ages of 27 and 45. Of this number, 328 were on active duty and 180 were on inactive status. As you know, the classes of personnel in the reserve of the Public Health Service are the same as in the regular commissioned corps, that is, physicians, sanitary engineers, and dentists.

The functions being performed by reserve officers now on active duty fall into three general classifications:

(1) About 15 percent are detailed to the United States Coast Guard.

(2) From 40 to 45 percent are assigned to duty in the United States Marine Hospitals.

(3) The remaining 40 or 45 percent are engaged in public health work directly or closely related to the war or defense preparation effort. For example, 13 are members of a medical commission to the Burma-Yunnan Railroad sent to the Burma Road in Southwest China to control disease in connection with the construction of the railroad which is being financed by Lend-Lease funds. Also at the present time the medical officer attached to the American Embassy in Great Britain holds a reserve commission.

Other reserve officers, in cooperation with the Surgeon General of the Army, are making studies in arsenals to determine the health hazards associated with the manufacture of munitions and to formulate recommendations as to the necessary medical facilities for the occupational diseases arising from this kind of work. Others are on duty in the Division of Industrial Hygiene of the National Institute of Health and are making studies in aviation medicine at the request of the Bureau of Aeronautics of the Navy. The Chief Medical Officer of the Office of Civilian Defense and the regional medical officers of that organization are reserve officers. Still other reserve officers are assigned through State departments of health to critical areas adjacent to military zones or to war-industry establishments. Others, acting for the Public Health Service or through State departments of health, are engaged in environmental sanitation work concentrated primarily in places where there are large Army cantonments and war industries. A few persons are assigned to assist local health departments in operating venereal disease clinics in areas adjacent to military reservations.

Because of the character and importance of the duties of reserve officers in the present situation, and in order to obtain an authoritative interpretation of their status in relation to the Selective Service Act, a letter was addressed to General Hershey by the Federal Security Administrator under date of December 29, 1941, reading in part as follows:

"Your opinion is respectfully requested on the question of whether Section 5(a) of the Selective Training and Service Act of 1940, exempting commissioned officers of the Public Health Service from registration, and from training and service, is applicable to the reserve of the Public Health Service."

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General Hershey in his reply of January 23, 1942, discussed at length the legal provisions of the Selective Service Act in relation to the question propounded and concluded with the following statement:

"Answering your question specifically, it is my opinion that section 5(a) of the Selective Training and Service Act of 1940, as amended, which exempts commissioned officers of the Public Health Service from registration and from training and service, is not applicable to the reserve of the Public Health Service.

"I am not unmindful, however, of the importance of the Public Health Service, including the reserves of the Public Health Service, to the national health and safety. The functions which such reserves are performing and the additional functions which they may be called upon to perform, were ably set out in a letter dated January 12, 1942 addressed to me from the Honorable Thomas Parran, Surgeon General, United States Public Health Service. The increased activity contemplated for such reserves as set out in that letter will result in increasing the rate of mobilization of the officers in the reserve of the Public Health Service. Accordingly, I am advising the various elements of the Selective Service System of the importance of the reserve of the Public Health Service so that the status of persons in such reserve will be fully considered by the local boards at the time of classification.

"I sincerely hope that this solution will be satisfactory to you and will enable the many programs of the Public Health Service which are vital to the health and safety of the nation to continue without impairment from the activities of the Selective Service System."

In making preparations for meeting emergencies which might be caused by enemy action, or by epidemics of disease in war time, such, for example as the influenza epidemic of 1918, it was apparent that some plan should be developed whereby trained and experienced public health personnel could be made immediately available to aid the public health authorities of stricken areas when they were in dire need of such assistance. The reserve of the Public Health Service seemed well adapted to such a plan.

Reserve commissions, inactive, are being issued to the professional public health personnel of State and local health departments, and of other agencies in which they are available, throughout the country. This procedure insures that all essential information in regard to the individual will be obtained and classified well in advance of the time of possible need. Immediately available in the office of the Surgeon General will be the names, ages, locations, and special qualifications of those commissioned, and the grades of reserve commissions to which they are assigned. In the hands of each reserve officer, inactive, will be the knowledge of the conditions under which he may be called to active duty, the grade of his commission, the compensation and travel allowances he will receive, the type of uniform required for active duty, where it may be obtained at short notice. The Public Health Service has been authorized to call reserve officers to active duty in case of emergency and has been provided with funds to pay them.

When an emergency need for temporary supplementary public health personnel arises in any State as a result of enemy action, civilian evacuation, or a serious

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outbreak of disease the State health officer may request the Surgeon General to send to the stricken community such personnel as he may specify. Reserve officers with the necessary qualifications will immediately be called to active duty from the nearest available sources and will be directed to proceed to the place where needed. They will report to the official designated by the State health officer. Upon completion of the emergency duty they will return to the place from whence they came and revert to inactive status. Should a reserve officer be engaged in work of vital importance when called to active duty he would be expected to report this fact to the Surgeon General who would select another to take his place. Salaries and traveling expenses to and from the critical area would be paid by the Public Health Service. It would be expected that local transportation would be provided by the local authorities. Reserve officers, like regular officers of the Public Health Service, are compensated for travel at the rate of eight cents a mile. This constitutes the entire amount allowed for transportation, food, lodging, and all other expenses, regardless of the length of time an officer may remain at any place. It would be helpful, therefore, if the authorities concerned would reduce to the minimum the time that reserve officers are required to remain, or, if this exceeds more than a few days, if they would endeavor to compensate them in some manner for the costs of food and shelter which they must incur.

At the time of the Ohio River flood, as Dr. McCormack and others will remember, we sent regular officers and reserve officers to help in the national emergency. They left their homes at a moment's notice, they traveled to Louisville, Paducah, or to whatever places they might be ordered, and there they stayed for one week, two weeks, three weeks, six weeks, and in some instances for two months. After the eight cents a mile which the officer received for travel was exhausted, it was necessary for him to pay for his subsistence out of his own funds and, at the same time, to maintain his household back home. That is all right; it is what the law provides. We are prepared to accept it without complaint, but we do want you to know that that it is the situation and that when you can reduce the time that is necessary for young reserve officers particularly to remain on duty, we would like you to do so. Moreover, if it is practicable and you wish to do it, you might make some provision for a small allowance when the time is extended beyond a few weeks. It would certainly be appreciated by the man involved. We have tried to get this situation corrected by legislation in Congress, by amendments of the appropriation, but the Public Health Service is included in the joint pay act of the Army and the Navy, and so far we have been unable to get separate travel authorizations.

It should be definitely understood by all concerned that Public Health Service reserve officers recruited from official health agencies for the purpose mentioned will not be called to active duty to fill permanent positions, nor will they be kept from their regular work for a longer period than is necessary to meet the acute emergency need.

The reserve fulfils three purposes, as follows:

1. It furnishes a roster of professional personnel which may be sent quickly by the Surgeon General to any locality in any State where supplemental personnel are needed for the period of acute emergency.

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2. It gives recognition to the professional public health personnel serving in State and local health departments and in other agencies throughout the country by appointment as commissioned officers of the United States Public Health Service. It gives such personnel assurance that they will be called to active duty in the service of their country in the work which they are best qualified to do if and when the need arises.

3. It provides additional evidence which may be presented to local examining boards to indicate the importance of public health personnel to the national health and safety. General Hershey stated, "I am advising the various elements of the Selective Service System of the importance of the reserve of the Public Health Service so that the status of persons in such reserve will be fully considered by the local boards at the time of classification."

Under date of January 12, 1942, and again on February 14, 1942, the Surgeon General instructed the Public Health Service District Directors to communicate with the State health officers for the purpose of obtaining recommendations as to the personnel they believed would be the most useful and valuable for the purposes outlined for the reserve.

The circular of January 12 laid emphasis on the selection of persons occupying only key positions. Since that time conditions have changed and the persons whom we now desire the officers in charge of health departments to recommend are, in addition to those in key positions, ones who, in their opinions, would be most useful and valuable to other public health officials who might need public health personnel to aid them in time of great emergency. If each State health officer will recommend those persons who are of the type that he himself would like to have sent to him if localities in his own State were in trouble, the success of the Public Health Service reserve would be assured. It might be well to bear in mind that any one of you may be receiving the men whom some of the rest have recommended to help you when the need is greatest.

As the result of our efforts to date, 157 physicians, dentists, and engineers have applied for commissions in the Public Health Service reserve, inactive, for the purpose mentioned. We believe that there should be about 2,000 to help us meet your possible needs. I hope that you will agree that the matter is of such importance as to merit your immediate attention.

The Public Health Service, with the assistance of the Medical Division of the Office of Civilian Defense, is now also recruiting as inactive members of the reserve approximately 2,000 physicians in hospitals and private practice, including specialists. These officers will be available for call to active duty in time of emergency to supplement the staffs of Emergency Base Hospitals now being organized by the Medical Division of the Office of Civilian Defense. They will also be available for call in case of any other emergency requiring the services of Public Health Service physicians.

You heard what Colonel Seeley had to say in regard to grades of medical men entering the Army. Very much the same thing applies to grades for reserve officers in the Public Health Service. Ordinarily, if the applicant is under 36 years of age, he will be appointed to the grade of Assistant Surgeon, which corresponds to First Lieutenant in the Army. From 37 on, up to about 45, the grade ordinarily given will correspond to that of Captain, and for older men the

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higher grades may apply. But because of the ratio of reserve officers to other officers, and because of the fact, as Colonel Seeley explained, that we already have reserve officers and regular officers doing work of equal or of perhaps even greater importance, we cannot put a reserve officer in a grade higher than most of the other officers with similar qualifications and duties.

The pay and allowances of Public Health Service officers are equal to the pay and allowances of officers in the Medical Corps of the Army. It was not the intent of Congress to depart from this rule, and we cannot do it.

The Army has a certain amount of elasticity in the appointment and placing of reserve officers at the present time which the Public Health Service does not have. The Army has obtained authority to promote its regular officers to higher grades. That enables the regular officers of the Army to be placed in positions of authority and direction over new, incoming reserve officers. As a result, reserve officers may have higher grades under the promoted officers in the Army than they would ordinarily have.

The Public Health Service has legislation already formulated and will endeavor as rapidly as possible to get it enacted in order that its old line officers may have positions of authority over new, inexperienced reserve officers who should be given a higher grade, perhaps, than those in which they may be originally commissioned.

In general, I may say that the grades given reserve officers will be commensurate with the grades received by regular commissioned officers. We cannot depart from this general rule to any great extent.

One other point, namely, the physical requirements for reserve officers. Physical requirements ordinarily in force will be and are being waived. All that we ask of a reserve officer is that he be capable physically of doing the job that we have for him to do. Each individual case will have to be judged on its own merits.

I will be glad to answer any questions or give any information. . . (Applause)

DR. WILLIAM M. McKAY (Utah): The original instructions included only physicians and engineers. You are now opening the field to dentists?

CHAIRMAN DRAPER: Dentists are commissioned in the reserve and we shall be glad to have applications from them.

DR. ROBERT H. RILEY (Maryland): What is the upper age limit?

CHAIRMAN DRAPER: As stated yesterday, the upper age limit has not as yet been completely decided by Dr. Parran. He is giving himself a little latitude. We should not like to have a hard and fast rule which says that men cannot be taken into the reserve beyond a certain age.

DR. A. T. McCORMACK (Kentucky): I would like to suggest that you use longitude instead of latitude for that age requirement.

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Seriously, Dr. Draper, I am thinking of a health officer who has had a couple of cardiac attacks. He would be ineligible under the physical requirements because he could not be sent to some other place to do the work. But couldn't he be put in the inactive reserve with the provision that he should not be ordered to duty, so that he would have the standing amongst his people that he ought to have? In Kentucky, the situation is very serious so far as health officers and doctors are concerned. Any doctor who hasn't made an attempt to get in the Army and Navy is considered a slacker, and that is just a starter. Health officers must be able to justify themselves in the public mind and in their own and before their wives and children, or we are going to lose them all. We have to use some sense and not all sentiment in this matter.

I am wondering about the possibility of requesting the Surgeon General to have these men put in the inactive reserve and in uniform, with some sort of insignia to make it known that they were commissioned officers in the United States forces. If we don't do that we are going to lose a lot of young men; there is no question about that.

CHAIRMAN DRAPER: May I answer you, Dr. McCormack, by saying that I don't think that any discretion is possible in granting a commission to a reserve officer who can't possibly be called to active duty, because the law reads: "That for the purpose of securing a reserve for duty in the Public Health Service in time of national emergency, there shall be organized," etc. I don't believe it would be correct to give inactive commissions to men whom you knew couldn't be called to active duty.

DR. McCORMACK: Dr. Higgins got the national award in his health department. He is doing as good work as any man in the United States, but he couldn't be ordered to fly across the country.

CHAIRMAN DRAPER: Perhaps I misunderstood you. If the man can do limited active duty and could be ordered to active duty within limitations which might be described, that is all right.

A military officer on active duty does wear a uniform, but an officer does not wear a uniform until called to active duty. It has already been ruled by the Administrator that only when an officer is on active duty shall he wear the uniform which indicates that he is an officer.

DR. E. L. BERRY (Idaho): As I interpret the making of applications for reserve commissions in the Public Health Service, the individuals recommended should be on the State level. Is that correct?

CHAIRMAN DRAPER: State health officers and the public health personnel of State and local departments.

DR. BERRY: In other words, men in charge of our local health units are eligible?

CHAIRMAN DRAPER: Oh, yes indeed. We should be most pleased to receive your recommendations of public health personnel in any unit of public health work. Anyone whom you feel is qualified to give assistance in case of emergency--a State health officer, a county health officer, a member of a voluntary agency,

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a member of a university, a member of the Tennessee Valley Authority--is eligible. All we want to do is have a group of trained people who can be sent to aid some other public health official when he asks for supplemental assistance.

DR. J. W. MOUNTIN: Mr. Chairman, we have a communication which was just handed to me a few moments ago by Mr. Seger. It is from the American Osteopathic Associations, addressed to the Surgeon General. I will not take time to read it unless you chose, but the substance of it is this: they make inquiry as to what progress is being made toward recognizing osteopathy in the list of qualifications which have been prepared for health officers. I assume it is appropriate that this matter be referred to Dr. Bierring, Chairman of the Committee on Personnel.

CHAIRMAN DRAPER: Is there any further discussion to come before this session? If not, the session this afternoon will meet in this room at 1:30.

. . . The conference recessed at 12:20 p. m. . .

THURSDAY AFTERNOON SESSION

March 26, 1942

The conference reconvened at 1:50 p. m., the Surgeon General, Dr. Thomas Parran, presiding.

CHAIRMAN PARRAN: We have a fairly long program this afternoon, and although all of the members of the conference have not yet returned, I think we had better proceed.

The first report will be that of the Committee on Interstate and Foreign Quarantine. Dr. Neupert will report for Dr. Harper who is not here.

DR. CARL N. NEUPERT: The committee considered problems before it under two general headings, namely (A) those having to do with Interstate Quarantine, and (B) those having to do with Foreign Quarantine.

(A) Interstate Quarantine

1. Development of health organizations in military and defense industrial areas.

The matter of lack of legal authority to set up health districts in some States to cope with health problems incident to the establishment of military camps or defense industries was taken up. Wherever possible, it has been found advantageous to concentrate authority for district operations under one organization. A suggested form of bill for enactment by State legislatures for accomplishing this purpose is being formulated by the Federal Security Agency and should be available shortly for transmission to State authorities for their consideration and use.

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The committee recommends that where State health departments do not now have legal authority to formulate and operate such districts that consideration be given to providing such authority through State legislation for development of district health units, including permissive legislation for uniting two or more existing units.

2. Communicable Disease Control.

a. Plague and activities for its control

The committee recognizes the increasing hazard of transmission of plague to the human population from reservoirs of animal infection, particularly in the military areas located in plague-infested regions. The committee recommends that control activities be adequately supported in (1) areas now known to be infested, and (2) through the continuation of surveys to determine the extent of the spread of plague infection in animals eastward through the Plain States.

b. Typhus control

The committee appreciates the increasing problem of the incidence of endemic typhus fever and the urgent need of expanding control activities. It is in accord with the program of the Public Health Service to develop and expand both research and practical control work in the areas most seriously affected. The inauguration of such activity is urged on a State-wide basis where endemic rates justify such a procedure.

To make such programs effective a more complete reporting of cases is essential. Lay people should be educated concerning the dangers of rat infestation.

c. Malaria control

The committee is informed of the limitation of malaria control measures by the Public Health Service to military and industrial defense areas and locations where malaria is now prevalent. The committee believes that such limitation of Federal contribution is not in the public interest and that the protection of the health of the general civilian population is of continuing importance. The committee recommends that the Public Health Service be authorized to supply technical guidance for malaria control programs in non-defense areas where such programs are deemed essential for the protection of public health.

d. Yellow fever

In view of the anticipated increased hazards of yellow fever incident to increased world-wide traffic resulting from war activities, the committee believes that there is need for effective preventive measures for the protection of persons who may be exposed to infection. Attention is called to the extensive use of yellow

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fever vaccines for the protection of those in the armed forces. The committee recommends the possibility of the extension of the use of vaccines to sections of the civilian population which may be exposed to the infection.

(B) Foreign Quarantine

1. International Reporting of Communicable Disease.

The general situation throughout the world has seriously interrupted reporting of communicable disease in foreign countries. Fragmentary reports indicate the prevalence of certain quarantinable diseases in various parts of Europe, Asia, and Africa. No undue incidence of communicable disease has been observed in this country.

2. Quarantine.

Reinforced safeguards have been necessary to avoid the importation of communicable disease. Specific menaces include importation of mosquitoes and other insect vectors of communicable disease from West Africa and South America. The committee desires to emphasize the importance of maintaining a high state of efficiency in the foreign quarantine service of this country to cope with increasing hazards of importation of infectious diseases. This is now more necessary than ever since more and more vessels are arriving in this country without previous announcement and without having secured the necessary bills of health, as well as from ports where the sanitary status is unknown.

3. Control of Refugees and Immigrants.

Control of refugees at points of debarkation is not now so urgent as formerly but it may need to be reinforced. It will become of prime importance when conditions permit increased immigration. Provision for such eventualities should be made in advance.

4. Prisoners and Internment Camps.

The importation of prisoners of war as well as the provision of adequate internment camps may develop urgent problems of sanitation and communicable disease control in States where such camps are located.

CHAIRMAN PARRAN: Do you move the adoption of the report?

DR. NEUPERT: I move the adoption of the report.

. . . The motion was seconded and the report adopted. . .

CHAIRMAN PARRAN: The next report is that of the Committee on Business Management, Dr. W. C. Williams, Chairman.

. . . Dr. J. W. Mountin took the Chair . . .

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DR. W. C. WILLIAMS: This is a joint report of the old Committee on Records, Reports, and Administrative Practice of the State and Territorial Health Officers, recently changed by the Surgeon General to the Committee on Business Management, and the Committee on Records, Reports, and Administrative Practice of the Conference of State and Provincial Health Authorities. The change in name of the Surgeon General's Committee implies broadening responsibilities of the committee to make recommendations to the Surgeon General on matters of management pertinent to grants-in-aid programs.

The principal topics considered have been fiscal or budgetary procedure and the records and reports requirements of the Federal agencies. Satisfactory progress has been made toward the development of a joint budget form to be used by the Public Health Service and the Children's Bureau. At present, it appears that the joint budget form may be ready for adoption by both Federal agencies at the beginning of the fiscal year 1943-44. An effort will be made to have the proposed joint budget form installed experimentally in at least three States during the next fiscal year. The committee offers all facilities at its disposal for assistance in this experiment. The problem is more complex than was originally anticipated and will require more time.

The necessity for effecting immediate relief with regard to budgetary detail has been discussed with the Federal agencies. A number of possibilities for budget simplifications were explored by the committee in conference with representatives of the Public Health Service. The committee recommends that the following principles be incorporated in the budgetary procedure which becomes effective July 1, 1942:

1. Eliminate the line item control now required in all budget revisions.
2. Substitute for the present budget revision document a simple notification letter for changes involving the addition of new activities, discontinuance of projects, and transfers of more than $100 between personal services and other items of expense.
3. Permit States to use lapsed salaries or other salary items without requiring prior authorization by the Public Health Service, provided the States submit, at the end of each quarter, a list of the positions established or abolished during the quarter.
4. Eliminate the detailed quarterly financial report and substitute a quarterly summary of individual project totals for all funds.
5. Establish an annual detailed financial report reflecting all items of expenditures for all projects.

The committee appreciates the fact that the Public Health Service would, in the event of the adoption of these recommendations, be placing a greater measure of fiscal responsibility on the State administrative officials, and, therefore, recommends that the simplifications outlined be installed in whole or in part only in those States whose accounting, purchasing, property, and personnel controls are found to be adequate by the Public Health Service. It appears desirable to have regional conferences between Federal and State personnel during the next fiscal year for the purpose of discussing proposed changes in budgetary procedure.

A further possibility which offers considerable encouragement in the simplification of accounting procedure is a plan whereby there will be a proportionate

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charge-off of all expenditures in accordance with the contribution of each agency to the total of the individual project. An experiment of this type has been under way in one State during the present fiscal year. The committee recommends extension to several other States, if possible, during the next fiscal year. Discussions with the Children's Bureau have not progressed to the point where specific statements can be made as to probable accounting readjustments. The committee hopes something tangible may develop shortly.

In the field of records and reports, the committee gave consideration to some of the special reporting problems in connection with the war effort. The committee endorsed, as a temporary war-time measure, the proposal made by Dr. Leake of the Public Health Service that the States report to the Public Health Service on a weekly basis certain diseases which might become epidemic under war conditions. Dr. Leake further requested that the States make every effort to report paralytic poliomyelitis as distinguished from non-paralytic cases.

Apart from the above considerations, the attention of this committee for the past two years, has been directed mainly toward the problem of simplification and integration of the reporting requirements of the Federal agencies. The study has been completed and a detailed report has been prepared outlining an integrated system of reports which this committee feels should be adopted.

This report to the conference will not take up in detail the proposed changes in existing reports which have been considered during recent months. It is pertinent to the problem under consideration to state that the content of the system must be limited to material which is absolutely necessary for carrying out services that are most beneficial to the Nation as a whole. Items which are of interest and perhaps desirable, but which are not absolutely essential to intelligent interpretation of the plans and accomplishments of the program, must be eliminated. Energy and time expended in carrying health services directly to the individual has a more favorable influence on health trends than the filing of exhaustive reports covering details of service rendered.

The committee recommendations provide for the establishment of three basic types of reports to be made to both Federal agencies:

1. An annual report of facilities, services, and personnel available in each county.
2. An annual report of health department activities for the State as a whole. (which would supplant the reports by counties which have previously been made quarterly).
3. Combined annual narrative report and plan, which will be kept cumulatively and will not need to be repeated from year to year.

The committee is glad to report that the Commonwealth Fund has approved a plan to provide, for the rest of this calendar year, the services of a field representative, secretary, and travel to install the annual report and plan experimentally in selected States and Public Health Service district offices.

It was apparent to the committee, at the start of its work on Federal reporting requirements, that a common basic philosophy of administering public health grants-in-aid programs was essential before a reporting system could be

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developed. In arriving at a basic philosophy, the committee studied all other similar grants-in-aid programs of the Federal government and selected the principle of Federal-State relations in a grants-in-aid program which it considers the most effective basis of operation.

The principle proposed by the committee is: The State health departments are responsible for the administration and supervision of the health services within their respective States; the Federal Government's responsibility consists of providing financial assistance, consultant service, and audit control in order to help the States meet their established responsibilities.

An opposing theory is: the Federal Government is responsible for the effectiveness of the detailed operation of local and State health programs to which it gives financial aid, and the States' function is to carry out the type of program specified by Federal authorities.

In endorsing the principle of State responsibility for actual operation of programs, the committee recognizes that the executive heads of the Federal agencies are responsible for determining what information is essential in order to carry out the Federal responsibilities. The committee recommends, however, that the executive heads of the Federal agencies bring their reporting requirements into line as soon as possible with the principle advanced by this committee. It is further recommended that they establish a definite policy of seeking the advice or counsel of representatives of the State and Territorial health officers before the installation of any new reporting requirements. This policy need not apply to the emergency or temporary type of questionnaire so essential under war conditions.

In summary, the entire question of the simplification of Federal reports resolves itself into a determination of the basic conditions on which the grants-in-aid program should operate.

The committee, to the best of its ability, has devised a reporting system in accordance with the principle that the Federal Government is not concerned with the details of administration of State and local health programs. Therefore, the committee's work depends upon the acceptance or rejection by this Conference of the principle of State responsibility. The State and Territorial Health Officers Association has accepted this principle by roll call vote without dissent.

In conclusion, each State must assume more direct responsibility for making its own representatives in the Congress of the United States aware of the benefits which may accrue from the continuation of well-planned public health programs as well as of the results already attained. The Federal agencies have borne the brunt of presenting and justifying grants-in-aid requests before Congress in the past. In the future, more direct and tangible help must come from all States and Territories and from the organization representing them.

As Chairman of the joint committee, I move the adoption of the report by this conference.

DR. STANLEY H. OSBORN (Connecticut): I second the motion.

Courtesy CDC's Public Health Library and Information Center

CHAIRMAN MOUNTIN: The report is now before you for discussion. Does any one have any questions?

DR. I. C. RIGGIN (Virginia): The simplification of practice is absolutely essential at this time, and the elimination of unnecessary reports is absolutely necessary. We have talked about the loss of personnel; the people who are left must render the service. There is no question that certain reports must be required, but reporting just for the sake of making reports is not necessary at the present time.

Most of the discussion here has been about technical and professional personnel. Some of the States are faced with a serious problem as far as clerical personnel is concerned. In Virginia we are losing clerical personnel. We are getting some of the agencies being decentralized from Washington, and other agencies are going to other cities. Some of the clerical personnel in States which do not pay salaries as high as those under Federal Civil Service are leaving. In my own State we have lost any number of our clerical personnel to the Federal Government under Civil Service, and it has seriously depleted our clerical force. It requires clerical personnel to make up records, and I trust that the Service will give every consideration to this report as submitted by the joint committee.

CHAIRMAN MOUNTIN: I think, Dr. Riggin, you may be sure of that. We have worked very closely with Dr. Williams, and I trust we have been helpful.

May I ask a question or two? In the part of your report referring to fiscal practice, you made some reference to a check-off. I didn't understand the wording or the significance of that section.

DR. WILLIAMS: In one State an experimental budgetary procedure has been carried on whereby there was a charge-off (I believe that is the term I used) of all expenditures in accordance with the proportion which each agency contributed to the budget. In other words, in a budget in which the total was $10,000 a year and in which $5,000 were title VI funds and $5,000 were State funds, it was felt that it might be possible to work out some plan by which, if a total of $9,000 was spent on that budget for the year, $4,500 would be charged to State funds and $4,500 to Federal funds, instead of breaking the various items down on the basis of, say, 10 percent from one source and 90 percent from another. It is our belief, after discussing that with various individuals, that perhaps some such system would not only be workable but would certainly eliminate a vast amount of accounting detail.

CHAIRMAN MOUNTIN: It would eliminate the line item control which we have at the present time.

DR. WILLIAMS: Yes, sir.

CHAIRMAN MOUNTIN: I want to emphasize that in his report Dr. Williams suggested the elimination of much of the practice that now is carried on under line item reporting and line item budget control. There was one provision in the report which I hope you all noted, namely, that these modifications shall be put into effect, as I understand it, only when the fiscal practice and system in the State has been found satisfactory.

DR. WILLIAMS: May I read that to you?

Courtesy CDC's Public Health Library and Information Center

CHAIRMAN MOUNTIN: Not to me. I want you to read it to the audience because this plan won't work unless that provision is in effect.

DR. WILLIAMS: Preceding that statement, I mentioned five possibilities, any one of which might be utilized.

We state: "The committee appreciates the fact that the Public Health Service would, in the event of the adoption of these recommendations, be placing a greater measure of fiscal responsibility on the State administrative officials, and, therefore, recommends that the simplifications outlined be installed in whole or in part only in those States whose accounting, purchasing, property and personnel controls are found to be adequate by the Public Health Service." This is absolutely essential to the carrying out of the program. It is not only desirable from the standpoint of the Public Health Service, but it is also desirable from the standpoint of your own States.

CHAIRMAN MOUNTIN: May I ask Mr. Siepert if he wishes to discuss this? Mr. Siepert is in charge of our auditing service. Do you want to raise any points?

MR. A. F. SIEPERT: No. Any other points I might raise would be details.

CHAIRMAN MOUNTIN: In principle you agree?

MR. SIEPERT: In principle I agree with the recommendations of the report. But I think you are quite right in stressing the fact that this cannot work except when a State has sound and adequate fiscal procedures. I might add this: that the States Relations Division is building up a staff which will cooperate with the States in showing them what simple changes may be necessary in their systems in order to extend to them the full advantage of the simplified budget procedure if it is adopted.

CHAIRMAN MOUNTIN: There is one point I want to have clarified for my own guidance. I presume these principles of recording which you have enunciated apply to our routine grants-in-aid program. I mention that specifically because under our malaria control program, and under the community sanitation program if that is put into effect, we will be engaged in direct operation, and will be accountable for our own property and our own funds. We are assigning administrative assistants to the States concerned in the malaria program, but in those States we will have to have the kind of records which a State or a local health department would maintain in connection with its own program.

DR. WILLIAMS: That is right. We are referring only to established services and not to the emergency services which may be required in connection with the war effort.

CHAIRMAN MOUNTIN: All right, I am satisfied.

The question has been called for. Those in favor say "aye." Opposed? Carried.

. . . Dr. Parran resumed the Chair . . .

CHAIRMAN PARRAN: Report of the Committee on Federal-State Relations by Dr. A. T. McCormack, Chairman.

Courtesy CDC's Public Health Library and Information Center

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The question has been called for. Those in favor say "aye." Opposed? Carried.

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CHAIRMAN PARRAN: Report of the Committee on Federal-State Relations by Dr. A. T. McCormack, Chairman.

Courtesy CDC's Public Health Library and Information Center

DR. A. T. McCORMACK: I should like to express the appreciation of the members of the committee, Drs. Miller, Cogswell, Grayson, Moyer, Dr. Smith representing Dr. Council, and Drs. Hamer and McKay, to our consultants, Dr. F. W. Kratz and Mr. Raymond Sawyer, for the services they rendered in connection with the preparation of this report.

The questions which have risen in the minds of most of you in regard to amendments to this report were written out carefully several weeks ago and sent to each member of the committee. All of them replied except Dr. Council, who, of course, was too far away, and Dr. Smith, who didn't receive the communication in time. As far as this committee is concerned, I hope it will be a continuing committee. I would like to feel that the questions which have been in the minds of the members of the committee and the other State health officers will continue to engross their attention, and that we will be in the state of progressive evolution which both Mr. McNutt and Dr. Parran emphasized as necessary yesterday.

The report, which I shall read, has also been discussed with a majority of the members of the Conference. I am very appreciative, and the members of the committee are very appreciative, of your contribution to these important problems.

(Reading) "It is the unanimous opinion of the committee that the allotment formula for title VI funds should be continued in its present form for the fiscal year 1943 insofar as it refers to the amount to be appropriated by the present Congress and unpaid balances in the Federal Treasury at the end of the fiscal year.

"As an equalizing factor, however, it is recommended that the allotments, as determined by the allotment formula, be increased or decreased in accordance with the unexpended balances in each State treasury in order to effect a distribution to each State of its proportionate share of the total unexpended balances in all of the State treasuries."

In other words, the total resulting from the addition of the unexpended balances in States, the unpaid balance in the Federal Treasury, and the total appropriation for 1943 would be allotted on the basis of the formula as if that total amount were the amount appropriated. Allotments to individual States would then be adjusted by the subtraction of any title VI balances which have accumulated in the State treasury.

It was the unanimous opinion of the committee in regard to the malaria control program being carried on by the Public Health Service as the operating agency in cooperation with the States, that the States should take the necessary steps to assure an effective Federal-State program. The present arrangement is a very important improvement over the rather ineffective programs heretofore carried on, and we want to make good on it. To do that will require the effective cooperation of every one of the States which has a malaria control program.

We make the general statement, as Dr. Williams has emphasized, that required budget revisions be radically minimized or simplified.

Now, we are recommending the inclusion of the following additions to the regulations. These are slight amendments. One of them is a preamble which will enable the Service to have the general thought of the Conference before them in its conversations with the Budget Bureau:

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"Federal funds shall be available to assist States in developing a public health program designed to achieve a standard which includes provisions for establishing, maintaining, and improving local health services to the individual; the control of communicable diseases; maternal and child health services; dental health services; environmental sanitation; industrial hygiene; public health laboratories; collection and dissemination of information on vital statistics; training of personnel; personnel administration on a merit basis; and approved administrative and fiscal procedures."

With regard to the submission of plans and budgets, "Each State shall submit for the approval of the Surgeon General a plan for improving and extending State and local public health functions designed to achieve the standards outlined in the preceding paragraph." I am doubtful as to whether "standards" is the exact word which should be used there; it should probably be "programs." "The plan also shall include (1) a comprehensive statement of any changes in the State health organization (including personnel administration), programs, and appropriations since the last statement was submitted, and (2) budgets on forms prescribed by the Public Health Service showing the sources of all funds to be spent under the plan, and the detailed items for which expenditures are to be made. Plans may be amended only with the approval of the Surgeon General." That may be simplified according to the recommendations of this Conference.

"Prior to the beginning of each quarter, the State health officer shall submit an application for funds upon forms prescribed by the Public Health Service. The Surgeon General may certify quarterly to the Secretary of the Treasury for payment to the States an amount which, together with any balance on hand in the State, shall not, except in an extraordinary emergency, exceed 35 percent of the total amount available, provided that the total payments shall not exceed the total annual allotment, or the total amount budgeted, whichever is less.

"Payments shall be made quarterly to the State treasurer or other officer authorized by State law to receive the funds, and the principal accounting officers of the State Government shall account for the funds separately from any other funds, State or Federal. State laws and regulations governing the custody and disbursement of State funds shall govern the custody and disbursement of funds paid by the Federal Government under these rules and regulations, subject to such amplification or modification as the Surgeon General may find necessary.

"Funds paid to a State shall be expended solely for the purposes specified in plans and budgets approved by the Surgeon General, and shall not be used in such manner as to result in a reduction of State or local appropriations for public health services, or in the existence of a greater proportionate unexpended balance of State or local public health funds than of Federal funds paid to the State hereunder.

"If expenditures are made by any State contrary to the purpose of the Act, or of these rules and regulations, the Surgeon General may withhold from future payments the amount so expended. The Surgeon General also reserves the right to withhold all payments from a State which fails to maintain a standard of public health services commensurate with the health problems and the available resources."

"These rules and regulations and any amendments thereto shall be in full force and effect during each fiscal year for which funds are available under title VI of the Social Security Act."

As to the method of allocating funds to the States:

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"Allocations shall be made to States from the amount appropriated by Congress for the fiscal year 1943 and from the unpaid balance in the Federal Treasury at the end of the fiscal year 1942 on the basis of the formula now in use. These allocations shall be prepared and then adjusted in accordance with the following procedure:

"1. Prior to the end of the fiscal year the States shall estimate and report to the Public Health Service their expenditures (including actual encumbrances) from title VI funds during the fourth quarter of the current fiscal year.

"2. On the basis of the expenditure estimates submitted by the States the Public Health Service shall tabulate the estimated unexpended balance from title VI funds which the various States will have in their treasuries at the end of the fiscal year. (The total of the unexpended balances of all States at the end of the fiscal year 1942 will probably represent an amount equivalent to 10 percent of the appropriation for the fiscal year 1943.)

"3. Allotments to States from available title VI funds for the fiscal year 1943 will then be determined by the application of the present formula to the total sum which will include (a) funds appropriated for the fiscal year 1943, (b) any unpaid balance in the Federal Treasury, and (c) the estimated total unexpended balances in the several States.

"4. The allotment determined for any individual State will then be adjusted by subtraction of the estimated unexpended title VI funds in its State treasury. This adjusted allotment figure will represent the amount to be certified for payment to the State for the fiscal year 1943.

"The adjustment of allotments through the application of the steps outlined above will be equivalent in effect to the redistribution of unexpended balances in States at the beginning of the fiscal year on the basis of the allotment formula.

"For example: If State 'A' had a normal allotment of $400,000 based on application of the formula to a total appropriation of $11,000,000, and had an unexpended balance of $100,000, and if the total unexpended balances of all States amounted to 10 percent of the total appropriation of $11,000,000, that State would have available for expenditure $400,000 plus 10 percent, or $440,000; but the amount actually allotted to that State from the $11,000,000 appropriation would be $440,000 less the $100,000 unexpended balance, or $340,000.

"If State 'B,' on the other hand, had a normal allotment of $400,000 and no unexpended balance, it would likewise have available for expenditure $440,000; but since in this case there was no unexpended balance the full sum of $440,000 would actually be allotted to it."

Mr. Chairman, I move the adoption of the report.

. . . The motion was seconded by Dr. Felix J. Underwood, Mississippi . . .

DR. STANLEY H. OSBORN (Connecticut): I would like to amend that portion of the report enumerating the various items for which Federal funds shall be available, namely, maternal and child health, vital statistics, and other things, to include the word "housing." It seems to me in times like this it is extremely important to include that.

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DR. McCORMACK: I accept the amendment. I don't think the members of the committee would object. Dr. Osborn has suggested so many good things.

CHAIRMAN PARRAN: May the Chair ask Dr. Osborn if he includes the construction of housing or the hygiene of housing?

DR. McCORMACK: I would say "housing." Under existing circumstances we would encourage the development of housing plans. A great many years ago when father was writing our basic law, provision was made for a bureau of housing to promote adequate and sanitary housing, especially for those who were tenant farmers It is this sort of thing that I imagine we have in mind. Yet, I don't believe we ought to limit it, because if we specify "construction of housing" we run into considerably difficulties. I think Dr. Osborn's suggestion is good as an entering wedge.

CHAIRMAN PARRAN: Is there discussion?

DR. WILLIAMS: Dr. Parran, I would like to have Dr. McCormack clarify one or two statements that were made. In the general introduction to his report he mentioned what I interpreted to mean some limitation as to percentage or amount of funds which might accrue before they reverted at the end of the fiscal year. At least, some consideration should be given to that. Does he or does he not think that the complete reversion of those funds, if that is what he indicates, should be subject to whether or not the State health officer could show a real justification for carrying them forward? That is not brought out, but I can readily foresee, especially in connection with certain defense activities, that certain special services might be undertaken during the last quarter of this year with the intention of continuing them through the summer or well into next year. Under such circumstances, a health officer could fully justify the use not only of his regular allocation, but also of such balances as he might have available.

Question No. 2: I assume that the reversion of unexpended balances and their reallocation would be on a year-to-year basis. That is, if an individual State was normally entitled to $400,000 and under the new plan got $440,000 next year, at the beginning of the succeeding year it would drop back to its regular $400,000 allocation.

DR. McCORMACK: That is correct.

In regard to the first suggestion, the provision is very carefully covered and the decision is left to the Surgeon General when special justification is put forward. There is one consideration, however, which I believe is exactly in line with your own statement in regard to the impossibility of accepting records from any State which doesn't have accurate bookkeeping and purchasing records. A tendency has developed among us to project a program for the purpose of encumbering funds, without taking into consideration the likelihood of being able to fill positions. Such a practice is not fair to the Service. We all want to play the game squarely, and if a budget is submitted and approved, and then not made effective within a reasonable time, the money should be considered unearned income. I think we ought to have that very clearly in our own minds.

DR. WILLIAMS: Let us say, for example, that a particular State has an annual allocation of $400,000 and accrued balances of $460,000. Did I understand you to say that it would be permitted to have a total annual budget of not more than $440,000?

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DR. McCORMACK: Yes, I would like you to realize that the members of this committee have given a great deal of study to the proposition. I think we had every possible complication and objection brought before us. The members of the committee were largely from States which had not previously been represented on the committee. It was particularly interested to hear the intelligent inquiries which were directed at this program by Dr. Miller from Nebraska and other men from States which are developing local programs under difficulties that we can all appreciate. We know their difficulties and we want to help them in every possible way. I know that as a result of the suggestions that have been made to me, Dr. Blackerby and I will be able to do more effective work in Kentucky. I am grateful to all of you for the help you have given us in formulating this report.

CHAIRMAN FARRAN: Are you ready for the question? The question is called for. Those in favor will please say "aye." Opposed by the usual sign. It is carried.

DR. McCORMACK: If you will permit me, there was one other thing that I was asked to discuss. I realized the seeming futility of it in the light of certain things which were said this morning, but at the same time, I heard you and Governor McNutt say the other day that the time had arrived when precedent could not be allowed to stand in the way of winning this war, and that if it was necessary to violate a precedent which had interfered with the efficiency of our work we should make the change now.

When we first received notification in Kentucky that Public Health Service personnel would be placed in uniform I wired the Surgeon General and all of the others concerned protesting against the order. I am one who, in his thinking upon the score, dates back to the Magna Charta when they hardly believed in anybody being in uniform unless he was to be shot at. In Kentucky that has always been more or less our idea and purpose in regard to anyone who wore a uniform. We haven't excluded others, but we have been particular about them.

In Kentucky, however, I find that since the personnel who have been assigned to us have been in uniform, their efficiency has been tremendously increased. We have been able to accomplish some things which were absolutely unattainable before, simply because the same man who had been at the same place attempting to solve the same problem in his natural garb went back attired in one of these glorified propositions, and looked so good that the women flocked around and even the men voted for him. We have secured results in counties which were formerly very cool toward public health. We have overcome conditions that were extremely important. That part is fine; it has accomplished a great deal of good, whereas I anticipated that it would accomplish only harm.

But a difficulty has arisen with our own personnel, and their morale has been increasing in direct proportion to the increased influence of these other men. We find now that when you come amongst us in uniform, our health officers feel that the thing for them to do is to get into the service of the United States somewhere, and we are going to lose many effective men because they will apply for commissions. Colonel Seeley told us this morning that if they apply they will receive commissions. I am not so sure about that in Kentucky, because I am Chairman of Procurement and Assignment. They may get them in some other States.

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I know it would be a violation of precedent, but I am wondering if it wouldn't be possible to have a uniform and an appropriate insignia for working members of our staffs who are in inactive status in the Public Health Service reserve corps. It would unquestionably enable us to hold about a third of our personnel who will otherwise go into the Medical Corps of the Army or Navy. And that is as important to the defense of this country as any other type of medical activity in the service of the United States. I believe some means should be devised to make these fine young men feel that they are receiving recognition from their Government for their services on equal terms with the men in the Army and Navy. I feel we are on equal terms. I believe that the county health officer is serving in as important a capacity as an officer of the Army of the United States.

CHAIRMAN PARRAN: For information, may I inquire if this is a personal recommendation of Dr. McCormack or of the committee?

DR. McCORMACK: The committee recommended it with the thought that we didn't want to put it in the formal report unless the Service feels that it can be received sympathetically.

CHAIRMAN PARRAN: Is there discussion of the latest suggestion which Dr. McCormack has made?

DR. I. C. RIGGIN (Virginia): I am a member of the committee but I didn't understand that it was going to report that.

CHAIRMAN PARRAN: The Chairman would welcome the views of the State Health Commissioner of Virginia.

DR. RIGGIN: Dr. Parran, health officers and personnel of health departments are civilians, and I can't see how their prestige will be enhanced by wearing of a uniform. It seems to me it would be a mistake for State health department personnel to go into uniform simply to increase their prestige in the community. I think we all feel that we are doing a worthwhile, important service for the people of this country, and the work we are doing will have to stand on its own feet; and I do not believe a uniform is going to add anything to its value. I, for one, certainly would be opposed to such a proposal.

DR. STANLEY H. OSBORN (Connecticut): I don't know what the gentleman from Kentucky believes will be accomplished by putting such personnel in uniform. I should not like to see our civilian local and State health personnel in uniform, although I am not opposed to anybody's efforts to get a commission in the active service.

DR. EDWARD S. GODFREY, Jr. (New York): I have discussed this matter with the personnel of my department and none of them believes that he would feel comfortable in a uniform. Personally, I can't see any advantage in it.

CHAIRMAN PARRAN: Is there further discussion? If not, may I say, Dr. McCormack, that I should welcome any points of view which other health officers prefer not to express here publicly, and I would be glad to take the matter under consideration if a sufficient number of the State health officers request us to do so.

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DR. WILLIAMS: Dr. Parran, does that apply to insignia as well as uniforms? Dr. McCormack suggested insignia in his presentation.

DR. McCORMACK: Insignia are going to be sent every doctor who applies to the Procurement and Assignment Service and who is classified as essential and non-available. Such men will be given a certificate to hang on the wall, but most people are not going to see that. Insignia from the Elks and the Masons and other organizations will be confused with patriotic insignia, and it is difficult to differentiate between them.

DR. C. F. McCLINTIC (West Virginia): I think there is a little more involved here than a mere uniform. I think what Dr. McCormack is interested in is keeping our personnel in the States in order to get on with our health programs. I understood from Colonel Seeley this morning that if our personnel in the States are given commissions by the Service they will probably be deferred, and I think that is the crux of the matter. As I see it, the only point involved as far as a uniform is concerned is whether or not these men shall be permitted to wear a uniform in the reserve corps of the Public Health Service when not on active duty.

CHAIRMAN PARRAN: That is the way I understood Dr. McCormack's question.

DR. McCLINTIC: For that reason, I would be in favor of the proposal made by Dr. McCormack. I know perfectly well that I am going to be depleted of personnel pretty soon unless some provision is made whereby these young men can indicate to the people that they are patriotic citizens who want to do their part in the war. I think they will do more back there in the States than they will in the Medical Corps of the Army.

CHAIRMAN PARRAN: The next order of business is the report of the Committee on Health Programs, by Dr. Godfrey.

DR. GODFREY: May I request deferment until a little later? I have not received the typed copy.

CHAIRMAN PARRAN: We will pass to the report of the Committee on Personnel, Dr. Bierring.

DR. WALTER L. BIERRING (Iowa): General Parran and Members of the Conference: The Committee on Personnel desires to record its appreciation of the fine cooperation of university schools of public health, the Committee on Professional Personnel of the American Public Health Association, the several subcommittees appointed at the last Conference, as well as of the valuable assistance of eminent consultants in formulating this report, particularly as it pertains to the qualifications of the several types of public health personnel.

Special acknowledgment is accorded to Mr. Gordon F. Seger, Health Education Specialist, and his associates for the careful assembling of data by correspondence and attendance at subcommittee meetings during the past year, as well as for valuable advice and aid in arranging the many details of the final report.

This report is submitted under two headings.

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I. The committee recommends the adoption by the Conference of the qualifications which have been formulated by the committee for the following classes of professional personnel:

1. Chief Public Health Engineer
2. Public Health Engineer
3. Industrial Hygiene Physician
4. Industrial Hygiene Engineer
5. Industrial Hygiene Chemist
6. State Director of Public Health Nursing
7. Assistant State Director of Public Health Nursing
8. General Public Health Nursing Consultant in a State Health Department
9. Public Health Nursing Consultant in Special Fields
10. Public Health Nursing Supervisor in a Health Jurisdiction
11. Public Health Nurse in a Local Health Department
12. Director of Venereal Disease Control Services
13. Director of Dental Health
14. Dental Clinician
15. Nutritionist
16. Director of Vital Statistics
17. Health Officers
18. Health Educators
19. Laboratory Personnel

It is hoped that these recommended qualifications for the several types of professional public health personnel will serve as a guide and pattern for the State department of health directors, merit system administrators, personnel directors, schools of public health, and others interested in this problem.

These qualifications will be published in a booklet with further information relative to the training of personnel financed by funds appropriated under the Federal Venereal Disease Control Act and title VI of the Social Security Act.

II. As the second part of this report the committee begs to present the following recommendations:

1. In view of the existing war emergency, the committee recommends the establishment by State health agencies of interim classes for professional personnel with minimum qualifications which will permit recruitment of personnel with lower qualifications than would be desirable under normal conditions. It is further recommended that the duties of these interim classes be established so as to provide for a lesser degree of responsibility and a correspondingly greater degree of supervision than required in the standard classes.

2. It is recommended that the Committee on Public Health Procurement and Assignment Service (Dr. Carl V. Reynolds, Chairman) be asked to make a careful study of the latest roster in the office of the Procurement and Assignment Service, listing the names of physicians who are engaged in part-time or full-time public health work, and who might not be qualified for active military service but who might be qualified to perform certain services in State health departments.

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3. The committee recommends that a request be referred through the Surgeon General of the United States Public Health Service to the Surgeon General of the United States Army asking that consideration be given to the granting of provisional commissions in the Sanitary Corps of the United States Army to undergraduate students in approved schools of engineering who are preparing especially for public health or sanitary engineering, such men to be called to active military service upon completion of professional training or after one year of postgraduate or intern training in a governmental health agency.

4. In order to insure a reserve of trained public health personnel for future service, the committee recommends to the Surgeon General of the United States Public Health Service that provision be made through allotments from lapsed or unexpended funds, or through additional grants from title VI, Social Security Act, and the Federal Venereal Disease Control Act, to enable State health agencies to increase as necessary their quota of public health trainees in university schools of public health. The committee further recommends the establishment through the individual State health agencies of public health scholarships in approved schools of public health for the purpose of stimulating and enabling undergraduate students in medical schools to pursue further training in public health after graduation in medicine. After completion of the special public health training such persons may be called into military service, but they will constitute a reservoir of personnel for future service in public health work.

5. The committee recommends that the normal courses for the "M.P.H.," or "Dr. P.H." and equivalent degrees be continued by university schools of public health on approximately the present basis. It is understood that schools of public health are willing to arrange interruptions of the prescribed courses at the end of a quarter or a semester, and to allow the courses to be completed at a later period.

6. The committee is advised that university schools of public health are prepared to offer short courses in appropriate specialized field of public health as may be required by military or civilian health needs. The schools, however, have stated that such courses may or may not carry academic credit, depending upon the circumstances.

7. The committee recommends to State health departments that they establish brief apprentice or orientation courses of training in the more general fields of public health, and that they accept the offer of schools of public health to loan teaching personnel insofar as possible to assist the State health departments in the conduct of such training.

The committee has received a letter under date of March 25, 1942, addressed to Surgeon General Parran, signed by Chester D. Swope, D.O., Chairman of the Committee on Public Relations, American Osteopathic Association, Washington, D. C., directing attention to previous communications to annual sessions of this conference and requesting consideration of revising the basic qualifications for public health officers so as to recognize the degree, "Doctor of Osteopathy."

The committee after due consideration recommends that this communication be acknowledged with the statement that the Committee on Personnel has not been informed of the disposition of this matter by the Association of Schools of Public

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Health to which it was referred last year. The committee further recommends that the present communication be referred to the Association of Schools of Public Health for consideration.

This report is respectfully submitted by the committee, consisting of Walter L. Bierring, Chairman; Charles F. Dalton, Frederick D. Stricker, Stanley H. Osborn, James Stewart, E. L. Berry, C. F. McClintic, R. L. Cleere, with consultants, Mr. Gordon H. Seger, Miss Pearl McIver, and Mr. Norman Old.

Mr. Chairman, I move this report of the Committee on Personnel be approved.

. . . The motion was seconded by Dr. H. Allen Moyer, Michigan . . .

CHAIRMAN PARRAN: Is there any discussion? If not, those in favor will say "aye." Opposed by the usual sign. It is voted.

Is Dr. Godfrey ready to report for the Committee on Health Programs?

DR. EDWARD S. GODFREY, JR., (New York): Our country is engaged in a war which demands the best use of all our resources. Our most important resource consists of the people who compose our population. It underlies all others and provides the spirit which animates our struggle for the advancement of humanity in the way we believe to be most fruitful.

It is essential, therefore, that this resource be not only conserved, but that it be raised to its highest level of efficiency. It is incumbent upon the State departments of health to strive for this goal, and to enlist the assistance of the other agencies of the State and local communities which contribute to healthy living.

The Committee on Health Programs has considered a number of items in the programs of State departments of health, all of which are believed to be of importance. It has not attempted to fix any priority of importance, realizing that this is a function of the individual State and community; it is a matter to be determined by the local hazards and the resources which are available to combat them.

It seems inevitable that the physicians, dentists, and nurses caring for those in civil life will be seriously depleted. The withdrawal of such personnel will become increasingly serious, and obtaining and rendering of the customary medical, dental, and nursing services will become increasingly difficult. Therefore, it behooves the public to ascertain their present condition of health and to seek correction for any existing defects while these services are still to be had. It becomes more important that they maintain a high degree of personal health and observe the principles of personal hygiene more sedulously than ever before. It is incumbent upon the medical, dental, and nursing professions to think more intensively of the preventive aspects of their professions and to advise their patients more frequently and more carefully of the means by which their health may be maintained.

This brings out the need for health education and calls for interesting the organized groups of these professions in their preventive aspects, and it calls for education of the public so that they may better appreciate the importance of health

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maintenance. All of the media of mass information and personal instruction at our disposal should be used. The program of public health education in State health departments should be strengthened and should stimulate and assist such activities in their local health services.

The committee approves the establishment and operation of consultant and technical services in the United States Public Health Service for the purpose of assisting State health authorities in this work. It further approves the mass production of educational materials which deal with broad public health programs, composed in such a way that they may be readily adapted to the needs of particular areas of the country.

The committee has noted the evidence indicating an increase in the prevalence of tuberculosis in England, and more lately in Canada, and believes that unless present measures are maintained and strengthened, a similar increase may take place in this country. Full employment is undoubtedly calling into industry and business individuals with tuberculosis who, under the strains of war-time, will break down with the disease. This calls for not only more facilities for their care, but for an intensification of case finding and the early detection of the disease. The committee also recommends to the State departments of health that they insure that cases discovered by Selective Service boards and by induction stations, be reported to them. Such cases should be followed up in order to obtain more complete examinations and determination of their clinical status. When segregation or treatment, or both, are required, these facilities should be provided, and the household contacts, especially of open cases, should be examined and appropriately dealt with.

The committee has been advised of the failure of the physicians of a number of Selective Service boards and of the medical officers serving the induction boards in certain Corps Areas to report cases of tuberculosis among rejected men. In the former case, this failure appears to result from non-observance of Section 614 of the Selective Service Regulations; in the latter, to depend upon the decision of the Corps Area Surgeon. The committee recommends that the Surgeon General of the United States Public Health Service take such steps as may be proper (1) to obtain observance of Section 614 of the Selective Service Regulations by all Selective Service boards and (2) through the liaison officers of the Public Health Service, to obtain the consent of Corps Area surgeons and, if possible, their active support, for the prompt and complete reporting of tuberculosis by induction boards to the appropriate State departments of health.

The committee has noted the existing shortage of qualified nurses and a probable inadequacy of hospital facilities. It believes that the deficiencies in both categories are likely to increase rather than diminish. It follows, therefore, that existing resources should be utilized in the most efficient manner possible. Many hospital beds could be made available for cases needing this type of care if a sufficiency of home nursing care were provided. Home nursing care on a visiting nursing basis should not only greatly enhance the value of the individual nurse to the community, but should distribute nursing service more nearly according to the patients' needs. In the opinion of the committee, bedside nursing care is a proper function of a generalized public health nursing service. It should not replace the services usually rendered by public health nurses, but should supplement them. Where a visiting bedside nursing service does not exist, every effort should be made to establish such a service, preferably within an existing official public

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health agency. Furthermore, the programs of all agencies--public and private--employing public health nurses should be coordinated in order to provide against duplications in nursing service and to utilize most effectively every public health nurse employed. The tendency should be toward consolidation rather than toward the establishment of new organizations to meet recognized needs--toward a pooling of resources rather than a wasteful competition for community support.

The committee realizes that the more vulnerable parts of our country may be subject to enemy attack. The resulting mortality and degree of disability may be materially lessened by prior planning and organization of medical services to deal with such emergencies. The committee believes that it is a proper function of State and local health authorities to assist in the establishment and operation of such services.

The committee has been concerned with the great demand for certifications of births resulting from the requirements of war industries and governmental agencies. A continuance of the delays now prevalent in the issuance of such certificates cannot but bring discredit on State health departments, and, therefore, it behooves every registration office to increase its efficiency and, where funds are available, to increase the personnel devoted to this task. The committee is strongly opposed to any federalization of the registration of vital statistics. It believes, on the other hand, that since Federal agencies are in a large degree responsible for the increased burden, the Federal Government should grant financial aid to the States, through the Public Health Service, in order that they may meet adequately this obligation.

The committee has been advised of the increasing frequency of outbreaks of so-called Vincent's infection in the civil population of Great Britain. While not recommending that individual cases of this infection be reported to health authorities, it is the opinion of the committee that outbreaks of this disease should be so reported, and that when such reports are received they should be forwarded to the Public Health Service.

The committee also feels that more emphasis should be placed by State health departments on dental care, and on fostering the expansion of facilities for rendering it.

The committee considers that State agencies charged with the duty of promoting industrial hygiene should extend their efforts in accordance with the existing and expanding needs, and that they should be closely integrated with other divisions in the health department in order that the health of workers may be maintained at the highest level of efficiency and not suffer from diseases or disabilities acquired either on or off their jobs.

The committee has noted the work of the Public Health Service in directly operating malaria control activities in certain areas of the country, and the necessity entailed by this work of entering private property and instituting control measures, a right usually exercised by State and local health authorities. It recommends that State health departments cooperate with the Public Health Service and assume such responsibilities--fiscal, administrative, and legal--as may be necessary to prosecute this work successfully.

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It has also noted the difficulties in certain areas of operating the community programs for the construction of privies, small septic tanks, and improvements of individual water supplies, which were formerly carried out through WPA projects. The committee recommends that the Public Health Service seek a Federal appropriation for the execution of this type of work. If the Service should be successful in obtaining such an appropriation, the committee believes that State and local health departments should render such assistance as may be essential.

The committee approves the recruitment program of the Public Health Service by means of which urgently needed personnel have been loaned to State departments of health, and it desires to commend the Public Health Service for its efforts to meet the added problems created in areas of industrial expansion and military mobilization. We recommend that the United States Public Health Service be encouraged to expand this program of induction, training, and assignment. In order that this program may be readily expanded, the committee recommends that State and local health departments should, wherever possible, transfer such personnel temporarily or permanently to their own staffs.

I move the adoption of the report and the recommendations of the committee.

. . . The motion was seconded . . .

CHAIRMAN PARRAN: Is there discussion?

DR. OSBORN: In the preamble to this committee's report it seemed to some of us that perhaps there is an opportunity to go all-out on the health education phase of the work which at the present time would be readily accepted by the public and by the press, and which would be consistent with part of the President's proclamation in regard to people putting themselves in as good physical condition as they can. The substance is in the report, but I think it might be well to give some details which laymen, physicians, health officers and anybody else interested in health could profitably utilize.

Doctors are going into the service, as mentioned by Colonel Seeley this morning. I have forgotten the exact number but I think it was something like 40,000.

CHAIRMAN PARRAN: Thirty-two thousand by the end of this year.

DR. OSBORN: That is at least 20 percent of the physicians in the country. By the end of next year the percentage will be higher, and people who are sick will not be able to get physicians to attend them. If the public health organizations of the country can do anything to help people to get themselves into good physical condition now so they won't have to call physicians in the future, then we should act. We can tell them simple things. We can tell them that they should have a physical examination now; we can tell them that they should follow up certain findings; we can suggest to the physicians of the country and to the medical societies that they foster such a program; we can tell the doctors and the medical societies and the people and the health officers that they should take this opportunity now to urge that physical examinations be done while there are still physicians to do them.

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We can suggest that, in addition to the physical examinations, now is the time to carry out immunization procedures against many diseases such as typhoid fever, tetanus, scarlet fever, Rocky Mountain spotted fever, and smallpox, as recommended by physicians or as sponsored by the physicians of local medical societies. We should suggest that this is something which the medical societies might consider in their programs for their local communities.

I think the first part of the committee report might contain a few details which could be utilized, because we are so busy with everything that unless we do put details in where they can be readily seen they will be lost in the generalizations on the medical program. It is absolutely essential, as I see it, because the sick people who need doctors in 1943 will not be able to get the service that they can get today.

CHAIRMAN PARRAN: Does Dr. Godfrey wish to comment on the suggestion?

DR. GODFREY: I attempted to make the report brief. I supposed that since this was an informed body to which the implications of the recommendations would be apparent, and I assumed that the details based on the implications might well come in some other form than in the committee's report.

I am in thorough agreement with Dr. Osborn. It was one of the recommendations that such measures be taken up by local health departments, and that they be carried before their medical and dental societies and nurses' associations. I doubt whether the details properly belong in this report.

DR. McCLINTIC: There is another phase of this subject concerning which I think Dr. Osborn's remarks are pertinent. Something may have materialized about which we haven't heard over our mountains, but a number of young men are being rejected by the Selective Service boards for minor physical ailments and defects. It seems to me that while we still have the medical personnel in the field, in the communities, some steps should be taken to see to it that those who have remedial conditions are taken care of now.

One of the liaison officers of the Fifth Corps Area proposed that the Medical Corps send a group of physicians into the State to examine the rejectees and then recommend that they go to a hospital or back home to their physicians and, at their own expense, take treatment over a long period of time, in some instances, and be rehabilitated. It occurs to me if such persons can have minor defects corrected in this way so that they will be fit for military service, there should be some Federal aid available to them to insure that they get the necessary care.

Another point which I think is certainly in line with Dr. Osborn's suggestion is this: All of the youngsters in the junior and senior classes of the high schools of the United States should have a physical examination now so that they may get proper medical attention while we still have doctors available. Before this war is over, no doubt all of these boys who are physically fit will be in the armed forces of the United States. It seems to me that is another problem to which the public health organizations of the various States could direct their efforts. We have already made a beginning in this direction in our State.

DR. OSBORN: Mr. Chairman, I move that the following amendment be added to the committee report in a suitable section to be selected by the committee: In

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view of the impending decrease of physicians available to the civilian population because of the war activity, it is recommended that the people of the country have brought to their attention the important points with regard to their physical welfare. It is urged that the people insofar as they are able call physicians as promptly as possible for illnesses which they may now have; that all who are able should secure a physical examination in an effort to detect any unknown illness which they may have; and that immunization procedures be taken against diseases such as typhoid fever, scarlet fever, diphtheria, whooping cough, tetanus, Rocky Mountain spotted fever, smallpox, and others, as recommended by family physicians, in order that the population of the country may be in as healthy a condition as possible.

. . . The motion was seconded by Dr. Bierring . . .

DR. GODFREY: Mr. Chairman, I think this is implied in the report. I can't help but believe that adding a good many words might even limit the interpretation of what is recommended. The report says: "It behooves the public to ascertain their present condition of health and to seek correction for any existing defects while these services are still to be had." I don't think the recommendation should be limited to any particular group in the community unless it be those who are under sixty-five, or something of that kind. When we say, "It is incumbent upon the medical, dental, and nursing professions to think more intensively of the preventive aspects of their professions and to advise their patients more frequently and more carefully of the means by which their health may be maintained," that certainly includes immunization and all of these other measures. I can't see the need of burdening this report with verbiage.

CHAIRMAN PARRAN: Dr. Godfrey has moved that the amendment be tabled.

DR. McCORMACK: That will take the report with it.

CHAIRMAN PARRAN: The chair defers to the parliamentarian.

. . . The question was called for . . .

CHAIRMAN PARRAN: The vote is called for on the amendment. An affirmative vote will mean support of the amendment.

DR. McCORMACK: I would support Dr. Godfrey's amendment that sixty-five years be put in there, but if he is not going to take care of anybody over sixty-five I am in favor of Dr. Osborn's proposal.

DR. GODFREY: That isn't in the report.

CHAIRMAN PARRAN: The vote is called for on the amendment. Those in favor of the amendment will please say "aye"; those opposed "no." The "noes" have it. The question is called for on the adoption of the report. Those in favor will please say "aye"; those opposed "no." It is carried.

The last report will be by Dr. Riley, the Committee on Venereal Disease Control.

. . . Dr. J. W. Mountin took the Chair . . .

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DR. ROBERT H. RILEY (Maryland): I would like to give you the names of the other members of the committee. They were all present, and all supported this report: Drs. Cross, Chesley, Markwith, Cook, Mahaffey, McLaughlin, Underwood, Reynolds, Brown.

After the motion has been made and seconded for adoption of this report, I should like to have Dr. Vonderlehr read a letter which has been sent out to the health officers from the Surgeon General on the question of quarantine hospitals for venereal diseases. Then I should like to ask General Ireland to read a letter which is on its way to the Governors from the Secretary of War. There will be a similar letter from Secretary Knox.

You all have copies of this report. I will first read the recommendations on "The Development of Additional Personnel for Venereal Disease Follow-Up Work."

"Since the beginning of the preparedness program there has been an increasing shortage of public health medical and nursing personnel available for venereal disease contact-tracing and case-holding. This shortage has now reached a point which makes it impossible for many venereal disease control programs to continue effectively. The thousands of selectees who are being found to have positive serologic blood tests for syphilis are not in many places being followed up in order to insure their adequate treatment. Furthermore, in very few places are the alleged contacts of such selectees infected with early syphilis and with gonorrhea being brought in for examination and treatment if necessary.

"The dearth of nurses makes it impossible to develop a sufficiently large public health nursing staff in most of the health departments of the country during the war to conduct adequate contact-tracing and case-holding work. The members of the Conference of the Public Health Service with the State and Territorial Health Officers therefore recommend that for the duration of the war such keen, industrious, and intelligent persons as may be available without technical training in public health be employed as follow-up workers in the venereal disease program under competent supervision. Experience has shown in a number of health departments that persons of this kind are capable of performing follow-up duties very effectively when properly instructed and supervised."

Mr. Chairman, these are separate sections. Would it be well to act on each one as we progress, or shall we wait until the end?

CHAIRMAN MOUNTIN: As you prefer.

DR. RILEY: I think probably it would be better to act on them individually.

CHAIRMAN MOUNTIN: The first item is before you for consideration.

DR. RILEY: I recommend its adoption.

. . . The motion was seconded by Dr. McClintic . . .

CHAIRMAN MOUNTIN: It is open for discussion.

DR. OSBORN: May I ask what type of "industrious and intelligent persons" would take up these cases in the place of trained people?

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DR. RILEY: We want a fairly high type of person, a fairly intelligent person. The committee did not set up any specifications.

DR. McCORMACK: We have found two classes of persons available who, after training, have been satisfactory. One is school teachers, who have had the opportunity for contact and who can learn easily. Secondly, some of our best follow-up workers have come from a group of people recently unemployed, the tire salesmen. They catch on quickly. You would be surprised how well they do the work and how interested they are in it.

CHAIRMAN MOUNTIN: Is there further discussion?

. . . The question was called for and the motion was carried . . .

DR. RILEY: The second section of the report is entitled, "Utilization of Public Health Personnel in Venereal Disease Control War Program."

"In view of the difficulty in many areas of obtaining qualified personnel for duty in connection with the control of the venereal diseases, the Surgeon General of the Public Health Service is requested to continue for the duration of the war the policy of employing medical and other personnel to serve on a loan basis with State and local health departments in their venereal disease control programs. This system makes it possible to meet more promptly and effectively the emergency personnel needs of State and local health departments."

I move the adoption of this section.

DR. McCORMACK: I second it.

CHAIRMAN MOUNTIN: Section two of the report is open for discussion.

. . . The question was called for and the motion was put to a vote and carried . . .

DR. RILEY: Section three of the report is entitled, "Endorsement of Advisory Committee Report on Recommendations for a Venereal Disease Control Program in State and Local Health Departments."

"The members of the Conference of the U. S. Public Health Service with the State and Territorial Health Officers approve the 'Recommendations for a Venereal Disease Control Program in State and Local Health Departments' made by the Advisory Committee to the Public Health Service and published in the Journal of the American Medical Association, June 7, 1941, Vol. 116, pp. 2585-2589. The measures described in this Advisory Committee report will insure in the light of the present knowledge the development of an optimum venereal disease control program and all State and local health departments should include these measures in their venereal disease control plans.

"The empiric chemotherapeutic scheme for the control of gonorrhea, referred to in paragraph 3, page 5, of the Advisory Committee Report is published in an article entitled, "Management of Gonorrhea in General Practice" by the Executive Committee of the American Neisserian Medical Society in the March 1942 issue of Venereal Disease Information, Volume 23, page 88."

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I move the adoption of this section of the report.

DR. McCORMACK: I second the motion.

CHAIRMAN MOUNTIN: Section three is before you for consideration. Is there any discussion?

. . . The question was called for and the motion was put to a vote and carried . . .

DR. RILEY: Section four of the report is entitled "Responsibility of State and Local Health Departments in Maintenance of Matching Credits for Venereal Disease Control Work."

"Recognition is given to the policy adopted by the Surgeon General of the Public Health Service which does not require that State or local funds be made available as matching credits to obtain that part of the Venereal Disease Control Act allotment which is made for war needs. Your committee has been informed that this policy was adopted because of a desire to insure the rapid and prompt strengthening of the venereal disease control programs wherever necessary in the respective States without unnecessary restrictions under present war conditions.

"Many millions of dollars are being expended for services related to the war effort. State and local governments profit materially by such expenditures. Your committee therefore recommends that the State health officer do everything possible to develop matching credits for venereal disease control funds within his State even though such matching credits be not required on so high a level at the present time as before the war. This action is desirable because continuing State and local support of venereal disease control work is the most effective method of insuring the maintenance of an adequate program for the control of the venereal disease after the war."

I move the adoption of this section of the report.

DR. McCLINTIC: I second it.

CHAIRMAN MOUNTIN: Section four is before you for consideration. The question is called for. Those in favor say "aye." Opposed, "no." Section four is carried.

DR. RILEY: Section five of the report is entitled, "Procedure for Rules and Regulations of the Surgeon General Governing Allotments and Payments to the States for the Fiscal Year 1943."

"Recognition is given to policies established in the past with respect to procedures followed in the Rules and Regulations Governing Allotments and Payments for Funds Provided under the Venereal Disease Control Act. The members of the Conference of the Public Health Service with the State and Territorial Health Officers recommend that the procedures previously set forth be continued in the fiscal year 1943, with the following exceptions:

"1. That certain simplifications be introduced which will make these rules and regulations of a more general character and will permit them to stand unchanged from year to year.

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"2. That the plan of payment to States be changed to read, "Prior to the beginning of each quarter the State health officer shall submit an application for funds upon forms prescribed by the Public Health Service. The Surgeon General may certify quarterly to the Secretary of the Treasury for payment to the States an amount which, together with any balance on hand in the State, shall be equal to but not in excess of 35 percent of the annual allotment, provided that the total payments shall not exceed the total annual allotment." Moreover, the Surgeon General reserves the right to withhold all payments from a State which fails to maintain a standard commensurate with the problem and the available resources.

"3. That recognition is given to the existence of war needs with respect to venereal disease control and that in view of these war needs, after consultation with the State health officers, changes may be made in the basis of allotments, depending on the amounts appropriated for this purpose by the Congress.

"Your committee has been informed that the proportion of Federal allotments required to be matched probably will be considerably less, although the sums required to be matched by the various States will in many cases be in excess of the requirements for previous years."

I move the adoption of this section of the report.

DR. UNDERWOOD: I second it.

CHAIRMAN MOUNTIN: Section five is before you for consideration. Is there any discussion? The question is called for. Those in favor say "aye;" Opposed, "no." Section five is carried.

DR. RILEY: Section six of the report is entitled, "Need for Rehabilitation and Protection of Women and Girls Engaged in or Endangered by Prostitution."

"Since the working out of the Agreement between the War and Navy Departments, the Federal Security Agency, and State health authorities, which was adopted by this Conference in May 1940, experience has shown the need for and value of activities of the Division of Social Protection which has been set up by the Office of Defense Health and Welfare Services; and, since this Division of Social Protection includes aid and cooperation with the States in rehabilitation and protection of women and girls engaged in or being endangered by prostitution:

"The Conference commends such supplemental activities and urges their expansion by the appropriate Federal, State, and local official and voluntary agencies, particularly in all military, naval, and industrial areas concerned with the war activities."

I move the adoption of this section of the report.

. . . The motion was seconded by Dr. McKay . . .

CHAIRMAN MOUNTIN: Section six is before you for consideration.

DR. McCORMACK: I would like to ask Dr. Vonderlehr to explain to us the work of the Division of Social Protection. We have heard a good many questions asked about it.

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DR. R. A. VONDERLEHR: The Division of Social Protection was established about a year ago in the Office of Defense Health and Welfare Services. It is a welfare section in the Federal Government which is interested in the repression of prostitution and the rehabilitation of prostitutes. This section of the repor simply asks that the functions of the division be expanded and correlated with th State and local welfare agencies which are interested in this particular phase of prostitution repression work.

CHAIRMAN MOUNTIN: Is there any further discussion? The question is calle for. Those in favor say "aye"; those opposed "no." Section six is adopted.

Before calling for a vote on the report as a whole, I believe we have two communications, one from General Ireland and another from Dr. Vonderlehr.

DR. RILEY: Dr. Vonderlehr.

DR. R. A. VONDERLEHR: This is a letter from the Surgeon General which eac of you will receive when you return to your health departments. We wanted to get it out before you came, but Dr. Parran mentioned it in his opening address yesterday morning, and I wanted to read it, so that if you wish to raise questions about it you may do so now or privately in my office tomorrow or the next day.

"State Health Officers' Circular Letter No. 66 tells how, under the Community Facilities Act, Venereal Disease Quarantine Hospitals can be provided. Response from the various States indicates a need for additional information.

"Funds for the provision of Quarantine Hospitals may be requested for either of two types of development: (1) The construction of permanent facilities; and (2) the use of existing facilities to serve on a temporary basis.

"Permanent Construction. Where hospital facilities are inadequate to care for venereal disease patients in addition to others needing hospital care, funds may be requested for the construction of a new unit or for adding to an existing unit. Only where the latter course is impossible should a new self-contained unit be considered. It is recommended, however, that except under unusual circumstances no more than one such permanent structure be approved for each State, and that it shall operate on a State-wide basis, accepting patients from all parts of the State as directed by the State Health Department.

"Temporary Basis. Since labor and building material shortages may make permanent construction impossible or difficult, and since many communities will need venereal disease hospital facilities within their environs, it will doubtless be found expeditious to rent or to lease suitable structures in communities throughout the State and to convert them into temporary hospitals. In addition to space for beds, treatment, kitchen and laundry facilities, the building should be structurally safe.

"The Community Facilities Act makes the necessary funds available. Any State Health Department may apply for them. It has merely to direct to the Regional Engineer of the Federal Works Agency a simple statement outlining need, method of meeting the problem, and approximate cost of the undertaking, including operation and maintenance. This constitutes a preliminary application. If it is approved, the applicant is supplied with official application forms to be filled out and submitted to the Regional Engineer of the Federal Works Agency. Final

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approval from the Federal Works Agency, through which the funds are made av... the White House, the Federal Security Agency, and the U. S. Public Health Serv... frees the funds requested for the hospital.

"In most localities where there are concentrations of soldiers, sailors or marines, the Quarantine Hospital represents an indispensable link in the venereal disease control program. It is urged that State Health Officers investigate appropriate facilities in such localities at once and take such action as the facts seem to warrant."

DR. BIERRING: What funds are available?

DR. VONDERLEHR: Any of the Community Facilities Act funds for which we may get applications and obligate before they are obligated for some other purpose.

DR. McCORMACK: Aren't they exhausted now?

DR. VONDERLEHR: I don't think they are quite exhausted.

CHAIRMAN MOUNTIN: No, not the last appropriation.

DR. WILLIAM M. McKAY (Utah): I wish Dr. Vonderlehr would tell us about the provisions for dental care for these people.

DR. VONDERLEHR: Since the beginning of the venereal disease control program we have realized the existence of a need for the provision of dental care for patients who are under treatment for syphilis. Such care should be more or less preventive in character so as to maintain the oral cavity of the patients in reasonably good condition and permit the continuation of treatment until it is completed. Of course, we do not contemplate any complete oral hygiene program in this connection, but merely the provision of such dental service as may be required to keep the mouths of clinic patients in such condition that treatment may be continued without developing untoward reactions due especially to mercury and to bismuth.

DR. McCLINTIC: Does that bar fillings and plates?

DR. VONDERLEHR: That ordinarily would bar fillings and any extensive work.

CHAIRMAN MOUNTIN: General Ireland. (Applause)

MAJOR GENERAL MERRITT W. IRELAND: I have been very eager, Mr. Chairman, that this letter should be brought to the attention of this powerful organization meeting here in Washington. I did not expect to appear here. This is a letter from the Secretary of War to the Governors of the States. It has been in the mill for some time and there have been delays and delays. I have a similar letter from the Secretary of the Navy to all Governors in the States in which the Navy has an active interest.

This went out yesterday to all Governors of States, so you will find it in your headquarters when you return to your duties.

"Dear Governor ----------:

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"I am addressing you and the governors of all other States to call your attention to the serious dangers to the success of our war effort which will result unless prompt and effective measures are taken to suppress venereal disease.

"My concern arises because I am charged with primary responsibility for military efficiency; because I must rely upon industry and industrial workers to supply our munitions, tanks, airplanes, and other equipment to a greater degree than in any prior war; and because I am responsible to the parents of the splendid young men in our Army for seeing to it that they are not surrounded by vicious and demoralizing environment.

"I hardly need remind you that among these healthy young men of our Army, venereal disease produces more disability than any other single cause, and that among industrial workers it is one of the most serious causes of disability and inefficiency, especially in the boom towns of war industry. Furthermore, it has been demonstrated beyond question by any intelligent person that vice resorts are centers for the rapid spread of these epidemic infections because three out four of their inmates are themselves infected. Equally serious dangers arise because these vice resorts may well be employed as agencies of subversive and disloyal elements in our midst. These dangers can be destroyed by adequate health programs, by intelligent police work, and by vigorous educational campaigns.

"Specifically, I request you to assume responsibility for stimulating adequate State and local law enforcement not only in cities but in rural areas, using the State police if they exist and have jurisdiction. This means closing segregated districts and ending the farce of periodic examinations of prostitutes, as well as intelligent police follow-up that keeps out the profiteers on vice.

"I further request you to stimulate the State and local health programs for control of venereal disease, and to organize or give support to a vigorous program of public education.

"Several governors to whom similar special requests already have been made have found it possible to render outstanding services.

"A copy of this letter is being sent to the Corps Area Commanders who will be directed to bring this urgent matter to the attention of municipal authorities within their areas. Local commanding officers, medical officers, and military police will be instructed to assist local officers in all their business with which military personnel are concerned.

"The following major army post is located within your State: _____, besides other military establishments of varying magnitude, all of which are contributing to our war effort. _____ is the commanding general of the Corps Area of which your State is a part. I am instructing him to communicate with you on this subject.

"In giving this program leadership within your State you will be discharging a responsibility of the war effort for which the United States Government will be deeply grateful.

"Sincerely yours,

"Secretary of War."

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There is attached a copy of the letter which he sends to the commanding general in every State.

It has been proven on several occasions since our mobilization started that this program can be put over. It was proven in San Francisco, one of the worst cities, as I understand, in times gone by. Now, in watching the Army reports from San Francisco, I find that the venereal disease rates are among the lowest in the United States.

The Commissioner of Police in San Antonio, an old patient and friend of mine, got busy one morning and directed the closing of houses of prostitution in San Antonio; they were closed that night and the people moved to other towns. The people of the county in which San Antonio is located closed the houses of prostitution. But of course that is all local.

You will have all the support you need from the American Social Hygiene Association, from the women's organizations, from the Federation of Churches. My understanding is that the Federation of Churches is a Protestant organization and that there is a similar organization among the Jewish people and the Catholics. You will have the support of all of those.

I urge that your health officers give this program their earnest support. It is the greatest opportunity that any country has ever had to put on a campaign against this prostitution racket and it will be successful if everybody will lend a hand . . . (Applause)

DR. McCORMACK: Mr. Chairman, I would like to move, sir, that we receive with great gratitude this evidence of support from the Surgeons General of the Army and Navy in the campaign that we are conducting against venereal disease, and that the Surgeon General of the Public Health Service express to them our gratification at an opportunity to be able to assist our armed forces in a campaign in which we are all vitally interested and in which we are determined to succeed.

CHAIRMAN MOUNTIN: I assume that it is the general attitude of the Conference, and it is so ordered.

DR. GODFREY: I am not sure that two matters have been called to the attention of the conference. One is a letter recently written by Governor Lehman to all of the law enforcement officers of New York State, the mayors of the cities, the sheriffs, the prosecuting attorneys, and the chairmen of the boards of supervisors of the counties, calling their attention to the necessity for the suppression of vice and indicating that he intended following it up and seeing that they did enforce the existing laws.

If you do not have that letter, Dr. Vonderlehr, I think it might be of value to send it to you. Possibly you might make mention of it in Venereal Disease Information.

Another item of interest is that recently the Council of the Medical Society of the State of New York has declared that the examination of prostitutes for the purpose of issuing certificates of freedom from venereal disease is an unethical practice--that in substance is the wording of the resolution--and is to

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be condemned. Of course, if members are convicted of this practice they lose their right to membership in the association. I think this is an example which might well be emulated by other societies.

CHAIRMAN MOUNTIN: Dr. Vonderlehr, have you any remarks to make on the general subject?

DR. VONDERLEHR: I don't believe anybody has brought to the attention of the members of the Conference the venereal disease control work which the Army Medical Corps is organizing. Since December 7 the Army Medical Corps has organ a Division of Venereal Disease Control, headed by Dr. E. B. Turner, who has bee given a commission in the grade of Lieutenant Colonel, and Dr. Turner is doing splendid job. Some of you have heard from him, I know, because he has taken yo venereal disease control officers. He is appointing venereal disease control officers for each of the nine Army Corps Areas and we expect in the future that the venereal disease control officers in the Army will be in touch with you as well as with your own liaison officers who have been serving in the Corps Areas for the last year or so.

The program of the Army also contemplates the assignment of venereal disease control officers to all commands in which the strength is 20,000 men or more. I think we will notice very material progress; we certainly hope so.

DR. WILLIAMS: I would like to ask the privilege of the floor for Dr. Ireland.

CHAIRMAN MOUNTIN: That is assumed.

GENERAL IRELAND: I have received a letter from the Governor of New York--a remarkable letter. But I want to call your attention to the fact that he is the Governor of one State only. This is an effort to get the Governor of every State to put on a campaign against this prostitution racket, and I think that is the only way it can be carried on. We must have the support of the entire legal and police force of every State to put it over in a successful way.

CHAIRMAN MOUNTIN: We have not yet acted on the report as a whole. It was the suggestion of the chairman of the committee that we have the discussion on these communications first. If there is no other item to come up with respect to venereal disease, we will vote on the report.

DR. RILEY: I move the adoption of the report as a whole.

. . . The motion was seconded by Dr. Moyer . . .

CHAIRMAN MOUNTIN: The report as a whole is now before you. Those in favor say "aye." Opposed? The report is adopted.

I presume that it is in order that we express our appreciation to the District Medical Society for the use of its facilities.

DR. McCORMACK: I move the Chairman be authorized to phrase such a resolution and send it to them in the name of the Surgeon General.

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. . . The motion was seconded by Dr. Underwood and unanimously carried . . .

CHAIRMAN MOUNTIN: That, I believe, brings all of the matters on the agenda to completion. Is there some particular item which any one wishes to bring up?

DR. RIGGIN: I would like to make a motion that the State health officers thank Dr. Parran for calling this Conference. It has been a most successful one.

. . . The motion was seconded by Drs. Underwood and Moyer and carried unanimously . . .

CHAIRMAN MOUNTIN: Dr. Parran, will you come forward and close the conference?

DR. PARRAN: After the several days of discussion, I think any added words from me would be out of place. I would only express to Dr. Riggin and all of you my appreciation for the kind expression that has just been given. I know how busy all of you are. I know the many tasks that confront you. I know that with the rapid growth of the interests of the Public Health Service, and with the large number of people we are sending into the field, many problems and many difficulties may arise. I hope that you will be free in bringing those difficulties to my attention.

I may say to the Chairman of the Committee on Federal-States Relations, Dr. McCormack, that I have been informed of the discussions which occurred at his committee meeting yesterday afternoon and which I assume also were the subject of discussion at the meeting of the State and Territorial Health Officers, and that the Public Health Service will seek in every way possible to simplify its administrative field contacts in order to make that phase of our work as well as others even more efficient.

I thank all of you for coming here and participating so generously in the proceedings of this conference.

The conference is adjourned.

. . . The conference adjourned at 4:20 p. m. . .

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