California's Health

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HEALTH OF MIGRANTS*

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Before beginning my discussion, please let me say that I am a plain pediatrician. Indeed, a plain pediatrician with formal training almost exclusively in the care of children with rare and exotic diseases. In addition, that training was obtained at a time when the public health curricula in medical schools were geared more to privy construction and slaughter house tours than to the health areas now challenging our attention. Eight years of private practice at the Palo Alto Medical Clinic with physicians like Russel Lee, first opened my eyes to real public health needs. In the last year and a half, I have incurred a great debt to members of the State Health Department staff, such leaders as Dr. Matthis of Imperial County, Dr. Roswell Hull of San Benito County, and many others for their patience and their teaching. All have been most helpful in at least partially overcoming my naivete concerning priorities in major health needs in the United States today. Perhaps my admitted ignorance of major medical needs of even the area in which I practiced, is significantly representative of a general lag in the public's knowledge and in medical practitioner's knowledge of many important community health conditions. An example of such a community health problem is the acute need for migrant agricultural workers health services.

Failure in Medical Care

Our failure to meet the challenge of the striking health problems of migrants and their families is a failure in community medical care. The failure is not of any one group, the growers, the private medical practitioners, the public health and welfare departments, the county hospital staffs or the county, state or federal governments. The responsibility now does not rest with one of these groups but with all. Nor is the challenge the same as it was twenty or even ten years ago. Today, in contrast with times past, we have detailed documentation of need and of the special considerations required in the provision of medical care to migrant families. Further, we have demonstrations of types of programs that have worked. Perhaps the critical unanswered question at all levels concerns the willingness of all of us working in the health field to abandon our timidity and relinquish our strangle hold on the orthodox methods as the only possible ones we can use in providing medical care. We cling to the orthodox approaches despite their demonstrated failure to assist the migrants with their particular health problems.

U.S. Migratory Workers

Let us focus our attention on the seven hundred and fifty thousand migratory workers and the members of their families who are United States citizens. In numbers this group is greater than the total 1950 population of any one of seven whole states, and approximates the population of any one of six other entire states. In 1957 it was estimated that out of the three thousand and sixty-eight counties in the United States only eight hundred had as many as one hundred domestic migrant workers and family dependents at the peak season. About seventy-five counties had more than three thousand, and only twenty-two had more than ten thousand at the peak season which lasted from a few weeks to several months. (1) Seven of these twenty-two counties are in California. (2) The responsibility of communities to provide *not special* but *equal services* for this group as for other U.S. citizens is as clear as is the fact that we're failing to meet this responsibility. (3)

These three-quarter million citizens are difficult to identify. They seldom work under contract. They often present social problems as serious as health problems to communities. In the total group are an estimated one hundred thousand children under fourteen years of age. Among them are Mexican, Negro, Indian, Oriental, Filipino and American White families. They stay in the stream of migrant agricultural work for an average of two to four years. The families are large, averaging five to seven persons. Their annual earnings are low, due in part to the highly seasonal nature, as well as to the short duration of their work. A national survey in 1957 showed an average cash income of $1,160 for male migratory farm workers from both farm and non-farm sources. Ninety percent averaged only 101 days of work per year. Most family annual incomes, even when several members of the family work, was not more than $2,000.

The educational median of all ages is estimated at between four and five years of schooling. Travel facilities,

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housing, general living conditions, sanitation, nutrition, and medical care have been shown by repeated studies to have been in the past and are today strikingly sub-standard. The statement was made at a recent American Medical Association Conference on Rural Health ". . . health conditions of the migrant workers represent the major scandal in health in the United States". Diarrheal diseases, accidents, tuberculosis, venereal disease, and even nutritional deficiency diseases, have high relative rates among this group. Few are immunized. The Colorado studies reported on "Migrant Labor Health Project of the Lower Snake River Valley" in 1957 showed that less than fifty percent of the migrants had had smallpox vaccinations, and it was estimated that only twenty percent had been immunized against diphtheria and tetanus.

Residence laws in California and other states bar these people from welfare department assistance and prevent the provision of out-patient medical care by county hospitals for the great majority of these people. Distance from private practitioners offices, the sheer weight of numbers at peak season, and poverty, stand in the way of real "availability" to these people of private medical services. Few child labor or minimum wage laws apply to this group.

It is undeniable that these workers, together with the some half-million foreign "nationals" make an important contribution to our national economy. In certain communities the agricultural economy is now dependent on them and will continue to be. In California at least, the changes brought about by rapid agricultural mechanization with increased productivity, has been counterbalanced by increased demand for the products with the explosion in population growth. No decrease in demand for seasonal farm hand work is foreseen by agricultural economists in California in the immediate future.

Lack of Action on Problem

What are some of the basic reasons that the majority of the recommendations of numerous local, state, and national studies (4) and reports by countless conferences and committees of public and private agencies, all in general agreement on the seriousness of the problem, have not resulted in action and been converted into improved health services for these people?

1. We must first grant, and in no way underestimate, the difficulties presented by the economic, social, cultural, and educational characteristics, in addition to the geographical isolation and mobility, of these families. Their cultural and educational levels do not lead them to *seek* care; their isolation and fluctuating numbers make impossible the provision of essential health services by orthodox means by either private medicine or by orthodox patterns as employed by public health departments or county hospitals.

Just as it would be unwise to underestimate the difficulties; so does it appear unwise to overemphasize them, and to fail to consider unorthodox patterns of approaching our clear responsibility. To paraphrase one of Dr. Tuuri's statements: Agricultural migrants and other mobile or isolated population groups have long frustrated health workers efforts to fit them into conventional . . . health programs. All too frequently the belief that any deviation from standard procedures would preclude an adequate response has led health workers to avoid or belittle attempts to initiate unorthodox procedures when conditions would not permit following the usual pattern. (5)

This statement is an accurate, applied definition of a syndrome too common among all of us in health work, both public and private. This syndrome is known as "cenatophobia" or "the mortal fear of anything new".

2. A second roadblock to a solution is the lack of public knowledge of the acute nature and commanding importance of this matter on the list of health problem priorities. There is a lack of knowledge concerning the real nature of the problem among medical practitioners in general, even in some communities where the situation is critical. It seems time for us to refocus the attention of the public and the professional health workers in particular in communities where the migrants work.

Our reluctance to discuss and broadcast our failure is as understandable as it is indefensible. It has been said that local residents in these communities may be at best indifferent and at worst, hostile, afraid that the migrant and his family represent a hazard to the health, morals, and property of the established community. To this I take exception. Rather, in my opinion, there is strong evidence that in many of these communities the local residents as well as many members of the county medical societies indeed *do not* know the facts concerning existing conditions, and what might practicably be done with available personnel and facilities. Granted, this would have to be done by an unorthodox approach. The question can be reasonably asked whether we in the health field have in our affected communities offered sufficiently aggressive leadership in the mobilization of public opinion to help the migrants.

3. A third major roadblock lies in the ease with which we can, if we let ourselves, pass the problem on to someone else, and not tackle it as it must be tackled, and that is as a community health problem.

Health Insurance for Migrants

It is easy for us to relax and say, for example, that health insurance is the only answer and will take care of the problem. Surely we here today all look forward to someday in the future when migrant families will be covered by some sort of adequate health insurance. Just as surely we cannot realistically expect insurance to take care of the acute need this summer, or indeed in the immediate future. Follmann's study on health insurance for the migratory worker, published in December of 1958 for the President's Interdepartmental Committee would appear to confirm this point. (6) The study sought the findings and policies of the one hundred and sixty-seven United States companies writing health insurance. Only seventeen of the one hundred and fifty companies replying had any coverage for even a few migratory workers. The conclusion was that "there are many underlying factors in the existence of the migratory worker which are social and economic as well as physical, which are in their nature beyond the proper sphere of private health insurance mechanisms". As a long term goal insurance, yes, but how soon do we actually believe the migrants can be reasonably covered? By whom will the insured services be provided except the community, even if the migrants have a policy in their pockets? What of our present responsibilities?

Community Responsibility

It is also easy for us to say that the health of the "nationals" is a problem for the Federal Government; or that only Washington can be expected to handle the inter-state migrants. True, but two-thirds of the group's 750,000 are intra-state United States citizens. These people have a problem which is our problem. We cannot expect the Federal agencies to do more for them than provide informational, consultative, and technical assistance; and to support us in doing what is our own communities' job.

We can also say that it is the state governments' responsibility. Indeed the state departments, such as health and welfare, and the state medical societies do have a stake in the responsibility for spear-heading efforts to repeal our antiquated and uneconomical residency laws and to urge enforcement of housing and child labor laws among agricultural labor. These state agencies have a clear responsibility also in supporting efforts at a local level to meet the problems of the migrants, as well as the larger group of mobile state residents they represent.

We can say all these other groups should do our job, but I wonder if we can any longer really believe it.

Fresno Community Action

In recent years isolated community studies and projects, such as those in Colorado in the lower Snake River Valley and in Fresno, have within a limited scope clearly demonstrated that when an effective "partnership between local medical societies, growers, county hospitals, public health and welfare departments, workers and citizens groups is established, conditions *can be* changed". These efforts require an unorthodox approach.

In Fresno, California some nine years ago community groups did get together and developed the West Valley Clinics, which operate in an isolated area where the migrants work and live, seventy-five miles from the city. (7) These clinics are conducted at night when the workers can come for help. They are conducted as outpatient clinics of the Fresno County Hospital with no residence requirements for eligibility. They are staffed by volunteer private practitioners from the Fresno County Medical Society and resident physicians from the County Hospital service. Nurses on loan from the public health department assist at the clinics and do follow-up as well as educational and preventive health work. The housing for the clinics is provided in most cases by growers who have consistently supported the effort. Other community groups have supplied key services. Most importantly the Fresno Clinics have had able leadership from such people as Mrs. I. H. Teilman and Mrs. Hubert Wyckoff. The Fresno Clinics have not completely solved the problem. They have however clearly demonstrated a practical approach for us to take in other communities. They have further demonstrated that conditions can be altered. In 1951, in the first three months only eighty-eight persons came in for medical services to the West Valley Clinics. Last year in the same three months, one thousand three hundred and thirty-three came. Last year there was a total of some six thousand visits to the clinics. Two hundred and fourteen out of the three hundred and thirty mothers followed for prenatal care came to the clinics before the sixth month of pregnancy. The success of the Fresno program is borne out not only by the detailed accumulated statistics, by the attitude of the growers, the enthusiasm of the dedicated physicians who staff them, but by the community pride in their real accomplishments. The county hospital chief in commenting on the major health needs of Fresno County not long ago remarked ". . . what we need in Fresno is more West Valley type clinics".

The total Fresno plan cannot be, or need not be, adopted in all affected communities. The program has however shown that a practical pattern which is adapted to meet local needs is workable. They have shown that coordinated community effort is possible. Indeed they are suggesting a way to meet an even broader health need, that of provision of health services for nonresidents in isolated rural areas. The Fresno Clinics operate within the "framework of existing programs rather than through intermittent special programs". They are built on community-wide interest and support. They have recognized cultural differences and been flexible. They are unorthodox.

Alan Gregg once said "Orthodoxy must pay a penalty, like a parking ticket, for staying too long in one place". I submit that these migrant agricultural workers and their children cannot afford to pay *our* parking ticket.

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New advances in medical science and technology are rapidly propelling the modern hospital toward a dramatic new role as a community health center.—Herman E. Hilleboe, M.D., N.Y. State Health Commissioner, *Health News,* Vol. 36, No. 12.

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Influenza Declines Throughout State

Influenza in California has been on the decline since mid-February, with no new outbreaks reported in several weeks. Consistent with this time of year, however, a certain amount of respiratory illness continues to be present in the population.

School absenteeism has been one of the most sensitive indicators this year and has well reflected the increased incidence of flu in the general population. Absenteeism data were received each week by the State Department of Public Health from eight influenza listening-posts, representing an average of 100,000 elementary and high school children throughout the state.

It appears that school absenteeism is now approaching the average or expected level of five to seven percent. The reports submitted so promptly to the Department by the participating local health departments have served as an invaluable index in measuring the impact of influenza upon a community on a current basis.

The marked decline continues in the number of pneumonia and influenza deaths recorded in the eight cities which each week report mortality data. The number of deaths reported by these cities still continues to be greater than the expected number based upon previous experience. While not all of these eight cities have shown the dramatically sharp increase which Los Angeles experienced, they all have reported more deaths during the first twelve weeks of this year than during the comparable period in 1959.

Berkeley and San Francisco reported small increases, while Long Beach, Los Angeles, Oakland, Pasadena, Sacramento and San Diego reported varying increases in deaths this year over the same period last year. The twelve-week total of deaths in these eight cities numbered 840, as compared to 372 for the comparable period in 1959, and 508 in 1958.

An analysis is currently underway of all deaths due to pneumonia and influenza which have occurred in California during January. However, since there is a lag between date of death and the availability of death certificates for such a study, the results are not ready at this time.

Because the recent wave of influenza apparently had its greatest impact on both illness and deaths in the Los Angeles area, some provisional mortality data have been obtained through the cooperation of the Los Angeles City and County Health Departments.

Of the 345 pneumonia and influenza deaths recorded in Los Angeles during the first six weeks of 1960, 264 were attributed to pneumonia and 81 to influenza. The deaths were evenly divided according to sex, with 175 males and 170 females. More than one-half of the deaths were in elderly persons over 70 years of age.

Gamma Globulin From Red Cross: Allocations Made

The California State Department of Public Health has allocated among local health departments the six-month free supply of gamma globulin provided by the American Red Cross.

California's share of gamma globulin for the first half of 1960 totals 14,820 2cc vials, of which 1,000 vials are being held as a state reserve in event of an emergency situation when additional supplies might be needed. The remainder is distributed on request to local health departments on a population ratio basis.

While no restrictions are made by the Red Cross on the medical uses of this gamma globulin, the State Department of Public Health, because of the relatively small amount available, recommends that it be reserved for the two most effective uses, the prevention or modification of measles and the prevention of infectious or viral hepatitis.

The Department particularly would discourage use of the gamma globulin supplied by the American Red Cross in pregnancy and for the prophylaxis of German measles and polio because of the controversial nature of the evidence of its effectiveness for these conditions and because of the large dose required for each person, which would rapidly deplete the limited supply. Too, there is an ample supply available on the commercial market for the physician who feels its use is warranted for these conditions.

The American Red Cross program of distribution of blood derivatives is dependent to a large extent on public support with money as well as blood donations.

Los Angeles County population is now greater than that of all but seven states.—*APCD Report*, March, 1960.

Tentative Program Announced for Western Branch Meeting in May

"The Application of Behavioral Sciences to Public Health Problems" will be the theme of the twenty-seventh annual meeting of Western Branch, American Public Health Association, to be held in Denver, Colorado, May 24th through 26th. The convention, which will include general sessions and section meetings, will be held in the Shirley-Savoy Hotel.

The tentative program calls for John A. Lichty, M.D., President, to open the first general session. Hugh Leavell, M.D., Dr. P.H., Professor of Public Health Practice at Harvard School of Public Health, will then give the opening address on "Where Do We Need Help?" Following this, Ed Wellin, Ph.D., Consultant in Behavioral Science, APHA staff will discuss "How Do We Get Help?"

Tuesday afternoon Ruth Howard, M.D., M.P.H., will report on the Migrant Labor Conference of Western Governors, and George Foster, Ph.D., Professor of Anthropology and Sociology, University of California, will speak on "Teamwork of Behavioral Sciences with Public Health". The afternoon session will close with brief reports of field studies which illustrate this kind of teamwork.

Wednesday will be devoted entirely to section meetings. Thursday morning the annual Western Branch business meeting will be held, followed by addresses on the "Physiological Basis of Human Behavior" by Frances Ilg, M.D., Director of the Gessell Institute of Child Development, and the "Psychological Basis of Human Behavior" by Andie Knutson, Ph.D., Lecturer in Public Health and Director, Behavioral Science Project, University of California. These presentations will be followed by a panel of section chairmen bringing crucial questions to the two speakers.

Edward Lee Russell, M.D., Health Officer, Orange County, California and President-Elect of Western Branch, will preside over the fourth and last general session, when Malcolm H. Merrill, M.D., California State Director of Public Health and President of the American Public Health Association will give the closing address on "Implications of Behavioral Sciences and Social Change for the Future of Public Health".

Preventive Medicine Planning A Factor in Olympics Success

The Eighth Winter Olympics have come and gone from Squaw Valley, and no significant outbreaks of disease occurred.

The California State Department of Public Health, in conjunction with the Division of Housing and local health departments in the Tahoe area, had engaged in planning for several months before the Games to meet medical, food sanitation or sanitary engineering emergencies which might occur. Fortunately, it was not necessary to implement any of the emergency plans.

While no analysis of the Games medical experience is yet available, some tentative comparisons are of interest. Approximately 3,000 persons were either ill or injured seriously enough to seek medical attention during February. Of this total, about 300 cases of respiratory infections were cared for in the aid stations and hospital in Squaw Valley. These infections were in the great majority of instances mild; a few required hospitalization in the area, and a very few were evacuated to hospitals in Reno or the larger cities of California.

No known spread of influenza occurred, although two U.S. contestants ill on arrival in the Valley were proved to be A-2 Asian influenza cases. No additional laboratory-proven cases occurred, and less than 10 were clinically suspected of being influenza.

A few gastro-intestinal diseases were treated in spite of the large crowds that taxed public eating facilities in the Valley and in the nearby resort areas. This is a tribute to the pre-Olympic educational and sanitary inspection campaign carried out by the local health departments serving the area, as well as by the Bureau of Public Health Contract Services and the Bureau of Sanitary Engineering of the State Department of Public Health.

The organization established for preventive medical services began operation the first of February and functioned continuously through March 1.

There was continuous liaison with the state health departments of Nevada and California, and the local health departments of Washoe County, Nevada, and of Nevada, El Dorado, and Placer Counties in this State. The mutual exchange of information on disease incidence between the Olympic Medical Director's office and these official agencies aided in evaluation of the need for additional personnel, supplies, or study for any Squaw Valley health problems.

Cooperation was complete between the official health agencies in the two states involved in the problems presented by a large mobile population subjected to winter hazards. The application of previously agreed-to methods of communication and action to be taken under certain specific circumstances avoided many controversial health recommendations that might otherwise have arisen, thereby reassuring the press and public that everything was supervised adequately.

A complete analysis of the disease and injury records will be the final stage of this medical effort. Such a report will be of extreme interest to public health, since there are few reports of public gatherings of this magnitude in winter in isolated areas. This information will be of considerable aid to public health planners and of interest in future winter sports gatherings in this country and elsewhere in the world.

Course Offered in Rehabilitation Applied to School Settings

San Francisco State College announces a special summer course for teachers of exceptional children, directors of special education, occupational therapists, and others concerned with special education, habilitation, and rehabilitation, on "Rehabilitation Principles Applied to School Settings."

The three-credit course will be held June 27 through August 5, 1960, and will include the practical application of current concepts of rehabilitation and habilitation, as well as some techniques of evaluation and training that facilitate adjustment in society.

For further information write or telephone Daniel Sinick, Ph.D., San Francisco State College, 1600 Holloway Avenue, San Francisco 27, California. Enrollment is limited.

In June 1959, 261,200 Californians were receiving Old Age Security with an average monthly grant of $78.20 for the 1958-59 fiscal year.—*Annual Report*, State Dept. of Social Welfare.

New Test for Syphilis Demonstrated

A new and simplified test which may weed out many of the suspected false positives for syphilis was demonstrated to personnel from 30 local health departments in a workshop sponsored recently by the Microbiology Laboratory of the State Department of Public Health.

Local laboratory staff were instructed in the technical performance and the clinical usefulness of the Reiter protein complement fixation test, with the hope it can supplant the expensive treponemal immobilization test, which is the currently accepted reference test.

The Reiter test is still in the advanced experimental stage and needs final evaluation as to sensitivity and specificity. The standard serologic test now in general use sometimes shows a positive reaction in patients who do not have syphilis. The Reiter test now being developed, would, it is hoped, rule out these false positives.

Noteworthy was the experience with this test presented by several local public health laboratories, which confirmed the experience of the state laboratory. Miss Alwilda Wallace of the U.S. Public Health Service, Venereal Disease Research Laboratory, assisted in the workshop and presented the experience of the USPHS with the test.

Because of its relative simplicity, the test may in the near future become a reference procedure at the local level.

Dr. Busby Dies

Dr. Lauren Fletcher Busby, 58, known for outstanding service in the field of tuberculosis control in Santa Barbara County, died in Santa Barbara January 30 following complications after major surgery.

Dr. Busby had been on the staff of the Santa Barbara County Health Department since 1945. He had been director of tuberculosis control for the department and had made a comprehensive 20-year report of that disease in Santa Barbara County.

He was also the health officer for the county in 1953-1954 and in 1954 became medical director of the crippled children's program as well as director of tuberculosis control.

Dr. Busby was a graduate of Johns Hopkins University and the University of Nebraska.

Seven Counties Redeclared Rabies Areas

Seven counties in California have been redeclared rabies areas after meetings of the Rabies Regional Advisory Committees held during February and March, and one county has been recommended for initial declaration. The redeclared counties are Calaveras, San Luis Obispo, Alameda, Contra Costa, Marin, Sacramento, and Tehama. This brings to 36 the total number of counties in the State currently under declaration as rabies areas.

San Diego is the county whose Rabies Regional Advisory Committee has recommended that it be declared a rabies area since a coyote there was found to be rabid and also because of its proximity to numerous confirmed cases of rabies in adjoining Imperial County and Baja California.

By California law and under regulations of the State Board of Public Health based on the law, when a county has been declared a rabies area the declaration lasts for a twelve-month period and covers the entire county including the incorporated cities. Each quarter during the year each local governing body reports to the State Department of Public Health through the local health officer on the status of their compliance with the measures required for dog and rabies control in an officially declared rabies area.

MEETINGS SCHEDULED

April 10-14—Western Regional Conference on Migratory Labor, Phoenix, Ariz.

April 24-27—Calif. State Dental Assn., Annual Meeting, San Francisco

May 1-4—Calif. Assn. for Health and Welfare, Annual Meeting, Berkeley

May 4-6—Calif. Congress of Parents and Teachers, Annual Meeting, San Francisco

May 5—Northern Calif. Public Health Assn., Annual Meeting, Castlewood Country Club, Alameda County

May 6-8—Student American Medical Assn., Los Angeles

May 15-19—National Tuberculosis Assn., Annual Meeting, Los Angeles

May 24-26—Western Branch, A.P.H.A. Annual Meeting, Denver

June 1-4—American Assn. of Bioanalysts and California Assn. of Clinical Laboratories, Joint Annual Meeting, San Francisco

There were 166 laboratory-confirmed cases of animal rabies in California during 1959. Eighty-two of these were in skunks, thirty-four in dogs, and eighteen in bats. Forty-four cases were reported between January 1 and March 31, 1960. As in 1959, most of these cases were in skunks. The rabid dogs reported so far this year have all been in Imperial County. A serious rabies outbreak started in Imperial County in September of 1959, and reached its peak in December, 1959. There had been no new cases in Imperial County since late February until one case was reported March 30.

CASES OF ANIMAL RABIES BY SPECIES AND COUNTY CALIFORNIA

January 1-March 31, 1960

County	Total	Domestic				Wildlife		
		Dog	Bovine	Equine	Cat	Skunk	Fox	Coyote
California	43	7	2	1	1	28	3	1
Amador	2	–	–	–	–	2	–	–
Calaveras	1	–	–	–	–	1	–	–
Contra Costa	1	–	–	–	–	1	–	–
Colusa	1	–	–	–	–	1	–	–
El Dorado	1	–	–	–	–	1	–	–
Glenn	1	–	–	–	–	1	–	–
Imperial	9	7	1	1	–	–	–	–
Los Angeles	1	–	–	–	–	1	–	–
Marin	2	–	–	–	–	–	2	–
Mariposa	1	–	–	–	–	1	–	–
Merced	3	–	–	–	–	3	–	–
Monterey	3	–	–	–	–	2	1	–
Napa	1	–	–	–	–	1	–	–
Orange	1	–	–	–	1	–	–	–
San Diego	1	–	–	–	–	–	–	1
Shasta	2	–	–	–	–	2	–	–
Solano	1	–	–	–	–	1	–	–
Sonoma	2	–	1	–	–	1	–	–
Ventura	9	–	–	–	–	9	–	–

SOURCE: State of California, Department of Public Health, Epidemiologic Reports of Cases of Animal Rabies (Form ACD-77) and unreported cases confirmed by laboratory examination by the Division of Laboratories.

Advisory Committee Approves Three Local Study Projects

A study of medical and health care provided to Old Age Security recipients was one of three local health department projects recently approved by the State Department of Public Health.

Purpose of the study is to analyze medical, social, and economic characteristics of all Old Age Security recipients in the county, and to measure the utilization, cost, and resources of payment for medical and health services provided these persons.

A second project approved is concerned with a study of the problems of providing continuous nursing care between hospital and home, as the patient moves from home to hospital and again to his home.

It seems clear that maximum benefit is obtained for the patient when there is a clear provision for nursing care in the home following a hospital stay, and it is also clear that proper care in the home often leads to a shortened stay in the hospital. The problem of providing such continuous care, properly coordinated to the best medical advantage, is one which will be studied by an actual demonstration in a California community.

A third approved project is to be carried on in several counties of the State. It is designed to study means by which improved public health nursing services may be brought to more people.

The project will include intensive training of Junior Public Health Nurses in an effort to up-grade their skills and abilities, and attention will be given to evaluating in the field the results of such training. This project involves the University of California instructional system, as well as several local health departments.

In addition, the advisory committee to the State Department of Public Health approved supplemental funds for two ongoing projects, one on accident prevention in the home and the other on the provision of home care as an adjunct to hospital services.

Aspirin continues to top the list (25%) of accidental poisoning cases reported to the National Clearinghouse Poison Control Center. Last year, there were 4,000 accidental poisoning cases and 25 percent of these involved aspirin. *A.M.A. News*, Vol. 2, No. 13.

Robert T. Legge, M.D., Dies Suddenly

Death has ended the career of Dr. Robert T. Legge, one of the nation's leading authorities on occupational diseases and medicine. Dr. Legge collapsed and died as he stood in the academic procession at the University of California Charter Day Ceremonies, March 21st. He was 87 years old.

Dr. Legge was former physician for the University of California and the man chiefly responsible for the establishment of Cowell Memorial Hospital on the University Campus at Berkeley. He held the position of university physician from 1914 until 1938. From 1915 until 1942, he was Professor of Hygiene and served as chairman of the department at various times. He had been Professor Emeritus of Hygiene since his retirement in 1943.

Dr. Legge taught child hygiene and personal hygiene for men in the earlier part of his teaching career, but later his interest in occupational medicine and industrial health led him into specializing in the teaching of that field.

The William S. Knudsen Award, the highest honor in the field of industrial health, was presented to Dr. Legge in 1951. He was named an honorary member of the Academy of Occupational Medicine the same year.

Dr. Legge received a degree in pharmacy from the University of California in 1891 and his M.D. from the same University in 1899. He was accorded an honorary Doctor of Laws by the University in 1948.

Conference on Industrial Hygiene to Be Held

The Air and Industrial Hygiene Laboratory and the Bureau of Adult Health of the California State Department of Public Health are planning a two-day conference on industrial hygiene methods to be held in Berkeley in May, 1960. The conference will be of interest to technical staffs concerned with occupational health and industrial hygiene practices in governmental agencies, industries, and private laboratories. Its purposes are to exchange technical information among people interested in occupational health in California and improve methods of measurement and analysis needed in the rapidly changing field of industrial hygiene.

Short Course for Voluntary Agency Executives Offered in June

A course in community organization and administration is being offered to administrative personnel of voluntary health agencies in the West at the University of California, Berkeley, beginning in June. Following a concentrated two-week session at the University, participants will have 10 monthly field assignments through correspondence and a final two-week on-campus session in June, 1961.

This course is a part of the continuing education program of the University of California School of Public Health and the American Public Health Association, and is being offered in cooperation with the American Heart Association, the American Cancer Society, the National Society for Crippled Children and Adults, Inc., and the National Tuberculosis Association.

Additional information may be obtained by contacting the Western Regional Office of the American Public Health Association at 693 Sutter Street, San Francisco. Tuition for the year is $200.00. A number of voluntary agencies are offering scholarships for the course.

Western Branch is planning other courses for health department personnel as a part of the continuing education program of the American Public Health Association and the University of California.

Stanford Medical Center Approved for Heart Surgery

The new Stanford Medical Center at Palo Alto has been approved by the Bureau of Crippled Children Services of the State Department of Public Health for the diagnosis and treatment of congenital heart disease, including open heart surgery using the heart-lung machine.

Since the surgical team performing open heart surgery moved to Stanford from Children's Hospital, San Francisco, it was necessary to discontinue Children's Hospital approval until such time as they establish a new surgical team. Therefore, the approval did not result in an increase in the number of cardiac centers available in the Bay Area for surgery using the heart-lung machine.

Dr. Dunnahoo Transferred To Denver Office

Gilbert L. Dunnahoo, M.D., Chief of Special Health Services for Region IX, Public Health Service since 1954, has been transferred to the Denver office. He has been replaced by Charles R. Hayman, M.D., who has been a consultant in Region IX for about a year.

Before coming to San Francisco, Dr. Hayman served in Washington, D.C. as Assistant Chief of the Accident Prevention Program of the Public Health Service.

American Academy of General Practice Joins Health Council

The American Academy of General Practice has joined the National Health Council, bringing Council membership to an all-time high of seventy-one organizations. The Academy has a membership of more than 26,000 physicians in the general practice of medicine and surgery.

The National Health Council, established in 1921, brings together the principal voluntary, professional, and governmental health agencies and selected business and civic groups concerned with health improvement. It provides a mechanism through which member agencies can work together to promote individual and community health.

New Rehabilitation Center Opened in Los Angeles

A new $1,000,000 rehabilitation center has been opened at Cedars of Lebanon Hospital, Los Angeles. It is one of the most modern and comprehensive facilities in the West for treating disabling diseases and accidents.

The unit has been under construction since September 1958. It was financed by community support in addition to $305,000 in federal and state Hill-Burton funds.

The 20,000-square-foot structure is two stories high with another floor below ground level and is designed to allow the addition of two more stories. It is connected to the Cedars of Lebanon main hospital by an underground tunnel. The rehabilitation center has a capacity of 250 patients per day, triple the former daily patient average.

Public Health Positions

El Dorado County

Health Officer: Position combined with those of *County Physician* and *County Hospital Medical Director.* Salary range, $905-$1100. May be appointed above minimum depending on qualifications. As responsible county representative works with the State Department of Public Health to plan and direct the county's public health program. Valid California licensure and a minimum of four years' experience required. Training in the field of public health is desirable. Apply to the Board of Supervisors, El Dorado County, County Court House, Placerville, California.

Fresno County

Senior Public Health Microbiologist: Salary range, $5,400-$6,756. Excellent opportunity in progressive county health laboratory setting. Requires graduation from accredited college with major in Bacteriology, Medical or Public Health Bacteriology and two years experience as a Public Health Microbiologist. Possession of valid California Certificates as Public Health Microbiologist and Milk Technician also required.

Public Health Microbiologist: Salary range, $4,836-$6,036. Requires graduation from accredited college with major in Bacteriology, Medical or Public Health Microbiology or a similar major. A valid California Certificate as a Public Health Microbiologist is also required. A California Milk Technician Certificate must be obtained before completion of the probationary period.

Both positions offer all fringe benefits. Apply by April 29, 1960 to Edward W. Firby, Director of Personnel, Fresno County Civil Service, Room 101, Hall of Records Building, Fresno, California.

Sacramento County

Health Educator: Salary range, $490-$596 with upward adjustment probable July 1. Position in county health department carries responsibility for planning and conducting health education program in department and community. Master's degree in Public Health with specialization in health education required. Further particulars may be obtained from I. O. Church, Director, Sacramento County Health Department, 2221 Stockton Blvd., Sacramento 17, California.

San Bernardino County

Assistant Director of Public Health Nurses: Salary range, $507-$616. Graduation from university having public health nurses program including administration, supervision, consultation, or advanced preparation in a special field and three years experience as public health nurse in recognized agency required.

Supervising Public Health Nurse: Salary range, $484-$587. In desert area, start $532. Graduation from school of public health nursing, some formal training in theory and practice of supervision, and two years experience as PHN required.

Medical Social Work Consultant: Salary range, $483-$587. Completion of two-year postgraduate social work course and either one year experience in hospital, clinic, or health department or two years' medical or psychiatric social work experience.

Apply to Department of Civil Service and Personnel, Ground Floor, Courthouse Addition, San Bernardino, California.

San Diego County

Chief, Bureau of Maternal and Child Health: Salary range, approximately $1002-$1105 per month, plus 10% if certified by the American Board of Preventive Medicine and Public Health or Pediatrics. Position under direction of Chief, Division of Preventive Medicine has administrative responsibility for the MCH program of the County Department of Public Health at clinics and to County school children. Requirements are a valid California license to practice medicine by the time of appointment and at least four years of professional experience or residency training public health and/or pediatrics within the last ten years. This must include one year of experience with a recognized public health agency in a full-time position with administrative responsibility in an MCH program and either an additional such year of experience or a Master's degree from an approved school of public health. Applications for the examination must be received by May 12, 1960. Apply to Department of Civil Service and Personnell, Room 403, Civic Center, San Diego, California.

San Luis Obispo County

Health Officer: Salary range, $957-$1150. Appointment at second step dependent on qualifications. Retirement program, group health insurance available, paid sick leave and vacation accrues at one day each per month. Staff consists of over 30 technical and clerical employees. Department is housed in its own modern building with excellent laboratory facilities. Completion of a course in public health at a recognized college or university and eligibility for a license to practice medicine and surgery in California are required. Desirable experience would include two years full-time experience in an administrative capacity in a well-organized full-time health department. Apply by letter to the County Administrative Officer, Room 208, Courthouse, San Luis Obispo, California.

Stanislaus County

Public Health Nurse: Salary range, $395-$481, may start above minimum depending on qualifications. For County Health Department in community within two hr. drive of San Francisco Bay Area, mountain resorts, ocean beaches. Generalized program. Car furnished. Five day, 40 hr. week, three weeks vacation, 11 paid holidays, paid sick leave, retirement and Social Security plans. Good working conditions. California P.H.N. registration or eligibility required. Contact R. S. Westphal, M.D., Stanislaus County Health Department, P.O. Box 1607, Modesto, California.

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