

approved programs and policies and to make available in one book the essential subject matter in the industrial hygiene field. This Manual should prove extremely useful to all who are working on any of the health problems of war workers.

The Manual is in three parts. Part I deals with Organization and Operation of Facilities, and includes eight chapters. The authors make explicit and practical suggestions concerning such matters as the planning of the physical set-up of the facilities, the specific medical, dental, and nursing services to be furnished, the relationships with management and labor, and the integration of plant hygiene service with those in the community and the use of special services available from the State or Federal Government. Part II is on Prevention and Control of Disease in Industry. The thirteen chapters in Part II cover a wide range of subjects as may be indicated by selected chapter titles, as follows: The Problem of Occupational Disease, in which legal aspects of compensation and liability are briefly discussed, although most of the space is given to clinical descriptions of the principal industrial diseases with recommendations for their treatment and prevention; Engineering Control of Air Contamination of the Working Environment; Industrial Psychiatry; Health Education; Nutrition in Industry; Community Sanitation; Plant Sanitation; and Illumination, Noise and Radiant Energy. In Part III, The Manpower Problem, there is a discussion of the placement of handicapped workers in industry and of the various problems connected with the employment of women. The final chapter presents data on absenteeism because of sickness. The frequency of absences according to durations and according to causes of sickness are shown; and the relation of sex, age, season, and certain other factors to absenteeism is discussed.

The sixteen authors of this handbook have condensed a vast amount of information into a compact reference book. Most chapters include an extensive bibliography and the book as a whole is well indexed.

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PREVENTING WAR-TIME SPREAD OF TUBERCULOSIS

THE increase in tuberculosis mortality already noted in Great Britain and throughout Europe since the war and the threat of a similar increase in this country have made it urgent that measures be taken to

prevent the war-time spread of tuberculosis. The Committee on Tuberculosis in War-Time¹ has set forth specific recommendations for dealing with the problem in Great Britain. In this country Dr. H. E. Hilleboe² has outlined certain measures to be put into effect based on the objectives of the Tuberculosis Control Section of the States Relations Division of the United States Public Health Service.

Both programs emphasize the need for mass chest x-ray examinations by use of the small film technique. This technique has an advantage over the standard x-ray procedure as a method of case finding in that it provides greater speed and economy of examination without any significant loss of accuracy in detecting cases. In the United States, where a chest x-ray is already included in the physical examination for entry into the Army and Navy, Hilleboe urges that the x-ray be extended also to all members of the Coast Guard and Merchant Marine and that it be used on a large scale among war workers and their families. The British report recommends mass radiography for those about to enter the three Services, for those entering new employment in industry, and for selected employment groups such as munitions workers. The British Committee suggests periodic chest x-ray examinations for important manpower groups known to be at particular risk to tuberculosis.

Both reports recognize the need for adequate treatment of tuberculosis cases after they are discovered. Better use of existing hospital facilities is suggested by Hilleboe. The British Committee proposes a possible allocation of more hospital beds to tuberculosis, the use of convalescent homes as sanatoria for cases requiring relatively short hospitalization, and the use of wider powers to obtain staff should appeals for recruits prove unsuccessful. Both studies emphasize the importance of industrial rehabilitation of the tuberculous patient after treatment. An additional and necessary factor in the treatment of the tuberculous patient which the British report discusses is the provision of financial assistance. It is pointed out that financial aid may be needed not only for treatment but in order to prevent a return to work before recovery is complete or to prevent a lowering of the standard of living of the patient and his family during the long period of convalescence. Measures to provide financial assistance should be included in every tuberculosis control program.

¹Report of the Committee on Tuberculosis in War-Time. London, Medical Research Council, 1942.

²Hilleboe, Herman E.: Opportunities in the Newer Methods of Tuberculosis Case Finding. *Public Health Reports*, July 16, 1943, 58, No. 29, pp. 1094-1101.

Another important point which is included in the British program and not mentioned in the American is the effort to raise general resistance to tuberculosis, especially among groups considered to be more susceptible to tuberculosis than others, by "the maintenance of good nutrition, favorable working conditions, the avoidance of fatigue caused by over-long working hours, and mitigation of domestic crowding."

The problem of reducing the spread of bovine infection, which is discussed in the British report, is not considered by Dr. Hilleboe because measures of control of tuberculosis in cattle have already been put into effect in this country. The British Committee recommends measures for the pasteurization and hygienic production of milk. When pasteurization is not possible it is recommended that instructions be given for boiling the milk or that dried milk be used.

Additional measures suggested by the British Committee are: (1) examination of contacts, (2) periodic x-ray of patients in mental hospitals and institutions for mental defectives, (3) health education and propaganda both for medical practitioners and the general public, and (4) reorganization of the tuberculosis services.

Dr. Hilleboe's program also calls attention to the need for examinations in mental hospitals. He suggests routine chest x-rays for patients on admission to mental hospitals and also to general hospitals. In addition, his recommendations include the establishment of an efficient record system for follow-up of cases discovered among rejected recruits and industrial workers and the establishment of workable procedures with the Selective Service System for follow-up care of tuberculosis cases among rejected recruits. Dr. Hilleboe also urges the reorganization of tuberculosis services on a war-time basis; he calls for energetic and immediate action by all agencies in carrying out a program, stripped of all nonessentials, which will reach the greatest number of essential workers and their families in the shortest possible time.

The war-time spread of tuberculosis is already a reality in Great Britain, and for that reason the British report offers somewhat more specific and more detailed recommendations than those of the Public Health Service presented by Dr. Hilleboe. The British report also includes a discussion of the general trend of tuberculosis mortality from 1939-1941 and of factors which might be responsible for the increase in tuberculosis mortality.

Both reports contain important recommendations and should be ex-

tremely valuable to tuberculosis services in revising their programs to meet war-time demands.

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HOSPITAL DISCHARGE STUDY:¹ VOL. II

SURGICAL cases make up a large part of the total hospital case load in terms of admissions, and a considerable proportion of the surgery is elective in nature. Therefore hospital admission rates mean much more when they are for specific causes.

In the New York Hospital Discharge Study the records covered nearly all hospitals; thus rates for New York City and various districts of New York could be computed by age, sex, and color. The fact that a population was available made the New York Study different from nearly all other hospital studies for few have a population available.

An important point of view of the authors in presenting the data in this second volume was the distribution of the hospital case load as between voluntary and municipal hospitals and as between general and special hospitals and institutions for the chronically sick. Thus, for a considerable number of specific diagnoses there is set forth the distribution of cases according to these types of hospitals. In further pages are comparisons of different hospitals according to the days of hospital care, in terms of about five categories of length of hospital stay; no figures are given for average stay in the hospital or days of hospital care per 1,000 population.

An early chapter takes up surgical services in hospitals, showing for specific diagnoses the percentages that were treated surgically, the type and size of hospitals to which surgical cases were most frequently sent, the stay in the hospital for nonfatal and fatal surgical and nonsurgical cases. Following are chapters on appendicitis and tonsil conditions, a large proportion of both diagnoses being treated surgically. The percentage of hospital cases that ended fatally, computed separately for surgical and nonsurgical cases, is used in these and other chapters throughout the report.

Other chapters show similar items about important causes of hospital

¹Deardorff, Neva and Fraenkel, Marta: *HOSPITAL DISCHARGE STUDY, An Analysis of 576,623 Patients Discharged from Hospitals in New York City in 1933. Vol. II. Hospitalized Illness in New York City.* New York, Welfare Council of New York City.