HEALTH

JULY 1934

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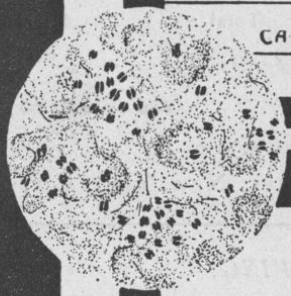

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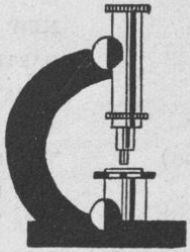

SPIROCHETA PALLIDA
CAUSATIVE ORGANISM OF SYPHILIS

JULY 1934

HEALTH

A monthly periodical for the discussion of personal and social health questions and for the reorganization of the medical profession

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What the Workers Should Know About Psychology, Psychiatry and Mental Hygiene

By DANIEL LUTTINGER, M.D.

MENTAL HYGIENE

MENTAL HYGIENE should not only concern itself with the salvaging of the mental failures that we find in and out of the asylums, the prisons, and the poorhouses, but should primarily be the last word in preventative medicine—childhood is the golden age for Mental Hygiene. The mental hygiene movement started with Clifford Beers in 1908. He was a Yale graduate who had been confined to an asylum for a number of years. Upon his recovery he wrote a book, "A Mind That Found Itself," and decided to devote his life to the prevention of mental diseases. In 1909, through the efforts of Mr. Beers, the National Committee for Mental Hygiene was organized, the first director of this committee being Dr. Thomas W. Salmon, and his successor, Dr. Frankwood E. Williams. These two men have spared no effort or energy in educating the public in matters of Mental Hygiene. They were very active in promoting the establishment of out-patient clinics for Mental Hygiene. But in spite of all

the efforts on the part of these two men, Doctors Salmon and Williams, the practice of Mental Hygiene in the United States, as well as in all capitalist countries, is a farce — because without economic security real mental hygiene is almost impossible.

Going back to the causes of mental diseases in the previous article, let us analyze them one by one:

Insecurity due to unemployment.—Here, aside from the actual physical pain produced by privations, the unemployed also becomes at first mentally ill at ease, and then actually mentally ill. For when a patient goes to a doctor for a pain in the stomach it is because the pain in the stomach gives him mental anguish, and when the pain in the stomach is relieved the mental anguish is also relieved. A healthy body can only exist as its behavior is influenced by a healthy mind. The mere giving of a job to the unemployed individual will not prevent a mental disease. But when, as in Soviet Russia, the individual realizes that his job is assured by the society he lives in, and which he helps to build, and that he himself is a useful and respected member of this society, then even though the worker may have inherited a so-called predisposition to mental sickness, I am certain that Mother Nature in her kindness will keep him mentally well. With economic security he feels himself to be a man among men, he will be sexually a more compatible mate to his wife, and a better father to his children. Being well adjusted to his environment, a healthy individual in a healthy society, he will reduce to a minimum the danger of laying the foundation for his children's maladjustment to their environment.

Syphilis, untreated, as a cause for insanity.—This could be prevented by public health education for the masses about venereal diseases, removing the stigma from a patient who contracts syphilis, making it easy for him to seek medical aid. But above all it is the removal of the economic conditions favoring prostitution that will make it possible for us to eradicate venereal diseases. Have we tried to eradicate prostitution in this country? Of course we did! The Rockefeller vice commission quite a few years ago came out with a string of remedies for the eradication of prostitution. Thousands of preachers from thousands of pulpits denounce vice daily and Sundays, but it is all a joke. What can girls do in the face of starvation and 16 millions of unemployed. Read the article by Erskine Caldwell in the

June 5th *Daily Worker*. It is in Soviet Russia,, where they redeem prostitutes, turning them into useful members of society and securing their economic conditions that they have succeeded in eradicating prostitution, and are well on their way in liquidating venereal diseases.

Alcoholism as a cause of insanity.—In 1920 the heads of all charity institutions had succeeded in convincing their philanthropic backers that the miners and other laborers were poor because they spent their money on alcohol, and presto we got prohibition. After thirteen years of this prohibition business the United States somehow or other succeeded in accumulating 16 millions of unemployed. Now is it not ridiculous to say that the masses are poor because they drink! Those workers who drink, drink because they are poor, and are not poor because they drink. They drink in order to escape a sordid reality, a reality of privations, misery and starvation. This is best illustrated in Russia where, under the Tsar the drunkards were millions, and where now a drunkard is a rarity.

Tuberculosis and other infectious diseases predisposing to mental disease. Now tuberculosis can be eradicated. But not by simply building hospitals, and having school principals advising the children by circulars as to what food are best to eat. Where the devil will 50% of these school children's parents get the money to meet the ever-rising cost of food? Tuberculosis can only be eradicated by giving everybody employment at good wages, razing the slums, building model apartment houses, (airy, sunny and sufficient playgrounds around them) providing enough recreational centers, providing vacations with pay (2-4 weeks yearly) for every worker, by reducing the work day to 5 hours, 4 days weekly, by reducing the number of children in the classrooms (20), by increasing open air teaching classes, by teaching the public hygiene and sanitation, and making it possible for every man, woman and child to have a health examination at least once every six months.

Inability to adjust to environment—by far the most frequent cause of mental disease. This inability to adjust begins in the home, becomes intensified in the school and the period of adolescence, and still more marked in college and real life. A human being is a social animal, but when he fails to adjust to his environment he becomes so to speak, socially inadequate—in other words the individual and society do not

harmonize. A social inadequacy does not develop overnight, nor does a mental disorder. The environmental influences, childhood experiences, especially with reference to relationship within the family group, are of major importance and are the chief determining factors of the future mental stability or instability of the individual. Let us consider, then, the different spheres of influence, namely the home, the school, the college and real life, where a maladjustment of the individual may be either prevented, encouraged or intensified. In the home, the parent child relationship is a very important influence on the growing personality of the child. Every member of the family leaves his impression on the child. It is invariably dragged into any quarrel that originates between husband and wife. Either the man or the woman is liable to pour out on the child unrestrained affection in order to make up for the choking of the normal outlet of love toward the mate. This unrestrained affection for the child injures him by giving him an entirely exaggerated idea of his own importance, and this acting as a preventative for the child's seeking of a healthier recognition in the group outside the family. The older children in the family are instrumental, through their attitudes to the younger child, such as in jealousy, discontent, unhappiness in any form, in encouraging a maladjustment in the later born. Another influence in the home, for social inadequacy, is parental fixation—meaning almost total dependence on one of the parents. Either consciously or unconsciously one of the parents encourages the infantile habits of the child, discouraging thereby its self-reliance and confidence. This condition of course has also a sexual basis, which we will take up in the next issue.

Answers to Letters

N. B., Cleveland, Ohio—Your feeling of guilt may or may not be due to your habits of masturbation in childhood. However, your reaction to the situation is not a healthy one. You should develop a good healthy hatred for the social system which is really responsible for your inability to find employment. Do not think yourself useless because you masturbated when a child. Join a class-conscious group of workers who probably have the same problems as you have, work

with them and fight with them for a better world, and your own mental difficulties will disappear.

S. G., Brooklyn, N. Y.—You yourself realize that the voices calling your daughter bad names are not real because as you say she never sees the people calling her those names. She is suffering from hallucinations. Better take her to a psychiatrist—he may be able to either take care of her in his office or he may have to care for her in an institution. The danger in these hallucinations is at the stage where your daughter begins to take steps to avenge the insults to herself on the people calling her the bad names—she may suddenly attack a perfectly innocent persons she thinks called her thief, etc. Then, of course, a policeman comes along and sends her to a psychopathic ward, and from there as a rule she is committed to a state asylum.

B. B., Newark, N. J.—Your little boy's aversion to food may be due either to physical conditions or psychic (mental). The normal appetite of a child may easily be led into peculiar likes and dislikes. A parent looking at an article of food from a dietary point of view, thinking that the physical welfare of the child demands his eating daily a definite amount of such foods as spinach and carrots, is liable to overplay her hand by simply making the particular food disgusting to the child, and he develops a strong antipathy to it, and may even continue his dislike throughout life.

As soon as the child begins eating in the presence of his family he may begin to show different reactions to his food, unwillingness to eat, eating merely enough to take away the sharpness of hunger, because of a desire to escape from the table and play, and a fit of anger of crying when this is prevented. Illness may frequently cause a loss of appetite—the mother persisting in the effort to feed the child who has lost his zest for food.

Trouble is especially liable to occur when the mother makes an issue of the child's eating something of dietary value. The child at once gets the idea that his eating or not eating is of more concern to his mother than to him. This gives him a chance to create a disturbance by protest or even rebellion—an unhealthy means of self-assertion. If the child feels that his parents do not care for him he expresses his hidden feeling of bitterness by refusing to do what is expected of him, showing his dissatisfaction with life by refusing to eat. D. L.

The Union for Pharmacists

By BEN ODINOV

IN THE June issue of HEALTH appeared a lengthy article under the above title, by James J. Burton, purporting to be a declaration of principles of the drug clerks organized as the Pharmacists' Union of Greater New York. It is based on the false premise that the interests of the public and pharmacy, the latter including employers and employees, can best be served by proper legislation, additional inspectors, N.R.A., etc. This is an assumption which is entirely at variance with the Union policy as expressed in the preamble to our constitution:

> "Whereas the interests of the employers and the interests of the employees of any group or industry are, in general, diametrically opposed, and
>
> "Whereas the employers, seeking the greatest net return at the lowest possible cost, constantly reduce wages and increase working hours, unwarrantably lay off and discharge workers, replace skilled by less skilled workers and maintain the minimum standards of safety and sanitation———"

The very first sentence proves the writer a snob. "—the licensed pharmacist-employee, the person dubbed by the public, erroneously, the drug 'clerk'—". He considers a pharmacist superior to grocery and haberdashery workers who are also called clerks. Not only is this snobbish, it is also highly inaccurate since the Union is open to *all* drug store employees, not merely the licenced pharmacist.

Further on he states that the immediate aim of the Union is "to raise his (the drug clerk's) pay to a level commensurate with the extent of the preparation required of him and the standard of living to which his education entitled him." Why does education, if a course in pharmacy can be classified as such, entitle one to a higher standard of living?

The Union, as such, has no "pride of profession." We are not proud of the fact that we learned a trade, or rather, part of one, in college instead of in a trade school or shop. As a matter of fact, the worst paid and least in demand are recent College of Pharmacy graduates

who have no practical drug store experience. By practical experience is meant primarily the ability to sell those same patent medicines Mr. Burton deplores. What is there to be proud of in this? Or what is there to be proud of in replacing the label on a patent "medicine" (lately renamed packaged medicine) with a store label and charging a higher price because it is a "prescription?" For that matter, what cause for pride is there in any vocation unless it be in a job well done, whether it be packing capsules, grafting a bone or grafting a branch on a tree? Grafting on the public by dispensing some of the weird concoctions we do daily,—patent medicine, proprietary article or, yes, prescription, makes a conscientious pharmacist ashamed of being one. Though I know full well the danger of the indiscriminate use of weight reducers, would I dare say so to a prospective customer? Not if I want to eat regularly!

The Union, as a union, is not interested in the competition among independent (so-called) pharmacists, chain stores and cosmetic shops. Nor yet in the "ethical" side of pharmacy. Let our employers fight it out amongst themselves for the spoils. We are interested primarily in establishing working conditions commensurate with the needs of the drug clerk and not with his education. The terms "ethical" and "cut rate" are relatives and their use depends on the locality. Every druggist calls himself a "prescription specialist" but his advertising will stress either "ethics" or price or both if in his judgment one or the other, or both, will yield better returns. He may, and frequently does own both an "ethical" and "cut rate" drug store, or several of each. In connection with the above the following excerpt from the "Union Pharmacist" of September, 1933, needs no comment.

"Mr. Galen, 'ethical' pharmacist of 169th Street and Walton Avenue, thought it was too much to pay five dollars for a thirty-five hour week. The summer months were coming on and the golf season was approaching. He therefore decided to have Mr. G—, a junior clerk, work 63 hours for seven dollars."

The Pharmacists' Union of Greater New York is a militant union and has been ever since its inception. When the N. R. A. Blue Eagle made it first tentative flight we recognized it for what it is and warned our members. We looked under the Eagle's crown and saw

the bald head of a vulture, an unnatural and perverted species of vulture that rends and devours carrion before it has quite become carrion, while it is still struggling and gasping for breath. The monthly news letter mailed to the members has the following on the subject:

August 14, 1933. "The prominent guest speakers, supplemented by our own most capable orators, were unanimous in the opinion that we have little of benefit to expect from the N. R. A. and still less from the Drug Institute. The convention approved this by its hearty applause. . . . . we have not surrendered our integrity or our conception of unionism by dealing with government agencies or trade associations."

October 12, 1933. "These clerks had been duped and betrayed by the N. R. A.—"

January 29, 1934. "Another hearing on the Drug Code will be held in the early party of February. We will be represented this time also, not that we expect to accomplish much in Washington. Any change in 'The Code' will have to be wrung from the employers here in New York."

Nevertheless, Mr. Burton states—"we believe that the N. R. A. officials as well as the President, were ill advised by the 'big shots' in pharmacy upon whom they relied for guidance in the intricacies of an unfamiliar field, but who betrayed their confidence shamefully."

The hell, you say, Mr. James J. Burton! Do you still believe that? The N. R. A. and our ever-smiling President must be as gullible as you to be so easily convinced that $16.00 per week is sufficient income for a pharmacist or any other worker. (Differential for South and small towns). They must be real simple in being misled into believing that a 62-hour week or "more in emergencies" is just and equitable for that same $16.00 (with differential for South and small towns). Nearly on an intellictual level with an "employee-pharmacist" who takes offense at being "erroneously dubbed a drug clerk."

In line with our policy of non-compromising militancy we have made consistant progress. Our unemployment committee harried the C.W.A. and C.W.S. until several pharmaceutical projects were created, employing hundreds of pharmacists. We fought for whatever gains we made. We had strikes where pickets were beaten up, arrested and

convicted. We have an injunction trial pending. But we have succeeded in putting the fear of the Union in the hearts of our employers. We are "persuading" them to sign contracts on our terms, with the alternative of a picket line. Some try the alternative for several days, but only for several days. We are organizing from several focal points in concentric circles, which are rapidly widening. This we will continue at an ever accelerating tempo until the Union will control pharmacy; until we will control our jobs,s our future and our income; until we will be able to refuse to handle mouldy pills, rancid ointments and wormy herbs; until we will have gained a place among other workers as skilled mechanics taking pride in our work and having the choice of materials and equipment to do that work right; until we will have compelled our employers to practice pharmacy as a branch of the healing arts; not as mercantile establishments. Then we will not need State Board of Pharmacy inspectors to look for a photograph on a license.

As workers we realize that our place is with all other workers in their daily struggles. We know that the cop who clubs a furrier will also club a pharmacist. We know that the judge who issues an injunction against bakers will also issue one against drug clerks. Knowing this, we have declared our solidarity with all other workers in their fight against our common enemies—the employers, police, courts. We have endorsed the Workers Unemployment and Social Insurance Bill H. R. 7598. We support the United Front Anti-Injunction Conference. We are a Labor Union, not a Professional Society.

We do not expect any assistance from politicians as far as legislation is concerned. Our greatest difficulty at first was to convince our more conservative members that legislators are not interested in workers. We sent committees and delegations to round-table discussions and conferences with the anticipated negative results. We got the regular run-around on one and all such occasions.

During the past year or so we were plagued by the A. F. of L. which saw that clerks were being organized and wanted to cash in on it. It set up a dual union which hampered us badly, but we finally succeeded in disposing of it. Now we are alone in the field and are rapidly covering it.

Health Through Sport

By MURRAY SCHEIER

IN JANUARY, 1927, the first step was taken to build a left-wing workers sports movement in the United States. The roots of this undertaking, however, lie in the European countries. Immigrants brought with them the traditions of workers' sports organizations, such as German Turnerbunds, Bohemian Sokols, Finnish Socialist Athletic League, etc. These foreign-language groups felt the need of organizing workers' sports here.

In the year 1924, the Workers' Sports Alliance was formed. It consisted of Finns, Czechs and Hungarians. This group dissolved after one year due to lack of initiative on the part of leaders, who were followers of the second international. Three years later, on January 24th and 25th, 1927, a conference in Detroit gave birth to the Labor Sports Union of America. The composition of the elements present at this conference gave it an encouraging outlook for existence. There were the Finish, Hungarian, Czech, Jewish and, above all, some American sports clubs represented.

The class-conscious trade unionists saw that employers were using company sport organizations in their own advantage. The revolutionary immigrants observed that the youth of their nationality was rapidly being won away from their working-class parents through sports organizations controlled by bosses. These workers took note of this and soon began to redouble their efforts in building up a strong workers sports movement under the leadership of the Labor Sports Union.

In 1927, the first successful national track and field meet was held in Waukeegan, Ill. A year later saw the first Labor Olympics, an excellent two-day meet held in New York. It featured a national track meet, a national swimming meet and a soccer game. At the third national convention it was voted unanimously to affiliate the Labor Sports Union to the Red Sports International. The same year a national physical training school was organized at Loon Lake, Mich. Some of the students today are active members, organizers and instruc-

tors in our workers sports clubs. In July, 1932, the L. S. U. arranged a Counter-Olympic meet in Chicago as an answer to the bosses' Olympic held in the state where Tom Mooney is imprisoned. This meet convinced those who were still skeptical about our organization that it is the only fighting worker's sports movement in the country.

The vast number of white and negro working-class athletes on the field, at the dining table and in the sleeping quarters, showed that it was a real workers' meet. Thus in looking over the seven years of the workers sports movement, we can say that it has splendidly justified its existence. The fact that it is as yet weak and narrow, in comparison with the labor sport organizations in other countries, can be traced to the relative immaturity of the American labor movement. With the growth of the mood of organization of the American workers, come greater opportunities for the organization of ten-fold larger workers' sports movement; a movement that must base itself on the workers, in big industry; a movement of negro and white athletes of all shades of opinion united on a fundamental program of the workers sports movement.

The fundamental purpose of the labor sports movement is the struggle against the organizational and ideological influence of the bourgeois sport organizations over the American working class sportsmen, and the winning of these sportsmen for the revolutionary struggles of the working class. It does not hypocritically state, as the reformists do, that its purpose is to improve the health of the workers; first, because it recognizes that it cannot provide the recreational facilities that the bourgeoisie can provide, and secondly because there are definite limits to the ability of sports to overcome the ravages of industry and living conditions of the workers. Its activities do, however, afford some beneficial recreational for workers who otherwise have little opportunity for such recreation.

During the summer these activities are naturally outdoor activities, especially walks and hikes. In spite of the lure of the automobile, hiking is growing in popularity among the workers of the city. This is probably due to the ease by which a large group can be organized and to the few facilities required.

Hiking has often been called the lazy man's sport. This theory is

entirely wrong. On the contrary, it is one of the most balanced and wholesome sports for both body and mind.

In our metropolis of New York, hiking territory is naturally diminishing. Where only a few years ago we found ideal hiking regions and almost untouched woodlands, there is today a new parkway. There are, however, still many hiking possibilities around New York. The beautiful Palisades, hanging over the Hudson, still has a large lure for interested hikers. It's forests, brooks, large rocky hills and vast lawns rank first amongst the many places to hike. Hunters Island in the Upper Bronx or Tibbets Brook Park are popular places amongst the walkers and climbers.

To enumerate all the hiking places would be of little interest to the reader. The writer recommends that the reader join one of the many sport clubs which endeavor to organize all workers interested in hiking and outdoor recreation. The Nature Friends, a section of the Labor Sports Union, and the only workers' hiking organization in this country with headquarters at 12 East 17th Street, New York, arranges well-conducted hikes every week-end. They know the trails, how to arrange outings, where to go and what to do once they are there. The various Labor Sports Union clubs such as the Red Sparks Clubs, 64 Second Avenue, arrange hikes as well as other sport activities such as baseball, basketball, calisthenics, volley ball, swimming, soccer, etc.

Hiking has its advantages, both from a physical and recreational point of view. We probably forgot how to breathe properly. This we will learn when in the company of good hikers. Then too, it is quite obvious that the nerves are in need of a little greasing either from hard work, pounding the pavement looking for work, or through the ceaseless class struggle. Once we are in the open, observing the natural surroundings, and escaping the turmoil of cars, elevators, subways, etc., the nerves will relax and begin to function along more natural and rational channels. The blood, too, will circulate better. The heart will obtain the proper exercise. The digestive apparatus will function on a better scale. The mind will be eased from the uneven taxation of city life. We will feel a little tired physically at first, and not be able to attend our regular Sunday movie; but all this will strengthen

us and at the same time make us feel relaxed. The sight and nerve systems will improve considerably. Remember, walking up a hill slowly is more wholesome than running down a hill quickly.

Hike leadership constitutes a fair sized job. The group must be willing to co-operate in order to obtain the greatest pleasures from this sport. Hikes in strange territory should be laid out. One or more leaders have to explore the trail and its surroundings. Schedules of trains, bus, or trolley must be consulted, and the leader must watch his time so as to conform with transportation. Wise walkers travel quietly, especially when passing through villages. A steady pace is better than alternate slow and rapid pace interspersed with rests, and the pace of the hikes must be regulated for the slowest walker in the group. Hikes on a Sunday should in general, not be more than four to seven miles. The hike should always end up at a place where there is playing space; for games after the hike prove the best possible means for joy and pleasure. To build a campfire at the resting place makes the hike more pleasant for all. The rest at the campfire makes it fitting for various discussions, get acquainted with the guests and have a chance to discuss our movement.

Especially does the hike become more beneficial when there is some sort of entertainment, or a talk on geology or botany by those who are well prepared to make this of general interest.

It is part of good sportsmanship to leave everything unmolested, to see that all fires are thoroughly extinguished, and that campus or rest grounds are left clean. Trees must be spared injury and wild flowers picked in a minimum amount, the rare ones to be merely enjoyed in passing. The best way to carry all necessary equipments for a long hike is in a knapsack. For a short hike, food and a poncho should be the only necessary articles. A canteen filled with water is essential only when the hiker has no knowledge of the drinking water regions. A large cooking pot taken along by the leader to make either tea or coffee at the resting place makes the hikers enjoy a real party. A first-aid kit with anti-snake bite serum should also be brought along by the leader. Photographs taken on hikes keep friendships and help to crystalize the experiences of the trip, as well as to give material for entertainment on rainy days.

Hikes or long walks to the country, parks or forests should be held often. This will enable us to get away from the noise and turmoil of the city and its dusty gas-filled air. One can tell very easily as the hikers mount the cars, busses, or subway for home that they had spent a delightful day somewhere in the open. The rosy flush of cheeks, the light of surprised happiness in shining eyes, the physically tired but buoyant steps as men and women come back singing revolutionary songs; the peace and contentment in the eyes of those who were tired and worn at the outset, indicate that the hike has accomplished its purpose—refreshing the jagged nerves, and stretching the cramped muscles of the cooped-up city worker.

The Man Who Restores Sight to the Blind

By JOHN GILMORE, B.A.

PROFESSOR FILATOV, Director of the Girshman Institute of Opthalmology in Kharkov, U.S.S.R., is the first eye surgeon in the world to successfully perform operations on a great number of workers suffering from corneal opacities.

Thickening of the cornea creates a white spot in the transparent cornea of the eye and nearly always causes partial or complete blindness to 80 per cent of all persons suffering from this condition.

In capitalist countries, none but the rich can afford the huge fees of highly skilled specialists for this operation. None but the rich can afford the usually necessary period of 4 to 6 months of hospitalization following such operations.

It is only the Soviet Government with its extensive program for the protection of the health of the workers, than can permit the "luxury" of keeping blind workers for operation and the lengthy hospital care in order to restore their eyesight.

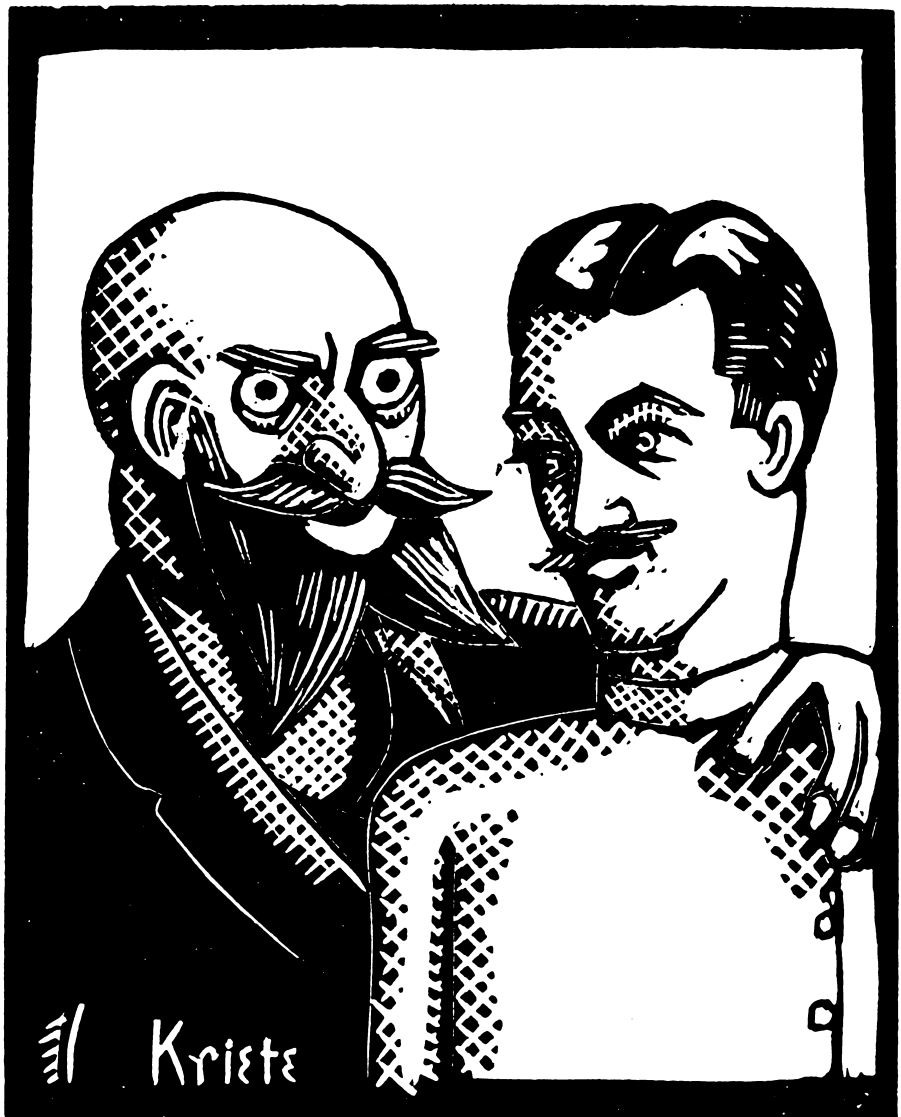
The idea of cornea-grafting, which is the means extensively used

by Professor Filatov in his work, is not a recent discovery. In 1908 Professor Elshning of Germany investigated the possibilities of such operations and restored sight to a number of patients who were either partially or completely blind. But because of the tremendous expense and the necessity for the employment of the most highly specialized eye surgeons for such a delicate operation, no country in the world, including the U. S., and with the only exception of the Soviet Union, has made it possible for the masses of the workers afflicted to avail themselves of this knowledge. The King of Siam spent nearly a million dollars in the U. S. to have a similar operation performed.

To fully appreciate the difficulties encountered in an operation for cornea grafting, one must understand the amazing complexity and delicacy of the structure of the eye. Every part of the eye, no matter how small must be in perfect working order, or else the sight is seriously affected. If the loss of transperancy of the cornea takes place over the center of the face of the pupil, sight is greatly lessened; often to the point where darkness cannot be distinguished from light.

For a long time doctors have attempted various methods of reestablishing transperancy of the diseased cornea. It was not until recently that Dr. Filatov used the cornea of eyes removed from dead persons and perfected a method of scientifically preserving the removed eyes of the dead.

At the last meeting of the Opthalmological Society in Moscow, Professor Filatov gave an extremely interesting report of his work and presented patients who had successfully undergone this highly delicate operation. Following Filatov's report, the Doctors Strakhov and Rosenthal of the Opthalmological Institute performed a number of such operations using Filatov's method and obtained excellent results. At present, doctors throughout the U.S.S.R., are studying and performing this highly skilled operation, with great success.



Old Practitioner to young medico: "Always remember that a plain bellyache is worth only two bucks; but if you call it gastritis, *you can collect ten dollars or more"!*

Modernizing the Medicine Man

By DAN HUT-LEHR

CIVILIZATION moves onward! But every step to the fore is bitterly contested by those who believe in the present order and venerate the past. One of the burning questions of today, in this connection, is the proposed change in the present system of medicine. I refer to the Socialization of Medicine.

In discussing the question of the institution of State Medicine into our society we are confronted with simply the problem of determining the benefits or evils which would ensue therefrom to (1) the members of society, (2) the members of the medical profession, and (3) the State itself.

The widespread notion that all those who require medical attention receive it in some manner or other is a false assumption and far from the truth.

Numerous surveys have shown that even eliminating minor ailments at least 35 percent of illnesses are uncared for by a qualified medical practitioner, and that between 25 percent and 35 percent of the childbirth cases are unattended by physicians. By far the greatest factor in bringing about this condition is the economic status of those deprived of medical aid.

Medical care is, at present, a commodity and must therefore be bought and paid for. Unfortunately, poverty brings about an increase in sickness. Thus, he who can less afford medical attention requires more of it. Further, it has been estimated that 65 percent of families have an average annual income of less than $1,500 so that even in the majority of those cases where medical aid is obtained it is a terrific strain on the family pocketbook.

The socialization of medicine would do away with such conditions and give every individual access to all the medical aid he requires.

The first benefit, then, is that medical service would be extended to everyone. That is, there would be an increase in its quantity.

But that is not all.

No one physician can possibly claim to possess even a fair percentage of the available knowledge of medical science. Errors are to be

expected. And many mistakes, some of which result fatally, are being made continually by physicians. Socialized medicine presents the opportunity of greatly decreasing the possibility of error in a given case.

The physician will have the facilities, (indeed, it will be required of him) to call upon his colleagues for advice where he has the slightest doubt as to his conclusions. This is not so today, either because the patient cannot afford the added expense, or the physician fears loss of his patronage, a consequent evil of private medicine.

The training of physicians, it has been suggested, would be radically changed so as to increase their efficiency and to insure their suitability to practice.

And in addition they would be compelled to keep pace with all new advancements in medicine by compulsory attendance of classes for this purpose.

Immediate diagnosis of an illness in its first stages often means the difference between a rapid cure and a prolonged illness or even no recovery at all. A State medical system would do away with the postponement (due to financial reasons) of necessary operations and of treatment of diseases.

2 The second benefit, then, is that the quality of medical service would be greatly improved.

There is still another broad benefit to the members of society to be derived from socialized medicine.

Medicine, to repeat, is a commodity. But unlike our procedure with respect to other commodities, medicine is still in the feudal stage.

The first step from feudalism to industrialism was simple cooperation among those producing a given product.

In feudalism each man had his own work-shop and manufactured his product by himself. The simple cooperation mentioned above brought a number of these men together in one huge shop and thus, even though each continued to produce his own article there was a great saving due to the fact that tools, heat, light, fuel, buildings, etc., could be used in common. Thus the cost of the article was cheapened.

The next step towards industrialism was division of labor, or specialization, wherein each man made, not the entire product, but merely a part of it. Capitalism today is based on these principles.

Now, medicine has actually progressed to a point where it is ready to adopt the methods used in dealing with other commodities.

Simple cooperation alone would be a great aid in decreasing the cost of medical service. Especially is this true since a vast amount of machinery and apparatus, which compels a large expenditure, has become essential to the practice of medicine.

But medicine has passed beyond this stage and its expanse is so great that specialization is already widely practiced, (although without simple cooperation,) and is continually increasing. We need, now, but to take the physicians from their small, scattered offices, amalgamate them in huge buildings, and put the principle of specialization into practice. When medical service will be thus modernized its cost will be tremendously reduced.

The members of society are offered, then, by socialized medicine, as compared with private medicine, an increase in the quanitiy of medical service, an improvement in its quality, and a decrease in its cost.

Surely there is no doubt as to which system is more beneficial to the members of society.

In fact, so great are the advantages of State Medicine over private medicine to the people, that even if it were disadvantageous to the members of the medical profession, it should still be installed in our society, since over 110,000,000 people would benefit by it and less than 150,000 suffer.

But unfortunately this is not the case. Physicians themselves would be greatly benefited by the modernization of medicine.

The main objection in this connection is the loss of the possibility of wealth which would naturally follow. The fact is, however, that, as in capitalistic society itself, although the possibility for great wealth exists actually very few attain it. The great majority remain poor.

Besides, the desired wealth is not attained until after many years. In the meantime, the doctor who will become rich, as well as he who will not, is compelled to be at the call of his patients for twenty-four hours a day; to take few if any holidays; to bargain and worry about fees; to continually invest in new appartus for which he pays for many years; to perform the most serious operations and solve the most baffling problems in diagnosis at a moment's notice, no matter what the hour, no matter how fatigued he is; to rush, rush, rush, for the

sick congregate in the waiting rooms of the doctor who is gaining a reputation.

Is it a wonder that the mortality of physicians is greater than that of other professions and trades, including steeple jacks and aviators?

Is such a system to be preferred to one where the physician will have regular working hours; a reasonable, guaranteed pay, vacations; no cares concerning the amount and collection of fees; no worries about additional investments in new equipment; no fears as to the loss of patients; a pension upon retirement?

Surely it is obvious that, to the members of the medical profession, socialization of medicine will be a great improvement over the present system.

And it is equally obvious that the State too will greatly benefit by this suggested system.

The modern state realizes that the health and well-being of its members is of prime importance to itself and has therefore assumed an increasingly important role in maintaining public health. There are some 25 agencies in the Federal government doing some kind of medical work. Every state has departments of health. At least one-half of the larger cities in the United States employ health officers.

Now, since the State realizes the importance of the health of the individuals and is attempting to better health conditions, it logically follows that it should do this by the best methods possible.

The methods it has used to date have failed. The public health agencies are uncoordinated and uncentralized. As a result many communities have insufficient medical service. In spite of the efforts to promote health by the state, the fact remains that a great percentage of illnesses are not attended by doctors. The decentralization has resulted in a great deal of duplication which has greatly increased the cost of the medical program of the State.

State, or Socialized, medicine would centralize the health agencies and coordinate them so that the cost should be greatly decreased, health service would be rendered to all, and many other evils of the present methods would be eradicated.

Surely the time has come when the replacement of private medicine by socialized medicine is, in addition to its advantageousness, an absolute necessity.

The Romance of Modern Drugs

By WILLIAM C. DEMBLING, PHAR.D.

II. DIGITALIS

THE best medical attention of the time was useless as far as Dr. Cawley's dropsy was concerned. The poor man had tried all the drugs and potions his physicians had prescribed, but to no avail. He was desperate. So desperate in fact, that he finally tried the tea which was brewed by an old herb woman in Shropshire. To his great surprise and relief he soon found himself cured.

Dr. Cawley's rapid cure interested one of his friends, a Dr. Withering, of Birmingham General Hospital. Withering decided to get the formula of that tea, but that was a harder job than he had anticipated. After all, a woman who made her livelihood from the sale of secret herb potions was not going to divulge their formula without either a hard fight or a lot of money. It is safe to think that Dr. Withering had to pay heavily and then fight for the recipe.

This recipe, he found, consisted of about two dozen herbs. He was sure that every herb was not equally effective; it was up to him to find out which ones were and which ones were not medically useful. This was a tedious job, each of the twenty-four drugs having to be tested separately. Finally he found that the active ingredient was the root of a very common flower, which grew on every roadside. This flower was the *foxglove.*

While Dr. Withering was the first person to use the extract of foxglove, or, as we call it today, digitalis, scientifically; it had been used empirically since the twelfth century. The name comes from the Anglo-Saxon *foxesglew,* which means fox music. It was thus named because of its bell-shaped flowers. Prior to Dr. Withering's researches, the root was the part of the plant which was used in medicine. Withering however, found that the leaves were more medicinally active, than any other part of the plant. He worked on the proper administration of the drug, and in 1785 he published his

Account of the Foxglove. This was the first instance of the rational and scientific use of digitalis.

From the death of Dr. Withering, in 1799, until the end of the eighteen hundreds, digitalis was virtually neglected. At the end of the century, however, another English physician became interested in it. He was a small-town doctor, and quite interested in heart disease. At first his interest took the shape of the invention of a machine for the recording of the pulse. After his work on that was complete, he turned toward the work which was to make him famous: digitalis research.

This doctor, James Mackenzie, by name, discovered that the drug digitalis had a direct effect upon the group of nerve and muscle cells known as "the bundle of His." This group of cells is really a track for the nerve impulses which control the beating of the heart. In heart failure the heart does not function properly because the nerve impulses come across the bundle of His so rapidly that the ventricles of the heart cannot beat fast enough to respond to them. Therefore the heartbeat is weak and irregular, and the blood supply to the body is poor. There is a weakening of circulation. Blood accumulates in the smaller blood vessels, its fluid part (serum) stagnates in the tissues and that is the condition known as *dropsy.* Digitalis steadies the bundle of His, and keeps it from transmitting so many impulses. The heart then beats slower and stronger, forcing the blood to circulate; thus preventing the serum from accumulating.

After Mackenzie had ascertained the action of digitalis it remained for the research chemists to analyze the plant to find out exactly what the active principles were. They found three glucosides, *digitalin* and *digitonin,* which are extracted from the plant by infusing in hot water, and *digitoxin,* a poisonous glucoside which can be extracted only by alcohol. Therefore, in cases where large doses of digitalis are required the watery infusion is used.

Digitalis is used as a heart remedy in cases of dropsy and other circulatory irregularities. Today, every physician has in his emergency kit a tube of Digitalis tablets. One important condition must be observed in the use of digitalis leaves, and that is the fact that they must not be too long in stock. The careful pharmacist will discard all stock on hand, once every year, and replace it with a fresh supply.

The reason for this is that the moisture in the air will gradually act upon the glucocides of digitalis and destroy them, rendering the drug inert, and to administer a useless drug in the condition where digitalis is indicated is considered not merely an unpardonable breach of professional conduct, but a crime, if the patient dies. Another great use of this most valuable drug is its administration together with drugs, especially the pain-alleviators, such as aspirin, antipyrine, or amidopyrine, since these have a depressing tendency upon the heart action. The digitalis here supports the heart and keeps it within normal function. And so we have the story of our second specific in medicine.

Medical Socialization *vs.* Individualism

By J. S. EFREMOFF, D.D.S.

BY THE TIME the fundamental proposition or axioms, stated by Dr. S. A. Tannenbaum in his article "The Medical League for Socialized Medicine," first issue of HEALTH, June, 1934, will make the rounds of every practitioner in the state and nation, may I register beforehand a pro and con discussion of this vital, too vital, subject of Socialization.

The question of socialization in general and socialized medicine in particular may already preoccupy the minds of a good many practitioners in our midsts, and it would be rather interesting to delve into what one may advance either as a stumbling block or a stimulus for socialized medicine.

In order to stage a sham battle on the subject: "Resolved, That the Socialization of the Medico-dental Professions will Improve the Economic Status of the Medical and Dental Practitioners and Promote Better Health service to the Public," we will name the two contestants Drs. C. and D.

The subject under discussion and the two imaginary luminaries (medico-dental luminaries) as discussers may attract a considerable number of physicians and dentists, both of the elite and the plebian type. The former will probably get interested in order to get an earful of the imminent danger of having medicine and dentistry socialized,

and the plebian will probably lend an ear in order to find out how soon will medicine and dentistry be socialized and thus save them from their present-day economic plight. As one can readily see, that no matter what either of the debaters have had in mind to do with the above-mentioned subject, one thing is certain, that one of them had to prove that socialization of the medical and dental professions will lighten the burden of the average physician and dentist and that the average citizen will benefit thereby; the other one had to prove that the practice of an individualistic kind of medicine and dentistry is better for the physician and dentist and that the average citizen benefits thereby.

In other words, Individualism vs. Socialization is really the bone of contention. Furthermore, the two opponents come to the battlefield with plenty of ammunition, but the ammunitions that are supposed to batter down each one's stronghold of contention are of two different types.

The defender of the individualistic kind of medicine and dentistry has at his command the present. He can marshal out all the blessings that are incorporated in the practice of the present-day individualistic kind of medicine. On the other hand, the defender of socialization has at his command a would-be contention of a better future for both doctor and patient. Of course an "experiment", as the socialization of the healing art in Russia of today, is not permissable even to insert edgewise, for the proof of socialization's blessings is supposed to be argued out and established right here.

Thus, a would-be quantity opposes an unknown quantity. Let us see, what does the defender do with his vast array of facts of the medicine as practised today?

Perforce he has to acknowledge that both patient and doctor are not faring well at the present time. True enough, that, here and there, one finds doctors who are still buttering their bread on both sides, but the fact remains that the majority of the medical professions are bankrupt.

Now, then, in order to get into the offices of so-called unwilling patients, Dr. D. advocates an intensive educational campaign. Education, in his opinion, is the panacea for a better life for all concerned. If all the medico-conscious patients who can be awakened through a proper drive,

would begin their steady pilgrimage into the medical and dental offices, the average practitioner would not have to stoop and clamor for a kind of a socialized levelling equal to the postman, policeman and even the soldier. Physicians and dentists busy in their offices would doubly see the negative sides of being socialized.

Dr. C., the defender of socialized medicine, calls the attention of Dr. D. as to the present anemic state of affairs in other fields is staring in one's face, in spite of the fact that the public is educated to its needs and is reminded of the good bargains on hand; mind you, Dr. D. with years of experience and by the best talent, plus millions and millions of resources, and still they are reluctant to buy. But, according to your opinion, the magic of medico-dental education for the public may do the impossible.

As said, heretofore, Dr. D. deals with a situation of the present and all the good and all the bad is just before our very eyes, why should we relegate our hopes into a distant future and rely solely on an educational campaign?

Would it not be easier to prove for a staunch individualist, like Dr. D., the great socio-economic achievements due to our rugged individualism. Enough time has elapsed since individualism has taken over the reins of our destinies and, behold, with what disastrous results. Just the countries where individualism is most pronounced, the economic condition and general welfare are the worst. Individualism may be a blessing in isolated cases, concerning the select few; but what concerns the great mass of people it proves to be devastating. In fact, the free play of the individualistic kind of endeavor is on the verge of wrecking our very existence, wherein is then the security of its further reliability?

Dr. D. admits that today the public, at large, is deaf and dumb to their medico-dental needs. Of course, by an intensive educational campaign we may—we do not know it as a certainty—bring into our dental and medical emporiums the slackers. This assumption of certainty by you, Dr. D. is a by-product from your principal contention that "the American buys everything he wants, so that he can be made to see a new want, health service." The fact, however, remains that at present a handful of people, almost a constant number, are medico-minded. In other words, in good times or in bad times, the number of

patients neither increase nor decrease. That is, so many patients, allowing a certain flucutation, are at the disposal of so many dentists and physicians.

In reality, we of the healing arts have to divide our bounty as best as we can, but herein lies the difficulty. As the resources, the patients on hand, are constant, the physicians' and dentists' economic condition must get worse with every deviation from the normal. On the slightest provocation, in an economic sense, this constant diminishes its purchasing power.

We may see clearly the working of this if we only examine a section of time, let us say, the period of the last fifteen years. Physicians and dentists, up to 1929, one better, one worse, managed their affairs without due alarm. Of course, even within this period of time, the afore-mentioned professions began to see the failure of free competition, but the average physician and dentist managed to hide their economic shortcomings.

What was really the underlying cause of this somewhat steady income for the average practitioner during the above-mentioned period of time? Simple enough, the people, that constant who cared for their health, had the money to pay to the dispensers of health: the doctor, the dentist, the pharmacist, etc.

Mind you, in those days the increase of professional talent, the competition with the clinics, centers, hospitals, etc., were not felt so keenly, because the few patients were able to pay for all our professional services and professional leaks. Both patient and professional were punch drunk. They staged a mutual combat in the full glare of plenty, but, with the gold set, they both found themselves prostrated.

With this difference, the professional remained with his old competitors: the newly graduates, the clinics, the centres, the hospitals, and worse of all, bad times and a steady decrease in numbers of even that constant—known as the medico and dento-conscious public. The patient, on the other hand, is in a sense better off, for he or she may avail themselves of the above agencies without remorse and without bleeding themselves white.

What really remains for the present-day practitioner, leaving out the elite, is to do what reminds me of Blatchford's story of the mariners

Continued on page 47

Laboratory Technicians Organize!

By A. J. KRELL

THE social and technical importance of laboratory work is obvious. Modern medicine, public health technique and production control in industry are dependent upon the precise methods of the laboratory. Compare this powerful position in a society dependent for its proper function upon the laboratory worker with his pay-check—when he has one.

In modern industrial administration, the expert figures the laboratory as part of the factory unit, and quite properly so. Government public health laboratories moving in a direction of large scale serum production, and mass diagnostic tests are organized in a factory plant manner. Unit methods of organization of large scale enterprises has in some measure taught laboratory workers that they are workers too. The chemists, bacteriologists and laboratory technicians are discarding the idea that they should accept cruel exploitation because they love their work. They cannot starve more gracefully because they have a degree. They have learned to be suspicious of the advice to take another course, and still another course.

The student emerging from school after years of academic discipline (many times with years of post-graduate study to his credit) finds ———? If he knows someone he will be given the privilege of doing volunteer work—that is work without pay. Under the guise of furnishing him with professional experience he is exploited.

Do not think the beginner is the only one that suffers from this system. The mature and experienced technician without work over a long period of time, is compelled to accept in many cases a "volunteer position." Prospective employers (if there are any left) may not wish to employ him if he has not been working regularly.

It is strange to find this archaic guild apprentice system in the peak of industrialization and tightly drawn economic lines. But the "Volunteer" has none of the benefits of the old guilds and all the evils of his Times. The Guild, briefly was a kind of protective organization

where the border line of mutual economic interest of Master and Apprentice were merged and defended. The "Volunteer" technician has only to ask money for his work to find where his interest lies.

In this oppressive system the "Volunteer" technician may continue for years. He may be given a pittance. If he asks for more money or an initial payment on what he hesitates to call a salary, he's told in haughty tones that he has the privilege of working even though it may be for nothing—or next to nothing. To many workers hard work in a laboratory even under these conditions is preferable to tramping the hot dusty pavement outside—there is no alternative.

The "Volunteer" worker in the laboratory has become an economic "Frankenstein." What was accepted hitherto as a life-line, now becomes a mill-stone around the collective necks of all laboratory workers. Does he get a paying position after he acquires experience? You can safely take Booky's odds he won't. How can they with plenty of students willing to do the work for nothing, and "to give their all," as one laboratory director heroically said (salary $3500 a year). The large army of free labor is used against the paid worker. His pay is cut, his standard of living is forced downward. He pays for all economy programs.

This is merely a small part of the whole problem. Economy programs in public health and preventive medicine drastically effect the well being of all workers. These economy programs were announced only after the most optimistic ballyhoo concerning "The good health of the population despite the depression." Laboratory workers, physicians, dentists and nurses must disavow their traditional professional snobbery wherever it still hinders them from gaining the goal of economic stability and the proper utilization of their services in the fullest social sense. The New York State Department of Health ironically says, (on diagnostic slips to physicians) that the health of a community is economic and each community can determine its own death rate.

The technician's answer to these problems is first organizational solidarity in its own ranks and the crystalization of their relationship to the working class. To this end the Federation of Architects, En-

gineers, Chemists and Technicians and the Association of Laboratory Technicians held a mass meeting April 27th, 1934.

The formation of the Joint Committee of Laboratory Technicians with representatives of both organizations and cooperating hospitals and laboratories was the result of this meeting. The meeting unanimously approved of the following resolutions, submitted to the public officials concerned:

1. Abolition of the Volunteer system in all hospitals and laboratories and the establishment of minimum wage schedules ranging from $25 per week for beginners to $50 per week for Director Technicians.
2. Non-competitive positions to be classed in Civil Service classification and examinations be held immediately.
3. Increased appropriations for public health budgets.
4. Establishment of the six-hour-day and the five day week.
5. Increased appropriations by Federal, State and Municipal Governments of the Technically trained.
6. Endorsement of the workers unemployment and social Insurance Act HR 7598.

June 15th, 1934 the Joint Committee of Laboratory Technicians called another mass meeting. Economic Federation of Dentists and the League for Unity in the Medical profession sent speakers and endorsed the resolutions. The position of the students was stressed. It was agreed that laboratory workers must continue to organize, laboratory by laboratory in one solid front to gain economic security and the proper social utilization of their services.

The Cross-Eyed Child

By PHILIP POLLACK, O.D.

"I HAVE a child of five," writes Mrs. S., "whose eyes are badly crossed. I have taken her to several eye-specialists and they disagree as to whether or not her eyes should be straightened by an operation. I am very much worried about it because she is a beautiful

child and the squint spoils her appearance. What would you advise? Will her eyes always be crossed? Do you recommend an operation?"

Instead of dogmatically handing down a decision on this case like an oracle, suppose we analyze the problem so that the reader will understand the basis for our conclusions.

To begin with, we must know that each eyeball is substantially a camera, continually taking pictures. The pupil is the diaphragm, the chystalline lens inside the eyeball is the camera-lens, and the retina spread over the back of the eyeball is the film that receives the image of the object looked at. Only, in the case of the eye, the image is very tiny, and when we look at an object *directly,* we turn our eye so that the image falls on a spot that is the most sensitive part of the retina. It is called the *macula,* and is less than 2 mm. in size. The purpose of the restless movements of the eye is to turn the eyeball so that the image will fall on the macula.

Perhaps it has never occurred to the reader to ask this question: if each eye receives an image of the same object, how is it that we do not see the object double? The answer is: when both eyes move in harmony with each other, the image of the object will fall on the macula of each eye. Only in that case can the two images be *fused* together into one image. If the will and the desire to see single is strong enough (and this is important), the brain will order the eyes to turn together in such a way that each image will fall on the corresponding macula.

Suppose that this desire is weak, then the eyes will not move together in harmony. In that case, the image will be on the macula of one eye, and off the macula of the other eye. Then the individual will see double at first. But the brain cannot tolerate double sight any more than the American Medical Association can tolerate socialized medicine. And so the brain goes in for the same tactics as the A.M.A., the policy of suppression; it suppresses the image of one eye, and notices only the other image. The individual thinks he is using both eyes; actually only one eye is functioning. The result is that the eye whose image is mentally suppressed will lose more and more of its vision. It may be a perfectly healthy eye, mind you, but its power fails from disuse, just as an arm would atrophy if kept in a sling for five years.

The danger of a squinting eye is not its disfigurement, but the fact that it is losing its sharpness of vision.

The eyeball is turned in its socket by the contraction of one or more of the six muscles attached to it. The nervous connections between the sets of muscles of the two eyes are so highly developed that when one eye turns to the right, the other does the same automatically, and vice versa. But in addition to these associated movements, the two eyes must learn how to converge for a near object. That is, the eyes are parallel to each other when looking off at the horizon, but as they look at a pencil held near the eyes and midway between them, each eye must turn in toward the nose. Notice that the right eye then turns to the left and the left eye turns to the right.

Now the ability to converge is not present at birth. Mothers often notice that the eyes of infants do not work together. The power of convergence and binocular vision is something that must be learned, that must be acquired from experience. It is not until the age of five or six months that there is definite evidence of a desire for binocular vision. In some cases it takes years to learn the trick, and an authority has even suggested that one cause of squint (cross-eyedness) may be the fact that reading and writing are taught too early in life, before convergence has been thoroughly mastered.

It used to be thought that a squint is caused by the fact that one muscle attached to the eyeball is too strong and another too weak. We know now that this is not the case. It is not the strength of a muscle, but faulty nerve innervation of the muscle that causes the trouble: too much nerve force is sent by the nervous system to one muscle, and not enough to its opposing muscle.

To sum up, then: many cases of squint are caused either by a lack of the desire for single, binocular vision, or by faulty innervation of the muscles that turn the eyes. Assuming there is no pathological condition, these cases can often be corrected by ocular exercises and visual training. Vision in the squinting eye is stimulated by covering the good eye and forcing the other to work. The desire to fuse the two images into one is stimulated by stereoscopic exercises. Has the reader ever looked into a stereoscope which combines two pictures into one, giving a remarkable sensation of depth? This is one of the instruments

used in these exercises. Another form of training is rhythmic exercise: the eye muscles are stimulated rhythmically by following a moving light. This helps to redistribute the nerve impulses to the proper muscles.

Only if these treatments are unsuccessful should we resort to operations. Operations to straighten the eyes are not at all dangerous, for no incision is made in the eyeball itself. The surgeon simply snips off the attachment of one of the muscles and re-attaches it so that the eyeball is turned and held in a straightened position.

What are the objections to operations for squint? They do not solve the real problem, for they are purely cosmetic in their results. They do not eliminate the cause of the squint, as shown by the fact that in many cases, the eyes become "crooked" again, a few years after the operation. Often the operation must be repeated several times during the life of the patient. The reader will understand why this is so if he will recall what we have said about the causes of squint. If too much innervation is sent to the muscle that rotates the eye in toward the nose, for example, then by operating and re-attaching this muscle, we do not change the fact of the innervation. The same muscle, after the operation, may continue to receive excess innervation. Nor will surgical treatment affect the lack of fusion, the lack of desire of the patient to see single, that is another cause of squint. Finally, if the squinting eye is losing its vision for the reason stated before, straightening it surgically will not restore the vision; the brain will continue to pay attention to the other eye exclusively, and this may cause the eye to turn in (or out) again after a few years.

Surgery is the only way out in certain pathological cases. For example, if a motor nerve innervating muscle is paralyzed, it is impossible to exercise this muscle. Certainly, the remarkable improvement in cosmetic effect that is obtained by operative means must not be brushed aside. At the same time, the "before" and "after" photographs that are frequently displayed as triumphs of the surgeon's art in this connection do not answer the important questions: how long will the eyes remain straight? and how about the half-blind eye?

Now we are in a position to answer the questions asked by Mrs. S. as quoted previously:

First take your child to an optometrist for a thorough eye-examina-

tion, and have him correct any defects with glasses. If ocular exercises and visual training are needed, they should be undertaken at once as directed. In many cases, this procedure will result in a marked improvement. Vision in the squinting eye can frequently be restored to a surprising extent by occluding the good eye and forcing the poor eye to function. Only if no improvement is noted after six months should there be resort to an operation. And many cases require visual training *after* the operation which, we repeat, is for cosmetic purposes only. Glasses and visual training get at the roots of the problem: operations do not.

The matter should be taken care of immediately. The advice sometimes given by physicians not to do anything but to let the eyes alone as they will straighten by themselves in due time, is criminal advice. The eyes cannot straighten by themselves, and the consequences of neglect may be permanent, partial blindness of the squinting eye.

Medicine and Hygiene in Soviet Russia

By Paul Luttinger, M.D.

CHAPTER III

Organization of the Public Health Service—Social and Health Insurance

The Union of Socialist Soviet Republics (U.S.S.R.) being the only state in the world which is not based on the principle of private property, but on those of the socialist commonwealth, it is natural that the national health should be considered one of the most important functions of the Russian government. By numerous decrees and supplementary regulations, the organization of the Public Health Service has been continually improved and coordinated with that of the Medical Administration, Social and Health Insurance, etc. At the present time the various agencies and other factors cooperating in the integral realization of the Soviet health program are so numerous

that it may appear confusing to visitors from bourgeois countries; but the basis organizational framework is really very simple:

Let us first remember that the U.S.S.R. is a Federal State, formed of seven large principal republics: The Russian Socialist Federated Soviet Republic (R.S.F.S.R.), The Ukraine Republic, The Republic of White Russia, The Transcaucasian Federation, the Republic of Uzbekistan, the Republic of Turkmenistan and the Republic of Tadjikistan; Moscow being the capital of both the R.S.F.S.R. and the entire U.S.S.R. There are also a number of lesser republics and autonomous regions within some of the principal or federated states; one of the latest being the recently created Jewish autonomous Republic of Bire-Bijan.

Each of the federated republics has its own independent government composed of a Central Executive Committee and of a Council of People's Commissars; the latter corresponding to the ministerial council or the Cabinet of bourgeois countries. Some Commissars are federal, i.e., they belong to the central government and have authority over the entire territory of the U.S.S.R. Such are the Commissars of War, Foreign Affairs, Agriculture and Labor. Others, like the Commissars of Public Health and of Public Education have no authority outside their respective republics. In other words, *each federated Republic has its own Commissar or Secretary of Health.* There is no Central or All-Union Secretary of Health; but there is a central Public Health Information Bureau in Moscow which has no political authority whatsoever on the Health Commissariats of the various federated republics. The health service of the Army and Navy and for the transportation workers, however, is administered by All-Union authorities and the health system established by the R.S.F.S.R. usually serves as a model for the other six constituent republics.

Each of the seven People's Commissars of Health is appointed by the *Presidium*, a committee representing the *Tsik* which is elected by the Congress of Soviets in each federated republic. The Commissar is assisted by one or two substitutes and by a *collegium* having an *advisory* function. This constitutes the Commissariat or Department of Health. A Scientific Council and a Sanitary Council are usual adjuncts to the Commissariat.

The Departments of Health of each state are divided into sections such as prophylactic, sanitary, medical, administrative, pharmaceutical, medical education, sanitaria and other sections embracing the entire field of public health of the Republic.

The health service of the lesser republics and of the Autonomous Regions which are a part of the federal republic is based on the peculiarities and economic interests of each region. Each Regional Health Service is under the central control and organized along the same lines with similar subdivisions. There are agricultural, industrial, mining and other regions.

The Head of the District or Regional Health Commissariat is appointed by the District Committee. The Commissar of Health nominates the candidate, who is rarely rejected. In some regions, the local authorities nominate the candidate, who is appointed if approved by the Commissar.

It must be remembered that there is no distinction in the U.S.S.R. between the executive and legislative power. Thus the Council of People's Commissars of each Republic (of which the State Secretary of Health is a member) not only executes the law, but can also decree new laws and regulations. The General Congress of Soviets determines the general political line and the Council of Commissars follows the line by issuing the necessary decrees. In Russia, any official may be recalled by the people at any time!

Each city or industrial center also has its local Soviet (Council) with its municipal Health Service which includes delegates from the surrounding regions; the aim of Soviet institutions being permanent contact with the industrial and agricultural masses from which they derive their strength and adaptability and which prevents them from falling into the ever-threatening rut of bureaucracy.

Every Autonomous Region or Republic comprises several medical districts. Each district has one or more physicians, a hospital and dispensaries. The collective agricultural enterprises (*Kolkhoz*) and the state agricultural exploitations (*Sovkhoz*) require special health services, owing to their distance from municipal and other centers. During harvesting and sowing, thousands of physicians are sent out from health centers, as "flying squads" to *kolkhoz* and *sovkhoz* farms, where they

not only give the necessary medical aid, but also lecture on hygiene, organize first-aid units and rural pharmacies. Each health center has also available a few doctors and nurses for special health work, in cases of emergency. The watchword of the public health system in Russia is not merely to cure the patient, but to increase his efficiency as a member of the community.

Social and Health Insurance

What distinguishes Soviet social and health insurance from the pseudo-insurance of bourgeois countries is that *the worker does not contribute to the insurance fund* and that the aim of the insurance law, promulgated in 1922, was to replace the grudging charitable relief of capitalist countries by adequate aid to which every worker is fully entitled. It is being extended every year, so that by the end of the second five-year plan, it is hoped that it will embrace *every* hazard which might threaten the life, health or job of the worker and his dependents.

At present, the provisions for insurance comprise temporary disability due to sickness or other causes, maternity, unemployment, permanent disability, old age, industrial diseases and accidents and burial. Since 1930, the branch of social insurance dealing with unemployment has been replaced by that of the Bureau of Skilled Labor, the function of which is to redistribute and instruct maladjusted workers; unemployment having been *liquidated in the U.S.S.R. four years ago.*

All salaried persons are entitled to insurance benefits: employees of state, public, cooperative, concession or private enterprises, including those who work at home. Peasants, apprentices and those deprived of their civil rights are not, as yet included. Deprived persons are former landlords, bourgeois, nobles, Tsarist officials and army officers, merchants and *kulaks.* Peasants have mutual aid societies, are partially relieved from taxation and receive free medical care. Practically 90 per cent of the salaried workers and their families are entitled to insurance benefits.

Before the Revolution, the law of 1912 had made an attempt to outline a scheme of social insurance; but it was designed to cover only those enterprises employing more than 30 workers or 20 workers, if the factory used mechanical power. The law was applicable to only 21 per cent of salaried workers. The fund accumulated while this

law was in existence is now being utilized for the provision of creches and similar institutions.

All workers disabled either when permanently employed or during the period of tryout are entitled to insurance benefits from the first day of disability until they can resume their work or become totally disabled. Temporary workers receive temporary disability benefits only during the season of work.

From the *Guide Book to the Soviet Union,* Dr. Calvin B. Hoover's book, *The Economic Life of Soviet Russia* and from Dr. A. Roubakine's monograph, *La protection de la santé publique dans l' U.R.S.S.,* the following data have been gathered:

Full wages are paid during disability due to illness, to quarantine because of infectious disease in the family of the insured, or during absence from work while nursing a sick member of the family. The amount of money received is calculated on the basis of the real salary of the insured during the three months preceding the illness or accident; premiums, overtime and other supplementary compensation are included as part of the real salary received. These wages are not the same for the same work all over Russia. There are six zones which are subdivided into regions, according to the average salary and cost of living; each zone having a maximum allowance.

If the assured worker is found to have purposely contracted the illness or aggravated his condition or if he uses his rest period contrary to the doctor's directions, he loses his right to insurance benefits. Only practictioners recognized by the Health Service and the Insurance Funds are allowed to grant leaves of absence for temporary disability. Sick leave after ten days can only be obtained after a consultation between the attending physician and a medical referee. If a difference of opinion arises, the case is referred to The Medical Supervisory Committee. Thus, malingering could be easily detected and checked, if a foolhardy individual should attempt it. As a matter of fact, malingering is so rare that it is said not to occur in Russia.

When an insured worker becomes ill, whether he is disabled or not, his case is immediately referred by the insurance fund to the Commissariat of Health or the Local Board of Health. In addition to the services of a physician, he or she is also entitled to those of a

nurse, hospital treatment, drugs and if necessary, one or more specialists. Rest homes, beds in sanatoria and health resorts (three-fourths of which are reserved for industrial and transport workers) are also provided when needed. An insured's dependents, all unemployed and all trade-unionists are likewise entitled to free medical treatment.

In cases of permanent disability, the worker is entitled to a *pension,* varying from one- to two-thirds of the regular wages, according to the extent of the injury. It is higher when the incapacity is due to an industrial accident or occupational disease. A person over 50, must prove that he had been working for, at least, eight years preceding his disability.

Instead of a pension, the assured may elect to go to a home for invalids, with the right of changing any time he chooses. The pensioned person and members of his family have certain other privileges in the form of cut-rates for railroad fare, rent, school tuition for the children, etc.

Dependent widows and old people also receive pensions. At the age of 60, all persons who have been employed for 25 years receive a pension of half their wages, based on what they earned during the last year of their employment. Miners, workers in the textile industry and the chemical trades are entitled to their old-age pension at 50 and, if they wish, *may continue to work at full wages,* in addition to their pension.

Female manual workers get eight weeks rest at full wages before and eight weeks after confinement. For pregnant clerks, stenographers and other non-manual employees, the rate is six weeks before and six weeks after labor. When the birth is registered, half of the mother's monthly wage is given as a *clothing bonus.* For the nine consequent months, a mother is entitled to one-fourth of her monthly earnings as *nursing* benefit. Theoretically, unemployed women and the wives of unemployed men receive the same benefits, based on the average wage received before unemployment; practically there is no need for this provision, as involuntary idleness does not exist now in Soviet Russia.

In case of death of an insured, an unemployed or a pensioned person, funeral expenses are paid to his family. The insured also receives a funeral indemnity at the death of the wife or husband, children and minor brothers and sisters (less than 16 years of age).

The free stay at sanatoria and rest homes is limited to ten weeks. During this time, they receive free board and free medical care, travelling expenses to and from the sanatorium and the allowance for temporary disability determined by the Insurance Fund. Industrial workers receive precedence at all institutions and they are sent to the rest homes preferably during their annual vacation.

The principles of organization of the medical care are established by the Commissariat of Health working in cooperation with the Commissariat of Labor and the Trade Union Council. A special fund derived from the insurance premiums is automatically transferred by the Insurance Fund to the Commissariat of Health.

Insurance premiums are *not* paid weekly or monthly by the insured, as in capitalist countries. The premiums are automatically created by the insured's *work. A person who works is ipso facto insured!* In each factory, mine or office, there is a Social Insurance Bank into which is deposited periodically certain per capita sums based on the amount of wages paid out by the enterprise. This bank is controlled by a committee of workers annually elected by the trade unions of the region. There is *no* representative of the administration on this local bank committee and it is forbidden to withhold any part of a wage or salary from a worker for the purpose of replenishing or increasing the insurance fund. The enterprise itself, be it a state, cooperative or private institution, must deposit into this fund a sum proportional to the number of people employed and the amount of wages paid them. The insurance fund is increased by the interest paid by the Republic on the sums on deposit in the insurance banks and by certain fines and other revenues.

The premium deposited by the administration varies according to the nature of the enterprise. For those who work at home, it is rarely over 5%; for those occupied in hazardous or dangerous undertakings, the premium may be as high as 22% of the salary.

The Insurance Funds have a territorial organization: all wage earners working in a certain region belong to the same Fund through their respective local banks. The minimum of insured, at one Fund is 2000. The Insurance Funds are intimately connected with the trade unions, while remaining state institutions. Each federated re-

public has a Bureau of Social Insurance in its Commissariat of Labor which supervises the regional Insurance Funds and local insurance banks. The Central Direction of Social Insurance is at Moscow, in the All-Union Commissariat of Labor of the U.S.S.R.

The local insurance funds and banks pay 3% of their income to the central federal body which is thus able to help the regions which have a deficit and to undertake prophylactic (preventative) measures.

The use of insurance funds is strictly regulated. Thus, the Commissariat of Health works out a plan of organization and a budget at the beginning of each calendar year. These are studied and approved by special budgetary commissions, composed of representatives of the insurance funds, the Council of Trade Unions and the Health Service. They are then approved by the Executive Committee of the local Soviet, after which they cannot be modified.

Besides the moneys spent by the Insurance funds for medical service, rest homes and sanatoria, vast sums are put aside for their construction and maintenance. Nearly all Insurance Funds have their own rest homes. More and more beds are added every year to accommodate the nearly 70 per thousand of the insured who are now making use of rest homes and sanatoria. In 1928 only 56.4 per thousand availed themselves of this service for which 5% of the total insurance funds were spent. When the local funds have an insufficient number of beds in their own rest homes (mainly for the tuberculous), they rent additional ones in other sanatoria. During the year 1931-32 the Central Social Insurance Fund of the Leningrad region increased the number of available beds for its members by 2500.

The expenditures for medical services rises rapidly. In 1926-27 the Insurance Funds spent 35 roubles per family or 25.69 per capita; while in 1924-25 the expenditure was only 18.87 and in 1925-26, 25.62 per capita.

In 1925-26, the cost of medical care was 28.16% of the total insurance budget. In 1926-27, 29.6%; in 1927-28, 29.7%; in 1928-29, 30%; in 1930-31, 31.2%; in 1931-32, 32.03% and in 1932-33, nearly 33%. Translated in cash terms, the insurance funds spent 123 million roubles for medical care in 1924-25; 701.5 millions in 1932 and nearly 800 million in 1933.

The extensive benefits received by Russian workers thus calls for the expenditure of enormous sums. It has been estimated that nearly 18% of the wages earned is spent by the various activities of the insurance funds. An idea of what this means can be gotten by studying their successive budgets. In 1924-25, the funds for the entire U.S.R.R. were 474 million roubles; in 1927-28, 1 billion; 1928-29, 1¼ billion; 1930, 1¾ billion; 1931, 2 billion 573 million roubles; 1932, 3½ billion roubles; while the appropriations for social insurance for the year 1933 has been estimated to have reached the vast sum of over *4 billion roubles.*

Temporary disability, unemployment and pensions absorbed 55% of the insurance funds. In 1930, unemployment having been eradicated, vast sums became available for temporary disability, old age pensions and orphanages.

The following table taken from Dr. Roubakine's book shows how the insurance funds were distributed for the period 1927-31:

Budget of the Social Insurance Funds in the U.S.S.R.

(*in millions of roubles*)

	1927-8	1928-9	1930	1931
RECEIPTS	1.051.1	1.258,8	1.796	2.573
EXPENDITURES:				
I.				
Benefits and Grants	630.8	764.8	813.7	942.4
1. Temporary disability benefits	244.	297.8	390.7	524.2
2. Other forms of assistance	68.4	67.2	54.8	64.6
3. Invalids, orphans and old-age	204.8	263.4	318.8	353.6
4. Unemployed	113.6	136.4	49.4	——
II.				
Medical Care	283.3	294.7	414.4	608.
1. Medical assistance and hospital construction	244.3	255.6	356.2	475.6
2. Rest homes and sanatoria	39.	39.1	52.6	95.3
III.				
Educational Grants	——	——	58.1	186.2
IV.				
Sanitary Installations	105.	123.3	190.1	351.6
V.				
Other expenses	31.	76.	319.7	484.8
Total Expenditures	1.050,1	1.258,8	1.796	2.573

Letters to the Editor

DEAR DR. LUTTINGER:

I enjoyed reading your magazine and it is with pleasure and hope of success that I enclose $1.00 for subscription to HEALTH. Please include the first issue. Your plan of including all categories of medical workers in your program places it on a sound basis. I hope you find time and space for articles on medical education and the medical student, also.

The ferment of economic change diffusing through society has, of course, not left the physician untouched. There is considerable dissatisfaction among physicians, but it is misdirected, narrow in its analysis and confused by traditions of medical ethics. Your magazine will do invaluable work in clarifying the issues involved, pointing out their relation to the social organization, and proposing a solution. It is for this reason that I am glad HEALTH took a definite stand on the question of socialized medicine, for now the alignment becomes clear-cut. However, there are a few objections I wish to make to Dr. Tannenbaum's article. Dr. Tannenbaum must know that the program of the Medical League for Socialized Medicine is impossible of achievement under the present social system and should state so. The very teachers and postal employes he uses as examples have had salaries reduced, drastic cuts in budgets and their forces curtailed. Why should "state medicine" fare any better? Also, to " . . . eliminate . . . nostrums, quackery, cultism, etc." means logically to eliminate business for profit. Here again the M.L.S.M. hits a snag which I see no way of removing except by changing society fundamentally.

The League's program must be supported not because it will achieve socialized medicine under the present system, but because the League's program will serve as a rallying point for progressive physicians and because their program, if honestly carried to its logical conclusion, will necessitate a change in society before it is capable of fulfillment.

I notice Dr. Tannenbaum uses the terms "state medicine" and

"socialized medicine" interchangeably. I wish some information on this. Do they really mean the same thing? I ask because it seems to me that "state medicine" implies organization and control of a group of people to serve either as a function of the state (post-office) or for preservation of the state (teachers), while to speak of achieving "socialized medicine" under the present system in America appears to me a contradiction. "Socialized medicine" in practice means to me more than practice of medicine under state beneficence. To me is a practice of medicine inherently bound up with the welfare of society. Under the "state medicine" for instance, I can imagine the development of a reactionary group of physicians, a thing impossible under "socialized medicine." And while I am on the subject, is the M.L.S.M. a national organization? Can branches of the M.L.S.M. be formed in other cities? Has the M.L.S.M. any program aside from socialized medicine?

Sincerely yours,

L. K., B.A.

DEAR DR. LUTTINGER:

I am just in receipt of your magazine HEALTH, and contrary to my expectations I was very well pleased with it.

I say "contrary to my expectations" because, as you no doubt know, most of our radicals are followers of various forms of quackery, cults and fads. There are a number of our radicals, not only naturopaths, osteopaths and chiropractors, but even regular M.D.s who sneer at scientific medicine, who deny the etiology of germ disease. I have even had a radical physician who denied the existence of hormones and vitamins!

I was therefore pleased to see that though a radical you are an adherent of scientific medicine.

Sincerely yours,

WILLIAM J. ROBINSON, M.D.

Answers to Questions

By THE EDITOR

UNSYMMETRICAL BREASTS

V. S.—We do not think that the "scrap" you had when you were twelve has any relation to the size of your breast. As a matter of fact, nearly every woman has one breast smaller than the other; but in most cases the difference is too small to perceive without actual measurement. In many women the two breasts are unequal enough to become noticeable at first sight. There is nothing that can be done about it, except to massage the smaller breast every night with cocoa butter; using a circular movement. This means that the breast has to be massaged from side to side underneath the nipple and from the opposite side above the nipple. Do not pinch or slap the breast and do not use the vacuum apparatus which are sold as "breast developers." What we mean is that you should not use the form of massage known as "tapotment" or "petrissage," but the one known as "effleurage" which consists in a *light* stroke.

THE STORK AS A DOCTOR

J. N., Chicago—If you are not using any preventatives, it is most unusual that a perfectly healthy couple should have no children. Are you sure that you are perfectly O. K.? What we mean is whether you have had an attack of gonorrhea before you were married. You have not given us your respective ages, and we, therefore, cannot tell how urgent it is for you to have a baby. It is impossible, of course, to give a definite opinion in such a delicate matter without a thorough physical and psychological examination.

Pregnancy as a cure for all ills is an old, but unreliable method of treatment. In most cases, we find that relatively slight complaints are aggravated after pregnancy. Notwithstanding the advice of your well-meaning friends, we would advise you to be cautious in calling in the stork as a healer. Owing to your wife's pain in the back, we should like you to have her urine tested.

Socialization *vs.* Individualism

Continued from page 28

wrecked on a desert island, who, in their dire extremity, "made a somewhat precarious living by taking in one another's washing."

It is one of the greatest blunders, on the part of any man, to think that the bringing about of an economic salvation of a particular group lies within the power of that group. Crises are not at all novel and in order to extricate oneself from these periodic economic plights, society, as a whole, failed time and again to stave off these monsters. Why? Because our socio-economic structure is conducive for such economic upheavals.

By far the clearest and most graphic of all statements of this theory is the one by Engels, in his reply to Duhring: "Since 1825, when the first general crisis broke out, the whole industrial and commercial world, production and exchange among all civilized peoples and their more or less barbaric hangers-on, are thrown out of joint about once every ten years. Commerce is at a standstill, the markets are glutted, products accumulate, as multitudinous as they are unsalable, hard cash disappears, credit vanishes, factories are closed, the mass of the workers are in want of the means of subsistence, because they have produced too much of the means of subsistence; bankruptcy follows upon bankruptcy, execution upon execution. The stagnation lasts for years; productive forces and products are wasted and destroyed wholesale, until the accumulated mass of commodities finally filter off, more or less depreciated in value, until production and exchange gradually begin to move again. Little by little the pace quickens. It becomes a trot. The industrial trot breaks into a canter, the canter in turn grows into the headlong gallop of a perfect steeplechase of industry, commercial credit, and speculation, which finally, after breakneck leaps, ends where it began—in the ditch of a crisis. And so over and over again."

To be continued in next issue.

Owing to lack of space a lot of interesting material had to be left over for the next issue which will appear on or before September 1st.—EDITOR

Capitalist Equality