

(moving and nonmoving), 46 persons in accidents "while at work", 107 persons in home accidents, and 73 persons per 1,000 population in accidents classified in the "other" category, which consists principally of therapeutic misadventures, and accidents occurring in public places such as schools, places of recreation, stores, and offices. The remaining 2 persons per 1,000 population were injured in accidents of "unknown" class. Among the total persons injured, 12 million, or 27%, were involved in accidents described as falls. About 4 million of these accidents resulting in injury were falls on stairs, steps, or from a height. Approximately 23% of the 45 million persons injured had one or more days of bed disability associated with the injury.

INDUSTRIAL MEDICAL PRACTICE

- 1114 The Beginnings of Industrial Medicine in England. H. Buess. *Brit. J. Ind. Med.* 19, 297-302 (Oct. 1962).

Industrial medicine saw its tentative beginnings among the inquiring minds of the 16th century physicians such as Paracelsus. In the 17th century, reports of conditions in mines on the Continent prompted natural scientists at the Royal Society to initiate a research program into what we now know as mercurial poisoning. The latter part of the eighteenth century witnessed the change from domestic to factory industry with its noncomitant social, economic, and technological upheaval, resulting in great shifts of population away from the countryside to the towns. Men, women, and children were employed in the new factories in primitive, unhygienic conditions, and mill fever and illness generally were rife. It was against this background that Percival and Thackrah prompted no doubt in large measure by the conditions of child labor, inquired into, and made recommendations for, the improvement of hygiene in the factories, thus laying the foundations of industrial medicine as we know it today.

-- Author's abstr.

- 1115 Guide to Small Plant Occupational Health Programs. American Medical Association, Council on Occupational Health. *Arch. Environmental Health* 5, 381-392 (Oct. 1962).

The objectives of any good occupational health program, whether it serves a plant of 50,000 employees or a plant of 50 or fewer employees, are the same; namely, those stated clearly in the American Medical Association statement on "Scope, Objectives, and Functions of Occupational Health Programs" and listed in the introduction of this guide. Activities undertaken to attain these objectives vary greatly, however, from one small plant to another. The small plant is likely not to be in a position to hire even a full-time nurse, let alone a full-time physician or industrial hygienist. Most small plants can obtain and afford the services of a physician and industrialist hygienist on a part-time or on-call basis, particularly through banding together with other plants and engaging such personnel cooperatively. Although the plant enjoys only a part-time service of a physician or the services of a nurse supervised by a physician, its occupational health program should include plant visits by the physician no matter how small the plant is. The individual physician, prohibited as he is in personally soliciting practice, should use the good offices of his local medical society in promoting small plant occupational health programs in cooperation with management, labor, and interested community agencies.

- 1116 Medical Services at Airports. A Study of the Need for Comprehensive Medical Programs at Large Airports. H. L. Reighard. *Arch. Environmental Health* 5, 344-357 (Oct. 1962).

The value of medical programs in improving the performance and effectiveness of employees in industry is well known and has been extensively demonstrated. Airport populations constitute sizable industrial communities. The nature of the operations conducted has important implications for the safety of air operations. Employers at the airport studied