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REPORT OF THE

HEALTH SECTION

Minidoka Relocation Center

Hunt, Idaho

Compiled by

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June 1, 1942 to October 19, 1945

War Relocation Authority
Washington, D. C.

R E P O R T

of

Health Section
Minidoka Relocation Center
October 15, 1943 - December 15, 1945

Compiled by
Bert Weston
Acting Assistant Project Director

General Report

of the

HEALTH SECTION

The Chief Medical Officer, working directly under the Project Director, was responsible for the complete health program of the center, the major objectives of which were:

1. Prevention of infectious diseases, the maintaining of an overall standard of health for the center at least equal to that with which the individual entered the camp.

2. Operation and supervision of the project hospital.

3. Making arrangements for contractual medical services for residents where the facilities of the project hospital were not adequate or where specialists were required for medical care.

The Chief Medical Officer had direct supervision over the Hospital Administrator, who acted as the Chief Medical Officer's administrative assistant, the project Sanitarian, Chief Nurse, Medical Social Worker, Public Health Nurse, Laboratory and X-Ray Supervisor, and the Chief Dietician, in addition to the medical staff.

The project hospital was adequately equipped to take care of approximately 250 patients, having two operating rooms, an x-ray department, laboratory, dental clinic, out-patient department, and separate wards for obstetrics, medical, pediatrics, surgical, and communicable disease patients, each ward being equipped with diet kitchen and tray room. The central kitchen and dining room seating approximately 300, were used for employees and diabetic patients who lived in the blocks but who came to the hospital for their special diet.

The administrative offices of the hospital employed an average of eight evacuees including one office secretary, one timekeeper, and five or six clerical typists who besides doing the clerical work of the office, acted as secretaries to the medical officers.

The hospital was the only building on the project that had steam heat, and in connection with the hospital, a complete power laundry was operated. The out-patient department had 24-hour ambulance service employing eight ambulance drivers, having two ambulances, one passenger car for emergency and obstetrics cases, and one convoy truck used to convoy workers from the hospital to their homes. A modern morgue with refrigeration facilities was operated in connection with the hospital and a contract

with an undertaking establishment at Jerome was in effect. There was also a contract with the crematorium at Ogden, Utah. The out-patient department conducted a prenatal and postpartum school clinic every Tuesday and a well-baby clinic every Friday under the supervision of the Public Health Nurse.

The average number of employees on the payroll, except for the closing months of the project, was approximately sixteen appointed personnel who were paid approximately $140,266 during the period from October 1942 to October 1945. An average of 180 evacuees were employed and paid approximately $145,596.76. Cost of all supplies for the hospital during this period amounted to approximately $332,890 with equipment purchased amounting to approximately $35,560. Other expenses, such as contractual services, travel, etc., amounted to approximately $5,565. During the three years the hospital admitted 3,094 patients, treated 88,021 patients in the out-patient department, treated 56,150 patients in the dental clinic, 4,120 patients in the optical clinic, 551 contagious diseases were reported, and 1,581 patients were referred to outside doctors. There were 188 major operations and 1,355 minor operations performed. There were 500 births and 187 deaths during the three-year period.

In the operation of the hospital, nurses aides and male attendants were employed for all nursing care under the supervision of Caucasian graduate nurses. With the exception of three Caucasian Medical Officers, the graduate nursing staff of nine nurses, the Chief Dietician, Sanitarian, Hospital Administrator, Medical Social Worker, Public Health Nurse, and Supervisor of X-Ray and Laboratory, all other employees were evacuees. The evacuee employee was required to work eight hours a day, five and a half days a week for which the rate of pay was $16 per month except for professional workers such as dentists, doctors, and pharmacists, whose rate of pay was $19 per month. All food handlers were subject to physical examination and blood tests. Drinking water and milk were tested regularly by the Sanitarian and a weekly report made to the Chief Medical Officer.

Through the Medical Social Worker, the health division cooperated with the State Public Health Department and held several crippled children clinics. A selective service representative was employed on the project and handled all procedures pertaining to the selective service and induction of evacuees for the armed forces. The project had a very fine record as to inductees with more than one thousand boys from the project being in the service.

During the closing months of the center one of the problems was the relocation of bedridden patients to institutions in states of their legal residence, due to the shortage of bed space in many of the institutions to which they were to be transferred. However, all patients were transferred and accepted prior to the actual closing date of the center.

War Relocation Authority
Washington, D. C.

R E P O R T

of

Chief Nurse
Minidoka Relocation Center
September 1942 - October 15, 1945

Compiled by
Josephine Rappaport

THE NURSING PROGRAM OF THE HEALTH SECTION AT
THE MINIDOKA PROJECT. Sept. 1942, to Oct. 15, 1945

The nursing program at the Minidoka Project constituted an integral part of the activities of the Health Section. The objectives of this program were the provision for the best possible nursing care within the hospital, the care, teaching and supervision of patients in the out-patient department, adequate health supervision and teaching in the home (see attached public health report) and the teaching of nursing techniques to lay personnel who were thus enabled to give simple nursing care to patients and give assistance to the doctors and graduate nurses.

The services provided in the hospital were medical, surgical, and obstetrical, pediatric, tuberculosis, care of the aged and chronic, as well as operating room and clinic. The care of the medical patients included general medical care, preparation for laboratory and x-ray tests, assistance with various treatments by the physician, and the administration of para oral fluids, intravenous and subcutaneous, by the graduate nurses.

Surgical patient care included pre and post operative care, as well as assistance with anaesthesia by graduate nurses. Most of the anaesthesia, however, was induced spinally by the assisting surgeon. Treatments included transfusion, infusion, nasal suction siphonage, etc.

Obstetrical care started with physical examination including pelvic measurements in the outpatient department, determination of weight, blood pressure, urinalysis and serology tests. Routine monthly appointments were given to the patients for visits to the out-patient department for the first seven months, then visits every two weeks for the eighth month, and weekly visits for the last month until admission for delivery. These patients were checked monthly by the graduate nurse in the out-patient department and referred to the physician for any unusual signs or symptoms. Routine visits included the determination of weight, blood pressure, presence of edema, fetal heart tone, and routine urinalysis.

Teaching was done by the nurse in this clinic. On admission to the hospital, the patient was prepared for delivery in the labor room and seen by the physician. The graduate nurse assisted with the delivery and the administration of ether with pains. On delivery of the infant, 1 cc of Pituitrin was administered intramuscularly to the mother; on delivery of the placenta, 1 cc of Ergonovine. Ergotrate grains 1/320 was given orally every eight hours post-partum for eight doses. 1% silver nitrate was instilled into the eyes of the newborn. Care of the infant included the application of a mixture of 5% sulfathiazole ointment and mineral oil in equal parts which seemed to be very effective since the infants rarely exhibited any skin lesions. A demonstration infant bath was given to each mother before leaving the hospital, as well as an opportunity to discuss any aspects of infant care.

Infants were brought to the Well Baby Clinic two weeks after discharge, and mothers came to post-partum clinic six weeks after delivery for examination. It was probably due to this care that there was but one mother lost out of 499 deliveries during the existence of the Project. She died due to placenta previa. There were but 8 stillbirths. Only 2 infants died during that period. There were 6 Caesarean sections done on the basis of physical findings of which 3 were pre-eclamptic with one viable fetus. Routine procedure for the care of mothers before, during, and after delivery together with the care of the infants was worked out by the Chief Medical Officer in

Nursing Program, Cont'd.

collaboration with the graduate nurses. This typewritten routine has been of great help and guidance to each new member of the Staff.

Pediatrics was only a small service after July, 1944. Isolation technique was practiced and there was no cross infection.

The care of the tuberculous presented one of the greatest problems in providing personnel. Inhibited by the prevalent community concept of the dangers of tuberculosis and consequent fears, most of the nurse's aides refused to work on this ward, even to the point of resignation from the staff. A few relatives of patients gave general bedside care to their kinfolk, others came on the staff and divided their time between husband, wife, son, or daughter and some other patients. Occasionally a few nurses aides would work for a few weeks or months at a time until family or community pressure became too great and the aide either resigned or asked for an alternative. In September, 1944, Miss Ethel Hempstead, a missionary, offered her services in this ward for 30 hours weekly and she solved most of the difficulties until August 17, 1945, when she resigned. The few remaining patients on this ward were then transferred to another ward.

"General Instructions for Patients and Workers on Ward 16" were discussed by the nursing staff, written up, submitted to the Chief Medical Officer for suggestions, additions, deletions, and final approval. These instructions were translated into Japanese, mimeographed both in English and Japanese and a copy given to each patient, relative, worker, and visitor for their own study. These instructions seemed to be exceedingly helpful since they gave re-assurance to the family and visitors and a sense of security to patients, aides, janitors, dishwashers and others coming into contact with these tuberculous patients.

The care of the chronic, aged, and senile was another difficulty. Older Issei were the principal aides employed there. It might be a husband, or wife who took care of their own and some old bachelors who had no one to render bedside care. These Isseis with instruction on a fairly low level learned simple procedures rather well and managed to keep the old men dry, clean, and fed.

The operating room was under the direction of a graduate Nisei nurse who trained a staff of nurse's aides. They did surprisingly well in assisting with minor operations, treatments, and the upkeep of all sterile supplies.

The clinics have been under the direction of a graduate nurse with a staff of nurse's aides; during the last year, with nursing personnel decreasing, the Public Health Nurse had charge of this unit until her resignation on August 1, 1945. (See attached Public Health Report for activities.)

It is found from existing records that a total of fifteen graduate nurses appointed by the Civil Service Commission have at one time or another been assigned to the Minidoka Project Hospital. On September 6, 1943, the record shows an evacuee staff of five graduate registered and three student nurses, a nurse's aide staff of 29 and of 7 male attendants. On February 5, 1944, the evacuee staff consisted of seven graduate registered nurses, 102

Nursing Program, Cont'd.

nurse's aides and 27 male attendants, as well as three Public Health Aides (see the number of patients at that time in the attached graph). On July 17, 1944, one week after arrival at the Minidoka Project Hospital, the nursing staff consisted of a chief nurse, two assistant chief nurses, four supervising nurses, one senior, and one junior staff nurse, one evacuee graduate registered nurse, 58 nurse's aides and three male attendants. The patient census on that day was 101.

Taking the 17th as an arbitrary date, I shall try to indicate the gradual reduction in patient census and hospital personnel through the succeeding months with ever increasing consolidation.

From July, 1944, to January, 1945, statistics changed very little with average patient census of 79.

Graduate Nurse Staff:	(9)	One Chief Nurse Two assistant Chief Nurses Four Supervising Nurses One Senior Staff Nurse One Junior Staff Nurse
Nurse's Aides		Full time - 35 Part time - 16 (22 hours weekly) Male attendants - 4

From February, 1945, to June, 1945, average patient census was 68.3.

Graduate Nurse Staff:	(8)	See appointments and resignations
Nurses Aides:		Full time - 30.5 Part time - 6.4 Male attendants - 3.2

From June, 1945, to October 20, 1945, patient census was 35.6 (ranging from 43 to 20).

Graduate Nurse Staff:	See appointments and resignations
Nurse's Aides	17.2 (ranging from 32 to 2) Male attendants - 2

CONSOLIDATION OF WARDS AND SERVICES

September 28, 1944:	Ward 10 (surgical) to Ward 12 (medical) Ward 12 to Ward 14 (senile and chronic)
June 17, 1945:	Ward 14 to Ward 12 Ward 12 to Ward 8 (pediatrics Ward 16 (tuberculosis) to Ward 14
October 15, 1945:	Services active: Ward 6 (obstetrics) Ward 8 (mixed ward)

GRADUATE NURSE STAFF

Appointments and transfers:

July 1, 1945, Miss Kimmel - transfer from Gila
August 6, 1945, Miss Quarry

Detail:			
	May 21, 1945	Miss Kimmel	
	June 18, 1945	Miss Johnson)	
		Mrs. Snyder)	Nurse's Aides
	June 25, 1945	Miss Pedersen	(to August 2, 1945)
	July 12, 1945	Mrs. Kimball	(to September 5, 1945)
		Mrs. Hall	

Resignations:

October 18, 1944, Junior Staff Nurse, Marie Talbott
February 12, 1944, Supervising Nurse, Mrs. Gurganus
February 24, 1944, Two supervising Nurses, Miss L. Talbott and Miss Travis
July 1, 1945, Mrs. Nakamura
July 31, 1945, Miss Greiner
May 22, 1945, Miss Rinderknecht

The graduate registered nurses have taken part in all nursing activities within the hospital. Each newly appointed or detailed nurse was given an introduction to the hospital and its services by a trip through the institution and shift assignments with another nurse for one day, one evening, or night. Conferences were held as necessary and weekly staff meetings for all nurses, the purpose being for discussion of common problems. Though recognizing the value of such meetings, it was, however, deemed necessary to discontinue them in January, 1945, with the staff was greatly reduced in number. Any matter warranting discussion has since been taken up during morning and evening report time. Weekly time and work assignment sheets for the graduates insured smooth administration. There was a rotation schedule for day, evening, and night duty, each staff member covering four week's service. Whenever possible the off-duty day was arranged as requested by each individual nurse. The graduate nurses supervised the actual bedside care rendered by the nurse's aides and clerks on the wards. Routines were discussed, formulated, and typed whenever the need for them was felt.

Since the opening of the Project, lay persons have been taught simple nursing procedure to enable them to do bedside nursing under the supervision of gradutate nurses. Teaching has consisted of formal class room instruction, bedside demonstration and return demonstrations. These persons designated as nurse's aides wore blue and white striped pinafores and white blouses, a uniform which was neat and attractive. A group of eight young people were assigned as ward clerks and after a short period of training were given responsibility for routine charting, requisitions, making appointments, and answering the telephine. They wore red and white striped pinafores with white blouses. By August 12, 1945, all ward clerks had relocated and no new appointments were made.

Records kept from July, 1944, show an aggregate of 127 nurse's aides who have bedside nursing care at one time or another to the hospital patients. Their ages ranged from 15 to 70. Class hours and formal teaching ranged from

5 to 49 hours exclusive of demonstrations and return demonstrations. During this time 19 male attendants were at one time or another on the Staff. Their ages ranted from 15 to 62. Whenever possible the younger members of this group were included in the classes.

By October 15, with all the nurse's aides and male attendants relocated, the hospital patient census will be seven, all located on Ward 8. The out-patient department is still quite busy, a few patients are still seen and many bring in their medications for re-fills. The appointed personnel are sent in for emergency treatment of burns, cuts, bruises, gastric upsets, and other ailments.

The nursing program has on the whole been effective and has shown satisfactory results in good care of the patients. In addition, many lay persons have learned by doing and by contact with others, good hygienic care of the ill, the aged, mothers and infants, which will be of benefit to them.

The only suggestions I would venture to make for any possible future use would be to select the best available personnel as nurse's aides between the ages of 18 and 50 and the best prepared nurses to teach these aides. The number of nurse's aides should be in conformity with nursing standards and not in excess of them to insure desirable attitudes and good work habits. Ward clerks would be valuable as interpretors, doctor's secretaries, answering the telephone and for doing errands. Graduate nurses would then be truly the administrative and teaching heads of the unit.

The janitorial staff should also be taught and supervised by the graduate nurse on each respective unit or by a competent housekeeper. Typed routine duties in the languages used by the people should be posted and given to each member of the designated staff to preclude any misunderstandings.

/S/ Josephine Rappaport, R. N.
Chief Nurse

War Relocation Authority
Washington, D. C.

R E P O R T

of

Chief Dietitian
Minidoka Relocation Center

Compiled by
Ruth Miller

DIETARY REPORT

I. INTRODUCTION(Descriptive Report)

As a transfer from the Jerome Center in Arkansas, I was pleased to find the food excellent and of high quality and variety for a camp of this type. As the center received closing orders and the farm became inactive, it was more difficult for the steward's division to receive the high quality vegetables and the variety due to transportation facilities of food supply orders to be received for the Project. This was also true of the meat supply. However, even with these delays, there was at no time unbalanced diets or any food shortage suffering for the evacuee population.

There was a deduction in variety at times but not for long periods; therefore, we were able to keep up the dietary standards of the evacuees until the close of the center.

The milk supply was most excellent, both for the area and the hospital. Both the adult and children's quota were supplied daily. The evacuees were rather skeptical regarding area milk and adults reluctant to drink it thinking that it was powdered milk. In this regard I was approached by block chefs, in dietitian classes, and also the community council. After making the rounds of all mess halls and assuring them that it was pure milk no more was heard regarding the milk supply.

Early in April our supply of S. M. A. for infants became critical, and we had to convert to evaporated milk. Expecting numerous complaints and mothers prematurely looking for upset stomachs of their infants, I immediately called all dietitians aides to a special meeting and invited all mothers and explained the situation to them and assured them there was no cause for alarm and that there would be no cause for upset stomachs. Formulas for evaporated milk were circulated to all mothers and we had very few cases where babies remained on S. M. A. The main question I was confronted with was that they were afraid of the mixture of the various evaporated milk brands. However, explaining that only the best brands would be used satisfied them completely.

In the hospital dining hall, and for patients as well on the area, methods of cooking were bound to displease some patients and workers. Some type of Issei cooking displeased some Neisi who desired more American type food menus. This condition exists wherever there is mass cooking.

II. JOB ANALYSIS OF DIETARY DEPARTMENT.

The position as dietitian in these camps offered a great challenge to one's ability and resourcefulness in meeting situations and obligations for a smooth operating program.

The following outline of duties seem to make a well rounded health program:

A. Under supervision of the Chief Medical Officer
   (a) Operation of hospital dietary department and area

supplementary diets
(b) Preparation of general and special diets as ordered by the physicians
(c) Supervision of all kitchen and related personnel
(d) Consult with physicians and nurses regarding diet requirements
(e) Participate in dietary studies and surveys
(f) Participate in nutritional and educational aspects of all public health activities
(g) Supervise a program of nutritional teaching for nurses aides and dietitian aides
(h) Organize a system of dietary food preparation for non-hospital patients eating in own mess halls

B. Tasks:
1. Hospital
(a) To organize and supervise all medical kitchen personnel and ward kitchens.
(b) To plan all special diets for the hospital in close cooperation with the medical staff, and make suggestions regarding diet needs according to the doctor's diagnosis of the patient.
(c) To insist and require sanitary preparation of foods
(d) To keep the Chief Project Steward's Department informed of the food supply needs in the hospital
(e) To interview discharge patients who need continued diets regarding food choice and habits, and, when necessary, give a special order for area dietitian aides to prepare food for the patient
(f) To hold classes and demonstrations in nutrition for diet aides
(g) To hold classes and demonstrations for nurses aides taking the prescribed course prior to diplomas and caps, if given here
(h) To interview hospital patients to ascertain any food dislikes and to correct, if to general welfare of the patient or does not interfere with the patients' needs
(i) To keep all patients dietary records up to date and a record of very special diet routines in hospital
(j) To observe and make suggestions regarding duties of evacuee dietary personnel, and suggest ways and means of obtaining a higher standard of efficiency without making the position too laborous
(k) Suggest minor equipment and justify its need for economy to cut down food wastes and expediate food preparation operations
(l) Requisition foods necessary for patients and personnel

2. Area-in cooperation with Chief Project Steward:
(a) To organize and supervise diet aidew in blocks
(b) To teach, hold conferences and demonstrations with block diet aides in special and infant feeding diets
(c) To advise mothers regarding feeding of infants when leaving hospital and sending a formula schedule with mother according to physician's formula orders

(d) To hold periodic discussion meetings for mothers regarding food requirements and habits of infants and pre-school children in cooperation with the health department

(e) Make out special food purchases, suggestions for special diet foods to Chief Project Steward for hospital and area employees and a friendly attitude from co-workers and evacuees has been gained

(f) Cooperation with all departments in the hospital and with all other health agencies and employees who help execute all duties for a cooperative institution has been gained

(g) Raised standards of food preparation and food service. It is not sufficient to supply the right food in the right amounts, but they must be in form that are acceptable and appetizing and, which will be eaten with pleasure and zest. Success is partially evaluated when few food complaints are expressed and a minimum of food wastes on trays unless some mental or physical conditions cause the contrary. Consideration to such factors as: palatibility, texture, flavor, color, attractiveness, etc. are important.

(h) The improvement of cooking technique for healthful food and economy has been accomplished

(i) Strong motivations for the willingness to accomplish assignments has been promoted

(j) A good working condition is established and all those working under dietitian seek advice, carry out all orders, and work for unity rather than to do their work under pressure and dislike. Keeping all happy in their work is an art

(k) Infant feeding regulations are established and a high standard of nutritional routine is accomplished

(l) A smooth operating and cooperative program for special diets in hospital and in area as well as infant and supplementary feeding have been put into operation.

III. HEALTH PROGRAM IN HOSPITAL

This report is not complete due to unavailable records prior to my activities on this project beginning August 1, 1944.

As to equipment, the main medical kitchen and the ward kitchens are most efficiently and adequately equipped.

The duties included supervision of all evacuee help in the medical kitchen, the diet aides and my office staff. There was plenty of help at all times to conduct a smooth operating department.

There were four meals per day served to the evacuee hospital staff, breakfast, dinner, supper, and midnight; three meals per day to the patients with an additional mid-morning and mid-afternoon nourishment period.

The medical kitchen staff numbered as follows:

Cooks - 14
These cooks had to prepare the entire meals for evacuee help, the hospital patients, and ambulatory patients in hospital hall. This sometimes involved as much as three types meals per meal. Three of which cooked and served the 10:30 to 11:00 P. M. meal for the night shift. The rest divided for the day meals.

Baker - 1

Kitchen helpers - 3
These were the vegetable cleaners and helped generally around the kitchen.

Dish and pot washers - 10
These people came in three times a day to wash dishes.

Waitresses - 7
These people came in at meal time to wait on tables and straighten up dining room.

Assistant Dietitians - 6
These people weighed out all the food and served the diabetic ambulatory patients who came in half hour before the employees for their meals

Tray girls - 11
These were part-time school girls who came to cover two meals per day. They carried by carts the food to the various wards and set up the trays for the patients. The number seems high but they only covered two meals per day and also allowed for days off of various tray girls. We arranged to have two girls for each ward covering six wards.

Pantryman - 2
The duties to sign in and out all food from steward's division and that used by cooks for meals. Keep the pantry clean and orderly.

Janitors - 2

Dietitian's secretary - 1

Clerk-typist - 1
These girls had as their duties:

1. Keep all hospital dietary records
2. Type out all menus for ward kitchens and medical kitchen
3. Type all special diets for trays
4. Record all meal counts
5. Record all dietary help time records
6. Type all area diets
7. Record all area infant and special diet records
8. Type all individual diabetic meal menus to those served in hospital
9. Make out the monthly report to Chief Medical Officer

Total number in dietary department:

Full time	47
Part time	11
Total	58

The following is the method that meals were typed and sent to wards and kitchen:

GENERAL	LIGHT	SOFT	LIQUID
Dinner - June 30, 1945	Beef patties	Beef patties	Broth
Beef steak	with gravy	with gravy	Jello
Baked potato	Baked potato	Baked potato	Fruit juice
Stewed carrots	Carrots	Pureed carrots	Choc. milk
Rice pudding	Rice pudding	Rice pudding	(very thin)
Bread & peanut butter	Toast and oleo	Toast & oleo	
Tea	Milk or tea	Milk or tea	
Supper - June 30, 1945	Baked fish	Baked fish	Soup
Sole Teriyaki	Beets	Pureed beets	Custard
Beets	Rice	Okayu	Plum juice
Tsukemono	Plums	Pureed plums	Milk or tea
Rice	Milk or tea	Milk or tea	
Tea			
Orange			
Breakfast - July 1, 1945	Orange juice	Orange juice	Orange juice
Grapefruit - 1/2	Oatmeal	Oatmeal str.	Oatmeal str.
Oatmeal	Egg	Eggs	Milk or tea
Eggs	Toast and oleo	Toast and oleo	
Toast and oleo	Milk or coffee	Milk or tea	
Coffee			

The above meals were variations of those sent by steward's division as sent into the blocks. The general diets seldom varied from those sent in from Steward. The light, soft, and liquid should have variations.

IV. HEALTH PROGRAM ON AREA

There was little or no dietary supervision in the area. The ambulatory diabetic patients were housed on the area near the hospital and fed there which made about 50 special diets for meals in the hospital.

Shortly after transferring to this center, an area program for taking care of new ambulatory patients, infant feeding, and special food health problems was started so as to relieve the hospital of this burden as much as possible. Before December, 1944, block nutrition aides already were in most all the block kitchens and weekly class instructions in special diets and trained how to convert the regular steward's division menus into satisfactory meal patterns for diabetic and special diets. Gradually the number of ambulatory patients served in the hospital receded and block mess halls were able to serve patients needing this service.

The main difficulty at first was that cooks seemed hostile to the serving of patients housed in their blocks or especially to ones of a neighboring block where there was no dietitian's aide, but due to the excellent cooperation of the steward's division who put pressure on their cooks, the difficulty was soon wiped out. The steward's division had several meetings with cooks and dietitian's aides to smooth out the ruffles

which Mr. Wilder accomplished beautifully.

Another difficulty encountered was that most nutrition aides were Issei and did not master the English language too well, but with weekly classes and personal supervision and guidance and with a Neisi to interpret, our Issei aides began to understand and had more confidence in themselves and their work. So with the cooperation gained with the chefs and the nutrition aides the program began to run smooth and a nice program was accomplished.

To aid the nutrition aides in their work, typed formulas for infants, special diets, and their work procedures were sent out to them regularly, the length of time a patient to be on a diet was determined by the physician. These physician's requests usually were for a one month duration, subject to renewal.

After the infant program and special diets were nicely organized, we began to broaden our program by giving a mid-morning and mid-afternoon snack to pre-school children. A survey was made to determine the number of children eligible for these snacks in each block and the names posted in each mess hall. The rules were as follows:

1. All children from 2 to 7 years are entitled to nourishment each day except Sunday
2. Children will have this nourishment at 10:00 A. M. and 3:00 P. M.
3. Dietitian aides will ring the dinner gong 10 minutes before serving in order to give children time to go home and wash their hands and face.
4. Must arrive at dining hall on time. No food will be issued to tardy ones.
5. Children must come to dining hall with clean hands and face or will not be served.
6. A list of children entitled to their nourishment is posted in the dining hall. Check if your child's name, age 2 through 6 years old is on the list.
7. The nursery school children are to have a separate table.
8. Each child must carry own cup or dish to dishwasher's table.
9. All food must be eaten in dining room and not carried out.
10. Children must be courteous to every one in the dining hall, boys must remove caps when they come in, and not run around in the dining hall.
11. Children must come in the door specified by the Dietitian aide and out the other door.

The menu was as follows subject to change according to food supply available:

	A. M.	P. M.
Monday	Orange	Milk
Tuesday	Jello	Cream soup
Wednesday	Milk	Orange
Thursday	Orange	Gladin milk
Friday	Milk	Milk
Saturday	Hot or cold Choc. Milk	Orange

1. The above menu may be changed according to food in hand, also according to class schedules. On day you have class serve oranges, have them counted out before you leave and they will be ready for someone else to serve
2. Use left overs such as jello or desserts if you have plenty
3. Milk or orange is to be use the most times per week
4. Left over carrots or celery may be ground and used to make cream soup

There were about 300 children served these snacks in the age groups up to 7 years of age. After school closed all nursery school children were added to participate in these snacks and the nursery school teacher aides took care of these children and saw to it that each child reached home safely, as the nursery school groups continued until August 1st and received the snacks in their regular nursery school block.

The entire program was a success and greatly appreciated by the evacuees.

V. STATISTICAL REPORT

The following statistical report is inadequate due to the fact that most records prior to August, 1944, were not available at all or were only partially available:

A. Hospitalized - according to diet meals served per month:
   1. Years 1942 and 1943 records not available
   2. Month of January, 1944, records not available

1944

	Feb.	Mar.	Apr.	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.	Total
General Diet	195	175	190	223	401	465	537	459	375	513	567	4100
Light Diet	16	25	13	10	15	33	18	33	27	21	30	241
Soft Diet	163	153	177	175	375	411	380	337	306	341	233	3051
Liquid	13	19	28	25	42	45	45	36	96	66	57	472
Hi Cal. Hi Vit.	26	17	18	25	44	69	45	54	96	105	112	611
Diabetic	8	12	14	10	24	24	54	51	42	33	36	308
Low Salt Low Fat	5	4					6	9	18			42
Baby Formula	19	16	13	5	9	3						65
Low Fat	4		5	13	24	24	15	15	15	18	12	145
Low Salt Low Prot.		6	3	10	24	51	27	30	30	39	33	253
Milk Diet			2	3	6	3						14
Sippy Diet			3	5	9	15	6			3	3	44
Low Protein			2	3					6	6		17

Cont'd. on next page

1944, Cont'd.

	Feb.	Mar.	Apr.	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.	Total
Semi Soft				21	15	22	12	15	12	18		115
Dry Diet				3								3
Soft Ulcer					9						12	21
Low Residue						6						6
Low Salt Hi Prot.							45	15	15	18		93
Salt Free											12	12
Totals	449	427	468	531	997	1171	1190	1054	1038	1181	1107	9613

1945

	Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sept.	Oct.	Center Closed	Total
General Diet	480	481	318	289	266	270	194	315	156	132		2901
Soft Diet	263	260	230	240	261	247	116	132	95	80		1924
Liquid Diet	21	119	90	125	60	51	15	90	16	24		611
Hi Vit. Hi Cal.	84	75	75	117	129	90	105	105	105	105		990
Low Fat	9				3	3	15	15				45
Low Salt Low Prot.	54	90	85	27	104	104	104	104	104	15		791
Low Salt Hi Prot.	15	15	21	84	84	84	168	168	84	62		785
Diabetic Soft	30	30	36	45	57	42	30	16	16			292
Light		21	21		24	21	15	114	114	80		410
Low Fat Low Prot.		3	15	15	27	30	30	30	30	30		210
Non-Residue		18			9							27
Sippy Diet						21	12	9		48		90
Low Salt Plain						24	24	15	15			78
Totals	956	1112	891	942	1024	987	828	1103	735	576		9154

B

B. Non-Hospitalized:
These are the ambulatory patients who were served their meals in the hospital dining hall
1. Year 1942 - January to November records not available
2. Year 1943 - July to November records not available

1942

	Dec.	Total
Diabetics	44	44
Ulcer	20	20
Gall Bladder	24	24
Soft Bland	12	12
Allergy	4	4
Non-gas-forming	4	4
Totals	108	108

1943

	Jan.	Feb.	Mar.	Apr	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.	Total
Diabetics	70	70	67	95	76	77						78	533
Ulcer	20	12	17	37	40	31						48	205
Gall Bladder	12	12	12	10	6	8						8	68
Soft Bland	12	20	20	5	4	4						4	69
Obesity	5	4	9	26	20	12							76
Hyper-nutritional	5	4	9	15	13	12						8	66
Allergy	10	8	7	6	8	10						2	51
Hypo-acidity	5	2											7
Semi Soft			1	4									5
Soft Diet				17	12	24						37	90
Low Carbo. Low Fat			2										2
Totals	139	132	144	215	179	178						185	1172

1944

Diabetics	106	92	88	105	145	342	342	435	476	487	480	525	3623
Ulcer	33	22											55
Soft Bland	5	2											7
Soft	29	6								12	12		59
Gall Bladder	5												5
Hyper-nutritional	10	2	4	4	5	12	12	15	15	15	15		109
Low Salt Low Prot.							15	40	60			39	154
Hi hydrocaloric											6		6
Totals	188	124	92	109	150	354	369	490	551	514	513	564	4018

1945

Diabetics	3600	3600	3600	3600	3600	3600	3200	3100			3293		31193
Low Salt Low Prot.	180	180	210	210	90	90	90	24			255		1329
Soft Diet			90	90	90	90	90	180			120		750
General Diet						90					6		96
Totals	3780	3780	3900	3900	3780	3870	3380	3304			3674		33368

C. No. of Employees served meals in hospital dining hall:
1. Year 1942 and 1943 records not available
2. January, 1944, records not available

1944

Breakfast	278	249	288	387	274	303	414	405	468	344	236	3649
Dinner	661	578	564	854	687	441	864	711	681	560	555	7156
Supper	485	373	414	607	482	495	646	601	587	510	447	5647
Midnight	197	210	203	253	221	202	250	250	250	250	250	2536
Totals	1621	1410	1469	2101	1664	1441	2177	1967	1986	1664	1488	18988

1945

	Jan.	Feb	Mar.	Apr.	May	June	July	Aug.	Sept	Total
Breakfast	306	295	399	398	358	373	314	253	250	2946
Dinner	598	682	688	597	647	636	494	391	490	5223
Supper	404	393	464	429	442	358	358	248	250	3346
Midnight	750	750	750	750	750	750	750	750		6000
Totals	2058	2120	2301	2174	2197	2117	1916	1642	990	17515

D. Area Special Diets (started from September, 1944)

1. Special diet meals service in blocks for ambulatory patients
2. January to August, 1944, records not available

1944

	Sept.	Oct.	Nov.	Dec.	Total
Ulcer	90		324	279	693
Hypertension	279	90	90	90	549
Bland	243	141	279	279	942
Low Salt Low Protein	549	483	480	510	2022
Children Under Nourished	162	54	90	90	396
Diabetic	414	138	450	465	1467
Hi Calorie Hi Vitamin		9	90	90	189
Totals	1737	915	1803	1803	6258

Total types of patients served special diets in blocks

1. Year 1944 - January to August records not available

1944

Ulcer	3		3	1	7
Hypertension	1	1	1	1	4
Bland	3	3	2	1	9
Low Protein Low Salt	16	16	15	15	62
Children Undernourished	1	1	1	1	4
Diabetic	5	6	5	5	21
Hi Vitamin Hi Calorie	1	1	1		3
Totals	30	28	28	24	110

VI. SUMMARY

This statistical report is not accurage due to many records that were unavailable.

My experience in both evacuee centers has been most pleasant and full of experience. I have found the Japanese very easily acceptable to guidance after you have established a feeling of trust in you by the evacuees. They most always followed my instructions and seemed eager to learn.

There are a few things I would like to expand if I were again to have this experience to repeat.

From my experiences in nutrition classes, I feel that more teaching of Japanese or any foreign people in American food habits, cooking is both desired by the groups and is most necessary. I have found a tendency of the Japanese to select most unbalanced diets, and if they didn't like a certain food would not try to have their children learn to like it. My hospital chefs were eager to learn new things, and during my visits in block mess halls some chefs were anxious to start a cooking class. Most all my medical kitchen chefs had me purchase standard cook books for them before they relocated. I have found that to have an occasional meeting with the entire staff under your supervision creates a better feeling and better working cooperation among the staff. A meeting of this type occasionally with those who were served diabetic meals tended to bring about better cooperation and an understanding of their particular ill and why they should adhere strictly to meals served them.

The sufcess in the dietary department would have been hard, had it not been for the cooperation of the entire medical staff as concerned the dietary program in the hospital. The excellent cooperation of the steward's division, the evacuee mothers and the nutrition aides, the school, community council, and the motor pool in supplying a car for my work, has made the area program successful and a happy memory to a worthful and satisfying experience.

The following two pages are copies of the method of monthly reports that were kept of meals served during the month.

The Minidoka Hospital Report for the month of August, 1945, to include the meals served per week tp employees, hospital diets and special diets sent out into the block is as follows:

		August 1	August 8	August 15	August 22	August 31
I.	Hospital diets (hospitalized					
a.	Special diets					
	General Diet	315	336	252	189	231
	Soft Diet	84	63	42	105	63
	Liquid Diet	42	42	42	21	21
Hi	Hi Vitamin Hi Caloric	21	21	21	21	21
	Sippy Diet	21	21	21	21	—
	Plain Low Salt Diet	21	21	21	21	—
	Diabetic Diet	21	21	21	—	—
	Semi Soft Diet	—	—	—	—	—
	Low Salt Hi Protein	42	42	42	21	21
	Light Diet	84	105	189	210	231
	Low Fat Low Protein	42	42	42	42	42
	Plain Fat Free Diet	21	—	21	21	21
	Low Salt Low Protein	21	21	21	21	21
	Total	735	735	735	693	793
b.	Special diets (non-hospitalized)					
	Diabetic Diets	651	630	630	294	—
	Low Salt Low Protein	42	42	42	42	—
	Soft Diet	42	42	42	42	—
	Total	735	714	714	378	—
c.	Employees fed in hospital dining hall					
	Breakfast	490	420	416	322	245
	Dinner	616	756	616	511	399
	Supper	420	406	385	364	245
	Mid-night	50	50	50	50	50
	Total	2026	2082	1917	1697	1389
	Grand Total	3496	3531	3366	2768	2182

2/

II. Number of diets in blocks new and number of diets continued from pervious month served by nutrition aides in blocks.

		Breakfast	Dinner	Supper
3	Bland Diets	90	90	90
16	Low Salt Low Prot. Diets	480	480	480
1	Children Undernourished	30	30	30
16	Diabetic Diets	480	480	480
1	Hi Caloric Hi Vit. Diets	30	30	30
3	Ulcer Diets	90	90	90
4	Soft Diet	105	105	105
3	Low Salt Hi Protein	90	90	90
47		1405	1405	1405

III. August Report of Area Travel

August 2, 1945 - Block 34, check baby food supply - take into block extra food necessary for diabetic - diabetic jellp, prunes, bouillon cubes, and saccahren

August 3, 1945 - Check food supply in Blocks 30, 32, and 28. No dietitian in Block 28, but promise to hire one. Block 26, food supply good and nursery school aides help block dietitian serve snacks to nursery children and snacks for others. Block 29, no serving nourishment to children as requested. Claim milk supply not sufficient but on checking found report unture; promised to start snacks.

August 10, 1945 - Checked Blocks 14 and 15, both blocks doing excellent job of serving snacks. Number of children in blocks reducing; however, burden on some blocks increased due to transportation from closed block mess halls to those still operating.

August 21, 1945 - Half of diabetic patients served in dining hall were returned to their own mess halls. This group was those on the highest ratio.

August 22, 1945 - Trip to Blocks 34 and 36 to try to obtain special foods for new discharged hospital patient. As no dietitians in blocks, food for own cooking to be furnished.

August 27, 1945 - Remainder of diabetics returned to own mess halls, due to the rapidly diminishing medical kitchen staff.

Ruth Miller
Chief Dietitian

War Relocation Authority
Washington, D. C.

REPORT

of

Sanitarian
Minidoka Relocation Center

Compiled by
C. O. Sullivan

SANITATION

Upon the writer's arrival in the Minidoka Relocation Center, it was discovered that there had been no general sanitation program instituted due to the fact that there had not been a sanitarian here previously. Due to the fact of the evacuees inherint cleanliness there was no serious condition at that time.

The first program instituted was to train two men as inspectors of all mess halls, kitchens, laundries, baths, and wash houses. Each man turned in a report of all inspection made each week and where an unusual condition exists a notation was made on the back of such inspection blank describing same.

At the time of the writer's arrival four wells were being used for the water supply and two large storage tanks for storage purposes and water pressure. This pressure was approximately 125 pounds. After a thorough inspection the Number 3 well was discontinued due to the proximity of the sewage disposal plant and being somewhat lower there was danger of contamination. A sample of the water from the 3 remaining wells was taken and in 14 months time all bacteriological reports were negative. However, due to the wooden main breaks and changes in the main line on several occasions a positive report of bacteriological sample was discovered in several sections of the camp. Immediately and during the summer months two chlorinators were operated at #2 and #4 wells. At no time was the second positive bacteriological report found to run in concurrence.

The milk was obtained from Young's Dairy in Twin Falls, a modern pasteurizing plant and of unusually good quality. Copies of the Dairy's milk bacteriological report was received from Twin Falls branch of the State Health Department and the bacteria count without exception was very low never exceeding 7,000.

On arrival it was discovered the sewage plant was not functioning properly and after a long interval a plan with the engineers a very good grade of effluent is now being removed. However, after continuous attempts to have a proper drying bed it has never been consumated.

Rodent control had been very satisfactory and fortunately there had been no rats to contend with in this area. Cockroaches in certain mess halls have been quite a problem but as a whole they have not been too bad.

During the spring and summer months oil was placed on all pools and lakes and a program of eliminating all stagnant water was active during the mosquito season. Fortunately no cases of malaria have been reported to date so feel this was satisfactory.

The only slaughtering done at this camp was the poultry and this was done at the farm in the same building where all the garbage cans were cleaned and steamed. So feel this function was also very satisfactory.

A small pickling plant was operated for some time under proper sanitary conditions, but this has been discontinued.

Sanitation, Cont'd.

The general center hygiene has been excellent. And whenever evacuees were called on for a general clean up campaign they responded very well and cooperated to the fullest extent.

The general sanitation program was definitely very satisfactory due to the fact that people who reside here as a whole have been very cooperative and willing to aid in this program. The writer feels that as the population decreases the sanitation program will become smaller and see no reason that there should be any need of a bad situation arising previous to the closing of the camp. By and large the writer has enjoyed his experiences while located here and while at times all the plans were not carried out to my fullest expectations I do feel that sanitation in this center has been unusually good and would like to share at least a partial responsibility for the general health of those who are in the center during the period I was here.

/S/ Mr. Sullivan

4-13-45

War Relocation Authority
Washington, D. C.

R E P O R T

of

Public Health Nurse
Minidoka Relocation Center
September 1943 - August 1945

Compiled by
Esther E. Greiner

Public Health Nursing at the Minidoka Project
from September, 1943, to August, 1945

The Public Health Nursing Program as carried on since September, 1943, may be divided into three catagories: Morbidity, Maternity, and Health Supervision.

I. MORBIDITY:

A. Non-communicable

Due to the necessity of having all medical care provided in the hospital or clinic the number of morbidity cases seen has been small as compared with the number a Public Health Nurse would carry in an average community. Any patient who required more than the minimum of nursing care was admitted to the Hospital. Families were never hesitant to assume the nursing care of patients who remained at home though occasionally it was necessary to give demonstrations of nursing care to the family. Morbidity visits were concerned largely with securing medical information, giving general advice, and referring the patient to the proper clinic for medical care.

It was noted that the evacuees learned to do simple nursing procedures such as taking temperatures, giving enemas, etc. in a remarkably short time. Families showed willingness to assume the bedside care of patients in the barracks and patients always appeared clean and comfortable despite the lack of room, plumbing, and ordinary comforts of the usual home.

B. Communicable Diseases

For some unexplained reason the numbers of communicable disease cases on the Project has been very small, and has been limited for the most part to chicken pox, German measles, and Vincent's disease. There have been a few cases of scarlet fever, mumps. measles, and one case of diphtheria in an adult patient.

The general policy has been to admit to the hospital only those cases of communicable diseases which were potentially serious. Families were instructed regarding isolation technique and quarantining was in accordance with the Idaho State Public Health regulations. However, due to crowded living quarters, lack of space for isolation, to the necessity of obtaining meals from a central mess hall, and to the use of central wash rooms and lavatories, it is doubtful if good isolation technique was carried out by even the most intelligent and willing of families.

Immunization against diphtheria, whooping cough, and small pox before one year of age has been the general rule and was quite universal.

On one occasion group Dick testing and Scarlet Fever immunization were arranged when a school child developed scarlet fever.

A discussion of tuberculosis and venereal diseases will be found under Health Supervision - parts B and C.

II. MATERNITY

A. Pre-natal

Pre-natal patients were seen regularly in pre-natal clinic by the Public Health Nurse prior to being seen by the physician. General instructions were given with emphasis being placed on the emotional adjustment of the rest of the family to the newborn infant. Clinic attendance was no problem and no effort was necessary to locate new pre-natal patients, though of course pregnant women not attending clinic were urged to do so if discovered through general visiting. Mothers' classes would have been beneficial but seemed too time consuming. Also the need for such classes did not seem as great as the patients were followed regularly in the pre-natal clinic by the Public Health Nurse.

B. Post Partum

For the most part mothers were seen in the Obstetrical Ward before discharged and were given general instructions regarding post-partum care. As often as possible, visits were made to patients shortly after discharge in connection with an infant health supervision visit. At times, due to the pressure of work, these visits were made only to primipara patients and abnormal cases. These patients were also seen at the time of their post partum clinic visit. Birth control information was given as the need was indicated and as patients showed a desire for such information.

C. Infant Health Supervision

Infant health supervision was started before the infant's discharge from the hospital by means of a bath demonstration to mothers on the obstetrical ward. A room adjacent to the obstetrical ward was used for the demonstration. Mothers who were ambulatory attended the demonstration and because of the small number attending at any one time many phases of infant care were brought up for discussion. At times it was impossible to make home visits to all newborn infants and, through these demonstrations and discussions, all patients discharged from the Maternity Ward were given some help in the care of their infants.

Home visits were made to as many newborns as time permitted with an effort being made to see all those who were the first born.

Infant care was supervised throughout the first year of life in the Well-Baby Clinics which were held weekly. Each infant was examined on the average of once a month. In the clinic they were stripped, weighed, had their temperatures taken, and examined by the physician after the history had been secured by the Public Health Nurse. Attendance was good at these clinics.

As the medical staff became more limited the clinics were under the supervision of the Public Health Nurse except for one clinic a month in which a physician would see newborn babies and other infants referred by the Public Health Nurse. These clinics were held in the administration wing away from the Out-Patient Department and it was emphasized that sick infants should never be brought to the Well-Baby Clinic. From the Well-Baby Clinic, infants were referred to the Out-Patient Department for immunizations at the age of six months. Very little persuasion was necessary to interest parents in the need for immunization.

III. HEALTH SUPERVISION

A. School

The school health work emphasized the establishment of a good working relationship between the principals, teachers, and the hospital. By working directly with the members of the educational department, the Public Health Nurse encouraged the teachers to assume the responsibility for health supervision. When requested, the Public Health Nurse attended teachers and Parent Teachers Association meetings to discuss special health problems.

Fall examinations were arranged for pre-kindergarten children. Recommendations made by the examining physician were then explained to the parents and assistance given them in carrying out the recommendations.

At various times conferences were held with the evacuee Nursery school teachers to discuss various aspects of health supervision, such as first aid, morning inspections, and nursery school lunches. A plan was devised for the giving of Vitamins A and D capsules to Nursery School children. (See orthopedic section).

In January, 1944, at the request of Hunt High School, two nurses aides were assigned to the school health room under the Vocational Education Program. The aides were trained by and were under the supervision of both the Public Health Nurse and the head of the Physical Education Department. In March, 1944, this service was withdrawn due to the discontinuation of the Vocational Education Program and to the shortage of full time hospital aides. First aid, however, continued to be administered by the physical education teachers. Two evacuee

teachers from Stafford and Huntville Grade Schools were taught to give simple first aid, which included the taking of temperatures as a means of determining when children should be sent home because of illness.

In September, 1944, a study was made to see if there were any undiscovered syphilis cases among the high school age group. A group of students coming to the hospital for physical examinations for work permits were given blood tests. A group of 202 students, approximately 20% of the high school enrollment, were tested. Out of this group three were found to have positive Kahns. One of these was a known congenital who was under treatment and the other two proved to be false positives following subsequent examinations.

The medical social worker was assisted in making arrangements for periodic psychometric testing of problem children by a consultant psychologist.

For eye screening and orthopedic program among school children see Health Supervision, sections E and F.

B. Venereal Disease

The venereal disease program dealt largely with the problem of syphilis, as there were only sporadic cases of gonorrhea.

Case finding for persons with syphilis was done primarily through routine, annual testing of food handlers with follow-up of positive patients and their contacts. No newly acquired cases were found in this manner. Comparatively little resistance was made to treatment.

Home visits were made when patients failed to attend clinic for treatment after having been sent two written notices. In most instances patients resumed treatment after an explanation was made as to the need for treatment.

At the time that the medical records review was made, all patients whose records showed positive blood reports and who were not receiving treatment were contacted for further testing or to discuss the need for continued treatment. A number of cases were discovered who had been given a rest period from treatment but who had failed to resume treatment at the end of that period.

Summaries of treatment of all cases were made in December, 1944, to enable the physician in making a decision as to whether further treatment was necessary. A 3 x 5 card file was then set up to include all persons having had positive bloods. This was divided into sections to designate those (1) under treatment, (2) treatment discontinued, (3) rest period, etc. This facilitated follow-up of all luetic patients.

C. Tuberculosis

The tuberculosis program consisted of follow-up of contacts of patients admitted to the hospital with tuberculosis. Occasionally visits were made to patients who failed to keep chest appointments. Case finding was done through annual fluoroscopic examinations of food handlers.

Patients with pathology or whose fluoroscopic examination was questionable were referred to chest clinic for diagnostic and follow-up care.

Because of the rapid turn over among food handlers it was extremely difficult to be certain that all employees were having annual examinations. A 5 x 8 card file was devised showing results of fluoroscopic examinations and blood tests for all food handlers. Arrangements were made with Placement to notify the Hospital of all new employees hired for this work and for the automatic referral of new employees to the Hospital for fluoroscopic and blood examinations. Fluoroscoping of food handlers was discontinued on October, 1944, due to the shortage of doctors.

D. Diabetic

Since most of the diabetics fell in the older age group and spoke little or no English, comparatively little supervision was given this group. Through an interpreter an attempt was made to explain the necessity for following medical instructions. At various times classes were held for the teaching of urine testing. As new patients were found and placed under medical supervision they were taught to administer their own insulin. A number of patients who had been coming to the hospital daily to be given insulin were taught to give their own injections.

E. Eye Testing Program

An eye screening program was planned in cooperation with the medical social worker as a means of determining appointments for refractions being done by an optometrist serving the Project on a contractual basis. Arrangements were made through the schools for eye screening of all school children.

This was accomplished by demonstrating visual acuity testing to teachers. Reporting forms were drawn up and a visual acuity testing report was secured on every child regularly attending school. Screening for adults was done by an evacuee, trained and supervised by the Public Health Nurse.

F. Orthopedic

Because of the excellent service offered by the Idaho State Children's Service, considerable time was spent in finding cases

to be referred to them. Through the Parent-Teachers Association and in individual conferences with the teachers, an effort was made to develop an awareness in every referring source of crippling conditions to be reported to the Public Health Nurse or Medical Social Worker. In cooperation with the Medical Social Worker, nursery schools and the first three grades were visited and the children inspected for crippling conditions.

After November, 1944, the Crippled Children's Clinics were held on the Project, and prior to that time children were transported to Twin Falls. As a result of the findings in the nursery schools and the number of children referred in that age group the plan was instituted of giving daily Vitamin A and D capsules to the nursery school children.

IV. OTHER

A. Medical Social Work

There has been a very close working relationship with the Medical Social Worker. During the time the latter was off the Project on detail her work was combined with the Public Health Nursing program.

B. Out-Patient Department

Due to the shortage of the nursing staff, since February, 1945, the Public Health Nurse has supervised the Out-Patient Department. Home visits have been continued on a limited basis, office conferences arranged, and as much health teaching done in clinic as time would permit. As the shortage of physicians became acute one pre-natal clinic a week was taken over, and many of the patients who were not acutely ill were seen and treatment prescribed in accordance with standing orders.

Clinical service could be improved if a method were established for follow-up of patients. With the changing evacuee medical secretaries there has been no means of assuring the supervising nurse of a knowledge of the necessary follow-up of the individual patient.

/S/ Esther E. Greiner
Public Health Nurse

War Relocation Authority
Washington, D. C.

REPORT

of

Laboratory Technician Supervisor
Minidoka Relocation Center

Compiled by
Gladys G. Kaiser

REPORT OF THE LABORATORY
of
MINIDOKA PROJECT HOSPITAL

LABORATORY FACILITIES AND REPORT:

The Hospital Laboratory occupied one large room which was lined with working counters and cupboards in a fairly convenient arrangement. It was excellently equipped with apparatus and well stocked with supplies of all kinds. Among the larger pieces of equipment were an incubator, Frigidaire, four centrifuges, four microsopies, one colorimeter, torsion balance, analytical balance, an Arnold sterilizer, and a microtome.

In the beginning the entire work of the laboratory was done by highly trained and experienced evacuee technicians. These, however, were among the first to relocate which made it necessary to secure a Caucasian supervisor for the laboratory.

For over one year I had a staff of eight apprentice technicians, none of whom had had any previous training or experience. They were for the most part eager to learn and interested in the work. There was usually a waiting list of young people desirous of entering laboratory training. These young people were quick to understand and mentally alert; also they seemed possessed of an unusual amount of manual dexterity. They seemed to have almost photographic minds, and once having seen a thing done were very adept and skillful in doing it themselves. At first, of course, each piece of work they did had to be checked and their technic carefully noted; but as they gained experience they were able to do the work alone and I had confidence in their reports. They quickly learned to do blood counts and urinalysis, and in time even learned to do blood chemistry examinations under supervision, as well as blood typing and cross matching.

The laboratory has always maintained call service at night and at our busy seasons there were frequent night calls. These were usually answered by one of the evacuee staff in rotation.

The services of the laboratory averaged between 1500 and 2500 examinations per month, with an average of 200 blood counts and 750 urinalysis per month. Other examinations in more or less frequent demand were Sputum examinations, smears, blood chemistry, Kahn tests, blood typing and cross matching for transfusions, Icterus index, Sedimentation Rate, Sulfa concentration, Pleural effusion fluids, stool examinations, Van den Bergh tests, Gastric analysis, Spinal fluid examinations and other miscellaneous examinations as the need arose.

A Sanborn Waterless Basal Metabolism machine was part of the laboratory equipment; and B.M.R.'s on about fifty patients were determined. On certain patients the results were rechecked from time to time to watch the result of the treatment.

The greatest handicap I found in employing evacuees as assistants was the fact that the relocation program made it impossible to keep any of them long enough to give them experience in all the phases of laboratory work. However, even with the training they did receive here several of them have secured positions in outside laboratories and are giving satisfactory service.

10-13-45 /S/ Gladys G. Kaiser, Supervisor

War Relocation Authority
Washington, D. C.

R E P O R T

of

X-Ray Technician Supervisor
Minidoka Relocation Center

Compiled by
Gladys G. Kaiser

REPORT OF THE X-RAY DEPARTMENT
of
MINIDOKA PROJECT HOSPITAL

X-RAY FACILITIES AND REPORT:

The Hospital X-ray Department occupied one rather small room which at times became rather crowded and inconvenient. The darm room was immediately off the x-ray room, and the control stand was situated behind a leaded partition in the room.

The equipment consisted of a Westinghouse 200 Milliampere Fluoradex X-ray and fluoroscopic unit which was used routinely, and a U. S. Army Field Unit portable x-ray machine, which was used when the condition of the patient required bedside roentgenography. Films taken with the portable machine were slightly inferior in quality but were for the most part satisfactory under the conditions imposed.

For over one year I had a staff of two x-ray assistants and a dark room technician, none of whom had ever had any training or experience in x-ray procedure. The first two weeks of their training consisted in trying to impart a slight knowledge of x-ray physics and acquainting them with the x-ray machine and impressing upon them the delicacy of such a fine piece of apparatus. (I find that the Japanese need to be taught to appreciate delicate machinery.) A brief course in anatomy was included in this probationary period and standard positioning was explained and demonstrated. As time went on and they progressed, the assistants were allowed to make the settings on the control panel and these were carefully checked before an exposure was made. In a remarkably short time they were able to carry out the procedures by themselves under supervision of a general nature; though at nearly all times I still kept an eye upon the settings before exposures were made.

The dark room technicians were photographers by profession and they did a beautiful piece of work developing the films.

Routine fluoroscopy was performed on the tuberculosis patients taking artificial pneumothorax.

4000 patients were given x-ray diagnosis, not including an extensive amount of dental x-rays taken for the dental department. The x-rays included extremities, skull films, mastoid and sinus films, jaw roentgenograms, spinal exposures for cervical, dorsal and lumbar vertebrae, also coccyx and sacroiliac joint films were made. Frequently request was made for films of pregnancy at term to determine the position of the fetus. Many gastro-intestinal studies were performed as well as barium enema studies. Intravenous retrograde pyelography was done in a number of cases with some splendid results. Chest roentgenography was perhaps the greatest single item requested and repeated films were ordered by the doctors to diagnose and check the progress of the disease and its treatment.

Another field of roentgenography practised in the x-ray department was Electrocardiography. This was done on a splendid machine, a Sanborn Cardiette. Not many requests were made for this test and I did only about 35 to 40 cardiographs - but those taken were of good quality, and it was a delight to operate such a beautiful piece of equipment.

X-ray Facilities and Report, Cont'd.

The assistants in the X-ray department were a little more permanent than the ones in the laboratory because it took so long to train them that unless they planned to be here at least six months I did not accept them as students. The three whom it was my privilege to train were apt students, and all three have secured positions as assistant X-ray technicians in the cities to which they have relocated.

10-13-45 /S/ Gladys G. Kaiser, Supervisor.

War Relocation Authority
Washington, D. C.

REPORT

of

Medical Social Worker
Minidoka Relocation Center
May 28, 1943 - July 31, 1945

Compiled by
Dorothy F. Cram

MEDICAL SOCIAL WORK
5-23-43 to 7-31-45

Medical Social Work at the Minidoka Project Hospital was first established by an evacuee, the wife of a physician in active practice at the Hospital.

The first appointed Medical Social Worker assumed duty on 5-28-43. The original program outlined was to cover case work with patients referred by the physician, cooperative work with the Social Welfare Division, School, and with other divisions, as interest developed. Very early in the program it was evident that there was an unusual awareness of the services available and the need for the service, on the part of the personnel of other divisions servicing the Project residents. It was also evident that the evacuees recognized a need for the service and demonstrated a willingness to avail themselves of the services. This represented an unusual opportunity in the field of Medical Social Worker; however, as the staff was limited to one Medical Social Worker and as there was an increasing need of the department to assume routine work, the amount of time that could be devoted to case work with the individual patient was greatly limited. The limitation of staff necessarily brought about a very close working relationship with the Public Health Nurse which was beneficial to the program. Many of the services were worked out in cooperation with the Public Health Nurse who was the only other representative of the Medical Division who did project visiting.

SPECIAL TRAINING PROGRAM

Early in the program it became evident that there was a need for occupational therapy and vocational training for hospital patients suffering from chronic diseases, and, for individuals on the Project who were handicapped in a manner which prevented them from taking part in the usual community activities. Although budgetary provisions were made to secure a teacher for exceptional children it was never possible to find a person with the necessary background for this position. To meet this need to some extent, a teacher was assigned from the high school faculty to work in cooperation with the Medical Social Worker in developing a program for these groups. Bedause of the limitation of time available, children who were mentally retarded were excluded. The service because of some physical handicap and to those permanently disabled who demonstrated an unusual need for outside contacts, or who had some unusual talent. Although this program was periodically interrupted by changes in the teaching personnel, excellent results were obtained. Example, a high school senior was told that she had congenital cardiac disorder. She immediately withdrew from all activity and spent her time in bed. At the time we first knew her she was emaciated and was so withdrawn that she had lost all interest in activity and hesitantly replied in monosyllables to all direct questionihg. After a complete physical examination she and her family were given assurance that activity within recommended limitations would be beneficial rather than harmful. Her activity was gradually increased over a period of six months and she was referred to the visiting teacher. Under the supervision and direction of this instructor she completed her high school work in one semester. Aside from her school work she became interested in handicrafts, in which she demonstrated a marked proficiency. By the end of the school year, the instructor reported that

this girl had developed an unusual command of English and had demonstrated great talent for writing. This girl and her sister (who has been under treatment for pulmonary tuberculosis, but who now has an excellent artificial collapse), are both being considered by the School Guidance office for referral for scholarship and special planning to permit them to secure further education through home teaching.

In some instances when regular school work was considered unnecessary because of the type of disability, efforts were made to develop interest in handicrafts in which the patient showed particular skill.

Several children who were temporarily unable to attend school were given an opportunity to continue classwork and were thus able to keep up with their class.

Unsuccessful efforts were made to secure Vocational Rehabilitation funds. There was a great need for such a program inasmuch as there was little opportunity to secure employment to meet the individual need of the handicapped.

The insecurity caused by the handicap was increased when those persons were torn from familiar surroundings and had lost the stability of an established home. Efforts to secure funds were first made through the Idaho State Board of Education, later through the War Relocation Authority and finally efforts were directed toward attempting to get the state of legal settlement to accept financial responsibility for special planning. It is now evident that many of these persons will now have training available when they return to their place of legal settlement. However, several years have been lost and many of them have lived through discouraging months of waiting.

One phase of the special training program was the development of a class in Braille. A young man, blind since childhood and trained in the Vancouver School for the Blind, was placed on the school payroll to give training in braille, typing, and music to any blind person referred by the Medical Social Worker. Arrangements were made for classes to be held at the Project Hospital as it represented a central location for the known blind on the Project; and transportation was available to the Hospital from all parts of the Project.

The cooperation of the Public Health Nurse was enlisted to review medical records and visit all blind persons on the Project. Home calls were made to determine the individuals need for training, his background and his ability to use the English language sufficiently to permit him to benefit from the training. Information was secured in regard to materials necessary for schooling and O. T. funds were made available to the instructor to purchase the required supplies. Although several patients were reluctant to consider training they were easily persuaded of the value of training after attending a few classes. One student who had had typing in high school was able to gain proficiency which will enable her to complete her training as dictaphone operator.

CRIPPLED CHILDRENS SERVICE

Soon after the Medical Social Work Department was established the practice was instituted of submitting a social history on every crippled child referring to the State Crippled Children's Division. During a 26-month period a total of 65 histories were prepared and submitted. To insure adequate follow-up a 5 x 8 card index was filed with identifying and diagnostic information. When the child was accepted by the Crippled Children's Service the card was flagged and all recommendations were recorded. The cards gave briefly the recommendations made and service completed. The file served as a guide for listing crippled children for each successive clinic. In cooperation with the Public Health Nurse a list was prepared to notify the State Crippled Children's Service of children to be seen in each dinic.

Prior to November, 1944, Project children were escorted to the Twin Falls Crippled Children's Clinic. Since each individual leaving the Project was required to have a pass to leave the Project, It was necessary to make home calls on every child prior to each clinic to give instructions regarding transportation and the pass for the parent who would accompany the child. The responsibility for this was divided between the Medical Social Worker and the Public Health Nurse.

In observing children on the Project it appeared that there were a large number of children manifesting various degrees of bowing of the legs. The Public Health Nurse and Medical Social Worker conferred regarding this. As a result, visits were made to all kindergartens and first grade classes and children were observed in play activity. The most noticible defects were noted and a joint conference was held with the Chief Medical Officer who agreed to hold a special clinic to examine the children referred to him, for possible referral to the Crippled Children's Service. All children seen in this clinic were referred to the Crippled Children's Service with a letter explaining the method of case finding and asking whether these children might be seen in the clinic. It was suggested that remommendations secured through the clinic for this selected group would serve as a guide for the treatment of all such cases found on the Project.

As a result of this clinic the Director of the Crippled Children's Service prepared general instructions for the use of the Public Health Nurse in supervising the needs of other children with a less noticeable deformity. To insure adequate follow-up of children relocating from the Project, an arrangement was made with the Crippled Children's Service whereby the Medical Social Worker would report to the Idaho State Crippled Children's Service the relocation address of all children permanently leaving the Project. The State Department then made an interstate referral to the state of relocation giving all necessary information for medical follow-up. In all instances to date parents have called at the Medical Social Worker's Office to discuss relocation planning and it was thus possible to advise them of facilities available to outside communities. This aspect of continued medical care was also stressed at the last Crippled Children's Service held on the Project to make parents aware of resources so that they might seek medical follow-up for children after relocation.

Of the total 65 children referred to the Crippled Children's Service only 31 are now under active supervision. One girl was a non-resident and was referred to an outside community, 13 have completed treatment and have been discharged, 9 have relocated and have been referred for follow-up care, two have transferred to another Project, and two were discharged after the second clinic as not being eligible for care. It might be added that while these two children were discharged, several others suffering with a disorder not generally accepted by the Crippled Children's Service, have been followed. The decision for acceptance for these patients was based on whether the child might benefit from the service available.

PSYCHOMETRIC TESTING

In order to have a better understanding of problems presented by the school age group the child Welfare Division was approached and it was agreed that the services of the state psychologist would be made available to the Project. Children were referred to the Medical Social worker for this service through the schools and the Social Welfare Divisions. Forms used by the State Welfare Division to secure information from the schools were revised and distributed to the schools. After these forms were submitted to the Medical Social Worker a social summary was prepared and submitted to the Psychologist prior to the date of the clinic. Testing results were submitted to the Medical Social Worker who then interpreted the reports to the teachers and offered services as available through the hospital. The first two testing clinics were held in Twin Falls, a community 23 miles from the Project. Many children transported to this clinic had not been in an automobile nor off the Project for 12 to 18 months and the experience was so exciting that it was felt that testing was not as successful as it might be were the children seen in familiar surroundings. Clinics were then scheduled to be held on the Project.

One problem given emphasis was that of testing for vocational aptitude. This was requested in an attempt to give the school some direction in their efforts with a group of high school age children who had lost interest in school work and who appeared to have little faith in their ability to face the uncertainty of the future.

This uncertainty appeared to be based on the loss of home life, loss of family income, and the fear of parents for the future. In several instances, where it was felt that the family attitude toward the child was partially responsible for the problem present, appointments were made with the parents to discuss testing results with the psychologist.

EYE TESTING PROGRAM

During the last two school years an optometrist was available to the Project on a contractual basis. In order to locate the children requiring this service a screening program was agreed upon. In a conference with the Public Health Nurse a plan was made for the Public Health Nurse to be responsible for demonstrating visual acuity testing to teachers, who would then give tests to every child in her room. The results

of this testing was filed on individual forms and sent to the Medical Social Work Department. From this file appointments were made for every child with visual acuity of 20/50 or worse. There were a few requests for financial assistance in securing glasses prescribed.

Since psychiatric consultation for adults was not available, except in two cases, the responsibility for supervision of the psychotic and neurotic group fell heavily on the Medical Social Work Department. This group required a great deal of time from an already overworked Out-Patient Department and Medical Staff. Little medical treatment could be offered and the patient was usually referred to the Medical Social Worker for all follow-up cases. Often, because of the accessibility of the Medical Social Worker, problems of emotional instability were first reported by the family to this department. In such cases the Public Health Nurse and Medical Social Worker called at the home to evaluate the problem. The situation was then discussed with the Chief Medical Officer and follow-up supervisions were given through conferences with the patient in the office or in the home. The non-English speaking group were particularly difficult in that the worker was not able to fully evaluate a patient's reaction to the problem and to the treatment through an interpretor's assistance. The work with the group as a whole was quite successful in that all persons known to be suffering from neurotic symptoms sufficient to indicate a need for special attention have now relocated or have gone outside to make relocation plans for the family.

The symptoms demonstrated were hypochondriacal complaints for the most part. These seemed to be based on fear of the future. The Worker was never able to secure information as to the personality make-up of the Japanese-Americans or of the incidence of neurosis and psychosis in Japanese on the West Coast. Thus it was not possible to determine whether evacuation had played a major part in the problems. This would appear likely.

One man, 42 years of age, had worked as a railroad mechanic for 27 years on the U. P. R. R. prior to evacuation. He was married and had one child. Mr. S. was well respected and was influential among the Japanese in his community. He was one of the men detained by the FBI for questioning. For 18 hours his family did not know where he had been taken and during this period he was uncertain as to what might be happening to his family. He was sent to the Santa Fe Detonation Station and was kept in custody for 16 months. After his release and return to his family he worked as a cook for a short time when he began to develop gastro-intestinal complaints, complaints of numbness on one side of the body, flushing, loss of appetite and insomnia. Numerous physical examinations revealed no disorder and he was referred to the Medical Social Worker.

At this time Mr. S. was in bed or resting on the bed all day. His wife found it necessary to carry his meals from the mess hall. Family relationships had become strained as Mr. S. complained that his 13-year old daughter was not sympathetic if she had friends in the home or if she made any disturbance while at home. Mr. S. and his wife were seen on several occasions at this time and in the office. He was finally persuaded to seek employment as a cabinet maker since he had shown some interest in this type of handwork. During this period Mr. S. continued

to receive medication which he considered beneficial. With this increased activity, many of his symptoms disappeared, and he is now visiting on the West Coast to determine his status with his former employer and with the Railroad Retirement Board.

Social summaries, including a statement of legal settlement, were submitted for all persons committed to the Idaho State Mental Hospital. Prior to commitment numerous conferences were held with the patient and his family to discuss the advisability of treatment in a mental hospital. There were a total of 20 commitments.

During the 26 months the Worker was on the Project, there were only three unmarried mothers known to the Project Hospital. In all cases the State Child Welfare Division assumed responsibility for supervision of the child and in two cases supervised the mothers who were hospitalized at the Booth Memorial Hospital at Boise. Two of the three children were placed for adoption in homes of Japanese who had already relocated and who were well established in their respective communities. The procedure used, was the referral of the adoptive family through the Medical Social Work Department to the Child Welfare Worker in Boise. A report was made of all information available on the family. Following a further investigation by the Child Welfare Division, adoption was arranged through the recognized state agency in charge of all adoptions. Arrangements were made in this manner for the adoption of a third child who was under the supervision of the Ogden Child Placing Agency.

The third patient known to the Project Hospital wished to keep her child and plans are still under way to find suitable work placement where the baby will be assured of adequate care.

The worker had frequent conferences with the individual members of the Social Welfare Division to discuss the medical social aspects of problems of joint interest. Frequent reports of special problems were made to the Social Welfare Division and there were frequent opportunities to explain the services available through that Division. The latter arose because of the continuity of staff in the Medical Social Work Department which enabled Project residents to know the Worker through previous contacts with the office. Because they had known the worker it was not uncommon for them to call at the office to report new problems for which service was available through the Social Welfare Division.

Steering services were used throughout the period of the worker's experience. Medical reports were released to establish financial need and to accompany special housing requests. With the impetus toward relocation the Medical Social Worker again enlisted the assistance of the Public Health Nurse for a review of all medical records to establish a listing of all persons whose physical handicaps would deter relocation or indicate a need for special planning. Recently an attempt has been made to recheck a large group of medical records for persons who reported physical handicaps at the time of a census study on the Project. This group of individuals who reported illness of a chronic nature had been listed by the Social Welfare Division as requiring special planning. Medical information available on the group has made it possible to release a large percentage of these for immediate relocation planning.

A review of all medical charts was also instituted on all persons relocating from the Project. A special reporting plan was devised and where a record is found to have no information contraindicative to relocation or requiring special planning, a form report is sent to relocation on request.

Numerous routines have been assumed by the office. The clearance of sick leave and extended illness compensation reports have been time consuming but of value to the hospital, the timekeeping section, and to the patient. U. S. E. S. forms have been routed through the office and files kept of reports made. Insurance reports from private companies were also routed through the office. Information available was reported and when necessary clinic appointments were made.

The 26 months spent on the Minidoka Project have been educational and exceedingly interesting from the standpoint of the reporting Medical Social Worker.

/S/ Dorothy F. Cram
Medical Social Worker

War Relocation Authority
Washington, D. C.

R E P O R T

of

The Acting Medical Social Worker
Minidoka Relocation Center
August 1, 1945 - December 14,1945

Compiled by
Betty Creusere

FINAL REPORT OF ACTING MEDICAL SOCIAL WORKER
by

BETTY CREUSERE

August 1, 1945 - December 14, 1945

On August 1, 1945, when the Acting Medical Social Worker assumed responsibility, the work which was to be completed before the Project Hospital could be closed was fairly well indicated. The principle problem was that of arranging for the transfer of twenty-one chronically ill bed patients to hospitals in communities where their legal settlement could be established. These persons were indignant, and accordingly social summaries, including references and documentary evidence had to be forwarded to Area WRA offices along with the patients' medical records in order that approval for transfer might be obtained from the proper Public Welfare Agencies. The bulk of these summaries had already been prepared and submitted; however, there were four recently admitted cases for whom application had not been submitted, as well as three patients whose after relocation care had been originally planned by the family. The complete hospital census included three patients who did not belong in one of the groups already mentioned, but whose families were planning, with the approval of the Chief Medical Officer, to provide privately for the outside care of the patient. There

were several instances in which it was possible for the Medical Social Worker to assist these people, as for example, in obtaining information, planning special transportation, and supplying necessary medical data to other Sections concerned with the relocation problems of these particular families.

Transfer of bed patients was far from being automatic once approval for return to county of legal residence was obtained as there was, almost without exception, a waiting period of from two to eight months for a bed in the type of institution designated. Because hospital facilities were rapidly becoming very limited due to steady reductions in both appointed personnel and evacuee staff, it was most important that the waiting list be frequently brought to the attention of the WRA Area Offices so that they might be reminded of the unavoidable pressure developing at the Center, and the resulting importance of maintaining contact with institutions in order that advantage might be taken of the first opening. In some instances hospitals were requested to make room for patients for whom there was not a vacated bed available, or to accept them out of the order of the waiting list; this was the situation for the last three tuberculosis cases in the Project Hospital when it became impossible to staff a separate Ward for them.

In Washington and Oregon prompt cooperation was received from the Public Welfare Organizations, but California withheld approval until a time when it became necessary to notify them that the date of Project Closing left no alternative but to send the patients to the State for temporary care until such time as they could complete their investigations. The two California bed-to-bed patients were transported on October 27, and they were the last patients to leave the Project Hospital. Before departure that morning, teletyped approval came for the Sacremento patient for whom information had first been submitted in March, 1945; however, it was necessary for the WRA District Office to make a special arrangement in Stockton for the other patient as he had not been acknowledged by that county.

The exodus from the Hospital began the latter part of August, with the transfer of two senile, chronically ill men to the King County Hospital. An attendant was necessary, and a member of the nursing staff accompanied. It was not until September, that notice was received that the Multnomah County Farm, near Portland, and the Morningside Tuberculosis Sanatorium near Seattle, were ready to accept three patients who had been previously approved. The rest of September passed without receiving authorization for other transfers,

the closing date had been set, and the majority of the patients were still in the Hospital with no destination yet assigned. King County, Washington, was responsible for nine of the fourteen medically dependent persons still in the Hospital. Residence had been established and King County had approved the entire group for assistance, but the WRA field office could not locate an institution for custodial care. The Area Relocation Advisor reported that King County has no tax-supported institutions which offer this type of care to the aged, chronically ill, but rather this problem is handled through private homes, licensed by the State. Usually these homes were filled to capacity, or were unwilling to admit Japanese-Americans. This problem was presented to the Friends Society in Seattle, which agreed to locate a suitable building and a Japanese couple qualified to operate it as a Home for those in need of supervision, and some practical nursing care. This would eventually be turned over to the couple as a private enterprise, and their revenue would be derived from the State. A license would be issued by the County, and the Department of Public Welfare would pay for the care of the medically dependent persons having State residence.

The home purchased for this purpose was highly satisfactory, and the inspectors who authorized

the license commented that it was superior to any that had already been established. October 15, was scheduled as the opening date for the Home, and all nine King County patients were to be admitted. The full capacity of twelve was selected from Minidoka; inasmuch as two of the hospital patients were partially paralyzed and entirely helpless, it was agreed that their wives should be taken in to assist with their care, and also admitted was an aged man who had been living in the special semi-invalid quarters which were located in the area, but were under hospital supervision. It appeared that the very best way to transport these patients and their attendants would be to convert a pullman car into a hospital car, with all berths made down. Accordingly, such arrangements were made with the Union Pacific Railroad, and a modern, sealed car was obtained for the trip. Several members of the Project Administrative Staff and the Hospital Staff drove to the station with the ambulances and special cars in order to see that loading was accomplished smoothly. Those who accompanied to Seattle were: (1) a nurse, (2) a nurses' aide, (3) an orderly, and (4) a dietitian. After the King County patients had been dispatched, the Hospital remained open to care for eight people. Within the next week six patients were escorted, one each, to the

Multnomah County Farm, Multnomah Tuberculosis Pavilion, King County Hospital, and the McMillan Sanatorium in Chehalis, Washington; two patients went to the Pierce County Hospital in Tacoma, Washington. As previously mentioned the last two patients went to Sacremento and Stockton, California. A large volume of work was directed to the Medical Social Worker from the two other Sections most directly responsible for relocation. The Relocation Division made a routine medical clearance for each individual at the time he began arrangements for his indefinite leave; these clearances were referred as inter-office memoranda, and reply was made after a check of the individual's medical chart. This was a time consuming service only because of the number of charts that had to be consulted. Very rarely was it necessary to reply except with a form statement to the effect that there existed no medical detterents to relocation. For individuals having either tuberculosis or a venereal disease it was requested that the Medical Social Worker be notified of the time and place of relocation in order that a report might be made to the Public Health Authorities informing them of the presence of the disease in the community, and the kind and amount of treatment already given. During September and October many

detailed statements were requested by the Relocation Division for persons who were claiming inability to relocate as a result of a specific health problem. Without exception the reply would point out the importance of relocation in order that the individual receive the required medical supervision as the Project Hospital was no longer staffed to offer anything but emergency treatment.

Rather complete and detailed statements were prepared in reply to Welfare inquiries. Frequently the decision as to whether or not an individual was to be referred to the WRA field office as a welfare case was dependent upon the validity of the applicant's claim that he was incapable of providing for himself for medical reasons. In cases where the individual was eligible for catagorical relief the medical chart was summarized so the information might be incorporated into the social summary. The fact that all social summaries were to outline the health problems of the family, or the individual, meant that many special appointments had to be made for physical examinations; of course, this was true only from September on, after regular clinics had been discontinued. There were a number of cases in which there was cooperation between the Welfare Worker and the Medical Social Worker in the formulation

of family relocation plans. Primarily this was true when one member of a family was hospitalized, and the family was planning to provide for his care privately.

Much time was devoted to the authorization of pullmans according to Handbook Section 60.13.12. A Hospital statement signed by the Chief Medical Officer had to be obtained before pullman reservations could be made for any evacuee; space was too limited to permit persons to pay for special accomodations out of their own private funds simply because they preferred traveling pullman. If this practice had been permitted there would not have been space available to the West Coast for infants, the aged, or the special medical cases. Many authorizations could be made on the basis of the information received over the phone from other divisions, or from the individual himself, but the special medical cases were ones in which medical charts had to be consulted and as a rule an interview followed if a refusal were necessary, in order that the reason for the unfavorable decision be explained.

During the time the Project was operating it had been necessary to commit several evacuees to the mental institution at Blackfood, Idaho. Continued efforts had been made to have these persons returned

to their state of legal residence as soon as possible after committment. The first of August there were eight remaining, and it was possible to have six returned to institutions in the Coastal States before the Project closed. However, it was not until November that the seventh patient was returned to Oregon; in this case the committment had not been made until July 3, 1945, and this fact would probably account for the late approval. At the date of this writing one patient remains at Blackfoot State Hospital, an Alaskan for whom it had been difficult to arrange transfer because of the question of residence.

It was not possible to take advantage of the last Crippled Children's Clinic which was to be scheduled in Twin Falls, during November. There were fifteen children on the list who would have been seen had the Clinic been held earlier. A letter was written to the Crippled Children's Commission explaining the situation and expressing appreciation for past services.

The work of the Medical Social Worker during the months just prior to the closing of the Center has been primarily a production job, mainly emphasizing service to other Sections. Work directly with evacuees was limited as a result of a heavy routine which had to be adhered to conscienciously

so that other Departments would not be delayed. Often as many as fifteen or eighteen residents were seen a day, and the waiting room was usually filled. Every effort was made to dispose of each one quickly in order that the volume might be served. Ordinarily, these were interviews in which requests were made for pullman accomodations, medical statements, or information concerning medical facilities in the proposed area of relocation. When the closing date was first announced many people sought an exemption on the basis of health problems, but curtailment of clinics soon demonstrated the advisability of making other plans to receive medical attention, and this kind of interview dwindled sharply. Evacuees who had received regular treatment in the Out-Patient Department, or who had been hospitalized considered it very important that a statement be made concerning their physical condition generally, and treatment given specific ailments. These statements, which amounted to a brief summary of the medical chart, were signed by the Chief Medical Officer.

Hospital closure would have been achieved several days prior to the closing of the Project had it not been for a transportation delay which was beyond the control of anyone at the Center. With the

attentive cooperation of the WRA Area Office in Seattle, the bed-to-bed transfer of patients was made with every consideration of the individual's future care, and personal preferences. The remaining portion of the closing phase of the Hospital for which the Medical Social Worker was responsible did n not have to be considered in such great detail because it constituted a service which was only incidental to the relocation of the individual.

/S/ Betty Creusere
Acting Medical Social Worker

PERSONAL NARRATIVE REPORT

of the

HOSPITAL ADMINISTRATOR

Minidoka Relocation Center

Hunt, Idaho

Compiled by:
Bert Weston
Senior Administrative Assistant, 8-15-43 to 7-1-45
Hospital Administrator, 7-1-45 to 8-13-45
On March 1, 1945, detailed by Project Director
to position of Acting Assistant Project Director,
but carried on duties of Hospital Administrator
Acting Assistant Project Director, 3-1-45 to 1-31-46

PERSONAL NARRATIVE REPORT

of the

HOSPITAL ADMINISTRATOR

On October 15, 1943, I reported to Dr. L. M. Neher, Chief Medical Officer, as Hospital Administrator.

Up to that time the hospital had been operated without the service of an Administrator, the duties of this position being carried by the Chief Medical Officer and the Chief Nurse.

After a conference with the Chief Medical Officer, I was informed that I was to act as his Administrative Assistant and that I was to take full charge of all matters not of a professional nature and also to make suggestions to the Chief Medical Officer on all personnel problems, including the professional staff.

In my opinion, Dr. Neher, in addition to being a very fine medical officer, is also a good executive, having the ability to delegate work and authority, and after so doing, backing up the decisions of his subordinates.

In the two years of my association with the health program, a very pleasant working condition was established.

In many of the W. R. A. projects there was a continual conflict between the hospital and the community. However, this was not true at Minidoka. Here the hospital

held a particular position within the community because of the importance of its functions and was at all times the concern of the residents.

The Chief Medical Officer remained as Chief Medical Officer from the beginning of the W. R. A. program until all evacuees were finally relocated, with the exception of short details to other projects. He was respected by the residents as a good doctor, sympathetic to their ailments and problems, and he never instituted a policy at the hospital that could be considered partial or unfair to the community.

GENERAL OFFICE

The offices of the Chief Medical Officer, Chief Nurse, Hospital Administrator, Medical Social Worker, Sanitarian, and Public Health Nurse, in addition to the general stenographic staff, were located in the administrative wing of the hospital.

With the exception of the above appointed personnel, eight graduate nurses, two medical officers, and one x-ray supervisor, all duties and activities of the hospital were performed by evacuee personnel, with an average employment of 185 evacuees.

The turn-over in evacuee help, especially in the

general office was always handicapped to uniform methods of filing and procedures. A comparatively accurate set of records was kept. Some exceptionally good clerical workers were developed in the general office. However, these workers usually secured good positions outside the the project as soon as they were trained and as relocation was the chief purpose of the Center, the placement of these employees on the outside was encouraged. In the latter part of July, 1945, the shortage of clerical help became so accute that a full time appointed personnel secretary and office manager was employed.

O. P. D.

In connection with the Out-Patient Department, including X-ray, Laboratory, Eye, Ear, Nose, and Throat Clinic, Dental Clinic, Well-Baby Clinic, Pre-Natal Clinic, Pharmacy, and ambulance service was operated. In the three years of the project more than 85,000 examinations were made in the Out-Patient Department. The X-ray and Laboratory were supervised by a full time appointed personnel supervisor. The Dental Clinic consisted of three chairs and dental laboratory and a total of ten licensed evacuee dentists were employed. There was a tendency at one time in the Dental Clinic for some of the dentists

to do a little private practice; that is, some of the dentists were showing partiality in making the appointments and doing dental work for the patients who were willing to pay them for the work. This practice was difficult to stop in view of the fact that the patient was never willing to give evidence that it was necessary for him to 'bribe' the dentist. I believe this practice was eventually stopped.

AMBULANCE SERVICE

The ambulance service was one of the headaches of the hospital. It was very difficult to keep close account of the use of the ambulances and during the night they were used for other than hospital business. Nine ambulance drivers were employed and twenty-four hour service was given. Two ambulances, one convoy truck, and a sedan were used for this service. In addition to taking the patients and out-patients to and from the hospital, all the hospital workers were transported between their residences and the hospital. The ambulance service was eventually placed under the supervision of the Motor Pool and the emergency-night service was handled by the Internal Security, this giving a much better control of the operations of the ambulances.

CLINICS

Pre-Natal and Post-Partum Clinic held each Tuesday Morning was under the supervision of one of the Caucasian doctors and the Public Health Nurse, as was the Well-Baby Clinic, which was held each Friday morning.

CENTRAL SUPPLY

The Central Supply room, which was a part of the Property Control, was under the supervision of a full time appointed personnel who was also a registered pharmacist. All incoming supplies were received on a receiving report, then stored and issued to the hospital under his supervision.

WARDS

Separate wards were operated for surgical, medical, obstetrics, pediatrics, and isolation patients. One of the difficult problems at the hospital was the inherent fear of the tuberculosis ward by the Japanese residents. It was always difficult to employ nurses aides or male attendants to work in the TB. ward. For a long time the hospital resisted any special concession to this fear. It was claimed that if nurses aides were exempted from taking turns in the Tb. ward there could be no educational campaign to change Japanese attitudes and opinions. But

near the end of the program some special arrangements were finally made to have tuberculosis patients cared for by members of their family and one of the Caucasian missionaries who volunteered for this work.

CONCLUSION

In conclusion, I would like to say that the experience of the past two years has been both interesting and educational. No one could accuse this position as being monotonous. One never knew what problem was coming up next. Within the hospital there was always a complex of vested interest. This is partly because of professional status - medical men, technicans, and graduate nurses - usually exact a greater difference in their status than is the case on the outside. To make the situation more difficult to administer, occasionally a professional rank cut across the usual caste line. A doctor is superior, for example, to a nurse or a dietitian; when the physician is evacuee and the nurse or dietitian is appointive, the usual pattern of authority no longer holds. Also when a group of nurses were required to live so close together in a wing of the hospital with outside activities as limited as they were in a project twenty miles from the nearest town, personalities were bound to clash and the job of promoting

harmony among appointed personnel was always a problem. However, as a whole, a very fine relationship was enjoyed between the appointed personnel in the hospital, and also between the evacuees and the appointed personnel.

The experiences I have had in my two years as Hospital Administrator at the Minidoka Project will be long remembered and many very fine contacts and associations, will leave pleasant memories.

Bert Weston
Hospital Administrator

PERSONAL NARRATIVE

of the

CHIEF MEDICAL OFFICER

Minidoka Relocation Center

Hunt, Idaho

Compiled by:

Dr. Lauren M. Neher, Chief Medical Officer
Term of Service at Minidoka:
June 1, 1942, to October 19, 1945, which included short details to the Tule Lake Relocation Center, San Francisco Office, Gila River Relocation Center, two Relocation Centers in Arkansas, Granada Relocation Center.

PERSONAL NARRATIVE
Of the

Chief Medical Officer
by
Dr. Lauren M. Neher
Term of Service at Minidoka:
June 1, 1942, to October 19, 1945

My experience in WRA began with temporary detail during the opening phase of the Tule Lake Relocation Center, and included detail to the San Francisco Office, the Gila River Relocation Center, the two relocation centers in Arkansas, the Granada Relocation Center, as well as covering the Minidoka Relocation Center from its opening to the departure of the last Japanese.

I found the Japanese people, on the whole, to be intelligent, courteous, and cooperative, but at times to be demanding of much more in the way of services than they were entitled to.

The early days of the relocation centers were characterized by a marked degree of disorganization and many shortages in materials and supplies. One of the worst features of all centers in the early days was the severe understaffing of all departments; and this condition lasted throughout the duration of WRA with regard to nursing personnel and clerical help.

One of the most critical problems always faced by the Health Section was the staffing and general care of the tuberculosis ward. We found Japanese people to have a very marked phobia regarding this disease and the belief that its presence is shameful not only to the individual but to the members of his family. For this reason many of the Japanese concealed the symptoms indicative of the disease until such late stages that they were no longer amenable to cure. This, I believe, was one of the main causes for the high incidence of the disease, for it was not found in its early stages nor the infected individuals taken out of contact with their families and friends.

The procurement of necessary supplies and equipment was difficult throughout my experience with WRA. Whether this was due to the procurement procedures prescribed or to other factors, I do not feel I should attempt to say. However, in the event of another such agency, I feel that one of the most important aspects to be considered in its establishment should be an efficient method of procurement and property control throughout the agency on a uniform basis.

I feel also that a uniform set of rules and regulations governing procedure and policies should be established and adhered to as soon as possible, rather than as was done in WRA, where bulletins and regulations were

issued from the center office at frequent intervals all during the history of WRA. Concerning the Health Section, I feel that such rules and regulations should be specific -- what medical procedures, surgical operations, etc. are permissable and what functions of medical practice are not to be performed.

I should like to place myself most strongly on record as disapproving and abhorring the idea of mass segregation of any group of persons on a racial basis, rather than on a basis of their potentialities for harm on an individual basis. I feel that large numbers of the Japanese placed in the relocation centers were entirely innocent and were done much harm by the segregation program. On the other hand, many of the individuals allowed comparative freedom within the framework of WRA were undoubtedly potential enemies of the United States and saboteurs and would have been much better confined in the frank concentration-type camp.

In looking back over WRA and the many difficulties with which it was faced, I think the agency as a whole and the individuals who composed it have done an excellent job in the light of the many difficulties and unusual problems they were called upon to handle.

L. M. Neher M.D.

Lauren M. Neher, M. D.
Chief Medical Officer