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An increasing interest in heart disease as a public health problem has been particularly noticeable during the past five years. During this time public health associations as well as institutions for the care of the sick have begun to spend more and more thought upon the problems of heart disease and these thoughts have been along various lines.

The American Heart Association and more particularly the unit in which I am more active, the Heart Committee of the New York Tuberculosis and Health Association, has been and still is studying many phases of the question of heart disease and public health. Every problem attacked has been one which has come forcibly to the physician and the social worker as they have observed the progress of heart disease in patients. The problems studied have not been theoretical ones set as interesting problems to be investigated, but because in the actual handling of patients with heart disease we have needed more information and guidance.

Let us briefly consider what happens or what may happen to any given individual with heart disease. Such an individual develops heart disease. We are at once interested in considering whether or not it could have been prevented or, if the cause is still present, whether or not such cause can be eradicated before further damage is done. But the amount of damage which has been done causes certain disfunction of the heart. Depending upon the amount of such disfunction the patient becomes handicapped and must make
various adjustments to his environment. At times during the course of his disease he must be in bed. At other times he should have ambulatory medical supervision. Between these two states there should be a period of convalescent care. Since he is either handicapped or, because of his heart disease, is potentially a handicapped individual the question of his occupation becomes of interest. If he already has a job and it is taxing, it may be necessary that his occupation be changed. Before such a change can be made sometimes it is essential that he should be trained for his work. If he is young and he has not yet chosen his life work, he may be guided and trained into a branch of industry in which his handicap is less apparent. Also if he is young the question of his relation to the general educational problems demands thought.

Particularly to you who are here will it be obvious that such an individual presents problems to nearly every branch of social activity which has a relation to handicap brought on by disease.

Let me simply enumerate the various organizations or agencies which we make use of at various times in our work with patients with heart disease at Bellevue Hospital. They are an out-patient clinic, a ward bed service for the temporarily handicapped, a ward bed service for the permanently crippled, convalescent home, venereal disease clinic, psychiatric clinic, oto-laryngeal clinic, dental clinic, prenatal and obstetrical clinic, vocational guidance and placement agencies, sheltered shops, school and various services in industry.

In this list I have not specifically mentioned a Hospital Social Service, for I assume that to this audience it is evident that the only way in which a group of patients could be guided to these various contacts would be through the cooperation of an efficient Medical Social Service Department manned by intelligent and efficient social service workers. The first cardiac clinic in the United States as a matter of fact was organized at Bellevue Hospital in 1911 by Dr. H. V. Guile at the request of Miss Wadley, the head of the Social Service Department, who felt the pressing need for the medical supervision of the ambulatory cardiac. In 1919 I took over this clinic, having during the preceding eight years worked in it at various times.

Since that time other clinics had been started and the New York Heart Association had seen the need of a classification of heart disease from the standpoint of functional capacity. It had adopted a classification, the one used by the American Heart Association,
first dividing all patients coming into a clinic into three groups, those with organic heart disease, those with potential heart disease and those in whom there were insufficient symptoms or physical signs for making a diagnosis and who were placed in a doubtful group labeled possible heart disease. The patients with organic heart disease were divided into four groups:

I. Organic heart disease with no diminution of cardiac reserve.
II(a). Organic heart disease with slight diminution of cardiac reserve.
II(b). Organic heart disease with marked diminution of cardiac reserve.
III. Organic heart disease with absence of cardiac reserve or with symptoms of heart failure at rest.

This classification has proved to be extremely useful but it is obvious that such a classification is only useful when one has a knowledge of the course of heart disease. The problem we are discussing today is that the natural course of heart disease depends on its etiology.

In heart disease we consider the structural or functional change of an organ as it is affected by different causes. It is seen that the fundamental problem is different from that of tuberculosis in which we consider a single cause as it affects various systems or organs of the body.

Many etiological classifications of heart disease have been suggested. I have found a modification of one used by Dr. Homer Swift most useful.

A. Congenital
B. Acquired

I. Infectious
   Known
      Acute—Pneumococcus, staphylococcus, streptococcus, haemolyticus, gonococcus
      Subacute—Viridans, influenza, melatenis
      Chronic—Tuberculosis—syphilis

Rheumatic
   Active—Acute, subacute, recurrent, chronic
   Inactive
Causes of Heart Disease

II. Toxic.

   *Endogenous.* Thyroid
   *Exogenous*

   Vegetable—digitalis
   Mineral
   Animal—toxins of bacteria—pneumo diphtheria

III. Concomitant State with other Diseases

Diabetes—nephritis—pernicious anaemia
cause of heart not clear

IV. Arteriosclerotic or Senescent

V. Neurogenic

It is my purpose to describe briefly the various forms and try to indicate how they present different medical and social problems.

*Congenital heart disease* presents little interest except to pediatricians. Many of these patients live only a few days and most of them die before reaching mid-adolescence. An occasional case lives to adult life, but of these the cases having pulmonary stenosis frequently die of pulmonary tuberculosis and one third of the other cases die of subacute bacterial endocarditis. It will be seen that a few of the cases during childhood and adolescence may need aid and adjustment but these present practically no problem to the social worker.

*Acute infectious heart disease.* The causes are pneumococcus, staphylococcus, streptococcus haemolyticus and gonococcus. This form of heart disease is usually masked by a general sepsis. It is rarely diagnosed unless a pericardial rub is heard or unless an embolic phenomenon calls the attention of the physician to the cardiac phase of the disease. If the endocardium is affected, as far as we know it is always fatal, lasting from a few days to a few weeks. The symptoms are chiefly septic, sometimes embolic and rarely cardiac. The only problem it presents to social workers in our present state of knowledge is that the patient may have a comfortable bed to die on.

*Subacute infectious heart disease.* This is otherwise known as subacute bacterial endocarditis and is caused by the streptococcus viridans, and occasionally by the influenza bacillus or the bacillus melatenis. This disease has received wide publicity in this country chiefly through the work of Dr. Thayer of Johns Hopkins and Dr.
Emanuel Libmann of Mount Sinai, New York, and his assistants. It is a disease which runs a subacute course for months, sometimes lasting a year or two. Structurally it is characterized by small vegetations on the valves and endocardium and by some myocardial change. The symptoms are those of mild sepsis, low grade temperature, palpable spleen, moderate leukocytosis and embolic phenomena as evidenced by petechiae, Osler's nodes, Phantom swellings, hematuria and signs of cerebral, pulmonary, splenic and renal infarct. The cardiac symptoms are usually not striking. Diminution of the cardiac reserve is nearly always present but frequently thought to be due to the anaemia. Cardiac murmurs may appear or, if present, change their quality. While cases have been reported which healed, practically all patients who develop this disease die after one or two years. In my experience I have never seen a proven case get well. In an ambulatory cardiac clinic about two per cent. of the patients seen have this disease. In the bed service of a large general hospital the proportion is somewhat greater, between three and four per cent. of the bed patients. While this disease accounts for a large number of deaths annually through the United States, it is not one of the important causes of cardiac mortality or morbidity.

Occasional cases during the bacterial free phases of the disease need ambulatory care and medical social service and nursing follow-up. Temporary occupation in the home is sometimes useful rather as a mental therapeutic measure to combat depression than as an effort to improve the individual's economic situation.

**Chronic infectious heart disease.** There are two forms, first: tuberculous, which may be dismissed with a word, and second, syphilitic, which is of extreme importance.

**Tuberculous heart disease** occurs in Bellevue Hospital in less than one fifth of one per cent. of the cardiac deaths. Tuberculous pericarditis is the most frequent form but tubercles in the endocardium and the myocardium are seen. It is generally part of a general tuberculosis and the heart as a rule is not the cause of death. This is practically never a cardiac problem but definitely a tuberculosis problem.

**Syphilitic heart disease,** the other form of chronic infectious heart disease, is of extreme importance, both as a cause of death and as a cause of incapacity. This disease structurally is characterized by changes in the aorta—chiefly in the ascending aorta—involving as the disease progresses, the coronary openings and the aortic
valve. In certain cases there is a definite syphilitic change of the muscle, though actual gumma of the heart is exceedingly rare. In other cases the myocardial change is probably secondary to the interference of the coronary circulation. The symptoms of this disease appear on the average twenty years after the infection. After the symptoms appear the progress is more or less rapid. If the disease is discovered before aortic insufficiency manifests itself, adequate anti-leutic treatment sometimes relieves symptoms and prolongs life. If aortic insufficiency has taken place the disease usually progresses to a rapid termination even in spite of anti-syphilitic treatment, the patients usually dying of congestive heart failure. Another structural complication of this form of heart disease is aortic aneurism; death may then result from rupture. This is a disease of middle life, the usual age of onset being at the age of 40. Although it is a cause of only about ten per cent. of the heart disease seen in an ambulatory clinic or a general hospital and five per cent. in private practice, it strikes down the man or woman (most usually the man) at the very height of his earning capacity and usually before his family has become self-supporting.

Theoretically, at least, this type of heart disease is absolutely preventable by the prevention of syphilis. It is probably also to a large extent preventable by early and thorough treatment of syphilis before it has attacked the heart. Even after the heart has become affected, if it is discovered early and thoroughly treated, the progress of the disease is frequently delayed. Here is a case-finding problem. For though the heart affection is probably preventable in the early stages of syphilis and the course of the disease influenced by treatment if discovered early enough, usually these patients do not present themselves until well developed heart disease has appeared and when treatment is of little avail.

The problem of syphilitic heart disease, though not so great as that of rheumatic and senescent heart disease, causes thousands of deaths a year and much misery and suffering to innocent members of the patients' families. It is a fascinating problem, both from the standpoint of the social workers and the physician.

*Rheumatic Heart Disease.* While it seems unquestionably true that the cause of this disease is a form of streptococcus and while we have followed with interest the work of Dr. Small in Philadelphia and Dr. Berkow of Rochester, it does not seem to have been absolutely proved that this disease is caused by a specific strain of
the streptococcus. The relation between this disease and the structural changes in the endocardium and myocardium were first discussed by Dr. Pitcairn in 1788. Aschoff first showed the characteristic histological picture in the myocardium. Structural changes have been described not only in the endocardium, myocardium and pericardium but in the arteries, subcutaneous tissues, the pleura and the brain. The course of the disease in its most frequent form is characterized by periods of activity and inactivity. During the periods of activity any or all of the structure of the heart may become the seat of acute inflammation, thus interfering with the function of the heart. As these lesions heal, scar tissue is laid down to a certain extent replacing the normal. During the inactive stages of rheumatic heart disease the amount of dysfunction depends upon the situation of these scars and their extent. In the course of rheumatic heart disease, therefore, heart failure may be secondary to an acute inflammation of the heart, in which case it is apt to disappear as the inflammation disappears; or it may be associated with permanent scarring, in which case it is apt to progress.

The usual life history of a patient with rheumatic heart disease is that of a patient who develops rheumatic fever before the age of ten. If he is under competent observation it will be known at that time that his heart is probably affected. During the next fifteen years the patient will usually have several attacks of rheumatic fever associated with active inflammation of the heart and heart failure. During one of these attacks he may die. Between attacks he is in a fairly comfortable condition, many cases having no diminution of the cardiac reserve. Finally there comes a time when even though the heart is not in a state of active inflammation, the heart muscle fails, either as a result of the frequent recurrent infections or possibly, in cases with severe valvular defect, because of long continued suboxidation, and death results. In about twenty-five per cent. of these cases some years before death a complication presents itself in auricular fibrillation. If this is not controlled, it wholly incapacitates the patient and probably hastens his end. If controlled by digitalis or eradicated by the use of quindin the course of the disease progresses as before described. In a series studied both at the hospital and in private practice in my experience comparatively few passed the age of fifty. Among public patients about ninety-five per cent. were dead before fifty and among private patients about ninety per cent.

I have spoken of the recurring type because this is the most fre-
Causes of Heart Disease

quent. There are three others. The first is an acute infection of the heart in which the patient dies in the first attack. Every pathologist knows how rare this is because of the great difficulty in getting pathological specimens of rheumatic heart disease in patients dying during the first attack. A second type is a chronic active inflammation of the heart, which occurs more frequently than is realized. This may go on for years, the patient always having a diminished cardiac reserve and never being free of symptoms of activity. About one quarter of the cases in the clinic are of this type. Still another type, unfortunately comparatively rare, is that in which the patient after one or two attacks of acute active rheumatic infection of the heart goes into an inactive state and rheumatism never again attacks the heart. It is patients with rheumatic heart disease of this type that grow to old age, and although we occasionally see such patients, at the present time they are only a small percentage, possibly one tenth of those having rheumatic heart disease.

It is obvious that next to preventing rheumatic fever altogether, our greatest desire should be to eradicate the disease in patients who have had it, with the hope that the damage done during the first attack may not be incompatible with long life. With this idea efforts are being made to produce and maintain immunity against rheumatic infection. Rheumatic heart disease, among adult ambulatory clinic patients in New York is the cause of heart disease in about forty-five per cent. of all cases. In children's clinics it is about ninety-five per cent. of all cases.

From the above sketch it is seen that there are very many similarities in the problem of rheumatic heart disease and the problem of chronic pulmonary tuberculosis. In both, many organs or tissues may be affected, but in both a single one usually dominates the others, in one case the lung, in the other the heart. They both are infectious in nature, both have periods of activity and inactivity, both may be acute, subacute or chronic. There is growing evidence that rheumatism is spread by contact.

This type of heart disease presents the greatest problem to us all. Here is a disease which may be preventable if we can only find the way. Our chief problem after the disease has been acquired is to try to develop in the individual an immune state to prevent the recurrence of infection and to meet such handicap as results from scar. It is of the greatest importance for all interested in heart disease to realize that in this type diminution of the cardiac reserve
or actual heart failure may come about with two types of structural change: (1) an active inflammatory change in the heart and (2) result of scarring.

Because of the paucity of constitutional symptoms during periods of subacute or chronic inflammatory stages, it is often not appreciated that heart handicap in rheumatic heart disease occurs in these two different ways. It is our belief from theoretical consideration and from some limited experience that as long as there are signs of activity these patients should be treated as patients with chronic active tuberculosis; that is, they should have complete rest, sunlight, fresh air and good nourishment. It was for this reason that the New York Heart Committee, after long and careful thought, advised against special classes for cardiac children in public schools because it was found that these classes contained not only a large proportion of children with no other signs of heart disease except an accidental murmur, but a very large proportion of children with active rheumatic infection who should have been in bed. We, of course, all hope that a more active method of bringing about immunity may be developed, but at the present time vaccines and sera are surely in an experimental stage. During the periods of inactivity the problem is not only to meet the different indications resulting from cardiac handicap but to prevent as far as possible the recurrence of infection.

Toxic heart disease. This may be caused by either endogenous or exogenous toxins. The endogenous toxin which most frequently gives rise to heart symptoms and heart failure is thyrotoxin. In certain parts of the country thyroid heart disease becomes a large factor in cardiac morbidity. The only structural change evident in the thyroid heart is hypertrophy. These patients tend to develop auricular fibrillation early. This fibrillation is difficult to control with digitalis, and, if paroxysmal in type, tends to recur unless the hyperthyroidism is controlled. The disease from the heart standpoint is slowly progressive and the patients who are unrelieved of the hyper-thyroidism usually die of progressive heart failure. The exogenous toxins which produce heart disease may be described as those which are of bacterial origin and those of either vegetable or mineral origin. Those of bacterial origin usually give rise to cardiac disfunction only during the time of the infection. This type of heart disease is experienced in forms of bacterial infection of the body where the bacteria do not invade the tissues of the heart, but the toxins act on it. It is seen in lobar pneumonia, influenza, tuberculosis and
other infections. In its most severe form it is found with diphtheria. The best example of the vegetable toxin acting on the heart is the toxemia from digitalis, which may even produce death. Phosphorus and other minerals may produce cardiac symptoms.

Here again, the early recognition of the underlying disease with every attempt made to control it, should be our endeavor. The characteristic state of mind of people with this disease presents a real problem in their management and unless this is recognized most attempts to meet the various problems of these patients fail.

*Heart disease as a concomitant state with other diseases.* The direct relationship between these other diseases and heart disease is not as yet clearly understood, but we are all aware that it does occur with pernicious anaemia, with nephritis, with diabetes and with gout. The types occurring with diabetes and gout are usually associated with an arteriosclerotic heart disease. These patients do not present any particular problem.

*Arteriosclerotic or senescent heart disease* is the greatest cause of mortality and morbidity of all diseases of the heart. When one rules out heart disease occurring as a concomitant state with other types of disease there is still left that form of senescent arteriosclerosis which, when it affects the aorta and the coronary arteries, causes disfunction of the heart, later heart failure and cardiac death. The symptoms of the onset of this disease are insidious. They are usually, but not always, associated with symptoms of arteriosclerosis elsewhere. There are two types of onset; one with gradual increase in fatigue, gradual diminution of the cardiac reserve, and finally the development of signs of congestive failure; the other type usually begins with substernal pain or discomfort on effort, which in uncomplicated cases gradually progresses, the patient finally developing congestive failure, after which the pain usually disappears and the patient then runs a typical downhill course. In either type, the life curve may be interfered with by the following physiological and structural complications: auricular fibrillation, heart block and coronary occlusion. By far the most frequent of these is the development of auricular fibrillation. With the development of this irregularity, marked diminution or obliteration of the cardiac reserve occurs. If this is not controlled by proper medication the life of the patient is shortened. However, if digitalis medication is instituted the patient returns to a condition as good as before the onset of the irregularity and the slow downward course of the disease continues.
Another physiological complication which occurs, but much less frequently, is that of a partial and complete heart block. During the stage just before the block becomes complete, the course of the disease is interfered with by attacks of Adams Stokes syncope. As the disease progresses, however, and a permanent idio-ventricular rhythm is established, the attacks of syncope disappear and frequently the patients then go on for years, though with diminished cardiac reserve.

The structural complication, which is the most important one interfering with the gradual course of this disease, is a coronary occlusion. This may abruptly interrupt the course of the disease, causing death even before the insidious symptoms of onset of arteriosclerotic heart disease have been noted, or it may occur anywhere along the curve of gradual descent. As before stated, it may cause sudden death. On the other hand the patient may recover and go on for a number of years, usually, however, with the reserve fixed at a considerable lower level. Death may then follow from progressive congestive heart failure or from other coronary occlusion, setting up possibly a ventricular fibrillation or causing a rupture of the heart.

The problem of the social worker here is the problem of handling a disease which is from its essence non-preventable and one in which there is usually a gradual, but definitely progressive increasing handicap. It is chiefly a problem of gradually removing the load from the individual, seeing that he lives a life which will tend to keep him as free as possible from complicating infection, the institution of a proper dietetic regime, the constant search for complicating disease carried on with common sense, for by this I do not mean the indiscriminate removal of possible foci of infection to which I think many old people are too frequently subjected in these days; last of all, the attempt to provide some slight comfort for them in their last months of progressive congestive failure which is bound to occur unless they are fortunate enough to be carried off by a sudden cardiac or cerebral accident or an intercurrent infection.

There is left one etiological type of heart disease to discuss: Neurogenic heart disease. In private practice it accounts for about fifty per cent. of the patients coming to one's office. While it has no influence on longevity, it is the cause of much suffering and frequently of great incapacity. The cardiac psychoneuroses have been classified by Paul White as follows: 2
1. Fatigue neurosis (Neurasthenia)
2. Introspective neurosis (Hypochondria)
3. Anxiety neurosis
4. Substitution neurosis (Hysteria)
5. Obsession neurosis (Psychasthenia)

The symptoms which are partly neurogenic and partly psychogenic in origin are chiefly subjective. In order of their frequency of occurrence they are palpitation, pain and breathlessness. The objective symptoms are irregularity, sinus bradycardia, sinus tachycardia, premature contractions of various types and at times paroxysmal tachycardia. If the subjective and objective symptoms are associated with an accidental murmur it sometimes takes much experience to be sure that one is not dealing with organic disease of the heart. One cannot stress too much the necessity of knowing that gross irregularities of the heart and subjective symptoms, particularly palpitation and pain, frequently occur in patients without organic disease of the heart.

It should be recognized that these patients have not heart disease and in private practice they are best cared for by the wise family physician. In hospital practice they are usually bandied from one specialist to another or if in a general medical clinic are usually neglected entirely. In my opinion they should be cared for in a special clinic or a special organization for the care of psychoneuroses, at least until such time when a sufficient knowledge of psychologic states is developed in all of our workers so that these patients shall not be neglected.

REFERENCES

1. Criteria for the Classification and Diagnosis of Heart Disease by a Committee appointed by the Heart Committee of the New York Tuberculosis and Health Association.
2. Cardiac Neuroses—Paul D. White—Nelson Loose Leaf Medicine, Vol. IV, p. 636, assisted by Dr. Stanley Cobb.
WHAT IS HAPPENING TO THE FAMILY?*

IRA S. WILE, M.D.

What is happening to the American family? Some would answer everything, and others, nothing. The answer lies between these two extremes.

The family is primarily a biologic unit, the result of a physical mating in response to underlying instinctive urges. The family is also a social unit, not merely because it consists of groups of individuals, but because the family ever has been held to be a functioning unit for and in social organization. It is evident, therefore, that all events, circumstances and conditions which alter the biology of the family or modify its social status must react upon it.

Biologic changes of the greatest import during the past generation have markedly altered social values of, in, and for the family. The decrease of the mortality rate and the shifting in types of morbidity have profoundly affected the health of families. The per capita health values today are higher than they ever have been. The average age at death is advancing within certain physical limitations. The average expectation of life at birth has progressed in this country to fifty-five years. The lower mortality rates and a marked change in the type of illnesses which exist have profoundly affected the social status of American families. There is more vitality, energy and enthusiasm and a higher degree of latent power because family unities are no longer afflicted by many of the diseases that formerly drained their physical as well as their economic and social resources. Tuberculosis and typhoid fever have diminished, summer complaint has practically disappeared, chlorosis or green sickness is scarcely known. Children are becoming taller, larger chested, heavier and with bigger feet. Biologic qualities have modified physical social values.

The reduced birth and infant mortality rates and the biologic

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values of small number of children per family have modified the social values of children in the community. Families have a higher degree of solicitude for children who thus become more prominent in their individual positions in family units. The parent has a shifting status as his possibility of immortality through children diminishes. Small families have likewise provided a larger degree of freedom and leisure which have weakened the permanent anchorage of parents in their social setting.

The combined effect of diminishing birth rates and general health rates have influenced the entire social behavior level of the community by lowering the proportion of people below age 25 and materially increasing the percentage of those age 60 and above. The shifting percentages of population groups—a biologic phenomenon—have altered the social status of the young and heightened the social values of the old. The former gap between youth and age is being socially bridged as the elders cling to exuberant youthfulness and youth rejects implicit obedience to parents, scorns servility towards middle age and repudiates reverence towards old age.

Social changes, however, have had a marked influence upon the biologic values within the family. Man's chances of survival have been lessened in part by his own inventiveness. Automobiles have brought with them an increased accident and mortality rate. All modes of transportation by steam, electricity, or gasoline have increased speed and the danger to life and limb. Industrial hazards, despite safety slogans, first aid and protective legislation, are threatening familial happiness. Whatever increases the likelihood of accidents tends to heighten the biologic values of the individual. This is especially true if society as a whole must bear the cost for accident and disease through Workmen's Compensation Acts, Employers' Liability Insurance or unemployment insurance.

The congested homes, with inadequate privacy and air pollution not suffered by older cliff dwellers, have affected the biologic values of the family. It is no longer possible for families in a city like New York, for example, to dwell as biologically independent units. The greater our congestion, whether in subways or in apartments, the greater the destruction of family unity and harmony. Human pressures force people apart. The physical home today is more of an inn than a shrine.

Science and religion are shifting. Most of the old anchors of
man are more or less adrift and unforeseen perils of the sea confront the world. Staking all faith upon man's machinery does not afford the same satisfaction as an undisturbed faith in a Creator superior to man. The family is suffering from an over-stress of scientific dogma and theories not well understood and an arrogant condemnation of faith in realms beyond the reach of present science.

The medical profession is undergoing profound changes in structure and form and function. Numerous problems of civic policy are arising. Various questions of an economic, social character confront practitioners. These changes are incidental to alterations of social sentiments and opinions from which the medical profession cannot escape. The medical service of the community desires opportunities for health to be as widespread, if not as free, as those for education. The family is conscious of every significant change incidental to the evolution of society. The relation between family and physician is changed and some believe to the disadvantage of both.

Customs, laws, regulations, traditions and mores are not static—they are dynamic. The family always has been subject to changing status and always will, because it must function as a unit in society which sees the family only a means for its own protection and continuance. The family as a biologic unit strives for its own satisfactions and goals of fulfillment; but they cannot be chosen and sought without reference to the social approbation or toleration of families united and diversified into special groups and movements designed to insure the preservation of the social system.

Among social trends urbanization has had a definite effect upon the family. The grouping of large numbers of people in limited areas has diminished family independence and has blunted its necessity. The rush to cities and tenement construction have brought about limitation of space within the home as well as some limitation of recreational space without the home. City life has increased familial dependence upon community resources for forms of activity which formerly were regarded definitely as responsibilities of the home makers. This is evidenced in modern entertainment, cookery, clothing and recreational diversions.

Mechanization has brought about man's enslavement by his own tools. New machinery has been created much more rapidly than man could make adjustments to their effects upon his own being and
welfare. The machine age has not been accompanied by an expansion of intelligence to meet the rapid and changing influences of the machine upon the structure of personal and familial life. Machinery has increased leisure in the home, but it has not taught the family how to use leisure. Machinery has caused changes in production and distribution, but without any more equitable distribution of the economic gains from manpower saved by reason of the installation of machines. The family has been impressed by a dynamic machine mold, and it has not taken a fixed static form, as it has changed mechanically, socially and even physically. Machinery has been devastating the home because it has taken away most of its creative values and also many of its cohesive values. The main centers of activity, of thought, of movement, are outside the family walls. The auto, the movie, the can opener illustrate the elements which have helped to reduce the cohesive forces that constituted the essence of family life. In recent years only the radio has tended to keep the family at home, although with doubtful peace and comfort. The mind of the family suffers from being geared with unthinking and unemotional machines.

To urbanization and mechanization as phases of social change, I add educationalization, individualization and equalization. Society has educationalized the home, although it no longer is the essential center of education. More and more stress is being placed upon public education,—in elementary schools, secondary schools, vocational schools, in trade schools and colleges. Education has become a shibboleth. The educational level of the parents in the home has not kept pace with the rising educational standards in the schools. Today the younger members of the family, especially the girls, are far better educated than were their parents at the same stage of age and development.

Women, because of more leisure and less necessity for creative work within the home, are searching for outlets for their intellectual and emotional satisfaction. The extra-mural activities of women, bringing new values into the home have destroyed the comfortable feeling of masculine supremacy so long fostered by an arrogant patriarchate. The per capita level of education is higher than mere schooling. The educational system is suffering from its own maladjustment to changing conditions and in consequence there are oftentimes sharp assaults upon the peace of the family because of the con-
ervative standards of educational institutions. The entire family seeks to learn through living.

Individualization has permeated the home because it is a part of the central philosophy of this area. In the family the idea of personal freedom is increasingly dominant. The marital partnership no longer boasts a dominant male senior partner, as there is growing recognition that both partners in matrimony are equally important and equally entitled to respect and consideration.

Individualization is manifest in the diminished size of families that promotes the freedom and development of the married pair. Contraception or birth control has profoundly affected the status of husband and wife. Few children by choice rather than many by chance have markedly influenced the viewpoint of father and mother. The one or two child family is not to be compared with a family with four or more children in terms of vitality, power, force and spirit.

The diminished number of children has transformed the emotional life of the family. It has increased parental solicitude, interest and attention and has afforded more abundant opportunity for the intellectual advancement and social growth of parents and children. The central status of the children in the present day small family has changed the nature and philosophy of family relationships, as well as the familial outlook upon parental responsibilities and social obligation.

Individualization, as manifest in careers for women, allows wives a larger freedom, whereby they become earners as well as spenders. No family can retain its old forms and disciplines when the wife becomes a potentially self-supporting producer. The wife no longer sacrifices her womanliness when she refuses to accept limitation to the traditional functions with kitchen, church and children.

Social attitudes towards marriage have changed and they have profoundly modified everything that enters into family life. The much discussed companionate, the greater freedom in securing divorce, the shifting ideas regarding children born out of wedlock reveal a new sexual psychology that has threatened family organization. Undeniably society in the United States and more particularly in the East is questioning its views regarding marriage as an institution adapted to present day needs. Monogamy itself is not sacro-sanct and inquiries into its value for communal living represent
new gropings for up-to-date adjustments. Marital experimentation
with new forms goes on now even as man has tested out polygamy
and polyandry, trial marriages and the various other forms of sexual
matings which history relates.

Society at present is in an age of relativity. Absolutes are few.
Speaking now in terms of a behavioristic determinism and in the
next moment in terms of the instability of moral values, society is
crossing treacherous quick-sands in the realm of ethics in order to
reach firmer foundations. The responsibility for this state of moral
unrest does not rest upon the younger generation, but upon middle
age, which lacks security and certainty concerning what it is doing
and saying. It is the mistaken freedom and indubitable laxity of
this group that has fostered the idea of individual rights among the
young. Egotistic hedonism urging the preeminence of individual
rights has shaken some of the foundations of the family as a social
unit.

Equalization of the sexes continues and markedly affects the
family. Women possess political equality, as a result of which their
moral ideas have deviated from their abstract ideals, as dictated
by a political pragmatism learned from males. Women have secured
industrial opportunity and working alongside of men they have
precipitated numerous economic problems and social questions which
are far from a satisfactory adjustment. Increasingly large propor­
tions of married women are entering into industry, thus changing
the home background and influences whether their children are in
homes, day nurseries or nursery schools. Society likewise has ap­
proved a higher degree of sexual parity of the sexes. Time was
when the question of a double standard of morality aroused hesitant
discussion, but today frank emphasis is placed upon the implications
of a single standard of chastity and that rather the one formerly
regarded as the masculine prerogative. Today males are not the
only sexual aggressors. This does not mean that the new generation
entering into marriage are inferior to their parents or are less virtu­
ous because they are more frank and honest. A better understanding
of sex and its relations to social growth bring into modern life ele­
ments that would have been impossible a generation ago. This
constitutes a very definite factor in many marital difficulties as re­
flected in and by the increasing divorce rate. Society is talking
more in terms of democracy, freedom, and emancipation in and
out of the home. Woman is no longer a chattel sexually or socially; she is gaining more control over her own money and has more rights in her own name. The consciousness of recognition as a being with equality and freedom has definitely changed not merely woman’s status as a wife and mother, but has altered every biologic and social factor in home making and family life.

This equalization of the sexes is still further represented by the increasing higher educational activity of women. There is no downward level of male education, but there is a rising feminine tide of knowledge with a consciousness of new power and acknowledged ability to function intelligently in society. What is happening in families can be understood better when one thinks of college girls, women’s study clubs and mothers searching for educational experience and activity. There is a constant equalizing education going on through the medium of the moving pictures, the radio and the press, all of which receive their main support from women. Hence woman is gradually rising to superior heights with opinions, judgments and sentiments expressed, as was impossible in an era when she was regarded as man’s inferior.

The family is in a state of flux. What is happening to it arises partially from the rapidity with which society is living. An era of speed, of movement, of ebb and flow has engulfed the family. No one can determine just where it is going nor how far it has receded or advanced from its older harbors. The present age cannot be completely evaluated until it is possible to consider it in relation to the ages preceding and following it. It is safe to say, however, that the old fashioned home and family life have gone. The family of today no longer takes pride in a home that is the center of moral and educational influences. What the family is to become depends upon times, circumstance and what some people call progress, although that progress may merely mean movement.

It is folly to judge whatever is happening to the family from the standpoint of absolute Puritanic standards and rigidities. One is not justified in saying that the present trends are indicative of degeneration, deterioration or disintegration. One can only say that society has changed and that the family is part of society.

A short discussion cannot reveal or explain all the things that are happening to the family. They are not to be attributed to a world war of ten years ago but rather to the elements which I have men-
tioned, namely, urbanization, mechanization, educationalization, individualization and equalization of the sexes. In addition I have suggested that society is guilty of a slowly but surely increasing absorption of familial responsibilities.

The centrifugal social phases of family unity have been removed too quickly to permit an easy adaptation. The centripetal biologic and sexual phases have been more or less isolated as society has taken on functions which formerly made the home the center of familial activity.

On the other hand the decreased birth rate, which indicates a diminished biologic procreative function, has modified the larger social unity of the biologic family while it has made possible the larger perfection of the members of the family acting as individual social units. Hence, with fewer family responsibilities and greater individual capacity for social activity, the family has been temporarily unstabilized. A rising intellectual level of potential family life has not been accompanied by an equal emotional development of its values. Hence there is an inadequate emotional satisfaction in the home which is leading to greater interest in outside sensation as an end rather than in home activity. The tendency to recognize in marital life two factors, one procreative and one social, has led to a serious shifting of ethical and moral values. There has been some emotional conflict with the home as one battlefield. The standards of familial life are changing by reason of new principles and ideas concerning what life means to individuals. The individual is no longer totally absorbed in marriage. The offspring of marriage are no longer absorbed in family life.

The family cannot be evaluated in terms no longer applicable. The family of 1928, with its speed and prosperity, cannot be standardized by the family of 1875 or of 1900. The only factors that they really have in common are the essential necessity of a mating male and female and a dependence upon work to secure means to satisfy their economic needs and social interests. The economic needs of today are not those of the past. The social opportunities of the present are not those of a generation ago. The ideas and principles, the literature, art and music, the psychology, science and religion, the customs, habits and the traditions of today differ widely from those of a generation ago. Bobbed hair and short skirts, cabaret and saxophone, the hip flask and delicatessen shops combined
with the frankness, freedom and energy of the younger and older generation bear witness to the powerful factors and deep social pressures that have influenced the family and will continue to affect the family life.

The family will not be destroyed. It may change its form, its goal, its means of expression. Its contribution to individual life may be continually altered, but so long as humanity struggles for contentment and happiness from a biologic-social relationship, the family will exist. It will continue to be a center for perpetuating man’s social heritage, while it ever relights and passes on the torch of life that warms and enlightens the world.
SOCIAL SERVICE FOLLOW-UP WORK IN CASES OF TUBERCULOSIS*

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Workers in the Section on Medical Social Service of The Mayo Clinic interview, as a routine, every patient having a diagnosis of active pulmonary tuberculosis. The purpose and method of this procedure have been explained in a previous article. In brief, the social worker in a personal interview tries to ascertain the patient’s attitude toward his disease and to help him face his problem as reasonably as possible. He is instructed in the necessary precautions to take so that he may protect his family until he has been admitted to a sanatorium. A pamphlet, “What you should know about tuberculosis,” published by the National Tuberculosis Association, is given him and the importance of sanatorium care and the available sanatoriums in his locality are discussed in detail with him. Descriptive literature of sanatoriums is given if desired. The patient is also advised of free facilities provided by his state and county for his care and for the examination of his family. The importance of having other members of the household examined is stressed and, when it seems necessary, social problems interfering with treatment are discussed with the patient. The patient is kept in touch with after he has returned home by direct correspondence, through his local physician, or through some health or social agency. This policy of referring patients to local agencies has been adopted because in most cases the patient needs outside assistance in carrying through his plans. This procedure is discussed with the patient in his interview with the social worker. If it is obvious that the patient wishes to make his own plans, and the worker considers the patient capable of carrying out instructions given him, reference to an agency is not

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made. The patient then is asked to write the worker or the physician about his plans.

A study was made of the social records of 233 patients with tuberculosis known to the workers of the Section on Social Service. Of these, 151 were referred to some local health or social agency; 21 were referred to sanatoriums only; and 61 were not referred to any local or social agency.

When a case is referred to a local agency the purpose is to secure that agency’s coöperation and if possible to transfer to the local worker the full responsibility of carrying out the recommendations. In studying the 151 cases referred to agencies, an attempt was made to ascertain the degree of responsibility assumed by each agency and the effort expended in time and correspondence to obtain this assistance. The tabulation shows the type of resource used, the number of times used and the degree of responsibility assumed. It shows that 151 cases were referred to various agencies 203 times. In only thirty-three instances (16.3 per cent.) was the entire responsibility of family and patient assumed. This means that the social worker at The Mayo Clinic must attempt to assist the patient from a long distance or seek assistance through other unorganized channels. It also explains why it is necessary for the workers of the Section on Medical Social Service to keep cases open over a long period of time in order to guide the plans until some agency will assume responsibility. For the total number of cases it was computed that the average length of time a case was kept open was eight months and one week, the longest period of time being four years and four months and the shortest period two days. In thirty-three instances (16.3 per cent.) the responsibility of the patient was assumed by the agency, and in twenty-one cases (10.3 per cent.) the responsibility for the family was assumed. In seventy-nine instances (33.9 per cent.) the agency gave some assistance. For forty-two cases (10.8 per cent.) a response was not made by the agency, and for fifteen (7.3 per cent.) response was made but coöperation was not given.

When the social worker refers a patient and his family to an agency the object is to aid the patient. When an agency assumes responsibility for the patient and his family the worker transfers the case to that agency. It is with great satisfaction that cases are referred to agencies in certain communities where it is known that the resources are well developed and where excellent coöperation will be
Follow-up in Tuberculosis

given. Many cases may be cited showing how satisfactorily a case may be transferred in a short period of time.

A woman, aged thirty, single, whose occupation was book-keeping was referred to the Section on Medical Social Service with a diagnosis of moderately advanced pulmonary tuberculosis with positive sputum. The patient had resided in a city in the southwestern part of the United States for four years. She and her sister, aged twenty-eight, lived with their mother, who was dependent on them. The father had died of pneumonia. Two brothers were married and away from home. A younger sister was also away from home and was working her way through a teacher’s college. The two sisters and their mother lived in a modern bungalow on the outskirts of the city. The patient had been sleeping with her sister. When the patient learned of the diagnosis she could not see her way clear to go to a sanatorium. She had earned $27.50 a week and she and her sister had recently bought a home on which they were paying $50 a month. Payments for three years were still due and she felt that her earnings were needed very badly. It took the worker some time to explain to the patient the advisability of beginning treatment immediately. The patient on her departure gave the worker her consent to write to the tuberculosis society in her locality. This was done, and the social history of the patient and the problems, both medical and social, were explained in detail. This society, which had a nursing service and medical assistance available, visited the home immediately. As the family could not afford the expense at a private sanatorium and as the only available sanatorium was one for destitute girls, to which the patient refused to go, the society erected a sleeping porch for her. They also extended to her free medical service. The mother and sister were examined; the sister was found to be normal, but it was discovered that the mother had chronic pulmonary tuberculosis. The tuberculosis society reported back to the social worker that they would continue supervision in this home, both of the patient and the mother. The case was closed by the Section on Medical Social Service when this report was received.

Another illustration is the case of a married man, a Greek, aged thirty-two. He understood English but had difficulty in expressing his thoughts. He said he had lived five years in a city of a bordering state but had not been naturalized. His family lived in Greece and he had not seen them for five years. He was a cook by trade, but
B. Peterson had not been able to work for two years and he did not have funds for medical care. He gave the worker the names of two friends in his city, but said he did not have relatives in this country. The patient had active pulmonary tuberculosis and tuberculous peritonitis. Immediate sanatorium care was advised. A telegram was sent to the social welfare league in his city to arrange for sanatorium care and to establish residence. Through this agency, communication was made with the Director of Immigration and the patient’s residence was established. County help was obtained and in six days the patient had been admitted to the state sanatorium as a free patient. Little was known about the living conditions in the home where the patient had resided. With the assistance of the first agency, a nurse in the public health nursing bureau visited the rooming house to investigate the hygienic conditions and to arrange for the examination of any persons who might have been in contact with the patient. Reports were received from the welfare league, the nursing bureau and the state sanatorium. Each was carrying out some phase of the plan and each knew of the other’s activity. The case was closed by social workers at The Mayo Clinic in three and a half months, and all agencies were notified of this step.

The tabulation also shows to what degree agencies do not cooperate. The lack of response from such a large number of county nurses may be attributed to the fact that it is difficult to reach them due to a changing personnel. Letters addressed to nurses who have left their districts are often lost or not returned.

That agencies do not always understand the methods and motives of the social worker at The Mayo Clinic is illustrated by the following case:

A single woman, aged twenty-four, was found to have advanced pulmonary tuberculosis. Until her sickness began she had worked in a restaurant and had also done housework. Her father, three sisters and one brother had died of tuberculosis. One sister and two brothers were married and lived away from home. The patient lived with her mother and step-father, and in this family there were three children, aged eight, five and two. The step-father earned five dollars a day as a laborer. He said he was tired of having her sick and he refused to help her. The mother received a pension of $20 a month and was able to help the patient to some extent. A state or county sanatorium was not available. The following letter was
written to the health officer in the patient’s town asking him what ar-
rangements could be made for her, as it seemed quite urgent that she
receive some sort of care:

December 5, 1925.

Dr. Blank, Health Officer,
City, State.
My Dear Dr. Blank:
Miss ———— of your city has been a patient here several
times. In September, 1925, she was found to have active advanced
pulmonary tuberculosis, positive sputum, and sanatorium care was
advised. Miss ———— told us that she did not know whether san­
atorium care could be afforded by the family. Her mother is Mrs.
—————. Miss ———— lives with her mother.

We referred the case to the community nurse but she wrote us
that she had discontinued the work and was unable to make the visit.
We have not had any answer to our letters to Miss ———— and we
are very eager to know in these cases of tuberculosis what arrange­
ments can be made for sanatorium care. It seems particularly urgent
that this patient should have some advice in making plans since her
father and four brothers and sisters died of tuberculosis.

May we hear from you as to what arrangements this patient has
made and what her condition seems to be at this time?

Yours very truly,

An answer was not received from the physician, but a month
later the following letter, published by the health officer in the state
medical journal, was noted:

December 16, 1925.

To the Editor:

Inclosed find letter which is self-explanatory and I trust that
it may be of some use to you in your editorial work. I was not aware
of the extent of The Mayo Clinic’s work along the line of social
welfare work until I received this letter. It seems to me there should
be some limit to that kind of stuff.

In ———— County we have no T. B. nurse, no community
nurse, no welfare workers and no free clinics. The two cities of
————— and ———— each have a school nurse. The county judge
of ———— County during the past year sentenced three chiropac­
tors, two to the penal farm for six months and one to the county
jail for violation of the medical practice act.

Being health commissioner of the City of ————, I believe I
am in a position to authoritatively state that health conditions in
—————County were never better in spite of the fact that we have
been deprived of the benefits of community nurses, Red Cross nurses,
welfare workers and social uplifters.

Yours very truly,
It is evident that the health officer resented having any outside activity or interest shown with regard to patients in his community. I do not believe that any worker (physician, county nurse, medical worker or family case worker) can work independently where tuberculosis is concerned. The medical social worker in this case did not have any idea of supervising the activities of a local agency. Her object was to seek assistance for the patient. When this was accomplished she would gladly relinquish the responsibility.

Another illustration is given to show how the work is handicapped when agencies do not cooperate.

A man, who was found to have active bilateral pulmonary tuberculosis, was referred to the social service worker. Sanatorium care was advised and it was also recommended that his wife and four children, who were less than sixteen years of age, be examined. As the patient had previously been under the care of a local physician, he did not care to have the worker make any arrangements. With the patient's consent, however, a physician at the clinic wrote to the local physician. This was followed up later by a letter from the social worker asking if the patient had returned to his care. Since an answer was not received from either of these letters, a letter was written to the patient, but a reply was not received. As there was a well organized nursing bureau in the state, the case was referred to this agency, with an explanation of the social and medical history and the previous action. A letter was received stating that the patient had not entered a sanatorium and was not attending their clinic. The social worker was unable to ascertain what responsibility the society would assume, since it failed to answer questions concerning whether the family would be visited again or whether the local physician would be reached. The case, therefore, was closed.

The social worker is aware that the degree of assistance rendered is governed by the number of resources in a community and that each agency is limited in its activities. It was found that in twenty-five of the 151 cases, the local resources were not adequate to assist the patient with his plans. For sixteen of these twenty-five cases there was neither a local nurse nor a health officer. The state tuberculosis societies reported that because of lack of funds or workers nothing could be done. For three patients, workers outside the locality were enlisted to help. Three patients were lost track of and local physicians were asked to assist with some social problem concerning three others.
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It is for patients from the Dakotas, Montana and the western provinces of Canada that the social worker's ingenuity is taxed to find some local organization or person to aid the patient in his plans. In a few instances, the only solution has been to notify the state organization of the circumstances. Where there are county nurses and health officers, the problem of transfer is simple. The extent, however, to which parts of the United States are without public health nursing service, as brought out by a census of public health nursing, is astounding. In the United States 1,800 (51 per cent.) of the 3,045 counties are without local nursing service. Only four states have nursing service in every county, and only nine have nursing service in three-fourths of the counties. These states are all eastern or northeastern states.

A study of the residence of the 233 patients in connection with the public health nursing services throughout the United States shows that only one patient came from a state where there was nursing service in three-fourths of the counties. The remaining 232 patients came from states in which less than three-fourths of the counties are covered by a public health nurse. Furthermore, 34.3 per cent. of the patients came from rural districts, 21.5 per cent. from towns of a population of 1,000 to 5,000 and 19.7 per cent. from cities of more than 50,000. Of the 233 tuberculous patients 80.3 per cent., therefore, came from rural communities and small cities of less than 50,000, where it is evident that medical facilities and social resources are not as adequate as in large communities. The following cases further illustrate the various problems that confront the social worker at The Mayo Clinic.

A woman, aged thirty-three, a farmer's wife, had a family of three boys and two girls, all less than thirteen years of age. She came to the clinic and was found to have advanced pulmonary tuberculosis. Although the prognosis was poor, in order that the children be protected, she was advised to go to a sanatorium. The patient said she could arrange this, as she had hired help in her home. The patient's mother and two sisters had died of tuberculosis and one brother had tuberculosis. The husband could pay something toward her care. Application to the state sanatorium was made immediately by the social worker. The county commissioners in the patient's county were written to, and asked to visit the home and make some arrangement with the husband for her care. The state tuberculosis
society was also written to, but as there was no county nurse, they reported that it would be months before a nurse outside the county would be able to visit the home. During this time the clinic social worker corresponded with the patient regarding plans for her care and her family. Since there was no nurse to assume responsibility, the worker next approached the child welfare board. They were unable to assume the responsibility so they in turn referred the family to the health officer. Letters were written to him repeatedly without response. Finally through combined efforts during a period of eleven months the home was visited, the children were examined and the mother admitted to a sanatorium. This case illustrates the amount of work and the length of time necessary to accomplish anything when there is no active local worker in the patient's community. On the other hand, the results justify the policy of keeping in touch with patients until the full responsibility has been assumed.

A girl, aged ten years, of Bohemian parentage, whose residence was in a northern state, had pulmonary tuberculosis, with positive sputum. She had four sisters, twelve, eight, six and five years of age, and two brothers, one three years old and one two months. The patient had had a mastoid operation, and when she came to the clinic she was poorly nourished and anaemic looking. The mother was not well and she said the children had frequent colds. The patient, she said, had slept with her grandmother, who had died of tuberculosis. Since there was an executive secretary of the child welfare board in the patient's community, the family was referred to this worker. Responsibility was assumed by her. She reported back that home conditions were good but that the father was not coöperative. It was evident that this family needed instruction, advice and education along the elementary lines of prevention. The child welfare worker continued her visits to the home. She succeeded in having the patient's tonsils removed and the patient seemed to improve under the care of a local physician. After ten months of repeated effort to secure sanatorium treatment for the child and to secure examination of the other children, it was reported that the work was discontinued by the county and that the best that could be done was to have the responsibility for the patient assumed by the child welfare board, where there was no paid worker. Since there was a local physician, and since the board was acquainted with the situation, the case was closed by the clinic social worker. The pos-
sibilities for curative and preventive work in this family were unlim-
limited, but because resources were not adequate, the work was at a standstill.

Lack of assistance and cooperation may be due, in some in-
stances, to lack of resources in the community or to a misunder-
standing on the part of some agencies as to what is the purpose of

TABULATION

Resources Used in 151 Cases

<table>
<thead>
<tr>
<th>Organized resources*</th>
<th>Number of times used</th>
<th>Degree of responsibility assumed by resource used</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Full responsibility of patient</td>
<td>Responsibility of patient and family</td>
</tr>
<tr>
<td>State tuberculosis society</td>
<td>39</td>
<td>7</td>
</tr>
<tr>
<td>County nurse</td>
<td>34</td>
<td>4</td>
</tr>
<tr>
<td>Public health department</td>
<td>23</td>
<td>2</td>
</tr>
<tr>
<td>Sanatorium</td>
<td>16</td>
<td>2</td>
</tr>
<tr>
<td>Local tuberculosis society</td>
<td>13</td>
<td>2</td>
</tr>
<tr>
<td>Red Cross</td>
<td>13</td>
<td>7</td>
</tr>
<tr>
<td>City nurse</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>Visiting nurse</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Veterans’ Bureau</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>County commissioners</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Social service leagues</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>United charities</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Child welfare boards</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>School nurse</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Health officer</td>
<td>3</td>
<td>2</td>
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<tr>
<td>State division of child hygiene</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Family welfare</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Industrial nurse</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>State department of public instruction</td>
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<td>1</td>
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<tr>
<td>State charities and department of correction</td>
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<td>1</td>
</tr>
<tr>
<td>Community chest association</td>
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<td>1</td>
</tr>
<tr>
<td>Indian agents</td>
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<td>1</td>
</tr>
<tr>
<td>Private charitable clinic</td>
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<td>1</td>
</tr>
<tr>
<td>Rockefeller Foundation</td>
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<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>203</td>
<td>33</td>
</tr>
</tbody>
</table>

*Only the sanatoriums that have social service departments are included.
follow-up work. It is believed, however, that keeping in touch with the patients in their local communities is necessary in the general plan for the treatment and prevention of tuberculosis. In cases in which resources are not adequate something may be gained through correspondence with the patient and his family to encourage them in their own efforts to carry out recommendations. Furthermore, by notifying proper health authorities, the attention of a community may be called to the lack of resources in their state to deal with tuberculosis and interest may be stimulated to develop more resources. In cases in which health and social resources are adequate to deal with the problem of tuberculosis there should be rational and balanced cooperation of all concerned. The function of each agency must be interpreted liberally, and in order to give the patient the benefit of every assistance, it is more desirable to have an overlapping of work rather than an underlapping.

REFERENCES

1 Peterson, Blanche; Medical Social Work with Tuberculous Patients at The Mayo Clinic. Hosp. Social Serv., 1928, xviii, 29-35.
No element of our population is more deserving of governmental solicitude, care and protection than our native Indian population. It is they who originally owned all the soil, most of which they were deprived of by treaties entered into largely in ignorance of the crucial consequences of all that was involved. As a result, the Indians have always been a difficult problem to deal with in the utmost fairness to all concerned, for obviously our government policy has of necessity often been dictated by the prior consideration of the white population. It is idle to deny that we have often been at fault in our attitude towards the Indians and the conservation of their rights and privileges. It is likewise self-evident to anyone familiar with the facts that substantial progress has been made during recent years towards a better understanding of their needs and in no direction as much as in that of an adequate medical and hospital service. Unfortunately, the government has never seriously attempted an accurate and complete enumeration of what remains of what must once have been a much more considerable population. The reports of the Bureau of Indian Affairs on population are largely estimates based on the guess work of local superintendents. The population problem is complicated by a considerable amount of white intermixture, for no precise definition of an Indian has ever been attempted. In my own judgment no person should be classified as an Indian who has less than one-fourth of traceable Indian blood. At the present time, the so-called Indian population includes adopted whites and a substantial number of negro freedmen and their descendants. Hence the estimate of 354,940 for the year 1927 is unquestionably an exaggeration. No order can be brought out of present chaos until a deliberate attempt is made to accurately count what remains of our Indian population differentiating half-bloods, quarter-bloods
and others. The first deliberate attempt in this respect was made during 1928 when the Bureau of Indian Affairs took a census of the Navajo Indians, in which they have been exceptionally successful, showing conclusively a much larger population than had been estimated in an over conservative manner by local superintendents. A similar census will be taken during 1929 of the Pimas and Papagos. It is to be hoped that this admirable procedure, which includes the distribution of consecutively numbered discs and the taking of fingerprints for every person enumerated will be continued on a much larger scale in the future.

The uncertainties of the actual number of Indians entitled to governmental consideration affects the appropriations required for their needs. There is a further complication of Indians no longer under government supervision and control. What their actual numbers are is not revealed by any statistics available at the present time.

For the present purpose, I am chiefly concerned with the hospital situation. The medical problems are better understood and are becoming gradually a matter of trustworthy record. During the last year, the Bureau of Indian Affairs has established a statistical division industriously engaged in the collection of accurate vital statistics, while aiming at the gradual perfection of an Indian registration area in which the population is known with reasonable accuracy and in which the returns for births and deaths are at least approximately complete. Not much reliance can at the present time be placed upon the statistics published as to births and death rates in view of the inaccuracies which underlie all population estimates. The official report of the Commissioner of Indian Affairs for the fiscal year 1928 gives a birth rate of 28 and a death rate of 21.8. In the light of many years of interest in Indian vital statistics, I am satisfied that the birth rate is somewhat higher, while the death rate, properly computed, is somewhat lower, or approximately a birth rate of 30 and a death rate of 20 per 1,000, which would leave a margin of population increase of 10 per 1,000, which is normal and sufficient for the purpose of preventing the Indians from dying out. I am absolutely satisfied that many of the Indian tribes are well holding their own. Little faith should be placed in the frequent attempts to malign the Indian Bureau as regards its medical administration. The Indians are unquestionably peculiarly susceptible to tuberculosis, respiratory diseases and trachoma. But these are matters of race
rather than of environment, although much can be done by improving sanitary conditions. The Indian medical service for years past has suffered much from inadequate appropriations. Doctors and nurses have been badly underpaid and the large turnover in the service has been decidedly to its detriment. In all these matters rapid progress has been made during the last few years since the medical service was placed in charge of Dr. Guthrie, formerly of the United States Public Health Service and delegated by that service to the Bureau of Indian Affairs. The following observations, particularly regarding the number of hospitals, bed capacity, number of whole time and part time physicians, nurses on duty, etc., refer to authorized positions rather than to the actual number on duty. The turnover in the medical and nursing personnel is still so high that considerable fluctuations occur in the actual number on duty at a given time. The turnover, however, for the last year has been less than for previous years, the reduction being due to an increase in salaries, and particularly to improvements in living conditions, as well as to the increased number of nurses on duty in several hospitals. In the past at many of the smaller institutions one nurse only was employed, which meant an excess of nursing service, with resulting fatigue complicated by a lack of proper accommodations.

The following table will visualize the present situation at a glance. It is not correlated to population for the reason that this would require an extended statistical investigation as to the actual number of Indians affected by the accommodations provided.

HOSPITALS U. S. INDIAN SERVICE—FISCAL YEAR 1928

<table>
<thead>
<tr>
<th>Name of Type Operating</th>
<th>Number</th>
<th>Bed Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>General, School and Agency, Hospitals</td>
<td>77</td>
<td>2123</td>
</tr>
<tr>
<td>Sanatorium Schools</td>
<td>10</td>
<td>874</td>
</tr>
<tr>
<td>Sanatoria, tuberculosis</td>
<td>2</td>
<td>94</td>
</tr>
<tr>
<td>Asylum for insane</td>
<td>1</td>
<td>92</td>
</tr>
<tr>
<td>TOTAL</td>
<td>90</td>
<td>3183</td>
</tr>
</tbody>
</table>

Note: Hospitals at Ft. Bidwell, 7 bed and Neopit, 6 bed capacity, not in operation at present and not included in the above figures.

Total number of physicians on duty, full time .................... 118
" " " " " " " " part time ........................................ 65

Note: Of the physicians, approximately 95 per cent. do agency and reservation work in connection with their other duties, while only 5 per cent. do hospital duty exclusively.
Total number of registered nurses on full time duty ...................................... 195
Total number of registered nurses doing hospital duty ................................... 149
                             “        “        “        “ field “ .................................... 33
                             “        “        “        “ traveling“ (Special) ................... 13
Total number of practical nurses on full time duty ..................................... 8

Note: Of the registered nurses, approximately 76 per cent. are on hospital duty exclusively, the remainder of which do agency and reservation work.

It is shown by the foregoing that the total number of hospitals and sanatoria, including one asylum for the insane, is 90, with a bed capacity of 3,183, and that the total number of physicians on full time duty is 118, and on part time duty, 65. The total number of registered nurses on full time duty is 195. There is need of more physicians and more nurses, particularly the latter, who are of inestimable advantage in dealing with the Indians, particularly when they have some knowledge of the native language. Possibly the most interesting experiment in this direction is one made by the State Board of Health of Minnesota which has charge of the Chippewa Indians in that State. The Board employs two full time registered nurses of Chippewa origin who have been unusually successful. But there still remains a large number of adult Indians who are unable to speak the English language or unable to understand it. I feel strongly that every effort should be made to encourage the study of native languages on the part of both doctors and nurses, but this will not be possible unless there is security of office and adequate compensation. Nowhere perhaps is this problem more difficult than among the Navajos of the Southwest, of whom the large majority of adults are ignorant of the English language and must, therefore, be dealt with largely through interpreters.

A number of new hospitals have been built, of which eight have been completed, while eight are still under construction. These in all respects will be superior to anything that has thus far been attempted. An effort is being made to construct the new hospitals along modern lines, with facilities for isolation, and wherever funds permit, provision is made for at least a small number of tuberculosis cases and the more adequate care and attention of obstetrical cases also. A further effort is made to incorporate new features which will improve the character and quality of the nursing service and reduce the manual labor incident to keeping these institutions clean and orderly. New building activities are confined to one story structures where the type of construction is not fireproof. Buildings of more than one story are now provided with elevator service, and at the same time with
better room facilities. During the current year the Service has purchased ten X-ray machines to add to the small number which during the previous year had been purchased for a few of the institutions.

Perhaps the best evidence of the foregoing in actual practice is the Southern Navajo General Hospital at Fort Defiance. This is not a strictly modern institution, but it will serve the purpose since a fairly comprehensive statistical report for the year 1928 is available. This hospital has 28 beds and on June 30, 1927, had 36 patients remaining. During the year 702 patients were admitted and 738 were treated, while 673 were discharged. There had been 35 deaths during the year, so that the number remaining June 30, 1928, was 30. The number of hospital days treatment during the year was 13,573. The total cost of operating the Southern Navajo General Hospital for the fiscal year 1928 was $14,511.79, so that the average cost per patient per day was only $1.07, while the percentage of bed capacity was 124 per cent.

I am familiar with this hospital as the result of frequent visits. Considering limitations of both construction and equipment, it is admirably managed and reasonably sufficient for the purpose. Too elaborate an equipment would be unsuitable for a primitive population. The medical and surgical results of the hospital have on the whole been quite satisfactory, but it must be evident that an expenditure of $1.07 per day per patient cannot produce the best results. The staff is underpaid and often overworked. During the year there were 16 live births. The number of contagious diseases treated in the hospital was 98, of which 41 were cases of measles with 2 deaths, 16 were cases of diphtheria with 1 death, and 41 were cases of chicken-pox with no deaths. Thus out of 98 contagious cases only 3 terminated fatally. There can be no better proof of satisfactory administration.

Aside from the foregoing, there were 248 vaccinations for smallpox, 21 vaccinations for typhoid fever, and 732 immunizations, by toxin-antitoxin, for diphtheria. Additional thereto, there were 5,210 examinations for trachoma, of which 2,338 cases were positive and 48 cases suspicious. The percentage of positive cases, therefore, to the total examinations is 46.

In the dispensary or outpatient treatment at the hospital, there were 19,386 such treatments, aside from over 250 home treatments at a total cost of medical work on the reservation given as $2,088.
This phase of the work includes regular home visits, clinics, dispensary treatment and examinations. Additional to the foregoing, there was the medical work in connection with boarding schools at a cost of $4,607.77. This consists of examinations, innoculations, treatment of the student body for all general medical needs and dental work. All surgical or other cases requiring extended treatment are transferred to the General Hospital.

At Fort Defiance, there is also the Southern Navajo Tuberculosis Sanatorium and school. The location of the sanatorium is fairly good considering the peculiar rockbound surroundings of the locality. The sanatorium has a capacity of 30 beds, and on June 30, 1927, had 26 patients remaining. The number of patients admitted during the year was 121, making a total of 147 treated during the year, of whom 110 were discharged, while 13 died, so that there were 24 remaining. The total number of hospital days' treatment was 11,684, while the total cost of operating the hospital or sanatorium was $11,200. The per diem cost per patient, therefore, was 96 cents, and the bed capacity utilized was 114.3 per cent. Here again the lost cost of operations makes it self-evident that more might be done if appropriations were more liberal. But it must never be forgotten that the native population requires very simple food and the minimum of attention. As far as I have been able to observe the patients are happy and contented. No complaint as to food or attention has ever come to my notice. The Bureau of Indian Affairs is now constructing a new tuberculosis sanatorium for the Southern Navajo Indians which will have a bed capacity of approximately 100 beds, while the present sanatorium building will be taken over by the General Hospital and used exclusively as a trachoma hospital when the new sanatorium is occupied, which will be in the near future.

The present staff of the sanatorium consists of a thoroughly competent physician and two registered nurses, who are assisted by five other employees. The staff at the Agency Hospital consists also of one physician and two registered nurses, assisted by five other employees. There is a third doctor who is the general superintendent in charge of both the sanatorium and the Agency Hospital, and a specialist on trachoma, to which most of his time is devoted. In this work he is assisted by two registered nurses, who are also competent in trachoma work. The new Southern Navajo tuberculosis sanatorium, when completed, will cost approximately $55,000. It is
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admirably located in the center of the Agency on a campus heretofore used as a recreation ground. Unfortunately the available space for buildings is very limited, but no alternative suggests itself for locating the sanatorium elsewhere. In my judgment, no serious mistake in location has been made. The plans of the new building are suggestive of skill in hospital construction. Much of the labor in connection with the building will be native. The new sanatorium will go far to improve the existing situation, for it will meet a definite demand for more adequate treatment of incipient tuberculosis cases.

Fort Defiance is the center of trachoma treatment. The disease is widespread among the Navajos, but diminishing. In 1925 the general incidence of trachoma in the U. S. Indian Service was 22.6 per cent. of positive findings. This by 1926 had increased to 24.8 per cent., but diminished to 15.1 per cent. in 1927, and during 1928 the proportion was 18 per cent. The number of treatments during the last four years has fluctuated widely, depending upon the response of the native population from propaganda for treatment and facilities therefor. The maximum number of operative treatments was 4,170 in 1925, while during 1928 the number of such operative treatments was 2,565. The maximum number of non-operative treatments reached 5,033 in 1926, while a minimum of 1,679 was reached in 1927, increasing, however, to 3,272 in 1928. The total number of examinations for trachoma increased from 30,112 in 1925 to 37,524 in 1928. Thus far but slow progress has been made in the direction of eradication, but the indications are encouraging.

Next to trachoma, tuberculosis remains the outstanding aspect of the Indian Medical Service. The sanatoria capacity throughout the country has increased from 541 in 1924 to 803 in 1928. This will be further increased during the next few years. The number of patients admitted has increased from 613 in 1924 to 1,035 in 1928. The number discharged as cured or arrested has increased during the last five years from 183 to 284. The number of hospital days treatment has increased from 133,721 in 1925 to 248,477 in 1928. All of this may be looked upon as evidence of progress, but decidedly larger appropriations and institution facilities are required to meet the pressing needs of the situation.

Aside from trachoma and tuberculosis, influenza, measles and whooping cough are the outstanding contagious or infectious diseases.
During 1928, 11,733 such cases were treated in the Indian Service, of which 3,716 were cases of influenza, 3,299 were cases of measles and 1,709 cases of whooping cough. These three diseases, therefore, constitute 74.3 per cent. of the whole.

Smallpox is relatively rare. Vaccination is enforced with reasonable thoroughness. During 1928, there were 10,107 vaccinations against smallpox, 4,200 against typhoid fever, and 14,112 immunizations against diphtheria. Typhoid fever was rather common on the Reservations in 1928, there having been 138 cases, equivalent to 1.2 per cent. of all contagious and infectious diseases.

The foregoing will be sufficient for the present purpose to emphasize the conclusion that much progress is being made in the medical and hospital service of our Indian population. Recalling the facts of the situation as I have known them for nearly thirty years, the contrast of the present with the past is an amazing evidence of advance in civilization. In 1911, or at about the time when I first became actively interested in this subject, the appropriation for relief of distress and conservation of health among our Indians was only $40,000. This by 1914 was increased to $200,000, and by 1925 to $500,000, while for 1929 the appropriation amounted to $1,440,000. When I first entered upon my studies of the question the medical staff of the organization was grossly incompetent and lamentably underpaid. There were practically no nurses, while hospital service was everywhere totally inadequate. At present, at least reasonable needs are well met while the medical service and the nursing service have both undergone a substantial and most encouraging improvement. Those who find fault with the shortcomings of the service at the present time fail to realize the tremendous difficulties of meeting the needs of the problem over a vast area of the country in behalf of a largely ignorant and often superstitious population. But never in the history of the service has more attention been paid to the medical and hospital needs of the Indians than at the present time. Never has the administration of the Indian Office been in more capable hands. Never has the efficiency of field employees been of a higher order. If ideal conditions are desired to be brought about substantially larger appropriations must be made by Congress. The Bureau of Indian Affairs cannot perform miracles, although, in my own judgment, it often comes near to doing it with the small amount of money available for their needs. The field employees with whom I have come in contact
are mostly typically American imbued with a spirit of sacrifice and a willingness to suffer discomfort and isolation in the furtherance of the purposes and higher aims of the government. I know of no finer type of public employees than the Agency staffs of our different Indian Reservations. Nor do I know of a finer spirit of medical and social service than is met with in many of our Indian hospitals and other medical institutions. The only matter of regret to me is, that as a rule neither doctors nor nurses are familiar with the local languages. To bring this about continuity of service is of the first importance, and this cannot be had unless living conditions for employees are improved and amplified by more substantial salaries than are available at the present time. Nothing is more discouraging than the continuous unfair attacks on the Service on the part of professional reformers and agitators whose destructive efforts are a menace to the Indian and his future. My own views are absolutely dispassionate, for I myself have in years gone by been one of the most severe critics of the situation when it was vastly inferior to what it is today and decidedly less encouraging for the future. Now the outlook is distinctly hopeful, but everything depends upon sincere cooperation with the Bureau of Indian Affairs and its officials to bring about the progress most urgently called for in directions indicated.

REFERENCES

Medical Problems of Our Indian Population, Eastern Indian Association, February 5, 1925.
The Indian Problem of the Southwest, Boston Herald, July 6, 1926.
Cancer Among the North American Indians, Prudential Press, April, 1928.
The Indian as a Life Insurance Risk, Prudential Press, 1928.
The American Indian Problem, The New York Sunday Times, June 3, 1928.
Governor Smith and the Indians, The Boston Transcript, October 31, 1928.
THE PLACE OF THE PUBLIC HEALTH NURSE IN
THE FIELD OF POSITIVE HEALTH*

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The place of the public health nurse in the field of positive health depends upon her preparation for teaching health by her life, as well as by her work and words.

This does not mean that a nurse must always be one hundred per cent. physically sound before her life and work serve as an inspiration and guide for younger nurses. One of the most admired and capable superintendents of public health nurses I have ever known, a nurse whose influence on my own life has been incalculable, was Elizabeth Upjohn, first Superintendent of the Municipal Tuberculosis Nurses in Boston. Miss Upjohn died from diabetes before she was thirty-three, years before the discovery of insulin. Every one of her staff realized that she was working with a woman whose days were numbered, and yet every nurse who had the privilege of being with Miss Upjohn so admired her courage, her endurance, her vision, her love of the work and her absolute disregard of herself that her short life left its eternal mark on her nurses who continued in the public health nursing field after her death.

One of the most beloved superintendents of nurses in a very well conducted hospital in Chicago—a hospital to which all patients went gladly because its atmosphere was so free from any institutional taint, was a bad cardiac, so ill in fact that she cleared her desk every night in order that the stranger who might have to assume charge the next morning would find things ship-shape. The nurses did not think of their chief as a dying cardiac; they thought of her as a woman whose work was a living example of what they all wanted to accomplish.

Both of these, Miss Upjohn, and Mrs. Bowen, of the Washington Boulevard Hospital, went through life handicapped, but they were unusual women. The work of the average public health nurse (and most of us are average mortals) must be the work of the physically and mentally sound person. Few of us can do great things in spite of bad health. Most of us have to have a firm foundation of adequate health before we can presume to teach healthful living to others.

Somewhere, Emerson says, "What you are speaks so loudly that I cannot hear what you say." Fate, or good fortune has put the public health nurse into an enormous field bristling with opportunities. Because she has presumably been taught to do one thing well, we ask her to do ninety-nine other things equally well.

We have proved that she is a good field worker and we know that research must have its areas of demonstration. But teaching is an art. It pre-supposes education and preparation for imparting that education to others.

To a few of us, education is something that savors of eternity and nothing that can be measured in terms of finite time. Adult education can be achieved only when the adult is in a receptive mood. Many people to whom the Visiting Nurse is sent look upon her as a nice woman or a sweet girl, as the case may be. It is not always possible to say just when the sweet girl slips over that line of demarcation. When conditions are serious and they are frightened, people accept her help gratefully. They are not particularly keen about living up to her instructions, especially when they have with their own eyes seen her do things that do not bear out her teaching.

Within a week our advice has been sought about a nutrition worker. For six months she has been under observation as a suspect case of pulmonary tuberculosis. On the advice of her physician, she has taken a four months' vacation. No-one told her how to spend that vacation wisely. She spent it thoroughly and none too well; consequently at the end of the first two weeks in her new position, she is flat upon her back, with somewhat vague instructions that she must go west as soon as she is able to get up and pack.

What is the matter with a nutrition course that enables a young woman to qualify for an academic degree and yet does not help her realize that the first step to nutrition is frequently to care for one's-self?

In a recent number of the Journal of the American Medical As-
sociation, in the Department of Social Medicine, appeared an article entitled "Debunking Health Education." All health workers and teachers should read it. After discussing the fallacy of thinking that exaggerated statements loudly presented take the place of proved scientific facts, the writer sums up his article by saying, "What goes into health education, therefore, should be correct, pertinent and psychologically sound."

The public health nurse has been hailed as another teacher of positive health. She has been discussed as the most strategic worker in the field, because she makes personal contacts in so many homes and with so many different groups. Have we stopped to realize that not everyone who has a nurse's diploma and is put into a public health nurse's uniform, knows even the first principles of health?

A good nurse should know sickness and the care of the sick. The quality of care that she is able to give and the observation that she is able to make and record depend upon the thoroughness of her teaching as well as upon her own mental capacity to absorb and act upon this teaching. Many hospitals teach excellent theory but their work is so badly organized that daily emergencies cause the actual care of the sick to be done so hastily that nurses are not given time or shown how to apply this theory in the care of their patients.

Other hospitals seem to think that a patient who does not die may get well. They pay very little attention to the actual physical comfort of the patients so long as treatments, medical or surgical, are done on time, trays are carried in and out and the general appearance of the hospital strikes the casual observer favorably.

Too many hospitals are still run for profit only and these hospitals also think that they can manage schools for nurses when all they really seem to care about is to get their work done as inexpensively as possible. Few hospitals pay any attention to convalescence; and patients, adults or children, are sent out weak and dazed because the bed is needed for someone more acutely ill. Are nurses from such hospitals (and their number is legion) equipped to teach health? Can a public health nurse who has never seen a well baby more than ten days old, know, without a great deal of experience as well as teaching, just what future care its mother should give that baby? Books really tell us very little about the hour to hour service needed by those helpless bits of humanity, and yet any sensible mother
knows that her baby, unless it is extremely well trained during the first two months of life, becomes a twenty-four hour task.

The teaching of health is not synonymous with the teaching of the care of the sick. The nurse who goes into a home to explain the correction of physical defects or to give actual nursing care, may by her demonstrations lead the family toward health. A nurse who knows all sorts and conditions and degrees of illness is a better judge of well people than a person who has no standard of comparison. But nurses who are to teach the value of health must know what good health is. A small boy, when asked to define health, said seriously, “Health is something you want when you ain’t got it,” and this is the attitude that most of us, even when we stop to think about it, take towards health.

Nurses must know a great deal more about the things that constitute good health: proper food, proper rest, proper recreation, proper mental attitude towards life and towards one’s work, proper many other things. Then they must know how to teach these homely truths, especially how to impart this precious knowledge to adults who do not want to be taught or who are apparently not teachable.

The public health nurse must learn to work with her patients, not to lead them always; to drive them never. The generalized vague statements that so many of us make when we are driven into a corner, are just as hard on ourselves as they are on our patients. A cut and dried rule-of-thumb in education, in nursing, seldom works with individuals.

When we know a subject thoroughly, we may have to learn how to present it in half a dozen different ways to as many different people, or we may have to learn how to say the same thing in six different ways to the same individual.

The public health nurse must be both Mary and Martha: Mary sitting quietly, seriously, pondering many things in her heart and doing her best by reading and studying, to keep up with a few of the tasks expected of her; and Martha bustling busily, anxious about many things, eager to make her corner of the universe a bit of the Kingdom of God on earth.

But nurses, by whatever name they are known, must not be stampeded into believing that they are health teachers any more than they are social workers, nutrition workers, physio-therapists. Their hospitals should have given them an excellent foundation with
which they may learn how to live and teach positive health, but they
must learn health just as they would learn occupational therapy or
any other specialty which they want to teach. We talk too loosely
about teaching. The public health nurse is a big factor in the advent
of better lives for many people, but she must know her job.

In the last analysis, the public health nurse must not only know
her work, but she must love it. Knowledge is a useful commodity,
but mere accumulation of facts never helped an individual lead a
more useful life unless she knew how to share that information with
others less fortunate in that regard than herself. “The light of a
whole world dies when love is done” and the great responsibility
which a public health nurse is privileged to carry means that her
facts must not only be “correct, pertinent and psychologically sound,”
but that she must care so much about the people with whom and
for whom she is working, that she will strive to make her life a living
example of what they, too, may become through her teaching.
A hospital or dispensary gathers within its walls a typical cross section of a community. One finds there the young, the adolescent, middle aged and old, men and women of different national and racial backgrounds. They come to the medical institution primarily seeking aid for physical or mental ills. Examination will disclose that they may be suffering from various types of disease and are acutely, chronically or fatally ill. Similarly social study will reveal that they are also suffering from numerous personality and environmental maladjustments which have been created or are aggravated by illness and which may form grave obstacles in regaining health or comfort. Sickness is an alarming factor in a group of patients who are of limited economic means, whose resources will become more and more depleted if disease and disability progress. Illness affects the social equilibrium of even a stable group and it works more havoc within a group whose status has never been too strong. Coupled with poverty or any of the other social ills such as ignorance, bad housing, immorality, childhood deprivations, lack of educational and industrial opportunities, sickness indeed presents a sorry picture.

The modern, complex, highly organized hospital and clinic tend to impersonalize the patient and to minimize the personal relationship of patient and physician. Consequently one of the major contributions of hospital social service to the welfare of the patient is bringing to the physician by means of the social history an objective statement of the social medium in which the patient has lived and his reaction to

*Read before the Administrative Section of the American Hospital Association, San Francisco, Cal., August, 1928.
it. The history furnishes an account of the heredity, the early life with its establishment of behavior patterns, whether constructive or destructive, the interrelated life of the family, the working conditions, financial resources and obligations, recreational outlets and home setting of the patient. Whether this contributes to the specific medical diagnosis or not, it presents a picture of an individual against the background of the lights and shadows of his life.

The first contact of the patients with social service generally occurs in the out patient department. Here, following the recommendations of the medical staff and within the scope of the policies established by the administration, the social workers endeavor to see that medical treatment with the aid of treatment of its social implications, is made as effective as possible. In instances where the number of social workers is insufficient for service to all patients, the intake is naturally limited to those patients whose medical-social needs are considered most urgent by administrative, medical and social service staffs. In many dispensaries certain groups of patients are routinely referred, such as the tuberculous, the cardiac, the diabetic, the pregnant, the venereally infected, those suffering from mental disorders and those for whom hospitalization is recommended.

The health needs of each patient and the physician's advice for meeting them must be accurately learned, not alone from the medical chart but in consultation with the physician. Suitable opportunity for securing this information from the physicians in a busy clinic, where the time of every one seems to be at a premium, is one of the problems of the social service department. Then it is the social worker's responsibility to see that the patient or his family understands the medical condition and cooperates in the plan for treatment.

Interpretation of the medical institution in general, of his physician's medical recommendations in particular, is needed in the attempt to dispel the patient's fears and misconceptions of medical institutions and to build up a spirit of confidence. If he has faith in and is satisfied with the medical care he is receiving, if he cooperates with his physician and if personal and environmental difficulties are adjusted, the patient's progress is facilitated appreciably. Hospital social workers are in a favorable position to carry out this interpretative process through which confidence is established and the medical plan becomes integrated into the patient's scheme of life. Treatment must therefore include not only the necessary drugs and physical
measures, such as diet, rest, electricity, massage and exercise, but applied psychology and the utilization of resources within the patient, his family, his friends and the community. Interpretation, adequate follow-up and removal of any obstacles which may interfere with the observance of medical advice are necessary if the time and skill of the physicians as well as other trained personnel, are to be safeguarded and the waste of laboratory facilities is to be prevented. For examinations begun and not completed or treatment inaugurated and not carried through, are a loss to the patient, the physicians and the medical institution.

A problem of the administrative and social service staffs and one in which the physicians are interested as well, is that of the patient who is unable to meet the cost of laboratory tests or medical treatment. A report of the medical situation and the economic resources and obligations of the patient should be given by the social workers to the administration with whom the decision is left as to whether the prescriptions will be made free or the patients referred elsewhere for suitable treatment. In like manner all questions which are raised concerning the financial eligibility of patients should be promptly referred to the administration. Decision concerning the remission of fees is one of the most difficult phases of dispensary management but one in which the social service department should act exclusively in an informative and advisory capacity.

The social service department is interested not only in the care of the patient admitted to the dispensary, but in the health of his immediate family. Sometimes this means a conflict between the policy of the medical institution and the program of social case work. Some clinics because of limited staff or space and an ever increasing clientele must refuse contact or health examinations in spite of their interest in preventive work. On the other hand, the social worker as part of her case work plans, wishes to prevent the spread of disease and to promote the health of the family group. In dispensaries where such examinations cannot be undertaken, members of the patient’s family must be referred by the social service department to other medical resources within the community. For the welfare of the individual patient is inextricably fused with the well being of his immediate family.

In medical institutions where social workers are not placed in the admitting office as part of the administrative staff, the social service
department should be directly concerned with all patients for whom hospitalization is recommended. These patients must be interviewed in order to explain the medical situation, the probable duration of stay, period of convalescence, extent of disablement and hospital rates and in order to ascertain and adjust any social complications which may interfere with hospital admission.

An interesting problem arises here as to how much persuasion should be exerted in influencing hesitant or ignorant patients to enter the hospital for operative procedure. How can a wise course be steered in interviewing the patient whose only chance for life lies in the knife and the patient who may secure relief through operation but where a fatality may occur in spite of every medical and surgical precaution? The physician is frank in explaining the nature of the operation, the results anticipated, any possible dangers and the percentage of successful operations of this type. The process of interpreting this to the patient and offering advice as to ways of meeting any personal or environmental difficulty preventing hospitalization creates a real sphere of influence and places a grave responsibility upon the social worker. By means of this she may be the one who swings the balance between admission or non-admission in spite of an objective mode of approach and every effort to place the ultimate decision upon the patient.

Occasionally hospitalization is advised for patients who may not be eligible for care in the hospital wards because of their medical condition, residence, race or finances. These patients are still the responsibility of the administrative and social service departments until suitable care is secured. For patients who are considered ineligible for hospital admission because of non-residence and lack of finances, the social service department can frequently organize resources within the patient's own community either to furnish medical treatment or to assume the obligation of meeting the hospital fee and of seeing that the patient receives any necessary post-hospital care. Sometimes non-resident patients must be admitted as emergency cases in spite of lack of funds or are accepted because they give every indication of being able to carry the cost of hospital rates, but whose resources rapidly dwindle under prolonged hospital sojourn. These patients are a mutual problem of administrative and social service departments. Occasionally residence cannot be established in any community or if established, it may be difficult to secure any financial remuneration
from public departments, once the patient has been admitted without their authorization. If the non-resident patient has a chronic condition requiring institutional care, the problem becomes even more difficult as he is not eligible for any of the public institutions in the community and his discharge from the ward may be delayed many days much to the consternation of administrative and medical staffs before suitable provision can be made for his continued treatment. If the physicians or nurses report these cases to the social service department as early as possible, that is, as soon as a decision is reached concerning the type of treatment needed, their discharge could be facilitated appreciably.

A patient in a hospital bed is in a controlled environment, he may willingly respond to his physician’s advice, but will medication or other medical measures prevent worry over his wife and children whom his illness has left dependent on unwilling relatives or friends? Then there is the patient whose carefully hoarded savings have rapidly dwindled under the inroads of physician’s and hospital fees. He has no one who can help financially, yet he has just been told that he is almost ready for discharge, but must not work for six months. Ease of mind can be brought to these troubled spirits only through assurance that the hospital social worker is seeing that the wife and children are not suffering any undue hardship in the one case and that prolonged convalescence will be arranged in the other case. Worry may or may not impede the patient’s progress but its elimination makes easier the tasks of physician and nurse and aids in keeping up the morale of the ward to say nothing of what it contributes to the welfare of the patient by easing his troubled mind.

The discharge of patients from a hospital ward is of interest to many of the departments of the hospital; the administrator wishes to be sure that the patient is satisfied with his hospital stay and that suitable arrangements are made for his immediate post hospital care; the physician wants the medical treatment begun in the hospital brought to the best possible conclusion; the nurse and dietitian wish to be assured that any nursing or dietary needs will be met. The social worker concerned with all these interests is frequently the one who reaches out into the community utilizing those resources which will safeguard the welfare of the individual patient upon whom these interests converge.

To the nursing staff the social worker should bring the social
interpretation of the patient. This may be done by means of conferences and social histories or through aid in writing case studies. The nurse has a great opportunity in the course of her nursing duty to advise sympathetically and intelligently with patients. If she relies solely upon the information given her by the patient without the opportunity of learning the entire situation, her sympathy and advice may be often misdirected.

Problems of diet instruction and supervision for patients discharged from the hospital or attending the clinic affect both the dietetic and social service departments. If the dietitians do not visit in the home of the patients the social worker should bring to them some knowledge of the environment of the patient. The dietitian in turn must see that the social worker has an accurate knowledge of special diets prescribed if she is to carry out some dietetic supervision of patients during home visits. Occasionally questions of finances arise which create problems difficult to solve. The dietitian recommends that the undernourished children in the H. family should have so many quarts of milk a day. The social worker agrees as to the children's needs but she knows that the parents have refused to purchase the milk. If it is furnished to them, they will either allow some of it to sour and be thrown away or will use it to reduce the family budget, thereby enabling them to treat the children with more candy and more movies. Of course there is some solution to this problem but it must be found through the close coöperation and understanding of the dietetic and social service staffs.

The social service department is not concerned exclusively with those patients who are of limited economic resources. Their services are frequently sought for patients who are paying full rates in side rooms or private pavilions. The social worker's knowledge of community resources may aid in suggesting suitable places for convalescent or institutional care. The patient may have a general knowledge of such resources but may not know the particular place which will meet his specific need. While the social service department, because it deals with numerous and varied problems, necessarily has such information readily available. In instances where the patient's difficulty may lie in his personal or family relationships the social worker's skill in eliciting such data and presenting it in organized form for the use of physician or psychiatrist may prove extremely helpful. She may also aid in learning the basis for behavior problems in children.
through her study of family life and reactions. Pediatricians often find that these children of wealthy parents present some of their most difficult problems and they seek the help of the social worker not only in history gathering but in treating the maladjustments as well.

Social case work necessitates interviews with patients and others about matters which are frequently of a confidential nature. This means that the social service department should have office facilities which afford privacy, yet are easily accessible to patients and physicians. Other departments within the medical institution also require suitable offices. This creates a problem for the administrator whose crowded institution allows limited space with which to meet the needs of the various units.

These are some of the problems of the hospital which affect the welfare of the patient and are the concern of the social service department. They are related to the treatment of the patient for which the hospital exists. It has been said that “the treatment of disease is the art of medicine.” With this in mind it may be said that the treatment of the personality and environmental maladjustments related to the health problem of the patient is the art of hospital social service.
PROMOTION OF HEALTH Vs. PREVENTION OF DISEASE*

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Such a title, it seems to me, needs explanation. If anyone raises the old familiar war cry ‘Prevention versus Cure,’” it is as if we sounded a certain note in our televox mechanism and we all give the standard responses. But if we speak of the promotion of health versus the prevention of disease we must abandon our mechanical reactions and ask, why make a distinction between the two? Also if there is a valid distinction between the promotion of health and the prevention of disease is there any essential antagonism between them, as perhaps suggested by the title? If so, why?

As a text from which to answer these pertinent queries let us consider a comparison between the mortality rates of the acute infectious diseases and the degenerative diseases according to the United States Census figures for the original ten registration states. In 1900 the acute infectious diseases showed a mortality rate of 298.2 per 100,000 population and the degenerative diseases a closely similar rate of 317.8. In 1924 the infectious diseases mortality rate had dropped to 105.1 and the degenerative diseases mortality rate increased to 442.9 or over four times the rate of the infectious diseases.

These figures are most striking, but just what do they mean? One meaning is so clear that he who runs may read, namely, that the intensive effort for control of acutely infectious diseases is bearing rich fruit.

There are many of us today who can recall the terror inspired by the cry of “yellow fever” in our own country. Now the International

*Delivered as part of the Symposium on Positive Health which was sponsored by the Foundation for Positive Health, formerly the Women’s Foundation for Health, at the Annual Convention of the American Public Health Association, Chicago, Illinois, October, 1928.
Health Board is engaged in hunting it down in its last foreign strongholds. Of the more generally epidemic diseases the typhoid fever death rate of 35.9 deaths per 100,000 in 1900 was reduced to 6.5 in 1926, for the United States Registration area. Diphtheria, causing a mortality of 43.4 per 100,000 in 1909, was responsible for only 7.5 in 1926. All who contemplate the splendid story of achievement in cutting down the devastating effects of the acute infections will rejoice in the fight and wish to see it carried forward vigorously.

But what of the other side of the picture? While we are gaining so rapidly on infections, the mortality from the degenerative diseases has jumped from a status equal to that of the acute infections until it is now four times as great. Why has not the great cry for prevention instead of cure been equally effective here? It requires only a cursory consideration of the diseases affected and the methods used in combatting them to see clearly that this notable reduction of deaths due to acute infections has been brought about largely by control measures of a public character in which normal changes in the habits of individuals have played a comparatively slight part. Even in the case of diphtheria where individual initiative is at a premium, no one questions that the excellent progress made has been due in considerable part to vigorous efforts by public authorities for increased immunization of children, in addition to the therapeutic effects of antitoxin.

It would seem to be obvious, therefore, that our next and largest health task lies in the field of building up the physical and mental vigor and the resistance of the individual against the degenerative diseases which are exacting an increasingly heavy toll of death. The urgency of this job becomes more evident when we realize that long term impairment of ability and decrease in earning power from disease are far more apt to be found resulting from the degenerative group than from the acute infections.

It is important then, to inquire as to what is being done to reduce or prevent this class of diseases which are caused, in part at least, by what might be called the artificialities of modern life, such as overheating, improper moisture content of air, sedentary or exhausting occupations, lack of sunshine and exercise, over refined or badly balanced diets and too much night life.

We certainly cannot say that our scientific laboratories and health experiment stations have not been doing their share toward a solution of this problem. During the past two decades they have added
greatly to our knowledge of how to obtain a higher level of health and vigor. With the facts discovered during that time, as to the cause and effect relationships of diet, exercise, sunshine, mental adjustment and the general health regime to the fullest enjoyment of one’s powers, we now have a much more reliable base upon which to build our program of practical advice and guidance to the individual who wishes to improve his health status.

However, it is necessary to do more than merely disseminate this sort of information through literature, lectures and newspaper articles. Much of that has been done and still our mortality from degenerative diseases increases. Such information must be definitely related to the individual’s already assimilated knowledge, to his habits of living, and to his actual physical and mental condition in such a way that he cannot escape the application. Let us state, then, as a general proposition, that what is needed is a health advisory service which shall determine with all the precision that is humanly possible the individual’s health status, his peculiar personal and environmental needs and which shall follow this through with advice and guidance in a way of life that shall bring him the greatest amount of robust good health.

What is medical practice now giving in the way of such a service? We turn to the preliminary report (published January 1927) of the Commission on Medical Education consisting of a distinguished group of physicians and educators. The Commission sent a questionnaire to all medical graduates of the classes of 1915 to 1922 inclusive, who were confining themselves to general practice in communities of 50,000 or less in twenty-four states of the United States and two provinces of Canada. From an analysis of the 500 answers received and comparison with similar data on morbidity secured by others, the Commission concludes that “communicable diseases represent less than ten per cent. of the demands made upon the general practitioner. Over ninety per cent. of the demands made upon the general practitioner are for illnesses which cannot be controlled on a community basis but are the problems of the individual patients.” It is evident that here, in contact between physician and patient should be a most hopeful opportunity for driving home the great lessons of health building as distinguished from treatment and from prevention, in the narrower sense of prevention through measures of community control. While much can be done and undoubtedly has been done for health promotion through public dissemination of information on
healthy living, the physician holds in his hands the real touchstone to a change in the individual's way of life. Not only has the doctor a deserved prestige because of his training, knowledge, and experience, but, most important of all, the patient comes to him because he believes he can obtain relief from his troubles. That should be an open sesame to the doors which bar the individual from interest in sound living habits. But, instead, we learn from the Commission on Medical Education that "Practitioners are doing relatively little health advisory work with individuals who are not ill; i.e., such work as regulating infant feeding, correction of physical defects, advice in personal hygiene and in family health matters. In most instances the physician is sought for relief of symptoms—pain, insomnia, shortness of breath, accidents, malaise, fatigue, cough, diarrhea, abdominal distress, etc.—not for health advice."

This is very disheartening. The opportunity for notable service, in reducing disease materially and in greatly increasing the individual's capacity for usefulness, vigor and general enjoyment of life, seems so plain that the thoughtless are inclined at once to blame the physician entirely for failure to take advantage of it. That is certainly unfair. We must remember that there is a mutual relationship between patient and physician. The former asks for a service which the latter gives. It is true that patients to a certain extent put themselves in the physician's hands and some at least will, to a greater or lesser degree, follow his advice with thoroughness. It is true also that many physicians not only neglect but actually take little interest in the open doors to genuine health stimulation that stand in front of them. But when all is said and done the fact remains that the doctor who sets out to build up a practice of real health development is facing an uphill fight in the present state of public interest in such matters. When to that is added the fact that his training, both didactic and practical, has been concerned so largely with morbid conditions, which are what he is asked to treat as soon as he enters practice, we can understand how difficult it is for him, as one individual, to break the circle.

The American Medical Association has through statements by its leaders, recognized the importance of this problem. It has gone further and carried out an active campaign of promoting periodical health examinations by practicing physicians. This is an excellent move which has resulted in much good, especially in a few places where it has been pressed with real vigor under a well organized
educational plan. One reason that it has not reached larger numbers of persons is that it has not had the public support which it deserved. Again, many practitioners have been inadequately prepared for a positive health service and consequently have lacked enthusiasm for it. The vast field for producing health, and more and more of it, has scarcely received a surface tilling, much less a subsoil ploughing.

Therefore, if we are really to make headway in handling our next big health problem, instead of allowing it to gain on us, we need two things and need them badly. They are:

1. Interest of physicians in positive health advisory service and preparation for it.
2. Public demand for such service.

It is more or less futile to discuss which should come first. We must have both and should have them with the least possible delay.

If we are to have physicians' interest in and preparation for such a service a changing viewpoint is needed. This is well expressed by Langstroth:

"We must have new standards for comparison in matters of health. I have pointed out that the present practice is to mark the beginning of disease by structural change, to assume that its absence means health. But there is a long downhill road before this point is reached. At its beginning is the condition of positive health. There is never any question about this rare quality. Persons possessing it stand out by themselves from the host of dull-eyed, sallow, tired, complaining humans who pass as well. Clear and shining of eye, warm and glowing of skin, erect and at ease, these rare beings are alert and mindful of their changing environment and adapt themselves rapidly to it. But positive health means more to me than adequate adaptation to the environment. It means also a rounded development—the maintenance of a proper balance among all our capacities. The moment of its decline should mark the beginning of disease.

"The adoption of this new standard of health will open up an entirely new field for medical practice. The tired, irritable, complaining patients who for so long have had nothing the matter with them will fall naturally into some category between the stage of positive health and that of structural disease. They will be interesting problems for analysis and constructive therapy. Inherited qualities and capacities, early nutrition, environment and training, physical and intellectual equipment, personality characteristics, adjustment to and
interest in the environment, habits of eating, sleeping and exercising, will all come up for review. The thing or combination of things that has brought the individual to the point of complaining of his health will be determined. Therapy will be ameliorative or completely corrective depending on the degree to which the various factors are susceptible of modification. The emphasis in medical practice will be placed on those patients for whom it is still possible to get results and not on the intricacies of structural disease.

It is one thing, however, to say that there must be a changing viewpoint on the part of the physician as to the need for maintaining and building up what Langstroth calls positive health. It is another matter to say how that shall be brought about. Naturally and rightly we look to the medical schools as the places where the most effective work for the future can be done in teaching the medical practitioners of tomorrow, and of the day after, what a well person looks like and how to keep him so. But we cannot wait for tomorrow and the day after. The need is with us today and is urgent and the practitioners of today are those who will deal with it for some time to come.

The answer seems obvious. The physician now in practice, must have opportunity to observe well people and to perfect himself in the technique of keeping them well and of guiding them in building themselves up to the maximum of health and vigor, physically and mentally. As a corollary, the stimulation of increased public demand for such service should, by all means, be managed first so that the practitioner may prepare himself beforehand to give such service and second so that he may personally secure, through observation and consultation, the fullest benefit from any health advisory service that may be available to illustrate the quality and results that should be expected where a high standard of such service is to be maintained.

Nothing is gained, however, by preparation for a health service if no one takes advantage of it. Some way must be found of stimulating a public demand such as has not existed heretofore. It is here that the public health worker should be able to render signal service. Here is a large group of sufferers from disease, who, if they are being reached, are receiving such inadequate attention that their mortality is mounting at a rate that should cause everyone grave concern. Obviously the physician is the one who should, with increased observation of well people and improved technique for keeping them well, be acting as the health advisor to these sufferers and better still, to the prospective sufferers from degenerative disease, so that real
prevention may ensue. However, as we have seen, the physician is at a disadvantage in attempting to build up his own practice in a field where he is met on every side by public and individual indifference. What better service can the public health worker render to the cause of health than by breaking down this indifference? A major health problem, if not the major health problem of today, is falling between physicians and public health workers without being vitally touched by either. It is true that some efforts have been made toward stimulation of greater demands for positive health service on the part of health agencies. But we do not have to search the morbidity records or make wide studies of individual health status to appraise the net results for the country. Unfortunately the death-rates tell the story all too plainly.

The reasons for failure in the past are not difficult to discover. In addition to the fact that the movement has not been sufficiently widespread it has had certain inherent weaknesses. In the first place it has not, so far as known, been a major concern of any considerable number of groups anywhere. A major problem must be a major concern if it is to be solved. In the second place, in few if any communities, so far as known, has there been either adequate preparation for such health service, (by the physicians themselves as well as by a public educational program), satisfactory illustration of what such a service should be like, or sufficient provision for follow through so that the individual served may receive advice in a continuous program of health development that shall cover the whole range of his needs in the way of diet, exercise, rest, environmental adjustment, and all of his living habits which affect his health.

What is needed then is a systematically organized plan for stimulating health advisory service in a way that shall avoid the defects that have been mentioned. It is for that reason that the new program of the Foundation for Positive Health appeals to me as strongly as it does. It is built upon the eight years of experience of that organization and in its recent expansion extends the application of the principles tested in the work to the wider field of service to both sexes. I wish to mention only a few of what I consider its salient features.

(a) The main purpose of the Foundation's program is to increase the demand for health supervision of persons who are presumably not ill, by their family physicians, and to aid in raising the standards for such supervision.
(b) So far as health supervision offered by the Foundation itself is concerned, it will be to strictly limited groups in order to illustrate quality and continuity of service and to stimulate its wider application in private practice.

(c) Such health supervision to limited groups will be made available to communities only when there is evidence that the local medical and public health groups desire it and wish to cooperate in making it effective. Similarly a prerequisite will be a thoroughgoing and cooperative educational program for arousing intelligent interest and demand for such service on the part of the public and for the actual preparation of the physicians themselves for taking fullest advantage of such demand.

(d) The data accumulated on examination and follow-up and through the records furnished by coöperating physicians are to be the basis of careful and thoroughgoing research for the purpose of building up a continuous picture of physical development in relation to health, of revealing the causes of degenerative ailments and their prevention and of illustrating the results of health supervisory work for various age groups and the best methods by which such work can be introduced into private practice.

(e) The results of such study and methods and technique developed in building up an advisory health service will be freely at the disposal of the practicing physician.

I wish to repeat that these points in no sense constitute a description of the Foundation's whole program but are cited merely to illustrate the soundness of the way in which it proposes to offer a most important contribution to a solution of this problem of building for positive health.

I am convinced that unless some such plan as this is carried out in the public spirited way proposed by the Foundation, the field is going to be preëmpted by some highly commercialized system or systems of medical or quasi medical practice. I fear that the main purpose of these systems will be the greatest quantity of results for the least cost (that is, for the least cost to those promoting the systems, not to the patients) and that the quality of service will be a secondary consideration. It is going to require real unity of purpose and subordination of individual differences among those who see this problem in the large to avoid such an undesirable solution and to bring about a desirable one.
To return then to our original questions; is there a valid distinction between the promotion of health and the prevention of disease? If so, is there any essential antagonism between them? If this is true, why is it so? We have seen that prevention of disease at present is being effectively practised only in the case of infectious diseases and that for the acute infections this is largely by measures of community control. The only conflict between prevention of disease and promotion of health, if conflict it can be called, is due to the fact that the most excellent work that has been done in preventing infections has to some extent clouded the actual downhill progress in the field of degenerative diseases.

As a matter of fact the cure of disease, the prevention of disease and the promotion of health are the three logical steps leading to our goal of the most healthful and vigorous possible manhood and womanhood for our nation.

For these reasons and because the phrase more aptly describes a positive health building program, I believe that “promotion of health” is a better term by which to name the large task that lies ahead of us. It is one which challenges every instinct of humanity and public service that any of us may possess. I sincerely trust that it is one which may serve as a rallying cry which may unite us all for a common purpose with no disruptive differences between us.

REFERENCES

1Acute infectious diseases: Typhoid, Measles, Scarlet Fever, Whooping Cough, Diphtheria, Influenza, Pneumonia, Malaria, Smallpox, Erysipelas.

2Degenerative diseases: Diseases of the Heart (while diseases of the heart include some acute infections the number is so negligible as not to affect the picture materially), Cerebral Hemorrhage and softening, embolism and thrombosis (not cerebral) nephritis and diabetes.

THE PHYSICIAN'S PART IN DISEASE PREVENTION THROUGH HEALTH PROMOTION*

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In attempting to distinguish between the proper sphere of activity of public health workers and private practitioners, we frequently hear it said that the work of practicing physicians is to cure disease—that of health workers, to prevent it.

That is not a proper distinction. Health officials have no monopoly of the work of preventing disease. Practicing physicians are, every day, engaged in preventive work. Health departments deal especially with organized efforts applicable to the community as a whole or the relationship of the individual with the community. The work of practicing physicians deals more with the individual as such.

Disease Prevention is a large subject. It deals not only with the prevention of communicable diseases or of those associated with hazardous occupations, etc.; it deals also with the prevention of those mild, gradually beginning, insidiously invading chronic forms of illness which not only keep us from attaining the full span of life of which we are capable, but which also prevent us from rendering the efficient service or attaining the happiness that is possible when one is in vigorous good health. Many persons continue in poor general health for months or even years before seeing a doctor. When medical aid is eventually sought, the physician discovers possibly a diabetes, a nephritis, heart disease, or perhaps something more indefinite as the result of the accumulated effects of bad hygienic practices; all of which might have been discovered months or years before and many of which might have been prevented by proper living.

For it is well to bear in mind that, barring the physiological

changes that accompany age—including, of course, the normal changes of senility,—the conditions which interfere with the full enjoyment of good health, are really disease conditions, many of which are preventable, particularly if detected in time. It is here that the periodic health examination renders one of its two most valuable services. The purpose of the periodic health examination is not only to discover some as yet unrecognized disease—but to note, also, errors in diet, exercise, rest, living conditions, etc., which, if persisted in, are likely, some day, to result in an abnormal—a disease condition, which may interfere with one's ability to work or to enjoy living to the fullest degree.

Because of the value of this health examination in disease prevention and health promotion, an enormous amount of publicity has been given to periodic—usually annual—health examinations during the past few years. I think no one—private practitioners or public health worker—cares to deny the movement a right to develop; in fact many wish it well; some even, are its active supporters. For example, the movement has the endorsement of the National Health Council, a combination of the thirteen greatest medical and public health organizations in America. One of these organizations—namely, The Women's Foundation for Health—is making such, with its follow-up, its major activity.

Since these periodic examinations are made by physicians, the medical profession should fully appreciate the following four important points:

1. Physicians should be interested in the making of thorough examinations of well or apparently healthy persons.

2. The health examination must mean much more than simply an examination. It is not enough to discover, simply, evidence of disease and to give treatment with the idea of curing it or preventing its further progress. Nor is it "enough," as is so well stated by Dr. Lenna L. Meanes, Medical Director of the Women's Foundation for Health, "to tell the individual he is free from disease; not enough to give him general directions concerning his diet and exercise. He has been told that the periodic health examination will lengthen life; that it will decrease disease; that it will increase efficiency and joy in life. He accepts all of this and decides to try the thing out. Health education, pushed so zealously the last two years, has taught him that he has about six to eight chances out of ten of reaching that
top notch by following the rules of his own health road. The one who can help him most to interpret those rules—as well as give them—is his own physician. The individual wants to live longer,—yes; he wants to decrease disease, yes; but he wants also—wants mightily to live to the full while he does live.” Continuing, Dr. Meanes observes: “If, on the other hand, his physician advises him to report week after week so long as necessary, and the examinee accepts that advice and pays for it, the individual will be eager to return annually for his periodic checking up to mark improvement. At that point the new relation between physician and individual will be on a sound basis. In other words, unless the physician and the individual both ‘stay by,’—‘stay by’ together—just as they do, for example, in a siege of typhoid, the individual will fail to reach the promised goal of ‘increased efficiency and joy in living,’ and the physician will have lost one follower of the health examination movement.”

In other words, unless physicians, after making examinations, will give the proper advice and encourage the examinee to call on him for check-ups on the advice and results obtained, this wonderful movement will not result in the great good hoped for and reasonably to be expected.

3. Physicians should not discourage, but should rather encourage non-medical organizations in their endeavors to promote general periodic health examinations. If such are urged only by physicians, they will be accused by many of selfish motives; that is, they will be accused of urging that the examinations be made partly because they receive a fee for making them.

4. Physicians must maintain the leadership in this and similar health movements.

The appreciation of the great good that may be accomplished by education of the public in health matters and the eagerness with which health information is sought, have led many organizations to carry on health programs in an organized way. These organizations usually want and seek the advice of physicians regarding their subject matter and plans of procedure. Sometimes, however, they seek in vain—and not getting the desired help proceed as best they can. As a result, their activities along health lines have not always been sound either as to the subject considered or the conduct of the program. Physicians need not necessarily take the initiative in these public health movements. They should, however, not discourage
such activities, if sound. They should indeed welcome them as co-operating agencies in the great game of preventing disease and promoting better health.

With this professional guidance volunteer health organizations may not only educate the lay public to a better understanding of what health means, to an acceptance of the difference between disease prevention and health promotion, but may act as a very necessary liaison between that public and the medical profession, so that men and women will come in steadily increasing numbers for health direction as they now come for relief from suffering. Then the field of preventive medicine will have extended to its proper limits through including the apparently well individual, and then the public health worker and the private physician will be playing into each others hands to the furtherance of real health promotion.
BIRTH CONTROL FOR THE BRITISH WORKING CLASSES:

A Study of the First Thousand Cases to Visit an English Birth Control Clinic*

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HISTORICAL BACKGROUND OF ENGLISH BIRTH CONTROL CLINICS

For more than one hundred years England has had an organized birth control movement. No sooner had Malthus in the second edition of his notable "Essay" suggested that the way out of the problem of over-population was "moral restraint" than a select group of "Philosophical Radicals" and Utilitarian reformers objected to the solution of postponed marriage. Francis Place, radical tailor of Charing Cross, friend of working men, counsellor to statesmen, and one of the most "solid-minded" and influential of nineteenth century reformers, brought to his point of view and gathered about him a

* The data with which this article mainly deals were gathered in the course of a residence of fifteen months in England as a fellow of the Social Science Research Council, which body financed the research. In the study of the work of the clinics I was assisted by my wife. The North Kensington material under consideration here constitutes only a small part of the research now in progress on the clinical and historical aspects of birth control.

The authors wish to express their appreciation of the generosity of the officials of the North Kensington Clinic in opening their files for this study. That this cooperation required some independence of action is testified by the fact that the two largest London clinics, the Walworth Center and Dr. Stopes' clinic, have never permitted their records to be put at the disposal of independent investigators desiring to make quantitative analyses.

Special acknowledgment is due Dr. Louise Stevens Bryant, Executive Secretary of the [New York] Committee on Maternal Health, who criticized the manuscript, recast the tables, and furnished ideas for more effective graphic presentation. Dr. Bryant, with the cooperation of Dr. R. L. Dickinson, also prepared the footnote on medical indications for contraception. Much of whatever merit this paper may have is due Dr. Bryant; for its shortcomings the authors alone are responsible.—Norman E. Himes.
number of ardent workers in the cause. One can scarcely do more here than mention their names. His most immediate disciple was Richard Carlile, stalwart warrior in the fight for the freedom of the press, whose unbounded enthusiasm carried him to excessive lengths in championing the new program. Place, through his disciples in America, Robert Dale Owen and Dr. Charles Knowlton, was influential in founding the American birth control movement which began in this country in 1828.

In the century of agitation in England the outstanding figures (other than those already mentioned) are Dr. George Drysdale (the "Doctor of Medicine" who wrote "The Elements of Social Science"), the anonymous "Anti-Marcus," the able lawyer Charles Bradlaugh, and the energetic and eloquent Annie Besant. These and many other pioneers, working with precious little public support and much opposition, have done much to bring to the working classes reliable knowledge by which the so-called "lower orders" might control the frequency and the time of birth of their offspring.

With the approach of the latter part of the century general interest in the subject widens, and in the first three decades of the twentieth century, it gradually dawns on the leaders of the Church that the people have determined quite among and by themselves that they will no longer be mystified. The medical profession, urged from within by the more far-seeing leaders of the healing art, and impelled from without by the pressure of a gradually but definitely crystallizing public opinion, begins to inform itself lest the function of furnishing contraceptive advice be taken entirely out of its hands by laymen. The medical periodicals begin to look with sympathy upon what they used to view before with haughty detachment.

The newspapers start debating the subject to the tune of hundreds of columns each week. The topic vies with the Prayer Book dispute in claiming public attention. Men and women of social and intellectual standing, who once discussed the subject in furtive whispers, now mount the rostrum and let their views be known with unabashed fortitude. Government officials and influential private citizens begin to see the relation between the problems of the birth rate and the welfare and prosperity of the state. The National Council of Public Morals, a strictly voluntary body of thoughtful, public-spirited citizens, institutes the National Birth Rate Commission (a unique institution) with its subsequent committees investigat-
ing the ethical, the medical—and we hope shortly, the economic—
aspects of birth control.6

The countryside is inundated with a flood of literature, some of
it useful, most of it trashy and perhaps even harmful. Since the
war it has been calculated that not less than fifteen million books,
pamphlets and brochures furnishing practical contraceptive advice (or
stating where it can easily be obtained) have been circulated in
England. This figure does not include newspaper or magazine adver-
tising.

In England the sources which are bringing about the diffusion of
contraceptive information among various social classes have been
operating for more than one hundred years. However, the dates
1877 (when Bradlaugh and Besant were prosecuted for publishing
the Knowlton pamphlet) and 1921 are important landmarks in the
concerted, organized attempts to get this information to working class
mothers. The propaganda of 1823 led by Francis Place was relative-
ly ineffective so far as immediate results were concerned. Although
much was attempted before 1921 in behalf of the working classes,
the clinics opened up a new period in the history of the movement
aiming at the emancipation of women from their slavery to the re-
productive function.

The First Clinic. The first birth control clinic in the British
Empire (but not the first in the world) was opened by Dr. Marie C.
Stopes (in private life Mrs. H. V. Roe) in March, 1921, at 61
Marlboro Road, Holloway, London, N. 19.7 In the years 1917-18,
when attempts were being made to interest others in opening a birth
control clinic—large numbers of hospitals had consistently refused
such information to their patients—Mr. H. V. Roe offered a guaran-
teed annual income of £1,000 for five years, and £12,000 in his will
to an English hospital on condition that it set in operation at once a
birth control and maternity clinic.8 The committee of the hospital
approached, refused the offer. In Dr. Stopes' work "The First Five
Thousand," and in her biography by Aylmer Maude there is related
the origin of Dr. Stopes' own interest in the subject. She believed
that to the educated and well-to-do contraceptive information was
readily available—there never has been any specific, restrictive legis-
lation in England—but that to the poorer classes, unable or reluctant
to pay the necessary fees, this advice was relatively inaccessible. Dr.
Stopes and her husband, therefore, opened "The Mothers Clinic"
where more than ten thousand cases have now been advised. The
The clinic is open each week-day for free advice from the nurses and midwives in attendance. It also has the services of a trained woman consulting physician one afternoon a week. Otherwise it is without immediate medical supervision, Dr. Stopes not being a physician.

Later Clinics. Before Dr. Stopes opened her clinic, Dr. and Mrs. C. V. Drysdale, the former for many years president of the Malthusian League (founded in 1879 as a consequence of the Bradlaugh-Besant trial), had plans for opening a similar clinic. For reasons which need not be detailed here their plans were delayed and the Walworth Women’s Welfare Center at 153A East Street, Walworth Road, London S. E. 17 was not opened in the poor district about Walworth Road until November, 1921, nine months after Dr. Stopes had opened her clinic. For a short period this clinic was more or less under the guidance of its sponsors, the officials of the Malthusian League. The fact that Dr. Norman Haire, the Harley Street gynecological specialist was in charge (assisted by trained nurses) made this the first English clinic under medical direction. Substantial assistance was received from Mr. John Sumner, a Birmingham manufacturer, whose liberal gifts to the Birmingham clinic and to the Malthusian League have furthered similar work in other quarters. After the Walworth Center was well under way, the Drysdales and the Malthusian League dropped out and control was turned over to a new group calling itself the Society for the Provision of Birth Control Clinics.

Since this organization was founded, two other clinics have been opened in London: the East London Women’s Welfare Center, and the North Kensington Women’s Welfare Center. Similar birth control clinics have been opened by interested voluntary groups in two university towns, Cambridge and Oxford, in industrial centers like Birmingham, Wolverhampton, Manchester, and Liverpool. Scotland has similar centers operating at Glasgow and Aberdeen. In several instances the Society for the Provision of Birth Control Clinics has been influential in the formation of these local groups, following this up by assisting in problems of organization, administration, and finance. At Walworth, physicians and nurses from the provincial centers have been trained in the technique—which differs somewhat from that taught at the Mothers’ Clinic run by Dr. Stopes. In addition to such clinics operated by responsible voluntary groups, advice is furnished by a few hospitals and regular dispensaries. There are also a large number of so-called private birth control
clinics in charge of nurses and midwives throughout the United Kingdom. But these "clinics," being managed by individuals, partly at least for private profit, are on a somewhat different footing.

**North Kensington Clinic**

The North Kensington Women's Welfare Center—the clinic whose records form the basis of this study—was opened in November, 1924 at 12 Telford Road, Ladbroke Grove, London, W. 10. Although Kensington is one of the most wealthy sections of London it is not without a poor, over-crowded, inadequately-housed section. It was in such a locality that those responsible for the initiation of the clinic decided to open it. Like all other British institutions of its kind it is dependent entirely upon voluntary contributions, the patients' small fees being entirely inadequate for its support. The consultation fee of one shilling, payable on the first visit, is not collected on the subsequent visits so that the total fees, plus whatever small profit there may be in the sale of appliances, constitutes only a very small proportion of the total income. It has received no support whatever from the government. The hours of attendance are Mondays, 3-4 p. m., and Tuesdays, 6:30-8 p. m.

When the clinic was first opened very few women came, as was expected; for in the absence of extensive propaganda it necessarily takes time for the community to realize that such a center has been opened in its midst. North Kensington's first clinic report states that when the center first opened mothers were "much too shy; they didn't know what would happen, but gradually more and more came, at first in the evenings, when it seemed easier to slip in and out. Then they found that after all it was not so alarming." In the first nine months 255 women had come for advice, and 196 had already returned for their second visit. The North Kensington Center thus received substantial recognition from the beginning, if its record is to be compared with that of similar institutions.

**Clinic Procedure.** The patient enters a fairly attractive waiting room, is called into the office of the representative of the clinic, usually a volunteer, who takes down on one side of a large filing card the answers to a few simple but necessary questions (See Forms 1A and 1B). The questioner usually finds little difficulty in securing the required response. The patient then takes her card to the woman physician in attendance upstairs who fills in the details of the medical history. This is followed by a pelvic examination, after which the
patient is fitted with the proper size of appliance. The clients receive “as much time and skill and patience as if they were private patients.” The nurse then sees that the client is properly instructed in the use of the appliance, the patient trying and retrying until she learns its proper use. A printed card of instructions (Forms 2A and 2B) is then handed to the patient who buys her supplies at cost, i.e., at a little more than wholesale price.

The fact is impressed upon her that no methods are fool-proof, that she has her own responsibility in the technique, and that the clinic must have her sincere cooperation, particularly in the matter of follow-up. It is of basic importance that the patient be convinced of the necessity of returning within a week and again within six months. We shall see later the extent to which these instructions are carried out. After receiving full instructions and purchasing her supplies the patient returns her record card to the attendant downstairs. It is filed according to number after the patient’s instruction card (See Forms 2A and 2B) is correspondingly numbered. An alphabetical file of patients’ names is also kept with number cross-references.

RESULTS OF STUDY OF CASE HISTORIES

Source and Character of Data. Through the cooperation of the executive committee of the North Kensington Women’s Welfare Center, who were the first body to open their files to this investigation, it is possible to present the data on the first thousand cases to visit this clinic. The cases here summarized range in number from 1 to 1006 inclusive, since it was necessary to discard certain records due to incomplete information; or because of individual variations which made it seem likely that a bias, even minor in nature, might be introduced into the summary figures. In one or two instances the patient was married twice and it was impossible to determine the exact number of years spent in the marital state. The records of three single women were discarded because they did not receive the advice usually given to applicants.

This report naturally falls into two main divisions. The first deals with a simple statistical summary of the facts of the first thousand records, the second part with a follow-up study of some one hundred cases made through home visits.

Limitations of Data. Certain limitations of the data need to be observed. The feeling seems to be quite general among the officials
**FORM 1-A (Face, Clinic Record Card).**

**NORTH KENSINGTON WOMEN'S WELFARE CENTRE**
12 Telford Road, W. 11

<table>
<thead>
<tr>
<th>Date</th>
<th>Born Alive</th>
<th>Born Dead</th>
<th>Miscarriage</th>
<th>Age at Death</th>
<th>Cause of Death or Miscarriage</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
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<td>20</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
FORM 1-B (Reverse, Clinic Record Card).

<table>
<thead>
<tr>
<th>Date</th>
<th>General Condition</th>
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</thead>
<tbody>
<tr>
<td>Bowels</td>
<td>Micturition</td>
</tr>
<tr>
<td>Dysmenorrhea</td>
<td>Dyspareunia</td>
</tr>
<tr>
<td>On Examination</td>
<td>Vulva</td>
</tr>
<tr>
<td>Uterus</td>
<td>Tubes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>How —— is fitted by Patient, etc.</th>
<th>Visit or Letter for New Appliance</th>
<th>Letter sent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

FORM 2-A *(Face, Patient's Instruction Card).

N. KENSINGTON WOMEN'S WELFARE CENTRE
12 Telford Road, Ladbroke Grove, W. 10

SESSIONS—MONDAYS, 3—4 p.m.
TUESDAYS, 6.30—8 p.m.

Name .................................................................
No. ...........................................................................

(1) Please return in a week's time, so that the doctor can tell you if you are using the appliance correctly.
(2) Never leave the —— in for more than 12 hours.
(3) Always smear the —— with ointment before use.
(4) Syringe before you take the —— out, and after you take the —— out, with warm soapy water.
(5) Wash —— after use, dry it, and powder it with French chalk. Keep syringe clean.
(6) The ——, when new, is round, but tends to get out of shape. Gently press into a round shape before use.
(7) It is very important to avoid constipation.
(8) Appliances can be sent by post. If writing to us, please mention the number on your card.
(9) Come back every six months if you can. Your —— may need renewing.

*[Underlined words in red].
ADVICE ON CONSTIPATION

Constipation must be avoided. Much ill-health is directly due to this. A regular habit at the same time every day is most important.

Any one of the following aperients is good:

- **Senna Pods**—4 to 15 daily. 6d. an oz. (The pods should be soaked in cold water for 8 hours, and the water taken at night.)
- **Liquid Extract of Cascara**—10 to 60 drops daily.
- **Epsom or Glauber salts**—1 to 2 teaspoonfuls daily.
- **Medicinal Liquid Paraffin**—1 tablespoonful daily. 8 oz. 1/6.

THE FOLLOWING DIET HINTS ARE USEFUL

- Drink plenty of water.
- Eat brown or wholemeal bread instead of white.
- Cooked, or better, raw fruit (oranges, apples, prunes, figs), and salads.
- Vegetables of all kinds. Porridge.
- Eat slowly and chew thoroughly.

of English clinics that detailed and accurate records are not of paramount importance. The records of the North Kensington center are kept as well as those of any of the other English clinics. The main reason why the record forms are not more elaborate is a strong feeling among the directors of the clinic that further questioning of the clients might unduly embarrass them or even reduce attendance. And since it has always been considered the major purpose of the center to give the poor classes access to information heretofore readily available only to those of more initiative and higher economic status, it has been felt desirable to limit questioning. In the last year or two, however, there has been a move away from this tendency to gather only meager data and an increasing desire to collect more complete information. This is particularly reflected in a new research committee now cooperating with the North Kensington center. Their case card is much more elaborate than that which has been heretofore used either at North Kensington or at any of the birth control centers.

The information gathered is further limited by the patients' own knowledge. In the summaries which follow, for example, the figures on wages are unreliable; the patient often does not know how much
her husband earns, merely how much she receives each week on which to run the household. Sometimes it is difficult for mothers of large families to remember how many pregnancies they have had. Still more frequently they are unable to account accurately for what is here called pregnancy losses, that is, the difference, after allowance has been made for twins, between the number of pregnancies and the number of living children at the time of the mothers' first visits. Since some pregnancies were unaccounted for on the records, the exact type of loss (See Table I) is unknown. The same difficulty was characteristic of all the other clinics, and North Kensington stood up comparatively well in relation to the others. The limitations in other series of data will be noticed as each series is considered.

**TABLE I**

**PREGNANCIES AND RESULTS REPORTED BY 1,000 WOMEN SEEKING BIRTH CONTROL ADVICE AT NORTH KENSINGTON CLINIC**

<table>
<thead>
<tr>
<th></th>
<th>Pregnancies</th>
<th>Per cent of losses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Per cent</td>
</tr>
<tr>
<td>Total pregnancies</td>
<td>3,855</td>
<td>100</td>
</tr>
<tr>
<td>Cases of twins</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total living children</td>
<td>3,005</td>
<td>78</td>
</tr>
<tr>
<td>Total losses</td>
<td>886</td>
<td>23</td>
</tr>
<tr>
<td>Abortions c</td>
<td>(65)</td>
<td>(2)</td>
</tr>
<tr>
<td>(Abortions recorded as induced)</td>
<td>(65)</td>
<td>(2)</td>
</tr>
<tr>
<td>Still-births</td>
<td>72</td>
<td>2</td>
</tr>
<tr>
<td>Post natal deaths d</td>
<td>295</td>
<td>8</td>
</tr>
<tr>
<td>Type unknown</td>
<td>59</td>
<td>1</td>
</tr>
</tbody>
</table>

a. Children living at the time of the mothers' first visits. Families incomplete with few exceptions.

b. Since the figure "total losses" (886) includes the losses of the second child in cases of twins, the percentage, calculated on a basis of pregnancies, is 23 instead of 22, bringing the total percentage to one point higher than one-hundred per cent.

c. These losses were classed by all the English clinics as "miscarriages" except those known to have been self-induced, for which group the term "abortion" was retained. This seems to be in accordance with lay usage, but Dr. Louise Stevens Bryant of the Committee on Maternal Health advises that this is not the best present medical usage. Any expulsion before viability is now considered an abortion, classification being subdivided into induced, accidental, and spontaneous. Only the first of these carries with it any crim-
Another reason for the fact that our data are not as elaborate as one might wish is to be found in the fact that this clinic, like all birth control clinics, is a comparatively new institution. Further, there has been what we believe to be a mistaken notion that patients are reluctant to answer questions in relation to their sex history and experience. There are many sound reasons for believing that this is not borne out by experience. Every psychiatric and hospital social service worker in America weekly gathers data which many English clinic officials believe it impossible to secure. Some American (notably New York) clinics gather quite complete sex histories.

inal implication, and then only under circumstances which vary in different localities. While the authors have adopted this newer terminology (since it seems to be in accordance with the weight of authority) they cannot help feeling that it is, in a sense, misleading and incomplete. For example, to medical persons the term “induced abortion” undoubtedly carries the dominant connotation of a delivery made by physicians under modern aseptic conditions, after consultation with at least one colleague and upon substantial medical indication, yet not one induced abortion in a hundred—perhaps not one in a thousand—is produced under these conditions. Preferably the term induced abortion should be further subdivided into (a) therapeutic, those done by a physician under the conditions outlined and (b) all others, whether by physician or laymen. In most countries all others would be illegal. The figures at North Kensington, however, do not permit of such refinement. We think it well, none the less, to bear this classification in mind for future study.

Objections can likewise be raised against the medical sub-classification of “accidental abortion.” Suppose a woman with an unwanted pregnancy repeatedly jumps from a table; perhaps she is successful in inducing an abortion or miscarriage. Since it had more serious consequences than she contemplated she consults her physician who, refusing to sit in judgment on the woman’s intent, or being, indeed, totally ignorant of it, considers the abortion “accidental.” Obviously it is nothing of the kind.

The difficulty of determining when abortions are genuinely “spontaneous” is not to be minimized. While it may be a convenient term to apply to those cases where the cause is unknown—as one speaks of a fire being caused by “spontaneous combustion”—it should be remembered that there is a cause even if we are unable to detect it. And if the sub-classification now accepted by the weight of authority aims to classify abortion on a causative basis, it is seriously defective. In working out new classifications for the study of this phenomenon we would suggest the urgency of considering such a psychological factor as the patient’s intent along with the physiological aspects of the act itself. The law has, for example, always considered the intent in committing an overt act as of almost equal importance (in determining guilt) as the commission of the act itself. In the study of the causative factors in abortion, if our classification is to be based upon this, it would seem that medical science could advantageously draw a similar distinction.

d. From the data available it is impossible to separate deaths occurring within the first few months and within the first year from those occurring later but prior to the mother’s first visit to the clinic—as desirable as such a classification would be. Therefore, the term “post natal deaths” means, whatever it may imply in studies of infant mortality, deaths occurring after birth and prior to the mother’s first visit to the clinic.
I. FINDINGS FROM CASE RECORDS

The items on the case records susceptible to tabulation fall under the headings of obstetrical history, with number of pregnancies and their results (Tables I-VI); the number of years married and the ages of husband and wife (VII, VIII); the husband's occupation (IX). The reasons for refusing treatment, and the results reported on follow-up are presented as summaries in the text.

Pregnancies and Their Results. The first item of interest is the obstetrical history of these patients. As shown in Table II, among the thousand women, 957 reported from one to fourteen pregnancies, and 43 had never been pregnant. There were a total of 3,855 pregnancies or nearly four apiece. This is important as showing that the clinic is not visited by women seeking to evade their "natural" responsibilities.

Referring again to Table I, it will be seen that, since there were 3,855 pregnancies and 36 twins (roughly one per cent. of the pregnancies), the expected number of live births was 3,891. However, owing to various types of losses before maternity only 3,345 foetuses, according to the records of the clinic, resulted in live births. After allowing for various losses there is a discrepancy between the total number of children born alive as recorded by the clinic and the number actually born alive as deduced by allowing for these losses. This is partly to be accounted for by the fact that it could not be determined from the clinic records in just what type of loss 59 pregnancies resulted. But by a process which need not be detailed here, it has been estimated that probably 18 pregnancies resulted in still-births or accidental or spontaneous abortions and 41 in post natal deaths. Deducting the total number of children now living from the expected number of live issue (3,891) there is a pregnancy loss of 886, or 23 per cent. of the total number of pregnancies.

Pregnancy Losses. It is a striking fact that in this series 52 per cent. of all the pregnancy losses were due to abortions of some type (See footnote to Table I). Seven per cent., or one in 14, are definitely known to have been induced, undoubtedly self-induced. Figured on the basis of all pregnancies the waste due to abortions is of course much smaller—12 per cent. for abortions of all classes, 2 per cent. for those known to have been induced. That the percentage of losses due to abortions (7 per cent.) is far below the actual figure
is certain. The clinic staff do not press patients for this information; the induction of abortion is not a fact which women readily admit, at least to strangers. For these reasons a certain number of unclassified abortions should undoubtedly be listed as self-induced. Clients very often come to the clinic with the hope that the doctor will interrupt a pregnancy. Not a week and hardly a day passes but that some patient comes to the clinic for this purpose. As we shall see later, pregnancy or suspected pregnancy is the chief reason why patients are turned away unfitted after their first visit. This subject is dealt with more extensively below.

The singular fact about this table of losses (Table I) is that the abortion percentage (52), far exceeds the percentage of losses resulting from both still-births and general deaths (41 per cent.). In so far as this group is representative of the rather poor mothers of the English nation, and in so far as this fact is borne out by the experience of other clinics distributed throughout England and Scotland, it is a social fact of first-rate importance. Moreover, it is a fact which is emerging alone from the records of the birth control clinics. It will be found in no census returns. Its significance is in demonstrating the one-sided emphasis now current in focussing upon infant mortality alone rather than viewing the problems of maternity as a whole; rather than directing attention to the essential relation between the human effort and sacrifices expended in undergoing pregnancies (i.e., the "costs" physical, social, and economic) and the results achieved by way of obtaining the birth of live children, and if possible bringing them to maturity.

Analysis of Results. The source figures for the most important of the obstetrical data are given in Table II, which is divided into three parts as follows: Part A shows the total number of women reporting each number of pregnancies, from none to fourteen, the total pregnancies in each order, the number of living children surviving at the time of the first visit, and the number of losses of various kinds, by abortion, stillbirth, deaths, and undetermined causes. Part B shows the distribution by per cent. of these various totals through the different orders. Part C shows the proportion of each order of pregnancy surviving or lost in the various ways.

Increase of Losses with Frequency of Pregnancy. A steady increase in per cent. of losses is shown in Part C as one descends the column from the lower to higher frequency orders. Conversely the proportion of survivals decreases. There is some irregularity in both
TABLE II

ANALYSIS OF RESULTS ACCORDING TO NUMBER OF PREGNANCIES REPORTED

A. Total pregnancies, living children and losses

<table>
<thead>
<tr>
<th>Number of pregnancies</th>
<th>Total</th>
<th>Living children</th>
<th>Losses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Women</td>
<td>Pregnancies</td>
<td>Total</td>
</tr>
<tr>
<td>Total</td>
<td>1000</td>
<td>3,855</td>
<td>3,005</td>
</tr>
<tr>
<td>None</td>
<td>43</td>
<td>0</td>
<td>0</td>
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TABLE II (Continued)

B. Distribution of results by per cent of instances

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<th>Losses</th>
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</table>

a. Corrected for twins.
TABLE II (Continued)

C. Distribution of results by per cent of pregnancies

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<th>Total Pregnancies</th>
<th>Living children</th>
<th>Losses</th>
<th>Total</th>
<th>Deaths</th>
<th>Still-births</th>
<th>Abortions</th>
<th>Cause unknown</th>
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<tbody>
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<td>Seven</td>
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<td>16</td>
<td>2</td>
</tr>
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<td>12</td>
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<td>17</td>
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<tr>
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<td>2</td>
<td>0</td>
<td>12</td>
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</tr>
</tbody>
</table>

a. Corrected for twins.

instances in the last two orders owing to the small numbers and the presence of some exceptionally healthy families. The tendency to increasing rate of loss is shown more clearly in Table III where the figures for results in the various orders of pregnancies have been grouped into four groups as follows: (1) those with none, one and two pregnancies; (2) those with three; (3) those with four and five; and (4) those with six to fourteen. These groups were determined by adding the numbers of women in the whole series and finding where the first quartile, the second quartile or median, and the third quartile points came and assigning all having the number of pregnancies included between these various points in the same group.

The figures are shown graphically in Figure A, where it may be noted that Group 1, including 38 per cent. of the women with not over two pregnancies, had 14 per cent. of the pregnancies, 16 per cent. of the survivals and only 5 per cent. of the losses, whereas Group 4, the 23 per cent. at the other extreme with six to fourteen pregnancies, had 59 per cent. of the losses.
In Table III it will be noted that the total losses in Group 1 were 51; in Group 2 they were 85; in Group 3 they were 228; and in Group 4 they were 522. The per cent. lost in each group is shown graphically in Figure B, which also shows the proportion of abortions. However, despite the very high rate of loss in the third and fourth groups, these show the largest number of survivals, illustrating "Nature's way" of insuring continuance of the species. In Table III and in Figure B, it will be noted that 10 per cent. of the pregnancies in Group 1 resulted in losses, and 16 per cent. of Group 2, while 24 per cent. of Group 3, and 28 per cent. of Group 4, were lost. Conversely, in the first group, 90 per cent. of the pregnancies resulted in living children; in the second group 84 per cent. of the pregnancies resulted in living children; in the third group 76 per cent. of the pregnancies resulted in living children; while in the fourth group only 72 per cent. resulted in children who were living at the time the mother first visited the clinic.

While it cannot be deduced from this table, it may be stated that the women in the series studied who had 12 pregnancies, experienced a rate of loss six times as great as the patients who had only one.
### English Birth Control

**TABLE III**

**Analysis of Results in Various Pregnancy Orders by Groups**

**A. Total pregnancies, living children and losses**

<table>
<thead>
<tr>
<th>Number of pregnancies</th>
<th>Total</th>
<th>Living children</th>
<th>Losses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Women</td>
<td>Pregnancies</td>
<td>Number of pregnancies</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-------</td>
<td>-------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>Total</td>
<td>1,000</td>
<td>3,855</td>
<td>2,969</td>
</tr>
<tr>
<td>None, one and two</td>
<td>381</td>
<td>525</td>
<td>474</td>
</tr>
<tr>
<td>Three</td>
<td>173</td>
<td>519</td>
<td>434</td>
</tr>
<tr>
<td>Four and five</td>
<td>221</td>
<td>975</td>
<td>747</td>
</tr>
<tr>
<td>Six to fourteen</td>
<td>225</td>
<td>1,836</td>
<td>1,314</td>
</tr>
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</table>

**B. Distribution of results by per cent of instances**

<table>
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<th></th>
<th>Total</th>
<th>None, one and two</th>
<th>Three</th>
<th>Four and five</th>
<th>Six to fourteen</th>
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<tbody>
<tr>
<td></td>
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<td>100</td>
</tr>
<tr>
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<td></td>
<td>100</td>
<td>22</td>
<td>26</td>
<td>26</td>
<td>28</td>
</tr>
</tbody>
</table>

**C. Distribution of results by per cent of pregnancies**

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>None, one and two</th>
<th>Three</th>
<th>Four and five</th>
<th>Six to fourteen</th>
</tr>
</thead>
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<td>100</td>
<td>100</td>
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<tr>
<td></td>
<td>8</td>
<td>76</td>
<td>24</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>72</td>
<td>28</td>
<td>10</td>
<td>2</td>
</tr>
</tbody>
</table>

a. Corrected for twins.

pregnancy. After the third pregnancy, the rate of loss is high—the rate ranging from 21 per cent. to the maximum of 41 per cent. The peak rate of loss was reached in the twelfth order, while the group that had only one pregnancy had the smallest rate, despite the extra hazards of first births.

The third, fourth, fifth, and sixth pregnancy orders furnished 50 per cent. of the total number of pregnancies and 13.6 per cent. were provided by the first and second order pregnancies. Sixty-two per cent. of the total number of living children were provided by the second to sixth order pregnancies, inclusive.
All Pregnancies

One and Two

Three

Four and Five

Six to Fourteen

Abortions

All Losses

Figure B—Percentage of Losses from All Causes and by Abortion According to Number of Pregnancies
Although the data do not all appear in Tables II or III, it may be observed that the first and second order pregnancies experienced six per cent. of the abortions, while the third to seventh orders, inclusive, bore the brunt of more than 60 per cent. of this type of loss, an average of 12 per cent. for each of the last mentioned orders.

Early in 1925 Dr. Marie C. Stopes published a report on the first five thousand patients that visited the Mothers' Clinic up to August 31, 1924. Table IV is a comparison of the rate of loss in the series here studied and the rate of loss in Dr. Stopes' larger group which included some women having as many as 17 pregnancies. Both sets of figures illustrate the same principle: the tendency for the rate of loss to increase with an increased frequency of pregnancy.

### TABLE IV

<table>
<thead>
<tr>
<th>Number of pregnancies</th>
<th>Per cent losses reported in</th>
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<tr>
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<tr>
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<tr>
<td>Five</td>
<td>22</td>
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<td>Six</td>
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<td>Seven</td>
<td>33</td>
</tr>
<tr>
<td>Eight</td>
<td>21</td>
</tr>
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<td>Nine</td>
<td>29</td>
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<tr>
<td>Ten</td>
<td>29</td>
</tr>
<tr>
<td>Eleven</td>
<td>36</td>
</tr>
<tr>
<td>Twelve</td>
<td>41</td>
</tr>
<tr>
<td>Thirteen</td>
<td>30</td>
</tr>
<tr>
<td>Fourteen</td>
<td>14</td>
</tr>
<tr>
<td>Fifteen</td>
<td>—</td>
</tr>
<tr>
<td>Sixteen</td>
<td>—</td>
</tr>
<tr>
<td>Seventeen</td>
<td>—</td>
</tr>
</tbody>
</table>

Table V deals with the distribution of abortions according to the number reported by each woman. A few patients experienced as many as four, five, or even six abortions previous to seeking advice, at the clinic. Two hundred ninety-two had had at least one. Of those reporting any abortions at all, the preponderant proportion had only one or two. The first two groups suffered 68 per cent. of the total number.
TABLE V

DISTRIBUTION OF ABORTIONS ACCORDING TO FREQUENCY

<table>
<thead>
<tr>
<th>Number of abortions</th>
<th>Women</th>
<th>Abortions</th>
</tr>
</thead>
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<td>Number</td>
<td>Per cent</td>
</tr>
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<td>100</td>
</tr>
<tr>
<td>One</td>
<td>187</td>
<td>54</td>
</tr>
<tr>
<td>Two</td>
<td>62</td>
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<tr>
<td>Four</td>
<td>13</td>
<td>5</td>
</tr>
<tr>
<td>Five</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Six</td>
<td>1</td>
<td>0.3</td>
</tr>
</tbody>
</table>

Size of Family. Up to the time of visiting the clinic for the first time the patients had on the average 3.86 pregnancies and 3.00 living children. Reference to Table II, A, and to Figure C will show that the mode for both pregnancies and living children is two. Those who had a larger number of pregnancies and children brought the arithmetic means considerably over the modal numbers. Roughly speaking, it may be said that the clinic patients had undergone, on the average, nearly four pregnancies each, and that they now have, on the average, three living children.

These families are much smaller than one is often led to believe representative of those who seek advice of birth control clinics. There were a few large families. On the other hand, 43 cases had had no pregnancies at the time of coming to the clinic. This last group had, however, been married only 2.93 years; if one case (possibly sterile), married 22 years, is omitted, the no pregnancy order averaged only 1.42 years in the marital state. When the relevant facts pertaining to the group as a whole are taken into consideration it will be seen that the families are not small. Moreover the clinic families are far from being completed families. The mode (Figure D) for the distribution of years married is at six years, with other peaks at two years and ten years, the simple arithmetic mean being 8.7 years. Details are shown in Table VII.

Ages. The greatest number of patients come under the age group 26-30 years as shown in Figure E and Table VIII. The same holds true of the clients’ husbands. The arithmetic means were,
however, higher; for men it was 33.9 years; for the clients 31.3 years. The patients had a reasonable number of children, therefore, despite the fact that they had been on the average only eight and a half years in the marital state. The average number of pregnancies and the average number of living children is somewhat larger among the patients attending certain clinics outside of London. Comparison may be made by consulting a table which one of the authors has published elsewhere.12
Table VI

**DISTRIBUTION OF LIVING CHILDREN ACCORDING TO NUMBER PER WOMAN**

<table>
<thead>
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<th>Number of living children</th>
<th>Women</th>
<th>Children</th>
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</thead>
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</tr>
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<tr>
<td>One</td>
<td>193</td>
<td>193</td>
</tr>
<tr>
<td>Two</td>
<td>248</td>
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<td>175</td>
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<td>Eight</td>
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<td>Nine</td>
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<td>117</td>
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<tr>
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<td>70</td>
</tr>
<tr>
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<td>0</td>
</tr>
<tr>
<td>Fourteen</td>
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<td>14</td>
</tr>
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</table>

Table VII

**YEARS MARRIED BEFORE SEEKING BIRTH CONTROL ADVICE AT CLINIC**

<table>
<thead>
<tr>
<th>Years married</th>
<th>Number reported</th>
<th>Years married</th>
<th>Number reported</th>
</tr>
</thead>
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<tr>
<td></td>
<td>Couples</td>
<td>Cumulative</td>
<td></td>
</tr>
<tr>
<td>Less than one</td>
<td>22</td>
<td>22</td>
<td>Fifteen</td>
</tr>
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<td>56</td>
<td>206</td>
<td>Eighteen</td>
</tr>
<tr>
<td>Four</td>
<td>70</td>
<td>276</td>
<td>Nineteen</td>
</tr>
<tr>
<td>Five</td>
<td>75</td>
<td>351</td>
<td>Twenty</td>
</tr>
<tr>
<td>Six</td>
<td>85</td>
<td>436</td>
<td>Twenty-one</td>
</tr>
<tr>
<td>Seven</td>
<td>62</td>
<td>498</td>
<td>Twenty-two</td>
</tr>
<tr>
<td>Eight</td>
<td>56</td>
<td>554</td>
<td>Twenty-three</td>
</tr>
<tr>
<td>Nine</td>
<td>41</td>
<td>595</td>
<td>Twenty-four</td>
</tr>
<tr>
<td>Ten</td>
<td>62</td>
<td>657</td>
<td>Twenty-five</td>
</tr>
<tr>
<td>Eleven</td>
<td>50</td>
<td>707</td>
<td>Twenty-six</td>
</tr>
<tr>
<td>Twelve</td>
<td>36</td>
<td>743</td>
<td>Twenty-seven</td>
</tr>
<tr>
<td>Thirteen</td>
<td>40</td>
<td>783</td>
<td>Twenty-eight</td>
</tr>
<tr>
<td>Fourteen</td>
<td>36</td>
<td>819</td>
<td></td>
</tr>
</tbody>
</table>

The smaller number of living children among the patients in this series may be due to higher living costs in London, to scarcer hous-
Figure D—Years Couples Seeking Birth Control Advice Had Been Married
ing, and to factors associated with urbanization, such as the ease of communication of birth control information. Whether this group previously used contraceptives to a greater extent than the patients visiting some other clinics is unknown. It is doubtful whether this factor is important. Whether or not these patients have previously employed contraceptive measures was not inquired into when these data were recorded. Dr. Stopes found that *coitus interruptus* prevailed in her cases.\(^{18}\) It is usually ineffective as a method of limiting the size of the family. If, therefore, it was used to any great extent by the patients in our series, its general effectiveness in producing the result mentioned above is extremely doubtful.

There is a widespread notion that the clinics deal mainly with patients who have had excessively large families. The officials of such centers are themselves responsible for the currency of this opinion. They have sometimes published the details of extreme cases as representative of those with which they deal. This unintentional misrepresentation is unfortunate. On the other hand the position is not tenable that contraceptive advice should be given only to those who have had three or four children. This overlooks the cases in which contraception may be medically indicated\(^{14}\) even in cases where the patient may have borne no children at all. Then too, the clinic has no more the right than the medical profession to set itself up as the censor of the conduct of others. What it dare not say to the rich and those in high social status, it should not presume to dictate to the poor. Furthermore, the economic position of this group must be borne in mind.

**TABLE VIII**

**Ages of Wives and Husbands at First Clinic Visit**

<table>
<thead>
<tr>
<th>Age groups</th>
<th>Wife</th>
<th>Husband</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>1000</td>
<td>1000</td>
</tr>
<tr>
<td>16-20</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>21-25</td>
<td>179</td>
<td>92</td>
</tr>
<tr>
<td>26-30</td>
<td>304</td>
<td>279</td>
</tr>
<tr>
<td>31-35</td>
<td>246</td>
<td>244</td>
</tr>
<tr>
<td>36-40</td>
<td>192</td>
<td>215</td>
</tr>
<tr>
<td>41-45</td>
<td>63</td>
<td>109</td>
</tr>
<tr>
<td>46-50</td>
<td>6</td>
<td>40</td>
</tr>
<tr>
<td>51-55</td>
<td>1</td>
<td>12</td>
</tr>
<tr>
<td>56-60</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>61-65</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>
Figure E—Ages of Wives and Husbands at First Clinic Visits
There was a high degree of relationship between the number of years the clients were married and the number of pregnancies undergone, the correlation coefficient being .73. The relationship between the number of years in the marital state and the number of living children in the family was lower, the correlation coefficient being .60. The standard deviation of the mean of pregnancies (3.86) was 2.83, the standard deviation of the mean for living children being 2.56; while the standard deviation of the mean for years married (8.77 years) was 6.0. Partial correlations, to correct for the ages of the wives and husbands, have not been made, partly on account of the labor involved but essentially because it was doubtful whether the figures could thus be refined usefully.

**Economic Factors.** The economic position of the clients needs to be considered in relation to the size of their families and their need for contraceptive information. Table IX, which is a classification of the husbands’ occupations, makes no pretense to being accurate. The meager information furnished on the clinic cards is only approximately correct, and, at best is difficult to classify. As defective as this table must be, it gives some picture at least of the occupational and economic status of the clients who call on the clinic for assistance. The term “higher business” simply denotes the more responsible of business positions. It is clear that the clinic served the wives of no industrial magnates. It can be said with assurance that more than half the clients’ husbands are skilled, semi-skilled, or semi-responsible workers. Of the definitely unskilled there were 379 cases or 38 per cent. of the total. There is a notable group of motor traffic employees (90), mostly ‘bus conductors and drivers, which classification includes a few chauffeurs and mechanics. The fact that husbands of 9 per cent. of the clinic’s patients belonged to so definite an occupational group is accounted for by the fact that one of the London ‘bus routes terminates directly in front of the clinic. This illustrates the intercommunication of such knowledge in a given economic group, as no doubt word went round that contraceptive information could be obtained at the queer looking little place one worker pointed out to others.

Additional light on the economic status of the group is given by a study of wage incomes. No tabulation has been attempted of the wages recorded on the clinic cards on account of incompleteness of the data. In many cases it is impossible to distinguish between wages received by the husband and the amount turned over to the wife.
There are husbands who do not permit their wives to know how much they earn. The wife receives a certain amount on which to operate the household and that is the extent of her knowledge of her husband’s earnings. We doubt whether there are any motives operating tending to induce patients to understate their husband’s earnings. Despite the fact that some figures on the clinic records represent weekly wages and others the wife’s allowance, it is possible to secure a fairly definite idea of the wage rates and of their range. Not infrequently the amount recorded is one pound fifteen shillings ($8.75). Very seldom does it exceed two pounds ten shillings ($12.50). In fewer than one per cent. of the cases would the amount run from three to five pounds ($15-$25) per week. The highest weekly wage recorded in this series was five pounds ($25). It is a very conservative statement to say that the average family of five in this group—for it will be recalled that there were, on the average, three living children in each family—must support itself on an income that seldom exceeds twelve dollars per week. Since prices are very nearly as high as in this country, this fact must be taken into consideration in judging the need of modern contraception in this group. Then again, not a few patients were the wives of disabled soldiers, unemployed men, or men on the dole. In a very few cases the husband was described as “a mental patient.”

The percentage of wives of skilled and unskilled workers has a direct bearing on the important question of the selective influence of the birth control clinics. Fourteen per cent. of the clinic’s patients were the wives of labourers. In all, at least 38 per cent. may be considered definitely unskilled. If one were to include the petty tradesmen and assistants, clerks, policemen, soldiers and sailors, 55 per cent. of the total group would be considered the wives of unskilled workers. While the husbands of a few were unemployed, those on the dole, or those receiving unemployment pay constituted a negligible proportion of the total group.

There has been no direct way of gauging the intelligence of the patients except by observing their general conduct, their capacity to learn readily the method taught them, by studying their attitudes and the nature and extent of their coöperation. One of the authors (Mrs. Himes), who volunteered her services to the clinic for several months, and who came into considerable contact with a number of the patients both in the clinic and in the course of the home visits summarized later in this paper, came to the conclusion that few patients were of
very low intelligence. With a few exceptions most of them seemed to belong to the more prudent, far-sighted, and intelligent elements of the working classes. It is doubtful whether the clinic has ever advised a feebleminded person. It is, however, hardly within the province of the clinic’s work to serve this group. The problem of restricting the continuance of such strains is a task not for voluntary birth control clinics but for the State which is trying half-heartedly to control it by segregation. We say half-heartedly, because there is no officially recognized sterilization in England of those feebleminded individuals who, once detained in training schools, are subsequently released into the community, often to propagate their kind. What one might term the poor-law group also seems to be scarce in the North Kensington series.

The question remains an open one, therefore, whether the clinic is getting contraceptive information to those members of the community who have but little foresight, initiative, intelligence, and germinal capacity.15 A few leaders of informed opinion are inclined to the belief that the voluntary centers giving this advice will always be limited in this regard and that this constitutes one of the main reasons why such advice should be made available by the government at the two thousand or more infant welfare centers throughout the

### TABLE IX

<table>
<thead>
<tr>
<th>Husband’s Occupation Reported by 1,000 Women Seeking Birth Control Advice</th>
<th>1000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>1000</td>
</tr>
<tr>
<td><strong>Unskilled labor</strong></td>
<td></td>
</tr>
<tr>
<td>Common</td>
<td>143</td>
</tr>
<tr>
<td>Porters</td>
<td>50</td>
</tr>
<tr>
<td>Car men</td>
<td>26</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>160</td>
</tr>
<tr>
<td><strong>Skilled and semiskilled labor</strong></td>
<td></td>
</tr>
<tr>
<td>Motor traffic</td>
<td>90</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>238</td>
</tr>
<tr>
<td><strong>Petty tradesmen</strong></td>
<td>70</td>
</tr>
<tr>
<td>Clerks</td>
<td>57</td>
</tr>
<tr>
<td>Police</td>
<td>33</td>
</tr>
<tr>
<td>Higher business and professional</td>
<td>17</td>
</tr>
<tr>
<td>Soldiers and sailors</td>
<td>14</td>
</tr>
<tr>
<td>Unclassified and unknown</td>
<td>102</td>
</tr>
</tbody>
</table>
United Kingdom. It is surely the height of folly to expect those of limited initiative or meager intelligence to demonstrate in action qualities they do not possess and which they go on spreading in the community because we are unwilling to act promptly in the matter.

**Follow-up Study Based on Clinic Records.** Of 1,000 cases which constituted the original series studied, 855 were fitted with the appliance usually recommended by the clinic and 145 cases were not so fitted for the following reasons:

- Certainly pregnant: 30
- Probable or suspected pregnancy: 57
- Referred to hospital: 15
- Other method wanted: 5
- Too constipated: 3
- Too small introitus: 2
- Too run down: 1
- "Did not stay": 1
- Miscellaneous: 4
- Reasons not specified: 27

English clinic officials often call attention to the fact that birth control clinics assist in the discovery of conditions needing treatment not available at birth control clinics. Probably, however, they refer only the most glaring cases to hospitals and dispensaries.

Of the 15 patients in this series of 1,000 referred to hospitals, five wanted children. The others had the following conditions:

- "ready bleeding of cervix on touch;"
- "large cystocele;"
- "retroversion;"
- "enlarged uterus, no sign of pregnancy;"
- "uterus bulky, slight blood-stained muco-purulent discharge, question condition;"
- "miscarriage one week ago, still losing;"
- "small tumor on anterior lip;"
- "cystocele, rectocele, lacerated and eroded cervix;"
- "second degree prolapsus uteri, tender left ovary, torn cervix, deep scar;"
- "question of left salpingitis, tender left ovary."

Of the 13 cases in which follow-up by home visits was possible, one-third (4) had carried out the clinic's recommendations and one-third (4) had not. Another third (4) could not be located and one case had died.

This is a much smaller number of refusals than the experience of American clinics shows, doubtless owing to a selective factor—the British clinics having no restrictions on admissions "for medical reasons only." But perhaps the most striking feature of this sum-
Mary is the number who came for advice after they were already pregnant. Of those not fitted, 87 patients, or 60 per cent., were definitely pregnant or probably pregnant. This group constituted nearly nine per cent. (or one in eleven) of all the patients seen. In such cases the usual clinic procedure is to refer the patient to an antenatal center and to urge the patient to return after delivery. It would be of interest if we knew what proportion of the patients so referred had the initiative to return to the clinic for contraceptive advice after the baby was born. The authors believe the percentage would probably be small. Judging by conversations we have had with the officials of provincial (i.e., up-country) clinics, we are of the opinion that pregnancy or suspected pregnancy is the chief reason for the non-instruction of patients in other clinics as well. A more definite answer on this point will be forthcoming when the summary of records of the provincial clinics is completed, which study is now proceeding.

There are many reasons why clients come to the clinic after they are already pregnant. Some are doubtful about their condition and come perhaps more with the aim of ascertaining whether or not they really are pregnant than for the purpose of securing birth control advice. Others, confusing birth control with abortion, come with a faint hope that the doctor or nurse will interrupt their pregnancy. This tendency of patients to come for advice after it is too late also suggests a tendency for which there is other corroborative evidence. We refer to the unwillingness of many women to undergo the necessary trouble and inconvenience which modern contraceptive measures necessarily entail upon the individual. It is partly due to a lack of foresight and to indifference; but there are other extenuating circumstances; sometimes poor housing conditions, or the presence of children make the application of methods a little difficult. When all has been said in favor of the patients' coöperative spirit, however, it needs to be added that often clients do not seem to have either the desire or the will to do their share. It is pathetic, for example, to note cases of women who are not fitted at the clinic because they are pregnant, returning home in despair only to try some futile and perhaps expensive home or "chemist shop" (i.e., drug store) remedy. She is delivered of a child several months later, still she has not learned that contraception is preferable to ineffective, self-damaging attempts at abortion; she will not return to the clinic of her own initiative to seek the proper preventive for this ghastly business of
repeated abortions. A few patients seem “too poor to care.” A few
call for advice have been so harassed by grinding poverty that
any spark of initiative they once had has evaporated into an air of
despair or discontent.

The veriest tyro in hospital work knows that it is next to useless
for a physician simply to dole out advice if patients will not, or indeed
cannot, owing to character difficulties or home circumstances, follow
the advice in their homes. It was with the purpose of overcoming
difficulties of this nature that Dr. Richard C. Cabot many years ago
instituted medical social service. Perhaps the greatest shortcoming
in the procedure of all the British birth control clinics is inadequacy
in extra-clinical or home follow-up. There is need for the adoption
of American methods in this respect. Such a change would not only
render the clinics’ services much more valuable but would enable
them to determine where they were heading.

Returning to the summary on page 606, pregnancy is the main
reason why patients are not treated on their first visit. Though
occasionally a client loses her courage after she reaches the clinic
and will not see the doctor, such cases are rare. Usually the person
who has courage enough to step inside the clinic has courage enough
to go through with the simple examination necessary.

The North Kensington Women’s Welfare Centre has not experi­
enced the trouble with so-called “difficult cases”—meaning difficult
to fit—which Dr. Marie Stopes reports in her “First Five Thousand.”
According to Dr. Stopes’ report the percentage of abnormal and diffi­
cult cases increased from 1.75 per cent. in 1922, to 13.77 per cent. in
1923, increasing even to 33.80 per cent. in 1924. Whether or not the
difference may be the result of the use of a non-cervical cap at North
Kensington we are not prepared to say. This may be an important
factor, though of course Dr. Stopes would deny that this was a rele­
vant consideration.

Second Visits. The purpose of the second visit is to determine
whether or not the client has so learned the technique taught her that
she can carry it out herself safely and without danger to her health.
The patient is, therefore, advised to return one week after the first
visit so that the doctor or nurse may see that the patient inserts the
appliance properly and otherwise carries out instructions. This first
week is often referred to as the “practice period.” At the second visit
the douche or syringe as well as the pessary ointment are sold to the
patient, these being held back during the “practice” period in order
to induce such a return. It is a convenient way of impressing on the patient her own responsibility.

Of the 855 fitted patients 654, or 77 per cent., returned for the second visit though not always promptly. This relatively good percentage showed that they were for the most part cooperative. At least 513, 79 per cent. of those who returned for the second visit, inserted the instrument correctly after having been taught on the first visit. In 21 cases, 3 per cent., it is not possible to determine, owing to defects in the records, whether or not the patient had learned what she had been taught on the first visit. Nearly one-fifth of the patients had to be retaught.\textsuperscript{16}

Of the 120 whom it was necessary to reteach, 36 returned the following week when they were successful; or, if not successful, they repeated their visits until they had learned the technique, one patient returning for four weeks in succession. Forty-four did not return the following week as directed but visited the clinic later. However, 40 lost all contact with the clinic.

Follow-up Visits. The “follow-up visit” to the clinic is supposed to be made by the patient six months after the first visit. The patients are instructed very carefully to visit the clinic once each six months. If they do not call after six months, it is the clinic’s aim to send a “six month letter” reminding the patient of the importance of this visit. A similar procedure is followed if the second visit is not made.

For the purpose of the study of these follow-up visits, 813 cases constituted the series, since 187 cases had made their first visit to the clinic within the seven months period immediately preceding the date on which the data for this summary were collected. Sufficient time had not elapsed, therefore, allowing a month of grace, for the six month visit to be expected. In all, 445 letters were sent, 82 being second visit, and 363 being six month letters. Some patients, therefore, received no letters at all. The failure to be more thorough in sending out follow-up letters results mainly from two causes. First, a lack of funds entails the use of the service of volunteer workers for all save the duties of doctor, nurse, and housekeeper. The secretary is burdened with many duties. Second, there is considerable doubt as to the effectiveness of follow-up by means of the use of letters.

Of the 813 cases mentioned as available for the study of follow-up:
Therefore, in all 386 cases have personal follow-up records, and of these 21 were not fitted. This leaves a series of 365 cases for the study of the effectiveness of the method taught. The reports may be summarized as follows:

1. After six months to two years the methods were being used satisfactorily in 263 cases, 72 per cent.

2. The rest, 102, were not using the methods prescribed, or this was unsatisfactory, for the following reasons:
   - Uncertainty in technique ........................................ 34
   - Lack of confidence ............................................... 11
   - Other methods preferred ................................. 8
   - Pessary hurt patient ......................................... 4
   - Pessary hurt husband ....................................... 3
   - Husband refused to allow patient to use method .... 5
   - Lost pessary ...................................................... 3
   - Menopause .......................................................... 2
   - Separated from husband ................................... 3
   - House too inconvenient .................................... 1
   - Wore ring .......................................................... 1
   - "Failures" ..................................................... 8
   - Conception before pessary used ....................... 3
   - No reason specified, record incomplete .......... 16

II. HOME VISITS

When it was seen how ineffective letters were in bringing old patients back to the clinic it was decided to visit the patients in their homes. Hundreds of them were never heard from after their first or second visits, and consequently the clinic had no way of ascertaining the value of its work. Several observers who have lately published statistics on the merits of their respective methods have taken it for granted that patients who have not returned or reported to the clinic have been using the method successfully since their first visit. In other words, it has been assumed that "no news is good news." It was partly with the purpose of testing this theory, the tenability of which was doubted, but primarily with the purpose of studying the effectiveness of the clinic’s work, that home visits were made by one of us to as many patients as time permitted. The persons thus visited
had all been given instruction with the exception of the small number already considered who had been referred to hospitals. No report had been received from these patients since their first or second visits, which had taken place one or two years previously.

The population of the slums is a shifting one, and, as was expected, many patients had moved or could not be located. Those who were interviewed were friendly and gave whatever information they could. Several people were particularly cooperative, inviting the investigator into their homes and speaking of their experiences at length.

In the interviews an attempt was made to cover the following points: whether the patient was using the appliance or not; if not using it, the reasons; if using it, whether or not it was satisfactory. It was also the investigator's aim to ascertain the patients' psychological reaction to the use of contraceptives but little success was attained. The failure was due to the fact that the limited time at the disposal of the investigator did not permit of establishing the necessary confidence which is an essential prerequisite to securing information of this sort. A social worker employed by the clinic and in constant and friendly touch with the patients served by the clinic would have little difficulty in gaining the information desired. However, the clinic's executive committee were not convinced of the desirability of such a study, and it probably will not be attempted.

Many of the women interviewed were rather inarticulate; if they were not using the appliance or found objection to its use they expressed their reactions by saying that they hated to "mess around," or they "couldn't be bothered," or they were "too nervous." There were, of course, some outstanding exceptions. Several women not only discussed the general theory of contraception but also spoke frankly of their own opinions of the various methods they had tried. The investigation into the psychological attitudes of the patients visited in their homes, while not as satisfactory as the home visitor had hoped, demonstrated the usefulness of the procedure.

The women coming to the clinic for advice on how they can become pregnant are always of special interest, and a particular effort was made to see them during the course of the home visits. But definite reports could be obtained from only two. One woman had gone to the hospital but had been told that nothing could be done for her. Since that time her husband had been taken to an insane hospital and she felt that under the circumstances it would be better for her
not to have any children should her husband return. The other woman, following the clinic’s recommendation, had had an operation at the Samaritan Hospital. Shortly after the visitor had called at her home, she returned to the clinic where the doctor diagnosed “early pregnancy.”

**Analysis of Home Visits.** Of the 96 cases visited in their homes 28 could not, upon repeated visits, be located, so that 68 patients were interviewed. Since 10 of these were non-fitted patients referred to hospitals only 58 of the patients interviewed had received treatment. Of this number, 26, 45 per cent., were not using the appliance recommended while 32, 55 per cent., were employing the device, 18, 31 per cent., satisfactorily, and 14, 24 per cent. unsatisfactorily. In this last group all but one woman had become pregnant. The patient who had not become pregnant had, subsequent to her first clinic visit, consulted another physician who recommended a medicated sponge. This had been successful for one and one-half years previous to the investigator’s visit. Of the 13 cases who became pregnant the device seems to have failed in 3 cases, to have hurt so that it was probably not regularly employed in another case, to have been used with carelessness or faulty technique in the remaining 9 cases. In the 26 cases not using the method taught the following reasons were given: 6 preferred other methods (the sheath or withdrawal), 9 lacked confidence in the method, 1 desired another pregnancy, 4 were not permitted to use it by their husbands, 1 said the appliance hurt her husband, 2 were separated from their husbands, and in 3 other cases the appliance was either temporarily or permanently not needed because of the husband being in a hospital or because the patient had been sterilized or reached the menopause. Practically all of these 26 cases had never used the method taught.

The North Kensington Clinic does not inquire whether or not the husbands approve of the wives’ visits. At Liverpool, however, where this information is gathered, we have found that, in a series of 234 cases, the husbands approved the visits in 66 per cent. of the cases and that in an additional 30 per cent. of the cases there was no definite information with perhaps a presumption in favor of their approval. In only one case was there a record of a husband disapproving of the visit. It may be remarked that a goodly proportion of the Liverpool patients are the wives of common dock laborers.

The fact that nearly half the fitted, interviewed patients were not using the methods taught demonstrates the need of a more adequate
follow-up by trained social workers. In some instances, to be sure, there was no further need for the appliance, but in other cases where the woman lacked confidence in her technique or an ignorant husband refused to allow her to use the device there has been need for a greater effort aiming at the elimination of mal-adjustments and special difficulties. This the clinic might well be able to carry out if funds were available to employ a full time staff social worker who could maintain a constant contact with the patients. There are countless difficulties repeatedly arising in the patients' attempts to carry out instructions which could well be investigated by a visiting nurse or social worker and referred to the staff physician. There is, for example, great need for work among the husbands as their ignorance will always be difficult to combat. It might not be altogether infeasible to undertake a special type of educational work in such cases. Perhaps the clinic could arrange regular meetings for husbands to be addressed by the staff physician (tried at Walworth Clinic in London for a while) or, preferably, they should be seen individually. When patients have active tuberculosis, an uncompensated heart condition, Bright's disease or any other serious disorder likely to render pregnancy extra hazardous (see the discussion of medical indications in footnote 14), the clinic has an unusual responsibility to see to it, by means of follow-up, that the patient successfully applies the technique she has been taught. The same duty is clearly present when either parent is likely to give birth to syphilitic, defective, or deformed children.

We hope the home visits have shown (1) that one cannot tenably maintain that the women who have lost contact with the clinic are successfully and satisfactorily employing their newly gained knowledge. No news is not necessarily good news. Often it is bad news, if indeed it may be said to be any "news" at all. (2) Thorough follow-up in the form of home visits, though expensive, is absolutely indispensable to the intelligent service of the clinic. This can best be done by trained, full-time, salaried social workers.

REFERENCES

1 "An Essay on the Principle of Population..." London, 1803. The first edition published in 1798 was essentially a reply to the Perfectionists (Godwin and Condorcet) who held misgovernment responsible for most of the world's misery. In his first edition Malthus showed the influence of the rate of population increase on welfare but had had no constructive plan at that time for keeping the population within reasonable bounds. It was not until 1803 that he proposed "moral restraint."
2 In the last edition of the "Essay" published during his life-time (1826) Malthus made it clear that he meant by "moral restraint" "a restraint from marriage, from prudential motives, with a conduct strictly moral during the period of restraint." In so far as Malthus entertained the idea of birth control—and he never seems to have examined its merits—he repudiated it. As Professor James A. Field has observed, "Malthus' spirit of reform stopped at the threshold of marriage. He was radical enough in interposing difficulties between the desire to marry and actual marriage; but once persons were married he left them to the undisturbed guidance of the ethical sanctions which religion and custom had provided."

8 Among these radicals were the well-known political economists, James Mill and John Stuart Mill, quite probably Jeremy Bentham, the jurisprudential reformer, George Grote, and, of course, Francis Place, Richard Carlile, and a small group of less influential individuals.

4 Carlile published in 1825 a coarse essay entitled "What is Love?" Reprinted with modifications in February, 1826, as "Every Woman's Book; or, What is Love?" it rapidly went through many editions including an abridged one. It achieved international notoriety. Despite the fact that it was written in bad taste—Carlile was an oppressed radical with distorted judgment—it must needs be remembered that Carlile deserves some credit for being so bold as to write the first book in the English language exclusively devoted to a consideration of the medical, social, and economic aspects of birth control.

6 Space is not available to discuss at length the important place that birth control now occupies in British politics. It may be said, however, that it appeared at one time as if birth control might cause a serious cleavage in the Labor Party. The Women's Conferences have repeatedly demanded the lifting of the "embargo" on information at the two thousand odd local government welfare centres, the Executive group in the Labor Party as often side-tracking the adoption of these resolutions. From many newspaper clippings received monthly I learn that the subject is continually cropping up in Local Government bodies in one form or another. It has been much discussed in the House of Commons, while the House of Lords has voted 57 to 44 "That His Majesty's Government be requested to withdraw all instructions given to, or conditions imposed on welfare committees for the purpose of causing such committees to withhold from married women in their district information when sought by such women as to the best means of limiting their families." [Parliamentary Debates, House of Lords. Wednesday, 28th April, 1926. Vol. 63.—No. 29.] The House of Lords is thus the first legislative body in the world to take any such action.


Subsequently it moved to a more central location at 108 Whitfield Street, Tottenham Court, London, W. 1.


The Third Annual Report of the North Kensington Women's Welfare Centre (1926-1927) has the following to say about the newly formed Investigation Committee (p. 4):
"It is realized that the ideal method of Birth Control has not yet been discovered. There is no method extant that does not require intelligence and care in use, and many are cumbersome as well, and unsuitable for use in overcrowded homes. It is satisfactory, therefore, to learn of the formation of the Birth Control Investigation Committee which has, as one of its functions, the investigation of methods and the endeavour to improve Birth Control technique. It was started last March [i.e., March, 1926], and is an independent and impartial Committee formed, as its name implies, to investigate Birth Control. It is not propagandist, and its objects are to discover, and eventually to publish, facts as to methods, effectiveness of methods, and the after effects of contraception. The personnel of the Committee comprises two groups; scientists and experts in various aspects of the question on the one hand, and lay representatives with practical knowledge on the other. The following are the experts:

"Professor Sir Humphrey Rolleston, Bart., K.C.B., M.D., F.R.C.P., (Chairman), E. D. Adrian, M.D., F.R.S., C. P. Blacker, M.B., M.R.C.P., C. J. Bond, F.R.C.S., C.M.G., Professor A. M. Carr-Saunders, Frank Cook, F.R.C.S., Mrs. Gladys Cox, Professor Winifred Cullis, D.Sc., Professor Arthur Ellis, M.D., Professor Julian Huxley and Professor F. H. A. Marshall, D.Sc., F.R.S. The lay group consists of Mrs. Lella Florence (Cambridge Women's Welfare Association), Mr. J. F. Huntington (Walworth Women's Welfare Centre) (Treasurer), Mrs. Margaret Lloyd (Workers' Birth Control Group), Mrs. Margaret Spring-Rice (North Kensington Women's Welfare Centre), Mrs. Mary Stocks (Manchester, Salford and District Mothers' Clinic), and the Hon. Mrs Marjorie Farrer (Hon. Secretary). A questionnaire is being drawn up, and is now in use in a trial form at the North Kensington Centre.

Although no mention is made of this fact in the North Kensington report, I believe the initiative in organizing this research committee was taken by officials of the Cambridge Clinic, notably by Mrs. Lella Sargant-Florence.

11 For example, inquiry is now being made into the previous use of contraceptives; the method used, period of use, effectiveness, reasons for disuse, and whether adopted immediately after marriage. A more concerted attempt is being made to find out the number of abortions. More space is available to report the results of general medical and gynaecological examinations. There are questions dealing with the reasons for asking advice, the method recommended, and the patient's ability to learn. This last should prove of some eugenic interest. It should also ultimately throw light on the effectiveness of the methods recommended. An innovation is the use of a second card for the further visits. Heretofore, return visits have been recorded on the back of the patient's file card. The patient is asked whether the appliance has been used continuously; whether it has been effective, and whether any difficulties or disadvantages were experienced. Inquiry is also made into the question as to whether or not any supplementary methods are being used in addition to that recommended by the clinic's doctor; whether or not the method recommended has been abandoned, and if so, why. Space is available for recording the opinions of the doctor, the investigator, and the patient as to the good or bad effects of birth control. There is a place for making note of any changes in the size or kind of appliance recommended. Considerable room is left for additional notes.

12 See Eugenics Review (London) October, 1928, on the "British Birth Control Clinics. Some Results and Eugenic Aspects of Their Work."

13 Stopes, op. cit., p. 42.

14 In the United States most clinics giving contraceptive advice are limited by law to accepting cases with medical conditions or histories which would make pregnancy inadvisable for health reasons. In a few states such advice may, in the absence of special restrictive legislation, be given for social and economic reasons. No authoritative formulation has been made of the principles upon which contraceptive therapy should be based, though attempts have been made to establish these for therapeutic abortion. The Com-
mittee on Maternal Health (2 East 103rd Street, N. Y. C.) is compiling material on this subject from medical literature and also by the study of case records. In New York clinics the decision rests upon the result of individual examinations, both as to the medical need “to cure or prevent disease” and the type of treatment advisable.

From records of some seven hundred cases the medical indications recognized in practice fall into two general kinds so far as the mother is concerned: (A) pathological conditions, either of active disease or functional and structural disturbances and weaknesses which might render pregnancy and delivery extra hazards, and (B) non pathological considerations, having to do with optimum conditions for pregnancy and delivery, including the spacing of offspring and the best seasons. In addition there are eugenic considerations having to do with the quality and health of the children. Among specific conditions listed, five groups bulk large: (1) Gynecological and Obstetrical, including recent delivery or abortion, deformed pelves, and recent plastic operations; histories of repeated dangerous pregnancies, or deliveries with such symptoms as toxemia, pernicious vomiting, convulsions, too frequent, prolonged, or instrumental labors, and cesarian sections. (2) Cardiac disorders especially with decompensation. (3) Tuberculosis, laryngeal, pulmonary, or osseous, if active, and sometimes if arrested. (4) Nephritis and hypertension, especially where there is a history of toxemia with earlier pregnancies. (5) Mental and Nervous, especially insanity, feeblemindedness, and epilepsy, and certain other nervous disorders.

Besides these five great groups occasional entries appear of anemia, toxic goitre, extreme malnutrition, extreme obesity, diabetes, arthritis, syphilis, and gonorrhoea.

Women with some of these conditions should be sterilized rather than left to depend upon contraceptive measures. Conditions of a clearly incurable kind, especially those inevitably calling for interruption of pregnancy if it occurs, should be indications for sterilization rather than temporary measures. Some hospitals are developing a policy of sterilization whenever interruption is resorted to for non-accidental or incurable conditions.

Eugenic considerations include history of sufficient degree of insanity or feeblemindedness or epilepsy in the immediate family, especially where defective children have already been born. Here again sterilization of the mother or father is indicated. Tuberculosis in the immediate family and active syphilis or gonorrhoea of the father are other eugenic considerations, however, not calling sterilization into the question. Contraception has not been systematically applied to other large groups in the community who for their own sake or that of their possible offspring might be asked not to reproduce, such as carriers of strains of mental disability, hemophilia, the deaf, especially deaf mutes, a considerable proportion of whose conditions are increasingly recognized as hereditary, the blind or those otherwise hopelessly crippled, who are so handicapped as to be unable to support children, and possibly, those with family histories of cancer.

—Statement from the Committee on Maternal Health.

This subject has been discussed at length in the Eugenics Review article mentioned above.

While the fact that a patient had to be retaught does not mean that she was incapable of learning the technique, it is interesting, even though the figures are not exactly comparable, to compare English and American experience on this point. Dr. Hannah Stone of the Clinical Research Department of the American Birth Control League, reports that less than one and one-half per cent. (ten out of 1,457) patients “could not learn the technique of using any of the methods.” [“Therapeutic Contraception” p. 4. Reprinted from The Medical Journal and Record March 21, 1928.] It is known that 36 of the 120 English patients were eventually successful in learning the technique, but how many of those who failed to return were actually incapable of mastering the method we do not know. The difficulty some patients met
with suggests that a higher percentage in London than in New York might be totally incapable of acquiring the necessary skill. On the other hand, Mrs. Himes, who had intimate contact with many patients, has the impression that all or nearly all the patients who returned times enough eventually learned the technique. Certainly all save the feebleminded and morons should be able of learn it.

17 Since this article has been written the authors have been informed by letter from a clinic official that the clinic has added a salaried social investigator to its staff.
EDITORIAL

Church and Social Work

In the November number of Hospital Social Service Mr. Frank J. Bruno makes a statement that it would be well for all of us clergy to face. He says:

"In the near future the social worker is going to challenge the church on the ground that it alone of all the resources which the social worker needs is not available for the group which requires it most." And then, in the next paragraph, he states the case as it should be.

I agree with what he says about the frequent failure of the churches to do the one job for which they were created. The church has imperceptibly made itself a rope by which to hang itself. In the welter of activities which have been created, partly by the needs in a local situation and partly by the necessity of finding work for the people of any given parish, it has allowed this organization work to smother the greatest need that many knows, that of a personal relationship to Christ. There is a more or less prevalent belief that, without doing anything about it yourself, beyond trying to be kindly and unselfish, religion will enfold you in a sort of agreeable fog. It isn't possible to ooze into a religious experience, or to have it ooze into you. The will, as much as the emotions, is involved.

At Calvary we use the case work approach to religion. Men and women everywhere have heard in sermons or read in books much that is fine but theoretical about God. Many of them believe, but many of them do not know what to do about their belief, so they do nothing at all. Particularly among young people, religious hot air cools before it reaches them. I believe that God can be made that motive power to redeem men's lives, which social workers have looked for in vain from psychiatry. A good diagnosis and a good plan are of little value unless there is something that can be done to produce action. I have seen men and women delivered from drunkenness, theft, business dishonesty, jealousy, lust, hate, through the surrender
of their lives and wills to God. We do not expect them to find this experience alone, although it is possible; nor through sermons and books, although that is possible; we expect them to find it, and they do, through hearing the stories of lives that have been changed, and being thrown into contact with people who can tell in practical, plain English what an experience of Christ and a decision of the will to find His plan for their lives day by day, and follow it, has done for them. Theological information and argument helps very little. Creeds are formulations of experience. The experience must come first, then the interpretation.

I believe that social work can only accomplish its high aims when it links itself with the practical knowledge of how Christ, the Cure for despair, sorrow, sin, can change the lives of our "cases."

S. M. SHOEMAKER, JR.
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NEWS NOTES

The Social Service Section of the American Hospital Association meeting in Atlantic City from June 17th to 21st, will have two sections of its own. One of these will be a program meeting with papers on the “Function of Hospital Social Service” and “Social Work With Patients Able to Pay Hospital Fees,” and a second will be devoted to the reading of copies of the districts’ and secretaries’ reports which will be made officially to the San Francisco meeting. Besides these, there will be round table discussions of “Statistics,” “The Hospital’s Responsibility for Furnishing Medical Data to Qualified Persons and Agencies” and a third round table on “The Contribution of Psychiatric Social Studies to Medical Diagnosis and Treatment.” Hospital social workers have been invited to participate in the meetings of the Teaching Hospital and Administration Sections and in a round table discussion of the Out-patient Department Section. Among the subjects here discussed will be “The Teaching Hospital’s Part in the Training of Medical Social Workers” and the question “What Responsibility has the Social Worker for Dispensary Fees?” The American Hospital Association believes that this Atlantic City meeting will be a very remarkable one in view of its having joint sessions with the International Hospital Congress. Many foreign hospital administrators will take part in the program of the Association.

A recent issue of the Statistical Bulletin of the Metropolitan Life Insurance Company gives the following interesting facts regarding health conditions among the industrial policy holders for the year 1928. The death rate from diarrheal complaints dropped to the new minimal figure of 8.6 per 100,000—a decline of 69 per cent. since 1911: The death rate from pregnancy and childbirth was only 14.1 per 100,000—or 9.6 per cent. below the previous minimum, 15.6 for 1926. The 1928 figure is 29 per cent. lower than 1911. The 1928 mortality rate from influenza-pneumonia despite the two distinct outbreaks did not run as high as in 1926, 1923 or 1922. The diabetes
death rate rose for the fourth consecutive year and the figure for 1928 (17.8 per 100,000) is the maximum recorded. Since 1911 the diabetes death rate has increased 34 per cent. The cancer situation continues to grow definitely worse. The death rate for 1928 was 76.4 per 100,000, the highest yet recorded.

Through the financial assistance of the Rockefeller Foundation the Laura Spelman Rockefeller Memorial and the Commonwealth Fund, Yale University has established an “Institute of Human Relations,” the purpose of which is to undertake physical, mental and social research and investigation in all phases of human behavior.

The new Beth Israel Hospital, Stuyvesant Park, East, New York City, is now open. The old hospital at Jefferson Street will be maintained as a dispensary.

World-wide gifts and endowments amounting to $38,082,058 to universities, colleges, charities, religious organizations, social research undertakings, etc., were made by the Laura Spelman Rockefeller Memorial in 1928.

Unvaccinated Barred From Church

Baptist, Christian and Methodist preachers in Eldorado joined hands in a campaign against smallpox recently when they agreed to close their respective churches against the unvaccinated. Nurses were employed to greet the parishioners as they approached the sanctuary on Sunday morning and to demand of each the exhibition of evidence that he or she had been vaccinated or had previously recovered from smallpox.

That’s a splendid example of cooperation between the agencies devoted to physical and to spiritual health. The preachers closed the church doors to the unvaccinated as an aid to the local board of health which had the problem of dealing with an epidemic thrust upon its hands.—Ill. Health Messenger.

The National Society for the Prevention of Blindness reports that through increased medical facilities and wide-spread education on matters of hygiene throughout Kentucky the number of trachoma cases has shown a dramatic decrease.
The following interesting items of the health activities of the South American countries were gleaned from the Pan American Union:

In Brazil an "anti-alcohol week" was held in October last under the auspices of the Brazilian League of Mental Hygiene.

In Colombia the Director of Education of the Department of Cundinamarca has established a visiting nurse service for public schools.

In Costa Rica a graduate nurse from the United States has been appointed to assist in the campaign against tuberculosis. Her special work will be to instruct a group of Costa Rican nurses to carry on the work.

The National Society for the Prevention of Blindness, 370 Seventh Avenue, New York City, issues from time to time interesting bulletins on the subject of care of the eyes and methods employed to prevent blindness. A recent issue contained an abstract of an article by Mildred G. Smith on eye diseases and the care of the eyes. The author stresses the importance of recognizing the interrelation of good physical health and healthy eyes.

The American Association of Psychiatric Social Workers has issued a Bibliography of Psychiatric Social Work for 1928-1929. Social workers will find this list valuable for reference.

A statistical summary of the work of the Contagious Disease Hospitals of the New York City Department of Health, for the quarter ending December 31, 1928, shows a gratifying decrease in incidence and mortality. The total number of cases treated during the quarter at all hospitals was 1,289, of which 106 ended fatally, a case fatality of 8.2 per cent. During the corresponding period in 1927 the total number of cases was 1,414, with 146 deaths, a case fatality of 10.3 per cent.

The National Training School for Institution Executives and Other Workers, Dobbs Ferry-on-Hudson, New York, will hold a Summer Institute July 9th to August 20th, for institutional workers and executives. The topic for study and discussion is "The Child and the Institution." The outline of study covers all phases of child
health and child care and organization, management and policies of the child caring institution. For further information apply to Leonard W. Mayo, Dean.

The National Bureau of Public Health recently opened in Santiago, Chile, the first of four large maternity centers as part of its program for extending child-health work.

An infant welfare exhibition was held recently at the headquarters of the Argentina Red Cross in Buenos Aires.

The British Red Cross has succeeded in raising £40,000 to establish a clinic for the study and treatment of rheumatic diseases.

Miss Julia Wilkinson has been appointed Field Secretary of the American Nursing Association.

The University of Bordeaux, France, commencing July 22, 1929, will inaugurate a course for American physicians only, in ear, nose and throat diseases. Dr. Leon Felderman, 413 Equitable Building, Philadelphia, Pa., is in charge of the registration.

The Harmon Association for the Advancement of Nursing has been incorporated to administer the annuity system for registered nurses made possible by the Harmon Foundation. The annuity plan makes it possible for nurses to provide for the future by depositing a small sum monthly during their working career and obtain a guaranteed monthly income when they reach retirement age. The plan has been endorsed by the National Nursing Associations.

The United Hospital Fund of New York City has issued a list of hospitals which maintain hay fever clinics.

During 1928 the Ontario Division of the Canadian Red Cross established four new outpost hospitals in sparsely settled communities.
The $10,000,000 appropriation by the Dominion Act of 1919 for the promotion in Canada over a 10-year period of technical education of less than college grade, has resulted in the development of vocational education, apprenticeship, and vocational guidance and placement. A number of the vocational schools established—notably those of Toronto and London (Ontario)—have undertaken to obtain employment for their ex-pupils and help them to become adjusted during their first year's work.—World's Children.

Miss Dorothy J. Carter, Executive Secretary of the Dutchess County Health Association, has been appointed a member of the Poughkeepsie Board of Health.

The Metropolitan Life Insurance Company has for the fourth successive year granted $10,000 to help in the New York Upstate Immunization Against Diphtheria Campaign.

Sea-bathing or spraying for children with tuberculosis of joint and bone disease has been found very beneficial at Millfield, Rustington, Sussex, England. Sheltered compartments of wattle, six feet high, are used for spraying when the sea is too rough or the children unfit for bathing. A raised tank supplies sea water, and the children are sprayed either standing, sitting or lying, according to their condition. This treatment is carried out from May 14th to October 10th.—The Nursing Times.

In cooperation with the Bellevue-Yorkville Health Demonstration the New York City Department of Health has opened a special clinic for the study and treatment of vaginitis in children.

Joanna C. Colcord has been appointed Director of the Charity Organization Department of the Russel Sage Foundation in succeeding the late Mary E. Richmond.

The Honorable George W. Wickersham has announced the establishment of the Thomas William Salmon Memorial to provide
News Notes

recognition to the scientist who has made the greatest contribution in the fight against mental disease during each year. Awards are to be national and international and will provide for the wider dissemination of the knowledge of mental hygiene and insanity through cooperation with the New York Academy of Medicine, in whose hands the administration of the $100,000 fund is to be placed.

Madison House, the new settlement building, 226 Madison Street, New York City, has been formally dedicated and is open for neighborhood use.

Mrs. Schiff, widow of the late Jacob H. Schiff, Mortimer L. Schiff his son and Felix M. Warburg, Mr. Schiff's son-in-law, have donated $150,000 toward the new building fund of the Montefiore Hospital for Chronic Diseases, New York City.

A survey of the New York State Department of Health shows that men in rural communities are healthier than women.

The Home of Old Israel for aged and indigent men and women of the Jewish faith has been moved to its new quarters, 70 Jefferson Street, New York City.

The records of 42,000 school children in Massachusetts examined and tested by the Massachusetts Department of Public Health during a recent 3-year period indicate that over ¼ of them were infected with tuberculosis. No difference in susceptibility was found among children of various nationalities, but approximately twice as many with a history of exposure to pulmonary tuberculosis showed infection as those who had no such history. The school children of Farmingham showed a markedly lower rate of infection in 1926 than had been found in a former investigation in 1917. During these nine years an intensive tuberculosis campaign had been carried on in that city. The reduction corresponds to the substantial reduction in the death rate from the disease in Massachusetts.

A well-baby center for children of parents of moderate means is being tried out in London. The center was established about a year ago by a committee of women from Kensington and Chelsea,
those two quarters of London made famous by Peter Pan and the literary and artistic groups who have lived there. It is called the Babies' Club, and the fee is £5 5s a year, though this is reduced in certain cases. The mothers receive instruction in child care and home visits from the matron, and may have as many consultations with the club physician as are necessary to keep their babies in good condition. The cooperation of the family physicians must be secured by the mothers before she joins the club, the object of the enterprise being the prevention of ill health and not the treatment of the disease. —World's Children.

Dr. George K. Pratt, Chairman of the Mental Hygiene Committee of the National Congress of Parents and Teachers reports that parent-teacher associations in 32 states include mental hygiene in their educational bulletins. The National Committee for Mental Hygiene supplies the literature.

“What Every Woman Should Know About Cancer” is the title of a new pamphlet issued by The American Society for the Control of Cancer. This pamphlet is written in simple non-technical language and will no doubt not only create interest in the disease but assist materially in the early diagnosis campaign.

The Polyclinic Medical School and Hospital, New York City, has opened a physical therapy department for teaching and research. This department will care for both in- and out-patients. Dr. Richard Kovacs will direct the work.

Miss Marcia Wittenberg who has for a number of years been in charge of the children’s cardiac work at the Lenox Hill Hospital has resigned to organize the Social Service Department of the Brownsville-East New York Hospital. Mrs. Charles Solomkin is chairman of the Social Service Committee.

The New York School for Social Work plans to give annually a series of lectures by representatives of professions and fields of knowledge outside of social work.
The University of Florida, Gainesville, in cooperation with State authorities is broadcasting a series of radio talks on the laws governing the protection, care, health and welfare of children.

Dr. M. P. Ravenel has been appointed editor of the American Journal of Public Health.

Private family homes are being used to an increasing extent in Oregon for the care of dependent children, not only by private and public agencies but by the institutions. The Oregon Child Welfare Commission reports that during the past fiscal year the child-caring institutions placed twice as many children in such homes as during the preceding year.—*World’s Children.*

Miss Sophie Van S. Theis of the Child Placing Department of the State Charities and Association is on leave of absence to conduct a course in general child welfare in Texas. Miss Theis will be in charge of the Child Welfare Division of the Southwest Social Service Institute of Dallas, Texas.

Miss Jessy C. Palmer has been appointed General Director of Social Service for the Department of Hospitals, New York City.

The California Commission for the Study of Problem Children, established by law in 1927, has made its report to the State Legislature. The problem of juvenile delinquency is considered from every angle, individual and environmental, and a comprehensive program to meet outstanding needs is presented. Mental health problems receive prominent recognition in the recommendations, which include a mental hygiene survey of the state, the training of teachers in child guidance and mental hygiene, formation of community clinics for the study and treatment of problem children, the development of psychologists, psychiatric social workers and visiting teacher personnel, better care and training of the feebleminded, and the establishment of a hospital for emotionally unstable children.—*Mental Hyg. Bul.*

Dr. Paul Schilder, Professor of Psychiatry at the University of Vienna and author of noteworthy works on neurology, psychiatry
and mental hygiene, is in the United States giving special courses on these subjects in Baltimore, New York and other eastern cities.

A survey of the motion-picture theaters of Buffalo has led the juvenile-protective department of the Children's Aid Society and the Buffalo Council of Churches to recommend a more rigid State law relative to the construction of the theaters, better enforcement of safety rules and sanitary supervision, increased use of public schools for children's matinee pictures, and legislation permitting and regulating special matinees for children in the theater buildings. The final recommendation offered is that a representative group of citizens be formed in each community to work in coöperation with the theater managers toward the development of higher standards in the pictures presented. The managers have indicated that they will be only too glad to confer with responsible groups and that they will welcome constructive suggestions.—World's Children.

John Malcolm Forbes, a former student of the New York School of Social Work has made it possible for the School to inaugurate a series of lectures which will be given annually by men and women from the various professions outside of social work. The plan is to enrich the social worker's knowledge of the contributing factors in other fields which have helped to build up a technique for social work. Professor Amy Hewes of Mount Holyoke College gave the first series this spring on "The Contribution of Economics to the Field of Social Work."

In order to keep active growing boys out of mischief members of the local police forces of three English towns, Norwich, Ipswich and Hyde, have voluntarily organized and financed boys' clubs. The plan has been successful and the towns in which the clubs are situated show a marked decrease in juvenile delinquency.

"Clearing Classes" in public schools in which every child entering school for the first time can be studied with a view to determining the grade to which he should be assigned, is recommended by Dr. Ira S. Wile, a New York psychiatrist. One ground for Dr. Wile's suggestion is the fact, as he points out, that the needs of mentally defective children are given more attention than the special needs of normal and superior children.—Ment. Hyg. Bul.
It is expected that nurses from 40 different countries will attend the International Congress of Nurses in Montreal, Canada, July 8 to 13.

The Lying-In Hospital will merge with the New York Hospital as a maternity unit, in the new $60,000,000 Medical Centre, which will be known as the New York Hospital-Cornell Medical College Association.

Greenwich House has affiliated with Columbia University thus enlarging the social, educational and research work of both institutions.

Miss Mary V. Dempsey, who for the past 5 years has been statistician of the Milbank Health Demonstration of Syracuse, has been appointed to make a study of occupational mortality and will work in Washington in the Bureau of the Census. Miss Dempsey's appointment is part of the plan for social research work carried on the budget of the Committee on Social Research of the National Tuberculosis Association.—Digest Nat. Health Council.

Social workers will be interested to know that a limited number of copies of the Michigan Hand-Book of Hospital Law are now available for $1.00 each. While the text covers the laws governing hospitals in the State of Michigan the book will prove a useful source of information to hospital administrators and social workers in other states.

A recent issue of "The Pioneer" quotes Dr. C. A. L. Reed, former President of the American Medical Association as advocating the English practice of eating 5 or 6 light meals a day instead of the American custom of eating 3 square meals. "At Oxford University, England, there are 6 opportunities for eating every day. Breakfast consists of porridge (oatmeal), fish, bacon, toast, marmalade and tea. Eleven o'clock is the time for coffee and wafers; one o'clock is the lunch hour. At four o'clock we have the long-established and invariable English tea. The seven o'clock dinner is the really substantial meal of the day. Between ten and midnight there is often a hot drink, usually cocoa, the heat of which conduces sleep. This schedule of food-taking tends to prevent extreme hunger
with consequent gorging. It prevents the prostration of the digestive apparatus by overworking it. It saves the pancreatic functions by not overloading it at any one time with starches and sugars and this tends to prevent diabetes."

A scrapped Japanese warship—the Muashi—has been rebuilt to serve as a “floating prison” for boy delinquents, who are to be given a 6 months’ course of instruction in the practice and theory of navigation, fishing and the making of fishing equipment, weather observation, and kindred subjects while they are on the boat. The announced purpose is to give the boys plenty of work in a healthy sea atmosphere while teaching them a useful occupation. Fifty boys 14 to 23 years of age are to be selected for this training from the prisons of the country.—World’s Children.

The Garden of Childhood is the name of a new motion picture film, relating especially to the hygiene of the run-about child, placed in circulation by the John Hancock Life Insurance Company of Boston.

The East Harlem Centre, New York City, is making a drive for $350,000 for building purposes. The Centre consists of 23 health and welfare agencies working under one roof for the welfare of the neighborhood and coördinating the various activities so that the maximum of health teaching and health service is rendered with no waste of effort or duplication.

A gift of $2,000,000 from the General Educational Board for a pediatric laboratory and dispensary for the New Haven Hospital has been announced. The hospital is affiliated with the Yale University of Medicine.

Chicago University has planned to erect at an approximate cost of $7,000,000 buildings which will be used as a children’s medical centre.

San Francisco is planning to erect a new Cancer Institute.

Although the disorder is confined to a very small organ, a toothache disturbs the equanimity of the whole body and prohibits the full
use of mental and physical faculties in productive occupation. In like manner the sickness of one person is at best an economic burden to the community in which he lives because one or more other people who might otherwise be engaged in some wealth producing task is found at the patient’s bedside. Thus every person ultimately profits by any measure that prevents disease or promotes health because by just so much have opportunities to gain wealth or participate in the pleasures of life been increased.—_Ill. Health Messenger._

“Doctors ought to be like the mechanicians who take contracts to keep clocks going and on time, rather than emergency men to be summoned when timepieces stop or are too fast or to slow.”

G. E. VINCENT.

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**BOOK REVIEW**


The author states that he has prepared this little book so that the information will “be quickly apprehended” by the “busy physician or medical student.”

It is not always because the doctors are “busy” that they fail to study the patient as well as his disease. There are some exceptions, but as a group they still fail to realize that, while the human body is a machine, a most delicate, intricate piece of mechanism, that there is always present a mental factor that plays havoc with their best intentions to repair that machine.

The chief surgeon of one of New York’s largest hospitals writes “It is the business of the doctor to apply his technical training and skill in such a manner as best to assure the recovery of the patient.”

Occupational therapy is a big factor in assuring “the recovery of the patient.” The author states that it is excellently defined as “any activity, mental or physical, definitely described and guided for the distinct purpose of contributing to and hastening recovery from disease or injury.” Properly applied then it will aid decidedly in adjusting the obstructing personality so the effort of the doctor will better “assure the recovery of the patient.”
The author himself says when explaining why he has at some pains explained the various types of persons and their reactions, "I have given these details in order to impress upon the physician the importance of a study of personality of the patient."

The occupational therapist, says Mr. Dunton, should have "the same relation to the physician as the nurse, that is, she is a technical assistant." To have this relation there must be developed a recognition on the part of the doctor of the importance of occupational therapy and a confidence in the training of the occupational therapist. Professional training courses for nurses have been instituted as a part of the larger hospitals, the nurse fills a place recognized by all doctors and surgeons as most necessary and in many states must have a state license. The medical profession as a body has interested itself in the training of the nurse and it does, as the author says, rely "upon the specialized training of a nurse." We who know the value of occupational therapy realize that more and more the doctor is accepting it as necessary and that to hold the ground which has been won and to gain more ground not only thoroughly trained occupational therapists are needed, but official state recognition.

Mr. Dunton's book will do a great amount of good in bringing before the physician knowledge of how occupational therapy will aid them in the recovery of their patients.

Very thoroughly does he deal with the subject matter in each chapter. Under the headings, Significance, Prescription and Fatigue, he sets up a background of general principles pointing out the necessity of medical supervision of the instruction.

In Part II he carries the reader into the special application of the subject and most interestingly discusses mental, surgical, orthopedic, cardiac and tuberculosis problems.

Not alone, however, for the physician is the book of value. It is so written that everyone dealing with crippled persons in any part of the work carried on for them will be able to more intelligently serve them after reading it. It is recommended to social workers as one of the most helpful guides in their work. They will recognize all their old friends, the nervous, the irritable, the fussy, the neurasthenic, the apathetic, the talkative and the reticent but here they will find a simple, intelligent discussion of the causes and the remedies.

Mr. Dunton has used no padding and no lengthy discussions, the subject matter has been handled in a manner that indicates the expert
who knows what he wants to say and says it. It is a little manual full of valuable, interesting and accessible material.

F. C. ELTON
Managing Editor, Rehabilitation Review


In that day when we shall fully recognize the importance of child study, when we come to realize that the child is more potent for good or ill than any other force in civic life, when we come to fully understand that the child’s stream of thought, action, habit and character cannot be dammed up, nor should be, but with proper, intelligent, persistent effort may be largely directed into useful channels, when we admit the full possibility of fixing the future character of society by having the embryonic society of today composed of the best possible type of childhood, surrounded by the best environment, in that day we will have entered upon the highway that leads to an ever increasingly improved human type.

This can be accomplished only by a complete and sympathetic study of child life, its traits, tendencies, volitions and environment. We must recognize the continually changing conditions to which children are subjected and we must reconstruct our plans and modify our methods of dealing with their problems to meet those changing conditions. To accomplish this, it is essential that we first learn and appreciate the problems involved and then with intelligent effort seek the wisest solution thereof.

It is a healthy and encouraging sign that considerable is being spoken upon the subject of the child—its peculiarities, its failures, its achievements. The subject is one of world-wide interest and universal importance, and suggestions and help from every possible source are desirable. Therefore, such a book as “The Child in America,” should be warmly welcomed.

“The Child in America” is, in the main, a compilation and tabulation of the findings and results gleaned from experiments conducted by many leading institutions and prominent authorities who have devoted years to the study of child welfare. It approaches the problem from a practical standpoint. Children were subjected to varying influences and stimuli and their reactions carefully observed
and recorded. Upon the basis of the material so obtained, the experimenters sought to build general laws or rules for the guidance of people interested in the rearing of children.

Perhaps the only satisfactory conclusion to be drawn from the study is that the solution of the problem of child welfare is one of great difficulty; but its solution is so vital to the future well being of society that it will more than compensate for any effort put forth.

To date we have but scratched the surface. "The Child in America" is a source book of material which should find its way into the hands of every potential parent, every school, and every institution, which has the good of children as its object—not as a guide, but as a starting point from which to initiate our journey toward the shining goal of social well-being.

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NEW PUBLICATIONS

Uncle Sam’s Farm. A map project and teacher’s guide published by the Quaker Oats Company, Chicago, Ill. This publication which is one of the school health series consists of a large outline map 44x30 inches of the United States, divided into states, a set of colored illustrations depicting the nation’s chief farm, dairy and live stock products, which can be cut out and placed according to the states producing them, and a teacher’s guide which gives the names of the products, the state in which they are grown, the average yearly production, the years included to produce average and references for authorities. When completed the map gives a picture of the country as a whole and enables one to accurately place the state and its production in one’s memory. The map and chart were prepared for 5th, 6th and 7th grades and have special value in social science and geography projects. Teachers may obtain copies free of charge by writing to the Quaker Oats Company, School Health Series, 80 East Jackson Street, Chicago, Ill.

“Adventuring for Health” is the title of an attractive booklet published by the Metropolitan Life Insurance Company. The text
which briefly outlines and tells in pictures, in words and in statistics the story of “adventuring for health” in the past 20 years. As a result of the intensive health educational program undertaken by the Company the general health among its industrial policy holders has improved and their life expectancy has increased nearly 10 years. The Metropolitan Life Insurance Company was recently characterized by President Hoover as being “The greatest single institution dedicated to the public welfare.”

ABSTRACTS


Medical research, purer milk and application of better methods of feeding, better sanitary conditions, higher standards of living and the various means used to educate and interest the public in health and hygiene have all been instrumental in decreasing the mortality rate of infections and diarrheal diseases among children, but no specific treatment has been found for the respiratory diseases, including pneumonia, although the death rate has been lowered as a result of better sanitary standards. The author describes the different forms of pneumonia and their complications and treatment. The importance of prevention is emphasized and warning sounded against exposure and neglected colds. One of the greatest preventives is to keep the young child under careful medical supervision by thorough physical examinations two or three times a year. The author pays a tribute to the public health nurse for her contribution to preventive medicine.


Starting with the quotation “Malnutrition is responsible for more degeneracy than alcohol” the author clearly and definitely shows the baneful effects that under-nourishment and improper feeding has upon the growing child. Appetite plays a leading part in the feeding of a child. When food is taken without appetite the body does not properly assimilate the food. Strong emotions of all sorts, particularly worry, fear and anger stop all digestive processes. Severe mental labor also affects digestion. Poor ventilation and lack of
free activity are found to have marked effects in decreasing the "attentiveness" of the body and organs to food. Malnutrition is to be combated in the same way as bacterial infection—by all the measures required for bringing about free and full development of all the capabilities; that is, by relief from strain, by happy play, by activity in the open and by agreeable home surroundings. The author goes thoroughly into the external conditions leading to malnutrition and gives explicit and careful advice in the care of children from infancy, with special reference to the kind of care and training which will keep the child in a state of physical and mental fitness. This article will be completed in a later issue of the Journal, but the first installment contains such sound advice we draw it to the attention of our readers.


Whether the attention given by the general public to overweight and dieting is traceable to greater knowledge and a more intelligent appreciation of health, to fashion's decree or other causes, is a debatable question. The fact remains that both subjects are deeply considered by both professional and non-professional groups. A number of medical men and dietitians doing notable work with metabolic diseases were asked to give their opinion upon pertinent factors relating to both subjects. The first question read: What do you consider some of the most serious results that may be attributed to overeating? The answers were classified as follows: General debility and diminished life expectancy, 51 per cent.; hypertension, 47 per cent.; diabetes, 44 per cent.; heart disease, 41 per cent.; organic disturbances, 31 per cent.; nephritis, 28 per cent.; liver disturbances, 16 per cent.; orthopedic difficulties, 7 per cent.; appearances marred, 7 per cent.; gout, 4 per cent.; constipation, 4 per cent.; cerebral hemorrhage, 1 per cent.; varicose veins, 1 per cent. On the question of diet: 29 per cent. approved of restricting fats and starches; 68 per cent. thought sugars should be restricted more than starches; none thought that starches should be restricted more than sugars; 16 per cent. were equally divided. Concerning meat restriction: 8 per cent. would restrict fat meat only, while 26 per cent. would restrict meat generally. The question was asked: Have you found a diet of coarse foods to be harmful in general? 65 per cent. answered "No" to this question; 15 per cent. answered "Yes." The consensus
of opinion was that to be effective the prescribed diet must not be based on starvation methods but must conform to the fundamental principles of nutrition if serious damage to health is to be avoided. A generous use of liquids, such as broth, tea, coffee or orange juice and in a majority of cases, water should be encouraged, the replies indicated. The greater part of the article gives the opinions and recommendations of well known physicians and dietitians and contains much that will be helpful to those whose overweight is an indication of faulty health habits.


The chief factors in the production of heart disease in children is the rheumatic diathesis under which we must include chorea, growing pains and repeated sore throats. To control cardiac disease early diagnosis, continued observation and removal of all foci of infection are necessary. Children who have had rheumatism or chorea must be considered potential cardinals and be kept under medical supervision. The author gives an example of a child with acute rheumatic fever, the aftermath of neglected physical defects and unheeded minor disorders which a physician would have recognized as forerunners of the ultimate breakdown and voices the opinion that little progress can be made to limit and control heart disease in childhood until knowledge of the great danger of mild infections is broadcast to parents and others responsible for the care of children. Periodic examinations and careful supervision of children with a rheumatic history are weapons in the prevention of cardiac disease. The actual care of children suffering from heart disease consists of rest, gradual exercise and diet. Sunlight or ultra-violet rays also improve the general condition of cardiac children.

"Fitting Clinic Charges to Patients’ Purses." Beatrice Kaiser. *Mod. Hos.*, 1929; XXXII, 81.

Medical care for the rich and the destitute poor present no serious economic problem. The great army of the self-respecting, financial middle-class are the sufferers. They are not eligible, neither do they wish charity, but the prohibitive cost of modern scientific specialized medicine is beyond their means. Failure to meet the need of people who make up this large group has led to the present serious problem of medical economics. A study by the National Bureau of Economic
Research on the distribution of personal income reveals the fact that 86 per cent. of all persons in the United States have incomes of less than $2,000, that 94 per cent. have less than $3,000 and that 98 per cent. have less than $5,000. In Detroit a "Minimum Budget for Wage Earner's Family" has been scientifically worked out by the Visiting Housekeepers' Association. This budget represents the bottom level of health and decency below which a family cannot go without danger of physical and moral deterioration. Admission to clinic is based on this budget. The careful admission of applicants for out-patient service calls for a trained person at the admission desk. This social worker obtains the necessary information regarding social and financial standing and advises accordingly. A visit to the home is made if necessary. The experience of the author, and other social workers leads her to say that the majority of applicants make truthful statements when applying for medical care. Applicants to a clinic are classified as follows: 1) those who are distinctly private patients of physicians and referred back to them; 2) those whose incomes are adequate to provide the care required and who have no physicians and are referred to the private offices of staff physicians; 3) those whose income lies distinctly within the limits of the minimum budget and who are entitled to all services; 4) those who are accepted on a temporary basis for the current illness only, because of some outstanding sociological fact which has temporarily reduced their resources; 5) those with obscure medical conditions whom private physicians refer to the clinic for diagnosis; 6) those who are distinctly charges of the city or county and as such should be referred to the municipal and county agencies for care. "All fees, whether blanket or graded must be administered in the light of sociological factors or they defeat their own purpose." The author has taken into consideration the private physician's position, the rights of the applicants for clinic treatment and the responsibility of the hospital and out-patient department to both physician and patient. The argument for and against clinic treatment of patients in the various classes is sane and well balanced and even the disgruntled private physicians who condemn clinic care could not take exception to the methods used at the Harper Hospital. The author who is a Clinic Executive at Harper Hospital, Detroit, Michigan, has written an interesting and enlightening article. Private physicians, hospital administrators and social workers will profit much by reading the theory and practice of clinic care as outlined by the author and based on actual experience.