The Hospital Social Service Quarterly

A Magazine Published in the Interest of Social Service and Dealing with the Many Problems of the Hospital Superintendent, Doctor, Auxiliary Committee, Volunteer and Nurse in Relation to Medical Social Service.

PUBLISHED QUARTERLY UNDER THE AUSPICES OF THE HOSPITAL SOCIAL SERVICE ASSOCIATION OF NEW YORK CITY

EDITORIAL STAFF
DR. E. G. STILLMAN, - Editor
MISS MARY H. COMBS, - Associate Editor
MISS N. F. CUMMINGS, - Associate Editor
405 Lexington Avenue, New York, N. Y.

CONTRIBUTING EDITORS

MICHAEL M. DAVIS, JR.,
Director, Boston Dispensary

JOHN E. RANSOM,
Superintendent, The Central Free Dispensary of Chicago

MISS IDA M. CANNON,
Chief of Social Service, Massachusetts General Hospital, Boston

MISS MARGARET S. BROGDEN,
Supervisor, Social Service Dept', Johns Hopkins Hospital, Baltimore

MISS M. ANTOINETTE CANNON,
Chief of Social Service, Hospital of University of Pennsylvania, Philadelphia

MISS MARY E. WADLEY,
Chief of Social Service, Bellevue Hospital, New York

MISS EDNA G. HENRY,
Director, Social Service Dept', Indiana University, Indianapolis, Ind.

DR. JESSICA B. PEIXOTTO,
University of California Hospital, Berkeley, Cal.

SUBSCRIPTION PRICE, - - - $1.50
SINGLE COPIES, - - - - .50

Advertising Rates may be had on application

Copyrighted by E. G. Stillman
CONTENTS PREVIOUS NUMBERS

Vol. I No. 1

The Epidemic of Influenza.  DR. LOUIS I. HARRIS .......................... 3
Medical Social Work and the Influenza Epidemic.  M. ANTOINETTE CANNON 15
Extension of Medical Social Work to Naval Hospitals.  RUTH V. EMERSON 22
Summer Training School in Social Reconstruction at
  Smith College.  PROF. F. STUART CHAPIN................................. 72
The American Association of Hospital Social Workers ..................... 33
St. Luke's Hospital Course for Social Service Volunteers.  AMY L. CLEAVER 41
THE MEDICAL SOCIAL UNIT
The Next Step In Medical Social Service*
SIDNEY E. GOLDSMITH
Director, Social Service Free Synagogue

It was my first intention to prepare a paper upon this subject, The Medical Social Unit; but I have come to the conclusion after some little thought that the experiment is too young to warrant a formal presentation. The utmost it would be wise for us to do is to discuss a number of points suggested by our theme.

In reviewing the history of Medical Social Service, whether we go back to 1905 when Dr. Cabot organized Medical Social Service in Boston or to 1894 when Dr. Chapin established medical social care in New York City, we find that we have limited ourselves almost altogether to the cases that have come to us in the dispensary and hospital. During the past decade we have both intensified and extended our work. We have extended our service from one group of cases to another, from the medical to the surgical group, to the cardiac, the tuberculous, to the syphilitic and to the mental hygiene, and we have made an intensive study of each group and have worked out the technique and procedure that insures to the patients that come to us, the most efficient and adequate care.

We have also discovered that in order to be of maximum service in these cases that are brought to us it is necessary for us to go beyond the institution and to go into the home. It is necessary to go into the home in the first place to relieve the

*Read by title before the American Pediatric Society, Detroit, Mich., June 1, 1904
emergencies that arise. When the mother or father is admitted to the hospital we must go into the home to take care of the children who are left in need or to take care of the wife who requires service. We must go into the home also to rebuild the family that has broken down through accident or disease and this rebuilding process frequently takes weeks and months of home care. And then also we find that we must go into the home in order to remove the cause of the trouble for very frequently the source of distress is not in the patient in the hospital or dispensary but in the home. The baby that is brought to us is often ill because the mother is ignorant and the home environment is unsanitary. In other words, we have learned that the home as well as the hospital and the dispensary is a point of beginning in our work.

In some forms of health work we do not fully appreciate this fact, that the home is a point of beginning. In some forms of service we have begun with the school, and the school remains not only the beginning but also the end of our work. In the school lunch movement in New York City and elsewhere the work begins in the school and ends in the school. We forget that a glass of milk and a few crackers given to the child in the school basement does not begin to touch the problem of starvation in the home. In other forms of service we have begun with industry. Industry is undoubtedly a point of departure in health work. Our industrial field ought to be free of all the dangers that surround working men and women. Industrial hygiene is an important and most effective form of health work, providing we have a Health Commissioner who is willing to entrust this service to experts and not to make it a pasture ground for politics. But it is partially solving the problem to improve the sanitary conditions in the factory and to leave the home without proper light and ventilation and the conveniences necessary for the preservation and promotion of health.

These experiments in the school, in industry, and other experiments in the community have suggested to us the establishment of what we have ventured to call The Medical Social
Unit. Some of those who have seen or heard this term have inquired: "What is a Medical Social Unit, and what is it to do?" Reduced to its simplest terms a Medical Social Unit is just this: A Medical Social Service Department reorganized and reorganized in such a way as to permit us to do for all men and women and children, for all members of the community, what we are now doing for babies through the Infant Hygiene Clinic. What are we doing for the babies in our clinics? In the first place we are giving to the mother and family instruction in the elements of hygiene and sanitation in the hope of reducing infant mortality. In the second place we are arranging for expert nursing care when the baby is ill, and very frequently this care is needed during the first five years of its life. In the third place we are offering expert medical counsel and care for the babies that would otherwise go without such attention. This is why we have our babies brought to the clinics and have them weighed and re-examined and have the doctor talk to the mother and watch the child's progress. In the fourth place we make provision for social care when we find the family unable to give the baby the proper milk or other nourishment, when we find that the father or mother cannot give the child the proper clothing or convalescent care. Through these four forms of service instruction in hygiene and sanitation, nursing care, medical care, and social care, we have been able in New York City to reduce infant mortality in some sections to an incredibly low level. In the city as a whole the infant mortality rate runs between 9 and 10. In one infant hygiene clinic in which there are between 500 and 600 babies constantly under care the infant mortality rate has been reduced to less than 1%.

If we can achieve such results with the babies why can we not accomplish something similar with the children between 2 and 5, with the children between 5 and 16, and also with the adolescents, and the adult members of our community? Why can we not raise the whole health tone of the district in which we work and lower the mortality rate? All of this could be done if we could reorganize our Social Service Department and undertake an extension of service, or the next step in medical
social care. I cannot stop because of time to indicate in detail just what reorganization would mean or the program of work that would be undertaken. But I must at least outline the way in which we should begin. First of all we must draw a circle or square around the hospital or dispensary in which we are working and designate this as our district, a district that is going to be our field of service. Then we should begin with the square block opposite the hospital, such a square block as I see opposite Bellevue, Roosevelt, the Presbyterian, Mt. Sinai, Lebanon, or Beth Israel. Then we should visit every home in this square block and become fully acquainted with every individual in the family. Through such visits and acquaintance we shall be able to make a list of the health needs of the square block and the conditions that militate against the health of the men and women and children who have become our charges.

Following this initial and preliminary work we find it necessary to organize classes and clubs for instruction in hygiene. Some will say that this is not the work of the hospital or the Social Service Department. But is it not true that the hospitals and Social Service Departments have failed to grasp the opportunity that lies at their very door? Every hospital has an auditorium and in most instances the auditorium is empty the greater part of the time. This could be used as a lecture room. Every hospital has also a staff of physicians who could speak expertly and popularly upon health problems. Every hospital also has specimens and illustrations that could be exhibited and that would make the club and class work most vivid and instructive. Through such group work our people could be trained in the elements of hygiene and sanitation, and taught to avoid or overcome many of the dangers that now surround them.

In addition to these clubs and classes we should organize at once for men and women and adolescents what we now have for the babies, that is, clinics for examination and counsel. Our Infant Hygiene Clinics are not for the purpose of making sick babies well, but of making well babies better and stronger. Why should we not do the same thing for those who have outgrown the period of babyhood and childhood? For many years we
have talked about the physical and mental examination of all members of the community, either voluntary or compulsory, but we have not offered them the opportunity. We have not said: Here is a clinic. Come and be examined and re-examined and let us help you to outgrow your weaknesses and build up your strength and resistance power. We know that the average length of life is less after we reach the age of 35 than it used to be and that it has gradually been growing less during the last 25 years. The causes of our decline we could help men and women to understand through hygiene clinics; but they cannot come for examination until we have provided the facilities and persuaded them of the wisdom of our program.

The third thing we must do is to arrange for adequate nursing care. This care should be given not only during great emergencies but throughout the year. Those of us who went through the influenza epidemic know that thousands of families suffered because they could not get proper nursing service and we also have come to the conclusion that proper nursing service would be effective at all times and that nursing work should be better organized, and that we should have a district service in the full and complete sense of his term and not in the restricted and limited sense in which we have it to-day. What is true of nursing is also true of medical care. During the epidemic, families went altogether without medical attention and when there is no epidemic many a family hesitates to call a physician until it is too late to be of service. The Medical Social Unit, in other words, would be organized to meet health needs at every point and especially at these four points of hygiene and sanitation, nursing, medical and social care.

Some people will say when they hear this program: Do you not know that such a program would mean a reorganization of some of our health agencies? I think it would, and I also think that some of our health agencies should be reorganized, and re-organized at once in the interest of communal service. The first agency that should be reorganized is our District Nursing Service. Those of us who have studied district nursing service know how it originated; that it began in the Settlement and that it
also continues to develop with the Settlement as the center. The Settlement, it seems to me, is not the logical center for district nursing. When the Settlement is a center many complications arise in district service work. When the family is in need of medical care and cannot afford it, the nurse must call in some other agency. When the family is in need of social care the nurse again must call in another agency. And thus it happens that frequently three or four agencies are at work on one family in which there is only one case of sickness, and no one agency has control in directing the progress of the case. Those of us who venture to look forward are of the opinion that the whole district nursing service in New York City should be reorganized and that not the Settlement but the hospital or dispensary should and must be made the center. The medical institution is the logical point of beginning.

Medical care will have to be reorganized in the same way and this is probably what will happen through the program of health and social insurance. The State will undoubtedly arrange for district care of all families and the hospital or dispensary should be designated as the center to which calls shall be sent and from which they should be answered. This would permit the general practitioner to immediately call upon experts when in doubt and to arrange for institutional care when necessary.

Social care likewise should be reorganized and reorganized in such a way as to permit families in need because of sickness to receive more adequate care than they are getting at the present time. Some social agencies may think that the families are getting all they should. Those of us who are especially interested in the social care of the sick know that few are getting sufficient financial assistance to permit them to outgrow their distress and they are not getting the special attention that they require. How is it possible for them to get this special attention when the social investigators are trained only for general service and are not especially trained for the social care of the sick. Families in need because of sickness should be placed under the supervision not of a general relief agency but of an agency that is specializing in the social care of the sick, that is, the Medical
Social Unit, and this Unit should be equipped to render whatever service such a family may require, whether it be instruction, nursing care, medical attention, counsel, supervision or financial assistance.

What now would be the relation of the Medical Social Unit, such as we picture, to other agencies in the community? The relation, of course, would at all times be one of very closest and cordial co-operation. But it seems to me all of us together in the social field must try to realize that in the community different Units are required. In every community there should be a Health Unit; in every community there should be an Educational Unit and a Recreational Unit, and a Social Agency for the care of the generally dependent; and every case of distress or need that arises should be referred to a Unit or Agency, in accordance with a principle that has become perfectly clear and convincing to many of us. This principle is that cases should be referred in accordance with the major cause of distress. The major cause of distress must determine the Agency to which the case is to be referred. If the major cause is delinquency, then the family should be referred to an Agency specializing in the care of the delinquent; if the major cause of distress is sickness, then the family should be referred to the Medical Social Unit and nowhere else.

One more point. In the Medical Social Unit as I have outlined it we have, I believe, an agency that will serve admirably in the process of reconstruction. The Medical Social Unit would in fact be operating as a reconstructing agency. It would be reconstructing the health life of the district and building up in the community a health consciousness. This is reconstruction from the bottom up. The Medical Social Unit would also take the laws passed by the City, State and Federal Governments, and interpret these laws to the people and carry them into practice. In this way it would become an agent of the State in working out all health measures and legislation. And more than this, the Medical Social Unit could make a thorough and careful study of the health field and in the course of time suggest new legislation, the things that ought to be done to preserve and
promote health. In other words, the Medical Social Unit would become a great Educational Agency.

The Medical and Lay Boards of the hospitals to which this plan has been presented realize also that the Medical Social Unit could become of great service to the institution. It would not only follow up cases systematically and cover the whole problem of after-care, but it would also make the hospital recognized as a factor in communal life and would help men and women to understand that the hospital is here not merely to serve as a reception house for the sick, but to develop into a great, active agent in communal service.

Many will ask me: How are we going to do this work? How can we reorganize our Social Service Departments? No Social Service Department can be suddenly transformed into a Medical Social Unit, but the transforming process can begin at once and in the course of five years the Department will reach the point where it will be able to render the larger service of which we have spoken. Our present work must not be neglected. We must continue to care for the families and the patients who come to us, and we must prepare ourselves and train ourselves for communal service. We must extend ourselves into the homes and family life. We could begin with one additional worker to our staff and in the course of six months or a year the achievements of this one worker would, I am convinced, demonstrate to every Social Service Committee the value and validity of this new service. After all the Medical Social Unit is nothing more than an endeavor to do through one agency what we are now doing through many, an endeavor to do thoroughly and completely what we are now doing only in fragments, an endeavor to gather together in one place and in one center the experiments that have been conducted and the work that is being done in various ways in the health field.
THE CLOTHING COMMITTEE OF A HOSPITAL SOCIAL SERVICE DEPARTMENT

MARY BELKNAP MURPHY
Chairman Clothing Committee, St. Luke's Hospital Social Service

Many hospital social service organizations are started without a Clothing Committee. The workers and members of the relief committees soon find that in most cases where relief is needed, clothes are one of the forms which it takes, in some cases clothing is the only relief given which has a money value. Without a Clothing Committee the members of different committees are continually buying or begging clothes for the cases they are taking care of. It becomes a great source of annoyance for several reasons, the main one being, that the clothing brought by the different members never seems to be on hand when needed. For example, a member of a committee will this week give a girl's coat, there will be no call for it on her committee, some time later there would be a call for just such an article, but it would be gone, and no one would know where. It had been needed for a case being taken care of by another committee and had been used by the worker on that committee. Then gradually the members would determine to keep at home the clothing they had to give away, until a definite call came from their committee for such an article as they had. Under such conditions it is impossible to keep a well-stocked clothing closet.

A Clothing Committee is an asset to any hospital social service. Merely to have a committee advertises the fact that you need clothes, and never forget "it pays to advertise." No matter how self-evident a need seems to you, it is well to speak of it, remember the other people are not thinking of your job any more than you are thinking of theirs. If you need flannel nightgowns or shoes, say so and the chances are you will get them.

There will be two classes of clothing to be taken care of and distributed, second-hand and new, each kind presenting different problems. The second-hand clothes you will get by advertising
The Clothing Committee of a Hospital

the need for it. This you can do by speaking of it at every opportunity, sometimes to only one person, then again to a few, and sometimes to many; but keep at it, it will pay in the end. You will be surprised to find how many people will be glad of the suggestion, for just as soon as you make them think about it, they know that they would rather have some person you know of using that coat they have finished with, than have it remain hanging in their closet, to become in time a feast for moths.

For overcoats and suits for men and boys, for coats, suits and warm dresses for women and girls, you will have to rely mainly upon your donations of second-hand clothing. Children outgrow their clothes and women's fashions change, so you will receive in proportion a larger amount of women's and children's clothing than you will of clothing for men, who are not troubled with change of fashions. The call for clothing is received in about the same proportion. If there is not money enough in the family for everything, the mother's clothing is the first thing to be neglected, then the children's, and finally the man's. When the bread-winner has not a neat suit of clothes to wear when looking for a job, the family are indeed in a bad way. A good suit of clothes at the right time may help a man to a good position and bring comfort to a whole family, when the lack of such clothing may bring despair to the man and continued distress to his family. Just because men's clothing is hard to get, a Clothing Committee must lay greater stress upon that need.

As one of the lessons the social service worker is trying to teach is personal cleanliness, it does not do to give out soiled clothing, which can be cleaned by soap and water. Sad to relate, people have been known to send in underwear which has not been laundered since the last time it was worn. Generally some member of the committee will be willing to take such articles home and have them washed, which must be done before they can be used.

What to do with some of the clothing sent in is a question. Satin slippers, lace petticoats and gauzy negliges have no place in hospital social service work. Still you dare not even suggest that to the donor, for often there comes with the unsuitable
articles just the things which are most needed, and you can not take the chance of losing them. We must look forward to the time when people will know and appreciate more fully than they do now what hospital social service stands for and what it needs in the way of clothes. In the meantime we must find a suitable place for what we can not use. Often such articles can be sold, but if not we would advise giving them to some society that makes a practice of selling clothing for a nominal sum to art students.

Most packages sent in bring joy to your heart, for you realize what comfort the contents will bring to many homes, but some other packages bring the thought that perhaps you would enjoy it more if one of your ancestors had been a rag-picker. You must learn not to despise even the rags, for you may find just the piece of velvet you need to put a collar on a coat, from which the fur collar had been ripped, or a piece of embroidery to put on a dress where lace has been taken off.

Some clothing committees make a point of repairing all second-hand clothes sent in, others do not repair any of it; it seems as if a middle course might be of most value. To help people to help themselves should be the first aim of social service. To give a boy a pair of shoes needing some slight repairing and have him exclaim, “Me uncle is handy, he’ll fix it!” and to give a woman a dress with a tear in it and have her say she can mend that nicely if you will give her a small piece of goods, will be of more help to those people than if the shoes had been sent to a cobbler or the dress had been mended before the boy or woman saw them, also think of the effect on “me uncle.” In some cases the repairing should be done, but whether it is done for or by the recipient should be left to the judgment of the worker in charge of the case.

The problems presented by the new clothing are many of them the same as those which enter into the management of a small store. Your funds are probably limited and you must make the best use of them; at the same time you must have on hand a supply of staple articles. You must be careful not to overstock, for you may find that you have some of your small
capital tied up in an article which you will not need again for six months. At the end of a season if you find you are coming short of any article, it is better to take a chance of having to buy one or two of that article at retail, than to carry over to the next season a dozen or more which have been bought at wholesale.

Heavy undershirts and drawers, flannel nightclothes and sweaters for men, women and children, stockings for women and children, socks for men, flannel bloomers for girls, rompers for children up to six years of age, and baby layettes will be needed in large quantities. Some of these garments you must have on the shelves of your clothes room the year round, others need only be there during the winter months.

The donations of second-hand clothing do not in any way cover the need for the warm clothing, and it cannot be expected that they ever will. The people who send in clothing live in steam-heated homes and have no need for warm underwear and flannel nightclothes or heavy stockings. The underwear and stockings you cannot have made; therefore they must be bought, unless the Needle Work Guild of America comes to your aid with one of their splendid donations of new garments. Sweaters and woolen socks are much too expensive to buy, so you will have to rely on the friends of your social service to donate these articles.

If you have groups of people sewing for you, such as a Junior Auxiliary, Church Societies or Sewing Classes, it will pay to have flannel nightclothes up to the 16-year-old size, flannel bloomers, rompers and infants' clothes made, even if you have to supply the material. It is cheaper to buy the large size nightclothes.

There are three types of sewing classes, each one useful to a Clothing Committee, and the committee having at least one of each kind of these sewing classes working for it is indeed fortunate. First is the sewing class organized and managed by the committee. At the meetings of this class the members sew on garments prepared by the committee out of material bought by it. These members will pay from $3.00 to $5.00 in dues, and the money received in this way will more than cover the cost of material used by them. Second is the group of women who
are organized and can supply their own material; all they will want from you is a pattern of the garment you would like them to make, and instructions as to what material you want them to use. Finally there is the group of women who like to meet to sew and chat, but cannot afford to give anything more than their time, so to this group must be given both material and patterns.

When first taking charge of a Clothes Room the inclination is to keep several sets of records, one set to be kept in such a way that you will know at any time what you have in stock. After trying two different ways in which to do this, I abandoned it entirely, and came to the conclusion that here again a clothes room is like a store. Stores take stock twice a year to learn what they have on hand. If they could tell this from their records, they would not go to the trouble and expense of stock-taking. Why should a Clothing Committee try to accomplish what the commercial houses do not seem to attempt? If when putting clothing in a clothes room, all the second-hand clothes for women are put on certain shelves and the new clothes for women put on the shelves just above, the same arrangement being used for the men's clothes and the children's any one familiar with the room can tell at a glance if the supply of any kind of clothing has become so low as to need replenishing.

The place where the bed clothes of an institution are kept is spoken of as a "Linen Room." Can you remember when it was called a "Linen Closet"? Now that Hospital Social Service has come to stay and Clothing Committees are recognized as an essential branch of the work, let us do away with the "Clothes Closet" and be promoted to a "Clothes Room." A room with at least one window, two rows of deep drawers and then as many rows of shelves as there is space for between the top row of drawers and the ceiling. These drawers and shelves should be built on all sides of the room, only leaving space for the door and window. The shelves to have sliding glass doors, and all the shelves and drawers fitted with locks. A long, narrow table, made higher than the ordinary table, on which to fold and sort
garments, and a stepladder should be the only pieces of furniture in the room. This is the picture of an ideal Clothes Room.

A thorough scrubbing twice a year, a coat of paint every other year and an occasional dusting when a shelf becomes empty, will keep a clothes room in good condition. All renovating should be done between seasons. This is also a good time to take stock. In the spring all winter clothes should be brushed and packed away with moth balls in deep drawers or trunks for the summer, then summer clothes which had been put away the preceding autumn should be returned to the shelves.

Records of all garments handled by the committee should be kept. It is essential for an intelligent direction of the work, that the chairman know how many new and how many old garments have been donated, how many garments have been bought and the number that have been made, either by the committee or by sewing classes organized by the committee and working under its direction. These records of incoming garments are comparatively simple, because all garments should be inspected by some member of the committee before being put on the shelves, and a record can be made of them at that time. The records for the outgoing garments are a very different matter. It is not feasible to have a member of the Clothing Committee present all day and every day, so these records must be left to the worker. For that reason they must be few and simple in form, so as to take as little of her time as possible. These records should show the name of the person receiving the clothes, if an adult, the size of the clothing used, and if a child the age, the name of the worker in charge of the case, and the committee under which she is working. The simplest way the writer knows to accomplish this is to have slips printed in size about 3x5 inches. These slips to be made into pads.

When a worker needs some clothes for a case, she takes what she needs from the clothes room and makes a slip. At the next meeting of her committee she presents her slips for the Chairman's signature. This enables the Chairman of each committee to know which ones of their cases are receiving clothing relief, and how much. Once a month these slips are sent to the
Chairman of the Clothing Committee. These slips will read something like this:

THE CLOTHING COMMITTEE

will please deliver to Miss Miller

for John Doe

the articles itemized on the back of this order.

M. J. Hodge,

Chairman

Child Welfare Com.

Size. Age 10

On the back of the order is written, "1 overcoat, 1 undershirt, 2 pairs stockings (new)." All articles not marked "new" are understood to be second-hand. The time consumed in making out these slips is small; even if a worker had five or six to make out at one time, it would not be a burden. This system does take for granted the closest kind of co-operation between the workers and the heads of the different committees, and it has the great advantage of leaving the clothes always at the disposal of the worker. At the end of a month, when the slips reach the Chairman she has a definite record of what has been done. She can learn from the slips the amount of clothing given through each committee, the amount given by each worker, the number of garments given to each case, and what they are. She also knows the number of individuals helped and what proportion are men, women, boys, girls or infants. The sizes most in demand and to what extent the second-hand clothing has been able to meet the need.

This method of recording the clothing originated at St. Luke's Hospital Social Service, and has been in use for a little more than two years. The first year records were kept of 2,004 garments. At the end of the year there was a difference of two garments between the records of the garments received and the garments distributed. The records were not as accurate the second year, but the difference was less than fifty garments, and it is accounted for by the fact that several workers left to do war work,
and it took a day or so for the new worker to understand the importance of the slips.

If this article has shown that a clothing committee can be made an asset to a social service department and so becomes the means of starting a clothing committee in a social service department already in existence; if it has made it plain that a clothing committee is a necessity, so that no group of people interested in hospital social service will think of organizing a department without such a committee, and if some committee now in existence is discouraged from lack of funds, has been shown how to get money through sewing classes, then the article has not been written in vain.

JOURNAL OF INDUSTRIAL HYGIENE

A new publication, The Journal of Industrial Hygiene, which will cover the problems of industrial hygiene and sanitation, community hygiene, reconstruction and vocational training of disabled employees, etc., is to appear in May. This magazine is to be published by Macmillan Co., N. Y. Price $5.00 per year.
THE FOLLOW-UP WORK AT PRESBYTERIAN HOSPITAL

E. T. PATTERSON, R.N.

Instructor of Visiting Nursing and Social Service
Presbyterian Hospital, New York

A follow-up system for medical and surgical cases was inaugurated in the Presbyterian Hospital in August, 1914. A small group of physicians and surgeons with vision realized how such a service might assist the hospital, the doctors, and especially the discharged patients. The first purpose of this work is to give the patient more efficient care. The second is to save the hospital beds by preventing unnecessary relapses; and the third, the education of the physicians who, by following the patient, get accurate information as to the ultimate results of their treatment. The possibility of the work along the line of research and teaching is also of great value.

Machinery of the System

When it became apparent that follow-up work was an essential part of the work of any up-to-date hospital, it was thought necessary to have a unit history. This was accomplished by giving each patient, on first entering the hospital, a number which was put on the bedside card and on the history. This same history number is used on every future return of the patient to the hospital. If transferred from one department to another, the patient's history accompanies him, and other notes are added. If a patient has been admitted from the Out-Patient Department, the dispensary history is sent to the ward with him, and subsequently bound with the hospital history on discharge. Should this patient later go to the Out-Patient Department, either for treatment, "follow-up" work, or observation, his history accompanies him. All notes are made in the bound unit history. Furthermore, should the patient be re-admitted to the wards of the hospital, the same bound history is sent to the ward with the
The Follow-Up Work at Presbyterian Hospital

patient. No matter where the patient is treated in the hospital, he has but one record.

The names of the patients are given to the follow-up nurse by the head nurse in charge of the ward. So, before discharge, the ward patients are seen by the follow-up nurse who explains why he should return. She leaves with him the following printed instructions:

ADVICE AND INFORMATION FOR

Please read the following pages carefully and bring this pamphlet with you when you return for your visit on.................................................

If you have a private physician, report to him to let him see the result of your treatment.

You will be given a card asking you to come back to see us on a definite date. Please make it a point to return on that date at nine o'clock. You will then see the surgeon who was in charge of your operation. You may be asked to come back a few times more for observation. This is very necessary after an operation because it is the only way in which we may know the result of the operation, and at the same time be able to give you personally what advice may be necessary.

The reason why this pamphlet is given to you is to give you the advice necessary to patients who have been operated upon or have had hospital treatment. After operation and after hospital treatment, certain rules of health must be understood and followed in order to insure the surest, quickest possible return to health. Since this hospital began to ask patients to return regularly after operation for advice and observation, we have learned that many patients do not receive or did not understand this advice which you will find on the following pages.
Please read this advice repeatedly and become thoroughly familiar with it before leaving the hospital. Ask questions if the advice is not clear to you. When you come to see us on the date written on your card, let the doctor who examines you know whether you have followed our advice.

Upon leaving the hospital, you will have probably lost weight; you will not feel as strong as you did before coming in; you are likely to be constipated and may have certain symptoms which sometimes follow your particular operation.

For some time you may notice that you tire easily and cannot resume your work as soon as you had expected. This usually is the case after operation. Do not let it worry you. Resume exercise gradually, being careful to stop when tired, but do a little more each day than the day before. Get as much sleep as possible. Rest for an hour after each meal, if possible, but always after the midday meal by lying down flat on the bed, relaxing all your muscles.

Try to get as much sunlight and air during your convalescence as possible. If you go to the country, this will be easy. If in the city, try to get into the parks, recreation piers or on the roof several hours a day.

EAT—

Eat slowly and at regular hours. Eat plenty of vegetables, especially green vegetables; brown, whole wheat, rye, or bran bread; fruit in season or stewed fruit once a day.

DRINK—

Drink at least eight glasses of water daily, buttermilk or one of the prepared sour milks rather than sweet milk.
DO NOT DRINK—

Do not drink more than one cup of coffee or tea daily. Avoid alcoholic drinks with the idea that they are necessary to your health, or that they will do you any good. Alcohol is a poison and you should know it.

BATHING—

While dressings are still on use sponge bath. After dressings are removed take daily baths. Daily baths are very beneficial as well as desirable.

Constipation

Constipation is common after operation. It is not due to the operation itself, but is due to the restricted diet, lying in bed, catharsis, and, most of all, by the irregular bowel habits learned in the hospital. After you leave the hospital, this constipation can and should be corrected immediately to prevent a great deal of future trouble. Let us impress it on you that this disturbance causes more misery than is credited to it. Constipation is cured by the following rules. They are simply rules of health and common sense and always work. Follow them carefully and you will have no trouble. Neglect them and you will suffer.

1. CATHARTICS.

Avoid all cathartics or medicines which make the bowels move. These cathartics contain a substance which irritates and inflames the bowels and naturally this causes a mild diarrhoea, depending on the dose of the poison. The movement which results from this medicine is not at all like a normal one. Avoid all enemas, suppositories or any other artificial means, since they are absolutely unnecessary for correcting chronic constipation.
2. HABIT.

You must train your bowels to move at a definite time each day. *Never permit them to move at any other time.* If you do, the bowel will forget the time at which it is supposed to move, and you will again become constipated. In addition, eat your meals at the same time each day. Also get up and go to bed at the same times each day.

3. DIET.

You must eat food which, when it is digested, leaves plenty of unused material. This material will collect in the rectum and form a large bulk which is necessary in order to have a proper movement. The foods which have this residue are as follows: Asparagus, spinach, string beans, carrots, turnips, lettuce, celery, sauerkraut, cabbage, brussels sprouts, boiled onions, corn and greens of all kinds. Eat two cupfuls of any of the above foods during the day, dividing it up to suit your taste. Also eat either oatmeal, shredded wheat, cracked wheat, black bread, bran bread, oatmeal bread, rye bread, or whole wheat bread. Eat fruits at least once a day; fruit in season, and especially stewed fruits.

Eat sparingly of the foods which contain no residue, such as: Rice, barley, farina, gruel, white breads and potatoes. These are all good foods, but contain little which is left over, and consequently contribute very little to the bulk down in the rectum.

4. WATER.

Drink at least eight glasses of water a day. This is not only necessary for your general good health, but will aid in the softening of the residue left from the coarse vegetables mentioned above.

The following schedule is designed for your particular case in order to teach the bowel the habit mentioned
The Follow-Up Work at Presbyterian Hospital

above. Follow the schedule carefully since it is important that all the acts be performed at precisely the same hour each day.

............Rising hour.

............Drink two glasses of cold water or one cup of hot water while dressing.

............Breakfast.

............Go to the toilet for the bowel movement. Do not strain. If the bowels do not move after ten minutes, don't worry, but wait until the same time next morning. DO NOT PERMIT THEM TO MOVE AT ANY OTHER TIME IN THE DAY. This is very important.

............Drink two glasses of water.

............Luncheon.

............Drink two glasses of water.

............Dinner.

............Eat some fruit. Drink glass of water.

............To bed.

DO NOT TAKE MEDICINE OR USE ARTIFICIAL MEANS TO MAKE THE BOWELS MOVE.

On the loose sheet inserted into this folder are the particular items of information and advice which deal with your particular case. If you do not understand them, or wish further information, let the House Surgeon know, and he will supply what you wish. Again, let us urge you to come back to see us at the given date and time, in order that we may accurately know the result of your treatment here and give you such advice as can come only from those who perform the operation upon you. If you have a doctor, show him this card and ask him to call on us for any information he may wish.
A 3x5-inch follow-up card on which is his name and history number is also left with the patient. The return date on the patient's card is filled in by the House Officer.

**FOLLOW-UP CARD—Front**

<table>
<thead>
<tr>
<th>Name</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please come to the Out-Patient Department, Madison Ave. and 70th St., at 9 A.M. on</td>
<td></td>
</tr>
</tbody>
</table>

If you change your address, please send new address to The Presbyterian Hospital Record Room 41 East 70th Street, New York City

ALWAYS BRING THIS CARD

**FOLLOW-UP CARD—Back**

<table>
<thead>
<tr>
<th>Date of Next Return</th>
<th></th>
</tr>
</thead>
</table>
A date is set which corresponds with the time that the Attending Physician or Surgeon in charge of the case is on duty in the Follow-Up Clinic. If the patient is referred to some special class in the Out-Patient Department, he sets a date to correspond with the time when that class meets. The House Officer is provided with a schedule showing when the classes meet, and what physicians are on duty in the Follow-Up Clinic. He must exercise care not to set dates of Sundays and holidays. In case the patient is a nurse, doctor, or private patient, the House Officer so indicates on the discharge card, and adds in his final note, "This case not to be followed."

When a patient is discharged, his history and bedside card are sent to the Record Room. From the bedside card the Record Room Clerk makes out the patient's 5x8-inch calendar Follow-Up Card.

### CALENDAR FOLLOW-UP CARD—Front

<table>
<thead>
<tr>
<th>NAME</th>
<th>HISTORY No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>AGE</td>
<td></td>
</tr>
</tbody>
</table>
On reverse of this card there are three calendars similar to the above.

This Follow-Up Card is placed in a dated card index file under the date of return. The history, after the sheets are assembled in their proper order, are stitched together on a bookbinder's sewing machine. If the patient is a re-admitted case, the new history with the former history is stitched together in the same cover.

The routine work of following up a patient begins in the Record Room. When the appointed date arrives, should the patient fail to appear, the date on the patient's calendar card is advanced and the card itself filed under the proper date in the dated card index file. If he has not returned at the end of the week, the calendar card is advanced one week and the following form letter is mailed:

We asked you to come to the hospital on............ and have not yet heard from you. As we explained in the last notice, we wish to find out your present condition.

The treatment in the hospital gives different results
in different individuals. It is therefore extremely im-
portant that we should know your present condition
in order that we may be able to give you correct advice
and at the same time complete our record of your case.

If you will call at the hospital...............you
will be directed to the Doctor with whom you are to
consult.

Very truly yours,

If at the end of the week he has not yet appeared, his name
is given to the Follow-Up nurse, who is allowed two weeks to
bring him back to the hospital. If he has not appeared at the
end of that time, his record is given to the Medical or Surgical
Follow-Up Committee. These committees of doctors decide
whether the case should be followed further.

When a patient lives out of town, he is not visited by the
Follow-Up nurses. Instead, a second letter as follows is written
asking him to come back if possible:

My dear.........................

We asked you to return to the hospital for examina-
tion on.........................and suppose you
were unable to do so, as we have not seen or heard from
you. We would like very much to see you personally,
but if it is absolutely impossible for you to come to the
hospital for examination, will you please answer the
question on the enclosed blank, so that we may know
your present condition as well as possible.

As we told you in the hospital, the result of treatment
or an operation differs in different individuals. It is,
therefore, very important that you should be examined
occasionally for a considerable period. It is for this rea-
son that we are anxious to find out your present con-
dition.

Kindly answer as clearly as possible, and if you have
a family physician kindly send us his name and address.

Very truly yours,
In this second letter the following information blank is enclosed, which he is asked to fill out in case he cannot return:

**Surgical Condition**

Effect of treatment on chief complaint (pain, deformity, function, etc.)

Wound closed...........months after operation.
Symptoms developed since operation.

**General Condition**

Weight. Present weight. _

Strength. Present strength ....% of normal. _

Appetite. Present earning capacity....% of normal.

Work resumed.

Bowels (regular) with catharsis.
" (irregular) without catharsis.

General body systems.

If nothing further is heard from the patient after two weeks, the following letter is sent to the family physician if he is known:

Dear Doctor: .................has been discharged from the hospital.

We have asked........to return for observation, but have not seen or heard from........or seen........recently. We would appreciate any information you might give us concerning present condition, in order to complete our records.

We thank you for your co-operation in this matter.

Very truly yours,

........................
Record Clerk.
Occasionally the patient is located in another hospital. In such cases, the following letter is sent to the Superintendent requesting information concerning this patient.

\[ \text{........... is reported to us as being in your institution for treatment.} \]

Would you kindly give such a transcript or abstract of the record as will indicate to us the present result of the treatment received by the patient in this institution.

The diagnosis and treatment were as follows:

\[ \text{Diagnosis:} \]
\[ \text{Treatment:} \]

Thanking you, we are,

Very truly yours,

Record Clerk.

To save time, all these form letters are printed. The patient's name and address is merely added.

**The Follow-Up Clinic**

The patients, returning on dates specified to the Out-Patient Department, show their Follow-Up Cards, and are referred to the Follow-Up Clinic. The history is obtained by messenger from the Record Room. Some patients forget or lose their Follow-Up Cards, so, to avoid errors, each patient's name is looked up in the name file where the unit history number, if any, is recorded. The Follow-Up Nurse determines whether the patient has returned for some form of treatment only, or for follow-up. If the latter, she sends him to the proper room. If the former, she takes the temperature and pulse, weighs the patient, and records the data on his history. The doctor conducts his examination, makes his notes, indicates the results of the various operations or treatments, and either closes the case or gives the patient a new follow-up date. At the end of the clinic, all histories are returned to the Record Room, and the return date entered on the calendar file.
Every human being has, at certain times, a natural craving for sympathy, especially during illness. Not only does the sick man need sympathy, but he needs human interest, encouragement and advice to help him obtain the all-important right mental attitude and control which aids so much in overcoming physical defects. This help from without naturally falls to doctors and nurses, and perhaps more so to the nurse who has more time and opportunity to get into closer contact with the patient than the busy doctor. The Follow-Up Nurse does just what her name implies. She follows up our hospital patients. Her tools are sympathy, tact, interest, and perseverance. Her first interview with her patient is in the ward where she visits and makes his acquaintance a day or two before he is discharged. As has already been stated, he is given his Follow-Up Card with return date, and, what is more important, he is told the reason why he is asked to return. He is told of the Follow-Up Clinic, of the doctor who will want to see him, and that the nurse herself will be there to welcome him on his return.

Several hours each day the Follow-Up Nurse spends at the Follow-Up Clinic where she sees the same patients whom she visited in the wards and in their houses. She thus becomes the link between the hospital and the outside world. Before or after clinic hours, she writes up the results of her home visits on the hospital histories in the Record Room, and then makes rounds on the wards assigned to her. The rest of the day she spends "Following-Up." Perhaps it would be interesting to know just what this means.

Besides the patients who gladly present themselves for examination at the appointed time and the ones whose memories are jogged up by a form letter sent after their failure to report, there are many trailers who must be rounded up personally. These can be divided into three classes: First, there is the well-known class whose experience in the wards has not been all that was anticipated. The treatment or operation did not bring immediate return to health as expected. In other words, they
The Follow-up Work at Presbyterian Hospital
did not “get their money’s worth.” Finally they find themselves at home and alive, only to be “followed up.” Then again there is the shiftless crowd whose whereabouts it is a matter of days to discover, although they may be willing enough to be the object of interest to whomsoever wills, when once found. It is hard to locate these cases. They are continually on the move. These patients naturally take most of the nurse’s time, for they have to be traced through relatives, friends, landlord, or real estate agent, church or society, by neighboring shopkeepers or by means of the Post Office Department. When once found, you must sufficiently re-educate, implore, or torment the victims until a full consciousness dawns upon the ex-patient’s mind of its real worth and importance. Then he is requested to report from time to time at the Follow-Up Clinic. The third class is composed of a certain small percentage of the so-called inoperable cases who have at best but a short time to live. These, when found unable to return, are turned over to the care of our student District Nurses. Thus, they still have the interest of the hospital as long as they live. The hospital in return is able to follow the course of the disease and obtain a complete and final report on the case.

The Hospital

In the old days a patient would often lose all contact with the hospital on being discharged. As a natural result, he would go to another institution if ill again, where he would meet with another group of strangers. It is now our endeavor to have the hospital act as medical advisor to these people. We try to make them feel sure there are doctors and nurses who are interested in them—not merely as cases, but as individuals as well. Furthermore, that we are anxious to have them feel that the hospital is the place for them to return to when in need of help of any kind. Many of the patients have been referred to the Social Service Department for convalescent care, surgical appliance, help in obtaining work or financial aid.

As the patients are kept under observation for a long time and from the very nature of the work the number of patients is constantly increasing. As the nurses cover the Boroughs of Man-
E. T. Patterson, R. N.

In Manhattan and the Bronx, we have been most fortunate in having, through the interest of the Board of Managers of the hospital, the use of a car and chauffeur. This means that many more patients are visited than would otherwise be the case. We feel that the good which the Follow-Up service accomplishes and the comfort it has brought into the lives of the people whom the hospital serves, more than justifies the financial outlay it requires.

---

NURSES AND HEALTH DEPARTMENT

It is greatly to be desired that social service nurses throughout the city should be enrolled as an auxiliary to the Health Department. There are innumerable homes which the social service nurses enter, which, on account of the limitations of staff, the representatives of the Health Department rarely, if ever, visit. In such homes, the social service nurses, if they were recognized as having a semi-official connection with the Health Department could serve many useful purposes, both in the enforcement of the law and in public health education. The authority which they would derive from such association with the Health Department would also make it possible for them to correct violations of the law which they might observe in their daily rounds, and thus they would greatly assist the Health Department in its activities, and they would multiply the agencies for public health education and public health service.

DR. LOUIS I. HARRIS,
Director, Bureau Preventable Diseases,
New York City Board of Health.
THE NUTRITION CLASS—AN OPPORTUNITY FOR PREVENTIVE WORK

MISS LUCY OPPEN

. The Child Health Organization, New York

The problem of the “Recurrent Case” or “Repeater” presents, on the surface, one of the most discouraging phases of the work of the hospital social service worker. When attacked fundamentally, however, it becomes a stimulating opportunity fraught with rich possibilities of constructive work in a field which has been as yet little explored.

The typical recurrent case is known to many members of the hospital staff in many departments. He appears first in one clinic, then in another, for minor repairs. Now and again a serious breakdown occurs, and he makes his appearance in one of the wards. Always there is “something the matter” with him. He appears to have no vigor, no stamina, no ability to resist whatever disease happens to be making the rounds. Often a weakness of will accompanies the general weakness of body. The amount of time and energy which these patients absorb cause us, in moments of depression, to wonder whether our attempts to patch up these inferior organisms, are after all worth while. “Perhaps”—comes the insidious thought—“it were better to follow the philosophy of Nietzsche, with its glorification of physical strength, rather than to attempt by such futile, patchwork methods, to invert the law of the survival of the fittest!”

The attempt to make strong men and women out of this inferior human material sometimes seems about as successful as trying to carry water in a sieve.

When, however, we begin to attack the problem of the recurrent case with a thoroughness which gets at root causes, the work leads to some of the most inspiring opportunities in the field of preventive medicine and social readjustment. It is quite true that in working with adults, the task of the hospital social service worker is frequently one of shreds and patches. The real problem is that of preventing in the growing child that
condition of low vitality and physical defect which culminates in the physically inferior adult. In an overwhelming number of cases, these incapable adults were the malnourished children of yesterday, and if we would harness our energies where they are likely to bring the most fruitful results, we must learn to distinguish and build up the malnourished child.

"Malnutrition" is a condition whose significance is just beginning to be appreciated by the medical profession. It has always existed, but only recently have we taken cognizance of it as a definite departure from health which should be recognized just as is tuberculosis. It has certain definite causes and definite after-effects. Moreover, some of these after-effects can never be entirely overcome. The child who during his growing years suffers from serious malnutrition will never be so strong and capable as he might have been. Malnutrition is in the great majority of cases preventable and curable. In its recognition and eradication the hospital social service worker will find an unparalleled opportunity for raising the standard of health in the community.

The draft revelations are by this time sufficiently well known to need no repetition. The American people have discovered that we are not the physically superb race we supposed ourselves to be—that one out of three of our young men who ought to be in the most vigorous years of their lives, were physically unfit to bear arms when their country called. The condition of the school children of the land is not so well known, but it points to the cause of this lack of physical vigor in adult life. It has been estimated by our best medical and educational authorities that approximately one child in four—in all about six million children—are suffering from a condition of malnutrition. It is these malnourished children who recruit the stream of "recurrent cases," who absorb so much of the time and energy of the medical worker.

"Malnutrition" is not necessarily the result of poverty, or even of a lack of the right kind of food. Anything which will prevent the intake and assimilation of the right kind and amount of food must be regarded as a cause. Uncorrected physical
defects, such as tonsils and adenoids, bad health habits, acute
disease, ignorance, poverty and overcrowding, faulty school hy-
giene—all these are common causes of malnutrition in children.
The case of each child must be carefully considered, and the
causes of his condition searched out and eliminated through
proper medical attention, education in hygienic living, and espe-
cially by training in food knowledge and correct food habits.

Considering the ease with which malnutrition is detected, it
is surprising that in the past so little attention has been paid to
it. The child with a faulty heart or kidney, or a tuberculosis
lung is immediately given attention in the proper clinic, but the
child who is simply "delicate," who has no definite troubles, but
who yet seems to be generally below par, has been the concern
of nobody in particular and left to shift along as best he might.
In order to prevent his drifting from clinic to clinic, in order to
give him the thoroughgoing attention his case requires, the Mal-
nutrition Clinic, or better, the Nutrition Class, has been devel-
oped. The success which has attended the malnutrition clinics of
Dr. William Emerson in the Massachusetts Hospital and Dr.
Charles Hendee Smith of Bellevue Hospital, has recently resulted
in their establishment in many other hospitals throughout the
country. It is to be hoped that in the near future no hospital
social service department will be without its nutrition class, and
its workers trained to deal intelligently with this problem of
ever-increasing proportions.

Although the causes of malnutrition are sometimes obscure
and complex, its detection is simple. It requires no expert
medical knowledge or microscopical examinations. The weight
of the child and his rate of gain usually tell the story. The mal-
nourished child is always under weight, and one may class as
malnourished every child who is as much as 10% under weight
for his height. Such children are usually pale and anemic, in-
attentive, listless in their studies, and disinclined to run and play.
They are easily fatigued both mentally and physically, and are
often retarded in their school work. The muscles of the mal-
nourished child are soft and flabby. He is peculiarly susceptible
to disease, and is always catching whatever disease happens to
# Class-Room Weight Record

**Health in Education**

**Education in Health**

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Height</th>
<th>Year</th>
<th>Actual Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**RIGHT HEIGHT and WEIGHT FOR BOYS**

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**ABOUT WHAT A BOY SHOULD GAIN EACH MONTH**

- Age 2-3: 1-2 pounds
- Age 4-5: 1-2 pounds
- Age 6-7: 1-2 pounds
- Age 8-9: 1-2 pounds
- Age 10-11: 1-2 pounds
- Age 12-13: 1-2 pounds

**RIGHT HEIGHT and WEIGHT FOR GIRLS**

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**ABOUT WHAT A GIRL SHOULD GAIN EACH MONTH**

- Age 2-3: 1-2 pounds
- Age 4-5: 1-2 pounds
- Age 6-7: 1-2 pounds
- Age 8-9: 1-2 pounds
- Age 10-11: 1-2 pounds
- Age 12-13: 1-2 pounds

Height and weight to be taken in house clothes, without shoes. Weigh on the same day each month. For additional advice on how to use this Record Sheet and other material, apply to the CHILD HEALTH ORGANIZATION, 309 Fourth Avenue, New York.
be in vogue. The first step in building up the vitality of such children consists in finding the causes of their failure to assimilate food, and then eradicating these causes as quickly as possible.

Although poverty and insufficient food are a frequent cause of malnutrition, it will be found that the undernourished child is, as a rule, the product of a defective health program in which many interwoven factors act and react on each other. The whole situation points to the need of some thoroughgoing education in right habits of living, and it is essential that the hospital social service worker shall get the co-operation of the child and make the small patient willing and eager to do those things which will help put him into top-notch physical condition. It has been found by Dr. Emerson, Dr. Smith, and all the other workers who have been interested in developing ways and means of getting the co-operation of the child, that the best point of attack is to interest the child in his rate of increase in weight, as an index to his general health. Every child can be interested in the Game of Health. The child whose monthly rate of gain in weight is below normal is losing points in the game of health. In order to play a winning game, he readily understands that he must obey the rules of the game. These rules of the game, as formulated by the Child Health Organization, are:

1. Drinking as much milk as possible, but no coffee or tea.
2. Drinking at least four glasses of water a day.
3. Eating some vegetables or fruit every day.
4. A full bath more than once a week.
5. Brushing the teeth at least once every day.
6. A bowel movement every morning.
7. Playing part of every day out of doors.
8. Sleeping long hours with windows open.

It has been found that by arousing the group spirit and spirit of competition, more effective work can be done than when the child is dealt with individually; hence it has been found that the best way to give children definite training in the fundamental laws of health is to gather them together in a Nutrition Class. The Nutrition Class should meet at least once a week and may be conducted in public schools, settlement houses and play-
grounds, as well as in the Out-patient department of hospitals. The class should always be under the supervision of a physician, but it is upon the hospital social service worker that the success or failure of the plan depends. It is she who must weigh the children, keep their weight charts and decorate them with the gold or silver stars which denote satisfactory progress as a result of obeying the laws of the health game. It is, moreover, the social service worker upon whom devolves the duty of seeing that one of the parents of each child is present at each class meeting. It is the social service worker, too, who carries the gospel of right living most effectively into the home, and it is she who must frequently reconstruct the home before conditions of right living are even possible there.

A careful medical examination of every child at the outset, and a careful history, are highly desirable to avoid the mistake of considering as cases of simple malnutrition children suffering from some actual disease. Such examination should aim to detect organic disease, such as tuberculosis, syphilis, etc., as well as physical defects, like decayed teeth, diseased tonsils, enlarged adenoids, defective vision or hearing, flat feet or other deformities.

The first step of the physician is to make a careful diagnosis in each child's case. This must include a study of his history to discover if any past illness has influenced his nutrition, a study of his habits of life, his diet, and of all the social factors in the home which affect the child. These facts, including those ordinarily kept on separate social service records, should all be recorded on the history, so as to be available at once. The physical examination should be as complete as possible, including the weight, height, and chest measurements.

When a child is admitted to the class, every detail of his daily life and hygiene must be gone over with him and with one of his parents. The importance of sleep, fresh air, sufficient exercise, good habits of eating, and all other matter of hygiene must be dwelt upon in detail. Especial attention must be given to the diet. Printed directions in diet and hygiene should be explained by the physician or nurse, so that they are understood and may be
studied at home. This individual attention at the beginning is essential, because it starts each child out with the feeling that a personal interest is felt in him and in his life.

Remediable defects should be corrected as soon as possible. Decayed teeth (even if only the first teeth) should be filled or extracted. Enlarged adenoids and diseased tonsils should be removed as soon as the child is in fit condition for the operation.

At subsequent meetings class talks may be given to groups of children and parents. In these talks the same points are repeated and discussed in detail. Talks on foods should consider their cost, their relative value and their digestibility; what foods are necessary, useful or harmful; what variety and quantity should be taken. With intelligent children and parents, actual caloric values may be taught. When dealing with the ignorant, the talks may well be confined to simple instructions as to the best kind and amount of food which can be obtained at the lowest cost.

At each return visit, the child is weighed. The height may be taken at three-month intervals. The weight is noted on the child's record and also on the weight chart. Both child and parent should be questioned as to diet and daily life, and as to how the instruction given has been carried out. The child presents his home record, which shows at a glance exactly what he has done during the week. There must be a constant reiteration of the important points, such as eating slowly, chewing well, regular hours for meals, going to bed early, open windows at night, getting up early enough to have time for breakfast and a bowel movement before school, an afternoon nap or rest (at least up to school age); clean teeth and clean bodies, etc. It is necessary to demonstrate to the child that he cannot gain well unless all the laws of health are obeyed to the letter every day in the week.

It is evident from this program that the underlying principle of the nutrition class is one of education in health. This process of education is necessarily slow and exacting, and requires an almost infinite amount of patience and tact and scrupulous attention to a large number of details. The largest share of the
work devolves upon the hospital social service worker, and only a worker of the highest type can successfully meet its multi­tudinous requirements. The investment of time and energy which such work requires is richly repaid, however, by the permanent results to be achieved. It is a task, not a patching up, but a building up. The establishment of nutrition classes throughout the country will do much toward improving the health of our school children, and toward helping the 6,000,000 malnourished children in this land to develop into strong, vigorous adults living up to their highest possibilities of health and happiness.

In order to help raise the health standards of American children, the Child Health Organization, including in its membership many of the foremost physicians and educators in the country, has recently been formed. Its objects are:

To teach health habits to children and to secure adequate health examinations and health records for all children in the public schools of the country.

To consider the urgent problem of malnutrition among school children.

To safeguard the health of children in industry.

To co-operate with other bodies in securing an enlightened public opinion and legislation in these matters.

The following literature has been prepared:

1. Weight Card—Showing proper relation between weight and height for boys and girls from five to eighteen.

2. Class-Room Record—A method of interesting groups of children in weight.

3. Teachers' Service Booklet—Facts about malnutrition and ways of combating it in the classroom.

4. Demonstration Pamphlet—A report about twenty-five Food Scouts who grew strong while eating Mr. Hoover's kind of lunches.

5. Tag—Used in weighing contests to carry facts into the children's homes.

7. How to Conduct a Nutrition Class. By Charles Hendee Smith, M.D.

8. The Diet of School Children.

9. Child Health Alphabet.

Any physician or hospital social service worker who is interested in helping to work out the problem, may obtain a complimentary set of the publications named above by addressing The Child Health Organization at 156 Fifth Avenue, New York City.
MEDICAL SOCIAL SERVICE AND THE HOSPITAL ORGANIZATION

RICHARD MacKENZIE

Staff of Reconstruction Commission of State of New York dealing with Institutions

“There has come to this country the social service movement as a rebuke to our medical institutions for the narrowness of their service and the meagerness of their sociologic effort.” That was said by Dr. A. R. Warner in 1913, and it looks as if we had taken the rebuke gracefully and given our chastizer a good reception. One hospital after the other in all parts of the country is adding to its organization workers who are known as Social Service Workers.

The first organized effort recorded to do medical social service was that done by Sir William Blizzard, of the London Hospital, in 1791. That effort was little known, but today this form of service is of sufficient importance in this country to warrant the publication of a quarterly devoted to the subject. In this country the greatest credit is due those men of great vision and understanding who first conceived the idea in this country and have proven not only the advantage of such service, but the necessity for it.

But to give the fullest service, hospital social work must coordinate with the general understanding of the scheme of Public Health work and the hospital organization. It would be a difficult task to grasp the general scheme of the whole movement and chart it out with this new service shown in its exact relation to Public Health work, which is sometimes under the management of the city administration, or sometimes under a private association or institution. I have been astonished at the number of organizations which are independently working out a Public Health scheme. Literally scores of them, overlapping and duplicating, and still we speak of organized charity. Fortunately
a start has been made to have a clearing house for these organiza-
tions, and an attempt to co-ordinate the many different move-
ments.

The great need for medical social service can be realized after
Dr. Devine, in his book on "Misery and Its Causes," shows that
in the thousand families taken as a basis of his statistics, 75% of
these families asked aid of the Charity Organization Society be-
cause of some form of physical disability.

In order to find the niche which this new form of service is
to occupy in the general scheme, let me quote from M. M. Davis,
Jr.: "Medical Social Service is part of a very much larger move-
ment which has many sides, because there is not only infant
mortality and tuberculosis, but also the movements dealing with
mental diseases, with the problems of obstetrics and the super-
vision of pregnancy, and with the health of industrial workers.
. . . Medical Social Service has one foot in the institution,
and one foot in the field. . . . The community organization
of health work is a form into which we need to fit our organiza-
tion of Medical Social Service. . . . The relationships of
Medical Social Service are largely institutional, that is, we reach
the community by starting with the institution; whereas the
Public Health movement as a whole BEGINS with the com-
munity and reaches INTO the various types of institutions."

I believe we are all in accord with Mr. Davis in selecting the
hospital as the home for this form of service. What is it called?
Social Service, Hospital Social Service, Medical Social Service,
Medico-Social Service, Sociologic Department and Medical Aid
Service, depending to some extent on the work which is covered,
and perhaps it is better that way, for often a label is a distin-
guishing mark which not seldom has an extinguishing effect.
But a good name will help to interpret the service to the patient,
and to the public. In a certain neurological hospital the work is
called Sociologic Research, and that is the function of the depart-
ment.

Speaking of the function of Hospital Social Service in general,
Dr. Cabot said: "The social worker is needed in the hospital to
make the place less grim, to keep the standards of good manners
Richard MacKenzie

and decency higher than it otherwise tends to be, to bring to bear on hospital routine and hospital management the criticism of a friendly, keen-sighted observer, and to focus upon each individual patient all the forces of helpfulness existing in the charities, the churches, the labor unions, lodges, and other voluntary associations, as well as the opportunities for education and recreation of which the patient may be especially in need.” That in itself is a large program and an important one. It might be summed up as the “tangible evidence of the social conscience,” as Miss I. M. Cannon describes Social Service.

If a fund has been given to a hospital for social service, where will this department fit in in the organization? To help answer this question, I give several quotations to show what some of the leaders in Hospital Social Service have said of the functions of that department, and in that way the place for that department in the hospital organization may be more clearly seen. Dr. Chas. P. Emerson, Director of the School of Medicine of the University of Indiana, says: “No matter if a man leaves you a million dollars, don’t do any charity work in connection with your hospital or dispensary; because if you do, you will lose sight of the greatest charity of all—accurate medical attention.” And again he says: “The Social Service Department reaches its highest development when it is considered not as a charitable department, but as a therapy department.”

As this department relates to the training schools, part of the program of the Massachusetts General Hospital will be of assistance. As Miss Ruth V. Emerson, of that hospital, expressed it: “If a nurse is to know the various aspects of heart disease, she must know more than the medical-clinical picture; she must know also the social-clinical picture—under what conditions her patient has lived and worked, whether his tenement is on the top floor and his work that of pick and shovel. She must realize that to think in hospital terms she must know the dialect of the home and working conditions, so that Rx ‘no stair climbing, little exercise, good hygiene,’ will not be glibly quoted and handed to the patient as unthinkingly as the doctors order for pill No. 6.

“We are teaching our nurses the various curative and pre-
ventative measures of attacking disease, as well as the functions of the various departments of the hospital. So have they not a right to expect to learn the purpose and aims of that department which has been added because found necessary for the effective treatment of hospital patients?"

So far, we can say that the Social Service Department is to be the tangible expression of the social conscience; it is not to give charitable relief, but is to be a therapy department. It is to take part in the work of combating infant mortality, tuberculosis, mental diseases, and the work of obstetrics and pregnancy, and the health of industrial workers. And within the hospital to bring the opportunities for education and recreation to the patient, and to aid in the education of the nurse. Then there is the work of seeing that patients follow out instructions given by the doctor as they leave the hospital for a convalescing period.

The recommendations of the Study of Hospital Social Service in New York states that: Relief should be given as medical-social relief, such as: Special medicines, surgical appliances, special diets, transportation, convalescent relief and preventive work.

Surely there is sufficient work here for a large number of workers and teachers, who will need direction by a competent person trained for the work.

Dr. A. R. Warner wrote: "Preliminary to all other reforms, dispensaries must recognize the established principle of our better hospitals—that the medical treatment and the sociologic management of patients must be completely separated. The medical staffs of dispensaries must have undivided authority to prescribe the medical treatment for the patients placed in their care, but there should be an executive or sociologic chief and assistants in every dispensary having unquestioned authority in all matters pertaining to admissions, and direct control of the efforts to better social conditions of the patient, of his family and of the community." Dr. Warner also said: "Institutions have not generally recognized, or at least have not assumed the responsibility for the far-reaching effects of the careless, hap-
hazard work of an admission officer, and have not taken the necessary action to make this work efficient, just or anything short of a farce."

The work of the admitting officer is neither entirely sociological nor entirely medical, but a combination of both which the trained medical social service worker is best fitted to do.

One of the recommendations of the Hospital Social Service Association, as a result of its study was: "All hospital social service organizations should be distinct departments of the hospital."

One more quotation from Mr. M. M. Davis, Jr., and the main functions and also the points of contact of the Medical Social Service Department (or shall we call it the Medical Aid Department?) have been established: "The Social Service Department should be part of the organization of the institution and under the direction of the managing board and the executive officer."

From the quotations given the functions of this department in general may be said to be:

1. To aid the physician in making a diagnosis.
2. To aid in the medico-sociologic treatment of the patient.
3. To bring opportunities for education and recreation to the patient in the hospital.
4. To complete the training of the pupil nurse.
5. To do follow-up treatment and education.
6. To give medical-social relief.
7. To make the hospital less grim.
8. To direct the admission of patients.
9. To be under the direction of the managing board and the executive.

These functions bring the department in direct contact with the physician in much the same relation as the laboratories and the X-Ray in aiding in the making of a diagnosis. To the school of nursing, the relation is much the same as the laboratories
which offer training to the internes. At the admission desk, the medical aid worker would be responsible to the executive officer of the institution.

Some may say that to place this new department on the same status as the X-Ray department or the Pathological Laboratory is absurd. The answer to that might well be that to realize the extent to which this service promotes the medical efficiency of an institution one should read the literature on the subject and visit some of the hospitals of the country where the work has been developed.

The man who is interested in the business side of hospital work usually wants what makes for efficiency if it does not cost too much. But it is safe to say that methods that are really efficient, methods or work that do a real service are also the economies if we have the faith to make the venture. Dr. N. Gilbert Seymour, Director, Governeur Hospital Tuberculosis Clinic, who is in a position to speak for the hospitals managed by the city, wrote: "The social service departments in our city hospitals have made for efficiency in treatment and economy in administration, despite the expense of maintaining them—an expense which would be promptly increased by the payment of adequate salaries of our social workers. They have made for efficiency by providing etiological data not otherwise obtainable, which assists in making correct and complete diagnosis; by rendering treatment more effective through intelligent co-operation in the homes of the patients; and by adequate after care. They have made for economy by reducing recurrences and securing the completion of treatment. Finally, they have rendered the hospital acceptable to the public, which is, in itself, a service of magnitude. The social service department is the shock absorber of the institution, serving as the intermediary between the patient and his family outside the hospital, on the one hand, and between the family and the hospital authorities, on the other. The amount of friction and time saved is incalculable—it is an economy of both time and energy."
THE HANDICAPPED EMPLOYMENT BUREAU

MISS E. RIGBY

Massachusetts General Hospital, Boston, Mass.

Many more disabled persons are likely to be seeking employment for one reason or another, and since the activities of United States Employment Service for the Handicapped are suspended or permanently closed, it is most important that all interested in the development of such service should consider what the important functions of similar bureaux should be.

The first obligation of an Employment Bureau is the obvious one of placement. No longer is it sufficient for a modern employment office simply to bring employer and applicant together—for an agency receiving a call for a typesetter to look through the list of typesetters available, and send out the man who applied first. The technique of placing requires the services of one who first of all is able to make a "job analysis."

This means the worker should be able to visualize the mental and physical requirements for a large range of positions; should know the degree of intelligence necessary, the kind and amount of education and training most desirable, and what other qualities, such as judgment, tact, ability to manage men, alertness, dexterity, etc., will be needed.

From the physical point of view the worker should understand the position it is necessary that the employee maintain, whether sitting, standing, bending, walking, what parts of the body must be called into play, which motions can be eliminated. Modern industry lays tremendous and varied strains on the worker and a general knowledge of the effect of these on the eye, back, nerves, etc., is essential. There are many trade hazards from dusts, poisons and fatigue and some information along these lines also is important, so that a painter, for example, suffering from lead poisoning shall not be placed in the printing business at certain processes where there is also danger of the same disease.

It is desirable, too, that a worker should know a little of
The Handicapped Employment Bureau

the prevailing rates of wages in various trades, that no employer may use the bureau to exploit handicapped labor, and that an applicant may be advised when he is demanding more than it can reasonably be expected he will receive.

As a good placement worker will find it necessary to analyze the job registered, it will also be found essential to study the applicant mentally and physically, but first of all, it is important to understand a little of the cripples' background and treatment prior to application for employment.

The first care the handicapped person needs is obviously medical, whether he is disabled by accident or disease. This treatment often covers a period of months, particularly when his condition is caused by disease such as tuberculosis, poliomyelitis, some skin diseases, etc.

We now realize that it is during this period that many become unnerved, and for the first time feel incapable of reaching the goal of their previous ambitions. The shock that results from their condition, the pain suffered, the hopelessness of the future, together with the state of mind produced by the enforced hospital idleness, contribute to this. Remember that the Surgeon General of the U. S. Army finds occupational therapy and the curative workshop necessary to complete the treatment of the disabled soldier. The civilian has yet none of these advantages and therefore his cure is not so rapid.

After medical care is completed the cripple is usually faced with the necessity of earning his own living, only occasionally is he in a position to take vocational training. It is most regrettable that there are so few schools for the normal student that are fitted either in personnel or machinery to meet the problem of the handicapped. The result is that many a cripple finds it necessary to obtain employment when he is unskilled and he often does not realize that he no longer can sell his strength.

Too often he starts with an exaggerated idea of his own worth or else with absolute indifference and lack of initiative. The employment worker must remember that the disabled applicant has had a dreadful struggle to maintain his independence and that perhaps he is still fighting the mistaken sympathy and kind-
ness of relatives and friends, who are ready to take every burden (temporarily only) from him.

We have considered very briefly the stages through which the handicapped person passes and touched upon the subject of what his attitude frequently is when he first seeks employment. We may now turn our attention to the study the Employment Bureaux should make of him, and the most obvious thing to learn first is what is his real physical condition.

It is becoming more and more general for employers, particularly in large plants, to require all prospective employees to submit to a physical examination. In many cases this is for the purpose of eliminating a poor risk, and as long as the Workmen's Compensation Law remains unchanged this is likely to be the motive, since the laws act against the employer. The majority of firms, however, require examination in order to assist the employment manager to ascertain the physical limitations and possibilities of the applicant. If, therefore, such examination is wisely urged for normal workers, how much more is it advisable for the disabled, and how much more efficient and accurate will be the work of an Employment Bureau which requires it of applicants.

It is not difficult to explain the reason for examination to the employment seeker, and in most cities and towns there are facilities for obtaining it without expense. It is the duty of the placement worker to know of and how to use these resources.

In a large number of cases the services of a specialist will be found necessary. A tuberculosis specialist alone is competent to advise whether it is safe for an applicant to undertake any activity or how much it may wisely be increased; and only an eye specialist can correctly advise whether a certain type of work will cause such strain to one with defective vision, as to endanger complete loss of sight.

Physicians on the whole have very little idea of the strain entailed by different kinds of work in factories, and to obtain from the applicant a report that the doctor states he can do light work, or work outdoors, is not sufficient to enable placement workers to do accurate work. Thus it rests with the latter either
to have sufficient medical knowledge to be able to ask intelligent and suggestive questions of the doctor himself, or to know how to obtain information regarding diagnosis and prognosis through someone capable of giving the correct interpretations.

So far the physical condition only of the handicapped person has been considered; it is equally important to study him mentally. Bearing in mind what has already been suggested about the background of the cripple, the most likely questions to arise in the worker's mind are, what is his attitude toward employment, what are his ambitions, what are his preferences? It may happen that the cripple's plans are impractical and that it is necessary to spend much time in dissuading him from them, but it is time well spent if eventually we gain his complete confidence and co-operation. Of course his preferences should be carefully noted, for it is a poor plan which has not the co-operation of him whom it is intended to benefit, and his co-operation will be lacking unless his wishes are taken into account.

Next to his preferences naturally the education, training, and previous experience should be considered, and it is the work of a vocational guider to be able to sum these things up and advise wisely regarding industrial opportunities and the future possibilities of each.

The early treatment, or lack of it, given to the handicapped civilian, now makes necessary a most careful follow-up system. The finding of a position does not relieve a bureau of all further responsibility. The job may prove unsuited to the cripple's physical condition; mentally he perhaps has become a little warped, and a frequent word of encouragement may help tremendously. Then of course it is desirable to know from the employer's point of view whether he is receiving satisfactory results through using the Bureau. None of these things can be known unless follow-up work is done; sometimes it should be very intensive; sometimes a more casual supervision will do, but it is certain that it may in many instances prevent great catastrophe, physical, mental and social, to the disabled individual.

The second function of an Employment Bureau is that of research, and the more different kinds of disability a Bureau
undertakes to place, the greater will be the need for work of this sort. So varied are the physical conditions of applicants, that the positions they can fill will be almost as diverse and a constant search and investigation of opportunities should be carried on.

Studies have already been made of many trades to learn the physical requirements and the modification of machinery possible for cases of amputation, paralysis, limitation of muscle and nerve functioning, but so far little has been done in the study of industrial hazards from dusts, poisons, etc. This offers a tremendous field; industrial medicine is coming to the fore, and the Employment Bureau for the handicapped should be of practical assistance in such studies.

The attitude of labor toward these problems is always interesting, and pains should be taken to know accurately the trade unions and various labor groups, and their co-operation sought when working a Bureau on a large scale.

Lastly, knowledge of the law is too often overlooked, and too little is known of the laws relating to health and sanitation in factories and mercantile establishments, the hours of employment for women and juniors and the minimum wage.

All this work, however, will not require as much time as the actual placement, but it will be found very helpful to carry on some features if not all at the same time.

The keynote to good employment work is co-operation; it should start with the placement worker, who should be highly trained, and not the unskilled clerk we sadly enough expect to find in general employment work.

Unless co-operative relations are established with the handicapped applicants little can be accomplished with the employers. Granted, however, that this intelligent working together is the principle on which the Bureau is founded, efficient work will be the result, and there is no doubt that its merits will redound to the moral and physical well-being of both the individual and the community.
OCCUPATIONAL THERAPY FOR INTERNED PATIENTS

ALICE H. WALKER, R.N.

Director of Hospital Social Service, Harper Hospital, Detroit, Michigan. Social Worker, Michigan State Board of Health

In January of last year, Harper Hospital set apart one floor of fifty beds for women who were interned by the State Board of Health for treatment of venereal diseases.

Obviously it will appear that this group of women created a new problem for both nurses and social workers. The hospital is designed and equipped for the treatment of sick patients who pass through an acute illness or surgical operation, and, after a short convalescence, pass out into the world again. This new group was made up of women who were not ill, who were restless and discontented under confinement and who were very unstable and wholly undisciplined. The necessity immediately arose for supplying them with some form of occupation suited to their mental capacity and ability.

From a study made of a group of three hundred of these young women, it was revealed by Psychopathic tests that 80% were abnormal mentally. Fully 25% of this number were distinctly subjects for institutional care. The majority had not gone beyond the Fifth Grade, had received no vocational training and had been very irregularly employed at the most menial types of work. In this group the co-relation between venereal disease, prostitution and subnormality was clearly demonstrated.

Since the need for Red Cross supplies was so urgent at that time, the Solarium was converted into a workroom and with a trained Red Cross worker in charge. Tables and cupboards were provided and four sewing machines secured. The amount of supplies turned out each week was enormous. Unfortunately the Solarium would only accommodate from ten to fifteen women, which left the majority still idle the greater part of the time. Sweeping, dusting, bed-making and the serving of meals was performed under supervision.

We had hoped that we might introduce some form of voca-
tional work which would help, in a measure at least, to send these young women out into the world better fitted to cope with it than they were when they entered, but after consultation with a number of leaders in vocational work and with our psychologist, it was agreed that it would be impossible to introduce any form of work which would prove vocational considering the limited time these young women were with us and the abnormal mentality which the greater number possessed. Consequently we changed our phrasing from vocational training to occupational therapy.

The social workers who are endeavoring to rehabilitate these women when discharged from the hospital have found the industrial field offers the greatest opportunities. The majority of the factories have welfare departments. The work does not necessarily require preliminary training and the remuneration is greater than that afforded by any other job now open to the unskilled laborer. The latter consideration offers, perhaps, the greatest argument in appealing to the prostitute who has been imbued with the desire to live differently. Other tasks which she is capable of performing command such low wages that they do not appeal to her. For this reason, as well as for the therapeutic value of work, we endeavored to make some practical connection with industrial occupation.

The President of one of the large industrial concerns of Detroit very generously agreed to equip and maintain a workshop at Harper Hospital. A large, light room was selected, and the necessary equipment installed for sixteen workers to do the same type of bench-work, assembling, etc., as young women are doing in the factory and on the same wage scale. The work is supervised by an expert young woman who has been in the firm's employ for years. The workshop is open eight hours per day.

The work is optional. No one is required to do it, but rather it is offered as a privilege. Each girl who cares to avail herself of this privilege is given a factory number and is placed on the payroll. The money earned is deposited to her credit and given to her when discharged from the hospital. As a rule, each girl has an amount ranging from twenty-five to fifty dollars when
released. Many have earned much larger sums. One young woman went out recently with seventy-five dollars to her credit. She had the small sum of one dollar in her possession when admitted.

The matter of providing suitable clothing for the girls had proved a serious problem until the workshop was opened. In order to instil principles of order and neatness and to break from the slovenly kimona habit, it was found necessary to provide suitable one-piece percale or gingham dresses. The State Board of Health was unwilling to provide these gowns, hence the inroads on the Hospital Social Service funds were serious. But after the workshop was opened, it ceased to be a problem. Now each girl pays for her own clothing. The material is purchased, the girl's individual taste being consulted as far as possible, and the dresses are made by the girls under supervision of a skilled teacher. Shoes and other articles are purchased on request. This system tends to foster a commendable spirit of independence, pride in possessions and neatness in appearance.

We believe this is a long step in the right direction to be able to send these young women out from the hospital, decently clad and with a few honest dollars to tide them over the difficult period of readjustment.

When the Red Cross work was discontinued early last summer, a graduate of a School of Occupations was placed on the floor to teach rug-weaving, basketry, toy-making, wood-carving, etc. The proceeds of a toy-sale at Christmas time were set aside for the purchase of a Victrola.

Nor is all the time devoted to work. The Recreation Commission furnishes a playground worker for games, folk dancing, theatricals, singing, moving pictures, etc. The Y. W. C. A. has charge of the religious instruction of these young women and also provides many pleasant entertainments.
RELATION OF DISPENSARY SOCIAL SERVICE TO THE SYPHILITIC*

DR. ANNA M. RICHARDSON

In selecting this subject, I did not realize how distant the relationship of the Social Service to the syphilitic is in New York. Among 648 Social Service records that have been copied in connection with the Dispensary Survey, 15 are the records of patients suffering with syphilis. In visiting 14 clinics where syphilis is treated, only 3 use Social Service in any systematic way. In six there is a postal follow-up system employed more or less irregularly. Five clinics do nothing special to ensure the return of patients.

To plan constructive Social Service co-operation in the care of syphilis we must first understand present Social Service work, and secondly analyze the special problem the patient with syphilis presents.

The 648 records copied from 21 Social Service Departments give a general idea of the kind of cases now receiving assistance in these departments. Few acute conditions appear in the group, and practically no cases are referred from the surgical clinics. A few cases of influenza, operative cases needing hospital care, and pregnancy illustrate the type of acute condition referred to Social Service departments. The problem in these acute conditions is one of organization, as arranging for hospital admission, convalescent care, and family readjustment, when the patient is the mother or an essential wage earner. Plans are temporary, and while the contact frequently leads to the discovery of chronic conditions these cases are not problems of long duration.

For chronic conditions a readjustment of the mode of life of the patient and usually also those closely associated with him is necessary. The patient must either be interested to bend his energies to throw off a disease or must adjust his life so as to attain comfort if not efficiency with a physical handicap. This

*Read before Hospital Social Service Association, March 26, 1919.
process is the broadest possible type of education, for it teaches the patient how to live.

To educate in each type of chronic condition, a different emphasis is necessary. In tuberculosis, nutrition and environment are the vital elements. Muscular exercise, physical work and rest are of first importance to the cardiac. The question repeated at each visit is "Can I do more?" or "Must I do less?" In the children's clinic, as in tuberculosis, the problem is one of nutrition, or in this case growth, but differs from tuberculosis in the importance of habit formation and the absence of danger of spreading disease. The first consideration in mental and drug cases, including alcoholism, is rest from responsibility, even from self-direction. This requires custodial care or other method of preventing injury, mental or moral, to the patient or his associates.

Syphilis, on account of its various phases and long duration, presents elements of the problems of the other chronic conditions and several special ones all its own. Like the acute conditions, it attacks people irrespective of previous health. Its later stages require custodial care. The infectious nature of its open lesions require precautions similar to tuberculosis, while its possibility of transmission vastly increases the need for intelligent understanding on the part of the patient. Syphilis differs from all other conditions, with the possible exception of malaria, in the vital importance of drug administration. It is well for the patient to have a clean home and good nourishment, but his hope of cure lies in his receiving accurate medication adapted to his condition and continued with directed intervals of rest until his blood and spinal fluid show absence of disease. To add to the importance of intelligent medical care, the patient is rendered more difficult of cure by neglect of regular early treatment. As it is much more difficult to see the importance of medication, than to understand the need for extra nourishment or country care, so the education of the syphilitic by the Social Service department is more difficult than the education of any other patient. The sense of shame surrounding this disease increases the problem and
Dr. Anna M. Richardson

makes it especially difficult to get the other members of the family examined.

Many reasons are given by patients for the neglect of treatment. Their variety suggests the half truth of most of them, and leads to the belief that the real cause is inability to realize the necessity of following treatment when feeling well.

The cost of the salvarsan is the most usual complaint. In some clinics this is met by referring the patient elsewhere, which usually means that he forfeits his chance for treatment. Two clinics have a fund to pay for salvarsan raised by charging extra to the patients that can pay. Another clinic meets its opportunities by working with relief societies.

One clinic feels it should punish its patients by refusing care if they do not respond to follow-up postals and are irregular or careless in following treatment.

Although in all the clinics treating syphilis the doctors were careful to instruct all the patients individually as to the exact nature of their trouble, patients do not appreciate the importance of treatment enough to go to the expense and inconvenience of following it. To tell a patient too much discourages him, and to say too little leaves him careless. To wisely give pertinent directions, the doctor must know more of the patient's life than can be gained from talking to him. This intimate knowledge comes from the acquaintance a social visitor acquires in the understanding of the patient's ambitions. Again, the current low standards of health, make it hard for a patient to follow treatment when he has no pain. Such symptoms as weakened functions or vitality, loss of weight, fatigue or impeded gait will be tolerated, while an insignificant pain will drive a patient to seek help. Out of 240 patients coming to the General Medical Department in a New York Dispensary 90% had pain as their leading symptom.

Dispensary Social Service in New York City has probably reached its best and most uniform development in the tubercular clinic. Every dispensary case of tuberculosis is automatically a Social Service Case. This has had a most stimulating effect on the medical care. Every patient has a thorough physical
Social Service and the Syphilitic

examination, frequently repeated. While it is true that accurate physical examination is the essential to a diagnosis in tuberculosis, and that treatment is difficult without diagnosis, it does seem that better care could be given the syphilitic with more thorough physical examinations. In 12 different institutions and 192 cases, we found 99 patients had no physical examination recorded. Twenty-four of the 192 cases had heart examinations, and 42 had special sense examinations recorded, while 57 had examinations of the nervous system.

Ideally Social Service approaches its problems with a long vision. It does not temporize. This long period plan is especially needed in syphilis. When Social Service takes the active part in treatment of syphilis that it now takes in tuberculosis, several things much needed will come to pass.

First with regard to organization, cases will then be reported and not allowed to drift from clinic to clinic. At present cases are recorded in a book which is inspected and names copied by an agent of the Board of Health periodically. One of the clinics feels that this is an imposition on their time. They do not write the cases in the book. They want a chance to discuss the matter. Nothing has been said about it, and cases come and go in that clinic and the Board of Health knows them not. The pay for salvarsan, and the sorting of patients unable but willing, from the unwilling but able, will be gradually worked out. It is unwise to have patients taking treatment irregularly and not following medication until discharged. Possibly patients could pay a certain sum at the beginning of treatment and have a refund when treatment was complete. Social Service could surely make some wise adjustment in this matter. We may reach a stage some time when the contracting of syphilis is regarded as a misdemeanor punishable by confinement (for treatment) or fine. The fine to be refunded when the condition is cured. A follow-up system would be an easy problem for Social Service to develop.

Many dispensaries are handicapped in the diagnosis and treatment of syphilis by having no hospital facilities. Before discharge patients should have lumbar puncture and at times
cases need intra-spinal treatment. Two clinics have a small infirmary for this purpose. Two others can follow their cases into the hospital. Others can send their cases to the hospital, but have to let different doctors treat them.

The problem of educating the syphilitic to appreciate his responsibility for the transmission of the disease needs the development of a type of conscience little understood at the present time. Careful work and thought along this line by Social Workers will bring light on this subtle problem. The possibilities of preventive work by family examinations would be another field for active effort.

It is possible to scare a person into doing the right thing for his health, for a time. Sometimes teasing and jollying will succeed for a time. To interest a person sufficiently to follow expensive treatment when he feels well is a difficult task, but one that Social Service can accomplish when it turns its energies to help the syphilitic bear his burdens.
Because of its historic interest, this article by Dr. Henry Dwight Chapin, which appeared in the Archives of Pediatrics in April, 1905, is here reprinted. This appears to be the first article published in America about Hospital Social Service work. Furthermore, this article apparently shows that organized Hospital Social Service work was first developed at the Post-Graduate Hospital. We wish to express our thanks to E. B. Treat and Company for permission to re-publish this article.—Editor.

THE WORK OF THE BABIES' WARDS OF THE NEW YORK POST-GRADUATE HOSPITAL FOR CONVALESCENT CHILDREN*
BY HENRY DWIGHT CHAPIN, M.D.

New York

The collection of infants and young children in a hospital presents many problems beyond the mere medical treatment of the cases. As far as lasting good to the children is concerned, the purely medical function may be the least important feature. The reason of this is twofold—first, the effect of the hospital itself upon the child; and, second, the essentially faulty life conditions that send the child to the hospital. Unless these two factors are attentively considered, the results of care and treatment will often prove unsatisfactory and ephemeral. Work in any one line of charity, if properly conceived, almost invariably opens up new and converging lines of effort that are necessary to employ if the work is to be made permanent. To treat a child successfully for pneumonia in a hospital, and then send it to damp and unhygienic rooms in a tenement house, is but to invite another attack of the original disease; hence, the housing problem looms up for consideration. Again, after relieving an infant of gastro-enteric irritation in hospital or dispensary, the work is only half done unless steps are taken to procure pure, fresh milk for future feeding, so that the food problem must be considered. As the hospital is not a good place for recuperation, when the patient is

*Read by title before the American Pediatric Society, Detroit, Mich., June 1, 1904.
Work for Convalescent Children

115

discharged the work will often fail in lasting results unless the child can be thoroughly invigorated, and here convalescent homes in the country at once claim attention.

Hospital statistics, as such, are of little value unless they take into consideration the ultimate condition of the patient. Until hospital managers are able or willing to extend their work along these lines of permanency, or have agencies that will do so, their work fails in much of its possibilities. No place more than a hospital gives the chance to trace needs and opportunities to their ultimate sources. It should not alone be a place for treating the sick, but a social laboratory, where future prevention should be constantly studied in connection with the cases under observation.

In considering the lasting good of the child, the hospital itself merits the first consideration. For infants and very young children it should simply serve as a temporary place of refuge, where all hygienic, medicinal and surgical appliances should be of the latest and best types. After the acute illness has subsided, the case should be immediately removed, as, otherwise, there will be constant relapses and reinfections. The latter will occasionally occur even with the best nursing and under the finest hygienic surroundings in the hospital. No hospital should admit infants or very young children to its wards unless all the appliances are of the very best as regards hygiene, air space, ventilation and skilful nursing. The nurses must likewise be sufficient in number, one to 5 or 6 cases, and specially trained in this line of work. Even where all these conditions are fulfilled, the greatest care and watchfulness will be required and the infants must be discharged at just the right time, when the acute symptoms have subsided and before a general cachexia or atrophy has had time to develop. In order then to ensure a good convalescence, the infant must be kept in the hospital for only a short time, it must be carefully guarded from auto- and hetero-infection while there, and, finally, sent out to recuperate under favorable conditions. When detained too long, certain phenomena invariably develop. Those especially to be noted are a slow but progressive loss of weight not entirely dependent on the original disease, dryness of the skin, hydremia, hypostatic pneumonia of a peculiarly in-
sidious character and great susceptibility of the mucous membranes. The latter are specially shown by bowel irritation, and vaginitis in female infants.

At the Babies' Wards of the Post-Graduate Hospital, forming a separate division of the hospital, the greatest care is exercised to avoid the dangers of prolonged hospital environment. Constant vigilance is employed in preventing infection from entering or spreading. On admission the clothing is removed and retained in the examining room and the child given an antiseptic bath before being taken to the wards. All female children have a smear taken from the vagina, which is immediately examined in order to ensure freedom from the latent infection which is so frequently found in these parts. No child is admitted from a house where any contagious disease exists, slips furnished by the Board of Health being constantly consulted. When a mother visits her child she is furnished a gown before being admitted to the wards. All stools and napkins are promptly disinfected. No mattresses are employed, the bedding consisting of woven wire springs that can be washed, covered by blankets. When the child is discharged, all the bedding and clothing are placed in a large sterilizer and subjected to live steam.

The wards are large, sunny, well-ventilated, and with all the best and most modern hygienic devices. The infants are daily removed to a sun parlor at the top of the building in order to get a complete change of air, and, when the weather permits, to a roof garden. The plant here in existence and the plan of treating the cases now serve as a model for many similar institutions throughout the country.

In order to make permanent the benefits of the hospital, the infants are kept only during the period of acute illness, and then discharged, but still kept under observation outside. This system started with the plan of simply having a visitor, but has eventuated in methods of fresh-air treatment that are aimed to ensure a thorough convalescence, if such a thing is possible. In 1890, a voluntary committee of three ladies, at the request of the writer, undertook to visit and report on the cases discharged from the hospital. As the work grew in importance it became evident that
a more systematic effort was required, and, accordingly, a special committee was formed from the Ladies' Auxiliary Committee in 1894. A paid visitor, who could work at all seasons, was appointed, and this plan has been in operation ever since. During the past five years a female physician has done this work. A combination of medical knowledge with tact and observation here give the best results. A blank that is of proper size to be attached to the regular hospital history is filled out by this visitor, so that the attending physician can at once be posted as to the life conditions of the child, and hence be governed as to the time of discharge from the hospital and what steps may be necessary to take in order to improve faulty conditions. The following items are placed upon this chart:

Name.
Address.
Age.
Number of rooms, No. light, No. dark, No. on air shaft.
Sanitary condition of house.
Sanitary condition of street—Fault landlord or city.
Physical condition of parents.
Intelligent care of children at home.
Condition of child second week after return to home.

A full history of the child's parentage and personal condition having been already taken by the examining physician on admittance, a pretty complete record is in the hands of the attending physician for his guidance in managing the case.

The visitor has placed in her hands a certain sum of money to purchase clean, fresh milk, when necessary, and to relieve any pressing needs that may interfere with the child's convalescence. She also sees that the food is properly prepared, medicines given, and the hygienic surroundings improved as much as possible. Rules of instruction in feeding and hygiene for mothers, translated into German and Italian, have proved of great value. The
**TABLE NO. 1.**
**HOSPITAL STATISTICS.**
**BEING A RECORD OF 1,000 CASES, EXTENDING FROM MARCH, 1900, TO MARCH, 1902.**

<table>
<thead>
<tr>
<th>CONDITION OF STREET</th>
<th>CONDITION OF HOUSE</th>
<th>CONDITION OF ROOMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good</td>
<td>464</td>
<td>New and clean</td>
</tr>
<tr>
<td>Fair</td>
<td>157</td>
<td>Old and clean</td>
</tr>
<tr>
<td>Bad</td>
<td>155</td>
<td>New and dirty</td>
</tr>
<tr>
<td>Not indicated</td>
<td>220</td>
<td>Old and dirty</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TOTAL NUMBER OF ROOMS</th>
<th>NUMBER OF LIGHT ROOMS</th>
<th>NUMBER OF DARK ROOMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Room</td>
<td>58</td>
<td>384</td>
</tr>
<tr>
<td>2 Rooms</td>
<td>165</td>
<td>169</td>
</tr>
<tr>
<td>3</td>
<td>327</td>
<td>58</td>
</tr>
<tr>
<td>4</td>
<td>168</td>
<td>46</td>
</tr>
<tr>
<td>5</td>
<td>55</td>
<td>7</td>
</tr>
<tr>
<td>6</td>
<td>12</td>
<td>3</td>
</tr>
<tr>
<td>Not indicated</td>
<td>211</td>
<td>Not indicated</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NUMBER OF ROOMS ON AIR-SHAFT</th>
<th>NUMBER OF BOARDERS OR LODGERS</th>
<th>PARENTS' DRINK HABITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 Room</td>
<td>207</td>
<td>386</td>
</tr>
<tr>
<td>1</td>
<td>49</td>
<td>69</td>
</tr>
<tr>
<td>2 Rooms</td>
<td>104</td>
<td>39</td>
</tr>
<tr>
<td>3</td>
<td>37</td>
<td>12</td>
</tr>
<tr>
<td>4</td>
<td>24</td>
<td>3</td>
</tr>
<tr>
<td>Not indicated</td>
<td>54</td>
<td>Not indicated</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PARENTS' AVERAGE EARNINGS</th>
<th>PARENTS' NATIVITY</th>
<th>PARENTS' RELIGION</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1-5</td>
<td>173</td>
<td>American</td>
</tr>
<tr>
<td>5-10</td>
<td>379</td>
<td>German</td>
</tr>
<tr>
<td>10-15</td>
<td>152</td>
<td>Irish</td>
</tr>
<tr>
<td>15-20</td>
<td>12</td>
<td>Other Nations</td>
</tr>
<tr>
<td>Not indicated</td>
<td>284</td>
<td>Not indicated</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MARRIED, WIDOWED, OR DESERTED OR SINGLE</th>
<th>NUMBER OF OTHER CHILDREN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>724</td>
</tr>
<tr>
<td>Widowed</td>
<td>79</td>
</tr>
<tr>
<td>Deserted</td>
<td>92</td>
</tr>
<tr>
<td>Single</td>
<td>73</td>
</tr>
<tr>
<td>Not indicated</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>1,000</th>
<th>1,000</th>
<th>1,000</th>
<th>1,000</th>
<th>1,000</th>
<th>1,000</th>
</tr>
</thead>
</table>
TABLE NO. 2.
HOSPITAL STATISTICS.
BEING A RECORD OF 700 CASES, EXTENDING OVER A PERIOD OF ONE YEAR, FROM MARCH, 1903, TO MARCH, 1904.

<table>
<thead>
<tr>
<th>SANITARY CONDITION OF STREET.</th>
<th>SANITARY CONDITION OF HOUSE.</th>
<th>NUMBER OF ROOMS.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicated in only 146 Report Cards.</td>
<td>Good</td>
<td>33</td>
</tr>
<tr>
<td></td>
<td>Good</td>
<td>125</td>
</tr>
<tr>
<td></td>
<td>Fair</td>
<td>88</td>
</tr>
<tr>
<td></td>
<td>Bad</td>
<td>96</td>
</tr>
<tr>
<td></td>
<td>Not indicated</td>
<td>391</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not indicated</td>
</tr>
<tr>
<td></td>
<td></td>
<td>700</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NUMBER OF LIGHT ROOMS.</th>
<th>NUMBER OF DARK ROOMS.</th>
<th>NUMBER OF ROOMS OR SHAFT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Light room</td>
<td>137</td>
<td>1 Dark room</td>
</tr>
<tr>
<td>2 &quot; rooms</td>
<td>64</td>
<td>2 &quot; rooms</td>
</tr>
<tr>
<td>3 or more</td>
<td>93</td>
<td>3 &quot;</td>
</tr>
<tr>
<td>Not indicated</td>
<td>400</td>
<td>Not indicated</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NUMBER OF LODGERS.</th>
<th>AGE OF CHILD.</th>
<th>NUMBER OF OTHER CHILDREN.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Lodger</td>
<td>17</td>
<td>6 Months or less</td>
</tr>
<tr>
<td>2 Lodgers</td>
<td>17</td>
<td>1 Year</td>
</tr>
<tr>
<td>3 &quot;</td>
<td>9</td>
<td>2 Years</td>
</tr>
<tr>
<td>Not indicated</td>
<td>657</td>
<td>3 &quot;</td>
</tr>
<tr>
<td></td>
<td>4 &quot;</td>
<td>64</td>
</tr>
<tr>
<td></td>
<td>5 and over</td>
<td>60</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not indicated</td>
</tr>
<tr>
<td></td>
<td></td>
<td>700</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HOME CARE OF CHILDREN.</th>
<th>PHYSICAL CONDITION OF PARENTS.</th>
<th>AVERAGE EARNINGS OF PARENTS.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good</td>
<td>105</td>
<td>Good</td>
</tr>
<tr>
<td>Fair</td>
<td>97</td>
<td>Fair</td>
</tr>
<tr>
<td>Bad</td>
<td>105</td>
<td>Bad</td>
</tr>
<tr>
<td>Not indicated</td>
<td>395</td>
<td>Mixed</td>
</tr>
<tr>
<td></td>
<td>700</td>
<td>Not indicated</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NATIVITY OF PARENTS.</th>
<th>RELIGION OF PARENTS.</th>
<th>MARRIED, WIDOWED, DESERTED OR SINGLE.</th>
</tr>
</thead>
<tbody>
<tr>
<td>American</td>
<td>168</td>
<td>Catholic</td>
</tr>
<tr>
<td>Irish</td>
<td>48</td>
<td>Jew</td>
</tr>
<tr>
<td>German</td>
<td>54</td>
<td>Protestant</td>
</tr>
<tr>
<td>Other Nations</td>
<td>307</td>
<td>Mixed</td>
</tr>
<tr>
<td>Mixed</td>
<td>123</td>
<td>Not indicated</td>
</tr>
<tr>
<td></td>
<td>700</td>
<td>700</td>
</tr>
</tbody>
</table>
work of the visitor has been in many other ways of far-reaching utility. Landlords have been brought to terms in putting premises in a sanitary condition rather than be reported to the Board of Health; fewer children are deserted than formerly, as a special effort is made to make the mothers realize the crime of deserting their children; all existing charities are made use of in as far as they apply to the case in hand, such as the free ice in summer, depots for milk distribution and all the fresh-air agencies. The mothers have explained the great advantage of allowing the children to have a change, even although it be only for a day, but efforts are made for a longer outing. It is believed that this work has been of the greatest utility to our convalescent children during the ten years that it has been systematically employed. Many facts of great social interest have also been brought out. Some of the records have been carefully studied and tabulated. Two tables have been thus prepared, covering different periods.

While it is impossible to get complete data in all cases, it is believed that these tables will give some idea of the work actually done and the good accomplished.

The efforts of the hospital to aid its convalescent children do not end with the work of the professional visitor and the help she can muster. Two other special agencies are constantly employed, which, although not under the same management as the hospital, have grown out of its work and are closely affiliated with it.

A fresh-air home at Sea Cliff, L. I., specially built and equipped for convalescent children, is open from May to November, and takes all needed cases for intervals of from two weeks to several months. It is situated on a high-promontory, sufficiently wooded, with a porous soil, overlooking Long Island Sound. Everything than can conduce to healthy, outdoor living is here supplied. A resident physician and nurses, specially trained in the Post-Graduate Hospital, keep careful oversight of the cases, and no child is discharged until it is believed that the improvement will be permanent.

Several years ago the author resolved to try the plan of boarding out in the country bottle-fed infants who were not doing well
in institutions or in their homes. At his request several ladies started the nucleus of such a work, which has since grown.

The Speedwell Society, located at Morristown, N. J., a very healthy district, has resulted and is in operation during the whole of the year. The plan of this Society is to board out infants and very young children in country homes in the vicinity. The success of this method of placing bottle-fed infants in private homes where they can have individual attention has been thoroughly demonstrated during the three years of the operation of this work. This is true even if the woman taking the baby into her own home is fairly ignorant. The mothering she gives the infant often makes up for her lack of accurate knowledge, and this is especially true in marasmus cases. However, a paid physician and two trained nurses keep these cases under constant observation. It has been found that bottle-fed infants and cases of general malnutrition do better under this plan of treatment than in the best-managed institutions. Many of our youngest cases have thus been completely restored to health and strength after the acute illness has been relieved in the hospital.
CONTRIBUTIONS

The following comment from Miss Weiss, of Biltmore, N. C., so aptly expresses the value of reviewing the experiences of workers in the field, that it is here reprinted as an editorial. We will be glad to receive papers from social workers which tell of how problems are met. Brief stories of unique experiences or development of new social service departments are also requested.

E. G. S.

"To a person with good command of English and daily experience, it is not any more difficult to write an *article* than it is to write an interesting report to the Board of Managers. I imagine that the chief trouble with us, workers in the small social service departments, is that we are too busy doing the actual work for which we have been engaged to take up time with trying to break down the barriers between ourselves and those directors and chief workers of larger organizations. We receive innumerable circulars and blanks, we read them, fill them out, send them dutifully to the place and person designated—and the incident is closed. These communications are never answered or acknowledged, further chance for discussion or interchange of ideas is not afforded us. This condition, or attitude, or whatever one may call it, prevails also at the National Conferences; thus one feels like shouldering one's own burdens, meeting one's own problems face to face, and working them out the best way one can.

"There are many small hospital social service departments in the United States, while there are comparatively few very large ones. The problems of administration are bound to be entirely different, and if the Quarterly will publish some articles written by workers in small organizations, describing their own experi-
ences, presenting their own problems, it will not only be helpful to the majority of hospital social workers, but it will be a means of spreading hospital social service, as these articles would, I am convinced, illustrate not only the difficulties, but also the ease with which these departments can be started in the smaller, but still large enough hospitals. I do hope that at last the lesser workers, who, by the way, are not doing less work, will be given credit for having original and perhaps valuable ideas and experience to contribute to the field of medical social service; and when one remembers that Moses was born in slavery and that the Apostles were of "the least," but they had vision, the above-mentioned possibility should not be so difficult to accept."
The passage of the Chamberlain-Kahn Act, creating the Division of Venereal Disease of the Federal Public Health Service, has greatly facilitated the work with syphilitic patients in Department L, our syphilitic clinic. A night clinic for the treatment of venereal diseases has been opened under the Public Health Service at the Johns Hopkins Hospital Dispensary and one at the Mercy Hospital, with ten beds at the Mercy Hospital, to which patients needing hospital care may be admitted. In July, regulations were passed by the State Board of Health, making venereal diseases reportable in Maryland and requiring persons in the infectious stage of these diseases to take treatment. No steps had been taken to enforce this law until December, when M—, a young colored girl, reported by the social worker in Department L to the City Board of Health, was taken as a test case. She was in a highly infectious stage of syphilis, was being treated by a physician on the outside for tonsilitis. She was told to report once a week for treatment, but did not do so. Repeated visits and a frank statement of her condition and the inevitable consequences to herself and those with whom she came into contact, if she did not take treatment, failed to impress her. She was reported to the Health Department. A Health Warden visited her several times, but could not find her at home. Upon the suggestion of the social worker, a policeman was sent to see her, who found she had secured a health certificate from her physician. The physician was summoned before the Health Department, and the girl admitted to Mercy Hospital.

This has resulted in the installation of a system, whereby a full record of all infectious cases of syphilis is kept on file at the
Health Department. Those not returning for treatment on the
day assigned are visited by the social worker, and, if they do not
then keep their appointment, she reports them to the Health
Department, with recommendations as to whether the Health
Warden or police shall handle the case. If the patient goes to
another hospital or takes treatment elsewhere, it is reported to
the Health Department, who keep the social service informed
until the patient is discharged as cured. Since this stand has
been taken by the Health Department in most unco-operative
cases, it is only necessary to tell the patients of the steps that
will be taken, if they refuse to report for treatment.

WORK OF CHILDREN'S MERCY HOSPITAL,
KANSAS CITY, MO.

ANNA A. ANDERSON, R. N.

Children's Mercy Hospital, Kansas City, Mo.

Although the Out Department work of The Children's Mercy
Hospital of Kansas City, Mo., has not followed in the ordinary
lines of Social Service, we yet feel that you will consider its
activities worthy of a rating among the Bureaus of helpful work;
and in response to your request I am pleased to give an outline
of its methods and growth.

Mercy Hospital's Out Department last year cared for 4,919
patients, and in the interest of children made 2,003 visits to
homes. Its work is done entirely without pay. It maintains
a Surgical, Orthopedic, Dental, Eye and Ear, Nose and Throat,
and Massage Department, and is now introducing a general and
very comprehensive system of Curative Play. It confines its
work strictly to the recovery of its little patients and does not
at all enter into recreative or home problems, except so far as
these directly influence the cure of disease. In other words, it
is strictly a medical and surgical Out Department work in co-
operation with other agencies for the betterment of social condi-
tions, but confining its activities to the care of little sick and
crippled children of the poor.
History

The Children's Mercy Hospital and all its departments are maintained solely by the voluntary help of individuals, clubs, etc. The work of the Out Department was founded, and up to the close of this year will have been maintained by an organization called "The Mercy Auxiliary." This body of women at first furnished the money to pay for two-thirds of the time of a visiting nurse, the idea being that the pupils of our Training School should attend to the work of the hospital proper, and that the Outworker should spend her time in attention to FOLLOW-UP details. This arrangement continued for two years, when it was found that the work had developed to such an extent that more help was demanded, and that the classification and recording of cases, and the proper and sympathetic treatment of children called for the closest co-operation between the Out Department and Wards, and the continued attendance of a competent director and a general assistant. The Auxiliary's beneficence kept pace with the requirements of the Department, and at present the Out Work is under the control of a Director, a Follow-Up Nurse, one or more pupil nurses from the Training School, and those students coming for especial instruction from other institutions. Each pupil nurse is given two months' training in Out Department work, and a Ford car provided by the Auxiliary increases the usefulness of the workers. The Director and her assistant are especially trained registered nurses, and the Department offers post-graduate instruction to those interested in Medical Out Service work, or to pupils of regularly recognized hospitals. Only children who are patients in some one of the hospital departments are considered eligible for Out Service care. Others needing help and coming under the observation of the Director or her assistants are referred to the Visiting Nurse, Provident Association, Jewish Educational Institute, Juvenile Court, or other agency providing for the care of such cases.

The Out Department works under no special constitutional direction except that controlling the entire hospital, of which
it is so valued a part. It is therefore “Non-sectarian, non-local and for those who cannot pay.”

The children under its care are provided with all hospital facilities necessary, except in the matter of braces. The Brace Fund is a very limited one, subject to voluntary contributions, and is free only in the case of those who positively are unable to pay.

While the success of Mercy Hospital's Out Department is unquestioned, there are still many problems very difficult to solve, and for which we hope for much help from an interchange of opinions in the Social Service Quarterly. One of our most distracting questions deals with the children who live in furnished rooms—whose parents move when rent is due and who have many different names. However, Mercy Hospital's Out Service work moves along comparatively well, and its Director is pleased at this opportunity to compare failures and accomplishments with those of others engaged in Social Service activities.

THE AMERICAN ASSOCIATION OF HOSPITAL SOCIAL WORKERS

The American Association of Hospital Social Workers, on March 24, 1919, had 341 members, of whom 152 are active, 151 associate, and 11 corporate, 19 contributing and 8 sustaining.

The Association has held two meetings—one on the occasion of its organization in Kansas City in May, 1918; the other at the time of the Annual Conference of the American Hospital Association, in Atlantic City, in September, 1918. The Executive Committee has held three meetings, one in Philadelphia in June, one in Atlantic City in September, and one in Washington in December, 1918. Besides this a number of meetings have been held by the Committees on Membership, Ways and Means, By-Laws and Constitution, and Training.

The Committee on Training, wishing for information as a basis for discussion, has issued a questionnaire to all Heads of Departments and Directors of Schools known to be in any way
concerned with the training of medical social workers. The questionnaire asks for the number and kind of courses given, number of students, employment of graduates, etc., and also for the experiences and opinion of the persons answering in regard to the courses of most value. It is planned to give opportunity for special discussion of this subject at the Annual Meeting.

The Annual Meeting is to be held at Atlantic City during the first week in June at the time of the National Conference of Social Work. The exact time and place of the meetings and the program are to be announced later. The Secretary will be glad to send notices and programs to anyone interested.

The Pennsylvania Association of Hospital Social Workers, since it is nearest to the scene of action, has constituted itself hostess to the other members, and will provide a place for informal social meetings.

The Secretary has for some months been gathering the material for a new Directory of Social Service Departments. It is hoped that the Directory will be in print by June, and ready for sale at the Annual Meeting. The many changes in the personnel of departments during the past year has made it nearly impossible to keep the Directory information up to date. Any information concerning such changes and concerning departments newly formed will be most gratefully received by the Secretary (A. Cannon, University of Pennsylvania Hospital, Philadelphia, Pa.).

The Secretary has acted as representative of the Association on the Health Division of the Committee on Americanization, of which Mr. Allan T. Burns is Chairman. Mr. Michael Davis is Chief of the Division on Health. Hospital Social Workers will remember the questionnaire sent out by Mr. Davis last summer. The study being made through his Committee promises to be not only a basis of an intelligent program for better American citizenship, but also more specially a means whereby medical social workers may enlighten themselves as to the dark problems of the health of the foreign-born in the community.

All departments, known to the Secretary, have been asked to send to her samples of their record forms, together with their annual reports, and the degree held by the Head Social Worker. The records and reports received are on file at the University
Hospital, Philadelphia, and may be consulted by any visitor interested in comparing or studying the methods of different departments.

SMITH COLLEGE COURSE IN SOCIAL WORK

The New Training School for Social Work which has been established at Smith College, Northampton, Mass., is a graduate professional school offering work that falls into three divisions: a summer session of eight weeks of theoretical instruction, combined with clinical observation, at Northampton, Mass.; a training period of nine months' practical instruction carried on in cooperation with hospitals and settlements; and a concluding summer session of eight weeks of advanced study at Northampton.

In an endeavor to prepare workers for social reconstruction, the school will give a somewhat new emphasis to its teaching. The approach to social problems will be psychological. A scientific, as well as a technical, basis of training for social work will be provided by instruction in psychology, psychiatry, medicine, biology and sociology. The discussion method of teaching will be stressed in an effort to train for fearless and resourceful thinking about social problems. According to their interests, the students will be grouped in college dormitories during the summer session. Continuous study will thus be carried on in an atmosphere of intense application.

It is believed that the uninterrupted field practice for nine consecutive months under central supervision with group conferences will provide a better method of training than the usual method of intermingled theoretical study and field work.

Dr. Richard C. Cabot is Chairman, and Miss Ida M. Cannon, a member of the Medical Advisory Committee. The course in Social Medicine is in charge of Dr. Catherine Brannick, and Miss M. Antoinette Cannon is Supervisor in Charge of the field work. The summer session begins July 7th and extends to August 30th. The period of field practice begins in September and continues until July, 1920. The second summer session of advanced work runs from July 5 to August 28, 1920.

A catalogue will be mailed on application to the Director, F. Stuart Chapin, Smith College, Northampton, Mass.
PROGRAM OF THE PUBLIC HEALTH SECTION OF THE NATION OF CONFERENCE OF SOCIAL WORK TO BE HELD AT ATLANTIC CITY, N. J., JUNE 1 TO 8, 1919

I. Standards of Living in Relation to the Housing Problem.
   Bad Housing and Ill Health.  Prof. James Ford.
   Housing Development as a War and a Post-War Problem.  Thomas Adams.

II. Standards of Living and the Family Food Supply.
   Poverty and Malnutrition.  
   Education in Food Values as a Preventive of Dietary Deficiencies.  Lucy H. Gillett.

III. Standards of Living and Tuberculosis.
   The Economic Factors in Tuberculosis.  Charles J. Hatfield.
   Raising the Standard of Living as a Weapon in the Anti-Tuberculosis Campaign.  Bailey B. Burritt.

IV. Standards of Living in Relation to Medical and Nursing Care.
   How Far Does the American Family Budget Provide for Necessary Medical and Nursing Care?  Lee K. Frankel.
   Health Insurance as a Means of Securing Medical and Nursing Care.  John A. Lapp.

V. Standards of Living and Infant Mortality (Joint Section with Division on Children).
   Infant Mortality as an Economic Problem.  
   The Reduction of Infant Mortality by Economic Adjustment and by Health Education.  Julius Levy.

VI. Standards of Living in Relation to the Health Hazards of Industry.
   The Problems of Industrial Disease.  

VII. Standards of Living in Relation to Venereal Disease.
   Economic Pressure as a Factor in Venereal Disease.  Edgar Seydenstricker.
   The Federal Campaign against Venereal Disease.  C. C. Pierce.
   The Prostitute as a Health Problem and a Social Problem.  

VIII. General Session.  Poverty and Health.
   Chairman's Address.  C. E. A. Winslow.
   Sickness as a Factor in Poverty.  Karl de Schweinitz.
   Poverty as a Factor in Sickness.  Royal Meeker.
A problem in social service work that seems to confront me often is the inclination on the part of many patients to attend regularly several clinics. It seems hard to make them understand that the medicine given at the various places when mixed will do more harm than good. In talking this over with one of the Diet Kitchen nurses, she remarked that a baby was brought in to her one morning with very sore eyes. The doctor treated them with silver nitrate, and she accidentally discovered that afternoon that the baby, before coming to the Diet Kitchen, had been treated at the Eye, Nose and Throat Hospital, the same treatment of silver nitrate having also been used there.

A colored baby was brought in one afternoon with cervical adenitis. In following up the case, I discovered that the child was being treated at the Diet Kitchen, the Nose and Throat Hospital, and by a private physician. Just what treatment the child was really getting I don't think anyone ever knew. And the trying part is that they seem to consider this a clever system, and try to make each doctor think his special treatment the only one being used.

In working with the Russian Jews, I find it very hard to make them understand and carry out a doctor's order as given. We had one very bad case of pediculosis. The doctor ordered applications of crude petroleum for three nights. This to be followed by combing with a fine tooth comb dipped in vinegar. They seemed to understand the instructions perfectly, yet when they returned several days later they had applied vinegar for three nights, then used the comb dipped in crude petroleum.

MISS M. WELLER, R. N.,
The Children's Hospital,
Washington, D. C.
CONVALESCENT CARE

One of my problems has been to secure convalescent care, as no such need is provided for in the State. As Wilmington, Delaware, is only a short distance from Pennsylvania, and as I had had co-operation in the past with two convalescent homes in Pennsylvania, I explained the situation to the management, and am successful in having two of my patients accepted.

The children of both patients were placed through the Children's Bureau. One of our lady managers gave the use of her limousine, and the trips to the convalescent homes were made with comfort and gave great pleasure to the patients.

In the case of Julia, a Polish woman, all four children are at a Children's Home, from where they attend public school. The staff there are becoming fond of the children, who are unusually attractive. Sophie, the oldest, is twelve, and had been doing the housework at home for many months. She is most helpful at the Home and desirous of helping, and told the matron she had forgotten all the naughty things she knew when she came there. Nick has confessed he was on the street until late at night when living at home, but says he will give up this habit. The Welfare Worker at the shop where the father works reports that he has never worked so steadily or been so free from sprees as since this family have been under the supervision of this Department. We feel the whole family are benefiting by the social work being done.

Mr. P. was suffering from paralysis. He was in a stupor much of the time, and when aroused could give no information regarding himself. No one came to see him and he was referred to the Social Service Department to be transferred to the County Hospital, as he was considered a chronic case. He has no relatives, but investigation by the worker located intimate friends in another part of the State, who came at once when told of his illness.

The Motor Messenger Service of the Red Cross detailed an automobile for us for three hours every Friday, and eight little paralysis cases are thus being brought to the hospital for massage who had no other means of coming. A splendid volu-
teer corps, consisting of eight people, are now ready to assist in bringing patients to the clinics and to take the worker out in their automobiles.

Although this is a city of 150,000, there was no orthopedic specialist located here. Children were being taken to the Jefferson Hospital, Philadelphia, for diagnosis and operation. Our Junior Board paid a skilled masseuse to give treatment here three days a week. In August, Dr. Henry W. Banks, of the Jefferson Hospital, assumed charge of a clinic to be held here every two weeks. This is most successful, and we now can give the benefit of his skill to all the crippled children of Delaware. The work is steadily growing.

MARY L. COOK, R. N.,
The Delaware Hospital,
Wilmington, Delaware.

CARE OF BABIES DURING INFLUENZA EPIDEMIC

The influenza epidemic left in our hospital ten babies, with only one parent, needing skilled care badly. Seven were satisfactorily placed, but three remained: two with no mothers; one, a tuberculous adenitis case, with no father and a pregnant mother, who is an arrested case of tuberculosis. All three babies had been feeding cases; all came from such dreadful home conditions, that return to the homes in normal times would have meant poor care, but return after illness and death meant no care. The orphanage was full; no boarding homes were available; the hospital beds were needed imperatively for acutely ill babies.

The problem was a most unhappy one, needing immediate solution. Miss F., a practical nurse of excellent training, ability and experience, was much moved by the need of the babies. She offered to take them to her own tiny apartment and keep them as long as possible. Miss F. had no income except the remuneration from her nursing, so the Hospital Social Service Nurse was constrained to refuse her offer, as thus taking advantage of kindly
134 News Notes

genosity would mean creating a new social problem, while solving the old one.

However, the Social Service Nurse set happily about a real solution. Armed with the stories of the convalescent babies needing care so badly, and with the story of the sacrificing woman so eager to share all she had and give them that care, the nurse approached the suburban neighbors and found them ready to help both babies and Miss F. Interest grew apace, and at once a temporary nursery was established, entirely financed by this community. Here the babies were given the best opportunity to weather the winter and have a real start toward health.

At the end of four months, we can feel that this problem was a real blessing—for all the individuals and societies that helped have retained their interest and have gained a vision of the great need for Infant Hygiene and better public health; every baby has improved wonderfully; every family problem has been attacked by the proper social or public health organization; and the practical nurse has decided to devote the remainder of her life to needy babies.

MISS ELIZABETH DINES,
Orange, N. J.
ABSTRACTS

The Hospital as a Social Agent in the Community; Lucy Cornelia Catlin, R. N., W. B. Saunders Company, Philadelphia, 1918. $1.25. Miss Catlin's book not only well illustrates the relation that a hospital bears to the social community, but will further advance the movement that the hospital be made the center for all medical social work of the community. Case histories are used freely to illustrate how fundamental causes of illness must be discovered to suggest a remedy or to effect a permanent cure. In many cases the hospital, dispensary, or doctor cannot effect a cure unless the home conditions are improved. In the larger dispensaries the social service worker could hardly be admitting officer, executive director of the dispensary, and at the same time look after the general social problems which affect the health of the community as Miss Catlin suggests. She points out that duplication of work should be avoided by co-operating with existing agencies; hospital social workers are specialists, they should confine their work to their own fields. As Miss Catlin aptly expresses it: "Hospital social workers have no more right to interfere in general family reconstruction that is being handled by associated charities than the latter have to dictate the kind of treatment a patient should receive whom they are sending to the hospital. This sort of interference indicates low standards of social work, a narrow conception of the individual and community needs, and should not be tolerated." A hospital worker has special opportunities to help as illness incapacitates the individual, and, as a consequence, many social problems arise. The hospital's function should not be merely to cure the ill, but to prevent sickness by means of education. This is especially true in the tuberculosis and venereal diseases clinics. In an appendix a valuable set of forms are given. "Social Histories which exist in the memories of workers are utterly valueless, yet it is many times a question with busy workers whether to sacrifice the social work or the records." In her book, Miss Catlin explains in detail the daily problems which confront the hospital social service worker, but offers no solution for these problems.

E. G. S.

"The Dietitian in Social Work"; Lucy H. Gillett, The Modern Hospital, XII, 63. The problem of giving knowledge of food values to the mothers of the high percentage of improperly nourished children, is best solved by the co-operation of the doctor whose diagnosis is respected by the mother; the trained dietitian who interprets the values of food, marketing and the family budget; and the social worker. That social agencies recognize the need of action is shown by two studies recently made by the New York Association for Improving the Condition of the Poor co-operating with Professor Sherman of Columbia University, and the League for Preventive Work in Boston. Each tried to determine whether poverty or lack of training is the largest factor in malnutrition. Both studies show that the latter is the greatest problem. Protein foods were used in excess at sacrifice of
Abstracts

calcium, phosphorus, and iron. These deficiencies explain the high rate of malnutrition. Where 27% of the food budget is spent for grain foods and less for meat, the same amount of energy is received for $\frac{3}{4}$ the cost. Calcium is the diet parallels the amount spent for milk. The best results are obtained when one-fourth the total food budget is put into cereals using coarse grains liberally, a like sum for milk and meat, and more fruit and vegetables used than meat. (Prof. Sherman.) Nutrition classes and weight cards arouse the children's interest and lead to competition. The New York Association for Improving the Condition of the Poor has one nutrition class in a school and two in milk stations. The League for Preventive Work in Boston is made up of eighteen social agencies who study causes and then form a constructive program. They became aroused to the need of a Dietetic Bureau, which offers as a social agent its advice to the city and state, thus hoping to avoid duplication.

N. F. C.

"The Need of the Industrial Nurse"; Mabel Boyd, The Public Health Nurse, 1919, XI, 19. Humanity of the employer and efficiency of the worker are demonstrated by a hospital and nursing service in the industrial plant. From the operative's standpoint, the service relieves his physical need and will place his social needs before the employer. The nurse tabulates the facts required to adjust compensation and is a useful member on the Committee on Safeguards. From the viewpoint of the nurse, co-operation in the health, social and economic system clear her vision of more effective preventive work.

N. F. C.

"Relation of Field Dietetics to Social Service"; Blanche M. Joseph, Modern Hospital, 1919, XII, 66. Field dietetics include two departments: (1) Clinic dispensary work where the doctor's diagnosis is made. (2) Follow-up work by a dietitian, assisted by volunteer workers who have had some training in dietetics. The dietitian sees that the doctor's instructions as regards foods are followed and instructs the patients about food values with special reference to their individual needs. Instruction is given in cooking, canning and marketing in relation to the family budget. Little mothers classes are practical where girls from fourteen to sixteen are taught plain cooking.

N. F. C.

"A System of Dietary Follow-Up Work"; Beth B. Titus, Modern Hospital, 1919, XII, 67. The Minnesota city hospitals established in 1918 a system of dietary follow-up work which has provided trained supervision of diets for 450 discharged patients a month. This work included tubercular and diabetic patients as well as those suffering from stomach disorders and convalescents from contagious diseases. A very valuable field has been work with babies. The dietitians obtain from the dispensary the patients'
history, doctor's directions, etc., then assume field work, as part of their course of studies. This work has greatly helped the homes where war prices were most felt. Similar work has been done successfully in other parts of the United States.

N. F. C.

"Nursing as a Learned Profession: A Sociologist's View"; Arthur J. Todd, The Public Health Nurse, Vol. XI, 1919, 15. "All of these cases illustrate the complexity of social life and the complexity of causes in modern social problems. They indicate the need for the nurse's training in sociology, economics, and psychology in order to be equipped with the ability to recognize the contrasting problems of city and country, the characteristic race psychologies, the role of instincts and feelings in individual and in social life, the effect of imitation, fashion, and fads, the function of leadership, the problems of wages, unemployment, and collective bargaining. Every nurse, as well as every social worker, should be familiar with the analyses of the background of social problems as are given in Mr. Ordway Tead's little book, "Instincts of Industry." Such analyses frequently give amazing leads to the solution of public health reform."

N. F. C.

"The Relation of Prenatal Nativity to the Infant Mortality of New York State"; P. R. Eastman, American Journal of Diseases of Children, 1919, XVII, 195. Eastman has studied the statistics of infant mortality for the year 1916 of New York State exclusive of New York City. This data shows that the infant mortality of the state compares favorably with most other communities of similar size, and a steady reduction has been present during the past decade. But this improvement has been largely among children over one month old when the great majority of deaths are due to communicable, respiratory, and gastro-intestinal diseases. About three-fourths of the infantile deaths under one month of age are due to prenatal causes. The conclusion is evident that child welfare workers must in the future pay more attention to the prenatal causes of infant mortality. The customs and racial characteristics play an important part in the infant mortality rates. Among the Italians and the Slavic races the communicable, respiratory, and gastro-intestinal diseases, all of which are directly influenced by unfavorable environment, predominate. The fewer deaths from prematurity and congenital defects among the Italian, Russian, Polish, and Austro-Hungarian infants may be due in part to their better constitution. But this is counteracted by the excessive mortality during the latter months of infancy, due in part to the ignorance of the parents. Compared with the foreign born, the death rate from prenatal causes is exceptionally high among children of native mothers. In conclusion, Eastman says: "A careful study of the character and habits of the population should be the first step taken in any attempt to improve child life. . . . If the population is discovered
to be preponderately native, the proper course to be adopted should be mainly one of education in regard to prenatal conditions. If it is found to be largely of foreign born stock, it will be necessary to plan principally for a course of instruction in the proper feeding and care of the infant and for the improvement of sanitation."

E. G. S.

"A Hospital Library and Some of Its By-Products"; Elizabeth Green, Modern Hospital, 1919, XII, 161. The Barnes Hospital library was put in the record room as there was spare shelf room and the record room force made time in which to issue the books. The books were obtained at first from the traveling department of the St. Louis Public Library. Soon the Training School added some of their books. Before long books were sent from friends outside the hospital. During the first year books were issued to private and ward patients, doctors, nurses, and even to others of the hospital staff. The cost of the few supplies needed was more than covered by the fines imposed. Volunteer workers came once a week to issue books to the wards. The patient who is in the hospital a long time looks forward to "book day." Carefully selected books may be of distinct therapeutic value to certain neurological, exophthalmic, or orthopedic cases who are in the hospital for long periods. Books with small type or glazed pages should not be issued to patients, as they are apt to cause eye strain.

E. G. S.

"Relation of Hospital Social Service to the Successful Treatment of Gonorrhea and Syphilis"; Ida M. Cannon, Modern Hospital, 1919, XII, 199. Miss Cannon calls attention to the fact that the program outlined by the United States Public Health Service in its crusade against the so-called "venereal diseases" is dependent upon the use of the dispensaries and hospitals of the country. Yet not so long ago these sentiments were expressed by some of the leading medical institutions: "Persons suffering from alcoholism and venereal diseases shall not be treated, being victims of their own sexual indulgence." The change from this puritanical viewpoint clearly reflects the social change which medicine is undergoing. A survey made in 1916 showed that of 126 social service departments, 39% were giving special attention to syphilitic patients, 30% were dealing with gonorrhea in children, and 14% with gonorrhea in adults. By now many more departments are probably working on these problems. The work as conceived by one worker is as follows:

I. Within the clinic:

A. To meet and obtain a minimum social history of every new patient.
B. To supplement the instructions given by the doctor regarding treatment and prevention of the spread of the disease.
C. After conference with the doctor to select those cases which need special medical social service.
II. Outside the clinic:
A. Supervise the follow-up system.
B. To place the responsibility for payment of salvarsan properly on (1) patient or family, (2) hospital, or (3) another social agency.
C. To give special supervision to selected groups as determined by the doctor and social worker.
D. To bring in other members of the family for examination.
E. To correlate the work so that the entire group of patients receive attention proportionate to their needs.

The worker's task is largely education for the nurses and medical students who are learning the medical-social aspects of syphilis and to the social workers who refer the patients to the clinic. The social service department have invariably been called upon to help secure payment for salvarsan. But this question of financing the treatment of syphilis has been somewhat modified by recent legislation. The worker has, however, still to determine the ability of the patient to pay. The question of hospital bed care for patients in the infectious stage is a serious one for the social worker when there is the danger of a whole family becoming infected. If but one bed were available in a hospital with careful planning for after care, this bed could be made to serve 18 to 20 patients a year. The term venereal disease is unfortunate. The moral implication is unjust in the case of the innocent wife, the girl accidently infected, or the baby with ophthalmia neomatorum. Another loosely used term is "follow-up." Much of this work is merely mechanical, but should be done by a worker with a social sense. Many social service workers also do "follow-up" work, but this in itself is not "social service." However, these two distinct services are closely allied, as the follow-up work often uncovers cases needing social service.

"The After-Care of Infantile Paralysis in the Home"; Mary C. Perkins, *Public Health Nurse*, February, 1919, XI, 110. The Visiting Nurse Association of Chicago deals only with convalescent cases of infantile paralysis and all cases are referred from the isolation hospitals. The work is unique in that all treatments are given in the homes after a clinical examination where careful instructions are given to the nurses, and brace makers, by the doctors. Miss Plastige, who has been an assistant of Dr. Lovett, of Boston, supervises in detail the exercise with the children, the massage and adjustment of apparatus. Three-quarters to one and one-half hours is the average time for a home treatment. The nurses in turn instruct the mothers who have attained some remarkable results. The problem of the expensive apparatus must be solved by the Visiting Nurse Association, who contribute when necessary. Work with younger children offers a special situation, as the young minds cannot grasp the scheme and, therefore, gentle massage
and passive exercises are used. Many times the treatment is given with the patient in a warm bath, which has a stimulating effect, and this system has produced improvement in the family hygiene. The work makes a special appeal because of the high economic value of good results to the community.

N. F. C.

"The Industrial Nurse in Relation to Public Health"; Jeannette D. King, *Public Health Nurse*, February, 1919, XI, 100. In industrial work we reason that each employee is in close communication with an average of five people who respond in part to the knowledge he receives and, therefore, the nurse must be well equipped for her special work. The values of personal and home hygiene, and suitability of dress can only be adjusted by a worker who is keen to sense the crude home facilities for cleanliness, and the normal desire of girls to dress nicely. Five dentists are employed at Montgomery, Ward & Company. The new employee is allowed two months' time to have his defective teeth treated, done at cost, and weekly payments are deducted from his wages. Employees are taught the value of X-ray examinations. Tuberculosis work is based on the theory of the upward curve of efficiency until mid morning or afternoon, so malted milk is given at these hours and weight charts kept of this class of operatives. During the past six years 25% of time was given to remedial work and 75% to preventive at a cost of $60,000, which the firm consider a good investment.

N. F. C.

Health Centers; *Health News*, Monthly Bulletin, New York State Department of Health, February, 1919. Increased knowledge and demand for service with the need for conservation of resources of labor and money have given impetus to health centers. One central plant reduces overhead expenses, and combines the knowledge of different officials. The faults of previous methods are made clear. A health center may be developed best by a committee of citizens with civic spirit working with the Health Department. No two cities have the same problems, but all have some in common with others.

N. F. C.

Mental Hygiene Clinics and Health Centers; Walter B. James, M.D., *Health News*, February, 1919. The plan of the State Health Department of establishing health centers through the State is an advance in duty fulfilled to the state. The facilities for mental examinations are not adequate and therefore the following suggestions are in order. The excellent State Hospital Commission Clinics are little used by other agencies. A joint Board of Control has been informally assembled from the personnel of the State Organizations for Mental Hygiene. The Board may later be enacted by legislature. It will establish clinics in several places, which will be possible future health centers, though the immediate purpose is to operate as do the admirable clinics under Dr. Fernald of Waverly, Massachusetts. Medical service will be supplied by members of the staff of the State institutions for Mental Hygiene. This plan co-ordinates several State mechanisms and utilizes their common resources.

N. F. C.
Municipal Supervision of Public Health; C. R. Hervey, M.D., *Health News*, February, 1919, 34. Federal, State and municipal bodies acknowledge the responsibility of protecting life and property, which includes health. A proper interpretation should cover entire provision for health needs. Civic responsibility has developed slowly, and private charities have assumed much health work. An efficient plan of functioning will centralize these activities with the municipality as the responsible leader in supplying and systematizing the program. The recent epidemic offered an illustration of the necessity for co-ordinating forces, and an adequate plan for protective health work will hold itself in the same constructive form in normal times, which proves efficient in meeting the emergency which may come with overwhelming force. If centralization and system were useful during the great epidemic, the same principles may apply to more common conditions of disease. The Health Center meets this demand.

The Health Center Plan in Philadelphia; Wilmer Krusen, M.D., *Health News*, February, 1919, 38. Begun primarily, where morbidity was high among children in Philadelphia, Health Centers have developed into local branches of the Health Department with authority to act. The ideal of the Health Department is to centralize all its functions at each Health Center. The workers give instruction in sanitation, prenatal care, child welfare, and care for the tuberculous and crippled. They report on sanitary conditions to the division of housing and sanitation.

N. F. C. 
The Hospital Social Service Quarterly

Copies of the Proceedings of the Hospital Social Service Association of New York City may be obtained from the Hospital Social Service Quarterly at the following prices:

Volume I .... (Out of print)* Volume IV .... One dollar.
Volume II .... Fifty cents. Volume V .... Fifty cents.
Volume III .... Fifty cents. Supplement .... One Dollar.

*Complete set for Three Dollars.

VOLUME I.

Introduction—History of Organization
Medical Social Service and Efficiency Tests .......... Mr. M. M. Davis, Jr.
Industrial Training for Cardiac Cases ............... Mrs. William K. Draper
Employment of the Handicapped ...................... Miss Blanche Potter
Convalescent Care and Industrial Training of Cardiac Cases

Dr. N. Gilbert Seymour

The Workless Man .................................................. Dr. Herbert J. Hall
The Standardization of Hospital Social Work ...... Dr. Alexander Lambert

VOLUME II.

The Desirability of Securing Uniform Hospital Social Service Records
Dr. Sidney E. Goldstein
Unemployment ...................................................... Mr. S. Herbert Wolfe
Police Commissioner Arthur Woods
A Record System for Medical Social Service ...... Dr. Sidney E. Goldstein
Dispensary Night Clinics ........................................ Mr. James K. Paulding
The Sharon Cardiac Experiment ......................... Dr. N. Gilbert Seymour
The Treatment of Mental Hygiene Cases ............... Dr. Menas S. Gregory

VOLUME III.

Medical Social Service Past and Future .......... Dr. Alexander Lambert
Making Ready for the Normal Life ...................... Dr. S. S. Goldwater
Hospital Social Service Courses in the Training School

Miss Anne W. Goodrich

Employment for the Handicapped ....................... Miss C. S. Foster
Health Insurance ............................................... Mr. S. Herbert Wolfe
Influence of Health Insurance on Social Service Work

Dr. I. M. Rubinow

The Reaction of the British Health Insurance upon the existing Charities

Miss Olga S. Halsey

Please Mention Quarterly when writing advertisers