THE SCOPE OF MEDICAL SOCIAL SERVICE IN A GENERAL HOSPITAL*

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It is indeed a difficult task to set down in any concise and complete fashion a statement of the manifold, and often difficult tasks which confront the medical-social service department in a large general hospital. The complications encountered in the average hospital case are often so troublesome that when these difficulties are multiplied by many hundreds, the accumulated details seem frequently overwhelming, and the problems, if because of their number only, insurmountable. Moreover, when indigency is added, with its accompanying blighting effect on the patient's ambition, self-reliance, and outlook on life in general—and especially as it affects his own self-respect, and his desire to quickly leave the hospital and take up old, or learn new duties—the problem is indeed complex. For, when indigency is complicated by disease, or the reverse, the physician and the social worker must needs use all of their skill to prevent what is even worse—permanent hospitalization. What is more discouraging to the physician, nurse, or social worker, than to minister to the patient who is ill because he wishes to be so?

The malingerer is a barnacle on the keel of many an otherwise seaworthy hospital craft.

One of the first lessons which all of us who approach the bedside of the sick with any application of the healing art in our hands should learn is that all who say they are ill are not in need of the physician or the nurse—that the man who comes to a city hospital with sheep's blood on his shirt, and a lying story of a pulmonary hemorrhage on his tongue, because he knows such a story will guarantee a warm bed in a pleasant ward, with the luxury of food regularly served, is not a myth. Such a patient is not infrequently seen in one guise or another in the receiving ward of a general hospital. Students of human nature we must be, and no perception

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is so keen or no social diagnostic sense so acute but that this hospital impostor will frequently elicit sympathy where none is due. It is just as important to be able to decide when not to act as to know what to do when action is indicated.

But you are expecting me to make some more definite statements relative to my conception of the scope of medical hospital social service. Could I paint a canvas showing the physician and his patient in a general hospital ward, I would sketch him surrounded with his specialists, each equipped with his expert training ready to bring his advice or labors to the bed of the patient in order to more quickly and more certainly restore health and usefulness. I would place the social specialist prominently in this group, not in drab and uncertain tints in a dim background as she is so often depicted. But to take her place in this group, she must not be mediocre in her personality or training. The bacteriologist, whom we see there, has had years of training, his judgment has been tested, his skill is undisputed; the surgeon is not only a graduate in medicine, but has since graduation spent years of preparation for his specialty and his opinion is, therefore, of value. The roentgenologist comes to the bedside with a knowledge of his work not gained by a brief and uncertain experience.

So we who believe that medical-social service is an all-important hospital department, expect and demand that the social specialist, whom we summon to our aid, shall be a specialist in fact as well as in name. Herein lies, in our opinion, the gist of the permanent and widespread recognition of the need—yes, the absolute indispensability—of the service which the hospital social worker can render to the patient. Can we place any hospital activity on any firmer basis than to say that it serves to speed recovery and return earning power? All of the varied acts of our hospital life and experience which do not in some way, directly or indirectly, favorably affect the patient’s condition will bear suspicion as to their soundness.

But I hear some murmurings that the medical-social worker must not be considered as aid only of the hospital physician. If not, what is she? What is her “raison d’être?” True it is that most physicians know but little of the underlying principles of good hospital social work, and it is equally undisputed that few physicians, except those specially trained, know the technique of either accurately estimating the amount of glucose in the blood or of taking an electrocardiogram, but this fact does not restrain them from intelligently applying this data when once secured.
It is our belief that in the organization of a general hospital there should be no broken lines of authority or purpose between the medical-social service department, the medical administration or the medical staff. The medical-social service department in some hospitals is asked to undertake tasks which consume so much time that little opportunity or energy is left for what appears to be more essential work. This department should not be made a collection agency. The social worker may learn in her investigations valuable facts relative to the ability of the patient or his family to pay for maintenance in the hospital. She can, and should, transmit such information through the proper channels, but it seems that this service must be but a by-product of her activities, and that the amount of money which her visits realize for the hospital should not in any degree be looked upon as a criterion of her worth or efficiency.

The hospital social service department must not be made a general messenger service for the transaction of all of the miscellaneous errands for which no one else seems to have time. On occasions when the worker is going to a distant section of the city, she may oblige by doing some such service but this service again must be but a minor portion of her day’s work. The dignity of, and the consequent respect for, a specialty is not enhanced by the acceptance of duties not directly connected with the ethical prosecution of its work. The social service department is not a telephone exchange where a great bulk of extraneous hospital phone service is transacted. I strongly question the wisdom or efficacy of requiring the busy social worker to give out phone information concerning the condition of hospital patients. Nor is this department an inexhaustible catch-all for the deserving widow of a former staff physician, or the society woman, or the daughter of a member of the board of trustees who wants to help somebody but has no training and only a genuine human sympathy as her stock-in-trade.

The public at large has yet to be convinced that to do social work in any form requires long, thorough, and arduous training, and that the social worker does more than ask searching questions which are frequently embarrassing.

We have suggested these few negatives by way of laying emphasis on several misconceptions which I fear exist in some hospitals as to what their social service department should return for the money spent thereon. Let me mention in some detail what appears to me to be the more essential functions:
In general the medical-social service worker is the hospital social diagnostician and therapeutist. She is not infrequently called upon to do some social surgery; for her actions do not infrequently cut deeply into what appears to be a healthy pride and which later is seen to be a pathologic conceit or stubbornness. The phthisical mother, who is separated from her child, does not see that the present pain means future happiness for both. She above all is the liaison officer who strives to obliterate the distance between the home and hospital bed—to bring to the physician her word-picture of the home in which the patient lived and became ill. She is the arm of the hospital which reaches out to search for and to bring in all facts which will enable the hospital to more quickly return the patient to usefulness.

This activity has many ramifications and applications and implies far more detailed and varied exertions than merely compiling a history of any particular patient. It may be that the starting point of this quest was in the hospital ward where a conversation with the patient revealed that financial difficulties at home had unduly delayed his entry, that his recovery was being hindered by worries about his position, the payment of his insurance on time, or the collection of some small debt. A visit to the home with its subsequent report hastens his convalescence because his worry and fears have been relieved—this is successful social therapeutics which likewise proves that the worker's diagnosis was correct. This information which our medical-social worker secures at no little effort on her part and at the expenditure of considerable of the hospital's time must be of a different sort to be useful than that secured when some other end than that above suggested is sought.

General hospital social histories must take on a distinctly medical trend. For example: It is of interest to know that Bessie Smith, a patient in our Children's Hospital, came from a home where only inadequate funds were available for food and clothing. It is also not uninteresting to know that she has four sisters and no brothers, that the father has been missing since January, and that he is said to have had a venereal disease. It is of the greatest importance to know that Bessie was taken ill two days ago with fever, cough and coryza, and that she complained that the light hurt her eyes—her sister having just recovered from an illness with a rash which covered her entire body. Such information saves lives and preserves a ward for service to the community.
Mode, time, and manner of onset of disease, health prior to attack, contagious contact, family history as to tuberculosis, cancer, and lues, general home sanitation, source of water, milk, etc., are but a few of the many headings which a good medical social history, especially of children, should cover.

It is also possible on discharge to take much of the hospital life and teachings home to the discharged patient. Improved home and personal sanitation; the lessening of stress and strain to accommodate a diseased myocardium, the lessening of intemperance, all must prolong the intervals between hospitalizations in the chronically ill. It is the function of the social worker to translate these admonitions and warnings into the language of every-day home life. To explain and interpret the physician’s orders, so that a spirit of healthy cooperation on the part of the patient will result because he understands that his own and his family’s good only is sought. It is not infrequently necessary for the judgment of the worker to be the only guide as to when the hospital’s aid must again be sought as well as to overcome a reluctance to return; to explain that the taking of blood for a Wassermann reaction, or the somewhat painful spinal puncture, were all necessary for his good, and not merely an experiment of no or doubtful value. The interpretation of many of the troublesome and terrifying happenings of hospital life by the worker frequently replaces fear and distrust with confidence and a desire to co-operate with the physician’s efforts. The social worker is able to get the viewpoint of the patient and consequently can secure his confidence more easily than can either the doctor or the nurse and he looks to her as his advocate and defender in seeing that he secures a fair deal from the hospital.

This is a healthy attitude for the medical-social service department to engender. To be of the greatest service to any community the fair dealing and high motives of any hospital must be unquestioned.

There are a number of special departments in most hospitals where the greatest care must be exercised in the selection of the worker because of the difficult nature of the work yet where the complexity of the situation and the good which may be accomplished are in direct proportion. I refer to the work with the venereally infected, the unmarried mothers, the psychopathic wards, the children’s department, the general medical wards (cardiac and diabetic cases), and the admission office.
Is it not as unreasonable to expect a social worker to be able to expertly and efficiently handle the greatly diversified work in all of a general hospital's departments as it would be for the public to demand of the ear specialist that he must also do good pediatrics or of a general surgeon that he must be able to diagnose and treat mental diseases.

We believe that to do good work in the venereal ward much special training and tact are required, and that the woman who can do good psychiatric social work might bungle the work in a children's ward and merit no special blame for so doing either. Should the worker, who has no knowledge of the deceits, the trickery, the moral and mental decay so often seen in the drug habitue, expect other than to be ridiculed by her patient for her gullibility? It is evident, then, that within the ranks of our hospital social staff there must appear the member who knows one department, its patients, their disease, its relation to the individual's past or future community life, better than any other, and to her is assigned by the directress all problems affecting her charges.

In the receiving ward, where all is hurry and bustle, and where personalities may easily enter because of the urge of work, the fatigue of the long day or because of duties and authority ill-placed or explained, all the tact and skill of the social worker is called upon. But here a skilled person may do much to detect social need or to quiet the fears of the patient or his relatives. Here may be added that touch of personal interest which makes the patient sure that he is to be treated as an individual and not as a grain in the grist for grinding and that his story of a fall in childhood, or of overworking at school will be sympathetically listened to. She may learn of contagious contact, of home distress, of the relation of occupation to disease, and of the one and one hundred important facts to which the skilled worker's eyes and ears are always open. Here she may quietly yet efficiently survey the great flood of sick humanity flowing past her and classify its social needs as to urgency and importance. This information, when submitted to her superior, may then be properly acted on as she sees fit.

In the venereal wards of all places it seems that the judgment and tact of the worker must be most trained. The worker assigned here must know the character and characteristics of her patient most thoroughly. She must be able to learn by her questioning just what is absolutely necessary for the medical and social diagnosis
of the case and no more. I fear that workers become sometimes incautious in their questioning and risk losing the confidence of their patient by asking questions the answers of which would add but little of importance in the handling of the case to the best interests of the patient and the community. Modesty in some degree exists in the most hardened venereal patient and some times is the starting point toward a partial moral restoration.

The hospital medical-social worker must understand the interpretation of meaning of the Wassermann reaction in so far as it affects treatment and infectiousness. She must strive to disseminate the information that the magic word "Wassermann" is just the name of a laboratory reaction called after its discoverer and that when the word "positive" or "4+" is prefixed the patient possessed of this characteristic is not always either a community peril or a breaker of the Seventh Commandment. Contrary to the belief in some circles Wassermans cannot be treated. In this department, a genuine human sympathy can do much, for here and there is a brand which may be plucked from the burning. The follow-up work relative to bringing these patients back for dispensary care is of no small bulk or importance and the worker assigned to the venereal department should also assist in the genitourinary dispensary. One of the problems, which so frequently confront the medical-social worker in the venereal wards, is to know just how to handle an urgent request by husband or wife for information as to the other's real condition. To be too frank often means home-breaking and suffering certainly brought on innocent children or even on an innocent patient. Good rarely, if ever, follows in the wake of deceit. Such a dilemma usually can be best solved by referring the inquirer to the physician but if lying is necessary as it rarely is, the physician's soul may be more callous and, therefore, suffer less from the sinning. It is rarely necessary for the worker to more than transmit for the physician a message that the presence of the husband or wife is wished at the hospital when serologic studies on the blood of others than the patient are deemed advisable, for the request for a blood examination usually requires difficult explanations.

In the children's department, constructive and most interesting work awaits the social specialist. The securing of really valuable histories; the tranquilizing of the mother's mind; the planning for
the future of that poor, little, unwelcome, and nameless waif—the foundling; the home follow-up, nutritional and preventive clinics—all offer many opportunities for service.

Time prevents me from making more than a general mention of the possible activities of the worker in the hospital's many departments.

Too few hospitals have been able to properly conduct clinics for the diabetic, the cardiac, for the study of occupational diseases, or for the proper prenatal instruction to mothers. In these activities the alert and intelligent service which the medical-social worker can bring is of greatest importance. These clinics are not infrequently of service in direct proportion to the efficiency of the social service work done therein.

There is one other great function which can be performed: this is the co-ordination of the hospital with the activities of other institutions doing similar work; to prevent duplication of work; to make known to others the facilities of her hospital in caring for any unusual type of case; to learn like facts from others; to uphold and defend her institution when it is unjustly accused and to do her part in correcting a wrong when such exists.

I have spoken in some detail of the medical-social worker's obligations to her hospital. Let me conclude by expressing my conception of what the hospital should mean to her.

The hospital must mean an institution with no other aim or excuse for existence than to help the sick get well and to endeavor to keep them so. It must show its appreciation of good social work by granting adequate salaries. It must realize that good work cannot be done in a poorly-lighted, ill-ventilated, out-of-the-way office. It must impress the worker as an ethical well-run business where regard for ethical procedure is insisted on. It must mean an institution where loyalty is expected and given. With such an understanding and with the great possibilities for service to the community which this combination makes possible, the command must be given, "FORWARD MARCH!"
THE PLACE OF PSYCHIATRIC SOCIAL WORK*

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The term "psychiatric social work" has been in use only a few years (it was used in print for the first time, I believe, in 1918), but it came quickly to have a definite meaning and an extended use, because it met a practical need that had been germinating for a good many years.

Every movement is a focusing of many trends. It is interesting to think back and trace some of the influences that contributed to the development of the psychiatric social worker. Going back to the first National Conference of Social Work in 1874, we find the program devoted to "The Duty of the States to Their Insane Poor;" but though insanity figured largely in the early conferences, the social worker did not enter the insane hospitals. England in 1880 began a system of after-care for patients discharged from mental hospitals. Physicians and social workers were urging after-care in this country. A state hospital superintendent, in 1897, in writing a "Text-Book on Mental Diseases," said: "Insanity, practically, is loss of the power of conformity to the social medium in which the patient lives. This power is regained in convalescence gradually, and it is a part of the psychotherapy to furnish a normal personal environment to which the patient is to practice adjustment." * * * "The physician who has conducted a case of mental disorder through all the vicissitudes of an acute attack to perfect recovery has a final duty to perform. There are to be laid down definite rules of life, points in physical and mental hygiene, suggestions of the best way to meet social and business difficulties, and advice as to domestic relations."

But still the application of organized social service was not thought of. So far as I know, the first time that a social worker was engaged to assist in the care of mental patients was in 1905, when Dr. James Putnam got Miss Burleigh to come to the Neuro-

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logical Clinic at the Massachusetts General Hospital. Bellevue, a year later, placed a social worker in the Psychopathic Ward. The State Charities Aid Association in New York took the next important step in offering the services of a social worker to two of the New York state hospitals. A year later, 1911, she was taken on to the state payroll, the first psychiatric social worker to be employed by a public institution. In 1913, in Massachusetts, social work was begun at the Psychopathic Hospital, Danvers State Hospital, and Boston State Hospital. The same year the Phipps Psychiatric Clinic in Baltimore opened with provision for a social service. Meanwhile a National Committee for Mental Hygiene and a number of local branches were developing a sentiment for complete medical and social care of mental patients. Another important influence has been the psychiatric clinics in connection with courts and reformatories, of which Dr. Healy's clinic in Chicago was the forerunner, involving necessarily social study and treatment of delinquents.

Along with these influences of medical origin runs an equally strong trend developing in social work itself. Naturally the dominant interest in social work in its beginning was economic—economic needs come first—then gradually the emphasis came to be upon bodily condition, partly through the influence of medical social work and partly through internal forces in general social work; and recently there has been a growing emphasis upon mental condition. For twenty years at least, there have been social workers here and there who have insisted upon seeking out motives and studying the effects of past experiences in their clients as well as the more obvious facts of mental deficiency and mental disease. Mr. Birtwell of the Boston Children's Aid Society, was one of those who contributed much along this line. Dr. Cabot with his insistence that social work was the training of character under adversity exerted an influence from the direction of medical work.

This is but a sketch of the ideas and efforts that have gone into the making of this new division of social work, but any sort of account would be incomplete without mention of Dr. E. E. Southard, for undoubtedly he made the greatest single contribution. Dr. Southard claimed no novelty or originality for the social work of the Psychopathic Hospital, (it is the application of social case work in a new field), but he claimed to have created the part that the social worker is to play in the mental hygiene movement and to have given it a name. I found among Dr. Southard's papers a memorandum which is of interest here:
"The social service movement seems to be waxing fast, although not fast enough for its problems.Personally, I seem to have been greatly influenced by some of Professor Royce's earlier ethical papers touching the social "consciousness" so-called, by Professor Putnam's contentions, and by the point of view of Professor James which culminated in his marvelous address on "The Moral Equivalent of War." Then came brief but uplifting observations of the Social Service Department of the Massachusetts General Hospital under the leadership of Miss Ida M. Cannon. After the establishment of the Psychopathic Hospital, I began to get light from a group of persons interested in social service, among whom, besides Miss Cannon, I should especially count my colleague Dr. W. P. Lucas, Mr. Michael M. Davis, and Miss Katherine MacMahon.

"My own ideas are derived from many sources. The need of a social service in the new Psychopathic Hospital became obvious at once when the plans were tentatively begun in 1909-1910 and the obvious need was expressed in so many words in the State Board of Insanity's report of 1910. So far as I can remember, space was reserved for social service in the very first of the plans from which the eventual plan was developed. To be sure, many physicians who were shown the plans affected astonishment at the large space assigned to the out-patient work as a whole, and there was almost no general appreciation of either the whole out-patient work or its social service constituents. These critics are now easily won over by the practical results obtained."

Psychiatric social work has two immediate tasks: (a) to develop this new branch of social work, and (b) to put back into the main stem whatever it may gain of special knowledge and technique.

The chief contributions that psychiatric social work has to make to social case work seem to me to be: (a) greater individualization in the study and treatment of clients, and (b) more objective and accurate methods of observation.

In the family welfare agencies, case work has steadily tended to become more individual. Necessarily so, for when you get beyond the stage of economic emphasis, you must deal with each person in the family group individually. You can relieve an economic problem by group treatment, but each individual of the group must be considered separately when you come to questions of health.

Observation that is accurate and objective is a leading principle in psychiatry. The facts must be obtained by the psychiatric social
worker, not what seems to be true or would be true if we were in the place of the patient; but what actually is true of that particular individual.

The relation of psychiatric social work to the mental hygiene movement is the same that medical social work bears to the public health movement. Just as some physicians elect to work for prevention and treatment of mental disease and others for prevention and treatment of physical disorders, so there are some social workers who choose mental hygiene for their field and others who choose public health. Within medicine there are a number of special fields in which both physicians and social workers prefer to work according to their various interests; and also in psychiatry specialties are beginning to appear; but medicine and psychiatry are in the main differentiated by a dominant interest either in the physical or the psychological features of illness.

The more the social worker specializing in each field knows of the other, the better social worker she will be; but the two types of social worker are not interchangeable. The psychiatric social worker is not a medical-social worker who happens to be placed in a mental clinic, nor can first-rate medical-social work be expected of the psychiatric social worker. A person is led by a certain sort of interest and a certain kind of temperament to choose one or the other of these fields. The medical-social worker and the psychiatric social worker have a purpose in common—they are working together in the health field and, therefore, they are united by considerations more fundamental than those by which they are differentiated.
SOCIAL WORK BY A HEALTH DEPARTMENT

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Reviewing the history of nurses' training courses, one is impressed with the development in the scope of this work, due to increased education and enlarged opportunities. During our training we had a superintendent with rare foresight. In every lecture or class, she insisted that we were not only to familiarize ourselves with the care of the sick, but learn how to teach people how to keep well. In order to accomplish this, she emphasized the need of developing our powers of observation. For instance, in caring for a patient we not only were taught the personal care necessary, but to look for and recognize the contributing causes of any change in the symptoms.

In Public Health Nursing, one's opportunities for development are almost unlimited. Unlike the hospital ward, with its proper equipment and cleanliness, our problems are found in very different environment. A nurse would be a sorry failure indeed, if she could only see the medical needs in a home and could not appreciate the social or other contributing causes. Health is not maintained solely by the resistance of the individual to germ infection. Lack of nourishment or cleanliness, low financial status, worry, disorder, unsuitable locality, lack of employment, low mentality, bad associations, child labor, drunkenness, immorality, ignorance, cruelty, or vice may be the specific cause of existing distress.

There are five divisions in the Nursing Service of the Detroit Health Department: 1—Pre-natal, Infant Welfare, Pre-school. 2—School. 3—Contagious. 4—Venereal. 5—Tuberculosis.

Each division has its own supervisor who receives written reports from nurses on her staff, relative to social needs of families in her care. These reports are delivered by the supervisor to the Department of Special Investigation. Search is made to see if the family is registered already in the department. The confidential exchange is consulted and the case referred to the proper agency for relief.

The agencies with which we co-operate are the Department of Public Welfare Juvenile Court (with Mothers' Pension Department), Municipal Courts, Child-Placing Agencies, Industrial Social Service Departments, Hospital Social Service Departments, Depart-
ment of Education, Police Department, Psychopathic Clinics and various charities. After the case has been referred to the agency for relief, our nurse continues her health visits until the problem has been eliminated, and furnishes the office with findings of each subsequent visit.

The Public Welfare is the principal relief-giving agency in the city, therefore, our co-operation with them is very active. The destitute family is furnished with the original of a duplicate-written request, signed by one of our nurses. With this the parent makes personal application for whatever is needed—employment, fuel, grocery order, milk, glasses, shoes, burial provisions or medicines. The duplicate is sent to the Department of Special Investigation. Since the family makes personal application, they do not get the erroneous impression that the Health Department is furnishing relief, but they do know that the City Departments maintain a wholesome co-operation for the efficient conduct of their own activities. As public agents we are compelled to safeguard the city's relief agencies from imposters as far as possible. We do not pretend to be expert investigators of social conditions, so sometimes our requests are refused as a result of their more extensive investigations in these matters.

We cannot speak too highly of the manner in which the Public Welfare responds to the requests of our various departments. To make it possible for an undernourished mother to nurse her child, milk is furnished upon request. Many of our babies' formulas are made up of milk provided by this same department, undernourished pre-school and school children need not suffer from lack of their chief article of diet because their parents cannot afford to pay the milkman. Tuberculous patients, too, are given special consideration with milk tickets and grocery orders. School children need not stay at home indefinitely for lack of shoes, nor is it necessary for them to suffer from eye strain from the need of glasses for the prescriptions from our eye clinics are honored by the city physician and secured at a nominal fee from the optical store.

The workers of the Public Welfare Department and the Mothers' Pension Department are much interested in medical matters and familiarize themselves with the facilities of the Health Department and direct their families to have physical examinations made in our clinics. They assist materially by impressing the recommendations of the clinics upon our patients: i. e., attendance for subsequent examinations and treatments, attendance at open air schools, accep-
tance of sanitorium or hospital care. They also make reports of unsanitary housing and needs of public health nursing service apparent to them.

Our widowed mothers and mothers deserted over a year are referred to the Mothers’ Pension Department, where an allowance provided by the county is paid them regularly for the maintenance of their families. Once they are registered with this department all subsequent needs are reported to them and either furnished by them or upon their request by the Department of Public Welfare. Regular visitors supervise these families. Any lack of co-operation with our nurses, through lack of understanding, is reported by us to the visitor for adjustment. Recently our nurse found in one family under their care one child practically dying of heart trouble and another suffering with Pott’s disease. The mother, terrified at the thought of hospital, refused to let them go. As a result of our report to their visitor, the boy was placed in the hospital for months and the girl also admitted in order to have a frame applied. We constantly call upon the Child-Placing Agencies to place children for us, to enable mothers to go to the hospitals for confinement or operation, or the sanitorium for treatment of tuberculosis. In case of emergency we are permitted to place children in the Detention Home and in the Receiving Hospital until the agency can place them.

The Christ Child Society furnishes layettes for our expected babies where necessary. Our request is made in writing, with a brief explanation of the case. The society delivers the box of garments with only a card: “Compliments of the Christ Child Society.” It would be difficult to describe what a sweet token of sympathy this is to many a discouraged and hard-working mother. The materials and styles are sensible and comfortable and encourage duplication. Our unmarried pregnant women are referred at once to the Social Service Department of the Woman’s Hospital for medical and social care. Unmarried mothers are also sent there with their babies. This department sees to it that the father of the child is apprehended and made to bear his responsibility. They protect the mother during her pregnancy, care for her during confinement and enable her to nurse the baby during the necessary period, and if deemed advisable, file application for adoption with the Juvenile Court. Delinquent girls, under seventeen years of age, suspected of pregnancy, are reported to the Girls’ Department of the Juvenile Court for investigation and care. Older delinquents are referred to the Girls’ Protective League, or to the Catholic Bureau for friendly guidance.
The Bureau of Wet Nurses at the Woman's Hospital accepts reports of mothers with an over-abundance of breast milk. When breast milk is prescribed for babies by our doctors, we refer the matter to this bureau. They furnish it at a price suited to the financial status of the family.

The Social Service Departments in out-patient service of general hospitals furnish splints, belts, etc., to our destitute children who are referred to them for this care.

The Juvenile Court readily furnishes writs to take babies found suffering with ophthalmia to the hospital. This is not necessary as frequently as in former times. More general appreciation of the danger of "baby's sore eyes," makes the public more willing to cooperate instantly to save the baby's eyesight. The Social Service Department of the hospital makes arrangements to have the mother furnish her own milk for the baby while it is in the hospital. Complaints are filed with the Juvenile Court in cases of neglect of the health of babies or children. Wilful exposure to tuberculosis, personal cruelty, failure to provide proper home, food, clothing or medical care are some of the complaints we register. These existing conditions are due to mental weakness of the parents, to the use of intoxicants or drugs, or to obstinate defiance of authority. During the year 1920, forty-six such complaints were registered by us with the court. Such action is not resorted to except when there is no other possible solution of the problem that will give the children the greatest consideration. We are sometimes called upon to testify in the Juvenile Court regarding the suitability of a foster-parent for the guardianship of a child we have been supervising. If a child is found suffering physically as a result of personal cruelty, the matter is referred to the Juvenile Court for the protection of the child and to the Municipal Court for the punishment of the guardian. We had occasion recently to have a step-mother arrested for burning her son of six years with a red hot poker. She was sentenced to three years in the House of Correction. The boy and his little sister were taken from the custody of the father and placed with a Child-Placing Agency for boarding care.

An astonishing percentage of our difficult problems is complicated by mental subnormality. The Psychological Departments at the Juvenile Court, Department of Education and Receiving Hospital make tests for us and make recommendations regarding methods of treatment. When commitment to institutions for feeble-mindedness, insanity or epilepsy is recommended, we encourage the guardians to make application to the Probate Court. If they are unwilling to do
so, we make the application and have it signed by the sheriff. We appear at the hearing of the case and show cause why we feel the commitment is necessary. In some instances the Juvenile Court has transferred our mentally complicated cases to the Psychopathic Clinic for study and intensive supervision.

The work of our school nurses links up closely with that of the truant officer. Children absent from school, supposedly ill, when found to be physically fit for school, are reported to the attendance department.

Children who have been recommended for treatment or for special room supervision, who have failed to follow instruction, are reported to the attendance department and the parents are charged with truancy in the Municipal Court. It is necessary then for them to show cause why the child has not received the care recommended to permit him to return to school within a reasonable time.

The control of venereal disease and tuberculosis is largely prevented by the presence in our midst of faith healers, fake advertising quacks and unscrupulous physicians, who lend their registration for the protection of sharks. Tuberculous patients are particularly gullible. They are only too glad to give their money to someone who assures them that they do not have tuberculosis and that they will be cured of "that cold" in a short time. These patients, of course, evade detection as they are not reported. Their progress is retarded, time wasted and money spent, while the disease spreads and is transmitted before opportunity is afforded to do anything for them. The advertising sharks make a practice of diagnosing patients as venereal disease and after collecting as much as two hundred dollars give a couple of injections of questionable medicine and assure their victims they are cured. No reports are made of these cases and the number infected by them would be hard to estimate. Seventeen fake healers and six advertising quacks were prosecuted in 1920 by this department. Three physicians were reported after conviction to the State Board of Registration and their licenses revoked.

Children are constantly being found in school, or found not attending school, who are deaf or partially sighted, crippled, blind or mentally deficient. For these types the Department of Education has special rooms. These children are referred to the Department of Education and placed by them in the correct room to suit the condition.

The Industrial Social Service Departments have co-operated in providing work more suitable to the physical needs of our patients.
They also use their influence in persuading patients to accept hospital care and assist in the disposition of the children, and in some instances provide work for other members of the family.

At times we are confronted with an abnormal pre-natal patient who will not consent to hospital care. If it is impossible for us to reach her husband in the home, we apply to the Social Service Department of the plant at which he is employed, and are able to reach him through some interested person who explains the matter to him. When he is made to see the gravity of the situation, persuasion by him brings her consent to hospitalization.

Through the American Legion we are enabled to secure additional sanitorium facilities for tuberculous soldiers.

The Visiting Housekeepers assist us in teaching nutrition work, etc., in the homes.

The License Clerk upon our request denies marriage licenses to diseased people.

The advantages in having all this work done by a special department, the Department of Special Investigation, are that nurses having the greatest experience with medical-social cases, handle the most difficult and obstinate cases, thereby minimizing the necessity of court interference. A department vested with police power, as this is, may do many things which the field nurse may not safely do. Cases requiring repeated and unusually unsatisfactory visits are eliminated from the field nurses’ already overburdened shoulders. Long hours required by court procedures are shifted from field work, no matter in what type of medical service they originate. It makes possible one center for all socially complicated cases. It provides persons familiar with all data, on duty at all times. Having a clearing house in a large organization of diversified interests tends to stabilize the relationship with other city and voluntary agencies. It makes possible a supervisor interested in medical-social complications, available for instruction of nurses in such case work. It eliminates duplication, for as social work is common to all five divisions, five supervisors would otherwise have to teach the same subject, to smaller groups, and last but not least it removes the odium attached to coercive work so that the field nurse does not lose prestige in her district.

Unless the close co-operation between us and local agencies existed, much of our important work could not be accomplished, and certainly great credit is due them for helping the department make our community a healthier place to live in.
The work described in this paper was done with children attending the cardiac clinic of the pediatric department of the New York Post-Graduate Hospital. Certain cases were selected by the physician in charge of that clinic and sent to the physical instructor for exercise. The cases selected included all kinds of heart lesions and functional disturbances — mitral stenosis, mitral regurgitation, aortic insufficiency, double mitral and aortic, "potential" cardiacs, tachycardia, etc. The cases were allowed to start the exercises at any time after the acute stage of infection or attack was past. The ages ranged from four to fifteen years.

The children came to the hospital for exercise twice a week, and during this time went back also, at first once a week, later once a fortnight, to the cardiac clinic for examination so that the physician could keep track of their progress and make suggestions to the physical instructor as to the increase or decrease of the exercise. Simultaneously the social service department was visiting the home and the school, if the child was in school, regulating the child's life so far as possible, and instructing the mother as to diet, rest and fresh air. Arrangements were also made as rapidly as possible for the removal of causes of infection as tonsils, adenoids and decayed teeth.

When a case is referred for exercise, in addition to the doctor's examination, the physical instructor takes certain measurements and tracings for the purpose of detecting anatomical irregularities and weaknesses which might bear on the case. A tape line, adhesive plaster, orthopedic lead tape, and curved ruler are used and tracings made of the spine to show lateral and anteroposterior deviations from the normal. Measurements are taken of the chest, tracing of the intercostal angle and of any irregularities of outline of the chest, such as occur in rachitic conditions. Note is also taken of flexibility, condition of musculature, condition of skin, etc.
Certain complications in the way of structural faults are so common as to form a typical picture of a slight child, somewhat under weight, with rigid spine, one shoulder high, constricted chest, narrow intercostal angle, flabby muscles, and general air of inflexibility combined with weakness. The flat chest crowds the heart and lungs and is too inflexible to permit of free respiration. The rigid spine interferes with proper circulation. The stiff joints and flabby muscles make a correct posture impossible. The child's life is lived under the double handicap of the defective heart and of general strain and weakness. With this typical physique goes the typical temperament: nervous, anxious, fearful, excitable, restless. This temperament is exaggerated by the cautions of anxious friends, parents, relatives, teachers, physicians and all who come in contact with the child and constantly warn him against over-exertion.

The life of a normal child is full of activity. By this means he keeps his muscles in tone, his nutrition normal, and by constant exertion deepens his respiration and increases his lung capacity. But the life of these children, with cardiac disturbances, has not been normal. Cut off from free play, they have mostly no substitute for it either to aid their general health and growth, or as an outlet for their natural impulses for activity. The result is general lack of stamina and often a restless, difficult, wayward disposition.

The problem of the physical instructor is three-fold. First, to provide a form of activity which these children can take which will benefit their general health without injury to the heart. Second, so to adapt that activity that it will have a tendency to remove their structural handicaps. And third, to go a step beyond and give exercise which is positively beneficial and therapeutic with regard to the heart condition.

It may be said that any form of activity which cardinals can take without positive injury to the heart is better than none. For the theories as to the need of exercise for cardinals and their tolerance to exercise have undergone almost complete transformation within a few years. A tremendous impetus has also been given to this subject through the experience with cardiac soldiers during the war. It is noteworthy in this regard that much of the exercise was planned as a test of exercise tolerance and proved itself of therapeutic value.

The public schools are attempting to supply the need by segregating the cardiac children in special schools, where in addition to facilities for rest, extra food, etc., the children are examined and
graded as to their exercise tolerance in order to limit their activities to those which they can safely take, and yet be encouraged to exercise up to their exercise tolerance.

What we are attempting to do in the Post-Graduate Hospital is to apply scientific methods in adapting exercise to the individual needs of the children. We consider the kind of exercise and the manner in which it is done to be of the utmost importance. We feel that by the selection and adaptation of exercise, the cardiac child can not only do more without injury, but that he can simultaneously be improving his cardiac muscle, general musculature and circulation, and also be correcting those structural abnormalities which are handicaps to the child and aggravations of the heart condition.

None of the work is class work. The children work in groups, but in groups so small that they may receive individual instruction and attention. The system used is that of W. Curtis Adams.

The first exercise given is a simple flexion exercise for arms and legs. The patient lies on his back on the mat with legs extended, toes pointing toward the ceiling, elbows bent, hands clasped but resting lightly on the side of the chest. From this position the patient extends both arms toward the ceiling, fingers extended, at the same time flexing one knee and bringing it as far as possible toward the chest, keeping the other leg completely extended. On second count he assumes the original position, on third the arms are again extended with the other knee flexed, etc., eight counts with the hands toward ceiling, eight with hands toward walls, eight above head. At first with most severe cases these flexions may be done with arms and legs separately, later combined. The motions should be made rhythmically. Breathing should be continuous, and correlated with the leg motion, expiration coinciding with the thigh flexion. The body should lie as relaxed as possible, with no undue tension in any muscle, and the muscles not actively in use should be relaxed. Mental effort and excitement is reduced if the instructor at first goes through the arm motions with the child, for imitation is simpler than obedience to command and explanation. From the beginning a form of deep breathing is also given, aiming to bring into use the abdominal muscles and the diaphragm, and to increase the flexibility of the chest.

New cases work about fifteen minutes, including rests between exercises. This time is gradually increased as the child learns the exercises, and new exercises are added according to the child's ability. The number of exercises used is not great and the same
principles are exemplified in each—relaxation of the muscles already strong in order that the weak muscles shall be brought into play, correlation of the breathing which should be continuous, and never interrupted. This development of the diaphragm, aided increased flexibility of the bony structure, and the building up of the muscles needed in poise is brought about.

How much exercise should be given to a case? We watch the pulse rate and rhythm, but we judge principally by watching for the obvious signs of distress: flushing, pallor, tremor, perspiration, dyspnoea, etc. And we adhere to certain principles, namely, to begin with effort less than we are sure the child can stand. We make an allowance at first for the excitement of a new game with a strange instructor, increase very gradually, and work with a group small enough so that we can study each child's individual needs and progress.

After the exercises have been done for a shorter or longer time according to the case, we teach most of the children a few stunts. These are very popular: roll-overs, backward and forward; head stands, hand stands, crab walk, etc. They are invaluable on the psychological side, in stirring up ambition and hope of physical prowess, which have been deadened in these children by constant restraint. They bring out the first gleam of real enthusiasm in some of the discouraged cases and are something to look forward to for the weaker ones. They have also their value physically in increasing flexibility and giving a certain co-ordinated muscle control and sense of balance that are helpful in many ways.

Since almost without exception the children themselves enjoy the exercises, it is a simple matter to awaken their interest and enthusiasm; the older children are quick to notice their own improvement and to report on it with pride—one boy that his back is straighter, another that his thighs flex much farther, another that his deeper breathing has reduced his fear and nervousness.

With regard to reporting on the effect of the exercises, the work has not as yet been carried on under conditions in which it was possible to limit the problem and control the environment sufficiently to give exact data. We can make a general statement as to what percentage of the cases have improved, but we cannot state with assurance what part of this improvement is due to the exercises and what to other treatment, such as rest, diet and elimination of infection.
About ninety per cent of the cases worked with last year improved. The other ten per cent included those cases that had a reinfection, cases of mental deficiency, and such lack of co-operation by the family that the cases had to be dismissed. There was no instance where sudden adverse symptoms appeared during or after the exercises and no case of retrogression could be traced to the exercises. We believe the improvement of the heart condition which can be credited to the exercises to be due to the following causes:

1. The blood is drawn out of the heart into the peripheral vessels thus relieving the engorged heart. The opening and shutting of the hands help to draw the blood to the fingers, and there is an actual massaging of the deep veins of the groin by the thigh flexion, provided the patient is relaxed.

2. Improvement of the general condition of musculature improves the heart muscle.

3. The heart muscle is directly developed through use.

4. Nervousness, fear, and excitement are reduced by toning up the nervous system, and by deepening the respiration.

5. The chest is lifted and the intercostal angle widened, giving the heart and lungs more room.

6. Improvement of posture and general muscle tone, permitting the child to walk easily instead of with infinite effort and fatigue, reduces the work which the heart is called upon to do.

So far as the structural changes go, our tracings, taken at intervals, show changes in spinal curves, chest outlines, intercostal angles, etc. It is necessary in discussing exercise for cardiac cases to distinguish between exercise done to test the heart and that done for its therapeutic effect. Very often similar exercises are used for the two purposes but selection of the kind of exercise should depend on which object is primary.

The system of exercise used at the Post-Graduate Hospital, the Adams system, is similar in some respects to the pedestrian exercise used by Oertel in Switzerland and in this country at Battle Creek and other places. Both systems make use of exercises of endurance, which McKenzie defines as “consisting of motions rhythmically repeated without great muscular expenditure for each one and depending for their effect upon continuous repetition.” In such exercise, each movement is well within one’s power, but the total amount of muscular work is great. The development of any one group of muscles is secondary to the indirect effect on circulation
and respiration, and the effect on the general system is much more profound than that which follows exercises of effort. Our object here is not to increase the size of any one group of muscles (as is the object sometimes with athletics) but to cultivate constitutional vigor.

Yet the Adams method differs from the pedestrian in several ways; first, it is all done lying down. The strain always present in the erect position is thus taken off the heart, and if the exercise is correctly done, all the muscles of the body not actively in use are relaxed. It is thus possible to develop the long, deep, and weak muscles of the body which are needed in poise.

Secondly, the amount of exercise can be controlled and the patient carefully watched since the work is done in a gymnasium under supervision.

Thirdly, it effects the structure—lifts the chest, improves the posture, and therefore relieves the heart. We are here working simultaneously at the circulatory system and at the structure, not with two separate problems, but with one.

I am indebted to Doctor Roger H. Dennett, Director of the Pediatric Department, for his courtesy in allowing the use of the records.
HANDICAPPED DEPARTMENT
I. M. DUGGAN, Editor

The Difficulties of Follow-up Work With Patients of Heart Disease and How to Correct Them*
I. M. DUGGAN

When Dr. Halsey invited me to say a few words in regard to the follow-up of the cardiac, he said that one of the most important functions of the cardiac clinic is the continual follow-up of the patient. This statement applies also to the Handicapped Employment Bureau which, since it was established in August, 1918, has been doing pioneer work in the placement of cardinals. The Committee of the Employment Bureau for the Handicapped, of which Mrs. John S. Sheppard is chairman, feels that we must leave nothing unaccomplished in following up the cardinals placed in positions in order to be of great assistance to you.

The greatest difficulty experienced by the bureau in placing the cardinals comes from insufficient information of the applicant's condition and the greatest difficulty in the follow-up work is the fact that the clinics lose track of the patients because the patients will not co-operate.

During the past six months we have made an intensive follow-up of the placed applicants by visiting the clinics the first of the month to learn if they are attending the clinics and whether their conditions are improved or deteriorated since placed in the positions. In going over their old history cards we find the handicap, in many cases, is simply "cardiac" with no added information. To correct this condition and avoid mistakes, I would like to suggest the use of the Association of Cardiac Clinics classified blanks, with classification noted and signed by the doctor in charge of the clinic, also stating the kind of work the applicant is capable of doing. This information is entered on the history card of the applicant. I shall then return the card to the social worker stating the kind of position in which placed. By having this classification we can be of the greatest service to the clinics and always do the right thing. When I find that I have placed a cardiac in a position in which he has, or will deteriorate, I immediately remove him from that position. In the past month

*Read before the Meeting of the Association of Cardiac Clinics, at the Academy of Medicine, April 23, 1921.
I have placed two cardiacs as watchmen in industries. The work was misrepresented to me by the employer, not intentionally but because the average employer thinks that the work in his particular factory is nothing at all. As soon as I learned that both men were climbing several flights of stairs I insisted that they give up the positions, which they did. I had a complete diagnosis and classification in both cases, and these two instances, in which I have been able to rescue the cardiac, will show you how I can help to prevent the breaks by having the classification. When you discover that I have placed an applicant in a position in which he will deteriorate, if he refuses to give up the position, I shall be glad to take the matter up with the employer and find more suitable work for him. Many times the same employer fits him into some lighter work and I always have another handicap, not a cardiac, to take the former position.

It is a great pleasure to be able to be of assistance to the doctors and social workers in the clinics from whom I have always received the greatest support.

In closing I would like to tell you of a bright boy of sixteen years who was referred to the bureau from the New York University Medical College. He told me that the cardiac doctor would mail the necessary information concerning his case. I said to him: "Are you a cardiac?" and he said, "No, ma'am, an electrician's helper."

THE FUNCTIONAL CLASSIFICATIONS OF CARDIACS

Class I. Patients with organic heart disease who are able to carry on their habitual physical activity.

Class II. Patients with organic heart disease who are able to carry on diminished physical activity: (a) slightly decreased, (b) greatly decreased.

Class III. Patients with organic heart disease who are unable to carry on any physical activity.

Class IV. Patients with possible heart disease. Patients who have abnormal physical signs in the heart, but in whom the general picture or the character of the physical sign, leads us to believe that they do not originate from cardiac disease.

Class V. Patients with potential heart disease. Patients who do not have any suggestion of cardiac disease, but who are suffering from an infectious condition which may be accompanied by such disease, e. g., rheumatic fever, tonsilitis, chorea, syphilis, etc.
DEPARTMENT OF DIETETICS
E. F. WELLS, Editor

The New York Nutrition Council
Committee Reports

The first annual meeting of the New York Nutrition Council was held in New York on Friday, May 20, at the Sage Foundation Assembly Hall. Mr. Bailey B. Burritt, of the A. I. C. P., was elected chairman for the coming year, taking the place of Dr. Mary S. Rose of Teachers' College. Mrs. Amy D. Storer, of the Atlantic Division of the American Red Cross, was elected secretary, succeeding Miss Emma A. Winslow, of the Charity Organization Society. Dr. Rose was elected Chairman of the Program Committee and the other members of this committee are to be: Dr. M. Alice Asserson of the New York Tuberculosis Association, Miss Jean Lee Hunt of the Bureau of Educational Experiments, Miss Grace Schermerhorn of the New York City Department of Education and Dr. Hugh Chaplin of Bellevue Hospital.

Since its inaugural meeting last October at the Morningside Nutrition and Homemaking Center, twelve sessions of the Council have been held with special programs arranged by the Bureau of Educational Experiments, the Atlantic Division and the New York County Chapter of the American Red Cross, the Babies' Welfare Federation co-operating with the Pediatric Section of the Academy of Medicine, the Child Health Organization, the A. I. C. P., and the New York Tuberculosis Association. The medical aspects of nutrition work were discussed in an interesting program arranged by Dr. Charles Hendee Smith of Bellevue Hospital. Various problems connected with nutrition work in schools were presented at two conferences with programs arranged by Miss Grace Schermerhorn of the City Department of Education and Dr. S. Josephine Baker of the City Department of Health.

Approximately one hundred different organizations are represented in the Council at the present time. Attendance at conferences increased rapidly last fall from forty to sixty, then to ninety, and more than one hundred and fifty have been in fairly regular attendance beginning with the January meeting. As yet the separate financial burden of the support of the Council has been negligible,
for the only expenses have been in connection with the arrangements for meetings, and these have been borne by the various groups assuming responsibility for the different programs. During the next year, however, it will probably be necessary to have the Council established on a somewhat more definite financial plan.

Four important committees presented reports at the annual meeting, the Committees on Record Forms, Training Standards, Correlation of Nutrition Activities, and Nutrition Bibliography. The bibliography recommended by the committee is soon to be printed for general distribution through the courtesy of the Health Service Department of the New York County Chapter of the American Red Cross. Copies of the suggested record form may be secured from the secretary of the Council, and also copies of the recommendations of the Committee on Training Standards and the Committee on the Correlation of Nutrition Activities.

EMMA A. WINSLOW,
Secretary, New York Nutrition Council.

REPORT OF COMMITTEE ON CORRELATION OF NUTRITION ACTIVITIES
MAY 20, 1921

I. The committee believes that the best possible basis for any correlation of nutrition activities is to make easily accessible detailed information concerning the methods and aims in various types of nutrition work. The Nutrition Council has already accomplished much along this line through its frequent conferences during the past winter, and the committee recommends that next years program continue to provide at certain meetings full and definite reports of different kinds of nutrition work being developed under various auspices, both here and elsewhere. In order to correlate the work of all those most interested in nutrition problems, it is also suggested that a larger proportion of meetings be held in the evening when it will be more easily possible for physicians to attend.

II. The committee wishes to emphasize the fact that nutrition work cannot be considered all-sufficient unless it includes:

1. Adequate medical service for the careful diagnosis, supervision and treatment of physical causes of malnutrition.
2. Effective educational work reaching both children and adults.
3. Adequate social work for the diagnosis and treatment of social causes of malnutrition.
Nutrition Council

Certain types of agencies are especially well qualified to handle these various phases of a well-rounded nutrition program, but just how their work may best be correlated will vary considerably in different localities. The committee, therefore, recommends that any group attempting to do nutrition work in a particular neighborhood make a careful study of the agencies best qualified to assist locally along these three lines and that a joint program be developed which will reach as effectively as possible as large a proportion of the community as possible.

In organizing such co-operative work in New York City it is suggested that use be made of the information in the Directory of Child Welfare Agencies published by the Babies' Welfare Federation, and the Directory of Social Agencies published by the Charity Organization Society. Much valuable information may also be obtained from the report of the survey of nutritional activities in New York, entitled "Watch New York Children Grow," published by the New York County Chapter of the American Red Cross, and from various other reports listed in the bibliography soon to be published by the Nutrition Council.

III. The committee believes that an important factor in the correlation of nutrition activities is the use of common forms and standards with reference to essential factors. Judging from the discussions of the present year it would seem that there is special need for:

1. Better record forms for uniform use in different types of nutrition work.
3. More accurate information and a uniform classification of the wide range of possible causes of malnutrition.

The committee recommends that members of the Council keep in close touch with whatever research is being done along these lines, and that a certain amount of time be spent at the conferences next year in the discussion of these and other important factors in securing uniformity in the nutrition work conducted under various auspices.

IV. Because of the limited amount of time at its disposal in comparison with the magnitude of the task, the committee wishes this
report to be considered a preliminary report and that a committee with similar functions be appointed as one of the main committees of the Nutrition Council during the coming year for further study of problems of correlation.

Mary Arnold, Babies' Welfare Federation.
S. Josephine Baker, M. D., City Department of Health.
Lucy Oppen, Child Health Organization.
Grace Schermerhorn, City Department of Education.
Beatrice Borg Stein, Federation for Child Study.
Emma A. Winslow, Charity Organization Society.
Paul S. Barrett, M. D., Post Graduate Hospital.
George R. Bedinger, New York County Chapter, Red Cross.
Bailey B. Burratt, A. I. C. P.
Charles Hendee Smith, M. D., Bellevue Hospital, Chairman.

REPORT OF COMMITTEE ON TRAINING STANDARDS.

The Committee on Training Standards for Nutrition Workers held three sessions for discussion. Without exception the committee realized that training was essential not only for the success of the nutrition worker but for the success of the work itself. Knowing that the number of competent nutrition workers is small and that the demand is a growing one, the committee aimed to be practical by erecting standards that are within reach; moreover, in formulating standards that were too high the committee felt it would not only limit the possible number of workers but would put boundaries on nutrition work itself as it would confine the work to those communities that could afford to pay the high salary of an expert. The committee tried to make its recommendations general, yet definite enough to be helpful. In specifying the ground to be covered during the course of study the committee aimed to think in terms of "subjects" rather than of "courses." No attempt is made to state the length of time needed to complete the course. Much will depend on the previous training of the applicant. Probably the personnel of the students taking the course may be divided into two classes:

(a) Students who elect these subjects during a regular four-year college course.

(b) Nurses, instructors in physical education, social workers, domestic science teachers and other teachers who wish to supplement their previous training in order to become nutrition workers.
If an applicant has completed satisfactorily some of the subjects specified in this course of study she should be given credit for same. It was felt that good judgment and the experience that comes with living were desirable; consequently the committee decided that one ought to be twenty-one years of age before beginning to work in this field. Though the committee made no attempt to define "personality," all agreed that personality was an important factor.

Training for Field Workers in Nutrition.

Definition—A field worker in nutrition is one who works with the physician on the nutrition of children, either in nutrition classes or the homes, or both.

Prerequisite to Training—The prospective nutrition worker should be a high school graduate.

Training—Subjects taken during training should be on a collegiate basis.

Course of Study.

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<th>Food and Nutrition</th>
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<th>Per Cent</th>
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<tr>
<td>General Chemistry (Prerequisite)</td>
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<td>Dietetics</td>
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<tr>
<td>Cookery</td>
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<tr>
<td>Physiology (including Bacteriology) and Hygiene</td>
<td>240</td>
<td>16</td>
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<tr>
<td>Psychology and Methods of Pedagogy (including child study)</td>
<td>120</td>
<td>8</td>
</tr>
<tr>
<td>Sociology and Economics</td>
<td>240</td>
<td>16</td>
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<tr>
<td>Case Study (study of family problems)</td>
<td>120</td>
<td>8</td>
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<tr>
<td>Record Keeping</td>
<td>45</td>
<td>3</td>
</tr>
<tr>
<td>Symptomatology (to be given by a physician)</td>
<td>30</td>
<td>3</td>
</tr>
<tr>
<td>Public Speaking</td>
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Total ........................................... 1500 100

An hour is a period of fifty to sixty minutes.

Training in Field Work.

Intensive course of three months under supervision.

Age Limit—The nutrition worker should be at least twenty-one years old before beginning work.
There are organizations large enough to employ several nutrition workers. In order that a program may be worked out that will be coherent, it is very desirable that a nutrition supervisor be appointed by these organizations. The committee recommends that in order to qualify for this position the applicant should not only complete the subjects outlined above, but should have a year's experience in field work. She should also have attended a nutrition seminar in order that she may become acquainted with recent research work in nutrition and prepare herself to follow developments in this subject in the future. For the person about to become a supervisor of nutrition in the schools, a course in school administration is recommended. It is also recommended that the supervisor of nutrition be a college graduate.

The following persons were asked to form the Committee on Training Standards for Nutrition Workers:

Miss Mary G. McCormick, State Dept. of Education, Chairman.
Dr. Hugh Chaplin, Bellevue Hospital.
Miss Lucy H. Gillett, A. I. C. P.
Miss Annie V. Goodrich, Henry Street Settlement.
Mr. W. F. Johnson, Children's Aid Society.
Dr. Mary Swartz Rose, Teachers' College.
Mrs. Amy D. Storer, Atlantic Division, American Red Cross.
Dr. Ira S. Wile, Mt. Sinai Hospital.
Dr. Jessie F. Williams, Teachers' College.
EDITORIAL

The Objective of Medical-Social Education

During the coming year there will be a re-alignment of the problems and resources which contribute to clear educational policies in the fields of medical, public health and social services, each of which, while not new, is the object of quickened comprehension. The after-war conditions have accentuated the short-comings of the educational processes in their chief function, that of preparation of men and women who will be able to adapt the sum total of experience of the past to effective achievement in the present. The war has been the greatest demonstration of social, scientific and material power which mankind has put upon the page of human history. The lessons of the war as a tragic exponent of misapplied resources cannot be too profoundly dwelt upon. It is certain that future historians will find that the political and social organization of this period has been inco-ordinate, over-organized, and wasteful of opportunity to realize the fine ideals of living which the characters believed in, who held our country firm in its pioneer period. The increased complexity of life which has kept pace with rapid growth of the products of civilization must be reduced to simpler terms. The force of education is now challenged to the utmost, that order may be restored, while we are conscious that in terms of years rehabilitation must be extended through an indefinite period.

The election of Dr. Hubert Work as President of the American Medical Association has given ground for the expectation that the medical profession, which in common with the hospital organizations, and social and public health agencies, has failed to appreciate the responsibility of the field now recognized as hospital social service, will accomplish definite activities in medical-social work. The note of public health and social business in the medical journals and in general discussions is stronger with each annual assembly.

The annual program of the American Association of Hospital Social Workers is concentrated upon the discussions of function and educational requirements.

The committee on study of public health nursing education, of which Professor Winslow is chairman, will present its findings during the coming year. There is so much material on the program of each of these agencies which has a similar objective that thought-
ful attention should be given to efficient co-ordination, that strong and enduring foundations, and a minimum of confusion of effort may be ensured. We have paid heavily for over-individuality of organization and for confusion of purposes. Equally so for the separation of modes of education from the applied service. Wisely balance the one to the other. Scientific achievement has made wonderful contributions to life, the qualities of erudition and culture are gracious and spiritual, but they may effect the working organism of the system like a surplus of any selected nutritious matter in the body if they are not well proportioned to the realities of the individual environment. Human experience and occupation is a ceaseless process of education.

In medical-social education we make direct contact with the realities of human problems which tax the depth and breath of social theory, physical therapeutics, and community morale.

Dr. Ernest Fox Nichols said, upon the occasion of his inauguration as President of the Institute of Technology in Boston, Mass.:¹

"I know no better measure of a man's real education than the adequacy of his thought and action in whatever actual situations he may find himself, for adequacy of thought and action imply some hold on world experience. Our daily use of the phrase 'common sense' has no other meaning.

"Vital possession, conscious or unconscious, of this world background enables a man sanely to face and interpret reality. You rarely find such a man seriously occupied in chasing rainbows or fighting windmills. His chief mental characteristics are breadth, balance, sanity. To train such men and women should be the dominant ideal of the educational process."

¹Boston Transcript, June, 1921.
THE AMERICAN ASSOCIATION OF HOSPITAL
SOCIAL WORKERS

IDA M. CANNON, President
Massachusetts General Hospital, Boston, Massachusetts

RUTH V. EMERSON, Executive Secretary
American Red Cross, National Headquarters, Washington, D. C.

MIDDLE ATLANTIC DISTRICT

The District which includes Philadelphia, Baltimore, Wilmington, Camden, Chester, Lancaster, and Wilkes-Barre has, with the approval of the Executive Committee of the American Association of Hospital Social Workers, adopted the name "Middle Atlantic District."

The Executive Committee of the Middle Atlantic District has appointed a Philadelphia Sub-Committee of the District, the duty of which is to consider matters of local interest and to assemble the Philadelphia members of the District to consider such matters whenever it may seem necessary. Miss Agnes Jacobs, who was president of the former Pennsylvania Association of Hospital Social Workers, is chairman of the Philadelphia Sub-Committee. The Pennsylvania Association is thus formally superseded and absorbed into the Middle Atlantic District.

It has been found that questions in regard to local conditions of hospital social work arise and must be considered more frequently than it is possible to have a meeting of the whole District. For this reason, sub-committees in the separate cities seem expedient. All members of the District will be notified of city meetings, and any subject brought up at a city meeting may, if of sufficient importance, become the subject of a District meeting.

Two matters have recently been referred to the Philadelphia Sub-Committee which illustrate its use. One is the report and recommendations of a sub-committee of the Philadelphia Parenthood Conference, regarding the medical and social care available in the city for unmarried mothers. The other is the report of the Philadelphia Intake Committee's sub-committee on "Use of the Social Service Exchange by Medical-Social Agencies." Both these reports...
must be submitted to a group of hospital social workers before they are accepted by the organizations to which the two sub-committees belong.

On the 21st of April the Hospital Association of Philadelphia held a meeting at which the hospital social workers of the city were asked to join in a discussion of social work in hospitals. Dr. Mohler, Superintendent of Jefferson Hospital, read a paper on “The Organization of the Social Service Department,” and Antoinette Cannon, Director of Social Work in the University Hospital, read a paper on “The Function of the Social Service Department.” Both papers were discussed frankly and with interest. The main points of difference of opinion were in regard to the comparative advantages of supervision of the department by the hospital superintendent and supervision by a special committee or board, and in regard to the localization of “humanity” in the Social Service Department, and the wisdom of much record keeping. The hospital social workers felt that the meeting was most worth while in improving mutual understanding of the common interests of the Social Service Department and the rest of the hospital.

The Jewish Hospital, Philadelphia, invited the District to meet at that hospital on the 4th of May. At the meeting Mrs. Williams, of the Prison Reform Committee of the Philadelphia Civic Club, gave an excellent talk on the penology of Pennsylvania and proposed improvements in the prison system. The Social Service Committee of the Jewish Hospital served tea. Perhaps the most valuable part of the occasion was the opportunity to see the beautiful setting and fine equipment of the Jewish Hospital, and to learn of the enthusiasm and activity of the Social Service Committee. This committee has been organized since the reorganization of Jewish hospital social work following last year’s survey. Members of the committee do a great deal of volunteer work for the Social Service Department, including transportation of patients, for which they have a well-developed motor corps.

NEW ENGLAND DISTRICT

Studies at the Massachusetts General Hospital:

There has been a survey of one hundred new consecutive cases in the male medical clinic.

In order to study problems and work out plans for more discrimination in the social work for children in the hospital, there has been a study made of the children’s ward.
There has also been a study of thirty-six cases of mitral stenosis occurring in patients between fifteen and thirty-five years of age, to determine how social factors affected medical diagnosis and treatment.

_Social Work at the New Haven Dispensary Combined Under One Head With That at the New Haven Hospital:_

This change is consistent with similar changes in other departments in the two institutions. The work has been very much helped and stimulated by reorganization in other departments, the introduction of a better record system, the arrival of a full-time superintendent, the enlargement of clinic rooms and equipment, the change of hours from afternoons only to both afternoon and morning hours, and the organization of the staff with regular meetings. All these changes have improved the work of the institutions from a medical and administrative point of view and have reacted on the Social Service Department, enlarging the opportunities for development.

_From the Naval Hospital:_

At the Naval Hospital at Newport, Rhode Island, social histories are secured from Home Service Sections on all mental patients. All boys to be given medical surveys are referred to the hospital service. In special cases the survey board wait to get a report of home conditions before the final decision is made. All the interviewing for the Federal Board for Vocational Education is done by the Red Cross.

The work in the venereal ward is becoming more effective with the co-operation of the United States Interdepartmental Social Hygiene Board. The boys are under treatment at the hospital from one to three months without pay or liberty. They are increasingly willing to talk things over. Where the girl's name and address is given it is sent to the Interdepartmental Social Hygiene Board and reports are now coming in which show that these girls are being put under medical supervision. This has made a real difference with the doctors in breaking up the attitude that nothing can be done about it at all.
The Chicago Group plan to organize as a district under the American Association of Hospital Social Workers.

In January Miss Ruth Emerson visited Chicago and met a small group of medical-social workers at a luncheon, and gave an interpretation of the national activity. It was spontaneously agreed at this meeting to organize informally and the small group took upon itself the function of a program committee with the idea of calling the larger group together within the next month.

From this spontaneous and informal beginning, a wide-awake, virile conference has evoked and at our April meeting it was voted to draw up a constitution and petition the National Association to accept us as a District Organization.

A rough outline of our activity may be of interest to other groups who may be contemplating organization. The purpose of the first meeting in February was to get workers together and to make clear that we had common problems which had need of solution. About seventy workers gathered at the Presbyterian Hospital, Miss Breeze was hostess, and fifteen departments were each represented by a speaker who outlined the program of her department in a three-minute talk.

At the March meeting held at Children’s Memorial Hospital, Miss Adelaide Walsh, hostess, Mr. John Ransom, Superintendent of Michael Reese Dispensary, gave a report of the New York Rockefeller Foundation meetings, which included a discussion of Dr. Anna Richardson’s Survey on Hospital Social Service.

In April, a cardiac program was planned and Janet Schoenfeld, Assistant Director of Social Service of Michael Reese Dispensary, presented the paper for the Cardiac Committee. The meeting was held at St. Luke’s Hospital. Miss Tompkins, Director of Social Service, acted as hostess.

The May meeting was given over to the discussion of organization as a local district. Miss Gage, Director of Social Service at the Institute for Juvenile Research, presented a constitution which was adopted by the group with the recommendation that it should be sent to the National Association for immediate action.
Beside the general activities, three sub-sections have also held meetings on problems of particular interest to their special group. The executive, the psychiatric and cardiac workers have formed such sections. It is planned for such groups to meet not less than once in two months next year perhaps alternating monthly with the general meetings. These conferences were well attended and among the late meetings as many as one hundred and ten workers were present.

Miss Lambert of Central Free Dispensary, has resigned as Director of Social Service, and Miss Gertrude Howe Brutton has succeeded her.

Since January 1, 1921, Michael Reese Dispensary, Michael Reese Hospital and the Chicago Winfield Tuberculosis Sanatarium have united their Social Service Departments under a common directorship.
NEWS NOTES

ANNUAL CONFERENCES ON SOCIAL WORK.

The National Probation Association, the Social Workers of the Protestant Episcopal Church, the National Conference of Jewish Charities, and the American Association of Hospital Social Workers, convened in Milwaukee concurrently with the National Conference of Social Work on June 20-30. These conferences were called late in the season to make it possible for allied workers, school teachers, etc., to attend. The next meeting of the National Conference of Social Work will be held in Providence, R. I., in June, 1922.

Officers elected for the coming year are: President, Mr. Robert Kelso; First Vice-President, Mr. Sherman Kingsley; Second Vice-President, Martha P. Falconer; Third Vice-President, Gertrude Vaile.

As one of the youngest members of the group of social agencies in the accepted form of practical service, the Protestant Episcopal gathering met for the first time. Its purpose is to be active in uniting the church in a program of Christian Social Service, to consider the duty and policy of the church in modern social service, and to be prepared to state its policy clearly to other social agencies. Ideally each diocese should conduct the entire work of its missions, religious educational work, and social service activities. Dean Charles Lathrop, executive secretary of the Social Service Workers of the Protestant Episcopal Church, organized the general program of the conference. It included the fields of organization, the church's relation to Social Service Commissions, the Women's Auxiliary, the Girls' Friendly, such problems as the defective, delinquent, and other interests.

The formal meetings of the National Conference of Social Work began on June 22nd with an address by Mr. Allen Burns, the retiring president. Mr. Burns' address was forceful and it struck a note of self-analysis in social work which was touched upon frequently during the entire week. The preparation of the workers and their motive power in social progress under the changing conditions of the present must be adapted to elements of striking difference to those of the past. Evolution of woman, independence of the workman, changing attitude in religious faith, rapidly increased foreign population are among these features. Important constructive and social
measures have been achieved by business and civilian interests without
definite co-operation from social workers, who must be ready to
accept the status of a co-ordinate body where they have not attained
leadership.

The welfare work of today, according to Joseph Lee, must
acquire the driving power which energized the war measures. Each
individual in all communities felt at that time a share in responsibility.

Among the factors in welfare work were assembled the church-
men, philanthropists, educators, health specialists, labor leaders,
criminologists, and jurists, who discussed the problems before the
conference from their angles. It is essential that the social worker
understand his relation to these allied interests, rather than to proceed
on the basis that social work comprehends all of them. All workers,
even the humblest artisan, are social workers, and no one profession
can include all.

Mr. Burns declared in his opening address, that the removal of
these barriers of the narrowing spirit and the “inflated conscious-
ness” will release the workers of today to much larger activity.

Mr. Whiting Williams and Mr. Sidney Hillman, the latter of
whom is President of the Amalgamated Clothing Workers of
America, discussed unemployment with much sympathy for the
workman. They reason that uncertain and irregular work are the
strongest factors in discontent and outlawry among workmen. The
employer knows little of the thinking process of his operatives and
vice-versa. The workman will develop sense of higher responsi-
bility through the medium of citizenship in industry. Meantime he
deserves patient comprehension.

Professor E. C. Lindemann, of the Rural Welfare Organization,
gave a dynamic talk on practical values for the farmer. He believes
the rural church will lose spiritual power as it enlarges its welfare
activities in the community. People everywhere need a sanctuary
which is sacred to reflection and pure religious feeling. The farm
bureaus, the Boy Scouts and farm clubs are more suitable for the
promotion of community measures.

Mr. Kelso's address before the closing meeting was a ringing call
for a welfare program which will insure adequate health measures.
He said: "If we can better the physical being of this generation one
degree we shall effect a marked decrease in poverty and crime. The
social workers of the world can no longer act as a repair brigade—they must prevent in the future the kind of damage to which they are now devoting themselves by remedial work.”

The keynote of the utterances of the retiring and the incoming president are distinguished by practical insight and their selection for leadership is indicative of progress.

ANNUAL MEETING OF THE AMERICAN ASSOCIATION OF HOSPITAL SOCIAL WORKERS HELD IN THE AUDITORIUM, MILWAUKEE, WIS.

Further account of the proceedings of the American Association of Hospital Social Workers will be published in a later issue. The opening meeting on June 22nd was devoted to a discussion of the findings of the Survey of Hospital Social Service. In the absence of Mr. Michael Davis, Chairman of the Survey Committee, Miss Ida Cannon presided over the discussion. Miss Johnson, of the United States Public Health Service, American Red Cross, read a paper presenting the conclusions of the Chicago group. Miss Cummings read the comment of the New York group. Miss Hayward represented the Middle Atlantic District. Discussion followed during which Miss Farmer asked for action on the definition of a function of the duty of the hospital social worker. At the afternoon session, which was devoted to annual reports and general business, Miss Cannon appointed a committee to act on definition of function, Mrs. Bessie Russell, of Michael Reese Dispensary, chairman. After several meetings the committee brought in a majority report on the following definition of the function of the hospital social worker. This definition as printed here is subject to minor changes of grammatical wording.

PERMANENT

1. By the method of social case work to care for ward and out-patients whose medical and social condition indicate the need of adjustment in order to render their hospital treatment effective, and to restore them to health and economic efficiency.

2. Research—To study social causes of health and behavior.

3. Education—(a) To co-operate with schools of social work in the training of students for hospital social work.

(b) To give students in training schools for nurses, students from medical schools, psychiatric training schools,
some insight into the social and environmental aspects of their vocation through short courses in field work, lectures, and required reading.

(c) To interpret the hospital to the community by posters, charts, public speaking, etc., and help make more available the various resources of the institution.

(d) By the same means to educate the public in hygiene and in relations between health and social conditions.

(e) To co-operate with such outside agencies, institutions and interested individuals as may serve to enlarge the function of the hospital and to render its care of the patient more effective.

Temporary

It may be necessary to undertake for a time certain duties that are not essentially the functions of the business of hospital social work. These functions may include the duties of clinic clerk, financial investigator for the hospital, messenger, etc., and may be performed for a time in the hope and with the definite intention of helping the hospital to fulfill its duties toward the community as well as toward the patients. In undertaking these temporary and supplementary duties it is important that we should not lose sight of the fact that the primary function of hospital social work is social case work with hospital patients and that the fulfilling of this function is our best contribution to the hospital and the community.

This definition is now before the Association and allied workers for discussion.

The following officers were elected for the coming year:

President—Miss Ida Cannon.
First Vice-President—Miss Suzie Lyons.
Second Vice-President—Miss Gertrude Farmer.
Third Vice-President—Miss Helen L. Hillard.
Secretary—Miss Ruth V. Emerson.
Treasurer—Miss N. F. Cummings.

New members of the Executive Committee:

Miss Kate McMahon, Miss Margaret S. Brogden,
Miss Mary C. Jarrett, Miss Harriet Gage,
Miss E. Howland.
New members of the Advisory Committee:

Dr. Richard Cabot, Dr. MacFie Campbell,
Mr. Michael Davis, Dr. Frank Billings,
Dr. C. P. Emerson, Miss M. A. Nutting,
Dr. Winford Smith, Miss E. Foley,
Dr. W. P. St. Lawrence, Miss Mary Richmond,
Dr. A. R. Warner, Mrs. Henry Thomas,
Dr. Edward Strecker, Mr. John Ransom.

In addition to the business meetings, round table discussions were held on the following subjects: "Psychiatric Social Work," "Training of the Hospital Social Worker," "Organization of Work in Small Communities" and "District Associations." Miss Brogden read an account of the present status of district organizations. A luncheon was held at the Hotel Astor, which was attended by one hundred and fifty workers and their friends. Among the speakers at the luncheon were: Miss Elizabeth Fox, Acting President of the National Organization of Public Health Nursing; Dr. Herman Adler, Mrs. Julia McLenegan, and Miss Deborah Barus. Miss Ida Cannon presided and opened the meeting. A tea was given for the members of the American Association of Hospital Social Workers and the Association for Organizing Family Work, at homes of residents of Milwaukee on the lake shore.

The booth of the American Association of Hospital Social Workers was located on the main corridor. Charts from the Social Service Departments of the Massachusetts General Hospital, St. Luke's Hospital, New York; Johns Hopkins Hospital, Baltimore; the Institute for Juvenile Research, Chicago, and the Milwaukee Children's Hospital were displayed. Record forms, illustrations, and other data were included in a plan of consultation service which is now accepted as a valuable feature of conference meetings. The Milwaukee Children's Hospital had a booth next that of the American Association with a display of handicraft work, charts and other interesting material. The Association also had a table in the space devoted to kindred subjects, as did Smith College Training School for Social Work, and this magazine. This department was given a large section of the auditorium and the kindred subjects included many social and public health organizations, each of whom were represented by their leaders.
Papers from the sessions on hospital social service and the general sessions will appear in later issues, as will the report of the Secretary, Miss Ruth V. Emerson.

The Catholic Hospital Association held its annual meeting in St. Paul, Minnesota, June 21-24. Father Moulinier was re-elected President of the Association, and Father McGrath was re-elected Secretary-Treasurer. Important features of the proceedings were an opening address by Dr. William Mayo; demonstrations of staff meetings conducted by Dr. Frank Jennings and members of the staff of St. Catherine's Hospital, Brooklyn, N. Y., a questionnaire in booklet form which was compiled by sending preliminary inquiries to members, after which the answers in form of topics for discussions and questions were printed with blank spaces for replies. The topics covered clinical work, dietetics, records, standardization, organization, and all subjects pertinent to hospital service. The round table discussions took up these topics. During the formal proceedings a resolution was reported on by the Resolutions Committee urging Catholic hospitals to organize hospital social service departments.

ANNUAL MEETING OF THE AMERICAN HOSPITAL ASSOCIATION.

The program for this meeting which occurs at West Baden Springs, Indiana, on September 12-16, will be given in detail in the next issue. Thus far the plans provide for an unusual number of the round tables which have been popular in the past. Topics will be discussed at the round tables covering all phases of hospital activity. The formal proceedings promise interesting developments.

DEMONSTRATION OF DISPENSARY WORK.

A new motion picture is being made which will comprise in brief time an animated diagram of which the first section shows a bird's-eye view of a model venereal disease clinic with the floor vacant, but by means of a symbol the observer will follow the procedure from the social service department to the laboratory by way of the waiting-room, history-taking and treatment rooms. The second section of the reel will show the same floor plan with the personnel of the staffs and patients taking the successive steps in an orderly and expeditious manner. The method of keeping the clinic clear and busy at one
time will be shown. Records and physical properties of the depart-
ment will be demonstrated at the dispensary booth. Consultation
service is being arranged. Mr. J. A. Ransom and Dr. Alec Thomson
are organizing this exhibit. A dispensary and out-patient program
will occur during the general sessions.

Mr. Michael Davis will have a consultation service on the activi-
ties of the Committee on Dispensary Development at the conference.

Miss D. R. Hamlin, Director of the Hospital Library and Service
Bureau of the American Conference on Hospital Service, will have
special features from her department at the conference, and she will
give consultation service daily.

Dr. A. R. Warner, Executive Secretary of the American Hospital
Association, is arranging for special sessions preceding the opening
of the conference that visitors who desire to make a longer stay at
this attractive resort will find an inducement to do so.

The annual meeting of the National Tuberculosis Association
was held in New York City, June 14th to 17th, inclusive. Sections
were held on clinical pathological nursing and sociological interests.
A modern health crusade luncheon and a round table on the same
subject gave thorough attention to this field. The practical accom-
plishment of the past was presented and future work outlined.
Motion pictures on tuberculosis work were shown on Friday after-
noon. On Thursday evening an impressive pageant was given for
the first time with the title, "The Spirit of the Double Barred Cross."
It was written by Miss H. V. Williams and Miss E. Coler. Costumes
and effects were provided by interested friends at a minimum cost.
The six spirits were based on an allegorical story and its relation to
the achievements of the tuberculosis medical and public health
development from the period of Laennec, who discovered the use of
the stethoscope. Dr. Koch’s work and Dr. Trudeau’s followed and
the close represented the broad and ambitious program of the present
tuberculosis movement. The orchestral arrangement and the spirited
acting of the players with artistic and realistic settings made this an
interesting feature of the annual meeting.

Miss Lulu Graves has resigned as Professor of Home Economics
of Cornell University and will become Supervisor of Dietary Work
of the private patients and children’s departments of Mt. Sinai
Hospital, New York. Miss Graves will also organize classes in
nutritional work for nurses of Mt. Sinai.
In order to provide trained care for the rehabilitation of ex-service men the American Red Cross offers a number of scholarships for training in psychiatric and hospital social work in recognized schools for post-graduate periods. The scholarships will be in part a loan to the student, who is asked to pledge at least one year's service to the American Red Cross after the course. Applicants may address the division office at Washington, D. C.; their local division office, or an executive at a standard school, for further information.

A tonsil and adenoid clinic with fifteen beds has been created in Chicago to operate in connection with Michael Reese Dispensary and Hospital. It is conducted on similar lines to the Rochester Clinic, which Dr. Goler directs.

The Social Service Department of the New York Hospital has established a library for the patients under the direction of a nurse whose service is a donation to the department. An affiliation has been arranged with the New York Public Library and, therefore, books in many languages are available. Among the publications asked for recently are the Constitution of the United States, and books for technical study. Two hundred and sixteen books were taken out in May.


BOOK REVIEW

"VITAMINES" by Benjamin Harrow, Ph. D.


Dr. Harrow's book on "Vitamines" is well written. It is interesting and instructive. He deals admirably with the subject of vitamines—a subject comparatively new in the field of science. His language is graphic in the setting forth of fine details; the logic of his arguments is convincing. He uses illustrative charts to advantage
throughout the book in the effort to make his subject as intelligible as possible to the average reader. In certain parts the book appears to be somewhat of a treatise on hygiene in the marked digressions to generalities, though that does not detract from its values. "Vitamines" is worth reading, in that it brings one to the present advancement in food analysis. The opinions of prominent men are given concerning certain experimental phases of the subject and these opinions impress the reader with the immense importance of food factors in relation to our bodily health, both for the prevention and cure of scurvy, rickets, and beri-beri.

True enough, good judgment as the result of bitter experience in the past has been the guide in the selection of proper foods. But today we must look to the domain of science for wise guidance. The importance of vitamines is paramount. Vitamines are known to be in the fat portion of our food, and are known to be vital to the organism. Dr. Harrow says: "One fifteen-thousandth of an ounce of vitamine product which, please remember, is still not pure vitamine, cannot add much to the energy value of the food; yet its presence makes life possible."

Dr. Harrow concludes his book with an excellent summary with practical applications. For those seeking tabulated information on food composition, the appendix will be valuable. The closing pages are given to a detailed source of references, which will prove helpful to any persons desirous of further knowledge on dependent subjects.

ABSTRACTS

"Labor Shows Constructive Initiative in Health," I. A. Galdston. The Nation's Health, 1921, III, 309. The Union Health Center of the International Ladies' Garment Workers Union is a pioneer organization which has been created by the initiative and executive force of the members of the garment workers, because of the inefficient medical attention provided for persons of moderate income. The facts gathered during the work of promoting compulsory health insurance in various documents were offered as irrefutable evidence of inadequate attention for the large middle group of persons who comprise a high percentage of the industrial workers. Boston long ago recognized the condition and established a co-operative clinic. As yet attempts have been made in New York but they have not been effective. Therefore the International Ladies' Garment Workers
Union, whose membership is about sixty thousand, voted a sum of fifty-five thousand dollars to erect and equip the Union Health Center at a total cost of one hundred thousand dollars. It serves as a department of health, a hospital, and clinic to eighty-five thousand members of the union. The unit houses the Joint Board of Sanitary Control, a Medical Division, a Dental Division, and an Educational Division. The Medical Division has daily clinics for general and special treatment, an operating room, an X-ray room and a laboratory. Each new member of the union is required to have complete physical examination. The immediate members of his family may also have the services of the center. Medical and dental work is done on the basis of cost, and professional associates of the clinics are paid reasonably well. The Union Health Center has been in use for three months. Its service as a preventive educational measure is great, and it is a valuable demonstration of the policy, that in health matters as in economics, the progress of the workers is best achieved by their own bodies.

"National Research Council and Health," Vernon Kellog. Nation's Health, 1921, III, 275. This council is, as its name implies, of national scope but is not under the government. It is affiliated with the International Research Council whose membership includes representatives of scientific academies. The Council was established under the National Academy of Science during the war, to assemble scientific and material resources, and because of its usefulness, became a permanent body. It is well endowed. The work is carried on under divisions, such as chemistry, physical and mathematical sciences, geology and geography, biology and agriculture, anthropology and psychology, engineering and medicine. Another branch relates to foreign bureaus and universities. The problems of national health are considered by the division of medical sciences, whose chairman is at present Dr. G. McCoy, director of the hygiene laboratory of the U. S. Public Health Service. The Council has desired to attack the field of public health and, therefore, made a general survey. Certain agencies such as the Rockefeller Foundation, and the School of Hygiene and Public Health of Johns Hopkins University were among the agencies which are well provided for. Others are in need of assistance. The Division of Medical Sciences has formed a program for study of nephritis, and for certain nutritional research. An information service is maintained.
"The Rooming House and Its Problems," C. V. Craster. *Nation's Health,* 1921, III, 319. Dr. Craster divides the city population into two classes—those who can afford to live comfortably and those who cannot but must be housed individually or with others in single rooms. The majority of these are in the common lodging houses. The war created more intensive conditions of discomfort in these places than ever before. Often several families were forced to occupy one tenement. A survey was made in the fall of 1920 of one hundred and thirty-seven typical lodging houses and it was found that there was in the section chosen for the study, no serious overcrowding. Fire hazards were found to be common and frequently the plumbing was poor. An interesting side-light of the study was the data on the changing character of the roomers. More races are found in the houses than formerly. Modern conveniences in the houses were rare. The community should take action to improve this type of house. A series of model laws are advised as a result of the study. They cover license requirements, ventilation, airing of bedding, cleanliness, toilet facilities, renewal of dilapidated walls and floors, water and soap supplies, fire escapes, good plumbing and lighting fixtures, sufficient heating, and registration of lodging houses. Fines are advised for violation of the rules.

"Conflicting Ideals of Public Health and Family Welfare," O. M. Lewis. *Family,* 1921, II, 49. This paper presents an interesting commentary upon the different policies of public health work which is organized on the basis of broad community end-results; and family welfare work which begins with the individual and standards grow with the accumulation of individual results. The two activities should find ways and means of coming into closer co-ordination. It seems to us that the individual health case work of the units of public health nursing in pre-natal, maternity, child hygiene care, school nursing, tuberculosis, orthopedic, mental hygiene care, industrial nursing, supervision of midwives, venereal work and medical-social units in hospitals are by reason of their extensive field workers, (eleven thousand enrolled under the National Organization of Public Health Nursing), which are operating under the direction of health centers, municipal departments, and other welfare agencies, doing individual work co-extensive with any other agency. The attack of intensive work is from a different angle. Miss Lewis appends a group of interesting case studies to her discussion which illustrate
the obstacles which are met in the treatment of venereal diseases where health regulations are not sufficiently clear or not far-reaching from the viewpoint of perfecting a complete case treatment.

"Seven Years of National Health Insurance in England—In Retrospect," Alfred Cox. Jour. Amer. Med. Ass'n, 1921, LXXVI, 1397. The points which are answered in this inquiry upon the results of national health insurance in England begin with the question—has the system decreased or increased the professional work of the average medical man? It appears from the study of results that the work of the average industrial physician has increased, particularly in treatment of minor ills which formerly the patient ignored. Clerical work is much greater and it is unpopular with older men. What is the effect upon income? This has steadily increased among physicians who accepted service under the Act. Rural men especially are often paid for the class of patients who formerly paid nothing. Taxation and high prices have hit the medical men rather hard. Aside from the war increase the Act has raised standards. What proportion of his time does the doctor give to the work? This varies with the volume of work. What is the average fee received? This is found to be 2s. 10d. and the majority of visits are for surgical attendance. It is impossible as yet to give accurate comparison between these sums and the former fees. What effect has the system on the professional morale of the doctor? There are many opinions as to this but the violent reaction against radical changes must be considered in summing up. A section of the Labor Party desire a whole-time medical service which would be very expensive and call for additional bureaucracy. The first is impossible for lack of funds, the second unpopular. The medical profession has received great publicity during the promotion of the national insurance act and its commercial methods were attacked in an unreasonable manner. The certification rules of the system were a source of irritation to men unused to them. However, a secure income as provided by the insurance system usually has a beneficial effect; the plan has compelled enlightenment and co-operation; the forward-looking men see in the service possibilities as government consultants as well as general practitioners. What effect has the plan had on scientific research? It was the means of setting up the first state endowment of medical research. What effect has it had on public health? There is no complete statistical evidence bearing on
this but the points of certain progress are in the volume of records of conditions; any work which cuts short an incipient condition is valuable. On the other hand one of the mischievous results is the chance for political uses of the professional career. Mr. Lloyd George, as author of the Insurance Act, was accused of perversion of the medical service by his opponents. A public controversy must always discredit its object. Would the profession vote for the Act if it was open to a decision again? This question calls for many points of view according to the individual qualifications of the physician. Government control is disasteful to one person; money earned by contract is equally so to another. However, the majority would not go back to the old plan of club practice at 2s. 6d. to 3s. 6d. per head per year. Bribery was common at that time in order to obtain club work. As the doctors have an increasing share in the administrative duties the objections decrease. In conclusion, if it is possible to give adequate medical service to each one of the population without charity or insurance, do so; if the contrary condition is present the state should find a method of care for the neglected. The doctors would like to make the system more complete by giving auxiliary attendance from specialists, nurses, institutional care, thereby carrying on to a thorough result. Stronger insurance committees are desired that more authority over local sanitation, etc., may be permitted. The American group, who are working upon this issue, should ensure a good working policy from the medical aspect before a scheme is definitely fixed.

"The Social Responsibilities of Modern Medicine," F. R. Green. Jour. Amer. Med. Ass'n, 1921, LXXVI, 1477. The problems of social medicine are due to the change from individual medical practice of the past to the period of 1850 when an appreciation of the sources of disease, due to research by far-sighted medical men, led to the final comprehension of preventive medicine. The social value of preventive medicine has not been accepted in the educational curriculum, or in public medical conferences. It is apparent that unless the field becomes a part of medical education and practice it will be taken over by the non-medical worker and some times by those without scientific training. Among the important measures in social medicine are the systems of compulsory health insurance and health centers. The former was of German origin. It has been adopted in several foreign countries with the purpose of reducing morbidity,
and assuring competent medical care for the working class. The plan as used abroad distributes the cost of sickness equally upon employee, employer and the State, although the two latter do not share the risk. All the cost will ultimately come upon the consumer. Alternatives as suggested by Dr. Green are: adequate wages and community health resources, development of thrift, industrial insurance, and systems of voluntary benefits among wage-earners. In 1920 the American Medical Association almost unanimously adopted a resolution which rejected the plan. Health centers are as yet only slightly developed and definite criticism is not in order. Having rejected the first plan and delayed action upon the second, the obvious duty of the medical profession is to study ways and means of service in the problems they have left unsolved, and to formulate a policy of meeting the needs of social medicine.