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HOSPITAL SOCIAL SERVICE

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THE DEVELOPMENT AND CONDUCT OF A CARDIAC CLINIC IN AN OBSTETRICAL HOSPITAL

HELEN R. FOWLER, R. N., MARGARET DUNN, BURTON E. HAMILTON, M. D.

Boston Lying-In Hospital, Boston, Massachusetts

We shall describe briefly the origin and development of the cardiac clinic at the Boston Lying-In Hospital and show the need for such a cardiac clinic in direct conjunction with a pre-natal clinic.

During the last few years there has been great activity in connection with the whole problem of heart disease. There are at the present time 125 cardiac clinics in the United States. These clinics are either in general hospitals or dispensaries, or in hospitals for children. There are but two, to our knowledge, within lying-in hospitals exclusively for the treatment of women with heart disease complicating pregnancy—the cardiac clinics at the Sloane Maternity Hospital, New York, and the Boston Lying-In Hospital.

It has always been recognized by obstetricians that special care in addition to that which an obstetrician is fitted to give should be afforded cases of heart disease complicating pregnancy. For this purpose, at all times, in the history of the Boston Lying-In Hospital, consultations on cardiac cases have been freely requested, as, indeed, they have been requested to cover any special complication arising outside the immediate obstetrical field.

This system, which we may call the "casual consultant system" covers the individual needs of any special cardiac emergency case very well. But modern obstetrics, as is well known, demands that every pregnancy case receive pre-natal and post-natal care, and it logically follows that the pregnant women with cardiac disease deserve repeated consultations between obstetrician and heart consultant. The "casual consultant system" is, therefore, ill suited to the standards of a modern pregnancy clinic, including any large number of cardiac cases. Nor does that system tend to make possible the collection of accurate data, which is a necessary function of all modern clinics.

When, in recent years, special cardiac clinics grew up in the general hospitals, this hospital (and other obstetrical hospitals elsewhere did likewise) took advantage of the opportunity and affiliated with a
neighboring cardiac clinic. This proved of great benefit, but necessitated a patient’s attending two separate clinics, and as can easily be seen there were difficulties in the transfer of records from one clinic to the other and hence delay in consultation; also a gap was left in consultations and in record keeping during the patient’s stay in hospital (during confinement and puerperium and during preparation for confinement, which among the cardiac cases often necessitates prolonged rest in hospital.)

The ideal system, to which the “casual consultant” and the “consulting clinic” leads, is clearly a special cardiac clinic within the lying-in hospital.

In 1921, a policy was tried in this hospital of grouping certain cases, representing a few of the more prominent obstetrical problems, in special services, and assigning each group to different members of the staff for intensive study during the period of a year. For example, in one group bleeding cases were placed, in another cases of toxemias, in a third cases with complicating heart disease,—with only the last of which we are concerned. The formation of this special service for pregnant cases with heart disease led by degrees, with the increasing interest and experience in the difficulties of this special problem, directly to the formation of the cardiac clinic in conjunction with the hospital’s pre-natal clinics, and its growth to its present proportions. The present clinic then, represents not a preconceived plan forced upon the hospital, but the result of a natural need, and actual experience in meeting this need.

Functions of the Clinic

A cardiac clinic within a pregnancy clinic has three broad duties:

(1) Care of the patient’s heart condition, which includes watching the individual case as its requirements demand through pregnancy and puerperium, and the disposal afterward of the case as a cardiac with a baby.

(2) To afford prompt information of the patient’s cardiac condition to the obstetrician in charge of her pregnancy.

(3) To collect accurate and easily available data for statistical purposes.

The pregnancy cardiac clinic in this hospital meets one morning a week. It has special rooms which are suitably equipped, adjacent to the Out-Patient Department. It is in charge of a cardiologist, a
member of the hospital staff, who is on continuous service. A specially trained graduate nurse in the Social Service Department attends the clinic. In addition to the usual duties of a nurse in attendance in an out-patient clinic, she superintends and records results of simple effort tests and vital capacity determination on each patient at every visit.

The Social Service Department is at all times in close cooperation with the cardiac clinic. It supervises the operation of the clinic and acts as Clinic Secretary. Every patient is given pre-natal care in her home and conditions noted. This department has the whole responsibility for the follow-up work during pregnancy and for the post-partem examination, and the responsibility for establishing contact between the patient and the general cardiac clinic after the obstetrical problem is closed.

There are, of course, many details to look after in such work. In case a patient is referred to the hospital for rest, or recommended for hospital delivery, and her home and financial conditions are such that she feels she cannot comply with the physician's orders, the department makes the necessary home arrangement. This requires either finding suitable temporary homes for the children, or placing a mother's helper in the home with them; this necessity also arises at times when the physician makes recommendations for special restriction of the patient's home activities. One patient with a severe cardiac condition was referred into the house twice during her pregnancy for complete rest, and it would have been impossible for her to have complied with the physician's orders had not the Social Service Department made all the arrangements. When she was sufficiently recovered to be allowed to return home, a mother's helper was secured for a few hours a day to do the washing and all heavy work, which she was forbidden to do. In all such cases, the patient's transportation to and from the clinic must be provided. The responsibility rests on the Social Service Department to investigate the financial condition of the family, and if it is found too much for them to meet the extra expense of hospital rest or delivery, to recommend that these cases be accepted by the hospital with even the usual minimum hospital fee reduced. We are fortunate to have the sympathetic co-operation of the superintendent of the hospital in this matter.

Arrangements are now being made for the routine reference of all babies born of cardiac mothers to a children's hospital for ex-
amination and observation. A social service worker will make the
first visit with them to establish the necessary contact, and this
department will co-operate in every way with the pediatrician in the
follow-up work of such cases. This special care of the children born
to cardiac mothers is a development of a growing appreciation of the
breadth of the problem of heart disease within the whole community.
And the results of this work if it can be carried on for a long time
should yield valuable information.

The second and third functions of the cardiac clinic are best
described by the following analysis of the present record system.

Proper cardiac records require rather elaborate data and more
than is appropriate to general obstetrical records. To collect this
data, keep it where it is readily available to the cardiac clinic, and at
the same time to incorporate into the obstetrical records promptly and
continuously the cardiac data important to them; to collect case sum­
maries from both cardiac and obstetrical records for statistics; and
to keep records necessary to the social service work,—these are
the minimum requirements which the record system of the cardiac
clinic must fill. It is a real problem to do this practically and
economically. Through experience we have worked out the follow­
ing system, which we find very satisfactory.

On the patient’s first visit to the clinic, a special cardiac history
record is made out. This record contains all the essentials of the cardi­
ac history on physical examination, a summary of past pregnancies
and a brief family history. Notes are made on this card by the
cardiologist at each visit. A short note summarizing the diagnosis,
present condition and the recommendations is also made at each visit
and these summaries are copied at once on the regular obstetrical
record sheet by the attending nurse. The cards are kept in the heart
clinic alphabetically filed under three headings: “undelivered,”
“delivered,” “discharged.” This saves the special cardiac records
from being buried within the general records of the hospital and the
copied summary serves to keep the obstetrical records complete with
the particular findings of the heart examination with which the obste­
trician is concerned.

In addition to the cardiac records, a small card is typed for a visi­
ble cross-index file to facilitate the collection of statistical data. This
card summarizes the patient’s diagnosis and recommendations
at dates of visits and later the dates and type of delivery and obstetri­
cal discharge; the post-partem visits are recorded on the back. These
cards are kept in a visible card index file which never leaves the clinic
rooms and is always easily accessible for reference. This particular
problem of the record system—to have a reliable and useful cross-
index for statistical data—has required a detailed study of the general
hospital records of all patients having heart disease complicating preg-
nancy, and has resulted in the following system of classification,
which we will describe in detail.

The simplest classification of cardinals requires a number of head-
ings. Each case is classified primarily, so far as is possible, as
follows:—

1—Severely or dangerously damaged heart.
2—Doubtfully or potentially damaged heart.
3—No significant or dangerous heart damage.

All cases also required classification under suitable diagnostic
headings. A colored flag has been selected for each of these headings
and is inserted where it is visible in the file.

- Rheumatic Heart Disease ............... Red
- Congenital Heart Disease ............... Blue
- Cardio-Vascular Syphilis ............... Yellow
- Arteriosclerosis .......................... Pink
- Paroxysmal Tachycardia ............... Purple
- Possible Heart Disease ............... Green
- No Heart Disease ........................ Orange
- Special Group ........................ Brown

In addition it is shown on each card in the file of closed cases
if the patient died and if the baby died. In the first case a black flag
and in the second, half of a black flag is used. If the patient at any
time shows heart failure (decompensation) this is noted by a black
and white striped flag.

The visible index system used is simply a stand with a revolving
spindle to which as many panels as necessary may be attached. Each
panel contains sixty-four (64) envelopes, each to hold a card. The
lowest line of each card is visible. The file is checked every morning.
The cases in hospital are in one panel. The out-patient deliveries are
in another and the pre-natal clinic cases are in a third. These last
are arranged chronologically under the month of their prospective
confinements. The delivered and obstetrically discharged cases are
arranged alphabetically within groups classified by their cardiac
diagnosis. For example, a group of rheumatic heart disease, another
of congenital heart disease, etc., each card retaining its proper diag-
nostic group flag wherever it is moved on the file as the case pro-
gresses,—from clinic to hospital or home delivery to the closed case
file.

For example, here is the visible portion of an index card of a case
among the delivered and discharged rheumatic heart group.

<table>
<thead>
<tr>
<th>Cl.</th>
<th>Brown, Mary</th>
<th>(½ black)</th>
<th>(white and black)</th>
<th>(red)</th>
</tr>
</thead>
<tbody>
<tr>
<td>i</td>
<td>P.M.</td>
<td></td>
<td></td>
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</table>

From this, we see that Mary Brown was a clinic case (not an
emergency case sent into the hospital without previously coming to
the Clinic); she was considered a serious heart risk (1); her baby
died, (small black flag); a post-mortem examination was performed
(P.M.); she had heart failure but recovered (large black and white
striped flag); the red flag at the extreme right marks her as a “rheu-
matic heart disease.” To get a complete summary of her case, it is
necessary only to raise the envelope above.

28 Dover Street, City Para iii O.P.D. Rox. 187
Age 32 Ho. Adm. No. 287
Diag. 2-25-23 R.H.D. M.S. Rec. hospital delivery and offer of sterilization.
Delv. 5-29-23 Cesarian Section and Sterilization. Scopolamin and mor-
phine anesthesia.
Disch. 2-18-23 Mother well. Baby dead; cause prematurity.
Cl. Brown, Mary i P.M. i i i i i

To ascertain the detailed findings of her first and subsequent visits
to this Clinic, the cardiac clinic card with all necessary data is at hand.
We find that the advantages of such a system are many,— the
final data, being easily available, are constantly under criticism by all
interested in the clinic, and the accuracy of the data is thus checked.
The clinic statistics are always up to date. All concerned know
what cases are approaching term. The results of all the closed cases
are available, and information from past experiences with groups of
rare cases is easily obtained when occasions arise.

This clinic has been in actual operation since March 22, 1922,
working up by degrees to its present state of development. From
then until the end of the year (1922) 82 cases were referred from
the hospital pre-natal clinics to this clinic. These patients made 112
visits to the clinic. In 1923, 148 cases were referred and 375 visits
were made by the patients; 12 emergency cases were seen in consulta-
tion in the hospital. Since August, 1923, at which time the intensive follow-up work was organized, 105 visits were made by the Social Service Department on these patients in their homes. These figures show the amount of work the cardiac clinic handles at present.

We believe that a cardiac clinic organized and operated along these lines is a very valuable part of an obstetrical hospital holding prenatal clinics. It will afford better advice to an important group within the pregnancy clinic; it will furnish prompter consultations to the obstetrician on the cardiac group than would otherwise be possible; and it is the most satisfactory way to collect accurate data for reference and statistics.
Heart disease has become a striking menace to the present generation. It has taken the place of tuberculosis as the most prevalent cause of death in American cities. Like tuberculosis it invalidizes a great number of persons who may ultimately die of some other affection. When it is once established it is incurable, but may be arrested, at least for some time. The majority of the cases of organic heart disease begin in early life and prophylaxis to be effective must begin then. It has been determined by careful examination of a large number of school children that from 1½ per cent to 2 per cent of these are suffering from organic heart disease. There are of school age a very considerable number of children who are too ill, from this cause, to attend school. From the best sources of information we have at present, it is estimated that from 2 per cent to 2½ per cent of our total population are subjects of some cardiac defect. This will probably apply to the population of our larger cities, but it is doubtful if these figures would be borne out in rural communities, where infections are less prevalent. Schmidt reports that after a hasty examination of 148,000 school children of Detroit he found 1,873 with some cardiac defect. Halsey estimates the number of school children in the United States suffering with heart disease as about 200,000. Over 3 per cent of the drafted men in the U. S. during the late war were rejected because of organic heart disease. This, it must be remembered, represented the results of a selected 3,700,000 of our young men. It has been estimated that over $200,000 a year is spent in New York City for indigent heart cases. These figures will give a faint idea of the economic problem facing the community because of this one rapidly increasing disease. It is evident that whatever means can be found to check this menace to humanity and efficiency should receive our careful study and application.

What preventive measures are now known against heart diseases? Are they effectual? Organic heart disease is the result of an infection usually originating in some local focus, such as the tonsils, adenoid vegetations, teeth, nasal sinuses, middle ear, gall bladder, appendix, prostate, fallopian tubes or renal pelvis, or from certain general infec-
tion especially in early life as scarlet fever, measles, diphtheria, pneumonia or syphilis. Of these the most frequent focal infection is in the tonsils and adenoid tissue. In large cities where over crowding, and close contact in schools, cars, theatres, especially picture theatres, etc. is so common, transfer of infection is frequent, and easy. Certain infections such as streptococcus, staphylococcus and pneumococcus are much more prevalent today than they were a generation ago, and must necessarily increase with the increasing concentration of population in our larger cities. The most prevalent infection causing organic heart disease is the streptococcus infection although in infancy and early childhood the pneumococcus is not an uncommon cause, and less frequently scarlet fever, influenza, and gonococcus infections.

The symptoms of so-called rheumatic infections may be so mild as to escape notice and vary from that to the well known inflammatory rheumatism with fever and severe joint pains. In the young, it should be emphasized, rheumatism is a cardiac disease, and in them the cardiac symptoms may often be found in the absence of other lesions. This is especially the case when the stiff and sore joints and muscles, commonly called "growing pains," are the only other symptoms noticed. It should be remarked that owing to the delicacy of the structure of the young heart the early lesions are often undetected, and only later when ensuing valvular deformities and adhesions and muscular hypertrophy occur, the sounds become more audible. Thus many cases of organic disease are overlooked in early life, until the disease is well established and considerable damage has been done to the heart. Some of these cases are the result of unrecognized or poorly treated attacks of rheumatism.

It is thus important that rheumatism be early recognized and persistently treated, remembering that the heart is the primary consideration. Absolute rest in bed should be the first order. When a child has had a rheumatic attack he is liable to recurring attacks, and sooner or later the heart is liable to attack. Such a child is to be regarded as a potential cardiac subject and should be carefully examined for any possible focal infection which might lead to other attacks.

Infected tonsils and adenoids, carious teeth, sinus or middle ear infections should especially be eradicated, as the most likely to cause attacks of rheumatism. It has been stated that from 80 per cent to 90 per cent of the cases of organic heart diseases result from rheumatism. If this be true, the prevention of heart disease resolves itself into the problems of preventing rheumatism. As rheumatic in-
Infection is believed usually to originate from focal infection, its prevention means a search for and the removal of these.

As above stated, infected tonsils are the most frequent source of rheumatic infection. The tonsils may be infected from carious teeth, infection of the nasal sinuses or by close contact with other persons having such infections, such as the mother, nurse, father, brothers or sisters. It is well known that an ordinary acute follicular tonsilitis is communicable from one person to other members of the family. The author has seen a chronic tonsilar infection apparently communicated in the same way. This matter has not received the attention it deserves. The close associates of a potential cardiac should be examined with reference to infected tonsils or teeth. How far the communicability of tonsilar infection may explain the susceptibility of certain families to rheumatism cannot be stated with certainty. There may be other inherited peculiarities which may be factors in producing the rheumatic family, but the communicability of such infection cannot be denied.

Tonsilitis, especially recurring attacks, is usually too lightly regarded by the laity and often by the physician. It is often difficult to decide when the tonsils should be excised, but after an attack of rheumatism or after several recurrent attacks of tonsilitis there can be no question. In fact, tonsilar infection is so common in recent years that it seems to be almost the exception to find a pair of perfectly normal tonsils in a child. Complete removal of the tonsils has been shown to prevent recurring attacks of rheumatism and is the most efficient preventive measure now known. Complete removal of the tonsils by operation, according to the statement of St. Lawrence, was accomplished in only about 70 per cent of cases examined by him. The fact that the tonsils have been operated upon, is not enough unless they have been completely removed. Chorea, or cardiac lesions associated with it, do not seem to be prevented by tonsilectomy. The treatment of enlarged or infected tonsils by X-Ray cannot be recommended as a substitute for excision. While the tonsils can thus be reduced in size, it cannot be depended upon to remove the infection.

Another measure for the prevention of heart disease is the watchful care of the heart during the course of and during the convalescence from all acute fevers, and especially rheumatic fever. This applies to both children and adults. Children convalescing from the “usual diseases of childhood” or from severe colds, influenza, pneu-
monia, etc. should be confined to bed much longer than is customary, especially if the child be a potential cardiac, and special attention should be directed to the condition of the heart, with the idea of protecting it from undue exertion. The usual quarantine period established for the communicable diseases, is not long enough to allow of complete convalescence of the heart muscle after an acute infection. The physician is too apt to regard his task done when the temperature reaches normal, especially if the heart shows no abnormal sounds or no disturbance of rhythm. No time limit can be set for complete convalescence, but must be determined in each case by careful examination which should include exercise tolerance tests. The effect of physical fatigue on the heart muscle is to exhaust its reserve force and lay the foundation for cardiac exhaustion and possibly for the invasion of germs into the tissues. It is well known that after one attack of influenza, for example, even of mild degree, the patient often suffers for some days or weeks from shortness of breath and weakness on exercise. I am mindful of the difficulty of keeping patients in bed after the acute symptoms have subsided, but its importance is not lessened by this fact. In the treatment of rheumatic fever and acute tonsilitis prolonged rest in bed is imperative.

The rapidity of the heart beat which accompanies rheumatic fever, and most acute infectious fevers, is probably the best guide to complete convalescence. The patient should therefore be kept at rest until the pulse shows a normal rate, without drug treatment. If the pulse rate be ten beats per minute above normal this means 600 extra beats in each hour or 14400 extra contractions per day of 24 hours. Certain it is that the myocardium should be protected from the strain of bodily exertion at such a time.

A measure of prevention of recurring attacks of rheumatic symptoms, which has been suggested by a number of authors and which has some value, is the administration of salicylates one week of each month for several months or for a year after recovery from a rheumatic attack. To a child of six to eight years we may give 5 to 8 grains of sodium salicylate three times a day, watching the urine for signs of renal irritation. While this treatment is of no value as a corrective of previous cardiac injury, it is of distinct value as a preventive of future attacks. The restriction of diet in cardiac subjects has been overdone. It is the practice of many physicians to restrict the nitrogen intake of all cardiac cases, and especially to interdict all red meats. I know of no clinical proof that a reasonable amount of
protein food does harm in cardiac disease especially in the young. On the other hand, a liberal mixed diet is the one best suited to maintain good nutrition of the heart muscle as well as those of the whole body.

I believe that by a concerted effort on the part of the whole medical profession, and by a campaign of education of the public as to the increasing dangers of heart disease and its relation to tonsilitis, rheumatism, chorea, and other acute infectious fevers of childhood, many cases of heart disease can be prevented and much suffering and disability avoided.

REFERENCES

CARED FOR TUBERCULOSIS AMONG EMPLOYEES*

HORACE JOHN HOWK, M. D.,
Physician in Charge,
Metropolitan Life Insurance Company Sanatorium,
Mount McGregor, New York.

The decline in the tuberculosis death rate in the registration area of the United States from 195.2 per 100,000 in 1900 to 112 in 1920 is a striking thing and a gratifying testimonial to all of the intelligent efforts that have been made to lessen exposure to tuberculosis and raise the resistance of individuals. I am one of those who believe sincerely in the efficacy of the anti-tuberculosis campaign that has been waged during the past fifteen years.

It was obvious that the Metropolitan Life Insurance Company, with about fourteen and a half millions of policyholders who were working people, should concern itself actively with the effort to reduce tuberculosis mortality and morbidity. The death rate among the Company's Industrial policyholders in 1911 was 224.6 per 100,000. In 1921 this rate had been reduced to 117.4, and in 1922 the rate was 114.2, a reduction of 49.2% in eleven years. These figures have been taken from the reports of Dr. Louis I. Dublin, Statistician of the Company, and he shows that 100,000 fewer people are now dying each year from tuberculosis in the United States than under the 1900 mortality rate.

I shall not attempt to discuss here the various measures that have been utilized by the Company among the policyholders to make effective its campaign against tuberculosis. The Company's plan of nursing sick Industrial policyholders and the placing in their hands of helpful literature is well known to you.

Naturally we have given a great deal of study and thought to the various means of aiding in the elimination of tuberculosis as one of our great killing diseases, and some years ago we arrived at certain tentative conclusions concerning the disease. These were, first, that tuberculosis depended largely upon an exceptional opportunity for infection and a poor environment after the implantation of

*Read before Hospital Social Service Association, New York City, December, 1923.
infection; second, that poverty, improper housing, bad working conditions, and other diseases of the respiratory tract, predisposed to tuberculosis; third, that tuberculosis is not solely a medical problem, but largely social; fourth, that early tuberculosis is very amenable to treatment; fifth, that a wholesome, intelligent respect for tuberculosis is a desirable asset for every individual to possess; sixth, that there are three things in life to which people tie—their family, their church and their job.

Having in mind these factors, and as a contribution to the anti-tuberculosis campaign, the Metropolitan Life Insurance Company decided in 1909 to establish its own sanatorium at Mt. McGregor, New York, for the care of her tuberculous employees. The first patient was received in November, 1913. The present number of employees approximately 30,000 are engaged in nearly all parts of the United States and all provinces of Canada.

One thousand five hundred and ninety tuberculous patients have been admitted up to December 31, 1923. It has always been a great desideratum in tuberculosis to get patients under treatment while their disease is in the early stages. Naturally one of our first undertakings was to make possible this achievement. With the opening of the Sanatorium all obvious cases were admitted at once, and during the first year, 1914, 28% were admitted as incipients, 57% moderately advanced, 14% far advanced, and 1% with non-pulmonary tuberculosis. We were enabled to start, promptly, annual examinations of all employees. This procedure served two purposes—first, it actively interested the Company's medical examiners throughout the country in the physical welfare of the employees, and, second, it brought above the clinical horizon many latent and early cases. Our working forces are divided into small groups which are scattered throughout the country and are supervised by managers. It was evident that the supervisors should get a clear understanding of the Company's purpose in establishing a sanatorium, and they were invited to come to Mt. McGregor and see what provision had been made for the care of the sick. Their active co-operation was at once enlisted and it was possible from that time on for each manager to assume a personal responsibility for the health of his staff and to know that the development of advanced tuberculosis among those under his eye might imply neglect or carelessness. Active correspondence was carried on with the medical examiners and the managers to stimulate their continued interest in detecting tubercu-
H. J. Howk

Ilosis. Finally, when it became possible to discharge recovered patients we were able to equip them with a knowledge of tuberculosis which enabled them to be of invaluable assistance in their home communities in the detection of tuberculosis.

Largely as a result of these various efforts the percentage of incipient cases admitted increased each year until 1917, when we had 66.5% admitted in the earliest stage of the disease. The following table will show the stages of disease of the 1,590 tuberculous patients admitted from November 24, 1913, to December 31, 1923.

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<thead>
<tr>
<th>Stage</th>
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<td>69</td>
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</tr>
<tr>
<td>Incipient</td>
<td>818</td>
<td>51.4%</td>
</tr>
<tr>
<td>Moderately Advanced</td>
<td>561</td>
<td>35.3%</td>
</tr>
<tr>
<td>Far Advanced</td>
<td>125</td>
<td>7.9%</td>
</tr>
<tr>
<td>Non-pulmonary</td>
<td>17</td>
<td>1.1%</td>
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Our patients are rehabilitated as completely as possible. There is no stated time for which they may remain under treatment and we purpose to restore them to working ability. As a rule they return directly to work from the Sanatorium. We therefore aim to give whatever rest cure is required in the individual case and then restore their body tone and strength through exercise, under observation, which will make possible a gradual transition to working conditions. We realize that most patients with recoverable tuberculosis thrive while in the sanatorium and that relapses are common within a few years after discharge. We believe that many tuberculous patients are at present under-treated from lack of facilities and are pushed out into the world quite unfitted to cope with its problems. To overcome this defect we have provided a somewhat longer period of treatment than usually obtains. Our incipient cases have been treated on an average 7 months and 15 days throughout the 10 years, while our moderately advanced patients have remained with us an average of 1 year and 27 days. The majority of our patients return directly into the Company’s service and continue there. We make every consistent effort to keep in touch with their condition from time to time and aid them in the maintenance of their health. At our Home Office it is possible to provide intermediate diets of milk for any ex-patient of the Sanatorium who requires it. They are weighed at frequent intervals. Physical examinations are made every three months for the first year and every six months subsequently.

As a result of our endeavors to rehabilitate our tuberculous em-
employees under treatment we find that their condition on discharge was as revealed in the appended table.

TOTAL NUMBER OF TUBERCULOUS DISCHARGES 1914-1923

<table>
<thead>
<tr>
<th>Condition on Admission</th>
<th>Apparently Arrested or Improved</th>
<th>Unimproved</th>
<th>Died</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Cases</td>
<td>Quiescent</td>
<td></td>
</tr>
<tr>
<td>Suspected ..........</td>
<td>59</td>
<td>1</td>
<td>1.7%</td>
</tr>
<tr>
<td>Incipient ..............</td>
<td>795</td>
<td>628</td>
<td>79.0%</td>
</tr>
<tr>
<td>Moderately advanced ....</td>
<td>504</td>
<td>219</td>
<td>43.5%</td>
</tr>
<tr>
<td>Far advanced .........</td>
<td>96</td>
<td>10</td>
<td>10.4%</td>
</tr>
<tr>
<td>Non-pulmonary ..</td>
<td>16</td>
<td>1</td>
<td>6.2%</td>
</tr>
</tbody>
</table>

This chart gives a comprehensive idea of the very hopefulness of treating incipient tuberculosis, and the rapidly increasing morbidity and fatality of advanced disease. Ninety-six and six tenths per cent of incipient cases left Mt. McGregor with their disease arrested, quiescent or improved, while only 79% of the moderately advanced cases were able to achieve such a result in a much longer period of time, and only 31% of the far advanced.

Notwithstanding all of our efforts a considerable number of patients do relapse, and of these 143 or 9.7% of the total number of tuberculous patients discharged from the Sanatorium during the ten years have been readmitted to the Company's Sanatorium.

It is customary to measure the efficiency of all hospital treatments by the length of time and the degree to which patients maintain their health after discharge. There are obviously some tuberculous individuals who cannot be restored to working efficiency even when placed under treatment in the early stages. These people lack somehow in essential resistance to tuberculosis and find themselves with re-activated disease shortly after they resume work. We have observed cases of this kind whom we have treated three times without being able to induce any effective barrier against the disease. We do not know what percentage of tuberculous patients fall into this class, but certainly there are enough to present a discouraging aspect of the treatment of the disease to those who are easily downcast.

Our method of following up our discharged patients, which has been described, has kept us in constant contact with the vast majority of the 1,354 tuberculous patients who were discharged from 1914 to 1922, and we find that of this number 972 or 72% are at work, 209
or 15.4% are dead, 32 or 2.3% have been readmitted to the Sanatorium for treatment, 87 or 6.4% are at home and unable to work, while 54 or 3.9% have been untraced. It is very helpful to note again the great advantage in treating incipient tuberculosis. Our records show that of those who came to the Sanatorium as incipients 85% are still at work, while 58.5% of those admitted in the moderately advanced stage are working, as are 19.5% of those admitted in the far advanced stage. This covers a period of nine years. Some of the patients have been at work only a year, while others have been engaged during the full period of this observation.

The majority of our patients have returned to their former occupations with the Company. We firmly believe, and our records will show, that those who have resumed their original occupation have carried on more effectively and with better health than those who have changed their occupations. Our constant advice to patients about to be discharged is to get back into the field of work to which they have been habituated. Forty per cent of our ex-patients are clerks, 33% are agents, and the remainder are engaged in 12 different occupations, such as managers, assistant managers, bookkeepers, cashiers, nurses, printers, stenographers, typists, etc.

Those who have left the Company have engaged in 56 different occupations, many of them light in nature, and some heavy. A few have become farmers, engineers, and carpenters. It is especially interesting to note that next to the largest group is still engaged in the insurance business, bearing out still further the dictum that it is better for tuberculous convalescents to follow the occupation to which they are accustomed.

As years have gone on we have seen more and more the valuable work that can be carried on in communities by ex-patients of the Sanatorium. Large numbers of our patients are restored to their positions as agents. They are in daily contact with our Industrial policyholders; they enter homes and are intimately consulted about matters having to do with the health and well being of those among whom they work. We have ample evidence that large numbers of individuals with tuberculosis have had their disease brought under observation and treatment by our ex-patients. They have preached constantly the gospel of wholesome living, the benefits of simple foods, good ventilation, proper housing, clean milk, and other necessary measures. This health missionary work has indeed been recognized by our patients as one of their great privileges and they have
lived up to it. With this opportunity before us we have naturally taken occasion to see that our patients are well instructed in the recognition and treatment of tuberculosis.

While primarily intended for the sole treatment of tuberculosis, we began soon after the opening of the Sanatorium to admit employees with other diseases and conditions. The number of non-tuberculous individuals has increased each year and the total number of admissions now equals that of the tuberculous. This is not the place in which to discuss any features of this phase of our work, save to point out the almost unconscious contribution that has been made to the anti-tuberculosis campaign. We are all quite aware of the fear of tuberculosis that was engendered in people's hearts fifteen years ago, which ultimately resulted in the practical ostracism of tuberculous patients from general hospitals. There still exists a deal of fear of tuberculosis among people generally and I am satisfied that it would be a misfortune if this were wholly lost. We shall always need a substantial if not fearful respect for this major disease. Anything that contributes to a sane understanding of its manifestations and means of prevention will eventually help to reduce the discriminations against the tuberculous, which still add so direfully to their burdens, and will promote a more earnestly helpful attitude on the part of the well. To have treated in the same hospital equally large groups of tuberculous and non-tuberculous individuals for ten years has, I think, given a substantial impetus toward this very desirable end, and it must not be forgotten that this impetus has been carried to hundreds of cities and smaller communities throughout the United States and Canada.

Finally, then, we may say that one very substantial contribution of the Company to the anti-tuberculosis campaign has been the providing of full and free care for every one of her employees who has become sick with tuberculosis during the ten years past. That this contribution has resulted in a spread of wholesome, sane knowledge of tuberculosis among 30,000 employees of the Company is only too obvious, and it is equally apparent that those who have been cared for at Mt. McGregor have become veritable missionaries of health in whatever community they may abide.

REFERENCES

The promotion of worthwhile public health movements depends largely upon the initiative and enthusiasm of individuals. Hospital social service workers occupy a strategical position for advancing meritorious health doctrines. As liaison officers between the hospital and the medical profession and the public, they have unique opportunities for bringing to the attention of the latter measures of preventive medicine of benefit to the people. One of the chief of these movements which is now holding the center of the public stage is the Health Examination. Sanitarians, physicians, sociologists, and the intelligent public are now agreed that periodic physical examinations of all persons, whether apparently well or not, are essential to modern life and prosperity and are among the necessary next steps in the public health campaign.

A health examination is a thorough physical and mental scrutiny of an individual made by a competent doctor of medicine in order to detect physical and mental impairments and faulty habits of hygiene, with a view to their correction. Health examinations have been defined in numerous picturesque ways. They have been called, for instance, medical appraisals, audits of one’s physical assets and liabilities, human inspections, medical surveys, individualized longevity promoters, physical inventories, and periodic human stock-takings. The late Dr. Hermann M. Biggs put the health examination first among the practical objectives of public health endeavor for the next twenty years. Just why this is and should be so forms an interesting chapter in modern sanitary science.

The arguments in favor of health examinations are more or less obvious. They serve, of course, to bring out latent defects which, if undiscovered, might result eventually in serious diseases requiring much time, money, and medical skill to cure. The best thing about the health examination, however, is that it reveals when a person really is healthy. To emerge from a physician’s office with the knowledge that one has no organic defects and that the only thing needed, for example, to attain perfect health, is a little more exercise,
gives one a feeling of exhilaration and inspiration which needs the pen of a literary master to describe. Even when physical impairments are brought out, the realization that they can be remedied at the start and prevented by prompt action from ever becoming serious is an eminently satisfactory idea.

All age groups need health examinations. The statement has occasionally been made that every person past forty years of age should have such a periodic physical examination. As a matter of fact, to be of real value, every person of whatever age, between zero and one hundred, should have a health examination at least once a year, and some, oftener. The period to begin checking up on one's health is not at middle age, but at the time life itself begins. No competent business man ever thinks of starting a new and important venture without making a scientific survey of the situation and then following that up with regular inventories. The business of life is quite the most important affair with which any of us has to deal and it pays to evaluate it annually. The baby, the youth, the young adult, as well as the adult and those of middle-age should have their health examinations and assiduously apply the hygienic knowledge which comes therefrom.

Although all age groups should cultivate the health examination habit, one of the features of these human surveys is the prevention of the encroachment of the degenerative diseases which sometimes become manifest in later adult life. These organic diseases include such maladies as heart disease, cancer, apoplexy, diabetes, Bright's Disease and other kidney affections. The death rate and the prevalence of most of these have been increasing of late years. Most of them are chronic in their action and often give no warning by symptoms, until they have made considerable headway. The secret of combating these diseases lies in early diagnosis, which can be advantageously accomplished by the health examination. As the prevalence of these organic diseases has gone up, that of the communicable diseases has, generally speaking, gone down. Typhoid fever has been reduced by two thirds in the last decade or so by the efforts of the sanitarian; the tuberculosis rate has been cut a little more than one half since 1900. Most of the communicable diseases, except the respiratory infections, are definitely on the wane. The control of the communicable diseases is to a considerable extent an environmental matter, though personal hygiene plays as important role; the control of the organic diseases on the other hand is almost
exclusively a matter of personal hygiene and the conduct by the individ­ual of a sensible regimen of life.

The health examination is the keystone of personal hygiene. The facts concerning our physical make-up which it brings out, and the habits which it indicates should be changed or corrected, allow us to determine the right way to regulate our lives for health. That the majority of individuals really will be discovered to have physical impairments has been amply demonstrated by actual experience. The army draft, the only adequate national physical inquisition which the country has ever had, revealed a 33 per cent rejection rate on account of physical disability and a 47 per cent rate of physical impairments of those accepted. The Life Extension Institute has examined over 250,000 persons since 1914 and is authority for the statement that nearly all of them had physical defects. A perfect human being seems as rare as the dodo.

Other data are equally impressive. At Framingham, Massachusetts in 1917, during the notable community health demonstration, 77 per cent of 4,473 persons given medical examinations were classed as “ill.” Of a total of 903 persons of low economic status who were examined under the auspices of the Committee on Dispensary Development in New York City, only about 2 per cent were regarded as in normal health. The Community Health Center of the Jewish Welfare Society of Philadelphia reports that of 4034 examined between May, 1922 and May, 1923 only 13.5 per cent could be rated as normal. A somewhat higher percentage of freedom from physical defects, namely 29 per cent, was found in examining 1,397 department store employees in Cleveland. Fifty thousand garment workers have been examined in New York City since 1913 and of these one per cent had tuberculosis, two per cent other pulmonary affections, 1.5 per cent chronic heart troubles, 15 per cent gastro-intestinal disease, and 25 per cent suffered from neurasthenia. These figures are sufficiently convincing to show the need of health examinations, for there is no doubt and indeed plenty of scientific evidence to prove that most of these impairments are remediable and generally could have been prevented.

Educational efforts are needed in order to convince the general lay public of the desirability and necessity of health examinations. Progressive sanitarians and health agencies have been urging this matter for many years and the organized medical profession, through the American Medical Association, has twice gone on record as favor-
ing such examinations. In order to crystallize the sentiment for health inventories, the National Health Council* has inaugurated a nationwide campaign for health examinations. Having started on July 4, 1923 with the slogan "Have a Health Examination on your Birthday," this campaign was planned to extend until July 4, 1924, although it will undoubtedly last considerably longer, as some of the states were several months late in getting under way.

To date, this campaign has been organized and carried on in nearly all the states. Since the movement was endorsed by the Conference of State and Provincial Health Authorities, all of the state health officers were invited to take the initiative in developing the work. In some states the campaign has been under the personal supervision of the state health officer, while in others he has served as honorary chairman and the educational activities have been carried on with his approval by some other agency, as the state public health association, tuberculosis league, council of social agencies, or congress of mothers and parent teacher associations. A vast amount of publicity material has appeared in newspapers, magazines, and bulletins, and the National Health Library of the Council has prepared a bibliography of the principal scientific papers on the subject. This bibliography is available for the asking.

The National Health Council has also prepared for the use of local groups in this campaign a quantity of educational material. This includes an eight page pamphlet for popular distribution, two editions of which have been necessary; a poster in two colors; a set of thirty lantern slides with lecture outline; and a number of reprints and mimeographed bulletins, one of which outlines a suggested state plan. All of this material, except the reprints, is sold at cost price. The American Medical Association has prepared standard examination forms and also has several reprints. The Metropolitan Life Insurance Company has co-operated by producing a one reel motion picture entitled "Working for Dear Life," which can be obtained without charge, other than transportation costs. Other organizations,

*The members of the National Health Council are: American Child Health Association, American Public Health Association, American Red Cross, American Social Hygiene Association, American Society for the Control of Cancer, Conference of State and Provincial Health Authorities of North America, National Committee for Mental Hygiene, National Committee for the Prevention of Blindness, National Organization for Public Health Nursing, National Tuberculosis Association, United States Children's Bureau, United States Public Health Service, American Association of Industrial Physicians and Surgeons, Women's Foundation for Health.
such as the Women's Foundation for Health, which has health examinations as the central feature of its program, have suitable material, and the state tuberculosis associations have posters for this purpose.

Local hospitals can appropriately take part in this campaign, for the modern hospital is not merely a repository for the sick, but an important factor in the positive health of the community. While the campaign is educational and not clinical in scope, and the procedure advised for individuals is to go for their health examinations to their own family physicians, nevertheless it may be proper under certain conditions for hospitals to offer such examinations. They may be staged as demonstrations for the medical profession in co-operation with the local medical society. Such a demonstration, in which obviously only a small portion of the public would be reached, could well serve as an example and would be useful in inducing greater numbers of the population to embrace the opportunity for an examination by their own doctors.

In any event, the function of hospital social service workers is apparent. Somewhat like the public health nurses, they are the carriers of the gospel of good health into the homes of the people. The public will listen respectfully to advice coming from this source, and there is no danger of the criticism which has occasionally been heard that physicians, by themselves urging health examinations, are trying to get business. Of course, any sensible person realizes that the health examination is preventive medicine and that keeping a person well is much less expensive for him than curing him when he is sick. A nationally known business executive has received considerable publicity because he has a contract with his physician to keep him well and pays him for it, deducting from the fee if he becomes ill. As President S. W. Stratton of the Massachusetts Institute of Technology said at a recent banquet, every man of affairs now comprehends that it is the best economics in the world to maintain health.

The value of health examinations can be further proven by citing the experience of a prominent insurance company. The Metropolitan Life Insurance Company, has offered to its policy holders such examinations without charge since 1915. In checking up the records of the first 6000 of these human appraisals of policy holders, it was found that the company had returned the principal on its investment and made a profit of 200 per cent. This was accomplished because there was a saving of 28 per cent in the mortality rate of these individuals and this saving has been scientifically demonstrated to
have been due to the beneficial hygienic effect of the examinations. Another notable argument in favor of the health inventory is the fact that in the twenty books of the National Health Series, covering all phases of human health, and written for the National Health Council by the leading sanitarians in the country, nearly every author, writing independently, most strongly advocates the health examination. All in all, the evidence in favor of health examinations seems overwhelming.

Hospital social workers do have, then, an unexcelled opportunity for constructive effort in the public health movement by sponsoring and fostering propaganda for these health examinations. If all the people would apply and profit by the medical and hygienic advice forthcoming, there is no good reason why twenty years could not be added to the average span of human life.

REFERENCES


National Health Series. Published for the National Health Council by Funk & Wagnalls, New York (20 volumes).


MEDICAL SOCIAL WORK FOR CHILDREN IN A MUNICIPAL HEALTH DEPARTMENT

ELEANOR McGARVAH

Supervising Nurse, Department of Health, Detroit, Michigan

The group of about 200 nurses on the staff of the Department of Health of Detroit make up the largest body of representatives of any one organization visiting in the homes of this city. Their visits are made in the interest of Infant Welfare, Prenatal, School, Contagious, Tuberculosis and Venereal work or Departments. All districts are included but the greater amount of work is done in those localities where the rate of morbidity and mortality is highest. It would be difficult to describe all the situations seen and reported by the nurses. They are engaged to do health work and each one is expected not only to obtain results for her particular department, but to observe and take care of any health needs present in the homes and to report all matters that hinder or complicate their progress.

The Department of Special Investigation is interested in remedying these complications so that ultimate correction of the health situation is possible. Not only are we engaged to do health work, but we must recognize the fact that we are city employees and that we owe to the people that type of co-operation with other city agencies that makes for efficiency, economy and good service. Co-operation with outside agencies is directed by the Department of Special Investigation which has been in operation since 1918. Complaints are received by this department from all health employees including nurses, outside agencies and individuals and are distributed by this department for investigation or if necessary are taken care of directly by this office.

Detroit is well equipped to care for all the needs of a very cosmopolitan and constantly growing population. An unusually large proportion of welfare work is provided for by city and county taxation. A happy condition of harmony and common interests makes it possible for one city department to dovetail into the services of the other without duplication. The greater number of private agencies are maintained by the Community Fund contributed by the general public.

The Health Department receives the most gratifying co-operation
from all outside agencies. A remarkable appreciation of the importance of health in the welfare of individuals has been developed in all these organizations.

We were recently notified by the Tuberculosis Department, that a mother of two small children was in an advanced state of tuberculosis and was sorely in need of sanatorium treatment. A bed was available for her in the hospital but she was unwilling to go until a home was provided for the children. We asked a child caring agency to investigate and place the children. They reported that the father was not only utterly indifferent to the disposal of the children, but refused absolutely to pay any board for them. He was regularly employed and making a fair wage. We entered a complaint at the Juvenile Court, claiming the home unfit for the children because of the mother’s diseased condition. A summons was issued and a hearing took place the following day. The Judge committed the children to the society for boarding care, the father to pay part of the board. The mother was taken the same day to the hospital.

We were asked not long ago by the Mother’s Pension Department of the Juvenile Court to secure a writ to take a child suffering with pneumonia to the hospital. The child’s mother, a mother pensioner, was not only an epileptic but was also about to be confined. She was therefore unfitted to care for the child. Despite these facts she was determined to keep her child at home. The City Physician’s Office sent an ambulance to meet us at the house and the child was removed to the hospital without difficulty. The following day our nurse called to take the mother to the hospital to see the sick child. While at the home she noticed that one of the other children was sick and so took her along to see the doctor. Scarlet fever was suspected but the following day it proved to be measles. However still another child had developed scarlet fever. These two children were sent to the contagious ward of the Herman Kiefer Hospital. The Mother’s Pension Department sent a woman to clean the house so that quarantine would be terminated and later provided a nurse for the mother’s confinement.

The County Agent refers children proposed for adoption to this Department. Investigations are made regarding the child’s parents and health and the would be foster parents are also investigated. During one of these investigations our nurse learned that a little girl was being adopted by her own mother and her step-father. She had been previously deserted by her foster parents and placed for adop-
tion. The mother confided to the nurse that she was anxious to have her daughter with her but because of her husband, feared for her safety. This information was submitted in our report to the Court. The Judge questioned the mother and as a result the child was placed in safety with a child caring agency.

Foster parents are instructed in proper infant feeding, (for example when they give the baby condensed milk) so that the need of proper formula is pressed upon them. All assistance is likewise offered in instruction covering general care of the child.

Our school nurses are at times unable to persuade difficult parents that their children’s defects need correction. When the child’s progress in school is impeded or his general health or prospects in life are in danger through the defects, the case is referred to this department. Both parents are seen or communicated with and the matter placed clearly before them. If, after this, they still refuse to recognize their responsibilities, a written report is secured from the examining physician or the director of medical school inspection and a complaint is made in the Juvenile Court. Occasionally before the hearing the family will consent to the necessary medical or surgical care since it has been given into the hands of a court.

Several months ago Nellie U. was reported to us as having tuberculosis of the spine. Following a factory accident in which he had received a severe head injury, the father of the child was incapacitated and mentally unstable and so was only receiving compensation. Repeated visits and appointments were made but the parents continually postponed any action in the care of the child. Finally we reported the matter to the Juvenile Court. The father decided he would consult a certain orthopedic surgeon and if he would do the work without charge he would consent to the child’s being cared for. The doctor’s co-operation was secured through a hospital social service department and the operation was performed.

Jennie B. was reported to us in September, 1922, by an orthopedic clinic which had known her for a year. A cast had been applied for a tubercular hip by the surgeon in charge and was removed three months later by the father. The mother was determined to have nothing further to do with the clinic. She said she was taking Jennie to a private physician, which proved untrue. A complaint was made in the Juvenile Court. As soon as the court investigators called the family removed the child, claiming she has been sent to Cleveland. They gave a fictitious address and doctor’s name to the judge. At
a later hearing a writ was issued inasmuch as the father failed to bring the child to court. A call was made at the house with a police­man and she was removed to the Children’s Hospital. After a cast had been applied she was permitted by the Court to go home and to return as often as directed to do so by the clinic. Again they failed to co-operate and the Court had to issue another order to the father to bring her back. This time the hospital was advised by the Court to place her in their convalescent home. She has been there now for 6 months and is making a good recovery.

Lorraine C., 10 years old, was reported to one of our school nurses by her teacher as the child seemed to have difficulty in sitting in her seat. The nurse made an investigation and found her back and shoulders covered with welts. She had scarcely enough clothing to cover her decently. She acknowledged with reluctance that she had been severely beaten by her sister two evenings before. Lorraine had recently come to Detroit; her parents and three brothers and sisters were living in the South. The sister worked all day and her husband worked at night while Lorraine was evidently made a drudge. The child was expected to do the greater part of the housework. Her hands were red, rough and hard. We referred the case to the Juvenile Court and to a child caring agency for investigation. It is planned to send her back to her mother.

Frank K. was reported absent from school because of sickness. Our nurse called to investigate and found him suffering with chorea, and receiving no medical care. The mother explained that the child had had a very bad fright a week before and since that time had shown these nervous symptoms. The father of the child had deserted his family four years previous to this. The investigation proceeded very well until the nurse asked how the family managed financially. The mother became furious at that and almost put her out. The next day the nurse called again and offered to take the mother and the boy to the Hospital Clinic. They had gone only a block when the mother changed her mind and would neither go nor allow the child to be taken. From the office we wrote the mother a letter explaining that Frank must have adequate care or we would have to make a court complaint and we asked her to come in. She did not do so. We called at the home and found the child in a pathetic condition, thrashing about unceasingly. The mother was apparently frightened for the boy and consented to go to the hospital with us the next day. She did
so and the boy was admitted. He will be sent to a convalescent home in the country after he has some corrective work done in the hospital.

The above cases give some little idea of the type of service this department extends for the benefit of children.
Because of its difficulty, the problem of educating the crippled child was neglected long after schools for the education of the deaf and blind were established. In these days when the Rotarians are so deeply interested in promoting schools and the Masons in providing homes for crippled children, their education is receiving special attention. I am sure we all want these brave, optimistic little ones to receive the best.

In the state of Ohio, where a few years ago there was but one school, there are now schools or classes in 14 different cities or towns. The new law says that a board of education shall establish a school wherever there can be found more than 7 crippled children not receiving an education in the regular schools. It provides for the teaching of children while in hospitals, and states that children not able to attend the special school for crippled children shall have a home teacher. Before the state law went into effect, Cleveland was already furnishing home teaching to some of its crippled children. Since this law was passed, many have been found in small towns and country places with no education whatever. One, a girl of twelve years of age, born without legs and with but stumps for hands, was found up in a cherry tree picking cherries. She was brought to the Home for Crippled Children in Cleveland and entered our school. Although a bright child she had to be started in the first grade.

It is estimated that there are two crippled children to every thousand inhabitants, making the number in our state 12,000. The state will pay $300 towards the education of a crippled child, thus making it possible to establish classes in small towns.

Formerly schools for crippled children were started through philanthropy and when well established, the cities were asked to assume the burden. This was true of our own Sunbeam School. About 25 years ago, a small class of girls in a Sunday School became

*Read before the All-Philadelphia Conference for Social Work, Philadelphia, Pennsylvania, April, 1923.*
interested in buying crutches and braces for crippled children. As they grew older, they enlarged their work and later formed the Sunbeam Association, which was incorporated under the laws of the State. Through donations received, they established a kindergarten to which they brought the children in their own horse-drawn busses. In 1910 they persuaded the Board of Education to assume part of the responsibility—the board furnishing the building and teachers and they the transportation, lunches, cook and helpers. In 1912, the State passed a law allowing $150 towards the education of each crippled child attending a special school. The school board then assumed all responsibility.

There is a Home for Crippled Children in Cleveland. Several years ago, the Board of Education furnished a teacher for the Home and when it came under my supervision, there were twelve children receiving instruction. I found that the work done was lacking in effectiveness because the classes were too small, sometimes but one or two in a class, and that the children needed to be brought into contact with other children and given new interests. Now the Board of Education sends a bus for these children and they attend the various classes of our special school where they are much happier. To me it seems a great pity to require crippled children to attend school and associate only with those with whom they live seven days a week. I wonder if any of us would like to live in such a little world!

The rest of our pupils come from their own homes, where they are in contact with their brothers and sisters who get about more than they do and are thus able to bring the outside world to them. That the Day School for Crippled Children carries on the education of the crippled child while in the home environment, is the strongest argument for such type of school. Institutional care sometimes becomes necessary when one or both parents have died, or where the home life has been proven morally or physically unfit. For surgical purposes, it is often advisable temporarily to commit a crippled child to a hospital or a convalescent home, but this is usually done with the parents’ consent and because they realize that the proper care cannot be given in their own home. It is however true, that in some cases children are committed to hospitals through Court action, against the parents’ wishes, but this is rather a medical than a social question. The fact that fathers and mothers are generally reluctant to have
their children leave the home roof is a significant and encouraging condition of society.

The transportation of crippled children is the most difficult and expensive problem in their education. Our board owns six auto busses heated by electricity, with a carrying capacity of 180 children. These are driven by experienced chauffeurs who are paid by the month. In each bus there is a guard whose duty it is to carry the helpless children to and from the bus. Many children able to get about in our one story building, as well as the wheel-chair cases, must be carried up and down stairs at their own homes. Because the busses cannot go on unpaved streets, the parents of pupils living on those streets are required to bring the children to a store or other safe place located on a paved street. When the home is very near the corner, the guard may call for the child. Each child must be ready when the bus calls, because in collecting so many children, much territory is covered and much time is consumed. The guards are paid for their time in making the trips.

Not every crippled child is eligible for admission to the special school. According to the State law, he must be of “sound mind.” To be accepted in the special school, a candidate must be physically unable to attend school unless transported or in such condition that it would be unsafe for him to go to a regular school. Applications are made through the parents, hospitals, district nurses, attendance officers, principals, etc. Upon the receipt of an application, our field-worker either makes a home visit to investigate the case, or the child is brought to the school for examination. If he is eligible, he is admitted. If he is not eligible, he is placed where he belongs. We may find him perfectly able to attend the regular school or we may find him of such mentality that he cannot be accepted. The placement may mean home instruction, temporarily.

We are often asked “What do you do for defective cripples?” Our city has classes for mentally sub-normal children. These classes will not accept a child with a mentality below that of a five year old. If the defective cripple registers higher than that, he may be entered in the nearest center. All of our mentally defective cripples who test above five years are cared for by our educational system. Before we had a state law, there were several defectives brought to our school. I remember one boy took about a third of the time of a teacher who had three different grades. I asked our Superintendent to have him removed. He at once placed the child in one of the centers for
defectives. The boy was in his proper place and the teacher was able to give her full time to her class.

There are schools for crippled children that also do admit the sub-normal. We object not only because they cannot be taught with normal children but because they are in the busses with the other children on their long rides and are with them during their noon meal and playtime. In the regular elementary schools the defective does not mingle with the others. Why should normal crippled children be required to associate with the sub-normal? A short time ago, a pupil entered our school from another city. When his mother came to visit us, she said “R—— likes this school so much better than the other school because there are no queer children here.” One of our teachers visited such a school. She found the atmosphere most depressing. Our State law protects our crippled children and I wish it might be so in every state.

A nourishing noon meal is furnished free. The menu has been carefully worked out as to calories, nourishment and variety. At least once a week ice cream is served. The tubercular bone cases and underweight children have Guernsey milk at 10:30 A.M. Those who are able, pay for this milk.

The medical inspection is the same as in the regular schools. The doctor and nurse attend to the vaccinations, examinations of the eyes, ears and throat and advise parents in regard to rectifying those defects. First teeth are taken care of free at one of the school dental clinics. Groups of the older children are taken in the school bus to the Dental College Clinic. The school nurse attends to all dressings, following the instructions of the orthopedic doctors.

Special attention is given to the upbuilding of the children’s physical condition by the physical training department. Each child has individual orthopedic gymnastics. Much attention is given to infantile paralysis cases. Not only are the affected parts massaged and exercised but also the muscles of the arms, legs and body are strengthened because of their need in climbing and in raising themselves. This attention is also a precaution against scoliosis. Each child knows when he should go for his exercises. If he wears braces, he must remove them himself, if possible. This is required in order to make him independent, and also to save time. He must be clean when he comes for massage and the cleaning up process must be done in the home. We have always followed this policy and so did not have bath facilities installed in our new building. It is astonishing
how well little children whose mothers are slack, can attend to themselves.

Physical training teachers in our school must be graduates of a credited school of physical education and must also have had experience under an orthopedic physician, either in a hospital or in private practice working with crippled children. These teachers take groups of children in the school bus to the hospitals to receive instructions from the orthopedic doctors as to the exercises to be given. The children are again taken whenever it is observed that there is either great improvement or apparently little response to the exercises.

Children who are obliged to take long rides or who are weak are given rest periods of thirty minutes. All kindergarten and first grade children have their rest periods, as do also the tubercular bone cases. We have twenty cots in the sun room for little children and an open air and rest room for the older children.

The weather permitting, all pupils are required to go out of doors at recess and at noon. Those having poor circulation, as many of the infantile paralysis cases do, stay out only a short time in cold weather. Many of our children are more eager to go out to play when it is quite cold than is the normal child. Visitors often comment on their great activity. The physical training teachers have over-sight of the games. We had a hockey team composed of girls using one or two crutches. As they often fell, they made rules to fit their needs, and played an enthusiastic game, using a crutch for a hockey club.

Before the Board of Education took over the school, the Sunbeam Association provided a nurse who visited the homes of the crippled children. She urged the necessary operations, took the children to the hospital, saw that they were transferred to the convalescent hospital, and when they were able to attend school, notified us. The Rose Fund paid for the operations, hospital care etc., if the parents were unable to do so. This arrangement was ideal for that time. As a public school, we could not continue under one orthopedic surgeon or one hospital. Our public school children are treated at several different hospitals and there is a fine spirit of co-operation between the school, the orthopedic doctors and the workers from the social service departments of the various hospitals.

Our educational objective is to get the crippled child out of the special school and into the regular school as soon as possible. There are however, very definite conditions which govern to a considerable
extent every transfer. A pupil is not discharged until he is able to perform the necessary school activities with safety and without undue effort, nor is he discharged unless there is reason to expect that his progress towards recovery will continue under new condition following the transfer. Children are not always kept until the maximum physical improvement is reached. In the majority of cases, it is not necessary for physical reasons to segregate children in a special cripple school over a long period, and it is often unwise when considered from a general educational or from a social viewpoint.

Whenever school arrangements and the child's condition seem to indicate that a transfer is in order, the pupil is taken to his orthopedic doctor for an opinion. If the transfer is approved, the child is sent to the regular school.

A special teacher of physical training visits this building once a week if necessary, for the follow up work. She gives individual gymnastics to the pupil, looks after his school activities, keeps in touch with the home and the orthopedic doctor, co-operates with the other teachers to whom this pupil goes and in fact has general supervision of his physical welfare.

If the child does not seem to progress as rapidly after transfer as we think he should, or if the environmental conditions of the regular school have changed in such a way that he cannot be adjusted without physical detriment, he becomes a candidate for readmission. The number referred back to the school is very low. Only one boy was returned last year.

Nearly all the pupils are transferred before reaching the senior high grade, and the majority before reaching the junior high grade.

Parents must see that their children go to the dispensaries whenever necessary and that the braces are kept in good condition. This is and should be considered an important part of the parental obligation, which if assumed by or delegated to others is bound to result in harm to the child. Especially is this true during vacations, when school days are discontinued, and in cases when the family moves to a location where the parents must take the initiative or where there is utter neglect. The parent is advised to attend to brace repair and make hospital visits on Saturdays if possible. The school neither provides transportation nor does it assume any financial responsibility. This method saves time and expense to the school and eliminates a duplication of effort. Our policy is in harmony with the social service workers of the dispensaries and is as satisfactory to them as to us.
Many of you are familiar with “Care and Education of Crippled Children in the United States” published in 1914 by the Russell Sage Foundation. At that time there were public schools for crippled children in only four cities,—New York, Chicago, Detroit and Cleveland. Now there are so many classes and schools, it is hoped we may soon have another survey.

In the fall of 1918, our Superintendent appointed one of our own teachers to make a Survey of all the crippled children in the public schools. This teacher was specially fitted for the work because of her physical training education and experience, her work under orthopedic doctors and her knowledge of conditions in our school system. A thorough canvass was made of all the schools, elementary, high and special, which resulted in obtaining a record of name, location and physical condition of every crippled child in our schools. Up to this time, only the crippled children in the special school were receiving any organized attention. Each child was examined and recommendations made as to his care. When found desirable, the parent was asked to take the child to an orthopedic doctor or to an orthopedic dispensary for advice. Principals and teachers were much interested and through their co-operation the results of the undertaking proved satisfactory. As a result of this Survey, the next year the Board of Education authorized the superintendent to assign a teacher for work among the crippled children in the public schools.

After several years of this extension work among the schools, the experimental stage is over, and the oversight of all the crippled children in the public schools is now an established part of the educational program.

There is maintained the necessary co-operation between the school system and the social agencies of the city and the state, and a very close co-operation with the orthopedic doctors and the hospitals.

This systematic organization for the education of the crippled child, whether he be in the regular or in the Sunbeam School, whether he be in the home or in the convalescent hospital is gradually having its effect upon the so called “retarded crippled child”—retarded because of his physical disability. There are fewer each year. A condition where the continuous schooling it not being carried on for our crippled children of school age and normal mentality is the exception. With our present system, it seems quite possible to reduce the number of those retarded in their school work to a very low per cent, especially if these children reside in Cleveland at the time they reach
school age. This however cannot apply to children who have moved into our city from other places and who have previously missed much schooling.

Thus far I have said nothing of the academic education of the crippled child. The transportation, individual exercises, rest and nourishment are the problems in the education of the crippled child. His mind is the same as the normal child’s and he needs no special method of instruction as do the blind and the deaf.

We are under the same superintendent and the same supervisor as the regular elementary schools. We attend the same teachers’ meetings. Our system of transfer makes it necessary that we do about the same work. With our small classes and efficient teachers, we are able to give more individual instruction than is possible in other classes. In this way, we can take care of children whose irregular attendance in the ordinary schools would retard them and we can give to the brighter and to the physically stronger an opportunity to do the work of two classes.

A boy just entering the third grade lost his leg in a street car accident. It took one semester for him to recover, so as to be able to attend our school. While with us he was fitted with an artificial leg, and learned to walk well, did the work of two semesters, and in the fall returned to his class in the regular school.

We have one half hour less than the regular schools as we are in session from 9:30 A.M. until 3 P.M. with an hour intermission at noon. To do the work of the regular schools, we cannot give an undue amount of time to hand work. What is given is for its educational value and not for the purpose of preparing the young crippled child to earn his living.

The old idea of having crippled children caning chairs and cobbling shoes started in the industrial schools, financed through philanthropic people. I understand even St. Botolph’s Industrial School in Boston now gives much less time to industrial work in the first eight grades than in former years. We have found that crippled children wish for the higher education. The kindergarten is the ideal place to start a crippled child. We all know there is a tendency in the home to favor the crippled child. Coming to the kindergarten he is taught consideration of others and made more dependent upon himself. He has individual exercises and massage, rest and nourishment and because of this care is often ready to start in the regular schools when he is six years old.
We do no senior high school work. Very few must remain with us through the eight grades. When a boy or girl has been obliged to attend our school through the eight grades, he should be given the opportunity to mingle with normal children even if he must be transported. Where there are elevators, they can take care of wheel-chair cases. Our senior high schools offer so many courses and are so well equipped, that every crippled child should be given the advantages of such an education with the normal child.
SOCIAL SERVICE IN THE NEW YORK INFIRMARY FOR WOMEN AND CHILDREN

FRANCES A. STONE

Director, New York Infirmary for Women and Children.

Down on the Eastside at the corner of Livingston Place and Fifteenth Street, once the most select residential section of the City, a group of women doctors have, for many years, been doing a piece of work well worth the attention of a much larger number of New York residents than are really aware of it.

This work was started by pioneers in the medical profession, when college doors were closed to women and only the possessor of a true pioneer spirit could succeed in practically forcing an opening sufficiently large to crawl in. It was this same spirit that started a college where only women could be admitted. The doors of this college remained open until 1899 when the Cornell Medical School awakened to a sense of justice and co-operation, signified a willingness to allow women equal rights with men. Then, and not until then, the doors of the Medical College of the New York Infirmary were closed.

A number of the graduates connected with the hospital and dispensary established many years before, concentrated their attention on the remaining interest—the hospital. Year by year this work has continued and developed, until today it is numbered with the best. It has taken its place in class A with the American College of Surgeons and all other associations claiming the privilege of investigation.

Though closed for a few years during the Great War, the buildings were reopened and are now equipped in every department with all that is necessary to an up-to-date modern hospital. It accommodates 139 patients including an active obstetrical service. With this number, in such a locality, it is not difficult for the management to carry out the original intention of the pioneers whose policy has always been followed.

The work is in the greatest sense educational for the young internes who come from the best medical schools in the country. The patients receive the individual care and attention which is sometimes impossible to give in a large institution. Every patient appli-
ing to the hospital for free or part pay accommodation is referred to
the social service department for investigation and later follow-up
care. It is the greater individual care given the women and children
attending the daily clinics that is now developing so splendidly.
Naturally one thinks of the children first—perhaps as much for the
interest and enthusiasm they inspire as the greater opportunity to
build for future better living.

Mrs. Lillian Montells, in charge of the work, has a broad experi­
ence, enthusiasm and an unusually magnetic personality. She has
been so splendidly co-operative that there is an absolute absence of
the slightest friction through the entire work. With an able corps
of assistants, all graduate nurses, much has been accomplished even
during the past year.

The children’s clinic has almost the entire time of a worker, who
gives the follow up attention in the homes. Another has under her
care the women and children attending the skin clinic. Still another
attends the medical clinic which include special heart patients, and
administers insulin treatment in the homes when necessary. All the
clerical work, including the usual social service programme of letter
writing, telephoning, interviewing, arranging for better home condi­
tions and convalescent care in the various institutions provided for
the purpose, is done by this group of workers.

During the summer of 1922, a Play School was started on the
dispensary roof, which was well adapted to carry out such a pro­
gramme. The Federation of Child Study had this work in charge,
providing teachers, lunches, games and out door recreation. This
was made possible through the generosity of some members of the
Board of Trustees. The children were selected from the hospital
and dispensary group. The initial plan was so successful it was
repeated during July and August 1923 when the number cared for
was increased from twenty-five to a daily average of sixty-five. Dur­
ing this time, the children were sent in groups for a two weeks stay
in the country. They returned improved in health, weight and
manners. Attendance was prompt and unvarying. Early in the
winter of 1924, the Federation made the offer of the services of a
very competent nutrition teacher, who has since held classes regularly
once a week, teaching and demonstrating food, its principles and
value. These classes have been well attended, far beyond all expecta­
tions. Later these classes have alternated weekly with a talk on home
problems between mother and child. It was decided to eliminate the
hospital or clinic atmosphere and make the afternoon one of pleasure
and entertainment. It is pleasing to see with what interest the
mothers respond to the drinking of afternoon tea, creating a real
social atmosphere. Many questions are asked and problems are
brought up for discussion. As this is rather an experimental venture,
it is being watched with much interest.

The expense of conducting the entire social service department
is borne chiefly through the efforts of the very able and attentive
committee, the hospital, and individual members of the Board of
Trustees, who have shown special interest in the development of this
work for children.
This is the age of specialization, and it stands to reason that if attention is centralized on a given subject, more knowledge on that one point is afforded. The Italian Welfare League, Inc. specializes in service to Italians, and furthermore gives most of its time and thought to the newly arrived. Entering on its fourth year, it has its main office at 345 Lexington Avenue, New York, an office at 121 Union Street, Brooklyn, and since January 1, 1924, an office on Ellis Island. Major Curran, Commissioner of Immigration, had asked the League to assume the work hitherto undertaken by the Italian Immigration Society, which closed its work after twenty-four years of service, on December 31, 1923.

The object of this article is to give a necessarily short account of the policy and workings of the League, and to show how work among Italians requires a peculiar psychology. An Italian is not difficult to approach if he is understood, and the League has made a special study to understand and be understood by the applicant.

In stating the policy of the League, it should be said that its main object is immigrant aid, in a constructive rather than in a merely palliative manner. Now that the League has taken over the work at Ellis Island, it is more than ever anxious to concentrate along these lines. Its policy is not to give financial assistance or subsidize families who have been in the United States longer than two years, but the League gladly co-operates with other organizations in particular cases where Italian psychology is the difficult problem. It stands ready to interpret whenever possible. Other organizations of experience are solving the problem of those families who have been in America for a longer period, and it would seem a duplication of effort for the League to intrude in this work.

We feel that both in the New York and Brooklyn offices we can give expert information regarding Italian problems, and can solve difficulties that many times confront the average social service visitor. The League will endeavor to follow from Ellis Island all cases that seem to “need” watching, and it hopes in time, by preventive measures, to do away with the lack of understanding of American laws and American ways on the part of the immigrant. Among other
organizations, it co-operates with the Italian Consulate by allowing it to turn over to the League any cases requiring social service assistance, that come to the doors of the Consulate.

There are two types of Italians in America,—the Italian who can grasp American ideas and ideals, and the Italian who still imagines himself in Italy. The trouble is that most of us are not willing to face the second type. It takes time to make inroads on his stolidity; but show him the advantages of American ways and frequently in the long run you may make an admirable citizen of this type. Of course, a knowledge of Italian is essential, and all our workers must have that equipment. In order to get that we have trained several Italian girls who came to us with background, but who needed further study in social service. It is absolutely necessary for a worker to have some knowledge of Italian geography, for many times when an Italian cannot be drawn out in any other way, by showing him a knowledge of his home and its surroundings, you immediately establish cordial relations. As soon as sympathy is established and the applicant freed from restraint by reason of understanding, the way is clear. Italians coming from certain localities have certain characteristics. Different groups may be appealed to or reasoned with in special ways. An Italian waiting in an office for his turn becomes unduly impatient, and finally difficult to approach, but if on his entrance into the office a word is spoken to him explaining how long he must wait, and how sorry you are to keep him waiting, his impatience disappears and a smile greets you. Regular interviews cause him to be distrustful, but your records may be filled out by conversation rather than by direct questions.

The League is a young institution, and it has a long road to travel, but it hopes by constructive effort to prevent a great many difficulties that usually confront the Italian when he first comes to this country. The League is not only for the very poorest, but it aims to assist any Italian who comes to it for help, including legal or medical,—in fact, it serves as a bureau of information for the Italian, and as a consulting bureau for the social worker.
EDITORIAL

Social Service—A Civic Duty

The value of Social Service has been demonstrated so forcefully by private organizations in the past few years, that the day is not far distant when it will become a part of public duty and will be welded into the machinery of the municipal government. More and more, legislators are realizing that personal service extended to the individual or family is doing more for the ounce of prevention as against the pound of cure than any other element.

I would term Social Service the Peace of the Mind element in the treatment of the world at large. Without it all kinds of aid would be more difficult and often impossible. The poor man who goes to a hospital for an organic operation and is assured that his family is being cared for and not left to the winds of chance will get well much faster than he would otherwise. The mother who leaves her children for a protracted period in the knowledge that someone is looking after them is in a similar position. More and more the world is recognizing the importance of this personal touch, this constant interest, until the trouble is obviated. Any person stricken affects many others. Social Service has taken upon itself to relieve the burdens of those afflicted so as to put them in the way of getting better as speedily as possible. We have spent millions of dollars curing ills and evils that could have been averted by this much needed personal interest that is now being so strongly manifested on all sides.

The preventive tendencies of Social Service have developed every kind of aid from the direst necessity to the most wholesome of amusements and pleasures. In a word, experience has taught that no matter what is done to aid a person physically, the work is almost useless if not followed up by some satisfaction of his spiritual needs. In the case of any kind of pain or suffering, if the patient is spiritually depressed, his illness is greatly aggravated. This is where Social Service plays its great part. This may include material things, not only those that a patient cannot afford himself, but a bright outlook and an assurance of continued mental comfort. Therefore the scope of endeavor may reach to the nth power. Certainly where such aid must be continuous and sure it should not be left to the spasmodic giver of alms but to a properly subsidized public agency.
Private charity is always the pioneer, pointing the way for more human happiness, but once the particular service to make life better is established, such a work must be assumed by authorities entrusted with the welfare of the public. If the people who give money for philanthropic purposes could only be made to realize what genuine Social Service means in the way of rehabilitating the unfortunate, there would be less difficulty in securing such moneys so badly needed for carrying on this work. Of course, the wheat must be taken from the chaff. That is, only such social agencies as go right into the heart of humanity and reach out to each as a distinct human being—these should be developed to the highest degree so as to force attention of all public authorities on this most vital element in a better citizenship—a better civilization.

Sophie Irene Loeb.
NEWS NOTES

The Public Health Committee of the New York Academy of Medicine has accepted a plan submitted by the Department of Health and passed resolutions declaring that medical interns in hospitals should have a short internship in a hospital for contagious diseases. The Committee also approved a plan submitted by the staff of the Willard Parker Hospital to give nurses an opportunity to take special training in communicable diseases.

Dr. William F. Snow, General Director of the American Social Hygiene Association has been appointed by the League of Nations as chairman of a committee to investigate the international traffic in women and children.

Seaside Hospital of St. John’s Guild, at New Dorp, Staten Island, will open for the reception of patients on June 2nd, 1924. Mrs. C. S. Varney is in charge of the New York Admission Bureau, 45 West Street, New York City, telephone Bowling Green 7927. The Admission Bureau is a new feature, and it is requested that all inquiries relative to the admission of children to the Guild’s Hospitals be referred to Mrs. Varney at the above address between the hours of 9 a.m. to 5 p.m.

The Floating Hospital of St. John’s Guild will continue its regular day trip service for ailing children, mothers and babies during 1924. The first trip will be made on Monday, June 30th.

The Day and Night Hospital Ward Service, which has a 32-crib capacity for sick babies will be conducted as heretofore.

The temporary shelter built for mothers and babies by the Jewish Board of Guardians at 183 East 95th Street, New York City, is now open.

The North Eastern Dispenary, New York City, has established a clinic for the diagnosis and treatment of cancer. Hours 2-4 p.m., daily.

The Reconstruction Hospital, New York City, has enlarged its capacity by opening a new wing.
The New York Nursery and Child's Hospital, New York City, has arranged an appointment system in the Children's Clinics. It is expected that this system will expedite the work of the physicians and relieve mothers and children of the long and tedious waiting for consultation and treatment.

Following plans laid out by the American Child Health Association, May Day this year was celebrated throughout the United States, not alone with the old May Day customs and ceremonies but also with special emphasis laid on health. In fact the day was devoted to the exaltation of the health of children.

School medical inspection has been organized in all of the States of the Commonwealth of Australia.

The Masonic Order has definitely decided to assist in the reorganization and support of the Broad Street Hospital, New York City.

The Boston Tuberculosis Association opened a summer camp for 100 children, June 1st.

The Boston City Hospital announces an extension of its X-Ray service. All types of X-Ray treatment will be given. In addition, adequate amounts of radium will be available for the various kinds of radium treatment.

An addition to the New York State Sanitary Code, making it compulsory to pasteurize milk and cream used in the manufacture of ice cream has been adopted by the New York State Department of Health.

The American Seamen's Friend Society celebrated its 96th anniversary this month.

The Jewish Hospital of Brooklyn has established a night gynecological clinic—Mondays and Wednesdays, 7-9 p.m. Also an asthma clinic—Wednesdays and Saturdays, 1-3 p.m.

The Guild of Our Lady of the Visitation at Detroit, Michigan, has arranged the following program to welcome visiting Catholic
nurses who attend the American Nurses' Association Convention. On June 18th, at 8 o'clock in the morning there will be a Mass and Communion breakfast for Catholic nurses at the Church of our Lady of the Rosary, Woodward and Medbury Avenues. At the Communion breakfast, the Reverend E. F. Garesche, S. J., spiritual director of the International Catholic Guild of Nurses, will speak on the plans for the Guild. On Thursday evening, June 19th, a meeting of the Catholic nurses will be held at the Providence Hospital Auditorium.

During the first two months of this year 424,986 visits were made by nurses representing the Metropolitan Life Insurance Company to care for acute cases of illness among the company's policyholders. These visits were made to 109,395 individuals living in the 3955 towns and cities scattered throughout the United States and Canada where the Metropolitan nursing service is available.

In order to encourage and promote health teaching in the elementary schools, the Metropolitan Life Insurance Company, co-operating with the American Child Health Association has offered fifty scholarship prizes of $500 each for the teachers doing the best health teaching for the current school year.

A loan fund of $2000 to assist needy students has been created by an anonymous friend at the Harvard Medical School in honor of President Emeritus Charles W. Eliott.

The Hudson Guild Farm at Netcong, New Jersey, is a delightful place for week-end parties. There you will find fishing, swimming, hiking and other sports. There is no formality at the farm and simple camping clothes are worn.

The Sisterhood of Social Workers, Incorporated, has opened a new Children's Shelter at 235 West 113th Street, for children whose families are unable to care for them during the illness or convalescence of the mother. Children to be eligible must be between the ages of three and six years.

The Clearing House for Maternity Cases operated by the Children's Welfare Federation of New York which correlates all forces giving pre-natal and maternity care, guarantees to all mothers whose
names are registered, continuous supervision until their babies are safely enrolled at the baby health stations. It gives information to Maternity Hospitals, clinics and district nurses, and prevents duplication.

The Federation has operated this service for Manhattan and the Bronx since April 1st, 1923, and is in daily contact with 27 hospitals and 26 district organizations. The records for the year show that 9398 mothers have registered; 8431 mothers were assigned out for prenatal care; 13,983 new born babies were transferred from Maternity Hospitals to the Baby Health Stations for care.

Kate Hubbard, writing for the Survey, reports the result of an investigation sponsored by the Blind Association of Mississippi to provide for blind negro children. 1700 letters of inquiry were sent to physicians including county health officers. This survey showed that there were only 30 cases of blindness in negroes (ages ranging from infancy to 25 years) in the whole State and not a single case was reported as due to infection at birth.

The Brooklyn Jewish Home for Convalescents, Avenue “U,” Eighth and Ninth Streets, is now open. The home will care for poor patients for two weeks after their discharge from hospitals.

The Long Island College Hospital has established a clinic for mentally defective children.

The Catholic Charities has moved to 477 Madison Avenue, New York City.

The Jenks bill which would have permitted managers of moving picture theatres to admit children under 16 years unaccompanied by parent or guardian, was defeated by a vote of 131-14 in the New York Legislature.

The offices of the National Child Labor Committee have been moved to 215 Fourth Avenue.

The Chicago Branch of the Salvation Army has opened a new maternity hospital and home mainly for unmarried mothers.

Cornell University has announced an anonymous gift of $200,000
to establish an endowment fund for research work in the department of pediatrics.

The Boston Tuberculosis Association has formed a “placement committee” to undertake the work of finding suitable employment for certain type cases of tuberculosis.

Health Commissioner Monaghan of the New York City Department of Health issued an appeal to parents requesting that during the month of May all pre-school age children be given a complete physical examination so that there might be a complete check on health conditions among the city’s younger children.

The American Legion has made definite plans for starting a Community and Civic Betterment Bureau. The Legion will work through its 11,000 posts and will assist in all phases of civic and community work which will aid in making better and healthier communities.

The United States Public Health Service in co-operation with Public Health Summer Schools offers work for the summer of 1924 at the following universities:

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<tr>
<td>Columbia University</td>
<td>New York City</td>
<td>July 7 to August 15</td>
<td>John J. Coss, A.M.</td>
<td>Haven Emerson, M.D.</td>
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<td>University of California</td>
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<td>June 23 to August 2</td>
<td>John P. Buwalda, Ph.D.</td>
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<td>University of Iowa</td>
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<td>June 9 to July 18</td>
<td>C. H. Weller, Ph.D.</td>
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<td>University of Michigan</td>
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June 23 to August 2*
E. H. Kraus, Ph.D., Dean of the Summer Session.
John Sundwall, M.D., Ph.D., in charge of Public Health Courses.

*Certain courses at the University of Michigan will continue two additional weeks. Requests for announcements should be addressed to the Deans of the Summer Sessions.

HUMOR IN VITAL STATISTICS

Among the papers in the office of the Division of Vital Statistics there has recently been found the following note collected some years ago by some unknown member of the staff.

The following causes of death have appeared on death certificated in former years.

1—"Paralises of the Hart."
2—"Celery morbis."
3—"Nateral causes."
4—"Tired of living (99)."
5—"Erley rising and marriage."
6—"Suicide—self inflicted."
7—"Why nobody knows."
8—"Double broncopneumonia."
9—"A decedent named Anna Kidney died of hart failure as certified by two nabors."
10—"Amediate caus of deth sleeping paralesis."
11—"Worried to death by troublesome neighbors."
12—"Serving God and living with her husband and children."
13—"Taking Dr. Bostwick's medicine." (This death certificate apparently signed by a competing physician.)
14—"Visitation of God."

News Service—State Dept. of Health.

A Diabetic Patient and His Dog.—Every diabetic child should have his dog. A dog is a diabetic's thoughtful friend. A dog never says to a diabetic, "You are thin," never speaks about his diet, never tempts him to break it and to eat a little more, never refers to the delicacies he himself has eaten or the good bones he expects to eat; in fact, never implies in public or in private that he knows his master has diabetes. A diabetic is never embarrassed by his dog. How often he wishes his friends were as considerate. His dog shows the
diabetic how to rest and sleep at odd moments, shows him how to exercise and play and indicates the value of sunshine, and sets him a good example by cleaning his paws every night. A dog is cheerful. Friends of diabetics sometimes wish that diabetics would take lessons from a dog. From experiments on a dog, Minkowski found that diabetes originated in the pancreas. From experiments on a dog, Allen learned that undereating helped and overeating harmed diabetics. From experiments on a dog, Banting and Best discovered insulin.

When I see a little boy and his dog, and their devotion to one another, I am reminded of the remaining 999,999 diabetics and future diabetics in the United States who are alive today or will be alive in the future, enjoying better health and happiness, because a few dogs, through the instrumentality of multitudes of scientific workers, have revolutionized the treatment of diabetes.—Joslin, E. P., Jour. Am. Med. Asso., 1924, LXXXII, 1502.

PERSONAL

Miss Ethel E. Hawkins has been appointed New York State Supervising nurse for orthopedic work in the aftercare of infantile paralysis.

Miss Cecilia P. Houston has been reappointed instructor of nurses in the New York State Division of Maternity, Infancy and Child Hygiene.

Dr. A. J. Lanza, who for the past three years, has been in Australia assisting in the organization of the Commonwealth Health Department has been appointed Executive Officer of the National Health Council.

J. Byron Deacon, Director of the New York Tuberculosis Association, has resigned his position and will enter business.

Miss Mary Donogh of the Brooklyn Hospital Social Service Department, has resigned to be married.

Mrs. L. S. Stowe, Social Worker in the pediatric division of the Brooklyn Hospital, has accepted a position with the Sea Cliff Convalescent Home. Mrs. M. H. Williams has been appointed to fill the vacancy.
Miss Olga Lange, Director of Social Service of the Skin and Cancer Hospital, New York City, has resigned.

Miss Hannah Chrystall has resigned her position at Josephine Home, Peekskill, and will spend the summer abroad.

WANTED: Public health nurses wanted for child hygiene and tuberculosis work in both city and county districts. Part of work under Milbank Memorial Demonstration. Salary $125 monthly plus traveling expenses. State age, education, nursing training, and experience; also give references. Onondaga County Tuberculosis and Public Health Association, S. A. K. Building, Syracuse, New York.

MEETINGS
American Association of Hospital Social Workers—Toronto, Canada—June 26th-July 2nd.
The Biennial National Nursing Convention, Detroit, Michigan—June 16th-21st.
The Catholic Hospital Association of the U. S. and Canada, Spring Bank, Wisconsin—June 30th-July 12th.
The Canadian Association of Nursing Education holds a joint meeting with the National Association—June 23rd.

BOOK REVIEWS
When Fathers Drop Out
WM. H. MATHEWS

When Fathers Drop Out is the story of 115 widows and their 470 children who came under the care of New York Association for Improving the Condition of the Poor, through the death of husbands and fathers. The story is told by William H. Matthews, Director of the Family Welfare Department of that Association who, as is intimated in the foreword of the report checked up "the case records" by "personal acquaintance with many of the families." Several of the families whose history is given in considerable detail in the report
were under care for eight or more consecutive years. The story of
their travel through the period of dependency until they again reached
the level of self support is told in simple, realistic fashion.

It differs from the usual report of such work in many ways—
not once in its pages does one find the families referred to as "cases"
—not once is such term as "point of contact" and other such terms
that usually abound in case work stories found in its pages. Rather
does one get the impression that the writer of the report is talking
of people of flesh and blood whom he knows intimately and whom
he counts and values as his personal friends. Again does it differ
from the usual report in the generous credit it gives to the mothers
themselves for the achievements wrought in their homes in spite of
great odds and immeasurable difficulties. Summing up, for instance,
the story of Mrs. McNeil which covers several pages, it says—"Here,
in one of the hardest, coarsest districts of New York City this
mother, broken in health, her years from early married life fraught
with struggle and hardship, has raised five fine boys, has kept their
love and affection and has wrought in them a character which one
can but believe will hold them true and steady throughout the years
ahead!"

There is a comparison of the old method of relief giving which
consisted of spasmodic, intermittent giving with the method later
adopted of granting a regular monthly allowance with the assurance
to the mother that it would be continued so long as the need existed.
The former is condemned in plain, unsparing terms. Of the latter
method the report states—"careful study was given to the needs, the
resources and the possibilities of each family. The assistance given
has been definite, continuous and sufficient to supply at least the ele­
mentary necessities of life. Of the mothers themselves we have asked
one thing, that they make all effort to use the money placed in their
hands to rear and shape into fit, honorable manhood and woman­
hood their growing boys and girls." And of the results attained we
would quote one sentence—"Generally speaking there has been re­
sponsiveness to fair treatment. In many instances seeming defects
in conduct have disappeared under the stimulus of education and
opportunity. There is abundant evidence that once the vicious cir­
cle of poverty and ill health and ill health and poverty was broken,
there began to work of their own accord a healthy, invigorating suc­
cession of redemptive forces!"

There are interesting and significant sections of the report that
have to do with the health work done in the families; of work done by dietitians in the interest of delicate children; of country outings planned each summer for all the families. Of special interest is the section on vocational training, which deals with the history of forty-three children of the group for whom special educational opportunity was provided.

In conclusion the writer sums up the main principles that "seem to have been accepted and followed in the treatment of these families." Perhaps it is a bit significant that he gives more space to No. 10 than to all others—"the necessity of the establishment of friendship and comradeship between family and visitor." In these times when there is so much discussion as to the value of service as against "mere giving of material things," the paragraph is worth quoting in full—

"To a discouraged life there is, perhaps, no greater stimulant than love and friendship. Material relief, improved physical surroundings, clinic service, health and food education, these are in considerable part the tools with which visitor, nurse and dietitian work. They are as indispensable as the equipment which the carpenter carries in his tool chest as he goes forth to his house building job. Yet his lack of experience, his ignorance as to the use of materials may well result in a poorly built house in spite of a perfectly equipped tool chest. In dealing with people, the communicative power of personality of the artisan is, of course, of even much more importance. The influence that instils virility, initiative, hope—that makes people eager and able to rise, to stand upright and walk is, we know, often the influence that flows from individual to individual. This form of service one finds coupled with that of material giving all through the history of these families. We have no desire to value one against the other. They were as a two-horse team pulling evenly together. The strength of one gave strength to the other. The friendship, the personal service rendered by the Good Samaritan to the sufferer by the roadside, the money spent to restore him to health and efficiency—one was as essential as the other to the accomplishment of that end. Our complicated social order today does not make easily possible individual Good Samaritan acts on the part of people hurrying to market and to work. Organization, machinery, case records have become a necessity. Our problem is one of creating and using the necessary organization and machinery only as channels through which will flow immediately, freely, and completely, such service as individuals and the community may need."—Warren Lightfoot.
“The Policewoman—Her Service and Ideals”
MARY E. HAMILTON
Frederick A. Stokes Company, New York, 1924

The book is dedicated to “Policewomen, whose service and ideals are consecrated to the great cause of humanity.” This dedication crystallizes the function of the woman officer. Her duty consists mainly of caring for women and children and other cases where a woman’s motherly sympathy is needed. “Police work is no longer a matter of handcuffs and truncheons,” said Lady Astor, in pleading for the continuance of women police in London, “but of prevention of crime as much as possible, and the preventive work that has been already done by the women police, even with their limited powers, is a piece of national economy which it would be hard to beat. . . . Surely it is better and cheaper to give stranded girls warning and advice, and to find them shelter, than to allow them to drift until they become charges on the community as short-sentence prisoners and gradually degenerate into habitual criminals. . . . The value of the women police will never be fully realized until the whole question of dealing with women of the unfortunate class is put into the hands of women. When that is done the community will reap the full benefit of their services.”

It is a well known fact that in a single year, thousands of runaway girls and boys reach New York City and find alas! that a big city without friends or money is a terrifying place. In these cases alone, it requires very little imagination to evaluate the policewoman and the advice and aid she gives these children whose whole future depends upon the skillful untangling of their problems, real or imaginary.

Social Workers will find the chapters on “The Runaway,” “Fingerprinting and Identification” and “Missing Persons and Unidentified” interesting and instructive. The future of the policewoman is full of promise and as crime is a “super-social disease,” the very best type of trained women will be drawn to the work.

Mrs. Hamilton says, “If I were asked to choose a foundation upon which to build a strong force of policewomen, Social Service would be the corner stone.”

NEW PUBLICATIONS

Public Charities Aid Herald will be issued monthly by the Public Charities Association of Pennsylvania. The purpose of this pub-
lication, which is in booklet form, is to secure co-operation and to give information on social service activities. George R. Bedinger is the editor.

ABSTRACTS


"Should a social worker always tell the truth to clients, to other agencies and to the general public?" In answering these questions, Cabot takes issue with the statements made in an article which appeared some time ago in a social workers magazine and goes on to further discussion of the necessity for truthfulness. Social workers should not deceive people of suspected mental trouble, unmarried mothers, nor suspected criminals. There should be no misunderstanding on the client's part concerning the taking or the use made of records nor the connection with the confidential exchange. In referring cases, agencies should be honest with each other while annual reports should tell the whole truth to the public, exhibiting failures as well as successes.

"The Social Worker and His Community," E. C. Linderman. Survey, 1924, LII, 83. Linderman has noticed that many social workers are discontented with the position which they hold in their respective communities. He believes that the relation of the worker to the community may be viewed from the angles of technician, statesman and prophet. The trained social worker is no longer the embodiment of sentiment, but rather the symbol of a technique. He is the expert. However, the stuff out of which his technology is built can be gained only by giving regard to the humblest human elements. The expert's experience and the experience of the community must somehow interpenetrate so that the expert will be humanized and the people educated. Discussions of the social worker as statesman and as prophet are to appear later.

"Uses of Volunteers in the Hospital Social Service Department," J. Schoenfeld, Nat's. Health, 1924, VI, 248. Schoenfeld believes that volunteers in hospital social service departments who are carefully chosen, trained and supervised are invaluable aids. She discusses the types who may be expected to offer volunteer service, the standards to which they should be held and the sort of administration
into which they will fit. These assistants must be trained for the jobs to which they are assigned but must be given some variety of work as well as an opportunity for growth and progress in service.

“The First Year of the Sheppard-Towner Act,” S. J. Baker, Survey, 1924, LII, 89. Baker discusses the history and main features of the Sheppard-Towner Act, the states that are co-operating, and the various ways in which they are functioning. Among the achievements of the first year are the focusing of attention upon the problem of the mid-wife; increased interest in birth registration; and state wide surveys concerning the welfare of mothers and babies. Although adequate facilities for delivery and post partum care are to a great extent lacking in the rural communities affected by the new provision, it is expected that awakened public interest in the pre-natal period will lead to extended work in this direction.

“Spending a Million Dollars for Care of Women and Children in New York City,” S. J. Baker and J. L. Blumenthal, Med. Woman’s Jour., 1924, XXXI, 59. The work of the Bureau of Child Hygiene of the New York City Department of Health is outlined and discussed by Baker and Blumenthal. Pre-natal literature is sent to prospective mothers and fathers and nurses follow up cases in the homes; every mid-wife must be a graduate of a recognized school and is further instructed and supervised; infants are registered at the 70 baby health stations for guidance and instruction of the mothers; an effort is made to have pre-school children brought to the station regularly; school children are examined in the first, third and sixth year and again before going into industry; 3,137 private boarding homes are under the supervision of the Bureau. The annual appropriation for this work is $1,000,000.

“Mental Clinics: Four Kinds,” D. A. Thom, Survey, 1924, LII, 93. Thom believes that unless the development of clinical facilities is kept abreast of the educational program for the preservation of mental health, this movement will soon spend itself in “idle prattle and vain wailings.” Mental clinics, so called have existed for a long time, but for a number of reasons they have failed in their purpose. There should be four main groups of clinics to serve the following: children of pre-school age; school children; patients with insipient
nervous disorders; ex-hospital patients. All of these demand that the psychiatrist in charge be a fully qualified physician.

"Some Extra Curricular Problems of the Classroom," B. Glueck, *School and Society*, 1924, XIX. Glueck believes that the basis of most of the problems, at least those not purely academic, lies in the conflict between the personality of the teacher and that of the child. Method in education has been stressed but it is the teacher as a human being and "not some impersonal educational process to which the child has to adjust primarily, and his joys and sorrows as a human being as well as his successes and failures as a pupil are largely determined by the nature of this contact." A healthy personality, a vision of the importance of the rôle she plays and an objective attitude toward the pupil as well as toward herself should be prerequisites for a teacher. Then, with a better understanding of the child and a system in which he can be himself, many of the problems of the child's behavior and development will be solved. The visiting teacher is an experiment in this direction.

"Nutrition," W. R. P. Emerson, *Survey*, 1924, LII, 103. "Nutrition" is commonly misused as a synonym for "food." What the nutrition program means, according to Emerson, is the carrying on of our program for infancy throughout the entire period of growth. "Malnutrition refers to the results of serious disturbances of the process by which the child takes in and utilizes food substances!" The chief causes of this condition are physical defects, lack of home control, overfatigue, faulty food habits. A reading list is given which is selected with reference to these causes and to the "point of view fundamentally necessary in an effective health program."

"A Taproot of Public Health Nursing," J. E. Hitchcock, *Pub. Health Nurse*, 1924, XVI, 187. Hitchcock describes the four years work of two women, one a nurse, the other a teacher who settled in one of the remote coves of the Southern Mountains in order "to establish a model homestead and to live as residents in the valley, sharing and stimulating community life." To pedagogical and nursing duties were added those of barnyard and field, for the latter of which the nurse prepared herself by a course in agriculture. The details of this community experiment are interestingly told.
"The Care of the Tuberculosis Patient in the Home," A. H. Conway, *Pub. Health Nurse*, 1924, XVI, 203. Conway describes the home care of the tuberculous patient in minute detail. The procedure is so practical that it would be helpful knowledge for social workers, whether or not they are concerned in any degree with nursing.