THE REHABILITATION OF CARDIAC AND DIABETIC CASES*

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A generation ago it was tuberculosis which led all causes of death, sickness, poverty; which claimed the breadwinner in the years when his support was most necessary; which took the mother of the family and left young children to the mercy of circumstances and relatives. Heart disease is now the greatest single cause of death in the United States. Heart disease in a recognizable form interferes with the work, play or comfort of at least 2,000,000 people in this country today. Among 5,000,000 men of military age examined in the army draft during the World War 200,000 were disqualified for service because of heart defects. Of all serious and ultimately fatal diseases, those of the heart are of the longest duration and with the possible exception of certain diseases of the mind, they cause the most persistent chronic handicap to self-support.

The economic loss and individual suffering from heart disease is enormous. The tax on the individual and the State is very great. Heart disease impairs the efficiency of the worker, reduces his output and earning capacity. He and his family may become dependent on the community for support. At least fifteen of every thousand school children have already acquired some definite disorder of the heart. These handicapped children lose much elementary education; they may fail to become self-supporting; they are excluded from all but a few occupations, and they are usually dependent upon their family or upon the public throughout their lives. Ten per cent of the total bed capacity of our general hospitals is used year in and year out for the care of patients with heart disease.

Among the most important of relief measures, from both a medical and an economic standpoint, is the vocational training of children

*Read before the Inter-State Rehabilitation Conference held in Grand Rapids, Mich.
in suitable trades, and the adjustment of the adult heart cripple to some form of labor which is within his physical limitations. Today, with our increased attention to rehabilitation and occupational therapy, hundreds of men and women who are admittedly handicapped by heart disease can under proper supervision and control carry on suitable manual work and continue to earn wages without injury to their somewhat precarious state of health. Under favorable conditions most persons suffering from chronic heart disease maintain a fair degree of health for many years.

What work can they do? How long can they work? Here is the keynote. No effort should be made to rehabilitate a man who has a cardiac defect until his disability has been ascertained. This can be done only through a medical institution, the hospital or dispensary or through his family physician. The cardinals will fall into the following groups:

1. Patients with organic heart disease who are able to carry on their habitual physical activity.
2. Patients with organic heart disease who are able to carry on diminished physical activity: (a) Slightly decreased; (b) Greatly decreased.
3. Patients with organic heart disease who are unable to carry on any physical activity.

With the second we are most interested, because the first class can care for itself and the third class is entirely dependent. The second class lies within the sphere of the rehabilitation worker. In order to reap the greatest rewards the worker must accept the physician’s statement regarding the man’s limitations and outline procedure within bounds. The cardiac seldom suggests the type of work he desires, but it must be suggested to him. The quicker he can become adjusted to his work, the better. The less adjustment he has to make, the less likely he is to become despondent. Whenever it is possible to have him remain at his old trade with slight changes, he should be encouraged to do so. Placement of a cardiac is more difficult than placement of other disabled people because his disability is not evident. If a man is minus a leg, he is not asked to stand all day, but a cardiac, often more disabled, is frequently required to do work far in excess of his strength. The desire and inclination of a patient must always be taken into consideration. He not only wants work, but wants it to suit his temperament and be congenial. There are certain limitations common to them all. Lifting is the outstanding
work to be guarded against, which eliminates certain kinds of work, such as that of a driver, a porter, or shipping clerk. There are numerous jobs which are safe for a cardiac. All processes of jewelry designing are excellent. Watch and clock repairing offer the advantage that the skilled workman can work at it part of the time at home. Proof reading and copy-holding in the printing trades, draughting, bookkeeping, stenography and accounting all offer good opportunities for the patient who is young enough to be trained. The older patients usually have to try unskilled work or short courses of training which offer employment for men, such as: elevator operator or switchboard operators, watchmen, ticket collectors at theatres, and cashiers in restaurants. Women can be placed to pack and examine hair nets, hosiery and gloves, fold and wrap dress patterns, label and finish goods in drug supply houses, and color lantern slides, etc.

If the social worker who refers the case for rehabilitation is familiar with the disability and knows the medical advice given she is in a position to render a great deal of service. But even with her knowledge of the situation, if her advice and recommendations are not followed as closely as possible, an enormous amount of damage may be done to the patient which may contribute to an early death.

The selection of an occupation must depend primarily upon the mental equipment, education and previous training of the individual. Is he fitted for skilled or unskilled labor? Those in the latter class are more difficult to place in positions for most of the work of this type demands more physical exertion than many should be allowed to give. It will be readily understood that the important feature of any work is not its product, whether automobiles or fountain pens, but the demand which the work makes upon the physical endurance. There are but few cardinals, when carefully selected according to diagnosis and prognosis, who cannot do something to earn a living and many of them can earn as good wages as if they had no disease whatsoever.

Statistics show that Diabetes Mellitus is a widely distributed disease, but it is more prevalent in some countries than in others. Race is not without influence. Hebrews appear to be particularly prone to the disease. In this country the whites suffer relatively more than the blacks. Loss of gangrenous limbs, blindness from cataract or other cause, disease of the cardio-vascular system and other similar changes are responsible for almost as much suffering and economic loss as are the symptoms of diabetes itself.
The elderly diabetic almost always dies of a complication of diseases. Unless the situation of the diabetic is understood, a plan of rehabilitation is impossible. The diet is of the greatest importance and incurs more expense than treatment for almost any other type of patient outside of an institution. With the contents of butter, eggs, cream and vegetables the year round, his diet will naturally be more expensive than the man's diet which contains staple products. The individual who has to secure his diet outside of his own home will have to count on at least ten dollars a week for food alone. The average diet costs six dollars per week.

Aside from the diet it must not be forgotten that the manner in which the patient lives is also important. It may be accepted as a general rule that the measures which promote the health of a normal individual will improve the condition of a diabetic. It is especially important for the diabetic to conscientiously follow the laws of personal hygiene; illness that only temporarily disturbs the healthy man may aggravate and increase the severity of diabetics, and may, because of lower resistance of the patient, be serious or dangerous in themselves. This does not imply that the diabetic should consider himself an invalid. The less he thinks about his disease outside of meal-time, the better off he is. Exhaustion and severe mental strain are to be avoided. Ten hours of rest in bed every night is the least he should allow himself.

It is frequently asked whether a patient should give up his work. No general answer can be given, as this depends both on the individual and his work. If the occupation is one that requires unusual mental or physical exertion he should change to one less exacting or exhausting. In the one case the mental strain may aggravate his diabetes, in the other his allowance of food may be too small to supply enough fuel for high power and great speed. Idleness in one accustomed to work or economically responsible for a family is to be avoided. Cessation of work is accompanied by worry, restlessness and lack of motive in living that is damaging. In general it may be said that diabetics should avoid employment where there is paint, varnish, complex machinery, severe physical or mental strain; long hours and low wages. Diabetics are able to return to their former employment with slight adjustments more frequently than cardiacs. The diabetic man can be gainfully employed in such work as steel engraving, bookkeeping, shoe repairing, draughting, some kinds of assembly work, timekeeper and many others. The diabetic woman
as a skilled worker can do millinery work, mend lace and embroidery, bookkeeping, fashion designing, etc.

The diabetic and cardiac are similar in that both have a permanent disability. Both can live the average length of life (unless there is some complication) and be gainfully employed, providing they act upon the medical advice given, are properly rehabilitated and careful follow-up work is done. If the physician advises employment for a cardiac where there is little emotional disturbance, surely the rehabilitation worker would not suggest work as a street car motorman in a large city, where there is a great amount of nervous and emotional strain involved. Close co-operation between the medical agency and the rehabilitation department is necessary. The advice of the medical agency must be accepted and a plan carried out accordingly. This is true not only with cardiac and diabetics, but with all types of disability where a plan of rehabilitation is to be carried out. Rehabilitation workers cannot be experts in medicine, law, social service, etc., but can be experts in their own work. In knowing their own job, they know how to accept the diagnosis and prognosis made in other fields and assimilate advice given in such a manner that cardiacs and diabetics will no longer have to be considered sick and dependent, but can become self-supporting throughout their lives.

To train a man and place him in employment and say, “Well done, the man is now self-supporting and our work is complete,” is indeed an erroneous idea. Human being cannot stay put and are as variable as the atmosphere. The physician would not consider his patient cured merely after an examination and one prescription. He would continue to observe him over a period of time to see the end results, and perhaps the medicine is too strong, the dosage should be reduced, and taken less frequently. So it is with the man who has been rehabilitated. He should be followed and observed periodically for a time to see that proper adjustments are made. A slight change in his plan might save him from becoming despondent or dependent. Perhaps his “dosage” should be decreased or increased.

It is more economical to adequately rehabilitate a few than to touch a thousand. The returns to the State for the few are much greater than for the thousand. Men cannot be measured in terms of money. A department which rehabilitates on a per capita basis only is surely working under a great handicap. It can never attain the highest good if its aim is to show in terms of money the work that has been done because on this basis it will have to turn down
the more severe cases which are much more in need of assistance. If the State spends $1,000 to rehabilitate a man, to make him self-supporting, to contribute to the support of his family, the money is certainly well spent. Suppose he should live and support his family during a period of ten years. He would have saved for the State certainly nine times as much as was spent, which would certainly be considered a paying proposition. The State is only beginning to realize its problem but if adequately handled, many families can become self-respecting and self-supporting citizens through rehabilitation.
MEDICAL SOCIAL SERVICE AS THE PHYSICIAN SEES IT

Report of a Committee of the Section on Medicine of the Associated Out-Patient Clinics, New York*

Function of Medical Social Service

The physician's problem is to restore his patient to health, efficiency and earning power at the earliest possible moment. In order to do this he must have all the necessary facts concerning the individual before him. Furthermore he must have resources at his command for bringing about the execution of his plan of treatment. Social work used by the physician in diagnosing and treating disease brings to him these aids which enable him to render a well-rounded service.

The Committee on Training for Hospital Social Work of the American Hospital Association in describing the "primary duty" of medical social work, lists the following specific duties:

"1. Discovering and reporting to the physician facts regarding the patient's personality or environment, which relate to his physical condition. ["Personality" should be broadly interpreted here to include personal habits and activities as well as characteristic behavior tendencies.]

"2. Overcoming obstacles to successful treatment such as may exist or arise in his home or at his work.

"3. Assisting the physicians by arranging for supplementary care when required.

"4. Educating the patient in regard to his physical condition in order that he may cooperate to the best advantage with the doctor's program for the cure of the illness or the promotion of health."

It further states:

*Committee: I. Ogden Woodruff, M.D., Chairman; Jesse G. Bullowa, M.D., Edward Cussler, M.D., Martin J. Echeverria, M.D., Harry Greisman, M.D., Charles E. Hamilton, M.D., Theodore Sanders, M.D., Dan H. Witt, M.D., John Wyckoff, M. D., and Janet M. Geister, R.N., Secretary.
“Social work used to further restoration and maintenance of health becomes a part of the practice of medicine. It is a special process used in medical diagnosis, treatment and research, as are certain laboratory processes. Its purpose becomes one with the purpose of medicine, namely, health.”

The physician confronted with certain symptoms that in themselves are insufficient evidence for a diagnosis, may need to have for early consideration the facts concerning the patient’s personal and family health history, health habits and environment. Or where response to treatment is unsatisfactory, where cooperation from the patient is not good, the physician may need to know what are the untoward factors in the patient’s life that influence this. Before treatment can be instituted or completed it may be necessary to make social adjustments, to educate in health activities, to change certain behavior. It is for the purpose of rendering these services to the physician that medical social work is organized.

Successful medical treatment often depends on the physician’s recognition of the influence which the patient’s personality and his social and economic conditions have on prevention and cure. The patient requiring modification of mode of life, as well as medication, may need social diagnosis and treatment in order that medical treatment may fulfill its purpose. These factors, too often disregarded, need to be recognized by the physician in dealing with his patient.

Relation to Dispensary

The activities of the social service department are inextricably bound up with the administrative as well as the medical divisions. All of the work done in this department, interviews, records, social and economic adjustments, health education, is a direct concern of the dispensary and should be included in the dispensary activities. Operated as an independent unit with a separate and independent control the way lies open for imperfect understanding of purpose, imperfect utilization of resources; it permits of a divided responsibility, of certain duplication in records, of an isolation that partly defeats the purpose for which the department was organized. It has brought about in some instances, a supervision over case work by individuals who are not in touch with the medical aspects of the case. The social service department that serves its purpose best is an integral part of the dispensary unit.
Committee Report

Relation to Physician

The physician is in charge of the patient; it is his responsibility to diagnose the disease and to prescribe treatment. He is the head of the unit organized for the benefit of the patient; the social worker is a part of this unit. Working with the physician, fitting her specific qualities into the plan of action, her work reaches its greatest usefulness to the patient. Working alone, touching the physician only casually, she cannot function to the best advantage. It is therefore highly important that for the exercise of her primary duty “to further restoration and maintenance of health” she work under the immediate direction of the physician. It is equally important that the physician outline the principles for the social worker to follow.

Relation to Ward

In the dispensary attached to the hospital there are always a certain number of cases passing from dispensary to ward or from ward to dispensary. The rotation, in certain types of cases, may occur several times in the experience of one patient. The organization of one social service unit to serve both in and out-patient departments offers the best opportunity for continuous service. The social worker who is able to maintain a continuous contact with the patient throughout his ward and dispensary experience, is in a position to render the most valuable service to both doctor and patient.

Relation to Records

The isolation of the social service record from the medical record of the patient is undesirable. The notes entered on the social service record bear largely on factors that influence the patient’s well being. Obviously these are essential to the physician in a well rounded study and treatment of his case. From a practical viewpoint it may not be possible or desirable to combine the records, but an arrangement should be worked out whereby summaries or duplicates of significant entries could be attached to the medical record.

Relation to Other Social Agencies

Social work in dispensaries is a form of treatment which may include a variety of activities. Its chief aim is to speed up the processes that make for the patient’s recovery. The social worker may herself carry out the necessary steps in removing obstacles and in
making adjustments or she may act as intermediary between the patient and the agency specially qualified to carry out this procedure. Because of the variety of tasks that fall to her lot she needs to maintain a nice balance between the work that is peculiarly hers and that which should be delegated to other agencies.

Her initial work on a patient demands immediate action in rounding up the necessary information for the physician's study of the case. Her subsequent work may demand continued activity but there is rarely a case where the need is urgent enough to justify the rendering of material relief. Medical relief, in the form of appliances, etc., is quite a different matter; this is entirely within the province of the dispensary. Material relief, however, in the form of rents, food, clothing, etc., is only in the most immediate emergency a function of the institution organized to diagnose, treat and prevent disease.

Relation to Financial Investigation

The social worker's function is chiefly therapeutic. A failure to recognize this fact has sometimes resulted in making her chief duty that of financial investigation for the purpose of excluding patients who are ineligible for dispensary care. While in the course of her work she may obtain information regarding finances that is of value to the administrator, obtaining this information should not be her main objective. Not only does this tend to lessen the value of her real purpose but it places upon her a duty that belongs elsewhere. It is likely to place her in a false position with the patient—it may lose for her the friendly relationship with him that is essential for the successful execution of her work.

A member of the social service department may very appropriately serve in the admissions unit for the purpose of determining the patient's eligibility for care. This is a broader function, however, than that of financial investigation. Moreover it is a separate and distinct activity, which though it is both administrative and medical in character, is an administrative duty. The ideal admitting system has within its admitting unit the trained worker for this task; where this is not practicable the social service department lends its services for the purpose. Routine financial investigation in which the social worker's chief duty is to act as the agent of the dispensary in excluding the patients ineligible for dispensary care should not be assigned to the social service department.
The investigation of the patient's financial resources after a diagnosis has been made when the physician is faced with the problem of prescribing treatment that may be beyond the patient's means is distinctly another matter. Certain adjustments in the home requiring the expenditure of money may be necessary before treatment can be completed. The social worker in making the type of financial investigation that rounds out the physician's effective treatment of the case is not only within her province but she is performing one of her distinct functions.

Selection of Case for Social Service Care

It is probable that all cases attending the dispensary have facts bearing on their conditions that merit the attention of the social worker. Ideally there should be a social service record on every case. Administratively it may not be possible or practicable to survey all cases with a view to determining those in need of special care. There are certain special clinics, however, such as cardiac or tuberculosis where the essential social data on each case should always appear on the record. The social worker taking the data should call the attention of the physician to certain cases that represent urgent needs.

The policy of selecting the cases for social service should be determined primarily on the basis of the patient's only reason for attendance—medical needs. Underlying the medical need or contributing to it may be urgent social and economic factors—but the condition that brings the patient to the dispensary is essentially medical.

Therefore, upon the individual whose task it is to meet this need, the physician, should fall the responsibility of selecting the patients whose problems require supplementary aid. The social service department should not select the cases and work them up without conference with, and approval of the physician.

Summary of Recommendations

The committee recommends:

1. That the primary function of the social worker in the dispensary should be to assist in the medical care of the patients; that this assistance is rendered in the form of—
   Reporting on personality and environmental facts.
   Overcoming obstacles to treatment.
   Arranging for supplementary care.
Education in regard to physical condition.

2. That the social service department should be an integral part of the dispensary.

3. That all work done for the diagnosis and treatment of the patient be under the direct supervision of the physician who, in referring a case to the medical social worker, shall state the objects which he desires to have attained in each individual case, should indicate the general principles which are to be followed in connection with his medical plan, and should check up on results.

To the social worker should be left the responsibility for carrying out the social treatment of the case in accordance with established principles and technique of social case work; her plan to be worked up through conference with the physician and with his approval.

4. That wherever possible the social service department should be so organized as to offer continuity of service to the patient in both in and out-patient departments.

5. That the relationship between social service records and the dispensary record should be such that no loss or duplication occurs.

6. That the social worker does not include in her activities the giving of material relief, except in emergency where conditions demand immediate action pending relief from proper sources.

7. That the social service department be not charged with the responsibility for the financial investigation of patients for the purpose of determining the patient's eligibility for admission. This work should be carried out in some independent unit. A study of the patient's financial resources made for the purpose of helping the physician to guide his treatment, is a part of the social worker's function.

8. That the approval of the physician be required in the selection of cases for social service treatment.
A SAFE AND SANE CHILD HEALTH PROGRAM

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The infant death rate in New Jersey has declined steadily from the year 1910, when it was over 150, to the year 1924, when it fell below 70. This tremendous saving of infant lives with its tenfold saving of infant illnesses undoubtedly is the result of many factors, but not the least important of these factors is the continuous child hygiene program carried out under the supervision of the New Jersey State Department of Health.

The New Jersey continuous child hygiene program has for its objective the saving of maternal and infant lives and the promotion of child health by means of instruction and demonstration carried
on by especially trained child hygiene nurses. The program provides for the supervision of the health of the expectant mother, the teaching of infant hygiene, the care of the preschool child, and the health supervision of the school child. In this program one nurse carries out these functions, thus doing away with duplication of effort. In addition to this health supervision of the child, the attack upon related problems was included in the program. Midwives attend about one-third of the deliveries in the State; and the necessity for the supervision of midwives was early apparent; baby farms and boarding homes for children were known to be the cause of excessive infant mortality, and were without supervision; and the need for extension work to interest communities in this program was evident from the beginning.

How the Continuous Child Hygiene Program Is Carried On

The State of New Jersey is divided into twelve districts with a supervisor in charge of each. It is her duty to keep in touch with the nurses carrying out the child hygiene program; to supervise the midwives in her district; to inspect and report on boarding homes; and to carry the message of the importance of child hygiene to municipalities in which it is not now undertaken. Throughout the State there are ninety-eight nurses engaged in teaching child hygiene under State supervision. Most of these were employed originally by the State Bureau to demonstrate the importance and the value of child hygiene. After a demonstration of one or two years at the expense of the State, the communities have taken over the salary and expenses of the child hygiene nurse. The State funds are then released for demonstrations in other communities.

Tangible Results of the Work

During the past year these ninety-eight nurses made 116,300 visits to expectant mothers and infants and 48,274 mothers brought babies and preschool children to the seventy-six baby keep well stations operated under the State Child Hygiene Bureau. There were 4,699 defects detected by the nurses among infants and preschool children, of which 1,736 were corrected during the year. The manner in which nurses co-operated with the practicing physicians of the State is indicated by the fact that 3,525 cases of illness were referred to the family physician.
The protection of the health of the school child has been successfully combined with the preschool work in 178 communities in which the nurses are carrying on the school work as part of the continuous child hygiene program. In these communities they have made 278,526 inspections, either alone or in co-operation with the medical inspectors; 35,250 physical defects were detected and 8,740 corrected in the past year. In connection with this work 17,350 visits were made to parents in the home. More than 700 throat and nose cultures were taken in the school, of which 233 were positive for diphtheria.

The midwife of today is entirely different from the midwife we met in 1918. She is a clean, carefully trained woman, licensed by the State Board of Medical Examiners and registered annually; she is closely supervised in her work; her cleanliness of person and equipment is assured; she is followed up in all abnormal cases, especially those of puerperal deaths, still births and infant deaths. She is supervised and instructed to call a family physician in cases where abnormalities present themselves in pregnancy, labor, or delivery.

Following a survey of the boarding home situation, the New Jersey State Department of Health added to its Sanitary Code a chapter to regulate the conduct of boarding homes, requiring every person who maintains a boarding home for children to have a written license from a Department of Health which shall be renewed at the expiration of one year. No fee is attached to the obtaining of the license from the State. During the past year ninety-nine homes have been licensed by the State Department of Health and fifty homes have been recommended to local authorities who have passed boarding home ordinances. No baby farms have been discovered during the past year which is very good evidence of the effectiveness of the State license plan for the elimination and prevention of baby farms.

For the control of ophthalmia, silver nitrate is distributed to all midwives and to physicians who ask for it. Midwives are compelled by law to use silver nitrate in the eyes of the new-born. Effort is continually being made to interest local authorities in the care of the unmarried mother and her child in order to keep the mother and baby together, to insure the baby its birth right, that is, maternal care. This important work also tends to prevent foundlings.
Does the Continuous Child Hygiene Program Pay?

It suffices to point out that, in addition to a tremendous saving of infant lives, the New Jersey records for the five-year period, 1919-1923, show the following significant figures:

Deaths Under One Month Per Thousand Live Births
(5-Year Average):

(a) for the entire State.........................................................36.92
(b) for infants whose mothers received pre-natal supervision.. 24.6

Still-births Per Thousand Deliveries (5-Year average):

(a) for the entire State.........................................................42.12
(b) for infants whose mothers received pre-natal supervision..21.34

Puerperal Deaths Per Thousand Deliveries (5-Year Average):

(a) for the entire State......................................................... 5.72
(b) for mothers who received pre-natal supervision.............. 2.56

These figures are of those expectant mothers who were supervised by the ninety-eight nurses carrying out the continuous child hygiene program throughout the State.

The continuous child hygiene program of New Jersey is a practical, workable program which is producing tangible results. It includes no spectacular features, such as nutrition classes, pageants, or contests, but it is a well-rounded plan, complete in itself, capable of being carried out by a nurse after a preliminary period of special training in child health work. Perhaps the fact that it lacks stunts and measures to appeal to the popular fancy militates against its rapid adoption, but the work has exhibited a satisfactory, steady growth. The proof of the pudding is the eating thereof.
VOLUNTEER WORK IN MOUNT SINAI HOSPITAL, NEW YORK, N. Y.

ANGIE JACOBSON
Chairman, Volunteer Committee, Mount Sinai Hospital

There are so many inquiries at the present time as to the value of the volunteer in hospital social work, that it seems to me that my experience with their services in Mount Sinai Hospital might be of some little interest.

During the war women awoke to the fact that there was much to be done in hospitals by untrained people that would allow those with technical knowledge to go overseas with the various units. After the armistice the knowledge that they had been of such value remained with them and in many cases it was so difficult to let down from their activities that they stayed on in their various posts.

This fact was realized by our Social Service Auxiliary, and in February, 1918, we undertook to increase our staff of volunteer workers. Many nurses' aids had been trained in the hospital, but after the return of the unit our thoughts turned more to the outpatient department than to the wards. At that time there was just a handful of women working in the Dispensary, some of whom I may mention are still working with loving faithfulness. It took some little time to get the co-operation of the doctors, as they felt that a volunteer would not be conscientious and in consequence the clinics would suffer from their lack of application. Fortunately the women who came were so earnest in their work that the doctors soon began to appreciate their willingness, and now I am happy to say we have requests for more workers daily.

As the news spread that we were using volunteers, many applications were received and now we have more requests for work than we can always suitably fill. Most of those applying have had little or no experience, and in many cases where the clinics have special

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requirements we have had to seek those who had training along such lines.

We select the volunteers carefully, and in consequence have met with splendid co-operation. We have established a filing system which has proven of great value and of late the women are dressed uniformly, which adds very much to the hospital environment.

With the exception of a few special clinics, nearly every department in the Dispensary is covered. Most of these women are clinical secretaries, but in the metabolism clinic for instance, there are five workers doing different tests, and one young woman who instructs the diabetic patient how to weigh and prepare her food. In both adult and children's asthma clinics the workers have been trained to give the tests.

In the Children's Health Class we have psychologists and someone to teach the children who have speech defects. In the Occupational Therapy Department we have two assistants to the professional worker. Of late months the follow-up work has become very important and we have several for the various surgical services, the gastro-intestinal, etc. They are even using occasional volunteers in the Pathological Laboratory, so we feel that a good deal of ground is being covered.

At present our corps of assistants numbers around seventy-five, which is quite an advance in six years.

I must say that although we have no definite rules and regulations, there has been very little annoyance in the six years I have had the pleasure of being their chairman, and I sincerely hope that other organizations will have the splendid support and enthusiasm that we have met with.
THE IMPORTANCE OF TEACHING SEX HYGIENE
TO CHILDREN

HERMAN N. BUNDESEN, M. D.
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Children are born neither good nor bad. They are what we make them. A child has been compared to a white canvas sheet set in a frame ready for the painter. What is the picture to be, an unfinished daub, a scene of horror, or a beautiful painting? The painter decides. Again, the child is said to be clay in the hands of the potter and it is his skill that determines the shape and beauty of the pot. Parents are the painters and the potters.

Good home atmosphere, which means not merely food, clothing and shelter, but also interested parents who take child rearing seriously and as a life job, is one big factor that makes a permanent impression on the mind of the child.

I am not discounting the great influence that the school teacher has in moulding the child morally, mentally and physically, but her sway is at most five or six hours in the day to be balanced against eighteen or nineteen hours of the home surroundings.

Children are born with traits that may be developed, modified or stunted by environment and training. They are also more or less individual and should be treated so. They also inherit with all the instincts the bump of curiosity predominant in early childhood. Children are constantly seeking to know, and this is a manifestation of the curiosity instinct. And it's what they learn early in life, whether good or bad, that sticks.

The youngsters absorb impressions as a sponge does fluid. They repeat what they see and hear without knowing why. It is therefore very important that the example before them is such as to make the desired impression.

Example is teaching to a child. A child may be taught by parents, teachers, or others, because its curiosity demands satisfaction. The
average normal child learns rapidly, repeats the things that are easy and pleasurable, and goes in the way of least resistance. He dislikes studies and tasks; he'd much rather play. Cognizance of this fact by parents would save much sorrow and pain for themselves and children. It is easier for many parents to let someone else be the taskmaster for their children than to shoulder the work of answering the questions of these youngsters, choosing the right work and play for them, and doing those things which would serve as an object lesson to their offspring.

And therein lies the danger. If parents shirk the great responsibility by creating an atmosphere of indifference, what may they expect of their children? If parents are easy-going and swing along the line of least resistance in child training, then the example set is readily accepted by their children until such time as an impending mind and body disaster in their children jerk up the parents to the realization of harmful neglect and its result. This is notoriously true in the matter of sex education of children.

The hush and damper put on the subject of sex is not so much a question of possible turpitude as it is an easy way to get out of showing an ignorance or indifference to the vital point in the training of the child. It is astonishing how little the majority of parents know of the best way of informing their children on sex matters. Many of them believe that children will gain their knowledge is some way when the proper time comes, shutting their eyes to the fact that children get sex knowledge in spite of their prescribed silence. But how? Often, yes, only too often, parents are shocked to learn that their youngsters have a knowledge of sex and sex manifestation, crude, most of it false and all of it filthy, gotten from other children equally misinformed. Instead of having respect for the sublimity of the functions of the sex organs, he knows them only as a vulgar means to an obscene end and treats the whole matter with contempt. What, then, can be his attitude towards womanhood? Lust is confounded with pure love, woman is merely a creature of physical satisfaction, and a noble instinct is debased.

My purpose here is not to moralize. This whole matter has a health phase, the importance of which has been minimized to such a point as to permit the venereal sore to eat into the core of our growing manhood and womanhood.

With the sex urge strong even in the normal average young fellow, the result of wrong or indifferent sex education, is the
keeping alive of the "wild oats" idea, disdain for virginity, and cheapening of sex morals. With it comes lack of restraint on sex gratification, adding to the ever-growing venereal disease corps. Out of the 1,000,000 boys who each year reach their majority, 500,000 will probably have a venereal disease before the age of thirty, unless we do something. This can be predicted with sickening certainty. The loss in time and working efficiency due to this disease is enormous and unquestionably has a crippling effect on industry.

Then, too, we must consider that venereal diseases make recruits to the insane asylums, homes for the blind, and operating tables in the hospitals. I am not a calamity howler when I make these statements. In the pamphlet, "Everybody's Problems,"* facts and figures are given to prove these statements. We see this daily in the course of our work. Our own venereal clinics, the reports of venereal cases from doctors, and the fact that a certain venereal institute in Chicago treats as high as 20,000 cases of venereal diseases a month alone all add more evidence to the appalling condition created by ignorance, wilful neglect, and the damnable policy of silence on sex matters. Fortunately, there is an awakening of the health conscience of the public and an honest desire for sex knowledge by parents and teachers that may be transmitted to the children.

The people wish to know what to do, rather than what not to do. Positive health that goes further. Instead of describing in detail the horrors of gonorrhea and chancre, better results will be obtained by showing the general means of prevention of disasters. In "Everybody's Problem" the essential points given to save our children from the evils of venereal diseases are discussed under: "A Truthful Answer," "Guide Your Child's Thoughts," "Directing Energy." Under the caption "Our Ultimate Goal," is pointed out:

"Have your son join one of the organizations for boys that do so much to supplement the training in the home and school and that serve as a healthy outlet for their super-abundant energies. . . . This unquestionably has a marked influence on our American manhood for fair play and high moral standards. . . . For the girl there are similar organizations with the same purpose in view—the moulding of red-blooded Americans. . . . Take your child to church. The greatest uplifting influence in civilized life is the church and cold and cheerless indeed is the churchless community. Even the one who

*Everybody's Problem.—Chicago Health Department.
does not go to church feels the effect of its influence and receives the benefits that come from its presence. Its good offices reach out in countless ways and directions embracing the community in an atmosphere of unselfishness and morality. . . . We must develop in our children a love of morality for its own sake rather than righteousness based upon fear of the consequences of immorality. Mere laws cannot create morality; force does not create righteousness. These qualities come from within, from the soul and from the enlightened mind.”

It can readily be seen that more interest on the part of the parents and the understanding that sex knowledge does not come from some supernatural power directly to children, but that it takes pains and care to make children what we wish them to be, well and strong in body and noble in thought, is the only way to eradicate the venereal Moloch.
PERIODICAL PHYSICAL EXAMINATIONS OF SCHOOL CHILDREN*

By MRS. AUGUSTA DUBLIN and JOHN C. GEBHART,
Director, Department of Social Welfare, New York Association for Improving the Condition of the Poor

Educators, public health officials, social workers and parents are today devoting much thought and time to child health. The ideal we have set before us is that every child shall be perfectly healthy and free from physical defects: that every child shall be spared the illnesses now due to the infectious diseases and so grow up to manhood and womanhood unhampered so far as is humanly possible by many of the physical handicaps which are now found among them.

In spite of the progress that has been made in the past quarter of a century in the conservation of child life, the actual health conditions prevailing among the large mass of our child population are still quite deplorable. While we have succeeded in cutting our infant deathrate in half in the last twenty-five years and have taught the average mother a higher standard of infant welfare, the same methods are still to be applied to children over two years of age.

Medical science is constantly placing in our hands weapons for the control of the infectious diseases of childhood. Already our statistics are beginning to show the effects of toxin-anti-toxin in the control of diphtheria. The deathrate from this disease in New York City, for example, has declined from 36 per 100,000 in 1900 to 12 per 100,000 in 1923. Scarlet fever, whooping cough and other infectious diseases of childhood are now being studied in the health laboratories of the country in the hope that they too will soon be brought under control.

The better organization of our health department is year by year gaining ground in the saving of life and the conservation of health.

*Read before the National Conference of Social Work, Denver, Colorado, June 10-17, 1925.
A vast network of visiting nursing services over the country is bringing to the people everywhere the information and help which medical science affords.

The schools, realizing their responsibility in safeguarding the health of the child, have developed a school hygiene program and technique which is constantly growing in effectiveness. The early idea that school sanitation and the prevention of the spread of the contagious diseases were for the purpose of making the child a "fit subject for education" has given way to something better. Health is regarded now as the right of every child. The schools are interesting themselves in the health of the children not merely because healthy children learn better, but because it is the duty of the school to assist them in the attainment of health both for present efficiency and greater future usefulness.

There is a fairly general agreement as to the three main essentials of a school health program of today:

1. Proper sanitation of the school plant and hygienic school administration.

2. Periodical inspections and physical examinations and the correction of physical defects which are thus disclosed.

3. The moulding of the habits, interests and ideals of the child by health teaching and health training both within and outside of the school.

Sanitation of the school plant and hygienic school administration have reached a high point of efficiency in many of our schools. Sanitary drinking fountains or individual paper cups have taken the place of the old tin dipper. Toilet facilities are generally good. The lighting is arranged so as to avoid eyestrain. Even textbooks for elementary grades are now being standardized with regard to type, paper and margin to conserve the eye-strain of young people. Adjustable seats and desks are eliminating some of the defects of posture which were so often caused by improper arrangements. Much thought is also being given to methods of ventilating the classrooms, heating of school buildings, and many other details.

Medical inspection of school children both for the purpose of controlling contagious disease and for the detection of the more obvious physical defects plays an important role in the daily practice of school hygiene. According to a recent government report, 39 states now have laws providing for medical inspection. In many states, however, the law is permissive only and many local communi-
ties have as yet failed to make even a beginning. Because of the difficulty of securing financial support, adequate medical personnel is lacking. Much of the work of routine inspection is frequently delegated to the school nurse and occasionally to the grade teacher. These assistants, after some training, can usually select from a large group of children those who appear to show marked deviation from the normal regarding either vision, hearing, posture or symptoms of malnutrition. They can also detect some of the marked symptoms of contagious disease. The children thus selected are referred to the school doctor if there is one available for final diagnosis. He makes recommendations to the family or to the family physician.

The advantage of calling upon nurses and teachers to assist in making routine inspection is that such an arrangement gives the school doctor more time to make really thorough examinations and to deal adequately with those children who present serious medical problems. Some of our state laws require a medical inspection or examination for every child once a year. Unfortunately, however, very few communities have as yet provided adequate medical personnel to make such annual examinations really worthy of the name. The result is that the doctors are in most cases obliged to do a very superficial job. In order to cover the ground, the doctor must often examine as many as 300 children in a forenoon. In such an examination the doctor has no opportunity to use his skill and training to the best advantage.

We therefore find ourselves today confronted with the fact that three-fourths of all our children have remediable physical defects which interfere with proper growth and development. Is this not an indictment of our present methods in child care? According to the report of the National Education Association in 1918 the following estimate is given of the prevalence of physical defects:

From 50-75 per cent of our school children have defective teeth;
25 per cent have defective vision;
15-25 per cent have diseased adenoids and tonsils and glandular defects;
25 per cent are undernourished;
1½ to 2 per cent have organic heart disease.

It must be remembered that these figures are the result of cursory medical inspections and it may be reasonably assumed that more thorough physical examination would reveal many more serious con-
The program of thorough health examination is still in its infancy. The few studies which have been made clearly indicate that such examinations not only reveal a larger number of obvious defects but, more important still they discover more of the serious impairments than could be possibly discovered by cursory inspection. In 1920 the New York Association for Improving the Condition of the Poor made a study of the findings of the examination of 2,186 Italian children in New York City whose ages ranged from 2-16. The study showed that 43 per cent of the children had nose and throat defects, 38 per cent were undernourished and 3 per cent had serious involvement of the lungs. A study made by the Life Extension Institute of 326 children whose average age was 9 years found that 36.5 per cent of the children had faulty posture; 32.2 per cent had constipation; 5.5 per cent showed definite or marked traces of albumen in the urine while a slight trace of sugar was found in the urine of 6.2 per cent of the children.

While considerable progress has been made in perfecting and extending our school medical inspection, very few of our children are receiving the benefit of a thorough health examination. It is this phase of the health program for school children which is still seriously neglected.

The value of the periodical health examination has been amply demonstrated in our program of infant welfare. Pediatricians have recognized it as a most effective form of procedure in the care of infants. In health centers, "well-baby" conferences and baby clinics it is an important part of the routine. These agencies are gradually extending their work to include children of pre-school age.

The periodic health examination of the adult is also being rapidly recognized as a valuable means of maintaining and improving health and of extending human life. Such data as have been collected by the Life Extension Institute and the Metropolitan Life Insurance Company bear eloquent testimony of what can be accomplished through periodical health examinations. Among 6,000 policy holders who for six years availed themselves of periodical examinations by the Life Extension Institute there followed a saving of 24 per cent on the expected mortality. This obviously meant a saving of the companies' money through deferred death claims during this period. Indeed it is estimated that on the basis of the cost of the examination the Company made a profit of 200 per cent. Many industries have instituted health examinations of their employees solely for the purpose of increasing efficiency and of reducing labor turnover. If industrial leaders
find that this method more than pays for itself in conserving the health of its employees, surely the community cannot fail to include periodical health examinations in its child health program.

The technique of health examinations for apparently well children is still in an early stage of development. The trend of medical education in the past has been to train physicians to care for the sick. The newer idea of prevention is, however, slowly gaining ground. The practice of thoroughly examining children, apparently well, for the detection of impairments which while unsuspected may lead to ill health is an important step in preventive medicine.

Further progress of medical inspection in schools may eventually lead to the provision of periodic health examinations. In certain localities in England school medical inspection has almost reached this point. The practice there is to provide a very complete inspection at school entrance and three times thereafter during the elementary school career of the child. The type of inspection called for and the time allowed for its performance in the English school system allows the school doctor to give a reasonably thorough medical examination. In many communities in America such a program is quite possible, if the time of the school doctor is reserved solely for strictly medical examination by delegating to the nurses the bulk of the task of routine inspection.

There is much difference of opinion, however, as to whether the schools should provide a thorough periodic health examination or whether this should be left to the private physician and the parent.

Many health officers and supervisors of child hygiene take the stand that it is the responsibility of the schools merely to sort out the more obvious defects, to report these conditions, usually through the school nurse, to the parents and to assist wherever possible in securing the necessary medical treatment. Complete examinations and final diagnosis must be left, they claim, to the family physician or to private clinics and dispensaries. One cannot escape the feeling, however, that the advocates of this policy are largely influenced by the difficulty of securing adequate financial support necessary to furnishing a high grade medical service and also by the very serious problem of providing adequate supervision to insure proper medical standards for the work.

The correction of defects becomes a real problem just as soon as medical inspection is effective in discovering them. To secure prompt and adequate treatment many have advocated school clinics
for defects of teeth and even those of nose and throat. While many admirable school clinics are conducted in England and on the continent with a fair degree of success, practice in this country so far has favored leaving the corrective work to the private practitioner or to well-organized clinics and hospitals. An exception is often made in the case of dental clinics. Dental clinics, where the work is restricted to prophylaxis and to repairing the first permanent molars among younger children, have had an excellent educational effect in training children in the care of the teeth and in the habit of going to the dentist. Such clinics are regarded not as a means of correcting defects, for dental defects have a way of not staying corrected, but as an effective means of teaching oral hygiene and of preventing serious dental trouble later.

Our schools have undertaken, however, to provide special classes for physically handicapped children. Open-air classes for anemic and so-called pretuberculous children, sight conservation classes, classes for children with cardiac defects are provided in our most progressive schools. It is obvious that children with physical handicaps must receive at school special care and instruction in order to make normal progress through the grades and to conserve their health and strength.

It is the feeling of many progressive educators and health workers, however, that the school can and should serve as a means for preventing the occurrence of many of the common physical defects. This feeling has grown out of the realization that the school more than any single institution is qualified to instill in children the practices, attitudes and ideals essential to healthy living. Efforts are already being made to include in the training of teachers, a knowledge and appreciation of the essential facts of healthy living and the acquiring of a technique of health teaching. It has been discovered that health training can be integrated with the entire school curriculum to the profit of education and health.

Even this brief survey indicates that while during the past quarter of a century great progress has been made in protecting and conserving child life, there are still certain needs which must be met before every child is assured of his birthright of health. They may be summarized as follows:

(1) We need more and better physical examinations and better follow-up of children of all ages.
(2) We need a standardization and uniform procedure for health examination of children. This procedure should be consistent with the best medical standards possible and yet practical enough to lend itself to wide application.

(3) Provision should be made in our medical schools for the adequate training of our physicians in the value and technique of the periodical health examination of apparently healthy children.

(4) The schools and all other agencies should be utilized for establishing higher standards of community health and for imparting knowledge to both parents and children regarding the essentials of healthy living.
WHY SHOULD I GIVE?

C. R. CONKLIN, M.D.

Medical Director, Children’s Aid Society, New York, N. Y.

When in the course of my work I meet, as I often do, with lack of co-operation, with ingratitude and with unjust criticism, the thought sometimes comes to me—is it worth while? Why should I give up my whole life to this work? Why should the Society with which I am connected spend millions of dollars in the effort to help these children? After all does it really pay? Of course no worker who is really worth his salt is going to permit such thoughts to discourage him for more than a moment or two but it is a good plan to face these questions occasionally and to be ready to answer them if necessary. Suppose that we ask some business man to contribute toward the support of our work and he replies—"Why should I give? What claim have they on me? There is a law of nature known as the survival of the fittest. Why oppose that law? Why not let these weaklings fall by the wayside as nature intended they should? Will not the race as a whole be better and stronger to be rid of them? It is said that primitive races such as the Indians followed that law. Why should not we?"

But are we opposing Nature’s laws? We were sending some children to one of our Homes in the country recently and the mother of one of them wanted to run after the party. When I detained her she said, "Oh! but it pulls so on the heart." What did she mean? Have you any children? Why do you labor and suffer and sacrifice for them? Have you ever felt that pull? "Oh, yes," you say, "that is the parental instinct." Where did you get it? Where did every bird and animal in the field and woods get it? Nature gave it. And is it only for the strong healthy child? Have you ever awakened in the night thinking you had heard your child cry? Why did you spring from your bed and, hastening to his crib, assure yourself that he was not ill or in trouble? Do you know the agony
of having a child sick? Why do they say a mother loves her crippled or otherwise handicapped child more than the others?

Nor is this confined to our own children. They naturally, have our first and deepest thought but who can see any little child in danger or suffering and not feel that "pull" and a desire to hasten to his relief. These are queer impulses and instincts if Nature intended that only those able to maintain themselves unaided should survive.

“But there is another law of nature called the law of self-preservation. Charity, you know, begins at home and I cannot afford to give to others.” For many years we had at the head of the Bureau of Child Hygiene of the Department of Health a very wonderful woman. Her name is Dr. Josephine Baker. In her public addresses she often made the statement that “No child is safe until every child is safe.” Rather a peculiar idea isn’t it? Do we mean that the health of the child on Fifth Avenue protected by all that wealth can provide is more or less dependent on the health of the poor neglected little child living in a filthy East Side Tenement? Yes, that is exactly what we do mean. If a child in one section of the city contracts scarlet fever or infantile paralysis or any other contagious or infectious disease, the children in every other section of the city are in danger for there is no form of protection that will guarantee safety to a child with disease in the neighborhood. This is a well recognized fact for although the general public may become careless and indifferent at times we have only to recall the panic that ensued even in remote communities a few years ago when there was an epidemic of infantile paralysis. If our child is to be protected we must fight disease wherever it is found not only in our own town but in the uttermost parts of the earth.

This protecting and helping the other child will also help our child in another way. Should you or some member of your family become ill tomorrow you would not be content to have your physician begin his study of the disease on you or experiment in the treatment on your child. You want him to know all about such matters before hand and this information is in a great measure obtained in the institutions where those unable to pay are treated free. The bare law of self-preservation demands that we meet the enemy outside our home and before he has had a chance to enter our family circle.

“But there are so many charitable organizations and they spend so much money. It is a very expensive business.” Yes, it is and it is much more so than you ever dreamed. Unless a person is actually
engaged in the work he cannot have the slightest conception of what a tremendous task it is and what enormous sums are necessary to maintain it. There is nothing more wearisome than to listen to the criticisms of some people whose only benevolence, if any, consists in giving a coin to a beggar on the street. They will often condemn the rich for not being more generous and boast of what they would do if they were wealthy. Wise giving is one of the most difficult problems that anyone can meet and indiscriminate giving on the street is far from wise. Furthermore the rich do give and they give generously. If they did not give in abundance it would be impossible for most organizations to exist. My own Society requires nearly a million dollars a year to maintain its work and there are said to be two thousand charitable organizations in New York City alone. In this connection philanthropic organizations are approaching a new problem which may mean that we will have to re-adjust our method of collecting funds or diminish our work. It is quite evident that in the future it will be the policy of the government to tax the wealthy much more heavily than in the past and if this is done they will not be able to contribute as liberally as they have done. The so called middle classes will then have to assume a larger share of the burden. I also think that one phase of our policy toward our beneficiaries in the past has been a mistake. We have, too often, gone on the plan that because an individual could not pay the entire cost he was to be considered a pauper and treated free. This idea is not as prevalent as it was but many workers still are influenced by it. Better results all around are accomplished when beneficiaries are encouraged and permitted to contribute what they are able and philanthropy only makes up the balance. This plan must be handled very wisely and tactfully and no child permitted to suffer or be neglected because its parents are unwilling to do their share. The amount collected in this way will be only a small part of the expense but is worth consideration from the financial side as well as for its educational value.

But, however raised, great sums are needed and are justified. It is worth it to have the good will of a man because you sympathized with and helped him in his hour of need rather than his hate because you were indifferent and permitted him and his children to suffer when he lacked the ability to help himself. It pays to have men, women and children aided into helpful lives rather than to become criminals and prey on society. It pays to fight disease and have your children grow up strong and healthy. It pays to have the handi-
capped saved from lives of helplessness and aided in becoming self-supporting and even more. Is Helen Keller a paying investment? Extravagance and wastefulness must be guarded against but even though they persist the sum total of results will more than pay all that is invested in philanthropy.

"Why should not the government take over this work and bear the expense?" That is a fair question and in response the government has come forward step by step. But today the government, city, state and national, is under such a tremendous expense that it is unable to properly carry on the tasks already assumed. Who wants to increase taxes? Furthermore much of the best work being done by the government was originally done by private individuals or organizations and this probably will always be the case. It is usually necessary for someone to call attention to a need and to demonstrate the best way of meeting it before the public is sufficiently aroused to authorize the government to undertake the job.

But even though the government was willing and able to undertake the entire job it would not be wise for us to surrender it all. We cannot afford to get out of personal touch with such things. Where the government controls and directs everything men become narrow and selfish or mere puppets without the power of individual action or initiative.

It is evident then that we must take part in and support philanthropic work because,

First—It is obeying one of the noblest impulses of nature.
Second—It is necessary for our own protection and preservation.
Third—It is a profitable investment.
Fourth—The Government cannot carry the burden and we cannot afford to surrender it.

In this discussion no reference has been made to Him who said, "Thou shalt love thy neighbor as thyself" and "Inasmuch as ye have done it unto the least of these, my brethren, ye have done it unto me." We have been talking to a business man from a strictly business standpoint but even a business man cannot afford to neglect the spiritual side of his life.
LETTER FROM NEW MEXICO

Ojo Caliente, New Mexico.

HEALTH WORK AMONG THE INDIANS

You wrote to me at a time when I was leaving the Navajo Desert and coming up here to the mountains and under the driving necessity of getting over my head a roof that didn’t leak too badly against the winter storms! And since then I have now and then hoped you wouldn’t think me too rude that you weren’t getting the article on Health Work Among Indians for which you asked. I didn’t write it because I know too little about the subject to deliver myself thereon. Indians are everywhere, from Maine to California. And I’ve seen them only in New Mexico at the dance festivals of the Pueblos in the Rio Grande Valley, the Zunis for three extraordinary months close at hand at Zuni, and the Navajos at a trachoma clinic in their desert last summer.

Of course the health of the Indian is the professional charge of the Bureau of Indian Affairs of the Department of the Interior at Washington. Departments live forever, and their red tape unwinds and stiffens from generation to generation. I sometimes think that if all the works of the Indian Bureau were suddenly lifted skyward—schools, hospitals, inspectors, matrons, doctors, superintendents,—the Indian, by and large, would go on very much as he does at present, and the cessation of the various offenses against his culture and his intimate life performed by High Government might give him again a very pleasant sense of peace in his own lands. The proper retort to this is of course, that the white man would very shortly have looted from the Indian all the lands that were worth looting, and his water where there is any. So, granted a Bureau of government to which the Indian is ward for his protection, and some program of health and education, the interest of the nation at large lies in seeing that better administrative, educational and medical work is done. So much better that these matters cease being the de-
plorable subject for comment they are at present. The Indian infant
death rate, the incidence of tuberculosis and trachoma among Indians,
the poverty of his hospital care and his too frequent medical and
nursing neglect, are commonplaces of the discussion.

There is a real work for nursing organizations to do in connection
with the standards of nursing in the Bureau of Indian Affairs, and
certainly it has been a move in the right direction that the Bureau
has recently appointed as Supervisor of the Field Matrons in the
service, Miss Elinor Gregg, R. N. I do not know Miss Gregg, but
the news of her appointment has given me great pleasure. I have a
shrewd suspicion, moreover, that Miss Gregg will need all the
backing-up she can get from anybody in attempting to liberalize and
improve the nursing standards of her Bureau. There seems to be
no reason of overwhelming importance for calling a woman a nurse
and giving her nursing work, even hospital work to do, when to the
naked eye and by her personal records she is graduated from the
sewing room or the matron's office into nursing. In other words
there is no really good reason why nursing standards which prevail
in the City of Washington, for instance, should not prevail in a
Bureau conducted by Washington and affecting the lives of gentle
and admirable peoples whom we persistently wound and perplex,
but who for good or ill are in our hands. Except of course, the
general lethargy we exhibit about government works, and that's not
a good reason.

I am quoting from a recent address on the "Medical Problems
of Our Indian Population," by Frederick L. Hoffman, Consulting
Statistician, delivered before the Eastern Association on Indian Af-
fairs: "Next to a better medical organization there is the utmost
necessity for a larger staff of qualified nurses. Such nurses should
have a fair measure of familiarity with the Indian language of the
tribes to which they are attached. Regardless of much progress in
education, the older members of the race in many cases are still
unfamiliar with even the simplest expressions in English. On the
Navajo Reservation, for illustration, regardless of treaty obligations
there are thousands of children who are not receiving even elementary
education regardless of the fact that because of linguistic difficulties
the Navajo in later life cannot acquire the English language however
much he may try. The nurses attached to Indian reservations should
be exceptionally well qualified and be prepared for social service as
well as for the discharge of more strictly professional duties."
The Eastern Association on Indian Affairs, whose Secretary is Miss A. E. White, 115 East Fifty-fifth Street, New York, has recently introduced two nurses to the New Mexican scene, working in co-operation with the Indian Bureau. The sight of Miss Hilda M. George, R. N., in a blue uniform with white collar and cuffs, motoring rapidly after the trachoma in San Juan Pueblo with a Henry Street bag on the back seat, is a delight to the beholder, and Miss Elizabeth Duggan, R. N., has gone to Zuni. Miss Duggan is lucky; Zuni seems to me to be the least penetrated and the most magical of all the New Mexican groups.

Very faithfully,

(Signed) Gertrude U. Light, M. D.
EDITORIAL

Adolescent Instability

Formerly we thought the adolescent period extended from about the twelfth to the sixteenth year and that it began and ended with the establishment of certain physiological functions in both sexes. However more recent studies have shown that the adolescent must adapt himself to social and emotional demands much more bewildering and complex than those involved in his purely physical development. This difference in our conception of the problem has made us aware of the fact that many individuals do not emerge from adolescence until the middle twenties and that some never really out-grow adolescent traits and reactions.

Probably the old legal concepts of minority and individual responsibility contributed to our failure to recognize the existence of other factors than the purely physiological and another delay in our appreciation of the emotional and social difficulties of the adolescent sprang from that resistance to the significance of sex which has since largely broken down under the influence of modern psychology. Increased educational requirements and the extension of preparation for economic independence have not only partially recognized but confirmed the fact that adolescence does persist beyond the teens.

Actual observation of the average adolescent reveals instabilities more or less inevitable when the problems involved are considered. The individual undergoes certain physical changes which affect his whole attitude and the range of his emotional interests; he has a new sense of his own ego, his own individuality, his separateness from the adults of his world; he has to break away from the domination of home and his infantile dependence on his parents; he must find expression for an individuality he does not himself understand and struggle with new idealisms and fantasies as well as with the disillusionments in which they result; and finally he has to
choose a vocation when he is most at sea about his own abilities and about the demands reality will make upon him.

The adolescent problem is not a new one. It used to be expressed in terms of “puppy love,” dime novel ideas and “sowing wild oats.” Translated into modern terms we have “flappers,” “cake eaters,” “bobbed haired bandits” and such diversions as “petting parties” and all night automobile excursions. The exploitation of these current symptoms is a partial denial of the fact that these tendencies are normal, spring from adolescent instability and are not simply fashions to be disposed of by mass attack from moralists. Treatment of the subject by the movies, the press and the pulpit has probably only stimulated the adolescent’s rebellion against adults who he feels do not understand the impulses finding expression in the conduct they condemn. As a matter of fact our codes of manners and conduct are themselves fluctuating and have been undergoing some interesting reintegrations. It is perhaps our own uncertainty about our social attitudes which makes us so liable to panic about present adolescent problems. We are ourselves in a transitional period quite comparable to the instability of idea and attitude we observe in the young. We need not only a better objective understanding of adolescence but a revaluation of our own social standards and ideals in the light of modern psychology and modern social conditions.

We find that in clinical work with the problem adolescent, the only way to get to the root of the difficulty is to study the individual in terms of his family background, his personality makeup and his experiences; to discover his physical assets and liabilities; to estimate his intellectual capacities; and to analyze his reactions to himself and his situation. Treatment involves giving more or less gradually to the individual insight into his own qualities and defects, and appreciation of the reality that confronts him and assistance in working out an adjustment. All this is accompanied by any indicated medical treatment, educational and vocational guidance, the provision of recreation, and patient social interpretation of his problems and needs to the family, school and any others intimately concerned with him.

On the whole the only safe generalization about adolescence is that each adolescent should be studied and treated as an individual who has individual problems and individual reactions to them.
Otherwise no specific has been formulated for saving the adolescent from the stresses of his own instability and the problems of adjusting to the adult world.

RALPH P. TRUITT, M. D., Director,

Division on Prevention of Delinquency of the National Committee for Mental Hygiene.
NEWS NOTES

The American Hospital Association has made definite plans to operate an employment bureau. This much needed service will, it is hoped, supply qualified workers to hospitals throughout the country.

Decided reduction in infant mortality rates in all sections of Michigan is reported by Dr. Blanche M. Haines, Director of the State Bureau of Child Hygiene and Public Health Nursing, in connection with her summary of two-and-a-half years' work under the Maternity and Infancy Act. In the Northern district the maternal mortality rate was also lowered during this period.

World's Children.

An examination was held by the American Board of Otolaryngology on May 26th, 1925, at the Medico-Chirurgical Hospital, Philadelphia, with the following result:

Passed .... 137
Failed .... 20

Total examined 157

The next examination will be held at the University of Illinois School of Medicine on October 19th, 1925. Applications may be secured from the Secretary, Dr. H. W. Loeb, 1402 South Grand Boulevard, St. Louis, Missouri.

The Nurse in Hospital and Community

"To both medical education and public health work the modern trained nurse is indispensable. She is found in the wards and dispensary of the hospital; she follows discharged patients to their homes; she responds to the calls of the sick poor; she reports cases of communicable diseases; she is an attendant in the health center
and in the industrial clinic; she serves in the school and in the families of the pupils; she goes her rounds in city, town and village and of late has made her way to isolated farmsteads in the open country. She is at the same time nurse, teacher, public official and friend.

Because of an interest in medical education and public health the Rockefeller Foundation has aided demonstrations in nursing education in several countries. During 1924 it continued to support a training school experiment at Yale University, contributed to a school of nursing in Rio de Janeiro, assisted a bureau of public health nursing in France, helped to establish schools of both public health and bedside nursing at the University of Cracow, Poland, and at Zagrab, Yugoslavia, aided in public health nursing service in the Philippine Islands, granted 39 fellowships for training, made surveys of nursing education in several European Countries, invited leaders in nursing education to visit foreign countries, and sent a commission from the School of Nursing in Lyons to observe hospital schools and methods in Great Britain.

*Information Service,*
*Rockefeller Foundation, New York, N. Y.*

The Syracuse city library has allocated to a special section, all its books relating to public health and hygiene.

The Maternity Centre Association, New York City, reports that during the past year 2,897 mothers were given advice and care, an increase of 464 over the previous year.

The Anti-Tuberculosis Society organized in Palestine two years ago, now has three branches in operation, one in Jerusalem, one in Tel-Anid and the third in Haifa.

The Church Home, for 58 years an orphanage under the auspices of the Episcopal Diocese of Buffalo, N. Y., has been closed. This step was taken in order to give the best possible individual care to dependent children under church care. A Child Welfare Committee has been formed and an experienced social worker engaged to investigate each case and provide for care and maintenance according to the individual needs of each child.
The Rhode Island Hospital, Providence, R. I., has established a Problem Clinic in connection with the Neurological Clinic.

Dr. James A. Hayne, State Health Officer of South Carolina and Collaborating Epidemiologist of the United States Public Health Service, has instituted a new and decidedly more effective system of disease reporting by physicians. Each week a card is mailed to physicians for the report of the number of cases of diphtheria, gonorrhea, syphilis, malaria, smallpox, tuberculosis and certain other diseases. The greater effectiveness of this system of reporting is shown by the fact that in the first month of its operation 734 cases of syphilis were reported as against an average of 245 cases for each of the preceding ten months, or three times as many cases as were reported formerly. There is a still higher rate of increase in the number of reported cases of gonorrhea. Over seven times as many cases of this disease were reported under the new system as were reported formerly.

U. S. Public Health Service.

The American Heart Association, Inc. bulletin reports that the Philadelphia Heart Association has 24 cardiac clinics with an attendance of 3,410 patients. There are also ten diagnostic heart clinics for school children under the direction of the Department of Public Health.

An infant mortality rate in Belgium of 93.1 per 1,000 births in 1923 is announced by the Belgian Children’s Bureau. This figure is contrasted with the 1922 rate, which was 107, and the rate for the years 1901-1905, which was 147.7.

World's Children.

The New York College of Dentistry has affiliated with the New York University but will remain at the present location, 209 East 23rd street.

During the year 1924 the Greek Red Cross printed and distributed in schools even in the most out-of-the-way districts, a million copies of health rules and literature on hygiene.
The name of the Massachusetts School for the Feebleminded at Waverly has been changed to the Walter E. Fernald State School in honor of the late Dr. Fernald, who for 37 years was superintendent of the school and was a pioneer worker and leader in the study, education and care of the mentally deficient child.

Mercy Hospital School for Nurses, Hamilton, Ohio, has become affiliated with the University of Dayton.

Dr. Lee K. Frankel, Second Vice-President, Metropolitan Life Insurance Company, addressing the annual meeting of the State Committee on Public Health of the State Charities Aid Association, predicted that there would be no diphtheria in New York State in 1930.

Dr. Helen T. Wooley of the Merrill-Palmer School, Detroit, Michigan, has been appointed Director of the Institute of Child Welfare Research and Professor of Education, Teachers College, Columbia University, New York.

According to Dr. S. B. Sinclair, Inspector of Auxiliary Classes for the Province of Ontario, Canada, special classes for abnormal children have increased ten fold in the past five years.

Health News reports an interesting case of a diphtheria carrier, a young boy whose throat after an attack of diphtheria persistently showed positive cultures until a tonsillectomy was performed. After operation the throat became normal and the child was released from quarantine.

A Pan-Pacific Conference will be held in Honolulu next summer.

The Board of Directors of the Oregon Life Insurance Company recently gave $1,000 to the State Tuberculosis Association of Oregon, Idaho and Washington to fight tuberculosis in the Northwest.

Medical and social leaders of France are stressing the demand that expectant mothers should have adequate medical care, and that,
therefore, it is essential to make compulsory the early notification of pregnancy, so that venereal affliction, when present, may be detected and the coincident danger to the unborn child prevented. It is not sufficient to protect the child only from the moment of its birth, as according to Professor A. Couvelaire, of the Baudelocque Hospital of Paris, 41 per cent of the deaths of infants during pregnancy are due to syphilis. There is considerable evidence that the number of such deaths may be greatly reduced by timely examination and care of expectant mothers. Similarly the Conference of Venereal Disease Control Officers of the State Health Departments and the United States Public Health Service, held at Hot Springs, Arkansas in December of last year, urged that special attention to all details should be given in the "treatment of women, because of the possibility of the transmission of the disease to the child."


The International Narcotic Education Association which is making a vigorous campaign against the drug evil, has decided to hold a world conference on Narcotic Education in Philadelphia in the summer of 1926 in connection with the Sesqui-Centennial celebration.

The United States Department of Labor, Children's Bureau, Washington, advocates home or foster-home care for dependent children. "As there will always be children who for various reasons must be cared for in institutions the bureau has provided for this class by modelling in miniature an ideal cottage institution and recommending that this model be accepted as a standard.

"This model shows a miniature 'cottage institution,' pleasantly located in the midst of a rolling countryside boasting a brook or small river, woods and open meadows—ideal surroundings for growing children. A paved road and electric trolley connect the institution with a near-by town or city, the outskirts of which are represented in the model by miniature houses, churches, schools, stores, and even a moving-picture theatre.

The institution itself as shown in the model is far different from the conventional idea of an "orphan asylum." Eight small cottages, looking like very attractive family bungalows, each surrounded by shady lawn, provide living quarters for approximately 100 children. Each cottage would, in real life, accommodate 12 children, a house
mother and her assistant. The children of each house would have their own dining-room and living room, and the whole atmosphere would be that of a big family. Conveniently near all the cottages is a playground with all kinds of apparatus, a gymnasium, a baseball diamond, a swimming pool, and individual gardens for each child, affording ample facilities for recreation and exercise. Other buildings included in the institution are an administration building, a reception and isolation cottage where new arrivals are housed, a superintendent's house, a farmer's cottage, a big barn, a central power house, a garage, and a central laundry. The children's cottages are all one-story. The general buildings are in most cases two stories. There is no school or church connected with the institution because it is considered desirable for the children to attend the town churches and the public school, thus making normal contacts with the community.

In studying this model of a cottage institution, it must not be forgotten that institutional care is only one of several methods of providing for dependent children. The prevention of child dependency through family-relief work and public aid for dependent children in their own homes, and other factors in the social and economic life of the country, have definitely lessened the need for institutional care. The Children's Bureau believes that it is far better to prevent the break-up of homes through mothers' pensions and constructive social-welfare measures than to build institutions for the care of children for whom home life might have been saved. A growing number of people have come to believe in foster-home care as approximating most closely the conditions of normal family life, and as offering better opportunities for individual upbringing than is possible in institutions. Broadly speaking, the purpose of an institution for dependent children should be the care of children who can not be provided for properly in their own homes or with relatives, and for whom the institution is better adapted than any other form of care available."

Personal Hygiene

Personal hygiene is the art of so conducting one's life that health is promoted, disease avoided, happiness secured, and life enriched. A wise philosopher once said, "It is not life to live, but to be well." The chief rules of personal hygiene may be summarized as follows:
Begin with a human appraisal by having a health examination. Begin immediately to improve any defects or correct any faulty habits which such an examination may disclose. Breathe fresh air all the time. Get outdoors as much as you can. Seek the sunshine. Eat plenty of wholesome, well selected, nutritious food. Drink plenty of water every day. Do not over-eat and avoid overweight. Work hard, play often, and have a good time at both. Sleep enough: outdoors if possible. Exercise every day. Wear sensible clothes, light and loose. Be cheerful, serene and contented. Don’t let your nerves ever get the best of you. Take proper care of your eyes and other important human organs. Have a bowel movement at least once every day. Keep away from persons having communicable diseases. Keep poisons out of the system. Get your hygienic advice from reputable regular physicians or scientific health agencies and not from cults, quacks, and patent medicine advertisements. Stand up and face the world, for the world is at your feet.


Evolution

“A neighbor’s child was sick—whose turn tonight? The case was at the crisis; mother went. She had an art in sickness—moved quietly, Knew symptoms well, and herbs, roots, essences. She learned them from her mother—she, from hers.

Now the times change, the ancient lore gives way, Or meets the keen, relentless test of science. As blacksmith grew to engineer, and barber became surgeon, The kindly neighbor now is nurse; and studied skill Adds to the art of friendly ministration.”

Antioch Notes.
Coming Meetings

American National Red Cross, St. Louis, Mo., October 12-15.
American Academy of Physiotherapy, Boston, Mass., October 15-17.
American Public Health Association, St. Louis, Mo., October 19
American Hospital Association, Louisville, Ky., October 19-23.

BOOK REVIEW

“Simplified Nursing” Florence Dakin, R. N., J. B. Lippincott Company, 1925. Miss Dakin has given to the laity, the trained attendant and the practical nurse, a text book which will prove invaluable. With the present shortage of nurses and the soaring of prices of all commodities of life, the families of the great middle class (judged by financial standing) find it necessary to do home nursing except in serious cases and then the patient is usually sent to an hospital. The book is written in simple style and covers every conceivable point in nursing. Any one of average intelligence can follow the simple instructions very much as one would follow the directions of a cook-book. Each lesson is prefaced by an explanation, this making it clear why the treatment should be administered in a certain way and the results to be expected. The book has 77 illustrations of the various parts of the body, methods of preparing beds, douches, pack, bandaging, etc. Miss Dakin has not only succeeded in the object of her book in presenting the rudiments of nursing in a simple, direct form, technically correct, but has rendered a very great service to the public at large.

NEW PUBLICATIONS

The Cornell Clinic, New York City, the aim of which is to give medical service to people of moderate means, has issued an interesting report of the work accomplished during the period 1921-1924. Approximately 60,000 patients have been treated.

The United States Department of Labor, Women’s Bureau, has issued an interesting report of Standards and Scheduled Hours of
Work for Women in Industry, a study based on hour data from 13 states, Bulletin No. 43.

The Quarterly Bulletin of the Milbank Memorial Fund contains interesting articles on health and notes items of the various health demonstrations sponsored by the Fund.

The Child Health Bulletin, which will be published by the American Child Health Association from time to time in place of the Child Health Magazine, contains interesting articles and notes of interest to child welfare workers.

"Juvenile Courts at Work," by Katherine F. Lenroot and Emma O. Lundberg, U. S. Department of Labor, Children's Bureau, bureau publication 141. An interesting study of the organization and methods of ten courts. Every phase of court organization and procedure is studied. Workers interested in juvenile delinquency, especially from the physiological and psychiatric viewpoint, will find the report both interesting and helpful.

"Health" is the significant name of a quarterly magazine published by the Council of Health Education, Shanghai, China. One-half of the magazine is printed in English, the other half in Chinese.

The Executive Committee of the Cambridgeshire Tuberculosis Colony has issued an illuminating report of the past year's work. The colony, or Papworth Village, as it is called is an ideal settlement for the victims of tuberculosis, voluntary recruits from the tuberculosis hospital, and their families. The village is like any other pretty English rural community, with churches, schools and stores. Workshops have been established and the ex-patients are employed at their various trades, such as carpentry, cabinet making, manufacturing trunk and suitcase, printing, etc. A ready market is found for the goods and the whole enterprise is run on a self-supporting basis. The families live in pretty cottages and lead a normal happy life under the best possible conditions plus expert medical supervision and care.
Abstracts

The U. S. Department of Labor, Children's Bureau, has issued a summary of current child-welfare legislation. The summary gives important data regarding the attitude of the various states to child labor, child hygiene, dependent children, the maternity and infancy act, children born out of wedlock, etc.


ABSTRACTS

"Employment for Arrested Cases of Tuberculosis." W. J. Dobbie, Can. Lancet and Pract. 1925, VLXV, 11. The author emphasizes the fact that there exists three prevalent misconceptions regarding arrested cases of tuberculosis. The first mentioned is advising the patient to secure employment in the open air. It is always difficult to get a suitable out-of-doors job and when obtained in most instances the patient is required to do work to which he is not accustomed, and in addition is exposed to all sorts of weather conditions and undue fatigue. The second false idea is that such cases should seek a different climate. This the author considers unwise if change of climate is the only reason for sending patient away. The third mistaken notion is that the arrested case is a menace to fellow workers. Men and women can be safely permitted to work after they have been pronounced arrested if conditions meet the requirements of the patients and the patient is qualified to meet conditions. The thing to be considered is what demand, physical and mental, do the jobs actually make upon the worker? Does the applicant present the physical and mental capacity necessary for the successful performance of the job under consideration? In referring cases for employment the important fact to be remembered is that in most cases the arrested case of tuberculosis reacts to life and its responsibilities in quite a different manner than before contracting the disease; also
the fact that each case, although apparently well, presents a degree of disability not easily recognized. The author advocates careful analysis of the job and a study of the patient, his education, training, preference for a kind of work, previous occupation, etc., also conditions under which he will work, type of work, temperature, ventilation, humidity, dampness, posture while at work, hours of work, etc. With the patient’s ability and suitability for the job understood and the requirements of the work tempered to the strength and skill of the patient, the arrested case of tuberculosis can work without recurrence of the disease providing he is willing to husband his strength by careful living.

"Two Practical Suggestions for Occupying Desperate Cases." S. E. Tracy, Occ. Ther. and Rehab., 1925, IV 181. All doubts as to the value of occupational therapy will be dissipated after reading the graphic account of how a violently insane patient found herself. A young woman was a patient in a private sanitarium where it was necessary to keep her in bed in almost constant restraint as she was obsessed with the desire to mutilate her body and kill herself. At the end of a year the patient’s family appealed to the author to see if it were not possible to permit the patient to have her hands free for at least a short time. A box of cloth animals, sewn and ready for stuffing was given to the patient, who at first did not respond but within a few days she finished one and within a short time she had stuffed one hundred cases. Owing to her condition she was not allowed the use of any instrument, simply the cases and a roll of cotton, the work being done with her fingers. The nurses did the closing up, sewing on eyes, etc. The animals were sold and the patient, although wealthy, was delighted that she could earn money by her handiwork. Within a few weeks she was allowed to walk under close guard in the garden. To stimulate her interest her work was changed to making blue prints of flowers, leaves and ferns which she selected and picked. This work, together with animal stuffing was kept up until after eighteen months of desperate suicidal mania the patient recovered.

"Social Case Work in Relation to the Mental Health of Immigrants." M. C. Jarrett, Ment. Hyg., 1925, IX, 346. The author quotes the fact that there are many more foreign born persons and
more children of foreign born parents in asylums than native born Americans, and points out the opportunity that social agencies have to alleviate conditions and prevent mental breakdown by a clearer understanding of the conflicts which beset the immigrant family. With the children it is necessary to see the viewpoint of the young American who adopts the customs and language of the country with alacrity, and rebels against old world discipline and suppression of freedom; also to understand the conflict of the parents who see their children acquiring new manners, a new language, and a certain independence which would never be countenanced on the other side. The author advocates the keeping of accurate and adequate records of foreign born families in order to study their mental reactions to the new life.

The appendix consists of a very complete outline of a social record for immigrant families. If this record were carefully kept for a certain definite number of families in various parts of the country, very valuable data would be available and could be used as a working basis to help the immigrant find himself and make it possible for him to surmount the mental conflicts which play such a tragic part in the lives of the foreign born.

"The Diagnostic Significance of Children’s Wishes.” F. L. Goodenough, *Ment. Hyg.*, 1925, IX 340. Asking the question “Suppose a fairy were to grant you three wishes, what would your wishes be?” was the unique method of approach to causes of behavior problems in children used by the Child Guidance Clinic, Minneapolis. From information thus gathered it was found that the answers of children under nine years of age were of very little value as in most instances they asked for childish things such as toys, candy, etc. With children in the early adolescent or pre-adolescent period the answers were frequently significant and suggested underlying causes of the child’s maladjusted attitude. One case cited was that of a nine year old boy who was taken to the Juvenile Court by his mother on a charge of incorrigibility. The court referred the case to the clinic for investigation. The mother, a nervous, highstrung woman, twice married and twice divorced and contemplating a third marriage, exaggerated the child’s misdeeds to such an extent that the worker sensed that the child was an obstacle in her plans for a third marriage. The child was popular in school both with teachers and play-
mates and the school authorities were amazed to find that he was considered a behavior problem. His first wish was more than significant of his suppressed rebellion in his home life; it was “for a nice home and mother.” Another child whose mother showed great partiality for a younger brother, misspelled his heart-hunger in the following wish—“that I wood be lovved by my fokes.” There are several other graphic cases, but the two mentioned well suffice to show the actual tragedies enacted by children. Fortunate indeed is the so-called problem child who is directed to a clinic, where he finds an understanding worker who can and does help materially in adjusting home conditions and warding off or ameliorating the conditions which react upon a child’s emotions.

“The Control of Disease by Diet.” O. H. Petty and W. H. Stoner, *Nation’s Health*, 1925; VII, 450. An interesting account of the Department of metabolic diseases of the Philadelphia General Hospital and the results obtained in controlling diabetes. The service is equipped with everything for diagnostic, dietary, therapeutic and instructional procedures in the treatment of the disease. The personnel, physicians, nurses, dietitians, emergency technicians, orderlies and maids are specially trained and duly qualified to carry on the work. Each patient is instructed in the technic of insulin administration, the calculation of diet, diabetic hygiene with particular emphasis upon the danger of contracting colds, injuries, infections, and care of the feet, in fact everything that will help them to understand their own condition and enable them to maintain the best possible standard of health. The dispensary has at present 95 per cent co-operation from the wards. Nurses visit the homes and give practical instructions in diet and hygiene. When social conditions demand investigation or aid the case is referred to the social service department. Many helpless and dependent diabetics have been restored to health and independence.

The established fact that heliotherapy has been successfully used to combat and prevent tuberculosis is the basis for urging sun baths for all babies and young children. The trend of medical thought at the present time is not so much the cure, but prevention of disease. Rickets, the most common disease of infancy, is now con-
trolled and deformities prevented by the direct rays of the sun or the artificial sun lamp. The author points out that according to tradition babies are delicate and must be safeguarded from air and sun and are therefore swathed in layers of clothes and then placed in the sun, usually in carriages with the hoods pulled up. The ultraviolet rays do not penetrate these canopies, neither do the healing rays penetrate window glass. It is essential that the child's body be exposed to the direct rays of the sun. The method and time to begin must be governed by climate and season. Normal infants can begin sun baths in the early spring, exposing face and hands for a few minutes and gradually lengthening the time of exposure to one hour in the morning and one hour in the afternoon. In summer the child will wear fewer garments and on very hot days the entire body should be exposed. The author accepts the fact that very little explanation has been made regarding the beneficial effects of direct sunlight, but stresses the importance of the findings in the treatment of rickets. An interesting comparison is made between the healthy and vigorous appearance of the outdoor baby or child in contrast to the pale, flabby child who has been kept indoors.

"How Visiting Housekeepers Supplement the Graduate Nurse.' S. Irmin, Tr. Nurse and Hosp. Rev., 1925, V. LXXV, 26. Every one who has done district work has felt the great need of just such a service as the visiting housekeeper department of the Dayton Ohio Visiting Nurses. In 1921 the Junior League of that city, desiring to do a piece of constructive social work, consulted Miss Holt, Superintendent of the Visiting Nurses, who immediately requested a visiting housekeeper. The worker who was engaged proved to be the right one for the job as she did not give advice and supervise the work, but pitched in and did the work herself. Homes and families were kept together during illness and death, mothers were taught sewing, housework, how to live within a budget, and the hundred and one things that are apparent to a housekeeper or social worker. So successful was the experiment that there are now several supervisors, visiting housekeepers, and helpers who go to the homes to do the rough housework. Several cases where the visiting housekeeper tided families over difficult periods are cited and show clearly that the visiting housekeeper is needed wherever visiting nursing, district or social work is established.