RHEUMATIC HEART DISEASE IN CHILDREN

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Strictly speaking the title of this article might almost appear redundant, because, with the exception of a few cases of heart disease due to congenital malformations, practically all cardiac affections in children are looked upon as rheumatic.

The term "rheumatic" is a little unfortunate because being applied to many diseases that differ from each other in so many ways, it has become almost meaningless.

A century and a quarter ago rheumatism was defined by Babington as "a denomination of disease including affections which though connected with and often changing into each other, yet differ considerably both in their respective assemblage of symptoms and method of cure." Since the above was written, many diseases formerly regarded as rheumatic have been relegated to other categories more in accordance with modern ideas as to their nature. It will be of assistance to a more thorough understanding of the condition as it affects children if a brief reference is made to the main features of these various manifestations.

There is first of all that variety known as acute or sub-acute rheumatism and which also receives the name of "rheumatic fever." This form chiefly affects children and young adults. It is characterised by high fever, profuse sweating, swollen and exquisitely painful joints, implication of the heart and possibly before or after the acute stage, St. Vitus dance or chorea. The condition just described is the classical or "text book" acute rheumatism and is perfectly easily recognized. The joint affections in this variety usually recover
perfectly and leave no ill effects. The brunt of the damage falls on the heart about which more will be said later.

The malady known as chronic rheumatism is evidenced by pain and stiffness in the muscles and tissues round the joints and occurs in much older people. It is as its name implies chronic and lasts a considerable time. But acute rheumatism does not pass into this kind of chronic condition. Speaking generally the two conditions have very little to do with each other and it is most unfortunate that the nomenclature should be so confusing.

Rheumatoid arthritis might from its name give the impression that the affection was in some way or other connected with rheumatism. It has, however, no relation in any respect with either of the affections just dealt with.

The kind of rheumatism that chiefly affects children differs from those described above. It does not “flare up” as the acute variety and is therefore apt to remain unrecognized for some time. It is quite as liable to be followed by heart complications and this constitutes its chief danger. The “classical” kind of rheumatic fever already mentioned may affect children and often does but according to hospital statistics the prevalence of the condition is becoming decidedly less. At one time current medical literature contained numerous references to cases of hyper-pyrexia occurring in acute rheumatism. Such instances are comparatively rarely heard of nowadays. Effusion of fluid into the pericardium was also formerly a much commoner accompaniment of rheumatic fever than it is at present. Directly a child or young adult becomes affected with this distressing disease there is no question about diagnosis or treatment. In the majority of cases they are sent to hospital at once. The only drawback lies in the fact that owing to pressure of accommodation the cases cannot be retained long enough to ensure immunity from heart mischief. The children leave hospital and run about and thus strain an already damaged heart. The only measure likely to obviate this risk is prolonged rest and a very gradual return to ordinary conditions of life. In practically every “hospital” case the parents are unable to afford the necessary supervision neither can they understand why a child discharged from hospital and not obviously very ill should be made to rest.

The position with regard to rheumatic heart disease in children would not be nearly so difficult if the condition just outlined were responsible for all the cases. Unfortunately it is not. There is an
insidious affection—some observers would say “infection”—of children which if overlooked is quite capable of producing serious and lasting damage to the heart. For want of a better description children suffering in this way are called “rheumatic.”

The chief symptoms of rheumatism in children do not conform to those of what might be termed the “text book” rheumatic fever. The joints are rarely affected but pains in the limbs are common and erroneously ascribed by the parents to “growing pains.” There is a slight amount of fever oftener than not confined to a rise in temperature in the evening. The child seems generally “out of sorts” and there is at first apparently very little to account for its indisposition. In course of time the little patient gets thinner and somewhat anaemic. It is then noticed that there is a disinclination to run about and play. This is entirely due to shortness of breath. Accompanying these signs there may be choreic twitchings or fully developed St. Vitus dance. Tonsillar enlargement is usually present from the beginning.

If a case exhibiting these signs and symptoms is carefully examined it will be found that the heart’s impulse is displaced outside its normal position. This is the earliest sign of an enlargement of that organ. Now a rheumatic inflammation of the heart is quite different to any other inflammatory affection. It is possible to have an inflammation of the pericardium or membrane that surrounds the heart and equally possible to have an affection of the inside membrane or endocardium and these conditions are known respectively as pericarditis and endocarditis. Both may arise by themselves. A pericarditis alone or an endocarditis alone whatever else they may be, are certainly not rheumatic. The distinguishing characteristic of the rheumatic heart lies in the fact that the WHOLE heart is affected at once. The inflammation attacks the pericardium, the myocardium or muscle and the endocardium or lining. Dr. Carey Coombs has pointed out the reason for this. He says that the heart is affected from within. The toxin, whatever its nature, may be, is carried by the blood stream all through the body and produces changes in not only the muscle of the heart but in other muscles. This accounts for the pains scattered up and down the body the children complain of. The changes really consist of the formation in the fibrous connective tissue of the muscles and elsewhere of small hard nodules. These nodules are always formed in connection with a small blood vessel and are a manifestation of an inflammatory
reaction. They are found not only scattered throughout the heart muscle but along the edges of the valves.

One of the characteristic features of these nodules is that they never suppurate or form abscesses. This distinguishes the rheumatic inflammation of the heart from that affection known as malignant endocarditis where small portions of infective matter may be carried by the circulating blood and set up abscesses in various parts of the body.

Beginning then with this general enlargement of the heart, if the case does not receive adequate treatment a progressive increase in size follows. The muscle grows and in consequence the fibrous rings which surround the valves stretch. The valve cusps become infiltrated with nodules and no longer thoroughly close up the valve opening. There is a shrinkage of the curtain or cusp and the chamber of the heart concerned does not empty itself with each contraction. The condition is very much that of a pump with defective or leaking valves. More pumping has to be done to get the same result with a defective pump as would obtain with one in good order. The heart has to work harder and to do this the muscle gets bigger and bigger. If anything interferes with the nutrition of this much enlarged organ the muscle becomes flabby and gives rise to inefficient contractions. When this happens the condition of permanent heart disease is fully established and all the unfortunate victim has to look forward to is a life of varying periods of invalidism and incapacity with the almost certain prospect of an untimely death.

Associated with this condition in children is that curious nervous disturbance known as chorea or St. Vitus dance. It does not occur in its fully developed form in anything like every instance but the milder varieties are fairly common. Twitchings or tremors are always regarded as due to faulty nerve control. Trembling is one of the commonest signs of mental agitation. It is therefore easy to understand that the debilitated child who is the subject of rheumatism is more likely than not to manifest disturbances in other systems beside that concerned with the circulation of the blood.

Nearly all these children have enlarged tonsils. Whether the tonsils have anything to do with the causation of the condition is not yet thoroughly worked out. Many children have enlarged tonsils who never show the slightest signs of rheumatism. It is an open question whether the routine removal of all enlarged tonsils would have any effect in diminishing the incidence of the disease.
Opinions as to the causation of rheumatic heart disease in children are pretty sharply divided. Most authorities look to some infective organism and the general consensus of ideas is that it is some strain of streptococcus as yet undiscovered. Experimental inoculations have so far entirely failed to reproduce the disease in animals. The question is still "sub judice" and any theory that might be advanced in this connection would be largely conjectural.

Another school of observers are arriving at the conclusion that the disease may be due to some failure of adaption. These conclusions are strengthened by the findings of a Committee of investigation that was appointed by the British Medical Association. The report of this Committee was only issued a few months ago. Dr. Reginald Miller, a member of the Committee makes the following significant statements at the conclusion of his report. "The disease in England is essentially one of children of the artisan class, living in damp rooms, attending an elementary school and suffering from tonsillar sepsis." Conditions of great poverty, destitution, under feeding, over crowding and excessive dirtiness do not seem to have an influence specifically towards rheumatic infection. The key to the rheumatic problem would be in our hands if we knew why the disease in its definite forms is one of hospital as opposed to private practice. Why is the rheumatic scale always tipped against the children of the poor?

It will be seen from the above extract that this authority emphasises the fact that the disease specially affects children of the artisan class not the very poor and destitute. No known disease has such a curious class incidence. He points out later in his report that fully two thirds of the cases come from damp rooms and asks the pertinent question as to whether the slum dwellers are not protected by their overcrowding, largely living in one warm room used as a kitchen.

It has been long known that the disease is very rarely encountered in the schools attended by children of the richer classes. It is obvious that in such schools the pupils do not sit about in damp clothing. In the average elementary school attended by the children of the artisan class the facilities for drying clothing are usually quite inadequate. It will no doubt be agreed that from one cause or another the children belonging to the town dwelling artisan are more subject to prolonged "surface chilling" due to dampness than perhaps any other. The organ primarily affected is the skin. The heat of the body is regulated by this organ. One third of the entire blood supply of the
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body is capable of being contained in the skin capillaries. Not only is it a regulator of heat and an “adaptor” but it has most important excretory functions. Waste matters are largely got rid of by the skin. If the skin fails in its functions these waste products are retained within the body and act as poisons or toxins. A cold humid atmosphere inhibits perspiration. The skin remains cold and clammy. A cold dry atmosphere on the other hand stimulates metabolism and as the skin perspires the moisture evaporates. If the air is surcharged with moisture it cannot take up any more.

Children of the artisan class living in the country are not as a rule exposed to the same damp atmosphere as the town dweller. The air is clearer and purer and evaporation takes place more readily. The sun is not obscured by a pall of smoke and dirt.

Although as stated above the organ primarily affected is the skin, it has most important “repercussions.” Skin functions are largely under the control of certain ductless or endocrine glands. The particular ones concerned are the thyroid, supra-renals and pituitary. These glands are also deeply concerned with the oxidative functions of the body. If waste products are not being got rid of these glands must of necessity be adversely affected. Their oxidative functions will suffer. This further means the circulation of toxins in the blood. It is more than likely that the toxins responsible for inflammation of the fibrous and muscular tissues are produced in this way. Speaking generally this is the view taken by Llewellyn and those who consider the theory of causation by a specific micro-organism not proven.

Whatever the ultimate cause may be, this affection of the heart in young children is responsible for practically all the deaths from heart disease up to early middle life. After that period other factors come in such as syphilis and degenerative changes in the vascular system.

Anything that can be done to lessen the risk of rheumatic heart disease in children ipso facto lessens the incidence of heart disease later in life. The evil effects of rheumatic heart disease do not declare themselves at once. Following the initial attack the patient, if not adequately looked after, never quite regains strength. There follows a period of semi-invalidism a prominent feature of which is a gradually increasing shortness of breath and consequent disinclination for exertion. When the time comes for such an individual to take up some employment it is found that he or she can never remain
long at work. There are continual broken periods due to ill health. Eventually the day arrives when the patient definitely joins the ranks of the "cardiac cripples," from which relief can only be obtained in one way.

It is estimated that in The British Isles 30,000 people die every year from the effects of rheumatic disease contracted in childhood. The question naturally arises as to how this appalling wastage of life can be prevented. In this relation as in most others, preventive measures are by far of the greatest importance. Once gross changes have taken place in the structure of the heart there is very little likelihood of that organ entirely recovering its former healthy state. It is true that by careful selection of a suitable occupation much can be done towards prolonging life by the avoidance of undue strain. There are abundant instances of people living to a good old age with permanently damaged hearts. Such individuals cannot however afford to take risks and metaphorically speaking, the sword of Damocles is for ever hanging over their heads. As already pointed out the whole heart is enlarged when structural changes have taken place and so long as the cardiac muscle is well nourished it can do its work in spite of leaking valves. Again using the analogy of the pump with the leaking valves, so long as the pumper has sufficient strength to exert more than the usual force required to obtain the water all is well. If the pumper's strength fails the contrary is the result. This is exactly what happens in the case of the heart.

The treatment of the established condition does not come within the purview of this article, as an attempt even to outline it would far exceed spatial limits and would prove utterly unsatisfactory because a subject of such importance can only be adequately dealt with in a text book on medicine.

Turning now to preventive measures the first step towards their adequate provision is early recognition of the condition. It should be thoroughly realized by all who have the care of children that there is a "pre-rheumatic" stage in the disease. A great deal is heard of the "pre-tubercular-child" and the recognition of such children has done much to lessen the incidence of that dreadful disease. It is just as true that there is the "pre-cardiac" stage in rheumatic heart disease. Many observers have learned to distinguish a certain type of child who is specially prone to be affected. Such children are unstable bodily and mentally. They suffer from attacks of asthma, headaches and digestive disturbances together with other ailments of an obscure nature. They oftener than not have pale
waxy skins with red cheeks. They sweat profusely in patches while the rest of the skin may be unduly dry. Skin eruptions are by no means uncommon in these cases. Their mental instability is shown by twitchings in their muscles which may develop into St. Vitus Dance or chorea. This type of child always seems tired and unwilling to join in games. They are moreover irritable and difficult to manage.

It has been pointed out by Vincent Coates and Thomas that if children of this type be carefully examined, in many instances definite nodules can be detected under the skin in various regions of the body. Apart from the actual occurrence of these nodules complaints of muscular pains are very common.

Environmental conditions playing such an important role in the production of the disease it is perfectly obvious that its prevention lies in improving them. The quickest and most certain way of effecting an improvement is to remove the child to more suitable surroundings. The necessity for this is self evident when it is remembered that the disease very rarely affects children of richer parents who are able to maintain their offspring in a healthy environment. This entails the establishment of special schools situated amid hygienic surroundings where children of the type just indicated would derive all the benefit enjoyed by their more fortunate sisters and brothers. These schools should be placed in rural neighborhoods within easy reach of the large centres of population. Experience that has already been gained in connection with one or two such institutions that have been provided has shown that the open air life, abundance of fresh air, good wholesome food and plenty of sunshine materially raises the resistance of the little patients in that they are less prone to suffer from the ailments so prevalent among town dwelling children. It is hoped in the near future that a national scheme for the provision of these schools will be realized. Into the details of such a scheme it is unnecessary to go.

If measures can be adopted to deal with rheumatic heart disease in its undeveloped stage much will be done towards diminishing the continual flow of fresh cases. The success that has attended the concerted efforts to diminish the toll of human suffering due to tubercular disease is a direct encouragement to the adoption of similar methods toward further promoting the health of those who come after us.

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THE CARE OF CHRONIC CANCER PATIENTS IN MASSACHUSETTS

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As I think over the huge undertaking we are launched upon in trying to make a lasting impression upon the rapidly increasing death rate from cancer, there comes to my mind over and over again a little anecdote told by Dame Rachael Crowdy (when she was in this country last May) of a quiet little woman, who, in spite of enormous difficulties and utterly inadequate resources, had been doing a remarkable piece of work among the refugees in the Near East.

There was danger that the small appropriation which the League of Nations had been making to carry on this work was to be withdrawn. One of the committee members, after listening to the speaker, who was Miss Yippa of Denmark, said, "If the problem is so great, and what you can do amounts to so little, perhaps it is not worth while to do anything." To this the little lady replied, "Though our candle is small, the night is very dark." The appropriation was continued.

So I hope may we succeed in our problem of gaining control of the appalling cancer situation, by making use of all the light we have—every bit of it—until little by little more light is added through further studies in field and laboratory.

The brightest spot we can see at present is this: that certain forms of cancer in accessible regions of the body are curable with the use of modern facilities. An estimate of the extent to which this is true has just come to us from the Mohonk Conference, where it was stated that at least 30 per cent of all cases should be curable by modern methods. At present, our surgeons state that only 10 or 12 per cent are being cured. The same reason is given by all: 473
"We did not see the patient early enough." To shorten the time between the patient's discovery of his trouble and his first visit to the physician is therefore the first aim of our preventive program.

Whereas it seems that but little can be done in our present state of ignorance, it is helpful to recall the small beginnings in the Tuberculosis campaign. There was scarcely more knowledge of Tuberculosis available at that time early in this century than we now have of cancer. Yet the use of each bit of knowledge, as soon as it was known to be true knowledge, has led step by step to the greatest conquest of a disease which the world has ever known.

At any rate, the Legislature of 1926 became convinced that something could be done about the cancer situation in the State, and that something must be done. The Legislature has placed the responsibility for the doing of this something squarely on the shoulders of the Department of Public Health. (Chapter 391, Acts of 1926).

This Act calls for three forms of effort:

1. A State Hospital.
2. Diagnostic clinics.
3. Further study of the Problem.

We shall here concern ourselves with only one phase of this program, which according to our subject title is the "Care of Chronic Cancer Patients." As cancer is always a chronic disease, we might interpret this as meaning, "chronic care," so to speak, of the terminal case.

The cancer patient who through failure of our present-day methods to control his disease or failure on his part to take advantage of such knowledge as we have, has come to the stage where he needs regular skilled care through long, tedious months, when the best we can hope is that he be kept as comfortable and happy as may be under distressing and disheartening circumstances, is in a difficult position.

One of three procedures usually is open to him:

1. To remain at home.
2. To go to a local hospital or a nursing home.
3. To go to a hospital far from home.

Let us look for a moment at his needs as we see them in trying to help him make his choice.
1. He must have a light, airy, and reasonably quiet room, either to himself or providing ample space which he can have to himself.

2. He must have nourishing and well-cooked food, adapted to his digestive capacity and served at regular intervals.

3. He will need probably about four months of bed care, with all this involves in constant attendance, bathing, feeding, entertaining and condoling. His permanent attendant need not necessarily be a graduate nurse, but whoever he or she is, whether a member of the family or an employed attendant, she should always act under the instructions of both a physician and a skilled graduate nurse.

At times a degree of nursing skill, equal to that required in surgical nursing will be needed, in order that we may give such relief as we owe to these sufferers.

Where at present can our incurable cancer patients receive such care?

1. Some will find it in their own homes. It is to be hoped that it will always be true that most of these patients can be provided for in their own homes. At present about 70 per cent remain at home throughout their illness. Here they are happier, less lonely, and home is the only place where the sufferer can be made to feel that he is not being cast aside when most in need of help.

Such efforts as are made in our communities to relieve the cancer situation will, I trust, be made always with the home in view as the place of choice for the care of the terminal cancer patient. A way can often be found to keep the patient at home if all the facilities of a community are taken into account. First, foremost, and never-to-be-forgotten, whatever may be the financial resources of the patient, is the visiting nurse. I would not add to the duties of the individual nurse, but we must have more of her.

The expense of nursing service to the community in comparison with hospital care is not to be mentioned. Hospital care is by all means the most expensive solution of the problem. Moreover, the organization supporting health nursing can frequently increase its income sufficiently to cover the care of all needy patients, by the simple expedient of charging those who can pay the per visit cost of service.

2. Some will look to the local hospital or a nursing home. Every physician, nurse or social worker has had the experience, without doubt, of trying to place a chronic case in a general hospital. There is seldom difficulty in securing hospital accommodations for the
operative case, but few hospitals are ready to give the long time care needed for the terminal case of cancer.

The committee appointed by the Legislature last year to study the cancer problem, made a survey of the hospital facilities for handling cancer in 19 cities, (including the Metropolitan area as one city) and 16 towns, selected in such a way as to give an idea of the situation throughout the State. This study brought to light the fact that there is great need for additional beds in the cities, whereas in the rural communities, the demand is almost negligible. One reason for this is, undoubtedly, the lesser incidence of cancer found to exist in the smaller towns.

In three of the cities surveyed, they will care for a few. In one city, the hospital limits the stay to a six weeks’ period, while in one other city, the limit is two weeks. In ten of the cities surveyed, all the hospitals refused to admit terminal cases of cancer. In Boston and the Metropolitan area, five hospitals take late cases. In only three cities of the group surveyed do the hospitals freely admit cancer cases. The policy of the hospitals in the smaller towns (where the need, however, is less) is somewhat more liberal toward the cancer patient, as most of these hospitals admit cancer patients who have no other place to go.

Most communities have one or more of the nursing homes familiar to all. Usually a married nurse takes a few cases into her home, giving them nursing care. Some of these nurses will take cancer cases. The standard of care in these homes varies from the best to practically none at all, and the expense is usually heavy because of the long time during which care is needed.

3. The patient may seek one of the larger hospitals in a medical center. There are a few hospitals situated in the larger cities which accommodate incurables to a limited extent, but there is no approach to adequate provision at moderate cost for all needing long time care. Moreover, patients dread leaving home to go to a distant city and are often unwilling to accept hospital accommodations even when they are available. Some wise person has said, “Anyone will go to the ends of the earth to be cured, but we all want to die near home.”

4. An almshouse or the state infirmary represents to the average individual the last resort life offers, and this indeed it often proves to be for the cancer patient. It seems a sad pity and a reflection on our sense of community responsibility that persons who have all their lives been self-supporting, and self-respecting must in their
last illness, become public charges, because of a lack of hospital or home provision for their care. Furthermore, most of our local almshouses are quite unprepared to give the skilled nursing which is often needed by a cancer patient, not to mention the total lack of modern means for palliative treatment which are often of great benefit in the relief of suffering.

These appear to be about all the avenues of choice that are open to the average patient facing long months of illness from inoperable cancer.

There have been approximately 5,000 deaths from cancer annually in this state in recent years. The committee of last year estimated that about 30 per cent of these, or 1500 patients, will need hospitalization, usually for the last four months of life. At present, the average length of time during which hospital care is available is 1½ months. At this rate, by a process of mathematical reckoning, the conclusion has been reached that at least 340 additional beds are needed. It has recently been considered that this number is nearer 400. The greatest need appears to be among people in moderate circumstances who can pay from $7 to $12 a week.

1. The General Hospitals have been assuming each year more and more of the load of inoperable cancer, for the increase in the number of cancer admissions has been more rapid than the increase in the number of cancer deaths.

i.e.:—

In 1912, 20 per cent of cancer deaths occurred in hospitals, while in 1923, 26 per cent of cancer deaths occurred in hospitals, in spite of an increase in the total number of cases.

The cancer patient who knows or whose friends know that he will not recover is far happier in his own city among his friends. Many of the general hospitals could take a larger share of the load of terminal cancer cases than they are now doing.

2. The County Tuberculosis Hospitals. In one instance, the county tuberculosis hospital, under special authorization of the Legislature of 1926, has opened its doors to sufferers from chronic disease other than tuberculosis. This seems a satisfactory solution in one instance, and one wonders whether it may not prove to be a solution in other counties.

3. New Facilities in Boston:— The Palmer Memorial Hospital for the Incurable now under construction will furnish 75 beds for chronics all of which except about 10, will be reserved for terminal
cancer cases. The Holy Ghost Hospital is erecting an additional wing which will provide 100 beds for all types of chronic, incurable cases. No distinction will be made between cancer and other chronic cases.

4. A State Hospital, as provided for in the Legislative Act of 1926, is being fitted out at the present time. The Norfolk State Hospital (formerly used for alcoholics and drug addicts, and later used by the Federal Government as a psychopathic hospital) has been chosen as the best available place for the immediate purpose. This will provide 90 beds for all type of cancer. Policies with regard to charges and other matters have not yet been determined.

This covers to the extent of my knowledge the promise of the immediate future toward meeting the need for hospital care for terminal cases of cancer.

The Department of Public Health is recommending:

1. That physicians, social workers and nurses bend their efforts toward encouraging home care just as far as it is possible to bring it about.

2. To this end, we urge fuller recognition of the great value and of the comparative economy of the extension of the Visiting Nurse Service now available.

3. Again, we hope and trust that general hospitals will still further increase their provision for terminal cases of cancer, so that a patient who cannot be cared for in his home may at least receive care near home and friends.

4. The Commonwealth will stand ready within a few months to care for cancer cases of all types to the number of 90, at the Norfolk Hospital, whenever, and only whenever local provision cannot be made which will better meet the patient's need. It would be most unwise to send to this hospital patients already well cared for at a local hospital.

In closing, may I urge all social workers to look at this problem of cancer broadly, keeping in view always the preventive aspect. The patient now past real help, in whom we are interested and who has our unlimited sympathy might at some time have obtained permanent cure had he but known when and where to seek it. Every cancer starts as a local affair, and if it were so situated that it could be easily removed while thus localized, there was at that time a good chance for cure. This chance comes once and once only, at, or near,
the beginning of the disease. An opportunity lost at this time is lost never to return.

Let us not overlook the opinion of a large group of our best surgeons, that 70 per cent of the cancers in accessible localities are literally curable in the sense that they do not recur within five years. To mention a few of these which are amenable to early treatment—cancers of the skin, of the mouth or larynx, of the female breast, of the uterus, and of the rectum are all possible of early discovery and amenable to prompt and effectual treatment. Taken together these constitute about 60 per cent of all cancers.

One, at least, of our expert cancer men goes so far as to state that no cancer of the skin ought ever to be allowed to reach a stage in which it is not curable by thorough removal.

As a means by which the individual may find this golden opportunity and take advantage of it in time to prevent the development of hopeless cancer, no better way has yet been found than the annual health examination. Let us practice and preach the doctrine of health examinations in season and out of season until having a health examination becomes the thing to do, a fashion as inexorable as the unwritten law on the proper time for men to wear straw hats or on the prescribed length of skirts for women. Thus, and thus only, will the medical profession be in a position to make prompt use of the light which is constantly being thrown on the subject by modern research, while the patient will find in his own physician the friend in need who will be able to discover the slight indication of danger, before it can lead to serious trouble.
A BASIS FOR A BETTER UNDERSTANDING BETWEEN MEDICINE AND MEDICAL SOCIAL SERVICE

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The lack of understanding between the groups representing the medical profession and social service has existed for so long that it is almost proverbial, and is quite taken for granted by both groups. Such an attitude is most unfortunate from every point of view. These two groups are basically and fundamentally complementary in their inspiration and ideals and the efficiency of each is limited by any lack of understanding and sympathy. From time to time efforts have been made to secure a common basis for activity in certain lines of endeavor, but many of these efforts have been directed toward the solution of particular problems of medical social service such as financial eligibility for admission to a dispensary or for material aid. Often the lack of understanding has been very real, but in all probability, it has been considered of too great significance and importance, per se. To my mind this lack of ability to arrive at a common ground of understanding is but a symptom of a far deeper and more important lack of understanding. It corresponds to the fever of a disease and not the disease itself. To attempt to iron out these superficial disagreements without considering the difficulty of which they are symptoms is but to treat the fever alone, permitting the disease to develop all its sequela unchecked.

An individual's point of view on any subject involves many considerations of education, of training, of environment, of personal attributes and characteristics, of occupation, of habits of thought and so on indefinitely. One's particular point of view is a composite of all his experiences, subjective and objective and his reactions to them. Consequently we have all the multitude of ideas and reactions of various individuals toward every subject of our every day life.
one has any desire so to standardize people that the stimulation of varying points of view is lost. Individuality is the well-spring of progress in any field. But we cannot recognize this without at least implying our recognition of the broader fact that it is absolutely absurd to expect unanimity of opinion in any large group engaged in similar activities, that is, so far as the details of their work are concerned. It is then still more inconsistent with facts to expect that two groups such as medicine and social service should have identical points of view when practically all the elements entering into their points of view are so dissimilar. By that I mean that we cannot consistently expect a superficial accord in their attitudes since their points of view on the same idea are made up of such dissimilar elements.

But these very differences are an inspiring omen of ultimate concord indicating as they do the very elements of real cooperation, namely independent thinking, originality of ideas and individuality in expressing them.

Very many times in discussions of different phases of social work the knotty problem of the “doctor’s point of view” is brought up and almost invariably it is accompanied by a hopeless shrug of the shoulders. It has been accepted as one of the inevitable burdens that social service has had to bear and in spite of which it must do its work. But is it not rather inconsistent that while social service recognizes the necessity of carefully studying and evaluating all the elements that enter into any particular, difficult social case problem, it has made so little consistent effort to understand the “doctor’s point of view,” and to evaluate the factors that enter into its composition?

The “doctor’s point of view” appears to the average person as the very conservative, almost reactionary attitude that is unwilling to accept anything new or progressive or out of the ordinary. The profession is slow to put its stamp of approval on new ideas of medicine and in the popular mind this is often interpreted as a selfish antagonism for personal or financial reasons, toward all newly conceived cults or isms or ideas. Its questioning attitude toward social organizations is accepted as further evidence of the profession’s reactionary and narrow comprehension of social questions. I believe that it is the passive acceptance of this idea that has led social service to consider the doctor’s point of view in the same light as death and taxes.

The “doctor’s point of view,” conservative as it is, has its roots deep down in several great sources of inspiration. The profession’s great age has taught it many things. The profession of medicine is
greatly influenced by a practical understanding of the philosophy of history and much of its real, solid conservatism can be traced to this influence. Then there is the broad scientific attitude of mind that determines the real progress of the profession and this latter has a very pertinent interest to every social worker who is conscientiously interested in the development of medical social service.

What is this scientific point of view? Certainly no one would have the temerity to hazard a definition, for one can hardly define an attitude of mind, particularly if he himself has the habit of accurate scientific thought. For even though he may present many factors that enter into the formation of this attitude of mind, he cannot be certain that all the factors have been presented, that those presented have been properly evaluated or, granting the accuracy of these steps, that the conclusions reached have been consistent with available facts. In other words, the scientific point of view is never arbitrary, and never dogmatic. It may present a belief, but at the same time it presents the evidence upon which that belief is founded so that everyone has the opportunity to pass his own critical judgment upon that evidence and may arrive at his own conclusions. The scientific mind searches out all facts available bearing even remotely upon its subject and devises means of securing further facts, recognizing all the time that at any moment further information may be secured that will prove only that everything that has gone before was wrong. Such has been the actual experience of many observers. The very multiplicity of such experiences in the centuries of the development of the medical art has led the scientific minds of the profession to demand sound basic principles, logical thinking, clear logical presentation of facts, most carefully controlled conditions of observations, demonstrated results and results repeatedly demonstrated before they will even tentatively accept any contributions to medical science. Long experience has taught that only by adhering to such rigid standards can medicine safely add to its knowledge in combating disease in the individual. Koch's Laws, for example, are a clear-cut presentation of this requirement. They deal with the establishment of a causal relationship between any given bacteria and disease. First, the bacteria must be present in all cases of the disease and must be isolated from cases that present the clinical picture of the disease. Second, the organisms so isolated must have a certain consistency in their reactions in culture and, third, these organisms must be able to reproduce the original disease, and, fourth, they must be isolated from the disease so reproduced. How many
apparently worthy investigations in bacteriology have never seen the light of publicity because they could not satisfy the requirements of these laws, will never be known. But our definite knowledge of tuberculosis, pneumonia, typhoid, scarlet fever, diphtheria, and many other diseases owes much to the rigid enforcement of such standards.

But even though many investigations pass the difficulties of these preliminary requirements, the observations and experiments must be of such a nature of accuracy and so carefully reported that they can be repeated by other observers and similar results obtained. There may have been some slip in technique, or some error in observation or interpretation that, when corrected, would make the whole investigation worthless. Such has happened repeatedly to investigations and studies that apparently had all the ear marks of accuracy and authenticity. Of course, this duplication and re-duplication is time consuming and most discouraging. If the scientific observer were not possessed of infinite patience and faith the contributions to medical science would be very few, since sudden epoch-making discoveries in medicine are exceedingly rare. Usually such great contributions are based on information and data provided by countless workers and observers whose individual contributions were not of themselves of enough apparent importance to attract more than passing interest.

The wonderful work in yellow fever illustrates this point most beautifully. In the early days of its study it seemed proven adequately that yellow fever was a disease of filth. It was endemic in areas where the sanitary conditions were most unsatisfactory. Then, too, while it was prevalent in some northern cities it disappeared when the sanitary conscience of these cities was aroused and the cities were cleaned up. This was particularly true in Baltimore and Philadelphia. Apparently the cleaning up of the cities, eradicating filth, indicated a relation of cause and effect. In 1898 General Gorgas went to Havana, then in the grip of an epidemic, and on the filth theory cleaned up the city until it was a veritable Spotless Town. The result was most disappointing. While the general death rate declined, the deaths from yellow fever greatly increased. Also the mortality from yellow fever among the natives living in the more unhygienic quarters did not increase while the mortality among the better classes, living under the best hygienic conditions, increased by leaps and bounds. Surely the filth theory was untenable and this fact was frankly recognized.

But it is interesting to note that as early as 1881 a Cuban doctor
named Finlay had convinced himself that yellow fever was transmitted by the stegomia mosquito, basing his idea on certain observed coincidences. He noted that the disease flourished at temperatures and elevations that were best adapted to the mosquito. He noted also that mosquitoes were always abundant during an epidemic. However, he was unsuccessful in reproducing the disease in himself by permitting mosquitoes to bite first a yellow fever patient and then himself. He repeated this many times, always unsuccessfully, apparently discrediting his own theory. His failures, however, did not deter him from continuing his observations.

In 1900 a commission was sent to Havana to study the disease. Men destined to stand high among the benefactors of mankind; Walter Reed, James Carrol, Jesse W. Lazear and Aristides Agramonte. First, they attacked the filth theory of the causation of the disease and for weeks they and heroic volunteers from the army were in intimate contact with the excreta of patients dying of yellow fever, even sleeping in beds stained with the horrible “black vomit” that is so frequently the sign of impending and inevitable death. No one contracted the disease so long as mosquitoes were kept away. Then they secured stegomia mosquitoes from the mosquito menagerie of Dr. Finlay and allowed themselves to be bitten by mosquitoes that had previously bitten infected patients. Still no one was infected with the disease for some time. They persisted and finally it was proven by experiment that the mosquito must bite a patient during the first three days of his illness in order that the mosquito may become a carrier of the disease and that there is an incubation period of three days in the body of the mosquito before it can transmit the disease to man. In the course of the investigation Lazear permitted a mosquito of known infection to bite his hand. He was fatally infected and died.

Once having established the mosquito as the carrier of the disease, they studied the life habits of the stegomia until they had the most detailed knowledge of all her habits and characteristics. This pains-taking study of “gnats,” as they were called in ridicule, certainly had little of the heroic about it, but it illustrates the infinite capacity for detail and appreciation that is so characteristic of the true scientific point of view. The fact that it proved of such tremendous value to mankind is beside the point, for the work was done in the absence of assurance that it would prove to be so.

But this may appear to be going rather far afield from the subject
under discussion. It is really quite germane, however, since it illus-
trates in part the way the scientific point of view works in the case of
medical problems. This habit of thought requires the very highest
quality of clear thinking, of courage, of reasoning, of observation and
interpretation. It requires these things of itself unceasingly and un-
relentingly.

With this attitude of mind as the background against which the
medical profession has developed for the centuries of its existence, is
it not clear why the profession as a whole is slow to accept, without
reservation, ideas that have never been measured against the stand-
ards of the scientific point of view, at least so far as possible? I do
not believe that the profession should be criticized for making the
standards and requirements too high. Rather hospital social service
must recognize that in order to insure its permanency it must be able to
thrive on just such critical inspection and criticism.

Then let us ask ourselves some frank, straight questions. First,
what is social service? There are various rather distinct general con-
ceptions as to the nature of social service. Unfortunately, the popular
conception often places too great emphasis upon the emotional and
sympathetic side of the work, corresponding to "the cool hand on the
fevered brow" idea of nursing. Many have the idea that morbid
curiosity prompts the social worker's inquiry into the intimate details
of family life.

Of course, such conceptions are wrong, but the fact remains that
they do exist. Those of us who have had the opportunity of close
contact with social service have seen aid given intelligently and
thoughtfully, and have seen the growth of self-respect and self-
reliance under the tactful suggestions of the social worker and have
seen economic derelicts transformed into relatively valuable members
of society. But the doctors who have had the opportunity for close
association and observation are relatively few, and while this small
group may in time "leaven the whole loaf," as to the real value of
social service, still a complete dependence upon this influence will
postpone indefinitely the consummation of a happy understanding be-
tween medicine and social service.

The need of such a mutual understanding is recognized, I believe,
by both the profession of medicine and by social workers. Attempts
have been made from time to time to bring it about, but many difficul-
ties have intervened. Primary among these is the lack of definiteness
in the statements of principles and policies of medical social service.
Generalities have been made to take the place of clearly thought out or at least, clearly and definitely stated concepts. The scientifically trained mind cannot well arrive at even a preliminary judgment in the absence of a definite and probable premise clearly stated and logically presented. Such is required of itself in every instance. This sort of premise is not, I believe, available and it surely is one of the first tasks of social service to correlate its thinking so as to formulate its basic principles.

Further, I believe the tendency to pre-suppose a knowledge of social service and its underlying ideals and concepts on the part of the medical group is a very fruitful source of misunderstanding. It is true that medicine is social in its ultimate analysis, but the assumption that a knowledge of the art of medicine connotes a similar knowledge of all other phases of social activities is hardly warranted. Though it can well be assumed that every doctor has a well grounded training in the basic subjects of medicine, nevertheless, in the majority of articles on medical subjects considerable space is given over to a review not only of the literature on the subjects, but also to a review of the salient points of anatomy or bacteriology or pathology involved in the discussion. This is but a form of defining the premise from which the discussion starts but it is a very essential part of the scientific presentation of any subject to a group of men and women trained in the critical point of view.

The willingness to present for criticism, not only the end results or conclusions, but also the various successive steps leading from premise to conclusion, is another of the distinguishing characteristics of any profession, notably the medical profession. Facts must stand on their own intrinsic merit and must seek favor or indulgence from no one. The more searching and penetrating the criticism the greater its value, for no fact is sound that cannot stand the most rigid scrutiny and investigation. If an idea cannot stand this sort of criticism it is abandoned at once, possibly to be presented again with further supporting evidence, but not until the new evidence has itself been most carefully criticised. If social service expects to work in close cooperation with the medical profession and have its principles and aid accepted as part of the armamentarium of the medical group, it must be prepared to subject all its principles and ideals and policies to such a type of criticism. It must in fact welcome and court such inspection, not as a concession to the medical group but simply because ideals and
principle that can survive such criticism are the only materials from which a profession can be built.

But even in the absence of clearly stated premises, medical social service has gone forward and reached out to include many and varied activities. To the scientific point of view such a policy of expansion without the most detailed consolidation of occupied territory is little more than inexcusable lack of clear thinking. Understand, I do not say that medical social service has not thought clearly, but rather that the absence of clear statement of the steps involved and the conclusions reached, gives that appearance to anyone not intimately associated with medical social service. I have tried to show how rigid are the demands for logical thinking and clear statement that the scientific point of view insists upon in its own group. How then can we expect the medical profession to accept with open arms an idea that is by its own statement near medical, when that idea has apparently made so little effort to meet the minimum requirements that the profession demands of itself.

Medical social service is a highly specialized form of social work, implying on one hand the ability to understand medical questions of prognosis with an understanding of non-medical social work on the other hand. Its main function then is interpretive—interpreting social service and home conditions to the doctor, the doctor to the patient, the hospital to the community, other agencies to the hospital, etc. Its field is the border zone between medicine and non-medical social organizations. Its net result must be the better medical care of the individual and his better relationship to his life within the limitations imposed by his physical condition.

If this function as interpreter between the two groups touching the border zone is accepted, logically then, medical social service must realize that it cannot hope adequately to cope with its problems without the counsel and aid of these other two major groups. I realize that at first thought, it might be feared that in such a procedure, prejudice would be encountered. But it certainly is true that such a fear must have its roots in a feeling of doubt as to the justification of the idea to be presented. Any idea that is sound will grasp at any prejudice or criticism as an opportunity for the logical presentation of the facts on which its ideals and principles are based.

In all group discussions medical social service as the interpreter must show how the points of view of all the interested groups fuse together to make a resultant idea that is consistent with the facts in
hand and must demonstrate how medical social service can bring a trained intelligence to bear on certain phases of the problem. Of course, this function of interpreter is made more difficult by the very diversity of the points of view of the two groups with which medical social service must work. On the one hand is a group trained in the scientific appraisal of things as they are with impressionism playing a small part. On the other hand is a group less adequately trained in this scientific appraisal.

Still the problem of medical social service is somewhat ameliorated by the opportunity the workers have for daily contact with the scientific point of view. That is not as presumptuous as it may sound for is it not true that the education of the doctor is one of the expressed purposes of medical social service? Furthermore, does not the true social worker make great effort to gain an insight into the workings of the minds of the people she is trying to help? I believe that the process of education may conceivably work both ways. Just bear in mind that a manifestation of the scientific point of view is not a protective reaction of the individual doctors you may meet. They do not think that way because they are doctors but rather they devote their time to the study of medicine because the scientific method of thought appealed most to their minds. They are expressing only the general point of view that the experience of the ages has proven to be sound. I believe that medical social service must recognize and accept the scientific habit of thought not because it must make concessions to the medical profession, but because it is a sound workable basis for future activity. I do not believe that medical social workers should study medicine but I do believe that they should make themselves reasonably familiar with the mechanics and standards of scientific reasoning and how the scientific mind works. This will produce, not only a greater insight into the habits of thought of one of the greater groups with which they work, but it will give also a method of approach that will prove of very great value in the solution of their own problems.

That is briefly the impressions of one doctor regarding some phases of medical social service. My premise, my development and my conclusions may, of course, be wrong in presentation, evaluation or interpretation, but the very criticism of this paper may be productive of some good if it be logical and clearly stated. Perhaps then I will have made my point.
I have no idea of the population of this world we live in, but I truly believe that at least sixty per cent will, if requested, gladly undertake to advise and maybe treat you, if in an unguarded moment, you request their aid upon matters dermatological.

A Dermatologist is a well trained physician, who has augmented his general knowledge of Medicine, by becoming conversant with the diagnosis and treatment of diseases of the Cutaneous system. Hence, it is no anodyne nowadays to gaze at the windows of our skyscrapers, and to note the number of folks who believe or appear to believe they are qualified to treat skin diseases. I refer, of course, to the so-called "beauty parlours."

Quite recently a very foolhardy gentleman, resident in London, stated, never fearing for his life, that only one woman in five hundred was beautiful. He professed to be conversant with the matter of feminine pulchritude from a professional standpoint. If, then, beauty is so rare in London, shattering as it does an old time illusion, one wonders is it as rare in this fair country too! Must I, before I see a beautiful woman, pass by five hundred of her sisters? Someone else must solve this problem, but assuming that it is correct, then we see the reason for the existence of so many flourishing beauty parlours. But are they successful in their efforts to beautify women? Apparently they are an abject failure, if we must take the word of one man. At the present day, it is hardly to be wondered that the perpetual shoving, rushing, overeating and injudicious eating are stamping on the faces of our lovely young girls the indelible mark of ill health. Ill health is never lovely. Therefore, I believe that the beauty parlours are not accomplishling their purpose. What is needed is medical advice, or rather more medical propaganda either through the medium of the newspaper or by the radio. "Hygeia" a publica-
tation of the American Medical Association, is the type of magazine which should be in every home. It gives invaluable advice on every known medical subject. I do not wish to be unfair to all beauty parlours, for some not only fulfil a need but are especially unwilling to assume the knowledge of a dermatologist.

When we come right down to bedrock and find out the type of individual seeking a Utopian complexion, we will note, in most cases, that she belongs to that great group who look upon bodily exercise as anathema. Or, to be perfectly frank, she is confoundedly lazy. Dean Inge recently noted that the art of walking was becoming lost. So, too, I insist, are complexions. If you sit all day, revel half the night, get insufficient sleep, eat without judgment, smoke incessantly, and grow violently hysterical if your living quarters are not overheated, then Ladies of this Era, you are going to the funeral of your lost beauty, at an early date. Endless visits to beauty parlours, unceasing massage, face-lifting, etc., are going to help you in no way whatsoever.

From what I have just said, it is easy to prophesy what I will now say. If you would possess a clear unblemished skin, keep regular hours; be never afraid to walk; avoid unsuitable foods and never overheat your homes. Constipation is a stiletto in the health of many people. It should be remedied by consulting a physician. Constipation may be due to general gastro-intestinal atony, or it may be caused by some grave but easily rectified bodily derangement.

It would be interesting to discover how many technicians in the beauty parlours, know the anatomy of the skin. Can they give a physiological reason for the pathological conditions they often undertake to treat? Are they able to enunciate a proper diet for Acne Vulgaris? Do they know the drugs used in the ointments and creams they recommend, and do they know their pharmacopeial action? Could they distinguish between the eruption of Syphilis in its secondary stage and that of papular acne? If they cannot and do not recognize syphilis, then it is quite possible to both acquire it themselves and bequeath it to others. Quite recently a young lady consulted me for an eruption on her feet. It was of a syphilitic nature to her astonishment and dismay. Whilst in its secondary stage she had visited beauty parlours for the treatment of falling hair and "pimples" on her face. Of course, these were syphilitic. I wonder how many were infected in that beauty parlour. The trained eye of a physician will recognize the disease. The world at large calls it
“two much acid in the blood” or something equally futile. Therefore, if you have an eruption of any nature on your skin, visit your family physician. If it baffles him he will refer you to a specialist. Too often these skin diseases are treated by one’s neighbors or friends or the neighborhood druggist. Remember that syphilis tends to disappear temporarily only to fulminate in the late and dreaded stages.

The cold cream craze is a fairly insane idea that soap and water are injurious to the skin. There is no conceivable valid reason why the normal skin should not be properly washed, nay even scrubbed. I believe the face should be washed twice daily using considerable vigor and a mild superfatted soap. The water should be very hot. If there is a tendency to blackheads, enlarged pores, oiliness of skin, or Acne Vulgaris, it is my habit to recommend Bon Ami soap, even if it is marketable for purely utilitarian and domestic purposes. It is very efficient and easily tolerated by most skins. At least five minutes should be spent in this wise, followed by lavage in cold water. The face is vigorously dried, and then, if it is desired, a cold cream may be applied. This technique causes an engorgement of the underlying blood vessels, glands, and muscles, with a consequent abolition of effete matter, and a reinvigoration of all layers of the skin.

As a rule, men do not use cold creams for cleansing their skin. As a matter of fact, most men shave daily using soap and hot water. For all this and because of this, the complexion of the average man is superior to that of the average woman.

Without any doubt, there is a certain restfulness about the average hairdressing parlour. One visits that most democratic of public institutions, primarily to not only have one’s hair made rationally short, but also to gleam the latest news of the gridiron, track or automobile industry. As long as the hairdresser confines himself to his trade, and as long as his sanctum sanctorum does not develop into a clinic, so long indeed is he serving a useful purpose. If he could only, by some as yet unknown method, make beautiful the present day hirsutial atrocities of women, he would be accomplishing a great and noble deed. But, I have seen and heard, in barber shops, a vast number of ways for the cure of every possible disease of the face and scalp. Mud-packs, clay-packs, vibratory massage, oil shampoos are all extolled as being unique in the treatment of such diseases as Acne Vulgaris, Seborrhea capitis and Alopecia Areata. Equipped
with modern instruments and well versed in the etiology and pathology of skin diseases yet we Dermatologists are never so blatantly confident as some hairdressers I have seen. The moral here then, is to beware of the barber who would have you trust yourself to his tender mercies. Beware of his styptic pencil for it might have been used on a syphilitic. Enjoy the restfulness of the barber shop, its soapy atmosphere of steamy cleanliness, and listen to the prophets that congregate therein. But be not so gullible as to consider your hairdresser knows anything more about hair than how to cut it properly. Never fail to insist on his personal cleanliness.

There are very few people who will bring a watch in disrepair to a plumber. But let them suffer the slightest twinge of bodily disrepair and be sure of this, they will, in fifty per cent of cases, seek the aid of the local druggist. Undoubtedly, a druggist can, or rather should be able to dispense well, despite the modern tendency to prostitute his shop with the soda fountain. But he is in no way fitted to undertake the duties and responsibilities of a physician. Nevertheless, these worthy souls will rarely hesitate to diagnose your ailment and then treat it. A cough means a cold, never pneumonia. Diarrhea calls for bismuth although it may be typhoid fever. A sore throat receives a gargle when it might need diphtheria antitoxin. Eczema, Acne Vulgaris, Scabies, Syphilis, Pruritis, Furunculosis will all be treated with the utmost confidence with the latest fad on the market. Of course, this is more than criminal. It is also to some extent, amusing. I like to hear the young drug clerk, fresh from High School and secure in his citadel of Importance, expound Medicine as it was expounded in the dark ages. Certain members of the community express horror at the mention of whisky, but they would be doubly horrified at the malpractice carried on by some druggists.

Quite recently a very brilliant German scientist, Professor Conrad Roëntgen, discovered the X-rays. As time passed we have discovered the value of these rays in the treatment of certain skin diseases. We also realize their obnoxiousness in certain others. To wit, we in no hesitant manner, wholeheartedly condemn their use for the removal of superfluous hairs. As if to “strafe” us, sundry quacks have come into existence proclaiming that the X-rays will eradicate superfluous hairs. The distinguished French dermatologist, Sabouraud placed upon a firm footing the technique of depilation of the scalp in Ringworm. Most emphatically, whilst advised for this disease, it is contra-indicated in the treatment of superfluous hairs of the face, lest
atrophy and telangiectases follow at a more or less distant date. The practice is not only unethical, but also dangerous. Beware then, of the flamboyant advertisements that appear in the magazines, proclaiming that X-ray will remove hair harmlessly. It will not!!

That part of the body most frequently sought for dermatological advice is the face. Therefore, I believe brief mention should be made of the commoner skin diseases of that locality.

Every case of Acne Vulgaris demands a thorough physical examination, because it is quite possible to do our utmost for the patient and fail miserably if there is a co-existent and active focus of infection in some part of the body. Undoubtedly the X-rays are the best external method of treatment. Such therapy demands the care and watchfulness possessed only by one skilled in X-ray work, either the Dermatologist or Roentgenologist. If the patient is careful to follow the dietetic and hygienic instructions of the physician, and receives about twelve to fifteen fractional X-ray doses, the disease will disappear or be greatly improved.

The only correct way to remove superfluous hairs is with the electric needle. Quite frequently patients desire the removal of a very vigorous growth on the upper lip. This also can be done, but it is a moot question if the result is worth while. There is a possibility that so many tiny scars will be undesirable. Removal of the longest and blackest hairs, and the application of hydrogen peroxide to those that remain is wise conservation.

Pigmented naevi (moles) can be efficiently removed by the electric needle or monopolar endothermy. Black naevi are potentially dangerous, and if removed at all, should be dealt with by endothermy following the technique of Dr. George A. Wyeth, i. e., circular desiccation to seal the lymphatics followed by monopolar desiccation of the growth. No one but a physician should interfere with a skin tumor. We are confronted by "electric needle specialists" at every street corner. They are a source of danger because their knowledge of medicine is nil. Why the average sane individual will permit these charlatans to tinker with these potentially dangerous growths, is a mystery. Certain it is, he would think twice before consulting such individuals, if the potentially cancerous nature of these growths were known to him.

If the ordinary port wine stain—Naevus Flammeus—is capable of being blanched by pressure, without doubt considerable improvement and possibly cure will result from the application of the Kro-
mayer Lamp. In any case, treatment does good, no matter how great the infiltration. Patience and time are necessary to secure good results.

The red nose, although historically famous, is without doubt infamous to its possessor, and a source of intense chagrin. If the redness is due to fairly large dilated blood vessels, their removal is possible with the electric needle. If the redness, however, is due to excessive overgrowth of the tiny capillaries, their obliteration by scarification is the method of choice. The scarifier is a small instrument possessing a series of parallel blades. The affected area is criss-crossed so that the cuts present a chess-board appearance. There is profuse bleeding. The operation is repeated until the final result is satisfactory.

One of the most inane things a middle aged lady can say is “Doctor I am getting old, so why should I bother about my complexion?” To those of my middle aged readers, who may possess chronic brown scaly patches, I would suggest the advisability of seeing a dermatologist. Radium will readily cure these keratoses. At times, I am requested to see a slowly advancing, intractable, usually painless growth, which may or may not ulcerate. These small tumors are called basal cell Epitheliomas, and are amenable to treatment by radium, X-ray, or diathermy. They are cancerous and although of slow growth, have great mutilating possibilities, especially when near the eye, nose or ear.

Undoubtedly at the present time, when the feminine element of the community, both young and old, prefers bobbed and shingled ease to the grace and beauty inseparable from long hair, the question of attention to the scalp merits a passing word. There is so much soot, soft coal and dust in the atmosphere of big cities that it is essential for the sake of cleanliness to wash the hair once a week. This should not be irksome when it is fashionable to cut the hair short. But “water waves” being expensive, the scalp rather than the purse necessarily suffers. Washing will not cause the hair to fall out or deprive it of its natural oil. Washing stimulates the vascular supply of the hair roots, as well as the sweat and sebaceous glands of the skin. Moreover, it will certainly cleanse the scalp. If the scalp is dry, apply a suitable lotion once daily. The lotion may be and generally is alcoholic with a sufficiency of oil to counteract any dryness present. But, if the scalp is very oily—Steatorrhoea—the lotion, also alcoholic, should contain very little oil. The best therapeutic effects are ob-
The lotion is gently massaged into the scalp, spending time over the operation. The dermatologist muses rarely on water waves or permanent waves. But it is well to remember that excessive heat will damage the hair.

Along with the present day mania for speed, there exists an equally vicious form of mental derangement; namely, indiscriminate, unguided, self dosage with patent medicines. If a man needs medicine he also needs medical advice. If he takes medicine without advice, he is as wise as a navigator on the high seas without a compass. We are forever confronted with strange eruptions due to drugs. Certain pills, “blood tonics,” and “nerve restorers” are potentially very harmful. Aspirin, quinine, bromides, acetanilid et al nauseum are all able to undermine the health and cause serious and permanent bodily damage. Danger even lurks in the soda fountain. There is a type of reveller, who having spent the previous night in a more or less tempestuous manner, seeks to calm matters by a “bracer.” “Bracers” are obtainable at a soda fountain. They are really effervescent sedatives, and are harmless as a rule. But a habit is easily formed and there are many addicts to this type of drug. A certain nerve sedative obtainable at nearly all soda fountains contains:

<table>
<thead>
<tr>
<th>Ingredient</th>
<th>Weight</th>
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<tbody>
<tr>
<td>Potassium Bromide</td>
<td>7 grains</td>
</tr>
<tr>
<td>Acetanilid</td>
<td>3.6 grains</td>
</tr>
<tr>
<td>Caffein</td>
<td>0.8 grains</td>
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A teaspoonful, therefore, contains seven grains of Potassium Bromide, three grains of Acetanilid and 0.8 grains of Caffein. In other words, the maximum pharmacopoeial dose of a dangerous heart depressant is placed in the hands of a more or less irresponsible drug clerk. Naturally trouble does occur. Curious eruptions and vague cases of heart disease have been reported.

It would be wise, therefore, to condemn the present day curse of taking patent medicines unnecessarily. If they must be taken, the physician should direct their use.

At the present time, in addition to the atrocities of jazz and the inane mannerisms and hopeless witticisms of certain radio announcers, we have another aerial parasite, who will insinuate his inerudite remarks between good programmes. In this way, he is sure to catch
his man. This particular nuisance offers to the listening millions a new way to cure rheumatism, the latest fad for baldness, something unique for the complexion or the latest thriller in the cold cream market. Without proper supervision, we will, undoubtedly, be deluged with a great deal more of this boresome advertising. If the public need medical advice by radio, which I greatly doubt, then the best men in their chosen specialities should be requested to deliver suitable lectures.

In conclusion I would impress upon the nursing profession and the social workers of this country, the necessity for regarding skin diseases with due seriousness. The skin, by virtue of its protective function, should be treated as skillfully as the other organs of the body. A dermatological derangement mirrors a pathological focus somewhere. A skilful physician, and in particular the specialist in cutaneous diseases, can usually discover the cause and outline correct and sane treatment.

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REFERENCES


MEDICAL SOCIAL SERVICE AND OUTSIDE AGENCIES*

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The Medical Social Service Department has ready access to the sources of information, personal and written, regarding the medical condition of any patient, and by virtue of the training of its staff in social case work, is in a position to understand the point of view and needs of the social welfare agency which brings its clients to the hospital or clinic. It thus appears logical for the social service department to act as the intermediary and interpreter between the medical case work of the physician and the social case work of the family welfare worker.

In several other cities this integrating and intermediary function of the social service department has been effected on an extensive scale. For example, in Cleveland this function, formally recognized by the leading hospitals, has gradually brought about well-established and successful working relations between the social welfare agencies and the medical institutions. Clients referred by the agencies come in the first instance to the hospital or the clinic via the social service department, which undertakes the responsibility of finding out the nature of the problem for which the agency seeks help, of interpreting this problem to the physician, and of transmitting to the agency the medical findings and recommendations. In Boston, St. Louis, Indianapolis, and Chicago, similar well worked-out examples of such relationships are found, though not on so large a scale.

In New York City, the great number of organizations, both medi-

*This is a second report on the situation outlined under the same heading in this Journal for April, 1924. It is an elaboration of the seventh chapter of a monograph by Doctor Bryant entitled, "Better Doctoring—Less Dependency," published by the Committee on Dispensary Development of the United Hospital Fund of New York, 151 Fifth Avenue.
Outside Agencies

cal and lay, and the complexity and variety of their functions, render
the establishment of similar relationships far more difficult. In Bos­
ton and Cleveland, for instance, eight or ten persons could represent
all the leading institutions on both medical and lay sides, making a
responsible representative group sufficiently small for intimate and
effective cooperative planning and current adjustment of difficulties.
In New York City, from three to five times the number of persons
would be required to constitute a similarly representative group, and
a gathering of this size is impractical for such purposes. The or­
ganization of the Welfare Council now promises what New York as
a city has never had—a functional group so set up as to render
possible joint conference bodies of workable size, and yet of a suf­

To determine the extent to which social agencies were availing
themselves of the services of hospitals and clinics, and how the co­
ordination of their activities was effected, an inquiry was addressed
in June, 1923, to seventy-six social service departments in the city.
Of these, fifty-one answered in full. In general it appeared that the
medical social service departments were assuming considerable re­
sponsibility for clients of non-medical agencies, and that while the
problems these present were commonly recognized and met in various
ways, there was no consistent policy affecting the practice in different
places, or with all agencies. Difficulties and differences of opinion
existed about such matters as the desirable character and extent of
reports, and the relative responsibility of the two groups for carrying
out plans and for meeting expenses. The full report was published in
this journal in April, 1924.

Following the presentation of the report of this survey of condi­
tions in New York, the Executive Committee of the Hospital Social
Service Section of the Associated Out-Patient Clinics called a con­
ference between the social service departments of various hospitals
and clinics in the city and certain large social agencies doing work on
a case basis. The medical institutions, selected by location and type,
and also because of special interest known to exist in the social
service department or in the general administration, were as follows:
Hospital for Ruptured and Crippled, Lebanon Hospital, Mt. Sinai
Hospital, New York Dispensary, New York Eye and Ear Infirmary,
New York Hospital, New York Nursery and Child's Hospital, St.
Luke's Hospital. Later four other hospitals joined the group: Sloan
Hospital for Women, Presbyterian Hospital, New York Infirmary
for Women and Children, and the Brooklyn Hospital, making twelve in all.

Five large family welfare agencies were included, the Association for Improving the Condition of the Poor, Charity Organization Society, Jewish Social Service Association, the Brooklyn Bureau of Charities, Catholic Charities; and two others, the Henry Street Nursing Service, and the Association for the Aid of Crippled Children.

The Conference, after considering the report of the survey just outlined, discussed the feasibility of a cooperative experiment in case treatment along lines already successfully applied in New York and elsewhere. From this it was hoped to learn: first, how social agencies can best secure medical service for their clients; second, how medical institutions can insure the best results of their treatment for patients requiring material relief or more intensive social treatment than can be supplied within the hospital or clinic; third, how both these ends can be accomplished without undue strain upon the resources or facilities of either group, and what mechanical factors can best be utilized to this end.

The accepted conditions during the term of the experiment were as follows:

a. All clients of the cooperating agencies sent to clinics for examination and treatment, on whom reports were requested, were to be referred through the social service department.

b. In each case a written statement was to be furnished by the case-working agency outlining the problem for which medical help was needed and giving pertinent social information.

c. After examination of the patient a written report interpreting the findings of the physician and outlining a plan for future treatment was to be furnished to the case-working agency by the social service department, providing that the consent of the patient had been secured when necessary.

d. When the social service departments sought material relief for patients, they were likewise to furnish a written statement to the relief agency giving the facts on which they based their requests.

e. Forms for these reciprocal reports were decided upon after considering the experience of other organizations in similar cooperative ventures.

f. Financial questions were to be decided upon a basis of mutual agreement; as, for example: the social agency to be the one to decide whether its client was able to pay any or all costs of dispensary service. If he was not, the dispensary was to provide for this service without charge, to the same extent as it would for any other patient. The agency, on its part, to give emergency relief in medical-social cases on the request of the social service departments, accepting their word for the need.

During the term of the experiment the social service departments
were to register all cases referred to them with the Social Service Exchange.

h. This plan was understood not to cover general examinations of whole families as a matter of routine; that is, the so-called "health examinations."

i. A joint committee of not more than five persons was to be responsible for deciding such problems in management and disposition of cases as might arise, including two representatives of the non-medical agencies, two of medical-social service, and one representing neither, but rather the general social service interests of the community.

During the year and a half from its first meeting in November, 1923, to its latest in April, 1925, the Conference met eight times, being well attended. In addition, there were six meetings of the joint committee, originally called the "arbitration" committee, as it was expected that cases would arise requiring discussion and adjustment by a small and impartial body. As no such need arose, the committee really acted as an executive committee for the Conference. A staff member of the Committee on Dispensary Development was executive secretary for the Conference and the committee, and made many visits to social service departments and the various agencies, talking with workers in the field and acting as general instructor and interpreter to the various conference members.

The main accomplishment of the Conference was to clarify the situation sufficiently to determine what were the real obstacles to smooth cooperation between the medical and non-medical social workers. At least two sources of trouble were made clear. The first affects the outside workers, who evidently are not accustomed to formulate the particular problem for which they require help from the clinic in such a way that the clinic can easily give them the information required. Second, the medical-social workers find it difficult so to interpret the clinic reports that the social agency obtains the information it needs. Neither of these difficulties is insurmountable, but they cannot be cleared by mechanical means alone, nor quickly by any means. This may be seen by a description of the blanks, and of some of the results observed in their use.

The forms which were used by the Conference are shown in Forms 1, 2 and 3. The Steering Blank used in referring clients from the agencies to the medical institutions was based upon those found useful in other cities, particularly in Baltimore, Boston, Cleveland, Philadelphia and St. Louis.

Identifying items are confined to those required for immediate hospital identification. The blank provides for five statements in
addition to these, arranged in the order of their relative importance to the clinic.

First is the Patient’s Complaint or Symptoms. Earlier blanks overlooking the simple fact that the clinic is primarily interested in

<table>
<thead>
<tr>
<th>STEERING BLANK BETWEEN MEDICAL AND SOCIAL AGENCY</th>
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<tbody>
<tr>
<td><strong>(Fill in duplicate and forward both copies.)</strong></td>
</tr>
</tbody>
</table>

Name................................................. Age........... Address......................................

Referred from ............................ To .................................

(Name of Agency( Hospital or dispensary through Social Service Department)

Check:

- Patient states he is ( ) new to dispensary.
- she ( ) now under treatment in ...........Clinic Disp. No.
- ( ) a former case in ...........Clinic

1. Patient’s Complaints or Symptoms
2. Previous Medical Treatment
3. Any social facts that bear on patient’s condition
4. Social problem that medical information may help to solve
5. Patient’s ability to pay dispensary fees

Date .................. Signed .................. Medical Worker

<table>
<thead>
<tr>
<th>REPORT FROM DISPENSARY TO REFERRING AGENCY</th>
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<tbody>
<tr>
<td><strong>(Keep one copy and return other to agency)</strong></td>
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Disp. No.________________________________

1. Medical Conditions Found and Interpretation (Note seriousness, probable duration and outcome)

2. Medical plan: (a) Recommendations as to other clinical references, examinations or treatment
   (b) Recommendations as to occupation or social re-adjustment, diet, rest, etc.

Date.......................... Signed.......................... Worker

**FORM 1—THIN, TOUGH PAPER, ALLOWING USE OF CARBON DESIRABLE, OF STANDARD LETTER SIZE, 8½ x 11, AND OF DISTINCTIVE COLOR.**
the patient's bodily and mental condition; began with the family and social background, employment and school record, and only then stated the immediate reason for reference.

The Previous Medical Treatment is the next in order of interest to the clinic. This should specify the nature of treatment, and the date and place should be given that the earlier records may be consulted.

Any Social Facts that Bear on Patient's Condition. This is a real source of difficulty, as the outside worker complains that physicians do not seem interested in the social history of the patients. While this may be true, one reason is that frequently the reports have been simply transcriptions of chronological social case records with no selection of facts pertinent to the immediate medical condition.

The Social Problem that Medical Information May Help to Solve is the crux of the whole matter for the agency, but the clinic's interest in this is supplementary to diagnosis or treatment.

The Patient's Ability to Pay Dispensary Fees is by no means always answered by "none." As a rule; however, some modification of charges is necessary.

The Consent of Patient is supposed to be secured by the referring agency before he comes to the clinic. The place for the signature is on the back of the blank so that the patient does not need to see the entries and so is not disturbed by them, nor does he consider that he is signing or subscribing to them. The wording is noteworthy; instead of the more usual, "I hereby give my consent to have the

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<tr>
<th>Consent of Patient</th>
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<tr>
<td>To the Superintendent of ..................................................</td>
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<tr>
<td>I hereby request that the doctor's report .............................</td>
</tr>
<tr>
<td>(on my condition) ; (on the condition of ...........................</td>
</tr>
<tr>
<td>(name and relation)</td>
</tr>
<tr>
<td>Be given to .................................................................</td>
</tr>
<tr>
<td>(agency)</td>
</tr>
<tr>
<td>Date .................................................................</td>
</tr>
<tr>
<td>Signature of patient or guardian of minor</td>
</tr>
</tbody>
</table>

FORM 2—TO BE PUT ON REVERSE OF FORMS 1 AND 3.
doctor's report given to 'so and so'! this form reads: 'I hereby request that the doctor's report be given, et cetera.' This makes the patient an active, instead of a passive, participant in the whole affair.

The social agency asks for two things from the clinic: first, a statement of Medical Condition Found and its Interpretation, including a statement as to the seriousness, probable duration and outcome. This was so worded in order to avoid the misleading terms "diagnosis" and "prognosis," which elicit a technical reply from the clinician. And, second, the Medical Plan including recommendations: (a) as to other clinic references for examinations or treatment, and (b) as to occupation or social readjustment, diet, rest and so forth.

The general understanding was that the social service departments should prepare these reports after consultation with the physician, or physicians, as soon as possible after the examinations. Wherever necessary, the worker accompanied the client to the clinic, and even remained during the examination.

The corresponding "Reference Forms" for referring patients from medical agencies to family welfare agencies (Form 3) were not used to such an extent as the steering blanks, and this is partly because so many individuals under the care of hospital social service who need intensive family welfare treatment, are already known to some agency. Another reason, however, is that hospital social service workers are prone to consider the family welfare agencies mainly as dispensers of relief, and to overlook their other functions which now outweigh the giving of material relief.

Most of the complaints about the reference blanks were to the effect that the family welfare agencies delayed in giving material relief when asked for it, and did not report soon enough on the immediate disposition of the case. Sometimes it appeared that a case was actually taken over by the agency, but the reference form was not returned.

This phase of the relationship between medical and non-medical agencies needs study and it is possible that a more satisfactory condition will develop as medical-social service defines its own function more clearly. Those interested are referred to a forthcoming report by a Committee of the American Association of Hospital Social Workers, on this subject.

At the end of two years the workers in both the medical and the non-medical agencies were asked to give a frank evaluation of the
Outside Agencies

experiment as a whole and their opinions as to the efficacy of the blanks. Of the twelve hospitals, only four expressed a wish that the use of the forms be continued. The workers in two of these expressed themselves as unqualifiedly in favor of the use of the forms. Here they considered not only that the client-patients were benefited by systematic handling and prompt service, but that they themselves

REFERENCE FORM FOR MEDICAL SOCIAL DEPARTMENTS REFERRING PATIENTS TO FAMILY AGENCIES
(Fill in duplicate and forward both copies.)

Name................................................. Age...... Address.................................

Referred from ................................................. To ................................................
(Hospital or Dispensary through Social Service Department) (Name of Agency)

Reason referred (state distinctly what is desired of the family agency in behalf of patient or family)

Significant medical facts (Include probable duration of illness and tell, if possible, how long and to what extent patient will be disabled)

Date ....................................Signed ............................................Medical Worker

REPORT FROM FAMILY AGENCY TO MEDICAL SOCIAL DEPARTMENT
(Keep one copy and return other to Medical Worker)

Statement of action taken by family agency. (Include report of first contact with family, emergency treatment, if any, and tentative plan. Do not delay return of blank longer than three days for the sake of covering the last item.)

Date ...........................................Signed ...................................................... Worker

FORM 3—THIN, TOUGH PAPER, ALLOWING USE OF CARBON DESIRABLE, OF STANDARD LETTER SIZE, 8½ x 11, AND OF DISTINCTIVE COLOR.
had profited by an increased insight into the nature of their medical-social problems through preparing the statements of the agencies and studying their reports. Incidentally these were the only hospitals that had adhered exactly to the terms of the experiment. The other eight hospitals were making slight, if any, use of the forms.

The non-medical workers were practically unanimous in wishing to discontinue both steering and reference forms. They considered that on the whole the effect had been to complicate rather than to simplify their problems. One difficulty was that the plan did not apply to all medical agencies. Hence it was necessary to use different methods in various places, in itself confusing. But quite aside from this obviously minor obstacle, the workers were convinced that delays were greater, work increased, and service to clients not improved.

While this nearly unanimous verdict against the forms and procedure devised by the Conference must be taken for what it is worth, it does not mean that the experiment has been without value, nor that forms of some sort are undesirable, or lacking in utility.

Some five hundred returned steering blanks were examined in order to interpret the situation. Marked differences were found among both hospitals and agencies, in the way in which they used them. Thus, while the A. I. C. P. actually used more blanks than all other agencies combined, their use was entirely different from what was intended. Case after case contained literally nothing but identifying material, and a request for "diagnosis" and "prognosis," with absolutely no indication of the social problem involved for which help was required. In fact, among over 200 blanks from this agency, only ten were found with any entries indicating a social problem. The explanation is to be found in the fact that this agency has a divided service, all health work being done by the nurse group and the social case work proper by the social workers. Also, only 50 per cent of the clinic service is sought in institutions not supported by the A. I. C. P. The Catholic Charities made little use of the blanks, as they refer so few clients to the hospitals included in the experiment, but the workers wished to have the system applied to the diocesan hospitals.

However, in nearly three-quarters of the 245 cases from the C. O. S. and the J. S. S. A. which were examined in detail, the problem faced was stated in a way which seemed entirely satisfactory. Moreover, the returns from the hospitals were satisfactory in about the same proportion. On the whole, the better the original statement, the better the returned reply. Thus: for every hundred satisfactory
Outside Agencies

Statements by the agency, eighty-five were reported upon similarly by the hospitals, whereas for every hundred problems stated, only fifty-one satisfactory replies were made. Considering the transaction as a whole and excluding the cases where either statement was at fault, fifty-six per cent were entirely satisfactory. While this is far from perfection, it certainly is not total failure. Furthermore, there was a definite correlation between the number of cases referred and the way in which they were handled, so that, on the whole, notable progress was made in the manner of using the blanks as the experiment proceeded.

Another contribution of the blanks was to show the sort of medical-social problems most frequently presented by the agencies to the clinics, and which ones seem to be best suited to handling on a cooperative basis. Perhaps the most significant discovery was that two-thirds of all the cases required a general medical examination. This is a far larger proportion than would be ordinarily found among clinic patients, most of whom are candidates for special examination or treatment. One explanation lies in the reasons for referring the cases. In a third of all, the question was an economic one—relating to earning capacity. "Can the man or woman work, how much, and when?" While the immediate disability might be the result of an injury, long illness, or even a definitely local condition, such a question could only be answered after a general medical examination, supplemented by special examinations where necessary. It also requires something besides a particular medical diagnosis. This single group was the best handled by both sides, over two-thirds being both stated and reported upon in a satisfactory fashion.

In 17 per cent, the examination was required because of some general family situation, such as tubercular or syphilitic parents, or the necessity for placing a child while the parents were under medical care away from home. Here again more than a particular diagnosis had to be made, but the tendency seemed to be to limit attention to the special condition mentioned, and not to consider the entire problem. Less than half of these cases were handled satisfactorily by both the medical and non-medical workers.

In another 16 per cent general examination was required because of some reason affecting the individual, such as his need for convalescence, country care, or further treatment following illness or...
These were handled nearly as well as the economic problems, probably because of the simplicity of the situation.

In contrast to the general run of clinic patients, who suffer actively, or are in need of treatment for some acute or chronic condition of which they are aware, only twenty per cent, or one-fifth, of these clients were referred because of emergent needs. In this group were included all accidents, acute respiratory conditions, digestive upsets, active nervous or mental conditions, and special handicapping defects of eye or ear, painful teeth, or suspected contagious disease.

This probably reflects a genuine difference between ordinary clinic patients and the clients of social agencies, but it should be noted that this particular group may have been selected by the workers for reference by means of the steering blanks, and that cases of real emergency were cared for in clinics not in the cooperating group.

Finally, there was a miscellaneous group of cases, accounting for 16 per cent, which were not suitable for handling with steering blanks, because they were cases either under active treatment at the time, or old cases no longer under the care of the clinic, whose former records were called for, or they were referred for a "health examination," which was distinctly excluded by the terms of the experiment. Only one-fifth of these were handled satisfactorily.

The blanks also served to point out particular features of clinic administration which handicap a successful interchange of information.

The absence of a unified record system for the different divisions of the out-patient department will mean that the social service department, in order to report on the clinical findings with respect to any one patient, must consult several files. In at least one instance there is not only no unified, but no central, recording and filing system or even a central alphabetical index of patients. This lack of unification sometimes extends to the organization of the social service department itself and to its records.

In some places the social service departments receive cases only after they have been in the clinics and on medical reference. Without regular representation in the admission system, the plan of utilizing the social service as an intermediary would have to be specially provided for. Sometimes the organization of the department is such that workers are not available in those clinics where most clients are referred. Sometimes the offices of the social service department are so located as to make it inconvenient to refer cases on admission.
Certain other details of administration have been clarified by the use of the steering blanks. For example, it was found that much time is ultimately saved if all clients are referred to the medical division at the outset, even though a specialty like gynecology seems indicated. Such a consideration might be useful in determining a general admission plan.

Another advantage of the conference and experiment was the separation of the factors which might be handled satisfactorily on a mechanical basis from those which involved real differences of opinion. The latter seemed to be reduced to three main problems. First, the question of which agency should undertake the details of "follow-up," and second, the question of relative financial responsibility; third, "emergency relief."

Opinions vary as to which agency, the medical or the social, shall undertake to carry out the recommendations of the physician, to instruct the patient, and to see that he returns as often and for as long a period as necessary, and all the complicated activity of supervised treatment known as "follow-up."

The question of costs as it affects the relations of medical social service and non-medical agencies is part of the whole problem of follow-up of client-patients. There is general agreement that fees, such as for admission, or charges for direct medical examination and ordinary treatment, should be remitted, and this is generally arranged by the medical-social department. But there is considerable difference of opinion about who should pay for accessories required in treatment, such as braces, crutches, orthopedic corsets or shoes, and for costly and unusual laboratory tests, or long courses of costly special treatment, or for operations and bed care.

Another difficulty seems to be that there is neither a generally accepted policy in the matter among hospitals generally, nor a consistently followed plan even within single institutions, so that the same hospital will insist upon payment for X-rays for one client-patient and not for another. This is one phase of the generally chaotic condition with respect to clinic fees and charges generally, brought out in various studies made by the Associated Out-Patient Clinics. So far as the general community interests are concerned, it makes little difference which agent finally pays or secures the funds for repayment, provided the patient is benefited. But it makes considerable difference to individual departments and agencies, especially
in a city where there is no community fund for social service activities.

Emergency relief is an important practical issue between agencies and hospital social service departments. The agencies object to emergency relief being given to their clients without their consent, and on the other hand the social service departments frequently consider emergency relief necessary as a first step in treatment and that the elaborate investigations of the social agency need not always be made before giving this relief.

Closely associated with this is the whole question of relief and social treatment other than medical that may be needed for patients under the care of the medical social service departments. Any adequate plan for cooperation between medical and non-medical agencies must include provision for this. In this connection, the statement made by a special committee of the Associated Out-Patient Clinics, on the relations of medical social service with outside agencies, is of interest.

"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 especially 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."

It is obvious that the lack of success in New York City with steering blanks is due to quite fundamental causes. It has not been lack of effort to understand or willingness to work together on the part of either group. The general spirit has been excellent, and genuine interest has been shown by practically all concerned. Indeed the very workers who had the most serious doubts as to the feasibility of the plan to begin with, gave the most wholehearted service and ex-
The greatest energy in trying to make it work. Nor has the trouble been with the blanks themselves, or even in the way they were used. One real trouble seems to be that the steering blanks forced an issue upon the hospitals which they were not ready to consider; that is, the concept of medical social service as an interpreter as well as a transmitter of information to outside agencies. This was clearly shown in the steering blanks, where the weakest place was always in the interpretation of the significance of the medical findings and the formulation of the medical plan in relation to social treatment. On the other hand, the non-medical agencies were unwilling in many cases to accept this concept of the function of the medical social workers. They were willing to utilize the departments as intermediaries, and as a means of facilitating the arrival of the clients at the examining room and of securing reports from physicians, but they did not consider that the medical social workers should be their sole point of contact with the physicians.

Thus, the two groups were really in agreement, and the upshot of the whole matter seems to be that there is no single way of effecting cooperation. In view of the success with a steering system in other cities—Boston, Indianapolis, St. Louis, Chicago, and notably Cleveland, and also in view of the fair measure of success evident in a dispassionate study of case records, it would seem rash to dispense with the idea altogether. Two suggestions occur:

The steering blanks might be broadcast among hospitals, so that the ones wishing to use them may do so, requiring that the agencies refer cases, with the accompaniment of the report, in regular form. There should be a provision that they need not be the exclusive means of communication. Then let all concerned work out a selective basis by which the rank and file of cases may be handled via the social service departments with the use of steering blanks. This will leave for handling in an entirely different way such cases as may require continuous social treatment because of the intimate relation between the medical and social factors. The outside worker in these cases should have access to the examining physician, and perhaps even to the records. It is believed that some such plan would satisfy the requirements on both sides. The hospital social workers are loath to take on intensive social cases for which they cannot be entirely responsible. On the other hand, the social agencies are loath to give up the handling
of their more complicated problems even temporarily. The objection to the presence of outside workers in crowded clinics will not hold if the cases where this is necessary are reduced to a minimum.

Another suggestion depends on the experience in other cities. Where there has been the greatest success, it was not attained quickly. Also the initiative was on the part of the medical social workers, who saw the need and tried to meet it, and gradually worked out a plan, taking the lead, but always carrying the non-medical workers with them. In New York, the experiment was to a great extent conducted by an outside agent, and while it was entered into quite eagerly, was not really a native growth.

REFERENCES

1 "Clinics, Hospitals and Health Centers," by Michael M. Davis, Ph. D., 1927, N. Y., Harper Brothers, p. 50; "... from two thirds to three fourths of clinic patients come for specialized service."

2 However, at least one large metropolitan hospital has gone on record as unwilling "to accept patients referred from other charitable organizations of the city at free or reduced rates. The basis of this ruling is the fact that the hospital is forced to appeal continually to the public for support and assistance in caring for the indigent sick who apply directly to us for aid and it would be obviously unfair for us to divert any part of the moneys so received to the furthering of the work of some other organization. Under special agreement cases so referred to us are accepted at the regular dispensary rate for service rendered and charges made against the referring organization." (Manual of the New York Post Graduate Medical School and Hospital for 1925.)
A RURAL NURSING PROGRAM*

LAURA A. GAMBLE, R.N.

Director of Public Health Nursing, Cattaraugus County Health Demonstration, Olean, N. Y.

Cattaraugus County with a population of 74,000 and an area of 1,343 square miles is a fairly typical rural county having only two cities of, approximately, 10,000 and 23,000 population respectively. It is relatively isolated and has 927 Indians on reservations in the County. Transportation is chiefly provided by motor this being made possible by the large number of improved county and state roads.

The Cattaraugus County Health Department began in January, 1923, with the creation of a County Board of Health by the local board of supervisors; the first to be established in New York State: and the general health program prepared for the County provided for all branches of public health work including a generalized public health nursing service.

Following a preliminary survey and organization of the County into six so called "health districts," well equipped district stations were established in each to serve as headquarters for the nurses and as health centres for the districts. From these centres the nurses carry on the different phases of public health nursing including maternity, infancy and child hygiene; school; tuberculosis; communicable disease and some bedside nursing.

This program is carried primarily on a district basis: each nurse being responsible to and for her own district. The nurses live in their districts, they have complete records for all cases under supervision and serve more or less as independent nursing units under the general direction and supervision of the central office of the County Board of Health. This plan serves to fix the responsibility for nursing service in each section of the County and to stimulate a more in-

*Read before the Annual Meeting of the National Tuberculosis Association, Washington, D. C., October, 1926.
telligent interest and coöperation on the part of the communities in
the work of their nurses.

In the organization of the County Board of Health into bureaus
having charge of the different branches of the work, no separate
bureau of public health nursing was at first established but the time
and activities of the nurses were allocated to different bureaus. How­
ever, as public health nursing developed a Bureau of Nursing was
established from which all the activities of the nurses are directed
and supervised.

Some indication of the growth of the work can be shown by the
steady increase of personnel from the appointment of the first public
health nurse in 1923 to the present staff which consists of a director
of nursing, three special supervisors, fifteen staff nurses and five dis­
trict clerks.

In the first six months of this year—and in four of these we had
lots of snow, many bad roads and stormy days, these nurses made
10,764 visits or an average of six visits per day per nurse.

In the development of our program we have followed certain
policies, namely:

1. The decentralization of the work—which I have already
outlined.

2. The provision of specialized supervision for the general­
ized work of the staff nurses. This provision has been
gradual, starting with the general supervision of all activ­
ities by one supervising nurse, later by the appointment of
a special supervising nurse in tuberculosis who serves more
in the capacity as a consultant or advisor, going with the
nurses to their difficult and problem tuberculosis cases and
helping them in their general field work. Following this
appointment, special supervisors were provided for mater­
nity, infancy and child hygiene, school and social hygiene.
By this specialized supervision much is accomplished to
keep the work of the staff balanced and steady.

3. Each public health nurse is essentially a teacher—the edu­
cational aspect of their work is stressed and developed.

4. Bedside nursing is limited to emergency service and for
demonstration purposes.

5. Social problems are referred to the county social workers
who, in many instances where it is considered advisable, work with the nurses in handling cases. Cases not carried in this way become the responsibility of the social workers.

6. The development of local nurses’ committees whose purpose it is to understand the program that they may be able to participate in and identify themselves with the work.

In all of this progress we have encountered many problems such as the difficulty of securing trained personnel interested in rural work; the isolation of the nurses in rural districts and the lack of social contact; the difficulties of transportation during the long winters and the problem of providing bedside nursing service. With a continually increasing demand for all types of nursing service it becomes increasingly difficult to keep the program within the bounds of the actual ability of a given staff to best serve the community as a whole.

One of the first activities undertaken by the County Board of Health was a county wide program for the control of tuberculosis and in this the nursing service has taken an active part. Prior to the establishment of the County Board of Health there were 237 known cases of tuberculosis in the County but only 77 of these were actually on the visiting list of the County tuberculosis nurse, and in the check up made in 1923, it was discovered that even a large percentage of these 237 cases had either moved out of the County, had died or could not be located. It was evident therefore, that an intensive case finding campaign would be necessary to locate as many cases as possible and in this campaign the generalized nursing service was of distinct advantage in giving the nurses many contacts with the people of their districts. This was particularly so in their school work which gave them an entree to practically all the homes of their districts. Many instances might be cited where the problem taking the nurse into the home was not tuberculosis but where tuberculosis was found.

Following the case finding campaign, which has resulted in having on July 1, 1926, 583 known cases, registered and under supervision, a plan of home supervision was outlined in a manual prepared by the Bureau of Tuberculosis of the County Board of Health to be followed by the nurses in their supervision of cases, their contacts and of undiagnosed cases where the careful observation of symptoms is necessary.
The cases were classified and divided into three groups:

1. Sanatorium-home treatment group included all active cases of tuberculosis in the first and second stages of disease, who had at least three months treatment and education in a sanatorium, and who agreed to coöperate with their physicians and the district nurse, and whose home conditions were satisfactory.

2. Home treatment group included all active cases in the first and second stages of the disease, who agreed to coöperate with their physician and the district nurse, and whose home conditions were satisfactory, but who did not have preliminary sanatorium treatment and education.

3. All other cases were placed under what we term "home supervision," because of the fact that conditions will not allow of the application of the requirements and specifications of the other two groups.

The home visiting by the nurses to these cases is carefully supervised by the special supervisor in tuberculosis nursing who is responsible for the carrying out by the district nurse the plan of home visiting and examination which is outlined as follows:

1. All active cases to be visited weekly and examined each month.
2. All quiescent cases to be visited monthly and examined monthly.
3. All apparently arrested cases to be visited bi-monthly and examined bi-monthly.
4. All arrested cases to be visited every three months and examined every six months.

Approximately one half of our tuberculosis cases are in homes in isolated districts and off the main roads, making home supervision difficult, but when weather and roads permit, these cases are visited regularly and every effort is made to maintain this schedule of visiting.

The nurses assist at the clinics held regularly in the health centres; make the follow-up visits from the clinics; investigate home conditions; distribute prophylactic supplies and give instruction in care and disposal of sputum, etc.; arrange for the admission of patients to
sanatoria; give all the assistance possible for the necessary changes in living and working conditions by putting the patient in contact with the proper persons or organizations. They spend slightly more than 20% of their time, which is the equivalent to the entire time of three nurses, in direct service in tuberculosis work. In this manner and by these means our rural nursing service has been functioning in the tuberculosis program in Cattaraugus County.

Realizing that we are and have been working under unusual circumstances, it would seem perhaps that such a program would not be a feasible one for the average rural community. But we hope to demonstrate that this program modified to be accommodated in the County budget for public health but still adequate to meet the needs of the County, can be made a practical program for a rural community. In doing this the same underlying principles will be adhered to, namely, the decentralization of the work, the generalized service with bedside nursing confined to emergencies and demonstration, the stressing of the educational aspect of the nursing service in home visiting and in group teaching and the close cooperation of the nurse and her lay committees.

In conclusion, while we all no doubt think of many factors which contribute considerably to ensure any effective rural nursing program, it would seem that much depends on the well qualified public health nurse who is equipped with training, personality and ability and who is ready to go to the rural communities; who can realize her opportunity and responsibility in developing her community especially through her nursing committees, whose potential usefulness in a rural program is almost unlimited. In the past the rural nurses have found little precedent to rely upon but that situation is rapidly changing and much information is becoming available regarding rural nursing. In her book on “Public Health Nursing,” Miss Mary Gardner has truly said, “the county nurse who works well and thinks intelligently is sure to do much more than affect the limited area in which her work lies, for she is blazing a trail that will in time become a broad highway.”
THE HOSPITAL SOCIAL WORKER IN HER VARIED RELATIONSHIPS*

CONSTANCE B. WEBB

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In choosing this topic I did so deliberately, realizing full well that the Hospital Social Worker has too many relationships for me to attempt to discuss them all or perhaps even to enumerate them. We have heard much and read much about her relationship with her patients, with the doctors, with the hospital administration, with cooperating agencies. These are her daily concern and the very foundation of her work lies in these contacts. They are in fact essential to her existence as a Hospital Social Worker. The force of daily pressure, the demands expressed on every side, the urgency of the immediate task are constantly moulding the standards and the technique of these relationships. That we have much to learn and far to go in raising those standards and in developing that technique is obvious.

It is a temptation to stop at this point to elaborate upon our responsibility in those relationships and together to contemplate the vision of what the future may hold along these lines. But instead let me just touch on each one very briefly. The patient, the necessary center of all hospital activity challenges us to see him as a whole person, to interpret his needs to himself and to others, to educate him in health matters and in social adjustment and through him, those about him. Our responsibility to the doctor, the final authority on questions of medical care and health, is to understand his aims and methods, to contribute, if may be, to his fuller knowledge of the patient, to work as his side partner with his patient. It is essential that in our relationship with the administration, the pilot of the ship,

the directing force, that we fit in smoothly, contribute helpful infor-
mation when possible and appreciate the composite viewpoint of
other departments. With the cooperating agencies, those supple-
mentary forces in the patient’s rehabilitation, we have the opportu-

nity to share our knowledge freely, to exchange facilities and to
develop with them a fuller appreciation on their part of the medical
viewpoint, and, on the physician’s part, of the agency’s viewpoint.

Whole papers could be written on each of these relationships, but
in this connection it need only be said that the more fully the Hospital
Social Worker thinks of herself and her every day work both as a
necessarily integral part of the hospital as a whole, and yet as a force
contributing a peculiar element to the prevention and remedial phases
of medical work in her hospital and through it to the community,
the more fully will she be fulfilling the legitimate demands of these
more immediate relationships.

Since, in the nature of things, however, no relationship into which
we as Hospital Social Workers enter can fail to have its effect on all
four of those nearer relationships I have just mentioned I am asking
you this afternoon to consider with me certain of the less obvious
and demanding ones and see in what way they may vitally affect
those to which we have been accustomed to devote the majority of
our discussion. Of these relationships there are four to which I
want to call especial attention; our relationship with our local group
of Hospital Social Workers; with our district; with the National
Association; and with the American Association of Social Workers.

It is frequently the contacts which seem most removed from our
daily concern that prove to be the most dynamic, and frankly, I be-
lieve there is no one thing which will more surely serve our patients
than that we look to these relationships and take heed lest our con-
tact with them be weak and unavailing. I suppose there is no group
of people even pretending to be professional who have less time at
their own disposal than have the social work group. The hours of
work are long, the days are many. The fact that the Social Worker
is on a salary presupposing eight hours of work, five and one-half
days a week and eleven months of the year circumscribes her activities
to a greater degree than those of any other professional worker.
Other professions either have shorter hours or can regulate their
time because they are not working for someone else. For these rea-
sons we should, perhaps, not be surprised that a schedule comparable
only to that of industrial or clerical workers should have caused us
to use those oft repeated phrases, "I haven't the time to do this;"
"I'm too busy to do that," the "This" and the "That" usually being
attendance at meetings, special reading, or study focussing upon
original or research work of any kind.

It is indeed true our prescribed working time is long, but in using
this argument we are really hiding behind a convenient excuse and
one which will not hold water very long. If we allow our days to
be machine-like or to put it differently, if we neglect the opportunity
to use selection in our tasks and fail to apportion our time in accord­
ance with analytical thought we obviously shall not have time
for these relationships we are discussing. Even though social work­
ers are on a salary and have certain hours of work, I know of no
administration which does not allow, and more than that, expect its
social workers to develop their own activities to a very large and
free extent. With this condition of affairs it appears the social
worker is really no worse off and perhaps is even better off than the
physician whose day becomes just as crowded and whose hours are
not limited by anyone but himself. For neither group will there ever
be any lack of tasks or details; they are as numerous as the sands
of the sea and anyone of us may be buried under them if he will.

Dr. Beaumont, the Army Surgeon on the Island of Mackinak, of
whom Dr. Osler tells us in his "Aequinimitas," certainly had no
especially set aside time and no outside urge to impel him to carry
on the painstaking study of Alexis St. Martin's gastric reactions with
such infinite patience and perseverance. He had certainly no assur­
ance and perhaps no inkling that his efforts would bring forth so
valuable a contribution to medical knowledge. The point is that in
spite of "circumstances the most unfavorable" this busy army surgeon
did find time for the sake of his profession, medicine, "to keep pace
with, and to aid in, the progress of knowledge," and not be content
with "the perfunctory discharge of the daily routine." I quite ap­
preciate that the physician has all the urge of an old and well estab­
lished tradition of study and research behind him. He has well
developed and vital organizations, local, state, and national. He has
a vast bulk of literature to lure him on. The question I want to put
before ourselves fair and square, is this: "Are we willing, by our
own individual efforts and sacrifices, to build up a similar tradition,
a comparable literature and an equal organization and are we using
that which we now have effectively?" We have been criticised and
rightly so because we are not truly professional, because we have not
been scientific, that we jump too easily to conclusions, that we take
refuge behind vague generalities. Associated as we are so intimately
with the medical profession it seems to me we can scarcely fail to
realize our responsibility for following its footsteps more closely in
our efforts to take our profession seriously and for making the in-
dividual sacrifices necessary to further it.

If we are to take our proper place beside other professions it
seems to me we must each of us face this question honestly and
bravely. There are, of course, other reasons why we have been slow
to do this besides that of being so woefully hard-pressed. There is
our newness, our own lack of concept as to our function due to that
newness. There is, too, if we are ruthlessly candid with ourselves,
the fact that we have been granted a professional standard by popu-
lar opinion. We have borrowed it to some extent from those older
professions with which we are so frequently associated. We have
to often been willing to accept the benefits of a professional rating
without paying the price. Like many other big considerations from
politics to religion this is a matter for the individual. You and I, as
separate social workers, are inescapably responsible for the way in
which we respond to efforts at professional development whether
within our own town, our district, the national body or the compre-
hensive field of social work as exemplified by the American Associa-
tion of Social Workers.

It is important that the study of big social questions, basic prin-
ciples and guiding standards be made really broad. That means such
studies must be carried on, not by a few outstanding individuals
whose experience and reputation so often cause them to be looked
to for pronouncements on these subjects, but rather by you and by
me, by the rank and file of case workers daily in the field.

When illustrations, opinions, judgments, have been checked and
re-checked, tested, criticised, modified in the light of experience under
many conditions and in varied locations, there needs to be the coördi-
nation of those studies, the common sharing of these viewpoints. It
is too easy for most of us to sit by and wait for the Records Com-
mittee, the Functions Committee, the Training Committee, and what
not to announce the results of their deliberations instead of appreci-
ciating that it is we ourselves who must do the real work and the
real study if it is to be of professional value.

As chairman of one of these committees for three years, it was
a great satisfaction to receive expression after expression from in-
dividuals about the value they received from participation in that study which happened to be on the question of Function. The wholehearted enthusiasm which produced over a thousand cases studied in the light of sixty-six searching questions showed that when we enter into a relationship with basic problems affecting our work we are gaining something of vital value. It is all inextricably woven together. We cannot ourselves be benefited without having thereby more to give. We cannot advance our profession without gaining the respect and greater coöperation of our professional confreres, again inevitably helping the patient.

The program of our Association in Cleveland during the week of the National Conference was an indication of the fact that we are more and more considering our responsibility along these lines. The tentative report of the Functions Committee, the latest report of the Records Committee, the report of Training, the luncheon address on professional education, the round-tables on relationships with committees and on prize records, all showed a definite tendency toward the analytical approach to our daily job and that the solution to all of these questions is to a large extent dependent, as I say, on your individual contribution and on mine.

That we may be more effective in the intimate and pressing relationships within the sphere of our every day contacts I am urging earnestly this afternoon that we give serious and very personal individual consideration to our less demanding, less obviously pragmatic relationships; the meetings and studies of local groups, the programs of districts and of the national associations. It is those relationships which will through study, deeply searching and original, further advance us toward the goal of a truly professional standing and will by that very means dignify our rating with the other professions and will more fully benefit our patients for whose service we exist.
THE CARE OF THE CRIPPLED IN NORWAY

IV. RUMMELHOFF

Oslo, Norway

The Handicraft School for Cripples, started in Oslo in 1892, was the first organized effort on behalf of the crippled in Norway. The leading personality, in the first twenty years until her death in 1909, was Miss Agnes Fleischer, herself a cripple from an affection of the spine with paralysis, which confined her to her bed for the greater part of her life. As she lay in her wheel-chair, with its board serving at once for the telephone, writing materials, and meals, she maintained constant communication with those interested in the care of the crippled both at home and abroad.

In 1896, at the annual exhibition of the school, it was visited by our King at that time, Oscar II. His Majesty was so much struck by the beautiful articles of work, that the King immediately gave a large order for the palace,—and two months later the school was informed that the King and Queen had agreed that the jubilee gift, received by them from the Norwegian people, should be applied to the advantage of the crippled.

With these funds a new school was built, and the foundation laid of the great Central Institute for Cripples, which will henceforth be the nucleus of the work in our country. The Institute will, when fully finished, have room for 300 cripples, and contain workshops for the following handicrafts: the making of bandages, orthopaedic and ordinary shoes, brushes, baskets, painting, watches, metal-engraving, carpentry, bookbinding, toys, wood carving, knitting, weaving, tailoring, dressmaking and plain sewing. Various other kinds of work may be taken up by degrees.

A Cripples Institute requires to be built out with various organs and institutions. Therefore the Central Board for Cripples was established for the purpose of organizing and practicing care for the cripples in cooperation with the existent and coming institutions.
all over the country, especially the Municipal Cripples' Committees in the various communities. The object of these committees is to help and assist the cripples, especially in obtaining the necessary treatment and training and also an appropriate occupation. The arrangement of establishing such local cripples' committees, consisting of three members, of which one should be a physician, the other a man or a woman interested in social affairs, and the third the Inspector of State Insurance, was an excellent administrative principle. The organization is inexpensive and efficient. The members receive no remuneration for their work.

The first thing which the Committees had to do was to proceed to a registration of the cripples. About fifty per cent of the committees responded to the call, and about 3400 cripples were listed. We found that more statistical material was desirable, and on the schedule to be filled out for the general census 1920, a special item for infirmity was inserted. It was limited to men and women under sixty-five years of age and only the severe cases of infirmity among children were included.

Of the entire population amounting to about 27 millions, 8891 were cripples under sixty-five years of age, a number very nearly corresponding to that of all the deaf, blind, and mentally defective of the same age.

According to our census in 1920, the crippled men had been in this condition on an average for sixteen years, the woman for nineteen years. From a purely economic point of view, effective care of the crippled in our country with its 27 million inhabitants, may be relied on to yield an annual profit to the community of about four million kroner. This amount is probably below rather than above the result to be expected. But to this we must add all the moral and ideal values which are to be gained by an effective organization of the work, and which cannot be expressed in figures or in financial estimates. We have, moreover, long left behind us the question why, and are now concerned only with how an effective care for the crippled is to be carried out.

During the last years the Central Board has been available to the individual cripple and to the various cripples' agencies as a clearing house for information. A great number of questions have been submitted to the Central Board, touching special cure, possibilities of training and occupation, purchase of prosthesis, infirmity chairs and carriages, assistance in applying to other institutions for stipends,
free tuition and various allowances, assistance in obtaining work, application for gratuitous legal services, assistance in obtaining work from the same employer in whose service he became infirm, applications to public institutions, help to start in business, purchase of horse on instalment plan, purchase of materials, sale of ready-made articles, etc. Later on, we expect to appoint a traveling secretary who will act as a guide in cooperation with the Central Board and the other organizations for the care of cripples.

The Board has published ten pamphlets in about 63,000 copies, as enclosures to the School-magazine, Medical Magazine, Cripples' Magazine “Sunbeam” and a number of other periodicals. In this way, the pamphlets are scattered around into the various circles. The expenses have been covered by advertisements. The daily newspapers have shown much courtesy. The Central Board has distributed between fifty and one hundred articles to the press. A list of them has been inserted in the report published on the occasion of ten years' activity of the Board.

The importance of early special treatment for crippled children is a question, which we seize every opportunity to emphasize. The surgical and orthopaedic resources of today can often effect an entire or partial cure in many cases which were formerly more or less hopeless, and the patient is thus enabled to support himself entirely or in part. Instead of being “on the parish” he becomes self-supporting and a taxpayer.

Many such cases, which in childhood appear insignificant, and which cause no alarm for the future, may become worse with the child's growth, so that schooling, training and therewith the capability of self-support, are hindered or rendered impossible, if special treatment is not given at the right time.

Many cripples avoid, instead of seeking, a cure for their infirmities; and their relations frequently fail to realize their duty in this respect. The public authorities and especially the municipal cripple committees are thus obliged to do their utmost to obtain information as to such neglected cases.

Crippled children of an age to attend school are as far as possible placed in the ordinary schools, since it is most desirable, for the child and the adult cripple alike, that they should be assimilated in social life and not isolated. For children who are too severely crippled to be placed in such schools the necessary teaching is provided either in their own homes or in a special school-home.
When a pupil is dismissed from the cripple school, the committee in his home district will be notified so that they can be prepared to help him to get suitable work, etc.

Through the Central Board our cripples have for many years received scholarships for training them in studies, for attending teachers' schools, commercial schools, etc., aggregating an amount of about kr. 50000,-. These scholarships have given good results, and many of the students have secured profitable positions.

All experience teaches us how important it is that a man having become crippled in adult life as a result of an accident or illness, as soon as possible can be directed into activity, so that he hardly will have time to stop and reflect on his infirmity. The longer time passes, the greater power of mind will be required by him and his aides. Consideration should also be added to the psychological fact that it is easier to get people interested and make them ready to help where the infirmity is fresh in mind, else such unfortunates are apt to be "forgotten." A "reconstruction-plan" should therefore as soon as possible be drawn up.

In most of the cases only a "push" is sufficient to make the cripple absorbed by his daily work, and the duties and privileges therein embodied. By means of good will much can be accomplished by only replacing and reassigning the infirm from one post to another, i.e., if a mail-carrier has lost a foot, he may be assigned to a job at the post-office, if a slaughterer has got his arm damaged, he may be placed in the shop or the like. In some cases many attempts will be necessary before the right position is found, and it requires patience and ability as well.

In order to get in the quickest possible touch with the invalids, it is required in Norway that all cases, in which a person is allowed a high indemnity by the State Insurance—fifty per cent. and more—should be reported to the Committee located in his district. In case of necessity, the Committees are also notified, regardless of whether or not he be covered by insurance.

No one is in a better position to encourage the invalids than one who has himself been in a similar condition, but has overcome the difficulties. What he often needs most is to get his mind restored, so that his self-confidence will be awakened, enabling him to look forward to certain aims and prospects. A physician said once to a war-invalid: "I have no more medicine for you. You must go out in the
fresh air and sunshine, and mix with other people. You need more to practise the word 'I must' than for want of one hand or a foot.” The duties of the Government and the Communities in employing cripples is a question which has been much discussed lately. Through the Ministry of Social Affairs, the Central Board in the autumn of 1925 urged upon the Government’s various administrative branches to appoint disabled persons to positions which they could fill as well as the able bodied. A similar recommendation was made to the various communities. The Ministry acted with much courtesy in the matter, and recommended it to the proper authorities.

The State as well as the Communities have interest in and are under obligation to help such a disabled person to get a position, suitable to his or her physical and mental abilities, and a great number of positions are available, but to fill these men of giant stature are often preferred. This is the sort of economy that breaks nuts with a steam-hammer, and the result is often that such a man is discontented. The scattered efforts hitherto made in this direction have—as a rule—proved particularly successful. In the postal service alone there are about 3,000 or 4,000 positions, as post office officials, postmen and the like, which in many cases could be well filled by the one-armed or by those otherwise disabled. It is to be hoped that a systematic survey will soon be made as what positions would preferably suit them. Time will certainly show that the functions of the society will be carried out in proportion to each man’s ability and physical strength, but no compulsory measures will in Norway bring any good results.

In spite of all the resources and the experience of the present day, there will always remain a number of cripples, whose defects and infirmities are so extreme that they can obtain the necessary care and attendance only in Homes specially fitted to their need. These cripple-homes in different parts of the country will be combined nursing and work homes, started and carried on by private means. In spite of the poor financial conditions prevailing, more than 100,000 kroners have during the last couple of years been donated to these “homes.” Besides, the “Storting” has appropriated 50,000 kroners of the funds of the “Lottery” destined for the “Home” at Northern Norway. A fully equipped building has been bequeathed by Testament to serve as a cripples’ home in one of the other parts of Norway.

Our cripples have formed their own unions, one of each part
I. Rummelhoff

of the country, and they have shown a rapid growth. This summary would be incomplete, if their important work in this line was not mentioned. The number of members of the cripple-unions already exceeds 1,500, and to these we may add a number of young people’s unions, sewing societies, children’s clubs and the like, all working on behalf of the cripple-unions and their aims. The unions have first and foremost concentrated their activities on building the above-mentioned homes for helpless and homeless cripples, but they have also given valuable help to propaganda for improved provision for cripples as a whole, and especially the cripples’ right to be helped towards self-help. The unions hold their annual meetings each summer, and these have been attended by as many as 100 to 200 cripples, some of whom have come from great distances. These gatherings have done much to stir up the public conscience, and it has been a joy to witness the sympathy and helpfulness shown by the people at large.

Last summer a seventeen-year-old boy, lame in one foot, came to the cripples’ meeting at Trondhjem in a motor-driven three-wheel bicycle—Automouche—which only is operated by the hands. He managed to drive from Asker near Oslo across the mountain Dovre (1000 meters above sea), a distance of about 600 km., in three days. In the beginning of September, 1926, he drove from Oslo to the cripples’ homes in Stockholm, Gothenburg and Copenhagen, a distance of about 1400 km.

There is splendid coöperation between the cripples’ unions, the Central Board for Cripples, and the other institutions taking part in this work. When a man lately bequeathed a large amount of money to this cause, without having mentioned which branch of the work was to benefit thereby, all the authorities agreed that the sum should be employed by one of the unions for a Home for the crippled, since all held the opinion that the legacy would thus bear the most fruitful results. Most important has been the deliverance of the cripple from his or her isolated position, in which egoism of thought and interest threatened to stifle all development and, in place of this, the inspiration of common interests and of fellowship in the lot of others. In this way the individual has grown both in his own self-respect and in the eyes of his fellow-citizens; and this, together with our cripples’ own work for daily bread, has, beyond all else, contributed to raise them to a higher level than was theirs before.

The day after the airship “Norge” had passed Oslo in April, 1926,
the following call, which Roald Amundsen together with Fridtjof Nansen had signed some hours before Amundsen left for the North, was published in all the newspapers of Norway:

“To the Sporting Youth of Norway!”

“We give our warmest recommendation to the plan of the Norwegian League of Football to arrange football matches on a certain day in 1926 for the benefit of the establishment of homes for the helpless and homeless cripples in the different parts of the country. This initiative must be heartily welcomed by all. Very few men in our country are as badly situated as the cripples, whom the homes shall take care of, and this is just a task for the youth, enjoying strength and health to assist in foundation of those homes.”

(Signed)

FRIJOF NANSEN.  ROALD AMUNDSEN.

The plan approved by the league is to the effect that on one of the “hottest” football days in September, when many thousands meet at the sporting places, the income may be granted to the league of the cripples in that district where the match is taking place. “No one is nearer to assist the helpless than precisely we, who are possessing our full strength to show sport and to watch it,” says the president of the football-league of Norway, and he adds: “The gratitude of the cripples for every sign of sympathy is quite touching.”

During the meeting of the Southeastern League of the Norwegian Cripples in Oslo some time ago all the members were Roald Amundsen’s guests in his home near Oslo. This meeting between the conqueror of the South Pole and the North Pole and the guests, representing those who are more fastened to the place than anybody else, was from the very first moment of charming impression. To all the attendants it will remain a memory for the life.

Some days later—Sunday, September 5th,—was “the football day for the cripples” for this year with matches on fourteen different places. At the match in the Capital the King and the Crown Prince were present. Sixty thousand tickets had been sent out, with Nansen’s and Amundsen’s message. The days before, this message was also published by all the cinematographs. The newspapers had articles concerning the “day,” and speeches were held through the broadcasting stations and by different entertainments.
Such a "sportsday" will in future be a fixed link in the big finishing football matches,—as a yearly showing of the heart of the youth towards our cripples.

A proposal for the enforcement by law of the care of cripples has lately been brought forward by a committee of experts appointed by the Department of Social Affairs. This Act is in substance as follows:

Doctors, who, in pursuance of their calling, observe a cripple, are to give the committee concerned notice thereof within a month, together with information as to the nature of the defect observed; and similar injunctions are given to midwives, clergy, teachers, parish nurses or those otherwise serving in the district.

Cripples or persons apparently in danger of becoming crippled are, on receiving notice from the Central Board or the Committee concerned, obliged to let themselves be examined by the doctor whom the said authorities assign. The doctor's fee is to be paid by the cripples' parish without right of refund. If the cripple has claims on no particular parish, the expenses will be paid by the State.

Crippled children between the age of seven and eighteen may be summoned by the Central Board, after conference with the local school authorities concerned, to share in the curriculum of the ordinary school; or, if necessary, to become pupils in the schools for crippled children that are or may be founded by the public authorities.

In the proposed Bill for a "Cripples' Law" an elastic system has been adopted, which would adjust itself to the various conditions and which necessitates no new positions. The Bill is looked upon favorably by all parties concerned. The Medical Director has strongly recommended it, and the County Councils and City Councils have approved it. But not all have as yet expressed their opinion. Unfortunately, it is to be feared that some time will pass before the Law takes effect on account of the financial situation.

I finally take the opportunity to emphasize the importance of an organized coöperation between the various countries for the exchange of experiences, plans and improvements in the field. Each country has much to learn of the other countries, and the coöperation has hitherto been too scattered. It should be given a more concise and firm form, and all countries should participate,—not only some of the nations who took part in the World War.

When one knows that one of the results of this war was to leave ten millions cripples, and that the number of "peace" cripples is also
to be counted in millions, one realizes the extent of this problem, both economically and from a humanitarian point of view.

As far as the Scandinavian countries are concerned, the coöperation is in progress, and a committee has been appointed to prepare the organization of a Nordic Cripples' Society.

It is about time to institute a permanent international clearing house for the cripples' care.
The diagnosis of tuberculosis in childhood is one of the great problems in clinical medicine. It affords a field for study which brings into play keen observation of symptoms, full clinical examination, careful investigation of history and home surroundings past and present, experience in radiological interpretation, and sound clinical judgment. The important part played by the latter is indicated by the repeated statement that in a child who reacts to tuberculin, ill health, recurring attacks of fever or loss of weight, not otherwise accounted for, may be due to tuberculosis. Many children are therefore kept under observation as probably tuberculous, not because of definite findings pointing to tuberculosis but because of findings not otherwise explained.

The child who shows a reaction cutaneous or intracutaneous, to old tuberculin is certainly the host of the tubercle bacillus, and is therefore susceptible to constitutional disturbances from extension of his infection within, or from reinfection from without. Even small lesions, and lesions principally limited to the lymphatic system may cause such disturbances. And physical examination will not reveal them until there is rather massive or widespread involvement. In overcoming these extensions or reinvasions the child presumably increases his immunity to reinfection and this may be temporary or permanent.

That a child beyond the age of infancy reacts to old tuberculin (cutaneous or intracutaneous), is of itself of no significance in diagnosis, for the reaction indicates nothing more or less than his sensitiveness to tuberculin. It is a reaction much more often associated with immunity than with disease. Yet we must remember in all our clinical judgments that such a child may have constitutional disturbances at

*Read before the Annual Meeting of the National Tuberculosis Association, Washington, D. C., October, 1926.

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any time due to extension or activation of his infection, with the focus so small as to escape our present day clinical methods of localization.

In general medical literature we find most statements regarding the incidence of tuberculous infection in children are based upon the old figures of von Pirquet, and Hamburger and Monti, which deal with Vienna where there is a dense population with a high death rate from tuberculosis. We often wonder why American medical writers do not make use of the more recent figures obtained at home in American communities. In a work just published by an outstanding American pediatrician we read “In round numbers, it is probably safe to say . . . that at sixteen years not more than ten per cent. to twenty per cent. have escaped infection.” A number of surveys in the United States show the incidence to be much below this. The surveys made within the past four years in Canada show a decidedly lower rate. In Saskatchewan a survey of 1,184 children showed that at age fourteen, 61 per cent. reacted. A survey of 1,321 children in an Ontario community, town and rural, showed that 52 per cent. reacted in age group sixteen-eighteen. In this latter survey the greater incidence in the town children as compared with the rural was well illustrated. In the age group ten-fourteen, 47 per cent. of the town children reacted and only 27 per cent. of the rural. In the age group fifteen to eighteen the town figures were 59 per cent. reactors and the rural only 32 per cent. reactors.

<table>
<thead>
<tr>
<th>Ages</th>
<th>Town</th>
<th>Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>67</td>
<td>25</td>
</tr>
<tr>
<td>5-9</td>
<td>412</td>
<td>166</td>
</tr>
<tr>
<td>10-14</td>
<td>378</td>
<td>161</td>
</tr>
<tr>
<td>15-18</td>
<td>81</td>
<td>31</td>
</tr>
<tr>
<td>Total</td>
<td>938</td>
<td>383</td>
</tr>
</tbody>
</table>

The result of this survey town and rural, in age groups is given in this table.
**Intracutaneous Tuberculin Tests—According to Age Groups**

<table>
<thead>
<tr>
<th>Ages</th>
<th>Intracutaneous Tests</th>
<th>Total Positive</th>
<th>Per Cent Positive</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>92</td>
<td>14</td>
<td>15</td>
</tr>
<tr>
<td>5-9</td>
<td>578</td>
<td>132</td>
<td>23</td>
</tr>
<tr>
<td>10-14</td>
<td>539</td>
<td>222</td>
<td>41</td>
</tr>
<tr>
<td>15 plus</td>
<td>112</td>
<td>58</td>
<td>52</td>
</tr>
</tbody>
</table>

The complete results of the survey appear in the publications of the Canadian Tuberculosis Association.

That there is a close relation between the incidence of infection in children and the general death rate from tuberculosis is suggested by a comparison of the figures obtained in this school survey in Ontario (Dundas and West Flamboro township) with a somewhat similar survey in Quebec province (Victoriaville and Arthabaska county).

<table>
<thead>
<tr>
<th>Ages</th>
<th>Intracutaneous Tests</th>
<th>Per cent Positive</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>120</td>
<td>14</td>
</tr>
<tr>
<td>7</td>
<td>120</td>
<td>25</td>
</tr>
<tr>
<td>8</td>
<td>128</td>
<td>23</td>
</tr>
<tr>
<td>9</td>
<td>130</td>
<td>35</td>
</tr>
<tr>
<td>10</td>
<td>124</td>
<td>42</td>
</tr>
<tr>
<td>11</td>
<td>132</td>
<td>36</td>
</tr>
<tr>
<td>12</td>
<td>104</td>
<td>40</td>
</tr>
<tr>
<td>13</td>
<td>104</td>
<td>45</td>
</tr>
<tr>
<td>14</td>
<td>75</td>
<td>45</td>
</tr>
<tr>
<td>15</td>
<td>51</td>
<td>53</td>
</tr>
<tr>
<td>16</td>
<td>29</td>
<td>52</td>
</tr>
</tbody>
</table>

**Fever**

A rise of temperature observed for several days and otherwise unaccounted for is often a factor in making a diagnosis of tuberculosis in childhood. We must be very careful to rule out physiological causes. In observing children in a large clinic it is not unusual to find temperatures above 98.5 as a result of excitement or anxiety while waiting for their turn. This is particularly the case if the waiting room be crowded or the room unduly warm. The observations of temperature made in the Ontario survey already mentioned illustrate the fact that normal healthy children will record a mouth temperature above 98.5. Of 1,392 children examined in the schools 1,091 or 79
per cent. had a temperature of 99° or over while 443 or 36 per cent. had a temperature of 99.6° or over. Further observation, days or weeks later of this group with elevated temperature showed 85 per cent. of them to have a temperature of 99° or over and 38 per cent. recorded 99.4° and over. Temperature variations in healthy children are not necessarily due to disease and we must be careful not to place too much emphasis on slight unexplained rises of temperature as evidence of the existence of disease.

X-ray

I need only refer to the 1922 report of the special committee of this association to point out the many possible fallacies in attempting to diagnose lymphatic tuberculosis on the X-ray plate of the chest alone. Any shadows in the lymphatic areas due to tuberculosis may be simulated by changes due to other etiology, if we except, possibly, those which show undoubted calcification.

Tuberculin

If we accept as a working concept that tuberculosis is to be considered a probable diagnosis, in a reacting child with the constitutional disturbances found in tuberculosis and not otherwise explained, we at once acknowledge the skin tuberculin reaction to be one of our greatest helps in diagnosis. Yet it is to be considered of value only in conjunction with other findings, never alone. There are two possible fallacies in the use of tuberculin. One of frequent occurrence is the appearance of a skin reaction due to the meat extract in the culture fluid. Though these are usually under 6 mm. in diameter, they may show infiltration or hyperaruna or both, like a small tuberculin reaction and may persist three days or more. This we hope will be overcome by the production of a standardized tuberculin on synthetic media. The other is the fact that some of the tuberculins on the market are unreliable or impotent.

This Association is now working in conjunction with the Public Health Service and the Health Section of the League of Nations upon the problem of standardization. In some countries tuberculin may be manufactured and sold only under government supervision or license and subject to an official test; in others, as in Canada for instance, there are no such restrictions and consequently no hindrance to the sale of unreliable tuberlin. In a study made by the Pathological Division, Health of Animals Branch, Ottawa, of eighteen commercial
tuberculins there was a variation according to the contents of Koch's old Tuberculin per c.c., as printed on the labels, from 0 to 6,000 units. Three of these tuberculins did not produce any reaction and appeared to be quite inert. Six samples showed only a slight antigenic activity, three were fairly active but below standard, one was equivalent to standard, three slightly over standard and two much in excess of standard. The clinician who uses tuberculin should be sure of its potency and reliability.

PREVENTION

Until we know more about the conditions which cause a tuberculous infection to become active and spread within the body we are not in a position to lay down definite lines of preventive treatment. Animal experiments lead us to believe that fresh infections from without play their part, and the greater the dose and the more virulent the type of bacillus, the greater the possibility of active disease resulting. Applying this knowledge to children, we must protect them from the open case of tuberculosis either by having them live apart or by having the open case observe such precautions as will protect the child from any possible massive infection. We feel sure that with the reporting of all open cases with the follow-up of all cases treated at home or in sanatoria and with the various methods of survey now devised, the physician and public health departments will succeed in further lessening primary infections, secondary infections and the development of open cases. These are perhaps the most important measures in our program of prevention.

We must not forget that in the home of a tuberculous patient the non-reacting child is in danger as well as the reacting child, possibly even in greater danger as having no degree of acquired immunity, which only comes through infection. Any degree of debility in the children in a home where there is open tuberculosis or in tuberculin positive children living in any home must be looked upon as affording opportunity for active tuberculosis to develop. If such children can be watched by careful, interested physicians, much may be done to lessen the frequency with which tuberculous infection becomes disease. Here is a wide field of prime importance for the family physician, the school physician, the pediatrician, and the interne and externe staff of our hospitals for children.

Our program for the prevention of tuberculosis in childhood must include these essentials:
1. The discovery and supervision of all open cases.
2. The isolation of the far advanced and the careless case.
3. Examination of all contacts and a search for sources.
4. The supervision and re-examination of contacts.
5. Periodic health examination of all children.
6. Adequate treatment of debility in all contacts and reactors.
7. Pasteurization of the milk supply.

I shall not attempt to even outline the organization necessary to accomplish this. There must be at least competent medical inspection of all school children and those of pre-school age, well staffed chest clinics, notification and follow-up of adults and children, hospitals, sanatoria, preventoria, open air schools and above all a well organized health department with a wise chief who has wide discretionary power.

With such an organization and with adequate facilities for survey, observation, diagnosis, treatment and follow-up, the incidence of infection, morbidity and mortality will show a marked decline.
EXPERIENCE WITH A HOME HOSPITAL METHOD*

BAILEY B. BURRITT

Director, Association for Improving Condition of Poor,
New York, N. Y.

The Home Hospital was wrought from the experience of the New York Association for Improving the Condition of the Poor. This organization is one of the oldest and largest voluntary organizations in New York City devoting its attention to problems associated with poverty. It has had a long history of relief administration to families in distress and a consistent and continuous record of initiating, demonstrating and introducing into social practice broad community projects aimed at the removal of conditions which have caused poverty and distress.

It found in its work that tuberculosis was one of the most prolific sources of poverty and the unsocial results flowing therefrom. For the simple purpose of giving background to the experience from which the Home Hospital grew, I would indicate that the Association has under its supervision during the course of a year, some for shorter and some for longer periods, approximately 7,000 families with approximately 36,000 individuals. Its expenditures for all operating purposes during this last fiscal year were $1,160,000. The daily average census of the families under care is approximately 2,300 of which approximately 400 are families in which diagnosed tuberculosis is a definite factor. In a careful analysis of expenditures it has been shown, however, that tuberculosis as a definite direct factor, accounts for one-third of the total relief expenditures. Indirectly, tuberculosis requires at least an additional one-sixth of all relief expenditures through being the most common factor in the death of bread-winners in widows’ families, which are under the care

*Read before the Annual Meeting of the National Tuberculosis Association, Washington, D. C., October, 1926.
of the Association, a little over 40 per cent of widows in need of care being widows, because of their husband's death from tuberculosis. Tuberculosis, therefore, accounts for about one-sixth of families under care of the Association and for about one-half of expenditures for relief purposes.

It has therefore clearly been the business of the A. I. C. P. to concern itself with the best practical methods of dealing with tuberculosis insofar at least as it affects the ability of families to be self-supporting.

One of the outstanding facts which was apparent from the experience of the Association was that no matter how adequate the facilities of the sanatoria and hospitals of the community, a very large percentage of cases of tuberculosis must be cared for and supervised in their own homes. (In May 1926, there were 6,634 cases of tuberculosis in institutions out of a total of 26,053 registered cases in New York City.) It was found that many cases never reach a sanatorium or hospital and that the experience of many more, who had for a short time been in a sanatorium or hospital, had been unsatisfactory both to the patient and the sanatorium, usually resulting in the patient's withdrawal from the sanatorium or hospital against the advice of the physician. The A. I. C. P. was the residuary legatee of many of these family situations. Not only that, it found that it was almost impossible to persuade the mother under any circumstances to go to a hospital or sanatorium and that in those cases where she was persuaded, it was necessary to break up the home at least temporarily by committing the children to institutions. The breaking up of a family with young children even for a temporary period is always a dangerous expedient.

**Organization and Methods**

It was out of experiences such as these that the Home Hospital grew. It was organized in 1912 by taking over an apartment house which was adapted and used for the purposes of the Home Hospital. Into these apartments families as a whole, suitably selected, were moved. The apartments were organized and placed under the direction of a carefully selected Medical Committee with an attending physician, a nurse, superintendent and necessary staff. Roof facilities for patients were provided and a playground for children. A common dining room was used for the children and adults in families where the mother's condition was such that she temporarily could
not go on with the normal processes of home life. Wherever the condition of the mother warranted it, however, the families continued to prepare their own food and to live their normal life, but under very careful and constant daily medical and nursing supervision with necessary income provided to make a normal life possible, where the income of the family made this necessary.

No family was admitted unless one or both parents had tuberculosis and unless there were children in the family. Families were admitted for a minimum period, as a rule, of six months although the average length of stay in the Home Hospital was longer than this.

The Home Hospital was maintained continuously from 1912 to 1925. In 1918, however, it was moved from the East River homes, model apartments in East 78th Street and John Jay Park, to a much more ordinary, normal apartment house located at 315 East 158th Street in the Borough of the Bronx. It thus demonstrated its possibilities with several years' experience under rather ideal apartment conditions and several years' experience under very ordinary apartment conditions. During some of this period accommodations were provided for as many as 44 families at one time, but during much of the time there were accommodations for only 20 families.

**Costs of a Home Hospital**

A summary of the cost experience of the Home Hospital shows that it cost about $6.93 per family per day or about $1.33 per individual per day, or attempting as Mr. Gebhart did to reduce this to cost "per ammain," the cost was $2.46, the "ammain" being the unit of value arrived at by reducing the expenditures of all the members of the family to the common denominator of the adult male. It is interesting in this connection to point out that of the total cost of $1.33 per individual per day, 96.7 cents were living costs and 36.6 cents were cost of nursing and medical services. It worked out in Home Hospital practice also that 47.3 cents of this 96.7 cents per capita per diem living cost was provided by the A. I. C. P. and 46.2 cents was provided from family earnings, the remaining 3.1 cents being provided from other sources. In other words, family earnings provided nearly one-half of the total living costs and the remaining one-half had to be provided by the A. I. C. P. in addition to the medical and nursing service.
RESULTS OF HOME HOSPITAL EXPERIENCE

The results of the Home Hospital experience have been published in much detail in various publications issued by the Association for Improving the Condition of the Poor. They have also been summarized in an article, prepared by Dr. James Alexander Miller and Mr. John C. Gebhart, which was published in the American Review of Tuberculosis for February 1925. It is not the purpose of this paper, therefore, to present in detail the results of the Home Hospital experience. I would refer, however, to the fact that Dr. Miller and Mr. Gebhart compare in tabular form the condition of the patients on admission at the Home Hospital with four other leading sanatoria and also the condition on discharge. This comparison, without going into detail, was interpreted by them as indicating that the results of the Home Hospital treatment compared favorably with results in our leading sanatoria. An attempt was also made to compare the results of a study made by the National Tuberculosis Association of 12,708 patients discharged from American sanatoria with the patients discharged from the Home Hospital. This comparison showed a much larger percentage of persons alive and able to work among patients discharged from the Home Hospital than was found in the follow-up of the patients discharged from leading American sanatoria, 60 per cent. being found alive and able to work as compared to 39 per cent. alive and able to work as found in the data studied by the National Tuberculosis Association.

Results secured with children also were very satisfactory in the Home Hospital. Indeed the progress made in contact cases of children constituted one of the greatest satisfactions in the experience of the Home Hospital. It has the additional distinctly advantageous results of educating a whole family as to methods of living, including food, rest, personal hygiene and the importance of constant medical examination and supervision. It was found, in short, as a result of the experience in dealing with children that it is possible to secure results with children in their own homes, continuing normal school life, that compare very favorably with results that can be secured by taking children from their homes and sending them to preventoria. It is significant also that in the whole Home Hospital experience no evidence was obtainable that any contact child developed tuberculosis under this plan of treatment.

It is not the purpose of this paper, however, to remarshal detailed information published elsewhere which supports the main con-
conclusions that the Home Hospital experience led to. I will, however, re-state in summary form the main conclusions arrived at. The facts gathered from this experience seem to point clearly to the following demonstrated conclusions:

1. That it is possible with carefully selected cases to keep the family intact and to make it a unit of preventive and educational work.

2. That this can be done and at the same time results can be secured for the patients in these families that compare favorably with results secured with patients in leading sanatoria and hospitals.

3. That this can be done without menace to the other members of the families, no such members so far as can be ascertained having acquired tuberculosis during residence at the Home Hospital through contact with tuberculous patients.

4. That in contact cases of children results can be secured that compare very favorably with results at the best preventoria and this without disturbing the normal family or educational life of the child.

5. That there are many advantages in the education of the whole family for future living to be gained by treating the family rather than the patient as the unit as was done in the Home Hospital.

A More General Application of the Methods and Conclusions of the Home Hospital

In 1925 the Association had under its care 761 families in which tuberculosis was a definite factor, with a daily census of such families ranging from 400 to 450. There were 737 tuberculosis patients in these families and there was a constant census of from 2,100 to 2,400 individuals in the families under supervision. Prominent among the purposes of the Home Hospital was the object of working out a method for making the combined medical and social supervision of this large number of families scattered throughout the Boroughs of Manhattan and the Bronx as effective as possible. In December 1925, the main aims of the Home Hospital having been accomplished, it was closed and the Association is now concentrating its efforts and its funds on a wider application of the Home Hospital methods and experience, first of all by applying these methods and this experience in its supervision of the families under the care of its Tuberculosis Division.

A specially trained group of nurses has been developed to deal with the problems in these families. These nurses are trained not
only to deal with the health problems involved but also as social visi-
tors to deal with the social and economic problems of the family. It
is our contention that it is well nigh impossible to separate the health
factors from the economic factors in these families and that a pro-
gram of health supervision of tuberculous families that does not have
prominent in it very definite plans for dealing with the economic
facts involved in the loss of income from the bread-winner of the
family through tuberculosis, not only falls far short of ever being
an adequate remedial program for the patients involved, but also falls
far short of being an adequate preventive program so far as pre-
veting tuberculosis in the next generation is concerned. The Home
Hospital with its 13 years of hard learned experience taught us the
essentials of dealing with health and poverty problems of tubercu-
lous families as a single inseparable problem. It taught us that you
cannot succeed in a radical re-education of a family in health habits
without accompanying the educational efforts with an adequate pro-
gram of seeing that the family has enough income to insure the es-
sentials of a decent standard of living including decent housing,
adequate nutrition and those other elementary necessities which go
with a decent standard of living.

We expended in our Tuberculosis Division last year a total of
$233,000 in our efforts to apply practically to a large number of
families the experience and conclusions of the Home Hospital itself.
As a result the Association is now accumulating a volume of ex-
perience in dealing with a considerable number of families that we
believe has much of significance in it for the whole tuberculosis move-
ment.

The foundation of the medical work of this larger application of
the Home Hospital experience of a community is based directly on
tuberculosis clinics maintained by the Board of Health and the vari-
ous hospitals, public and private, in the City of New York. To the
Tuberculosis Division of the A. I. C. P. are referred families which
combine both the problem of tuberculosis and an undermining of
economic independence. The supervision of these families has been
worked out with great care and has been intensively applied. It is
not only linked up closely with the tuberculosis clinics as the medical
foundation for its work, but it is also intimately linked up with the
tuberculosis hospitals and sanatoria of the community. These are
freely used wherever the condition of the patient makes this seem
necessary. The point is, however, that the family is kept under close
supervision, medical and social, whether the patient be in a hospital or sanatorium or in his home. This supervision is continuous and intensive and, where necessary, is accompanied by a supplement to the family income. It is not discontinued until at least twelve months after the patient has been an arrested case and has been restored to his ability to earn his own living and the living of his family, or until, if it be a progressive case, the family has been kept under supervision for at least twelve months after the patient has died. It is this precise, continuous, intensive supervision founded on medical diagnosis and periodical examination linked up with the use of the hospital and sanatorium where necessary, and accompanied by supplementing income where that be necessary, that the chief gain from the Home Hospital experience has come to the general field of dealing with families in which tuberculosis is a problem.

**APPLICATION TO THE WHOLE TUBERCULOSIS FIELD**

Drawing our opinions from the experience and conclusions which we arrived at in the Home Hospital experience we are convinced that the whole tuberculosis movement has a real vital interest in the application of this experience. Most communities have developed their hospital and sanatorium provision for tuberculous patients more fully than they have developed the community-wide facilities for dealing with a complete and continuous supervision of the family which has tuberculosis.

The objective which further progress would seem to point to is a more adequate development of social facilities including clinics and a carefully trained visiting staff of social work nurses that would make possible a much more intensive home supervision of tuberculosis with the family as the unit. This development should be accompanied by such a thorough coördination of the public and voluntary organization work in the community, including the clinic, nursing supervision in homes, the sanatorium and hospital, indeed, all the community facilities which can be brought to bear on the tuberculosis problem, that it results in a single, well knit unit of social engineering having as its main object a complete and continuous supervision of the health and social factors of the family as a unit from the time that tuberculosis is discovered as a factor in it until it has completely disappeared as a factor. In this supervision the family rather than the patient should be the unit of medical and nursing supervision.
EDITORIAL

Federal Health Correlation

The plan proposed by Representative James E. Parker for the coordination of the health activities of the National Government was not acted upon by the Sixty-ninth Congress, which came to an inglorious end on March 4th last. This measure will, therefore, have to be re-introduced next December for consideration in the Seventieth Congress. The only progress made on the bill at the last session was the holding of hearings before a sub-committee of the House Committee on Interstate and Foreign Commerce. These hearings, held on February 24th and 25th, were characterized not only by a brilliant array of witnesses who testified in favor of the plan, but also by the intelligent conception of public health activities and the apparent sympathy for the measure manifested by the members of the sub-committee, who included Messrs. Carl E. Mapes, John E. Nelson, Adam M. Wyant, Clarence F. Lea, and Parker Corning. The tardiness in reaching the hearing stage on the bill, nearly a year after its introduction, was, furthermore, not the fault of Congress, but was due to failure to secure earlier a favorable report on this proposal from the Director of the Budget. Such a report was, in fact, not obtained until the matter had been laid directly before the President, who was given a copy of the 425 book embodying a survey of federal health activities with recommendations for their more effective coordination, which had been issued under the auspices of the Institute for Government Research of Washington, D. C.

Public Health is, under our plan of government, primarily a state responsibility. The National Government does have certain legitimate functions in this regard, nevertheless, based chiefly on its exclusive power over interstate and foreign commerce. In order to exercise its health duties, there are now in the federal executive departments some forty administrative agencies which are interested directly or indirectly in some phase of the public health, although with about half of them the health work is of incidental or of casual
significance only. Half a dozen bureaus conduct health work of such importance that it comprises the major function of the particular agency, while in half a dozen other instances, the health work is of great importance, though secondary to the general scope of the bureau.

The remedy for this unsatisfactory condition lies in grouping together the chief public health agencies of the government, with the Public Health Service as a nucleus, or else providing for a system of liaison or coöperation by the detail of scientific personnel from a central federal health agency to other government bureaus which undertake health work, and which, because their major interest is in other lines, could not logically be transferred to the central health bureau. A well qualified assistant secretary for public health is another desirable step, though the creation of such an office was not called for in Mr. Parker's excellent bill.

The endeavor to secure a more efficient organization for federal health activities must go on. The Parker bill contained many other valuable provisions, such as that giving a status to sanitary engineers and other qualified scientists in the Public Health Service comparable to that now enjoyed by commissioned medical officers. It also provided for a national advisory health council. All of these items will be placed before the next Congress, and it is to be hoped that favorable action may be secured. But for the tactics of the Bureau of the Budget, the bill had an excellent chance of passage at the last session. It will certainly go through a year or so hence, not merely because the proposal is logical and has the support of the leaders in the public health field, but because health workers generally are going to get behind it and make it their business to see that Congress gives to public health the recognition which is due it.

James A. Tobey.
NEWS NOTES

The Massachusetts Institute of Technology, Cambridge, Massachusetts, announces a Public Health Institute for health officers and other public health workers, July 5th to August 2nd inclusive. The course includes biology, general bacteriology, health education methods, hygiene of the school child, public health and laboratory methods. The course is planned to provide for health officers or other qualified public health workers, an opportunity to study public health procedures and to examine modern public health practices under the direction of experts in the respective fields. For further information address Committee on Summer Session.

Civilization not so bad after all. It has long been held that civilization has an ill effect upon the physical condition of primitive peoples, but an examination of the teeth of over 6,000 Bantu children living in Kraal villages of the Transvaal showed that less than twenty per cent of them were free from dental defects, while fully forty-five per cent had at least mild physical defects due chiefly to malnutrition.—World's Children.

"Social Legislation," a small pamphlet published by the Public Charities Association of Pennsylvania, announces the glad and significant news that the main legislative objective of the Association at the past session of the General Assembly was the passage for the second time of the $50,000,000 Bond Issue for the State's unfortunate. This measure passed both House and Senate without one dissenting vote.

The following plan for cooperative health work of the Church and the Medical profession was announced in the editorial notes of a recent issue of Health and Empire, the official Journal of the British Social Hygiene Council.

"Dean Inge has made a proposal that will be welcomed by all British Social Hygiene Workers. It was made in the middle of
January at a meeting convened by the Societies of Medical Officers of Health, and it was that, if possible, the pulpit of St. Paul's Cathedral should be reserved on the Sunday nearest St. Luke's Day for a special sermon that should be delivered by a Medical Officer of Health. Dean Inge took a broad view of the whole situation and was inclined to blame the medical profession for having been less outspoken than they might have been on contagious diseases much more serious in consequences than smallpox."

The Legislature of the State of New York has approved of the request made by Mrs. John Alden, Honorary Chairman of the Department of the Blind of the State Federation of Women's Clubs, to increase the budget for the care of the blind babies and blind children too young to take advantage of the State Institutions. The appropriation now will provide for thirty blind babies at the rate of $1.50 a day, under the care of the International Sunshine Society, a Philanthropic Newspaper Club, Inc., with headquarters at 96 Fifth Avenue, New York City. This has caused much rejoicing all over the State. Blind babies will now be given scientific care and training from the time of their birth, in order that they may be ready for the New York City Institution for the Blind when they reach the proper kindergarten age. A blind baby needs help from the first day of its blindness if it is to be kept normal mentally and physically and social workers and public health nurses are requested to report such cases.

The 100th anniversary of the birth of Lord Lister, who introduced antiseptic methods in the practice of surgery was celebrated in England in April. Impressive services were held at the Royal College of Surgeons and at Westminster Abbey, where Lord Lister's body is interred.

The International Society for Crippled Children which convened recently emphasized cooperation and the need for "national programs." The Society will appoint a committee consisting of an orthopaedic surgeon, an educator and a layman to confer with the Chief of the Federal Census Bureau on the possibility of including cripples in the National Census for 1930.

A National Child-Welfare Conference has recently been held in Japan under the auspices of the Japanese Central Social Work
Association. The 350 delegates represented both public and private agencies and came from all parts of the Empire. The problems of certain classes of children in need of special care, the desirability of child-welfare legislation and of subsidies from the Government were discussed and suggestions made for the inclusion of unmarried mothers and deserted wives as beneficiaries of the mothers' pensions proposed for widows and their children in a bill drafted by the present Japanese ministry.—*World’s Children.*

Dr. H. C. Schumacher of Cleveland, Ohio, has been appointed director of the new permanent child guidance clinic organized in Cleveland, Ohio, to succeed Lawson G. Lowrey's successful experimental clinic.

The American Public Health Association has instituted a custom which will receive instant approval of the Association members, of sending out from time to time friendly and interesting news letters. This means of direct communication between the Executive Secretary and the members will undoubtedly foster and stimulate a better spirit of cooperation and create a greater interest in the work of the Association.

About sixteen years ago physicians in this country began the general practice of dropping a medicinal solution in the eyes of new-born babies in order to prevent ophthalmia neonatorum, or blindness resulting from eye infection at birth. The treatment is proving effective, for while twenty-five years ago one of every three children in the schools for the blind in the United States was blind from this cause, in 1926 the proportion had been reduced to about one out of every ten. As an indication of the success which may follow special efforts by the health authorities, Maryland's two State schools for the blind reported not a single pupil admitted in 1925 who was blind from this type of eye infection. The State has made the disease reportable, like diphtheria or small-pox, and its board of health supplies the preventive solution to physicians free of charge.—*World’s Children.*

The American Association for Medical Progress, Inc., 370 Seventh Avenue, New York City, in recognition of the Lister Centennial celebrated in England in April, has issued a very interesting resumé of the life and achievements of the man who did so much for
the advancement of medicine and surgery. The material is intended primarily for teachers of hygiene, biology and science, but will be of value to anyone interested in the conquest of disease. A list of reference books is included.

The New York Office of the National Jewish Hospital, Denver, Colorado, formerly located at 1737 Broadway, has moved to Room 903, 119 West 57th Street. Applicants for the hospital, which is free and non-sectarian, will be interviewed every day, excepting Saturday and Sunday, from 9 a.m. to 5 p.m.

The New York Maternity Centre Association takes care of pregnant women, and last year—1926—it was so successful in this work that not one of the 2,000 mothers cared for died as the result of childbirth. If this group had shown the same maternal death rate as that for the city in general, eight or more of the 2,000 would have lost their lives. The Association formerly gave care exclusively to poor women, but last year it offered its services to mothers of the professional and salaried classes and nearly 200 such mothers took advantage of the offer.—World's Children.

Dr. Erich W. Schwartzze has been appointed to the senior incumbency of the Multiple Industrial Fellowship on Cooking Utensils of the Mellon Institute, University of Pittsburgh. This Fellowship has been established for the purpose of making a comprehensive chemical and pharmacodynamic study of the effects of the corrosion of metallic cooking utensils on food and health.

Miss Bertha Strange, formerly Executive Secretary of the Committee for Crippled Children of the Brooklyn Bureau of Charities, has been appointed Executive Secretary of the California Society for Cripples.

A new Red Cross outpost has been established at Bancroft, North Hastings, Canada. The opening of this outpost in so remote and sparsely settled a section is a godsend to the settlers, as the nearest hospital is 150 miles away.

Mr. and Mrs. Alfred A. Cook of New York City, recently gave $50,000 to the Mount Sinai Hospital Social Service Department for
special and experimental work. Bequests and gifts to hospitals and clinics are of such frequent occurrence that they excite little comment outside the walls of the fortunate institution, but the bestowal of so large a gift of money for furthering the interest of medical social service is rare—if indeed it is not the first to be recorded.

The Training School for teachers of backward or mentally deficient children, Vineland, New Jersey, has announced the nineteenth session of the summer school, from July 11th to August 19th.

The Winfield Day Nursery is the name of a new nursery opened at 75 Horatio Street, New York City.

The Wisconsin Association for the Disabled reports that 78 per cent of the crippled children found in its survey of Fond du Lac County were disabled before the age of seven years. This fact seems to emphasize the need for physical examination of the pre-school child.—World’s Children.

Health News reports that Dr. Le Roy W. Hubbard, Sanitary Supervisor of the New York State Department of Health and orthopedic surgeon in charge of the after-care of poliomyelitis cases in the State, has resigned to accept the position of Director of the Hydrotherapy Centre at Warm Springs, Georgia. The Centre consists of several hundred acres, spring, pool, hotel and cottages, and has been purchased by Franklin D. Roosevelt, and is now open for the treatment of poliomyelitis cases from all parts of the country. The work is to be carried on on a semi-philanthropic basis, the only cost to the patient being that of actual maintenance. Mr. Roosevelt, who himself was a victim of poliomyelitis during his childhood, feels that the warm mineral spring water will be a valuable therapeutic remedy in the after-care treatment of poliomyelitis.

The May-June issue of The Crippled Child, a magazine published by the International Society for Crippled Children, is edited in the form of an anniversary number in honor of the birthday of “Daddy Allen,” otherwise known as Edgar F. Allen, President of the Society, who has devoted twenty years of his life in the interest of crippled children.
The Minister of Health and Social Welfare of Chili, recently issued a decree for the institution of a Nurses' Home in Santiago. The aim of this institution is to contribute to the moral and material welfare of graduate and other nurses recognized by the Medical School of the University of Chili: (1) By bringing the nurses into closer touch with one another. (2) By protecting the interests of the nursing profession. (3) By doing all in its power to raise the standard of the nursing profession and to confer on it the dignity and social standing it enjoys in other countries. (4) By facilitating the professional improvement of its members through the provision of a library and the organization of courses, lectures, scholarships and study trips abroad. (5) By founding a magazine to be called the Enfermera Moderna (The Modern Nurse). (6) By establishing a social centre to be known as the Nurses' Home. (7) By creating an information bureau which will act as an employment office and will draw up rules governing the employment of nurses. (8) By encouraging and facilitating saving and insurance on the part of the nurses. (9) By establishing a code of nursing ethics. The Nurses' Home will enjoy the privileges of a corporate body and will have three classes of members—honorary, contributing and active. Active members, who shall be nurses holding diplomas from the University of Chili or from other officially recognized schools, alone have the right to vote. Inf. Bul. League of Red Cross Societies.

A lip-reading department under the direction of the principal of the Detroit School for the Deaf has been established in the elementary schools of Detroit, Michigan.

The Greek Red Cross is conducting a vigorous campaign against malaria.

The National Urban League of New York City has moved its office from 127 East 23rd Street to 17 Madison Avenue.

The National Bureau for Maternity and Infant Welfare of Italy is sponsoring courses on prenatal and postnatal care for graduate physicians and for midwives. All applicants for positions with institutions or agencies established or subsidized by the Bureau must possess diplomas showing that they have successfully completed the prescribed course.
Wisconsin sends out a traveling children’s clinic called the “Child Welfare Special,” which visits rural communities remote from cities and hospitals. During the past five years this “Special” has traveled about 30,000 miles, visiting seventy counties of the State and examining 23,579 children. Most of the children were infants or of preschool age, and more than three-fourths of them were found to have preventable or remediable defects. The doctor and nurse of the “Special” give no medical treatment but provide the parents with records of the physical difficulties of their children and suggest that they be taken to the family doctor. This traveling clinic is very popular, and many requests are received from parents, teachers and local officials for its return.—World’s Children.

The original private pavilion of Mount Sinai Hospital, New York City, is to be remodeled to accommodate private patients of moderate means.

A health clinic has been opened at the Broad Street Hospital, New York City.

Miss Adele S. Poston has opened a psychiatric nursing bureau at 124 East 40th Street, New York City. The purpose of the bureau is to supply hospitals and private individuals with nurses, occupational therapists, physical therapy aides, etc.

The late L. N. Littauer of Gloversville, N. Y., bequeathed the sum of $5,000 a year for five years to Cornell Medical College to establish a fellowship in the chemotherapy of cancer.

COMING MEETINGS


American Hospital Association, Minneapolis, Minnesota, October 10-14.
BOOK REVIEW


Accurate information interestingly presented and written in simple terms, is available in this new book by an author and scientist of standing. His effort to bring together and put in logical sequence information concerning recent developments in the knowledge of human reproduction has had a happy result and his direct approach to and common sense handling of his subject matter are most refreshing. He has scorned the circumlocutory "hems and haws" of many previous attempts in this field and has stated his facts without giving the reader the impression given by some previous writers in this territory, i.e. we must be extremely delicate as we are treading on dangerous ground.

In his opening chapter the author deals with the various "differences" distinguishing male and female. He follows this by two most helpful chapters on the mechanism of reproduction (a) in the male and (b) in the female, using scientific terms to some extent but keeping his discussion understandable to the reader who has a reasonable knowledge of biology and physiology. (This is true of the entire book and we doubt if any devotee of the "tabloids" would get far in it.)

Succeeding chapters take up such subjects as the implantation and development of the embryo, pregnancy, childbirth, sterility, menstruation, circumcision, miscarriage, and the book concludes with a chapter on "Happiness in Marriage." A table of references and a carefully compiled index are further aids to efficient reading and study.

We believe that this volume will be found helpful to any intelligent person who wishes to be informed on the problem it deals with and that it will prove a most useful addition to social hygiene literature.

—Ray H. Everett.


Dr. Meaker has produced a book which will be welcomed alike by the medical profession and mothers or expectant mothers. Physicians are now able to put in their patient's hand a book containing authorita-
tive advice and instructions at a time when the mind is most receptive to such teachings. Every physician wishes his patient to know the facts about pregnancy and childbirth but few indeed have the time to impart such knowledge in full detail. Dr. Meaker has done this in so clear and simple a manner that any woman of ordinary intelligence will be able to understand her condition and by following the advice and instructions during the period of pregnancy will do much to insure her child being well born.

The first chapter is devoted to the mother, the child and the race as inseparable in thought; better mothers means better babies, and better babies means a stronger and more vigorous race. Chapters two and three, by means of scientific but simple test and illustrations, teach enough of the physiology of the mother's body and the development of the child before birth to give the mother an intelligent understanding of the phenomena of reproduction. The rest of the book is devoted to the symptoms and signs of pregnancy—what to expect and how to meet each step, the every-day hygiene to be observed, including rules for diet, care of the teeth, sleep, rest, exercise, fresh air, clothing, etc., etc. Chapter seven discusses the special disorders and discomforts frequently attending pregnancy and how to avoid them. Chapter eight deals with the necessary preparation for mother and baby and chapter nine with the arrival of the baby. The succeeding chapters are devoted to the lying-in mother, the care of the newborn infant and after-care of mother and child. In referring to the expectant mother the word patient is used throughout the book, not because the woman is ill but rather to emphasize the fact that the expectant mother should be under the care of her own physician during the entire nine months of pregnancy.

The book teaches that prevention rather than cure is doubly applicable to to the expectant mother and unborn child, as not only the mother's health is involved, but the future health of her child and through her child the future generations. The book is an inspiring one and should be placed in the hands of every intelligent expectant mother to prepare her for motherhood.


Feinblatt has written an excellent, concise and practical book on a subject of growing importance. The style is clear and in spite of the fact that the book only covers one hundred and thirty-three pages
there is very little omitted. The detailed description of technic should be especially helpful to the beginner. If the author devotes a somewhat disproportionate amount of space to the transfusion method devised by himself who can blame him? He regards it as the best method and perhaps it is. The discussion of underlying physiological considerations is brief but clear and might well serve the interested layman who wishes an introduction to the subject.

From the point of view of the hospital there is one vital subject omitted—an omission for which the author cannot be blamed. The whole question of the best methods of organization for securing, examining and handling the increasing numbers of professional donors now used in our hospitals has not yet received the attention which it deserves. Where organization exists at all it has grown up haphazardly. Some hospitals actually depend on the irresponsible commercial "donor exchanges" which have sprung up. In other hospitals there is so much division of responsibility between laboratory, interne and visiting staffs, that hours are wasted in obtaining donors for cases in which minutes count.

The subject is a large one and cannot be discussed here: perhaps in a future edition of his book the author will give it the consideration which it needs.

—R. Ottenberg, M.D.

**NEW PUBLICATIONS**

What Constitutes Adequate Medical Service? Samuel Bradbury, M.D., introduction by Richard C. Cabot, M.D., published by the Committee on Dispensary Development of the United Hospital Fund of New York. This study was undertaken in order to determine what the term "adequate medical service" really means and to establish a definite standard for future work. With this object in view some 200 ambulatory cases of the Cornell Clinic were carefully investigated and studied. The analysis of so small a number of cases will not be of any special value from a statistical point of view, nevertheless many interesting facts have been brought to light on two important and somewhat neglected phases of medical service: e.g. the analysis of the aspects of treatment which involves the intelligence and cooperation of the patient and the formulation of criteria of methods whereby results of treatment can be systematically judged.
The fact that ambulatory clinic cases are more difficult to diagnose and treat to a successful finish is brought out in the report. "Disability rating," or in other words an estimate of the patient's physical condition, was found useful to the physicians in working out a plan of treatment and for the purpose of judging results. In outlining plans for treatment the function of the medical social worker was an important one as her appraisal of the patient's intelligence, personality, background and resources was of great assistance to the doctors in removing obstacles in the way of successful treatment. The author emphasizes the fact that the study is not at a number of points conclusive, but hopes that as a piece of research work in a new field it may stimulate others to make similar investigations with a large number of patients. Dr. Richard C. Cabot in an introduction characteristically sums up in a few words the past and present shortcomings of out-patient department care and approves wholeheartedly Dr. Bradbury's frank analysis of the practice of medicine, treatment and results as found in Cornell Clinic and concludes by saying "All of us, who are interested in hospital work are to be congratulated upon the completion of this admirable survey by the Cornell Medical Clinic."

Copies of this study may be obtained without charge from the office of the Associated Out-Patient Clinic Committee, 244 Madison Avenue, New York City.

Securing Employment for the Handicapped. A Study of Placement Agencies for this group—in New York City, by Mary La Dame of the Department of Industrial Studies, Russell Sage Foundation, and published by the Welfare Council of New York City. This valuable study of the placement of the handicapped was made at the request of four New York City agencies interested in rehabilitation work, for the purpose of determining if possible, a means of pooling interests and working out a program which would eliminate duplication of effort and to formulate a more constructive policy for future work. The report points out the extent and variety of services which are being carried on by organizations engaged in rehabilitation and placement work and describes their services and analyzes their inter-relationship in a clear and comprehensive manner. The subject of the study is well handled and impartially analyzed; the conservative and well thought out recommendations for a more cooperative and efficient working plan, if accepted by the various agencies, will lead to a more
constructive policy and better work. This report will be of value to all agencies and individuals interested in the employment of the handicapped.

The Annual Report of the Association of Day Nurseries of the City of New York. This interesting report gives an account of the work of the Association for the year and in addition gives a report of the annual meeting as well as the Conference of the Association held recently.

Deaths from Lead Poisoning. By Frederick L. Hoffman, L.L.D., U. S. Department of Labor, Washington, D. C. This interesting statistical report of chrome lead poisoning in the United States and foreign countries will be of great value and interest to those engaged in or interested in industrial hygiene. Bureau publication No. 426.

The Nineteenth Annual Report of the Colored Orphan Asylum and Association for the Benefit of Colored Children. This interesting report gives a brief synopsis of obstacles overcome in the early days of organization when race prejudice made it impossible to rent a building for the purpose. A cottage in Twelfth Street near Sixth Avenue was purchased, and a few children who otherwise would have been sent to the Almshouse, were admitted to the Asylum. The work has grown steadily and at present 435 children are cared for in the beautiful home buildings in Riverdale-on-the-Hudson, and being trained to take their places in the community as self-respecting, self-supporting citizens.

Public Aid to Mothers with Dependent Children. By Emma O. Lundberg and issued by the U. S. Department of Labor, Children’s Bureau, Bureau Publication No. 162, is an interesting account of the growth and development of State aid for dependent children in their own homes. The inception of this plan of conserving the home for the child was due largely to the late President Roosevelt, who in 1909 called a conference on the care of dependent children. The principle of home care met with ready response and has been adopted by many States. In 1926 forty-two States and Alaska and Hawaii had adopted laws authorizing this form of assistance. The report outlines the fundamental principles of the work, its scope and the extent of its adoption and practice by the various States. Single copies may be obtained free upon request. Additional copies five cents the copy.
The Twenty-ninth Annual Report of the Guild of the Long Island College Hospital. This interesting report gives an account of the activities of the Guild, which contributes by divers ways to the support of the hospital and the comfort and welfare of the patients. The Guild also acts in an advisory capacity to the Director of Social Service. The members render valuable assistance in the routine hospital work by giving their time to practical work, such as preparing dressings, etc., and by serving as clerical aides in the various clinics.

Women Workers and Industrial Poisons. By Alice Hamilton, M.D. and issued by the U. S. Department of Labor, Women's Bureau, Washington, D. C. Bureau Publication No. 57. This interesting reprint of an address delivered before a recent meeting of the Women's Industrial Conference deals in a comprehensive way with the employment of women in trades involving health hazards, usually in the form of poisonous materials, dust and vapors.

Changing Jobs. Published by the U. S. Department of Labor, Women's Bureau, Washington, D. C. Bureau Publication No. 54. This study, which was made by students in the economic course at the Bryn Mawr Summer School, under the direction of Professor Amy Hewes throws interesting light on industrial conditions as they affect women. The report is interspersed with tables in which the labor turnover of women is analyzed according to nationality, age, years of experience, trades, duration of employment, etc. etc.

ABSTRACTS

"The Prenatal Care Demonstration in Tioga County." R. W. Lobenstein. *Child Health Bul.*, 1927; III, 37. A few years ago it would have been a bit disconcerting to be told that any phase of public health work is accomplished under greater difficulties in a rural community than in a city or town. We have been forced to realize that urban dwellers have a better chance for health and hygienic living than their rural neighbors. This is particularly true in the field of maternal and infant welfare. In the cities the problem of providing adequate care for the expectant mother has been faced with intelligence, zeal, and as the author states with definite success in some cities, and as an example cites the splendid achievements of the New
York Maternity Centre Association in New York City. “This organization has endeavored to face the many questions that arise in the development of a maternal welfare program amidst city life; there has been definite standardization and progressive education as well, of doctors, nurses and mothers.” When Sheppard-Towner funds became available the New York State Department of Health expanded its maternity welfare work and in cooperation with the Maternity Centre Association the now well-known maternity nursing program was established. The work was placed under the direction of that organization and the nurses were chosen from the Association’s staff because of their special qualifications for demonstration work. Every effort was made to enlist the sympathy and interest of the medical profession through the County Medical Society. In January 1925, one prenatal clinic was opened; others followed. Each clinic was equipped with a teaching exhibit, and consultation and demonstration clinics were held. The nurses made home visits and gave talks at county fairs, women’s clubs, etc. From the very beginning the mothers welcomed the service and the doctors came to realize the value of prenatal follow-up and appreciated the fact that the nurses stood ready to aid them if necessary at the time of confinement. Tioga County, which has a population of approximately 25,000, was chosen for the experiment because of the general intelligence of the people and because its size made it possible to establish easily accessible centres. The fact that the doctors were generally interested and therefore cooperative was also a determining factor in the selection. During 1925 there were 247—or more than half of the expectant mothers of the community, under care; sixty-three per cent of the cases were being referred by physicians. In 1926 the number of patients increased to 356, and of this number 133 were reported by physicians and 116 by laymen; there were 238 deliveries with 225 live births. During these two years there were no maternal deaths. The author realizes that the experiment was conducted on too small a scale to be of any statistical value, but feels that the educational value of the work cannot be appraised. It has aroused an interest in preventive medicine and established the fact that prenatal care safeguards both mother and child and that good medical care during pregnancy and at delivery is necessary.

“The Problem of the Cripple.” E. F. Allen. *Occup. Ther. and Rehab.*, 1926; V. 259. This interesting article makes it possible to appreciate the great need for uniform method and cooperation in
working out a solution of an ever present community and state social problem. In discussing his subject the author deems it advisable to define the meaning of the term cripple, and qualify the term. To this purpose the cripple is "one who by reason of congenital or acquired defects of development, or trauma, is deficient in the use of body and limbs." Another definition for the orthopedic cripple or handicapped person is that of "A person whose (muscular) movements are so far restricted by accident or disease as to affect his capacity for self-support." The author also quotes another description which applies to all ages and conditions as "one whose activity is, or, due to a progressive disease, may become, so far restricted by loss, defect, or deformity of bones or muscles, as to reduce his normal capacity for education or self-support." Communities are prone to say that they have few or no cripples; this belief has been shattered in many instances. A survey usually uncovers evidences to the contrary. When the census is complete three phases of aid must be considered: (1) professional need; (2) economic need; (3) humanitarian need. The professional need includes medical and surgical care, hospital nursing, social service, convalescence, physiotherapy, special classes in schools, occupational therapy, employment service, etc. The economic need includes the cost of care, relief, education, placement, etc., which must be available not to the few, but to all cripples. The humanitarian need embraces all that the word humanitarian means and affords a splendid opportunity for the layman, fraternal organizations, women's clubs, etc. for service. The layman as well as the various organizations can be instrumental in awakening interest in the cripple and by supporting civic and legislative measures which are introduced in the interest of the handicapped. Coördination of all agencies representing the professions, lay organizations and the state is essential if a successful program of rehabilitation is to be carried out effectively. It has been stated that there are probably 500,000 crippled persons under twenty-one years of age in North America. The average self-supporting citizen is estimated to represent a money value of $10,000 to his country. In the face of these figures this army of handicapped persons represents a tremendous social problem. But great as the financial loss is, it pales into insignificance when balanced against the cripple's sense of inferiority, unhappiness and dependency. The cripple has always been recognized as a problem and as the author states, has been until recently greatly misunderstood and therefore badly handled. The International Society for Crippled Children is an effective solu-
tion to the problem and invites the systematic, intelligent aid of all people and organizations interested in the rehabilitation of the handicapped.

“Nursing Outposts in Canada.” F. W. Routley. World’s Health, 1927; VII, 127. This fascinating account of pioneer health work carried on by the Canadian Red Cross in the vast unbroken forest tracts of Canada will give every adventurous nurse a thrill plus a strong desire to render service to the daring band of settlers wrenching their homes from virgin forest land. The author makes it possible to visualize the great unbroken stretches by giving a few figures which show the vastness of the country. There are 3,500 miles from the Atlantic to the Pacific with a population less than ten millions and eighty per cent of the people living in towns and cities which comprise a very small percentage of the total area of the country. The courageous pioneers with their wives and children founding homes in the wilderness are in dire need of nursing and medical care. “In one district may be found a group of settlers scattered here and there over an area of 1000 square miles or more.” The fact that these settlements are from 50 to 100 miles from the nearest doctor leaves no doubt in one’s mind as to the urgent need of the Red Cross outpost and nursing service. While the nurses are not supposed to act in the capacity of a physician, sudden illness, childbirth and emergencies force them to render medical aid. The author aptly describes a nurse in such a district as the physical Mother Confessor and Sister of Mercy of the whole community. The author sketches briefly but clearly the method of financing the project, the policy or policies observed according to requirements, the aim and achievement, and the effect on both the supporters of the work and the people in the settlements. It is about five years since the first outpost was established and a few figures will suffice to show the study, growth and development of the work. In 1925 there were—nurses employed, 52; bed accommodations for patients, 160; in-patients admitted, 2,138. Total hospital day of in-patients, 24,404; births in out-posts, 427; major operations, 259; minor operations, 694; home visits for nursing care, 3,152; home visits for consultation or advice, 966; confinements in homes with doctor attending, 19; confinements in homes without doctors attending, 114. These few figures quoted from the report give an idea of the services rendered. It is estimated that the 1926 figures, when completed, will be one-quarter to one-third larger. The author
emphasizes the fact that the nurse for this pioneer work must be not only highly trained and efficient, but specially prepared by a course in welfare work and public health nursing. To meet the demand for such training several Canadian Universities are giving this course as part of the regular university work.

"Music in Medicine." E. W. Grothe. *Occup. Ther. and Rehab.*, 1926; V. 353. This interesting article on the importance of music as an aid to recovery and rehabilitation will stimulate nurses and occupational therapists to take a keener interest in music and to acquire a broader knowledge of the subject. In the realm of therapeutic treatment music harks back to ancient times. The Egyptians used it in the form of incantations. King Saul's demon of unrest fled while David played his harp. Two centuries after the birth of Christ flute music was used by Aulus Gellus for sciatica. Music was used in the Spartan armies for the same purpose and with the same effect as it is today. The physiological effects of music are many: a few briefly quoted are, metabolism is increased, muscular energy is decreased and increased; music also has a marked effect on the volume of the pulse as well as upon the blood pressure: fatigue is noticeably reduced and the whole system responding to suitable harmony, is rested and stimulated to do coordinate work. In the case of nervous and mental cases the therapeutic effect is even greater; moody forebodings, fear, terror, grief and rage all respond to the soothing effects of melody. During the convalescent stage of illness music has a tendency to promote fresh interest in recovery and life. Singing expands the chest muscles and is especially beneficial in the treatment of diseases of the lungs. The author emphasizes the fact that music as a therapeutic measure should not be employed unless under the careful direction of a physician. Individual patients must be carefully studied as the success of the treatment will depend upon the temperament of the patient, his knowledge of music and the music chosen for treatment—this is particularly important in dealing with nervous and mental cases. While the effect of music has been more or less understood and spasmodically used throughout the centuries, in the actual field of nursing and occupational therapy as an aid to recovery it is quite new.

the venereal diseases. When clinics were established for the free
treatment of these diseases it was found that in order to do effective
preventive and control work it would be necessary to provide some
means of resident care during the acute stage of the disease. Many
of the patients treated in the clinics are working girls, who when
free from infection are capable of returning to their former occupa­tions. To bridge this gap between the acute stage and the stage when
the patient is no longer a menace to others, hostels were established.
The author describes two of these lodgings—one for pregnant, the
other for non-pregnant cases—attached to the Royal Free Hospital,
London. Two roomy London houses, surrounded by large gardens,
were chosen as being particularly adaptable for such purposes. There
is no atmosphere of a detention home and life is carried on under
pleasant conditions. Each hostel is in charge of a fully trained sister
who has a staff of three or four nurses to assist her. While in resi­
dence the girls attend the hospital clinic twice weekly for inspection,
and if necessary have daily treatment in the hostel. Patients remain
in the hostel until pronounced non-infectious. Before discharge the
patient is warned against neglecting treatment and so far there has
been very little difficulty experienced in getting them to return to the
clinics regularly. Those who neglect to return are carefully followed
up by the almoner of the clinic. The non-pregnant case usually re­
mains in the hostel from two to three months; the expectant mother
remains longer, usually three or four months after the birth of her
baby. During this time the infant is breast-fed and given every
possible chance for health. Every effort is made to keep mother and
child together but where it is impossible for the mother to secure
employment with her child the baby is placed in a carefully selected
foster home and if the mother cannot meet the expense the almoner,
through cooperation with one of the many relief agencies, provides the
necessary funds. Supervision, interest and care do not cease when
the patient is pronounced non-infectious. Every social problem is
considered and adjusted according to the need. Considering the vari­
ous activities carried on in the campaign against the venereal diseases
there appears to be none finer or more worth while than the establish­
ment of hostels for women and girls. In these homes every provision
is made for the spiritual, mental and physical welfare of the patients
and small wonder it is that they respond wholeheartedly to the sym­
pathetic and understanding care of doctors, almoners and hostel staff
workers.
"The Development and Extension of the Parole System of the New York State Hospitals." H. M. Pollock. *Psychiatric Quart.* 1927; I, 53. The parole system as we understand it today, evolved in part through the sidestepping of an obnoxious law. Chapter 446 of the Laws of 1874, the general Insanity Law which preceded the State Care Act of 1890, provided that "no insane person confined in any county poorhouse, or county asylum, shall be discharged therefrom . . . without an order from a county judge or a judge of a Supreme Court." This law did not apply to the Counties of Kings and New York. In up-State institutions the physicians either disliked taking the responsibility of making out the required certificate or going through the form of appeal to the authorities; therefore, while the law definitely stated that no patient could be discharged unless through the regular official channels, there was nothing said about allowing patients to leave the institution for a period of time. It was found expedient to grant this privilege to patients whose conditions warranted freedom from custodial care. Thus the system of parole was unofficially but firmly founded. In recent years the Law has been amended and we are all familiar with the enlightened attitude of institution authorities, the courts, the Legislature and the general public towards mental illness. The function of the hospital for the insane is now looked upon as curative rather than custodial. Among the many important developments affecting the parole system is the provision for after-care of the patients. After-care consists of three principal factors, e.g. voluntary after-care committees, social workers, and mental clinics. The late Louise Lee Schuyler, with her unusually rare vision, organized the first after-care committee in 1906. This Committee was connected with the State Charities Aid Association. A social worker was engaged and she began her work with the paroled and discharged patients of the Manhattan and Central Islip State Hospitals. In 1913 the Legislature passed a Bill providing for the establishment of dispensaries by the Superintendents of State Hospitals. At the end of the fiscal year of 1906 there were 196 patients on parole from civil State hospitals; these figures represented 0.7 per cent of the total patient population. In 1910 the number on parole reached 589 and in 1913, 813. In 1913 further impetus was given to the movement largely through the publication of papers written by eminent authorities. More social service workers were engaged and a start was made in the organization of out-patient clinics. At the end of that year there were 1300 patients out on parole. The impor-
tance of these clinics has been demonstrated. In 1920 the daily average number of patients on parole reached 2,322 and in 1925, 3,362. In 1926 the number dropped to 3,231. Figures showing the percentage of patients on parole in many institutions are also given. The author considers, in view of the serious overcrowding of institutions for this type of patient, and basing his opinion on previous experience, that an increase in the number of paroles might be made safely. The first three months of hospital care are the most important in determining the future status of patients and the treatment should be as specific and intensive as possible. The author calls attention to the fact that the transition from hospital to community is too much of an ordeal for many patients and considers an intermediate placement, such as a farm colony similar to the Lake Farm of the Rochester State Hospital, or a sheltered workshop colony like that established at Papworth, England, for arrested tuberculosis cases, desirable. The author deplores and protests the outcry against the parole of patients when one of their number commits a crime; this he considers unfair to the vast majority of patients and gives figures to prove that paroled patients on the average commit fewer crimes than so-called sane people of a like age distribution. An intensive study made by Dr. Ashley of 1,000 paroled and discharged patients covering several years brought to light the interesting fact that only twelve had been arrested, an annual rate of only a fraction of one per cent which is decidedly a good showing as in many communities the annual number of arrests equals five per cent of the population. This article will be appreciated by any one interested in the preventive and curative aspect of the parole system as it affects nervous and mental cases.

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