AFTER SANATORIUM—WHAT?

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If it is true that it takes from two to five years to effect a cure in the instance of tuberculosis, and that the average stay at a sanatorium is six to nine months; that a well conducted sanatorium is fundamentally an educational and training institution, it is fair to ask after sanatorium—what?

Many years ago, in a circular appealing for funds, we asked two questions: Would you help a blind man half way across Broadway and then leave him to find the rest of the way as best he could? Would you help a patient with tuberculosis half way across the road to restored health and economic usefulness, and then leave him to find the rest of the way as best he could?

At the institution the patient soon learns the “sanatorium glide” and the philosophy of selfishness. After his, often too brief, sanatorium experience, his family who have been anxiously awaiting his return expects him to take his old place. There is a clash, for his new philosophy has no place in the normal family home. His friends if considerate, allow him a few weeks for readjustment and welcome him as an active member of the circle. If his family is dependent, the social worker eagerly awaits his return. She has perhaps been making a generous allowance. Now that the man has returned he can relieve the agency and there is a clash between the social worker and the patient.

We are satisfied that he has been demoralized—he has been. There is a conflict between all the elements of cure as he has learned it—self-interest and self-preservation; when in doubt—don’t; learn not to worry for mental rest is as important as physical rest; cheerfulness helps you as much as it does others—and the every day life which when reminded is kind and sympathetic, but in the bustle demands the maximum return from each member of the community.
The man with one arm has the serious problem of readjustment. The man with tuberculosis has, in addition, the constant fear of relapse; and experience shows the percentage of relapse is very high. Several studies showed relapses after sanatorium experience ran as high as fifty per cent.

As with all problems, to understand its extent and difficulties, is the first step towards solution. A sympathetic appreciation of the problem of "after the san" is essential. I am not urging a sentimental interest. Much harm is done patients by well intentioned people, who constantly remind them that they must be shielded from the cruel world; who preach well, frighten effectively and often the only real assistance they render, is a bottle of milk.

The problem is one of gradual readjustment. There are general principles, but the application must be individual. The ideal is to fit the work to the changing physical condition of the patient; to allow the patient to help himself.

The man on the street is apt to judge health work by its fruition. Can the patient who has tuberculosis be returned to a normal life and made economically useful, so as to maintain himself, and if he has a family provide for this family?

The problem is complicated by many factors in the personality, experience and education of the patient, as well as his physical condition. Fortunately a large percentage of the tuberculous make their own adjustments. Where his physical condition is good and the patient succeeds in placing himself he is apt to be more successful than we are and the percentage of relapse is apt to be less than among our group. He usually secures a job at his old trade with much higher wages than the placement worker can secure, and we know high wages is one of the most effective cures for tuberculosis.

Among those who cannot place themselves we find the most difficult patients, many who were unequal to the competition of the so-called normal life before they developed tuberculosis. Perhaps social workers who are our severest critics, compliment us when they expect that we will secure an abnormal response from this subnormal group. Many whom we find incompetent and illiterate are unskilled workers because they never had an opportunity to learn a trade. They require trade training as well as physical rehabilitation.

The other participants in this program are better equipped to discuss placement and re-training of the handicapped. I would rather discuss briefly the problem of that large number of sanatoria gradu-
ates, who on discharge are unequal to the full time job or whose work capacity is uncertain. Many of these patients are permitted to stay at home or forced to enter institutions because the doctor or the social worker cannot secure the work which they feel the patient may reasonably undertake. As we have tried to indicate, we have a mental as well as physical problem; we have a breakdown in morale, a fear, perhaps an exaggerated fear of relapse to overcome.

The light out-door jobs are myths for the most part, and where they exist are usually light in pay. Part time jobs in industry are rare and difficult to secure, although they offer the greatest hope for the successful placement of a large number of patients.

To meet the need for graduated work and to determine whether a rounded out scheme of medical, social and industrial care of the tuberculous might reduce the large percentage of relapses, the Altro Work Shop was started in June, 1915. Here the doctor is the boss as far as hours of work are concerned. He prescribes maximum hours on periodic examination. It is recognized that the family must be the unit of care to secure maximum results and experience has shown that medical care of other members of the family is almost as important as medical care of the patient himself. As part of social care, the family is assured the necessary minimum income. Where relatives are not in a position to assist, the patient receives his necessary minimum in his weekly pay envelopes. This minimum is made up of cash representing earnings, and a personal check for the subsidy. The patient is said to be proving out, if, in the course of time, his hours of work increase, which means improvement medically, and the cash or earnings increase, indicating improvement in effort. As he becomes proficient and his earnings increase, he is allowed more than the minimum which gives him some margin of choice and encourages him to earn more.

It was decided to pay on the task basis and never less than the union wage for similar work. Very few commercial factories, making the same garments, pay as high a wage. At first patients do not produce more than one-quarter to two-thirds as much as a well worker in the same hours. The patient is working hard, for during the first year after sanatorium treatment it requires greater effort to turn out half his normal capacity.

The workshop is not organized or planned as a training school. The practice is to follow the method that enables the patient to earn quickly and to increase his earnings while “on the job.” He is taught
to sew on rags, this training period varying from a few hours to two
days; he then is given work which requires the least expertness, and
is slowly graduated through various grades until he is taught the best
grade of work for which he seems to have capacity. He is taught to
work on the sectional basis, doing a specific part of a garment, as
this is comparable to the usual factory practice. The patient is paid
the equivalent of the union rate as soon as he can produce acceptable
work.

The nurse at the factory supervises the patient at work and at rest,
for he spends his working day at the work-shop resting in-doors or
out-doors, when not at work. The nurse is literally the welfare
worker of the establishment for her concern is always the patient.

The Altro Work Shop does not look like an institution. It faces
three streets, South, East and West, and 50 feet open space to
the North, assures light and air on all sides. The equipment, modern
throughout, with many labor saving and fatigue reducing features, is
similar to that found in many ideal factories. A very interesting
pressing arrangement is in use which sterilizes and adds to the at­
tractiveness of the garments. Uniform making, which includes all
kinds of washable garments for use in the hospital and hotel, was
chosen because approximately half of the patients applying for care
had come from some branch of the needle trade. The newcomer be­
gins to earn the second day and when he regains his health he may
return to his old trade or continue at the sewing trade where skilled
workers can earn a living wage. Unfortunately present day condi­
tions in the sewing trade make it more difficult to place the factory
graduates.

The slogan at the workshop is “you can’t make it too good.”
Even an inexpensive hospital bed gown is made well. The patient is
taught that for his own protection he must learn to do good work, for
as he acquires skill he can depend less on speed.

The output of the workshop is sold on value, not sentiment, to
hospitals, institutions, nurses, hotels and housewives.

The demonstration of the Altro Work Shop, we believe, is signifi­
cant, showing that the fundamentals of care can be provided by large
industries. Not only can relapses be cut down to approximately one­
third that found by the studies of what happens to sanatoria gradu­
ates, but these men and women can be made partially, or completely
self-supporting.
A very large corporation with branches all over the United States is trying to work out a plan for its tuberculous employees. The need for some plan was brought home by numerous requests for loans to start small business after sanatorium treatment. This company accepts its responsibility toward its employees by paying for sanatorium treatment and assisting the family during the cure period. We are trying to convince this corporation that they can take their employees back into their own organization and under medical supervision, provide carefully graduated work. They would retain skilled workers, raise the morale of their employees, and secure for themselves a return on the investment in paying for sanatorium treatment and assisting the family. There are some large business organizations—Standard Oil Company of California, New York Telephone Company, and the Metropolitan Life Insurance Company that are doing this now.

In the invitation to the dedication of the new Altro Work Shops, in December, 1924, we read, “The business of this unusual manufacturing enterprise is that of giving the convalescent tuberculous paid employment, and of allowing them to do only the amount of work per day for which they are fitted. A time clock and a trained nurse see to that. The balance of their time they give to development of hope in their own hearts and health in their own bodies. This turns invalids into men and men can compete in the open market, just as the wearing apparel, made by them during their working hours, competes in the open market, on a quality basis.”
Social Service workers are a wonderful aid to physicians in charge of hospital clinics by their exhaustive reports regarding the patients, whom they bring forward for expert advice. I have found a great tendency to give extremely full reports on the subject of the environment and heredity, of these patients and a full account of their conditions and troubles that led to their downfall, but there appears to be a singular lack of study of the mental makeup of the women themselves.

I am endeavoring, therefore, to bring forward a brief account of the more important factors that enter into the lives of these mothers, in order to show you a method which enables you to understand those with whom you work and makes it far easier to decide what should be done in their interests.

To my mind, the basal condition to be stressed is that of instinct and I have separated for this purpose a group of the more important instincts, which I have found predominating in the cases attending my clinic in order to give a plan for a more prolonged study.

One must admit that the instinct of nutrition is a most important one in human life. From the day we are born to the day we die life appears to be the question of degree of nutrition which must be indulged in, for the growth of our bodies and the pleasure of our minds. This instinct is normally present in all human beings, and one realizes at once that controlling it appears to be the second factor of mental life which we term habit. Our parents originally trained the habit in us of taking meals at regular intervals, and to a great extent decided as to the type of food which we should take. Later there developed what we term intelligence, that is to say, our highest mental activity, took control over habit and instinct and allowed us
to decide for ourselves what foods are best, both from the standpoint of nutrition and the standpoint of enjoyment. So that, the three factors, INSTINCT, HABIT and INTELLIGENCE, form the background for the study of this great bodily instinct.

Yet one must admit that even under normal conditions when we may have realized that certain foods are absolutely unsuitable for our particular bodies, there is a great tendency to lose our control and to take them, even though knowing that they are liable to do us damage. So that the intelligence and the control of a normal person over such an instinct as nutrition, is often characterized by showing as marked weakness, as would in the case of any other instinct lead us to suppose that the person was mentally defective.

The next great bodily instinct is that of sex, and again one realizes that it is normally present in the whole human race. So that I disagree with many of my colleagues who consider a large proportion of these illegitimate mothers as being possessed of an over-sexual instinct. As life goes on, one would expect to see that control had been taught them by their parents, and that sex had become a trained habit. On the contrary, we find that many of these cases show a most remarkable ignorance about the whole question of sex. Yet on the other hand, one must admit that parents are much more apt to warn their children against irregular sex habits, than concerning the control of the normal instinct. Their education in this is largely from companions in school, or in factory and workshop, and a great deal depends, therefore, on their associates during this period of life. When you pass to maturity, one might claim, as with the instinct of nutrition, that their intelligence would render them more apt to lead a wiser life, but, similarly, to the conditions referred to under nutrition, we find here also in the sex instinct that intelligence often is not necessarily accompanied by control.

It is my intention to show that illegitimate mothers usually lapse, not so much from excessive sexual instinct, but from a lack of control over other instincts, which predominate in them.

The third great instinct of life, and to my mind the most important, is that of SELF-PROTECTION. Natural to all of us, tremendously enhanced into a habit, by over-anxious and careful parents, and finally becoming in the intelligent adult, one of the greatest factors in life, self-protection may be a curse rather than a blessing. When we see again, the loss of control exhibited in person
after person, where their close relations pass away and they are left alone in the world, or where their bank savings are wiped out, or where sickness or very minor affections of the body disturb their feeling of confidence in themselves; considering any of these or a hundred other conditions, one begins to realize that this instinct of self-protection controls the intelligence of a large part of the human race.

Amongst these cases we are discussing, the self-protection instinct tends to the prevention of illegitimacy and amongst ordinary girls of the High School class, it is largely the instinct that parents tend to develop; yet occasionally I have noted cases in which the actual fear that physical damage would be done to them has placed some of our girl patients in the class of illegitimate mothers. When I find that these girls that are brought to the Clinic have a strong sense of self-protection, it is my experience so far that they are far less likely to become second offenders.

The next instinct which is common to womenkind—perhaps, I should say, also to men—is that of a desire for admiration. One sees it from time to time in a highly developed condition in many cases, and with the rouged and painted girl with the smirking face, who attends the clinic, one will frequently find that this desire for admiration is an important condition in her case. Because, I think you will admit that the craving for satisfaction of admiration leaves them not only open to the plans and methods used by the other sex for gaining control, but also for the same cause this particular group frequently admit that their downfall was due to their desire to be admired by their girl companions, because they possessed a “beau.”

The instinct of play, which recalls to one’s mind in early life the puppy chasing the rubber ball; the small child with its romps and tumbles, finally develops into the adolescent habits of work followed by play, whether it means gymnasium, dancing, picnics, or whatever sport they prefer. All these normal manifestations of the play instinct finally fall under the control of our intelligence, and yet again may show the absence of control, where it is all play and no work that makes the dull boy. These girls, particularly those in the domestic class and among the immigrants from the Old Land, have a good deal of the monotony of work in their lives and frequently very little play, and they are liable to grasp at an opportunity to enjoy themselves, even though their intelligence may tell them that they are
risking their moral life by doing so. Then we see them going to parties, where their frequent story is, that a bottle of liquor was passed around, and that is all, that they remembered about the causes of their downfall.

The final instinct to lay stress on is the desire for companionship, and it is frequently claimed that girls preferring the companionship of men to that of women, as being a sign of increased sexuality, but I would oppose this suggestion, as I believe that, on the contrary, there may be no sexual instinct of any moment, present in such selection. On the other hand, with this desire for companionship actively present with all that it means in many other ways, it is natural that its satisfaction must frequently lead the girl into danger, particularly where she knows little or nothing of her companion.

I have tried to show, therefore very briefly, in the study of these unfortunate women, that it is necessary to discern what their basic instincts are and to realize that it is generally the lack of control, even in intelligent girls, of some predominating instinct, other than sex, that places them among those that are brought to this Clinic.

Passing to a different phase of study, the Social Service Worker should note with care the question as to whether the girl has an ego plus or an ego minus; whether she has a more or less exalted idea of her own capabilities, or falls into the class of the self-depreciative individual. This information is easily arrived at, and at once places in the hands of the Social Worker the realization as to whether the girl must be controlled, as in the second class, or whether on the other hand, she must be approached by more tactful methods. Where the girl is self-depreciative, one may be almost sure that she will blame herself for all that has happened; and, on the other hand, if she is self-appreciative, she may realize that her reaction to other people and to those that are related to her present condition will be one of resentment and of suspicion.

The final question, namely, that of their intellectual state is, of course, greatly assisted by the determination of their mental status. Our experience shows that while a group of these girls are shown by the "Binet Simon" to be definitely mental defectives, yet a larger group still are in the class who possess a fair intelligence, but probably little control, properly termed, weak individuals, while a smaller group still remains, as normal.

In studying the question of the disposal of the illegitimate
Illegitimate Mothers

mothers, every factor must be considered, and first of all, let me lay stress on the fact, that a knowledge of the instincts, the ego and the intelligence must be made. Then a knowledge of the future environment of the patient must be considered and the relationship of hereditary forces in the past may be added. The maternal instinct should also be noted, and it has surprised me that, where formerly I considered the maternal instinct a sign of normality, and the desire of these illegitimate mothers to keep their children appealed to me as what one would expect a normal mother to do, yet my experience has shown me that the most intelligent of these girls, having realized the difficulties in bringing up a child and also in giving it a fair chance in the world, have reasoned that it was better to give the child up to strangers and have it adopted; where, on the other hand, the mental defectives would desire to retain control of their baby.

It is interesting also for the Social Worker to study the question of initiative, because to my mind, the intelligent initiative is one of the first signs of a normal person. When you are making your examination, try to find out what the girls desire and what their intentions are, as to the future both of themselves and child. In fact this point is of such importance that I frequently advise a separate section being given to the questions:—What does the patient herself think about her own case, the cause of her condition, and the best way for her to be managed in the future? Also, it is interesting to judge what her initiative will be, if conditions were made happier for her in the future, offering a suggestion for instance, as to what she would do in case she were left a large sum of money; over and over again, I have found that the girl’s instinctive reactions will be shown by her answers to this test question, if it is carefully placed. Frequently, however, their idea of what they can do is quite outside their bounds from the standpoint of their previous education, so that again one obtains fresh information as to their intelligence by studying their initiative.

In conclusion, it appears to me that some such classification as is given below may be useful in dividing up the types of individuals, who form the illegitimate mothers:

(a) Of normal intelligence—(1) Downfall due to environment alone. (2) With poor control over some instinct bringing them into association with an unfortunate environment. (3) Over-sexed.

(b) Less intelligent individuals, with the same three sub-divisions.

(c) Mental defectives, including morons, imbeciles and idiots.
THE VALUE OF COÖPERATIVE PLANNING IN SOCIAL WORK*

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This subject naturally falls under two main heads: first, the value of coöperative planning by agencies and workers in dealing with individual cases or clients, and second, the value of such planning in dealing with social problems of a community.

As Mary Richmond says, there was good social case work before there were social workers. Likewise there was undoubtedly coöperation in dealing with cases centuries before the word had been coined. One can imagine that a thousand years ago, in passing a transient on from one monastery or hospice to another, the monks frequently sent along a script to indicate whether the bearer was a rogue or an honest traveler.

Coöperation is constantly being practiced by social workers in all communities in dealing with cases and its values more or less clearly recognized. You are all familiar with them from practice. They need no exposition on my part. Yet I must ask your indulgence while I go over a few instances in the case work field as an approach to the subject of coöperative community planning in social work, of which values have not been so long experienced and are not so generally recognized.

First let me relate a negative example. In a certain city, a very personable young man appeared one day at the Community Chest office to ask help, telling plausibly one of the common 57 varieties of stories about having come from some distant point, looking in vain for light work, being unable to do heavy work due to a recent operation, etc., etc. The Community Chest referred him to an organization operating a salvage industry where it was pretty certain he could be

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given light work, and found that he had been there the previous day and was supposed to have returned for work.

From the boy's own statement and from information supplied by various agencies it was learned that during a sojourn in the city of ten days or two weeks he had appealed to, and in some instances been helped by, five different agencies, besides the salvage industry and perhaps others of which the deponent knoweth not. One of these societies had made a definite attempt at constructive diagnosis of his case, but he had slipped away before remedies could be applied. The others thought they had seen him safely on his way home or had let him get away without any attempt at solving the problem. Due to an uncertain policy about registration of transients, his case had not been registered at the Social Service Exchange. None of the agencies had apparently thought about consulting others. Too great a spirit of emulation in well-doing may have prevented such consultation.

Now the wastes in such a case are obvious, but worth repeating. There was a waste of time and effort of the workers in various societies which might have been largely avoided had they possessed information from agencies previously visited by the boy. There was a waste of human values in making it easy for the boy to perfect himself in the art of begging and getting away with it. There was a waste of esprit and mutual confidence among the agencies, each of which would be inclined to feel that the other fellow ought to have solved the problem without letting it get past him. There was at least a potential waste of public confidence in welfare work and workers. For when such things are frequently occurring, sooner or later the public finds it out and visits the penalty of its distrust on all social work. And what greater condemnation of welfare work can there be than that it should be found uncoöperative, inefficient and wasteful of material and human resources.

Now let us consider a more encouraging case.

An ex-service man with a wife and small child came to the attention of a family welfare society in Norfolk. Prompt registration with the Social Service Exchange revealed the fact that the Red Cross had seen the man through incipient tuberculosis, had arranged for him convalescent care at a Government hospital, and had just secured a disability rating which provided for him and his family quite adequately. About this time his child was taken desperately ill, and was operated upon at a baby clinic. Unusually severe hemorrhages de-
veloped and the child's life was barely saved. A few weeks later the social service worker of a hospital called the Exchange to report that the same child was in her hospital for an operation and to ask if any other agency was acquainted with the case. The Social Service Exchange named the other agencies by which contact with the case had been reported. The hospital social worker consulted them and learned of the previous operation and of the hemorrhages. All previous experience with the case was thus made available for the new emergency. "Forewarned is forearmed," and the doctor and the nurses say the child's life was probably saved by the special precautions against hemorrhage which they were able to take.

This isn't quite all of the story. There were other details of interchange of information and help among agencies, all playing their part in the constructive solution of this family's difficulties. It is enough however to indicate the obvious values of cooperation, namely:

A conservation of time and effort through being able to take up the case history where other had left off.

The conservation of human values—in this case presumably the life of a child with all its undeveloped possibilities.

The strengthening of the bonds of fellowship between agencies, which inevitably follows a partnership for joint participation in human service.

A buttressing of the base of support of all welfare work, that is, public confidence. For while few cases may come to the attention of the public, social work is judged by those that do, which of course in the long run represent the average performance. And as a city set upon a hill cannot be hid, so efficient, co-operative social service cannot long remain unrecognized in a community.

I would like you to turn with me now to the factors through which co-operative effort is secured and made effective, the first of which is human factor, or the social worker.

A man whom we will call John Jones, a former farmhand and an unskilled worker, an elderly amiable, conscientious fellow of fair mental capacity, lost his job and was having trouble finding another. So he came to the attention of a social worker who helped him get a position as a man of all work in a small private hospital. She found that he wasn't giving satisfaction there and discovered that his eyesight was very poor and he was threatened with blindness.

She arranged with a dispensary for treatment for his eyes and
later with a public health hospital for work on his teeth at cost, which he was able to pay from his meager earnings. Finally his eyes became so bad that he lost his position.

He turned again to the social worker who found temporary lodgings for him at a mission, while he sold papers for his other meager necessities.

Vocational work for the blind had just been started in his city, and it was natural that he should attend the classes, but a living must be provided. So his social worker arranged for him to stay at the City Home and further arranged for his transportation into the city each morning on the public school bus. To provide for his return car fare in the afternoon and other incidental expenses she arranged for two or three hours work each day at a salvage industry. With his limited vision he has advanced rapidly in his vocational training and with his amiable personality he has become a favorite at the school. His future seems fairly well assured now as a supervisor of work for the blind either in his present place or in a state school.

All this is sketched in briefest outline and covers in time a period of four or five years. It omits many interesting details and the names of several other organizations that played minor parts in solving this man's problem; all without diminishing his self-respect, but on the other hand sustaining it by helping him constantly toward self help. In all, ten or a dozen agencies assisted in this case, and all of them were able to help with necessary knowledge of what the others had done or were doing. Many informal conferences were held to consider special situations.

Enough has been told to point to the utter importance of the first factor in cooperative effort, namely, the social worker herself. It is she who pieces together the separate available bits of helpfulness supplied by various agencies and individuals into the pattern of a reconstructed human life. And if she is a master of her work she makes each individual and agency that helps feel a partnership in the task. She must of course be a patient, sympathetic, unwearying, skilled craftsman, rising to the heights of artistry in building human lives. Above all she must stand not too much on ceremony or professional pride in dealing with other agencies whose workers may not be as skilled as she.

Without cooperative social workers no impersonal pieces of cooperative mechanism can be fully useful. Yet mechanisms are
needed, such as a social service exchange in cities of more than mod­
erate size; or case conferences in cities or towns of any size where two or more social workers may be gathered together to talk over baffling cases in which both are interested. A case conference com­mittee meeting regularly is probably the easiest, simplest and most necessary form of mechanism of cooperation, especially in small cities and towns. For this to be successful there must be at least some sense of comradeship among those taking part; a willingness if not an eagerness to sit down and reason together. Lacking this, there have been instances where case conferences became battle grounds rather than centers of allied strategy.

But there is in each community of whatever size, a need for co­peration beyond that which concerns individual cases, that is, a need for dealing in a broad way with community social problems. Of course in a sense these embrace the individual problems. Every sick person is a unit in the community morbidity problem; every juvenile delinquent is an item in the sum total of a city’s delinquency; each impoverished family is a by-product of those manifold and compli­cated conditions which make for dependency. So community planning has a very concrete and vital relationship to the planning for individuals which is the daily grist of every social agency’s mill.

Community planning in social work is not a very involved or abstract process, in spite of its formidable name. It can be reduced to very simple fundamentals, no more difficult than, and somewhat analogous to, planning for the individual case. As a matter of con­venience, for a community problem in social work may I also use the term “community case,” as being comparable with the term “individ­ual case.” Let me cite two or three community cases, not ones that are the best that could conceivably be found, but ones with which I happen to be familiar.

In a certain large city there were eighteen or twenty children’s homes, an S. P. C. C., and of course the average outfit of health, recreation and family welfare societies, contributing their bit to the welfare of children in that city. These numerous children’s institu­tions were in general admitting children without adequate investiga­tion, and had very limited facilities for home finding and child plac­ing, or for otherwise disposing of their young charges. As a result the line of least resistance was being followed and children were stacking up in institutions. As for medical care, the practice varied
according to the alertness of those in charge of the institutions, and
the way they had happened to link up with some doctor or some
clinic for their medical work. The whole situation was unstand-
ardized, chaotic and muddled. The only thing sure was that there
was room for vast improvement.

To this end a group of those especially interested in the subject
came together to take counsel. They began a series of monthly eve-
ning meetings with dinners and other social features, held at the
various institutions. Usually an interesting speaker on some phase of
child welfare work was provided. Many a Protestant worker thus
saw for the first time the inside of a Catholic or Jewish institution,
and vice versa. A fellowship and esprit developed. Came the time
when someone in the group proposed a careful survey or study of the
whole field of child welfare work. The idea was discussed fully and
finally was quite unanimously endorsed and carried through.
Thorough educational publicity was developed on the findings of the
survey. On the basis of facts and recommendations and needs dis-
closed, and backed by an organization competent to carry out its
recommendations the field of child welfare in that city has experi-
enced in a few years a most remarkable development, reflected in
better service to every dependent and neglected child. Today you
will find there a Children's Bureau to which all institutions refer
applications for admission. You will find adequate home finding and
child placing facilities. You will find the pediatric departments of
certain hospitals and clinics improved and enlarged to serve efficiently
the health needs of the children of the city. You will find a receiv-
ing home where dependent children can first be observed and studied,
and the best resources of medical knowledge, psychology and psychi-
atriy brought to bear on them before temporary or permanent solution
of their problems is determined. You will find a well-equipped child
guidance clinic. You will find many other things. Every agency and
every worker in the field of child welfare in that city is today doing
more satisfactory, constructive work because of these changes; and
they work more coöperatively because channels for teamwork have
been provided.

I have cited this example particularly to illustrate the steps that
were taken in regard to this community case. These were as follows:

1. Those interested in the problem got together in a friendly way
for consideration of it. They found grounds of common understanding and mutual confidence.

2. There was a process of fact-finding, and definition of program and objectives.

3. There was education and persuasion leading to the acceptance of these objectives by the agencies concerned.

4. There was organization for action to the desired and defined ends, eventuating in a solution of the problem.

This series of steps might be summed up briefly as:

1. Fraternizing or friendliness
2. Fact-finding and fact-analysis
3. Education
4. Organization and Execution

This is what I meant when I said that community planning in social work can be reduced to very simple elements. I believe that the above steps, in about the order named, are applicable to most community social cases in which common action is desirable.

Now let us apply them to an altogether different kind of problem to see how they work.

A city appeared to need additional free hospital facilities. It was thought that the obligation was one that belonged to the city government. There was full discussion of the subject with city officials. The facts were carefully determined, then an intensive and rather expensive campaign of public education, including much newspaper publicity was staged, leading to the voters' approval of a special bond issue for the purpose of building an additional unit of the city hospital. The unit was built, equipped, put into operation and is now daily serving its useful purpose.

The same steps were observed of fraternizing between city officials and interested private social agencies and citizens, fact-finding, education, organization and execution, in turn. To be exact, however, in this particular case, the first step, that of winning the cooperation of city officials, was probably incompletely done. As a result, while the immediate objective was secured, some city officials may have felt that they had been bludgeoned into action, and hence no sound basis was laid for their willing participation in future joint action. This flaw in the instance does not invalidate the formula but points to the extreme importance of the first step—the securing of pretty complete
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accord among interested parties based on personal friendliness before next steps are taken. Naturally too, the time sequence of the various steps as stated is not absolute. For example the process of education goes on continuously, from the first step to the time that the case is solved and its solution accepted by the community or by whatever other or smaller group is concerned.

Assuming the correctness of this general formula it would apply alike to changes which need to be effected in other fields such as delinquency, family welfare, recreation, or to more fundamental community aspirations such as for better housing programs, industrial reforms, or city planning.

It is interesting to note in passing the analogy or at least resemblance between the above formula and the steps taken by the case worker in dealing with an individual case. Aren't these steps in order something as follows?

1. Winning the client's confidence—friendliness or fraternizing.
2. Collecting and assembling facts leading to diagnosis of the case—fact-finding.
3. Persuading the client to accept the diagnosis and the prescribed treatment—education.
4. The organization of the client's resources—economic, mental, moral, physical, so that the prescription will be carried through successfully, and the problem solved.

Likewise the values of coöperative planning in community cases are somewhat akin to those in individual case problems.

There is a conservation effected of the time and effort of social agencies by a clearer definition of their objective and greater orderliness and team-work in their approach to them. It is the difference between a volunteer fire department and one well organized and trained so that each member does his part in his turn and place. As someone has pointed out the volunteers may have more fun, but the trained firemen are more likely to extinguish the blaze. The children's institutions mentioned in my recent illustration are each one doing a better institutional job because they are all working in coöperation, enabling clearer specialization of function and closer attention to their own main job for someone else is at hand to care for the old harassing side issues, such as investigation of applications, placement of children in foster homes, and medical and psychiatric necessities.
It follows as the night the day that this means conservation of human values; just as is true when individual social workers cooperate in a case problem. Because of coöperative planning in that one city with respect to its social work for children, more children are having their needs far better met than under the old, uncorrelated plan. This certain conservation of human values is always demonstrable whenever coöperative planning in community social problems has been wisely done. These values are the chief end and reason for such planning—not just that we may see the wheels go round.

Also, community planning in social work, working together on the same problem, tends to develop a finer esprit, a better spirit of teamwork among agencies and groups, just as is developed between individuals in working on the same case. For example the children’s institutions will have a better opinion of the clinics and the family welfare society a better opinion of both of them because of their association in some united effort, especially as this working together grooves deeper the channels for coöperative effort.

Likewise there is an immense gain in public confidence when a community once realizes that the social agencies are not jealous of each other and are not contending with each other for the privilege of doing good, but are working and planning together with the needs of the community as their objective. It will take time for the public to sense this, but sooner or later if it is realized that harmony prevails among “the up-lifters” and that they are losing themselves in a task as big and as worthwhile as the community, the public will respond with appreciation and support.

Such a conception will enlist the active interest of many of the best men and women, to whom less comprehensive pieces of social work will make no appeal whatever. Keen business men are not interested in the peregrinations of Lady Bountiful, but they may become interested in a community recreation program or a city health program, or a Community Fund. Perhaps as the future weighs the community chest plan in the balance, it will find that its greatest value has consisted in helping awaken public interest in social work as a necessary and momentous community enterprise. Certainly this awakening will be one of the most valuable by-products of all coöperative social effort.

And finally, in community cases there must be both human and mechanical factors. As someone has said, coöperation requires a
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mechanism and a process. There has to be some individual or group of individuals in whom is vested the definite responsibility for the sort of thing the case worker does in the individual case—to devise, follow up and bring into coherent execution the various things worked out under the general head of coöperative social service planning. This person or these persons must have all the patience, persistence and sympathy of the case worker, for so-called “social” agencies are occasionally just as unsocial in their attitude toward other agencies as is the client in his attitude toward the things recommended by the case worker.

As for mechanism, the larger city of course requires a Council of Social Agencies with executive service, and a Social Service Exchange, as a minimum equipment. Nearly every large city now also has a Community Chest with which the Council of Social Agencies is linked up in one way or another. For a smaller place a Civic Improvement League or perhaps the leading case working agency such as the Red Cross chapter or the county welfare worker, if there is one, with her committee, may take the initiative in promoting and providing machinery for the necessary degree of coöperative effort. But, whatever form it takes, I believe that any community large enough to have any organized social work is large enough to require a process and a mechanism for community coöperation.

I have undertaken to point out some of the values of coöperation in case work, and some of the necessary factors and processes involved. I have tried to do the same for community coöperation and community planning in social work. The average individual social worker may wonder what bearing her own daily work has on this latter and larger phase of coöperation. She may be inclined to think that community planning in social service is something for which she personally is not responsible. Such is not the case. Let us examine for a moment the relationship of the average social worker to the four steps in community social planning previously outlined.

This kind of planning is based on fraternizing, fellowship, friendliness among groups, and this has to begin among social workers themselves or we cannot expect it to extend to the groups of laymen interested in various agencies. On the attitude of the social worker toward other social workers and other agencies, all schemes of community coöperation eventually are largely conditioned.
In the second step, fact-finding, the experience and the records of the social worker again furnish the factual ground-work of social studies. Herbert Hoover says, "I was taught young the potency of truth—that it would prevail. The raw material of truth is facts. Statistics are not mere mental exercises; they are the first step toward right decisions." That social worker who painstakingly, conscientiously, accurately, keeps up her case records and her statistical work is preparing for the first step toward right community decisions in social work.

As to the third step, education, the field of the individual social worker here is simply unlimited. Public support and interest in social work are absolutely conditioned on public understanding of it. And who is so well qualified to be its exponent as the person who is daily in touch with the baffling, fascinating, human problems it presents? It is not the job merely of the executive, or a board or the Community Chest to "sell" social work to the public. They are at least once-removed from direct contact with it. It is the obligation of all social workers to help convert the public to a belief in their work and their profession, whether by writing or speech or daily conversation; but above all by the thoroughness and sincerity of their work.

Likewise, when the final stage in community cooperation on a given project has been reached, it is the social worker who is generally responsible for the details of the organization and execution of the plan. The smoothness with which a new plan operates depends on the operators—that is, the social workers.

Social work is growing up and coming into the full stature of its greatness as a constructive force, affecting beneficially the whole community. There is more public interest in it, closer scrutiny of it, and better public understanding concerning it than ever before. Such a time tests social workers. They must be open minded to new methods. They must be expert in their tasks. They must be above petty bickerings or jealousies or undue ceremoniousness among themselves. They must be frank and comradely with each other. They must do their own work with intelligence and faithfulness, and cooperate with other agencies in letter and in spirit. Above all they must each one feel a personal responsibility for the development of those devices which will lengthen the arm of their endeavors by enabling a community viewpoint to be achieved, and community planning to be fulfilled in the whole broad field of social work.
If we as social workers fail in these things, the public, wiser than we, may eventually turn a cold, impatient shoulder on our work or take it out of our hands and remake it into something else: something less human, less helpful, less constructive than that mingled product of applied science, common sense, and love which we call social work.
Modern thought and human outlook are changing rapidly; perhaps in no aspect of social life is this more obvious than in the treatment of prisoners. A well-known writer very appropriately calls a modern prison a “Hospital for sick minds.” That apt expression epitomizes the present humane method of treating prisoners.

In former times, when the minds of rulers were less enlightened, the main purpose of imprisonment was to punish the offenders. The main purpose now is to reform the character. The Prison Commissioners are enlightened men, and realize that by giving greater attention to the moral side of prison treatment, the protection of the public will automatically follow. It needs not a very high flight of the imagination to realize that we, who are outside prison gates, owe it probably more to our happier circumstances, sheltered from many temptations which have led to the downfall of the prison inmates, than to our greater virtue.

When one learns of the manifold causes which have led to detention in prison, one wonders how it is that we have not gone further in discrimination and wisdom in the treatment of prisoners. It is said that the effect of sleeping sickness on some people is intermittent instability, which of course means that they are at times irresponsible for their actions. Such people therefore must be regarded as two-fold victims, and some place—other than prison—should be found for them. I could tell of such a victim in one of our prisons, a nice—not a bad lad.

The women in Holloway Prison who are suffering from venereal diseases are given outdoor occupations, such as attending to the grounds, mowing the grass, etc.

Great attention is given to the health of all prisoners. It is realized
that a sound mind must have a sound body for its habitation. Hard work and physical exercises tend to attain this end. Ample provisions are made too, for mental activities.

The Community does not hear much of a body of disinterested public servants, whose unselfish work is among the finest in the Country. Voluntary teachers, at the end of their day’s work, visit the prison to instruct the inmates.

Life is full of paradoxes. A baby in a prison is entirely out of place. The Women’s prison at Holloway, North London, near to which I live, is in the van of progress. It has a full staff of trained certificated State-Registered Nurses, who are also required to hold the certificate of the Central Midwives’ Board. A Labour Ward is part of the hospital equipment, and here babies are born. To be born in prison seems an undeserved stigma on an innocent babe (they are not registered as having been born in prison) and yet some babies are far better off, owing to that untoward circumstance! That is the paradox.

It is certified that they thrive under prison care, which is, as I have shown—skilled care. One mother took with her, at her discharge, a particularly fine baby, the pet of the staff. “Where is your baby?” was the question asked when the mother returned later to Holloway. The baby was dead. That she had to return to prison sufficiently explains the tragedy.

Most people would certainly say that a short term of imprisonment was better than a long one. Nevertheless, if we look thoughtfully at things as they are and not as we want them to be, and if we are really interested in the welfare of the patients (body, soul and spirit) undergoing treatment in the “Hospital for sick minds,” we must honestly admit that—in some cases—a long term of imprisonment, proves by results to be advantageous to the patient. When the sentence is sufficiently long to give time to get at their minds, great and lasting benefit may follow, from the prison visitors, the voluntary teachers, and that beneficent Organization “The Discharged Prisoners’ Aid Society,” which is always at their service. Cooking classes are also given to women undergoing sentences of three months or more, by a teacher from the London County Council.

The problem of the Mental Defectives is always with us. There are certain to be, in every prison, many mental defectives of both sexes. If their conduct does not bring them within the scope of the
Mental Deficiency Act, they suffer for their offences in prisons, where they ought not to be. They ought to be in Homes for mental cases, but such establishments should bear a name of greater euphony, of course. Unfortunately our civilization has not yet reached that altitude. Such unfortunates are of course continually in and out of prison.

It is claimed that the male convict prison at Maidstone is one of the pleasantest in England. All who find themselves under such restraint, have committed some dreadful crime, sometimes it is only one, a first offence, committed perhaps under great provocation, or fierce temptation, but whose record otherwise has been good and whose faces show it—refined, gentle and of kindly disposition. The Chapel of this prison is approached between beds of flowers. An elderly warder addressed the guide of a visitor, asking if he had shown him the garden, the real garden, especially the ten-rod allotment. This garden was of his own creation—a man with a passionate love of flowers, and who spoke of what they—the flowers, could do for the souls of men, such as the unfortunates under his charge. He spoke no hard word of them, whom he regarded as fellow men who had experienced misfortune.

There can be no doubt that the humane and scientific treatment of prisoners today by our Prison Commissioners, is having its effect on the minds of the officers both male and female; a new type is being created. A man who will help the inmates of a "Hospital for sick minds" by means of flowers, is no ordinary type. It is scarcely too much to say that such a man is a God-sent messenger to help them. In this connection one is forcibly reminded of the familiar lines:

"A garden is a lovesome thing, God wot!  
Rose plot, fringed pool, ferned grot.  
The veriest school of peace, and yet the fool  
Contends that God is not!—  
Not God! in gardens!  
When the eve is cool;  
Nay, but I have a sign  
'Tis very sure, God walks in mine."

The Governor of Holloway prison is a doctor, a man of scientific habit of mind together with an understanding heart, which accounts for the progressive nature of his rule. The Deputy Governor is a
woman, with a long and wide experience. Small things are not always the measure of their importance. Such a small thing as a change of name, may conceivably be of psychological importance. At Aylesbury—another Women's Prison—the prison is known as an "Institution," (within the walls) the cells are now called "rooms." It is for the treatment of three classes of wrong-doers: (a) Star convict women (first offenders). (b) Borstal girls. (c) Recidivists. It is therefore a three-in-one Institution. The ruler of this Kingdom is a woman; not a mere woman, a remarkable woman; her character and personal magnetism might be summed up in the following words of a visitor: "The famous lady who rules as Governor has a job which no man could manage, and which would break the heart of ninety-nine women out of a hundred. She is one of the ablest women of our day, and one of the profoundest."

A profound woman must be one with a penetrating mind, one therefore very suitable to be the Head of a "Hospital for Sick Minds." And what is the secret of her success? After gaining—with great patience—their confidence and affection, she proceeds to uplift their minds to the guiding principles of the Christian Religion. In her own words—"I tell them that it is no use hanging on to my love for them because I may go away, and they themselves, when they are released, will not have me at their side to help them. I try to make them realize that there is a far greater Love than mine always ready to enter their lives if they will only open their hearts to it. I get them to see what I mean."

The Howard League for Penal Reform has done, and is doing very much to bring about improved conditions of prisons and prisoners. There is probably nothing, of which we are more ashamed as a Nation, than our treatment of prisoners a hundred and fifty years ago, when that great man John Howard—philanthropist and humanitarian, began his visits to prisons in this Country and others, and revealed in his published works the appalling conditions everywhere. He was the means of bringing about certain improvements, but very much remained to be done when Elizabeth Fry took up the same work in 1813. The aim of both these great reformers was identical, namely, the improvement in prisons and the treatment of prisoners. Both undertook tours of inspection, not only in various parts of Great Britain, but in many European Countries. Both of them were led to inquire into conditions of other houses of detention, such as the
British Hospital system, and—in the case of Elizabeth Fry, the treatment of the insane.

The best way to honour the memory of these great pioneers is to continue to build upon their foundations, by working for the happiness and health of mind and body of the most pitiable members of Society. We feel sure that nothing would have given them greater pleasure than this latest and greatest development of Prison reform, namely, trained nurses for the inmates. Among the Nursing Staff, two of them hold the Certificate of the Medico-Psychological Society, a most necessary qualification, in view of the fact that many of the inmates are mental defectives. The nurses wear the State Registered Uniform.

The ideal must ever be, in the sphere of nursing, that it knows no limitations. A sick prisoner has the moral and hereditary right to the best nursing care in times of sickness, equally with any other member of the Community.

The great reform of trained nurses in prisons is only partial at present. The Women's Prison at Holloway is the pioneer; it is the only one as yet with a full staff. In the Aylesbury Women's Prison there is only one trained nurse, and in the prison service in Scotland there is likewise only one trained nurse, and I have not heard of any in the Men's Prisons.

The Discharged Prisoners' Aid Society is of a value quite indispensable, and is probably the lineal descendant of the Prison Visiting Societies founded by Elizabeth Fry. It cares for the family when necessary, during the detention of the mother, and also gives temporary assistance when she is discharged. Some of those discharged, evince pathetic gratitude to the lady visitors, with whom they keep in touch. The following letter is a specimen and may be of interest.

"I wondered if you would allow me to send some flowers for the altar of Holloway, as I do feel I should like to give, shall I say just a little thank offering, in return for all that has been done for me."

Our present Home Secretary, under whose ultimate control our prisons are, has publicly stated that every trace of unnecessary degradation has been removed from the prisons, and we thank God for it. Before the present staff of nurses were established at Holloway prison, two trained nurses were appointed for six months as an experiment. When one of them, who was well known to me, was about to leave, she found upon her bed a note containing these words,
from one of her patients—"*Dear Nurse—I am very much obliged to you for being so kind to me.*" This pathetic incident is in itself ample proof that the sphere of trained nursing must extend to prisons.

This brief account would not be complete without reference to the "Hostel" of Holloway Prison, where those discharged prisoners go, who have no work, or perhaps no home to go to. They are allowed to live there free of charge, for two or three weeks while they look for work.

The readers of this magazine may—or may not—have heard of our "Church Army," whose splendid work for all classes of persons *"who are in any way afflicted or distressed in mind, body or estate,"* is one of the finest organizations for good in the Country. At the risk of exceeding the limit of space I cannot resist telling the following story, which I heard recently in the course of a sermon by the Venerable Founder, Prebendary Carlile: A woman of the worst character, who had been in and out of prison more than 50 times, was again found there by one of the Church Army "Sisters," who, by permission, visited the inmates of a certain Northern Prison. On this memorable occasion Sister Mary said on entering her cell, "Jane, I want you to come and live with me." Jane replied in utter amazement—"*You—want—me*—one of the worst of women—to live with you! Who has put you up to that?" Sister Mary quietly replied: "The Lord Jesus has put me up to it." The invitation was accepted. Jane became a completely reformed character, and died seven years later, a good and penitent woman. Who shall dare to say, in the face of this sublime story that any wrong-doer is "hopeless," which one hears far too often. Possibly we all need to have our imaginations quickened and our hearts stirred, and to remind ourselves of those unforgettable words—"*I was in prison and ye came unto me,*" which to the thoughtful and imaginative mind, constitute a Divine Command.
PSYCHIATRIC SOCIAL WORK IN THE BOSTON CHILDREN'S HOSPITAL

MARGARET L. WIRT, A.B., M.S.S.

The Children's Hospital presents an especially fertile field for the study of behavior problems for it is the natural place to which a parent will turn for help. This is true regardless of the economic status of the family. Children are brought to it from different parts of the state and in fact from all over New England, as many parents regard the hospital as an authority on all the disorders of childhood.

For some time Dr. Crothers has felt the need of a Psychiatric Social Worker in the Nerve Clinic, not for the sake of institutionalizing the feeble-minded and the epileptics, which has already adequately been handled, but for help in the study and adjustment of the more subtle behavior problems.

Furthermore, the need of this type of service has been demonstrated in the general medical clinic where at the end of the day, the medical records frequently have such notations as: "No disease," "Poor habits," "Disciplinary problem," and no further recommendations made. More and more the hospital has realized that in addition to caring for the many cases with physical ailments it has a responsibility in assisting the mother who is in need of advice. The mother's problem in child training is just as real as if her little boy or girl had some physical disease and it will persist and become more difficult if adequate measures for helping her are not taken.

For this reason Dr. Crothers, Miss Wilson and the Medical Staff of the hospital petitioned the Board of Managers through their Social Service Committee to employ a Psychiatric Social Worker whose duties were to cover the Social Service work of the Nerve Clinic, to study behavior problems in the general Medical Out-patient Department and on the wards, and to undertake any private cases referred from the private ward or by physicians in their private practice.

The employment of a Psychiatric Social Worker in a hospital of this kind seems like a very logical development as it makes possible
close medical supervision along with the simpler methods of Mental Hygiene treatment. This is especially important as many of the problems are a combination of physical disease and behavior disorder. A majority of the heart cases present difficulties in feeding and management so great that specialized instruction to the mother is advisable and yet reference to an isolated Behavior Clinic is impracticable and perhaps dangerous as a thorough understanding of the heart condition at all times is essential.

Many diabetics need help from the Mental Hygiene standpoint. Someone must take time to understand what is going on in the minds of these patients and take pains to change their attitude and secure their cooperation in maintaining the very strict diet necessary.

Other cases where this close combination of supervision is essential are those in which it is hard to differentiate between the physical and functional conditions. This is true in cases of chorea and in children with various twitchings and habit spasms. Many cases of convulsions are investigated by the Psychiatric Social Worker in an attempt to determine whether they have organic or functional basis.

A third very interesting type of case under this classification is that of cyclic vomiting, where the boy or girl can be placed under observation on the ward and the case thoroughly worked up from the physical standpoint, including X-rays, bismuth series, etc., at the same time that the environmental situation is being investigated and attitudes studied. We have had several fascinating cases of this type. One was a little girl of ten who had vomited at every meal from the time she was about two years old. This child who had been injudiciously fed in early childhood,—which probably gave her a good beginning in a bad habit,—was at the time of admission, in an overcrowded home where the family were over-solicitous about her vomiting. She was very sensitive and liked attention. This child was sent to the country for two months while the family was regularly visited and instructed in regard to her management upon her return. Since that time there has been no further trouble.

The need of a medical organization interested in the behavior problems of childhood and yet equipped to make a thorough-going physical examination, including the various laboratory tests and X-rays, is illustrated I think in the following three cases referred for observation on our hospital wards, from other hospitals and private physicians.
Sarah was eleven years old. She had had two operations in an out-of-town hospital—first for appendicitis, then as vomiting persisted, for obstructions. Nothing was found and vomiting continued. She had become so weak that tube-feeding was resorted to. Finally she was sent home to see if a change might help her. It was after she had been sick at home several days that her family brought her to the Children's Hospital. The nurses managed to make her eat but other than that there was no improvement. She lay in bed with a vacant expression and drooled. No one could make her talk. X-rays, bismuth series and all laboratory findings were negative, nevertheless, she vomited every meal and became more and more emaciated. Her condition became very critical and was approaching that of life or death. Sarah appeared feeble-minded and psychometric tests were attempted twice but were finally given up as they upset her emotionally and caused severe vomiting spells. For a while institutional care seemed to be indicated. Our doctors hesitated to recommend commitment as the child seemed in special need of individual attention.

The home conditions were quite surprising. Sarah was the oldest of four children, the others appearing normal and the youngest of superior intelligence. All were well disciplined. The home was prosperous and both parents were intelligent and showed judgment and understanding in the management of the family. Sarah had always been the odd member. She was super-sensitive and very touchy. If the other children splashed water on her she had a tantrum. She was so fastidious and sensitive to odors that she would not use a neighbor's bathroom when she was away from home a day, because it was painted a different color than her own. At home she seemed to be the dominant member of the family, loved to show off, sang, danced, played school, having the other children for her pupils. At school she was in a special class and showed no special abilities.

The vomiting had commenced directly after the death of an invalid grandmother who had been living in the home under the care of a trained nurse. The family were rightfully worried over Sarah's condition and very solicitous. The best solution seemed to be to send this little girl to a convalescent farm in the country where there would be every suggestion of health and where she could have new interests, an entire change and where no one would worry about her vomiting.

The mother saw the wisdom of this plan but when she came to escort the child to the country she said, "Sarah is too sick, she is so
pale and frail, why she can't even talk to me. I must take her home for a short time at least." As the child was indeed in very poor condition she was allowed to go home. The mother was given careful instructions not to let her notice that she was worried or perturbed if she vomited, to treat her as nearly as possible as a normal child, to make sure the others in the family did not refer to her ill health, ask her how she felt, etc. and above all to occupy her mind in outside interests as far as possible. If the mother had any doubts or worries or wished advice even in the smallest way she was to telephone the hospital.

Sarah vomited the first and second day after she went home and her mother telephoned the hospital several times for advice which consisted chiefly in encouragement. After three weeks Sarah was playing normally and was talking fluently of her experiences in the hospital, not only recounting episodes but telling the names of doctors and nurses. She did not vomit after the first few days at home and after a while everything seemed to be quite normal, except that she was backward and had to go to a special class at school.

Case II. Joseph was admitted to the wards from a mental hospital, where, although a psychometric examination had been made, a psychiatric examination was postponed pending a building up of his physical condition.

At time of admission he was thirteen pounds underweight and had a triple positive tuberculin. At home he refused to eat, wet and soiled himself, often smearing the feces, refused to play with the other children, spending much of his time sitting limply in a chair with head bowed.

On the ward he improved rapidly, gaining eight pounds the first week. He seemed happy and talkative but insisted that he did not want to go home, stating that his step-mother was not good to him.

Investigation brought out the facts that Joseph had been brought up by his grandmother from the time he was two years old, having been legally adopted by her. His mother had died of tuberculosis and his father had remarried a widow who had three children. It seems that the father, because of family quarrels had not been on speaking terms with either the mother's people or his own. As a result he had seen almost nothing of his son, who had been taught to hate him and think of him as a terrible person.

A year before Joseph came to the hospital his grandmother died
and the grandfather asked the father to re-adopt the boy, for the former living alone felt incapable of bringing him up. The father was very glad to do this because he was anxious to have one of his own children inasmuch as his wife had three of her own. Evidently the change from a fairly prosperous home where he was the petted darling of two adoring grandparents to a poorer home with three children already established, a stepmother whom he did not know and a father whom he had been taught to fear and hate, to say nothing of a new name, for his grandmother's name was not the same as his fathers, was too much for little Joseph. He gradually failed until in a year's time he was in the condition described upon entrance to the hospital.

It was felt that Joseph would do well in congenial surroundings. Therefore, an attempt was made to send him to his mother's grandparents whom he had often visited. The father objected due to family antagonism and even the Society for the Prevention of Cruelty to Children could not force him to give up the boy.

Joseph was sent to the Convalescent Home of The Children's Hospital, where he did very well and was very popular with the other children. The father was urged to visit often and win the boy's confidence. Finally, the father decided to take him home. Within an hour he brought him back to the Convalescent Home saying that he could not manage the situation. Joseph had cried and said he was not his father and the latter had been stopped twice by the police who thought he was kidnapping the boy.

In spite of this experience the father insisted that he would not give up the child. He was warned that the child's adjustment was difficult, and every attempt was made to show him the boy's point of view. Nevertheless, within a week Joseph was at home. Three days after his return the father telephoned that Joseph cried all the time, was not eating and already had begun to wet himself. The stepmother was ashamed of him and feared that she would be accused of neglect. The father was finally convinced that in spite of anything which he and his wife might do, Joseph could not get along well at home and therefore, agreed to board him out through a child placing agency. The boy is now in a foster home doing very well.

A third case of interest from a Psychiatric standpoint is that of Edith, age eleven, who was admitted to the ward for observation upon the recommendation of a private physician. For the past few months
Edith had been having spells of being irrational, not being able to recognize her father or mother, refusing to eat and having nightmares in which she thought her mother was dying. These spells lasted about three days and would occur at intervals of two weeks. The physical findings were negative, including lumbar punctures and X-rays. Although irrational upon entrance, after a few days on the ward she seemed to be normal and happy. Edith was the second youngest of six in a Greek family of moderate means. The home was crowded and full of confusion. Invariably during a visit, interested friends and relations would drop in to get posted upon the latest developments. Edith had always been difficult, was very sensitive, cried easily, demanded a great deal of attention, and would not go to sleep unless her mother lay down with her.

Her spells had commenced following a coasting accident. She had seen a little boy killed in a collision, and later had gone into his house and seen the corpse. A week previous to this she had attended her first funeral, and afterwards had told her sister that she wished she had not gone as she kept thinking about it. Her family were very much worried over her spells, talked a great deal about them and the incidents of the accident, and both family and friends would inquire frequently about her health and in every way show great solicitude.

Upon discharge Edith was sent to a farm for two months, in an environment suggesting nothing but health. She had no further spells. The family was relieved because of her improvement and it was possible for them to treat her as normal when she returned home, controlling themselves in their solicitude and suggesting good health rather than ill health.

In addition to the above types of cases which need medical care and supervision as well as study from the behavior standpoint, are those children mentioned in the introduction, who are brought to the Out-Patient Department because the parents regard the hospital as a place of authority on all disorders of childhood. Many of these are problems of feeding, sleeping habits, night terrors, enuresis, thumb-sucking, masturbation, fears, and poor discipline. Many of these disturbances can be handled by the pediatricians with the help of the Psychiatric Social Worker. Others need more specialized treatment and are studied in the Nerve Clinic and the more complex problems are referred to specialized hospitals and clinics.

Certain cases are referred to the Psychopathic Hospital for psy-
chometric tests and when advisable are transferred there for treatment. Cases are also referred to the Judge Baker Foundation for careful personality studies. Furthermore, close cooperation has been secured with the New England Home for Little Wanderers, the child-placing agencies and the Habit Clinics.

One of the most interesting features in the employment of a Psychiatric Social Worker in the Children's Hospital is the development of private case work. Dr. Crothers and other physicians at the hospital have called upon the Psychiatric Social Worker to study behavior problems in the homes of their private patients. This phase of the work has taken marked strides. While at the beginning, cases were referred solely by Dr. Crothers, now pediatricians, both inside and outside the hospital have become interested in the possibilities offered by this new type of service. Whereas, formerly it was possible for the "family physician" to take the time to become familiar with the patient in his home environment, usually knowing more or less intimately not only the entire household but frequently other persons associated with the child, the increasing specialization of the present day generally makes this impossible. Even where the physician has the opportunity of knowing the family background in some instances he has found it valuable to have the child studied by an impartial observer trained in child psychology.

Not only is the Psychiatric Social Worker's technique and understanding of personality at the service of the doctor but also her resources, her knowledge of the various schools, camps, places where children can be sent for vacation and of individuals who have had experience in straightening out difficult problems. She not only knows of these schools, etc., but through her past experiences knows just which school or camp or person will fill the psychological need of a particular problem child.

That families feel the value of a private Psychiatric Social Worker as well as specialists is shown not only by their willingness to have doctors recommend this new type of service but also by their readiness to pay for it. The Psychiatric Social Worker sends a separate bill for the professional services, just as does the doctor. This work is conducted in various ways. Sometimes a week-end visit is required in which the worker is treated like a guest of the family and can study the children under as normal conditions as possible, at the same time learning something of the family life, the habits of the
household, and the personalities comprising it. In other instances a
day with the family is sufficient, or a house call, with possibly subse­
quent visits, sometimes supplemented by a school visit or interviews
with relatives. The family always makes the arrangements for the
worker to talk with persons outside the family. The following case
illustrates this type of service:

Helen was eleven years old at the time she saw the doctor and
had such a terrible fear of fires that she not only had stopped going
to school but had gradually withdrawn from the usual activities of
childhood. She refused to go to parties and making her go out to
play involved a scene. A week-end visit brought out the fact that
she had well educated parents but that they were over-conscientious
and solicitous. They bent over backward to tell the truth to such an
extent that they confused the child.

Helen was one of three children, not spoiled in the usual sense but
very dependent upon her mother emotionally. However, she had
varied interests, was bright and resourceful, was clever with her
hands, played the piano and enjoyed reading. She was popular with
children, and had friends who came to play with her. Nevertheless,
the child would not go out and when forced, resorted to babyish tricks,
or temper tantrums in which she would cry and cling to her mother
or else relax and lie limply on the floor. This behavior had become
increasingly worse since the child had seen a house burn down some
months before.

The family arranged for the worker to interview the school
teacher and family doctor. The former was baffled by the child’s
behavior as she was a good scholar and well liked; the latter de­
scribed the mother as a very solicitous person who was continually
exaggerating the children’s ailments and was more likely to suggest
troubles than allay them, the father as a quiet, retiring man with
little force.

The worker felt that it would be impossible to reconstruct that
child in this home. She was strengthened in this decision by one
remark of the mother wherein she stated when asked why did she
not have open fires and help the child get over her fears, that on wet
days she could have a fire in the fire-place and assure Helen that
there was no danger, but on dry days this was not so as a spark might
set the roof on fire.

The specialist upon receiving the worker’s report called a confer­
ence of the parents with him and the worker, at which time the whole case was discussed and a plan made.

Helen was sent away from home for four months to live with a woman who had had experience with problem children, attended an open-air school and was given orthopedic treatment for very poor posture. She was allowed to go home during a short vacation. One day when she was having one of her babyish tantrums her mother asked her what Miss Snow did when she behaved like that. Helen looked rather surprised and said, “Why, nobody ever does that with her.” This very vividly showed the mother the keynote of the difficulty. That summer Helen went to camp and the following fall returned home and went to an open-air school in her home town. There has been no further difficulty. Helen is not only leading a healthy, normal life but has seen a house burn to the ground not far from her home with no occurrence of the old fear of fire.

In closing I might emphasize the fact that the aim of this new development of Psychiatric Social Work in the Children’s Hospital is to make sure that all children manifesting behavior difficulties who come to a hospital which is primarily interested in the general medical problems of childhood, are either adequately handled at the hospital or else are referred to another agency where they will receive the necessary more specialized treatment.
To begin with, let us define the word "convalescence." Does it not really mean "getting back step by step to normal responsibilities and good health after a surgical operation, or physical or mental illness?" For this reason, one can readily appreciate the fact, that the further away the patients' minds can be directed from the idea of illness, so much quicker will the progress be in their regaining their good health normal to themselves. This can be brought about only by having trained persons, who, because of their preparedness and understanding of human nature are able to continue the work of caring for these patients when the doctor's job is finished. Who is better fitted for this particular mission than the Nurse, because of her high qualifications?

There are few subjects, if any, so deeply interesting to mankind as that of the duration of human life. As you know, the sciences of Biology, Psychology and Physiology have been developed with the fundamental purpose of revealing the underlying principles of vital processes, so that eventually it might be possible to prolong the length of life to the maximum number of years. For ages, the chief object of certain groups of people has been to influence community and individual conduct and responsibility, so that sickness and death from preventable causes might be reduced. In this great scheme of life, especially in this age of complex civilization, convalescent care is contributing a most important part to this interesting study.

Convalescent homes, as some of you may know, date back as far as 1650 in France and England. There, they were small places run by the Sisters of Mercy in conjunction with the hospitals and destitute homes. This type of work is not very old in America. At first, throughout this country, it was carried on about the same way as by our foreign Sisters, until public spirited people thought out the
idea of standardized homes for this particular work. The home which I represent, The Solomon and Betty Loeb Memorial Home for Convalescents, was one of the first standardized homes of this kind in the United States. It was established in 1904 by the late Professor Morris Loeb and his sisters and brothers in memory of their parents.

The purpose of the Home as then stated in its by-laws was to care for persons recovering from a severe illness or those needing country care who, because of their economic status, were unable to receive the proper convalescent care at home. You can well appreciate how impossible it is for poor people of the City of New York to regain their strength and health in congested surroundings and poor homes.

The Home is administered on the cottage plan and covers 68 acres of land, a great deal of which is used for recreational purposes. In the Administration Building which contains the dining rooms and quarters for the staff, a wing has been set aside for convalescent professional workers and nurses, clinic and vocational rooms. There are two cottages for women, each with a capacity for 32 adult patients; and another cottage for children with a capacity for 34. The Home accommodates 108 convalescent patients. This number increases during July. The Home maintains its own laundry, power plant, and farm.

One of the outstanding features of the Home after two decades is that it is still a model home doing convalescent work, operating under the same plans originally laid down as well as with the same facilities originally provided by the founders. This only goes to show what keen foresight the founders must have used in the planning of this splendid memorial.

The entire scope of the work is more or less based on what Old Gotham Graham once wrote to his son. "Health is like an inheritance. You can spend the interest in work and play but you must not break into the principal." The Home is used by persons who have broken into their principal of health and are in need of rehabilitation.

Convalescent work of yesterday was looked upon more or less as some one's fancy. Today it has become a definite part of the medical treatment of patients recovering from more or less severe illness, injury, exhaustive state or post-operative experience, and aids in the re-establishment of normal health to the individual.

You can well appreciate how very important it is, to intelligently
Convalescence

care for the patients needing convalescent treatment. That great question of mind over matter is one that convalescent homes have to cope with in order to help the patients regain their normal health. It is a great satisfaction to me in knowing as well as seeing what this work means not only to the medical profession but to the community as well.

Hospitals too, have in the past few years felt more keenly than ever before the need of proper convalescent care for their patients. This is true particularly in reference to the ward cases for two-fold reasons. First, ambulatory patients requiring only the routine care, are a great expense to the hospitals if they can continue to receive the proper intelligent treatment at a lesser cost elsewhere. The hospital cost per capita is between $5 and $8 per day for ward patients, depending upon the size and type of hospital. Convalescent care in a convalescent institution averages $1.80 to $2 per capita. Does this not mean a tremendous saving to the hospital as well as to the community if patients are sent during this period of time to the proper convalescent home? Secondly, is it fair to keep patients well on the mend in hospital surroundings, occupying hospital beds that can be used for more emergent hospital cases if there is a convalescent home where these patients can receive the proper treatment? Here again, by sending these patients to convalescent homes, you are enabling a greater number of patients to be cared for at another saving to the community by a more rapid turn-over. What satisfaction it must be nowadays to the medical profession to be able to see their patients rightfully taking their places back in the community more quickly than ever before, due to the individual care received during their convalescent period in a convalescent home. The time is not far off when all hospitals of any size will have a convalescent country annex. These country homes will round out the medical care and bring about the rehabilitating of the patient as well as curing him of an illness. There must be close cooperation between the hospital and the convalescent institution, wouldn’t it be better to say home, as it sounds much more friendly and this is one place where friendliness must prevail.

The Public Health Committee of the Hospital Information Bureau of the Academy of Medicine has for a long time felt the need of looking further into this matter of convalescence. Two years ago they formed a Committee to study this situation. This Committee
has been spending considerable time in trying to fathom the many problems that continually arise in this field of work. Under the auspices of this Committee public meetings have been held and are being held to bring the convalescent homes closer to the social service workers who are actively engaged in medical social service.

The great problem that confronts convalescent homes in the care of their charges is that vast question of rehabilitation. Rehabilitating the body, rehabilitating the mind and rehabilitating the spirit. Body, mind, spirit—just what does all this mean? We will assume that the patients who are sent to convalescent homes are cured of their illness upon their discharge from the hospital or dispensary or any other place or organization from whom they are sent. If this is so, just what is all this treatment that they now require? Being mentally and physically debilitated as you know, they need a great deal in order to be restored to good health. Primarily they need happy surroundings. Contact with people who understand their psychology—wholesome occupation and entertainment all play a tremendous part in their recovery. Occupational therapy makes its entrance here. One must keep the mind free from unpleasant thought and fingers active in order to rehabilitate the body and help the individual develop a sense of independence.

There are several kinds of convalescent needs. Convalescent care for men—convalescent care for women—convalescent care for children. Each one of these groups requires a separate home or wing in order to be cared for properly. The Home which I represent cares for women and girls from 5 to 60 and boys up to 13 years of age. There are other homes that care for both men and women. Some care for children alone. In caring for both sex among the adults, you can readily appreciate that considerable care has to be given to the plans and lay-out of the home that cares for them. This is due to the fact that one must consider the large social problem plus the state of mind due to illness. Children and women, if dealt with collectively, do not do well. These groups, too, have to be treated separately. Babies and mothers do not do well except in a group by themselves. It must be taken into consideration that patients in need of convalescent care are usually ambulatory and need lots of freedom. Of course, this freedom is more or less supervised, but over-supervision is like having no freedom at all and no freedom at all is not good for convalescents. Bearing this thought in mind you can
well appreciate how difficult a problem it is to mix these various
groups. It is hoped in the future as new convalescent homes are de-
developed that proper consideration will be given to the plans in order to
care for these various groups properly under one administration.

The adolescent problem is another tremendous responsibility to
convalescent homes and should be given more study than it has been
receiving in the past. Dealing with all of these phases of illness, sex,
age and so forth, you can well appreciate how very much the study
of convalescence needs nurses in its field of work.

In caring for the New York City child absence from school must
be considered. For this reason the public school authorities of New
York City have established in most of the homes caring for the New
York child special classes to take care of this situation. This makes
it possible for the children to continue their education while regaining
their health. These particular classes have also included extensive
health programs which have proven vastly important to the children
during convalescence. We personally have found that in no way
has this school work impaired the physical progress of the child
during his or her stay at the Home. In fact, is it not an excellent
opportunity for the child to get back into the school system with the
least possible time lost?

It is most imperative that the Home be given complete medical his-
tories of the patients to safeguard them, if a relapse or any other com-
plication should occur while convalescing. A complete social history,
too, is important. You might question this, in view of the fact that you
might be assuming that our problem is post-medical and not social.
This assumption cannot be taken into consideration in doing con-
valescent work, for the one big problem that confronts convalescent
homes is that the mind plays a very important part in the reestablish-
ment of the body. Both go hand in hand and to both one must give
considerable thought. Social maladjustments often interfere with
progress, and by having a complete picture of all conditions, one can
often readjust what possibly seems maladjusted to the patient's satis-
faction. Here again environment plays an important part. Classifying
cases and treating those needing prolonged and individual care in
separate groups is always essential. Personalities must be taken into
consideration. Acute surgical and medical cases, chronic and semi-
chronic cases, nervous cases, and mental disorders all require different
kinds of care.
Another question that might come to your mind is just what types of cases should receive convalescent care. From my experience, patients recovering from acute illnesses whether surgical or medical who have required either hospital or dispensary care or who have been under the care of a private physician and are unable to receive the proper after-care, should be sent to convalescent homes. A great deal of preventive work can be done by having dispensary cases who are in need of convalescence, receive this care while acute illness may be prevented, thus saving a hospital bed. Semi-chronics, if curable, are entitled to convalescent care providing they do not need active medical attention. Many physicians are not always acquainted with these homes where patients can receive this important after-care treatment. No matter what field of work a nurse may pursue, her knowledge of these facilities may be of great importance to the doctor.

There are over 70 convalescent homes in and about New York City, caring for convalescents of one type or another. There is the Burke Foundation at White Plains which was established in 1915 and cares for both men and women. Dr. Brush who is in charge of this splendid institution is a pioneer in convalescent work and through a Research Fund of the organization many studies of convalescence have been made. Copies of these studies may be had by asking for them. The Neustadter Home at Yonkers was opened in 1918. At this home women and small children are cared for. There is also the Jewish Home for Convalescents, Grand-View-on-the-Hudson, the Hebrew Convalescent Home here in New York City, both of which care for men and women. The Caroline Rest at Hartsdale takes care of mothers and babies. Campbell Cottage and the Hebrew Convalescent Home at Rockaway Park care for children. Mary Zinn Home, Irvington House, Martine Farms and Pelham Home, all assume responsibility for cardiac children. The New York Orthopedic Hospital Country Branch and the Blythdale Home care for crippled children. The American Red Cross has a convalescent home for nurses at Babylon, L. I. The Children’s Aid Society of New York City have under their care several convalescent homes for various type cases. There are a great many other homes all working more or less to full capacity, trying to meet the many problems that arise in this field of work. The Hospital Information Bureau of the Academy of Medicine has published a directory of convalescent homes which can be secured directly from the Bureau at a cost of 25c a copy.
Still with these 70 or more homes, New York City does not seem to have enough facilities along this line to cope with the many problems that confront social workers, and we are looking forward to the time when there will be established special convalescent homes for those requiring special care. We know that there is a crying need for convalescent care for the mentally ill, especially mental disorders. It is very evident that these patients not suffering from intellectual or moral deterioration need convalescent care among pleasant surroundings in order to regain their health. There are only a very few convalescent beds set aside for this type of work.

There too, is a great need for more cardiac homes for adult patients, especially men. I believe statistics show that cardiac disease is first on the list of all causes of death. This surely needs consideration. Semi-chronics who need long periods of rest in a pleasant environment in order to regain their health and become useful members to society need convalescent care.

It is hoped that the future will hold forth more homes for the care of convalescent mothers and babies, children under the age of 5, the adolescent girl and boy and last but not least, more homes for convalescent men. Very few homes have been provided for men. Somehow or other women and children seem to make a stronger appeal.

As time goes on, these various needs will be felt by the community and the nurse ought to be there to contribute her service to this important field of work because of the splendid medical background that she has acquired in her training.
THE OVER-PROTECTED CHILD

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The family is, probably more than ever before, a subject for profound discussion in psychiatric and sociological circles, and well it may be. Within the setting of the family circle occur those parent-child relationships which make, on the one hand, for good character formation and a well adjusted personality, or, on the other hand, for bad personality and poor character formation. Much indeed depends on the character of the parents and on their ability to bring out and develop the child's personality as to what the child will be. The child's response to his parents will depend on their approach to him. Depending on their approach to him he will either love or hate them. Their various attitudes and tone of voice he senses and comprehends long before he understands their language.

It is frequently assumed that only those children who have no one to love them, who are cruelly treated and neglected, become problem children. However, we hope to show that the seemingly more favored ones also may become problem children and that in various ways; for in this parent-child relationship, for the unwary or unwise, many pitfalls may be encountered all along the path of the child's growth into adulthood.

In earliest infancy the child is entirely dependent upon the parents. But protection which is necessary during earliest infancy very soon becomes over-protection of the toddler, and what constitutes protection for him is over-protection for the school child, and so on through the various stages of childhood into man's estate. Let me illustrate.

Jimmie, a lad of five years, comes referred to a Child Guidance Clinic because "he is willful and obstinate and given to temper tantrums." Now Jimmie is a bright boy, in fact he rates in the superior group. Physically, too, he is quite a normal youngster. But what then brought about those poor personality traits complained of by his
fond parents? Jimmie’s father—I quote the mother—“is just crazy about Jimmie.” He must not stand near a door lest he catch cold. Yet every whim of the child’s must be gratified. He cannot bear to think of disciplining the child lest the child learn to fear him. Neither must the mother discipline him and for the same reason. Moreover, the mother feels much the same as does the father. Both feel that they must never leave Jimmie out of their sight day or night. Consequently, though they could at times leave him in the care of competent adults, yet they fear to do this, and of course the night air is bad for him so he cannot be taken out of an evening.

And how does Jimmie react to this training? When still a tiny tot the minute they ceased their fondling him and laid him down, he would set up a cry. He knew they could not bear to hear him cry. And as he grew up he found it still worked, so that today at five years of age his mother must lie down with him when he takes his nap or retires for the night, or he will cry and howl for hours. When awake he will not permit her out of his sight. He hasn’t learned to play by himself. She or the father must take part in the games with him. Should they hesitate a temper tantrum results, toys are broken and flung about, fiery words are spoken. Unable to stand it, the fond parents give in. Is it any wonder this child has not learned to play and get along with other children? Is it any wonder he is willful and obstinate and given to temper tantrums?

These parents in their over-solicitude forget the basic aim of all child training, namely, the development of self-reliance and independence in the child. There must be a gradual and steady release from dependency, but the start must be made early. All too frequently the path is made too smooth for the child, in that he is helped through all his difficulties, when he should be helped to meet new situations as they arise. He fails to develop any sense of independence, loses all initiative and self-reliance, and comes to depend upon his parents for the fulfillment of his every want and wish. And just as the parents fail to observe that the child is growing up and no longer needs their constant care and protection, so also in their over-solicitous love and affection they are apt to consider the child’s tricks as “cute” long after they have ceased to be so, if ever they were, and in consequence see no rough seas and rocks ahead of him as a result of such poor habit formation.

It often happens that this over-protective attitude dates from the time of a severe ailment of the child. Such is the case of Robert, age
thirteen, who was quite badly burned on the leg shortly after birth. As a result he was a very delicate infant; in fact, his burns did not heal completely until he was past two years old. In consequence he received much attention and solicitude from all the members of the family. He grew up to be a very sensitive lad who cried easily whenever his wants were not immediately granted.

When Robert finally entered public school at the age of twelve, having been tutored at home up to this time, he at once began to have difficulty with playmates. Never having had opportunity to associate with other children, he found it extremely hard to compete with them in their sports. And because of his sensitiveness, the outgrowth of the over-solicitous attention he had received in his own home, he reacted to the snubbing of his playmates by crying, which but increased their teasing of him. He began to find school intolerable and the world too hard for him. He wanted to be home with mother, to continue to be her baby. Thwarted in this by the firm attitude the father now assumed toward him, he began to fall back upon his early symptom—his leg hurt him too much to go to school. But the father still being adamant, the child added to his symptoms of physical unfitness by complaining of stomach trouble. (The father complained of stomach trouble, too.) This would usually disappear on Friday afternoons, only to increase in severity throughout Sunday afternoon and evening, until by Monday morning he was suffering most intense pain and cramps in the pit of his stomach. Should he be permitted to stay at home the pain always rapidly decreased in severity.

Here we see the over-protective attitude beginning on the basis of an actual physical ailment. Frequently, however, the child learns that the feigning of a physical illness will gain for himself more and more attention until at last, just as in Robert’s case, the child comes to demand this over-protection, since all initiative, self-reliance and independence have been destroyed. We have such a case in Mary, a girl of good intelligence, who has the asthma, that is when it serves her purpose to have it. In fact Mary has had various illnesses; they serve her well. When just a little girl an epidemic of poliomyelitis was raging. Her parents talked much about it and frequently before Mary. Finally they took her to another city. There one day after she had been refused a toy she feigned paralysis of an arm. Needless to say, she learned that having a physical illness worked. For the past four years she has had the asthma. Competent physicians can find no organic cause for this condition. But Mary has it and her
attacks duly alarm her fond and over-solicitous parents. Today she is a self-centered, egoistic youngster, quite dependent on the parents, especially her mother, who waits upon her every beck and call.

Mary is a sick child, but sick mentally. What a tremendous price she is paying for the satisfaction, such as it is, that she obtains in this parent-child relationship. And poor parents! Carried away through sorrow for their supposedly physically sick child, they have showered upon her love and affection in ever increasing measure until today the child lies robbed of all her self-reliance and independence.

The “broken home,” whether as a result of divorce, separation or parental disharmony, is often the cause of the over-protective and over-solicitous attitude on the part of one or both parents.

A wholesome division of the child’s affection between father and mother is necessary for normal personality development. But it is equally as important that father or mother do not turn to the child for comfort and shower upon him all the love and affection that should normally have gone to the partner in marriage. This is, however, what frequently occurs in the “broken home.”

Harry, age fourteen, was referred because of his seclusiveness and self-consciousness. Harry’s mother married the father because her parents wished her to. As might be expected, disharmony existed from the very outset. From earliest infancy Harry was taught to fear and hate the father. He would shrink away when he heard his father’s voice. His mother made much of him; in her he found his happiness. His play was solitary or his one companion in it was the mother. She read volumes to him. Everything was done for him, but everything to attach him the more closely to the mother. As he grew up he witnessed many scenes between mother and father. He always sided with the mother and hated the father the more.

Because of his seclusiveness and his ever increasing self-consciousness, the mother was prevailed upon by relatives to send the boy away to camp. He stayed less than a week. He had cried so much for the mother and had lost so much in weight that it was thought best to take him home. Later he was sent to boarding school. There his troubles increased. He believed the pupils and teachers hated him and looked down upon him. Finally, unable to stand the separation from his mother any longer, he withdrew from the school and returned home. Life away from the mother indeed had become too hard for him in his present state of mind.
Harry complains of his torturing self-consciousness. He states it “eats away like a cancer, turns his happiness into bile, his confidence into inferiority.”

So one could go on pointing out various personality deviations which may be produced in the child by over-solicitude and over-protection on the part of parent or parents. We have tried to point out that the violent temper, the loss of initiative and self-reliance, the hypochondriacal attitudes, and the over-attachment to and dependence on a parent, may be brought about by such over-protection. Traits so engendered may persist in the personality make-up of the individual throughout life and thus seriously interfere with vocational and social success.
A CITY TUBERCULOSIS SCHEME*

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The operation of a comprehensive city tuberculosis scheme presupposes that the solving of the tuberculosis problem is accepted as a regular community responsibility, that private initiative has already done its work of education and that there is sufficient general knowledge about the problem to guarantee an adequate and persistent support from the public funds for a period of years.

Because of the multitude of factors involved, it is possible only through a public organization to carry on a really comprehensive program. While tuberculosis is one of the most if not the most important contagious disease, a plan for its control cannot be carried on if it is entirely separated from all other community health problems; it must be a part of the general community disease control plan. In other words, a city tuberculosis control unit must be in close affiliation if not actually a part of the city department of health.

Control Activities

In the problem of tuberculosis, just as in that of any other contagious disease, the control consists in three principal activities:

First, treatment of active cases; second, prevention of immediate or contact infection; and third, study and elimination of general causative factors.

Theoretically, all cases of contagious disease, including tuberculosis, must be reported to the health authorities. The purpose of reporting contagious disease to a health officer is to make possible the supervision incident to quarantine and not necessarily that he may furnish treatment. Even if such cases were all reported as required,

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it would be impossible and undesirable for any public authority to take over their entire supervision and treatment.

The "treatment" under a city-wide scheme, then, varies from the simplest supervision to complete control, depending on the circumstances in each individual case, the economic status and whether or not the patient is in his own home under the care of a private physician or in a public institution.

**Home or Institutional Care**

Generally speaking, treatment may be divided into "home" and "institutional" care. For the purpose of discussion this arbitrary division is made, but in any given case there is always "home" treatment before and sometimes after institutional care. In spite of the fact that there has been rapid growth in the number of institutions for the care of those having tuberculosis, it is still true that the great majority of all cases do not receive institutional care of any kind.

The prevention of immediate or contact infection is of the greatest importance to the community and is accomplished principally by the separation of any individual having open tuberculosis from contact with children. This particular function, in order to be effective, requires the authority of a public health official.

The study and elimination of general causative elements are just as broad and varied as these words indicate. Such typical factors as the food supply, sanitation, housing and occupation have a more or less direct bearing on the activation of a tuberculous infection. The success of any comprehensive plan for the control of tuberculosis is in direct relation to the living standards of the community. Anything which lowers the general health increases the tuberculosis rate and conversely, anything which raises the general standard of living tends to reduce the tuberculosis rate.

**Discovering the Active Case**

While in most community schemes the hospital or sanatorium is the unit around which the rest of the plan is developed, the institutional care of those who are seeking treatment, important in itself, is not really the most valuable part of tuberculosis control as far as the community is concerned. Undoubtedly the most important part of any program is that part devoted to the discovery of active cases of disease. It has been true up to the present time and probably it will
continue to be true, that the private physician who does most of the medical service for the community is the one who discovers most of the cases of tuberculosis. Because of the nature of this disease, particularly its slowness in developing and its variety of symptoms, a large proportion of all cases are not discovered until the disease is well advanced. As stated before, a large number of all cases are discovered by the private physician, but the ordinary person does not go to his physician unless he feels that he is really ill. It is unfortunately the habit in most sections not to seek a physician or to pay him for services if there are no perfectly evident symptoms of disease.

Dispensary Service:—Because the presence of tuberculous disease is so unlikely to be discovered early, there is a very large field for public dispensary service. The fundamental idea of the dispensary is to encourage people to come for physical examination when there is still comparatively little reason to suspect trouble. Public health physicians who are not only specially trained in general public health but in the discovery of tuberculosis are able to do valuable service to the community by assisting and supplementing the work of the private physicians.

The Public Health Nurse:—The real point of contact between the community and the tuberculosis control organization is the public health nurse; district nursing in its various aspects has become one of the most appreciated public services supported by any community. While in a tuberculosis program the tuberculosis nurse has the principal responsibility, she is assisted by all the district nursing groups: the school nurses, the infant welfare nurses, the visiting nurses of all public and private organizations. To summarize then, the discovery of active cases other than those that are known to be seriously ill is greatly facilitated by the field work of the nursing groups who refer suspects to their private physicians and to the dispensary physicians for examinations when without this special nursing service the examinations would have been neglected.

THE CARE OF THE TUBERCULOUS PATIENT

Following the discovery of the active cases, the next problem is the care of these patients. Again it happens that the private physician carries the larger part of the burden. It has always been true and probably will continue to be true that irrespective of available institutions in any locality, the majority of individuals who have tuberculosis
will be taken care of in their own homes. Supplementing the home care by the private physician is the dispensary staff of nurses and doctors. Just as the private physician finds that in some cases the attention necessary is simple periodic supervision, while in others, in order to have control, the supervision must be almost continuous, so the dispensary groups of doctors and nurses are able in many cases to assist and get satisfactory results by simple direction, while in others daily visits of the nurse and weekly visits of the doctor are required.

The Need of Institutional Training:—A great many of the cases that are cared for at home would probably be very much better off, the chances of getting an arrest of their disease would be increased and the community would be better served if they had at least a few months' institutional training. On the other hand, a large number of those that show sufficient symptoms to warrant a diagnosis of a beginning tuberculous infection do not really need institutional care and can be supervised adequately at home. In actual practice it is found that one case goes to an institution for about every ten cases which are cared for in their own homes under the supervision of private and dispensary physicians.

The Hospital or Sanatorium:—In any modern community scheme a hospital or sanatorium is, as previously stated, the center of interest. In most sections there are some private institutions available. While it is frequently possible to maintain a higher standard of care in the private institution, usually the cost is beyond the reach of the average person, and the capacity of these private institutions is so limited that only a comparatively small number of patients can be cared for.

On the public institutions, then, falls the burden of this work. The standards set by the older private sanatoria have now been accepted by most modern public institutions. Simple custodial care is no longer tolerated. The standard requires that the sanatorium provide all the necessary facilities of buildings and equipment and a trained and competent staff. The work done must include all types of treatment from the simpler supervision necessary for early cases to the complete care of the advanced, complicated case. A modern sanatorium is no longer merely a place for rest care; it must really be a general hospital with facilities for giving all the medical and surgical care that may be indicated.

A large public institution is also compelled by modern standards to provide adequate laboratories for technical research. The com-
munity which supports a comprehensive scheme for the control of tuberculosis is not properly served unless there are equipment and personnel for the proper technical study of the clinical matter going through the institution.

**Prevention of Contact Infection**

Following the discovery and care of active cases of tuberculosis, the next step in the scheme is the prevention of the spread of the disease by actual contact with the open case. This prevention of infection must be begun in the home and continued through the school, at places of employment and in the community in general. While the major part of the effort to prevent contact is and should be devoted to the separation of children from the open case, it is believed that this attention to the children is not sufficient. The prevention of contact is largely a job for the field nurse and the health officer. While it is always necessary to have in the background the police authority, in actual practice the breaking of contact in all but a very few cases can be made through the instruction and efforts of these field nurses. Only in a few cases is forcible hospitalization advisable or necessary.

**Discovery of the Minimal, Suspected and Potential Cases**

The next step in the progress is the discovery of active cases not evidently ill. This is the part of the work which has to do with wholesale periodic physical examinations of adults. Year by year this practice is becoming more popular. The persistent propaganda by all public health agencies, including the tuberculosis prevention group, is slowly but surely producing the desired results.

In the process of discovery of “active cases not evidently ill” there is always found a large number who for various reasons are suspected of harboring tuberculosis. This group of “suspects” need advice and instruction. Probably this supervision given to the so-called “suspect” case has a great deal more to do with reducing the death rate from tuberculosis than we ordinarily believe. Often a “suspect” is found and classed as such, not because of definite chest findings, but because of general poor condition, then by a simple change in habits of eating and rest, the reason for his being suspected entirely disappears; undoubtedly in many cases the development of an open tuberculosis is prevented.

Still another large group comes under the supervision of the out-
patient department. These individuals, mostly children, do not even come within the suspect group, but are "potential" cases. In the routine examination of school children many conditions are found which handicap a child in his physical development. The correction of such physical defects tends to improve the general condition of these children, the so-called potential cases. Some are brought up to normal by supplemental feeding, while some of the group require such special care as is given in the "open window rooms." Still others are so far down in the scale of general health that they are brought up to a normal physical condition only by the kind of care that is given in preventoria. Just as a supervision of the so-called suspect case frequently results in the entire elimination of those conditions which make the case a suspect, the correction of physical defects, the supplemental feeding, the care in the open window room and in the preventoria have changed thousands of school children from what we ordinarily consider as potentially tuberculous cases into children whose health and development are within normal limits.

**A Study of General Causative Factors**

In a comprehensive tuberculosis scheme it is not enough to study actual and potential cases. This work is incomplete unless there is a constant effort to understand and correct those general causative agencies which are really the primary causes of a disease like tuberculosis. These general agencies are best understood through community surveys. These surveys must take account of such factors as the economic conditions, racial handicaps, housing, sanitary conditions, water and food supplies, and occupation. The following illustrates the importance of one of these factors. A recent analysis was made of the death rate in Chicago from tuberculosis which showed the importance of "racial handicaps." The figures show that there has been a steady and persistent decrease in the tuberculosis rate among all race groups except two and that the increase in rate among these two groups is sufficient to change the total rate from a downward to an upward course within the last three or four years. There has been a very marked and persistent increase in the tuberculosis rate among the Negroes and among the Mexicans in Chicago. This increase more than over-balances the decline among the other races. When one analyzes the occupational, housing, sanitary and general economic
handicaps which these two races labor under in Chicago, it is easy to understand why their general health is poorer than that of other races.

A city tuberculosis scheme would still be incomplete if no attempt were made to understand and evaluate the importance of labor conditions as related to health. For example, it has been repeatedly shown in Chicago that where the mortality rate from tuberculosis of occupational groups has been reduced until they now have almost no tuberculosis, this result has promptly followed improvement in the standards of living. These improved living conditions have been brought about by the better economic conditions under which these people are now employed.

COORDINATION OF PUBLIC HEALTH AGENCIES

All community health problems overlap. There is no such thing as a health hazard that is unrelated to other health problems of the community. The comprehensive solution or treatment of any one of these must of necessity coordinate with the plans for the solution or treatment of all the others. This is especially true of the problem of tuberculosis, the treatment of which involves almost every phase of medical and surgical practice as well as the use of most social and economic agencies. It should be perfectly evident that the closer the coördination between a community tuberculosis scheme and all other existing health schemes, the more successful the tuberculosis control.

In conclusion then, a modern city plan for the control of tuberculosis must be comprehensive, its activities must be aggressive and must be coördinated with all community health and welfare agencies. The activities of the group in charge of tuberculosis control must begin with fundamental causes and extend to supervision over all known cases in the community from the potential, child's case, through the group of suspects and including all known positive cases. The treatment must vary according to the needs of the situation from the simplest supervision to complete institutional control. Where an organization assumes entire charge of a case, then the treatment must be the very best obtainable. This applies particularly to public institutions. Indifferent care only means expense without results. Tuberculosis control is one of the most serious and important jobs that any community can undertake. It must be complete in every sense of the word and actuated by the highest ideals for community service.
THE MISSING LINK SUPPLIED

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9 a.m. The waiting room of the outdoor of a city hospital is filled with patients awaiting their turn for medical examination. In the various clinic rooms, busy doctors giving freely of their time and skill to help the needy ones, make ready for their coming. Very quickly, under the capable management of nurses and clerical workers, the patients are guided to their respective places and the work of the morning begins.

One of the first patients to be seen is Rosie, a bright little Ukranian girl of three years, half of which have been spent in a hospital ward because of a tubercular joint infection. It is just a short time since she was discharged, with the understanding that she must be brought to the outdoor twice a week. "Why is this not being done?" asks the doctor in an angry tone, as he tries to impress on the father the result of his apparent neglect. But the father, with his limited English, gives no satisfactory answer.

While we are still seeking one, Mike is brought in; such a poor, little, miserable baby, six weeks old, and getting smaller every day. He is in the arms of a neighbor of the family, and his little sister of nine acts as interpreter, she being the only one in this Austrian home who can speak English. "Take baby into hospital," she pleads, but the doctor realizing that the baby in its present condition would be an easy prey for any infection, refuses her request and instead makes up a special formula for baby's food and sends her away.

"This child is not as well as I expected to see her. Are you sure you are following the advice I gave you last time?" Mrs. B. hesitates. "I have tried, but it hasn't been possible to do everything," she says. "Well, it is useless bringing the child if you don't follow advice," the doctor replies, as the woman turns to leave the room.

As the morning advances, many patients come and go, some looking pleased and happy, others worried and anxious.
One tired little mother, with an infant in her arms and two other small children clinging to her, waits her turn, but after two hours she goes away without seeing the doctor, realizing that a greater effort must be made to get there earlier next time.

3 p. m. Those who were in the outdoor of the hospital in the morning are now at home.

Rosie’s home is just three rooms, which she shares with her father and mother and four little brothers. Her mother, who is lame, cannot travel on the street cars. Her father works all day for a small wage, which is decreased if he loses time. The parents are worried. They are wondering how they can manage to follow the doctor’s advice and get Rosie to clinic.

Mike’s home is badly kept. His mother does not understand English, and worse than that, she does not seem to have the intelligence which would enable her to take proper care of the baby. Two other little children show the effect of improper feeding. No wonder the worried father wants the baby in hospital, but he cannot go himself to ask, for if he does not stick to his job he will lose it.

What was it that made Mrs. B. look so worried this morning? Surely, in her neat little home, everything is going well. It takes some time to find out the difficulty there, but at last it is revealed. The extra diet and medicine for Mary are costing more than they can afford at present, with daddy out of work and likely to be for some weeks longer. The little bank account must keep things going until work opens up again.

And what about the little woman who hurried away without seeing the doctor? What a tiring day she has had! Up at six o’clock, preparing breakfast, getting the children off to school, making ready to go to the hospital, the long street car ride, the tiresome waiting, and then the anxiety about baby which she hasn’t been able to share with the doctor. She almost wishes she had waited a little longer, but then she had promised to be home at noon. John thinks she is fussing too much about the baby anyway. If only they could afford to have a doctor of their own come to see her!

Yes, these are the problems by which the district nurse is confronted as she goes in and out the homes day by day. Hers is the task of solving them and of interpreting to the hospital doctor the conditions under which so many of his patients live. In solving them she must seek the cooperation of others.
For Rosie, she must find the volunteer worker who will take her to the clinic and save the all too scanty wages of the father.

For Mike, she must discover a way of getting from the hospital dairy the feeding which his mother cannot prepare for him.

About Mrs. B., she must talk to the social worker, and together they must decide on some plan for getting the special food for Mary. Probably the club so interested in hospital patients will be persuaded to help.

And then the tired little mother. Why, of course, some member of the Junior League must be asked to take her in a car to the hospital.

In interpreting to the doctor something of the home life of the patients into whose homes he does not go, she must realize that the report which she writes is for him the only picture.

In Toronto, in all the public hospitals but one, the social service work is done by the public health nurses of the city. From a staff of one hundred and twenty nurses working under a generalized system, one group is assigned to this work. These nurses working in the hospital clinics maintain a close relationship with those in the district, by whom the follow-up work is done, and thus form a link between the hospital and the home.

Toronto public health nurses are helped very greatly in their work through an arrangement whereby the secretaries of a city wide federation of social agencies have their district offices in rooms adjacent to theirs. The fact that these social workers are close at hand to advise and assist in the problems which come to the nurses’ attention means much to the success of the work.

One rather unique organization which has been working very helpfully in the city for the last four or five years is the Junior League, which is composed of young society girls, who give of their time to help in various kinds of work. They are interested in the babies and are to be found assisting in hospital clinics and child health centres; also using their cars to get patients back and forth to clinics and to collect the breast milk that is supplied to hospitals by women in outlying districts.

The value of hospital social service work is becoming clearly realized as one observes the more sympathetic understanding of the patient on the part of the doctor, the more skilful interpretation of the home life on the part of the nurse, and the prompt contact made with the homes when necessary by the district social case workers.
It is surprising that in as wealthy a country as the United States, so many young people begin work during the early and middle adolescent period. The census of 1920, shows that of seven and three quarter millions of young people fourteen to seventeen years of age, three million had left school, the great majority to go to work. Of course, a larger proportion of those seventeen years old were at work than those younger. There were fourteen per cent of the fourteen year olds at work, and sixty-five per cent of those seventeen. To most of us the thought of more than three quarters of a million boys and girls at work under sixteen years of age is deplorable, and rightly so. On the other hand, those close to the situation know the complexity of the problem and are convinced that the question of age is not the chief point to be considered in planning for at least half of these boys and girls.

Dr. Keller, Principal of the East Side Continuation School of New York City, finds that the average age at which pupils drop out of elementary schools in New York City is sixteen years. The average mental age of these boys and girls judged by the National Intelligence Tests is only eleven years and three months. Certainly work, under properly guarded conditions, is better suited to the majority of such a group than further attendance in the average fifth or sixth grade. In Pennsylvania, continuation school attendance is required for those fourteen and fifteen years old. The Child Labor Law further requires that a pupil must have completed the sixth grade before an employment certificate may be issued. In other words a bright child of fourteen or fifteen, who could profit much from further education,
is permitted to go to work and many dull boys and girls of the same age are leading a miserable existence in the fourth, fifth, and sixth grades—miserable from the point of view of themselves, their families, their teachers, and many younger pupils. Although the very retarded fourteen and fifteen year olds make up a very small proportion (2½%) of the school population, they comprise more than one-third of the truants and a still larger proportion of the habitual truants. School has no happy meaning for them and the result is petty thieving, truancy, and other delinquencies. Surely, promoting delinquency is not even a proper by-product of the schools or of the school law. This lapse of John W——, a very retarded boy of fifteen, seemed both ludicrous and tragic. John was found to have stolen twenty-five cents worth of bread which he destroyed. He did not need it. The school principal insisted that he pay the baker. The next day John appeared proudly bearing the quarter, his earnings. He had picked a bag of coal from the freight cars standing on the tracks and sold it for thirty cents, and since the woman who bought the coal promised to take all he could bring, he was planning to steal a bag every Monday. The school had at least given him cause to turn his thieving to profit.

Because of the numbers already forced to continue their schooling long past all interest has fled, it seems unwise to raise the minimum age for work of the Child Labor Law, unless either a provision is made releasing for employment, under especially guarded conditions, the fourteen and fifteen year olds who have reached their limit of school progress, or, better still, provision is made for developing special industrial schools, not institutional, for this group. In the meantime under the present law an increasing proportion of the bright children are kept in school by the more varied curriculum and by more socialized instruction.

What are the special problems of the young workers? Can these problems be attributed to their age or to the fact that work is different from their past experiences? One employer in contact with several thousand employees laughed at the question of what were the special problems of younger employees. His reply was that on the whole the problems of the younger group were very similar to those of the older ones, and that, in many instances, it was easier to clear up difficulties of the younger group, especially if they were the result of lack of training, non-conformity to rules, and unfortunate traits of personality. The adolescent of disturbing personality was said to
be the exception. My experience leads me to agree with this point of view. On the whole, young workers are surprisingly industrious, even tempered and stable. It is the unstable ones that get the most attention.

And yet, those advising and placing young workers find cropping up, again and again, attitudes that are a handicap to the best success. Perhaps of first importance come lack of foresight and restlessness. It is normal that from fourteen to eighteen, a boy or girl can be easily distracted by all sorts of outside interests. Enjoying the present seems highly important, and the future has a very vague existence in his mind. The results are usually a careless selection of work, if work must be selected now, and a failure to grasp the importance of making a place for himself and winning promotion on the job. Another result of absence of foresight and restlessness is a tendency to change from job to job for very trifling reasons. A typical response to the question of what a youngster wants to do is: Anything that pays at least — dollars a week. This is partly due to ignorance of opportunities and partly to a very short-sighted point of view. This negative interest in work makes him blind to the chances of doing more than is absolutely required—the “nobody told me to” attitude. It is exceptional to see a youngster try to master his tasks and find time for new ones right from the start, and yet, a few youngsters do so and win promotion the very first week.

Many of the duller boys and girls may be intellectually incapable of thinking ahead and working out a more or less elaborate plan.

Shifting from job to job is frequent. In some instances it is necessary and valuable. Dr. Franklin J. Keller terms “hoboes” those who shift three or more times a year, not because of industrial depression. Those who change no more than twice a year he calls “self educators.” Such a classification is perhaps too rigid to apply in every case. Nevertheless, we would agree that the boy who held forty jobs in two years is adept in getting himself hired, but is a poor employment risk. It is not necessary to be too concerned at the many shifts of even the brighter young people. Such cases as that of a valued foreman of a large machine shop, who pleads guilty to employment during thirty-seven years in some fifty machine shops scattered over a wide territory, show that frequent changing is sometimes compatible with success. This record of the changes of employment
among nine thousand continuation school pupils of Philadelphia indicates the volume of shifting of one group of workers under sixteen: *\(^4\)

- 52% did not change in the course of the year
- 25% changed only once
- 11% changed twice
- 12% changed three times or more

Lack of any clear idea of what they want at work, or of what they may reasonably expect, makes them a ready prey to the suggestions of older fellow workers. Discouraged and incompetent employees have an uncanny success in showing newcomers that their employer is the prince of exploiters. The best possible job may be painted the worst possible job in the mind of the young worker after three days of such propaganda. The following case is typical of scores whom we see fall victims to this propaganda. From one shop which is well up to the state requirements for working conditions, a youngster said he left his job because he "wasn't gonna chew tobacco for anybody." It seems that an older worker had persuaded him that he would soon die of tuberculosis if he did not chew tobacco constantly. As a matter of fact, the job was probably unsatisfactory to him in other respects, but pessimistic persuasion had been one factor in his leaving the job.

Parallel to an indefinite idea of what satisfactions may be reasonably expected at work, there may be an idealism in the young workers that carries them in their imagination far beyond their real abilities. The timid little eighth grade girl who said she wanted to be a "lady judge" may be hoping for distinction at work. On the other hand it may be associated with a desire to please her ambitious mother. Two recent high school graduates, rather immature for their ages, had a trying experience getting started, because of a misplaced ambition that was emotionally conditioned. They failed utterly in an attempt to make ends meet at social work. Actually they tried one volunteer job after another, each time hoping for recompense. At last they gave up and took more suitable work. Towards the end of their struggle one tearfully admitted that an attractive and prominent young clergyman was at the bottom of it all and had inspired their philanthropic zeal.

The harm of exaggerated self-consciousness is less easily detected than that of impractical ideals, but the consequences are frequently more lasting as well as more pitiable. The situation is all the more
unfortunate when accompanied by a physical defect or by unhappy home conditions. Many stammerers are doing work below their ability because they fear rebuffs in attempting other work. This is also true with many young men markedly below the average in height. Self-consciousness that finds expression in a repulsive conceit is sometimes just a reaction to an unhappy home or to a series of make-shift homes. In making unreasonable demands and in refusing to adjust themselves to usual business conditions, may sometimes be read a determination that in work at least they will not be "gyped" to use their own expression. The supersensitive attach a personal meaning to chance remarks of fellow workers. They place a personal meaning to their discredit on many comments that were meant to be quite impersonal. Those who have some special talent which they hope to capitalize some day are often a trial to their employers. They justify falling below the mark and losing their jobs with the excuse that their talent is not appreciated, that not enough allowance is made for their temperament.

Shifting from job to job, too lofty aspirations and enhanced self-consciousness are all symptoms of the marked physical imbalance of the period. It is said that this physical imbalance is greater with the American boy and girl than with the European. The constant movement and complexity of American city life excites to over-activity the thyroid and other glands. This, added to the increased susceptibility to distraction is assigned as the reason that we cannot hold boys to the careful hand work necessary in many skilled trades which European boys learn quite contentedly at the same age. The result is that we depend on immigration for skilled artisans at the more tedious trades. Another result is that the young American worker seldom looks upon work in an industrial plant from a trade point of view, even when he is at a more stable age. He is all too ready to spend his energy on the so called "production" job, not realizing that the period of high speed production is short and that the "pre-pensioner" job as guide or watchman may be his recourse at forty-five or even younger.

Girls have a special problem because employers do not consider them candidates for training and promotion as they do boys. The commercial training in stenography and typing which girls receive in High School fits them for definite openings. Employers are too apt to consider them only as potentially better typists and stenographers rather than as a source from which to recruit office executives. I do
not urge that women be given the same work as men but it seems that employers are failing to secure the best service from their women employees by taking this position.

After a discussion of the handicaps of young workers, the question naturally arises in our minds of what can be done to help them. Angelo Patri writes:

"We like to see a man build his own bridges and then pass over them."

For the strong person this is perhaps the best plan. But the average boy and girl is not strong in all respects. He needs our help in building the first bridge and in preparing for the second.

Parents, social workers, and others can do much to help young people select work in which they may reasonably hope for success. The world at large gives young people an exaggerated idea of the importance of money as a standard of success. We can help by emphasizing the greater importance of usefulness to society and of personal achievement through the mastery of difficult tasks, as bases for selecting work. It is often a real service to encourage a boy or girl to stick to his job over the first more or less trying weeks. In many jobs too much is expected of the recent employee. Some industrial firms have tried to relieve this extra fatigue by dismissing their new workers several hours early for the first week or two. On the other hand, many beginners' jobs demand much less intelligence and effort than their school work required. In addition to routine clerical workers probably many social workers, lawyers and other professional workers meet this condition on their first job. The less highly trained cannot understand the need for practice at much preliminary routine before assuming work that demands their best effort. It is hard for parents and friends to refrain from sympathizing too openly with first difficulties, whether they be those of boredom or fatigue. The mother, who works as hard at her son's first job as he does, reduces his self-reliance. Occasionally parents take the opposite attitude and are eager for their children to struggle on by themselves. This is far better than insisting that John's work be near enough for him to come home for lunch. Too much stress cannot be laid on the value of encouraging young workers to add to their personal equipment by good reading and by evening school courses. For the boy or girl who starts a business career after completing a year or two of
Adolescent

High School such training may mean a difference of ten or more dollars a week a few years later.

From the employer the young worker may legitimately expect definite duties and definite compensation. He should also be informed of what opportunities his job may lead to. An employer cannot be expected to chart out the steps of advancement in detail. Employees develop at different rates. Many times an expansion of business or a shift in personnel is necessary before promotion can be made. In all cases in which further advancement seems unlikely the worker should be told of the true situation and the suggestion made that he transfer to other work. In other words an employer should have the same responsibility for giving an honest and frank description of the employment he offers as when selling food, textiles or other products. The best service an employer can give is to assume definite responsibility for the careful training of the younger members of his force.

The responsibility of the schools is not a light one. In addition to offering each pupil the type of education from which he will profit most, a definite place should be given to instruction on occupations, and to placement service. Continuation and evening school courses should be considered an integral part of the school program and of equal importance to standardize as the courses offered those who are fortunate enough to continue through High School.

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1Day Schools For Young Workers, Franklin J. Keller, 1924, pp. 8-11.
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3Day Schools for Young Workers, Franklin J. Keller, 1924, p. 85.
A STUDY OF 511 WARD INTERVIEWS—PARTLY PAID AND FREE

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It has been the custom for the past four years at the Mount Sinai Hospital to interview every patient in the public wards, whether free or part-pay, on the day following admission to the Hospital. In order to determine the relative number of services needed by patients paying part of the cost as compared to the free cases, a study was made on 511 consecutive discharges from the adult wards. These cases were divided as follows: 242 free, 259 part-pay, (the latter group including 163 cases paying $1.00 per day; 62 paying $2.00 per day and 44 paying $3.00 per day). Part-pay rates are based on the patients' ability to pay and are determined on admission to the Hospital by a lay admitting clerk.

Of the 511 patients, 375 (73 per cent.) required service of some sort. This percentage was the same with the free and part-pay patients, the former constituting 177 and the latter 198 of the total.

The 177 free cases required 492 services, an average of 2.7 plus per patient; the 198 part-pay cases required 312 services, an average of 1.6 plus per patient.

Figuring another way, 47 per cent. of the cases were free cases and received 61 per cent. of the total services; 53 per cent. of the patients were part-pay and received 39 per cent. of the total services.

Another method of calculation showed that, irrespective of whether the patient required any or no services, every free case on the service averaged 2.11 services per patient, and the part-pay patient averaged 1.16 services per patient. The greatest proportion of patients requiring no services were in the $3.00 per day group (47 per cent. of all of the $3.00 cases).

This short study confirmed our belief that free cases required relatively more services than the part-pay cases. The surprise in the study, however, was the discovery that the percentage of all free
cases and the percentage of all part-pay cases requiring service were the same.

A list of the kinds of services rendered follows. Over half of them consisted in the sending of messages and interviewing families. These services often take a good deal of time and are not always as simple as one might suspect.

An interesting study might be made of the differences in the qualities of services rendered the two groups, but this must await later opportunity.

The types of services rendered, according to their frequency, are as follows:

<table>
<thead>
<tr>
<th>Service</th>
<th>Frequency</th>
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</thead>
<tbody>
<tr>
<td>Messages sent for patients</td>
<td>225</td>
</tr>
<tr>
<td>Families interviewed</td>
<td>185</td>
</tr>
<tr>
<td>Referred for convalescence</td>
<td>75</td>
</tr>
<tr>
<td>Consultation with attending physician</td>
<td>62</td>
</tr>
<tr>
<td>Consulted with other social workers</td>
<td>30</td>
</tr>
<tr>
<td>Referred to other agencies</td>
<td>28</td>
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<tr>
<td>Referred to clinics</td>
<td>28</td>
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<tr>
<td>Arranged transportation</td>
<td>20</td>
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<tr>
<td>Referred to other hospitals</td>
<td>20</td>
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<tr>
<td>Messages brought to patients</td>
<td>15</td>
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<tr>
<td>Home visits</td>
<td>14</td>
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<tr>
<td>Obtained information from other agencies</td>
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<td>Helped collect lodge benefit for patients</td>
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<td>Temporary shelter for children</td>
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<tr>
<td>Passes procured</td>
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<tr>
<td>Recommended increase in hospital charges</td>
<td>8</td>
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<tr>
<td>Employers consulted</td>
<td>7</td>
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<tr>
<td>Recommended reduction in hospital charges</td>
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EDITORIAL

Where Is The Osler Tablet?

“Well, I dunno exactly . . . Somewhere round here, I think.” Thus spoke the white clad Orderly at the big Hospital front door. One was truly grateful to him for opening and closing that big door for all comers and goers this winter day. The sun looked wearily through the snow which was gathering in the sky and preparing to fall on the morrow as Probs had warned us, and the endless surge of the great Hospital’s floating population, staff, workers, visitors and all other ranks ebbed and flowed like the tide.

The Orderly moved towards the glass window, not altogether unlike a bank window, behind which sat a fellow-worker, the Assistant Secretary and stenographer, whose name was Enquiry. “The Osler Tablet?” . . . said that lady . . . “Let me see” . . . But she did not see, at least if she did she did not tell. The rest was silence. Well! At all events the “lift” was to the left and it seemed natural to turn to it. On the way there appeared a Nurse from Nova Scotia. The price of these Nurses from Nova Scotia is far above rubies. Did you ever hear the story that the former Superintendent of the New York Maternity Centre Association used to tell of her Nurse from Nova Scotia who skinned the rabbit? . . . No? . . . Well, then, ask the Editor of this magazine to get it told in an Editorial some day so that we can all read it for it is Hospital Social Service too . . .

The Nova Scotia Nurse knows everything. She knows where the Osler Tablet is and takes you straight to it with the speed of lightning . . .

* * * * * *

And then suddenly the Hospital and the Nova Scotia Nurse and the Orderly and the office all vanished. They dissolved. There was a change of state and time and place . . . to . . . Exeter in Devonshire and the Cathedral yard . . . and the bells ringing for early
morning service twenty-seven years ago . . . eight o'clock of a sum-
mer morning . . . twenty-seven years ago and more . . . Service 
over and the verger says that, if you please, he has to ask you to 
come back again at ten o'clock, when the cathedral will be open for 
visitors. So, slowly down the aisle, for you cannot come back at ten 
o'clock. You have to take a train at nine for Budleigh Salterton, 
that sweet place where Lady Raleigh lived in Queen Elizabeth's time 
and where there is a level grass space on the top of a high cliff by 
the sea, known as "The Quarter Deck," because the retired Admirals 
and other naval officers, whose ship is England, pace up and down 
there as though they still were at sea.

The Cathedral aisle brings you to a memorial tablet to some of-
ficers and men in the Royal Devon Regiment and you cannot pass 
that by. Where are the Royal Devons now? Near you is a man 
scrubbing the stone floor of the Cathedral kneeling on his knees on 
a folded piece of sacking. He is up at your first word and tells you 
where they are, in Egypt, and why, and all about it. And he looks 
at the tablet with a steady gaze. It means something to him . . . 
He knows where the tablet is and where the regiment are . . .

Another story climbs into your mind. You are again at the great 
State Reception, accompanying a Very Reverend. To him advances 
a Roman Catholic Priest with outstretched hand and the Very Re-
erend grasps it as he says . . . "Ah!" . . . I am glad to see the 
True Church is here." "Ah! The True Church is everywhere," an-
swers the Priest to the Very Reverend.

So it is . . . So also is the Osler tablet . . . Everywhere.

* * * * *

The Orderly has found it when you come back to the door on 
the way out.

But the spirit that Osler imparted and the torch that he lighted 
and the truth that he told are Everywhere . . . In every Hospital, in 
every doctor or nurse who studies his book and in the generations 
of medical workers who inherit his labours. Like the Royal Devon 
Regiment, all over the world, the hearts of those who belong, follow 
still.

Doest thou well to be angry with the Orderly and the Enquiry? 
Nay, verily. They do their part. Heaven gave thee the grace to
know Sir William Osler and to work under him. Not so did they. Thou art old and they are young.

Give thanks therefore for that grace and for all thy fellow-workers in the Hospitals who do their part.

M.D.
Owing to the growing frequency of street accidents in London, England, the police authorities have provided the mounted police with first-aid kits in order that persons injured in road accidents may have immediate attention.

"The Visiting Nurse" is the name of a moving picture film which portrays the various activities of the Visiting Nurse Service of the Henry Street Settlement, New York City.

Flower Hospital, New York City, has opened an out-patient clinic for expectant mothers who wish to be confined in their own homes. Dr. C. A. Burrett is medical director of the service.

The term "doctor" receives a full measure of protection at the hands of the law in Ontario, Canada. In a recent decision handed down by a Toronto judge it was held to be illegal for anyone but a registered physician to employ the title "as an occupational designation relating to the treatment of human ailments." The ruling was aimed particularly at chiropractors and at osteopaths, who are not licensed to practice in that province. The limitation of the use of the doctorate title is one of the most important steps in the prevention of quackery.—New York Medical Weekly.

The Brazilian League against Tuberculosis opened in January, 1927, the first tuberculosis preventorium in Brazil. The institution, which is in Paquetá, is called Dona Amelia Sanitorium. It furnishes a home for about 100 children predisposed to tuberculosis, giving them proper food, clothing, medical care and education in hygiene. After the children have reached a good physical condition they will be sent home, while others will come to be made strong and well. The institution is under the care of Sisters of Charity and
the first six patients were daughters of poor tubercular families of Paquetá parish.—\emph{Bul. Pan-American Union}.

Plans are on foot to modernize and enlarge the Italian Hospital, New York City. The bed capacity will be increased from 97 to 225 and provisions made for a maternity service, a pediatric clinic, X-ray service, a nurses' home and a social service department.

The University of Iowa is giving very interesting and comprehensive summer courses in child development and parent education. Special emphasis is being placed upon the study of infancy and preschool age problems.

The Mothers' Assistance Appropriation Bill recently passed by the Pennsylvania Legislature provides a State appropriation of $2,750,000 to the Mothers' Assistance Fund for the biennium 1927-1929. The passing of this Bill is due to a campaign organized by the Child Welfare Division of the Public Charities Aid Association of Pennsylvania.

The Philadelphia Child Guidance Clinic, which was made possible by the support of the Commonwealth Fund, has been so successful that plans have been formulated to raise the necessary funds to continue the work. Medical groups, social agencies, public and private schools and individual parents are unanimous in proclaiming the need for a centre for fostering an interest in the mental hygiene problems of childhood.

The Extension Division of the New York University proposes to organize an evening speech clinic and forum for foreign-born men and women of advanced education who are handicapped by speech defects, poor pronunciation or an inadequate command of English.

It is gratifying to report that the number of cases of smallpox has been declining since 1924. In forty-two states, the District of Columbia, and seven Canadian provinces, the number of cases reported in 1926 was 31,351, as compared with 37,616 in 1925, and 53,265 in
1924. The case-fatality rate, which shows the virulence of the disease, has likewise declined. In 1926 it was 1.2 per 100 cases which may be compared with 1.9 in 1925 and 1.7 in 1924. While the fatality rate for 1926 thus shows an improvement over the two years immediately preceding, it is still above the average for the period, 1916-1921. The case-fatality rates in Canada in recent years have, for the most part, been lower than in the United States.—Bul. Metropolitan Life Ins. Co.

A recent issue of the Child-Welfare News Summary tells of a decree of the Governor of Rome providing for the establishment of special classes for mentally-defective children, to be conducted by trained teachers. Children who are found to be markedly defective in intelligence, or delinquent, or who show no improvement after attending the special classes for two years, are to be placed in institutions, for the establishment of which provision is made in the act.

The News Bulletin of the International Society for Crippled Children reports that the legislative measures providing for the care and education of crippled children in California passed both houses without one dissenting vote, and that the State of Oklahoma has voted a $300,000 appropriation for a hospital for crippled children which will be located in Oklahoma City. The governing body of Oklahoma also provided an appropriation of $250,000 for a medical school building in connection with the University Hospital; an appropriation of approximately $20,000 a year for the ensuing biennium to match Federal Funds in Rehabilitation work; House Bill No. 170, provides for the care of crippled children at the University Hospital and other approved hospitals of the State.

A bill has recently been introduced in the French Senate which, if enacted in law, will make anti-typhoid inoculation obligatory for all.—Nation's Health.

Miss Lillian Kelm of New York, has been appointed Director of the Personnel Bureau of the American Hospital Association.
In India, King Asoka, who reigned in the third century before Christ, published an edict commanding the establishment of hospitals throughout his dominions. Not only did he do that, but he arranged that free lectures be given to his people on preventive medicine, "for," as the edict reads, "Asoka is grieved to see how many people die of disease that can easily be cured or prevented."—Modern Hospital.

The Venice, Florida, Chamber of Commerce has announced that a surgical clinic and sanitarium with an ultimate capacity of 1,000 patients, is now under construction. Dr. Fred H. Albee, the well-known bone surgeon, will be the directing head. The sanitarium, which is located on Venice Bay overlooking the Gulf of Mexico, will be ready to receive patients in the early winter months of this year.

The District Nurse Association of Scranton, Pennsylvania, is the recipient of a gift of $25,000 to found the Elizabeth Boies Endowment Fund, the income of which will be used for the care of chronic patients.

Miss Lola Yerkes, formerly Editor of The Farmer's Wife, a publication for rural women, has been appointed Director of the Social Service Department of Bellevue and Allied Hospitals, New York City.

At a recent meeting of the Toronto Branch of the Canadian Red Cross, the Visiting Housekeepers' Centre gave a report of the first year's work of the organization, the function of which is to supply housekeepers to families when illness or other emergency makes it necessary to relieve the mother or the one who is responsible for the care of the home and children from household duties. Some 422 families were furnished with the service of a housekeeper for a period of from one or two days to several weeks.

The twelfth child welfare clinic of the Public Health Service was opened last December in the Inhau'ma section of Rio Janeiro for the benefit of expectant mothers and children under school age. Dental
service for the children of the same neighborhood is soon to be established.—Bul. Pan-American Union.

The New York State Department of Labor, through the Bureau of Industrial Hygiene, has filmed a motion picture on resuscitation.

The Council of Adult Education for the Foreign-born, 280 Madison Avenue, New York City, publishes a mimeographed bulletin containing events, ideas and suggestions concerning the splendid work carried on by the Council.

The United States Civil Service Commission, Washington, D. C., announces the following open competitive examination: Occupational Therapy Aide (Arts and Crafts), Occupational Therapy Aide (Trades and Industries), Occupational Therapy Aide (General Agriculture), Occupational Therapy Aide (Poultry Raising), Occupational Therapy Aide (Gardening). Applications for the positions named above will be rated as received by the Civil Service Commission at Washington, D. C., until October 31st. Competitors will not be required to report for examination at any place, but will be rated on their physical ability, education, training and experience. Full information and application blanks may be obtained from the United States Civil Service Commission, Washington, D. C., or the secretary of the board of U. S. civil-service examiners at the post office or customhouse in any city.

The New York State Federation of Women's Clubs, through the Chairman of its Department of Social and Mental Hygiene, Mrs. Julius Frank, is sending to the various clubs in the State a leaflet containing the following questions:

Do you know—

(1) That the mental health of a community is as important as its physical health?
(2) That mental hygiene concerns itself with the ways and means, the rules and regulations that are necessary to normal behavior?
(3) That mental hygiene is as much concerned with the smaller deviations from normal behavior as with insanity?
(4) That adjustment is the most important thing in mental health and that the ability to adjust depends greatly on early training in the home and in the school?

(5) That the symptoms and warnings of mental disturbance and maladjustment may be recognized easily in their early stages?

(6) That education is the main factor in the fighting of mental disorders?

(7) That there are different degrees of mental health, just as there are varying degrees of physical health?

(8) That a large number of persons with mental disturbances are being cured today and restored to health and normality?

(9) That a large percentage of mental disease is clearly preventable?

(10) That you should have surveys made, lectures given, and conferences arranged for your community?

(11) That your chairman, the New York State Charities Aid Association (105 East 22nd Street, New York City) and the National Committee for Mental Hygiene (370 Seventh Avenue, New York City) are ready and willing to assist you in every way?

(12) That your personal interest is needed to carry on this work?

—Mental Hygiene Bul.

The Social Service Department of the Free Synagogue has issued a prospectus of a course in Medical Social Service for the fall and winter of 1927-28. This course will be open to nurses and social workers who wish to train themselves for service in the medical social field. For further information write to Mrs. May V. Fisher, Chairman Committee on Courses, Synagogue House, 40 West 68th Street, New York City.

Moore Cottage, Sea Bright, N. J., is open to receive convalescent girls and professional women. This delightful home accommodates ten patients and charges the very small fee of five dollars a week. Information concerning vacancies may be obtained from Dr. A. M. Frantz, 58 East 65th Street, New York City.
Dr. I. M. Rubinow, formerly an executive with the Jewish Welfare Society of Philadelphia, has been appointed Executive Director of the Brooklyn Federation of Jewish Charities.

The Bellevue-Yorkville Health Demonstration has opened a social hygiene clinic for the free treatment of gonorrhea and syphilis at 325 East 38th Street, New York City.

The Jewish Mental Health Society, New York City, has plans for a hospital for the treatment of patients suffering from curable mental disorders, especially those who in the early stages require custodial care. The present plan provides for patients in poor or moderate circumstances who cannot take advantage of the high-priced sanitoriums. The hospital, although maintained by a Jewish society, will be strictly non-sectarian.

IF I HAD MONEY

If I had money
I would find the washer-woman
And buy her a machine
In which she has only to touch a button
To do her work.
And she who sews—a similar device.
If a child with soulful eyes
Craves a piano, or musical instrument
I would buy it, and place it in his humble home.
And where youth needs another year or two of learning
To fit him or her for the chosen field of endeavor
I would give—make it easier.
And for the young girl of ambition
Who gave her youth for her family
I would buy her a few pretty things now and then
To buoy up her spirits
And save her from too much sordidness.
In the depth of winter
I would see that there was warmth in the heatless home.
To the boy who works in the grocery store
But wants to be an artist,
I would make it possible
Even though he failed to shine.
For the mother who has so many children
Who doesn't know what to do,
I would find a helping hand, and pay for it.
For the hard-working family in the congested corner
I would supply vacations in the open spaces.
For in doing these seeming little things
I would be taking the individual interest in the quiet way
In the home of each.
I would not build an orphan asylum for little children
Nor a poorhouse for the aged
As some people do.
For these are the houses of thousands
But are not the home of one.
I would save by prevention rather than cure.
And, therefore, there would be no use
For orphan asylums and poorhouses.
Thus I would not give charity, but a chance.

Sophie Irene Loeb,
In the New York Evening World.

BOOK REVIEW


Prompted by his own happy time in a hospital, Mr. Radley writes of his experiences in this book with a view to "selling" operations to the timid and uninformed, and to prove that being sick may be made a "business" by any prospective patient. Written by a self-confessed successful business man and golf enthusiast and intended apparently for the same type of reader, he speaks in the picturesque vernacular of the golfer and high-pressure salesman. The pages are replete with their esoteric phraseology and perhaps can be best understood by the initiate.

However, this reviewer, whose opinions must unconsciously be
tinctured by a medical training, feels that the author has overwritten his thesis. The first half of the book, a small one of less than 100 pages, is prolix and repetitious in its preliminaries leading up to the actual operation and in revealing the prejudices, later admitted wrong, of the author regarding surgeons, operations and hospitals.

The occasional and vague references of the author to the symptoms of his ailment, characterized chiefly by overweight, shortness of breath, nervousness, irritability, do not fit in readily with any very obvious condition requiring such heroic surgical intervention. While our experience with hospital routine has been limited to a period of but fifteen years, we cannot fit into any known picture the exclusion of visitors, especially one's wife and children, for the number of days apparently spent in relative comfort implied in the narrative.

The second part, beginning with the operation, is more interesting, even with its glorification of the hospital, the surgeon, the interns and the nurses. It is a very happy picture and one we should like to believe is true in all of the hospitals all of the time. Certainly the portrait of the doctors is quite at odds with that drawn by Pringle in the March number of the Mercury. Yet who are we to cavil at a picture which praises our profession and is not written for our consumption? Maybe Mr. Radley's picture is the true one and taking our cue from Pirandello's philosophic parable, we may say with him "Right you are, Mr. Radley, if you think you are."

JOSEPH TURNER, M.D.

NEW PUBLICATIONS

"The Welfare Advocate," which succeeds the mimeographed "Welfare Courier," is an attractively edited and newsy pamphlet-magazine published by the Public Welfare Commission of Rizel Avenue, Manila. The purpose of the "Advocate" is to stimulate an interest in welfare work and to foster a spirit of cooperation among the various public health and social welfare organizations in the Philippines.

The International Society for Crippled Children has issued a new Directory which lists affiliated societies and gives the names of officers and committee members in the various states and provinces.
Social workers are thus given the names of the "key" people in different parts of the country.

In order to facilitate the use of that delightful little book "Hob O' the Mill," mentioned as a new publication in this section of the magazine a short time ago, the Quaker Oats Company has issued a manual for teachers, suggesting and outlining methods of teaching whereby children will be impressed by the health value of foods and incidentally connect the information contained in Hob O' the Mill with the geographical location and histories of the countries mentioned in the story. Copies may be obtained free of charge by writing to Quaker Oats Company, School Health Service, 80 East Jackson Street, Chicago, Illinois.

Preliminary Report of Commission on Medical Education. This valuable report is the work of a group of individuals representing general education, the basic sciences, clinical teaching, public health, the medical profession and medical licensure appointed by the Association of American Medical Colleges to study and work out methods whereby the elevation and standardization of medical education and medical schools and medical practice might be made more effective. The report outlines the objective of the study and gives authoritative information on the demands, needs for medical service, distribution of physicians and specialization, supply of physicians and other information which will be of great value and interest to anyone interested in the protection and advancement of the medical profession. Copies of the report may be obtained free of charge by addressing the Commission on Medical Education, 215 Whitney Avenue, New Haven, Conn.

The New York Evening School News, published by the Evening Elementary School Students' Association, which is an organization of the foreign-born men and women in the evening schools is an interesting, newsy, eight-page newspaper, and is devoted to official and general news of special interest to principals, teachers and students, questions of a civic nature, letters and essays on subjects pertaining to American ideals and Americanization. One essay, "Why I am an American," written by a foreign-born woman student, and reprinted
New Publications

from the “New Citizen,” published by E. S. 150 Brooklyn, shows such a keen perception and beautiful appreciation of this land of ours that it might be well for many native-born Americans to read, ponder over and inwardly digest. Good luck to the News and the Council of Adult Education for the Foreign-born in its work of interpreting America to the foreigner, and making the immigrant more understandable to Americans.

Twelfth Annual Report of the Metropolitan Life Insurance Company Sanatorium at Mount McGregor, New York. This report gives a very interesting account of the health and welfare work of the Sanatorium, which is operated for the treatment and care of ill or run-down employees of the Company.

Annual Report of the Association for the Aid of Crippled Children, New York City. The report briefly sketches year by year the growth and development of the Association since its inception in 1900, when the only activity was a small class for crippled children organized under the auspices of the Children’s Aid Society, to the present day with some 3,272 children under care. Of this number 681 are children who were stricken with infantile paralysis during the epidemic ten years ago. The fact that this little army of children has been kept together and faithfully treated through the long discouraging years speaks volumes for the quality of the work. Another evidence of the fine, capable constructive work being done is the fact that the Association faced itself with the question “Are we doing the best that can be done for crippled children?” In order to satisfy themselves the Association requested the New York Academy of Medicine to make an analysis of the work. Dr. Lewinski-Corwin consented to make a careful study of methods and results and the Association, acting upon his recommendation, are prepared for even more effective work. Seventeen graduate nurses act as a link between hospital and homes.

The Health Bulletin Service issued by the American Public Health Association is an eight-page pamphlet which preaches the value of health by means of attractive and striking illustrations and vernacularized text.

The purpose of the study was to ascertain what was actually being done in the field of child placing. Ten well-known private child-caring agencies were selected as illustrating methods employed under different conditions in the New England, Middle Atlantic, Southern and Middle Western States. An exhaustive study of these agencies was made and the report covers the history, development, extent and methods employed in child-placing, which is defined as providing care for any child separated for a long or short period from his blood relations, other than his brothers and sisters, cared for in a foster home under the supervision of an agency, public or private. The report throws interesting light on this particular field of work and while conditions in all cases were not ideal, there is a growing tendency to stress the value of health work especially from the mental hygiene angle. Single copies may be obtained free upon application to the Children's Bureau. Additional copies may be procured from the Superintendent of Documents, Government Printing Office, Washington, D. C., at 35 cents the copy.

Health Survey of the Printing Trades, 1922 to 1925. By Frederick L. Hoffman and issued by the U. S. Department of Labor, Bureau of Labor Statistics, Bul. No. 427. This report consists of a comprehensive, impartial statement of the conditions in industry which affect some 300,000 workers in the various printing trades, with especial reference to health.

ABSTRACTS

"General Management of Children's Convalescence." A. Levinsohn. Nation's Health, 1927; IX, 21. The three essentials in convalescence are rest, good food and sunshine. The author brings out all the important points in convalescence as applied to children recovering from various diseases with special emphasis on the care re-
quired and complications to be looked for during the convalescent period of the contagious and infectious diseases. Visitors are advised against as the effect of contact with relatives or friends is detrimental to the child's best interest. Convalescence, whether in hospital, home or convalescent home should be under the careful supervision of a physician who will prescribe the kind of food, the duration of the period of exposure to the sun, the amount of rest needed and the kind of exercise, play and recreation suitable to the child's condition. A complete diagnosis should be made of every child entering the convalescent home, and in order to fulfill its function the convalescent home should be in very close association and cooperation with the hospital. The author summarizes the role in hastening convalescence as (1) to impress upon the mother that leaving the hospital does not mean that the patient is well, and that he still needs medical care. (2) To interest the mother in the management of the child during convalescence. This article is recommended to hospital nurses, public health nurses and social workers.

"Intestinal Infection in Relation to Chronic Rheumatism." T. I. Bennett. *Jour. Roy. San. Inst.*, 1926; LXVII, 205. The fact that certain kinds of rheumatism are caused by a germ infection is pretty generally accepted, and the author, basing his opinion on this theory, gives out some very interesting information regarding the two types of the disease. The first acute stage, or the so-called acute rheumatic fever type, does not affect the joints but invariably weakens or permanently damages the heart. The second type, chronic multiple arthritis, often called rheumatoid arthritis or simple chronic rheumatism, while affecting the joints with crippling results, does not injure the heart. Many cases where there is no apparent foci of infection or where infected parts, such as tonsils and teeth, have been removed, still continue to show active manifestations of the disease. The author believes that many cases of rheumatic infection have their origin in the intestines. The fact that harmful bacteria gets a strong hold in the intestinal tract is not to be wondered at in this day when rich and poor alike eat cold storage food, stale fruit and vegetables and foodstuff kept fresh by preservative measures. In the treatment of chronic rheumatism the author recommends a period of starvation and the use of acidophilus milk as a means of
eliminating and conquering the streptococcus infection. The author calls attention to the fact that the greater care and attention given to children's health in general and their teeth and tonsils in particular will in time undoubtedly decrease the number of cases of rheumatic infection in later life.

“Social Education Through Disaster Relief Work.” J. L. Fieser. *World Health*, 1927; VIII, 160. The author has brought out so many facts in regard to the splendid work of the Red Cross that one wishes that at this particular time, when all eyes and thoughts are focused upon the flooded areas of the South, that the article could be given the widest publicity. One also wonders if a great deal of credit for the country-wide interest in health and welfare work in the past decade should not be given to the Red Cross. The influence exercised by such an organization over its millions of members and volunteers who are banded together for service must have been a tremendous factor in awakening interest in public health and welfare work. Before the United States entered the World War the American National Red Cross consisted of an organization limited to approximately 100 local chapters mostly along the Atlantic seaboard, none of the branches fully staffed and with a membership which did not exceed 100,000. Today there are about 3,000 active Red Cross Chapters throughout the country and about 500 others in sparsely settled sections. These more remote chapters, while not active in any particular work, maintain a reserve for emergency work. The development and expansion of the work can be estimated by the author's account of the status of the Red Cross at the present time. “There is today a Red Cross unit of some sort in practically every county in the United States, with a total adult membership of 3,000,000 and a junior membership of five and a half millions; 758 of the more important chapters have paid secretaries, often supported by additional workers in varying numbers. Of these chapters, 538 are authorized to do work for civilian families as well as soldiers; 2,056 other chapters limit their work to soldiers' families; 605 chapters carry on a public health nursing program with one or more public health nurses employed.” The use of volunteers, the principles of disaster and relief, are discussed separately. The section “a manual of relief” gives a concise and illuminating description of the
Abstracts

methods employed in carrying on health and educational work and the procedure followed in emergency relief and constructive rehabilitation work necessitated by disaster.

“The Dietary Treatment of Eczema in Children.” E. S. O'Keefe. *Tr. Nurse and Hosp. Rev.*, 1927; LXIX, 509. Eczema is now generally conceded to be a cutaneous manifestation of indigestion and not a skin disease. This being the case the treatment consists largely of finding the cause of the trouble and restricting the diet. In some cases there is no doubt a familial predisposition towards eczema and in such cases great care must be taken in the early feeding of children. The mildest rash calls for careful regulation of the diet. If the child is known to have an inherited tendency it is advisable to eliminate eggs from the diet until the child has reached the age of two. Eggs, next to cows’ milk, are the most common cause of eczema in early life. Great care must also be exercised in protecting a child with a predisposition towards eczema from chafeing, wind, sun and other exterior irritants, as the slightest neglect will result in an eczematous condition of the skin. The present day theory is that the proteins are causative factors as well as the fats and carbohydrates and that the situation in eczema is similar to bronchial asthma. The hyper-sensitiveness, or anaphylaxis manifests itself in the skin in one case and in the bronchial tubes in the other. In the past few years the skin tests have been used extensively in determining the cause of the disorder and have been a valuable means of controlling the condition; although there are cases where the offending food does not give a positive reaction. The author considers that the protein skin tests in eczema require careful interpretation. For cases where it is definitely decided that a certain food is the cause of the disorder, the three methods of control are given: (1) elimination of the offending food from the diet. (2) desensitization of the patient. (3) rendering the article of food as easily digestible as possible. In the first case, if the cause is found to be in a food which can be eliminated or a substitute food given in its place, the problem solves itself. If the offending food is milk or eggs the situation is more difficult. Complete elimination of milk and eggs is not only difficult but dangerous; the method to be employed in these cases is to gradually build up a tolerance for these important articles of diet. The method
of rendering the food, especially milk, more digestible depends upon
the individual child and good results have obtained by a careful study
of the manner in which the child digests its formula and changing
according to indication. The author, who discusses his subject in a
singularly interesting and simple manner, stresses the fact that the
treatment of eczema, especially in children, not only calls for continu­
uous medical supervision, but for the closest coöperation on the part
of the person or persons responsible for the child's care.

"Ophthalmia Neonatorum—A Neglected Problem." A. Pfeiffer.
*Ven. Disease Inf.* 1927; VIII, 89. The author briefly discusses the
problem of acute infectious conjunctivitis in the new-born and while
appreciating the fact that much has been done to combat the disease,
considers it still an outstanding medical problem and sounds a warning
to health officers, physicians, nurses and midwives to be scrupulously
careful to use silver nitrate in the eyes of all new-born infants.
Before 1881 gonorrheal infection of the eyes of new-born infants
was regarded as the cause of 60 per cent. of the blindness in chil­
dren. After Credé introduced the use of silver nitrate there was an
immediate and tremendous decrease in the number of cases of
ophthalmia neonatorum. The author gives very interesting figures
pertaining to the incidence and control of the disease in this and other
countries.

"The Seymour Plan and Disease Prevention." M. M. Seymour.
*Nation's Health,* 1927; IX, 45. The author, addressing the Confer­
ence of State and Provincial Health Authorities of North America
held in Atlantic City last year, suggested that a concerted and inten­
sive drive be made to eradicate diphtheria, smallpox and typhoid
fever. The suggestion met with instant approval and a definite
method of attack to be known as the "Seymour Plan" was adopted.
Public and private health agencies have coöperated wholeheartedly
and in addition every available avenue of publicity has been utilized.
The first step was to educate the public and this has been carried
on by health departments and various other health and welfare or­
ganizations and through magazines, newspapers and last but by no
means least, the moving pictures. The success of the plan has been
most encouraging although at present no definite statistics can be
Abstracts

given out. Although writing briefly, the author emphasizes the need for preventive work against these unnecessary diseases and shows what can be done by a united effort to educate the people in preventive measures.

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