Hospital Social Service

PUBLISHED MONTHLY BY THE
HOSPITAL SOCIAL SERVICE ASSOCIATION OF NEW YORK CITY
INCORPORATED
200 MADISON AVENUE, NEW YORK, N. Y.

DR. E. G. STILLMAN, Editor

SUBSCRIPTION PRICE
Domestic $2.00 Canadian $2.50 Foreign $4.00 Single Copies, 35 cents
Advertising Rates may be had on application
HOSPITAL SOCIAL SERVICE
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THE MEDICAL SOCIAL WORKER'S RESPONSIBILITY TO OTHER COMMUNITY AGENCIES

GORDON HAMILTON

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New York, N. Y.

Two important trends in social work seem to be changing our concepts as to where agency responsibility to the community begins and ends. The first trend is external and administrative although it derives from the same source as the second. This trend is shown in the converging of agencies through various federations, welfare councils, chests, and so forth. To some degree this trend grows out of purposes of greater economy and efficiency, the avoidance of overlapping, the filling in of desert places. The word responsibility means ability to meet one's obligations—it implies stewardship or trusteeship: it is a social word suggesting interaction.

Implicit in the trend towards convergence and interaction is the growing realization that we are serving the same community, that we are all paid ultimately out of the same purse. From any agency point of view we are becoming aware that cross-purposes, duplications, or exclusive possessiveness of patients, are costly to the agency, the community, and patients themselves. I suppose it is a part of our American philosophy, this increasing concentration with greater output and presumably greater efficiency. It has obvious advantages and disadvantages, but its immediate effect upon our professional behavior is to break down intensive individualism in favor of larger social work groupings and areas.

The second trend is subtler, deeper, more intricate, and possibly more important. It centers around a concept of social case work that is more basic and a social work that is more truly social. We are determining professional entities not so much by arbitrary areas as by

*Read before the National Conference of Social Work, Memphis, Tenn., May, 1928.
flexible skills. No longer does the hospital social worker think of her function as a profession in itself, or the family welfare worker the same. Techniques, as well as administrations, are converging. Social work becomes the professional entity. Social case work is one of the necessary skills used by every practitioner in the field. Everything that the family, children's hospital or psychiatric fields have discovered is so general, so central, so "natural," to use Dr. Auchincloss' word, that every bit of this knowledge has to be collected into a common storeroom in order to equip what there is of professional knowledge. The rôle of the expert is partly to furnish knowledge, and leadership, taken in a social sense, does not mean inherent authority, but the term leadership will have a meaning only if the goals or direction of the leader are identified with the interest of the group and the leader identified as one of the group. This affects our sense of responsibility to the group. It is not authoritative but participating. If our technique and knowledge interwoven as between so-called field and field cannot suffice to build a structure of social work, our techniques such as they are, will no doubt be drafted into other professions,—social law, social medicine, social religion—and social work as such may cease to exist. Perhaps that is the destined end for us if we are to underwrite the full implications of the word "social." Meanwhile we must work while there is yet light, and I suppose our primary responsibility to the professional group today in our community is to merge, to integrate, and help to articulate our common skills and our common objectives.

The growing recognition that our approach to the problems of life is slightly different to that of other professional approaches has come slowly. If one should say that the primary objective for medicine is positive health, the primary objective for psychiatry positive mental health, the primary objective for education something in the nature of self realization, training and the moulding of character, in the same large way the common goal for all social work has been described as concerned with positive or constructively satisfying social relationships and self-maintenance taken in its broadest sense. The acceptance of some such philosophy tends to break down isolated categories which would suggest that medical social work is interested only in health; children's work in children; and family welfare work in economic conditions and domestic problems. Intrinsically as well as administratively we are interdependent and all interested in the
therapies involved in bringing about these positive or satisfying relationships.

Yet paradoxical as it may be, granted our common objectives and common techniques and knowledge, I believe our greatest responsibility as well as our greatest difficulty in dealing with both professional and lay members of the community lies in the function of interpretation. The truth is that most of us have been trained apprentice-fashion and in so rapidly evolving a professional situation that we have been often bewildered. Most of us have settled down in a small corner of practice and have made our further acquaintance with the major theories and practices of social work through conferences, by reading, by intuition, or by accident. We do not yet all speak the same language. Most of us trained prior to 1920 were trained almost wholly in the art of investigation and with very little facility in the art of diagnosis. Social Diagnosis, the great text book of our generation, inevitably dealt more fully with the nature of evidence and the requirements for a social study rather than with the intricacies of diagnosis, i.e., interpretation. For most of us beginning work before 1920, to set a recent date, emotional mechanisms were little understood and the part played by those attitudes with which we as case workers perpetually struggle, is only now being dynamically explored. At the same time all our own attitudes, toughened by weathering, were apt to acquire inferiorities and resistances to the brisk discoveries of the youth movement. We had scarcely got used to the idea of budgets when some one discovered four plus Wassermanns and we had not got over this when the unwanted child or a mother-son fixation appeared in every case. In 1908 we worried about pauperizing people; in 1928 the only notion in my town that really bothers a case worker is the idea that "something may be a threat to some one's security."

Perhaps the only things we have in common today are a fairly clearly defined purpose and some skill in laying bare the more obvious social data. It is no mere chance that the pattern for social histories from the Atlantic to the Pacific coast, whether gathered in the mental hygiene clinic, the child welfare agency, the hospital, or the family field, tends to cover much the same ground. But this very similarity of content in assembled facts constitutes a peculiar obstacle to understanding each other. Because one cannot discuss facts, one cannot argue them, one cannot reconcile or fail to reconcile them—they merely exist, and yet it is generally facts that we attempt to ex-
change with one another. Facts in themselves have no use, they have only values or meanings or implications.

Social research, too, is in its infancy. We are still in the arguing and impressions age. The nineteenth century was above all a century of invention, but the most important thing as Whitehead says, was that it discovered a method of invention. This is the method of science—an orderly disciplined attack on first one problem after the other. I suppose all progress depends on science working with some great imaginative design. Life to the philosopher may be a series of intriguing speculations, but to the scientist and artist it is like some great tapestry on which one works from time to time, bridging over, filling in, by a sort of inescapable relevance of pattern. Social work, then struggling to emerge from the stage of folk-lore and sentimental tradition, has had to find its own method of invention. Blurred by the familiar and everyday, it has to find a design before it can proceed in a disciplined and orderly way to attack one difficulty after another. Here and there, bit by bit, social workers are beginning not so much to delegate to a research foundation all their intellectual curiosities, but are taking pieces of the social pattern to tinker at, setting themselves problems beyond the individual case work problem, hoping to find more direct explanations in terms of cause and effect, which in turn may be rationalized in a more adequate social philosophy. Out of the stuff of research more accurate interpretations will come to be made.

Collections of facts, whether gained in social history or through the slower evolutions of social research, are important and interesting only as they take on certain meanings and one of the difficulties in our community interplay is that the same facts will have different meanings for different purposes, have inevitably different meanings for the doctor, the priest, the corner groceryman, the hospital worker, the family worker.

Every case worker willy-nilly assumes a certain rôle in any situation. He cannot remain in a neutral position to all of life, or, if we were golfers, I should be tempted to say, that a case worker has to take up a certain stance in order to hit the ball properly. We do not deal with all of life but rather with special arrangements of life which take on for us practitioners special and peculiar meanings. There is no point at which confusion more easily arises than in the comparison of obvious factual material from the point of view, for instance, of a hospital and a family welfare society.
A patient has heart disease, the patient has a wife and three children dependent upon him, the patient can do light work, there are no relatives to help, there is no income at present; a set of facts of this nature will take on different meanings for the doctor and for the different workers depending on the parts that they will be called upon to play in solving the difficulties. Assume for the moment that the hospital can do little medically and expects to confine its treatment to the observation and reassurance of the patient. Assume that the case worker is also trying to give a sense of security in the family. The presence of the economic fact creates a different set of implications, or at the very least, a different emphasis for everyone concerned.

Let me illustrate with a case: The T. family consisting of a man and wife, with no children, was known to a family agency for eighteen years, having been referred in December, 1910, by the recipient of a begging letter which stated that both the man and his wife were ill and the man unable to carry on his trade as a waiter. The man was of Hungarian birth and of good family. He served as an officer in the Austrian army and became estranged from his family after his marriage to a wife of inferior station. At times he represents her as Jewish and at times as not Jewish depending on the race of the person to whom he is writing. The man has constantly written to church members, clergymen of all denominations, and prominent members of the community, always basing his plea on his wife's ill health. Upon receiving relief he would give up his job for a longer or shorter period. The fact is that his wife was in ill health and was intermittently under the care of a hospital for lues. In 1926 a diagnosis of secondary anemia was made and an expensive diet of liver recommended. She was discharged from the hospital in good health and advised against convalescent care unless dietary restrictions could be insured. The hospital brought pressure to bear on the family society to provide a diet. As soon as the diet was begun, Mr. T. gave up his work. From the hospital point of view, Mrs. T. was an extremely interesting case and they were anxious for everything to be done at home which would facilitate her treatment. On the other hand it was quite clear that while the hospital wanted to follow Mrs. T., the family agency did not want to have Mr. T. follow it. The whole question of the productiveness of money spent in the family either medically or socially is a real one. The same facts here, however, undoubtedly have different meanings to the participants not excluding the patients.
If we are to be of real service to each other, we must not only look at the facts as a whole, but as a whole with several possible meanings. To assume that they necessarily have the same meaning from all angles and still worse, to insist that they shall have the same meaning, except for stated purposes, is productive of much irritability and frustration. A medical social worker is in a strategic position to interpret social data not only to the doctor within the hospital, but medical social data to the patient, family, friends and other social agencies. The day is not long past when we used to worry as to whether or not medical diagnosis should be given out to lay agencies. We are beginning to think that the medical diagnosis as a whole with meaning is of more use as it stands to the doctor than to the social worker. It has to be transplanted into other terms to be really helpful to any social worker. A medical diagnosis can be intelligently used only if it is broken down into various social interpretations, such as the extent to which the patient is disabled, how long he is to be disabled, the kinds of work he can do, dietary and other restrictions. Too often these interpretations are given incompletely. The extra-mural worker is too often ignorant as to what she should ask for, as to what she can reasonably be expected to get; she may fall back on gathering up what is scarcely more to her than diagnostic verbalism, which can be of very little real use in the social treatment of the case. She must be helped to realize the length of time it takes to make a medical diagnosis on deep-seated conditions, just as she must be prepared to help the doctor understand the length of time it takes to make a social diagnosis. The extra-mural worker is perhaps too impatient with the inevitable clinic limitations, just as the intra-mural worker is perhaps not impatient enough. Medical diagnoses are still, I am afraid, collected, by many social workers painstakingly, like specimens of flora and fauna. Nothing but a deeper sense of responsibility on the part of the medical social worker to offer something better in the way of interpretation will help us to get away from these routine and ineffective activities.

If we concede that the central objective for social work is adjustment along the lines of self-maintenance and self-direction, we must also concede that much social work both within and without strictly medical areas has tended to be diverted into blind allies of health-seeking. Social workers for a long time have recognized that illness is a precipitating, a major or at least a minor, factor in many cases of maladjustment. The statistics of any family agency will show the
extremely high incidence of health problems. Good health is so obviously a means to the good life that it is easy for case workers to pursue health as in the Middle Ages explorers sought the Fountain of Youth. What actually happens is that social case workers search for causes of dependency *too exclusively* in the realm of health, and the rehabilitation of “client patients,” involves both remediable and relatively non-remediable social situations. The medical social worker may unconsciously increase the problem by over-emphasizing health factors, the setting of which may be in these non-remediable social situations. The net result is that chronically ill people who may have been functioning tolerably well before the ministrations of various case workers, may become health conscious to a socially disabling degree. There are further psychological implications because case workers in all fields tend to make unusual concessions in times of illness—bills are remitted, relief is given readily, pressures ordinarily brought upon the client patient to be self-directing are relaxed. With all that we are coming to understand of emotional mechanisms we are realizing that there is danger of increasing dependency in our very search for the causes of dependency in that we may touch off latent emotional dependency by our own attitudes of over-solicitude. We must, moreover, be sensitive to any emotional dependency which exists prior to the onset of the illness and so meet it constructively, during the acute and subsequent periods of ill health. We must not let the mere presence of illness blind us to deep-seated personality traits. The very fact that self-maintenance is impaired in acute conditions often leads us into extending protecting Providence beyond the need of it. We may give too easily not only material things, but that sort of authoritative advice which occasionally affects unfavorably a patient's own ability to manage his own affairs. In this a well-balanced and far-sighted trained medical social worker can make a particular contribution to the extra-mural worker, often driven by a series of crises to overdirect the patient's somewhat feeble efforts. We all have much to learn and to give each other in the technique of what Dr. Cabot calls constructive “standing by.” Medical social workers have a great opportunity not only to help friends, relatives, and agencies, from being stampeded by conditions which often look worse than they are—they can enormously improve the attitude of the client patient towards his treatment, can meet resistance of the client patient by an understanding of the emotional and environmental causes of his resistance rather than by argument, can emphasize positive values of
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clinic attendance without creating anxiety or dependency attitudes, can minimize distressing features and inhibit the growing up of unpleasant associations.

I have heard it said that the first treatment problem for every physician is to meet the patient’s fear of doctors. There is probably no greater service that the medical social worker can render than in meeting over and over again the ordinary person’s anxieties, often completely unconscious, as to hospitals, and in building up attitudes of confidence without breaking down the patient’s will to self-direction. Everybody responds to satisfying rather than to unsatisfying stimuli. Everybody is motivated by what he approves and likes. The recognition that we are responsible to each other and to our patients insofar as we can resonably serve them—for positive satisfaction, is not merely a department store axiom, it is a central concept of psychology.

Real community service can be given also through a better selection of material in reports and greater skill in writing them. The outside agency, too, often makes futile and unnecessary inquiries and then on cases where changes of condition, recommendations, and so on, are of enormous consequence to the whole social treatment, is not informed at all. The outside agency should not be expected to accompany the client patient on each visit, neither should the outside agency write routinely for reports after each clinic visit. The name of the medical social worker will be blessed indeed if she discriminately can report on significant matters to suitable persons in the community. There is an insidious wastage and draining away of energy on routine and futile inquiries, energy which should be conserved for more important ends. Good business-like letter writing on both sides is an art that has to be acquired and practiced.

Frequently a client patient is not oriented as to whether he is better or worse, may work or not work, and this drifting is frustrating to all concerned, adds to the patient’s sense of failure and irritation, and may build up hopeless and negative attitudes always difficult to overcome. The actual personality disintegration that often accompanies illness is much increased when the patient is left in the dark as to his possibilities for recovery, for work, for self-help. Unwise direction of sympathy may increase this disintegration whereas the worker who has a clear picture of the social situation as a whole and the personality as a whole may be able to save the day.

In order to interpret adequately whether by conference or by
letter, the medical social worker has of course a responsibility to be really in touch with the community. We must be sensitive to new developments in the community and participate in them when our participation will be creatively useful. We are all conditioned by our settings. The institutional worker may grow provincially-minded just as the district worker may be so beat upon by every wind of heaven that the course is lost altogether. Actually as well as imaginatively, I believe, all institutional workers should follow a few cases through to a social conclusion, not because there is or is not a community resource relevant to the situation but because the distribution of cases in incomplete stages may foreshorten our vision unless our sense of teamwork is unusually accurate. Perhaps we are indeed on our way to a new sort of group social work where we shall all become shifting factors in a beautiful unity of treatment. I am inclined to think that we are growing away from the use of quite so much "transfer," i.e., complete withdrawal from the case, into the use of more intelligent and more flexible "refer," i.e., continuing joint treatment of the case. We are finding it easier to embark on joint projects, easier to follow several intersecting trails toward the same goal.

We say we are getting more able to live and work with one another but one sometimes takes a plunge of disillusionment into the Middle Ages. I recently sat in on a conference about a case known to and worked on by thirty-seven different agencies, all registered by the social service exchange but all taking up the case at much the same place, not quite accepting each other’s investigation although no really new facts were uncovered by thirty-four of the thirty-seven later arrivals, failing quite seriously to understand the different possible interpretations of somewhat baffling behavior. The man was a psychoneurotic with a very appealing way of describing his difficulties with life, marginal, unstable, borderline, dangerous. The woman was one of those docile and friendly souls with an I.Q. of 64, who kept an exquisitely clean home, and the ten children heartbreakingly beautiful and well-behaved were insidiously being warped, thwarted and menaced by an accumulation of unwholesome intangibles, that is so hard to define as improper guardianship.

However, some of the thirty-seven agencies, both board members and professional workers, did at last get together around a table and ask themselves what was a socially constructive approach to this problem, what were the real significances and on whose shoulders lay the responsibility. It was encouraging to see that no one around the table
felt that the case should be referred to some Atlas who would ever thereafter carry the burden. Conferences of this kind, and all over the country there are conferences around the table, reveal our interdependence. The developing of a group or a compound idea is far beyond the technique of compromise or of superimposing one agency's plan, and often leads to a genuinely constructive group action.

One source of irritation is being allayed as we come to see that the use of relief is at some times an integral part of most forms of case work treatment. In the main we are agreed that case work agencies should bear the relief incident to their treatment programs or such relief as is functionally relevant to them on the general principle that it is better for the person who prescribes to pay the bill, if the patient cannot. While there is no rule of thumb about this, there is a growing tendency for medical relief, such as insulin, apparatus, and glasses, to be carried in the budget of medical social work, just as subsistence relief is carried in the budget of family work and opportunity relief in the budget of "character-building" agencies. There are many marginal cases where responsibility for relief is not easy to fix. Great hospitals with large transient populations, areas advertised as enjoying beneficial climates, create their special problems. Moreover, in complicated medical social cases like tuberculosis, the question of health, subsistence, and employment over long periods are so inextricably mixed that it is not easy to say who shall pay for the milk. We can be clear-headed, however, as we remind ourselves that ultimately it is the community that pays the bill and that the community should have some choice as to where is the most efficient place to fix responsibility. We can only help them to a sense of functional relevance if we ourselves acquire it.

The main trends of convergence in the social work field today, convergence in respect to common knowledge, common technique, common skill in diagnosis or interpretation, and the increased awareness of a community to which we are all answerable, suggest that some day we shall be all alike. Fortunately this is not true. The energy released from everyone's doing the same thing at the same time goes into different things at the same time and we learn to select things that are appropriate or functionally relevant to us. Social workers have always the temptation more than most professional people to spread themselves over the whole face of the world. The younger the profession or the individual worker, the more inclined to
tilt at the universals, the imponderables, and the immutables! Case work is a fine tool somewhat easily blunted. It is faith rather than case work that moves mountains. The principle of functional relevance and conscious selection as to what in any period of our knowledge and development we can really hope to accomplish, makes us less possessive, less dogmatic, more openminded and more intellectually humble. Tentative and experimental attitudes instead of hard and fast traditions are becoming characteristic of social work.

All progress is difficult. No one can say in precise terms what our responsibility to each other is today, still less what it will be tomorrow. We hope for ourselves perhaps that we shall not be arbitrary but fluid; that we shall not expect artificial and easy solutions of stubborn difficulties, and that our principles whatever they may be will grow out of our genuine ability to give increasingly effective service.
HOW TO BEST HELP EVERY CRIPPLE FIND HIS PROPER PLACE IN EMPLOYMENT*

CARROLL PETERMANN

Community Service and Boys’ Work Committee,
Rotary International, Cincinnati, Ohio

The first step in helping the cripple to find his proper place for service is found in a change of our mental attitude toward these under-privileged people. Until we cease to think of disabled persons as economic incompetents and a burden to society, and until we begin to realize their great possibilities, we will not be able to help them to achieve their proper place in the economic and social world.

A parent realizes that his first duty to his child is to develop his character, that mental development and stiffening of character should go hand in hand, that the more self development a child achieves, the better he will be prepared to cope with the problems of life when he leaves the shelter and protection of his home. If this applies to normal children, it should apply as well to under-privileged or handicapped children, but too often parents, guardians, and teachers lose sight of the importance of character forming and think they are kind when they pamper and indulge a crippled child.

Where the crippled child has normal mentality, let us tap every possible resource of the community to maintain him while we give him all the education possible. In thus enriching his life we broaden his opportunity for service. If he cannot profit by higher education, help him to self development through learning to do well the things for which he is fitted so he may contribute to the general good and lead a useful and happy life. Lay as little stress as possible on his limitations, rather develop his talents and if we make him feel he is not different from normal people, he will respond normally. Do

*Read before the Seventh Annual Convention of the International Society for Crippled Children, Memphis, Tenn., February, 1928.
not pamper him in the school or the home and later he will not expect favor in industry.

The crippled child needs to be guided early into pre-vocational training so that he may begin to prepare himself for his life work; for the job which he can do as well as a normal person—something he likes and is interested in and in which he can eventually compete favorably with the normal individual.

If our foundations in character building, education, and pre-vocational training are well laid, the crippled child's attitude toward life will be such as to make it an easy matter to guide him along vocational lines. Put crippled youths into groups of ordinary civilian students without handicaps, wherever possible. In this way, they learn to regard themselves as just like everybody else, and get rid of a sense of inferiority. Help them to forget about themselves as being handicapped.

Each little cripple presents his own particular physical and mental problem. We must analyze his needs and difficulties and see that he is getting the right training so that when the time comes for placement there will be no difficulty. This is your and my civic responsibility toward the crippled child.

It is the duty of the state to offer to every citizen a complete vocational training which will enable him to use what mental and physical ability he has to the best advantage in earning a living; and we should encourage every child and youth to take advantage of these opportunities. You who have worked with the cripple know his mental attitude toward himself and toward the world. He is fearful and afraid to take the initial step.

The surgeon may do much toward restoring him physically; his teachers may give him the fundamentals in reading, writing and arithmetic; he may have had craft work and be able to use his hands skillfully, but all is lost if he cannot be well placed. This, like the training, must remain an individual service.

We must make it our individual business to see what is wrong and take steps to make it right.

(1) We must so educate our girls and boys that they will realize the necessity of doing very careful, honest work. Whatever the trade, it is the thoughtful planning, the extra careful execution, the beauty, the touch of originality which will build up a reputation for the cripple and help him to hold his own with the normal worker.
(2) We must show him what adaptability and general intelligence can do.

(3) We must study local conditions. Direct intercourse with business firms would react favorably on the whole school, keeping the training practical and up-to-date. The advice of local service groups would be valuable in arranging the curriculum and helping the teacher select what is best for boys and girls to study. The interest thus aroused in that individual and service group could be made very valuable in placing the cripple afterwards.

There is no difficulty in finding employment for highly skilled workers. The majority of crippled children, upon leaving school will be self-supporting and we will not have to worry about them, but there will always be a few who cannot earn their living in the normal way. Because of need for continued special transportation it would be well to establish a shop in connection with the school where this latter group of pupils may pass right from the school into the shop and become wage earners. This shop not to be run as a commercial undertaking but as an essential part of the scheme for providing interesting occupation and fostering a spirit of self respect among crippled workers.

I have in mind such a shop where such crippled girls and boys are engaged. The beautiful work which they are able to do is a constant source of pride and pleasure to them. In this shop one may see a department where the doubly handicapped child, being handicapped mentally as well as physically, is being trained in the art of "Weaving." The rugs are so beautiful in technique as well as in coloring that there is no trouble in selling them; in fact, the demand is always greater than the supply.

As it is recognized that our children can only compete in the labor market by having acquired during school years some skill, let us add to this skill a training in art that we may be able to help our children to a further superiority. If we give them dexterity, habits of industry and honest work, a high standard to aim at, combined with practical common sense, we shall have a set of keen, reliable, teachable young workers, who will have a value in the labor market and we will not have to worry about placing them as they will place themselves.
In the not far distant past, there was no such thing as medical social work. There were patients, and doctors to treat them, and homes and hospitals in which the treatment might be carried out. When the patient sought the doctor he did so because he was ill; and he expected the doctor to diagnose his condition, to treat him, to tell him whether he would live or die. If he was to die, he wanted to know how soon the fateful hour would come; if he was to live he wanted to know how long he would be sick, or whether he would be compelled to lead the life of an invalid.

As a matter of fact this relationship of doctor and patient holds today as much as it did a generation or two ago. The patient seeks medical advice and treatment, the doctor gives it. In the vast medical community of this country there is no essential deviation from this practice. Embodied in the general practitioner there was and is to be found a confidant, adviser, trusted friend. The veneration and love that surrounds the old family doctor is not a result of his medical cures entirely, but, if I may use the word, of his extra-medical activities as well, of his interest in the family as a human group, and its problems. You are all familiar with the story of that famous author-physician, Oliver Goldsmith, who sent a patient home with a box of medicine. The patient thought the box curiously heavy, and when he opened it he found in it some golden coins. Dr. Goldsmith had a social as well as medical point of view, recognized the bearing of the social factors on the medical cure, and treated the disease by social relief.

When patients, especially charity patients, are gathered in great hospitals, new problems arise. The problems of administration, of

*Read before the Conference of the American Association of Hospital Social Workers, Memphis, Tenn., May, 1928.
keeping the patients fed, and clean, present themselves and are answered by proper organization. The medical care of these patients comes likewise to be handled by an organization. There is a chief, and staff man, and residents and internes, and nurses, and laboratory technicians. The senior interne perhaps has some close personal relationship to the patient, but is a very busy man, and many of the details of the study of his patient are handled by his juniors and assistants. When the work is done, the patient with his record is presented to the visiting staff and to the chief as a medical problem, solved or unsolved, not as a sick individual. Such an organization and team work has produced splendid results in the scientific study and treatment of the patient, and has yielded a valuable harvest of new medical knowledge from the intensive study of special diseases.

In an organization of this type there is a definite responsibility. Everyone has his part to play, and must play it well. The senior interne is the central figure again, and has the immediate care of the patient. Technical studies are performed under his direction by his assistants, and he is responsible that their work is done well. But after all, the interne is still a student physician, and has not the complete responsibility that he will have as a practitioner of medicine. The last responsibility actually rests upon the shoulders of the experienced staff men and chief. But the responsibility rests lightly there, for as long as the internes do their work well, the patients are for the staff men medical problems and not individuals. They have not the time to come into the personal intimacy that makes the relationship of the patient and his family physician. Thus the treatment of patients in free hospitals by organized staffs tends to become more and more impersonal, as each member of the organization cares more and more strictly for his own limited work.

It was this lack of the human and sympathetic touch that stirred Richard Cabot, the great medical founder of medical social service. It was this sense of machine-made aloofness that stirred one of your active members, Ida Cannon, to work with Cabot to put friendliness back into the hospital, to make the organization's interest reach again into the heart and home of the patient. How well they have worked, how far their influence has spread, you know, as well as I and better than I, for most of you are their active disciples, and are here met together to further their aims.

I might at this point launch forth into a detailed description of what the medical social work has done for the medical care of special
diseases. I might tell you here how case studies have brought home to the physician the importance of knowing home, school, family, business relationships, the importance of understanding that a limited income absolutely blocks desirable and necessary medical care and apparatus. Instead I am going to look a little into the future of medical social service especially with reference to the private physician and the pay patient. Many possibilities of usefulness are there, but many and very serious difficulties stand in the way, and it will be worth our while to face them frankly.

As soon as you turn from the free wards of the hospital to the private rooms, the problems change. The greatest factor is the altered financial status of the patient. The patient now is able to pay his way. I recognize, of course, that great group of part-pay patients, or those who should be part-pay, but their problems are intermediate and probably will always be solved by compromise. When the patient can pay his way, he takes from the field of the medical social worker all those financial difficulties that now bulk so large in her struggles. For the moment she might almost approach such a patient with a gasp. What shall she do? What problems present themselves for her to work out? Such patients being self-sustaining are apt to be more or less self-sufficient in their own problems. If they do not solve them, they at least make pretense of doing so, and are more apt to be resentful of the social worker's efforts than many of those with whom she has already had experience. The intrusion of the third party into a relationship that is personal between patient and physician is quite a different matter than when the relationship is between a patient, harassed by poverty, and the great personnel of a medical organization.

The conquering of this difficulty will have to come through a fresh study of the social difficulties of the financially independent patients through a new conception of their psychology; and the social worker will have to develop in response to this knowledge a new approach and a new technique. It will be impossible to transfer bodily the present hospital technique to this new service.

As I see it the transition will have to be made gradually and should come through organized work in the great hospitals, through special classes and groups, and then on to the individual member of the group. This can be and is being done to some extent today, but chiefly by private physicians who treat large groups of patients with
special types of disease. You all can call to mind at once prominent physicians who have essentially private hospitals, who through trained assistants, dietitians and social workers hold classes for the consideration of group medical and social problems. It is easy to see how the social worker fits in this group, how she can act as the human arm and heart of the busy physician, extending his influence into the home. It is easy to see likewise how such a worker might receive adequate remuneration for her services, and how happy she might be working for a single chief to whom alone she is responsible.

But consider for a moment the difficulties that arise if such a class is transferred from the specialist physician, whom we have just been discussing or from the free hospital into a large institution with the private patients of many doctors. Think not only of the closed staff hospitals of some of the great medical centers where the difficulties will be less, because cooperation is habitual, but also of the open staff hospitals that abound in this country.

Instead of having a single medical chief to regulate the general policy of the class, and to control individual requirements, the social worker will be to all intents and purposes the chief, and the medical aspects will be controlled by perhaps as many physicians as there are patients in the class. Think of the difficulties that face the social worker, with each doctor trying to tell her what to do, and how the clinic should be run. If on the other hand there is a medical chief the problem is not solved, because physicians are jealous of their private patients, and hesitate to entrust to another not under his immediate control, the supervision of his patient. Even if he had the greatest confidence in the chief and in his disinterestedness, the psychology of the patient must not be neglected. Patients do not like to be turned over to some one else for things that they go to their own physician for.

The development of such group work therefore will have to be gradual, and circumspect. The way must be felt carefully, for again a new technique must be worked out dependent upon altered psychology. But there is no doubt that this can be done. There are many lines where special classes might be profitably developed, without detracting too much from the control of the physician, and where the coöperative endeavors of the patients lead to great benefit. These classes might be of various types. A food clinic for these patients seems eminently practical. The diabetics and obese and all those on
special diets might receive not only the benefits of group work and study, but individual attention. The approach to the patient’s front parlor for the social worker might be through this kitchen. Classes for the blind and cripples, rehabilitation through occupational therapy, and through new intellectual pursuits are avenues that are open to future development. Shops might be established for cardinals and arrested tuberculosis patients. These patients may be as yet unable to do a full day’s work, but are unwilling to be idle. The coöperative effort is stimulating, and the idea of working keeps up morale and self respect.

To be successful such classes should be under the immediate control of the hospital, but groups of physicians immediately interested in the special problems involved should be the guiding spirits.

To these classes might be referred the patient who would pay his dues as to a club. These dues should recompense the hospital for quarters, heat, light, and supplies, and should through the hospital pay the special technical and social workers their salaries. Only the exceptional physician enjoys a sufficiently limited and remunerative practice to do this individually. The great majority of physicians will have to combine in order to get for themselves the facilities of such special classes. And a disinterested organization such as the hospital must have the general control of the groups to avoid the pitfalls of professional jealousies, and patients’ psychology.

Analysis of the factors that are usually dealt with by social workers shows that many drop out as soon as the patient can pay his way. What is left by and large is the extension of medical care into the practical fields of the home and the work-a-day world, fields that every patient must enter and live in, but that are too far for the busy practitioner to do more than visit occasionally. The medical social worker must be the one to help the physician reach into these distant places.

In dealing with this newer problem, the social work, and social approach must be restudied and readjusted. The doctor’s psychology is altered when his patients change from the free hospital into the private patient group. The patient’s psychology is different in the two groups. The ability to pay his way changes his whole outlook on life. The relationship of the doctor to the hospital, to the social service class, professional jealousies and personal responsibilities must all be carefully considered. The patient’s attitude toward doc-
tor, hospital, social worker and class work, the intimate doctor-patient relationship are all different when he can pay his way. Each one of these factors will have to be considered in the development of medical social service for private patients. New problems, new psychologies, demand new solutions, new outlooks. Social service will rise to meet the demands in the future as it always has in the past.

224 Physicians and Surgeons Building.
THE VALUE OF OCCUPATIONAL THERAPY IN MENTAL HOSPITALS

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The therapeutic value of work, recreation, diversion and occupation has been recognized with varying degrees of clearness since the interest of the Hippocratic school in mental disorders. We find Greek and Roman physicians prescribing games, exercises, travel, diversion and outdoor occupation for hysterias, depressions and the graver mental disorders.

But for a cogent example of the value of occupational therapy, in its simplest terms, we need only to think back to those days in which our own institutions were struggling with the problem of restraint and seclusion. There was much speculation as to why patients in American hospitals were more disturbed and dangerous than those in English hospitals until finally it became apparent that the very restraint and seclusion which we regarded as necessary because of the violence of the patients, was in fact responsible for that violence. When efforts were made to discontinue restraint and seclusion, the results were unfortunate and impossible in those hospitals which did not develop some form of diversional and occupational therapy. It would appear indeed that a capacity and need for work is one of the distinguishing characteristics of the human as opposed to the animal.

We find that, when stated in its lowest terms, occupational therapy is regarded as a valuable part of any institutional program and that it prevents the outcropping of those serious characteristics which will appear in any group of men who are unoccupied and without interesting activity. Our question, however, begins at this point. In the old days the problem of occupying the patients had to be met by the ward attendant. The occupation was almost entirely limited to housekeeping activities and diversion in the form of games and
play. With the advent of the professional occupational therapist, our question is—what further value may we expect to find in this specialized activity? We may perhaps discuss the value of occupational therapy in terms of the number of patients to whom it is made available and the quality of the therapy which is offered. The quantitative value depends upon the appropriations which are available and also at the present time is limited by the absolute shortage of competent therapists. If more funds and a large number of trained therapists are to be made available, the increase must be effected as a result of a demonstrated improvement in the quality of the work.

It is the opinion of experienced institutional psychiatrists that there is no therapeutic weapon superior to occupational therapy for the majority of our functional patients. It becomes a matter for serious consideration in what directions we may expect to demonstrate the value of professional occupational therapy so conclusively as to lead to a further development both in quality and quantity. There are a number of ways in which the professional therapist can be expected to show increased value. It is a well-known fact that the majority of ward attendants are, and in the nature of the case must be for a long time to come, persons of limited and restricted education and background. The advent of the graduate therapist offers at once a means of bringing in direct contact with the patient on the ward persons with more general education, better social background and, at least, potentially better personality characteristics. Let us for the moment imagine the social service work of a progressive, mental hospital as it would be done if placed in the hands of ward attendants. Yet in a large degree, we have expected our occupational therapy to be successful and have felt that it was worthwhile when applied in this inadequate way. When occupational therapy is done by persons of similar qualifications and attainments as those in social service, the patient cannot fail to be favorably impressed and thereby benefitted.

A further gain for occupational therapy comes through the advent of the graduate therapist because this group tends to become organized and to acquire a definite status in the eyes of the other hospital employes and the patients, and a certain amount of propaganda can be carried out with the result of increased equipment and increased recognition of the seriousness of the work. In this way the patient comes to feel that occupational therapy is something more
than diversion, amusement or hospital housekeeping. It is indeed a reputable method of therapy.

We find that the trained therapist with her larger assortment of resources, her wider variety of crafts and her greater grasp of technical problems is able to fit her work to the needs of her patients and of the hospital. Through organized efficiency, she is able to reach more patients more effectively. There is, however, a limit to the benefit to be gained from mere technical efficiency. The patients who are in most serious need of therapy are precisely those who are not willing or able to give cooperation. Even the skilled occupational therapist who has little experience and less training in mental fields will find a strong tendency to limit her interest to those patients who can produce efficiently and thereby to lose interest in the specific value of occupational therapy, namely, as a means of treating mental disorder.

It is generally recognized that one cannot go beyond the presentation of opportunity to the patient. The means can be supplied, the working conditions made comfortable. Some patients can be persuaded to attend classes. The therapist must stand ready to help and instruct but the occupation must be undertaken by the patient. He must have some degree of interest and willingness and above all must not feel that he is being made to do that which he does not want to do.

The next step in increasing the value of the contribution of the occupational therapist is to be taken in the direction of bringing the occupational therapist into closer understanding of the problems and desires of the psychiatrist. As she comes to see these problems and purposes, it would be a logical step for her to become interested in the technique of the psychiatrist. In brief, this step is the building of a psychiatric technique on top of that of craftsmanship. In the social service field, it has been found that psychiatric work is a highly specialized field in which the competent worker has been trained both in the general field of social service and the restricted territory of abnormal psychology. In occupational therapy, if we still desire something beyond that which we now receive, we must set about the task of training the therapist along the specialized lines of abnormal psychology.

But it would be objected that the psychiatrist is asking too much of the therapist and is expecting her to do his work. To this objection it must be stated that in state hospitals there never have been
and never will be enough psychiatrists to do satisfactory work on individual patients. If the psychiatric service could properly administer the hospital, care for the medical indications, make diagnoses and unravel mechanisms, and discharge patients and still have time for the necessary teaching of those who come into direct contact with the patients, it would be indeed fortunate. The individual psychiatrist sees a constantly growing list of opportunities for individual work. His duties do not permit him to follow these leads except through recommendation to those who on the ward are in actual and prolonged contact with the patient. It would be indeed unfortunate were the occupational therapist to regard herself as a diagnostician competent to manage in its entirety the problem of a mental illness. However, her advantages over the ward attendant, while considerable, are not fundamentally significant until she has acquired sufficient understanding of the psychiatrist's viewpoint to translate his prescriptions into an intelligent application of her technique to the specific adjustments which he wishes to have improved in the patients.

Psychiatrists can be grouped into a number of classes, each stressing some particular phase of the underlying theory of mental disorder. For practical purposes, barring any differences in vocabulary and in emphasis, it is possible to formulate the practical opinions of the psychiatrists of various leanings in such a general way as to permit the therapist to have an impression which is sound. The situation to which the majority of psychiatrists would agree is that the patients have certain unfortunate attitudes and fail to make certain desirable adjustments. The therapist must be familiar with the general categories of those good and bad tendencies. Her problem is not the making of certain articles, not the conducting of a number of classes of certain sizes, not the elaboration of special crafts; rather her task is, through these crafts, these occupations, to effect certain conditioning of her patients' responses, or, seen from a different angle, her purpose is to make possible for the patient the relief of certain emotional tensions, fears, feelings of inferiority, inadequacy or insecurity and to offer the patient opportunity for recognition and friendship and social approval, and means whereby he may indulge his creative tendencies through the production of useful and attractive things. Insofar as her endeavor is successful, her patients will learn to recognize the beauty and sanity of work freely, voluntarily, and well done.

We cannot expect occupational therapists to think in these terms
without specific training. A great opportunity which the writer sees in the union of psychiatric and occupational training lies in the fact that the therapist has no ambition to be a physician, is not interested in the technical ramifications of psychiatry and thereby is to some extent freed from the danger of learning to accept certain categories of diagnosis. If psychology, normal and abnormal, is properly presented to the young therapist, the result may well be an absence of that furor for classification which has been the serious hindrance of institutional psychiatry and the inculcation in its place of a keen awareness that her patient is an individual who has personal attitudes which in the light of his experience and understanding and needs, seems to him necessary, which from the standpoint of society are inappropriate and inefficient. The therapist with the aid of the psychiatrist can acquire a considerable understanding of the individual patient with whom she spends sufficient time during the day to make close contacts, which, if she understands their significance, will permit her to lead the patient without undue persuasion, certainly without coercion, into better habits of activity and of thought.

The problem at this time in occupational therapy for mental patients must be solved in the same way in which the problem in social service has been solved by an organization of training which will permit the student in occupational therapy to acquire a sound foundation of fact concerning the human nature which she wishes to treat.

It has been the writer's privilege during the past year to have a part in the undergraduate training of a group of occupational therapists who were receiving practical experience in the state hospital. The attempt has been made to present to these students a brief course in the observed facts of human behavior and certain possible interpretations. Out of this experience has come a conviction that occupational therapists are not different from other persons who become interested in various forms of teaching and treating of their less fortunate neighbors. That is to say, that many of these therapists bring with them and are impelled by attitudes and motives which they do not clearly understand. One of the first considerations then in the presentation of special psychiatric training to occupational therapists has to do with the development of insight on the part of the student into her own problems. There is good evidence that certain of these students have considerably increased their efficiency and value through an understanding of some of their own
peculiarities. The time may be distant but it must inevitably come when all of those persons who propose to do professional work with the mentally ill will find it necessary to achieve this insight into personal attitudes, consciousness of personal motives and awareness of their own peculiarities and limitations.

For it is precisely the absence of such insight which renders psychiatric work crude and which in the field of occupational therapy permits the worker complacently to turn out good products and only slightly improved patients, or again permits her to carry on classes month after month without and definite purpose nor clear understanding of her progress.

The teaching of occupational therapists should aim to instill into the student a desire for insight into the patient. She would naturally be impressed with the gravity of the situation and warned against attempts at major exploration into the patient’s mechanisms. It is quite possible, in spite of cautioning for one to attempt a bit of psychotherapy. It has been the writer’s experience that one such an attempt is sufficient and afterward the worker is very glad to limit her quest for insight to attempting to look at things through the patient’s eyes, attempting to understand the patient’s attitude toward her and toward the work.

It is only in the light of some understanding of some of her own purposes and a little sympathetic awareness of the patient’s aims and desires that the professional therapist can intelligently organize her work. With this background she can reasonably be expected to develop an intelligent attitude toward her methods in their relation to other activities of the hospital and means which are brought to bear upon the solution of the patient’s difficulties.

To meet successfully the indications in the care and custody of mental patients, it is necessary that the various phases of hospital activity be developed from the simple angle of psychotherapy. The variety of special technique must remain subservient to this one central purpose, which is the solution of the patient’s difficulties of adjustment. In occupational therapy, the emphasis must be kept primarily upon the therapy. It will be the duty of the aide in this department to use occupation as a means of treatment, not as an end in itself.

The value of occupational therapy is not disputed. Efforts to find congenial occupation for patients segregated in hospitals have been met with more or less success since the beginnings of psychiatry. Wher-
ever these efforts have been made, conditions have been bettered. Since the development of professional occupational therapy, which has occurred largely since the war, we have come to feel that we are entitled to greater benefit than formerly could be expected when the patients' activities were in the hands of relatively incompetent ward employes. There is, however, a definite limit beyond which the specialized therapist cannot go in the specific problem of the mental patient because she has not been trained into the psychiatric viewpoint. Those hospitals which expect the most satisfactory service from occupational therapy must be prepared to present this specialized psychiatric teaching to their students. Occupational therapy must follow in the footsteps of the social service in the development of a definitely psychiatric division. When psychiatric therapy has become a reality, we may legitimately expect that its value will be much greater than it has hitherto been. We may then expect that same intimate cooperation which exists at present between psychiatry and psychiatric social service. Such a state of affairs should have a very definite result in decreasing the length of hospital residence of a large number of our patients.
AN ADEQUATE SCHOOL HEALTH PROGRAM FOR A SMALL CITY OR TOWN*

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The services required are the same whether the group of children numbers 7 or 70,000. The one most essential necessity in any system is that every teacher in the schools shall have a keen, intelligent interest in the health of the children. Since our normal schools and colleges have added health courses so comparatively recently this means there must be a health education program for the teachers in service.

This directs our attention immediately to another necessity, that there must be a superintendent of schools who realizes the necessity of, and makes provision for such teacher training; who picks out as new teachers those with the training, personality and interest in health matters that enable them to teach health in a positive way and qualifies them to cooperate successfully with the specialized health workers in the school.

If the children receive proper health instruction from day to day, it is because this same superintendent sees the necessity for allowing time on the teaching schedule for health teaching and for providing a director of health education as well as for music, physical training or art. Of course such a superintendent is in office because his board of education wishes to have such service and appreciates a superintendent who works along such lines. And such a board has been elected by the voters because that is the kind of a school system they want. So it comes back to our general public. New York State cherishes its local control of education.

Perhaps it is just coincidence but often an increased interest in health work is apparent after the election of a woman to the board.

* Read before the Health Institute held at Poughkeepsie, N. Y., May, 1928.

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Now does a nurse working in the schools have any part in these features of the health program—teacher education and health training and education for the pupils? There are instances where a nurse has taken a most important part, in assisting the superintendent in planning such a course, in suggesting possible extension courses from nearby colleges or in helping him get speakers for teacher groups on health subjects,—in many cases speaking herself on certain subjects especially at rural teacher conferences.

More valuable still in improving the health instruction the children receive is her work in stimulating the individual teacher's interest in it by supplying her with materials, by practical help to her in methods of testing eyes and ears, by helping her make application of the knowledge she does possess to individuals in her room, and by pointing out,—not in the class period on hygiene but at the instant the child complains of his difficulty,—possible connections between undesirable effects her pupils are feeling—headaches, stomachaches, lack of energy to play, an unattractive complexion, and with such undesirable health habits as staying up too late, eating improperly, lack of fresh air, etc.

For an adequate health program we must see that our teaching is made effective by giving the pupil an opportunity to practice healthful living.

We teach him the value of fresh air.
We must see that he learns to enjoy fresh air.
We teach him it is important to have an indoor temperature in winter of from 65-68 degrees.
We must accustom him to that temperature so that he will be comfortable then.

Unfortunately too many older people are so trained to a superheated temperature (teachers among them) that they cannot be comfortable in a proper one. So the nurse needs to check frequently the temperature by thermometer reading; the freshness of the air, or its lack is evident to her as she enters the room from the outside.

There are rooms where the children automatically step to the windows and open them whenever they see the nurse approaching. We all need such reminders for our perceptions become dulled, and the nurse can be very helpful to the teacher by bringing a fresh interest to many such boring, monotonous details as these.

Teachers always have assumed a responsibility in seeing that the children were dressed in their warm clothing when they went out-
doors. It is equally or more essential that they guard against over-dressing inside. But oh, so tiresome!

If we teach a child the necessity for washing his hands after going to the toilet, but in the school where he spends so much of his day we give him no opportunity to do so, we are ridiculous. Even in our city schools where water supply is not a problem, there will sometimes be no lavatories or an insufficient number of them in the basement, often no soap nor towels. Sometimes even no toilet paper. The nurse's check on such situations and her report reinforcing the teachers is well worth the effort. The nurse is constantly seeing new ways in which she can be of considerable assistance in this first feature of a health program—the teaching.

The second feature of any adequate health program is an intelligently planned course in physical education adjusted individually to the needs of each child. This necessitates adequate play and exercise space, indoors and outdoors, and an adequate staff to examine the children and to decide what their personal requirements are.

Now these two parts of our program would be sufficient without any more if we could do them perfectly and if we had an ideal environment for our pupils and if we were handed only perfect children to educate.

But since unfortunately this is not our situation we need another set of individuals to protect our children from the dangers which beset them from day to day and to help get corrected damages already done them.

We need medical inspectors and psychiatrists, dental hygienists and nurses to examine our children thoroughly once a year, and to inspect them frequently when communicable disease threatens or their individual conditions necessitate, and to guard against unhealthful environmental conditions. Sometimes the question is raised as to the necessity for such a frequent examination. Insurance companies have proven conclusively not only the value but the financial economy of annual examination for adults, and this value is, of course, intensified in the case of children whose physical changes are proceeding at a much more rapid rate. If we wait until the child has developed a defect obvious to a nurse's or teacher's inspection we are still working in the field of curative medicine and are far from doing real preventive or constructive work.

There must be proper working space provided for these workers in which to make the examinations and proper equipment with which
they may work. Every school should have its scales and measuring apparatus, its lighted Snellen Chart for testing eyes and the use of a phono-audiometer to test the ears.

For we must not try to educate children who are too poorly nourished, who cannot see, who cannot hear. Aside from all humane reasons it is only good business for the school to see that it has workable material. For we all know that real democracy in education isn't giving all children the same chance, but giving each his best chance.

The State provides special education for handicapped children to help them compensate for their handicaps. Children with orthopedic defects, and children who are blind are obvious enough and usually get the help they need.

But there are two other large groups who are often ignored though there is special education available for them. They are the near-blind and the near-deaf. They must be discovered before anything can be done for them. The functional testing of eyes and ears if properly done reveals them.

The nurse can help the teacher and the doctor with these tests. There is a new method of testing ears now in use that actually finds ten times as many of these children with these defects as are found by less accurate methods. I refer to the machine for testing ears called the phono-audiometer. With the watch or whisper test we find on the average one child in a hundred with defective hearing. With this machine we find in a hundred average children nine more who cannot hear well but who have been considered stupid or uncooperative instead of handicapped.

So an adequate health program must include not only the proper personnel for doing the examining work but necessary equipment.

Has the school fulfilled its entire responsibility towards the child's health when it examines him frequently through its doctors and psychiatrists and studies him constantly through properly trained teachers and nurses to observe early any danger signs of mental or physical variation from normal? Many schools still let their responsibility stop there. They hire a medical inspector to examine the children since it is required by law. He may give them excellent examinations but with no good result through no fault of his.

Our records show that where there is no follow-up on examinations only 23 per cent of the defects found are corrected. When nursing service is provided the per cent. steadily mounts according
School Health Program

to its completeness to even 80 and 90 per cent. with an average of 65 per cent. corrections as compared with the 23 per cent. where there is none.

How far should this follow-up go? Should the school do the corrections? Only in the exceptional case. The law makes it possible but usually it is inadvisable. The school must make the parent realize through the doctor, nurse or teacher the necessity for action. But the responsibility of caring for the child is the parent's.

Where a parent is financially unable the school must see that a connection is made between the case and a suitable relief agency, public or private.

One of the most valuable contributions the nurse can make to the health program of the school is to see that all the resources of the community, social agencies, clinics both for physical conditions and mental, hospital services, etc., are known to the school authorities, utilized by them and receiving cooperation and support from them.

Seldom do the school authorities have unlimited funds at their disposal, therefore they must confine their expenditures to fields that no one else will cover, that is for positive health education and scientific supervision of environment activities and individuals, to see that the children are working and playing in a healthful and safe environment, working and playing according to a hygienically arranged program; so that whatever they do in school, they do in such a way that they are forming proper health habits, for instance, if they have to eat lunch at school, it must be nutritious, well supervised and well served in a cheerful and adequate lunch room.

Many of these things sometimes seem more difficult to arrange for children in small groups. From an administrative point of view this is true.

But economically and fundamentally there is no reason why all these services and protections should not be furnished to every child in every school as well as is now being done to the children in the large population centers.

Legally it is possible, financially it is possible. The only thing lacking is a realization on the part of the managers of these schools—the public—of the necessity for and possibility of such provision.

No one can do more to educate the people of the community to a realization of such possibility, than the public health nurse.
SOME ASPECTS OF MODERN PHYSICAL THERAPY

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The employment of physical forces forms an important phase of the modern treatment of disease and injuries. Heat and cold, sunlight, water, massage, exercise and the various forms of electrical currents can influence powerfully the human body in part or as a whole. Physical methods, acting as outside repair forces, adding extra energy, help to repair the tissues of the body, relieve pain, quiet inflammation, kill germs, restore normal function and improve the condition of the entire body. They are especially important in the after treatment of injuries, in arthritis, in chronic conditions past middle life where they are the chief means of keeping patients comfortable or restoring them to functional activity.

Treatment by physical forces is as old as the history of mankind. They gradually emerged from the empirical stage with the advent of new discoveries in physics and electricity, especially since such potent measures as diathermy and ultraviolet radiations became known. Their value was especially brought out at the time of the World War when the problem of the speedy restoration to function of the many injured and diseased had to be solved differently from the time-honored medical, surgical and orthopedic procedures. For the first time all known physical measures were assembled and coordinated with each other and with the other therapeutic measures. Results were striking in most instances and served as a means of educating large numbers of medical men to the value of physical therapy and likewise impressed many thousands of wounded who soon returned to civilian life.

After the pattern of war hospitals, reconstruction hospitals for the benefit of those stricken by the eternal warfare of peace, the
accidents and diseases caused by industry, were created. Insurance companies established physical therapy departments. Model physical therapy departments in leading hospitals and teaching institutions furnish the means of proper scientific development equal to that of other departments of medicine. The American Medical Association three years ago created a Council of Physical Therapy, similar to the well-known Council on Pharmacy and Chemistry, the main function of which is to bring before the medical profession a proper evaluation of the various physical measures and curb commercialism and unwarranted claims. The American College of Surgeons in its latest report on Hospital Standardization has recommended that every hospital should have a well-organized physical therapy department under competent supervision.

Hospitals seem to be somewhat slow to provide up-to-date physical therapy departments. In the Hospital number of the A. M. A. Journal, March 24, 1928, only one-third of the general hospitals of the United States reported physical therapy departments, whereas approximately one-half of the industrial and of nervous-mental hospitals, and 42 out of 62 orthopedic institutions reported likewise. These figures show where the need for physical therapy is primarily recognized in institutional work. Every general hospital should have a physical therapy department, no matter how modest, because if properly manned and used it will benefit a wide range of medical, surgical and other conditions. The main consideration in establishing a department is that a well-grounded physician should be put in charge and he in turn should provide well-trained medical and technical assistants. The initial cost ought not to be more than $2,000 to $3,000 and as to running expenses, experience has proven that in most instances the department not only pays for itself, but actually produces extra revenue. Patients are perfectly willing to pay for treatment of which they see immediate benefits. A properly equipped and run physical therapy department will also serve as an educational center for other members of the staff and for the training of technicians and nurses, and incidentally furnish the means for clinical research which is at present so greatly needed in this new department of medicine.

In the limited scope of this paper one can present only some of the principal facts on modern physical measures, with some comments on their use and abuse.
Electrotherapy

As in commercial life, electricity in medicine can be used for heating, exercising or its chemical action. Treatment by modern methods of electrotherapy is not painful and in skilled hands no patient need be in fear of any pain or burn caused by electrical treatment.

Diathermy. The high frequency current or diathermy has mainly heating effects. With two metal plates placed on opposite sides of a limb or the body, all that the patient feels is a pleasant form of warmth. There is no pain; no jerking of muscles. This electric heat penetrates to the very depths of the tissues, much more so than the heat of a hot water bottle or an incandescent lamp. It brings on a strong, fresh blood supply that will powerfully help the parts to overcome inflammations. Joint troubles, sprains, muscular rheumatism, lumbago, neuritis, inflammation of the inner organs, like the lungs, liver, spinal cord and genitalia, respond often very promptly. Pain is relieved successfully without the use of any drugs.

The action of this electric heat may be brought to such a high degree that small and large warts, moles, cancer of the skin, of the tongue and other places on the surface of the body can safely be cooked and destroyed. Such operations are made without pain, without loss of blood, with very little if any shock. The surrounding blood vessels are sealed off at once so that there is no danger that cancer particles may get into the blood and start new growths somewhere else. Progressive surgeons now use these methods of electrodesiccation and electrocoagulation more and more in suitable cases.

Toy Machines. In drug stores and hardware stores, a cheap alternating current box is being sold the country over under the name of violet ray machines. This current will light tubes from which the air has been exhausted, but their violet color has nothing to do with ultraviolet rays and all their therapeutic action amounts to is a mild skin irritation and gentle massage, as any ordinary liniment would do. Nevertheless, in order to promote their sale to the public, ridiculous statements as to their health restoring action are made and the list of conditions claimed to be benefitted ranges, like that of any old-fashioned patent medicine, from dandruff to ingrown toe nails.

The danger of self-prescribed and applied treatment by such devices lies first in the fact that at times accidents, burns can be caused,
and quite often, on account of the hopes excited by wild promises, consultation of a physician is delayed too long and a real illness may make serious inroads before proper treatment is administered.

Galvanism for Removal of Superfluous Hair. The galvanic current is a safe and effective means for the removal of hairy growths, especially from the face. So-called beauty specialists have been reaping rich harvests from promising comfort to bearded women, often using the dangerous X-rays and causing disfiguring scars over the faces of their victims. Others sell "wonder" pastes which can give only temporary relief from unwanted hair. The galvanic needle, applied by competent persons, is the safest way to destroy unwanted hair, but it is one that takes time. By the same kind of electrical treatments in World War hospitals, large painful and tight scars of many soldiers were softened and with the help of massage and exercise the full function of limbs was restored.

Infantile Paralysis. Properly applied forms of electricity are doing wonderful work in infantile paralysis and other kinds of paralysis. It is an almost uncanny sight to see, for the first time, the working of a surging electrical current in these paralyzed limbs. Two wet pads are applied to opposite sides of the limb, the current is slowly turned on and while the little patient hardly feels anything, one muscle after another starts working and with continued skillful application in many cases active life returns in time in these muscles; the child learns to use them again. Of course, in these afflictions, as in all other cases where electricity is used, re-educational exercises must be used hand in hand with electrical muscle exercise, especially in older children. Proper braces must support the muscles while they continue weak and prevent deformities that would otherwise follow the pull of the unaffected strong muscles.

Exercise of weak muscles by electricity is successfully used in weakness after fractures, dislocations, and other injuries. Ingenious apparatus will exercise muscles of patients with heart trouble without any strain to the heart and so help the general circulation.

Muscle Testing. Because interrupted and wave forms of electrical currents enable us to work muscles of the body irrespective of the will, electricity in the hands of an expert is a valuable means of discovering whether a person claiming to be paralyzed is really so or not. The desire to collect "easy money" after some injury or accident makes quite a few people try to deceive doctors and juries. Among the known tests to prove the healthy state of muscles, there
is none more convincing than those by electricity. In the early stage of paralysis following an injury to a nerve, testing by electricity is often indispensable to the surgeon and nerve specialist to enable him to determine the extent of the injury and to tell approximately how long the trouble will last, and thus it is possible to start appropriate treatment at once.

Nervous Conditions. Electricity is generally believed to be most useful in nervous conditions because of a popular belief that nerves are run by electricity so that, therefore, electricity must be good for the nerves. This opinion, however, is not borne out by the large experience of those who have given the problem careful thought. In many of the conditions of supposedly nervous origin, it is much more important to study and overhaul the system of the patient, correct his or her bad habits, improve home conditions and ease mental anxiety instead of starting some makeshift electrical applications. Electricity is to be used only for those conditions in which, in the opinion of the trained physician, poor function can really be improved or an over function can be quieted down.

Who should prescribe and apply electricity? In every town one still finds signs in windows and advertisements in newspapers announcing "electrotherapy." Quacks and near-quacks, often wholly ignorant of the subject, are always ready to reap a harvest from any progress in scientific medicine and therefore it is quite natural that some of these frauds should buy electric machines and try to make money by going into the electric "game." The newly enacted Medical Practice Act of the State of New York expressly states that electrical treatments and other forms of physical therapy can be given only by a licensed physician or on his written order. Persons not educated to recognize disease conditions and not able to determine what is really the trouble with the patient have no right to recommend electrical treatments.

Massage

Massage is the oldest form of mechanical application to the body and has the advantage that it requires only a pair of skilled hands and a trained head and can be applied at any place.

Our modern conception of massage is that it aids circulation, stretches tissues, and helps the general well-being of the body by reflex stimulation through the skin and relaxation of muscle spasm. The conception about its power, however, to build muscle is not well-
founded because otherwise the man would be the finest athlete who would hire the best masseur. Neither does massage restore muscular power in real paralysis, and if ever used in such condition, it must be used only in the gentlest way. Massage works to best advantage when properly combined with other physical measures such as preliminary warming and subsequent active or passive exercise of the parts. “Baking and Massage” is an incorrect label for the often wholesale and perfunctory work done under the guise of physio-therapy by some insurance concerns. Insured workmen and others are entitled to the best of care which scientific medicine can furnish.

The profession of massage operator is a noble one and should be practiced by persons trained thoroughly in its art and science and in the proper conception of medical ethics. Many persons, unfortunately, think that any able-bodied man or women can learn in a few lessons how to “rub” with good results. This is far from the truth. To learn massage considerable training and real aptitude is needed. In Sweden, schools of scientific massage and medical gymnastics take several years to turn out a well-trained graduate. In our own country here we sometimes have occasion to pity the misguided household worker who, after having spent the best part of her life in working with pots and brooms, invests her savings in a new career, as a masseuse, for which she had not enough preliminary education and receives only too short a training. Women are, as a rule, more skillful in this field than men; their touch is more delicate; their hands softer and more flexible. There are, however, unquestionable objections to the application of general massage by a member of one sex to the other. Wrong practices of this sort and other abuses by advertising masseurs made massage almost fall into disrepute. This has now been overcome and in New York City the Department of Health is enforcing strict regulations as to the licensing, examination and supervision of masseurs. The County Medical Society of New York has advocated that training schools of massage be established by hospitals so that massage operators of the same status as nurses may be trained. It is hoped that such schools may be established soon and thus the present situation where people without education are trained by commercial schools will be remedied.

*Medical Gymnastics*

Medical gymnastics consist of systematically arranged exercises for the preservation or restoration of the functional activity of the
body. Regular exercise promotes good health and is in most people essential for the maintenance of the highest efficiency of body and mind. It has an important influence in keeping the digestive and nervous systems in healthy condition. The craze for indiscriminate use of exercise on the other hand, has created a situation that is not desirable. Self-styled experts holding forth in private gymnasiums, so-called physical culture studios, beauty parlors, are exploiting exercise for altogether commercial ends. Thousands of men and women take their morning exercise to the tune of the radio. The kind and amount of exercise they really need can be determined by careful examination only.

So much for active, voluntary exercise. When trying to restore function in disabled limbs, up to a few years ago elaborate, power-driven machines, called “Zander” apparatus were much in vogue. As they accomplish only rather coarse pulling and stretching and caused several accidents, in most cases we now employ free exercises in which the patient works actively under expert guidance. Stiff joints are usually first to be softened up by other measures that warm up the parts.

Occupational therapy is an important adjunct to active exercises because its furnishes healthful activity for mind and body, overcomes functional disability and reestablishes capacity for industrial and social usefulness. A well-conducted occupational therapy department should be part of any clinic or hospital devoted to the treatment of industrial disabilities.

**Hydrotherapy**

Hydrotherapy is the application of water to the body to produce profound general effects or to influence some wrong local condition. Everybody knows the refreshing, stimulating effect of a cold shower and the soothing effect of a hot bath. Water has the advantage of being the handiest and least expensive of all physical measures. Through its careful application as hot and cold douches, sprays, packs, baths and the like, vital forces can be favorably stimulated in many recent and chronic conditions. In physical therapy departments of modern hospitals hydrotherapy is mainly used for certain forms of arthritis, in the after treatment of fractures, and for some nervous disorders and run-down conditions, usually in combination with other physical measures such as massage, light and exercises.
Various health resorts in the United States and Europe provide elaborate installations for the external and internal application of water. However, change of climate, agreeable surroundings, rest and pleasant relaxation, regulation of diet, all play important parts in the success of the “cure” at these resorts, and many equally favorable results could be duplicated at home, under proper medical care and by resort to simple physical measures.

_Heliotherapy_

Heliotherapy, or sun treatment, makes use of the direct sunlight in the treatment of local or general bodily disorders. Sunlight contains a mixture of ultraviolet, light and heat rays and these may be either soothing or stimulating. Sunlight improves the defective quality of the blood by increasing the number of red and white cells and the needed amount of hemoglobin, while by its systematic exposure the skin develops a healthy tan. The treatment of rickets and of tuberculosis of the bones, joints, glands, skin and abdomen has undergone a radical change for the better since Finsen in Copenhagen and Rollier in Switzerland proved the beneficial action of natural and artificial sunlight. Cumbersome plaster casts and operations are often made unnecessary by its proper application. Every effort is being made to use the healing powers of the sun in our large cities, but unfortunately the dust and moisture in the atmosphere there interfere with the penetration of a most important part of the sunlight—the ultraviolet rays. Ordinary window glass also blocks these rays, while permitting the passage of heat and visible rays.

_Transparent Window Glass._ The present widely advertised ultraviolet transparent window glasses do not provide sunlight where there is none. The sky radiation from the north contains little efficient ultraviolet. The sun’s rays passing through these glasses will not exert any appreciable influence unless they reach a large surface of the bare skin. It has been proven that transparent window glasses deteriorate even quicker than the quarz containers of the mercury vapor lamps and so after a while transmit only a fraction of the sun’s ultraviolet. Their use, therefore, can be considered really beneficial only in special solaria and sun-parlors with southern exposure, where patients can be exposed fully or partly uncovered, with their bodies protected from cold.

Artificial light sources furnish a much more desirable and con-
venient substitute for the sun's rays and those mainly used in this country are the carbon arc and mercury arc in quartz.

**Mercury Vapor and Carbon Arc Lamps**

Electric mercury vapor lamps or arc lights produce "bottled" sunshine, which is available at all times and in any desired amount. These applications, though, should only be ordered and carefully supervised by physicians. There is considerable danger in the indiscriminate employment of ultraviolet lamps in homes by the laity. The tonic effect often ceases after a certain period and in very weak, run-down people, a very unpleasant negative phase reaction may occur. Incipient cases of tuberculosis, especially those running light temperatures may suddenly flare up. Some people blister easily and develop unpleasant itching conditions under improperly applies ultraviolet radiation.

**Radiant Light and Heat**

Radiant light and heat form the bulk of the sun's rays and the fact that flowers thrive in glass houses into which ultraviolet rays cannot penetrate proves that the light and heat rays are at least as essential to life and growth. Extended use is being made of these rays in modern physical therapy through incandescent globes of varying candlepower. These heat and light rays relieve pain and improve the circulation of the body or of any of its parts and prepare it for further treatment, if needed, by massage, exercise or electricity. These simple and efficient lamps have largely replaced the use of the larger, cumbersome electric or steam ovens, so-called "bakers" in which patients were likely to be easily burnt.

**Conclusions**

Physical measures applied either by physicians themselves or under their direction by skilled hands and trained heads are essential in the modern treatment of diseases and injuries. No hospital should exist nowadays without an adequate physical therapy department, and the safest way to counteract quackery by physical measures is the cooperation of the medical profession and of the hospital authorities in furnishing the means for the proper study and application of physical therapy.
EMPLOYMENT OF THE HANDICAPPED IN A COUNTY HOSPITAL*

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Those of us who are responsible for the management of an institution realize that the institution is not an end in itself but merely a means to an end; that of service to the unfortunates in our care. Yet we recognize that proper management and a high standard of service go hand in hand. With this in mind, let us consider the employment of the handicapped in a county hospital or any other institution, from both sides. First, are we rendering service to the individual by such employment? Second, is it good business for the institution to use this type of employe?

In voicing my thought on this subject, I hope to provoke a general discussion from which we all may gain information, as I have no tried and approved plan to submit. I want, first, to divide the handicapped that we are considering into two groups. The first group—those who are already inmates in our institution and whom we have no choice in caring for because they must remain there. Second—the group of single people, (married couples present a special problem) who are seriously handicapped and come to the hospital or other social agency for assistance and whom we refuse to admit, or later send away, as we feel that they are no longer strictly hospital problems and should find some way to care for themselves or get the help which they need from some other source.

Considering the first group, those regarding whom there is no question of eligibility, it is generally agreed that those who are able should be employed—for two reasons. In the first place, every individual needs employment to give him an interest in life and can only

*Read before the California Conference of Social Work, Yosemite Valley, California, May, 1928. 468
be happy when this is supplied. In the second place, no man should be pauperized by being cared for by public or private charities if he is able to earn his own maintenance either in whole or in part. In spite of the fact that there is a general agreement to this policy, I have found that in practice only a very small percentage of county hospitals do this in a real and efficient way. Perhaps our experience at Fairmont Hospital (of Alameda County) covering a period of about nine years, may be of interest to you. When the present administration took up the work, we found the same conditions regarding employment that exist in most county hospitals. A few of the more ambitious inmates who wished to do so were assigned in a haphazard way to any tasks at hand, and those who did not wish to work were not required to do so. The result was that a very few were employed, many who should have been were not.

At our request, the Board of Supervisors passed a regulation requiring us to employ all inmates who after a complete physical examination were found to be able to do any work, and to discharge any who refused to comply with this request. At first there was considerable objection on the part of some inmates but this was gradually overcome and it is no longer a problem. In fact, I feel sure that if it were left to a vote of the present inmates that they would oppose returning to the old system. When an inmate who does not require hospital care is received into the institution, he is interviewed by the Supervisor of Inmates, assigned his quarters and advised regarding the institutional routine. At this time, a record is made showing the name, age, former occupation and such additional information as may be of interest in fitting him into the life of the institution.

He is instructed to report the following morning for a physical examination. The Supervisor of Inmates is present at this examination. He confers with the doctor about what the inmate is able to do and then assigns him to work if he is able, taking into consideration his former occupation, personal preference, physical and mental handicaps. Often an inmate is temporarily disabled, and he is then put on a pending list and given treatment until such time as he is able to be employed. If the doctor finds that he is unable to be employed, he so states. No inmate is employed without the doctor's recommendation. It is frequently necessary to make several transfers before he is finally placed where he can do the best work and be the happiest. This record is kept on an employment card.

Inmates who do harder work or fill more responsible positions
Handicapped in a County Hospital

eat in a separate dining room, and are given more meat and desserts, than those who are not employed. In addition to this, those whose work justifies it are paid small sums ranging from $2.50 to $10.00, and in a few cases, $15.00 and $20.00 per month.

Inmates are employed in the various industries which are necessary to maintain the institution, such as the dairy, which supplies all of the milk and cream needed at Fairmont and Highland Hospitals, the poultry ranch which supplies the eggs, the hog ranch which supplies all pork, ham and bacon, the vegetable gardens and other farm activities.

The grounds are cared for by inmates under the direction of one head gardener, also the greenhouse, where plants and flowers are raised for use in and around the hospitals, and trees and shrubs grown for Highland Hospital grounds and all of the county institutions.

All mattresses used by the three hospitals are made and renovated by inmates. The shoe and tailor shops conducted entirely by inmates, take care of all clothing and shoe repair work. The blacksmith, tin and machine shops meet the need for mechanical work and repair of equipment. The carpenter, plumbing and paint shops, each under the direction of one outside employee, are manned by inmate helpers and keep up the maintenance and repair work of equipment and buildings. The power and refrigerating plants are operated by inmates, working under the direction of a chief engineer, with two assistants. A splendidly constructed and well equipped laundry, manned by inmates under the direction of one head laundryman, does all the institution work—amounting to over 260,000 pieces a month.

There are many activities in addition to those listed, and a large number of inmates are employed in the conduct of the institution as gate-keepers, ward porters, messengers, and in general work.

A daily report is prepared showing the number of inmates who are not in the hospital wards, the number employed, number temporarily disabled, number pending examination and those permanently disabled. In this way, all are accounted for every working day. We consider this very essential. Records formerly showed about 63 per cent employed. During the past year, due to pressure for room and a more careful check for discharge it has dropped to about 56 per cent.

Among the balance of the inmates for whom the doctor does not recommend active employment, are many who need an interest in
life that can only be supplied through occupation. For this group, we have organized our Community Shoppe, where we make chiefly baskets and toys, but also brushes and various kinds of handiwork. During the past year we have sold from the basket shop $3,657.00 worth of products and have $800.00 worth on hand. A recent order called for 14,000 baskets. Inmates are paid a part of the profit from this shop and the balance will go to the county for their care. Our experience has convinced us that we are giving the inmates, through this employment, that which they need. The following case, one of many, will serve to illustrate this point.

For three years an inmate, 79 years of age at admission, a painter by trade, who was unable to secure employment because of his advanced age and physical condition, was employed in our paint shop. He was a good mechanic, honest and industrious, and did good work in refinishing furniture, hospital equipment, painting fences, etc. He was advanced until he received $15 a month in addition to his maintenance. He more than earned this up to ten days of the time he died. When taken ill, contracting pneumonia, he was given the best of care. After his death, the painters' union, of which he was a member, conducted his funeral. By enabling this man to do the work he was able to do, and which could only be done under institutional conditions, he became an economic asset instead of a liability.

Our experience has also proved to us that it is good business for the institution if their employment is carefully chosen and the man fitted into his job. In some of the activities such as the farm, laundry and mattress shop where a careful cost accounting system is kept, we can show conclusively the saving in dollars and cents. In addition to this saving, there is an attitude developed among the inmates which makes them feel a certain responsibility for the institution.

Let us now consider the second group—those single handicapped people that they refuse to admit to the institution or who are discharged after being given, perhaps, a certain amount of medical care.

Each month, the Supervisor of Inmates submits to me a list of all inmates under 60 years of age, who are in the institution. This list is reviewed with the medical staff. All who are not almost totally disabled physically, are discharged unless there is a medical reason for their remaining. We have found that many men who are discharged return later, frequently several times. Each time that they are discharged and returned, they are less fit for employment. There are several causes for these handicapped misfits, as I will call them for
lack of a better term. Some are chronic alcoholics who drift back to old associations and environments and come to grief. Some are men of low mentality, just above the line which would require their being admitted to a state institution. Some are prematurely old but all are broken and have “lost their grip.” They are unable “to hold their own” as soon as there is competition for employment. They become unemployed, resulting in under-nourishment. This with exposure, alcohol, and what not, back to the hospital they come as patients or requesting admission as inmates.

Should we not endeavor to secure a SOCIAL diagnosis of their ailments as well as a medical diagnosis? If we do, I believe that we will find many who can be advantageously employed in the routine of and under institution conditions. But some of my friends will say, “You institutionalize a man by doing this.” I grant that, but in turn ask, “Is that entirely objectionable?” If these men (and I am speaking of middle-aged and not young men) have not been able to earn their living and become economic assets to the community, what is there to lose? I believe that it is possible that some of them would be rehabilitated just by keeping them employed for a sufficiently long period of time in one place, even if that is an institution. From the point of view of institutional management, I believe that it is economically advantageous to employ these men if a proper organization is developed in the institution for their supervision and direction. Are there not in each community a large or small number of men who are being helped by public or private charities who could earn their own maintenance and perhaps a little more, if given the opportunity to do so under institutional conditions? I believe from my experience with quite a large number of them that these men would be happier and that the community as well would benefit by such an arrangement.
THE CARE OF THE CHRONIC PATIENT*

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A chronic disease is one that has lasted over a long period, three months or more, and which is of sufficient importance to require medical and nursing care. The most common causes of chronic diseases are disturbances of the vascular system, or of the cardiac and renal organs; neurological conditions as paralysis; arthritis, diabetes, carcinoma, tuberculosis and gastric or metabolic disturbances.

Fifty per cent. of the ambulatory sick are afflicted with chronic diseases and wander from one dispensary to another seeking relief through symptomatic treatment. The neglect of the chronic sick by the medical profession is considered to be one of the chief factors in the development of various medical cults. A recent survey in Cleveland revealed that forty-two per cent. of the patients seen in their homes by the Visiting Nurses Association were suffering from chronic diseases that required institutional care. It is estimated that fifty per cent. of all deaths are the result of chronic diseases. Irrespective whether these figures are correct or not there is, nevertheless, a great deal of chronic illness which does not receive the attention which it warrants both from a medical and an economic point of view.

One of the main reasons for the neglect of the chronic sick is the tendency to call them "incurable." Incurable is a harsh word. To the sick it means lost hope; to the physician it spells defeat; to society it carries the sadness of a wrecked life and added economic burden. In the present state of medical knowledge the term incurable disease places a serious responsibility on the physician for not infrequently an "incurable" can be restored to comparative health and economic usefulness.

*Read before the California Conference of Social Work, Yosemite Valley, California, May, 1928.
Another misconception in regard to the chronic sick is the confusion of those conditions known as old age with those due to chronic disease. It must be noted that chronic diseases are not confined to the aged but may occur at any period in life. Boas reported that fifty per cent. of all chronic patients in the Montefiore Hospital during 1926 were not over fifty years old. Approximately one-third were between fifty and seventy-five years of age and but three per cent. were over the seventy-fifth year.

Elderly persons who become dependent may be divided into two main groups, the able-bodied and the sick. Among the able-bodied aged the problem is an economic one. Employers are prone to refuse to engage workers advanced in years often in the sixth and seventh decades. The relief to this problem must be through the development of old age insurance. Senile decay due to gradual decline of the physical and mental facilities becomes manifest after the seventieth year. Disability at an earlier period is due to disease and the person should be treated as sick and not as suffering from changes incident to old age.

Boas has nicely classified patient suffering from chronic diseases into three groups:

Group A, patients requiring medical study for diagnosis and treatment.

Group B, patients requiring chiefly skilled nursing care.

Group C, patients requiring only custodial care.

Poverty compels the majority to seek institutions which with few exceptions offer only domiciliary care adequate only for those in Group C. Those patients who are in Groups A and B require specialized hospital care analogous to that provided for patients with acute diseases whose stay is measured by days whereas the chronic patient may spend several months in an institution. Adequate hospital care for Group A patients requiring medical study for diagnosis and treatment is a constructive effort as it often leads to recovery, rehabilitation and to economic relief from the burden of illness. This claim cannot be made for patients in Groups B and C. With these, helpless invalids as well as the custodial group proper institutional care brings succor to the patient and relief to the family whose poverty and misery are often aggravated by the burden of a chronic invalid in the home.

Providing proper care for the chronic sick depends upon the end result sought. To take care of those who with proper treatment can
be restored to health and become economically independent is essentially a different problem than caring for those who will be helpless for the remainder of their lives. A comprehensive community program should include all groups of chronics, ambulatory as well as institutional. The ambulatory well-to-do patient can secure medical and nursing care either at home or in a special proprietary institution but the ambulatory patient of small means is dependent upon the Outpatient Department of hospitals. Many such patients may be kept out of hospitals and disruption of family life prevented by adequate dispensary care and proper treatment. Even patients who are disabled or bedridden need not enter hospitals when family ties prevent if organized visiting medical and nursing service can be obtained. There will always remain a considerable proportion for whom institutional care must be provided. It may be advantageous and humane to combine medical and custodial cases to eliminate the pathetic homes for incurables and almshouses.

The ideal is a completely equipped hospital where skilled medical, surgical, nursing, dietetic and technical care can be obtained. Adequate diagnostic and therapeutic facilities should be available. Patients suffering with chronic cases should not be in the same wards with acute cases because they will be neglected by the visiting and resident staff. A plan has been developed in Alameda County whereby the acute and the chronic sick poor receive the care to which they are entitled. The old Alameda County Hospital which was originally established in 1869 and which functioned as a typical county poor farm for many years has recently been entirely rebuilt. The acute sick requiring hospital care are accommodated at Highland Hospital in Oakland. The chronic sick are admitted to the Fairmont Hospital. This re-constructed hospital, beautifully located near San Leandro, has demonstrated in an interesting manner how much can be accomplished when a well defined program, adequate facilities and a competent staff are provided. The resident staff includes full time physicians and also a number of internes who rotate with those at Highland Hospital. A competent visiting staff interested in the study and treatment of chronic disease has been created. Experienced specialized surgeons operate upon these patients who, at the best, are poor surgical risks and must require greater pre-operative, operative and post-operative care. Many of the surgical procedures are palliative and done merely to give a more humane existence to the patient. The operative work done in surgical tuberculosis is of a very
high degree of skill. The chronic patients are cared for by attendants who are not highly trained but are supervised by graduate nurses. It is hoped that a school for the proper training of these ward attendants may be established. The Dietetic Department has become highly developed and provides more special diets, scientifically prepared, than in Highland Hospital. Social service, occupational therapy and dental services have been fully developed. About forty per cent. of the inmates require only domiciliary care, hospital service being provided when renewed progression of their disease occurs.

Only in large centers of population can institutions of this type be established. In smaller cities general hospitals, particularly those not operated to full capacity, can provide special accommodations for chronic patients. In most communities, however, the proper solution is the replacement of the almshouse by a county hospital so planned as to give proper care to chronic as well as to acute patients.
EDITORIAL

I wonder if, instead of the usual Christmas editorial, I might tell how some dozen of us, young, middle aged and even old, if one must be called old by reason of years lived, helped to celebrate Christmas with a lot of really old folks living together in a Home. We arrived in a truck at 11:50 P. M. Christmas Eve. Perhaps I might explain the lateness of our arrival by mentioning that we had made one stop on the way, at quite a different kind of “Home,” where one of our number had insisted on getting into a Santa Claus suit, actually disappearing in a chimney by way of a spacious fireplace and re-appearing again just as some seventy kids were about to march off to bed. Needless to say that it took some time to disentangle him from the youngsters. Needless to say also that the old folks had long since marched or ambled off to bed when our truck, with lights out and silence enjoined, stopped near the entrance of the big stone house. We were travelling equipped for fast action and in five minutes our two buglers were announcing our arrival with “It Came Upon the Midnight Clear” followed by other Christmas hymns. Watching from below we saw window after window of the house change from darkness to light, shades go up, windows open, hands move, heads appear. Retreating with bugle notes dying into silence, we waited until quiet and darkness again held sway in and about the house. Returning we entered, quiet as old Nick himself. From our truck we unloaded huge packages of Christmas red stockings, every stocking loaded to the top, every one bearing the name of some one of the household of old folks. All about the fire places, on the balustrades, in every nook and corner of the reception hall we hung them. What a place of Christmas it was! Again we retired. By connivance with the superintendent we had arranged that her big family should all come down to breakfast at about the same time on Christmas morn. Again we arrived, fifteen minutes before the breakfast hour. Buglers, singers, all concealed themselves as best they could behind screens and furniture. I see them now, these old folks as they appeared at the head of the stairway, looking, looking—wondering, wondering—
trembling a bit, some of them, smiles and tears a bit mixed up, yet both of happiness. And then from behind the screens and furniture came a burst of music and song—"Hark the Herald Angels Sing"—"Joy to the World." What a breakfast time it was! Afterwards, a still further search for each individual stocking and all through the day "a going over and over" of the contents. And in the evening, after dinner in the big living room the Santa Claus of the group again insisting on getting into that suit of his, compelling the others of the truck load group to dress up as little children, come down the stairs with lighted candles, hang up (this time) tiny stockings, hide once again, though this time behind the skirts of the old folks, so that he might once more appear from the chimney and after filling the stockings with baby playthings, he caught up "the babies." What a day we had! Why do I tell it—Because it was so personal, so intimate—the giving, the receiving, the exchange of greetings. And so, no matter how busy we are with our own immediate family groups at Christmas time, in our organizations, in our social service departments—let us plan to do a few other very personal, individual things so that some otherwise lonely souls, whether of young or old, will close their eyes on Christmas night with the thought they were not forgotten.

W. H. Matthews

SO SURE

She was so sure, this little girl who came
Into my room, to tell me all about
Old Santy Claus, so sure that he would come,
In some mysterious way on Christmas Eve,
And from his bulging pack of dolls and toys,
Leave her fulfillment of her heart's desires.
And to my question as to how she knew
Old Nick would find his way up all the stairs,
Or if by roof or window he should come,
How he would know exactly where she lived,
Her laughing eyes gave answer. They were sure!

And I just thought how tragic it would be,
If good old Nick by chance should lose his way,
Or if the many calls that he must make,
On streets where houses crowd on curb and court,
Should leave his pack quite bare before he reached,
The two small rooms where my young caller lives.
And she, instead of finding glad surprise,
No doll or toys to greet her laughing eyes,
Should find that, after all, it was not true.
But then such things don't happen—you know why,
Old Santy has your name, he counts on you.

And some day she will learn that all these years,
Her Santy Claus has lived and not grown old,
Because in children's hearts he first was born.
That time nor age can have no claim on him,
Because he is embodiment of love,
Not seen, but held by faith in things unseen.
And just so long as love of children lasts,
Will Santy Claus continue to hold sway,
In childhood's world where dreams and fancies play;
And you and I with others will keep faith,
With those who through the ages have conspired,
At Christmas time to make all childhood glad.

W. H. Matthews
NEWS NOTES

A New Christmas Label

The slogans "Shop early" and "Mail early," which have been so heartily endorsed in past years by the Retail Associations and the Post Office Department, have been adopted by the American Society for the Control of Cancer in the new label which it is this year offering for the first time for sale as a means of increasing the funds available for the work of cancer control. To these have been added another catchy phrase, "Let's put away till Christmas Day," and the three together form an attractive label which makes a strong appeal, entirely apart from the purpose to which the proceeds from its sale are to be put. This purpose, as every one should now be aware, is the spreading of what the Society calls its Message of Hope: Cancer is curable when taken in time. Thousands of persons alive and well today attest to this fact, while thousands of others bear unhappy witness to the truth of the other saying: Delays are dangerous.

Cancer is the one great cause of death that in recent years has shown an increase in occurrence, not a decrease. While the death-rates from most of the other dreaded diseases have fallen, that from cancer has risen. The number of cases occurring annually can only be guessed at, since cancer is not a reportable disease, but it is known that during 1927 it caused approximately 110,000 deaths throughout the United States. What this means in suffering to the patients and to their families cannot even be estimated, but viewed entirely from the economic side it has been determined that the money loss from these 110,000 deaths is practically eight hundred millions of dollars! Compared to this enormous annual loss, the small sum asked by the American Society for the Control of Cancer to enable it to carry on its educational work, through which many of these lives might have been saved, seems paltry indeed. The request is merely that you buy one or two dollars worth of these cheerful Christmas labels, which will brighten your Christmas packages. Perhaps by so doing you may make it possible for life-saving information to be placed in the hands
of some one near and dear to you. In such a work no one can ask, "Who is my brother?" All are our brethren who are in need of help. Labels can be obtained from the New York City Committee of the Society at 34 East 75th Street.

A state-wide survey to locate all the crippled children in Minnesota is being planned by the Minnesota Association for Crippled Children. Since 1916 there have been three epidemics of infantile paralysis in the State, each affecting from 700 to 900 children and leaving many cripples. A Minnesota law provides State aid to the extent of $250 annually for the education of each crippled child discharged from the hospitals but unable to attend the regular schools. The Michael Dowling School in Minneapolis, operating under this law, receives more than 100 pupils from Hennepin County; it is equipped with special apparatus for treatment of cripples, and the same educational training is given as that provided for physically normal children. Only one other county—St. Louis—has as yet made use of this aid. —World's Children.

The Ballard School, Central Branch, Y. W. C. A., New York City, is giving special courses to prepare young women as trained attendants and practical nurses.

The will of the late Robert H. Ingersoll provides for the creation of "The Robert and Roberta Ingersoll Foundation," the purpose of which is to aid needy and worthy boys to obtain college, university or professional education.

The Commonwealth Fund of New York has granted the sum of $5,000 to the Connecticut Society for Mental Hygiene for the purpose of conducting a survey of the mental-hygiene needs of the State.

The following interesting item on sanitary engineering 3500 years before the birth of Christ appeared in a recent issue of Health News:

Sir Arthur Keith, in describing the discoveries made in the recently excavated city of Mohenjo-daro, situated on the west bank of the Indus, 1500 miles from Babylon, says: "as regards sanitary engineering, this city of ancient Sind led the way; no city that can claim to be 5,000 years old so nearly approached our modern standard of
sanitation as does Mohenjo-daro. We know how well laid were the bathroom floors, with latrines occupying recesses in the wall. We know the manner in which drains were laid beneath the house floors; they had vertical pipes which carried the effluent from the latrines and the overflow of rain water to a brick-laid drain. A water chute was cut in the outer walls of the houses, and a great conduit was laid along the street to carry away the sewage. The street drains have been laid bare, and we can note the solidity of their workmanship and the even gradient of their fall. Last, we know how capacious were the main sewers, or drains, and the manner in which their roofs were arched with corbeled bricks.”

A survey recently made by the National Committee for Mental Hygiene reveals the fact that there are established psychiatric departments in 19 general hospitals, located in 9 States and the District of Columbia. These hospitals provide 1,767 beds, with 109 full and part-time physicians and 210 full-time nurses to care for and treat mental patients.

The September 1928 number of the Public Health News was almost entirely made up of topics and articles of special interest to school medical inspectors, school nurses, members of boards of education and staff teachers.

The office of the League of Catholic Women of the Archdiocese of New York has moved to 371 Lexington Avenue.

The United Parents Association of the Greater New York Schools, Inc., are giving a course of 6 lectures on parental problems in education. The course began in November and extends through the winter and early spring months.

Dr. Clemens Pirquet, Director of the Children’s Clinic at Vienna University and President of the Save the Children’s International Union has been elected Honorary Fellow of the Royal Society of Medicine, Great Britain.

The Child Study Association of America which has recently celebrated its 40th birthday held an anniversary conference and dinner at the Hotel Pennsylvania in November.
The office of the Ladies of Charity of the Catholic Charities has been moved to 338 Lexington Avenue, New York City.

Traffic is giving way to children in Tokyo. How far the “Flowery Kingdom” has accepted the motor car and shelved the jinrikisha is tragically indicated by the 2,500 child victims of street accidents in that city last year. And now the city fathers of Tokyo have accepted an even more modern development than the motor car and have set apart sections of 200 streets for children to play in after school hours, traffic being stopped on these streets from 1 to 5 P. M. The city officials are also endeavoring to establish more playgrounds, but they have been balked in their purpose by the difficulty of acquiring proper sites.—World’s Children.

The Public Charity Department of Buenos Aires cares for babies through three kinds of service-baby clinics with milk stations, child-care institutions, and the inspection of wet nurses. Each of the 20 baby clinics and milk stations is under the direction of a physician who instructs mothers how to care for their babies, while milk is modified in accordance with the physician’s formula and furnished free. There are five child-care institutes where mothers with children may be received instead of being treated as out-patients. Wet nurses as well as their babies are examined before they are permitted to nurse other children. During 1927 the 25 institutions of the kinds just described cared for 36,845 children, or 46.06% of the babies born in Buenos Aires. In 1908, when this work was started, the mortality for children under 2 years of age was 96 per 1,000 live births. In 1927 this rate had dropped to 80.2 per 1,000, said to be the lowest mortality rate of any South American capital and seventh among American and European infant mortality rates for cities. Of the 36,845 babies cared for in 1927, 60% were nursed by their mothers, 23% given mixed feeding (breast and bottle), and only 17% fed entirely artificially. During the same year 422,725 quarts of milk were furnished, as well as 6,009 kilograms of flour and 2,483,168 rations.—Pan American Union.

A recent issue of World’s Children calls attention to the fact that 20 years ago 4,000 children under 5 years of age died in New York City each summer of “Cholera infantum.” In 1927, although the population was 50% greater than in 1901 only 246 children under
5 years died from this cause. Compulsory pasteurization of the city's milk supply and the health and educational work carried on by the Department of Health and other agencies have contributed largely to this remarkable decrease.

The National Committee for Mental Hygiene in cooperation with the Commonwealth Fund of New York is aiding the Department of Public Welfare of Virginia to inaugurate and carry out a constructive mental health program.

Several cottages of the Hebrew Sheltering Guardian Society, Pleasantville, N. Y., have been closed in accordance with the policy of the Board of Directors of placing children in suitable foster homes. At the present time there are nearly three times as many children in foster homes, under the supervision of the Home Bureau of the Society, as there are in the institution.

We pass on this worthy appeal to our readers. "Anyone wishing to put discarded silk stockings to work will find a useful job for them, and a very warm welcome, by mailing them to Miss M. A. Pressley-Smith, Industrial Department, International Grenfell Association, St. Anthony, Newfoundland. The stockings are cut and woven by the native girls into hooked rugs and sold."

The State of Wisconsin has provided a yearly appropriation of $100,000 and an administrative fund to give State aid to local communities for the education of crippled children.

The report, recently published, of the departmental committee appointed in 1925 by the Secretary of State for Scotland to inquire into the treatment and training of young offenders in that country offers 214 recommendations which follow the trend of progressive social procedure in all countries. They call for the development of specially constituted and equipped juvenile courts, protection of children from the moral hazards of street trading or employment at betting or gambling resorts, a national system of probation, increased recreational facilities, better educational facilities in reformatory institutions, and the transference of defectives from prisons, Borstal institutions and reformatory schools to institutions for mental defectives.—World's Children.
An Executive degree of June 23, 1928, provides for the erection in Caracas, Venezuela, of a National Institute of Maternity and Child Welfare on a site generously donated by President Gómez, of the National Institute. Its purpose is to serve as a center for spreading knowledge along these lines throughout the nation.—*Pan American Union.*

A special health-exhibit train, furnished and equipped by the Missouri Pacific Railroad, was recently operated for a month in Texas. The train consisted of 2 exhibits, 2 lecture cars and cars to accommodate the staff of 12 to 15 physicians, sanitary engineers and technicians. The Texas health authorities, local physicians, and the U. S. Public Health Service and other Federal agencies furnished exhibit material and personnel to conduct lectures and demonstrations. One exhibit car displayed a model of a complete dairy farm and a miniature pasteurization plant in operation. The train traveled more than 2,500 miles during the month's tour, stopping at 115 towns and cities. It was visited by 70,000 people.—*World's Children.*

Miss Minnie H. Ahrens, former Executive Secretary of District No. 1 of the Illinois State Nursing Association, has been appointed Assistant to the Warden of the Cook County Hospital, Chicago, a position created for the purpose of coördinating, analyzing and reporting on the organization and service conditions in the medical, nursing and administrative sections of the hospital.

“The psychiatrist, the psychologist, and the psychiatric social worker are as essential to the proper application of the educational prescription or the preventive measures in a mental hygiene program as are teachers of music, physical education, industrial arts and English.—*Clinton P. McCord, M. D., Psychiatric Quarterly.*

The flat roof of the Department of Public Health in Havana, Cuba, has been equipped so that 250 children may simultaneously receive sun baths.—*Pan American Union.*

The 1929 calendar of the National League of Nursing Education, 370 Seventh Avenue, New York City, is unusually attractive and worth having. The frontispiece shows the Hospital of St. Jean, Bruges, in deep rich colors and there are 14 reproductions (brown
and white) of either the interior or exterior of centuries-old hospitals, with an historical description and quotation given for each hospital portrayed. The calendar is $1.00 per single copy, 75 cents per copy on all orders of 50 or over, delivered in one shipment. Proceeds of the sale will be used to help maintain and develop the activities of the National League of Nursing Education.

In the last five years hospitals maintained by church bodies have increased from 893 to 1060.—Better Times.

Children who “graduate” from the well-baby clinic which was started a year ago for babies born in St. Luke’s International Hospital in Tokyo will now have the advantage of the habit clinic which the hospital has just organized for their special benefit. Classes will be held for mothers in the training and physical care of their children of pre-school age. The roll of the well-baby clinic now numbers over 600 babies. A Japanese woman graduate of the University of Michigan, who for 6 years was assistant professor in the department of pediatrics of its college of medicine, has charge of the well-baby clinic. The supervisor of the field work is a graduate of the Peter Brent Brigham Hospital, Boston.—World’s Children.

A special report of the Medical Research Council of Great Britain on the relationship between housing conditions and the incidents and fatality of measles, states that in selected groups of Glasgow tenements measles had spread rapidly from family to family and was essentially a disease of children under school age, whereas in a section with separate-entrance houses it was found predominantly among children of 5 to 10 years. The report shows that the case mortality for children under 2 years of age is 10 to 20 times greater than for children of 5 to 10; hence the importance of a study of conditions which tend to bring about exposure to the disease at an early age.

Rome, Naples, Milan and Verona have established milk centers where all milk intended for consumption in the city is sent for sterilization. At Italy’s first conference on milk, held recently in Verona under Government auspices, the fact was brought out that the annual consumption of milk per capita in Italy is only 15 quarts, while it is 90 quarts in England, 235 quarts in Germany, and 265 quarts in Sweden.—World’s Children.
If you have health you probably will have happiness, and if you have health and happiness you will probably have all the wealth that you need, even if not all you want.—Elbert Hubbard.

BOOK REVIEW


Dr. Averill made a real contribution to education when he wrote the "Hygiene of Instruction." He stated very clearly and concisely the importance the emotional life of the child plays, particularly in his relationship to efficient school progress and the satisfactory adjustment of the individual to his environment.

He has not overlooked the part that physical handicaps play in effecting both the intellectual and emotional aspects of the child's life. Neither has he failed to point out that many problem children are only symptoms of problem environments.

I know of no better presentation of the subject of Mental Hygiene and Education than that which has been so admirably presented by Dr. Averill.

D. A. Thom, M.D.

Michigan Hospital Handbook. By Dorothy Ketcham, prepared in cooperation with the Michigan Hospital Association, 1928. pp. 237. Price $2.00 to non-members; $1.50 to members.

On the title page the words "Michigan Handbook of Hospital Law" are used and this indicates more particularly the material covered. In explanation of the demand for such a book the author gives statistics in the "author's note" showing the remarkable development of the hospital field in Michigan in the past few years. As the hospitals grew the laws relating to them were growing, and it seemed that "a simple and concise explanation of some of the usual legal requirements affecting the hospitals of the state, would be of use to the executives thereof."

The book contains then a digest of laws and decisions affecting the administration of hospitals in Michigan, five appendices giving a directory of hospitals, of agencies interested in hospital administra-
tion and patient problems, the registration and licensing requirements for physicians, nurses and trained attendants, estimates of constructive costs, essentials in a hospital approved for internship. Appended is a good index and table of citations.

There is probably no more difficult task in literature than to take material in the field of one profession and make it available for the layman or the member of another professional group, and at the same time do a good job. The tendency among such writers is to tell too little, or too much. Miss Ketcham has struck a happy medium and demonstrates how others may accomplish the same result.

The material is carefully arranged under alphabetical headings, and there is a cross-index. Most of the topics begin with a definition of the title phrase, indicating what it is all about. Then follows a brief summary of the statute and case law.

The style is clear and there is an effort to keep away from the excessive use of technical terms.

This form of treatment gives a general idea of the law coupled with extensive citations of authorities for further information. It warns the general reader that one should not make the mistake of believing that this is all the law on the subject. It aids the lawyer by giving him a handy reference volume to start his further studies.

The book shows the growing interest of the public in compilations of law on certain subjects. This situation is both an advantage and a danger. The advantage lies in the fact that everyone should have some idea as to what human acts are governed and controlled by law. The danger lies in the misconceptions likely to arise where a layman thinks he knows law because he has read a book on the subject. Knowing the law involves a process of reasoning by which the abstract rule is applied to concrete facts of a case. To make such application involves an extensive mental background in the process as well as a knowledge of the multitudinous rules of law which might be applied to a particular set of facts.

There is every reason to believe Miss Ketcham's book will fill a real need. Only those who have endeavored to write or compile similar books can appreciate the painstaking effort that must be put into such work.

JOHN S. BRADWAY,
Secretary of the National Association of Legal Aid Organizations, Philadelphia, Pa.

As expressed in the introduction by Mrs. Dummer, the purpose of this series of essays is to draw attention to and to discuss the “synthetic tendencies” and “the integrative actions of the unconscious.” Granting the need for such consideration, the reviewer finds the synthetic result of the book taken as a whole neutralized to some extent by the fact that the nine articles differ radically in style, terminology and point of view. As a matter of fact, each article is a complete entity and should be reviewed as such, but, since so doing would require another book, all that can be attempted is to indicate the nature of each contribution and point out where and in how much the author has promoted the original purpose of the symposium.

Professor C. M. Childs begins with an article entitled “The Beginnings of Unity and Order in Living Things.” It starts as an orderly systematic effort at expounding his fundamental concepts of dynamic gradients, after which, in less happy fashion, he endeavors to show that the unconscious is composed of “protoplasmic memory records” and that integration arises from the transmissive properties of the central nervous system. Despite the clarity of his style, an understanding of his previous work is almost essential to grasp the full significance of this meaty paper.

In the next article Dr. Koffka under the heading of “The Structure of the Unconscious” gives a rather clear presentation of the Gestalt concept of the unconscious. He stresses the existence of psychological units as needing distinct and individual consideration from the sensory units which go to compose them. These psychological units or Gestalten tend either to change within themselves toward certain standardized patterns or they “close” or coalesce or one might use the word synthesize with another Gestalt to form still a third, during which process conscious or unconscious activity occurs. He recognizes beside the force of “closure” of psychological units such drives as sex, hunger and ambition which he says are also Gestalten. What causes the attraction of units with resultant closure, Koffka says, is a question which cannot as yet be answered.

Anderson and Sapir discuss from different slants the genesis of many of the habit patterns, each emphasizing the extreme importance of the early years of life in determining reaction tendencies which become the stuff of the unconscious in later life. Dr. Kenworthy in
her article “The Pre-Natal and Early Post-Natal Phenomena of Consciousness” draws the attention forcibly but in a somewhat empirical fashion to the importance of the fetal and earliest infantile experience in the production of the unconscious material. All three of these articles give the genetic background with little or no mention of the synthetic or integrative factors.

Under the title “The Unconscious of the Behaviorist,” Watson has chosen to castigate Freud and the psychoanalysts, state his own concept of the unconscious as the “unverbalized,” and then proceeded to set forth “a few reflections upon the pedagogical implications of the unverbalized.” He would verbalize everything for the child and the extent to which he would carry this can only be realized by looking over the last seven pages of his paper. To read them makes one appreciate the vagaries of thinking at which one arrives if a specific dogma is followed to the exclusion of all others.

“Configuration of Personality” by Professor Thomas begins with a discussion of his well known division of four attitudes which motivate behavior. The unconscious is then linked up with habit responses and for the synthetic activity he adopts the Bergsonian concept of the “force creative” which he believes has cortical, visceral, lapsed conscious components.

“Values in Social Psychology” by Wells proves to be a highly philosophic essay on hedonism, replete with references to other writers and penned in a cryptic and occasionally subtly humorous style. Reading it is not easy, but the article does bring out rather nicely modern concepts of fundamentals of motivation.

The last essay by Dr. W. A. White under the title of “Higher Levels of Mental Integration” portrays in simple, clear cut language his concept of integration as the resulting compromise of two conflicting forces, the sex or creative and the ego or death instinct. This compromise or solution is a new emergent in the evolutionary sense of the word, and, as a new emergent, acts on a higher level from which new and different solutions are possible. Here again it is necessary to read the article almost in its entirety to get the breadth and continuity of the thinking.

Because of the widely variant nature of the essays, the book has a decidedly mixed appeal. Some of the essays demand knowledge of previous writings of the author and all of them suffer from too much condensation as is natural in a symposium. Both of these elements impair the readability of the book. Actually if one wishes to set one-
self down to the task of digging out the meaning of most of the articles, it will well repay one.

HARRY M. TIEBOUT, M.D.
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New York City.


Even a superficial glance through “Publicity For Social Work” reveals the enormous and commendable task which has been accomplished by its authors, Mary Swain Routzahn and Evart Routzahn who are most prominently known for their many years of excellent service in the field about which they write. Their latest volume which reflects the many fruits of their experience will fill a valuable place in the library of the social service executive and worker who wants a comprehensive and instructive guide to the manifold channels of publicity which are constantly developing with their expanding programs.

In “Publicity For Social Work” the Routzahns do not take anything for granted, but start with the elementary principles which may not be startling information for the experienced publicity worker. Nevertheless to those who want a familiar insight into all the mechanics of the business to aid them in discussing these matters intelligently, the volume will be a reliable bible.

The book is logically divided into six parts, starting with a general analysis and subsequently discussing the various divisions of publicity from the newspaper to the ramifications which develop in fund-raising campaigns. This reviewer, who has been through the various phases set forth in the volume, recommends most heartily to everyone in social work the very fine chapters devoted to the different types of printed matter such as handbills, leaflets, cards, folders and booklets. The expositions on these subjects, with their accompanying illustrations garnered from diverse sources, should not be missed.

Also, the advice and information given to the problems of how and when to get into the newspapers may be religiously accepted by anyone who has not yet discovered the necessity for serious and intelligent thought on this subject.

The Routzahns, experienced practitioners that they are, fully realize that the greatest problem confronting the social service publicity counsellor is not getting into the papers. They know and im-
press the reader with the fact that clipping worship is not alone the means to the end. The clippings must show that the publicity worker was sincerely interested in publicising for education's and not for vanity's sake.

If you haven't secured "Publicity For Social Work," this reviewer recommends that you do so before your next conference on publicity.

**Isidore Sobeloff,**
Director of Public Relations Federation for the Support of Jewish Philanthropic Societies.

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**ABSTRACTS**

"The Responsibility of the Hospital to the School of Nursing." G. O'Hanlon. *Am. Jour. Nursing*, 1928; XXVIII, 783. The question of the responsibility of the hospital to the school of nursing is old but ever new and hospital and training school administrators, physicians and nurses will find much to interest them in this clearly thought out unbiased analysis of the situation. In these days when nursing plays such an important part in the care of the sick and physicians require nurses to assume more and more responsibility in the care of their patients it is difficult to go back in thought to the old days, not so far away after all—1873—when Bellevue Training School for Nurses was established, and read of the opposition and difficulties encountered by the group of inspired women who fought to create, develop and extend the first school of nursing in this country. This school, like the one in connection with St. Thomas' Hospital, London, was established not by the hospital but in spite of it. From then up to the present day there has been conflict between hospital and training school officials as to where one's authority ends and the other's responsibility begins. Hospitals promptly recognized that with the advent of the nurse hospital conditions improved, and realizing the low cost of this service saw the advantage of absorbing the training schools. As new hospitals opened up they were incorporated into the hospitals. In 1880 only 15 schools were integral parts of the hospital; in 1890 there were 35; by 1900 the number had increased to 423. Today there are scarcely a dozen not dependently linked with the hospital. The author considers nursing requirements and the educational advantages offered the students and is not at all sure that the question of adequate education is being fully met. If it
were there would not be so much discussion on the subject. The solution of the problem is the responsibility of the hospital. If it be true that the hospital exists for the patient then it must be recognized that every department of the hospital having a direct bearing on the care of the sick has a direct relation to the nursing school. The various questions of hours, working conditions, recreation and other factors which have a distinct relation to the individual health of the nurse are briefly touched upon and while the author does not lay down any definite rules he firmly believes that every care should be taken to safeguard health and make the students life comfortable and happy. It is the duty of the hospital to meet and provide educational facilities so that nurses in training and leaving the school are equipped to meet the requirements of the state, to intelligently carry out doctor's orders and render satisfactory nursing care to the sick. This holds true whether or not the school for nursing is an integral part of the hospital.

"The Value of Heliotherapy." C. J. Hastings. *Canada Lancet and Pract.*, 1928; LXXI, 150. The author emphasizes the importance of proper technique in the use of heliotherapy and sets down the following advice and rules for guidance in exposing infants and growing children to the sun. (1) The ultra-violet rays do not pass through ordinary window glass, but are filtered out by it; (2) ultra-violet rays do not pass through clothing, not even the thinnest garment; (3) every infant should be given the advantage of sun treatment, beginning when it is two or three weeks old; (4) expose only the feet to the direct rays of the sun for five or ten minutes at a time for the first two or three days, and gradually increase to ten or fifteen minutes at a time, always keeping short of sunburn, until a nice coat of tan is produced. This when well established affords an almost perfect protection against any danger of sunburn or blistering; (5) after three or four days the lower part of the legs may also be exposed, and subsequently the whole of the lower limbs, then the hands and arms, and later the face and neck. In exposing the face and neck it is imperative to remember that the eyes and head should always be protected from the direct rays of the sun—this necessitates a light covering for the head and exposing the cheeks. The infant should be turned on its side so that the direct rays of the sun do not reach the eyes. Runabout children who have acquired a good coat of tan can safely spend two or three hours a day under the direct rays of
the sun clad only in bathing trunks and a light covering for the head. Even sheer or gauzy garments will filter out the ultra-violet rays therefore the skin must be exposed directly to the rays of the sun. Greater care must be exercised in the treatment of blonds as brunettes having a richer supply of pigment are less susceptible to sunburn or blistering. Sun baths should begin not later than the first of April in order to take full advantage of the months when the greatest amount of ultra-violet rays reach us. The whole article is full of interest and especially valuable as according to estimated figures from 75 to 80 per cent. of all babies in the north temperate zone suffer from some form of rickets and the ultra-violet ray is our potent therapeutic agent in the treatment of this condition.

“Training for Social Work.” F. Rajniss. Rev. Internat. de l’Enfant, 1928; V, 331. The author chose an opportune time to publish his ideas in regard to training for social work as the subject was brought up for discussion at the International Conference of Social Work held in Paris in July, 1928. Social workers now realize the need of a unified standard, both of professional ethics and technical skill, on a level with the standard demanded by other skilled services. The future of social work depends largely upon the standards of social education. The author takes the policies, heretofore recommended, the needs, requirements and aims of such training and judges them according to their merits and definitely states his plan and reasons for such plan in establishing training courses, which will fill the needs of modern social conditions. The author also advocates the establishment of an International School of Social Work in order to bring about a complete understanding of social needs, standards and methods.

“Shakespeare, the Psychiatrist.” Emanuel J. Cohn. Welfare Mag., 1928; XIX, 1124. Psychiatrists and students of psychiatry will be interested in this article which shows that Shakespeare possessed an uncanny understanding of the various forms of mental disease from border-line derangement to stark madness and many of his characters might be used as case material today by the alienist or psychoanalyst. The author analyzes the mental reaction and underlying causes which influenced Hamlet, Ophelia, Macbeth, Lady Macbeth and King Lear and is of the opinion that Shakespeare knew what science has recently hailed as a discovery, that the study of
madness and the study of normal people are not separate things but closely allied sciences, both based on a knowledge of the complexities of human nature.

“Sunlight and Childhood.” C. W. Saleeby. Rev. Internat. de l’Enfant, 1928; VI, 483. The author aptly remarks that this “new” subject is really as old as Hippocrates, the Father of Medicine. The names of the modern exponents of sunlight therapy, viz., Sonnet of Lyons, Florence Nightingale, Theobald Adrian Palm, Finsen, and Rollier, are given with a very brief note of their theories, discoveries and practice of heliotherapy. The value of sunlight in the cure of rickets and in the prevention of the disease in the prenatal state through the expectant mother is emphasized. The author predicts that it will be only a matter of time until sunlight, or failing it, artificial light, will be regarded as part of the hygiene of pregnancy. In discussing tuberculosis the author goes on to say tuberculosis is only secondarily and incidentally a bacterial disease; it is primarily an indoor disease, a deficiency disease, a social disease, a disease of darkness. “Let us spend our labor and money on pure air and light, the abolition of slums and coal smoke, the provision of schools and holidays in the sun in summer time, the use of our lungs and our limbs, always beginning with children, in the open air, and on the fight against those who turn our cities in winter into cold hells, calling the process industry, those who imprison well children in shadow in urban schools, calling the process education, and ill children in shadow in urban hospitals, calling the process medicine.” The author gives a very interesting description of the “School in the Sun” in Leysin, Switzerland, founded by Dr. Rollier. In this school the children’s bodies are constantly exposed to the sun and they soon become accustomed to weather conditions. One outstanding fact is that these children living close to nature thrive and soon become not fat but fit. Epidemics taken for granted in other schools are simply unknown. Physicians, nurses and all other disciples of health will be interested in this very interesting article.

“Relation of Industrial Medicine to the Private Practitioner.” Frank L. Rector. Ill. Med. Jour. 1928; LIV, 69. This interesting article is a convincing argument for understanding and cooperation between the industrial physician and the general practitioner and shows distinctly the inter-dependence of the two branches of medicine. The sphere of the industrial physician is a wide one touching
as it does the field of public health and social service. The industrial physician is instrumental in detecting physical defects and signs of disease in applicants for positions and turns these cases over to private physicians. It is a recognized principle of industrial medical work that industry is not responsible for illness or accident unless it is related in some way to the worker's employment, provided that equally competent medical service is available in the community. The practitioner profits in such instances. The industrial physician is in close contact with the workers and their families and in his work has need of the private physician and the cooperation and assistance of all public health officials and social workers. If the private practitioner will try to understand the relative value of the work of the industrial physician the results will show that industrial medicine has a distinct influence upon social, economic and physical well-being of the individual and the community.
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