HOSPITAL SOCIAL SERVICE

Editorial Notice to Contributors

SCOPE OF PAPERS.—This magazine is published in the interest of Social Service and deals with the many problems of the Hospital Superintendent, Doctor, Nurse, Auxiliary Committee and Volunteer in relation to Medical Social Service.

PRIORITY OF PUBLICATION.—Papers accepted for publication will be printed as far as possible in the order of their receipt.

MANUSCRIPTS.—Contributors should prepare their manuscripts with the greatest attention to detail. Manuscripts should be typewritten, double-spaced, and the original, not the carbon copy submitted. Manuscripts should not be typed on thin paper, should be packed flat, not rolled, and should be sent registered. Illustrations and charts will be accepted for publication, but if, in the opinion of the Editor, they are not required to increase the clarity of the paper they may be omitted.

REFERENCES.—Authors are requested to prepare their references systematically. They should be numbered consecutively in their text and collected at the end of the paper in the same order under “References.” References to literature cited should contain: (a) if a book, the name (including initials) of the author or authors, the title of the book, the place of publication, the publisher, and the date of publication; (b) IF AN ARTICLE IN A PERIODICAL, the name (including initials) of the author or authors, the title of the article, the name of the journal, the year of publication (in Arabic numbers), the volume number (in Roman numerals) and the page (in Arabic numerals) should be given.

REPRINTS.—At present the high cost of printing prevents our furnishing more than fifty (50) free reprints to contributors.

PRICE OF REPRINTS

Additional reprints of articles published in HOSPITAL SOCIAL SERVICE may be obtained at the following rates for one hundred (100) copies without covers:

<table>
<thead>
<tr>
<th>Number of Pages</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 pp.</td>
<td>$3.25</td>
</tr>
<tr>
<td>8 pp.</td>
<td>$6.00</td>
</tr>
<tr>
<td>12 pp.</td>
<td>$8.25</td>
</tr>
<tr>
<td>16 pp.</td>
<td>$10.00</td>
</tr>
<tr>
<td>20 pp.</td>
<td>$12.25</td>
</tr>
<tr>
<td>24 pp.</td>
<td>$14.00</td>
</tr>
<tr>
<td>28 pp.</td>
<td>$15.75</td>
</tr>
<tr>
<td>32 pp.</td>
<td>$17.00</td>
</tr>
</tbody>
</table>

For orders in excess of 100 copies the rates (at cost) are less.
Covers $4.00 per 100 copies. Additional 100 covers $2.00.
For each plate accompanying the article, add $.02 to the cost of each reprint.

These prices are based on reprint pages being the same size as the HOSPITAL SOCIAL SERVICE; for special sizes there will be an additional charge for imposition and make-ready.
THE RELATIONSHIP OF SOCIAL SERVICE WORK TO HOSPITAL ADMINISTRATION

EDGAR CHARLES HAYHOW

It would be interesting to hear a round table discussion as to what is the most effective way of measuring hospital productivity. What is the "yard-stick?" Is it the number of days treated—the average utilization of bed capacity—the average patient days' stay—or the per diem cost per patient? Are these not merely statistical indices of comparisons of performance established as a means of determining administrative efficiency—volume of work accomplished and average utilization rather than conclusively indicating the kind or completeness of medical and social service to the individual patient in particular or the community in general?

Hospitals "A" and "B" are similar sized institutions in like size and type communities. "A" afforded 42,000 hospital days and "B" 40,000 hospital days. Does it mean that Hospital "A" is doing a better job than Hospital "B"—because of this difference? Would 1929 prove so much more efficient in either institution because of 1,000 additional patient days treated? Would the same hypothesis be assumed in comparing the number of patients treated or the average stay per patient?

Cost accounting demands an accurate determination of institutional costs—preferably classified as to private patients—wards and out-patient departments. Can hospital productivity be measured by per diem costs? Two institutions publish cost figures—$3.75 and $11.50. Is one doing three times better work or is the other three times less efficient? Per diem costs serve better as a means of administrative expense comparisons and in no way is it an accurate check of the kind of service rendered.

Percentage of Occupancy is a means of measuring performance and serves as an index of hospital utilization. There is no question that an institution running at 90 per cent. occupancy cannot possibly handle peak loads—however—it does not necessarily indicate the
patient can not be taken care of in another institution. A hospital of 60 per cent. utilization is by no means conclusively inefficient—it might be doing an excellent medio-social job and it might be farsightedness on the part of the management in anticipating future expansion.

No—Hospital Productivity is measured in its broadest sense by the kind—the type—the completeness, the end results, of the work done and the effectiveness of the medical—social—educational and public health programs in their respective relationship to the individual patient or community. Hospital administration embodies one major performance, the “Care of the Patient,” and it is within the dictates and province of the Trustees and Medical Staff and they alone to define how broad or how limited the word “patient” is to be interpreted and what policies should be adopted concerning community welfare—public health and social medicine in general.

Cost accounting is important—vital—but not all inclusive. It is the responsibility of the trained administrator to differentiate or to set up those invisible lines of demarcation between the administrative-medical and social activities. It is the responsibility of the administration and an important responsibility to point out the accomplishments or the deficiencies of social relationships between the hospital and the community. An article “Can Hospital Productivity be Measured?” by Doctor Corwin excellently discusses this question from the point of view of Hospital Administration, Medical Research, Medical Education, Nurse Training and Social Service.

Hospital service to be truly effective must be “socialized” and this point of view must be inherent with everybody concerned—the trustee—the administrator—the doctor—the nurse—the ambulance driver—the servant. By socialized, I mean to realize that hospital service means more than a bed—a microscope—an operating room—a bill and nasty odors but a well thought out program of community service, including the economic and social aspects of the family—the necessary adjustments in normal society—the need of prophylactive measures and preventive education, and appreciating the existing problem of the convalescent, the senile, the mental, the unmarried mother, the chronic and dozens of other social misfits. This is one viewpoint of hospital policy and it is the duty of the social service worker—the social service department—or whatever you want to call her—to perform the departmental detail—routine—case investigation—for the administration. The function is applicable
in all endeavors—industry calls him agent or contact representative; military, the liaison; government, the diplomat. The relationship in each case is tantamount. I recall a case in point occurring in a middle-sized suburban general hospital.

CASE I

At ten o'clock one evening a woman—38—applied for one night's shelter. She was accompanied by three small girls—10, 8, 5—all showing marked evidences of hunger, fatigue, and lack of personal cleanliness. The woman gave an incoherent history of herself, and of her family relationships and stated she and the children had traveled from California, where her husband was confined in a mental institution and a son confined in a tuberculosis sanitorium. She was seeking a relative in the community, but became confused—tired and sought the hospital. The oldest child, questioned alone, gave a very different history—substantiating in fact the lack of food and fatigue. The intern classified the parent as definitely "psychopathic."

The institution had no detention rooms for psychopathic cases or admission observation rooms for children. The nearest county hospital offering these facilities was some 15 miles away and there were no detention facilities in the community except the police station.

A large room off one of the wards was used and three beds and a cot were furnished. All four were given admission baths—a lengthy toilet and food. There was no social service department and it took four days to determine that there was no relative in the community—that no relatives were in California and the patient and family were legal charges of an entirely different community.

Through cooperating social agencies the woman was committed to a mental institution for observation and the children sent to a children's observation home. The hospital received no compensation from any source—and it was purely the altruistic motive of the institution, and their desire to give social service that prompted their course.

I mention this case to illustrate an example of a socialized institution, without a definite organized social service department.

There is no question that while the underlying fundamentals of hospital organization are the same, the application must be differently applied. There are distinct problems of the municipal hospital as compared to the private hospital and differences of the urban, the suburban, the rural, the mental and contagious institution. It would spell absolute defeat were anyone to try and establish the complete social service organization of a large urban teaching unit to a private suburban institution, without a careful preliminary study of its methods, its approach, its visitation policies, and its interfunctional relationships. The social problems are different, the psychology of the patient, the doctor and the community is different, the community relationship and allied charity agencies are organized and managed with a different method of coordinating inter-policies. I am not criticizing either—I am simply making a distinction in the
economies and the problem of each group and calling attention that social service needs are all important in their individual classifications.

We hear so often that social service can not, need not be applied to the small wealthy suburban community. Is social service only a poor man's benefit? Is medio-social therapy only practiced in the ward or out-patient department? No, the private patient (the chronic, the cripple, the tubercular) often needs the same adjustment, but by different means and through different channels.

CASE II

Some years ago, the mother and sister of a young engineer and ex-army officer, were sent by a local physician to ask what neuro-psychiatric institutional facilities were available for their relative. The patient remained in their car with a private nurse. Without warning, the patient came into the hospital and in a few seconds made short work of any and all available pictures, magazines and electric fans. He was soon quieted and under sufficient 'guard' taken to another institution. When the particular physician was questioned as to why he sent the patient to the hospital instead of personally securing the information, he replied, "You know more about those things than I do. I knew if he got as far as the hospital he would be cared for."

That, at least, showed faith and was far better perhaps, for the family at least, than to resort to the police officials and police conveyances. Is the decrease in private hospital days and a corresponding increase in ward days a barometer of economic conditions and an index to a change in living standards and lowered income? Can unemployment be measured by Free Service and Increased Dispensary Visits? Unemployment must be met by private or public charity and available indices of economic conditions should serve as a signal for charitable agencies. Good hospital service anticipates this and good hospital service is good social service.

Social service, as such, is not new in its relation to hospital administration. It was social service that originally prompted hospital service. In 1821—Matthew Clarkson, a Governor of New York Hospital, gave an address to the public calling the attention of the modern means the hospital employed and then discussed the departmental operations of what seemed very comparable to our present day "occupational therapy." One hundred years has made a difference, however. Doctor Cabot in Boston in 1905, appreciating the significance of improved dispensary practice, developed our modern social service departments. The employment of the first social worker in most institutions is the outcome usually of continuously appreciating
the need and what was everybody’s job was nobody’s job—in consequence the additional worker was added and so on and on. Now we wonder how we ever did without them.

I do not believe that social workers should be called upon to do every job that needs outside attention. I do believe that a social worker (and by that I mean one trained to appreciate the economic as well as the social viewpoint) should take the original history on all admissions. Information concerning cases needing financial adjustment should be referred for approval. By no means should “free care” be “doled” out indiscriminately, or in contrast should hard and fast rules be enforced for payment of the impossible. As this paper is not a dissertation on “Hospital Charges or Payments” it will suffice to say that financial adjustments should not be left to the inexperienced clerk and in every case the initial “investigation” or “house call” should be made by one familiar and in sympathy with both sides of the question. Commercial collection agencies can be and should be employed for the “impostor” and social workers employed for the deserving.

I appreciate that qualified persons are not always available for the salaries smaller hospitals can pay their office staffs. Furthermore, I feel that hospital charges should be rigidly enforced—private service given where private service is due—free service where free service is due and a good sound policy of accounts receivable established, but established along social lines rather than purely commercial practices. Clinic cases should be scrutinized and care given when needed. Again, it is not always the visual poor that need attention—many patients may be respectable—appear “respectable” and still not be in a position to pay outside medical fees. It is the kind interviewer, who knows her job—firm but not too firm—efficient but not too efficient, “professional” but not too “professional” that answers the qualifications of a successful representative of the administration.

In every institution—and especially the community in which there is no municipal hospital, frequent relationships exist between the police authorities and the hospital. The alcoholic, the vagrant, the unmarried mother, the “wounded” prisoner—all need judicial care as well as medical and social care. It is the hospital—the superintendent—the social worker—that stands between the patient and the authorities and each one should exercise his care, his training, his influence in presenting the medical and social findings and recommendations in passing the patient over to their jurisdiction. It is
this inter-relationship—this mutual understanding that means so much to good community hospitalization.

A word concerning the convalescent and chronic. Let me refer to Doctor Boas' paper read in Minneapolis, "The Chronic and Convalescent Patient." How he expounds the label "incurable" and its meaning to the patient, doctor, and society. Let us keep before ourselves, our trustees, and community the need of better convalescent and chronic facilities and let us have the medical staff appreciate the need of increased turn-over in some cases—and prolonged hospitalization in others. The chronic cardio-nephritic—the senile-dementia raise ructions with the intern staff. Let me quote Doctor Corwin in addressing the Pennsylvania Conference last February, "The fact remains that at the present time many of those who are responsible for convalescent homes maintain a negative attitude toward the problem. They don't take a patient with a disturbing cough, or a patient requiring special diets, or patients who cannot make their beds, or patients requiring dressings or persons who are "queer," irrespective of the needs. . . . By this method of negative selection a large number of people who are greatly in need of convalescent care are being eliminated."

A word concerning the unmarried mother and the illegitimate child, a problem in all hospitals maintaining obstetrical services. Will the administration and the various departmental groups appreciate that the service, advice and counsel they render to young women of all types of society will have a direct bearing on the economic and social well being of the parent and a definite, social, significance to the well being and future of the baby.

In conclusion, what is the relation of the social worker and the physician as this relationship affects the administration? Social service offers better case records, better personal histories, it aids in a more thorough physical examination, it labels "danger" signals, it permits better "end results," it fosters follow-up, it reduces hospital days, it provides an increase of available vacant beds. Can more be asked?

Have I asked for an ideal social administration—are my demands academic? Perhaps. Irrespective let each of us strive for better community hospitalization—for a uniformed idea of what good hospitalization means—and what it costs and how its costs are met. Let the children grow up realizing that the hospital is a place ready to answer all their medical and social needs—intelligently and not necessarily for charity. Let the out-patient and the in-patient depart-
ments be organized to include the prenatal—the postnatal—the many preventive and "correctional clinics." In the congested areas foster summer recreation—give class instruction in personal and family hygiene. If patients are homeless—find them a home—if they are helpless—help them—if they are jobless—find them a job. Assist all the agencies in carrying out their individual charities and coöperate and coördinate in your relationships.

Liken the results of your institution to a stone cast upon the waters; realizing the radii of those circles depend—wholly on the force with which that stone is cast. The hospital in any community should be the focal point of community medicine and it is the administration that should reach out to gather together all the factors—all the integral efforts that embody a sound—effective program of public health and social welfare.
THE UNMARRIED MOTHER IN THE MATERNITY HOSPITAL

C. V. WILLIAMS

Superintendent, Illinois Children's Home and Aid Society,
Chicago, Illinois

This article will deal with some of the problems of the unmarried mother. What adequate provision can be made for her care? Can she be restored to her community without being subjected to the ban of social ostracism? Is it possible to provide a technique which will guarantee to her and to her child sympathetic, constructive, and scientific care during this, the most critical experience she will probably be called upon to face.

The problem of today differs from the problem as known twenty years ago. A great many of these girls have come from good families where they have occupied positions of responsibility in the community in the social and religious life of the town of their childhood. When they first discover their physical condition they are desperate. In some cases they are not willing to have the man responsible for their condition apprised of the facts. In other cases when the girl has gone to the man for help he has brutally denied his responsibility or has left the community. She is not willing to take into her confidence any of the members of her family. She will find an excuse to go to a maternity hospital in a great city. She will undertake to convince her friends that she has found employment there. In the isolation of the great city and under an alias she hopes to cover her identity, but the great problem confronting her is the disposition of the unwelcome child.

A great many things may happen. She may find a physician who knows of a childless couple who will never have children of their own and who desire a child for adoption. He may arrange for the child to be transferred immediately to this family after birth. Of course, the physician assumes no responsibility for the things that may later happen.
She may be discharged from the hospital at the end of ten days with the baby in her arms, a stranger in the city and not knowing which way to turn. In this condition she may be served by some well-meaning but irresponsible individual who is engaged in the business of placing children for adoption for a consideration. Or, she may insert in a newspaper an ad stating the case of a mother who needs a home for an attractive child. She may have no difficulty in disposing of her child in a most unfortunate manner. In some of the states the adoption of the child can be consummated without any investigation or delay.

This practice which is so common throughout the country has led to some of the greatest of tragedies affecting not only the child but also the mother and the family involved; for the treatment of the unmarried mother and her child presents one of the most serious problems of the social worker. It can rarely be dealt with satisfactorily in so superficial a manner. Through such procedure the mother is not necessarily permanently relieved of anxiety. There has been a mystery about the entire procedure—she does not know what will happen to her child. She may return to her home with the memory of an act that as a spectre will cause her anxiety for the rest of her life. “Suppose my friends should discover?” “I wonder if my child is receiving proper care?” The “sympathetic” physician or friend has not served the mother because there is no guarantee to her that this informal procedure may not result in publicity which she sought to avoid. In a great many instances the child has not been adequately served. There has been no suitable investigation of the home. The family who has adopted the child may be neither physically nor morally fit. As the transfer of the child has been made with no more care or ceremony than the transfer of a puppy, consequently we have the tragic spectacle of many helpless and defenseless children who are placed with families who will never care for them properly.

Almost every Juvenile Court and child-caring agency that handles any considerable number of children is called upon to make provision for the care of children who have been given away from maternity hospitals by well-meaning individuals to families who have consummated their adoption and who have later practically abandoned them or shunted them from relative to relative not desiring to be burdened with their care.

The family who has taken the child has not been served prop-
erly. There has been no accurate information concerning the child's family background. Some families have, to their great disappointment, discovered that the child whom they have received in good faith develops racial characteristics which make it impossible for him to ever become a real member of the family. Others have discovered only too late that the child can never develop mentally and his ultimate disposition becomes a state institution. Or, in other words, the family has accepted a responsibility which it is not able and which it does not desire to assume. Owing to the fact that the social history is unknown to the family adopting the child or to the court consummating the adoption, there is no guarantee to the adopting parents that the adoption may not at some later date be attacked and set aside due to some legal irregularity—a situation which can be safeguarded only by a knowledge of the social background of the child and his mother.

Some maternity hospitals have so developed the business of placing these children in family homes that the psychological atmosphere presumes illegitimacy itself as a status of dependency. There is no suggestion to the mother while in the hospital that she can make any provision for the child except through adoption.

There are commercial maternity hospitals that advertise their wares throughout the United States. They specialize in the obstetrical work and in adoptions following the birth of a child. They assume no responsibility for consequences because by the act of adoption the family who receives the child must assume full responsibility.

Here we have one of the most tragic of pictures—children given away to people who cannot care for them properly and by individuals who assume no responsibility for their action. For obviously, an unwanted or a maladjusted child cannot be returned to a maternity hospital.

All of the above occasions the observation that the treatment of the unmarried mother and her problem demands a type of service that cannot be given by an inexpert person. It is as great folly for the physician, although a specialist in pediatrics or obstetrics, to presume that that knowledge is sufficient in the handling of so delicate a work, as to reverse the condition with the expectation that the social worker can handle the work of the specialist. It seems shortsighted, to say the least, that any individual will assume the responsibility for the placement of a helpless and impressionable child in a
family home without providing some facilities for checking on what is to happen and for meeting unanticipated eventualities in the event of the breaking up of the home.

I will, therefore, indicate a procedure which carries out the general principles of protection to children which have been recognized in every part of America as minimum essentials. It embodies the platform adopted by the White House Conference of 1909 and reaffirmed in the Regional and Washington Conferences in 1919. It also recognizes the principles insisted upon by the Child Welfare League of America. These conditions are not the product of any one individual or any one association, but have been wrought out of the actual experience in dealing with great numbers of cases.

The unmarried mother should have the service and the treatment of a case working agency. She should be able to have the confidence of an understanding sympathetic woman technician who will secure from her the exact story covering her own family background and help to establish the paternity of the child. She should be shown that the ultimate and accurate legal disposition of the child depends upon a knowledge of the social, mental, and physical factors; that a knowledge of the child's family background is essential to his proper adjustment to a family home, and that the legal status of the child even though legally adopted may be affected by an absence of accurate family history. She should not be forced to a decision while physically and mentally handicapped.

The agency making the investigation of the child's family background should have in mind the determination of those factors which are to be vital to the child's future interests. Agencies all over the country are demonstrating the fact that these investigations can be made confidentially and that there is no more occasion to give unwise publicity to the fact than a physician may give to the treatment of his own clients, and that the records of the case may be preserved and conserved in like fashion.

The agency should inquire especially into the facts to determine the advisability of separating permanently the mother and her child. Later habeas corpus proceedings are rare when this course has been taken. Breast feeding for a period of at least several weeks should be encouraged in most instances. Information should be assembled to determine whether there is any insanity, epilepsy, or feeblemindedness, or other transmissible physical or mental defect in the child's near relatives. It is of further importance that the actual racial
The Unmarried Mother

descent of the child be established. It is of vital importance to the person adopting the child that the social status of the child be established. Has every legal step been taken prior to and at the time of the adoption to prevent a later attack on the ground of inheritance?

During the process of the study of the case the mother and the child deserve inconspicuous and sympathetic care. The child may be placed with a family at board, the mother assuming responsibility. In this she is at times aided by the father. The mother may desire to retain the child. There are remote instances when she will marry the father. This is not to be encouraged unless the marriage be prompted by love and confidence rather than by the sole effort to give the child the name of his father. There are cases when the mother has been persuaded to take some member of her family into confidence and when her parents have been willing to adopt the child or when the mother has later married, having advised her husband of the existence of the child and he has been willing to adopt the child as his own. There is no one set plan, but the ramifications of treatment are many and consequently no disposition should be made of the child until these factors receive consideration.

It is assumed that the alleged father will be seen and that efforts will be made to require him to assume the just responsibility such as facts may demonstrate as wise. In many instances the father, if dealt with squarely, will undertake the care of the child or will provide the needful funds for that purpose. There are instances when to accomplish this end the case will be brought into Court. Also there are some cases when the mother will not provide accurate information concerning the man, but in the great majority of cases this information can be secured.

When it is definitely established that the child needs foster home care away from its own parents the foster home should be selected with just the same care, by an agency certified by proper authority to accept the guardianship of children. This necessitates a personal visit on the part of a trained worker connected with the placing agency. The placement of the child should be on trial—adoption not permitted until after a suitable residence with the family indicates such step to be wise. The study of the family prior to the placement of the child is not merely to discover their fitness to receive a child, but to assist in the adjustment of a child who will be adaptable to their particular home.

And then after the placement and the subsequent adoption of the
child, the organization which is responsible for the placement should assume a continuing interest and should accept at least a moral if not a legal responsibility for the meeting of many of the unanticipated emergencies that may arise in the life of the child. If for any reason the home deteriorates, or circumstances arise that make the child’s residence with the family unwise, the agency which accepts his care and secures his adoption should be willing to receive him back and to render such service as changed circumstances indicate as wise. The agency should never abandon its children.

It has been my purpose, not to present a technical program but to emphasize the fact that crimes are being committed in the name of charity when well-meaning individuals perform the act of social surgery and separate for all time to come little children from their own kin, assuming no responsibility for the preservation of records and permitting the placement of children at times with persons who are unfit for their care. May the “Father of the fatherless” forgive these well-meaning individuals and help them to visualize the multitude of maladjusted children, or neglected children, or unwanted children who are thus unhappily placed and also that great multitude of men and women who are making futile efforts to discover who they are and where they came from, because after they reached their majority the fact has been brought to their notice that as infants they were given away and that no one considered it of sufficient importance to even keep the record of their antecedents. They will carry to their graves the sense of injustice—they are robbed of their birthright.

I am convinced that one of the most important tasks confronting our future state regulating bodies is that which will recognize the rights of these little defenseless children who are so unwisely served by well-meaning but shortsighted individuals.
SUPERSTITIONS AND HEALTH*

JAMES J. WALSH, M.D.

Medical Director of the Fordham University School of Sociology
and Professor of Physiological Psychology at Cathedral College,
New York, N. Y.

Superstition is a very interesting word and two etymologies have been suggested. One of these would deprive it from superstes, genitive superstitis, which means a survivor. James Russell Lowell suggested that superstitions were survivals of opinion left over from preceding stages of human thought, the reasons for which had disappeared. Cicero, however, some eighteen hundred years ago suggested another and undoubtedly the true derivation. A superstition is something that stands over people and keeps them from thinking or at least from thinking properly. While under the influence of it they accept certain conclusions which normally they would probably have refused to accept but the influence exerted over them overcomes their power to think straight.

We are usually accustomed to think that superstitions disappear with the progress of education and that in our time there are very few of them. It so happens that only ten days ago I stopped in a Chicago hotel, twenty stories in height, which has no thirteenth floor. I noticed that the next floor after the twelfth was numbered the fourteenth, so I asked about it and they told me that some people objected to being put on the thirteenth floor, so it seemed better to omit it from the hotel scheme. I mentioned the fact to a friend from Albany and he said that the office building in which he was located had no thirteenth floor. The street on which I live had until a few years ago no number thirteen. There was 12A, but not 13. I understand that there is no vessel of any importance which leaves the port of New York which has a stateroom number 13. I understand too that a number of people object to being placed


272
in stateroom 15 because that would be the room that normally would be numbered 13 and the jinx might be expected to go with it. I was told by one of the elevator boys in Chicago that occasionally someone from the country objected to the fourteenth floor of the hotel that I mentioned because they said by right that ought to be the thirteenth and of course they did not want to be there. That is how spirit and matter clash in Chicago.

I am not sure just where the superstition about thirteen and its unluckiness comes from though it has sometimes been said to be due to the fact that at the Last Supper thirteen sat down, Christ and His Apostles, and hence it is that no one now cares to sit down to table with thirteen, that is with twelve companions. I have seen hostesses in a great stew in New York because having arranged for fourteen one of their guests failed. I once knew a girl of twelve who had been sent to bed early being summoned from her room, dressed and brought to table because after an hour’s wait the fourteenth guest had not appeared. It is from this unluckiness of thirteen at table that the other thirteens have come, it is said, but anyone who thinks that superstitions are dying out with the diffusion of education should look around him and see how many superstitions there are influencing life at the present time. It is easy to laugh at them but for those who are affected by them they are the most serious things in the world. Trifles light as air become weighty as Gospel truth when they come to be superstitions.

Ordinarily superstitions are associated with religion and some people are inclined to think that it is only religious superstitions that affect people deeply. Those of us, however, who are interested in the history of medicine know how many superstitions that are supposed to have scientific authority are constantly turning up. Practically every new development of science of any kind whether physical or psychic is almost sure to be applied to medicine and to produce wonderful good effects for a time and then prove to have no efficacy at all. We have a whole series of cures of this kind that have failed. They are very probably best illustrated by that expression of Dr. Trousseau about the middle of the nineteenth century. A medical graduate who had been a pupil some five years before came to Trousseau at the time when he was probably the greatest living teacher of medicine, and said, “Should I take this new remedy that is curing so many consumptives? They tell me that I have consumption.” And Dr. Trousseau said, “Oh yes, take it now while it cures
because after a while they will find that it doesn't cure and then it won't do any good."

It is rather amusing to go over some of our most modern sciences and see how each new development has produced a state of mind in which people just were quite sure that good results would follow though there was no reason in the world for their conclusion and then they actually got better from the application of it. The science of electricity is a typical example. Every new development being applied to medicine with great acclaim, after a while has proved no use. The first important step in the invention of electricity was the invention of the Leyden jar which we owe to Canon Kleist of the Cathedral of Kammin in Pomerania. That was carried around Europe and produced wonderful cures. Of course the sparks from it were rather surprising things and people who received them felt that they must do them good so a great many proceeded to get better. All sorts of pains and aches in muscles were cured this way, to say nothing of heart aches and stomach aches and other such generic troubles. It is interesting to read the record of these cures in the old books and medical journals because now we know that the Leyden jar does not cure anybody of anything.

Then came the invention of the electrical machine, by Father Gordon, a Benedictine monk. This gave a ready source of electricity by successive sparks and you could stand the patient on a plate of glass and fill him full of electricity, take the sparks out of him in various places and presumably draw out the disease in this way. About that time Franklin discovered that lightning and electricity were the same thing and then the electrical machine got a great new boost as a therapeutic agent. The idea that electricity and lightning were the same just stood over people and made them feel that surely a marvelous power for good was being used on them since lightning in diminished form was flowing through them in this way. Once more many thousands of people were cured. The little electrical machines of those days are smaller than our electrical toys; almost needless to say they had no therapeutic effect, but it was surprising how many people proceeded to get well, most of them rather well educated, because it was not particularly the ignorant who were cured in this way. You had to have some understanding of lightning and of electricity to have the superstition get hold of you. Most of the ignorant people did not think so much of the lightning, they were disturbed by the thunder. Accordingly they did not come under the
superstition quite so much. Ever so many doctors and their wives, professional men, ever so many professors at universities, ever so many teachers, were influenced by this therapeutic superstition and a great many of them were benefited.

That was only the beginning, however, of the use of electricity in medicine though the electrical machine went out of vogue after a while, and they took up another form. This was magnetism. It was felt that there was some intimate association between magnetism and electricity and so magnets came to be used with wonderful success in the relieving of people of pains and aches and disabilities and lamenesses that had lasted for a good while and that defied the best efforts of a number of physicians. We had some rather striking instances of how people can get cured by something that has no physical effect. The beginning of the era of cures by magnets occurred in Vienna about the time that Vienna had the best medical school in the world at the beginning of the third quarter of the eighteenth century. It began with the cure of a chronic case of lumbago. None of the professors at the university could cure it and its cure by a magnet was very striking. Then they cured all sorts of cases, making the magnets in the shape of the various organs that they were meant to affect, heart-shaped and kidney-shaped, ear-shaped and so on. A dear good pastor came up to Vienna from a little town in Bavaria and saw the cures that were made by these magnets, so he took a set back with him hoping to cure a number of old people who were suffering in his parish. He succeeded admirably. Then people from all the surrounding districts began to come to him and then from all over Bavaria. He charged nothing for the application of the magnets but he insisted that people should go to the Sacraments before the application. After a while he found that a number of people were cured without the magnets and by religious influence alone. He proclaimed the interesting doctrine then that disease was not from God but from the evil one and that those who gave up the devil with all his works and pomp would not suffer from disease. This teaching would remind one of the Christian Science doctrine that disease is an error of mortal mind. Good Pfarrer Gassner's teaching was that it was due to too intimate relationship with the devil. Almost needless to say when this doctrine got down to Rome there was something of a rumpus over it. There were too many old cardinals who were nursing ills and ails of various kinds who knew that it was not any relationship between themselves and the devil that caused their ail-
ments and so Gassner was asked to stop his teaching which the old man very promptly did.

Another man besides Pfarrer Gassner went to Vienna and saw the cures by the magnets. This was the well-known Mesmer whose name is destined to be forever famous in the history of medicine. He went back to Paris to practice what he called animal magnetism and he made a great many cures. He was rather an impressive personality and he made a battery consisting of a large tub with bottles and wires and iron filings and people sat around it exposing the portions of the body that were ailing, the ladies being in one room and the gentlemen in another, and while they sat waiting odors of Araby floated through the room, soft music was played and Mesmer came in dressed in a long Oriental robe, with a burnoose, and carrying a wand in his hand. With this he touched the patients on the ailing parts and some of them jumped and some of them went into a sort of trance and some of them laughed hysterically and some of them went into slight faints and had to be supported but all of them felt some better and after a while, that is after a number of applications they proclaimed themselves cured of their ills and ails, though as a rule many physicians had been applied to in vain.

So many cures were made that the French Government offered to buy Mesmer's secret at a very good price and he refused to sell though he offered to give his secret to the physicians provided they would give him one-half of what they received. The physicians declared that there was nothing in Mesmer's cure. A committee of investigation was appointed then consisting of our own Benjamin Franklin who happened to be in Paris as agent for the American Colonies, Lavoisier, the father of chemistry and the discoverer of oxygen, and Bailly, the mathematician and physicist. I doubt whether we could get a better investigating committee now. After three months they proclaimed that there was nothing in Mesmer's cure, no electricity, no magnetism, nothing like animal magnetism though he talked much of it and used to magnetize trees so that people who stood under them came to be therapeutically magnetized and all that. It was not Mesmer himself who discovered what we call Mesmerism but some of his disciples who began the study of what now is known as the hypnotic trance. The French Government refused to allow Mesmer to go on with his work and there came near being a revolution anticipating that which came a little later in 1789. The populace insisted that the French Government had no right to suppress a man
who was healing the people. Mesmer had to give up, however, and it was not for some fifty years later that animal magnetism came back again during the '40's of the nineteenth century.

In all these cases the superstition that a great scientific discovery had been made stood over people and impressed them deeply with the thought that here was a new therapeutic agent and then a number of suggestible people proceeded to get well. The essential difference between religion and superstition and science and superstition in these cases, however, is very hard to recognize. Here, for instance, are two typical instances, one of religious healing, the other of supposed scientific healing, two centuries apart.

During Oliver Cromwell's time, the canny Oliver refused to touch for the king's evil. He was only the Lord Protector and not the king but for centuries since Edward the Confessor's time people suffering from various forms of illness and especially scrofula and certain obscure forms of tuberculosis had been cured by the royal touch. The ailing poor missed the opportunity for this royal healing and so an Irish adventurer who had been a soldier in Flanders set himself up as a healer. He declared that the Holy Ghost had come to him three nights in succession in a dream and told him to go and touch and heal people. It is well known in Ireland that whenever a man dreams of anything three nights in succession, it is surely true, so Greattrakes announced his healing mission. He cured some children by stroking them and then he cured a number of grownups the same way. He is known in history as Greattrakes the Stroker. After a while so many people came to him that all the livelong day was occupied with them. After a while Greattrakes moved over to England and had a great success as a healer over there. The king used to touch the ailing not only free of charge but those whose cases were especially recommended used to receive a gold sovereign at his hands, special coins being minted for that purpose. When Greattrakes stroked, however, he really touched people and the sovereign passed in the other direction. After a while he was detected getting old people to change their wills on condition that he would keep them alive and that was a felony in England and it was only that he was related to the Archbishop of Dublin and family influence was exerted that he escaped being hanged. But Greattrakes the Stroker had cured many thousands of people before this crisis in his affairs came.

The second case a century later occurred here in America. A doctor named Perkins, Elisha, from Norwich, Connecticut, an-
ounced that he had a new curative agent in the shape of what he called tractors. He had been reading some of Galvani's writings on the curious effects that can be produced when the nerve and muscle of a frog's leg are touched by metals in the presence of an electrical machine. Perkins made a pair of tractors out of various metals and putting these in contact at their blunt ends he stroked people. He called it tractoration and cured a great many chronic cases. He sold the tractors for twenty-five pounds, that would be over a hundred dollars in our money, and some of his patients who declared themselves cured had made the rounds of a number of physicians before coming to him. He was expelled from the medical society because they said his tractors represented nothing, but that only advertised him. People came from all over the state and from neighboring states to be treated by him. He went to Philadelphia, then our largest city, while an epidemic of smallpox and also of yellow fever was raging there. He said his tractors would prevent as well as cure disease, he must have forgotten about himself for he took smallpox and died of it.

That would seem to be the end of Perkins and his tractors, but it wasn't. The wife of the Danish Minister to this country was cured by the tractors and she took a number of pairs of them back to Denmark and they cured a lot of people there. It began with a member of the legislature. After a member of the legislature is cured, who would not be cured? It is cures in the families of the members of the legislature, cures by all sorts of funny things, that make it impossible for us to get such medical regulation as will prevent the constant recurrence of quacks and charlatans, and their imposition upon the people. The result was that the Danes fell for Perkins' tractors quite as they did for Dr. Cook and his announced discovery of the North Pole at the beginning of the present century and for several years they thought them a wonderful new discovery in the application of magnetism or electricity or something to human tissues.

Meantime Perkins' son went over to England carrying the tractors with him and the very first week that he was there he cured a duke and a duchess of lumbago and sciatica and after that, of course, anyone and everyone was willing to be cured by the tractors. The English thought so much of them that they erected a Perkinian Institution for the benefit of the poor, so that the poor might have the benefit of these wonderful new ministrations. Young Perkins was a very adroit advertiser. He presented a pair of the tractors to the
Royal Institution and used the letter of acknowledgment—usual after any gift, no matter what it was—as a declaration of confidence on the part of the Royal Institution in this wonderful new method of therapeutics.

We still have the tractors in our medical museums. They are about three inches long and about as thick as a lead pencil at one end tapered to a blunt point, and there is nothing in them that we can find. There is no magnetism, no electricity, nothing at all. The proverbial dead mackerel is very much alive compared with Perkins' tractors and yet Perkins' son declared that while in England he tractorated,—what a nice long mouth-filling word that is,—a million two hundred thousand people. Compare Greatrakes and Perkins. It is very hard to see any difference between the religious superstition in the one case and the scientific superstition in the other. In both cases impressive ideas stand over people and keep them from thinking.

Of course it would be easy to think that in Greatrakes' time when there was practically no common school education, and even in Perkins' time when there was but very little, that the ignorance of the masses brought them to be treated and led to their healing. It would even be very easy to assume that in our day when we have popular education and above all when we have the newspapers as the custodians of our liberties to keep us informed of what goes on in the world, that no such self-deception would be possible and that surely there could be no such delusion. Well, during the twentieth century a practitioner of medicine out in San Francisco named Abrams suggested that he had made a wonderful discovery with regard to the diagnosis of disease by means of electrical currents. He constructed a box by means of which when a drop of the patient's blood was placed in it, the diagnosis of various diseases was made by changes in the electrical tension. Cancer and tuberculosis and other affections were thus differentiated. There was even a curative effect that went with the box in some way. Properly announced in the lingo of the electrical scientists Abrams' box created quite a sensation. A number of physicians used it with a good deal of confidence. Abrams himself insisted that it was a great invention. People to whom it was sold had to sign a paper that they would not open the box. When the owner of one of the contraptions in England died, however, some of his heirs opened it and an electrical expert went over it and found that the wires were wrongly connected and that no
electricity of any kind could pass through the box. The inventor of it died worth over a million and a half, I believe, but a great many doctors not only in this county but in Europe were quite sure that Abrams' method was a wonderful new discovery. I have had thoroughly reputable physicians write to me from England and Ireland inquiring about the inventor and insisting that there must be virtue in it.

Any number of other electrical appliances have been used and we have had electric rings and electric belts and electric medals and even electric insoles. I remember a dear old uncle who had stood on his feet as a clerk most of his life and who suffered from flat feet when he was older, and I tried to help him as best I could, and then he said to me one day that he was ever so much better, and he showed me the reasons. He had a copper insole in one shoe and a zinc insole in the other. He said to me, "You know the electricity flows from the copper to the zinc up one leg and down the other and I feel much better already and I am sure that these are going to do me a great deal of good." He thought that somehow the current of electricity would just take out of him whatever was causing his discomfort and he would surely be better. The persuasion made him feel better at once. After a while he confessed that they no longer did him any good but the electrical idea just stood over him for a while and influenced him very much.

People often say to me, "Isn't it wonderful the way the mind cures the body," and I say in reply, "Oh no, that is not what is wonderful, that is putting the cart before the horse. What is wonderful is the way the mind produces symptoms in the body and when the mind produces symptoms only the mind can cure them." If you concentrate your attention on any part of the body two things begin to happen at once: first, you send more blood to the part, that is produce a certain amount of hyperemia in it and that makes the nerve endings more sensitive than they were before because it vitalizes them. Nature has a definite purpose in this because our attention is usually concentrated on a part whenever we expect anything to happen to it and the making it more sensitive enables us to avoid injury to it. When we go to the dentist, however, the thinking about the tooth that he is going to work on or pull makes it all the harder for us to stand manipulation. In this way even a slight discomfort may be multiplied into a severe pain. We all know that a toothache or a headache that was annoying can be distracted away by a good
play or a good interesting game of cards or above all preoccupation
with some intensely interesting thing, while when we are alone it be­
comes intolerable. Men have been wounded severely in battle when
excitement raged around them and have not known it. Colonel
Roosevelt during his campaign was shot at by a crank in Milwaukee
and the bullet penetrated four inches of muscle just over his heart
and then flattened itself on a rib and he did not know that he was
wounded. He thought that he had luckily escaped. It was only
when attention was called to the dark spot gathering on his overcoat
that it was found that he had been very severely wounded and just
escaped with his life. The pain and shock would seem to have been
enough to tell him, but not in the excitement of the moment. We can
dissipate pain, but then we can also multiply it.

Besides sending blood to the part that makes the nerve endings
more sensitive, concentration of attention on a particular part of the
body leads a great many more nerve cells in the brain to be occupied
with whatever happens in that part. If we have a pain in our little
toe, a few thousand cells in our brain may be told about it normally,
but if there is nothing else to think about, after a while there will be
hundreds of thousands and then even millions, and perhaps even a
billion of cells occupied with that discomfort. Almost needless to
say that will multiply a discomfort that was readily bearable at first
into a torture that is practically unbearable. A great many people
who complain very much of their ills and ails are just multiplying
their sensations which are sometimes scarcely more than physio­
logical into a discomfort—remember that is all the word disease
means—that is extremely difficult to stand.

Under these circumstances if there is something that stands over
us and makes us feel that we ought to get better, we can cure these
ills and ails that come from our overattention to some part of our
body. In some people who are very suggestible there are very defi­
nite tendencies to suffer from what have well been called complaints
of various kinds. They get cured by any of the new superstitions in
medicine, whether they be founded in religion or in science or if not
in physical then perhaps in psychic science. There is often likely
to be something mystical associated with these healing methods.
When electricity was found to be lightning, the idea that the thunder­
bolts of the Almighty were more or less in man's hand, stirred up
many people to feel that here was a wonderful new cure. When
magnetism came in it was discovered that the earth was just a big
magnet, here was another source of persuasion that there was a won­
derful terrestrial agent at work. Some people arrange their beds so that they will be in the line of the currents between the magnetic poles of the earth.

What seems physical therapeutics often proves on investigation to have a mystical element in it. Some twenty-five years ago I had a public controversy in the columns of The Independent, the New York weekly, with dear old Dr. Still, the founder of osteopathy. He lived near an Indian graveyard and became very much interested in human bones. That was the only part of human anatomy he knew anything about, so he got to be sure that all the ills and ails of mankind came from the bones. Hence the name osteopathy, or bone suffering. He was sure that various subluxations of the bones of the spine caused ninety-five per cent. of all the diseases of mankind. He thought that Lister and the surgeons were knaves and that Pasteur was a fool to think that he had found the bacterial cause of disease. There was, however, a mystical element in his teaching. He was sure that this new method of healing had been revealed to him from on High. We have his autobiography and in it are some of the speeches that he made to graduating classes of his. He used to say to his diplomats, as he called them because they were being given diplomas and not degrees, to remember that there was one God, one faith, one baptism and one mode of healing all disease, osteopathy.

I have been dwelling on the physical sciences as the sources of superstitions in healing but there is no doubt that the psychic sciences also furnish grounds for superstition. Ordinarily it would be assumed that psychologists know so much about the human mind that they would not be likely to fall into the error of allowing themselves to be influenced by something that stood over them and impressed them so deeply as to keep them from thinking straight. We have had some very striking examples of the way that the psychologists have allowed themselves to be led astray. A little over a hundred years ago the great belief with regard to psychology was what was called phrenology. It was said that you could tell all about a man's tendencies and his character from the shape of his head and the size of the bumps on it. That idea has come back over and over again and particularly it is noticeable in the criminology with stig­mata of degeneration that Lombroso made so much of about forty years ago. A great many educated people, including professors at
the English universities and our own as well as on the continent, accepted phrenology as a very important contribution to psychology. We have given up all that but for a while it was quite all the rage.

After that we had a period of animal magnetism or neuro-hypnotism, as it was first called, the word being shortened afterwards into hypnotism. We were curing all sorts of things with hypnotism and it did actually cure the chronic pains and aches and the disabilities, the lame backs and lame shoulders and lame legs of the old, just exactly the same class of patients as were cured by electricity and magnetism when they first began to be known. These are the cases that still get cured by all sorts of funny things. All the new-fangled modes of treatment, osteopathy and chiropractic and the rest get their cured cases from this group and acquire a great deal of kudos by the healing of them, for they have usually made the rounds to a number of physicians and people have seen their lameness and heard their complaints and think this new treatment must be wonderful.

In our own day the psychologists presented us with psychoanalysis. This attracted as much attention before the war as phrenology did at the beginning of the nineteenth century and as hypnotism did in the latter half of that century. It was supposed to be absolutely new and hitherto unrecognized. As a matter of fact it proved to be extremely old in all that was useful in it, while whatever was new proved to be fallacious. There is an amusing passage in Miss Agnes Repplier’s life of Père Marquette with regard to the anticipation of psychoanalysis by the Indian medicine men in this country some two hundred and fifty years ago. One of the Jesuit missionaries, Father Jouvencey, who was very much interested in psychology, traced this belief in the influence of suppressed desires in the production of disease symptoms among the Algonquins. He said that these medicine men “believe that there are two main sources of disease. One of these is in the mind of the patient himself which unwittingly craves something and will vex the body of the sick man until he possesses it. For they hold that there are in every man certain inborn desires often unknown to himself upon which his happiness depends.” It is easy to see that here you have the unconscious and the subconscious at work vexing the body of the sick man and then certain inborn desires often unknown to himself, the libido of which we have heard so much, and upon which happiness depends. Here is Freudianism among the Indians in America eight or ten gen-
erations ago. One passage more from Miss Repplier deserves to be quoted: "For the purpose of ascertaining such intimate and ungratified appetites, they summoned soothsayers who, as they think, have a supernaturally imparted power to look into the inmost recesses of the mind." Surely here you have psychoanalysis complete and the medicine men waxed in power and prestige and they came to be powerful in the tribes because of their success in ferreting out the unconscious and subconscious desires and satisfying or sublimating them, or cutting the Gordian knot of the complex or whatever it might be.

Miss Repplier notes that there was only one difference between the practice of psychoanalysis in the old time and in ours. Among the Indians it was the males or Indian braves who applied for treatment and were successfully healed and who, according to Père Marquette, rewarded the medicine men very handsomely; indeed they seemed to think that the more they paid them the surer they were to get entirely well. In our day it is not the men but the women who are treated by the psychoanalysts. The reason for this sex differentiation in patients after two hundred and fifty years in interval is not difficult to find. The Indian braves had seasonal occupations. They hunted at certain times of the year, they fished at others and when there was no war on they had a lot of time on their hands. They had to go to the psychoanalysts to be relieved from the internal disturbance that occurred during their leisure. The Indian squaws, however, had no such trouble. They had to work very hard. It was they who carried the burdens whenever the tribe trekked, it was they who did all the work around the house, it was they who planted and hoed and reaped the corn and they had no time to give to any suppressed desires. If they fell sick there was always the solacing thought expressed so naively by the old Ottawa chief to Père Marquette that it made no especial difference whether they lived or died.

We shall doubtless continue to have our superstitions in medicine until the end of the chapter or until man changes into a very different being from what he is at the present time or until he knows ever so much more than he does in our day. The most interesting feature of superstitions in medicine and the one which doubtless will interest sociologists more than any other is that it is not the ignorant who give vogue to these states of mind in which some idea stands over people and keeps them from thinking straight, but only too often it is the educated people or at least those who have been brought up
under conditions in which they should surely be educated if they had the capacity for it. Gilbert Seldes has recently called attention to the fact in his book, “The Stammering Century,” that the great majority of curious social movements that have taken place in American history and that have been directed to curing either social or physical ills have been able to secure disciples, particularly in New England, from among the descendants of the old English settlers. Brook Farm and Fruitlands in an earlier generation and New Thought in our own are striking examples.

Probably Spiritualism is the most outstanding instance of how a superstition, partly religious and partly physical, can spread. When Dr. Conan Doyle lectured on Spiritualism for a crowded audience at Carnegie Hall, he told us New Yorkers that we ought to be very proud to be New Yorkers. We did not need to be told that but we listened complacently to know why. He said that the three greatest human beings since Christ’s time had been born in New York. They were the Fox sisters and Andrew Jackson Davis, the seer of Poughkeepsie. The Fox sisters at the age respectively of nine and eleven by subluxations of the bones of their feet started the spirit rapping movement which gradually became the spiritualism that attracted so much attention just after the Civil War that there was scarcely a city of five thousand people anywhere in the country that did not have its temple of spiritualism. Andrew Jackson Davis became part of that spiritualistic movement but devoted himself to healing because the spirit of Galen, the old Greek physician, taught him how to diagnose, and Swedenborg, the modern mystic, taught him how to heal. It is a shock now to go back and see what a following the Fox sisters and Andrew Jackson Davis secured. All sorts of educated people came to be disciples of theirs and here is Conan Doyle, several generations afterwards, adducing them as striking examples in mediumship and proclaiming them the greatest people since Christ’s time.

Lest it should be thought that it is only here in America that such things occur, may I remind this audience that there is abundant evidence of similar popular delusions and adhesions in the older countries. Lord Macaulay described the work of Johanna Southcote in London in the generation before the Fox sisters and Andrew Jackson Davis in this country. Lord Macaulay characterized Johanna as “an old woman of no talents beyond the cunning of a fortune teller and with the education of a scullion who came to think of her-
self as a prophetess and soon found herself surrounded by tens of thousands of devoted followers, many of whom were in station and knowledge immeasurably her superior; and all this in the nineteenth century; and all this in London.” A great many of her followers were cured of diseases of all kinds because of their faith in the prophetess and her assurance that they would get better. Poor thing, at the age of sixty she proclaimed that she was to be the mother of Shiloh, the savior of men, but her condition was only dropsy, but even this did not disillusion her following. There are still some followers of hers; she left a casket with sacred writings that was to be opened a century after her death in the presence of a dozen Anglican bishops. Finally it was opened in 1925, but without the presence of the bishops. Nothing was found in it but some incoherent writing.

But what happened in the case of Johanna Southcote in London at the beginning of the nineteenth century happened to Alexander Dowie in Chicago in the twentieth. Hard-boiled Chicago! Man is incurably religious, but he is also incurably prone to allow himself to come under the influence of supposed scientific ideas that keep him from thinking so that he accepts all sorts of conclusions though there is little or no justification in his actual knowledge. Education does not protect him. Nature in this case would seem to mean more than nurture.
Juvenile delinquency of late years has become a question of serious consideration, not because of the mere fact that small crimes are being committed by children, but with the idea in mind that the child of today is the citizen of tomorrow.

There appears to be an apparent increase in the tendencies of children to become criminals in their early years. Some of the States, recognizing this serious condition, have appointed committees to investigate it. Early history shows that criminals were tortured in different hideous forms and at that time it was felt that crime could be suppressed by measures of severity which would intimidate would-be criminals. After failure revealed the futility of this method, the theory was then accepted that imprisonment could be made a legal penalty and at the same time reform law breakers. This gave rise to our method of jails, penitentiaries, prisons, and later to the present probation system.

A number of systems have been devised for the punishment of criminals, one being solitary confinement, with no thought given to its mental and physical effect on the prisoner; another, the isolation of prisoners during the night, and working them in common shops during the day, silence being the rule. Efforts were also made through labor, education and religion to rehabilitate the offenders in an attempt to return them to society. Later, the idea originated that many offenders, both juvenile and adult, could be made law-abiding citizens without the penalty of incarceration in prisons and the like, which gave rise to the present probation system.

At the present time probation is used most extensively by the

*(Published with the permission of the Medical Director of the U. S. Veterans' Bureau who assumes no responsibility for the opinions expressed or the conclusions drawn by the writer.)
States of Massachusetts, New York and New Jersey. Probation is the method by which the community, through its courts, seeks to supervise, discipline and reform offenders without imprisoning them. It is used especially for young or first offenders and others who are not hardened criminals. Those on probation must report regularly to the probation officer, abstain from evil associates and habits, and must work or attend school regularly. The probation system originated in the United States about 1878 in Massachusetts. In 1910 the International Prison Congress met for the first time in Washington, D. C., and adopted resolutions endorsing the indeterminate sentence in the probation system. Congress voted unanimously on this question.

A number of criminologists and judges have recently made the statement that crime is on the increase in the United States. In a recent article a president of one of the State colleges, in addressing the State Legislature, asserted that the United States now leads the world with an unsavory record. Large cities such as New York and Chicago are hotbeds of this crime wave. Criminologists recently made a study of the gang methods, especially in the City of Chicago, and it was found that in all probation cases among juvenile delinquents fifty or sixty per cent. proved failures. In New York and Massachusetts the failures are considerably less. The majority of criminals are among the younger group of individuals. Of three thousand cases studied in the City of New York, ninety-seven per cent. were males. One-half of these were first offenders, and one-half of this number range in age from sixteen to twenty-one. Sixty-three per cent. of these criminals were under the age of thirty-five. Contrary to popular belief and studies made some time ago, it appears that the school knowledge of these offenders is fairly good and that their intelligence tests were fair or better, thus disproving the fact that criminal cases are all mental. Many of these delinquents were unemployed and unskilled. Seven out of ten of these cases had no religion. A great majority of these cases show that broken homes were apparently a contributing factor. Environment probably plays an important part in these cases. Recently a study of 1,300 gangs in Chicago showed that ninety per cent. of these children became criminals. The gang feature is an interesting point and develops more or less from simple ideas of play such as "follow-the-leader." Children normally gang together, secure a leader and start in with innocent playground tricks. In poor sections they congregate about
the railroad tracks, wharves and similar localities. In a great many
cases their first trouble with the law is slight in itself, such as stealing
fruit from fruit stands. They apparently enjoy this adventure with
the law's fracture as the idea of pitting their experience and skill,
youthful as they are, against authority tends to awaken newly dis­
covered wits which, sharpened by practice, lead them into the busi­
ness of robbing freight cars, bootlegging and eventually murder.

People who commit crimes are not necessarily criminals and a
great many persons in corrective institutions are there primarily be­
cause of a crime committed against the law and not because of their
being criminals. In the majority of cases these criminals have not
been studied before entering prison, and after an individual gets the
name of being a criminal with a prison record behind him, reforma­
tion is difficult. He and his family are forever associated with the
stigma of prison and crime. The police are generally watching him,
and if he is in a locality where a crime is committed, it usually means
that he is picked up on suspicion.

The main principle involved in juvenile court work is that chil­
dren should not be held criminally responsible for their misconduct,
but should receive protection, care and training either within or
without an institution and should be segregated from adult offenders.
The Federal courts have not applied this principle. The proceedings
in Federal courts are formal; they frequently include several pre­
liminary hearings followed by grand jury action and public trial;
long delays are occasionally met by crowded calendars, the absence
of continuous session, and the distance of the court from the child's
place of residence. The Federal court has no facilities for securing
social service histories showing the kind of child being dealt with,
his past experiences, or the possibilities of his development. The
Federal court likewise has no provision for suspending sentences,
placing the child on probation and supervising him in the commu­
nity. Frequently during the period of apprehension and disposition
of their cases they must be held in detention, and jail detention is
frequently used by the courts. Here a child under age is held in
jail where he associates and comes in contact with adult criminals;
he is terrified by experiences in prison and if the child is set free,
it is very difficult to eradicate his impressions and it hurts his chances
for normal development into a good citizen. The Federal court con­
siders the delinquent from a different attitude than the State courts.
The juvenile court considers the delinquent child from a protective
point of view in dealing with him. The Federal court considers that a crime has been committed and punishment must necessarily follow. Federal offenses more frequently are apparently the violation of postal laws and regulations. Over ninety per cent. of these offenders are boys. Prior to December, 1916, Federal judges were allowed to use their discretion in placing offenders on probation. The United States Supreme Court ruled that these judges had no power to place offenders on probation except in the District of Columbia where a system of probation was provided. At the present time there is no definite probation system of a real constructive nature authorized by Congress. The records show that some of the cases convicted and committed to Federal prisons are apparently for minor offenses, as brought out in one instance, the case of a boy stealing one quart of milk from a freight car. This child was sentenced to one year and a day for this offense. Another child was sentenced to the penitentiary for shooting craps on a reservation. These offenses, while in themselves small, yet may lead to graver things and if correct probation had been instituted they might have become citizens without the stigma of a jail sentence.

Some States prohibit the placing of juveniles in jail and therefore the Federal courts in these localities, by an arrangement with the local and State authorities, place these cases as Federal juvenile delinquents in detention homes, industrial schools and so forth. At other times the United States Attorneys turn over to the State a child violating Federal laws and there the child is tried, his case being handled under the juvenile delinquency laws. The District of Columbia has a training school for boys as well as one for girls and a large number of children are committed to this national training school where they receive real training. The Federal Government also commits cases to local houses of refuge and other corrective institutions, the Government reimbursing the State for their maintenance. One trouble with this system is that a great many of these institutions receive adult offenders and Federal juvenile cases are not segregated, no provision being made for special treatment and for the care of juvenile delinquents.

The Federal court in Philadelphia used a very workable program with the municipal court of that city, the United States Attorney frequently sending juvenile delinquents immediately after their arrest to a house of detention where these cases were handled by the superintendent of the home acting as probation officer, the child being
placed on probation or discharged, which treatment is similar to the handling of a case wherein a State law is violated. By handling cases in the foregoing manner, more prompt action than is usually possible in Federal courts is obtained. The laws of New York City require that no child under sixteen years of age shall be placed in jail. Children arrested for violation of Federal laws are detained in that city in a home maintained by the New York Society for the Prevention of Cruelty to Children. Confinement of a delinquent in juvenile court does not necessarily mean conviction of crime and does not impose the penalty of a criminal record. In Federal court children found to have committed offenses with which they are charged stand convicted and suffer throughout their lives through disqualification by a criminal record.

Under the Federal law at the present time one of several courses is adopted: imposing penalties fixed by law, although at times there is doubt in the minds of the authorities as to whether or not such disposition is in accord with real justice, or dismissal of the case. Other courses may be carried out not specifically provided for by the Federal law, but where Government employees feel they are approaching better disposition. This lies in the correction and training of the offender and the protection of the community, either by immediate reference of the case to the local juvenile courts handling it as a State affair, or else a sort of informal probation by the Federal probation authorities, keeping the child out of prison as long as he is on good behavior.

Violation of the postal regulations could be materially reduced if the Post Office Department would adhere strictly to the policy that young children whose judgment may be faulty and not fully developed should not be employed in positions where they are entrusted with handling the mails or postal funds. The Federal Government could receive better handling of their juvenile cases if a definite system were adopted with reference to the State courts, preferably at the beginning and before the case reached the Federal authorities, by the establishment of a real workable Federal probation system. Through cooperation with the State courts, the Federal authorities could secure for the children the benefit of special facilities for detention, pending hearing, and intensive study through diagnostic centers for the purpose of giving physical and mental examinations. They could also secure more institutions specially designed for the
care of delinquent children unable to be safely cared for in the community.

Different authorities report various causes for juvenile delinquency. Among these are the decrease in home life, and the apparent disregard of the Eighteenth Amendment throughout the country. A bad impression is left on the formative minds of young children in both poor and better homes observing that their natural protectors and guides disregard this law. Other causes are the automobile affording chances for clandestine meetings, the easy accessibility of community gatherings, motion picture theaters presenting the inferior type of pictures which portray gang warfare, thievery, sex problems, illicit love, suicide, homicides, and similar events. It is generally conceded that children appearing before probation courts for their first offenses are very frequently charged with petty thievery and most of these are more or less mischievous in character. The majority of these cases are boys. The majority of girl delinquents are usually charged with sex delinquency. Mental and physical disorders, environment, and heredity are also contributing factors in delinquency and crime. Nervous disorders causing irritability sometimes lead to acute anti-social tendencies. Children lacking in physical stamina, feeling some phase of inferiority, from these conditions unable to accomplish their ambitions, frequently become morose and irritable. Truancy is the result and this leads to the more serious delinquency problems.

The immigrant plays an important part in our juvenile criminal courts. Of course this especially holds true in the larger industrial centers and sea-coast towns where immigrants congregate. Where colonization of immigrants exists in these localities, the process of assimilation is difficult in the extreme. The immigrant more or less clings to the customs and habits which are in vogue in his native country and with his poor knowledge of our laws and method of government becomes involved with the law. It is generally conceded that the Italians are more liable to commit crime against a person, while the Irish and Jews are more liable to commit crime against property. Housing conditions among the immigrants are deplorable, especially in the large cities. Sanitation and recreation facilities are entirely lacking. Again, a great many of the immigrants come to this country due to misconduct in their own country and the offspring from these are poor and unfit for citizenship.

Mental defectives and psychotics generally respond to outside
influences and unfortunate conditions more easily than the normal person. In studying delinquency we find in a great measure the constitutional psychopathic, mental defectives, and inferior type. Epilepsy is another etiological factor in juvenile delinquency. Dr. Haley of Boston states that epilepsy shows a remarkable difference in its incidence among Chicago and Boston delinquents—5.5 per cent. as against 1.8 per cent. He ascribes this difference a great deal to the fact that for many years there have been special State institutions in Massachusetts that care for epileptic children, so that there is a much smaller percentage of them in the community. The story of delinquency and crime among persons with uncontrolled epilepsy in Chicago is long, tragic and most expensive.

Dr. Healy also asserts that in following up the juvenile cases for a period of ten years, comparatively few of the abnormals have received adequate treatment. For example, of a total of 284 abnormal repeated offenders in Chicago fifty-six who were psychotic were either never committed to an institution for mental disease, or did not remain in the institution, only fifteen so remained, seventy-five with psychopathic personalities were given no special treatment, only twenty-three defective persons remained in institutions for the feeble-minded, one hundred nine were never committed as mentally defective or did not remain in institutions for defectives. Some of these have in the long run been fairly successful, that is, as adults they have had no court records, but some have worked well and have had good family records. The list of failures is, as might be expected, a long one, society paying dearly indeed for its neglect of proper treatment.

Taking 127 mentally abnormal boys recognizable as needing special care, ninety-three have been costly persons, at least six of them have been murderers, sixty-four have been definitely criminalistic, many of them engaging in desperate affairs—there are no more desperate criminals than some of the feeble-minded and psychopathic persons who have been allowed a long start in this direction—the others are the more occasional criminals or vagrants.

Prevention of juvenile delinquency plays an important part. The best method of preventing crime is to start early by a study of children in the early grades of school, through scientific approach, and if the child does commit an untoward act a complete understanding of the problem by a judge who is fair, and placing them on probation status without sentences are steps in the right direction. Sufficient
experimentation at the present time has been carried on, and one is led to believe that identifying delinquents in the early grades can be done successfully. A series of tests have already proved helpful for this purpose. This is given as a group test similar to that used during the war in classifying soldiers. These tests are primarily made to bring out propensities such as slyness, cunning, and traits of this character. The normal child will act as expected, while the abnormal or pre-delinquent child will exhibit tendencies toward crime. A great many times delinquents have not been recognized early and have been allowed to flourish until the seed is well rooted. If a system could be inaugurated in the early primary grades of selecting these special cases, separating them from their ordinary classes and instituting corrective measures, some help could be rendered no doubt.

Removal of the acute social attitude is important. Children incurring the displeasure of the law as a consequence become by public opinion the subject of disgrace and punishment and are isolated, shunned and avoided. The result of this stigma is a resentfulness against the world at large and a hostile attitude toward society on the part of the victim. A proper approach, removing the feeling of injustice, reestablishing his self-respect, and carrying to him a sense of his personal worth, and attempting to instill in this person the desire to obtain the approbation of his associates is extremely desirable. The family, unusually bitter toward the delinquent, must be instructed, as the helpful guiding hand of the family plays a great part in establishing and adjusting the delinquent. His neighborhood conditions, the employment factor, religious observances and recreation facilities require considerable thought and study. The juvenile court with its appendages and its attending specialists in mental diseases has a chance in preventing the development of criminal careers. Formerly children sentenced as hardened criminals, with no attempt made to better their cases, drifted on, while at the present time proper supervision and guidance carries many potential criminals on the straight and narrow path. Schools established throughout the country providing care for these delinquent children with proper supervision throughout the day, not used in any sense as a reformatory, and not under the jurisdiction of a legal officer in any sense of the word, might change a great many in this class. By the time a child reaches a definite reform school he has run the gauntlet of the whole system and generally there is an incorrigible hopeless child to be dealt with. His correction has come at a period too late in his life.
to change his formative mind. If any real hope is held out for these delinquent children, care must be taken early with proper segregation.

We now approach the situation where the child has reached the courts. In the larger cities proper aid could be rendered the judge by having a well organized social service department, probation officers well trained, considerate, and with a complete understanding of these problems, as well as an attending psychiatrist versed in juvenile delinquency. The case history could be presented to the judge in an understandable light, giving full findings worked up by this clinic. A complete mental and physical examination by the psychiatrist, a social service history and findings by the probation officers, social service report showing the child’s environment, heredity, social status, his religious background, factors causing the circumstances of his offense, and recommendations for treatment. His judgment would then be far better in disposing of the case. This picture presented to the judge should contain enough data in diagnosing the personality of the child to give him a clear idea of the manner and appearance of the offender, his carriage, gait, expressions, posture, personal cleanliness, whether he apparently is sincere, whether he is an aggressive or boastful individual, whether he appears enthusiastic or apathetic, forceful, or a self-conscious, timid, or irritable child. Attempt should be made to secure the defendant’s beliefs, his thoughts, moral ideas, any mental conflicts or defects in his school work, his stability, the presence of organic diseases such as syphilis, alcoholism, or insanity, and also if the causes may be traced to a broken home, indifferent parents, or being cared for in some institution, influences harmful in the neighborhood, recreation that has been improperly supervised, or unwholesome, absence of proper religious training, poverty, and defective education. The court psychiatrist very seldom finds the true psychotic among delinquents. A great many times continued delinquency is entirely accidental and at first starts more as an adventure, the child feeling that he is getting away with something, enjoying the thrill of combating law and succeeding, which sweeps him on to a greater and more severe crime, for which he pays the penalty. Sentimentality does not enter into criminology at any time. Safe, sane dealing with delinquent children should be paramount. If we are to succeed with probation, judges and probation officers must have a knowledge of work done by psychiatrists and psychologists with the understanding of human behavior, and must utilize the
treatment of delinquents together with the specialized knowledge of experts.

At this point the judge has placed the child on probation and now a serious problem presents itself. The personality of the probation officer ranks first. He should be selected for his character, ability and training. Complete coöperation of the social agencies in the community must be secured in an effort to surround them with helpful information for probation work and the progress of the system. Immediately on placing a child on probation, the probation officer should interview the child alone, endeavoring to explain the details of probation. Visits to the home should be made frequently, at least twice monthly. A definite constructive outline should be given the child, helpful kindly guidance, and an attempt to secure suitable work or re-establishment of his school work. Interest of employers should be secured and coöperation with employment bureaus maintained. Probationers should be sent to places where proper standards of work are maintained and statements should be obtained from employers willing to accept them.

The probation officer should maintain firm guidance, detect any infraction, and then by a frank discussion of his problems gradually the habits of self-discipline and self-control are increased. Minor lapses are inevitable, and forbearance and patience are required. It is frequently discovered that the probationer's disregard for the conventional habits of life is merely a defense reaction to his isolated feeling. In these cases, showing the individual that he is essential in community welfare eliminates this feature. Little improvement is ever made unless the parents and relatives forget their resentments regarding the person who has brought disgrace to their name. In adjusting the family within itself and also within the community, one must avail himself of the social agencies, community resources, schools, churches and employers. Health problems are also attended to by the probation officer, encouraging them in helpful recreation and educational facilities and securing better sanitary conditions about the home. If the environment and conditions surrounding the probationer are declared unsanitary or undesirable, the officer must endeavor to secure aid through the community resources and establish better conditions in that locality. The cities or villages must be made to clean up these unsightly and unsanitary affairs. Landlords should be made to improve the conditions of the homes and the persons themselves should be encouraged to establish better moral
and hygienic conditions. Financial independence is that of securing proper employment, and then care should be taken to train the probationer in proper budgeting of his expenditures, encouraging habits of thrift. For the most part, these children are lacking in ambition. They have been employed in meager and miserable jobs which provided the bare necessities of life, and unconcerned as to their future, they have spent their money as soon as it was received. Drastic measures are needed. Sometimes by appealing to a child's pride and showing him the success he may attain by increasing his economic and social condition will result in his accumulating property and money. After this step has been reached, improvement is marked. Leisure hours are difficult to handle. While at work his misconduct is more or less slight, but directing healthful, educational, athletic or recreational activities is a far more difficult task than placing him in some occupation. One must secure for him a new outlook on life, changes of his bad associates, and break up the old time habits of the corner gangs. Securing helpful assistance from civic organizations, settlements and clubs is very desirable at this point. The restoration of his social status is no easy task. The family, friends and employers are skeptical and in a great many instances those who have suffered from the depredations of the delinquent present a problem in reestablishing their feelings toward him. Consistent good work on the part of the probationers for a considerable period of time restores these desirable features and if the probationer makes good in his new place of employment and builds up his savings account, reverting back to a normal life, his family, friends and associates are more inclined to accept him on an equal basis. His education should be carefully supervised, studying his deficiencies and requirements should be carefully undertaken, and then schooling given him as far as his capacity and aptitude warrant. The elementary subjects can be given to some, while others can be encouraged in helpful trade schools, studying a profession that is remunerative, while others can be entrusted to take up the higher arts. The institutions of all natures play an important part in this work as all children who defy the law cannot be placed on probation.

Several years ago it was an accepted fact by the majority of social workers that the sooner all feeble-minded were placed in institutions the better society would be served. This was prevented primarily due to the fact that the cost was enormous and no provisions were available. Parole was then carried out as before mentioned and later
experiments of colonization were effected. It is an accepted fact that all feeble-minded people are not criminally inclined and a great many of them carry on in a manner similar to normal individuals. The colonization plan for the higher grade type of defectives can be worked out very successfully, this class working in mills, factories and on farms and receiving a certain portion of the wages they earn, while the remaining portion is utilized for their maintenance and upkeep. The question arises a great many times as to whether or not the habitual offender, the feeble-minded, or the psychotic should be placed on probation. It is apparently the consensus of opinion that effort should be made to induce the courts not to place on probation the definitely feeble-minded, confirmed criminals, inebriates, or drug addicts, as they are a menace to society and unfit subjects on probationary status. They destroy the confidence of the public in this system and lower the efficiency of the probation officers. It is best to eliminate indiscriminate use of probation, overburdening probation officers, having too short periods of probation, and also a lax system of supervision and incomplete knowledge of the offender. For the type of juvenile who is not suitable for probation, as mentioned above, corrective institutions must be maintained.

Habitual delinquents, confirmed alcoholics, drug addicts and mental defectives should be placed in institutions and an attempt made to neutralize their handicaps by constructive treatment. However, it is an accepted fact that good and bad are associated together in prisons and in the majority of cases while there is no hope for the bad, the good ones can be saved, and by placing these two classes together the good apparently have no meritorious effect on the bad, while the bad spoil any chance of recovery for the good. Therefore, in isolating these cases in corrective homes, a great deal of care and thought should be given before committing them.

More care should be given to the method in corrective institutions. A large number of these corrective institutions throughout the country are maintained primarily with the idea in mind of self-support, custodial care, or incarceration. Others have no occupation or recreation activities prescribed for these children. They are housed in rooms bared of home luxuries, reading material is nil, their idle hands cause more mischief, the child follows the line of least resistance, and rapidly passes down the scale. The corrective institution should be maintained as a part of normal home life. Attractive surroundings, plenty of recreation and athletic activities, well defined
H. E. St. Antoine

diversified reading material available, occupational activities throughout the day, with the idea in mind of training them in some helpful and gainful trades, religious services conducted in the same manner, and proper supervision maintained at all times. New York State maintains several of these homes, especially for the care of mental defectives who are unmanageable outside of an institution.

Dr. Branham, Psychiatrist, State Commission for Mental Defectives, New York City, states that this class of delinquents may be kept there for their entire duration of life, regardless of the crime committed. As he says, this may seem rather harsh in theory, but in actual practice the inmate is given every chance to "make good" before final decision is placed upon him. The institution serves the purpose by virtue of this power, of protection to the community from low grade sexual perverts and chronic misdemeants, and easily led habitual criminals who no sooner than they leave the prison are directed into fresh criminal acts by more intelligent accomplices. There are approximately 450 of these inmates at Napanoch, N. Y., now, whose segregation is coming more and more to be recognized by both the legal profession and by individuals as a distinct step forward in the treatment of crime.

Sterilization of both sexes has many advocates and there is considerable merit in this practice. A farmer eliminates at the source all bad stock for propagation as well as seeds for planting. By eliminating the potential source of misdemeants, mental defectives and psychotics, the condition of the criminal situation of this country today may be eliminated to a great extent.

The writer, under the auspices of the Boys' Work Committee of one of the local service clubs, for a considerable period of time has been assisting the local juvenile judge, the probation officer and his department in juvenile work, acting as attending psychiatrist to the probation court. The juvenile cases prior to their appearance before the judge were examined by the writer to determine the mental status of the case, environment, reasons if possible for the delinquency and then recommendations were made to the judge. These cases were followed through their probational period as well as their terms in some of the corrective institutions. The probation officer has only recently been appointed and is now making a very successful campaign in his follow-up work as well as supervision. With the assistance of his social service workers he is carrying out a very fine probational program. The increase in percentage of probational
cases who are proving successes is most marked and the causes of failures are probably due to several features mentioned in other parts of this article, namely, that the child was not received early enough, that funds were not available for proper organization and follow-up, and that the proper supervision in securing adequate employment is not perfected. Also, the State institutions are lacking in proper facilities in many respects and there the child does not receive the proper corrective measures. A great deal of help is expected in the near future by promoting in this State a proper educational program, securing more funds for follow-up and relief work and establishing a better type of institution in which these children will receive more gainful and helpful occupation, recreation, athletics, reading matter, religious and other necessary services.

The main question now presents itself. After the delinquent has passed from the care of the court, the probation officer, or the institutions of restraining influences, what will be the end result? The permanent placing of the individual in the community is the paramount idea of the entire system, and all steps heretofore mentioned were with the thought of returning the individual to his place in the community and rehabilitation. It would be advisable no doubt, after legal termination of this delinquent, to undertake sort of a follow-up or post-probation period. We cannot hope to expect that all delinquents leaving probation or institutions will be successful. As is true with all people who have achieved success, failures are inevitable at some time or other. Therefore, why should we be discouraged with relapses in these juvenile delinquents?

The thought in the above article is not for the purpose of showing the criminal conditions of this country, that the adults of today are worse than at other periods, or that the crime wave is on the increase, but with the idea of attempting to present the thought of reducing potential criminals in delinquent children, or even the pre-delinquent child. If civic organizations and social agencies can reduce this feature of criminal investigation, if they can save a large number of these children in their pre-delinquent or delinquent state, they will have saved just that many criminals and in the future the number of criminals will be materially lessened. Criminals, the maintenance of criminal investigation courts, the cost of maintaining non-supporting reformatories, penitentiaries and corrective institutions will be materially reduced and not only will there be a material gain in economic value, but the moral condition of the entire country will be elevated.
We have been asked to discuss the use of the Medical Social Terminology as published in "Hospital Social Service," March 1927. There has been a good deal of confusion, we understand, as to whether the classification of problems therein is or is not diagnosis. This confusion may be resolved perhaps by an analysis of the diagnostic process itself.

There are three major steps in diagnosis. Let us assume that a preliminary step has been taken, namely, the collection of data, commonly called either the "social study" or the "investigation." With this in hand or in mind, the social worker embarks on diagnosis.

First Step:

The essential here is to recall from the mass of collected data significant facts or factors or findings, or as they are sometimes designated, causal factors. These will be, for the most part, historical, and we may go as far back into antecedent history for significant findings as necessary. In some cases, however, the findings will be "situational" or immediate rather than historical in character, or they may be both "situational" and historical.

The important thing is to select, out of the total mass of information, items of significance for possible problems and possible treatment. These findings may be arranged quite simply in a "shopping list" or in narrative form. A useful device is to arrange them in two groups, positive and negative, sometimes thought of as assets and liabilities. The confusion about assets and liabilities arises, because it is not possible to tell which of these factors are liabilities or how much, until after the plan of treatment is determined upon. In the findings we would probably set down feeblemindedness in the negative column because of its generalized negative or unconstruc-
tive character. In any particular case, however, feeblemindedness may scarcely be a liability at all. It is conceivable that in certain job adjustments it may even be an asset. A woman having her eleventh child would be difficult to classify, either positively or negatively, and still less could we decide whether the fact was an asset or a liability without consideration of the treatment objectives in the case. It is only after the objectives are seen that findings become assets or liabilities— aids or obstacles, dynamic instead of static.

Findings may be also elaborately grouped under physical and mental health, symptomatic behavior, and socio-economic environment. In family agencies they are often classified by individuals and sub-classified in various ways. In Dr. Kenworthy's ego-libido scheme of analysis there are no less than eight classifications for each individual. The main principle, however, is the same—of recalling and arranging in some convenient form significant factors. In general we should say that findings should be as factual as possible and the chief value of the negative and positive conception is that this seems to help project the problems for us as well as supply treatment possibilities.

Second Step:

Anyone who goes through this process of analysis, weighing, balancing, rejecting, and selecting findings, will find that his problem consciousness which has been latent throughout the whole investigation becomes greatly heightened. It is at this level that problems are now discerned for statistical and indexing purposes. It is important that the problems should be named in the same way, that they should be clear, precise, descriptive, mutually exclusive, and standardized. It is because our problem consciousness has been so little developed along social work lines that it has seemed necessary to devise a scheme for defining and delimiting social problems within our area. By using a standard terminology, groups of cases can be indexed, found again, and studied, but the problem level of interpretation has little value for immediate treatment purposes. It should be conceived of as having chief value for research purposes.

One of the main difficulties in our use of the Medical Social Terminology lies in determining what problems are relevant to us and what are the most significant problems. There is no arbitrary way of answering either of these questions. Perhaps the important thing is to avoid if possible a list of problems, and to try instead to de-
termine what are the chief foci of social pathology in this case, and to work from these out to peripheral problems. For the medical social worker one inescapable focus is the medical problem, but the social pathology radiating from this may have considerable area.

Third Step:

The final step is equally important with the foregoing and is essential for treatment. Unfortunately most people do this step mentally and so we are apt to find on the records only findings and problems. This last step is, however, the diagnosis itself, and it should be recorded. It is implicit throughout the foregoing; it should be made explicit in a diagnostic statement. The problem form of interpretation is general and universal; the diagnostic statement gives the special instance of the general condition. The problem form is useful to study groups of cases; the diagnostic statement is useful for the treatment of any particular case. What are discrete problems for research must be interrelated to show the diagnosis of Mary Smith. Confusion arises because in medicine the same terminology is used for general classification as well as the particular statement of the case, but in the present stage of social work practice, and possibly peculiarly in social work practice, we seem to need both problem statement and diagnostic statement for clear understanding.* Cause and effect relationships should be made clear, but it is important to note that in general the diagnostic statement deals with immediate and proximate causes rather than with remote causal relationships. We should expect to find remote causal relationships in the findings. Findings tend to be historical; problems have no time element; but the diagnostic statement should be expressed in the present tense, as the situation looks to the worker at the point of study.

The above discussion represents the logical rather than the actual diagnostic process. In the mind there are not three steps, but a constant interweaving of analysis and synthesis—facts and interpretations of facts. The published Terminology deals only with the first two steps and we believe it is important that we should learn to master the total process. Getting out the factors and then naming the problems is an indispensable discipline, as well as being a convenient way of getting social factors briefly on the medical chart; and beyond that we must experiment with diagnostic statement. Mean-

*For fuller discussion of this see "Functions Report," "Hospital Social Service," May, 1928, Page 477.
while there is plenty of work to do on the more accurate naming of social problems, and we are struggling to get some sort of glossary published in the near future.

**The Diagnostic Process as Applied to a Case**

*H. — S.*

**Findings:**

Patient is a 17 year old high school boy living with his parents and three younger brothers and sisters.

Patient had an amputation mid-thigh following an extensive osteomyelitis; he has had six periods of hospitalization, is underweight and undernourished. He needs an artificial limb, is forced to remain for an indefinite period out of school.

Patient has been depressed and discouraged over his prolonged illness, is keenly aware of his inability to compete with other boys of his age; he is sensitive about being a burden to his parents, is sensitive about his appearance and his handicap so that he will not go out except after dark.

Patient has had much interrupted schooling, is ambitious, and frets over this. The school speaks in high terms of patient’s character and his work, describing him as industrious. The school interest offers treatment opportunity.

Patient’s parents are American born Catholics, hard working practical people with good standards of living, trying honestly to meet the unusual expenses of their son’s ill health. They have an intelligent understanding of the importance of not invalidizing him but are somewhat ignorant as to special hygiene called for.

The home is comfortable and offers good facilities for patient’s convalescence.

The father is sole wage earner with six dependents including patient’s grandmother; the income is about $2,600 a year, which does not allow of unusually heavy expenses, and the family is in debt

---

*The diagnosis should be conceived of as coming early in the whole case work process. In the accompanying illustration the diagnosis was made after considerable treatment had been done, so that the findings appear more selective, digested and interpretive than they would if made when the case was less well in hand. Generally speaking, the more specific findings the better. How similar the findings and diagnostic statement will prove depends in part on the nature of the material studied. Sometimes the findings will present so obvious a picture that the diagnostic statement adds practically nothing.*

**Gordon Hamilton**
because of repeated cost of medical care for patient; there has been additional expense because of illness of patient's father and two of the children; the family are unable to meet the expense of the artificial limb.

**Classification:**
- Locomotion Disability
- Lowered Resistance
- Discouragement
- Hypersensitiveness
- Family Ill Health
- Financial Strain
- School Interruption

**Diagnostic Statement:**

This is the case of a 17 year old school boy whose educational and social life has been seriously interfered with by intermittent, prolonged illness followed by amputation of leg. The boy is sensitive to and discouraged over his handicap, and feels acutely the expense to his family, especially as he is the oldest son and potential wage earner. The family income is not sufficient to bear the heavy medical expenses including the cost of the artificial limb.

(Signed) Florence Harvey, 
Social Worker.
I spoke on this subject at the meeting of Experts of Public Hospital Administration on February 6, 1925.

I presume that this has been the reason why the Congress of the German Association of Hospital Social Workers has asked me to discuss that question again before this committee today. A lively discussion which followed my first lecture brought the following resolution.

The Gutachterausschuss, which is an association of physicians, hospital administrators, members of the municipal administration, etc., and organized on the same principle as the American College of Surgeons, recommends giving more extensive consideration to the question of occupational therapy for the patients of general hospitals, and interesting the physicians of these hospitals accordingly. The Gutachterausschuss is of the opinion that, notwithstanding certain difficulties and considerations, a well organized occupational therapy service would promote the welfare of the patients in the general hospitals as it has already promoted the welfare of the charges of asylums and sanatoria. I am not aware whether there has been done anything of value to make a practical experiment of this resolution in which well known physicians of hospitals and representatives of the administration of hospitals have had a share. Though it has become known in wider professional circles, I doubt that anything has been done to carry it out. As far as I know, three and a half years have passed without the question having been discussed exhaustively at professional meetings or in the national daily press.

The importance of this question, however, as I mentioned the first time, makes it the duty of all institutions connected with the
administration of hospitals, not only not to neglect occupational therapy, but to try to promote it, notwithstanding the difficulties which are doubtless very great. Out of this reason I have welcomed the call which came to me.

In preparation for my statements I addressed a circular letter to a large number of general hospitals, in which I asked them to give their opinion concerning the subject I referred to. I would not attempt to discuss so difficult a problem exhaustively before this group of experts if I based what I said on my own experiences only, though they cover many years, I realize that they are seen from one viewpoint only. Using some fundamental principles of my own, I will give first a few theoretical references and go over then to the practical experiment of occupational therapy in hospitals.

Concerning the occupation of the insane, I go back to my own special knowledge of conditions in asylums which were partly under my care, of those on the outside, and to the literature published concerning them. What has been done in this field up to the present is very satisfactory and promises further success.

Since this is already well known in larger groups, and since this audience also is probably informed about it, it is unnecessary to dwell upon that part of my topic. I will only mention it as a successful example of organizing occupational therapy in other fields. Having no literature on the occupation of patients in general hospitals, I must go back to the replies which I received in response to my circular letter and which were fairly complete, and to my own relatively small experiences in our hospitals. I will also refer to certain professional publications concerning success in Anglo-Saxon countries. Since conditions are different in those countries, this information should be accepted with certain restrictions.

When I faced the material I had before me, I confess that a great deal of optimism was necessary not to lose hope for success in this branch of occupational therapy. I am of the opinion, however, that with good-will and concentration on the work for the welfare of the sick, much can be done in this line. So I hope that my optimism may be justified by the systematic treatment of the question.

I have now to discuss the fundamental principles and will limit myself to a few short explanatory remarks. Out of those fundamental principles the most important facts can be concluded:
1. Occupational therapy for both the physically ill and the mentally ill shall be considered.
2. Occupation wherever it is used, shall be medically prescribed.
3. Occupation when medically prescribed may be of benefit:

   a. To the physically diseased: Renewal of functions which have become inactive by operation, or serious illness, facilitating the return into every-day life. Occupation if medically prescribed, can be of mental benefit in keeping off boredom and depressing thoughts, in eliminating the mental effect of the hospital against work, avoiding discouragement during long periods of illness, rousing the interest for their environment with the mentally diseased, educating them to become socially fit, saving children from lack of mental development.

   b. To the general economic life and the institutions which carry the expenses: Quicker return of the diseased into professional life would save those expenses of charity which are not absolutely necessary.

   c. Occupation is of no natural benefit to the hospitals in general. On the contrary expenses are increased. By introducing new possibilities for occupation, difficulties of administration would arise. To asylums and sanatoria, there would be a certain material advantage by reducing expenses, and in consequence lowering rates, and saving on the budget, and finally improvement in economic conditions by lowering taxes.

   d. Ideal benefit: Decreasing the number of those who are dissatisfied by inactivity, will secure quiet and satisfaction to restless patients and relief to the personnel.

4. In spite of former difficulties, the healing effect of occupational therapy for the insane is now generally recognized. For general patients occupational therapy, as a healing factor, has not been developed so far.

5. In principle most of the directors of general hospitals are convinced of the healing influence of appropriate occupation. But facing the resistance of the patients, and those who carry the expenses, they do not think it possible to make a practical experiment. Where the directors of hospitals refuse by principle, the occupation, this attitude may be partly explained by a certain indifference and perhaps by fear of difficulties which are to be expected.
6. We should approach unprejudiced and without indifference the problem of occupation of the physically ill. It is necessary, therefore, that all physicians and directors of hospitals who do not yet favor the idea, become convinced of the high value of occupation for certain classes of patients, even if occupational therapy would lead to difficulties and expenses for most hospitals. An administration considerate of the welfare of patients and the economic advantages, will not shrink from fulfilling its responsibility for the healing and treatment of its charges by modern methods.

7. Only when physicians and hospital administrations have been entirely converted to occupational therapy, a gradual conquering of the resistance of the population can be approached. One has to realize that concentrated and difficult explanatory work has to be done so as to make the idea a generally recognized one.

8. Resistance exists or must be expected:

a. From legal considerations that occupational therapy would be outside the authority of hospital administration.

b. From those patients who do not believe in the value of occupation and who think themselves only fit for illness.

c. From the relatives of the patients for similar reasons.

d. From those who carry the expenses ("Krankenkasse", "Berufsgenossenschaften," public welfare or community chest) out of the reason given under b, and out of fear that patients occupied by the hospitals might be kept back unnecessarily in order that advantage might be taken of their work.

e. From the personnel who might fear that by expensive occupation of patients some of their positions might be done away with, and who might also fear that by the introduction of patients into occupation, their own work might increase.

f. Of the trade which might fear the undesirable competition.

9. Those different kinds of resistance are to be conquered on one hand by systematic instruction on the general value of occupation in hospitals.

To 8a: And especially by a gradual recognition of occupation as a healing factor, as it has already been done for other medical prescriptions, which would heal. As long as occupation is not generally recognized as a part of the medical prescriptions, an
explanation concerning this treatment might be given in the regulations of the hospitals or under the conditions of admission.

To 8 b & 8 c: By emphasizing the value of occupation for the patient.

To 8 d: Because of the fact that hospitals do not get any advantage from the occupation of the patients, and because of the limited number of the beds they do not wish to keep the patients longer than necessary. On the contrary occupation would result in a quicker dismissal of the patients. It would bring them earlier into normal life and so this would promote the interests of those who carry the expenses. It is desirable that in social legislation, which till now only knows the terms of those, capable and incapable of work, should be introduced a third term, the relative capacity of work.

To 8 e: By the fact that through the little value of work, at least for general hospitals, a diminishment of personnel is out of the question. In asylums and sanatoria, however, where patients do the work for which otherwise personnel would have had to be employed it is obvious that those institutions are not touched by the extension of occupation in general hospitals to which I refer. The present condition in asylums and sanatoria has existed for a long period and the public labor market reckons with it. Here also, a thoughtful direction will carefully avoid exaggeration in the occupation of the insane. When the personnel is afraid of complications of work, they should be reminded that they have legal protection in their contract concerning the work and the wages. That it has to accept certain changes of its work due to the occupation which has to be carried out in the interest of the patients.

To 8 f: By emphasizing that a competition, with patients, working in occupational therapy, even when carried to the greatest extent, is out of the question. If the work done in occupational therapy by patients in general hospitals should compete with the work of the handicraft trades, complaints would have to be rejected as unfounded, as it has been done before out of consideration for the healing power of occupational therapy which has long been recognized by healing institutions. Even an occasional selling of products should not be restricted, if it is necessary to promote the work of the pa-
tients in occupational therapy and if it is limited to the smallest possible scale.

10. When making a practical experiment of occupational therapy of the patients, one has to distinguish between distraction and occupation. To facilitate the introduction of the idea, one should use the word occupation instead of work for any kind of work.

11. Concerning distraction, its value is usually a mental one for the patients, an ideal one for the hospitals, but from which material and physical advantages do not result. It might be considered for all patients, for which the doctor has not prescribed absolute rest. The means of distraction are: A most extensive library of good books, which the patients would enjoy, keeping of amusing and instructive magazines, daily papers, radio with receivers for those confined to bed, loudspeakers for the living rooms, musical entertainments, instructive lectures, readings and movies in asylums and sanatoria, games for adults and children, gymnastic apparatus on which they could not come to harm, group singing, telling of stories, etc.

12. As to occupation the prescription for work and the amount of time be spent on it, should be made according to the patient’s condition. One should avoid an entirely impractical occupation. Patients who stay in bed can in certain cases share in occupation.

Kinds of occupation:

a. Have them do needlework which has been brought by them from home, or quite simple needlework given by the hospital, folding, cutting, pasting of paper, untying of knots in strings, etc.

b. Assisting the personnel in light work, as washing dishes, distributing food, scrubbing, cleaning, polishing the floor, making beds, rolling bandages, as is now done voluntarily by the patients. Bed patients also assist in making hospital supplies. Occupation of carefully selected patients in the kitchen seems to be quite safe. There are no hygienic dangers under continual medical supervision.

c. More independent and skilled occupation under supervision of the personnel would occur in larger hospitals only, as well as in asylums and sanatoria, namely, occupation in sewing of underwear and clothes for the hospital, occupation in office work and secretarial work, gardening, farming, in the various
shops of the hospitals, weaving of baskets and mats, feeding the looms, carrying fuel, in some cases tending the fires. With all due care, one should not be over-anxious in giving occupation to the insane.

13. A special occupation for children during a long period in a hospital would be schoolwork. It has been given successfully in many great hospitals (see Vortrag Dix i: Z. Krk. Hauswes., 1928, No. 7). In smaller hospitals instruction cannot be introduced, because of the small number of children staying for a long period. Besides teaching of the children in Froebelwork, the girls especially should be taught needlework.

14. The selection of the patients and the assignment of the different sorts of occupation should always be measured by the doctor according to the condition. This needs much reflection, and is in hospitals more difficult to select for men than for women.

15. Care should be taken to avoid forcing the patient to occupation, since then the healing effect on the patient would be doubtful. But it has to be expected that gradually the value of occupation will become universally recognized. It is the duty of the personnel including the physicians to influence the patients in question, by insight, tact, and patience, so that they do not refuse medically prescribed occupation. Consideration for the individuality of the patients and for the occupation suitable for them is necessary. The personnel also, if necessary should interest the patient in distracting work and occupation.

16. Though in the general hospitals the number of patients in question for occupation will always be a limited one still, with careful disposition one might give to many of them the benefit of occupational therapy. Those assigned to occupational therapy would be: patients infected with venereal disease especially, the chronically ill without essential physical limitations, patients with small wounds which do not affect the whole condition. Those with leg operations, convalescent tubercular patients, insane with a few exceptions, and so on. Not included would be: patients with fever, the acutely infected ones, those newly operated upon. Patients suffering from the venereal disease should not be employed in the kitchen departments.

17. Since occupation is considered as a medical prescription for physical and mental healing, remuneration should not be given.
In asylums and sanatoria the granting of certain special foods and an occasional increase of portions during heavy work will certainly facilitate the popularity of occupational therapy. Where it is advisable one might give to the patients the underwear which they have made, either without cost, or for the price of the material.

18. For the same reason one cannot differentiate between patients paying their own expenses, and those who are community charges; but one shall have to give certain considerations to the former in distributing the work and in certain cases inspire them to occupation with their own work.

19. In larger general hospitals the assistance of the hospital social worker will be very valuable. Voluntary auxiliary groups, and corporations like the Red Cross, etc., could secure successful cooperation.

20. In considering expenses increased by the occupation of the patients, it would be desirable that the institutions, before mentioned, as well as corporations interested in the extension of occupation and the quickest recovery of the patients as “Krankenkasse”, “Berufsgenossenschaften”, “Fuersorgeverbaende”, and also trade and industry should share the expenses of occupational therapy and so promote it.

21. It has to be considered that in the present state of legislation an accident insurance for the patients does not exist. As long as we have no change of the law, which may come in time, the administration of the hospitals has to stand for all damages by insurance of their own. Experiences of many years, in asylums and sanatoria proves that requests for damage on a large scale are not to be expected.

22. Occupational therapy should be introduced by the government in all institutions. Otherwise there would be danger that patients when able to select their hospitals would prefer those in which occupational therapy is carried on, as people are well aware of the value of occupational therapy as an important therapeutic agent in medical treatment.

I have finished. I hope I have treated the complicated problem assigned to me thoroughly and objectively, though, as I said before, I feel optimistic. Though I am convinced that a productive discussion might bring opinions different from my own, I think that I
might expect more sympathy from this audience than from a group of hospital physicians. I believe that as far as they have had experience with occupational therapy they would consider insurmountable the difficulties which doubtless exist and which they themselves have encountered. Without taking into consideration my efforts to prove the contrary they would keep away from occupational therapy rather than to increase the difficulties of their own position.

Those, however, who are assembled here for the promotion of social science in hospitals, who are not inhibited by former bad experiences and are willing to develop a department of their work which is essentially modern and the importance of which is generally recognized, might approach more favorably this problem of future importance which is opening at present.

Supposing that my plan would be approved of in the following discussion, I leave it to the committee of this union how to use my statements in order to make the idea a popular one in larger groups.

I believe that the introduction of occupational therapy will be assured, if those working in social service will be willing to work for it, and to make it their main object to conquer the resistance of the physicians of the hospitals by practical evidence. But over again I have to say that, with all my optimism, I have no illusions. Step by step only, can we reach the final aim. If by my talk a considerable step has been taken towards this aim, the time which you have given to me and which you will give to the discussion afterwards, will not have been in vain.
A MEMORY
EMMA FORBES WAITE

A few months ago, there went from the M——— Hospital a delicate nine-year-old boy, whose association with us has been so long and so intimate that his story may serve as a sort of abstract of our accomplishment with convalescent children.

The medical aspect of his case has naturally been recorded elsewhere, and the phases of its development are beyond the ken of a layman. We know only that he began his hospital life at the age of three, stretched on a frame, and six years later, limped forth unimpeded by crutch or brace. It is rather in his social and intellectual growth that he presents for us a unique record, and to this growth we have, in some measure, contributed.

“Everett,” as he is ubiquitously called, offered to us, at first, the usual amusement problem of the pre-school child. He learned easily to string wooden beads, and to distinguish letters on blocks. A little later, he acquired the use of pencil and crayon, and his ability to evolve from a stencil an animal or flower form, crudely colored, grew with the months, and has become an intense and lasting interest. Sliced animals and jigsaw puzzles aided in the coordination of hand and brain, and promoted recognition of outdoor objects and animals, with which he was mostly unfamiliar. A further help in this direction were the regular rides furnished by the motor corps.

Through the celebration of our characteristic holidays, he was further connected with the life of a normal school child, and became an authority on past joys of this sort, as well as a prophet of those to come.

Always eager to observe and absorb, he reached the age of seven unacquainted with school authority and regulations. At this juncture, an opportune gift of money enabled us to engage a trained teacher, and in class, as elsewhere, he forged ahead. Being somewhat mature upon entrance, he was able to complete three years in
two, and in his new environment, should enter the fourth grade. An illuminating sidelight on his outlook was his naïve comment on a real school which he was lately taken to visit.

In preparation for his departure, we had our share, as likewise a regretful satisfaction. A new suit, with money for accessories came from our fund, and a package of toys and games accompanied him to another hospital home.
THE HERITAGE CRAFT SCHOOLS

G. T. KIMMINS

Founder and Hon. Secretary, The Heritage Craft Schools and Homes for Cripples, Chailey, Sussex, England

The Heritage Craft Schools were founded in March 1903, and, therefore, have now more than celebrated a quarter of a century of work, so that it is possible to speak from a certain amount of experience. The objective during the twenty-six years of work has been to create a Public School of Crippledom with worthily equipped hospital units; sun and artificial light departments; and all branches of preventive and remedial work.

The Colony is situated around an open common of about a mile in extent, and this same open common provides almost unlimited playing fields for the cripples.

Close by the Girls’ School there is the well-known Sussex Landmark of the Chailey Clump with its tall pine trees, where by the gracious permission of the owner the girls are allowed to play, and as this clump adjoins the spacious grounds of the Llangattock School of Arts and Crafts for Girls, this permission is used to the full both for games and the purposes of an open-air school.

In addition to the Colony at Chailey there is the Marine Hospital at Tidemills, Bishopstone, on the extreme edge of the coast. Incidentally, the Warrene family (now spelt Warren) (so historical in Sussex, for it was a William de Waranne who married William the Conqueror’s daughter, and the name of this famous Norman is thus forever associated with the county town of Lewes) built the Heritage Marine Hospital on the historic beach at Bishopstone on a site near which King Arthur had a castle, and where the Danes landed to maraud and ravage Sussex. Tidemills, too, is intimately bound up with the history of one William Catt, whose experiment in the harnessing of the tides was responsible for a visit from King Louis Phillippe of France.
Thus this remote corner of Sussex can lay claim to history of an unusual interest. There is accommodation for 70 beds at Tide-mills, and extension is being discussed.

At the present moment there are two outstanding features of the Heritage which are arousing widespread interest, and it is to be hoped widespread support. The one is the most interesting piece of research work, which is being carried on in the best interests of “prevention” by the Medical Director, Surgeon Commander Murray Levick, at the Girls’ Heritage, where by the generosity of an American donor, Seymour Obermer, Esq., a clinic for tiny infants has been established with a view to the possibility of establishing this work on a firm basis should the experiment prove successful. That it will be so is beyond doubt, for at the moment of going to press the Medical Director is drawing up a brochure, which will be little short of electrifying to the medical world in its report of the year’s investigations, made possible by this generous donor.

The other outstanding appeal for 1929 is the erection of a worthy building for the housing of the out-patient boys, numbering some 110. At present these boys are still living in old army huts, which are a relic of the Great war. These Kitchener huts, now practically derelict, should be replaced by a building worthy of the other parts of the Colony, and it is confidently hoped that the £25,000 necessary for the rebuilding will be forthcoming, so that the work may be begun at once.

The new building when erected will be the “top stone” or the “crown” of the whole Colony, for the site is unequalled in beauty—commanding superb views over the Sussex Weald, and with unlimited space around. No public school for boys could offer a better site than the one selected for this Public School of Crippledom, with its pointed yew tree and old white windmill (which was unfortunately damaged in the great gale of January 1928, and the restoration of which is included in the rebuilding scheme in the very centre of the county). As the great writer John Galsworthy wrote “The Old White Windmill and Pointed Yew Tree stand as silent guardians of the Heritage Colony,” the foundation of which is the Boys’ Heritage. All other departments have since been added, as occasion offered opportunities.

The curriculum includes the customary elementary and craft work, and in passing it may be said that the special crafts include carpentering, with woodwork in all its branches (of which permanent
specimens can be seen in the great west door of the school chapel of St. Martin; various wooden stairways, and in the gigantic King Arthur table surrounded by chairs made from Sussex oak). Leatherwork of all descriptions is taught, and the latest trade to be added is that of printing, which promises great things for the future.

Perhaps nowhere is beautiful craft work taught and executed at such a high standard as that of silver smithing and metal work in the Boys' Hospital. The children in all conceivable positions in bed, and just convalescent, make, under skilled instruction, the most attractive articles of jewelry and table silver—pewter and copper work is also included in the course. The artistic craftsman in charge of this class has every cause to be genuinely proud of the results obtained. Original work is probably seen here at its best, for most of the jewel work is of the children's own design. Each child has his tiny microscope, with which he examines leaves and other beauties of nature. Visitors to Chailey find much food for thought in these hospital classes.

When in due course the children in hospital are discharged convalescent and take up their lives again at the Kitchener huts as outpatients they are in exactly the right spirit for their craft school proper, having found an occupation during their time in hospital.

The girls are given a complete training in all branches of fine needlework; Domestic Economy, and Housecraft, together with a Nursing and Mothercraft training, which is unique in the history of girls. Ample opportunity is offered, by having the babes in their midst, for particular courses in this subject, which would be impossible without the babes themselves.

Music is a special feature of the entire Colony—and the 300 crippled children are known far and wide as "The Singing Cripples."

To each of the craft schools above described, a hospital and outpatients' department are attached, working in cooperation. Ambulatory cases attending the schools attend the out-patients' department for the treatment which proceeds concurrently with their training.

The hospital wards are specially organised for carrying out to the full the principles of open-air nursing. The climate of Chailey is specially suitable for this purpose. Every child under medical treatment has either real sunlight or artificial sunlight, as a routine measure, until the patient's health is absolutely normal, but the interpretation of the word "normal" at the Heritage is narrow, as the
standard is a very high one. For example—no boy or girl is consid­
ered to be healthy who has not a wholesome weathered complexion, a clear eye and vigorous carriage. This state of health takes a variable time to acquire and of course those who have, for example an active tuberculous focus, or a widespread infection from acute osteomyelitis, may take some years of treatment before complete health is reached.

The average case of infantile paralysis with general debility, ac­quires perfect general health in about a year. The routine prin­ciples of treatment, apart from special surgical measures, embrace the following factors:

Real open air by day and night.
Light to the whole body.
A physiological diet.
Adequate exercise, as far as it can be secured. Medicine from the bottle is a measure rarely resorted to.

The treatment of orthopaedic disabilities is highly specialized. The Consultant Surgical Staff (Mr. R. C. Elmslie and Mr. S. L. Higgs of St. Bartholomew’s Hospital, London, and Mr. E. P. Brock­man of St. Thomas’s Hospital, London) visit the Heritage for op­erative measures as required. All the other measures of treatment above referred to are under the personal direction of Dr. G. Murray Levick, the Honorary Medical Director.

Very special methods for the physical treatment of infantile par­alysis have been devised and it has been specially found that the prin­ciples of constitutional treatment adopted at Chailey have made a great difference to the progress of this crippling disease. It has been felt that this complaint has been regarded in the past too much as a surgical matter and too little as one requiring very special constitu­tional treatment to enable the patient to recover from the shock of its acute onset—a state often lasting for many years and inhibiting the regeneration of nerve fibres that are trembling in the balance between recovery and destruction.

The nursing staff is highly trained and special lectures are given to them on the principles of open-air treatment, light, etc. All the artificial and real light treatment is carried out by the hospital nurs­ing staff, the masseuses being detailed solely to the local treatment of disabilities.
Doctors are always welcome at the Heritage, where there is a great deal to be seen, and Dr. Murray Levick is always pleased to see those visitors from abroad, and especially from America, who may visit England for the interchange of ideas.

Workers are gladly welcomed in the various departments and already visitors have been received from Iceland, Estonia, Switzerland, Greece, Holland, France, and other parts of the world, for short courses of training. Accommodation for the extension of this work is urgently needed, and has been planned for when certain necessary additions take place at the Boys' Hospital and the Girls' Hospital respectively.

It is impossible to overrate the value of this international interchange of ideas.

In conclusion, the whole treatment and training at Chailey can be summed up in the statement that Chailey in England and Leysin in Switzerland march along hand in hand, and that Dr. Augustus Rollier, that greatest of all pioneers, has set his seal of approbation upon the Heritage by several visits, and by sending his own daughters—and nurses—and directresses—for training here, and that the warmest friendship and the closest coöperation exists between the two places.

At this moment of writing His Most Gracious Majesty King George V is now benefiting by the Sussex air—not very many miles distant from the Heritage Colony. The crippled children gladly offered their ambulance to His Majesty, and received in reply a very gracious message from Her Majesty the Queen. It is to be hoped that the magic air of Sussex will heal His Majesty and cause him to be spared to his subjects for many years to come, and that many of his loyal crippled subjects will be given the fullest opportunities in life.
Mental Hygiene today concerns itself both with society as a whole and with the individual.

As a medical art, mental hygiene deals with the mental health of the individual, his intellectual and emotional stability. It stresses the vital importance of one's efficiency, contacts, relations, happiness, and success in life, in the solution of his personal problems, and his adaptation to his environment and to other human beings.

As an organized social movement, mental hygiene aims to promote and preserve the mental health of the community, to bring before the public eye the social and economic waste of mental disorder and to demonstrate the close relationship between mental disease and disorder and industrial and personnel problems, domestic relations, dependency, delinquency, social unrest, and other social problems. It endeavors to emphasize by continued repetition the humanitarian, therapeutic and economic aspects of proper care, and rehabilitation of the mentally ill, feeble-minded, epileptic and delinquent. It aims to give to the people tried and sound information and advice regarding mental disorder, its causes, nature, treatment and prevention.

The mental hygiene movement has stimulated a more careful and intensive study of the whole field of mental functions. It has changed our point of view of mental disorder in many respects, has caused us to explore along new lines and to place the emphasis upon aspects of the subject hitherto given only casual consideration.

The mental hygiene of today views mental disturbance as a failure on the part of the individual to adapt himself to the conditions of life and society in which he lives. It recognizes that man is the result of the whole range of his experience in life, that every act has a pur­pusive value for him at least, and that to understand adequately and intelligently him and his problem it is fundamental that the important elements which have exerted an influence upon his life pattern be known. It does not concede the original pessimistic point of view that all mental disorder and delinquency are due to an hereditary defect
of the germ plasm, but inclines to the doctrine of the multiplicity of causation of these conditions. It believes that maladjustment, delinquency, behavior problems and mental disease do not spring from a single root, but can be traced far back into the early life habits and experience of individuals as insidious growths year by year. It places appropriate consideration upon the hereditary, biochemical and physical bases of life. It evaluates the rôle of diseased processes, maldevelopments, metabolic and endocrine imbalance, native endowment, morphology, fundamental temperament and make-up, psychological types, environmental influences, habit training, discipline, home, social, economic and school conditions. It is partial to no one causative agent. In a word, it views behavior disorders objectively as symptoms of underlying factors and thinks of them in terms of cause and effect.

The mental hygiene approach individualizes every individual and his problem. It demands a broad perspective which is willing and able to take into account all the factors in the individual's life. This broad approach and view of mental disorders and disturbances takes the mental hygienist into provinces, hitherto unexplored by medicine. It is now obvious that the field of mental hygiene is too broad for any one professional group. The result of the separate experience of psychiatrists, psychologists, educators, courts and social workers has been a keen realization of the fact that each group is limited professionally to special phases of the subject of misconduct and delinquency. To be effective, all must join hands in order to be able to evaluate and deal effectively with the various undercurrents and often coordinate factors which reach into the realms of law, industry, education, public health, housing, politics, et cetera. As civilization and modern life become more complex, so do our problems in that the number of factors influencing the organism and his behavior become more numerous and more intertangled. Thus does the field of mental hygiene become more and more one for coöperative study, efforts, methods and a pooling of knowledge.

LeROY M. A. MAEDER, M. D.
NEWS NOTES

A sum of more than $30,000 has been given by American Nurses to complete the wing of the Nurses' Home in the Bordeaux School of Nursing in France. The building was given as a memorial to the nurses who served in the World War, but until this year the wing of the Home has remained unfinished. Hawaii leads the list of gifts from the States, having raised six times its quota.—Pub. Health Nurse.

At the request of President Hoover, the American Red Cross has sent a commission to China to examine conditions prevailing in the famine area.

A child guidance clinic for the study, examination and treatment of patients under 17 years of age will be established in Washington, D. C.

The age of legal marriage in Great Britain has been raised by Parliament to 16 years. Under the previous law a boy might marry at the age of 14, and a girl at the age of 12.

According to a report of the Bronx Committee of the New York Tuberculosis and Health Association 80% of the parents of babies who attend the baby health stations in that borough could not afford to pay doctors' fees for the service rendered by the health stations.

In commemoration of its 10th anniversary the Red Cross Society of Poland has established a School of Nursing in Warsaw.

The question as to whether tropical sunlight is best for tuberculosis patients is to be investigated by physicians in Porto Rico, Jamaica, and Trinidad and by groups of scientists in various parts of the United States and other countries.
The National Society for the Prevention of Blindness states that the number of children entering schools for the blind as the result of ophthalmia neonatorum has shown a marked decrease in the past 20 years.

The Central Welfare Council of St. John, New Brunswick, Canada, has established a family welfare bureau and a social service exchange as the result of a survey of conditions of child hygiene and protection in the Province, made by the Canadian Council on Child Welfare, and financed by the St. John Kiwanis Club.

Health News reports that a resolution passed and adopted by the Public Health Council at a recent meeting, prohibits the sale or distribution of cellulose nitrate (inflammable) film for X-ray purposes after September 1, 1929. This resolution will be effective in New York State outside of New York City.

The New York City Health Department in cooperation with the New York Tuberculosis and Health Association gave a series of health movies in the city parks during the summer months.

Chicago, Ill., is to have a 200 bed hospital for Negroes. The institution will be known as the Pentecost Hospital and will be under the management of the Sisters of the Holy Ghost.

The government of Mexico is conducting a vigorous campaign against alcoholism. An active educational program will be carried on in the Federal and private schools, theatres, amusement places, etc.

Not one case of smallpox occurred in Salvador during 1928, due to the efficient system of vaccination and revaccination carried out by stationary and traveling agents and to the unremitting watchfulness of the Chief of the Bureau of Vaccination. There were 65,949 persons vaccinated and 55,550 revaccinated.—Pan Amer. Union.

An anonymous donor subscribed the full amount of $150,000 to complete payments on the Neurologic Institute building at the Medical Centre, 168th Street and Broadway, New York City. This timely gift “clears the field” for the establishment of a $2,000,000 research endowment fund.
Through its Welfare Activities Commission, the Illinois Elks Association has perfected plans for carrying on a permanent orthopedic program in behalf of the crippled children of the State. Their plan contemplates a survey which will show the crippled children population and the organization of clinics where the patients and family physician may meet with an orthopedic specialist for diagnosis and expert advice concerning treatment.—Illinois Health Messenger.

It has been reported that Frederick Bauerschmidt of Baltimore, Md., has provided a fund of $1,000,000, the interest of which will be divided among 11 Baltimore hospitals for use in the care of patients of moderate means who are desirous of paying but cannot afford the full cost of medical and hospital care. After 20 years the principal will be proportionately divided among the hospitals chosen to disburse the interest.

The name of "Children" The Parents' Magazine has been changed to "The Parents' Magazine." The policy of the publication will remain unchanged.

Harvard School of Public Health is to give a special 4-months course for public health workers.

Indiana University has organized a full-time child-guidance clinic as a result of the demonstration clinic conducted in Indianapolis by the Commonwealth Fund and the National Committee for Mental Hygiene, both of New York. The clinic will care for the child patients in the hospitals of the university who need psychiatric treatment, and for children brought by their parents or referred by social agencies, courts, schools, and physicians. It will have the advantage of connection with various departments of the university for special services, and university students will be able to obtain through it instruction in the theory and practice of mental hygiene and psychiatry.—World's Children.

The Florida Department of Public Welfare has been authorized by the legislature and the Governor to conduct a State-wide survey of Juvenile delinquency and dependency.
The National Society for the Prevention of Blindness has announced that the Leslie Dana Gold Medal for 1929 has been awarded to Dr. Ernest Fuchs of Vienna, Austria, for "the most outstanding achievement in the prevention of blindness and the conservation of vision."

The Catholic Hospital Association of the United States and Canada has moved its general offices and the editorial office of Hospital Progress from 612 North Michigan Avenue, Chicago, Ill., to 1327 South Grand Boulevard, St. Louis, Mo.

The John Edgar Thompson Foundation of Philadelphia has changed its policy of maintaining and educating in an institution to one of care of children in their own homes.

The Illinois State Department of Health held classes of instruction in health and hygiene at the State Fair. Classes were conducted every morning for one week. Many people availed themselves of the opportunity.

The American Public Health Association has announced that the first award of the Sedgwick Memorial Medal for distinguished service in public health work will be awarded in 1929.

In 1928 the City of Seattle attained the distinction of having the lowest infant mortality rate of 54 cities with 100,000 or more population, its rate being 43 infant deaths per 1,000 live births in contrast with a provisional rate of 68 for the birth registration area of the country.

Health News reports that the Board of Regents of the University of the State of New York have advanced the requirements for entrance to registered schools of nursing. After July 1, 1930, 2 years of high school or its equivalent will be required. After July 1, 1931, 3 years of high school or its equivalent; and after July 1, 1932, the applicant must have completed 4 years of high school or its equivalent.

The American Society for the Control of Cancer has announced that The Grand Council of the British Empire Campaign has instituted a prize of £500 and medal with the object of promoting investi-
gations into the nature, causes, prevention and treatment of cancer. Essays embodying the results of original investigations are to be submitted. The prize and medal will be awarded to the one who in the opinion of the judges makes the best contribution toward the early diagnosis of cancer. This award will be known as the Garton Prize and Medal and will be awarded early in 1932.

World's Children reports that the first child guidance clinic in the Netherlands has been opened in the City of Amsterdam. The clinic is patterned after the best child guidance clinics in the United States.

President Portes Gil of Mexico is directing an intensive and extensive campaign against alcoholism in his country.

Following the International Ophthalmological Congress held in September, an international meeting was held at Scheveningen, Holland, to consider the question of preventive measures against blindness.

The work has been commenced on the 14 buildings which will comprise the New York-Cornell Medical Centre, York Avenue and East 68th Street.

The New York State Department of Labor has created a new division for Junior placement. Miss Clara Lewis is in charge of the work.

In order to help along the good work of eradicating diphtheria the Brooklyn Jewish Hospital, Prospect Place, Brooklyn, N. Y., has opened a Toxin-Antitoxin Station.

The State Charities Aid Association News reports that mental disease and associated physical disorders among hospital patients in New York State represent an annual economic loss of approximately $143,000,000. This arresting conclusion is reached by Horatio M. Pollock, Ph. D., Director, Statistical Bureau of the State Department of Mental Hygiene, in a study of the cost of hospital care and treatment, and the loss of earnings by mental patients.
The National Children’s Bureau of Italy plans to introduce in 10 large cities optional anti-tuberculosis vaccination of new-born infants. According to the plan, the registrar of vital statistics in each city will report the births every day to the pediatric clinic of that city. The clinic will then send to the family a circular, with a reply card attached, explaining in simple language the reasons in favor of anti-tuberculosis vaccination in cases where the child was exposed to contagion. If the parents agree, the child is given the vaccine. From that time on the child will be under the supervision of the clinic as long as this is considered necessary for its health. The purpose of the work is to reduce the incidence of tuberculosis among infants and to ascertain more about the nature of the vaccine.

Through Chapter 128, Laws of 1911, New York State created in the City of Buffalo an institution to be known as The State Institute for the Study of Malignant Diseases. The management and control of the institution was vested in a board of trustees of 7 members, one of whom is the state commissioner of health, ex-officio. The purpose of the institution is “to conduct investigations into the cause, nature, mortality rate, treatment, prevention and cure of cancer and allied diseases.” The institution is authorized “to receive in its hospital for study, experimental or other treatment, cases of cancer and allied diseases free of charge.” An appropriation of $65,000 was made for the construction and equipment of a state hospital for research purpose. Provision was made for the publication of the results of the research work.

Through Chapter 48, Laws of 1927, the management and control of this Institute was transferred to the State Department of Health and an appropriation of $120,000 was made for the work. A report of the 1928 activities of the Institute was recently published.

In the education of the public the State Department of Health issues a pamphlet on cancer for general free distribution.—Health News.

The Connecticut State Department of Health employs a full-time psychiatrist in its Bureau of Mental Hygiene.

A cancer clinic affiliated with the Northwestern University has been established in Chicago, Ill. Dr. W. A. Hendricks, formerly of the Mayo Clinic, is in charge of the work.
Hospital Commissioner Schroeder of New York City has announced that each of the 26 City-operated hospitals will be equipped with an ample supply of anti-pneumonia serum and an oxygen chamber by the Fall when pneumonia is more or less prevalent.

The United States Civil Service Commission announces the following competitive examinations: Chief nurse (Indian Service), head nurse (Indian Service), graduate nurse (various services), graduate nurse, visiting duty (various services), graduate nurse, junior grade (various services). Applications for the above named positions must be on file with the Civil Service Commission at Washington, D. C., not later than December 30th. Full information may be obtained from the United States Civil Service Commission, or from the Secretary of the United States Civil Service Board of Examiners at the post office or customhouse in any city.

Canada has approximately 100 automobile camps with first-aid stations. The police in the Province of Ontario are trained in first-aid work and supplied with first-aid wallets.

According to a recent newspaper report an instalment plan has been established by the Chicago Medical Society for the benefit of those who are unable to pay promptly for medical care. The financial arrangement is known as "the modern medical budget plan." Worthy sick people are financed during illness. A financing corporation pays the bills and the patient repays his debt over a period of time according to his ability to pay. This plan savors of the one in general use for the purchase of automobiles, radios, etc.

Toronto University, Toronto, Canada, has established through the Department of University Extension a special course for graduate nurses. The course will prepare nurses for teaching and administrative work.

The annual report of the Transvaal Branch of the South African Red Cross Society for the year 1927-28 indicates that, during the year 1927, the Health Van visited 42 centres throughout the Transvaal, including the gold and diamond mining areas. In this way, thousands of persons were reached and, in the majority of the places visited, Home Nursing or First-Aid classes were subsequently started or
Junior Red Cross links established in the schools. During March 1928, a special malaria tour, arranged at the request of and subsidized by the Department of Public Health, was conducted in North and North-Western Transvaal, 46 centres being visited and 3,900 persons addressed.—Inf. Bul. League, R. C. Societies.

Progress is being made in the organization of the First International Congress on Mental Hygiene, to be held in Washington, D. C., May 5-10, 1930. Educators, psychiatrists, other physicians, public officials, social workers, industrialists and many others from all over the world are expected to be present when the Congress convenes. The President has honored the Congress by accepting the position of honorary president. Already twenty-six countries are represented on the Committee on Organization, of which Dr. Arthur H. Ruggles, of Providence, R. I., is chairman. Dr. William A. White, of Washington, D. C., is president of the Congress, and Clifford W. Beers is Secretary-General. The Congress is being sponsored by mental hygiene and related organizations in many countries. Questions to be discussed at the Congress will include the relations of mental hygiene to law, to hospitals, to education, industry, social work, delinquency, parenthood and community problems. A world-wide view of mental hygiene progress will be given. The subject will be discussed also in specific application to the maladjustment problem of individuals, special attention being probably given to childhood, adolescence and later youth. It is the contention of those promoting the Congress that mental hygiene has to do with the conservation of mental health in general, not merely with nervous and mental diseases. The point of view of clinical diagnosis and treatment will be considered, as well as that of administration of institutions and agencies. Basic expenses of the Congress are being underwritten by the recently organized American Foundation for Mental Hygiene. Opportunity will be afforded for acquaintance among delegates of the various countries, and translations, together with other conveniences, will facilitate comprehension of all that may be said in unfamiliar languages. Administrative headquarters have been opened at 370 Seventh Ave., New York City, where John R. Shillady, Administrative Secretary, is in charge. A membership fee of $5 (including the Proceedings) has been fixed.
Never Say Die

A young man drove up to the Institute for the Crippled and Disabled the other day in his own car, which he controls entirely with hands, because both legs are paralyzed. He drove over from New Jersey to have his braces fixed. He unsnapped his knee locks and sat down in the Director's office for a chat.

He likes to tell how nearly 28 years ago Dr. Lorenz, of Vienna, shook his head over him, a helpless, crippled infant, and said to his parents, "Too bad! It would be better if he would die!" He didn't die but became an awning maker.

Nearly 8 years ago "Thumbs Up" printed a story of Bernard Turteltaub under the caption, "Is he a cripple?" It told of his struggle to get a foothold on the crowded paths of industry. How he accepted from the Institute's employment bureau jobs with long hours and small pay. In his spare time he learned in a friend's shop how awnings are made and then tried his hand at it. From that small beginning he has worked and saved until he has his own business.

Forsaking the crowded city he established himself in the charming New Jersey town of Teaneck, where he has built up a prosperous trade. Besides the pleasure car in which he often makes long tours he has a truck for his own growing business. He has identified himself with the business interests of his community and invested in New Jersey real estate.

So this infant, whom the surgeon said would be better dead, has grown into a substantial business man with a happy family and the respect of his citizens because he had pluck and a "never-say-die" spirit.—Thumbs Up.

Dr. H. C. Chang who has completed a course in social work at the New York School of Social Work, has returned to carry on his teaching work in the Department of Social Work at Yenching University, Peking, China. Dr. Chang and his colleagues at Yenching are developing a training school for social workers in China.

As a feature of the campaign against tuberculosis the Federal Government of Mexico will establish 40 tuberculosis dispensaries throughout the country.
Health News under the caption "Let the Antis Answer This," gives the following interesting vaccination history of 187 cases of smallpox reported to the New York State Department of Health.

Cases 187
Successfully vaccinated within 7 years............ 0
Successfully vaccinated more than 7 years previ­viously .................................................. 18
Never successfully vaccinated....................... 169

BOOK REVIEW


Although the names of Koch and Pasteur stand out in the field of bacteriology, it may be of interest to know that credit for the first recorded observation of bacteria is given to Anton van Leeuwenhoek, who in 1683 constructed a lens powerful enough for him to see and draw some of the bacteria obtained from tartar of teeth.

During the next 180 years or so, the theory that disease was caused by products arising from matter undergoing decay and putrefaction had such a firm hold that there was little progress made in convincing the world of the causal relationship of organisms to disease. Today there are many, and, fortunately, their number is becoming less, who cannot see or think of bacteria without feeling that disease is imminent.

Written for the schoolgirl, this manual contains some simple and instructive experiments combined with classroom exercises which illustrate some of the more homely truths concerning the health and hygiene of the household. For instance, in spite of exaggerated claims regarding the bactericidal virtues of odorous and malodorous solutions, nevertheless it has been shown that the old fashioned and conscientious cleansing with a brush, soap and water is by far the most potent way to reduce the bacteria count to a minimum.

It is not generally known by housewives that one of the simplest, cheapest, and, perhaps, the most practical antiseptic is the sunlight, and the writer's statement—"Sunlight is our greatest bacterial cleanser" cannot be emphasized too strongly, or repeated too frequently. It must be borne in mind, however, that direct sunlight is
the most effective sunlight, that is, the rays of the sun which pour into a household directly and not filtered through window glass or prevented entirely from entering the room by carefully hung drapes and like obstructions.

Thus with the generous use of soap and water, open windows and direct sunlight, the practical housewife has a very efficient agency to assist her in maintaining a healthy household.

Food, a most vital factor to increase one’s resistance against disease, is considered from the viewpoint of bacteria. The author points out the advantages of preventing bacterial decay and putrefaction of foods by such processes as heating, canning and refrigeration. The advice to keep the refrigerator sanitary and fresh is timely, in that this helps to maintain the natural flavor of food.

It is well that special attention is directed to the advisability of washing fruit and vegetables even if they are purchased in wrappers or otherwise seem clean. Following along the same ideas, the writer touches upon bacterial contamination from interchange of personal articles such as lipsticks, handkerchiefs and towels, which are sometimes instrumental in the spread of disease.

Part 2 of the book is merely a laboratory manual for classroom study with illustrative exercises concerned with the elements of bacteriology. Many of the problems are practical, and will, no doubt, serve to intensify the student’s desire to apply science with common-sense in household management.

Samuel Adams Cohen, M. D.


Since the time of the famous Belgian statistician, Quetelet, the fascinating science of demography or bio-statistics has developed. Karl Pearson and his school have given a great impetus to this science by the application of precise mathematical methods. A generation ago, Professor Mayo-Smith of Columbia University published two very interesting volumes; one called “Economics and Statistics,” and the other, “Sociology and Statistics,” in which he presented the then available data in a very interesting way. Dr. Dublin’s book is, to a certain extent, the sequence to Mayo-Smith’s book on “Sociology and Statistics.”
The book contains a wealth of information and is, in fact, an indispensable reference book for anyone interested in social biology or public health. It is based on the original researches and studies which Dr. Dublin has carried on for years as the Statistician of the Metropolitan Life Insurance Company. It is truly remarkable how he and Dr. Frederick Hoffman, the former Statistician for the Prudential Life Insurance Company, have utilized their opportunities for developing a body of science.

When I say that the title and subtitle of the book are not well chosen, and that the book suffers from lack of unity, as all books do which are a collection of essays written at different times for various purposes, I have almost exhausted all the criticisms of the book which consists of fifteen essays. In the reviewer’s estimation, the discussion of the problem of tuberculosis stands out as the most masterful of all the essays assembled here. The reading of it is heartily commended to all public health and social workers, for it supplies the best answer to the biological school of thought in whose judgment the environmental factors play a very moderate part in the results achieved by public health endeavor. It should not be inferred from this that Dr. Dublin does not recognize that race and inheritance have an important bearing on the situation. He stresses the fact, however, that “in spite of the racial limitation, it is entirely possible for any people to modify a natural tendency to a high or a low death rate through the development or neglect of safeguards which hygienic living apparently makes possible.” (p. 106).

The probable reason why the book is called “Health and Wealth” is that it points out, over and over again, the waste that society tolerates because of its unreadiness or unwillingness to use all available resources to prevent the occurrence of preventable disease and to postpone postponable deaths. Preventable disease and postponable deaths cost hundreds of millions of dollars, directly and indirectly, by cutting off economic productivity and by making necessary the costs of care. These have been mounting enormously during the past quarter of a decade. Dr. Dublin points out that this problem “is most acute among the large group of families whose income is over $5,000 a year and under $20,000. This class suffers most from the present organization of medical service and its high cost. . . . These families do not avail themselves of free or inexpensive medical service as do their poorer relations. They are usually charged in accordance with their economic resources. A major surgical operation will rarely
cost less than $1,000 when all items are included. Some leading surgeons charge a fee of 10 per cent. of the year's earnings. The birth of a baby in such a family usually costs the best part of $1,000 when all medical, hospital, and nursing fees are included. Hospital costs are especially high for this group. The use of a private room and special nursing care, together with the other incidentals of hospital treatment, make a total which is often prohibitive.” (pp. 23-24).

A sociologist some years ago suggested the need of social service for people of moderate circumstances. Dr. Dublin favors health insurance as “the best method yet proposed for meeting the cost of disabling sickness.” He believes that there are enough private insurance companies in the United States which are able to conduct this type of business efficiently and economically. Under his plan, the insured would be free to choose his doctor and his hospital, the plan providing for a weekly allowance to meet the costs involved.

Although he believes that the hospital situation, in its economic aspects, is changing rapidly for the better, he shares the view of all students of the problem that the convalescent situation has not received the attention it deserves. Discussing the campaign against heart disease, he stresses the importance of preventing and giving adequate convalescent care to many cases of tonsilitis and sore throat which appear often to bring on rheumatic complications. Rheumatic fever, which has been the arch enemy of childhood, calls for special attention. Sanatoria and convalescent homes can do a great deal in society's defense against heart disease which has become the leader among the destroyers of life, very closely followed by cancer, and other arch enemy of mankind.

According to the life tables worked out by Dr. Dublin, the probability, at the age of 10, of ultimately dying from cancer was exceeded in 1924 only by the probability of dying from three other causes, namely: cerebral hemorrhage, Bright's disease, and heart disease. It ranks fourth among males throughout life; among females it is third in the list of causes of death, being exceeded only by organic heart disease and cerebral hemorrhage. The book is replete not only with data, but also with an explanation of the methods of preparing them and the analysis of the significance of the available bio-statistical evidence.

In the discussion of the problem of old age, attention is called to the fact that because of the notable successes in the reduction of mortality in the periods of infancy and adolescence, a larger percentage
reach middle life. We have not as yet, however, succeeded in making much of an impression on the mortality rate in middle life, and in the period of old age the improvement is almost entirely negligible. In other words, in spite of our conquest made thus far, our chances of arriving at the threshold of old age remain unchanged. The fact that a larger number of people survive until middle life raises the question of adequately meeting the problem of chronic diseases, which is one of the most neglected phases in our social economy and a challenge to society.

All the problems discussed in the book are very clearly presented and make most interesting reading for the average intelligent person. It is to be hoped that the demand for the book will justify periodic republications with all the data brought up to date.

E. H. L. Corwin.

ABSTRACTS


An out-patient department has been defined by Michael Davis as a clinic attached to an hospital, i.e., that division of an hospital which furnishes service to ambulatory patients. A clinic is defined as an institution which organizes the professional skill of physicians and special equipment for the diagnosis, treatment and prevention of disease, or for the promotion of health among ambulatory patients. A clinic is an institution receiving ambulatory patients for diagnosis, therapeutic or preventive service. Keeping the above aims and purposes of the out-patient department in mind the author explains how the social worker fits into the organization, and what she brings to the diagnostic, therapeutic or preventive service of an out-patient department. In the diagnostic service the social worker supplies the necessary information regarding the background of the patient, his personality, environment and the many factors which have influenced his life and which incidently may be a contributing cause or the real cause of his illness. With this social data the physician is enabled to work out a plan for the successful treatment and care of the patient. In the therapeutic service the social worker not only gives the physician a picture of the patient in his home, work and play but she assists him in readjusting the patient by removing obstacles which
stand in the way of a successful termination of the case. The social
service in the out-patient department is the interpreter first of the
client or patient as he is called on admission to the medical institution,
and his needs to the physician; she also interprets the doctor, the hos­
pital and the prescribed treatment to the patient. The medical social
worker in the out-patient department must work in harmony and in
close coöperation with the various community agencies. She must be
able to interpret the social significance of certain physical and mental
conditions to these agencies and obtain their understanding and co­
oöperation in caring for the patient and the patient's family. In the
homes and in the various clinics the social worker has an unlimited
opportunity to preach and teach prevention. In all three services the
social worker aids the hospital, the physician, the patient and his
family by interpreting the hospital, doctor and treatment to the pa­
tient; by enabling the doctor to treat the whole man and by bringing
into activity the various resources of the community with the definite
object in view of restoring the patient to health and preventing future
illness. Whether dealing with individual or community problems the
social worker must be recognized as a valuable and integral part of
out-patient administration.

"Medical Leadership in School Medical Inspection and Health

School health service began in this country in Boston in 1894. Dr.
Durgin, at that time chairman of the Boston Board of Health, placed
physicians in the schools to control an outbreak of diphtheria. The
results were so satisfactory that physicians were regularly assigned to
the schools to control other communicable diseases. In 1895 Chicago
adopted the Boston plan, New York followed in 1897, and Phila­
delphia in 1898. The idea was adopted by other cities until today
school medical inspection is almost universal. In a short time the
program was extended to include examination for physical defects.
From the initial single purpose, the control of diphtheria, school
health service in 34 years has broadened and extended its purpose so
that school medical inspection seeks to deal with the whole child, in
short, it now consists of the practice of modern preventive medicine.
The physician from the beginning has occupied a leading position in
the development and administration of school health service and in
his daily work with school children he touches all phases of public
health and welfare work and works in close coöperation with the homes of the pupils, hospitals, clinics and the numerous relief and welfare agencies. The author is of the opinion that this work demands nothing but the heartiest coöperation and consideration from the medical profession. In school health service there is a wide opportunity for medical leadership as there should be in all health and welfare work. The school physician should seek better compensation for this all important work and for leadership on boards of education in the schools and in the community. The author discusses his subject from the physician's point of view but his desire for better conditions, more extensive work and medical leadership in school work merely emphasizes the importance of this very wide field of preventive medicine. Public health officers, school authorities and physicians in general will find much to interest them in this article which will certainly awaken one to the fact that school health service means community service, a service which the medical profession should support wholeheartedly.


Many controversies have been waged over the authenticity of Shakespeare's claim to authorship, but Dr. White invests him with a new authority and claims that Shakespeare, if not qualified as a physician, at least possessed a fund of medical learning. In fact his knowledge was in advance of the time and extracts from his plays show that he had well defined ideas regarding the circulation of the blood before the epochal work of Harvey was published. Analogy seems to prove that Shakespeare was familiar with the writings of the ancients, Hippocrates, Galen, Paracelsus, etc. Dr. White quotes from over a dozen of Shakespeare's plays and each quotation shows a profound knowledge of the function of the human body and mind. The author claims that neither the oath of Hippocrates nor any writer, ancient or modern, ever expressed the soul of the true physician in words truer than these: "And I can speak of the disturbances" etc., who seeks not "tottering honor or treasure tied in silken bags" but loves the profession for itself, delights in a correct diagnosis and received a thrill when he cures a patient.

"'Tis known I ever
Have studied physic, through which secret art,
By turning o'er authorities, I have
(Together with my practice) made familiar
To me and to my aid the blest infusions
That dwell in vegetives, in metal, stones;
And I can speak of the disturbances
That nature works, and of her cures; which gives
A more content in course of true delight
Than to be thirsty after tottering honor or to tie my treasure
up in silken bags
To please the fool and death.”

Pericles, Act III-2.

The author quotes in full the seven ages of man from “As You Like It” with the comment that even the best endocrinologists of today have not classified the endocrines more accurately than did Shakespeare in the seven ages of man. Those who delight in Shakespeare’s plays, physicians and medical students, will find this article vastly interesting.


“Hearing is health.” It is one of the principal avenues by which one maintains communication with his surroundings. Impairment of hearing is also impairment of health as to desensitize a great field of special sense function narrow the entire field of physiologic responses. Personal health and public health are indivisibly one and the same and public health is as much a social duty as is public education. The function of public health duty is primarily to discover causes and prevent disease. Secondly it runs to diagnosis of the mischievous results of disease causes and their cure. Public health is a new profession and is in the way of being recognized as a distinct calling. Out of the evils of the World War came the realization of the inordinate value of positive health, not restored health, but health as man’s priceless heritage. Among other health problems prevention of impaired hearing has become a public duty. In this great field of health activity the Leagues for the Hard of Hearing are rendering a high order of community service. These Leagues should be enlarged in membership, remodeled in form and provided with adequate support to enable them to encompass this new vision of service. The author advocates
the incorporation policy and give sound suggestions for obtaining membership, budgeting and conducting the Leagues. In some cities the Community Fund contributes to the League's budget, thus definitely recognizing the work as public health work. At present there is no conception of the prevalence of impaired hearing power, of its tendency to progressive increase; of the frequency of its beginning in early life; of the extent of the handicap it lays upon the victim. The author brings out forcibly the fact that to prevent deafness is a social and public health duty. Special attention to it should be given to the young, as childhood is the period which seems to present the gravest danger of impairment of hearing; therefore in children, as is true in all phases of social and public health work, will be found the most fertile field of endeavor.


Twenty years ago there were few recognized and formally organized hospital social service departments in the United States and Canada. There are now approximately 600 social service departments scattered from Montreal to San Francisco. Under present conditions no service department is self-supporting. The fact that the number has increased so rapidly goes to prove that there must be a firmly established belief that the hospital social service department is an asset to the community and therefore worthy of support. There is a reason for this belief in social service. The hospitals dating back hundreds of years and rendering recognized services to the community have an established background. Social service is new but has proven its value. Medical research, wider knowledge in regard to causes of disease and the practice of preventive medicine have brought about many changes in the hospital management. The hospital no longer merely cares for the sick. The reason why a patient is ill, what has caused this illness and how to prevent a recurrence are matters of deep concern alike to hospitals, doctors and the community. With this new interpretation of hospital practice, the social aspect of disease became an important factor. The social worker concerns herself with obtaining social data which will assist the doctor in diagnosis and treatment. She makes treatment and recovery possible by adjusting social conditions so that the patient can receive full benefit from his hospitalization. The hospital social service workers rôle is not confined
to medical interpretation alone. She comes in contact with every human problem. The social data which she gives to the physician frequently aids him in making an obscure diagnosis. The work of a well trained and understanding social worker should react favorably upon the patient, the hospital, the hospital staff and the community. The social worker desires to be accepted as a valuable part of the hospital body and from indications her desire will be fulfilled. The author touches upon training and qualifications for the work but the profession is new, and a proper technique has not been worked out. The true function and technique of social work will undoubtedly be fully established in the near future. In the meantime the value of social work is fully recognized.

**TelephoneNumber Gramercy 2137**

**Hours Daily Except Sunday:** 9 A.M. to 5:30 P.M. — Saturdays 9 A.M. to 5 P.M. — Summer Months, Saturdays 9 A.M. to 1 P.M.

**HERMANN MUELLER, Inc.**

Manufacturers of
TRUSSES, BELTS, ELASTIC STOCKINGS, CRUTCHES, ARCH SUPPORTERS, BRACES, SURGICAL CORSETS, Etc.

343 Second Avenue (S. W. Corner 20th Street) **New York**

**SPECIAL RATE TO SOCIAL WORKERS**

**LADY ATTENDANT** Joseph F. Victory, Secretary

**IF YOU ARE INTERESTED IN CALIFORNIA**

and what nurses are doing in the far West, you should read their magazine, *The Pacific Coast Journal of Nursing*. It publishes the nursing news of California as well as stimulating articles on the problems and activities of modern nurses. It should be read by everyone interested in nursing.

**PRICE, $2.50 A YEAR.**

**THE PACIFIC COAST JOURNAL OF NURSING**

609 Sutter Street  **San Francisco, Cal.**