THE SOCIAL SIGNIFICANCE OF THE VENEREAL DISEASES

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I value the privilege of discussing the correlation of social with medical aspects of this problem because in a long experience both in medicine and public health administration I have observed the necessity for carefully planned team work of this character. I have made a series of notes which I hope will serve as a general basis of the discussion your chairman wishes to lead to a consensus of opinion on this topic.

In such a group as this I assume we do not need to spend any time on the venereal diseases as a broad social problem. Similarly, I think everyone in this group understands the many-sided attack which must be made upon syphilis and on gonococcus infections if we are measurably to reduce their morbidity and mortality rates. In the symposium last week I summarized these measures under the following four headings:

I. Measures for the location and control of sources and carriers of infection.

II. Measures for reduction in the number of contacts and in the liability of infection developing after exposure.

III. Measures for elimination of environmental and other conditions favorable to transmission of the spirochaete and the gonococcus.

IV. Measures for promotion through character-building influences and agencies of knowledge and control of sex as a factor in human life.

Each of these groups of measures comprise varied and difficult
activities which require trained resourceful personnel and studied adaptation to each community.

We are now concerned chiefly with the hospital social workers' part in this broad field. As with the physician so with the social worker, the measures in the first and second groups mentioned are of chief concern. We must discover cases, secure adequate treatment and get in touch with persons having intimate contact with the cases discovered. We must also arrange for isolation of infectious cases, or their quarantine if necessary, to protect others until they may become non-infectious or are no longer a source of disseminating their infection.

Some cases are discovered through patients themselves realizing that they are ill or may be infected and applying for advice and diagnosis. Other cases are found through examination of food handlers, of barbers and similar operators, and applicants for employment, entrance examinations for the Army, Navy and colleges, for admission to lodging houses and other public institutions, and for numerous other purposes. The study of case-work of a large charitable agency has shown that venereal diseases were a physical problem in from 8 to 9 per cent. of all their families. In all such studies sex delinquency, feeblemindedness, family desertion, illegitimacy and other complicated social conditions have been large collateral factors.

With diseases of such character, complete and coördinated treatment is vital. Especially must this point be stressed when we realize that both the medical and the social problems frequently involve the whole family. Dr. John H. Stokes, who is one of our greatest syphilologists, has summed up the functions of social service for a Syphilologic Clinic in his recent treatise on "Modern Clinical Syphilology." He says: "The hand-in-hand development of social service and follow-up has transformed the modern syphilologic clinic, and it is no exaggeration to say that without adequate provision for them a clinic for syphilis exists only in name. The functions of social service include in most clinics:

1. The holding of patients to regularity in treatment and their return for periodic observation.
2. The house-to-house follow-up of delinquents.
3. The instruction and control of the infectious patient.
4. The bringing in of the family for syphilologic investigation and treatment.
5. The industrial and social rehabilitation of the handicapped and incapacitated.
6. The moral rehabilitation of salvagable human material among the derelict, including work with the juvenile delinquent, the prostitute, and other groups.
7. The financing of the expense of treatment for the patient."

"The effectiveness of well conducted follow-up is not in doubt. The Solomons at the Boston Psychopathic Hospital secured the examination and attendance at the clinic of 78 per cent. of the relatives desired for examination. The Boston City Hospital, by a five months' operation of a simple follow-up system in 1918-19, changed the complexion of its attendance from 80 per cent. who failed to receive adequate treatment, to 75 per cent. who did. In striking contrast, the Lewinski-Corwin investigation of 14 clinics in New York City in 1920 showed that in 5 clinics which had no follow-up system only 20 per cent. of patients received as much as a year's treatment."

This excellent and concise statement applies practically with equal force to gonorrhea. It applies also to what ought to be done in all private practice cases and as a follow-up of all hospital cases which have not gone through such a process of study in a clinic.

Adequate follow-up systems unquestionably add to the effectiveness of the medical work concerning these diseases. It has been demonstrated repeatedly that the percentage of women and children returning to clinics after follow-up is greater than in the case of men. This is a challenge to us to perfect our methods of approach and appeal to the men.

Home visits are of great value in dealing with women and children; but present a difficult problem in the case of men.

The personnel means almost everything in treatment and follow-up of venereal disease patients. Where physicians, nurses and social workers are considerate, efficient and recognize this class of patients as worthy of adequate treatment just as all other diseases are treated, the patients feel that they are recognized as individuals and human beings and are eager to come. Where the viewpoint is held that one case kept by the clinic is better than many lapsed cases returned the attendance records are high. This observation applies equally to private practice, although we have little data. Many studies of clinics show that a majority of them have no real follow-up system
or operate it only half-heartedly. The postcard notification plans, the one-visit system, the report of lapsed cases to the health officer, are all good in theory but usually weak in practice. Little is done to bring other members of patients’ families to clinics or physicians for diagnosis. What the employment of even one trained social worker may do has been demonstrated many times; as for example in the Trenton, New Jersey, venereal disease clinic when the average at-
endance was increased in a short period from 132 patients to 226 by one worker.

I wish to add two other points for consideration. First, a word regarding qualifications and training for hospital social workers. If they could have the benefit of a professional nursing course before

COBINED DEATH RATES FOR SYPHILIS, LOCOMOTOR ATAXIA, AND GENERAL PARALYSIS OF THE INSANE, UNITED STATES, ENGLAND AND WALES

The registration states of 1900 included 40.5%, the continental registration area of 1927, 91.3% of the estimated population. Death rates in the 1900 area continuously through 1927 are here indicated.
beginning their work it would be of great advantage to the patients and the public, just as health officers benefit by being graduate phys-

DEATH RATES PER 100,000 FROM SYPHILIS AND ALLIED CAUSES

Combined death rates from syphilis, tabes dorsalis, and general paralysis of insane persons 25 to 64 years, by color and sex. Industrial Mortality Experience, Metropolitan Life Insurance.
icians, although their work is not medical practice in the ordinary sense.

However this may be, hospital social workers must have a good general education, a knowledge of sociology and of people and their ways, and an unusually large fund of common sense and resourcefulness in meeting emergencies with sound decisions.

Finally, I wish to say a reassuring word regarding the progress which is being made. The question is asked so frequently, "Are we getting anywhere?" and so frequently answered by, "I don't know," that I believe we should include consideration of this question. The diagrams on pages 188, 189, 190 have been included to show the trend of such data as is available. Personally I believe we are making real progress in getting both syphilis and gonorrhea under control.

In conclusion may I register my opinion that the next great contribution to the combating of the venereal diseases will come from the perfecting of our social service follow-up methods and the provision of ample and adequately trained personnel for application of these methods to private as well as clinic and hospital practice.
THE SECOND GENERATION OF THE CHINESE*

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The subject assigned to me is "The Second Generation of Chinese-Americans as an Asset to the Community." In an attempted evaluation of this nature, one must be prepared to give its liabilities as well as assets, and not only these two items, but also a little of their historical background. To cover so much territory in a brief space of time must mean that this discussion be very general and fragmentary.

Let us dwell a little on the early Chinese that first came to America. Almost all of them were from the Province of Kwongtung. This is of great significance to those who are acquainted with China. Kwongtung may be said to be the most progressive, the most restless, and the most westernized of all the provinces of China. As early as the sixteenth century, it had carried on trade with the Dutch. Tide after tide of Mongolian conquest from the north never did quite penetrate this hardy province. Furthermore, it has always been a hot bed of political refugees, reformers, revolutionists, and adventurers of all kinds.

Just what was the status of these early Chinese? By vocation, they were predominantly artisans, farmers, and sailors. There was of course, the expected sprinkling of scholars, merchants, and professional men, this being especially true of the later waves of migration when the Chinese here began communities of their own. I think it is safe to say that they belong to the average middle class, with certain outstanding merits and defects of their own. As will be pointed out later, in so thickly populated a province as Kwongtung, it is difficult for any but the fairly capable to maintain a foothold. Again, it should not be forgotten that it took initiative and courage

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to cross the mighty Pacific. Some Chinese even came in native sailing vessels. As a group then, they were characterized by being more adventurous, more enterprising, and more energetic than the average. They had little capital and most of them were young and unmarried.

Almost all had but one desire, that of making money quickly and then returning home, a situation somewhat analogous to the rush of the gold-seekers to the Yukon. Hence but few of them came with any intentions of starting permanent business or industries here.

Most of them did return to China. Some, failing to make their fortunes, did not return, and died here without leaving descendents behind them. Some stayed, and not only stayed, but brought their wives. The reasons for this move were varied. Some stayed because they had yet to make their fortunes, some, because they had no prospect, were they to return to China; some stayed simply because of inertia, some because they were already blessed with children, to whom they wanted to give a little of the Western education; some stayed because they actually liked this country and were contented to have their homes here. From these people the second generation of Chinese-Americans trace their origin.

The second generation here is certainly a study. In their minds is staged a mighty conflict of cultures. To them goes the task of deciding on standards. On them we depend for the welding of the East and the West. They are responding by leading a truly double and romantic life of the Orient and the Occident. They study Chinese and speak English, admire Confucius or adore Jesus, like Chinese literature, art and festivals, but dance to American music, and motor, hike, and attend theaters as do the Americans. Never before had they experienced a change in their racial history more dramatic, more drastic, and more significant.

In evaluating the worth of this group, we might approach the subject from an eugenic and a social standpoint, although I am well aware that any such division is highly arbitrary. Nevertheless for convenience we might consider them first as individuals, and from a biological viewpoint, and then as a social unit, from an economic or sociological viewpoint.

From a biological viewpoint the Chinese strain is at once unique and interesting. The United States, whether we wish it or not, and whether for good or for bad, is a highly heterogeneous nation, incorporating in its vein, almost every conceivable shade and color. The addition of this dash of Chinese pigment to the palette is,
whether from an artistic or utilitarian viewpoint, well worth the experimentation.  

As a racially old stock contrasted with a racially new stock they have many interesting peculiarities. A doctor once told me that even their diseases differ. It seems that as an old stock they have acquired immunity to such afflictions as influenza and pneumonia. Structurally they are less given to ruptures, appendicitis and diseases of malformation. As a race they have fewer cretins, idiots and hydrocephalic offspring chiefly because of the long weaning or shifting process. They are less adventurous, less exuberant, but also more settled, more poised, and less given to such fanatic outbursts as characterized the Crusaders of Medieval Europe.  

The Chinese as a representative of an old racial group is noteworthy. As such they exhibit many desirable traits. For example, they are less given to drunkenness. Their early history is replete with instances of excessive drinking, but as they neared the modern era, the reckless drinkers appear to have been pretty well eliminated from the race. They have great capacity for endurance, great survival values. They could be found working in Alaska or Siberia in the dead of winter; they could be found thriving in the tropical heat of Java or the Malays. They exist on a few pennies a day and under condition that would kill off all but the most hardy. They are also able to stand wealth and luxuries, and the four thousand years of civilization failed to wipe them from the earth. If literature is the criterion of one's racial mental prowess then the Chinese literature, whose output is the greatest of any nation even up to the eighteenth century, is a fair indication of the Chinese mind for scope and depth of thought.  

They also have many desirable traits which are partly social and partly individual; traits which the Western World is only now beginning to appreciate. First of all, they have learned to be tolerant. They will tolerate evil, public nuisance, injustice, and even intolerance with a great deal of forbearance and realization that human nature is not perfect. That is why, although all of the great world religion is represented in China, there is no religious war or intolerance. In fact, many of the religions become merged with each other shortly after reaching Chinese soil. The Chinese have the patience to stay with a good idea till it blossoms or to endure a bad one till it withers.
They maintain a well-knit, well-organized family life, a family life which is based on love and respect for the elder or more experienced members. To the Chinese to maintain a harmonious and prosperous family is at once a duty and a source of inspiration. Government may change, and nations may crumble, but the Chinese family remains intact throughout these times. As individuals they have attained a philosophy of life which gives them poise and balance. They face frustration and adversities with the same calmness and steadiness as they do success or good fortunes. There is in them philosophical attitude which leaves no room for mad rush or neurotic fumbling.

They have developed a fondness for art and learning which is akin to religion. Their scholars are given the same recognition as an official, and a higher standing than a member of the priesthood. Indeed, their officials secure their posts only by way of competitive examinations, an institution which they established in the first century of the Christian Era. The Chinese expects of their learned men that they write with the style of an artist, and lead life with the spirituality of a divine. Morality, art, and learning are one to the Chinese, and artists, priests, and scholars cannot lead compartmental lives one apart from another.

They have learned to be honest, at least as a policy. A Chinese merchant will extend credit by years where a Westerner will reckon by months. Like Herodotus they have taught the world how to write history from an objective, impartial view. Despite all their admiration for Confucius, for example, they have not deleted a single line descriptive of what is not complimentary to him.

They have learned to be democratic without leveling their peaks. The writings of a scholar may smell of the classic, but in conversation the scholar and the man of the street are one. For there is only one spoken language, the pakwa, or the tongue of the men on the street. They are loyal to their governing body or sovereign until these are proven unworthy of their trust, whence they are removed in quick order. Local self-government is developed to such an extent that in times of turmoil, towns and cities can take care of themselves peacefully without any municipal ruling body. They are also peace-loving. The present internal conflict and frequent hostile attitude does not blind us to the fact that in all their recorded history they have practically waged no aggressive war. They have learned
to be frugal yet generous, practical yet spiritual, steady yet energetic, and democratic yet appreciative of superior merits.

From a sociological viewpoint the Chinese here are a decided asset. They have introduced into this country many Oriental products which enrich our living. Chop suey, chow mein and fuyoung are well known to the epicureans. Chinese lanterns, vases, gowns, furniture, and embroideries are made known to the Americans chiefly by the Chinese here. They have made the communities in which they live more colorful. The Chinatowns of Seattle, Portland, and San Francisco are measurable assets which the Chambers of Commerce and business organizations are fully aware of. Historically the Chinese here have contributed greatly to the building of the West. Their labor built railways, mined ores, and cultivated orchards. It is true that the Chinatowns of the past were characterized by tongs and gamblings and "ways that were queer." But it would be strange for any camp of pioneers, predominantly males, not to have their gambling and vices. Where the sex ratio is as high as several hundred to one certain social evils are to be expected. Furthermore, you cannot limit the vocational opportunities of any group of fairly capable people to just a few menial jobs as housework and janitoring and not expect some of them to make their money by some illegitimate means. The most enlightening sign is the rapidity with which these vices disappear as condition improves. As example I might cite cases of tongs turning into employment bureaus when jobs are more plentiful. Countless instances of sons and daughters of cooks and laundrymen attending universities or taking up arts are also indicative.

These Chinatowns, or rather, Chinese communities, serving as stop-over stations for traveling students and merchants, have greatly increased travels to the United States. They are also important means of increasing American trades abroad. The dozens of Chinese publications in this country are distributed all over the world, wherever Chinese are found, and the advertisements include many American products. The Chinese returning from America, needless to say, are instrumental in spreading American good-will, American ideas, and American products.

The Chinese people here serve as an introduction to a true understanding of the East. One cannot talk with a Chinese cook or a Chinese merchant and not feel that he is talking to a representative
of a race which has digested four thousand years of history as no professor can digest them, and who have, beneath their calm exteriors the integration of all human experiences and longings. Their presence has aroused curiosity as to their history, religion, and philosophy. They created an interest in things Oriental. They create an awareness that there are people on the other side of the Pacific. They supplement the scientific realism of the West with the humanistic realism of the East. And finally, as hinted earlier, they furnish to America a minute strain which from a biological viewpoint is wrought with possibilities. For whether they are aware of the fact or not the truth is that the Chinese here are slowly but gradually and surely being merged into the great American common-wealth.
A MODIFIED SPECIALIZED SANATORIUM REGIMEN*

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Hospitalization of every active case of tuberculosis in the United States would necessitate an increase of 500 per cent in sanatorium and hospital facilities. There never has been and never should be a sufficient number of sanatorium beds to care for every case of tuberculosis. The cost of providing hospital accommodations and service for every case would be prohibitive and, furthermore, the results achieved would not be commensurate with the expenditure.

In the registered area of the United States in 1927, there were 87,567 deaths from tuberculosis. Figuring on the basis of five active cases for each death, a basis which will underestimate rather than overestimate, we may figure that there are at the present time in the registration area of the United States, 437,835 active cases of tuberculosis. There are, on the other hand, at the present time, available in this country only 72,723 tuberculosis beds. Consequently, with 72,723 beds for 437,835 tuberculous patients, we are faced with the conclusion that after each bed is filled there will still remain 365,112 patients who must of necessity be denied sanatorium treatment. To care for this surplus in sanatoria would necessitate, as stated, an increase of sanatorium and hospital facilities by 500 per cent.

In greater Chicago we have available for tuberculous patients approximately 2,500 beds. There are, we estimate, approximately 20,000 cases of active tuberculosis in Chicago. Consequently, with 2,500 beds for 20,000 cases, it is apparent that there are in Chicago 17,500 tuberculous individuals who, owing to lack of hospital or sanatorium facilities, can not receive institutional care. To meet this

* Read before the Twenty-fifth Annual Meeting of the National Tuberculosis Association.

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surplus of 17,500 patients, our local sanatorium accommodations would have to be increased at the ratio of 800 per cent.

These figures make it evident that the sanatorium never has been and never can be the sole answer to the tuberculosis problem. It is physically impossible and financially inexpedient to attempt to hospitalize every active case of tuberculosis during the entire course of the disease. *In what way, through what series of reforms can the sanatorium, as an institution, be made best to subserve the needs of the public welfare?*

I use the expression, "series of reforms" advisedly. Most of us today are convinced that the great municipal tuberculosis institutions are not administered in such a way as to give the best possible return on investment and expenditure. In many of the municipalities, unfortunately, the idea seems to prevail that the public tuberculosis institutions are hospitals for the far advanced and hopeless cases, that the bed capacity is limited, that the patient in residence has priority and rights of domicile and is entitled to remain in the institution for indefinite periods. In other words, the two hundred, four hundred, or thousand patients in the sanatorium are reaping the entire benefit of the institution; the ten thousand tuberculous individuals in the community outside, with the same social and economic rights, are denied even a pretense of institutional care and treatment.

This is manifestly unjust, is poor economy and poor public health practice. An institution which is designed to serve all the taxpayers in a community should not be restricted to the few who through good fortune manage to gain admission and who, through poor management, are allowed to remain for indefinite periods. To do the greatest good to the greatest number a definite program of constructive reform must be applied both to the sanatorium service proper and to the field service.

Attention to detail, concentration of effort, intensification of study, acceleration or speeding up of activities and constructive innovations will answer the problem in the sanatorium. A patient will receive more benefit from a three months' stay in a sanatorium in which he is subjected to active, scientific treatment than he will from a two years' stay in a sanatorium in which indifference and passivity are the keynoting themes.

First consider the time-honored triad—Rest, Fresh Air and Food. The proper observance of these three considerations constitutes a large proportion of satisfactory sanatorium routine. It is important, in the
first place, that the patient during his period of residence in the in-
stitution, be given to the full the advantages of rest, fresh air, and
food. It is, in the second place, of still greater importance that the
underlying physiological principles on which the routine of rest, fresh
air and food are founded, be so inculcated into the patient that, when
he leaves the institution he will be qualified to plan for himself a
program of living in consonance with his impaired physique.

The patient, even in a short sanatorium stay, can acquire a good
knowledge of the automaticity of living and of the regularity of habits
that are essential in extra-sanatorium life. The maintenance of satisfy-
factory sanatorium routine demands unremitting vigilance and a
supervision that includes every individual that is responsible for even
the smallest detail of sanatorium regimen.

Absolute rest should be enforced when absolute rest is indicated.
In the average public institution patients who should be on absolute
rest are semi-ambulant and deprived of the advantages of complete
rest owing to the fact that they are assigned minor or part-time duties
in connection with the routine of the institution. Through a policy
of misguided economy patients who need complete rest are assigned
to the short shifts at room cleaning, bed making, tray handling, mes-
senger service, etc. The comparatively unimportant and necessarily
inefficient service which such patients render is quite manifestly a loss
rather than a gain.

The patient deprived of the complete rest which his condition in-
dicates, spends a longer time in the institution at the expense of the
taxpayer and indeed, in many instances, probably loses his only chance
of recovery. The spectacle of a consumptive needing rest forced out
of bed for a couple of hours daily to wait on another consumptive, is
incongruous and illogical; it is a saner and a sounder policy to hire
competent and adequate help to the end that the patient needing rest
may be put back to bed where he belongs and kept there.

In line with this principle, every patient in our infirmary division
was put on absolute rest and additional paid help hired to attend to
such details of service as previously were rendered by the patient
help. As a result exercise, when indicated, was established on the
basis of a medical prescription. It was no longer loosely measured
by the yardstick of irregularity and largely unsupervised work. Exer-
cise, under our new plan, procured through the medium of vocational
training, is carefully prescribed, regulated and supervised by the med-
ical personnel.
We believe that this policy of enforced, absolute rest in indicated cases has been, to a considerable degree, instrumental in shortening our average sanatorium stay and in increasing our turnover. The comparatively small sum expended for additional paid help is more than balanced by the improvement to the individual patient and the shortening of the period of sanatorium residence.

At first glance one is inclined to think that the problem of fresh air in the sanatorium itself should offer no difficulty. In this matter, however, attention to detail is again necessary. The definition of fresh air does not imply cold, physical discomfort and dissatisfaction.

We have made a very definite effort to give our patients the advantage of fresh air without the disadvantage of physical discomfort. Nurses and employees are designated to pass from room to room and porch to porch to make certain that windows are kept open, that the temperature is satisfactory, that the patient does not have to tax his strength in opening or closing windows at dressing or feeding intervals. The increased comfort consequent to this routine has considerable influence in elevating the patients’ morale and in promoting mental satisfaction.

The chemistry of the body, in its various reactions, is to a large extent dependent upon the intake of certain compounds contained in the dietary of the individual. There is no question that bacterial life, tissue growth and destruction are, to a large extent, dependent upon the chemical reaction consequent on tissue metabolism.

Medical science is on the eve of great discoveries; these discoveries, the speaker thinks, will indicate the dominant rôle of dietary in tuberculosis. It will be found that not only the basic protein, carbohydrate and fat constituents but, in addition, the vitamins and the mineral quotients, in their proper balance, contained in food substances, will be determined as the most important factor in healing of the tuberculous process. Furthermore, diet along these principles will be found, we believe, to be the most powerful influence in building up resistance to tubercle growth and development in pre-tuberculous and contact cases.

For the present then, a good institutional dietetic plan presupposes first class quality in the food, scientific preparation of the menu by a trained dietitian, painstaking preparation and cooking under the dietitian’s supervision and cleanly and efficient service. In our institution we think it good economics to buy first quality food, irrespective of price. We have two thoroughly trained dietitians to super-
vise menu preparation. We have recently installed electrically heated carts and speeded up our service system so that the food is served to the patient on the porch and in the room practically as hot and as appetizing as when it leaves the ovens.

Having assigned due significance and importance to the time-honored triad—Rest, Fresh Air and Food—we next study the question as to what type of institution best serves the interest of the community.

The old-fashioned institution serving merely as a rest haven for incurables is, of course, severely limited both as to scope and possibilities. The patients, owing to lack of equipment, personnel and facilities, can not receive the specialized care and skill which they, in some instances, require. The patients can not benefit to the proper extent from such procedures as scientifically applied pneumothorax, phrenicoexeresis, and thoracoplasty.

These modern procedures have, of course, a tendency greatly to shorten the sanatorium stay; their timely and proper application is an economic advantage to the community and spells the difference between arrest and progress of the disease or, in other words, the difference between life and death for the individual patient. The superimposition then of modern hospital equipment, management and personnel on the old sanatorium plan must, of necessity, act toward shortening the period of sanatorium residence and must inevitably redound greatly to the benefit of the individual patient.

How is the sanatorium, while remaining a sanatorium, to assume the guise, or rôle, of a modern, general hospital? The measures necessary to effect this transformation, at least in the case of sanatoria located in the vicinity of great cities, are not extraordinarily difficult. The fusing, or merging, of the sanatorium plan into the general hospital plan requires merely certain definite changes in the equipment and personnel.

First, as regards equipment. The large, municipal institution should have adequate provision of modern operating equipment. It should have large, light, and airy operating rooms which should compare favorably, from every standpoint, with the operating rooms of a well conducted, general hospital. The equipment and instruments needed by the various specialists in their various lines should be provided and kept ready for use.

As the first and most important change in personnel, I would be inclined to mention the appointment of a competent consulting staff.
In Chicago this problem was met by appointing to our staff, physicians of professorial rank in the various specialties at the class A medical schools. These men, of national and international reputation, visit the institution at definite intervals, weekly or bi-weekly, make rounds with the resident staff or conduct clinics as in a general hospital. Cases needing specialistic care are brought to the attention of the consulting staff and the necessary measures are instituted, either by the consultant or under his supervision.

One instance and one specialty will demonstrate how the plan works. The head of the department of surgery at the University of Illinois, is our surgical consultant. He reports at the Sanitarium at weekly intervals and personally performs any procedures of chest surgery or general surgery which may be indicated, the indications for such surgery having been disclosed as a result of careful and conscientious supervision of each individual case.

Relative to the diagnosis of tuberculous and non-tuberculous complications, the resident staff has been conscientiously and minutely instructed; they are on the alert for such conditions and have been taught as to the best method of psychological approach. The tuberculous patient frequently dreads an operation. It is the duty and the function of the members of the resident staff, at one and the same time, to remove the element of fear from the patient’s mind and emphasize the importance and necessity of operation.

Time does not permit consideration of the other specialties, does not permit consideration of the very great improvement noted in the tuberculous individual suffering with non-tuberculous complications when these non-tuberculous complications are adequately corrected.

The appointment and functioning of the consulting staff brings about spontaneously and ipso facto, a marked improvement in the morale of both nursing and medical resident personnel. The resident physicians, particularly, are stimulated by contact with men of established specialistic reputation. They become more interested in their work, in their professional duties and a general increased efficiency in their function is noted.

The affiliation of the Sanitarium with the universities, its conversion into a teaching institution stimulates the resident physicians to make a more careful study of the patient, to write better records, make more complete physical and laboratory examinations and, in fine, to give a more complete, more efficient and more satisfactory service.
With the consulting staff, professors of the medical schools, as the teachers, clinics on the various phases of tuberculosis and tuberculous complications are given to both graduate and undergraduate students. These courses of instruction at the Sanitarium have been so successful that they are now required for the students of the class A medical schools in Chicago. In this way again the sanatorium transformed into a general hospital, functions greatly to the benefit of the medical profession and the community. The future generations of doctors are given unparalleled opportunity for the study of a disease which they must frequently meet in future practice.

The sanatorium unit and the field service unit of a tuberculosis institution should function harmoniously and should cooperate in such a way that the pre-sanatorium, sanatorium and post-sanatorium life of the patient be based on a systematic and thoughtfully arranged plan. In the Municipal Tuberculosis Sanitarium this cooperation is made possible owing to the fact that the Board of Directors has complete charge of both the Sanitarium and field activities and, consequently, can formulate uniform policies which will direct the destiny of the patient both in the sanatorium proper and in the home.

The policies which guide our field force of 53 physicians and 189 nurses, working from eight dispensaries, tend toward preserving, as far as possible, a sanatorium atmosphere in the home. Our field nurses, insofar as possible, see to it that the triad—Rest, Fresh Air and Food—receive proper consideration in the individual home. A special Bulletin, entitled Home Treatment, is furnished each patient, as soon as such patient is brought under our supervision. The Bulletin is supplied to private physicians' patients only on request of said physician. In addition, a special Bulletin on Diet is given to our dispensary patients. This Bulletin discusses in simple language the various angles of dietetic regimen. The patient or the family is given the necessary instructions with regard to home hygiene, outdoor sleeping porch, instructions on Klondike bed making, etc. The indigent patient is supplied with porch equipment, blankets, porch curtains, etc.

In furtherance of our plan to consolidate sanatorium routine and regimen with field activities, we are about to develop a scheme for field operation somewhat similar to the plan already operative at the Sanitarium. Our dispensary physicians are being instructed to pay greater attention to the incidence of both tuberculous and non-tuberculous surgical complications. They are to notify Central Office
promptly concerning the occurrence of such complications as may be remedied by a brief period of sanatorium treatment. The patient whose complication may be remedied or improved by the indicated measures will be sent to the Sanitarium for operation in the same way that the average surgical case is sent to the private hospital. When the brief period of post-operative convalescence has elapsed the patient is returned to his home and the combined problem of post-operative care and tuberculosis treatment again reverts to our field department.

I have long felt that pneumothorax treatment in the field is an important or essential adjunct to a large dispensary organization. In the matter of refills, particularly, the application of pneumothorax therapy in the home or in the dispensary is indicated. Many of the patients live a long distance, some fifteen, twenty or more miles from the Sanitarium. It is inadvisable or injudicious to require patients dismissed from the Sanitarium while undergoing pneumothorax therapy to travel such long distances for a refill.

To meet this need we have established a pneumothorax clinic at one of our centrally located dispensaries. The clinic is equipped with all facilities available at the Sanitarium. Patients dismissed from the Sanitarium who need refills are instructed to report at this clinic and a physician especially trained in pneumothorax work administers the treatment.

Furthermore, at the present time there are many patients in residence at the Sanitarium who are kept there merely because they are in need of rather frequent refills. It is our purpose to have these patients dismissed, have them report at our pneumothorax clinic and so release for use badly needed accommodations at the Sanitarium. In this way we will increase our turnover at the Sanitarium and, at the same time, be in a position to give the patient the same effective treatment and care which he would receive in an institution.

Time does not permit further discussion of the intensive home treatment campaign which we are now conducting. I may summarize by saying that our aim is to shift as much of the responsibility for the tuberculous patient from the limited facilities of the sanatorium to the comparative untried possibilities of the home. According to our conception, the ideal plan is a pre-sanatorium program of home treatment—a short period of sanatorium residence—an intensive pro-
gram of post-sanatorium treatment. Under such a plan a far larger number of patients will receive the advantages of institutional treatment and the individual patient in his home, even if he can not gain admission to the institution, will live according to sanatorium routine and benefit proportionately thereby.

104 S. Michigan Ave.
HOSPITAL VISTAS—NUMBER II
LAPBOARD LEARNING

EMMA FORBES WAITE


In a former Vista, we discoursed on the Room of Fulfillment. It is today the same sky-lighted and many-windowed room, high above the noise of traffic. The tops of trees hem it in on all sides, and one looks out over them in one direction to the city's heart, the municipal clock-tower, factory tops and a spire or two: on the other side, straight into the windows of the “three-decker” tenements.

Within, a rocking-horse, various diminutive vehicles and a closet from the recesses of which games and toys are forthcoming, testify to a continuance of the room's mission, and a pictured face on the wall recalls its dedication.

There is today, however, evidence of another phase of activity, and that of a distinctly different flavor. In the alcove formed by a window-seat are seen a blackboard, a table bearing a globe and a set of progressive readers. Bird charts and health posters adorn the walls, likewise maps, crudely executed, and lists of spelling words, dotted here and there with a gold star for excellence. These scholastic accessories become of more significance when the little daily group of children is assembled and ranged in the alcove. A sizable boy on a cot, two or three in indiscriminate costume and wheeled chairs, a sixteen-year old girl who can propel herself, and a first grade aspirant may be denoted collectively heterogeneous but of one unreluctant aim. This aim is accentuated as much in that it admits of a temporary escape from daily ward routine as by the fact that school is an accepted feature of child life. In the present instance, this activity starts off with the giving out of an individual lapboard of heavy cardboard of the nature of a desk pad. This rests neatly over chair arms or lies easily across the knees, and thus becomes a truly material foundation for mental development. On such basis,
sober-minded Joe, the fourteen-year old, advances to the problems of algebra and Latin. He will spend many weeks on his cot and is not oblivious to the fact that he can thus keep apace of his home class. His father is an unlettered immigrant, but his promise to send on to Joe his school books argues a certain appreciation of what a fundamental education may do for his boy.

Estelle, sixteen and desirous of a job, faces it with a very faulty knowledge of the three R’s and a sudden realization that here a belated attempt to better herself is possible. Rose, with her leg in a cast and rather stodgily alert, wrestles valiantly with fractions. Her home is in a small mill town and school a long way off, but she is hopeful that between the school nurse and the bus a combination may be affected by means of which she may be enabled to carry on.

Frederick, the first-grader, reads cheerfully:

I-see-a-yellow-bird-The-yellow-bird-can-sing-

and so on through the astonishing activities of yellow bird’s life. Frederick is afflicted with a propensity to appropriate sundry attractive and hitherto inaccessible articles, such as crayons, pencils and the like, and has to be gradually brought to order in this respect.

And so they come and go! Only for a few weeks in each child’s life, and in favorably convalescent cases is this tiny class intended to function. Its presiding genius is peculiarly alert to its social and ethical problems and gifted in her ability to face and solve them. As in human relationships always, these offer, perhaps, its most fascinating and satisfying reason for being.
HOSPITALIZATION AS A FACTOR IN THE DECLINE OF TUBERCULOSIS*

H. R. M. LANDIS, M.D.


The need of adequate sanatoria or hospital facilities for tuberculous patients is essential for several reasons. (1) A well-conducted sanatorium offers the best opportunity of effecting arrest of the disease; (2) it is one of our most efficient methods of prevention, as it separates the sputum-positive patient from his family or other associates, and (3) the discipline necessary to bring about arrest of the disease is more readily carried out in such an institution.

When the present crusade was launched twenty-five years ago, it was thought and believed that the tuberculosis problem could be solved in a relatively short time if the disease was recognized in the early stages and the patient was given the benefit of sanatorium treatment. Thus the patient would be cured, and every case so removed from the active list would diminish the danger in the future. While this premise failed to be fully realized, it has never been lost sight of, and still remains one of our most efficient weapons in limiting the spread of the disease. This is susceptible of proof when we consider the results furnished by sanatorium figures. In every instance there is a high percentage of people cured or with the disease arrested, if you will, in whom the trouble was recognized early and adequate measures taken to check its advance.

More advanced lesions show a smaller percentage of cures or arrested cases, and far advanced lesions, as one would expect, show a very small percentage of recoveries. From the evidence we now have at hand it is apparent that the assurance of recovery is largely dependent on the recognition of the disease in its early stages. It is equally apparent that far too many cases of this type escape detec-

* Read before the Twenty-fifth Annual Meeting of the National Tuberculosis Association.
tion at the time most favorable for recovery. The recognition of this fact is evident from the nation-wide diagnostic campaign that has been sponsored by the National Tuberculosis Association the past two years.

While the original intent, that sanatoria were for curable cases only, has been considerably modified by the admission of patients in all stages of the disease, it is none the less true that one of the chief objects of a sanatorium is to cure. The word “cure” is, by many, regarded as an unsafe term, and for this reason “disease arrested” is urged. The argument against the word “cure” is that one of the characteristics of tuberculosis is the tendency to relapse—hence the danger of speaking of complete recovery. My own belief is that the disease can be and is cured in many instances, and furthermore, that the number of cures can be greatly increased by proper treatment.

The quarrel with the word “cure” began in the early days of the tuberculosis campaign when available beds were few. As the demand for admission into the existing sanatoria was great and the accommodations were inadequate, the plan was adopted of limiting the time the patient could remain under treatment. As we thought in terms of early incipient tuberculosis and sanatorium treatment at that time, the idea became more or less fixed that six months was the maximum limit. In that period of time the patient was supposed to be in condition to leave the institution. If not, he should be discharged to make room for someone else. I do not mean to imply that a six-months’ stay was rigidly enforced in all cases, but it became, none the less, the procedure in most instances. The belief that pulmonary tuberculosis can, in many instances, be permanently arrested in a relatively short period of time, persists. Far too many patients at the present time are assured that a few months will restore them to health.

As the years have passed by, I have arrived at the point where I believe that a year is the minimum even for early, non-toxic cases. While here and there a patient will come through safely in ten months or perhaps eight months, for the great majority a year must be regarded as the minimum time in which one can obtain a cure. The greater the extent of the pulmonary damage and the more marked the toxic symptoms, the longer will be the time needed to restore the patient to health.

In order to get a proper appreciation of what the time-element
means in treatment of tuberculosis, one must think in terms of anatomic and not symptomatic cures. In the past the disappearance of symptoms was the pitfall, and that continues to be our chief danger. It is an easy matter to allow oneself to be lulled into a false security by the rapid disappearance of symptoms and the appearance and the feeling of well-being in the patient. In so short a time as two months, or even less, an active case may be free from symptoms and present every appearance of perfect health. Clinical experience on the one hand and the increased use of the X-rays on the other have shown that a lesion may remain little if any changed months after the patient is practically free from symptoms, therefore until a good scar is formed in and about the tuberculous foci, a relapse is an ever-present danger. In my experience, patients with little damage and mild symptoms, and with a rapid disappearance of the symptoms, are the difficult ones to keep under treatment sufficiently long to ensure healing. And it is this group that furnishes many of the examples of relapse, from a few months to a few years, after leaving the sanatorium. For this reason I do not believe that there should be any fixed time as to the individual's stay in the sanatorium. A may escape from his difficulties in eight months, or possibly in even less time; B, on the other hand, may be fifteen months or longer in accomplishing the same result, although in the beginning both patients as nearly as possible presented the same problem.

When we more fully realize that each patient must be treated according to his individual needs, more will be cured and relapses will be less frequent.

Another factor that should never be lost sight of is that patients should be kept under surveillance until the sputum is free from the presence of tubercle bacilli. I realize that this is often impossible. In some instances the time involved is prohibitive, and in others the lesions are of such a nature that while varying degrees of arrest of the disease are possible, tubercle bacilli persist in the sputum. In every instance, however, pressure should be exerted to keep the patient isolated for as long a time as possible. This is especially true if there are young children in the household. The susceptibility of infants and young children is now so well recognized that no effort should be spared to protect them. The longer the patient is subjected to discipline in regard to the danger of his sputum, the more likely he is to carry out the proper precautions when he returns to his home.
I quite realize that keeping patients a year, two years or longer, as the case may require, increases the demand for beds, which in many places are already short of the number required. But, as is always the case in effectively dealing with public-health procedures, economy has no place in the plan. As a matter of fact, the most economical thing we can do is to make adequate and proper provision for tuberculosis patients and for as long a time as needed.

I should like to say a word in regard to the regimen of the sanatorium patients because this has much to do with the attitude of the public towards such places. From the beginning, it should be emphasized that tuberculosis can be cured, but it should be doubly emphasized that the price of obtaining a cure is time and patience, and that the foundation of the treatment is rest. Of all the alleged specifics and plans of treatment that have been advocated, the only measure that has endured is rest. There was a period in which it was felt that exercise also played an important part in the treatment of the disease. In the early days of the crusade, it was felt that patients could be put to work with benefit to themselves and also to the sanatorium. So far as the patient was concerned, it was the belief that inasmuch as their tenure of stay was limited, they should be hardened physically so that they might with less danger return to their home and employment. Happily this attitude is rapidly changing. More and more it is being realized that our primary duty to the patient is to obtain healing of his pulmonary lesions and, as I have already stated, there should be no arbitrary time limit to bring this about. To obtain this healing, rest is today the one means that we can depend upon. No better example can be cited of what rest and rest alone will accomplish in the case of a tuberculous process than that of laryngeal tuberculosis. At the beginning of this crusade, a laryngeal lesion of any considerable severity almost certainly doomed the patient. Today laryngeal tuberculosis is regarded as among the most amenable to treatment of any of the tuberculous lesions, and this has been brought about largely by resting the affected part. When we have become convinced that the pulmonary process has become healed, then and not until then may the patient be given exercise. At no time has exercise any place as a therapeutic measure in the presence of active symptoms, and so long as the physical signs and X-ray appearances indicate that the pulmonary disease shows no signs of retrogressing, rest must be adhered to.
Today, in my judgment, no sanatorium is justified in using individuals on the patient list for the performance of tasks about the institution with the idea of keeping down the overhead expense. Where this was once a matter of pride, it is now a reproach to the sanatorium following such a practice.
WHAT HAS THE LAW TO DO WITH THE CHILD?*  

GEORGE R. BEDINGER  

Executive Director, Public Charities Association of Pennsylvania  
Philadelphia, Penn.

A reply to such a question really largely answers the question as to whether social work is advancing, standing still or going backward. Let me try to suggest an answer based on facts alone. It would be easy enough to show amazing advance if one went back to the latter part of the eighteenth century when children were huddled with adult offenders and the poor victims of mental disease were shackled in mad houses; when smallpox, yellow fever and the plague mowed down young and old alike.

I shall confine myself to the last decade and a half. Statutes relating to social welfare furnish concrete examples of progress in social thinking or the lack of such thinking. What I shall say will naturally deal mostly with Pennsylvania, which is the State with which I am most familiar. I don't think, however, that in welfare matters Pennsylvania is either advanced or noticeably backward—an average, rather typical State, I imagine.


What does a comparison of these two books show? Where shall we begin? The logical place to start (and the keynote of

this Conference) is with the child. Have the last fifteen years meant more protection, more opportunity, more understanding for children?

In what I say about Washington social welfare laws, I am indebted to Miss Hathway, Secretary of your Conference, for generous help and for lending me a thesis on Social Welfare Legislation in the State of Washington written for the University of Washington by Audrey M. Brehrens.

The famous White House Conference on the Care of Dependent Children—called by President Roosevelt in 1909—focused attention on the need of conserving the child's home life. This Conference stated: "Home life is the highest and finest product of civilization. It is the great molding force of mind and of character. Children should not be deprived of it except for urgent and compelling reasons. Children of parents of worthy character, suffering from temporary misfortune, and children of reasonably efficient and deserving mothers who are without the support of the normal breadwinner, should, as a rule, be kept with their parents, such aid being given as may be necessary to maintain suitable homes for the rearing of the children."

So far as legislation is concerned, the principle of "home care of dependent children" has met with more ready response than any other child welfare measure ever proposed.

The first State-wide mothers' aid law was enacted in Illinois in 1911. Forty-four States and the District of Columbia, Alaska and Hawaii, now have mothers' aid laws, the exceptions being South Carolina, Georgia, Alabama and New Mexico. The prevailing method is either to permit aid to be granted to any mother with dependent children or to limit aid to certain types of cases, including those where the father is dead, deserted, divorced, physically or mentally incapacitated, or imprisoned, with necessary restrictions pertaining to cases of desertion and divorce.

In 1913 the Widows' Pensions Act, called in Pennsylvania the Mothers' Assistance Fund, was approved. Two years later the State of Washington enacted its Mothers' Pension Law. The Pennsylvania statute allows a monthly grant of not more than $20 for the first child under sixteen years of age and $10 for each additional child providing the mother is a deserving, needy widow or a woman whose husband is permanently insane. The appropriation is fifty per cent. by the State and fifty per cent. by the individual counties.
The Washington statute, I am sorry to say, permits but $15 per month for the first child under fifteen years and only $5 per month for each additional child under that age; but in Washington the law is applicable to all mothers who are needy.

Eight States and the District of Columbia permit aid to be granted to any mother with dependent children.

Experience in the administration of mothers' aid laws has shown, the Federal Children's Bureau tells us, that it is desirable to avoid strict limitation of grants and instead to permit assistance to be based upon the needs of each individual family. In determining the amount of the grant required due consideration should be given to the needs of the family as determined by its composition, as well as to the available resources from earnings of members of the family, aid from relatives, and other sources.

The laws of six States (Arizona, Colorado, Maine, Massachusetts, Rhode Island, and Virginia) and the District of Columbia do not specify the amount of aid that may be granted to each child or to each family but provide that the amount may be fixed by the administrative agency in accordance with what is needed in each family to provide properly for the children. In New York also the amount is not specified, but the law states that it shall not exceed the cost of institutional care.

In most States providing for a maximum grant this is specified as a given amount for each child. In order to make a comparison possible the maximum amounts specified in the laws of various States are here reduced to the maximum which might be allowed for a family with three children, grouping the States as follows:

Maximum, $50-$70 a month: 8 States (California, Connecticut, Indiana, Kansas, Michigan, Minnesota, Nevada, Ohio.)

Maximum, $40-$49 a month: 7 States including Pennsylvania, (Florida, North Dakota, South Dakota, Utah, West Virginia, and Wyoming.)

Maximum, $30-$39 a month: 10 States (Illinois, Iowa, Louisiana, Missouri, Montana, Nebraska, North Carolina, Oregon, Tennessee, and Wisconsin.)

Maximum, $20-$29 a month: 10 States including Washington (Arkansas, Delaware, Idaho, Maryland, New Hampshire, New Jersey, Oklahoma, Texas and Vermont.)

Chiefly because the mothers' aid movement was in the beginning an outgrowth of the juvenile-court movement, nineteen States have
placed administration in courts having jurisdiction over cases of delinquent, dependent, and neglected children. The types of local administrative agency in the States having mothers' aid laws may be summarized as follows:

Juvenile court .......................................................... 19
County poor-relief officials ......................................... 13
County or city board having other functions .................. 5
Special County board .................................................. 3
School board ............................................................ 1
No local administrative agency ....................................... 1

Nineteen States including Washington, place administration of mothers' aid in a court having juvenile jurisdiction: (Arkansas, Colorado, Idaho, Illinois, Iowa, Louisiana, Michigan, Minnesota, Montana, Nebraska, New Jersey, Ohio, Oklahoma, Oregon, South Dakota, Tennessee, Vermont and Wisconsin.)

Pennsylvania has special county boards of trustees of the Mothers’ Assistance Fund, seven unpaid women for each county, appointed by the Governor. Supervision is from the State Department of Welfare.

In Arizona and New Hampshire the entire expenditure for mothers' aid is made from State funds. Twelve of the forty-four States having mothers' aid laws are authorized to share with the counties or municipalities in the expense of aid. In Washington the grants are made solely from county funds upon orders of the Juvenile or Superior Courts. In Pennsylvania the State and counties share equally the expense.

It is estimated that at this time, on any one date, approximately 200,000 children are receiving public aid in their own homes. If estimate were made of the total number of children in the United States for whom aid should be granted in their own homes, it would be close to 400,000 and probably even beyond this if all types of more or less permanent family disability were included.

In Pennsylvania on May 20, 1929, 17,908 children, representing 5,534 families were being kept in their own homes by the grants of the Mothers’ Assistance Fund; in King and Pierce Counties in Washington on January 1, 1927, 1,168 and 766 children respectively were receiving such aid, a total for Seattle and Tacoma of 1,934.

Mothers' aid administration offers the most obvious evidence of the seriousness of placing laws on the statute books but failing to make them practically effective through adequate appropriation.
and proper administration. It is recognized that the chief problem at present in connection with mothers' aid work is most of the forty-four States having such laws is not to obtain new State legislation or amendments to existing laws but to obtain adequate appropriations and to raise the standard of administration so that the laws may mean adequate care for the children they are intended to benefit.

The record of the biennial legislative appropriations in Pennsylvania, each one matched by a similar grant from the respective counties, is:

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<td>1913</td>
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The greatest gain was in 1927—a clean increase of one million dollars. How was it effected? The story is one of the most encouraging examples of the way public opinion can be aroused for such a fine thing as mothers' aid appropriations and it shows also how well public officials and private welfare groups may work for a common end.

In 1926, under the direction of Miss Mary F. Bogue, State Supervisor, studies were made to find out just how far the Mothers' Assistance Fund was meeting the need. The study in Philadelphia County was financed jointly by the Philadelphia Mothers' Assistance Fund and by the State Department of Welfare.

Startling facts were revealed. In the first place, while some 3,500 mothers were receiving grants, 2,400 other mothers, equally eligible, were on the waiting list.

A number of them had actually been waiting for more than two years. Of some of these it was written: "There are many who frequently come back and write to appeal for help in situations that have become desperate, and the pictures these present are distressing in the extreme. They tell a story of hopeless wandering about in search of aid, with undernourishment and even death of children, and an attempt at suicide on the part of one of the mothers."

These facts were laid before the Mothers' Assistance Trustees in five inter-county conferences during the summer of 1926. Out of these gatherings came a unanimous request that the Public Charities Association of Pennsylvania should take the lead in telling
the story of these needs to the people in Pennsylvania, and to the Legislature which would assemble in January, 1927.

The Public Charities Association, through its Child Welfare Division, accepted this commission and agreed to serve as an organizing center for a State-wide educational and legislative campaign.

The Campaign Committee declared it to be the objective of the campaign “to secure the necessary legislation so that Pennsylvania may give adequate Mothers’ Assistance grants to all mothers eligible under the present Mothers’ Assistance Law.”

The appropriation of $2,750,000 secured after strenuous State-wide educational and legislative effort, was regarded as a substantial victory, inasmuch as it was an increase of one million dollars or 57 per cent. over the last appropriation. It was estimated that this additional $1,000,000 would wipe out 80 per cent. of the waiting list, extending the benefits of Mothers’ Assistance to 1,900 more mothers. With the 3,500 families already receiving grants, the new total would be brought to some 5,400. Pennsylvania had assumed the task of making good to more than five thousand mothers.

The gain in Pennsylvania from a biennial appropriation of $200,000 to one of $2,750,000 in only fourteen years is proof that in some respects at least we are making great strides in welfare legislation for children.

The mothers’ aid law is certainly one of the most beneficent examples of social legislation and the whole idea has been in operation barely fifteen years.

Yet, the requirements of our Pennsylvania act of 1913 are not yet fully complied with. A million and a half is still needed from the State and counties together to meet the full requirements so that every widow eligible under the present law can have support to keep her children with her in her own home. Also, our Pennsylvania law is inadequate in two respects: First, there is a fixed maximum grant, which, as any case worker can readily understand, in many instances is below the minimum requirements of the family. Second, we have no provision for the support of children of unmarried mothers or the children of women who have long been deserted by their husbands or whose husbands are suffering from tuberculosis or some other chronic disease or whose husbands are serving a prison term.

Pennsylvania and Washington both have been loath to grant the State the power to license agencies caring for children, and
other charitable societies as is required in New York, Massachusetts and many other States. Comparison of the two Pennsylvania books on welfare laws shows that an entering wedge for the licensing of agencies caring for children has been begun in Pennsylvania through the act of 1925 which authorizes the State Welfare Department to license baby farms. The act was sorely needed. These institutions were formerly licensed by mayors, justices of the peace and magistrates and some very serious situations were unearthed by the studies of the Children’s Commission of Pennsylvania which existed from 1923 to 1927. In 1929 our Legislature passed a statute to license maternity homes.

How about adoption of children? The Pennsylvania Children’s Commission also made possible a proper act for the adoption of children. Before 1925 a Pennsylvania child could be placed in adoption by a method as simple as transferring a piece of real estate. No investigation by the court was required,—a child to be adopted need not appear before the court, the adopting parent or parents merely presented a petition and the matter was settled. The Children’s Commission showed that in some cases courts had permitted the adoption of children by families well-known to social agencies, by families where there were communicable diseases such as tuberculosis and syphilis and in one case, at least, where the adopting parents were gypsies!

I am not saying anything relating to Juvenile Court laws, because most of our States adopted such laws more than twenty years ago. Their administration varies enormously as do their standards and types of probation officers employed. In Pennsylvania, for example, we have good Juvenile Court laws, but in some counties separate Juvenile Courts are not held and our standards of trained probation officers are low.

Two years ago, as the result of a bill introduced by the Public Charities Association, the marriage age in Pennsylvania was increased from twelve to sixteen for girls, fourteen to sixteen for boys; in each case, of course with their parents’ consent. People in our comfortable Keystone State were amazed and skeptical when they were told that a child marriage situation existed within their borders. But a study made through the coöperation of the University of Pennsylvania showed that in 1924 there was public record of 524 "child brides," that is marriages of girls who gave their age as under sixteen. At the same time we tried unsuccessfully to se-
cure the passage of a "hasty marriage act" which would require a lapse of five days between the application and the granting of the marriage license. Although this provision was incorporated in the Marriage Code and presented to the Legislature this year as an administration bill and the waiting period reduced from five to two days it still was defeated.

The marriage age in Washington is twenty-one for boys and eighteen for girls made upon affidavit. If written consent is obtained from the father, mother or legal guardian, the license may be granted where the boy is under twenty-one and the girl under eighteen; provided no license is issued unless the girl is over the age of fifteen. This year New York raised its standards for child marriage. The new law requires the consent of the judge of a children's court, as well as that of the parents, for the issuance of marriage licenses for girls under sixteen years of age.

Although the education of working children was advocated in the Pennsylvania Legislature over 100 years ago; a definite education standard was not fully established until the passage of the present Child Labor Law in 1915. This law requires the completion of a course of study equivalent to six yearly grades in the public schools before children fourteen and fifteen years of age may legally be employed. The continuation school, also established with the same law, requires that while public schools are in session employed minors under sixteen years of age must attend continuation schools at least eight hours each week. The school authorities provide continuation schools only in districts where twenty or more children are employed. With the establishment of the continuation school came the realization of the ideal of the early advocates of child labor legislation in 1824, that formal schooling for working children should continue after their employment.

Here is a splendid example of the perseverance of advocates of the protection of children. Disappointed biennium after biennium they still continued the fight and after three generations had passed a real standard was established.

There must be something funny about child labor legislation in Pennsylvania or else, we as the boasted bulwark of tariff protection, must be exceedingly unwilling to give a square deal to the child in industry. Since 1915 we have been able in Pennsylvania to make almost no improvements in the Child Labor Act of that year. Nine bills were introduced in the session this year. Only one of them—a minor measure—passed.
Again it was not until 1915 that fourteen years became the minimum age of employment for all establishments.

Also, the Child Labor Law of 1915 is the law at present regulating the employment of minors. Although this law decidedly raised the standard of previous laws for daily and weekly hours, minors under sixteen years of age may still be employed as long as nine hours a day and fifty-one hours a week. However, the Industrial Board of the Department of Labor and Industry in 1925 ruled “That the employment of minors under sixteen years of age more than six days in any week is prohibited.”

I am informed that not one single piece of legislation relating to children passed the Washington State Legislature this year and became a law. The few measures, like the law for a Children’s Code Commission, which passed both Houses were vetoed by the Governor.

The Workmen’s Compensation Law passed in 1915, by placing upon industry the cost of industrial accidents, served indirectly as a safety measure. This law provides for the payment of compensation to all workers injured in industrial accidents, with the exception of persons engaged in domestic service or agriculture, casual workers, and industrial home workers.

The status of the law as it affects children in Pennsylvania was materially weakened by a Supreme Court decision handed down in 1920, which declared that illegally employed minors were not eligible to the benefits of workmen’s compensation. Illegally employed children therefore have not the protection of the Workmen’s Compensation Law but must depend upon the highly uncertain action of a civil suit. In Wisconsin children illegally employed receive triple compensation, when injured in industrial accidents. It was not until the passage of the 1915 law that physical examinations were required of all children under sixteen years of age before they could be employed legally.

While children employed on farms and in domestic service do not come under the Child Labor Law, the School Code has included them in its provision for compulsory attendance at school. Work permits which must be secured by minors fourteen and fifteen years of age who desire to leave school and work on farms or in domestic service, are similar to the employment certificates required for minors employed at all other occupations.
An admirable State bulletin entitled “A History of Child Labor Legislation in Pennsylvania” prepared by Miss Charlotte Carr, Director, Bureau of Women and Children, State Department of Labor and Industry, says, in summing up child labor legislation in Pennsylvania: “By a slow and tedious process of education the State is coming to realize and accept its responsibility for schooling of working children and the protection of their health through proper legislation and law enforcement.”

Another children’s picture not to the credit of Pennsylvania is the fact that we still place children by indenture. This has been called “binding children out to slavery.” The 1927 legislature refused to repeal the indenture acts although they were urged to do so by the State Children’s Commission. Pennsylvania allowed its Children’s Commission, to die in 1927 after hardly four years of work.

What about welfare progress mostly affecting adult labor groups? Pennsylvania’s Workmen’s Compensation Law was passed fourteen years ago; the Washington act at about the same time. Few measures have had such far reaching benefits in social welfare. Like the Mothers’ Assistance Fund or Mothers’ Aid the compensation paid to workmen injured in accidents has enabled thousands of families to keep together. The break-up of countless homes has been prevented. But our Workmen’s Compensation law is nothing to boast of. The Consumers’ League of Eastern Pennsylvania writes as follows:

“Fourteen years ago a not very liberal workmen’s compensation law was passed. The intervening years have given few amendments in spite of the increased knowledge accumulated as to accidents and their social effects on the families involved and as to insurance costs. The result is that Pennsylvania’s law is one of the most illiberal in the United States—thirty-eight States, the Federal Government, Hawaii, Porto Rico and Alaska having higher maximum weekly awards and more liberal medical services. Pennsylvania is not among the more progressive States covering in under this law occupational diseases and making provision for double compensation for accidents to children illegally employed.

“Today we encounter difficulty in endeavoring to get an 8-hour day and a 48-hour week in spite of the fact that thirty-eight States and the District of Columbia already have that standard or a higher one.

“We have joined the States which have passed rehabilitation laws
for injured workers, but our administration of the law which is left to men who have to pass no examinations or show any educational qualifications leaves almost everything to be desired. We regret that we can show no improvement in fifteen years in the Woman's Labor Act."

Among public health measures mostly affecting children we find the new profession of dental hygienists made legal in 1921; the acceptance by Pennsylvania and Washington of their shares in the Federal subsidy accruing from the Sheppard-Towner act; and many other measures.

In the fifteen years we are considering there probably has been the most rapid and remarkable advance on record in the prevention of disease and the promotion of health. The successful victories of medical science over such age-old enemies as smallpox, typhoid fever, diphtheria; the diseases of infancy and tuberculosis (to quote just a few) is one of the most romantic chapters in human achievement. Probably more has been done to lengthen the expectation of life during the last fifteen years than during the preceding fifty. The age group to gain the most is the children’s group.

Pennsylvania turned a welfare milestone in 1921 by creating a modern and scientific State Welfare Department. It united and coordinated a number of different charities and their duties: the old Board of Public Charities; the Committee on Lunacy; the Mothers' Assistance Fund; the Prison Labor Commission. The law for the new Department was drawn in the offices of the Public Charities Association, and we felt a great advance was made in placing the social work of the State on the basis of scientific training and leadership. The Department, which has been functioning with great value for nearly eight years is divided into four Bureaus each with a separate head as follows: Bureau of Children (including Mothers' Assistance Fund); Bureau of Assistance; Bureau of Mental Health and Bureau of Restoration.

The Pennsylvania State Welfare Department has direct supervision over the State institutions caring for such unfortunates as the insane, feebleminded, epileptics, delinquents and penal offenders. The size of this problem, its many angles and the vast numbers of insane and feebleminded need in institutional care and training are just beginning to be realized by the public. Other States, notably New York, Massachusetts and New Jersey, outstrip Pennsyl-
vania in providing far more bed capacity per population for the State wards and in providing generally better care.

But in our fifteen-year period the following new State Welfare institutions have been opened in Pennsylvania: A new hospital for the mentally ill, opened in 1919 at Torrance in Western Pennsylvania; a new institution for the feebleminded opened at Laurelton in 1919 for feebleminded women of child bearing age; an institution for women offenders opened at Muncy in 1920; a new penitentiary in Central Pennsylvania at Rockview opened in 1921; an institution at Selinsgrove for epileptics opened this year; and the appropriation of a small sum by the 1929 Legislature to begin construction of the Cumberland Valley Institution for Mental Defective Delinquents.

This sounds on the face of it encouraging, yet the average annual increase of the mentally ill alone in Pennsylvania is estimated at over 800, which means a new hospital for the insane is needed every two years. The needs of the State's unfortunates are so pitiful and the appropriations for construction and development for the State institutions were so niggardly that in 1925 the Public Charities Association initiated the movement for a $50,000,000 welfare bond issue for capital improvements. The necessary joint resolution to amend the constitution for this purpose was successfully carried through the Legislatures of 1925 and 1927 for submission to the voters at the general election in 1928. An immense amount of educational work resulted. The most generous support was given the movement by all types of organizations and the press.

Unfortunately fourteen amendments were presented on a ballot thirty-eight inches long to our voters, already distracted from local issues by the importance of the presidential campaign. Five of these proposed amendments were for bond issues: $50,000,000 for Welfare; $50,000,000 for Roads; $25,000,000 for Forests; $8,000,000 for State College; $5,000,000 for Armories; a total of $138,000,000. Only four of the proposed amendments carried: all the bond issues failed. Supporters of the welfare bond issue, however, can point to the following advance in biennial appropriations for construction and major repairs to the State welfare institutions as due directly to the long, hard, four year fight for a $50,000,000 welfare bond issue to make possible a ten year welfare building program. In 1923 the appropriations for these purposes were $1,361,965; in 1925 they were increased to $2,109,323; in 1927 at the second passage of the bond issue resolution they were more than doubled—namely, $5,168,500;
and in this Legislature of 1929 another increase of 100 per cent. was achieved. The Administration bills carrying appropriations for construction and major repairs to the State Welfare institutions totalled $10,334,601.

To sum up, I believe we can feel that the last fifteen years have shown steady advance in constructive welfare legislation especially for children. The outstanding improvements have been, I should say, the enormous protection to family life by provisions of the mothers' pension and workmen's compensation acts; the amazing progress of preventive medicine, especially in relation to the promotion of child health; and the quickening of our responsibilities to those unfortunates who are wards of our State institutions, because these helpless and handicapped folk are in most cases children whether they be aged six or sixty.
WHAT CONTRIBUTION CAN PSYCHIATRIC SOCIAL WORK MAKE TO MEDICAL DIAGNOSIS AND TREATMENT?*

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Psychiatric Social Work as talked of today is as carried on by the Social Service Department of the dispensary of Washington University Medical School and affiliated hospitals—Barnes, St. Louis Maternity and St. Louis Children's. All of the work is under one director of social service. The same is true of the physician's work; it is under one medical director. The psychiatric clinic functions as a part of the whole. It has no regulations of intake other than those of the whole dispensary or social service but does limit its social treatment cases according to the prognosis.

One may question what psychiatric social work can contribute to the work of general medicine. The answer is that this particular type of social work is coming back to its starting point and brings with it what has been learned in its newer field psychiatry. Psychiatry has been demanding more attention to social needs in medicine and has given to this type of social work the emphasis upon mental and emotional factors in social treatment. In work with psychiatrists in general hospitals and clinics we must be able to bring social diagnosis and treatment that has this mental and emotional emphasis which can function when called upon.

At first the enlargement of psychiatric social work from the hospitals for mental disease and psychiatric clinics was in the fields wherein intellectual capacity, habits and human relationships are the outstanding factors to be considered. We see psychiatric social work functioning in schools, industries, courts, and correctional institutions.

*Read before the meeting of The American Hospital Association, Atlantic City, N. J., June 1929.

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Psychiatrists have urged the necessity of recognition of the underlying principles of their specialty. Internists have recognized that emotional and mental factors are a part of the clinical picture of physically ill patients as the physical findings are of those mentally ill. This field, certainly in the case of the busy dispensary or hospital, requires the services of the worker competently trained to bring a social diagnosis and treatment with the emphasis on the mental side. If then it is agreed that the special contribution lies in this mental emphasis the next question follows. On what accepted grounds can this emphasis focus its study in general medicine? These are that in illness there is a general lowering of the threshold of consciousness; attention may be centered on bodily illness; illness may be a means of escape. The first has been described before in “all looks yellow to the jaundiced eye.” The person that has been sick has lost power to throw off trivial incidents and complaints. Everything of a depressing nature comes upon him with greater force. All complaints and discomforts are magnified until he sees himself much sicker than he is. There follows a feeling of hopelessness with no energy to fight it off and the patient is profoundly ill not physically, but from the mental effects of physical illness, as evidence is the patient who has had one severe illness after another. At the end of this period she appears a chronic invalid. The invalidism is not from the actual physical effects of the disease but from the depression following it. When this depression is understood then one is on the road to effective treatment not only for the time being but for the remainder of the patient’s life. A boy fifteen years old had scoliosis and had been operated upon. All interests in outside affairs had been forced or allowed to subside in the long and painful treatment involved. At the end of the treatment he was ready to go out and make as good an adjustment as his physical condition would permit. But he had no place to go. Normal thought had given way to somatic complaints and back he came to the hospital to the surgical service which could find nothing wrong with him and after all diagnostic tests had been exhausted he was referred to the neuro-medical service and to psychiatric social service for study.

The centering of attention upon self is an accepted fact of mental illness and this self attention may be to worries, cares or ordinary difficulties which assume abnormal proportion. In this case the person is recognized as nervous, but this attention is as often on
bodily ailments. Then the patient becomes an habitue of first one clinic after another as the physicians exhaust methods of diagnosis or become tired of treatment which yields no results either to the medical students or the patient. That mental disease furnishes a means of escape, becomes a defense mechanism of the psyche against a situation intolerable to the individual is recognized. Cases of shell shock during the war afforded abundant illustration of this. Alcohol may serve equally well and as often physical illness is the escape. We find this in the case of a transplanted rural boy. He has adjusted well in his environment on the farm where his limited education and mediocre intellectual endowment are equal to the demands of his life. He comes to the city because of changed economic conditions. He is unable to make the grade. He cannot see the situation as another sees it and he lapses into illness as an excuse for his failure. A woman patient at the death of her parents faced responsibility, necessity for work and management of her own affairs. Until funds were exhausted she was the private patient of many doctors, faith healers, chiropractors. Now she is chronic. Efforts have been only partially successful in somewhat staying her assaults upon the clinics and physicians which consume time, expensive treatments and keep her from any gainful occupation. Out of ten patients who caught the attention because of persistent visits to the clinic there were found many similar complaints as pain in head, heart, arms, abdomen. In only three were there any real organic basis for these found. In seven there were worries which seemed important factors. In discovering these patients lies the opportunity of psychiatric social work. This worker must be equipped with ability to recognize physical symptoms that may arise from emotional states. They must be seen as other than entities which arise from organic disorder. Too much is this the attitude of general medicine. When exhausted in search for proof, the physicians blame the patient, call him a neuro, discharge him from the clinic with the orders not to return.

Joined to this recognition of symptoms must be a searching type of mind that makes a social investigation questioning the accustomed reaction of the patient, his background and present situation, the changes involved and his reaction to them, his personality now and before the complaint, his habits of work and play, his interests and ambitions, the family picture and how this patient fits in. A woman comes to the hospital. She complains of nausea lasting for weeks. Complete diagnostic tests are made in the medical service without
important disclosures. She is referred to the psychiatric clinic. The social history reveals that these started after a quarrel about a radio with a boarder with whom she is in love. She flew into a fit of rage; he left the house and the nausea followed.

Social factors, to have real bearing, must show a relationship with the physical disorder in question. A man has suffered acute pain because of gastro-intestinal disorder. He is unable to work, compels his children to go on each side of him so that he may run through the house and thus keep his thoughts off his physical condition. An opportune tornado hits the house. He goes to work and cured of his pain works over a year without return. This seems to prove more than that—"It's an ill wind that blows nobody good."

If these factors can be recognized and interpreted showing their relationship to the patient's condition then correct practice can be started, mistaken practice prevented, physician's time can be saved and last but not least, the patient may be saved possible operations and lasping into chronic illness. A foreign-born woman whose husband has suicided, comes to the dispensary. She is adequately treated for a minor condition in the gynecological clinic, and referred to the nerve clinic, where any clinic visits other than to the psychiatrist, are discouraged. She does not agree with the diagnosis. The agency is told the basis of her complaints. She goes to two and three other clinics. An operation for appendicitis is advised. When the psychiatric history is shown to the physician by the worker in surgical clinic, the plan of operation is dismissed. In this case she went to another hospital, was followed through the help of the family agency and the psychiatrist who practices in the other hospital. An operation, this time for removal of tonsils, was prevented and discharge ordered. With a change of physicians on the service and a change of location of the pain, an operation was finally accomplished. Post-operative diagnosis was sub-acute appendicitis. This could not be prevented but further complaints were understood by those who have her in their care and now she describes herself as well.

Employers are an important group to whom this knowledge must be given. They control one of the most important curative agents—work. If there has been friction with an employer at the onset of the attack, then it is the opportunity for the social worker to interpret the patient's conduct in the light of disease and pave the way for re-employment. There is no more important field in the therapy of
mental ills than developing an understanding among employers. Unless the family can help the person, thus troubled, who cannot help himself, treatment is of little avail. To them must be explained the view of mental trouble, which strips it of social stigma, the attitudes that help recovery and do not lead to hardship for the patient and themselves.

Unless this social aid in diagnosis can help in treatment then its effects cannot be far reaching. Of first concern is modifying the patient's attitude toward himself. A young woman comes after only one operation and complains of insomnia and many pains. The history reveals that since childhood she has been afraid of something, lessons at school, her speed at work, her bills as a housewife. In all of these fields her fears are groundless. It is explained to her that her fears are to be treated as any other minor discomfort that does not and will not upset her life. There is no need for her to take refuge in a religious cult that offers faith as a panacea. It is urged that the more she does both in working and playing the better off she is. She returns to the psychiatric clinic a number of times, each time reporting that she is better. Instead of giving up she has gone on. She is one of the most hopeful cases. The social treatment of these cases is the same as that of any other mental patient on whom diagnosis has been made and treatment advised.

How does a neuro-psychiatric clinic function in a general clinic to give this mental emphasis to physical complaints? It does so only at the request of the other services. When a patient is referred a brief history is taken by the social worker on a card. This record avoids stating details to which publicity is not desired. It is filed with the medical record. This touches only the high places and is usually taken in ten to twenty minutes, a brief space of time to give a whole background but it has been found possible in this brief time to show that patient has had many complaints, many work changes, an unhappy home situation, a changed environment. These histories have been recognized in a study made of the social service function in the clinic. The workers in other clinics are told informally of psychiatric findings. They in turn see the patient's complaints in the light of psychiatric diagnosis. These histories have been used in the study of gastric ulcer. One case may be cited. The patient has no control over his family. The one child died because of a gun accident; the wife forced an unfortunate move from the country. She next left him and put the children in an orphans' home; the
patient now cries a great part of the time. These factors were con­
considered as worth while in studying his digestive system.

In the hospital the same procedure is true but more time is given
to the history. Sometimes the patient is much sicker, there always is
more time before the physicians made the diagnosis, and the history
will be given more consideration before this is made. Requests
come from any service after psychiatric consultation. They have
been requested in research upon thyroid cases. All hospital histories
are filed as part of the hospital record so that with recurrent attacks
the social factors will always be present.

WASHINGTON UNIVERSITY DISPENSARY
DEPARTMENT—SOCIAL SERVICE—CASE NO. B16601

Name: E. W. — Age 27.
Religion — Divine Science.
Past and present situation:
Home: Pt. lives at home with second husband and children of
first husband. Pt. has three rooms—just has to push herself to do
this small amount of housework—this entails little labor and pt.
knows it, but feels unable to do this. Seems as though she can't get to
do the things she wants, as making Christmas cakes, etc. Wants to
do it—wants to hurry, but just can't get at it.

Work: Pt. worked as a cashier when a widow—held this job
the entire time she was a widow—made $12.00 a week. Pt. does her
own washing. She wants to see her house clean, but it seems as
though she can't, but pushes herself to do what she has to—never
seems to feel that she is through. Previous to first marriage, worked
five years in a factory—always afraid of what sewing she would
have to do next day.

School: Pt. went to 8th grade—finished at 15 years. Took up
shorthand for a while at business school—didn't keep at it—afraid if
she went at it she couldn't keep up speed. Always afraid of exam­
inations and lessons in school.

Economic: Husband works as a driver for S—'s Meat Market
—makes $25.00—gets meat cheaper. Pt. makes both ends meet,
but is always worrying as to what she should pay first—how much
she should spend. Must figure out total expenditures before she
feels free to pay out anything. Husband never complains of her
expenditures—is easy going.
N. Johnston

Marital: First husband, C—. S—. 8 years older than pt., was fond of him, but loves this husband more. This husband, F—. W. age 25, seems more of a companion. Pt. is constantly afraid of conception—aafraid she will have as difficult time in childbirth as with other children. Pt. was torn then and this was cause of first operation.


Religion: Goes on Thursday to Divine Science Church when they have special services for women. They teach to get thoughts off of things, and to think of enjoying one's self. There is no charge. She has been to their healers. There is one who hasn't charged her anything who has her under her care now. Healer tells her a prayer to say during the day and tells her that God helps everyone. "If I say my prayer, it sometimes helps me, but again I think what am I saying this foolish thing for." The effect does not keep up. Pt. has gone to Divine Science two years. A lady friend, the Healer got her to go there. Before that, went to Presbyterian.

Recreation: Pt. goes on Sunday to movies—went with children to school picnic—goes to see friends—friends come in, but she doesn't sit still while they are there—she keeps going. They will say to her "leave it go—tomorrow will be another day." After they leave she can hear them talking—somewhat relives in memory the events of the time she has spent with them. They have a radio—she likes to listen—husband bowls and wife often goes with him.

WASHINGTON UNIVERSITY DISPENSARY

DEPARTMENT—SOCIAL SERVICE—CASE NO. 78503

Name: A. H.

Past and Present Situation:

Home: Pt. lives with brother and sister-in-law. There are three besides pt. in home of three rooms. Pt. has been deaf fifteen years—thought caused by exposure and catarrah condition—deafness in family.

Work: Pt. was a general laborer—was a farmer until two years ago. At that time wife left him. She demanded one half of what they had—in order to make a settlement, they had to sell. Pt. does not like the city or his work here. Pt. went to Washington State in Spring of 1926—thought it would help his hearing—came back in
Nov. 1927. Had spent all his money—had two sick spells with stomach. Family had to send him money.

Economic: Pt. pays board—family just took him in—no friction.

Marital: Pt. was married in 1904 (?)—had seven children. Pt. and wife never got on together. She was not true to him—in treatment of children, undermined his discipline because of his deafness. One child was killed accidentally playing with a gun. Pt. always laid the child's death to disobedience. Pt. never "got over this" as he was the favorite child. It "bore on his mind" until people had to humor him. Informant thinks wife's advantage of his deafness was cause of friction—then wife insisted on coming to St. Louis. Pt. said they could not make a living. Then wife got divorce on grounds "that were not true" i.e., that he did not provide. This is not true so informant says. There was plenty on the farm and the family never lived in any display but never wanted anything. It was a pretty well stocked farm, and pt. may have possibly deprived family of some things to do this. Informant thinks wife cares for him, but pt. says he will never go back to her. Oldest children are working and four children are in an orphanage. Pt. has good disposition—once drank at times before separation—not drinking now.
PUBLIC HEALTH NURSING AS A FACTOR IN THE TUBERCULOSIS PROGRAM FOR THE NEXT TWENTY YEARS*

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When one tries to understand what the tuberculosis program of today is, as related to public health nursing, one feels very like the chameleon that became a nervous wreck attempting to adjust to a Scotchman’s plaid, so varied and uneven are the organizations and resources in the many communities of this huge country.

What do we look for in the tuberculosis program in the United States for the next twenty years that will be different from the present-day tuberculosis program? It seems a difficult question to answer.

The next twenty years will doubtless see an extension and an intensification of the various tuberculosis programs just in proportion to the number of leaders—medical, nursing, social—who, having the knowledge of tuberculosis, its prevention and treatment, have also the ability to use that knowledge so that tuberculosis really is prevented and arrested—provided that these leaders are given the support of their various communities. Perhaps there will be many additions to the knowledge about tuberculosis, but I fancy it will take even these many effective leaders the full twenty years to catch up in applying that which we already know.

Now, what about the public health nursing aspects of this evolutionary and educational program? Let us be very clear as to the function of public health nursing: It helps protect the health of the public at the request of at least a part of the public. There are no private practitioners in public health nursing—the service is the result of community thinking about community health needs. The

* Read before the Twenty-fifth Annual Meeting of the National Tuberculosis Association.
public health nurse is employed by a group of individuals who make up an organized board of management or by a public agency, municipal, county or state. Less than one-half the counties of the United States have requested such service, so there are great sections of the country—notably the South and some sections of the West—where there are no public health nurses. And at this time when appropriations for maternity and infancy protection are threatened, there may be many communities which now have the services of the public health nurse that will find themselves without this envoy of health in the near future.

Public health nursing is interpretative and instructive as well as curative. It aims to instruct the family in health needs, to interpret to the family the findings and recommendations of the physician. The measure of the success of the public health nurse in tuberculous families is her ability to translate into the language of every home she enters the scientific facts about tuberculosis, its causes, its mode of transmission, the treatments ordered by the doctors. In other words, the public health nurse tries in each family to bring knowledge and practice together.

If the public health nurse is to carry on her instructive and interpretative functions in families and community, she must during the next twenty years have a much greater knowledge of tuberculosis than she has had in the past and a much greater knowledge of family and community problems. Every nurse should have careful education in tuberculosis—its individual, family and community aspects. Every nurse should know what causes tuberculosis and how it is prevented, as well as the details of nursing which will make the patient’s recovery more certain and more comfortable. This can be accomplished probably only through affiliation with tuberculosis hospitals for that part of the nurse’s education, unless the prevailing policy of general hospitals to refuse admission to patients suffering from tuberculosis could be changed. At the present time it is almost impossible to employ a nurse who is equipped to do tuberculosis nursing by having had any experience in it during her period of education in a school of nursing.

Of course, to carry an adequate tuberculosis service, a public health nursing agency must be staffed with nurses who know every aspect of general health work. Because tuberculosis is peculiarly a family problem, an adequate tuberculosis program overlaps with every other type of public health nursing service. In the tuberculosis
family every age group may be found, and in the various members of the family every special health need of the human race may occur. The adequate public health nursing service for tuberculosis, therefore, must include maternity protection, infant and pre-school care, protection for the school child, care for venereal disease, bedside nursing care, mental hygiene, nutrition service. In fact, the good tuberculosis nurse should be an unusually well educated public health nurse generally with special training in tuberculosis.

But more than this do we want of our public health nurse in a tuberculosis service. The tuberculosis nurse needs to know family problems and facilities for taking care of family problems. Tuberculosis is a social and economic problem—an employment problem—a problem of education—and always a mental hygiene problem. Of little value is the clinic recruiting nurse who in a period of unemployment insists upon frequent medical examinations for the young workman, whose wife is in a tuberculosis sanatorium, whose mother is struggling to take care of his five children and who is fearful of losing his job, unless arrangements for night or Sunday examinations can be made. Of little value is it to teach special dietary needs when there is no family income to pay the grocery bills, unless that income can be procured; or to urge a careful mother to take a long period of rest unless her children can be cared for. Very often the nurse’s approach to the family because of health needs will reveal social facts which could not be dragged forth otherwise. Will you consider the Wheaton family with me for a few minutes?

This family was introduced to the tuberculosis nurse by a social service nurse in a maternity hospital, who said that Mrs. Wheaton had been interested in the social service work when her last baby was born, a little over a year ago, and now, because her husband had tuberculosis, she had come to the social worker for help in getting some work. The Wheatons were a thoroughly nice American family, living in a good section of the city, and Mr. Wheaton had been manager of a prosperous automobile service station for nine years. They lived well and planned well. There were four children ranging in age from twelve to two when little Bobby was born, and up to that time the Wheatons had progressed steadily, saving some, enjoying life. Mrs. Wheaton was scarcely out of the hospital after Bobby’s birth when Tom, an adorable, stalwart little chap of two, was taken ill. The doctor was called, but found the situation puzzling. Everything possible was done in the home. Mr. Wheaton insisted on Mrs.
Wheaton's leaving the burden of responsibility and night watching to him, for she had not yet regained her normal strength and the new baby took all her time and energy. The child's illness progressed and finally the doctor insisted upon a hospital. So little Tommy was taken to a small private hospital where he hovered between life and death for five weeks. At the end of five weeks he died, but not until every effort had been made to save his life. Now Mr. Wheaton—a splendid fellow—had of course tried to save his wife's strength and courage, tried to see that Tommy had everything that could possibly aid in diagnosis or recovery, tried to see that the other four children had what they needed and tried to carry his job. He was tired, and when Tommy was at home had taken a cold which he seemed unable to shake. He was somewhat troubled financially, too, for with the added expenses for the coming of the baby, extra help for Mrs. Wheaton and Tommy's illness, the savings had to be drawn upon and finally they were gone. Both he and Mrs. Wheaton were shattered by Tommy's death—and afterwards Mr. Wheaton felt very tired—really too tired to work. However, never in his life had it been more necessary for him to keep on courageously, and this he did. He tried not to let his wife know how weary he was. He had consulted the family doctor about his cold, early in the game, and carried out his instructions. It was only after several months, however, when the summer cold persisted, that he went again to the doctor, rather ashamed of seeming to make a mountain out of a mole-hill, when there were such real troubles on their horizon. The doctor advised him to take more rest, to get away to the country for a few months, and gave him medicine to make him sleep, for he had had broken rest since Tommy's sickness and death. During that time he tried to take most of the responsibility for night care of Baby Bob, as he felt that the strain on Mrs. Wheaton had been even greater than the strain on himself. He tried to follow the doctor's instructions, but the long rest in the country which was ordered was out of the question.

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Finally, a year and two months after Tommy's death, Mr. Wheaton faced the tragic diagnosis—"tuberculosis." He realized that all the savings were gone, he realized that never before had his ability to work and earn been so important to his family. And the tuberculosis specialist said positively, "No more work for a long period—imperative need of hospital care." What could he do? Mr.
Wheaton talked things over with his wife, who said "Of course you must do exactly what the doctor says. I am well—I can go to work. Bobby is a year and a half old—we can arrange somehow."

But how? The next day Mrs. Wheaton went to the hospital where her baby was born and talked to the social service nurse whom she had met there and liked, and who had told her a little about getting work for people who needed it. She asked the nurse where she could get some work, so that she could care for her children while her husband went to the hospital. And this is where the tuberculosis nurse took up her telephone. The hospital nurse told Mrs. Wheaton that the nurse to whom she was speaking knew a great deal about tuberculosis—knew how to help Mr. Wheaton understand what was wrong and how to help him follow the doctor's orders—knew how to teach her and the children so that none of them who had lived in close contact with Mr. Wheaton for the first year of his illness would run any further risk. She also told Mrs. Wheaton that the nurse knew that no family could keep on living without an income, that she was familiar with the readjustments necessary in a family when such a tragedy as had befallen Mr. Wheaton occurred. In other words, Mrs. Wheaton could get kindly counsel and constructive help in making a plan for her family from a nurse experienced in just such problems as Mrs. Wheaton's own. In tuberculosis, the nurse explained, a family must often plan for several years of illness and must safeguard the health of the children especially, as little children are very susceptible to infection—and where there has been contact with tuberculosis there must be frequent examinations by doctors, extra attention paid to food, sunshine and fresh air.

So Mrs. Wheaton said she would be glad to have the advice of the nurse who knew so much about her problems. That very afternoon, the public health nurse went to see Mrs. Wheaton. And Mrs. Wheaton was glad to see her, although somewhat reserved at first. Very soon, however, the public health nurse knew a great deal about the Wheaton family. She knew that Mrs. Wheaton dreaded Mr. Wheaton's going into a "free" hospital; that for the children's sake she was afraid to move into a poorer section of the city where the rents were lower; that Mrs. Wheaton felt she could not let Bobby be with the sort of woman they could afford to hire; that she feared unaccustomed work for which she was unprepared, but was staunch in her determination to do that work; that she was pushing into the background concern over her own health and was seriously concerned about William, jr.,
aged eleven, because he had lost considerable weight and didn't want to play so strenuously as he always had; that she refused to think of Margaret's education (Margaret was attractive and sensitive, loved school and it did seem so wrong to handicap her future). All these things and many more the public health nurse found out from Mrs. Wheaton on her first visit. But all that Mrs. Wheaton knew the nurse found out was that Mrs. Wheaton wanted as good a job as she could take as soon as possible. However, Mrs. Wheaton felt curiously relieved and relaxed. She even wept a little in front of that nurse whom she had never seen before, and did not feel ashamed. Mrs. Wheaton would never think of taking any money from charity—her sister and brother-in-law, with a growing family of their own, had been very generous and made a loan of $200, which, Mrs. Wheaton assured the nurse, would be paid back when she could get at her work. But the Wheatons could never again call on these only relatives who had never had so much as the Wheatons and couldn't possibly afford to help further.

The nurse went away with the promise to call again the next day. That nurse knew from the doctor that Mr. Wheaton was too ill to enter a hospital for patients with moderately advanced tuberculosis. She knew his illness would be long, with a questionable outcome. That nurse already knew in her heart that Mrs. Wheaton could not be spared from her home to work, that it would be difficult for her to get work, and that if she did get work she could not earn enough to care for her family. The nurse knew that her task as a nurse in this home was a delicate one. She must show this woman and her husband the real dangers, the practical first steps, the whole truth. And in the light of the whole truth, help them to make their future plans.

* * * * *

What happened? What is the condition of the Wheaton family now after eight months of help and care? Mr. Wheaton is in a tuberculosis hospital doing as well as possible, but very ill. One boy, William, jr., is under very close medical observation—probably tuberculous. Mrs. Wheaton did not go to work—the nurse was able to show her that she was more needed and would help more by staying at home, accepting financial assistance from the family organization. The family was moved into a smaller apartment in the same neighborhood. The radio and car were sold. Margaret is still in high school and will remain there until she has finished—she is getting
the advice of a vocational expert who will help her choose the classes which will best prepare her for work for which she is fitted. Very soon, because Mr. Wheaton is in the tuberculosis hospital, Mrs. Wheaton will receive from the city a pension which will be partly enough to care for her and the children, but the organization will supplement the pension, in order that the Wheatons may have a chance to keep well. Mrs. Wheaton’s sister and brother-in-law are keeping up the insurance. Four times each year every member of the family must be examined by the doctor. There have been teeth taken care of, eyes tested, all the children have been vaccinated against smallpox and immunized against diphtheria. The baby is well and flourishing. The family understands what has happened and whither it is bound. All of them are making an effort to do the very best things possible. Mr. Wheaton has read intelligently every book which the nurse has given him about tuberculosis, so that he can hasten his recovery. Mrs. Wheaton has learned from the nurse the most practical and economical way to live and care for children in order to keep them well. Both parents understand that William may have to go to a sanatorium for a period of care.

* * * * *

This bringing order out of chaos, replacing hopelessness with hope, helping the Wheaton family to make a constructive plan, was not a matter of simple formula—it was a long, careful piece of work which required all the resources and skill of the nurse and her supervisors. The public health nurse who deals with tuberculosis has a piece of important educational work to do. She must have accurate knowledge and must know how to pass on that knowledge to every type of family in her community. For the Wheatons are just one of the many families who find themselves faced with a long period of family tragedy due to tuberculosis. The tuberculosis nurse must teach and reteach by precept and demonstration and example. Every family presents a different problem and the nurse must be able to meet each different situation with fair judgment, with patience, with keen insight, with humor. Indeed, into the realms of health, recreation, religion, education, citizenship, home life, social traditions, must the nurse be able to go with her families, and guide them—always with courtesy, kindliness, interest, respect and understanding.

If there are few facilities for the care of the tuberculous in the community where the public health nurse finds herself, she will have
to accept cheerfully the fact that the community expects her to play a quadruple rôle—that of social worker, of nutritionist, of mental hygienist, of nurse. You will admit this is an embarrassing situation for the public health nurse. She recognizes that theoretically her part in a community tuberculosis service is a single rôle with part and cues quite definite. However, until such time as other indicated and possible facilities are established (and she will work like a Trojan to create interest and gain support for their establishment) she will do the best she can.

I wonder if the next twenty years will see more public health nurses who are also educated to be skilled family case-workers, taking care of the home part of the tuberculosis program?

In thinking of the three aspects of any tuberculosis service—case-finding, treatment, and prevention, what in the next twenty years will public health nurses contribute?

In relation to case-finding: It seems to me that greater success in case-finding for tuberculosis will be attained with further education of the people in the need of health examinations, which we are stressing now and shall continue to stress for the next twenty years, only provided that facilities for these health examinations (through private physicians or clinics, pay and non-pay) are made available. The nurse's part in this case-finding will be, first, in establishing such fine relationships with every family with whom she comes in contact that the family will be willing to be educated in the need for health protection; second, in arranging for health examinations; third, in interpreting family needs to the medical examiners; fourth, in interpreting the doctor's findings and any suggested treatments or recommendations to the individual and his family; fifth, in helping the family to make any indicated adjustment, physical and social; sixth, in staying by the family until the adjustments are made.

In relation to the curative program: The nurse's part in a curative program will be merely an extension of her present part and needs no repetition here.

In the preventive and promotion program, the part of the public health nurse should in the next twenty years be very important. We have already stressed the fact that the public health nurse is an interpreter and teacher. The future will probably bring better use of opportunities among groups. There is need for development in health work, first by extending the health service in the elementary schools so that adequate health examinations and follow-up service
are given; second, by establishing adequate health services in the high schools, and colleges; third, by concentrating on developing adequate health services in the great industries and business houses. If and when these developments materialize, the better prepared public health nurse will be called upon to interpret and to teach in schoolrooms, in clinics, in industries, but especially in the homes.

In summary, we shall hope to see during the next twenty years a better prepared public health nurse with careful education in tuberculosis, who will carry into every home into which she goes an effective lesson in the value of health examinations, so that early diagnoses can be made; we shall hope to see a nurse who fully realizes the significance of tuberculosis in the lives of every member of the family and who knows how to help that family to a satisfactorily adjusted regimen. We shall hope to see a more intensive program of health protection for all age groups, with perhaps much greater development of the opportunities for preventing and detecting tuberculosis in the ready-made groups—the elementary schools, the high schools, the colleges and the great industrial groups. We shall hope to see a more uniform distribution of health service in the United States, so that everywhere health education and protection will be available. The public health nurse, we hope, will valiantly keep her place beside doctor, dentist, social worker, nutritionist and mental hygienist in an effort to make effective in the homes of the people the scientific facts about tuberculosis—its prevention and its cure.
During the last twenty years, the literature of tuberculosis has contained many references to the necessity for better supervision of and assistance to tuberculosis cases after their discharge from our sanatoria. The numerous studies that have been made of discharged patients show that nearly, if not quite, 50 per cent. of them are disabled or dead within five years of their discharge. Either they have been insufficiently treated in the sanatoria or they have failed to follow the regimen taught them, or their economic status is such that they have been unable to follow it.

The greatest difficulty in the post-sanatorium management of tuberculosis patients is their employment. The farm colony, the urban workshop, the day camp, the home hospital have all been suggested, but in spite of all the discussion, little has yet been done in this country. The present outstanding efforts are Tomahawk Lake Camp for men supported by the State of Wisconsin, the Altro Work Shop in New York City established by the Committee for the Care of the Jewish Tuberculous, the Central New England Sanatorium at Rutland, Mass., and the Potts Memorial Hospital at Livingston, N. Y.

It was long ago determined that very few patients could be placed in agricultural colonies, but it has long been believed that the chances of complete recovery of these patients would be greatly enhanced if there were some intermediate station, so to speak, where under rural conditions and medical supervision, part-time employment could be provided until they are hardened up to do a full-day’s work. It has

* Presented before the Twenty-fourth Annual Meeting of the American Sanatorium Association.
long been realized also that many families with a tuberculous member would be better off in the country.

When, under the will of the late Ida Caroline Potts, money became available for a special institution for tuberculosis patients, it was determined by the trustees of the fund to conduct an agricultural and industrial center where tuberculosis patients could undergo industrial convalescence. Part-time employment was to be provided in productive occupations. Some of the cases would pass through the institution and go into the usual channels of business; while others would be more or less permanent residents of the community. It was, and has been, the aim to conduct this medico-sociological demonstration along lines that are in entire harmony with American economic, social, and governmental methods. It has been the aim also to reunite families separated by this disease, providing employment for the well members of the family as well as the disabled members, gradually restoring the family to economic independence. The main purpose, however, was not so much to increase immediate earnings as to increase future earning power. The object was to strengthen the body so that the tuberculous person might be better prepared to return to his old job or to some work allied to it that perhaps would call more for mental than manual exertion.

With this end in view, the Trustees of Potts Memorial Hospital purchased the Potts Homestead, comprising seventy-two acres of fine farm land in the Hudson Valley midway between the beautiful Catskills and the Berkshires, nine miles south of Hudson, forty-one miles south of Albany, and thirty-five miles north of Poughkeepsie, on the New York and Albany Post Road. Twenty-four acres have since been added to the tract.

The manor house, built originally on colonial lines, has stood for about a hundred and twenty-five years. There are two farm cottages in good repair, a fine group of modern farm buildings, and a garage for three cars, all equipped with the necessary machinery and utensils for the conduct of an agricultural project for the employment of patients.

Three new buildings were erected for the housing and feeding of forty-five patients. These buildings are fire resistant and built of textile brick on simple colonial lines. A double colonial house has recently been built for the accommodation of staff members.

Patients of both sexes between the ages of eighteen and fifty are received. Those who have had minimal or moderately advanced tuber-
culosis and have reached that stage in their progress toward recovery where they can engage in four hours of daily work are eligible. It is customary to receive those who have had actual sanatorium treatment, or have had expert supervision, so that they are familiar with the proper treatment.

Application forms are furnished to the superintendents of sanatoria, or to the patients direct, on request. The applicant who has been away for some time from the institution in which he took the cure is required to present a supplemental report from a physician skilled in the diagnosis of tuberculosis, showing his present physical condition.

All cases are received for the period of one month for observation and trial. At the end of this time it is determined by the Director, in conference with the patient, whether or not he shall remain as a resident worker. The right is reserved to determine the eligibility of all applicants, and also to request the withdrawal at any time of a patient who does not, in the opinion of the Director, prove to be suitable.

As the patients who are accepted are certified to be quiescent or arrested, there is little need of an infirmary. A few beds are reserved to take care of those who develop acute illness and for the temporary care of those who suffer a reactivation of their disease. The latter are expected to return to a sanatorium or to their homes for extended rest treatment.

At present, there are three major projects for the employment of resident workers.

1. The Administration of the Institution. The tasks include waiting on table, dishwashing, laundry work, stenography, bookkeeping, nursing, and laboratory work.

2. The farm. This project does not offer opportunities for the employment of many tuberculous persons. Most of the work is too arduous. However, the patients are successfully raising poultry, caring for bees, working in the vegetable, flower, and berry gardens, as well as keeping up the grounds, walks, roads, shrubbery, etc. A few have been employed in painting low buildings and farm equipment.

3. The Printing Shop. The carriage house has been altered to accommodate a first-class printing plant. The floor is solid concrete laid on rubble and covered with birch flooring so that there is no floor vibration. A hot-water system provides even temperature. Windows on four sides assure ample light and ventilation.
The equipment now comprises a Kelly B automatic press, two job presses, one of which has the Miller automatic feed, a motor-driven paper-cutting machine, a Mergenthaler linotype, a Baum folding machine, a proof press, stitching, perforating, and punching machines, and the very latest designs in type cases, imposing table, furniture, etc. All machines are motor driven, and each machine is protected by appropriate safety devices.

A highly skilled printer directs the operations of the patients who find employment in the shop. No pretense is made of teaching the printing trade, but patients who have had no former experience are taught simple operations such as feeding the job presses, folding, collating, stitching, punching, packing, shipping, etc.

The shop is run on a strictly commercial basis. Bids for jobs are made in competition with the regular printing trade. Many orders come from organizations, business houses, and individuals who are interested in the purposes of the institution, but the shop has to meet competition in prices and quality.

The printing shop carries on its business under the name: The Livingston Press, Livingston, Columbia County, N. Y.

A regular charge of $15 a week is made for medical supervision, room and board, and a limited amount of laundry service. This sum, which is considerably less than the full cost of maintenance, must be paid in advance.

Those whose circumstances are such that they cannot pay $15 a week, may be received under special arrangements with the Director.

Resident workers are paid for the work they do, usually on an hourly basis. Those who pay $15 a week retain all their earnings. Those who are unable to pay this amount may apply their earnings toward their maintenance charges. Probationary residents are expected to pay according to their means, but do not receive wages until they have demonstrated that they are able to work four hours daily. Those who are not able to work the requisite daily period after one month are discharged for further sanatorium treatment.

The Institution was opened in April 1926 and has therefore been in operation only three years. During this organization and stabilization period, 147 patients have been admitted, of whom there remain on this date 43, leaving 104 who have been discharged. So small a number covering so brief a period do not offer sufficient data from which any satisfactory conclusions can be drawn. A follow-up study has been inaugurated so as to determine what the end re-
suits may be; to find out how many of those discharged as fully rehabilitated, as partially rehabilitated, or not rehabilitated, have continued to improve. There are certain impressions, however, that may be noted from the observation of cases thus far admitted, and they are as follows:

1. A centrally located rehabilitation center receiving its cases from numerous sources finds it somewhat difficult to secure suitable cases for rehabilitation.

2. The medical history of our cases received indicates that many of them had not had sufficient rest treatment before undertaking ergotherapy.

3. Apparently arrested cases have the best outlook for full rehabilitation.

4. Quiescent cases without cavity have better than even chances for rehabilitation.

5. Cavity cases, especially those having cavities of more than one to two cm. in diameter have a very poor outlook. As many as 39 per cent. of cases under treatment at one time were cavity cases. Our failure to rehabilitate cases with large cavity is borne out by the studies of Harry L. and Lena R. P. Barnes, who reviewed 1,454 cavity cases and found 80 per cent. had died within one year after the establishment of the diagnosis; 85 per cent. within three years; and 90 per cent. within five years.

6. With the limited facilities at Potts Memorial, it would seem advisable that cases of marked cavitation should be refused admission.

7. The better educated and those skilled in some trade or profession have distinctly better physical and economic prospects.

8. The cost of full rehabilitation, while it does not seem excessive for the individual, is at present very great in the aggregate because of the wastage in dealing with so many unsuitable cases.
In what I have to say this afternoon I have made no attempt, as you will all too clearly realize, to write a learned disquisition on either the theory or practice of hospital social work. Instead of this I am going to try to recall to your attention certain of the things which have occurred during our last fiscal year which seem to me specially worthy of emphasis and comment at this time, in direct or indirect connection with the work of the Association. I also want to touch on the work of the districts and the committees and on certain problems in hospital social work which seem to be still of paramount importance to us, although some of them could be classified as pretty hardy perennials; references to which would be found in most of the programmes of our annual meetings, and in the reports of the minutes of the executive committees during the last ten years. Nevertheless some of these questions are still unsettled; still subjects of discussion, and the conclusions, when there are any, certainly the implications, are still unaccepted by the majority of even our active membership.

Within the limits of the time I can give to a resumé of the year's activities, only brief mention can be made of some of them. If I omit any which seem to you of more importance, please lay that omission either to limitations of time, to the wealth of material offered to choose from, to oversight, or personal idiosyncrasy, and not to any lack of appreciation on my part of any one's efforts.

I suppose that most of us as we journeyed to this conference remembered that the American Hospital Association was holding its annual meeting at Atlantic City from June 14 to 23, and that our Social Service Section was meeting with them from June 17 to 21. Usually, as you know, this meeting comes in September and October. Last year, however, it met in August in San Francisco, while this year the meeting of the American Hospital Association is in June, in order to join with the meeting of the International Hospital Congress. Owing partly to the presence of the International group, this year's meeting of the A.H.A. promised to be of unusual interest and importance, and we anticipated that a good many of our members would attend, owing to the distance and expense entailed in coming to California.

One of the high spots in social work for the year 1928 was certainly the first meeting of an International Conference of Social Work at Paris in July. Hospital Social Work was so fortunate as to have as its chief spokesman and exponent on this historic occasion Dr. Richard C. Cabot, Professor of Clinical
Medicine and Social Ethics at Harvard University. Dr. Cabot is held in honor by all hospital social workers as one of their pioneer leaders. Workers in California expressed an eager desire to have him address us at one of our meetings this year. I wish it could have been arranged, but Dr. Cabot is a busy person and an important previous engagement will keep him away from the National Conference this year.

Certainly any one interested in hospital social work should be keen to read, mark, learn, and inwardly digest his helpful and suggestive paper. It is a temptation to try my hand at a fairly complete summary at this juncture. There is so much that seems to me fundamental and convincing and worthwhile to discuss. Time forbids anything more than a few brief comments, and I would remind you that the paper was published in the New York magazine, Hospital Social Service, with the editorial office at 200 Madison Avenue, New York City, and reprints can be secured at our own executive office at 18-20 East Division Street, Chicago.

I wish that not only all hospital, but all social workers, all hospital physicians, and others interested in modern hospital organization would read this timely paper, for which our Association must tender Dr. Cabot their grateful appreciation.

Many of the things Dr. Cabot points out so frankly, especially in regard to hospital administrators, physicians, and others, would only be accepted by the medical profession, if they are so accepted, and by the world at large, when coming from one who speaks with the authority, and from the standpoint of one who is himself a hospital physician, as well as a leader in hospital social work, and a recognized authority in the field of modern medical teaching and practice.

I believe that names are important, especially in pioneer days, so I am interested in Dr. Cabot's explanation as to why he recommends the retention of the often discounted term social as part of our title. I, for one, was ignorant of its classical connotation. I am glad also that Dr. Cabot agrees that it is wise for us to define and limit our work further by the rejections of the word hospital as a part of our title. The reasons he gives seems to me to be convincing, but I have often heard the point argued, especially a few years back. The need of the recognition of this peculiar, institutional character of hospital social work, and what it implies in tradition and organization, that Dr. Cabot stresses, is what chiefly reconciled some of us to the severance of the psychiatric group with their more varied fields of service, from our National Association.

There are two or three statements in Dr. Cabot's paper with which I, as a practicing hospital social worker, must disagree, and which even seem to me disturbing emanating from an authority like the writer. I mention these two or three points not in any spirit of controversy, but because I believe these view points are contrary to the best interests of our organization.

We are told that in England and America hospital social case workers pay few home visits because outside agencies coöperate for this service. Believing as I do that the chief function of hospital social work is social case work for the patients, I must believe that visiting outside the hospital, to homes, churches, law courts, agencies, etc., is one of the most important methods that can be used; as important to the hospital social case worker as the stethoscope and thermometer are to the hospital physician. Moreover, my experience shows me that we do pay as many outside visits today as ever we did.

Another statement with which I cannot agree is where Dr. Cabot says that in England and America out-patients engage most of the attention of hospital social workers, to the exclusion of ward patients. I know of many
large, important hospitals in America, at least, where ward patients receive fully as much relative attention as out-patients. Certainly in the practice of hospital social case work the fact that a patient is vertical or horizontal, as I heard some one express it the other day, can have little bearing on the seriousness of the social, environmental situation which may or may not exist in his background.

Another reference that rather disturbs me is where Dr. Cabot is discussing the Future of Hospital Social Work. He speaks in the most interesting way of its development, and its progress as depending upon the type of persons drawn into hospitals as physicians, nurses, social workers. He points out that "medical and social work" can be standardized to a very limited degree. He augurs well for the future of hospital social work from the fact that "the calibre of hospital superintendents is steadily improving ... and more large hospitals are being connected with universities." At the same time he deprecates, as we all must, the low salaries at present being paid to most hospital social workers, but adds that he believes "an additional source of income will gradually open to the hospital social worker," namely "paid service to well-to-do patients." Dr. Cabot says he believes time should be allowed to the hospital social worker for private practice, "as is now allowed to hospital radiologists" for example. He might have added to physicians holding hospital appointments.

Now I feel that hospital social case work in connection with any large crowded hospital is a most time consuming job, and any possible percentage of intake by a case worker must be very limited, while the percentage of poor patients probably in need of some form of social adjustment would include not less than 40 or 50 per cent. of the total numbers admitted. I should fear that if a worker's time and thoughts were to be diverted to the service of well-to-do private patients that the percentage of those we entered the hospital to serve would be still more reduced, even if the salaries of the workers were increased. Certainly any reading of the earlier reports of the Social Service Department of the Massachusetts General Hospital would indicate that it was the neglect of the alien, the ignorant, the so-called unprivileged patient that led Dr. Cabot to install hospital social work in that hospital to which we all owe such a debt of gratitude. We went in to the hospital in order that there should be one group, at least, whose paramount duty should be to focus attention on the patients. I fear if we allow ourselves to be diverted to private practice within the hospital for the well-to-do that another group will have to be found to rescue patients from our neglect. I believe some other method must, and will, be found to raise hospital social case work salaries to something more commensurate with the type of worker sought and the period of training demanded.

Another literary effort, a book this time, which seems of special importance to us, was the issue of "The Social Worker in Family, Medical, and Psychiatric Social Work," by Miss Louise Odencrantz.

This is the first volume of a job analysis series to be issued by the American Association of Hospital Social Workers, under the Russell Sage Foundation. It is the first attempt, so far as I know, at an analysis on any such scale, although within a very limited field, of what some of us call hospital social work, and the result may well give us pause, and lead to the earnest hope that our Committee on Function may again get to work and help us to define "what we do, and how we do it."

Miss Odencrantz has done a most painstaking piece of work in a fine unbiased spirit, but so far as the section devoted to hospital social work is concerned she could only assemble what she found or had supplied to her. What the result would have been had she taken the four or five hundred departments
in as many hospitals, instead of the, I think, nineteen she did select, and tried to analyze what the workers were doing one rather shrinks from contemplating.

The analysis of psychiatric social work makes far easier reading, and one knows that the data supplied must have been far easier to handle, showing as it does the work of a small, recently organized, highly selective group, who have from the start set themselves a standard of preparation for their task, a definition of their function which those of us whom our psychiatric colleagues call "general medical workers," whatever that may mean, can admire, perhaps envy, but not emulate for some time to come, if ever.

Some of the departments studied by Miss Odencrants are in Boston, so we had the pleasure of seeing her a few times. One remark I heard her make, in answer to a question, seemed illuminating to me: she said that while she had known nothing of hospital social work when she began her study, when she had finished she had reached the rather unexpected conclusion that of all types of social case workers, the most carefully selected, and the best trained were needed for hospital social work, because of the pressure put upon the worker by all the complex details of a medical institution from which the worker would have to select herself what she could, and should handle. In other words, Miss Odencrantz seems to have felt that the struggle between the 100 per cent. idea with that of wise selection would be pretty serious within the hospital.

In this connection I am reminded of a statement I read not so long ago, written from the standpoint of a social worker in a crowded public hospital: "To discriminate wisely," that is between patients, "and to give the most to those who need the most requires rare judgment and human understanding."

One recent event which promises to be of importance to the future of hospital social work was the announcement of plans for the establishment of an Institute of Human Relations by Yale University.

I do not think that there is any one thing that has so hampered and delayed the development, and increased the difficulty of organizing hospital social work as the attitude of indifference, occasionally even of antagonism, met with on the part of many members of medical staffs the country over. That we have all known hospital physicians with broad social visions, keenly interested in teaching something of the social aspects of their patients' care to medical students none of us would deny, certainly I least of all, who had the wonderful privilege of knowing a little of the work of Dr. Francis Peabody during the five short years he was on the staff of the Boston City Hospital. But this attitude of a small minority does not affect the truth of the above statement. Did time serve the opinions of many physicians could be quoted to sustain it. No one, I think, who has been in close touch with hospital social work, whether as organizer or case worker, can have failed to recognize this attitude of many of the doctors as constituting a serious handicap to our work. While we have been planning courses for hospital social workers so that they could gain such knowledge of the medical aspects of the patient's care as would, at least, enable them to understand what the doctors were talking about, we have found it far more difficult to get recognition from hospital administrators and medical staffs of the importance of social needs and problems which may complicate the hospital patient's treatment; sometimes even defeat his cure.

No doubt much of our failure to get the recognition we have craved for work which we have felt was sometimes of real importance to the patients and to the hospital, has been due to our own faulty interpretation. Many of us have wished, however, that medical students could receive some regular instruction in the so-called social aspects of patients' diagnoses and treatment along with the pathological. Here and there this has been done, and an effort made
to enlist the services of a hospital social worker in the attempt. Personally, I have always believed, however, that if this kind of instruction is to be taught to students of medicine, medical schools should themselves assume that duty. So it seems wonderful that a great university should now have come forward to undertake it.

According to notices in recent issues of the Survey, the Compass, and elsewhere, Dean M. C. Winternitz of the Yale School of Medicine, is quoted as saying that the Institute of Human Relations will include a department of social work, or as it is to be called "clinical sociology," which will be incorporated in the curriculum of medical education on the theory that the training of the students in medicine must be completed by training in other sciences dealing with human beings. The institute is to put the emphasis of medical education on the individual rather than on specific disease. To some of us hospital social workers this has a strangely familiar ring, although Dean Winternitz is quoted as going on to say: "This affords an opportunity to introduce the first fundamental change in medical education that has occurred in half a century."

While plans for the "department of clinical sociology" are incomplete one plan seems to have taken shape in the form of a clinic for the study of "problem children." New Haven had to come to Boston for what was wanted here, as it seems to be a fact that this clinic is to be under Dr. Healy and Dr. Bronner of the Boston Judge Baker Foundation.

It seems probable that others of our leading medical schools and universities will, in their turn, follow Yale's lead. The idea contains unlimited opportunities for us and a real challenge to spur us on to a clearer definition and interpretation of our function.

I should like now to say something of the more direct work of our Association:

In any résumé of a year's activities emphasis should be placed, we will agree, on the work of the different districts, because, in a very real sense, the districts are the Association. I hope we shall never forget this, or fail to see that it is by the work that is being done in the different localities, and in the various hospitals, all over the country, that our Association must, in the long run, stand, or fall. Sometimes these district activities are being carried on in rather an inarticulate way, with a notable absence of trumpet blowing, but it is, nevertheless, in connection with the districts, and in the localities where as yet there are no districts but where there are active members, that much of the most important work of the Association is being carried on.

Recently the suggestion was made to the executive committee that it would be a more effective, a more workable body, if it could be decreased in size and the proposal was made that district chairmen be excluded from voting membership on the executive committee. This suggestion was not entertained last winter, and the danger of concentrating authority in a small group was emphasized, but it may come up again. Should it do so, and the motion be carried, I for one would be inclined to sympathize with the districts if they, on their part, were to seriously consider decreasing the amounts of their annual contributions to the National Association, in order that they should not have to suffer "taxation without representation." This feeling might be entertained, I think, by other localities than the one in which the historic tea party was staged.

Even at the risk of duplication I wish I had time this afternoon to discuss in detail some of the outstanding things the districts have been doing as they have come to my attention through correspondence or observation. But time will not permit me to do this. One thing I do want to say, however, and that
is to extend a hearty welcome to the latest addition to our district roster, that of Northern California.

In both the March and April numbers of the Bulletin you had the opportunity of acquiring a good deal of information about the activities of several committees, both the standing committees and others. This morning we listened with much interest to reports from several of the committee chairmen, and you would not, therefore, want me, on this occasion, to go much into detail on the work of each committee. I should, however, like to refer to a few matters connected with this important phase of the work of the Association.

This year's Executive Committee has had five meetings during the year. At Memphis, when the newly elected committee met twice, once in October at Chicago, and a mid-winter meeting in January at New York, and now here at San Francisco.

As you listened to the reading of Miss Wadman's report yesterday you must have felt that her committee had done a good job. As she told you, in January they suggested to the Executive Committee, that the Ways and Means Committee serve two consecutive years, in order to gain "continuity of effort, action, and programme," and "a highly important point, effecting definite saving of money." I am sure that the outgoing Executive Committee will be glad to recommend the reappointment of Miss Wadman's committee for a second year.

Work on a by-laws committee is apt to prove a somewhat thankless task, whether the purpose is the forming of new rules and policies or the revision of old ones. It is impossible to please everyone and a good many members are apt to be somewhat disappointed, even disgruntled, at the result. We must all feel very grateful to Mrs. Webb and her committee, who went at their appointed task with commendable promptness and energy, so that members were afforded ample opportunity to study and discuss the results of their labors.

In January again the Executive Committee had the opportunity to discuss the matter in detail with Mrs. Webb, and to recommend such action as seemed appropriate to the majority. Final decision, of course, can only be reached by the vote of a majority of the active membership.

At Memphis last spring a good deal of interest was expressed by several of the members present on the subject of the need which they felt existed to bring members of local districts into closer touch with the corresponding central committees in order that there might be a wider exchange of experiences and a better opportunity for the districts to know what was going on in the central groups. Many central committee chairmen sympathize with this desire on the part of the local districts, and felt that the plan would prove of mutual benefit. It was agreed that it should be tried out for a year. I hope we shall learn in the course of our present sessions how successfully the plan has worked. It would certainly seem that one good result must be that chairmen of local committees, in thus keeping in touch with corresponding central committees would themselves be getting in line and in preparation for central committee work.

Owing to one thing and another it is never altogether an easy thing to arrange a satisfactory programme for our annual meeting. This year Miss Waters and her committee had an especially hard task because so many persons who might have been asked to take part were not planning to come so far to a national conference. The thanks of the Association are due to Miss Waters and her committee. I hope you will feel that the result of their efforts has been eminently satisfactory.

In arranging the programme this year it was decided to place special emphasis on the subject of education and training for hospital social work. With
this in view a special meeting on education has been arranged at which our Educational Secretary, Miss McMahon, will give her report of her work in the field for the year, and the Chairman of our Educational Committee, Miss M. A. Cannon, will read a paper on "The Educational Programme of the American Association of Hospital Social Workers." The general subject of this meeting will be "Education and Professional Standards for Hospital Social Work."

One of the most important of our standing committees has been inactive during the year owing to the fact that arrangements could not be made to appoint a chairman. It is the hope of the present Executive Committee that the former Chairman of the Functions Committee, Miss Janet Thornton, will agree to serve again next year, and this recommendation will be made to the incoming Executive Committee. In the meantime Miss Thornton informs me that, in accordance with my earnest request, she has been giving the subject some consideration this winter, and has got together a consulting group which will meet here in the near future, and hopes to be prepared to offer some suggestions, at least, as to the best methods of carrying on the work on "next steps" so ably outlined in what Miss Thornton called "the interval report" of the last committee on Functions. (By the way I suppose you have all got copies of this report? If not, they can be obtained at our Chicago office.) Everybody interested in hospital social work should study this report, and in doing so it might be well to remind ourselves of one or two former efforts that have been made at the study of hospital social work and on the definition of function:

Some of you will recall a study that was made of Hospital Social Service by Dr. Anna Mann Richardson for a Committee of the American Hospital Association. This was published in 1921. Sixty-one departments were studied. No attempt was made to define what should constitute the chief function of the work. Certain "conclusions" which were reached, however, pretty clearly indicate that Dr. Richardson felt that there was need for reorganization and for what she called "a more unified purpose." More than once Dr. Richardson points out the variety of work which was being done in the 61 departments. She certainly makes her point here as she lists 90 varieties of what she calls the "activities of the departments." These range all the way from fitting glasses; collecting unpaid bills in amounts under $5.00; (over this amount the job had to be entrusted to a regular hospital bill collector). Passing on ward admissions; taking blood pressures in homes; lecturing to medical students; taking cultures and smears; errands and letter writing for patients; educating colored orphans; taking unmarried mothers into court; inspection of the sorting of waste papers for sale; and last, but not least, getting permission for autopsies. It is a temptation to go on, but you can read it for yourselves.

During our annual meeting at Milwaukee in June, 1921, a committee was appointed to formulate a report on the Functions of Hospital Social Work. This committee met several times at Milwaukee and finally made a report on the "Permanent and Temporary Functions of Hospital Social Work." This report was accepted by the majority of those present at one of the sessions of our annual meeting.

The report gave as the primary or permanent functions:

1. Social case work for individual patients.
2. Research into the social causes of health conditions and behavior.
3. Education.

While this committee was only appointed temporarily, so far as their findings went, they were, I believe, sound, and the result of a good deal of effort by a more or less experienced group.
Both Dr. Richardson’s study and this Milwaukee report are of considerable interest to anyone who wants to follow the development of hospital social work.

For some time now there has been a feeling on the part of some members of our Association that a special effort should be made to draw the so-called undistricted members into closer contact with the Association. There are at present, I think, twenty-five of these isolated individuals working alone or in a small group; sometimes in localities where there is also comparatively little community organization and fewer resources than elsewhere. Those of us who live and work in close touch with an active, well organized district, and in socially well organized communities, sometimes fail to realize, or to take full advantage of, the opportunities offered by this contact with a larger group all interested, more or less, along the same lines.

With this in mind, in October the Executive Committee voted that the Third Vice-President should undertake as her special duty to get, and to keep, in touch with the undistricted members, to study their special problems and needs through correspondence and otherwise and to report the result later to the Executive Committee. The experiment was to be tried out for a year. At the January meeting of the Executive Committee Miss McConnell submitted a very interesting, preliminary report. This morning you have heard her later one and will, I believe, agree that the idea is a good one and worth continuing.

Before I leave the subject of committee work I would like to add a few suggestions and comments on the subject. Some one has said recently in an address that working on committees means putting one’s mind at the disposal of an association in order to help to work out its problems, and that committees evolve as part of the process of the evolution of an association.

It seems important that the members show a willingness, even an enthusiasm to do their bit when asked to serve. To quote from this same address: “What one puts into the service rather than personal recognition is the worthwhile part of committee work.”

On the other hand the national executive committee and district chairmen should try to enlist the service from all active members. I believe that the use of new blood in our organization is important. It is better for the whole Association, in the long run, that hitherto untried members be given a chance, whenever possible, to show what they can do in the way of committee service. It is a sounder, a more democratic, a more enduring form of organization that we should avoid the duplication caused by one individual serving on several committees the same year, and that we should have a wider membership representation. Incidentally also one way to increase membership is to get more members to serve on committees.

I know that it is a temptation, and a far easier form of organization, in all committee work to keep on reappointing individuals whose ability has been tried and proved. Certainly the Association owes an immense debt of gratitude to these pioneers for the service they have so freely given. The plea I am making is that we should try to give more members a chance to learn something of the inner workings of the Association, and to show what they can do; especially while we can still call upon some of our pioneers to instruct and guide the new recruits.

When I was considering what I should say in my address this afternoon I asked a few people for suggestions. Among others I wrote to two or three I knew in California in order to try to find out, if I could, what were the special problems that our colleagues were facing here, which they might like to have discussed.
The replies I received served to convince me that the questions that need to be answered, the problems in hospital social work which some of you feel California finds it most difficult to solve, are precisely the questions and problems which are still troubling us in localities far east of the Mississippi River. So we meet on a common ground, not as students and teachers, but as learners together.

I imagine that many other groups that go to make up the National Conference will have this same experience; and that the pioneers that journey here this year, not in covered wagons, but in fast express trains, or even more modern methods of transportation, will find California not one whit behind in the march of social progress.

I wish I had more time this afternoon to discuss at length, if not to answer some of the questions which my California correspondents put to me; any one of which would furnish ample material for a paper or a round table discussion. To refer briefly to two or three:

One question was: "What is the type of education necessary for hospital social work and the type of mentality demanded in the student?" I think we may well postpone further discussion of this interesting and important question until the meeting tomorrow afternoon when we shall have an opportunity of hearing the whole question of the education of the hospital social worker discussed from the point of view of our Educational Secretary and the Chairman of our Committee on Education. I hope that Miss Cannon will tell us especially what type of mentality is needed for a hospital social worker, and in what way that type differs from that needed by an ordinary individual?

Another question was: "Is the essential task of the hospital social worker the aid of the patient or of the doctor? Are we first of all aides or are we a professional group working for the same end that the doctors are seeking, the welfare of the patient?" I believe we are the co-workers and colleagues of the hospital physicians and that our essential task is to promote the welfare of the hospital patient. Perhaps you will accept what Dr. Cabot says on this point in his paper read before the International Conference: "... the doctor and social worker should meet in the wards and out-patient departments of hospitals as colleagues and consultants, each contributing his quota to the patient's welfare, each teaching the other what he needs to know."

Another question referred to what "vital distinction is there between hospital social case work and psychiatric social case work?" This is an interesting and debatable question because the best type of hospital social case work undoubtedly often contains many of the elements which go to make up psychiatric social case work, and necessarily so.

However, in thinking over a more adequate answer to the question in my correspondent's mind I appealed to one whom you would all accept, I think, as a leader in the field of psychiatric social case work. She was at pains to answer my question at some length. I wish I could quote her letter verbatim. This gist of it was, I think, that the "vital distinction" lies in the emphasis involved in certain differences "in training and a different body of accumulated experience," which in the case of the psychiatric social worker comes from constant and close association with psychiatrists, and in the oft repeated experience of dealing with personalities and mental problems at first hand. The answer showed, I think, that the writer believed the difference was one more of degree than kind.

Another question was what is the best way for a hospital to handle its "eligibility" problem, through the social service or as a separate department? If the latter, what would be its relation to social service? To answer the last question first, I should say that our relationship with the admission desk would
be the same as would any other of the numerous departments of the hospital, each with a separate function; namely, kindly, courteous, cooperation in the interests of the hospital and the patients. Personally I do not believe that a department of hospital social work that undertakes social case work for the patients can possibly find time to handle, in addition, functions that, I believe, rightfully belong to the administration.

In conclusion I would like to say that it seems to me that we are justified in feeling some satisfaction in the progress our Association has to show as the result of twelve years of organized effort. Much remains to be done, especially in increasing facilities for the adequate preparation and training of more workers; a clearer interpretation of our proper function so as to make ourselves better understood and accepted by hospital administrators and medical staffs.

I believe that for a while it would be better for us to go ahead slowly. "Festina lente" is a good motto for us to adopt: "make haste slowly." Better far, I believe, to delay putting social work into individual hospitals than to put in the wrong kind, under the wrong kind of poorly prepared and selected workers.

This statement from an engineer, published anonymously in the Survey some time ago, contains wisdom for us to remember and lay to heart:

He is arguing that national social agencies should call a halt, "declare a five year truce, refraining completely from the occupation of new territory, and devoting their full energy to consolidating the gains they have made." He advises the use of engineering processes:

Four main steps:

1. Fact finding on a systematic and continuous basis.
2. Multiple counsels, interpretation of facts.
3. Multiple administration, getting it across to individuals and communities.

Let me recommend these suggestions for your earnest consideration.
EDITORIAL
Prevention of Mental Disease

The burden of the institutional care of the insane is constantly increasing. The ratio of patients in hospitals for mental disease per 100,000 of population in the country as a whole was 81.6 in 1880; 118.2 in 1890; 183.6 in 1904; 204.2 in 1910 and 245.0 in 1923. In New York State the ratio has increased from 266.6 in 1890 to 451.0 in 1928. In the meantime the per capita cost of new hospitals in New York has increased from about $500 to nearly $4,000 and the per capita cost of maintenance from about $200 to over $400. In many states extensive building programs are under way in the almost vain attempt to reduce the over-crowding of the mental hospitals. During the past five years New York has been appropriating vast sums for new hospitals, but thus far has not been able to keep pace with the increase of patients.

We naturally ask the cause of these conditions and the remedies, if any are available. That certain mental diseases are preventable has long been known. We know that the eradication of syphilis would eliminate general paralysis and psychoses with cerebral syphilis and tabes. It is, therefore, hard to understand why such timid warfare is waged against syphilis which is much more of a health problem than smallpox, typhoid fever or even tuberculosis. We know how to control syphilis and to cure the disease in its early stages. But the spread of the disease goes on and little is done about it. The elimination of syphilis would prevent fully one-eighth of all cases of mental disease.

That alcohol continues to cause mental disease in spite of the outlawing of the liquor traffic is a sad commentary on the good sense and social attitude of a considerable proportion of our citizenship. There can be no doubt that the liquor traffic has been and still is a curse to human society. With the effect of over-indulgence in alcohol so well known, it is strange, indeed, that so many should still literally drink themselves into a hospital for mental disease. Prohibition has
reduced the number of cases of alcoholic insanity but those still appearing are a blot on present day society. The entire elimination of the liquor traffic would reduce the first admissions from 2 to 8 per cent.

Narcotic drugs still are a menace but at present they cause few cases of mental disease.

Unfortunately the cause of most of the so-called functional mental diseases are not fully known. It is believed that the seeds of many of these diseases are sown in early life. It is quite certain that many of the behavior patterns in early childhood are continued for good or ill throughout adult life. It is, therefore, of the highest importance that the child be properly trained and that any marked behavior disorders appearing in children be given adequate attention, and normal adjustment be made whenever possible.

For the treatment of problem children, child guidance clinics are now being held in many communities. These clinics deal with maladjusted and defective children and make recommendations for suitable treatment of each individual case. Other mental clinics deal with incipient cases of nervous and mental disease among adults. These clinics are doing much to secure proper treatment for mental cases and undoubtedly assist many persons to make proper adjustment to the difficulties that threaten to overcome them.

Notwithstanding the progress made in recent years, there are many unsolved problems in the field of mental disease. These can be cleared up only by prolonged intensive research. Of almost equal importance is the dissemination of the known principles of mental hygiene. Urgent social need should spur us on to greater effort. We can take courage from the many victories that have been won in the field of physical disease; but it seems certain that the campaign for the elimination of mental disease must be waged with all our resources for many years. Rich rewards will come with ultimate victory. Who can imagine the great relief to humanity that would come with the lifting of the burden of mental disease! Who can imagine the progress that might be made by a society freed from all forms of mental maladjustment!

Horatio M. Pollock, Ph.D.
NEWS NOTES

Report of the Sub-Committee on Convalescent Care for Asthmatic Patients

People who suffer from asthma are exceptional individuals, exceptional in the sense that substances that are harmless to more than 95 per cent. of the people, produce in persons subject to asthma, distressing and disabling attacks. Asthmatic persons have a hypersensitivity to certain substances which cause attacks when inhaled or taken as a food, drink or medicine (coal tar products). Such simple foods, essential to life, as eggs, milk and bread which are taken with impunity by the ordinary person, produce in people sensitive to these foods, attacks of asthma. Substances breathed in, such as dusts of various kinds; chicken, duck and goose feathers; the pollen of trees, grasses, shrubs and weeds; animal emanations; wool; cotton; tobacco; insect powders and countless other substances are frequently exciting causes of asthmatic attacks. It is therefore important that the sufferer from asthma, child or adult, be placed in an environment free from contact with the substances that have proven to be the cause of his or her trouble. A convalescent home catering exclusively to the asthmatics, where control over inhalants and foods affecting individuals can be exercised, and where patients can be kept for a sufficient length of time (3 months or longer), to permit the building up of their resistance (immunity), will be a blessing for the unfortunate sufferers from asthma.

Since such convalescent institutions would be to a large degree experimental, our knowledge of the causation and control of asthma will be very much widened by the experience thus gained. This will undoubtedly result in considerable benefit to the large number of asthmatics throughout the country. For this reason we urge the early establishment of such homes, one for children and one for adults.

It was estimated that there would be needed a home with a bed capacity of 75 for free and pay cases. The Home should be within
a reasonable distance of the city and not on a high elevation. Children between the ages of 2 to 16 years would be eligible. All cases must be referred from an approved asthma clinic and must have been studied for at least three months following the period necessary for the testing. A report of the examination made at the referring clinic must be sent with the child. All patients applying for admission to the Home would have to be referred to the Clearing House for examination. Requirements for admission to the Home should be: (1) Complete history, (2) X-ray of the chest, (3) Complete nose and throat examination, (4) Horse serum test, (5) Dick test, (6) Schick test, (7) Manteau test, (8) Course in diphtheria toxin-antitoxin, (9) Protein tests and (10) Environmental study.

To be an approved clinic the following requirements must be met: (1) Adequate Staff, (2) Home visits made by the social worker, (3) Laboratory equipped for the necessary examinations, and (4) Adequate record system.

There should be a competent resident physician at the convalescent home. There should be one graduate nurse for every 10 patients, the nurses should have had training in the care of patients suffering from asthma. There should be a dietitian.

The furniture of the convalescent home should be either wooden or unpainted wicker. The mattresses should be made of horse hair; the pillows of prime japera kapok. All woolen blankets should be washed before used. Floors should be either cement or a composition but should not be wooden. There should be a school under the supervision of the Board of Education. There should be supervised recreational activities. All patients should remain at the Home at least 3 months. It is impossible to make a dietary for an asthmatic home universal but the prime factors have to be worked out with the dietitians so as to be able to eliminate certain basic foods in each individual case.

The Adults' Home. It was estimated that there would be needed a home with a bed capacity of 100 for free and pay cases. The Home should be at the seashore so as to be beneficial to the patients who are pollen sensitive. Adults from 16 to 45 years would be eligible. The source of application would have to be the same as for the children and the patients would have to go through the Clearing House.


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examinations, (4) Test for tuberculosis, (5) Protein tests, (6) Wasserman and (7) Environmental study. Staff and equipment would be the same as for the Children's Home. There should be supervised occupational and recreational activities. Patients should remain at the Home at least three months. Diet to be adjusted to the type of case.

Environmental cases should be admitted pending the proper conditioning of the patients' own homes. Pets should not be permitted on the premises. No exterminating powders should be used, if it is necessary to use anything it must be in paste form.

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**Report of the Findings Committee Conference on Marriage and the Home, Buffalo, N. Y., November 21-25, 1929**

Your committee herewith submits the following conclusions as the findings of the Conference on Marriage and the Home, held in Buffalo, N. Y., November 21-25, 1929, under the auspices of the Social Hygiene Committee of the Buffalo Council of Churches and the Marriage and Home Committee of the Federal Council of Churches of Christ in America.

**1. Statement of the Problem.**

We express our frank recognition of the changing status of the family in modern life. This change is due first to the changing social and economic factors in the wider community life outside the home. The reduction of the employment period of the wage earner, the entrance of women into industry and public life, the urbanizing tendency which submerges the individual and the family in great city populations where the old moral controls are greatly weakened, and the exploitation of the home's recreational needs by commercialized agencies, all combine in subjecting family relationships to unusual strain.

Furthermore, the development of scientific knowledge has resulted in an entirely new attitude toward life. There is a disappearance of the old fears which once figured as elements in family control. Many of the fears born of ignorance are gone. The uncertain family convictions of the community at large have lessened the fear of public opinion. As a result of known methods of contraception, the fear
of pregnancy in illicit sex relationships has been removed. Consequently, the youth of today is possessed of a questioning attitude toward the older traditions of family life. Encouraged by the philosophy of family failure as portrayed on the stage and in much modern literature, there is a widespread scepticism with regard to the conventional marriage relationship. It cannot be doubted that many individuals have adopted a policy of sexual experimentation as a substitute for the normal relationships of home. This situation constitutes a challenge to the Christian church which must be intelligently and vigorously met.

2. **Confidence in the Continuance of Our Present Family Organisation.**

Fully recognizing the need of adapting the life of the family to changed conditions, the conference nevertheless expresses its abiding faith in the family as now constituted, and re-affirms the ideals and sanctities of the Christian home. In the words of one of our conference speakers, "There is no undertaking today more secure than marriage." It is our belief that the time has come for an emphasis upon the success of the normal home, as realized by the great majority of people, rather than stress upon the failures and abnormal relationships. The restlessness of youth, so far from being a prophecy of future disaster, is in many cases an indication of a deep desire for a better and happier home life, in which the ideals and principles of Jesus Christ shall be more completely realized.

3. The conference believes that of all the social and educational agencies in the community, the church holds the key to the home's future. By reason of its measureless spiritual resources, its intimate contact with the family at all stages of life, and the unusual teaching and pastoral opportunities of its ministers, the church occupies a most strategic position in the safeguarding and encouragement of the family group. The Christian minister should consider himself as the moral engineer of family life. It is gratifying to the conference to note the eagerness and readiness of scientific men to unite their technical knowledge with the spiritual ministrations of the Christian pastor, in a cooperative endeavor towards the solution of the present problem. This growing understanding between the church and the scientific world is one of the most encouraging trends of the hour.
4. Recommendations of Policy.

In view of the above statements, the conference would submit the following recommendations:

An approach to the marriage problem not so much from the point of view of emergency measures and legal and ecclesiastical enactments on divorce, but rather an educational approach which will prepare people from their very childhood and youth for a successful family life. To this end we urge that a larger place be given in the curriculum of our church schools for teaching on marriage and the home, and commend the step taken by several of our denominations in providing for such instruction in the graded lesson material of religious education. We counsel the ministry of the church to conduct pastoral classes among their young people in preparation for home life, and classes for fathers and mothers in the field of parental education. We urge likewise a greater personal ministry to individuals particularly in extending personal counsel to young couples who come to be married, so that hasty and unintelligent marriages may be prevented and well considered marriages encouraged. Since many of our pastors feel themselves unprepared for the ministry that they would like to give in this direction, we urge upon all our theological seminaries a thorough training of the divinity student in relation to this future home ministration, particularly in the realm of mental hygiene family case work and sex instruction. For those already in the field, we strongly urge the continuance of social hygiene classes and conferences for pastors in order that they may keep in touch with developments of family life and prepare themselves for practical instruction in the family situation in their parishes. It is to be hoped that ultimately there will be established in every city a clinic on marriage and the home, in which there will be a staff consisting of a minister of religion, a psychiatrist, a physician and a social worker, who may render aid to any persons who may desire a consultation in regard to family plans and problems. Such a clinic should be on a paid, full-time basis. Pending such developments, however, voluntary experiments might well be conducted in this direction, in order that the church might give to the home the same expert technical advice in the religious realm that is now given to the community by specialists in other realms.

Dr. Miriam Van Waters, Referee of the Juvenile Court of Los
Angeles, has been appointed as director of a nation-wide study of child crime.

The purpose of the newly created Heckscher Institute for Child Health, New York City, is to provide periodic medical examinations and general health care of the children who attend the Heckscher Foundation.

During the summer months of the past year the Finnish Red Cross conducted an active campaign to interest school children in sun-bathing.

The new Provident Hospital for Negroes in Chicago is the first recipient of a grant of money—$750,000—from the Conrad Hubert Foundation.

The New York City Department of Health has opened a tuberculosis consultation service station in the Brooklyn Borough headquarters, Fleet and Willoughby Streets. Private physicians caring for patients suffering from tuberculosis, or suspected cases of tuberculosis, may obtain expert consultation service.

Dr. Jessie Marshall has been appointed to the staff of the American Social Hygiene Association, Division of Medical Measures. Dr. Marshall has had rich experience in children's hospital work and city health department work in England. Dr. Marshall will give special attention to the Association's program of activities on the medical aspects of social hygiene of childhood.

The 57th annual meeting of the National Conference of Social Work and Associated Groups will be held in Boston, Mass., June 6 to 14, 1930, at the Statler Hotel. Further information may be obtained from Howard R. Knight, General Secretary, 277 East Long Street, Columbus, Ohio.

Drug addiction is essentially a mental disorder, Dr. Walter B. Treadway, psychiatrist with the United States Public Health Service, declared at the recent annual meeting of the American Prison Association held in Toronto. Normal individuals might try drugs, he said, but would not ordinarily form a habit since drugs were not necessary
for the comfort of those enjoying mental health. He urged that the rehabilitation of drug addicts be attempted through a mental-health approach, not by any penal methods.

He estimated the number of drug addicts in the United States at 200,000, of whom in the past 3 years 12,000 have been committed to federal penitentiaries. He further stated that 70 per cent. of addicts started the habit following contact with other addicts and bad associations, chronic and painful illness accounts for 20 per cent. and curiosity, fatigue, etc., for 10 per cent. There are 4 male addicts to every female addict and the habit is confined to the third and fourth decades of life, relatively few being observed before or after 40, and few after 50. Fewer addicts are being noticed among the younger-aged people, suggesting that new and younger addicts are not now being made.—Men. Hyg. Bul.

As a result of several cases of supposedly food poisoning, which after investigation by health authorities were traced to the use in restaurants and public eating places of cyanide metal polish, a regulation relating to Section 149 of the Sanitary Code was adopted by the Board of Health of the City of New York, prohibiting the use of metal polish containing cyanide compounds.

The Hospital Book and Newspaper Society, 105 East 22nd Street, New York City, which in the past year distributed 3,530 books and 29,321 magazines and papers, is making an appeal for funds to carry on this worthy work.

According to figures reported by the Metropolitan Life Insurance Company the death rate from tuberculosis during 1929 will prove the lowest ever recorded in the United States. The cumulative mortality rate from all forms of tuberculosis up to the end of November, among approximately 19,000,000 industrial policyholders was 85.9 per 100,000—a drop of 5.7 per cent., as compared with that for the corresponding period of 1928.

An industrial hygiene clinic for the purpose of studying, diagnosis and treatment of industrial diseases is located at the Medical Centre, 630 West 166th Street, New York City.
During the past year $4,000,000 was expended from the $30,000,000 capital assets of the Julius Rosenwald Fund, Chicago, Ill., for educational and social welfare work in Canada and the United States. One tenth of the year’s appropriation was used to build 553 schools for Negroes.

The following interesting facts regarding New York City’s maternity were brought out by the Welfare Council as part of its health inventory of the city. Every 4 minutes a child is born in New York City—128,000 a year; 7,200 of these babies die before their first birthday; more than half of the number die within the first month; and about 40 per cent within the first week; for every 200 children born a mother dies at childbirth. To safeguard the life and health of mothers and babies the City provides through private and public welfare agencies 204 doctors, 120 nurses, 42 social workers and 67 others including nutrition workers, doctors and nurses in training, clerks, investigators, etc. There are 91 maternity clinics—14 maintained by the Department of Health and 77 by agencies outside the Department. There are 78 hospitals with maternity beds and 58 hospitals with maternity clinics. The report shows that 40 per cent. of the babies are born in hospitals; the 77 maternity clinics outside the Department of Health served 36,000 patients; the clinics supervised by the Department of Health cared for 3,300.

The result of these extensive health facilities is that New York City’s maternal death rate is lower than that of the State or of the country as a whole. A very large proportion of the staff of maternity hygiene agencies volunteer their services. Only 19 of the 204 doctors in the field are paid for their services. The visiting nurse plays an important part in this maternity service. Nurses from prenatal clinics made 63,000 visits and in addition the several nursing organizations reported 157,000 home visits to maternity patients attended by private physicians and midwives. A full report of the survey, a volume of 400 pages, has been issued.

The Pennsylvania Department of the American Legion is expanding its child welfare service.

According to the January report of the committee chairman 45 trades and professions in greater New York contributed $300,177.03
to the United Hospital Fund’s Golden Anniversary Campaign for $1,000,000.

The Congo branch of the Belgian Red Cross has undertaken the training of native men and women as nurses. The women are trained to practice midwifery.

The new building of the Florence Nightingdale School for Nurses, to which American nurses contributed $30,000, in Bordeaux, France, will be completed within a year.

The Standing Committee on Mental Nursing and Hygiene, appointed by the International Council of Nurses a year ago, met for the first time at the recent conference of the I. C. N in Montreal.

The program of the Committee for the next 4 years, as outlined by Karin Neuman-Rahn of Finland, Chairman of the Committee, is:

To secure the compulsory inclusion of mental nursing and hygiene in the curricula of all schools for nurses.

To encourage the various countries to arrange for post-graduate courses in mental nursing and mental hygiene and to secure the inclusion of this subject in post-graduate courses for public health nursing.

To get courses for administrators and teachers in this field arranged at universities or elsewhere.

To get all affiliated and associated members of the International Council of Nurses to appoint representatives or corresponding members of the committee.

To try to get the national organization to form national committees on mental nursing and mental hygiene.

To get the chairmen of these committees made official members of the national committees on nursing education.

To maintain contact between the national committees by sending our circular letters which can be discussed, criticized, and thus help to develop new ideas and bring about new suggestions, these to be returned to the chairman and then to be studied, assimilated, re-stated, and returned to the members of the committee.

The following public welfare activities of our Southern neighbors were reported in a recent issue of Pan American Union. Bolivia is making a concentrated effort to erradicate malaria. One of the pre-
cautions is the free distribution of quinine and free medical attention to Government and civil employees. The Government of Bolivia has issued a decree that all persons suffering from venereal disease may receive free treatment, medicine and hospital care in any Government institution. Clinics will be set up to treat the sick and carry on a campaign of prophylaxis. Chile has opened a community centre for workers in Santiago. This centre contains every facility for the recreation and improvement of the workers and includes a theatre, a library, classrooms and workshops. A park is also part of the centre. Colombia has opened a new hospital for lepers and is also carrying on a nation-wide campaign against the mosquito. Cuba has formed a national league to combat tuberculosis and has concentrated on reducing the infant mortality rate. The rate for the first 6 months in 1929 was 10.02 per 1000 births, a figure which shows a decrease of 1.64 per 1000 births as compared with the same period in 1928. The public health authorities of Haiti have established a visiting nurse service in Port Au Prince. Mexico has established a well-equipped school of child welfare. One of the features is a laboratory where mothers will be given practical lessons in child care. The Department of Public Education has completed plans for the erection of model houses (including furniture) in order to raise the moral and material level of rural laborers. Panama is to build several new and modern hospitals. In order to facilitate compliance with Law No. 54 of 1928, which provides for prenuptial medical examinations, free blood tests will be made in the laboratory of Santo Tomas Hospital. The Land Office of Paraguay has issued posters showing models of inexpensive houses, suitable for rural sections. These posters have been distributed in the schools in an effort to interest the children in the building of hygienic comfortable houses so indispensable to the health and general well-being of the people. A sum of 1,000,000 pesos has been appropriated by the Government of Uruguay for the construction of a hospital and two sanitariums for the treatment of tuberculosis.

As a result of a 2-year study of the health needs and facilities in each of the 5 boroughs of New York City, the Welfare Council concludes that in regard to cancer New York City's resources for the control and treatment of the disease are inadequate.

A large appropriation has been made to the New York City Police Department for the establishment of a Crime Prevention Bureau.
Crime prevention among girls and boys will form an important part of the program.

The Community Health Association of Boston, Mass., has appointed a social hygiene worker to the staff.

**Can Maternal and Infant Mortality be Reduced?**

Valuable indication that fewer mothers and infants die among those reached by public health medical and nursing services is contained in certain figures just compiled for the child health demonstration of the Commonwealth Fund and released for our use through their courtesy.

During the four-year period covered by this special study there were 10,444 births in the four demonstration communities. In 2,518 cases, about one-fourth of the total, nurses of the health department gave prenatal instruction and supervision in coöperation with the family physician. In the group under such supervisory care there were only 8 maternal deaths in comparison with 60 in the group not served, 65 stillbirths in comparison with 383 in the group not served and 40 infant deaths under one month in comparison with 297 in the group not served.

The comparative mortality and stillbirth rates are as follows:

<table>
<thead>
<tr>
<th></th>
<th>Maternal Deaths per 1,000 Births</th>
<th>Stillbirths per 1,000 Births</th>
<th>Infant Deaths Under One month per 1,000 Live Births</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Under care</td>
<td>Not under care</td>
<td>Under care</td>
</tr>
<tr>
<td>All Demonstrations</td>
<td>3.2</td>
<td>7.6</td>
<td>25.8</td>
</tr>
<tr>
<td>Fargo, N. D.</td>
<td>3.9</td>
<td>5.4</td>
<td>17.0</td>
</tr>
<tr>
<td>Marion County, Ore.</td>
<td>0.0</td>
<td>3.8</td>
<td>6.2</td>
</tr>
<tr>
<td>Clarke Co., Ga.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>6.5</td>
<td>15.2</td>
<td>30.4</td>
</tr>
<tr>
<td>White</td>
<td>4.8</td>
<td>6.3</td>
<td>9.7</td>
</tr>
<tr>
<td>Colored</td>
<td>7.9</td>
<td>28.6</td>
<td>47.6</td>
</tr>
<tr>
<td>Rutherford Co.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tenn. Total</td>
<td>2.5</td>
<td>8.3</td>
<td>43.1</td>
</tr>
<tr>
<td>White</td>
<td>1.8</td>
<td>7.3</td>
<td>38.9</td>
</tr>
<tr>
<td>Colored</td>
<td>4.0</td>
<td>11.5</td>
<td>52.6</td>
</tr>
</tbody>
</table>

In these 4 communities 6,234 infants between one month and one year of age had either field nursing service or medical supervision in health centres, or both, while 3,425 infants did not have such care.
There were 113 deaths in the group served and 163 in the group not served. The comparative mortality rates in this age-group (calculated in relation to the number of infants still alive at one month of age) were as follows:

<table>
<thead>
<tr>
<th></th>
<th>Under care</th>
<th>Not under care</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Demonstrations</td>
<td>18.1</td>
<td>47.6</td>
</tr>
<tr>
<td>Fargo, N. D.</td>
<td>16.5</td>
<td>80.7</td>
</tr>
<tr>
<td>Marion County, Ore.</td>
<td>4.3</td>
<td>25.9</td>
</tr>
<tr>
<td>Clarke County, Ga.</td>
<td>19.5</td>
<td>71.8</td>
</tr>
<tr>
<td>White</td>
<td>7.6</td>
<td>49.1</td>
</tr>
<tr>
<td>Colored</td>
<td>34.4</td>
<td>114.5</td>
</tr>
<tr>
<td>Rutherford County, Tenn.</td>
<td>31.5</td>
<td>57.8</td>
</tr>
<tr>
<td>White</td>
<td>28.9</td>
<td>48.6</td>
</tr>
<tr>
<td>Colored</td>
<td>39.4</td>
<td>83.7</td>
</tr>
</tbody>
</table>

Where care was given the infant mortality rates were especially low for congenital causes, respiratory diseases, and diarrhea and enteritis. Among infants under one month of age the mortality rate from congenital causes, was 11.5 for the group served and 31.0 for the group not served. Among the older infants the rates for the group served were 5.0 for respiratory diseases and 3.8 for diarrhea and enteritis, as compared with 14.3 and 13.4, respectively, for the group not served.

These figures are supporting evidence that a favorable showing can be secured in the form of low mortality rates where preventive maternity and child health services are organized.

NEW PUBLICATIONS

Why Sleep? This interesting pamphlet which is published by the U. S. Department of Labor, Children’s Bureau, points out the importance of rest and sleep for growing children. Minute details regarding regularity of the bedtime hours, covering and temperature of the sleeping room are given. If this important and simply worded pamphlet could be placed in the hands of every parent in the land the great army of nervous and unstable children and adults would in a short space of time be sharply reduced in numbers.

Your Child’s Teeth. By Percy R. Howe and published by the U. S. Department of Labor, Children’s Bureau. This folder stresses the mother’s responsibility for the teeth of her child during the
months of pregnancy and gives explicit and authoritative advice regard­ing diet for the expectant mother and for the baby after birth, through early childhood and the necessary care and precautions to be taken to ensure sound healthy teeth which will last through life. The important point is that teeth are not a unit in themselves, unrelated to the rest of the body, but are a vital part of the body, affected by whatever affects the body as a whole. Medical supervision, an adequate diet, sunshine, sleep, exercise and a happy environment all play an important part in body development and consequently tooth development.

The Annual Report of the Hospital for Joint Diseases, New York City. This report gives an interesting account of the splendid work accomplished in the past year. The Hospital was organized in 1905 and opened in 1906 in a small building which accommodated 7 patients. Year by year the Hospital has grown and it now consists of buildings with 277 bed patients, and out-patient department with capacity for daily attention of 1000 and over, and a Country Home which cares for 75 patients. The Hospital also maintains an active Social Service Department.

Improving the Dietary Habits of a Rural Community. By Ruby M. Odell, formerly Nutritionist of the Cattaraugus County Health Demonstration, Milbank Memorial Fund, New York City. The report gives an interesting account of the educational work carried on through the homes, schools and clubs in an effort to improve the dietary habits of a rural community. The study of the food habits of 100 families shows quite definitely the value of such work.

Signs of the Times. Published by the American Social Hygiene Association is a brief resumé of social hygiene in 1929 and gives a brief but graphic account of the vast amount of work accomplished. How truly wonderful would be the report were it possible to compile statistics regarding the educational value of the work in figures showing the vast army of young people who were given a clean wholesome idea of life and sex and, therefore, saved from the devastating venereal diseases.
Significant Facts Regarding the Turnover of Case Workers in Family Welfare Agencies During 1927 and 1928—a study of the Personnel Problems Committee of the American Association for Organizing Family Social Work, New York City. Workers in the various fields of social work as well as administrators and committee members will find much to interest them in this study. The facts brought to light are startling as one might expect when told the annual turnover of case workers in family welfare agencies is 35 per cent. The Committee hopes this examination of the factors entering into some resignations of 1927 and 1928 will arouse the family field to the seriousness of its turnover problems and stimulate further study.

The Report of the Rockefeller Foundation. This voluminous report—460 pages—gives a full account of the work of the Foundation for the year 1928. Concise and graphic as the printed and illustrated pages are no words can fully describe the far-reaching good accomplished through this stupendous effort to conquer disease and give light and health to the far corners of the globe. Dr. George E. Vincent, President of the Foundation, in a short review summarizes the work accomplished.

A total of $21,690,738 was expended during the year for research, educational and health work. Hookworm, veruga peruana and respiratory diseases were especially studied. Support was given to medical schools, colleges, nursing schools, public health organizations in all parts of the world. Aid was given to 21 countries in fighting hookworm, malaria and other parasitic diseases.

During the year 802 fellowships were granted to men and women from 46 different countries. From May, 1913, until December 31, 1928, the expenditures of the Rockefeller Foundation have totaled $144,189,000. A staggering sum but even that amount of money fades in the background as one catches a vision of the multitudes whose lives have been made safer, richer and happier because of this splendid service to mankind.
ABSTRACTS


It is now conceded that orthopedic surgery consists of the prevention and correction of deformities and the preservation and restoration of function. Notable advances have been made in all the principles of orthopedic surgery, but the greatest progress has been made since the World War, especially in occupational therapy. Without the assistance of physiotherapy, hydrotherapy, heliotherapy, massage and occupational therapy, the results of rehabilitation would not be so encouraging. Occupational therapy is based on the principle that occupation which requires a series of coördinated, specific, voluntary movements, involving the personal interest of the patient will attain or maintain the maximum physical condition of the parts involved. The effect of a beautiful and harmonious atmosphere was understood by the ancient Greek physicians, who surrounded their patients with beautiful pictures and diverted their minds with music. The same idea was voiced by American physicians as far back as 1803. In that year Reil wrote a book an the subject of work as a diversion for mental cases. Bloomingdale Hospital, New York, has employed various forms of occupational therapy for patients since 1813. It was not until the close of the Civil War that occupational therapy was used in hospitals other than mental. In 1906 Miss Susan Tracy, one of the pioneer occupational therapists advocated a course in this subject as a part of every nurse's training. During the World War it was found necessary to provide occupation for the sick and wounded soldiers. Needless to say occupational therapy proved successful as a therapeutic agent and it is now conceded to be of equal value in civilian hospitals. The aides are no longer looked upon as intruders but as important allies in treatment of disease and restoration of health. Occupational therapy should be prescribed and directed by the physician treating the patient. The work is divided into three types: (1) Occupation—with curative and vocational outlook; (2) Curative or therapeutic, and (3) Vocational, having economical value. Coöperation between the various departments is essential. The therapist must understand the physical and mental reaction of her patient. She must constantly supervise her patient's work and guard against fatigue. Types of movement, exercise and work are enumerated and described by the author who is of
the opinion that every patient no matter how short a time he is in the hospital should receive the benefit of well applied physical therapy.


Certain groups of women interested in protective work with girls were responsible for the first appointment of women police officers and their continued interest is largely the reason for the rapid increase in the number of cities employing women officers. In cities where competent women officers are doing satisfactory work the officials consider them as necessary members of the police force. In other cities where the women have not been chosen wisely they have failed at tasks which they were unfitted to perform. This has caused officials to question the value of women officers in police work, but those who have studied the situation feel that there is need for women officers in every police department. The problems which have to do with women and children undoubtedly can be handled by a woman officer. Two groups of women have been employed in police departments in the United States. The one group consists of civilian employees designated as matrons who are employed to supervise and attend women held in custody. The other group consists of women sworn in as police officers. (New York City presents an exception to this terminology—women elsewhere designated as matrons are called "policewomen," while women doing police work are designated as "patrolwomen"). In large cities where the work is well organized the duties are closely defined but in smaller cities there is less distinction, therefore, over-lapping. Three questionnaires on the subject of employing women police officers have been sent out. To Lieutenant Van Winkle's questionnaire (1919-1920) 146 cities made reply: 56 cities reported that they employed 175 women in their police departments. To the Bureau of Social Hygiene's questionnaire (1924) 268 cities replied: 210 employed women in the following capacity; 71 employed both as matrons and police officers; 65 employed matrons only; 52 employed police only; 22 employed 1 person as both matron and policewoman; 58 employed no women in their departments. Of the 100 largest cities in the United States 92 employed women in their police departments; 56 employed matrons and women police; 24 employed matrons only; 10 employed women police only; 2 employed 1 person as matron and policewoman. Commissioner Rutledge (1929)
received replies from 202 cities: 164 employed women in the following capacity; 77 employ women police only; 48 employ both matrons and women police; 39 employ matrons only; 38 employ no women in their police departments. These cities employ 465 women officers and 294 matrons. Since the earliest appointments it has been the practice of women officers to work almost entirely on complaints made to the police department having to do with women and children. In some cities there are enough women officers to take care of all such complaints; in other cities many charges covering women and children must be taken care of by men. In certain cities in addition to working on these complaints the women officers investigate community conditions that make for delinquency, supervise commercial recreation open to women and children and seek to make contact with girls who need protection. Some of the social problems represented by the complaints received by the police departments are: lost children who are problems because of bad family situation; dependent and neglected children and girls; truancy from home or school; petty larceny or waywardness; complaints about adolescent girls; leaders of gangs; immorality; runaway girls and women; cases of crime against children and crimes committed by girls and women. The tasks and duties of the policewoman are manifold: she is in direct touch with every conceivable community and human problem and those who understand the importance of social work agree that every city should consider woman officers as part and parcel of its police department. As a basis for estimating the field of service we may consider that woman officer will concern herself with any situation arising in a public place which might be harmful to women and children. She will give attention to downtown streets, depots, docks, parks, public rest rooms, burlesque theatres, moving picture houses, amusement parks, tourist camps, employment agencies for the unskilled and semi-skilled workers, questionable hotels, rooming houses, dance halls, cabarets, barbecues, suspected beer-flats, suspected blind-pigs and suspected disorderly houses. These are some of the duties which fall to the woman officer in her protective patrol work. The author goes into detail regarding the organization, the necessary coöperation and assistance given to the matrons in regard to women offenders held in custody, standards of appointment, salaries and legal status and the difficulties as well as the advantages of introducing women into a heretofore man-managed department. In regard to training the author believes that in addition to certain educational requirements ex-
perience in social work is most desirable for women police officers. Teaching and public health nursing are next in order of desirability. The women police officers must be familiar with all community resources and seek cooperation from the various agencies in handling her problems. Whenever possible treatment work should be turned over to the welfare agencies. The work of the woman police officer and the social worker is closely allied as each seeks to prevent social catastrophies and where prevention is impossible to remedy social ills and help people to self-realization and self-adjustment.


Hospitals meet the requirements of the sick public but hospitals and the medical profession in general until recently paid very little attention to the subject of chronic invalidism. The author draws attention to the fact that a large group of people suffering from nervous affections, tuberculosis, diseases of the heart and arteries and metabolic disorders can be restored to usefulness if facilities for adequate treatment are supplied. There is also another large group which is forced into chronic invalidism by a failure to recover from some acute illness. This class of cases frequently result from an attempt to discharge patients too soon in private practice or to discharge them too early from the hospital. An understanding of the patient and an adequate convalescence would do much to reduce or prevent entirely future invalidism in this group. Each group of chronic invalids has its own problems. The tuberculous patient is convalescent as soon as toxemia ceases to disturb him, unless the disease is too far advanced; the chronic heart patient feels quite well as soon as his reserve is restored and the metabolic cases often feel as well as usual soon after equilibrium has been established. However, all these patients are liable to further illness unless guided and controlled. The chronic nerve cases comprise many types; those who may be restored to usefulness and those who will never be restored. The problem of the future invalidism of these cases can best be determined in an institution with adequate facilities for carrying out treatment. Institutions for the care of chronic patients do not need the elaborate or costly appurtenances of the general hospital, but should provide for simple hygienic accommodations and be equipped with ample facilities for carrying out a regimen of strengthening the
individual and building up physiologic equilibrium and resistant physical constitution. The stay in such an institution is necessarily prolonged, therefore, the surroundings must be pleasant and interesting and the psychological aspects of the patients must be carefully considered. The food must be good and a varied diet provided to tempt jaded appetites. Every facility for rest, exercise and recreation must be provided, but the secret of success in managing an institution for this class of patients is to keep the patients happy and cheerful.


This article which appears in both French and English in the October issue of the I. C. N. will be of great interest to American nurses, social workers and others interested in public health and kindred work. Social problems in France present the same picture as in America and elsewhere. Changing conditions of modern life in France result in the same human problems. Industrial progress, over-population and slums of the great cities, the vast army of women working outside the homes, the decrease in the birthrate, stillbirths, infant mortality, the spread of venereal disease—particularly since the Great War—are a few of the outstanding problems which demand urgent treatment and intervention of medical science. These social and at the same time preeminently medical problems cannot be handled by the doctor alone. These rapidly increasing social needs are being met in France as in America by the public health nurse and the social worker who assist the doctor by carrying out his technical orders and instructions and supplying him with social data. The author gives an account of the training of public health nurses and social workers in France. One of the outstanding points in this interesting article is that the author's ten years' experience in training public health nurses has convinced her of the advantages of combining the public health nurse's functions with those of the social worker and to prefer generalized to specialized service.
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