WHAT CAN THE HOSPITAL SOCIAL SERVICE WORKER DO FOR INDUSTRIAL MEDICINE?

ALICE HAMILTON, M.D.

Assistant Professor of Industrial Medicine, Harvard School of Public Health, Boston, Mass.

Some twenty years ago when I first began to work in the field of industrial diseases there was no such thing as hospital social service. Never having been in clinical practice I did not realize the great need for it then, the need first made known to the world at large by Dr. Richard Cabot, but it was not long before I discovered that industrial diseases could not be adequately treated unless there were in every dispensary and hospital at least one person who would devote time and an intelligent attention to the industrial history of the patients and to the problem of their employment after discharge.

The situation at that time was truly deplorable, both to the seeker after data on industrial diseases and to the physician interested in preventive medicine, for a search through records showed only too plainly that, even when the disease was clearly one of occupational poisoning, nobody was concerned with its origin or with the future fate of the victim. A case of malaria in Chicago, or of amebic dysentery in St. Louis, or of typhoid fever in Boston, would arouse the liveliest curiosity as to where the infection had taken place, but ninety-four cases of lead poisoning could be recorded in the books of a St. Louis hospital in one year without anyone caring where they had come from. The interne was content to write "Lead worker" or "Laborer," although then he would go on to note with maddening detail how much alcohol, tobacco and even tea and coffee the patient had consumed. The amount of lead to which he had been exposed and the length of time the exposure had lasted did not interest anyone, nor did anyone know whether or not he returned to lead work after discharge. My own records showed that he very often did.

Nor was there any connection at all between the knowledge gained in the hospital and the conditions obtaining in the factories. Phila-
Philadelphia was at that time one of the great centers for industrial plumbism and there were certain plants which sent so many cases to the city hospital that they were commonly known to internes and physicians, not as cases of lead poisoning but by the name of the plant that sent them, it being taken for granted that all those men were leaded. The hospital knew that conditions in the plants were bad, worse, worst, knew it by the best possible evidence, the numbers of victims, but there was no way in which this important knowledge could have any effect in protecting the workers.

We all know that a great change has come in recent years, a change attributable partly to the passage of compensation laws, partly to better factory inspecting, partly to the activity of insurance companies, partly also to the awakened conscience of the employers and the increased value of a steady force of employees, for we see great improvement even in such states as Pennsylvania where there is no compensation for industrial poisoning. What part can the hospital social service worker play in the present situation?

Let me describe a system which I saw in one hospital where unusual attention is paid to industrial factors in disease, both by the out-patient department and in the wards. The industrial history of the new patient is taken by the clerk with more than the usual detail and these cards are gone over by the social service worker who selects all those which she believes might possibly have some bearing on the diagnosis. These individuals she interviews and obtains a full history of employment, which she notes on the card for the examining doctor. When in doubt she visits the factory in question and gradually in this way she has come to know conditions in many plants and the details of many industrial processes, together with the chemical compounds used, and has been able often to help in the diagnosis in doubtful cases, of which of course there are many. Her knowledge of the poisonous substances used in industry is greater than that of all but a small minority of practicing physicians. Upon the patient's discharge she is in a position to give intelligent help in finding him a safe job, free from the special risk which in his case must be avoided. For instance she would know that a woman who had had gastric and nervous disorders when working with rubber cement should not take a job in dry cleaning, and that a painter recovering from lead colic might accept a job of outdoor painting or of lacquer spraying with little risk.

When it comes to her help in obtaining compensation for victims
of occupational poisoning, the situation is less clear. It seems a form of aid which the social service department of a hospital should offer freely, but this is not so simple as it seems. Insurance companies can exert a good deal of pressure on hospitals and more than one has had to call a halt on the activity of the social service department in this field. It may be that some day sickness insurance in the United States may be a function of the State, as it is in other industrial countries, where profit plays no part in such insurance and where the furnishing of full information is simply a public duty. Even without this form of assistance, however, the social service worker has a large field in supplementing the work of the physician with regard to the victims of industrial poisons.
THE PLACE OF THE LEGAL AID CLINIC

JOHN S. BRADWAY

Professor of Law in the Law School of the University of Southern California and Director of the Southern California Legal Aid Clinic Association and Secretary of the National Association of Legal Aid Organizations, Los Angeles, Cal.

After a period of mutual appraisal, law and social work actually are establishing contacts in the interstitial field known as legal aid. Courses in law have been given in schools of social work; institutes in law are given at state conferences; papers on law and its relation to social work begin to appear. In the midst of this development from the social viewpoint it is not surprising to see similar growth from the legal side. Our purpose here is to consider one of the pieces of experimental machinery which the law is trying out and which helps to establish contacts with the social work field. The particular subject is the legal aid clinic. Let us consider it first from the legal standpoint.

The general field of legal aid is or should be reasonably familiar to the social worker and it should not be necessary to do more than indicate that a legal aid society is established to assist the poor person who, in his search for justice, is confronted by the three obstacles of court costs, delay of court procedure and the need for a lawyer. Legal aid societies have existed in this country for over 50 years. It is only recently, however, that attention has been given to the problem of how to secure adequately trained persons to serve on the staffs of such organizations or the even more interesting task of developing a body of informed public opinion at the bar to support legal aid growth. The legal aid clinic is a device to accomplish these two results. The point of view of the legal aid attorney has been developed more or less in a hit and miss fashion. When there was a vacancy in a legal aid society’s office, search was made among members of the bar who seemed to be kindly disposed toward clients
in general and the best man was chosen. The field of choice was limited pretty much to the personal acquaintance of the board members, and it has been a matter of satisfaction that the men and women chosen in almost every case turned out to be efficient, conscientious, hard-working, devoted public, or quasi-public, servants. As far as the quality of the service rendered by legal aid attorneys is concerned, there has been no real reason to change the time honored system of taking a man or woman, putting him in the position and letting him find his own philosophy and reason for continuing. When he was ready to go elsewhere the board of directors sought for a successor and the process was repeated.

In time it has become obvious that this procedure was not accomplishing anything more than supplying a succession of men most of whom started their legal aid career with little or no background as to the type of work to be done. What was serious was the utter lack of machinery for informing the Bar as to the legal aid field and its relationship to the work of the legal profession. As a result lawyers for the last fifty years have gone on with their work too seldom realizing that there was such a thing as legal aid. It is not to be wondered that the lawyers as a group showed little interest in a movement of which they had no information.

In late years Bar Association Committees and other channels of information have come into existence, and the bar now has much data on the subject. However there remains another task, to interest the younger members of the bar in the work. The strategic point at which to give this instruction is while the recipient is still in a position to view law broadly, while the need for economic return has not absorbed too much of his time, before he faces the soul searching years endeavoring to locate enough practice to make a living. The third year in law school, just before the student takes his bar examinations, is this strategic position, and the legal aid clinic is placed at that point.

A legal aid clinic, by whatever name it is called, is a legal aid organization operated in conjunction with a law school and sometimes with an independent legal aid society. The law students under proper supervision handle the cases and gain actual experience therefrom.

It is interesting to record that the clinics when first established probably were not designed either to instruct law students so that they might take up legal aid work as their career or to build a body
of members of the bar thoroughly informed about the legal aid movement. The original urge, regarded from the point of view of legal education, was to bridge over the gap that existed between the instruction in law schools as taught by the case book system and the practical exigencies confronting the young lawyer in handling his first few cases. This earlier purpose has not been lost sight of. It is merely that the legal aid point of view is being added.

Perhaps a word of explanation should be given as to the law school point of view. Originally in this country law students were trained largely in law offices. Even when law schools were established there was a considerable period during which the method of instruction required work in a law office on the part of the student. Of late years the pressure of the curriculum has rendered extra­mural activities in law offices difficult. So there is an increasing demand for something in the law school itself which will supply the law student with actual cases to work on. Mock trials, moot court proceedings, law clubs and other extremely interesting and valuable devices are now in extensive use. However, the final touch is to give the student actual experience with individual human problems where the psychological characteristics of the applicant lend a sort of mental hazard to each case. The legal aid clinic supplies a machinery where flesh and blood clients sit across the desk from the student. As a matter of protection to the clients it is usually considered desirable to have the work conducted under the supervision of a lawyer who is at the same time a member of the law school faculty.

The legal aid clinic is, then, a piece of machinery in the legal aid field placed strategically to provide instruction in legal aid problems to prospective lawyers with the definite expectation of impressing upon them a new point of view.

Before discussing that point of view it may be well to say a few words about the organization itself. It should be kept in mind that we are speaking here not of legal aid societies in general but of the particular class known as legal aid clinics where the organization is connected in some way with a law school and the work, or a large part of it, is done by law students. As far as the writer’s information goes the first legal aid clinic was established at Colorado Springs about 1911. This one and several others of later growth remained in existence only for a short time. The oldest existing organization is the Harvard Legal Aid Bureau operated by the law students of the Harvard Law School. Other clinics are now in operation at the
law school of Northwestern, Minnesota, Cincinnati and Southern California Universities. Less ambitious plans of the same nature are being tried out at Pittsburgh, Yale and Washington University in St. Louis. Thus it is apparent that the idea is being given a practical trial in many parts of the country.

While the machinery differs in different places and admitting that it is still in an experimental stage, we may set down certain aspects common to all the places where it is active. There must be cases to work on and people to do the work. The cases arise from the difficulties of the millions of poor persons who seek legal redress in some form or other. Ceaselessly day after day such applicants appear in large numbers at the doors of every legal aid society in the country. There is no dearth of legal aid problems. The difficulty is to secure the people to take care of them. At Harvard the legal aid work is done by honor students. Elsewhere the prevailing tendency is to make the clinic work a required course for credit and to expect from the students the same attendance and attention as in the other law school courses.

Briefly, then, a legal clinic is a legal aid society in which much of the work is done by law students under supervision. It is a law office with legal work to do. To that extent it is bound by the same traditions and operated in the same general way as other law offices. There are no bills sent out and the clients are more numerous than in most law offices but the work is advising and assisting people to secure redress by law. The type of client and the strategic position of the legal aid organization in the administration of justice make for a very distinct point of view which the legal aid staff holds toward the work.

So far this paper has been devoted to the legal aspects of the clinic and how it is related to the lawyer and the law student. The rather long explanation was necessary to give the setting of the clinic from the viewpoint of the field of law. There remains to orient it from the viewpoint of social work. It is this intention to give the student more than a purely legal approach to the cases that is the newest development in the legal clinic field and which promises so much.

The clinic as we have said proposes to provide a machinery for giving a law student a chance to obtain a new point of view. The law as a science has been studied for a long time. In recent years Dean Pound of Harvard has called our attention to the law as a
 Legal Aid Clinic

means to an end—one form of social control. The legal aid clinic, while recognizing the importance of these aspects of the law, endeavors to show the student the individual as an individual and the law as it appears to the common man in the street. The applicant to the legal aid clinic comes into the office with a problem to be solved. The problem may be legal, social, medical, or economic. The client is not concerned with a technical classification into professional fields. He is interested merely in whether or not he gets relief. His view of the law and of government will be based largely on whether he is able to obtain relief. The law student facing such a person has both a responsibility and an opportunity.

If the student fails properly to interpret the law to the client, he makes a technical mistake. If he fails to see the broader significance of the client's case, and thus overlooks important phases of the difficulty, the client may well feel that he has not had the most effective treatment. He may well believe that the student regards him not as a human being, but as a theoretical legal problem which may be conjured up or dismissed from the mind by opening a case book. To do justice to the client's needs requires an understanding by the student of many things not covered by law. The legal aid attorney has found by long and sad experience the importance of understanding the whole problem. He realizes that something approaching a social diagnosis is absolutely essential if we are to secure an adequate solution, and he trains himself to observe many extra-legal matters. The clinic seeks to encourage the law student to observe these points of view and to diagnose the client's trouble on a broad rather than a narrow technical basis.

All legal aid clients are poor. That is a cardinal requirement by which the jurisdiction is fixed. In that respect they are like a great number of persons who come to social agencies. Many legal aid clients have psychological difficulties. Feeble minded and neurotic individuals do not come to psychiatric clinics alone. The student in the legal aid clinic must meet and deal with such persons. The student who gains an understanding of the extra-legal difficulties of the applicants has made a distinct advance. In the process of training the student this recognition is the first step. He cannot expect to render adequate service until his point of view toward the work has been developed. But the educational problem does not end with the diagnosis. There is also the long period of treatment during which the student must conduct the case to some reasonably ade-
quate solution. If there is only a legal controversy legal machinery will dispose of it. When the diagnosis assures us that social as well as legal problems are involved, social machinery as distinguished from legal machinery is needed. The student then must make use of the social machinery of the community. If he takes a step further and learns what is the machinery in the community for handling extra-legal difficulties, he has equipped himself in even better fashion.

If he goes still a step beyond and finds how to work with social workers, doctors, and other extra-legal professional groups in the solution of problems part of which are legal and part extra-legal, his position as a valuable member of the community from a social standpoint is enhanced. This third step in the process of learning how to make the social machinery of the community function on a complicated problem involving law and extra-legal points is about as far as a legal aid clinic can expect to go at the present time in training the student. Until the technique is developed in this line, there will probably be no particular fourth step.

This in brief is the purpose of a legal aid clinic—to lead the law student to take these three steps to learn about his community in the intensely practical work of helping some unfortunate person who cannot help himself and thus make himself a more valuable citizen. The clinic gives him an opportunity for enlarging his social vision. Undoubtedly in time many students will be interested in the extra-legal phases of the problems that come to them, and in later life as active practising members of the profession will retain this viewpoint. The ultimate effect upon the community cannot now be estimated.

Probably it will be well to discuss briefly some illustrative cases showing how the wider extra-legal implications in clinic cases are forced upon the attention of the student. The cases are taken at random.

In the first case a woman tells us that she married A, and lived with him for a time. She then obtained a divorce from him with an interlocutory decree providing that after a year had elapsed she might secure another decree and be free to marry again. Disregarding the injunction to delay a year, she waited four months and then married B. They lived together for a period of three months and then B deserted her. After the year has elapsed she desires to marry C, and comes to inquire what is the legal effect of the marriage to B. Should there be an annulment, a divorce, or is any action at all required?
Quite aside from the legal problem in this case, the alert student has an opportunity to catch a glimpse of disregard for law and of social problems of some significance.

In another field we find the case of the young woman who takes her child and leaves her husband, alleging cruelty. An investigation reveals that the husband complains she has become infatuated with another man; that the husband bears a good reputation, and that the welfare of the child will be advanced probably by taking him away from the mother.

The student here learns the value of investigation from the social viewpoint, the importance of not accepting the applicant’s story at its face value, the social aspects of the parents and child in their relation to one another.

As a third illustration take the case of the foreigner (nationality shall be nameless) who has done a thriving business in a small restaurant. Suddenly local conditions beyond the control of the proprietor take trade away and insolvency stares him in the face. He comes to the clinic asking how to handle his creditors. When bankruptcy is suggested, he confesses that he is certain the creditors will murder him if he goes into bankruptcy. The subsequent facts justify him in his fear.

Here there is a touch of the dramatic—a tingling of the nerves as advice is given in a crisis and life or death may be the outcome. Yet the advice given consists not so much of rules of law as of practical business suggestions.

Wives beaten by their husbands, able bodied children who refuse to support their parents, tenants in dispute with their landlords, neighbors who quarrel over hedges that overgrow party lines, a woman who entrusts a watch to a sailor to sell for her, a widow who believes she has been swindled out of a small estate left by her husband, parents who urge that a bill charged by a physician for services to the young son is out of all proportion to the value of the services, a man with an idea for a patent, an old man looking for a pension—these and hundreds of other matters are the daily routine. Each one gives the student a glimpse of a human problem. Out of the wealth of facts he must select those legally pertinent but must remember that the human element can never be ignored.

We could go on multiplying the illustrations. Our purpose is to indicate that the student in a legal aid clinic meets people with both legal and extra-legal questions.
It is difficult to anticipate the effect of this on the minds of law students. Perhaps it is the case that oil and water will not mix. At the same time there is a fair chance that a student, having once learned that there are extra-legal problems, and that social agencies, medical clinics and other extra-legal agencies are set up to care for such matters, will find it easier to think of making use of them in his cases later on.

Law schools are to be commended for establishing such courses. Social agencies may expect from them in due course a closer contact between lawyers and social workers. There should be a better understanding of the legal-social field, and in time a better method of handling human problems involving legal and extra-legal matters. Having started the machinery, we may now devote our attention to observing it in operation, keeping always an open mind as to the ultimate goal and the extent to which our machinery is filling real needs.

The field of law and the field of social work are in contact because of the interstitial field of legal aid. The legal aid clinic operating in that intermediate field will, we hope, supply us in time with a group of men holding a point of view. What use they make of the point of view is a matter for the future.
CAUSES AND PREVENTION OF NEONATAL MORTALITY*

RICHARD ARTHUR BOLT, M.D.

Director, Cleveland Child Health Association, Cleveland, Ohio. Formerly Assistant Professor of Child Hygiene, University of California, Berkeley, Cal.

The marked decline in the total infant mortality in nearly all civilized countries in the past 20 years falls almost entirely within the period after 1 month of age. Though the rates have declined relatively less during recent years they can not be assumed to be near bedrock so long as a number of localities can show rates below 50 and a few even approach 40. If further substantial reduction is to be made the emphasis in prevention obviously must be shifted to the causes not yet under any considerable control. Approximately half the total infant mortality is neonatal; that is, about 50 per cent. of the infant deaths occur within the first month of life.

Neonatal mortality rates vary less and less with time and place from 1 month of age back to 1 week and on the first day of life; and the causes underlying mortality from 1 to 12 months of age apparently have little influence on neonatal mortality. But causes of neonatal mortality are mainly responsible for fetal deaths as well. Therefore, a study of neonatal mortality should include miscarriages and stillbirths. Maternal mortality is so closely related to early infant mortality that this also must be taken into account. No direct correlation with industrial, social, economic, sanitary, or meteorological conditions is evident in the early deaths. Some variability with race is indicated by certain data, but it is comparatively slight for infants under 1 week of age and under 1 day. Neonatal mortality is high among firstborn infants, those born early or late in the childbearing period, very soon after a preceding pregnancy, or in multiple births, prematures, and males.

* Presented at the Fifth Annual Conference of State Directors of Bureau of Child Hygiene, Washington, D. C., April 1928.
The cause of neonatal mortality showing the highest rate in official reports is prematurity, the next is congenital malformations. The former has declined slightly since 1915, the latter practically none since 1917. The rate for neonatal mortality due to injuries at birth has been rising since 1918 (owing perhaps to some extent to more exact diagnosis, reporting and classification). The rates for "congenital debility" and for "other diseases of early infancy" have declined slowly. It is inaccurate to assume that deaths in early infancy are largely beyond our control or that they indicate any selective process; some of their causes are demonstrably preventable, and apparently they are not related to the strength or weakness of the child.

Intimate knowledge of the causes of neonatal mortality is essential to any program for their prevention. Some progress has been made in description of defects of the embryo, fetus, and newborn, but the basic causes of constitutional weakness and congenital malformations are still not clear. Constitutional differences undoubtedly explain differences in vigor at birth, in resistance and immunity, and in adaptability to environment, but many dangers that are strictly environmental can be greatly reduced by thorough prenatal care and skilled attention at birth.

The factors predisposing to and contributing to the causes of neonatal mortality are difficult to analyze because the classification in official statistics of stillbirths and neonatal deaths does not bring out clearly the relative importance of the factors involved. In the stillbirth statistics of the United States Bureau of the Census (issued since 1918) more than a third of the stillbirths are attributed to "causes not specified and unknown." They are compiled almost entirely from the clinical diagnosis or opinion of the attending physician, the exact cause being determined very rarely by autopsy. Hence reports are inexact, and from year to year certain causes are transferred. Some life-insurance companies, lying-in hospitals, and other institutions have made statistical studies, and individuals have made social, clinical, pathological, and serological investigations. The United States Children's Bureau has made field studies that are especially helpful as indicating the complexity of the problems involved and the interrelation of various factors.

Under the convenient scheme of Ballantyne as modified later by Holland, who uses "fetal death" in place of the ambiguous term "stillbirth," both fetal and neonatal deaths may be classified as fol-
Neonatal Mortality

follows: 1. Antenatal: Fetal or neonatal deaths from causes operating before the onset of labor, due mainly to maternal or fetal abnormalities. 2. Intranatal: Deaths from causes largely traumatic operating in the course of labor (spontaneous or instrumental). 3. Postnatal: Deaths from causes operating immediately after birth and during the first days of life.

A modification of the classifications of Ballantyne, Holland, Hess, Ehrenfest, and others is here attempted, by grouping under direct, contributing, and predisposing causes so far as is possible, in view of the frequent action and reaction of these causes one upon the other.

I. Prematurity, the reason most frequently reported for neonatal mortality, can be due to many possible combinations of causes, but the majority are preventable in some degree (as has been amply demonstrated in the case of prematurity due to syphilis and to the toxemias of pregnancy). The criteria of prematurity should be more clearly defined and more generally accepted by the medical profession. Hess classifies as premature “those infants born three weeks or more before the usual termination of pregnancy.” He also points out that weaklings, born possibly at term or nearly at term, whose nutrition and development have been hampered during intrauterine existence, may be considered in practically the same category as prematures but are often classified as congenitally diseased or debilitated. The following should be taken into account in judging of prematurity:

1. Length of intrauterine life (gestation period less than 260 days).
2. Birth weight and length (less than 2,500 grams and 45 centimeters).
3. Functional capacity (especially as to sucking, digestion, and the regulation of body heat).
4. Clinical evidence of general weakness or lack of development.

The direct causes of prematurity may be grouped as follows:

1. Trauma or mechanical injuries, as falls, jolts, strains and blows on the abdomen, also long or rough journeys in train or automobile, fatiguing work in the latter months of pregnancy, and induced abortions.

2. Nervous factors, as fright, anger, shock, severe pain, and reflex stimuli (as from genitalia or breast). Exposure to sudden change in temperature, especially hyperpyrexia, and epileptic and choreic seizures may be mentioned here.

3. Intrauterine abnormalities, as placenta previa, placental degeneration, adhesion or premature rupture of the membranes, endome-
tritis, hydramnion, and tumors, also extensive cervical tears and relaxation of the outlet.

4. Acute and chronic infections as influenza, pneumonia, typhoid fever, smallpox, syphilis (an outstanding cause\(^2\)), tuberculosis (less often a direct than a contributing cause), and focal infections (undoubted predisposing or contributing causes), which may set off premature labor in case of operations for appendicitis, cholecystitis, kidney affections, or other reasons.

5. Acute and chronic intoxications with lead, mercury, arsenic, phosphorus, ergot, carbon monoxide, alcohol, and other organic and inorganic poisons.

6. Toxemias of pregnancy (as leading to eclampsia, which frequently results in premature labor or is an indication for inducing it), chronic nephritis (either a contributing or an exciting cause), and severe hyperemesis.

7. Maternal heart disease (which, according to Hess, leads to premature birth in 30 to 35 per cent. of the cases of broken compensation).

8. Congenital malpositions and deformities of fetus (as hydrocephalus and spina bifida), abnormal presentations (as breech, transverse, and face), and malpositions of the uterus.

9. Endocrine dysfunction (as suggested by a number of cases of prematurity in which the mother had diabetes or exophthalmic goiter or the infant was found to have enlarged thymus or congenital goiter).

Contributing causes of prematurity are early, late, and multiple pregnancies, pregnancy closely following a previous pregnancy, habit of abortion and miscarriage (recently suggested to be due to some dysfunction of the corpora lutea), placental diseases, emotional instability of the mother, constitutional weakness of the mother resulting in defective nutrition for the infant, and maleness of the infant.

Predisposing causes, which are many and complex, may be stated categorically to be inadequate prenatal care, overwork and anxiety, work away from home (as fatiguing industrial labor), insufficient and unbalanced diet, certain pathological conditions (as pernicious anemia, leucocythemia, and hemorrhagic diathesis), and pelvic and spinal deformities.

II. Injury at birth is an increasingly serious cause of neonatal mortality, as has been stated. Intracranial hemorrhage is shown on autopsy for 40 to 50 per cent. of neonatal deaths, and approximately
10 per cent. of the newborn show some blood in the spinal fluid. Cerebral concussions, hemorrhage into the cord, and visceral hemorrhage should also be mentioned. Ehrenfest believes mechanical factors to be probably nearly always the immediate cause of traumatic injury. He also states as now established that the traumatism of a normal labor can lead to serious consequences if it is rendered pathologically important by coincident predisposing and contributing conditions.

Direct causes of birth injury are mechanical factors, undue compression of the head, sudden release of moulded head, unequal or sudden changes in pressure, unskillful application of instruments, use of high forceps, internal podalic version and rapid extraction, extraction of shoulders and after-coming head in breech cases, injudicious use of pituitrin and ergot, and rough handling of the infant in resuscitation.

Contributing and predisposing causes are often difficult to differentiate: The former include pelvic abnormalities, abnormal presentations, maternal or fetal dystocia due to the causes mentioned and to others, hemorrhagic diathesis and delayed coagulation time, precipitate labor and premature rupture of membranes, multiple birth, rigid cervix and unyielding perineum. Predisposing causes are prematurity, syphilis, asphyxia (often a result rather than a cause), toxemias resulting in eclampsia, acute infections and intoxication of mother (as leading to prematurity).

It is fully recognized that birth injury is not always the fault of the attendant, but many of the causes leading to such injury can be prevented by a combination of good prenatal care and skilled obstetrical service, the latter including moderation between radical interference and equally disastrous overconservatism in "waiting for Nature to take its course."

III. Some congenital malformations and developmental defects mentioned in the preceding paragraphs lead to neonatal mortality, but so little is known about their causes that no suggestion for their prevention can be made here. They are more likely to occur toward the end than in the beginning of the reproductive period.

IV. The terms congenital debility, congenital weakness, marasmus, and atrophy are so indefinite as causes of neonatal mortality that they might well be discarded and replaced by their causes. The third and fourth already have been dropped from official statistics in this country, and the second is used less and less. Certain maternal dis-
orders and disabilities among those already mentioned, also infarction or premature separation of the placenta, prolapse of cord, and hematoma may cause congenital debility.

V. Neonatal mortality may be caused by unskillful treatment of the newborn, acute infection (as septic or gonorrheal, also pneumonia and occasionally tetanus), and injudicious or rough handling or overexposure in case of a weak or premature infant. Prematures should have special attention from a well-qualified pediatrist in a thoroughly equipped hospital, and the growing practice of putting all infants in the care of pediatricians as soon as possible after birth should be encouraged.

In prevention of neonatal mortality the *sine qua non* is skillful and judicious obstetrics. The major responsibility rests upon the members of the medical profession who attend women in childbirth. The midwife is a minor factor in the problem. General practitioners, who still do most of the obstetric practice in this country, frequently attempt with disastrous results procedures that specialists in obstetrics may adopt safely in hospital practice with well-trained assistants. Consultants called too late can not repair damage already done to mother and child. Medical students should be given expert instruction in the technique of obstetrics, practical conduct of normal deliveries, detection of abnormality, and decision as to need of operative measures or need to refrain from them. They should be thoroughly impressed with the necessity of adequate prenatal care, also the value of maternity services and out-patient departments of hospitals, and good home or hospital facilities. Proper care of the newborn and of young infants should also be emphasized. It has been demonstrated that sufficient knowledge and skill are at hand to reduce the present neonatal and maternal mortality a half to a third, also that the ability of physicians in both home and hospital practice varies greatly. Neonatal mortality has been shown to vary from 1.5 per 100 live births to 8.6 for one group of 20 physicians, and from 1.3 to 10.9 for the 13 hospitals in Buffalo. (See figures of Hollingshead for Buffalo studies, in The Buffalo Foundation Forum, January-February, 1928, No. 63).

Although the first responsibility for successful outcome of pregnancy rests upon the physician who attends the birth, he can not be expected to assume responsibility for all that prenatal care implies: Education of parents, provision for hospitalization, exact records, statistics, follow-up in homes, and the research necessary to collate
all factors bearing on infant mortality. The community must assume its share of the responsibility. This means prenatal and maternity centers, maternity hospitals, prematurity care, facilities for public-health nursing and follow-up work and for diagnosis and treatment of venereal disease, registration, licensing, and supervision of all midwives and thorough training of those demonstrably able to conduct normal deliveries. It means also better registration of births, efforts to determine causes of stillbirths and neonatal deaths, and education of the public to the point of demanding better obstetric practice in general.

More complete and more accurate vital statistics should be collected, and they should be tabulated more uniformly. Getting every State into the United States birth-registration area is a first desideratum. The data should be more exact in regard to time, causes, and contributing causes of stillbirths and neonatal deaths and should be compiled and published more promptly, with correlation of the outstanding data. More use should be made of local vital statistics.

Maternity benefits are urgent because the increasing cost of obstetrical service under modern conditions of hospitalization, nursing, et cetera, is already a hardship for the middle class. Some form of benefit insurance is necessary to take care of emergencies and to provide for home help, if medical and nursing service with hospital care for maternity can not be made available at rates the people can afford.

More research is required in regard to the mothers and babies who die and also those who survive. Studies should cover a large enough group of cases and a long enough period of time to give reliable statistical data. Investigations now being made by the United States Children's Bureau and the University of California Institute of Child Welfare furnish good examples. Studies of pregnancy in the light of the whole family background are needed, also fuller records of pregnancy and its outcome and more careful autopsy study of fetal and neonatal deaths.

Parental and preparental education is vitally necessary. Any plan of instruction should stress the importance of early and continuous prenatal care, of employing a physician who has sound judgment and obstetrical skill, and of having good hospital care. Detection and prevention of syphilis, prevention of and immunization against acute communicable diseases, advantages of community organization for maternity care and of maternity insurance should be emphasized; and
the notion that operative procedures meet all exigencies and that every labor must be hastened should be dispelled.

REFERENCES

1 In statistical practice birth is taken to mean "the instant of complete separation of the entire body of the child from the body of the mother. The umbilical cord need not be cut or the placenta detached in order to constitute complete birth for registration purposes. A child dead or dying a moment before the instant of birth is a stillbirth, and one dying a moment, no matter how brief, after birth, was a living child and should not be registered as a stillbirth (Mortality Statistics, 1907, p. 490, U. S. Bureau of the Census, Washington, 1909).

2 The incidence of congenital syphilis in the white population seems to be about 5 to 10 per cent. See the recent investigations of Adair and O'Brien, Holland, Jeans, and Williams, also Cruickshank's "Maternal Syphilis as a Cause of Death of the Fetus and the Unborn Child."
STAFF EDUCATION*

ELSA BUTLER GROVE

Lecturer in Social Science, Teachers College, Columbia University, New York, N. Y.

Perhaps at the outset we might stop for a brief contrast of the world in which we used to live with that of the present. Not too long ago a well known minister wrote a lecture called “Acres of Diamonds,” a speech which was repeated before many audiences and was found so appealing that a large university was founded upon the gate receipts (unless indeed myth and history have been confounded). There were two factors in the social setting which made such a large return on a single lecture possible; one that radios had not been perfected to bring about a universal audience for one brief moment of time; the other, that social conditions did not change while the minister referred to was travelling about to reach his new audiences.

Today conditions change while we write about them, much to the consternation of the social researcher. Speed is reflected in our shifting standards of social work, our constantly changing objectives, the increasing territory over which social welfare must play. Hence, the need for the new field or science (by courtesy at present) of social engineering.

The field of organized social work is fairly new; the field of medical social work is even newer, celebrating its 25th birthday in 1930. The salaries offered are small and the opportunity for advancement slight. Once a Head Worker, always a Head Worker. Quo vadis?

At present we find a great dirth of well qualified workers for all fields of social work; while the Schools of Social Work will eventually show us the way out of this shortage of workers, at present they are

*Read at a dinner of the Mid-Atlantic District of the American Association of Hospital Social Workers, Philadelphia, Penn., October 1929.
turning out executives and relatively few staff workers. The education of such leaders is becoming very expensive; covering 2 or 3 years of graduate university work, coupled with years of field experience; though whether this field experience shall antedate, coincide, or follow such graduate study is still a debatable point.

At Bryn Mawr this year (1929-30) there are some 11 students enrolled in the graduate department of Social Economy and Social Research; each student holds a scholarship or a fellowship. In other words the education of each student is being subsidized.

There are 91 schools preparing students for medical social work throughout the United States. In the Mid-Atlantic District of the American Association of Hospital Social Workers where there are some 230 members enrolled, there is no school training students for medical social work. In the North Atlantic District with 500 members we find that the New York School of Social Work reports that during 9 academic quarters, “42 students have had field work in hospital social service, and of these 4 have graduated from the School.”

In the report of the Educational Secretary of the American Association of Hospital Social Workers (Miss Kate McMahon) for 1928 she there is the following statement: “My estimate is fifty students graduating this year from the combined schools.” In other words there are fifty graduates entering a field employing about 1500 medical social workers throughout these United States. It is fairly obvious that for the present we cannot look to the Schools of Social Work to furnish medical social workers in large numbers.

One should mention at this point some efforts at staff education. During 1928-29, in Philadelphia a course of twenty hours was given to some thirty workers employed in Philadelphia hospitals and in New York a course of twenty-four hours was given to ten workers employed in Greater New York hospitals. While during 1929-30 eleven new workers are receiving similar instruction in New York. But such a single course in medical social problems should not be confused with the training given to a student graduating from a School of Social Work, fully equipped for the profession of medical social work.

As an experiment in teaching we might view for a moment the course in Hospital Management which has been inaugurated this year (1929-30) by Fordham University, in its School of Sociology and Social Work. Here lectures in Medical Social Work are an integral part of the theory of Hospital Management. There are
some thirty students enrolled in the course, of whom twenty-seven are Sisters, actively engaged in hospital nursing; an attempt is being made to create a demand for hospital social work by having people connected with hospital administration understand the function of social service in the larger plan of hospital management. Fordham University also has a two hour weekly seminar (one semester) in medical social work for students who have carried sixty hours of credit in the School of Sociology and Social Work. (In 1929 there were five students enrolled in this course.)

If then we keep in mind the fact that only fifty students graduated as medical social workers in 1928 throughout the United States; that in 1927-29 only four graduated in the North Atlantic District; that there were no graduates in the Mid-Alantic District; that in 1928-29 there were extension courses for a small number of staff members in the North and Mid-Atlantic District; then we need feel neither surprise nor shock at learning that in making new appointments to the hospital social service staffs in these two districts there has been recourse to attracting workers from other fields of social work, or to the appointing of apprentices. This is a situation which all medical social workers rightly deplore. But, like spilled milk, the situation is here and must be met to the best possible advantage, keeping the hospital (both patients and standards of care) in mind and also the need of protecting the already employed medical social workers from unfair competition. Thus we are not far from the questions which have been agitating Law Schools and Trade Unions; how to keep the numbers down to prevent ruthless competition and how to raise standards within the fold.

However, we can take heart from the allied field of Public Health Nursing; years ago when the supply of well-qualified nurses was small, graduation from Teachers College, Columbia University, was the entree to an executive position with a high salary. Today with an annual enrollment of 350 nurses at the college (and with other universities also having heavy enrollments) the public is better off but the public health nurse is not! She must perforce work her way up into an executive position. So today the Visiting Nurse Associations have less to do with breaking in raw recruits (apprentices) and more to do with raising standards within the staff itself.

But to the main argument; how to staff our hospitals. First let us turn our attention to the rôle of the Head Worker.
Our assumption is that the Head Worker in each hospital is a social engineer thoroughly equipped for her task of directing the social service program entrusted to her care. She has a complete understanding of the hospital and its policies and its capacity for service (its history, its equipment, its budget) and an acquaintance-ship with its Trustees, Staff, and minor personnel. She has a first hand knowledge of the neighborhood in which her hospital is located and of the neighborhoods in which the patients live and by which they are affected. She knows the social agencies in the city, both public and private, making a frontal attack upon the destructive forces operating in these neighborhoods (such as overcrowding, improper housing, unsuitable recreation, unemployment, premature old age, inadequate schooling, poor health). Thus having comprehended the total setting in which her hospital is functioning, this Head Worker must perfect the organization within her department to achieve the goal of social service set by her hospital. She must assign to staff workers the tasks involved for achieving this goal, giving enough variety of responsibilities to prevent dull routine and enough room for independence of thought to make for fine staff relationships and good group thinking; yet withal enough direction and teaching to develop the staff workers.

Along with the other duties of the Head Worker comes the too frequent necessity of replacing staff members who have resigned for one good reason or another (promotion or marriage are the usual happy reasons for leaving). Where shall she find a successor to the efficient worker who has left? Or, if her department is expanding, where shall she find a new person to appoint to her staff? Frequently an apprentice is the only solution. But how will this Head Worker teach this new staff member all that must be learned? By private tutoring? Neither tutor nor tutee like this method; it is wasteful of time and lacks that spark of stimulation which comes from group discussion. Besides the apprentice is lonely; she is like "the last rose of summer, left blooming alone; with no flower of her kindred, no rosebud nigh, to reflect back her blushes or give sigh for sigh." Professor Giddings has been kinder in his description of this disease; he calls it "consciousness of kind."

Besides in how far are we aware of the fact, when orienting new workers, that they may have come to the staff with preconceived notions regarding the nature of medical social service and their part in it, so that the person teaching the new recruit is finding resistances
instead of open-mindedness? Is not the person with ideas, if not too deeply rooted, a potential thinker and hence an asset? But does not such a person call for a different kind of orientation than the person coming with a blank sheet (speaking in terms of professional concepts) upon which the teacher may write what she will? Prejudices show up to peculiar advantage in class discussion and are quite painlessly eradicated there by fellow students!

Suppose that some fifteen Head Workers in Greater New York or Philadelphia right now are each appointing one apprentice; this you say should be the nucleus for a class group. True. But we need to do some more thinking before these fifteen apprentices will find their coming together of profit to them. Each comes from a different hospital. Do we know enough about the budgets, case loads, types of medical and social services in these fifteen different hospitals to get a bird’s eye view of what should be given in the classroom? Is the type of patient, the ward care, the social care given to the clientele of a large municipal (public) hospital comparable with the care given in a private hospital heavily endowed for teaching purposes? It should be; but is it? Let us be objective at this point. In the first case we have a public hospital, limited in its program to such care as the taxes will permit, with patients who would mostly be somewhere else in order to increase their social prestige (status outweighs most human desires); while the private hospital may largely pick and choose its intake, probably admitting “interesting” cases and graduating its chronics to the public hospital. How can we compare, except in the large, the types of social services to be rendered? So again we need to return to the consideration of what can best be given to these fifteen apprentices by group discussion and what best by private tutoring.

As a starting point one might hazard the guess of case work principles and cooperation with outside agencies for the class group teaching; leaving hospital procedures to be learned at the basis of operations from the Head Worker by the tutoring method. Let us assume a weekly conference of all apprentices for a period of sixteen weeks under the leadership of a trained teacher who knows something of the objectives of the fifteen hospitals represented by the apprentices and who can develop their understanding and give them an increasing feeling of professional comfort, assurance and insight.

This is my proposal for each large center in the North Atlantic and Mid-Atlantic Districts. It is fraught with difficulties; appren-
tices join the staff at no one definite time of year; the teacher is asked to know how to teach and also be conversant with the peculiar problems of each department represented; the Head Workers must find time to release their apprentices for a half day's class period weekly. Besides the hospital superintendent must be convinced that this course is wise, since we all know that the hospital wants service and does not relish the thought of paying for a worker's education.

So far we have concerned ourselves with the problem of acquisition of professional skills; but we need also to consider our apprentices as personalities, as real people with all sorts of experiences.

May I present a few clichés from my own teaching experience? I realize that this is laying myself open to the charge of violation of confidence; so I plead guilty. But I am sure that the persons whose stories follow will allow me this apparent liberty, for they know that all they know of social work has come from having heard about other people's troubles. I shall try to disguise my material somewhat.

_Miss A_ is very pretty, well poised, about 25 years old; she is engaged and has her life pretty well planned, but she must wait until her fiancé can establish a home for her. She is an only child, whose parents adore her. About six years ago she realized that this attachment was very bad for her so she went away from home and took up nursing. She enjoyed her work tremendously and was popular with the pupil nurses. Upon graduation she tried public health nursing which she thoroughly enjoyed.

Her mother was not very strong at this time, so Miss A went home and accepted a position as school nurse at a very small salary. It has taken her several years to save enough money to come away to study.

At home Miss A has felt very isolated and lonely. The other school nurses have had less training than she has had; furthermore they are about twenty years older than she is. In the last two years she has found herself slipping back into the old dependence upon her parents who want to do everything for her. She thinks she must be "weak-minded or something."

So Miss A has come to college partly to acquire some professional insight and skill and partly to test out her own personality; and she has just decided that she probably is queer since no one of the total enrollment of 4,000 students has become friendly within the first three weeks of her stay.

There is nothing vitally wrong with this young worker; she is bright, interested in her work, shows keen judgment in class room discussion and real ability in her written work. _But_ she has been handicapped by over-protective parents; her school nursing is poorly
organized and affords her no feeling of accomplishment but rather a sense of failure, since she constantly sees health needs that do not get taken care of.

This girl needs to learn more about the field of public health nursing in order to solve the situations which she meets daily. And she also needs help in growing up, so that she can see herself in proper relationship to her parents and to the community. Just now she is undervaluing herself and suffering because of her high ideals and extreme sensitiveness.

Mrs. J is married and has one child to support. She is separated from her husband for many unhappy reasons. So her problem is one of emotional adjustment and self-support. Her way out has involved moving to an entirely new community, where she has re-established herself upon her own merits without having to answer bothering questions about her past. She has come along nicely both in her work and in her community relationships.

Mrs. J is not very strong and suffers from an over-developed thyroid condition. Yet when she comes home at night, she must visit with her little son, plan her next day’s program, sew her clothes or wash and iron their wearing apparel.

All these things Mrs. J manages very successfully; she is very able, understanding, mature in her thinking if not markedly so in years. Yet she is overwhelmed with a chronic sense of failure against which she must constantly struggle. One wonders how much this lack of self-confidence affects her daily professional life. Wise appraisal of her work, with praise given where due, until Mrs. J can get a proper slant on her own very real potentialities would go a long way in releasing Mrs. J’s emotional tension.

Mrs. K is a very attractive widow with one growing daughter to support. For ten happy years she lived a sheltered existence in her own home, until the sudden death of her husband wiped out all her plans and left her almost penniless. She finds herself immersed by economic pressure, hard work, loneliness.

At work Mrs. K is blocked by a fellow worker who is constantly taking pleasure in refusing to share such simple information as the use of cooperating agencies or routine office procedures. In fact this co-worker refuses to say “Good Morning” very frequently. That she treats everyone else in the same ruthless fashion gives little comfort to Mrs. K who says she has never before had any difficulty in getting along with people and she won’t give up trying.

That Mrs. K is a spiritual type of person, completely feminine, whose rare charm of personality may be stirring up antagonism in this powerful Katrinka of uncertain years has never occurred to Mrs. K as a possible explanation of her present difficulties. The open mart has a code of its own where shyness and gentleness easily betray their owner into exploitation and suffering.
So Mrs. K must be helped to make the transition from home-making to self-support; she is going to have to grow thicker skinned before she can be happy and do her best work.

Miss Y is about 30 years of age, very pretty, poised, clever. For several years Miss Y did private duty nursing and recently she has plunged into the social work field. She sees her life lying ahead of her pretty clearly but has emotional hurdles to jump. Her family set-up has been good in the main but there have been hard elements too. Her mother died when she was ten; her father remarried. Miss Y idolized and idealized her own mother, but she is fond of her stepmother. All the Y’s feel sorry for their stepmother. When one sister married, she expected her husband to scold her violently, hold on to the purse strings and make home brew. She thought “all men were like that.” The husband has disappointed his wife by his livable qualities, but has set her and all the rest of the family thinking about why their home was and still is so explosive.

Recently Miss Y has spent a good deal of time reading Burnham’s “The Normal Mind” to get perspective on her situation; she says: “Perhaps the person who is hard to live with has a lack of integration. Poor man, how do we know how much suffering his temper tantrums or going all to pieces costs himself? He may have an inferiority complex and is seeking an escape. How does a daughter feel watching that father? He has sat up all night by her bedside when she was ill. He has denied himself necessities that she might have an education. He has provided wisely for her future in case of his death. He has instilled in her wonderful ideals of morality, honesty and courage. And yet with it all come these periods of infantilism; and added to that daily, steady drinking. While it is never to the point of intoxication it keeps the father always in a state of nervous excitability. The daughter has never been able to escape her feeling of responsibility in the matter. When she makes herself believe that her father is getting an escape for an inferiority complex and that he is to be pitied instead of censored, then she may become a perfectly balanced normal person. A sense of humor and a little more love shown the father may also help him to make his adjustments.”

Perhaps these brief analyses still serve to show the loads which just ordinary workers carry about with them while doing their daily tasks from 9 A. M. to 5 P. M., tasks which by their very nature require contacts with people in trouble who want help in re-establishing themselves to health, self-adjustment, adequate functioning within the social group. Leadership or sympathy with workers on the staff will be far more developing on the job than any amount of formal case work training. If case work is worth anything, let us practice it 100 per cent.
Listening to students gives an insight into the workings of the feminine mind. If young, the students complain that their supervisors lack modern ideas, are poor organizers, leaving too little initiative to the staff; they fail to get the young person's viewpoint on or off the job; so the young and the mature members fail to meet socially or intellectually. If older, the students find that accepting an interesting opening frequently involves going to a new center, and living alone or else taking aging relatives along who must be looked after and supported. If they stay at home on the same job, they too often find that younger people are being railroaded in to displace them (35 years is fast becoming the dead line for graduate study, if not for employment). Maturity of judgment in the art of living is not always wanted; in certain superficial circles a patter (not a profound understanding) of drives, complexes, repressions have displaced the need of thinking and living.

Surely so long as we concern ourselves with human beings, we shall need the viewpoint of both youth and maturity; both age groups need representation upon the staffs of social agencies. So the training we give each new addition to the staff must be thought out in terms of the past equipment (education, experience, and personality) of the new worker and of the challenge of the particular job.

REFERENCES

2 op. cit. June 1928 (no volume or page numbers indicated in this bulletin).
MEDICAL SOCIAL NEEDS IN CARDIAC CLINICS*

MRS. JOHN S. SHEPPARD

Chairman, Executive Committee, Social Service Committee, Presbyterian Hospital, New York, N. Y.

Heart disease now comes first in the list of causes of death in the United States. In 1927 approximately one death out of every six was from this disease, and a conservative estimate of the number of cardias in this country is two and a half million.

This is an immense health problem in which medical social service plays a large part.

In 1898, when Dr. Osler began his crusade against tuberculosis in Baltimore, he found that he could not get good results in his work without the aid of people who would investigate the home conditions of the patients, give them health instructions, arrange for their care and, in short, give them medical social aid, although it did not then have that name. Now the doctors who are fighting against heart disease have found that they, too, must have the aid of medical social service. This recognition of the importance of medical social service is shown emphatically by the requirement of the Committee on Cardiac Clinics of the New York Tuberculosis and Health Association, that there shall be a medical social worker in every cardiac clinic.

For the consideration of the medical social needs of these clinics, we must review briefly the medical social service necessary for cardias. Let us begin with the work for children, such as arranging for tonsillectomies and persuading parents of their importance, studying home conditions—not just the physical conditions in the home, but the whole emotional and psychic environment—arranging for proper work at school, arranging also for play and recreation which is suited to the child's physical condition. If the child is to

* Read before the meeting of the New York City Tuberculosis and Health Conference, New York City, November, 1929.
be permanently handicapped, his vocational training must be arranged for.

Another duty is impressing the child's mother with the importance of his regular and continued attendance at clinic, and as children with heart disease, in common with all cardiacls, are nervous and full of fears, perhaps the most urgent need of all is that medical social service shall teach these children how to take care of their health without becoming hypochondriacs. The importance of this need can hardly be over-emphasized.

Here I want to speak of the exercise classes and the classes in health teaching for cardiac children which have been carried on in several clinics by the medical social workers. These classes, under careful supervision, have had remarkable results. A fact of great interest is that, as the result of education and treatment given in the cardiac clinics for children, over 80 per cent. of the children were eventually enabled to carry on as normal individuals, and 15 per cent. of the remainder, though their physical activity has been impaired, will not be cardiac cripples. This statement I am quoting from the Health News published by the New York State Department of Health.

Let us now consider for a moment the cardiac clinics for adults. The medical social worker must see that the patient understands the value and importance of the necessary tests and examinations, and must arrange for these tests and examinations. She must also see that the patient understands the doctor's instructions and that it is possible for the patient to carry these instructions out. When printed instructions are used there is a danger that the worker will rely too much on them without being sure that they are thoroughly understood by the patient. This danger must be guarded against.

The home conditions of the patient must be investigated, not only the physical condition of the home, such as number of stairs, amount of light and air, etc., but the whole atmosphere of the home must be studied, as this is especially important in the case of cardiacls.

There must also be a careful survey of working conditions. It is useless to cure a patient of an acute heart attack and then have him return to his former work, which may possibly be moving furniture and pianos.

When we remember that during the war 42 men out of every 1,000 were rejected because of heart disease, we realize what a large group of men, just at the age most important in the industrial life of the country, are incapacitated by this disease, and how essential it
is that medical social workers shall understand working conditions so that these men can, if possible, be put back into industry. In order to keep cardinals at work their mental condition must be understood as they are apt to be more restless and nervous than other people. The worker must understand what effort can be made and under what conditions; that dust and noise are bad for a cardiac, and that he cannot stand on his feet for long hours or take long trips to and from work.

Important data on the effect of different occupations on heart disease can be gathered by medical social workers, but only if they are intelligent and have such thorough medical social training that they can follow from effect back to cause and can see the implications of social conditions and physical symptoms.

When it is possible for a patient to work in regular industry in normal surroundings, the effect on his morale is excellent.

For both children and adults, no duty of the medical social worker is more important than to combat the restlessness and nervousness of the patient and to help him to overcome his depression and discouragement. The patient is often overwhelmed by the anxious attitude of his family and friends. He is also often obsessed by the fear of sudden death. Intelligent and sympathetic work on the part of the medical social worker is needed if this attitude is to be overcome and the patient is to live the life which his physical condition, unhampered by depression and fear, will permit him to live.

The problem of the case load for medical social workers needs attention. Some directors of medical social service departments feel that workers can carry a larger case load than the generally accepted one of 100 patients per month, because in these cardiac clinics the same patient continues over a long period of time. This regular and continued attendance at clinic is one measure of good medical social work and shows that the worker has impressed on the patient the importance of his cooperation and that she has followed up successfully those patients who have lapsed in their attendance at clinic. In such clinics, the medical social worker can carry a large case load because of good organization and good medical social work. Where patients return regularly, the worker does not have to deal with so many new problems as are involved in a clinic with a constant turnover of patients. It is almost always true that frequent turnover of patients and few visits per patient indicate poor medical social service. But a large case load must, from time to time, be carefully
analyzed to be sure that the worker is carrying it successfully and has time to deal with all the medical social problems. In judging the size of a case load, the type of patient must be taken into consideration. The poor patients of low-grade intelligence, found in some of the city hospitals, present more problems than the better class of patients, found usually in the private hospitals. It is also important to take into consideration the cooperation of the doctors and of the hospital, for good cooperation makes it possible for the medical social worker to carry a larger case load.

To make work valuable for research and for the constructive solution of the problems of cardiacs, good medical social records must be kept. On the research charts of the Heart Committee, the social service sheet is an integral part of the medical record. All this work of the records can be greatly facilitated by adequate clerical help.

Also, by the right amount of clerical service, the efficiency of a clinic may be enhanced 50 per cent. at an increased cost of not more than 10 per cent. A good director bears this constantly in mind and, from time to time, goes over the work of the clinic to see if the medical social workers can be relieved of duties which can be equally well done by clerks and so leave the worker free for the duties for which she is specially trained.

The Committee on Cardiac Clinics gives, as one of its ideal requirements, that cardiac clinics shall be managed by competent medical social workers, and many of us feel that only under such management can a cardiac clinic attain its maximum efficiency. Certainly, those cardiac clinics which are managed by medical social workers seem to approach most nearly to ideal conditions. The position of clinic manager adds to the standing and prestige of the worker and gives her an easy and natural approach to the patient. The medical social worker, because of her training, is often better fitted than others to see ways in which the routine and administration of the clinic can be improved and the comfort of the patient can be added to. In many cases, it is through the effort of the medical social worker that an appointment system has been introduced into the clinic. Some people fear that the administrative duties of clinic management will take too much of the time of the worker and will not leave her free for the strictly medical social problems and case work. But in practice it has been found that the routine of clinic management can be delegated by the medical social worker to a clerk and that she herself need not be absorbed in it.
Another need for cardiac clinics is for better salaries for the medical social staff. It is wasteful and dangerous to have poor medical social service in a cardiac clinic. Of course, this is not always a question of salary because medical social workers are altruistic and, so, a low salary does not necessarily mean a poor worker, but, as a rule, a good salary attracts a good worker. It takes time and money to get a good technical training and a medical social worker who has this training deserves a good salary.

A poorly trained medical social worker hurts a clinic by giving the doctor a false sense of security in believing that the worker is discovering and caring for the medical social problems of the patient when she may not even know that these problems exist. She may be entirely overlooking important factors which would aid the doctor in his diagnosis and in his plan for treatment. It is better, I believe, to have no medical social worker at all in the clinic than to have a poor one.

Districting is of special value to the medical social worker because of the necessity of making home visits, visits to the school and to the place of business of the patient. The informal agreement now in force between the workers in the different cardiac clinics, that all patients shall be referred to the clinics nearest their homes, is a great help, in the absence of a more formal districting plan. Of course, the workers would not be willing to send patients to clinics other than their own except for the fact that, because of the work of the Heart Committee, they can now know of the high standard of work in these clinics.

If you have agreed with this outline of medical social service in cardiac clinics, then you will agree that the need is for more medical social workers in the clinics, more clerical service and a more general recognition of the value of the medical social worker as clinic manager. We also need better salaries. The need for districting the clinics would be very real except for the informal agreement to which I have referred. But the most important need of all is that the medical social worker shall not only have a thorough technical training, but that she shall also understand the psychology of the cardiac and that she shall be a person of broad humanity and deep sympathy.

Medical social service, whether given by the doctor in his private practice or by the medical social worker in the clinic, is the service which adds to the science of medicine the art of healing.
TUBERCULOSIS TOUCHSTONES

BEULAH WELDON BURHOE

National Tuberculosis Association, New York, N. Y.

The Early Diagnosis Campaign, to be conducted by tuberculosis associations in April, 1930, promises to be very successful because of the definiteness of its goal. It presents a concrete way of preventing the disease, tuberculosis, by anticipating it while yet in its latent stage. In the beginning of the tuberculosis movement twenty-five years ago, we busied ourselves in caring for the poor victim, in making him as comfortable as possible, and in providing sanatoria where he could be cared for without infecting other members of the community. Gradually, the emphasis shifted to the finding of cases early enough to effect a cure. Along with this attempt to cure, the general educational campaign for open windows, better housing, child health education, and summer camps has been carried on with the hope of prevention. The seeds of knowledge were broadcast through city and country with the devout hope that they would fall on fertile soil. Many energetic communities sought out the children who seemed undernourished, who were underweight, and who had physical defects needing correction. It was thought that, since tuberculosis is a disease of overstrain and insufficient resistance, building up general health should prove a real preventive. This is, of course, fundamentally sound, but at best it is a little vague.

The touchstone of the campaign is the question: How to recognize the individual who is a potential active case? During the last few years, studies have been carried on in Philadelphia, Chautauqua County (New York), North Carolina, Massachusetts and other places.

In Massachusetts, almost 100,000 school children have been tested during the last five years, not by the old method of general physical examination, but by two tests: the tuberculin skin test, and the X-ray. According to Dr. George A. Bigelow, health commissioner
of Massachusetts, about 28 per cent. of the children examined, who were not selected for underweight or physical defects but came from average homes, reacted positively to the tuberculin test. About 1 per cent. of these 100,000 children have adult type of tuberculosis (consumption). About 2.5 per cent show evidence of the childhood type of tuberculosis, characterized by calcified nodules and lymph glands, while 5.4 per cent. are catalogued as suspicious cases. These groups, together, constitute 9 per cent. of the school population; and it is this 9 per cent. from which will come, Dr. Bigelow believes, 70 per cent. of the tuberculosis deaths some years hence.

Here, then, is a group—a discoverable group on which we may well center our attention. From experience, we know that tuberculosis need not follow an inevitably fatal course but that, by proper care, the progress of the disease may be thwarted. Furthermore, the earlier the discovery of disease is made and the sooner care is instituted, the greater are the possibilities that a disastrous result will not follow.

What is now termed the childhood type of tuberculosis is not, of course, old-fashioned consumption but merely an early stage of tuberculosis. The child with this type of infection usually has no fever, cough, nor other clinical symptoms, but X-ray plates will show shadows caused by the deposit of calcium at the site of destroyed tissue. The tubercle bacilli have entered the body, but the resistance of the body has prevented them from destroying lung tissue to any appreciable degree. This initial infection has set up a mechanical process which caused the body to form capsules, or tubercles, around the tubercle bacilli. These, together with lymph nodes at the root of the lung which also often become infected, become calcified and cast shadows on the X-ray film.

Examination of adolescents and adults who have broken down with clinical, or the so-called adult type of tuberculosis shows that large numbers of them carry the scars of calcifications formed during childhood. If we find, through these two tests, children who have this type of tuberculosis, and if we prevent them from developing manifest disease during adolescence, is this not prevention? To accomplish this, however, two things are necessary:

A. To find the children.
B. To give them preventive care.
A. One way of finding children who have the childhood type of tuberculosis is to examine all school children routinely with the two touchstones, the tuberculin test and X-ray. This presupposes, however, an educable group of parents. It cannot be carried out to any great extent for some years to come. But we do know that most of the children who show evidence of infection and early disease come from contact families. Therefore, if we examine only the children in families where there is a known case of tuberculosis, we shall presumably discover a majority, and probably we must be content with this for the present. We must remember, nevertheless, that we are missing a large number. When the school children are tested en masse, there is the very great additional advantage of finding previously undiscovered open cases by following infected children to their homes.

B. When the cases are searched out, we must seek to prevent the development of manifest disease later in life by some such procedure as the following:

1. The child must be removed from the source of infection.
2. He must be relieved from all strain.
3. His physical defects must be corrected, his general health built up to the maximum, and he must be instructed in carrying on his life on an even keel.

The foregoing gives us a more satisfactory basis for evaluating anti-tuberculosis work. Johnny is underweight. He has bad teeth, bad tonsils. Across the aisle sits Mary, who is up to weight, rosy of appearance, and with no apparent physical defects. The class is given the tuberculin test and the positive reactors are X-rayed. Johnny gives a negative reaction to the test. Mary gives a strong positive reaction, and her X-ray plate shows calcification shadows of considerable extent. An examination of those who live in Mary’s home discovers that the colored maid in the kitchen has an active case of clinical tuberculosis. Johnny should not be neglected. The cause of his underweight should be sought and removed, his defects corrected, but Mary is the primary concern of the associations organized to combat the disease, tuberculosis.
SOCIAL SERVICE—ITS PLACE IN HOSPITAL ORGANIZATION*

BESS H. MEDARY

* Read before meeting of the New England Hospital Association, Boston, Massachusetts, October, 1929.

Director, Social Service, Rhode Island Hospital,
Providence, R. I.

The time has past when social service departments must try to justify themselves and beg for recognition by the administration and the medical staff. We have come to the place now where we can look back and ask, "How did you ever get along without us?" To the hospital, large or small, that has no department, we can ask,— "How do you keep faith with your patients, your medical staff, and your community without us? To whom do your patients turn when there is a critical situation in their homes—anxiety over which is definitely retarding their recovery, and thus prolonging their hospitalization? To whom does your medical staff turn when satisfactory convalescent care must be arranged if they are ultimately to see the good medical results they anticipate after weeks of careful work on their part? To whom does your community and its agencies turn when they must have adequately interpreted reports before they can satisfactorily adjust that patient and help him become self-supporting again?"

Coming from a department where eight medical social workers are kept busy eight hours every day, five and a half days a week—and where the work averages the same, every season of the year—and one challenging problem after another is referred to us for solution, it is difficult to explain the reason for our existence. We have reached the place where we have to take ourselves for granted,—and feel a certain professional confidence. We grant that the particular institution where we serve is both large and general in its work—but our existence is not only justifiable on these scores.
Every hospital, large or small, is eager to have its patients satisfied with the care given them and to have them return to their homes, their friends and their neighbors, spreading the gospel of good health and praising that particular hospital where they have regained their health.

Every hospital is anxious to have its medical staff progressive—and have the confidence of the community which it is serving. This is important, whether its funds be secured from the Community Fund, Guarantors or City Taxation, and a social service department using accepted standards and with high ideals, whether the department be large or small, whether with one worker or ten workers,—has proved that it can do more than any other one thing to interpret the hospital in its truest relationships to the patients, and thence to the community.

Since then, there is no longer any argument that there is a place,—and a very necessary, vital place,—let us discuss briefly where we belong in the organization and what we can do to make ourselves useful. Possibly some of you doctors and administrators have tried social service and felt it was not a success. Maybe the fault was in organization. A social service department should not exist if it is not soundly and correctly organized and clear cut as to its place in the institution and as to its functions. This is essential from the beginning, for once a department or individual is installed, it is often difficult to gracefully correct the faulty organization and clarify its functions.

When accepted, we should be received whole-heartedly by the Superintendent, for if we are shuttled off as a step-child with no place to call our own, and no interested medical director, to whom we can turn to help coördinate our activities,—it is better that we did not exist.—In other words, we should be directly responsible to the Superintendent, and an integral part of the hospital.

But there are three more necessary links which will strengthen the chain of organization.

The social worker, if given the confidence of the Superintendent, has a peculiar and particular vantage point which no other one person or department has. She is a pilot, gaining and interpreting information and criticism from sources both within and without the institution. Her training, her personality, her position, should all fit her to do this impartially, cleverly and with discretion. Not only private individuals from without, and groups from without, but
groups from within, and patients from within, are, from the very nature of her position bringing just those facts and those suggestions that make her peculiarly able to see the hospital as a whole and its problems from a helpful prospective.

It is necessary that the department have an Advisory Committee to whom the worker can go for discussion of both case problems and policies. Through this group—and it should be composed of women who are vitally and seriously interested in the hospital, and who are influential in their groups,—the institution has an opportunity to reach the biggest donors in the community, an effective and powerful group, who in turn are interpreters to their friends and business associates. Thus, the department,—if directly responsible to the Superintendent, and indirectly responsible to the Social Service Committee, is soundly tied to the institution, at the same time is reaching out into the community.

But in our organization, it is not only necessary to reach out, but to reach in and have the cooperation of the nursing group and the medical staff, and the confidence of the Board of Trustees. Therefore, we would suggest that the Superintendent of Nurses be on the Social Service Committee, also one or two representative members of the medical staff, and that the Board of Trustees, or Board of Directors, if they are to be kept convinced of the necessity of the work and want to use the most direct channels of sensing the criticism and the place the hospital is filling in the community, should be represented by two or more members.

If it is essential that we be taken into the bosom of the hospital family from an organization point of view, it is also sound and essential that we should at the same time be accepted as an economic responsibility and included in the hospital budget. We all appreciate most the things for which we pay. Whole-hearted acceptance on the part of the Superintendent, in my estimation, implies acceptance financially. We have proved in institutions where we are soundly organized that we are not liabilities but assets. The return may not be in the obvious collection of so many dollars and cents—and should not be measured as such,—but the returns are just as definitely manifest, by such essential things as I have pointed out above—general good will toward the institution—popularity—better understanding—and increased medical efficiency.

Many flourishing departments have only been able to start their careers after some ladies’ committee or hospital club has assumed the
financial responsibility and agreed to raise the necessary budget to carry the work through a definite or an experimental period. But experimental periods in general medical social work are no longer necessary, and from a psychological point of view it is better to be accepted at the beginning. The growth is apt to be sounder and more rapid and the department is relieved of the additional strain of "proving themselves financially" and raising money for their salaries.

In every community we hear a great deal these days about the relation of hospitals to Community Funds. That, I see is being discussed on this program. Some have suggested in hospitals which are not themselves being affiliated with the Community Fund, the advisability of separating the budget of the social service department and drawing its expenditures from the Community Fund. Psychologically, I still contend that it is best to remain a part of the hospital budget, thus keeping that firm, vital connection,—but many, I know, would consider this a debatable point. Many of this group are from small hospitals where social service has not been adopted—it very probably has been suggested, discussed, and then put aside until some future date. The reasons for postponing the establishment of a department are probably, first, because you are all doubtless working on a limited budget, and secondly, because you can not see just where the work would fit in your particular institution.

Every hospital has its own distinct place to fill in its own particular community. Every hospital has its own clientele, some of you are serving a different class in society than others,—some have a large percentage of free patients,—others can best accommodate the group that are able to pay ward rates—but others of you are serving primarily the private patients. Social service has a place and function primarily with the first two groups of patients, although some institutions and many private physicians are already using social workers on their private cases to advantage.

If a department were soundly and correctly organized with the right personnel, I believe that your economic qualms would vanish for as stated above, the service is far reaching. But some of you are wondering how to use a worker or a number of workers. Should she be used on questions of eligibility for admission?—Will our problems of the collection of bills be simplified if we have a social service department? Can the social worker do the follow-up work which we admit is necessary, and incidentally collect a few bills,—possibly admit in the morning and collect and follow-up in the afternoon?—
These are some of the questions that I believe are uppermost in your minds. I should like to think that we were capable of doing any and all combinations of that type of work besides carrying our own distinct functions, and I do believe that a few rare individuals have worked out a happy combination of activities in some of the small institutions, i.e. combining minor administrative duties and social service as we see it in its truest sense. But as Miss Ida Cannon, in a recent conference very aptly said, “It does not make for hospital organization if your medical director tries to be both medical director and clinic physician—either one job or both suffer.” And so with a social worker who has minor administrative duties and tries to establish and build a progressive social service department. I do feel that often in hospitals where the time is not yet ripe to place a social service department, and where the many minor administrative duties do bulk large, that a social worker may with credit, just because of the very nature of her experience and training, be appointed as a part of the administration but not necessarily as director of social service.

The work of Miss Edith Howland and her assistants at Johns Hopkins and the successful admission of patients at the Boston Dispensary have proved without a doubt that there is a place at the Admitting Desk for trained social workers. Other hospitals, too, have successfully used trained social service workers in determining the amount each patient should pay for care received. The nature of her training and her experience bids well to make such a person valuable. And my own experience has taught me that occasional and special cases of financial investigation can well, and rather easily be combined with other “refers” to the social service department by the administration. It is important, however, that in starting a new social service department that is to be far reaching in all phases of its work, that it be started not with administrative duties as major problems,—but that these if later assumed, be assumed as minor responsibilities. In other words,—it is very easy to make a social service department top-heavy with work which should be incidental to it.

But the department that is to correctly interpret the hospital to the community, to “popularize” it among all groups, and help to make it a social institution, understood, and beloved, must be established with a greater vision of service. We social workers have our own terminology and among ourselves, we agree that the best service is rendered when the “case-work method” is used, which implies a
limited intake, adequate clerical assistance, time for careful and pains-taking interviews, investigation, and social treatment.

Let us illustrate by citing two or three functions which we term as "legitimate" functions in a social service department that is given an opportunity to develop its work in this way—free from minor administrative duties, but at the same time working shoulder to shoulder with the administration. The functions of such a social service department have been more or less standardized, but must be adapted to the institution and the community in which the department is established.

The first function I would mention is *supplementing medical care* when necessary,—or, in other words, arranging convalescent care for the medical case or the post-operative,—or planning and arranging satisfactory chronic care for the patient who can no longer look forward to being self-supporting,—or seeing that the nurses in the district get adequate instruction about dressings and general care in case the patient is to be returned home. A hospital is no longer a unit unto itself. If it is to see good medical results, it must be constantly in touch with other institutions and agencies in the state and community which can continue to carry forward the treatment which has been started. Tuberculous patients must be sent to the tuberculosis sanitoria—the carcinoma patients, many of them, must be hospitalized in the institutions for chronic patients. It is with this group of institutions and agencies that the social worker is constantly in touch. They are the resources which a hospital social worker uses, and with whom she must be thoroughly familiar. She must be able to turn her patients over quickly to the other institutions which are better prepared and more specialized. Thus the hospital beds are released, the patient gets good care and the patient's family are satisfied,—for a case worker brings into play all the family resources and skillfully and wisely guides them in planning for the family member who is ill.

The second function is *procuring apparatus* such as braces, glasses, belts, etc., for patients who cannot provide such for themselves. It must be discouraging for a physician to work with a patient several hours or even weeks or months, and then when the goal is in sight, have the patient completely disregard the final advice because he cannot afford just at that time the piece of apparatus ordered. Case work with this group is worth while for often, providing the apparatus,
by one means or another, is only opening the door to an interesting adjustment problem in the home, in the school, or possibly in industry.

The third and last function which I will take time to mention here is removing obstacles in the homes and places of employment in order that the patients can carry through the treatment recommended. Let us cite briefly one case story which illustrates this function:

Mr. X was a hard working persevering Englishman who came to the Out-Patient Department early last summer. He was discouraged. He had been ill for three months, the doctors had told him that he could not return to his work for at least three months more. His savings were exhausted and his wife's earnings were not sufficient to support them, for they had three small children. The doctor asked the social worker to come to his assistance. She learned that Mr. X, after serving ten years in the English Army, had come to Providence twenty years ago and had been employed by one of our well known firms for a period of fourteen years. This firm, on being approached, and after understanding the man's physical disability, willingly assumed the rent until Mr. X could return to their employment. The local Director of Public Aid agreed to supplement the wife's earnings by sending in a regular grocery order, and the City Missionary Society aided by providing much needed milk for the children. With his mind relieved, Mr. X was able to rest and to report regularly for the bakes and massage which had been ordered. At the end of three months, he was able as the doctor had predicted, to return to work. The company further coöperated by giving him less strenuous work, but work that was equally as remunerative.

Here again a warning must be sounded, for a department may not only get top-heavy with minor administrative duties, but may very easily take upon its shoulders investigations in the community and major social adjustments which should rightfully be done by the agencies equipped to do just such pieces of work and supported by community funds for such tasks. But the skillful medical social worker will weigh carefully her data, make a social diagnosis, and know just when or on whom to call for assistance. If she is skillful and clever in diagnosing the social situations and if she has at her finger tips the community tools she can and should use, she may carry successfully a good sized case load and be a tremendous asset to the powers within the institution.

Hospitals, both large and small, should be represented in the
community activities and should have a logical and direct channel through which the library facilities, the volunteers of the Junior League,—the local business clubs, which are definitely interested in some such phase of charitable work as the crippled children, etc., should have an outlet and an inlet. Assembling, organizing, interpreting to these clubs and groups what they can do to be of help within the hospital is a logical function which may seem to some to be administrative, but when analyzed is really case work with the community. We might call this function, hospitalizing the community and socializing the hospital, and that is just what a real social service department with high ideals and a trained group which is correctly organized within the hospital can do.
DOLLAR AND CENTS ASPECTS OF CHILD HYGIENE*

H. E. KLEINSCHMIDT, M.D.

Director Health Education Service, National Tuberculosis Association, New York, N. Y.

How much does it cost to protect the life of a child? The child welfare worker waxes righteously indignant and replies hotly that the tears of a mother, the frustrated hopes of a father, the sufferings of a little child, can never be measured by the cash register. But, strangely, those who control public funds do not shrivel up at the scathing blast. Freely admitting that life cannot properly be measured in terms of money or statistics, they demand to know, in practical fashion, if money will actually purchase health and, if so, to what extent. We owe them an emotionless answer, based on cold arithmetic.

Louis I. Dublin, in his book, "Health and Wealth," has made a study of the economics of health, from which we cull a few figures. To be sure, any amateur statistician may find flaws in these estimates, but they do, at least, give some hint of the cost of child neglect and the probability of salvaging some of the waste. To whittle the problem down to a smaller, more concrete problem, let us consider only a group of 100 male children, aged one year or less. Dublin, like several other economists, has attempted to calculate the value of a human life. He rightly assumes that the infant, if allowed to reach maturity, will produce wealth for society in excess of the cost of rearing and maintaining him. The basis of his calculation is the economic experience of the average class; namely, those whose maximum earning capacity is about $2,500.00 yearly. On that basis, and making due allowance for various contingencies, Dublin finds that the American boy baby is valued at approximately $9,000.00

*Read before the Colorado State Social Workers Conference, Denver, Colorado, October, 1929.

325
at birth. As he grows older, his potential value increases to $14,000.00 at age 5 and $25,000.00 at age 15. The figures for girls he assumes to be half those for boys. Whether that assumption confirms the lurking suspicion of the anti-feminist that one boy is worth two girls, we pass over lightly lest we be drawn into hopeless controversy, and hasten to set down as our first item on the ledger: SOCIETY'S INVESTMENT IN 100 INFANT BOYS—$900,000.00.

Some of our potential capital is lost through death. The infant mortality for the country at large for 1926 was about 70 out of each 1,000 births or 7 per cent., which means in our calculation a loss of $900,000.00 x .07, or $63,000.00. We record, therefore, this item: SHRINKAGE OF CAPITAL THROUGH DEATH—$63,000.00. That represents a dead loss to society.

Those children who escape the grim reaper suffer sickness which costs money in terms of doctor bills, drugs and treatment. The most conservative estimate Dublin can make for that item is $5.00 per child per annum, or a total of $500.00 for our group of boy babies. Our next item, therefore, is: COST OF SICKNESS—$500.00.

Thus far, our ledger for 100 male babies of one year and under reads:

<table>
<thead>
<tr>
<th>Item</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial investment</td>
<td>$900,000.00</td>
</tr>
<tr>
<td>Wastage through death</td>
<td>$63,000.00</td>
</tr>
<tr>
<td>Cost of sickness</td>
<td>500.00</td>
</tr>
<tr>
<td><strong>Total loss</strong></td>
<td><strong>$63,500.00</strong></td>
</tr>
</tbody>
</table>

Next, we may calculate what we, as a people, spend in an attempt to salvage that waste, knowing that many infant deaths are preventable and that much sickness is avoidable. Again, Dublin bravely plunges into a maze of figures and emerges finally with the apparently sound estimate that in most American communities all the expenditures, official and non-official, which may be decently allotted to the health protection of children amount to not more than $1.00 per child. Multiplying this by 100 babies, we hang our heads and reluctantly set down this paltry item: EXPENDITURE FOR HEALTH CONSERVATION—$100.00.

Were a business man to sustain regularly through theft, fire, or “act of God” an annual loss of $63,500.00, would he be content to
risk no more than $100.00 as insurance against such a loss, even though he knew that some of it was inevitable?

What evidence have we that the wastage now suffered may be appreciably cut down? Of all the babies counted in the United States census of 1900, 170 out of every thousand died that year. Exactly 25 years later, the infant death rate had dropped to 75. At the present writing, it is still declining. Feeble as our efforts have been, this result did not merely happen; the conscious effort of man had much to do with it. And the limit has obviously not been reached, for the rate quoted is an average covering the country as a whole. That babies' lives can be saved with a little intelligent effort is evidenced by the experiences of certain enterprising communities. Of 697 American cities studied in 1925, 70, or about 10 per cent., reported rates under 50 per thousand births, and in 8 of these communities the rates had been depressed to 35 or less. Cities of the Pacific Coast have always shown low infant mortality rates, probably because general conditions for child life are favorable in that region. Yet, in the northeastern states, where climatic and industrial conditions are not so favorable, a number of cities with good health administrative machinery have shown that the infant mortality can be kept down to 40 or 50 per thousand births.

Dublin cites also a few examples of specific accomplishments. In a small Canadian town called Thetford Mines, boasting a population of 9,000 persons, the infant mortality in 1920 was about 300. A maternity centre was established; mothers were offered the facilities of a nursing organization, doctors cooperated, babies were visited. By 1926, the rate had dropped to 79.

Some years ago, the Maternity Center for New York made the facilities of its welfare clinics available and sent nurses to the homes of expectant mothers for instruction in the hygiene of pregnancy. In the area served by the Maternity Center, the prematurity rate of infants was reduced to 4.8 per thousand births, whereas in the general population of New York City, the prematurity rate in the same year was about three times as high.

In Auburn, New York, population 35,000, diphtheria annually claimed a high toll of little victims. In 1922, for example, there were 97 cases and 13 deaths. A campaign of diphtheria immunization was begun. The next year, there were 47 cases and 4 deaths. In the following three years, there was only one death from this terrible disease.
In 1917, the Metropolitan Life Insurance Company, under the auspices of the National Tuberculosis Association, began its demonstration in Framingham, with which nearly everyone is today familiar. In the beginning, the entire community was surveyed and it was found that the prevalence of tuberculosis was about the same as in similar cities of the United States. Recently, that is, about ten years later, the State Department of Health of Massachusetts made an independent study of tuberculosis among children in Framingham. Only one case of pulmonary tuberculosis was found among the entire school population and only 26 per cent of children from 5 to 15 years of age reacted positively to the tuberculin test, an extremely low record.

A few years ago, the Ohio Public Health Association published side by side two sets of statistics, one showing the decline in infant mortality by counties from 1913 to 1924, and the other showing, for the same areas and the same period of time, the increase of public health nurses. The inference that the reader was supposed to draw was that, as the number of nursing services increased, the number of infant deaths decreased. This challenged the statistical instinct of Dr. J. Rosslyn Earp, who felt that the inference was unwarranted. He asked for detailed figures by years and counties and set out to disprove the assumed correlation between increase in nursing service and decrease in infant mortality. But when he had finished his research, he found, after eliminating all conceivable errors, a coefficient of correlation of $-0.47 \pm 0.06$, which, as he pointed out, is a remarkably high association. He concluded, therefore, that “there is a close relationship between the amount of public health effort expended . . . and the saving of infant life.” In a later report, he undertook to estimate the actual cost to the state of saving babies’ lives and summarized the situation by putting to a hypothetical group of 1,000 pairs of Ohio parents this question: “Four children (of your community) are going to die unnecessarily this year. The chance that yours will be one of them is one chance in 250. Will you each pay 25 cents to make that chance zero?”

Our hypothetical public official, perfectly reasonable in his demand for evidence but ever alert to the protests of nervous taxpayers whenever the rates are raised, must by this time be convinced that public health offers certain bargains which he cannot afford to ignore. But precisely how much money can be spent economically? There are, of course, limits to what the tax health dollar will buy, though
few communities have as yet carried their experiments far enough to determine that limit. Framingham achieved its remarkable results at a cost of $3.00 per capita, of which about $1.50 would cover what is necessary for the protection of children. As a nation, we are now spending through health agencies, official and voluntary, national, state and local, about 40 millions for the conservation of child health. Were we to appropriate $1.50 per capita per year for this purpose, the total would amount to 175 millions—a huge sum but still only one-tenth the cost of preventable child deaths.

It is well, perhaps, that that enormous sum is not about to drop into our laps overnight. Money alone will not solve the problem. Leaders and technicians are needed—and brains are not offered for sale on the shelves of the chain store. Moreover, an enlightened public opinion that will be willing not only to provide the funds but also to sustain the good work with intelligence is essential. Creating a sound demand for, and a discriminating judgment of, sound public health measures is perhaps the greatest task now facing the social and health worker.

Hermann Biggs said, “Public health is purchasable,” and Eugene L. Opie added, “if we know what to buy,” to which may further be added, “provided the people are intelligent enough to buy.”
HEREDITY, EUGENICS AND HUMAN BETTERMENT

C. F. DIGHT, M.D.

President Minnesota Eugenics Society, Minneapolis, Minn.

While much has been done during late years to prevent disease and improve health, by improving man's environment, there has been very little done at any time to improve man himself in his innate, inborn mental capacity.

A work with this end in view might well be started, it seems, in connection with "hospital social service." There is great need for such work since people of stunted intellects and moral defects are scattered all through society. Such persons are responsible for nearly all crimes that are committed and for most of our social ills, including the spread of venereal diseases. Removal of such persons from society as rapidly as it can be done in a legal and humane way is essential for permanent human betterment and in order to have society composed wholly, as it should be, of persons who are sound in mind and morals. This better condition can very certainly be secured by the wise use of the laws of heredity and the principles of eugenics. This article, therefore, points out in part how heredity acts in transmitting qualities, good or bad, and how the better types of people may be increased and inferiors humanely eliminated.

It is now generally known that each plant and lower animal comes from a female reproductive cell, after it has been fertilized by a male reproductive cell. That fact is taught to the boys and girls in our common schools, in their study of botany and physiology. And we older people know that every person who ever lived came from a female reproductive cell called the ovum, after it was fertilized by a male reproductive cell called the spermatozoa.

These cells contain certain short, dark colored, thread-like bodies called chromosomes, which are the bearers, or carriers of all that is transmitted from parents to their offspring. The chromosomes
change somewhat in appearance at different stages of the ripening and development of the reproductive cell, but they can be seen and counted under the microscope. Their number varies in the reproductive cells of different kinds of animals and plants. In the germ cell of the seed of the tobacco plant their number is twenty-four, the same as in the human reproductive cell.

In the chromosomes—and this is the great fact to bear in mind—there are "determiners," so-called, which, during the development of the fertilized ovum, bring into proper form the various anatomical structures which the young animal is to possess. For every bone in the body and for every nerve and muscle there are determiners. For each different part of the brain, heart, lungs, and for each distinctly separate structural part of the body there is thought to be a determiner in the chromosomes of the reproductive cells, and each determiner, I repeat, brings out during the early development of the animal the anatomical structure to which it is related. If there should be no determiner for a certain bone, or if the determiner is a defective one, the bone would be absent or defective in structure. No animal can have any organ or part except that for which there is a determiner.

In the chromosomes of some people there are determiners for feeble-mindedness, or if not that there is an absence of determiners for normal-mindedness, and the outcome would be the same in either case. If in the chromosomes of both parents there is a determiner for feeble-mindedness, then their child early in its development will get a double dose, so to speak, of determiner for feeble-mindedness, and will very certainly be feeble-minded. There is perhaps no exception to the law that when both parents are feeble-minded by heredity all of their children will be feeble-minded. On the other hand, when in the chromosomes of both parents there are determiners for normal-mindedness or for any other good and desirable trait, their child early in its development will get a double dose of determiner for that trait whatever it may be, and will very certainly possess the trait in strong degree.

Inborn capacity is thus fixed by the determiners, and fixed irrevocably at the time of fertilization of the female cell. From that time on until birth the laws of heredity have complete control—ruling out disease and accident—and no act of man, it seems, can change results, can add to or take from them. These fundamental biological facts briefly outlined have come to us almost, as some one has said,
like the burst of a new sun out of heaven, and on these and related facts the science of eugenics is based.

The first great purpose of eugenics is to promote marriage matings between persons both of whom carry in the chromosomes of their reproductive cells the determiners of desirable traits. The second is to prevent, so far as possible, reproduction by persons in whose chromosomes there are determiners of undesirable traits or mental defects, for in this way only can socially unfit persons be eliminated from society and a better human stock be bred, a stock with mental capacity to respond fully to educational stimuli and to absorb and apply useful knowledge. Man can be improved permanently only by beginning his origin in the better grades of germ cells in which human life starts. These cells are the human seed and, like any other seed, they determine what the nature of the crop and its quality shall be.

I am stating only what science clearly indicates when I say that education, while indispensable, affords only temporary betterment of man, because it is an after birth affair. Ordinary impressions and traits acquired after birth are not passed on by heredity in perceptible degree to offspring, because they do not affect the determiners nor create new ones. Education of one generation does not, therefore, improve the next in mind or morals.

But with our present knowledge of heredity man could take his further mental evolution into his own hands and in three generations advance it greatly. In that time or less the wise use of biological laws do produce, as we all know, superior types of plants and lower animals. It took the red man a thousand years, we are told, to develop a certain kind of Mexican grass into Indian corn. No science was used in doing it. Nature acted blindly, depending on wind and insects to bring about fortunate polination of the growth from season to season. But Luther Burbank took this same Mexican grass, it is said, and in eighteen seasons, by selective polination, produced a fine quality of corn.

Until now the great mass of humanity has perpetuated itself at random, by chance with but little thought of improving itself. Poor quality of material has been built into most human automobiles and then we have tried to make them good machines by education and religion. We are slowly learning that it cannot be done, and that we must look to good breeding—to eugenics—for permanent race betterment.
A sane eugenics program for human betterment would provide:

1. For sterilization of some of our socially unfit persons;
2. For segregation of others;
3. For teaching, especially to young people, the great facts of heredity and eugenics.

A comprehensive State Eugenics Program would provide for the grading of its citizens as to their Heredity Soundness; their inborn mental capacity; their physical structure and its efficiency, from which would be deduced their fitness to procreate.

A program for race betterment in which every intelligent person might engage would be this:

1. Suggest to your minister that he preach sermons on eugenics, and organize young people's eugenic study classes.
2. Urge your physician to advocate biological race betterment, and advise against marriage of inferiors.
3. Encourage in young people pride in good heredity. It would promote better marriages.
4. Encourage parents to have their children read something on eugenics.
5. If you believe the movement for innate race betterment, and the abolishment of vice and crime thereby, is a worthy one, speak of it to your state legislators and urge the enactment of an adequate sterilization law.
6. Place in the hands of young people suitable leaflets calling attention to the essentials of heredity and eugenics. They need such knowledge for personal and social protection to avoid unwise marriage matings, for the bad results of which in delinquent children and disappointed parents no amount of education, good laws, prayers, tears or hospital care can ever compensate.
MENTAL HYGIENE IN THE PUBLIC SCHOOLS

EDNA G. BRIDGEFORD

Registered Nurse and Psychiatric Social Worker, Albany, N. Y.

Why do we talk of mental hygiene in the schools? Because children through early associations and influences adopt certain patterns of behavior and bring to the school all sorts of emotional difficulties that may hamper them in their school adjustment. The school should be equipped to detect these difficulties and help to correct them while the “wounds are fresh” rather than neglect them to become “scars” distorting the adult personality in the form of neurotic symptoms or definite mental disease.

A great philosopher, John Locke to be exact, said that a sound mind in a sound body he felt to be a “short but full description of a happy state in this world.” We are all agreed that a sound body is something within the reach of the majority. Most of us know that by observing the so called “rules of the health game” we can keep ourselves fit and strengthen our resistance to disease. Most of us know that by having a periodic health examination we bolster up our morale and feel sure that any abnormal physical condition will be discovered before it has had time to seriously catch us in its clutches. But how few of us know that the early emotional disturbances are often the very beginnings of serious mental disease and are surely setting the way to an unhappy state in this world.

Health is not generally understood to include mental health. Educators are very prone to think that the mental side of the child is exclusively within their province, whereas the fundamental approach should be through the specialist in mental hygiene. Mental tests as used by the educational psychologist cover a small part of the field of mental health. They are indeed an important contributing factor and furnish an index for special classification and study, but valuable as they are, they do not test the adjustability of the child to his school environment—that is a matter of the emotional life of the child and belongs for proper consideration to the field of psychiatry.
"The psychiatrist sees the problem pupil as a living and adjusting personality reflecting the social, physical and mental forces that direct his actions."

Teachers make very valuable observations and have much to contribute to the picture in the study of a problem case but we cannot expect them to know the real cause of the problem any more than we can expect the social worker to enter the classroom to teach mathematics or any subject that belongs in the field of classroom teaching.

Teachers cannot be expected to know how to deal with pupils presenting definite problems without some scientific knowledge of their behavior and the mechanisms at the basis of behavior. This information must be furnished by a staff specially trained and equipped to deal with these problems. The examination must include intensive physical, psychological, psychiatric, social and educational study. All those who have helped in the study must meet with their particular contribution to piece out the picture of the personality in question in order to work out a solution and outline a plan of treatment. Treatment in this sense largely means interpreting the pupil to those who work with him and what is more important to help the pupil to understand himself. To understand why he feels and acts as he does under certain conditions. This is not a matter of a few days—problems of emotional adjustment are problems of re-education. Those of us working in the field of Health Education who have an appreciation of the value of mental health realize how closely related are physical and mental health. A child frequently comes to us complaining of some minor ailment, using it as a device to escape the pressure of some emotional stress or to introduce some subject about which he is worrying. These children, of course, have no idea of what their real trouble is and one having insight into this big field of special education can only shudder at our lax methods of dealing with them.

When more of our leaders come to appreciate the true value of sound mental health, what it means in the joy of living, what it holds in increased efficiency with less effort, what it means to be more tolerant of others and to be able to meet the daily problems of life in a wholesome and open minded manner, then we may hope to realize mental hygiene as a part of the regular school program.

The modern school objective is to train the child for life and surely to help him to understand himself so that he can best fit into life is the greatest mission of the school.
BETTY FINDS A JOB AT INDUSTRIAL HEALTH CARDIAC SHOP

IDA MARGOLES KAUDERER

Lebanon Hospital Social Service, New York, N. Y.

It doesn’t seem very long ago that Betty went to Irvington House with Christmas hopes of a new heart and a baby doll. That was several years ago. In fact, Betty is now sixteen years old. It is an age when most girls are thinking of parties, beaux, graduation from high school, and planning for a glorious future. One is going to be a teacher, another an actress, and another a trained nurse, and some are planning to marry and some day have girls of their own.

Betty, as the years passed, also looked forward to things like that, but fate decided otherwise. When she was ten, she suffered an attack of rheumatic fever. She spent months in bed, and it left her heart greatly damaged. In the cardiac clinic which she attended, she was classified as 2B, which means in everyday terms, activity greatly limited. She was unable to go to school. The city has few home teachers and none seemed to be available for Betty. She had to trust to the chance tutoring of some kindly volunteer. So at sixteen, Betty had reached only the fifth grade in school, as her regular attendance had stopped then and there.

Sometimes the social worker from the cardiac clinic would pass Betty’s house and would see her standing in the doorway, a forlorn figure, aching to be a part of the busy life about and outside her. She was too ill for work of the usual sort in regular industry, and too ill for school, and yet she was not sick-a-bed. Her mind and hands unoccupied she became bitter and despondent.

Then one day, a new vista opened to Betty. A group of far­sighted women with broad sympathies, who were actively interested in Irvington House, opened the Industrial Health Cardiac Shop, for girls from sixteen to thirty years of age, who were Class 2B cardias. It was a new venture and an expensive one—this workshop. It meant
an out-put not only of time and money but also of enthusiasm in a large way. A young doctor interested in medical research, seeking after truth in cardiac disease, like the knight of old seeking the Holy Grail, was appointed the Medical Director. A sweet and kindly but very efficient trained nurse was made supervisor of the shop. She had previously been the social worker in a cardiac clinic. This staff was augmented by the addition of an instructor in the art of sewing and needlework. Various department store heads were interviewed and they promised to take the output, although, they were rather dubious of its value. Their well-meant philanthropy was later well repaid, for the things sold like the well-known hot-cakes.

To meet the special needs of this group and for the purposes of research, a cardiac clinic was organized in conjunction with the shop. Meanwhile the other various cardiac clinics, members of the New York Tuberculosis and Health Association, were notified to send their recruits. Betty was one of the first applicants. What a thrill it gave her to know, that she, who had always been considered an invalid, could now work—in an environment adapted to the health of the workers. Betty found the quarters, donated by the Y. W. H. A. at 110th Street, a very comfortable, busy and happy place.

Each morning at nine o’clock found Betty eagerly awaiting the taxicab provided by the shop to bring her to and from work. When she arrived at the shop in the morning, the nurse would take her pulse and temperature and would also record her general condition. She would then be served with hot cocoa, and at ten o’clock would be assigned to the day’s work. At noon luncheon was served at the nominal sum of fifteen cents, through the courtesy of the “Y.” The luncheon was always piping hot and invigorating.

Rest hour followed luncheon and was until two o’clock, when Betty would find a comfortable reclining chair and blankets, and would drop off for a short siesta. In the summer time the rest hour would be spent on the roof getting the sun’s healthful rays.

At first, Betty was paid only twenty-five cents an hour. But how large and munificent a salary that was, can only be visualized by one who had never been a wage-earner before. Later, Betty became more proficient and earned a little more.

Can you imagine how Betty feels now? Heretofore, all the day held was the passing of gloomy hours into days, and weeks, and months. Now, a member of a happy working group, handicapped
like herself, she has found friends, and happiness and improved health.

The Industrial Health Cardiac Shop is in the nature of an experiment. Beginning with a few, it is increasing its enrollment. It can not admit many, as their quota is soon filled, funds being limited. Applications, however, are still welcome, for if there is an obvious urgent need for expansion, perhaps, these women with their vision and high courage can find a way to finance a bigger project.

Certainly, it was worthwhile to keep Betty from being relegated to the scrap-heap—and there are hundreds like her, worthwhile young women handicapped by serious heart involvements, eager to work—and that is their only ambition for a place in the sun.
“Problems of race relations and the public good, if they are to be worked out by strong and good leadership in a statesmanlike manner, must be analyzed with clearness and approached through effective avenues of institutional, united and organized effort.” It was with thoughts such as these in mind that the Interracial Committee of the New Jersey Conference of Social Work approached its task as soon as it was organized.¹

The time was too short and the task was too big at the moment to organize a State-wide survey to study the problem on whose solution depends the well being of any racial group. Resort was had, however, to the questionnaire method to secure some facts regarding Negro life and the relations of white and colored groups in New Jersey.

The main topics of the questionnaire touched on population, housing, industry, business, health, education, religious life, community facilities, welfare work and race relationships. While an attempt was made to analyze the whole data submitted, particular attention was paid to social and health work activities among the Negroes in New Jersey for it is upon this subject that a detailed report is to be rendered at this time.

Questionnaires sent out to selected white and colored citizens brought back information concerning thirty-one towns and cities in New Jersey representing a very large proportion of the entire Negro population of the State, which is estimated at 141,400 and constitutes 4 per cent. of New Jersey’s population.

¹Read before the meeting of the New Jersey Conference of Social Work, Trenton, December 1929.
In order to determine whether the relations between the white and the colored differed in the sections of the State, the questionnaires were divided into three groups; the northern section representing the industrial cities around Newark and Jersey City; the southern section representing the farming, shore and rural communities south of Camden; and the Central section the remainder of the State.

The questionnaires asked for information regarding the existence of non-racial and Negro social service agencies serving the Negro and the number of colored social workers employed; and also regarding general problems presented by the Negro to the non-racial and Negro social service agencies in the communities.\(^2\)

**Northern Section.** In the northern section all non-racial agencies reported doing work among the colored but few employ colored social workers. There are very few definitely organized social welfare agencies conducted by paid colored workers for the colored people. As one colored writer put it “there is little sense of responsibility on the part of the Negroes for the financial support of social services; the prosperous Negro gives as little as the menial worker.”

The Urban League, the People’s Charitable League, the Women’s Coöperative League, the Helping Hand Union, the Big Sisters are organized in one or two cities but only the Urban League has reported any paid workers. Two day nurseries, a neighborhood house for the colored employ colored workers. One local church has a social service center. Five cities have colored workers in their Y. M. C. A.’s and Y. W. C. A.’s, and an occasional colored worker may be found in a day nursery, settlement house, visiting nurse association, Church Mission of Help office or tuberculosis league. One non-racial social service bureau employs 4 colored workers; another employs 2, another charitable society “does not encourage Negro social service workers.” One Negro worker is reported by a county tuberculosis league and one by a branch of the Church Mission of Help.

**Southern Section.** As in the northern section the non-racial agencies serve white and colored alike. With the exception of Atlantic City, where there are employed Negro Y. M. C. A. and Y. W. C. A. workers, there are no definitely organized colored social agencies or non-racial agencies which employ colored workers. The better side of the recreational life and the service side center around the colored churches.

One colored writer in a large city deplores the lack of any real civic spirit or any real organization among the colored for social wel-
fare, and at the same time expresses the belief that the “non-racial agencies have never exerted themselves very much to make a real study of the needs of the Negro.”

Juvenile delinquency, gambling, immorality, speakeasies, broken homes, neglected children and the like are the chief problems of the Negroes in the southern section.

Central Section. In the central section the colored social service workers are again Y. M. C. A. and Y. W. C. A. secretaries and workers in an occasional day nursery or home for children or for the aged.

The Negroes here need leisure time activities for children and for adults; they seek “equality in public places and work in industrial plants;” they wish some assurance of “placement for colored teachers and high school graduates;” through the National Association for Advancement of Colored People they solicit funds to raise the standards of the race at large. Unemployment, housing, health, illegitimacy, desertions, etc., are listed among the problems.

The picture of the “inadequacies” in the existing social and health work activities in New Jersey are essentially those presented at last year’s conference. They may be summarized as follows:

1. Absence of provision for needed services.
2. Inferiority of the services rendered to colored people, compared with the services given white clients.
3. Inferiority in standards applied to the competency and training of social workers.
4. Inferiority of standards applied by licensing authorities.
5. Inadequacy of service resulting from overlooking the differences in the needs of the two racial groups.

Among the colored people, just as among the white people, social and health problems grow out of certain unsatisfactory community situations. The problems are aggravated in the case of the Negro because of the greater prevalence of “economic poverty, poor housing, educational limitations and a precarious family situation.”

Because of the close relationship between these conditions and the social and health work needs among the Negro, a few of the more important aspects of the findings of this survey concerning the Negro’s community and health situation are brought forward here:

Northern Section. Rents are declared to be universally higher for the Negroes for the same type of accommodation. Practically all
Negroes in New Jersey

cities restrict the Negroes to certain sections. In the larger cities the better class Negroes are able to acquire property or rent in certain desirable sections, but for the most part the Negroes are forced to live in undesirable or unsanitary houses in less desirable residential or business sections.

Southern Section. Sentiment is equally divided as to whether rents are higher for the colored or the same for the same housing. Because of the poverty of the Negroes they live in the poorer houses in the back streets of the towns.

Central Section. Restriction to certain sections of the towns is almost universal in the central section. It is frequently difficult for the high type of Negro to get suitable living quarters.

Northern Section. The attitude of the industries as a whole is unfavorable to colored labor. A majority of the larger concerns discriminate against Negroes, employing a limited number mostly as unskilled workers and common laborers. The tendency is toward the non-employment of Negroes and many mills and factories refuse to employ them. Unions are generally opposed to the employment of Negroes.

The average weekly wage is about the same for the same type of work (although one writer classed it as 5 per cent. lower on all jobs), but since the prevalent opinion is that the colored do only the most menial jobs, the wage scale is very low.

Southern Section. The general attitude toward colored labor is favorable although that labor is limited to the lower grades. The wage scale may be slightly lower but that is generally dependent upon the poorer quality of the work.

Central Section. The central section finds the same general lack of opportunities for industrial employment. In one community, the main factory with 3000 employees excludes Negroes. In other communities they are given the lowest type of labor. One correspondent from another large city states that the colored are limited in advancement while another from the same city states that the employment of Negroes is increasing because of the satisfactory service they render.

City playgrounds and parks are open everywhere to all races. In an occasional playground Negroes are not welcomed and when swimming pools are included, they may be required to bathe at certain times or in certain sections of the water. Libraries everywhere welcome both races on equal terms.

Negroes are usually discriminated against in theatres and moving
picture houses all over the state, either segregated in certain sections or placed in the balconies. Only five or six cities report that the attitude toward both races is the same and in even those cities there is a difference of interpretation of those reporting.

**Physical Health.** In 1927 the general death rate for the white race was 1094 per 100,000 of the white population, while that of the colored was 2389 per 100,000 of the colored population. The greatest differences were found in the death rates for tuberculosis (317 for colored, 68 for white) and for pneumonia (196 for colored, 52 for white).

**Mental Health.** The unsatisfactory health conditions which have their deleterious influences on the physical well being of the Negro, also have their influence upon his mental health.

The colored sufferers from mental disease in our state and county mental hospitals constitute over 6 per cent. of the total patient population. There are 452 Negro patients to each 100,000 of the colored population as against 261 per 100,000 of the white population.

The mentally deficient and epileptics represent 6 per cent. of the total institutional population. The institutional rate was 69 per 100,000 for the white and 110 per 100,000 for the colored.

More than 7 per cent. of the dependent and neglected children cared for by the Dependent Children's Department of the State Board of Children's Guardians are colored.

It is commonly believed that there is more delinquency and criminality among the Negroes in New Jersey than there is among the whites. Superficially, the higher delinquency and criminality is substantiated by the widely disproportionate number of Negroes in the State's penal and correctional institutions.

In January, 1928, 26.3 per cent. of the adult prisoners and more than 22 per cent. of the juvenile delinquents were colored. During the three-year period 1926-1928, 24 per cent. of the total number committed to the State Prison and reformatories 15 per cent. of those committed to state juvenile delinquent institutions were Negroes.

Relating these figures to the population of the two groups, we find that the rate of present inmates per 100,000 of the respective population was 52 for the white and 477 for the colored adult penal offender; and 19 for the white and 141 for the colored juvenile delinquent.

An interesting explanation for the unfavorable situation of the Negro with respect to delinquency and crime is offered by the Trenton
Negro Survey made some time ago: "Offenses on the whole are not serious. A large share of the arrests are due to greater willingness to arrest Negroes and to the disproportionate emphasis placed on Negro minor offenses. On serious charges they get longer sentences and are least able to pay fines imposed. Over-emphasis in some of the newspapers is conspicuous, giving to the public distorted notions about Negro character and behavior. A large proportion of the juvenile crime is scarcely more than mischief brought into contact with the law."

Even the slightest consideration of the Negro situation as it is depicted here must make us realize that "without adequate housing conditions, good health and good surroundings in the home, neither the individual nor the race will go forward as it well might in this day and generation. Progress in individual and community life and in race relations will scarcely be achieved over the barriers of disease, poor health, wrong living conditions, unsanitary surroundings, immorality, preventable death."

The problems of the Negro are clearly not problems for one race to solve alone but must be solved by both. There may be divided responsibility; but there is perhaps more of the joint responsibility. The people of New Jersey working together with high standards and respect for the personality of individuals and the welfare of the community must see that the conditions are fair for the Negro, that is, see that he is given his rightful place in the community which means better economic opportunities, improved home living and community environment, wholesome recreation and adequate social and health services.

There is common agreement that if more adequate social and health work services were available to the Negro in New Jersey that his economic and cultural level could be materially raised. Such social and health work services would have to include:

1. Comprehensive family and child welfare work, clinic, hospital and psychiatric social service.
2. Public health work covering personal and community nursing and hygiene.
3. Community work through social settlements, community centers, and character building agencies with religious affiliations.
4. Positive efforts to create the kind of a social environment that will afford wholesome constructive social life throughout the community.

A few non-racial social and health work agencies have realized their opportunities to serve the colored citizens of the community and have added Negro social and health workers to their staffs to deal with specific Negro problems.

It would seem highly desirable that this policy be extended, for as one colored leader sees it "the Negro social worker is developing a strength of leadership that bids fair to make him as influential among the masses as the minister. This is because the efforts of the social worker touch the Negro in a more practical way than those of any other type of leader. The social worker who has tact and sympathy and organizing ability is an influence to be reckoned with."

One of the best instruments for developing improved social conditions for the Negro would be the establishment of permanent interracial committees in every community where they are any appreciable number of Negroes. Interracial committees composed of representative whites and Negroes could be of considerable value in developing a constructive social service program for the betterment of the moral, social, religious, educational, and industrial life of the Negro, to serve as a clearing house for the problems discovered and to provide a solution of the problem when no agency exists to cope with it.

While the specific tasks of local interracial committees would depend upon the particular local situation, their general programs could include:

1. Efforts to improve housing conditions among Negroes.
2. Creating new openings for Negroes in industry.
3. Development of facilities for wholesome recreation of Negro youth.
4. Promoting health movements among Negroes including nursing services and public health sanitation.
5. Removal of handicaps under which Negro business sometimes labors.
6. Removal of specific features in the Negro situation conducive to vice and crime.
7. Securing adequate educational facilities for Negro children.

The Interracial Committee of the New Jersey Conference of So-
cial Work in coöperation with the New Jersey State Department of Institutions and Agencies will be glad to give assistance in making fact finding studies of the social and economic conditions among Negroes in New Jersey, in developing social and health work organizations when necessary, in bringing about coördination of the work among existing agencies and organizations for improving the Negro's industrial, economic, and social conditions.

REFERENCES

1 The paper which follows represents the information gathered by The Interracial Committee of the New Jersey Conference of Social Work, which was headed by Professor W. R. Valentine, Principal, Bordentown Manual Training and Industrial School for Colored Youth, and includes in its membership the following white and colored representatives: Mrs. H. N. Simmons, Chairman, Council of Social Agencies, Elizabeth; formerly President of the New Jersey League of Women Voters. Mr. Montgomery Gregory, Principal, New Jersey Avenue School, Atlantic City. Mr. Robert T. Lansdale, Executive Secretary, Council of Social Agencies, Montclair; Co-director, Negro Survey, Detroit. Mr. Irving Nutt, Lawyer, Camden; formerly member of Board of Education, Camden. Mr. Thomas L. Puryear, Executive Secretary, New Jersey Urban League, Newark. Dr. Emil Frankel, Director of Research, New Jersey State Department of Institutions and Agencies.

2 The Interracial Committee is very much indebted to Miss Helen E. Heyer of the Research Staff of the New Jersey State Department of Institutions and Agencies for her painstaking analysis of the questionnaires. Thanks are also expressed to the white and Negro citizens who have filled out the questionnaire; these include principals of schools and teachers, Y. M. C. A. and Y. W. C. A. secretaries, ministers, probation and attendance officers, secretaries and workers of social welfare agencies, officers of such organizations as the Household of Ruth, N. J. Colored Women Voters Conference, the National Association for Advancement of Colored People, the State Federation of Colored Women's Clubs, and the Federation of Colored Organizations in New Jersey.
EDITORIAL

May Day—National Child Health Day—Parent Cooperation the Keynote for 1930

The real beauty of May Day lies in its purpose and that purpose is to work for the time when our nation shall have taken every means "to ensure to every child the complete birthright of a sound mind in a sound body." Besides this serious aspect, May Day has a joyous significance as well. It is a festive day dedicated to the happiness and health of all youth.

Preparations are now being made for the May Day of 1930 and the beauty and value of the day depend largely on the cooperation which the parents will give. Its permanent results will come from their increased understanding of what is necessary for their children's health as well as a realization of what those in charge of public health programs are trying to do.

May Day became a permanent part of our nation's public health programs through the action of the State and Provincial Health Authorities of North America last spring. A National Child Health Day Committee was appointed by them and met on November 18, 1929, with the General Executive of the American Child Health Association and with representatives of the Division of Publications and Promotion of that Association. It was at this meeting that parent cooperation was chosen as the keynote for May Day 1930, and the following resolutions were drawn up and later adopted by the entire Health Authorities group.

1. Name a permanent State chairman for May Day—National Child Health Day, preferably the Director of the State Division of Child Hygiene.
2. Organize immediately a State Child Health Council or designate some similar organization to function as a Council if no Council exists.
3. Request the Governor to issue a proclamation on National Child
Editorial

Health Day immediately after the President of the United States issues his proclamation.

4. Accept "PARENT COÖPERATION IN THE COMMUNITY PROGRAM FOR CHILD HEALTH AND PROTECTION" as the keynote of the 1930 National Child Health Day program.

In some states the forming of a State Child Health Council will come as the most important May Day achievement. The first of these Councils, which are an outgrowth of May Day Committees, was formed in Maine but was soon followed by one in Texas and then other states, until today there are 9 actively functioning State Child Health Councils. The value of the Councils lies in the fact that important lay groups are represented on them under the leadership of official health authorities, with the result that the work of the State Boards of Health and particularly of the Divisions of Child Hygiene comes to be more fully understood and supported. It is also important that through being brought together on the Councils, the leaders of these lay groups get a more comprehensive view of their own respective programs for child health and the relation between these and the official health programs.

The Councils are but one important development of the interest aroused by May Day—National Child Health Day. They are a means to fostering the purpose of May Day, the ensuring to every child, so far as it is humanly possible, the "complete birthright of a sound mind in a sound body."

Today the attention of those consecrated to child health and protection is focused on the President's Conference, the White House Conference on Child Health and Protection. May Day—National Child Health Day this year, in stressing the coöperation of parents, is preparing the national mind for the findings of the Conference. Every national and local group will find in May Day an opportunity to further the interest in the Conference. At the same time, May Day is flexible and adapts itself not only to rousing interest in a great national program for child health and happiness but very specifically to the program of each state and community, each official and non-official organization.

Complete coöperation on the part of every individual will make May Day a day of genuine happiness for children and genuine inspiration for those who are responsible for them. May Day is the parents'
day as well as the children's. It is the day when parents, answering the challenge to give their children every advantage and protection which the modern science of health has developed, demand in turn that these advantages be put at their disposal and that the community, the state and the nation put into practice those methods which have been discovered to be best for the protection of all children—children sheltered in their own homes, unsheltered and dependent children, crippled children, delinquent children, babies still in the womb, infants just entering on the experience of life, little children in the first year of school, and those older children who stand on the threshold of maturity.

AIDA DE ACOSTA BRECKINRIDGE,

Director, Division of Publications and Promotion,
American Child Health Association.
NEWS NOTES

The Second Canadian Conference on Social Work

The Second All-Canadian Conference on Social Work will be held in the Royal York Hotel, Toronto, April 28th to May 1st.

Nearly one hundred million dollars is spent annually in the Dominion by public and private social agencies, it is estimated. Personal maladjustment of the individual to the community and community failure in its duty towards the individual are the causes of this stupendous expenditure.

Fully a thousand social workers from all parts of Canada are expected to come together in these four days, for the better understanding of social maladjustment, and the sharing of knowledge of methods of prevention and rehabilitation.

Some of the subjects to be discussed are: Health; Child and Family Welfare; Immigration; Social Statistics; Social Work Publicity and Finance; Community Organization; Delinquency Courts and Probation; Community Centres and Recreation; Industrial and Economic Problems; Recruiting and Training of Social Workers. Dr. W. E. Blatz of the University of Toronto will conduct a special study group on—"Behaviour Problems in Parent-Education";—another study group will consider—"Problems of Family Case-Work."

Open meetings will be held on the first three evenings, and the Conference will conclude with a banquet to be addressed by Mr. E. W. Beatty, President of the Canadian Pacific Railway, and Mr. G. Howard Ferguson, Premier of Ontario.

The second series of lectures under the auspices of the United Israel-Zion Hospital of Brooklyn in its program of enlightening the community on vital matters of health was opened this winter at the Community Center, P. S. No. 164. The Health Forum concerns itself mainly with instructing the expectant mother in the essentials of prenatal care and sex hygiene.
The lectures are given by eminent men, each of whom takes up an important angle of the many problems that confront pregnant women. Interesting entertainment and musical programs are given at the conclusion of the lectures. At the beginning of the Forum a number of artists signified their desire to assist the hospital in its communal work by donating their services at these entertainments.

"In civilized communities the care of the mother during pregnancy assumes each year greater importance," said Mr. Boris Fingerhood, Superintendent of the United Israel-Zion Hospital. "The more advanced the country, the greater the care it exercises in safeguarding the health and longevity of the citizens. Hospitals, particularly, have a grave obligation in such matters. It is up to them to do everything in their power to prevent as well as cure human ills."

"Since our last Forum we have had repeated requests for a continuation of these lectures. We hope, from now on, to make them an annual features of our communal activities."

The list of special lectures includes the following:

1. Frequent physical examinations for expectant mothers essential.
2. Food, exercise, amusements, clothes must be regulated.
3. Significance of swollen feet or face; eye trouble; backache; headache; constipation; sex hygiene and care of body.
4. How to avert common accident.
5. Effect of some diseases upon mother and child.
6. Teething—popular cause of "all" infant ailments; causes and prevention of blindness in infants.
7. Care of infants and infant feeding.
8. How to prevent infants from forming bad habits; outdoor life of infant and child.

From January 1, 1926, to January 1, 1930, 20,533 children in the City of Yonkers, New York, were immunized against diphtheria. This resulted in a large reduction both in incidence and mortality, the former decreasing from 431 in 1927 to 66 in 1929, and the latter from 23 to 5 during the same period. Because of this diphtheria prevention work there was a marked decrease in the number of diphtheria cases treated at the Communicable Disease Hospital during 1929, resulting in a reduction in the amount spent by the hospital during the year of approximately $7,500.—*Health News*.
The New York City Department of Hospitals will establish plastic surgery divisions in municipal hospitals. The object is to make it possible for needy people, whose faces either through accident or disease are disfigured, to receive proper surgical care.

The Annual Conference of the New York State Health Officers and Public Health Nurses will be held at Saratoga Springs, June 24-26 inclusive.

The English Government has approved a bill raising the school-leaving age to 15 years.

The Commonwealth Fund of New York has given $250,000 to Washington University, St. Louis, Mo., for trachoma research. The study will be directed by Dr. Harvey J. Howard.

The American Hospital Association reports that the hospitals in the United States gave to charity patients $100,000,000 in hospital service during the year 1929. Approximately 4,000,000 women and children were unable to pay for hospitalization and were cared for on an average of 12 days' stay in a hospital.

A course in Lip Reading Methods for Teachers of Hard of Hearing Children will be given during the summer at Teachers College, Columbia University. Miss E. E. Samuelson will direct the course.

A national bureau for the care of Italy's war orphans has been created to reorganize governmental aid on a more generous basis. Needy war orphans who are under working age and those mentally incompetent of any age, whether of legitimate or illegitimate birth are to receive help in the form of cash or of educational and occupational training. The children are to be kept in their own homes when possible, though delicate children and those suffering from tuberculosis are to be cared for in special institutions. A national committee appointed by the Government, including representatives of certain Government departments and men and women actively interested in child welfare will carry on the work of the bureau aided by unpaid branch committees in the Provinces and municipalities with whom school authorities and other local officials are to cooperate. All agen-
cies which heretofore have been actively interested in work for war orphans will be fused with the new bureau, which is to be supported mainly by funds from the national treasury.—World's Children.

Congress has passed a decree providing for the appointment of an official child welfare committee by the President for the purpose of carrying on an exclusive child welfare program in Costa Rica.

The death rate among Metropolitan Life Insurance policyholders was lower for the month of November, 1929, than any other previous November on record.

Reports for the first 6 months of 1929 from 38 States and the District of Columbia and 7 Canadian Provinces indicate that although the case-fatality rate from smallpox dropped slightly, as compared with the same period in 1928, the number of cases declined materially.

The minimum age for marriage of girls in India has been raised to 14 years and the age of consent to 16 through the passage of a law by a very large majority of the Indian Legislative Assembly, which also raised the legal age of marriage for boys to 18 years by the same Act. The bill was introduced by a native member and had strong support from the Government. Penalties are imposed for celebrating any marriage below the legal ages, and the law is applicable to members of all religious communions.—World's Children.

One of the most important lessons that we should appreciate is the great complexity and the vast scope of the field of public health. It is not a definite science but comprises a great body of knowledge about as broad as experimental science itself. For that reason the study of public health should be excellently adapted for general educational purposes. In this field, not only are the fundamentals of practically every laboratory science applied, but here is ample opportunity for the study of classics, the humanities, social problems and economics; for all civilizations have been profoundly influenced by problems of health and disease.—D. J. Davis, Ill. Med. Jour.

The Committee on Neighborhood Health, New York City, has moved its offices to the Department of Health Building, 505 Pearl Street.
Care of the Unmarried Mother.—The "Heimstatte" (home for the protection of girl-mothers), belonging to the National Union of German Red Cross Women, celebrates this year its 40th anniversary. This institution, which began very modestly, has grown to such proportions that, during the past year, it was able to shelter 341 mothers and 516 children, and take care of 304 confinements. Unmarried mothers are admitted to the "Heimstatte" a month or two before confinement and many remain there with their babies up to three months afterwards.—Inf. Bul. League Red Cross Soc.

The Burke Foundation for Convalescents announces that additions, changes and improvements in its plant and services at White Plains and the City Office are now complete. These changes provide for flexibility in the sex ratio of patients and for better classifications; 210 men will be accommodated (boys 15 years, men no age limit). This will reduce the number of beds for women to 105 but it is so arranged that these proportions may be changed whenever desirable. The Health and Welfare Organizations of New York have furthered and endorsed the modifications.

The Foundation is also planning increased support of certain outside convalescent efforts; especially to attain better provision for colored people. An important piece of research also will be inaugurated during the year, under the Sturgis Fund direction.

The Beth Israel Hospital, Newark, N. J., has opened a cancer clinic for the relief of cancer in all its forms. The hospital has acquired 650 milligrams of radium.

An ordinance has been introduced into the legislative council of Hong Kong to abolish the system by which Chinese parents or guardians can sell their daughters and wards into other households.

Delinquent children will be the subject of a special study during 1930 through the grant of $33,000 by the Bureau of Social Hygiene of the Rockefeller Foundation. The first survey will be made by the National Probation Association.

Dr. Eugen Kahn of Munich, Germany, has been appointed Professor of Psychiatry and Mental Hygiene in the Yale School of Medicine.
The New Zealand census report for 1928 shows a further decrease, in the remarkably low infant death-rate. In 1926 the rate was 40 per 1,000 live births; in 1927 nearly 39 per 1,000 live births and in 1928 the rate was reduced to 36 per 1,000 live births.

The State of California is making a definite attack upon juvenile delinquency through clinical study of problem children.

The Commonwealth Fund has established a new division to be known as the Division of Public Health for the purpose of studying rural health problems. This health work will be carried on in 2 or 3 States and in coöperation with the State Health Department.

A medical centre to be known as the New England Medical Centre, will be erected in the City of Boston on the present site of the Boston Dispensary, which will combine with the Boston Floating Hospital and Tufts College Medical School.

The heirs of the late Thomas Taggart of Indianapolis, Ind., have given $60,000 to the children's department of the Methodist Episcopal Hospital of Indianapolis.

During the years 1900-1927 the deaths from cancer in the registration area of the United States increased from 63 per 100,000 population to 96 per 100,000. These figures merely cover the mortality rate and do not take into account the number of persons suffering from cancer or the cases which have been successfully treated.

It pays in the lives of both mothers and babies to give medical and nursing care before and after the birth of the infant. In a group of 10,444 births which occurred during a 4-year period in the 4 communities where the Commonwealth Fund carried on child-health demonstrations the death rate for mothers who received public health prenatal instruction and supervision in coöperation with the family physician was less than half that for mothers who did not receive such care. Among the mothers receiving care the stillbirth rate was only half as high, and the mortality rate for their babies during the first month of life was only 2/5 as high as in the uncared for group. The same favorable results followed field nursing service and medical supervision in health centres given the babies during the latter months.
of their first year, the death rate among the infants not receiving such care being nearly three times that for the cared for group.—*World’s Children.*

The 59th annual meeting of the American Public Health Association will be held in Fort Worth, Texas, during the week of October 27, 1930, with the Hotel Texas as headquarters.

The Department of Health of Salvador has established a child welfare and maternity clinic in San Salvador where mothers and expectant mothers can receive free treatment and advice.

A Division of Special Education, which will take charge of all special classes for mentally and physically handicapped children, has been established in Baltimore, Md. Dr. J. E. W. Wallin, Director of the Division, in coöperation with a staff of assistants has planned courses at Johns Hopkins University for special class teachers, mental hygiene workers and investigators of problem children.

The Costa Recan Red Cross is conducting an intensive campaign against leprosy.

The Jewish Home Finding Society of Chicago maintains a visiting housekeeper service for women who through illness or other causes cannot care for their homes and children.

The Illinois State Department of Health has had filmed 4 new motion pictures. The pictures relate to milk, nutrition, personal hygiene and periodic health examinations. Each picture is one reel in length, requiring about 15 minutes for screening. Another recently filmed picture is “The Garden of Childhood.” This picture is on the care of the preschool child.

The Committee on Cost of Medical Care has undertaken a series of mental health studies.

The New York Tuberculosis and Health Association has announced the establishment of a fund to assist New York City nurses (graduate or student) who are suffering from tuberculosis. The project will be known as the Tuberculosis Fund for Nurses.
A diagnostic cancer clinic has been established at St. Barnabas Hospital, Newark, N. J.

Dr. Matthias Nicoll, Jr., Commissioner of Health, New York State Department of Health, resigned to accept the position of Health Officer of the newly created Westchester County Health District.

The United States Civil Service Commission announces the following open competitive examinations: Chief nurse (Indian service); Head nurse (Indian service); Graduate nurse (various services); Graduate nurse, junior grade (various services). Competitors will not be required to report for examination but will be rated on their education, training and experience. Applications must be on file with the Civil Service Commission at Washington, D. C., not later than June 30, 1930. Full information may be obtained from the United States Civil Service Commission, Washington, D. C., or from the Secretary of the United States Civil Service Board of Examiners at the post office or customhouse in any city.

The latest device for the entertainment of invalids is a Pillophone. It consists of a radio receiving unit embedded in sponge rubber and contained in a pillow covering. The user merely rests his head on the pillow and listens to his favorite programs without fatigue and without disturbing anyone else. It takes the same electric energy as a pair of earphones, and may be switched off at the radio set, or at the pillow. It is unbreakable and hygienic and is in use in British hospitals.—Pub. Health Nurse.

The American Mouth Health Association is the name of a new national society organized for the purpose of impressing the lay public with the importance of healthful living with especial reference to oral hygiene.

The New York School of Social Work, during the month of February, conducted a 4-week Institute for the Personnel of Child-Caring Institutions.

A Child Welfare Clinic with a public health nurse in charge has been opened at St. Mary's Hospital, Brooklyn, N. Y.
A school of social work has been established in South Africa in connection with the University College, Pretoria.

The National Housing and Town Planning Council of England has suggested that a rebate on the rent of the minimum standard municipal houses should be made in the case of families with 3 or more children having a maximum weekly income of 55s (about $13). The English post-war housing schemes have greatly benefited the better paid workers, but they have not emptied the slums because rents for the new municipal houses are too high for the poorer families. Certain small municipalities have adopted the plan of making a rebate of 6d a week off the rent for each child, balanced by 1s added for each lodger.—*World's Children.*

**BOOK REVIEW**


Miss Zachry has had a broad experience as a teacher and has written in a very simple manner to meet the needs of teachers of children to whom the book offers greater assistance than to parents. Social workers will find many useful suggestions in the subject matter, but very little that is especially new to the psychiatric social workers.

Emphasis is placed upon the social basis of personality and due recognition is given to the part parents and schools must play in developing personality as an integrated whole. Discussion reveals the value of the visiting teacher and the entire school set up of a constructive environment as factors in bringing about personality adjustment. The parts played by the curriculum, the methods of teaching and the teachers are well elucidated. Fitting children to face the reality of life problems is made the goal of adjustment through the development of all their natural constructive mechanisms together with external efforts at integrating all the phases of personality. Possibly there is too great certainty and definiteness about the mechanisms although the author frankly recognizes them to be largely hypothetic.

The book is based mainly upon the case studies of five children denominated, “The Troublesome Child,” “The Quiet Over-Conscien-
tious Child," "The Child with a Polyglandular Difficulty," "The Over-Dependent Child," and "The Over-Anxious Child." The narratives are complete but somewhat complicated by efforts at oversimplification. Possibly there is too great certainty and definiteness about the mechanisms. One regrets to note a few errors as, for example, on page 26, a child is said to have a chronological age of 9-10/12 years and a mental age of 10-8/12 years with an intelligence quotient of 129, obviously an impossible intelligence quotient. On page 75 the total adult vocabulary is alleged to be 1000 which is, of course, absurd. On page 162 appears the suggestion that iodine be used in the treatment of exophthalmic goitre, which is far from a desirable procedure. Despite such occasional errors, the book should be very helpful to those who are interested in appreciating the responsibility of the school for fostering the personal adjustment of pupils and desire to know some methods that were found useful in solving the problems of five specific children.

Ira S. Wile, M.D.


Children of previous generations learned the technique of household nursing and care of the sick by watching their elders. They soon had first hand knowledge of making the sick comfortable in bed, giving enemas, changing the bed linen, bathing the patient, and otherwise contributing to the comfort and improvement of the invalid. For the growing child the home was the training school in domestic sciences, which included, of course, instruction in the care of the sick and the preservation of health. The spacious homes and large families afforded a greater opportunity to the children to assist the older folks in the various household duties which included, naturally, “tending the sick” or “minding the baby.” In each household the standards varied and children acquired many erroneous habits, practices and fetishes that reacted against the individual, family and community.

Today with smaller families, less sickness, greater household facilities and less room in the household the child has not the same opportunity to learn from unreliable sources some of the simpler and necessary household aids to the sick. It is now, therefore, an opportune time for the public school to adapt its curriculum to include some of the why’s and how’s in the care of the sick, and the pros and cons
in preserving the health of the individual and community. All this can be accomplished in a practical way. In other words, the classroom can be turned into an imitation sickroom so that the school child will experience her first trials and instruction at the bedside under the supervision of an expert. Because of this authoritative information the child will be able to keep abreast of the science and art of modern medicine. At present too few schools give this subject the time and consideration it merits, but judging from the rapid progress and satisfactory results obtained by the schools which have already instituted this phase of teaching in health and hygiene, it is obvious that before long all schools will include the course in the curriculum.

"Home Nursing and Child Care" is one of the books used in the Malden (Mass.) health series to teach the school child such health knowledge and technique which will be of practical use to the child and the family, and which is bound to add to the community's knowledge and regard for public health problems.

Here is an easily read, well written manual which will find favor with those looking for a worthwhile, handy book on home nursing and child care. Although the book is intended for use in classes at the upper-junior high school and lower-senior high school levels, mothers will find it a reliable source of information to guide them in the knowledge of simple household nursing.

The chapters devoted to child care and hygiene abound in common sense, and favorable comments can be made on the able and concise presentation of such an extensive subject as the hygiene and feeding of the infant and child. The book is moreover, well illustrated by carefully drawn sketches and photographs. Social workers and others whose professional duties bring them in contact with those who look to them for guidance in health and disease should add this manual to their collection of reference books.

The book cannot fail to appeal to all women, whether mothers or nurses. But because it makes a distinctive appeal to the girl in the schoolroom the reviewer recommends this authoritative exposition of "Home Nursing and Child Care" for the consideration of all school authorities.

Samuel Adams Cohen, M.D.
Book Review


Old age brings to all who attain it a real problem—that of adjustment—the finding of new objectives and values. To those who approach it without means of support during its non-productive years it comes as an impending tragedy. Mr. Epstein in his book sets forth with forceful and clear delineation the changes which modern industry and its social consequences have wrought in the problem of old age. He shows how medical science and more hygienic living conditions have prolonged life and have thereby increased the period known as old age and at the same time the period of self-supporting productivity has become shorter for the industrial worker of today than it was for his father or his grandfather in the pre-industrial era. Modern industry has two watchwords—efficiency and production. Machines and men who can no longer efficiently produce must be discarded. The efforts which industry and the workers themselves have made to mitigate the suffering of those who can no longer keep the pace have in their very operation tended to complicate and augment the problem of old age.

Though wages have been substantially increased during the last decade or two, increased costs of the necessaries of life and the higher standards of living which have been brought about leave no more margin of family income over expenditure from which savings for the rainy days of old age may be laid up. Production depends upon consumption, and there follows today encouragement to spend with hardly an urge to save.

Certain groups, for example, war veterans, Government employees, clergymen, teachers, certain fraternal orders, and the like, have established or there have been established for them pension systems whose purpose it is to provide some security, small though it may be, against the incapacity of invalidism and old age. But for the great rank and file of industrial workers there is not even this inadequate security.

Pension systems, based on compulsory old age insurance, to which industry and industrial workers both contribute, seem to be the most promising means of providing at least a partial solution of the problem. Several chapters of the book are given over to a presentation of the old age pension and insurance systems of various European countries and South American States.
Abstracts

Tables, bibliographies and references to reports and periodical literature enrich the volume.

The Challenge of the Aged is a book which should be in the library of every social worker, since the problems of old age complicate almost every phase of social work, and to the well informed social worker society must look for assistance, if not for leadership, in its efforts to meet the challenge of the aged.

John E. Ransom.

ABSTRACTS


Occupational therapy, as the term implies, is aimed to bring about curative effects through various means requiring certain mental activities which find expression in the production of articles of a definite form or pattern, also definite recreational activities. In mental cases normal operations of the mind are replaced, disturbed or distorted in a greater or lesser degree and depending upon the depth of this disturbance will be divergence from normal action, thinking and feeling. Some patients are mildly affected, but with others there is a complete disorganization of mental activities. Modern research in mental diseases has resulted in a better understanding of the inter-relation of mind and body and it has become evident that total deterioration of mental function can be prevented, and even quite deteriorated cases can be stimulated into activity by carefully selected and well directed occupation and recreation along therapeutic lines. This applies also to acutely disordered minds. No two mental ideas can occupy and be carried out by the mind at the same time; either one or the other will gain in ascendency and the stronger this becomes the less will be the effect of the other, and it finally may be suppressed to such an extent that it is practically crowded out of the conscious life of the individual. This shows the importance of replacing morbid thoughts by others of a normal and healthy nature. This is done through psychotherapy, physiotherapy, occupational therapy, medical and nursing care, social service adjustment and other measures; each plays an important rôle and requires appropriate time and application. Occupation is an important and beneficial agent in keeping the mind from morbid ruminations and if properly applied good therapeutic results
will be obtained. The work in the State institutions with which the author is connected is planned to reach all types of patients and special efforts are directed to those who are in a deteriorated state. Habit training is stressed in these cases. Results must be measured by the therapeutic effect upon the patient and not by the character, appearance or value of the article produced. Crude and worthless though the completed work may be if the patient’s mind has been diverted from morbid and dangerous thoughts into the safe channels of a better adjusted and more wholesome mental attitude the desired results have been accomplished.


This interesting article shows the value of Scouts and Guides organizations in counteracting the over-emphasis of present day concentration on child welfare. The child quite properly has become the centre of the world’s effort to establish a worth-while healthful civilization and culture. We hear much of the rights of the child and we see legislation introduced for the better education and protection of children. This is a course necessary if children are to develop into good citizens, but there seems to be a tendency to let the safety of the child come before his duty as a citizen. If this be carried too far we shall allow the altruistic instincts of the child to atrophy for want of use and it will not be the children’s fault if they grow up selfish, self-centred individuals, seeking each his own advancement, rather than the general welfare of his community. The antidote is such organizations as Scouts and Guides. Through self-government and play children acquire a sense of values. Scouting and Guiding develop leadership and comradeship. Children of all classes, types and different religious affiliation, working and playing together submerge self, and become part of a group. Leadership, self-determination and self-government are introduced in such a form that every child feels that he is an integral and vital part of the group and learns to appreciate the necessity for personal adjustment to the customs of the community and for acceptance of and obedience to such laws as are enacted for their general welfare and for the benefit of others. The honor of the gang or patrol, troop or company becomes a personal concern and is placed above selfish ambition or caprice. All this is a preparation for an appreciation of good citizenship. The Boy Scout Jamboree held in England during the past summer brought together
60,000 boys from nearly every country in the world, all banded together by the scout-law. The Scouts and Guides make a direct appeal to children's natural instinct to live fully, courageously and altruistically and to be taken seriously as a citizen in their community. No natural child wants to be protected, rather does he want to find out how to care for himself and others. Delinquency frequently can be traced to the fact that the child has had no chance of finding out among his equals, that such conduct is anti-social and therefore not acceptable to others. Censure and condemnation meted out by a group of children to an offender is far more effective than reproof or punishment administered by adults. In England the subtle influence of the Scouts and Guides is so fully recognized that the work is now extended to include children in institutions. The crippled, blind, deaf and dumb, children in correctional institutions and even the mental defectives have their own Scouts and Guides organizations. These handicapped children take the same oath, wear the same uniforms, work for equivalent badges, have similar activities adapted to their special needs, no longer feel that they are different from other children. Splendid results have been obtained with the mentally deficient groups as they respond actively to the discipline of the organization and become more amenable to restriction and therefore more dependable. The author has a keen appreciation of child nature and has written an article which should make all thinking men and women encourage and develop these organizations to the fullest extent.


Child health workers recognize the tremendous influence the classroom teacher has in encouraging and inculcating good health habits in the pupils under her care. The more progressive schools are now initiating their own health program and are calling on specialists for assistance according to the needs of the children. The teacher largely is responsible for determining these needs. Teachers' colleges and normal schools are cognizant of the fact that health instruction is essential if children are to be properly prepared for good citizenship. The problems confronting the person preparing young teachers are three: (1) the basic training and experience given on the college campus; (2) the observation and practice afforded in the demonstration school as the testing ground of all theory previously taught;
(3) the field itself in which the students finally prove the value of instruction received. The author discusses the problems of teacher training in health from these three standpoints. The college campus represents the problems of a small community when the students are learning positive principles of public health administration. The environmental conditions directly influence the personal hygiene and health of the student body. Through the health department of the college students learn the value of periodic health examinations, learn their own health rating and receive instructions in regard to defects, habits and attitudes related to study, recreational activities, diet and other important matters concerning positive health. Credit should be given for attaining and maintaining a high degree of personal health. The students should be thoroughly grounded in all phases of public health work. Biology and allied sciences, psychology, home economics, agriculture, physical education, elementary education, school supervision and administration make important contributions to the understanding of factors which influence the physical or emotional health of children. The content of these courses should be influenced by problems of the field to which the students will go. The author clearly shows the value of thorough theoretical training combined with practical demonstrations and the importance of close coordination of the colleges and all community health agencies and activities. If this be worked out the classroom teacher will go into her field equipped not only to teach health but to inspire a desire for positive health among the children, and not only the children but the whole community will benefit.


This inspiring article relates the story of a young girl, handicapped by the loss of an arm who achieved remarkable success in the industrial world. The girl planned to be a teacher but economic pressure made the fulfillment of her dreams impossible. So the next best thing seemed to be secretarial work. One business school refused in the face of her handicap to enter her as a student. The Institute for the Crippled and Disabled undertook her tuition with the result that she has not only made good but proved herself to be more competent than other operators using both hands. The girl’s employer is interested in tennis and when last year through an emergency it became
necessary to have someone attend the analysis scores of the lawn tennis championship games at Forest Hills, this handicapped girl was pressed into service and in her characteristic fashion again made good. Her scores were telegraphed all over this country and Europe. This short story is an inspiration for social workers as well as for those who are handicapped. Incidentally it proves the worth of the Institute for the Crippled and the Disabled whose leaders train their disabled students to place their handicaps in the background and face life courageously.

Telephone Gramercy 2137
Hours Daily Except Sunday: 9 A. M. to 5:30 P. M.—Saturdays 9 A. M. to 5 P. M.—Summer Months, Saturdays 9 A. M. to 1 P. M.

HERMANN MUELLER, Inc.
Manufacturers of
TRUSSES, BELTS, ELASTIC STOCKINGS, CRUTCHES, ARCH SUPPORTERS, BRACES, SURGICAL CORSETS, Etc.
343 Second Avenue (S. W. Corner 20th Street) New York
SPECIAL RATE TO SOCIAL WORKERS
LADY ATTENDANT Joseph F. Victory, Secretary

IF YOU ARE INTERESTED IN CALIFORNIA

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

PRICE, $2.50 A YEAR.

THE PACIFIC COAST JOURNAL OF NURSING
609 Sutter Street San Francisco, Cal.