HOW CAN WE BRIDGE THE GAP BETWEEN WHAT WE KNOW AND WHAT WE DO NOT KNOW ABOUT PREVENTION*

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I might give you quite a lecture this morning, but there is my lecture (indicating) on the chart. ("The Goal" published by the International Society for Crippled Children.) To occupy the time we might go into a few of the details about that "road map." It is a very interesting map, showing the progress of the cripple beginning back in the squalid village of Destruction, on through the backwoods town of Ostracized, and then through the complacement village of Neglected, I believe it is, on up to the modern little city of Reclaim.

I think we might imagine ourselves a crowd of tourists in this little city of Reclaim. We have been here for three days now, and we have gone all about. We have seen numerous hospitals, the care of crippled children, we have examined the programs that are inaugurated for the gathering in of the cripple and reclaiming him. We have had excellent talks on all of this work, and we ask, "How did this little city of Reclaim get to be such a center for the care of crippled children?"

We walk down the street and we meet an old timer. He is a little lame himself, and comes along the street with his cane, and we ask him if some great surgeon settled in this small town and worked so marvelously well that all the cripples flocked to him. If this great place was built up around some pioneer surgeon. He tells us, "Not at all. This little town of Reclaim happened to be on the road to a wonderful land over beyond the mountains, Prevention, and so the cripples through the years have come up from the squalid place

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Destroyed, and they have finally arrived at the progressive little town of Reclaim."

"Well, why didn't you go to Prevention when you came?"

"Oh, there weren't any roads to Prevention when I came here. We all had to stop at the little town of Reclaim. You see, it is a mountainous country. There are chasms and wide rivers and marshes between here and Prevention so that most of us have to stay in Reclaim."

"Why don't they build roads to the land of Prevention?"

"They are building a few. The Rickets Road has already been constructed. You go down Sunlight Avenue, you cross the Deficiency River over the new Vitamin Bridge built a few years ago, and the rest is easy going."

"Well, why can't we all go that way?"

"Why, you see this is a very peculiar country. We have to have a different road for every different kind of cripple. A few surveyors have been out surveying the land between here and Reclaim and they report it is impossible to construct the various roads necessary for carrying all of the cripples over to Reclaim."

We go into the meeting which is being held in this town of Reclaim, and this is an annual meeting. We hear the treasurer's report, and the treasurer reports that millions of dollars have been spent during the last year caring for all of the cripples that come to this town of Reclaim. He says you would be surprised to see how many are able to walk back home, but he adds, "We still have a great many with us and the outlook is discouraging. More and more are coming every year and the expense is mounting up. I don't know what we are going to do about it. The Treasury is almost depleted."

A business man in the meeting arises and says that he has a solution. He wonders if they might not devote a small amount of their resources to the construction of these roads on to Prevention so that they would have less cripples to reclaim in the town. He proposes that they set aside a small fund for this purpose. There is much dissension. Some of the members say that their function is primarily to take care of the cripple.

But the treasurer points out that it will be good business, that it would actually save money for them to construct a road that some of these cripples can go on to Reclaim. He figures it out on paper and he says, "We have 100 beds in the hospital here. Each bed costs us say $1,000 a year, so that even if we prevented one cripple in the course of a year we might well afford to do away with one bed."
So the prevention of one out of 100 cripples per year would actually pay for itself.

That project then, received a vote at this meeting, we will say. Now to put the thing in another vein, I am trying to say that the work of reclaiming cripples is of vast importance. We must take care of the cripples as long as we must have them. But reclaiming is an unsatisfactory thing because it is not 100 per cent. We cannot cure all of the cripples. We can make some of them 100 per cent better. We can make some of them 99 per cent, better and some we can help but little. I endorse every move that has ever been made to take care of the cripples as we are doing now, but I think we should go a little further considering the nature of some of these crippling diseases, particularly infantile paralysis, which is one of the major causes of crippled children. It never has been cured. It is not cured now, and never will be and never can be, for the simple reason that the nerve cells in the spinal cord which cause muscles to move are dead, and there is no way of bringing them to life.

The real reclamation in a disease like infantile paralysis lies in preventing the occurrence of the disease altogether. Now that is very good. We talk about the preventable diseases and I think we have oversold ourselves a little on that.

Infantile paralysis may be a preventable disease, but we do not know how to prevent it. So that means that we must, before we can prevent the occurrence of these diseases altogether, learn how to do it. And the only way to learn how is by continued investigation of the disease in the clinic, at the bedside, in the field, and in the experimental laboratory.

It seems to me that any crippled children’s society should have it as a part of its program to devote some of its attention to finding out what causes a crippling disease in the hope that some day we may be able to prevent the disease altogether. I should like to cite the little Vermont project as an example of that sort of work. In 1914 a fund was donated to the State Department of Health. First of all for the care of the cripples resulting from a severe epidemic of the disease. But this very wise person realized at the same time that that was not enough. “We must find out how to prevent the disease.” So that work has continued up to the present time, each year a part of the funds being devoted to the study of the disease. In the last few years this project has been combined with the Harvard Infantile Paralysis Commission which also undertakes the after-care
of the disease, but at the same time is bending every effort on how
to find out how to prevent its occurrence altogether.

So I feel that every cripple children's society should have that
as a part of the program. First of all, because people dealing with
crippled children realize better than anyone else the importance of
doing something to prevent crippling, and second, because it would
actually pay in dollars and cents for them to do so.

The research may find the solution of a problem within a compara­
tively few years. The outlook is very promising in many of our
diseases, but the after-care of the cripple will go on until doomsday.
Crippled children's societies should not be merely carvers of crooked
crutches for crippled children, but they should be real societies for
the prevention of crippling in children.

Just a word about research, how that may be done. There is
not any particular point in going into details, but such a research
could be carried on not necessarily by one local society for crippled
children, but by united effort. There are many research projects
under way which might be supported by money set aside from the
funds of crippled children's societies. And I dare say that the setting
aside of 1 per cent. even of all the money that is required in the
work of reclaiming the cripple would go a long way toward solving
the problem of the prevention of many of our diseases.

I don't know the exact figures at all, but I should say that for
every million dollars spent in the care of crippled children in one
way or another, probably less than one thousand is spent trying to
find out why they got crippled in the first place.
The general unrest and the new social adjustments attempted in China today are having a marked effect on many young married couples. Women realize the necessity of keeping pace with their husbands in intellectual development. Often they persuade their husbands and their fathers-in-law to consent to their attending the same universities as their husbands, and in most cases the necessary financial support comes from the father-in-law.

This is in contrast to former conditions. In the past when a young girl rode to her husband’s home in the red sedan chair, she expected to spend the greater part of her life behind the walls surrounding his home. Her own family ties were broken. When she had worshipped before the tablets of her husband’s ancestors, she was expected to give obedience to his people. She became a member of a “big family” in China. One has to be invited behind the walls into the home life of one of these families to realize what this means. There might be living in one household the grandfather, father and mother, younger brothers and sisters, and all of the older brothers with their wives and children. Often her husband left her there after the wedding ceremony and went away to complete his studies. There was little chance for further mental development on the part of the bride.

For those women who are pursuing their studies with their husbands, pregnancy creates a distinct problem. The following is a study of this problem in forty-four cases which came through the Social Service Department of the Peking Union Medical College Hospital during the past year.

All these women were studying either in a Higher Normal College or a university except one who was a High School student. Their
ages ranged from 18 to 32, with the majority at the ages of 20, 23, and 26. Their husbands were between 19 and 34 years of age the greater number being at the age of 23 and 24.

Their housing conditions varied according to the amount allowed them from home. Two were not paying rent but were living in the Hui Kuans, houses built in Peking by different provinces or cities in which students of these districts may live rent free. The lowest rent paid was $4.00 a month for three rooms, but a majority were paying over $8.00 a month for rent. The highest rental was $18.00 for an eleven room house, a high rent for students of even the highest class. Of the three couples who were not keeping house, one boarded at a small hotel, and in the other two cases the wives were living in dormitories.

In all but twelve cases, the husband’s father was providing the support. The amount varied according to the father’s financial condition. The smallest sum was $600 and the largest $1,440 for the year, which are very generous amounts even in the case of the $600. Fifty Mexican dollars a month in Peiping enables the Chinese to live on a standard equivalent to that of fifty gold dollars a week in America.

In one case where only $400 could be provided from home, the wife had bought a knitting machine and was making and selling stockings to help keep herself and her husband in school. Two of the husbands were working part time and earning enough for their expenses. One owned a leather shop the proceeds of which supported him and his wife. Although as a rule a wife never expects any financial aid from her own people, the money sent to two of these couples came from both sides of the family. This probably more than anything else makes one realize the great changes that are under way in China. Two couples were supported by Scholarships, one the very generous sum of $2,040 a year at a Military College, the other coming from a Mission School just enabled the young couple to live. In fourteen cases no definite information as to the financial condition of the family was given, in each case the wife saying that the money came from her father-in-law.

When these young students realize that they are pregnant, the first thought, often, is to have an abortion. One young woman who had been studying with her husband at Peiping University came to the hospital suffering from neuritis. The doctors on finding her pregnant insisted on her giving up her studies until after confine-
ment. She was so determined that nothing must interfere with her work that she asked for an abortion, which, of course, she was told the doctors would not do. One of the social workers finally persuaded her against it and she went home apparently to await her confinement. When a home visit was made a short time afterwards the woman was dead. She had been too impatient to await the normal delivery of the child and had tried an abortion. Fortunately not all the cases are as tragic as this.

T. M. C., 20 years of age, was attending a Normal College in which all of her expenses were paid by the government. No one there knew that she was married. Her husband was studying in an engineering college, his expenses being paid by the family. Because of his stepmother's objection to his wife's studying, his family would furnish no money for her. When pregnant she too came in to the clinic asking for an abortion. The social worker intervened and secured a part-time teaching work for the girl to help with her expenses. One month later, however, she was brought in to the hospital for after-care from a so-called "spontaneous abortion."

N. C. F., age 23, and her husband, a boy of only 19, both students at Peiping University, faced the situation in a more natural way. Immediately after their marriage one year ago they came to Peiping to study. She did not allow pregnancy to interfere seriously with her work, staying out of school for two months only for her confinement. She nurses the baby but has an amah to care for it while she attends classes. She has three more years before completing her university work.

Many of them are by no means willing to nurse their babies, but employ a wet nurse as did H. Y. C. Her marriage was arranged when she was a young child. Both she and her husband studied in Peiping before their marriage last year and came back together to continue their work immediately afterwards. She said it was impossible for her to nurse the child, for the loss of a half year from college would make it impossible for her to graduate with her husband.

Some of the women, however, do remain in college after their husbands have graduated. L. C. H. was a third year student in the Normal College. Her husband had completed his law course and was in Nanking. Supported by her father-in-law, she lived in a dormitory with five girls in a room. After the baby was born, she kept house
with the help of an amah. When the baby is a little older she plans to send him to her father-in-law's home and will stay one more year until graduation.

Sometimes it is the woman who finishes her studies first and helps to support her husband. F. M. T. on graduating from Normal College taught in a primary school making $40.00 a month, while her husband was still a student in an engineering college. They were able to live on the wife's earnings because, living with an uncle, they had no rent to pay. When we saw her she was in the hospital for her second pregnancy. The older child was living with her husband's people.

A situation unusual in the past but becoming more common in China is that of T. P. L. married to a divorced man. (She continued her studies after the birth of her child.) With the consent of her husband's parents, she was enabled to continue her studies by his mother's coming to care for the baby.

A girl of twenty came to the hospital for confinement saying that her husband had been called away on business. Since a baby would interfere with her studies, she asked if the Social Service could not have it adopted. When she realized that investigations would have to be made she preferred to keep the child. Two weeks later when a home visit was made she said the baby was dead. One wonders if the child had been given away.

P. J. H. became engaged last year to a son of a neighboring family in her village with the consent of their parents, but it was decided to delay the marriage until they had both completed their graduate work. Together with her brother, the couple made two weeks journey to Peiping. When she found that she was pregnant, her fiancé had gone to Japan to study while she was living with her brother and studying here. She feared that if the family should learn that she was pregnant they would follow the old-fashioned custom and put her to death. She came to the hospital begging for an abortion. She was finally persuaded by the social worker to wait for the natural delivery and to enter the hospital at that time without her family's knowledge. The plan is to board the baby out until she and the man have completed their courses in law and are married. After marriage they will adopt the child without letting any one at home know the circumstances.

Of the 44 cases studied, 5 of the women were undergoing their second pregnancy and 4 their third. In spite of this only one of
the number had given up her college work to devote her time to the children. A study was made of the hospital records of the babies from which the following table was made:

HEALTH OF THE BABIES

<table>
<thead>
<tr>
<th>Sick</th>
<th>Not brought to clinic</th>
<th>Good condition</th>
<th>Abortion</th>
<th>Died</th>
<th>Not yet born</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>19</td>
<td>14</td>
<td>6</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>44</td>
</tr>
</tbody>
</table>

Of the fourteen who did not bring their babies in to the hospital four have moved away and the babies of six of them were born within the last month, so that there has not yet been time to develop trouble. Of the nineteen which have been sick, malnutrition, respiratory infection and diarrhea were the chief complaints. Some of the babies have been to the clinic repeatedly. It is impossible to determine whether the illness of these babies is just what can be expected in babies of this age, or is the result of the mothers trying to carry on their studies. In two cases only of the nineteen, however, was there evidence of neglect on the mother's part.

This movement on the part of married Chinese women to obtain an intellectual development equivalent to that of their husbands will be watched with interest. Whether this method of study after marriage will become a permanent custom in China cannot yet be determined.
INTERRELATIONS OF HOSPITAL SOCIAL SERVICE DEPARTMENTS AND COMMUNITY AGENCIES


Repeated before the Middle Atlantic District, American Association of Hospital Social Workers, March, 1928.

I. Leader: Edith J. McComb, Director, Social Service Department, St. Christopher's Hospital for Children, Philadelphia.

Discussion

II. Miss Alice Swift, Director, Social Service Department, Germantown Hospital, Philadelphia.

III. Miss Anna Budd, Superintendent, Kensington District of the Family Society, Philadelphia.

IV. Mrs. Edith Seltzer, Social Service Department, University Hospital, Philadelphia.

V. Miss Frances Holbrook, Social Service Department, Graduate School of Medicine, University of Pennsylvania, Philadelphia.
INTERRELATIONS OF HOSPITAL SOCIAL SERVICE DEPARTMENTS AND COMMUNITY AGENCIES*

EDITH J. McCOMB, Leader,

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This is a subject which should interest every social worker, be she a family case worker, a children’s worker, home and school visitor, a medical social worker, or any other type of case worker. We all have many ideas on the matter, from agreeing in entirety to disagreeing in entirety,—hence, I should say, we have a good topic for a Round Table. Now is the opportune time for all of us to be frank and constructive in our criticism of the service we render each other.

After all, the Family Society’s client is usually the hospital’s patient, and many of the medical social worker’s patients need, and receive, the assistance of one or more community agencies. If we did a bit of research on the number of families known to social agencies, including all types of organizations, I am sure we would not be able to allot more than one worker to a family. But, even if there were enough well-trained workers numerically, would any one consider an expert from each field, having direct contact with the client, as sound case-working methods? As hospital social workers we must keep first and foremost in our minds that we are but a small part of an old-established profession and institution and that this profession and institution existed (I emphasize existed) for several hundred years without our assistance. Although we realize, as case workers, the importance of the diagnosis, treatment, and prognosis, and their interpretation, we cannot always secure, without some delay, this information, which is so vital in the making of adequate plans for your client. You must know and appreciate that a proper diagnosis


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accompanied by laboratory, X-ray, and other findings takes time and thought—that clinics, as a rule, are always overcrowded, and that many of your clients need special service. Gordon Hamilton, in discussing the value of interpreting medical diagnosis says:

"We are beginning to think that the medical diagnosis as a whole with meaning is of more use as it stands to the doctor than to the social worker. It has to be transplanted into other terms to be really helpful to any social worker. A medical diagnosis can be intelligently used only if it is broken down into various social interpretations, such as the extent to which the patient is disabled, how long he is to be disabled, the kinds of work he can do, dietary and other restrictions. Too often these interpretations are given incompletely. The extra-mural worker is too often ignorant as to what she should ask for, as to what she can reasonably be expected to get; she may fall back on gathering up what is scarcely more to her than diagnostic verbalism, which can be of very little real use in the social treatment of the case. She must be helped to realize the length of time it takes to make a medical diagnosis on deep-seated conditions, just as she must be prepared to help the doctor understand the length of time it takes to make a social diagnosis. The extra-mural worker is perhaps too impatient with the inevitable clinic limitations, just as the intra-mural worker is perhaps not impatient enough. Medical diagnoses are still, I am afraid, collected, by many social workers painstakingly, like specimens of flora and fauna. Nothing but a deeper sense of responsibility on the part of the medical social worker to offer something better in the way of interpretation will help us to get away from these routine and ineffective activities."

My criticism of cooperation between agencies is—that we don't discuss thoroughly enough the problems involved in our more difficult cases—we spend too much time and energy covering the same ground already covered by our predecessors—whereas a small case conference of the workers interested, with one or two experts to get the perspective, would be invaluable to the social worker handling a complicated family situation. After all, we agree with Dr. Cabot—good social case work is perfect team work.

If the family needs several experts to solve its problems—can this be done efficiently, without contact with more than one social worker? After a case conference, can the worker assuming the major responsibility have the only contact with the client, all plans
and suggestions of cooperating agencies going through her? Surely, we, as medical workers, are capable of interpreting to our colleagues in other fields the patient's diagnosis and plan of treatment, etc., and she, without a doubt, is able to understand and interpret in turn to her client. In the same way, the community agency worker is perfectly capable of interpreting to the medical social worker the family situation.

Do we know enough about each other's jobs and the rules and regulations of other organizations to appreciate their limitations, or are we unfair many times in our criticisms? Do we take enough time and thought to learn something of the real problems and difficulties of other agencies? Are we too hasty in referring to other agencies cases which we know very little about, allowing them to do an intensive investigation, only to find, in the end, that the problem really belonged to us? The Social Service Exchange is one of our most important tools, and yet—I'm afraid we do not receive the maximum value of it:—how necessary is it to get in touch with agencies before taking any action? Do we merely ask for summaries automatically, or do we convey to the agency or hospital our real need for a full report?

Does the community agency receive important reports promptly, or does the delay cause plans to be defeated? Does the community agency appreciate the importance of appointments with staff chiefs, special admissions to hospitals, special clinic service—arranged by the medical worker at a great cost many times, or does she just accept these as a matter of course—and let the plans take care of themselves? When orders for special diets, apparatus, temporary placement, etc., are given by the physician caring for the community agency's client and relayed to its worker through the medical worker, does she appreciate the importance of carrying them out? If there is some unavoidable delay, does she deem it important enough to get in touch with the medical worker before the patient returns to the physician, and does she take into account the fact that most doctors are accustomed to having their instructions completed or an explanation given?

I am afraid most of my criticism has been from the angle of the hospital social worker, but I am fully cognizant that the community agency worker does not find perfect service in every medical agency that she deals with in the course of her career. Now is her opportunity to tell us of our shortcomings.
I feel that the hospital and its departments should be an integral part of the community, ready at any moment to meet, appreciate, and serve the needs of its fellow-workers. The hospital social worker should be eager to understand their problems, to keep them informed of the latest developments in medicine, to arrange group conferences, to give expert advice on medical situations. She, in turn, will ask her community group for advice and solutions according to her needs. She will have more time to concentrate on one particular job, and do it well. She will have no fear of starting an intensive piece of work, having the assurance that her colleagues will not ignore her existence in the field of good case work. She will be big enough to desire what is best for her families. She will not refuse to turn over a case to an agency better equipped to handle the problem—knowing that she can continue her interest from a medical standpoint without any fear.

John Erskine says, "As civilization grows and the contacts multiply among us, either there is friction which comes of hatred and war, or there is a light touch on the sensitive surface which is tact."
I want to stress particularly Miss McComb's reference to the importance of gaining a better understanding of one another's point of view, or more strictly speaking, the viewpoint of other agencies. Most of us are fairly sure that we understand our own organization, but are we so sure that we interpret our own special approach or our own special difficulties, to other agencies.

A good interpreter must be an understanding person; must understand both the language he is interpreting, and the language of the person to whom he is interpreting. Before we can even attempt to interpret what we are doing, and why we are doing it, to the community; that community from which our clients come and the community that is footing the bill, we must have a helpful understanding of one another. Before we can even approach the accomplishment of our goal, we must perfect our team work. We have a definite objective, the same objective, although our approach may be from different angles, and we should constantly keep in mind the goal toward which we are striving. Are we not endeavoring to bring about a better relationship between human beings?

I sometimes feel that we become so engrossed in our own particular method, in the specialized technique of our job, that we lose sight of the real objective of our efforts. To be sure, this is an age of specialization, but specialization without coördination is liable to be disastrous. A surgeon who proceeds to perform a major operation without calling into consultation the pathologist, the medical expert, the rontgenologist, is not one to whom we would wish to entrust our family, our friends or ourselves. We want one of these experts to
assume the responsibility of the treatment, but we want his procedure to be influenced by the specialized knowledge and advice of the other members of his group; and we want him to be thinking not only of the technique of his procedure, but to keep in mind the ultimate aim of the treatment which is the restoration or improvement, at least, of the patient’s health. It is equally important in social treatment for different workers in the same field of endeavor, to frequently consult one another, determining together possibly what the diagnosis is, and who shall assume the responsibility of treatment, not forgetting the objective of the treatment.

We must earn a confidence in one another that will lead us to respect and accept the experience of one another. In a recent article by Gordon Hamilton, I was much interested in her description of a conference on a case that was known to thirty-seven different agencies. She said, “All registered the case through Social Service Exchange. The conference brought out the fact that most of the agencies had traveled over the same ground, frequently repeating the investigation, no agency quite accepting the facts brought to light by another agency’s investigation, though thirty-four out of thirty-seven agencies discovered no new facts.” That conference might be a picture of ourselves in action, one over which we should do considerable pondering. I am thinking, as you probably are, not only of the family concerned but of the time and energy used by all of the social workers, not forgetting the community which was paying for their services.

Just such an informal conference as this, where we can try to coordinate our effort, where we can explain to one another, the special difficulties we encounter in our own agency, is the best method I know to bring about a better understanding of one another. We all have difficulties and are quite aware of them. You may not understand mine, and I probably do not understand yours. This failing to understand often leads to the use of that deadly instrument, destructive criticism. Why not make our criticism constructive by bringing it in the form of a question to such a conference as this? Here you can tell hospital social workers that a medical diagnosis in Latin or Greek medical terms, or named after some man who first made the diagnosis, is not of much value to you. What you want to know in plain, simple language is how the disease affects your client, to what extent it will incapacitate him, whether the condition will temporarily or permanently disable him, and what method of treat-
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ment is advised. You can ask us, as hospital social workers, why we do not send reports more promptly when the reports are of such importance in the plan you are eager to formulate for your client? Why we do not notify you at least a few days before your client is to be discharged from our hospital? Here, I can honestly admit that we, as medical social workers, should become more skillful in our medical-social interpretation. I can explain that a medical diagnosis is frequently as complicated and takes as much investigation as a social diagnosis, and can sometimes be made only by standing-by and watching developments. I can explain that a physician cannot always tell whether or not a patient can work. I can tell you that we, ourselves, frequently cannot find out long in advance when the patient is to be discharged from the ward. This depends upon so many things, upon the patient's response to treatment, upon being able to see the Chief of service who comes in at different hours every day. Though we may try to find out exactly when a patient is to be discharged from the ward, we are not always successful. I can tell you how a social history from you, relative to the client you refer, is most helpful to us, and the doctor, in our contact with the patient; much more so than a card asking us to admit him as a free patient, and requesting a report. Let us get together to explain these things, to study together whether our method of treatment is merely palliative or whether we are approaching successful treatment. Let us gauge our usefulness. There is no such thing as standing alone, our social structure is so organized as to make us dependent upon one another for our very existence. Bringing this relationship into harmony is our common endeavor, the end toward which we are striving. What better method can we use than harmonizing our own efforts?
When various social agencies were started we needed the special fields to develop better each phase of social work. Each field still needs further development, but social work has progressed as it has developed, so that each field has reached a point where it can do a more rounded out piece of work, using the other agencies more in a consultative capacity only. It used to be considered good case work to have all the agencies active at one time in a given family; now the agency best equipped to meet the most outstanding needs, using the other agencies for consultative service, seems to me the way to render the clients the best service which the community offers.

I would like to see discussed Miss McComb's question, "Are we too hasty in referring to other agencies cases which we know very little about, allowing them to do an intensive investigation, only to find that the problem belonged to the Hospital?" How many hospital workers hear a client say they are in a "bad way" financially and on that basis with no further interview, refer the family to a family agency? Would it be asking too much for the hospital agency to discuss further with the client to see if there is a real financial need, whether or not the family could meet the need themselves or the hospital agency having contact, make it their undertaking to see that the family's temporary needs are met? And if the hospital worker has known the family in this capacity, wouldn't she then be able to refer the family to a family agency before a great emergency arises? It would give the family agency a so much greater opportunity to understand her families' real needs and to give the hospital worker some ideas of how she could meet those needs. Since family societies
have been having so many more families to assist than their budgets will permit—this suggestion would mean that often the hospital worker would prefer to keep the family under her care if she knew how little could be done for the family by the family agency. If too, the hospital worker understood her family situation better before referring—she very often would see no real need to refer—thereby releasing the family worker to do more for families which could not be helped by anyone else. Perhaps part of the difficulty lies in the fact that the family agency used to be considered (and still is unfortunately by some) as an investigating agency. BUT, hasn’t the time come when each agency—hospital, family, children’s, find out the needs themselves and if their findings make the family seem like one which more normally belongs to a family agency, then to confer with the family agency.

This brings me to a point on conferring a very successful experiment between hospital agency and family agency which has been worked out in the district in which I am. Whenever the hospital agency reaches a point in their contact with a family where they think the relief problems are of long duration and the family difficulties are more involved than hospital workers feel it advisable to carry, a conference is called of hospital staff and family case working agency representative to discuss the next best procedure. Sometimes the decision is reached that it would be better for the hospital agency to continue, sometimes it is decided it isn’t a family for either agency, and sometimes for family agency. The conference offers the opportunity to consider all phases of the situation, to discuss a working out relationship between agencies for these families. The family agency then in taking over the family will take over the entire responsibility, health and all phases, so that there will only be one worker visiting the family, instead of two as is so often the case. The hospital and family case worker continue to have conferences in order to keep each other informed of the developments, but most of all to advance each other knowledge and thinking in relation to all their work. This could prevent one agency acting as an interceder for the client or patient, and eliminate the client always returning to the initial agency to have her case taken up for her. The conference idea also eliminates the phoning in front of clients at time of referral. Phoning in front of clients almost invariably gives the client the feeling that you are asking and going to get exactly what is referred to in the conversation.

This conferring and sharing idea between hospital and family
worker would mean a great exchange of knowledge and eliminate so many workers visiting the same family. The family worker could sometimes make better use of additional health information than the patient—why not give this to her and equip her to carry the ideas across to the patient? Some workers fear this would be taking their jobs away from them, but haven’t we all more to do than we can do and wouldn’t this give us additional time to do things we are always longing to have time released for? On the other hand, there is lots to know about financial dependency, which family case workers could pass on to hospital workers through this conferring. Financial dependency is only a part of the whole emotional dependency make up of a client and since it is this that we want to consider in working out the best financial solution—it is important for hospital workers to know something more about relief philosophy even though they would handle only a small degree of relief.

Why encourage a client to go through the getting acquainted process with another agency for so short a time—only to return to hospital worker for entire treatment—if money is their only need? Hospital workers should be just as well equipped to meet a short-time relief job as family case workers. They should know natural resources, be able to interview clients and to discuss this problem with clients. Would it be too much to hope that hospitals will have their own funds for such short-time needs? If not, perhaps a city out-door relief department might have funds available for a hospital’s use if the case work was approved. This would enable the hospital to keep the case and yet meet the financial needs. I appreciate the many complications which could arise over this, but I would certainly like to hear its possibilities discussed.
"The real measure of a community's strength for good lies, not in the number and variety of its institutions, not alone in the personality or enthusiasm of its social workers, but in the effective joining of their forces. The effectiveness of such coöperative effort is a responsibility that rests upon each person who considers himself or herself a social worker."

This challenging statement made by Ida Cannon, a leader in the field of medical social work, is being answered tonight by this round table discussion of interrelations of hospital social service and community agencies.

I have been asked to speak with especial reference to the communications between these groups. It is in the every-day contact—the letters of inquiry from social agency to hospital social service department and the letters of reply, or vice versa,—that the practical basis for coöperative community relationship expresses itself. It is by this means that we grow to know each other better: that we are kept constantly aware of our interdependency and we are oftentimes forced to ponder as to more satisfactory methods than those in use.

I shall state at once some of the problems concerned with the giving of medical information to community agencies. Probably because many of us in medical social work have been family case workers in community agencies we understand your chagrin at delaying a family's plan while awaiting a medical report.

There are, for instance, State laws which make it practically prohibitive to grant information regarding certain diseases, without the written permission of the patient. We must recognize the fact that the Hippocratic oath taken by every physician often affects their
willingness to give medical information to any person or social agency. We must realize that there are very few, if any, hospitals which have clerical staff sufficient for the purpose of replying to this bulk of inquiries. We must make ourselves cognizant of the organization of hospitals and their record rooms, and consider the few which have central record rooms with the unit medical record. The majority of hospitals have separate medical records for clinic patients and house patients. There are also many large hospitals which have separate medical records for every clinic and every ward service. Thus, if Mr. Jones goes to the medical clinic and is then referred to four specialized clinics and later goes into the ward for further care; and if we receive an inquiry from a social agency about him—we must consult as many medical records as is necessary according to the administrative methods of the hospital to which we are attached. In this particular instance there would be six medical histories to read. To be fair to ourselves we must allow for interruptions and delays in procuring the records, over which we have no control. After this process is completed and the medical data collected, sifted and interpreted in the light of the social data made available by the inquiring agency, the reply is written. It is necessary to have the signature of the Chief Resident Physician, hence the letter is held until this is procured. This brief mention of some of the routine mechanical processes is given to remind us of the physical obstacles to quick replies. This does not account for natural delays to diagnosis caused by processes of medical study such as X-ray and laboratory procedures.

It is generally conceded by hospital social workers that the trite inquiries for "diagnosis and prognosis" generally elicit a very brief response from the clinician. Letters of inquiry about patients under care at the hospital should always contain some social data. Community agencies requesting "medical condition found and its interpretation and medical plan" instead of the diagnosis-prognosis form, might find our replies of greater value. One of the irritations experienced by medical social workers is the sending in of student workers by community agencies, or inexperienced persons to the clinics, where a detailed report is given. Shortly afterwards the medical social worker may receive an inquiry from the same worker requesting the report "in writing." Another form of request which is apt to cause a duplication of effort and waste of time, is the habit of writing to the hospital several times within a comparatively short
time for diagnosis and prognosis. The physicians and social workers who note these requests cannot help but feel that the medical data was not given serious consideration the first time the report was sent.

Community agencies must remember that we are not an independent group in the hospital but are merely a part of the entire institution, and in doing our case work in the hospital we often are forced to face some of the same obstacles and difficulties as the outside community agencies.

At present we accept and welcome the function of interpretation of medical data to the patient, the family and the community agencies. When the future generations of social workers come to their work with greater knowledge of hospital organization and diseases, we will probably find it unnecessary to spend quite so much of our time on the function of interpretation. We shall then be able to devote ourselves more entirely to case work with sick persons and hope in that way to apply the constructive and preventive program that will eventually lessen the burden of the community agencies.
INTERRELATIONS OF HOSPITAL SOCIAL SERVICE DEPARTMENTS AND COMMUNITY AGENCIES

FRANCES HOLBROOK

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The Making and Keeping of Appointments for special examinations is of utmost interest to the cooperating agency, the doctors, the patient and the medical worker and may also involve clerks, nurses and technicians. In the majority of medical organizations special examinations play an important part—Basal Metabolisms, Cystoscopies, Barony Tests, Gastro-Intestinal X-rays, Bronchoscopies, Sensitization Tests, etc., are usually done by appointment as are X-ray treatments, Immunization, etc. It is often necessary to make reservations for admission if hospitalization is indicated. The medical worker is the pivot around which the situation revolves.

If a worker makes arrangements for a doctor to see a patient at a certain time and notifies the cooperating agency to that effect the latter should see that the patient is at the appointed place on time or the medical organization notified otherwise, so that preparations can be halted.

In private practice if one does not keep an appointment a charge is usually made for this. The doctor, cooperating agency, patient, and worker all pay in one way or another if in dispensary practice appointments are made and not kept. This may take the form of time lost, reservation of space which might otherwise have been used, possibly spoiling of vaccines and serums, a ruined contact with a physician who has lost valuable time waiting and the inability to complete studies so that the cooperating agency may have a full report and proceed with their plan of social treatment.

The lost contact with a doctor may be very detrimental to the worker in her future dealings with this physician. The education of the doctor to the appreciation of social work and its place in the
hospital has been very gradual. Even one unfortunate circumstance like the above may have a far reaching effect.

When a bed has been reserved for a client of another agency and the social service department is advised by the admission department that there is a vacancy, we attempt to notify the agency at once who in turn should communicate with the patient. We should be informed as to whether the patient intends to come or not. We cannot ask that a vacant bed be held for any length of time. Agencies are often quite agitated if a patient coming for admission a day or two after notification finds that the bed has been taken. In a busy hospital an emergency case may have to be accepted at any minute.

The matter of a patient’s discharge from the hospital is as important as his admission. If he is not removed as soon as possible after the cooperating agency has been notified, the situation may be that a perfectly well person is occupying a bed which should be given to someone who is critically ill. In most hospitals at certain times of the year there is a waiting list for admission. The matter of expense is also involved here. It costs the average hospital about $5 a day to care for a patient. When the patient is receiving free care the cost of his maintenance must be paid by state aid or money received by welfare federation or some similar organization.

The outside agency may have to make temporary plans for a patient following his discharge. If this involves financial responsibility the agency should appreciate the fact that the money expended within or outside the hospital for this person’s care usually comes from the same source.

We would suggest that patients making an initial visit to the dispensary, coming for special examination or for admission to the hospital, report to the social service department first, otherwise we may not know that they have come and various complications may arise. We appreciate the fact that a person may be given instructions by cooperating agency and may not carry these out as they promise. So we also admit that at times a physician fails us and the patient waits in vain.

Only with the cooperation of the referring agency in having the patient complete studies, and if these have been advised by the physician, they are surely important enough to be carried out; can we submit our doctor’s findings interpreted so that they may be understandable and useful to the agency and beneficial to the client which is our ultimate aim.
THE STORY WHICH HAD TWO SIDES

ANNETTA W. PECK and ESTELLE E. SAMUELSON

The New York League for the Hard of Hearing, New York, N. Y.

Coming back to my office after that big child health meeting last fall, I looked in for a moment at small Peter and his lip reading teacher. The two of them were smiling away at their work, the nine year old’s bright little face and quick response showing plainly that there was pleasure as well as profit in this kind of learning. I turned away with an irrepressible chuckle as my mind ran back over the addresses I had just heard—particularly one of them.

It had indeed been wonderful, that great gathering of physicians, educators and social workers to discuss the health of school children. The conference had been opened by New York’s beloved Health Commissioner, and after several inspiring speeches the associate superintendents of schools were invited to address the meeting. Supt. Crosby—I am naturally not giving his real name—led the way by stating a grievance.

“One of the greatest obstacles to school health work,” said the superintendent, “is the obstinacy of the ignorant foreign-born parent. It is next to impossible to convince some of them that we know what is best for their children. I had an extreme case of this kind before me the other day, sent me by the principal of one of the schools in my district.

“It seems that when the usual school health day examinations took place, this boy, 9 years old, grade 3A, was found to be deaf. The principal sent for the mother and told her to take her child to the school for the deaf, which was the right place for him and the only place where he belonged. Now you know what a wonderful school for the deaf we have down on 23rd Street—a two-million-dollar schoolhouse with complete modern equipment for teaching deaf children language, speech and lip reading, giving auricular training and so on. But this mother flatly refused to comply, and so the principal arranged with me to see her.
"I found the woman what I expected, an illiterate peasant type of a monumental stubbornness which was nothing less than adamantine. I appealed to her motherhood, stressing the advantage to her boy of this education in a special school. It was no use—I never saw such a stupid and selfish woman! All she would say was that the boy would stay where he was, that he was studying lip reading at some social agency and that she positively would not have him go to school with those deaf children. And over and over she repeated: 'You cannot make me. I know the law. I know the law!'

"Well, she did know the law and she had me there. I was helpless. I told the obstinate creature to have it her way. To my surprise she was overcome with gratitude and insisted upon kissing my hand, thanking me profusely. 'My boy will bless you when he grows up,' she said."

Mr. Superintendent's face registered a bitter disgust as he concluded: "No," I told her. "He will bless you when he grows up!"

Laughter and applause from an equally uninformed audience followed. I suddenly became aware that an immediate appointment was calling me away from the meeting without any possibility of being able to get into the discussion myself, but I left with a warm feeling of satisfaction that Peter's mother had stood her ground so well. Not for nothing had I spent an entire afternoon with her and also the next morning, when she came to me distressed at the school principal's determination to railroad her little son into the wrong kind of a school, explaining the law to her and encouraging her to stand firmly upon her rights. Peter, you see, is not deaf; he is slightly hard of hearing, which is something very different indeed. His school principal and her superior were merely the victims of their own sloppy terminology. Deaf—hard of hearing; two distinct handicaps connected with the ears. Let me explain and you will see at once that there is no sense at all in calling the hard of hearing deaf. You can't make them so, any more than you can make the New York City school system recognize the educational rights of the hard of hearing child as 100 smaller cities have done. A two-million-dollar schoolhouse is entitled to very respectful consideration!

Deaf children never hear or lose their hearing so early in life that they have no conscious knowledge of language or of communication by speech. They are comparatively few in number. They require a long, intensive, special education which is expensive, and the school
for the deaf is equipped to provide for them admirably. The deaf
are also called deaf mutes.

Hard of hearing people, young or old, are merely hearing people
who have lost some of their hearing. Everybody knows them, for
they are exceedingly numerous. Hearing impairment usually starts
in childhood as a result of neglected or unsuspected ear and throat
conditions, and many cases can be cured or minimized if taken in
time, so that early detection is of the utmost importance.

Peter is a typical case. He was sent to us—The New York League
for the Hard of Hearing—by the social service department of a hos­
pital, with the history of his case, the otologist’s diagnosis and prog­
nosis, the audiogram and the recommendation that he enter our lip
reading classes for children. Peter had had several of the childish
diseases which so often attack hearing acuity, and which will sooner
or later be stamped out by such efforts as are now put forth by city
health departments, medical societies and social agencies. Somehow
amongst his various illnesses, his auditory nerve had become affected.

The audiogram showed that Peter had lost about 40 per cent. of
his hearing. This means that while he can hear ordinary conversation
at a distance of about six feet, he must have a front seat in class and
a little consideration from his teacher, besides lip reading. He had
also a speech defect, which was not helped any by the fact that his
foreign-born parents not only spoke strongly accented English, but
also did not know their adopted language well enough to recognize
his defective speech and help him correct it. He is alert, attractive,
quite like other lively nine year old kids in his love of active play.

Peter in a school for the deaf? Can you imagine yourself in that
environment of painfully acquired, unnatural speech, making slow,
slow progress for a slightly hard of hearing boy, totally unable to
appreciate the marvelous soul-flowering taking place in the deaf chil­
dren as they gradually acquired the use of language? What would
his speech be like after a few years of association with the made
voices, the difficult articulation of the deaf—what would be the con­
fusion of his mind, what psychological limits would have been im­
posed upon him—*with 60 per cent. of hearing!*

We have given Peter intensive lip reading work and correction of
his speech defect in addition to the Saturday morning class work with
other children—hearing children who have lost some of their hearing.
He is now a fine lip reader and his school reports are excellent. He
need never fear an increased loss of hearing now. All this has meant
extra work for his busy mother, who brings him to League headquarters in the Grand Central Palace from her home in the Bronx.

There are many Peters in the United States—approximately one to every classroom, but as I pointed out in an earlier paragraph, only 100 cities are interested in their hard of hearing children. In almost every case they have become interested through the efforts of the American Federation of Organizations for the Hard of Hearing, a national organization having 75 local groups. In 1921, at its second annual meeting, the Federation launched a program for prevention of deafness which demands periodic examination of the hearing of school children, otological examination and treatment and, for those found to have a definite hearing loss, lip reading in the regular school. Hospital social workers are doing a valued share of cooperation in this program, and when the Federation holds its 11th annual meeting at the Hotel Roosevelt in New York, June 16-19, 1930, they are cordially welcome to attend to make a closer acquaintance with its leaders and their work.

Peter and his mother will be there too.

*January 8, 1930.*
ENVIRONMENT IN RELATION TO PHYSICAL AND MENTAL HEALTH*

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Theories of the influence of environment upon man are not new. They did not originate with Huntington's *Pulse of Asia*; nor with the equally fascinating *History of Civilization in England* by Henry Thomas Buckle, which appeared about the middle of the nineteenth century; nor did they begin with Montesquieu's *Spirit of Laws* a century earlier. Even in ancient times we find some rather thorough going treatises on the theory of environment. Hippocrates' great work on *Airs, Waters and Places* contains observations and suggestions of great importance. Greeks, Romans, medieval philosophers and modern writers too numerous to mention have dwelt at great length on the subject. Nor is Hippocrates the only physician who has made contributions. Richard Mead, in the early eighteenth century, made what is perhaps the first attempt at a systematic study of the influence of atmospheric conditions upon the vital processes of the body. John Arbuthnot, another famous English physician, in his essay *Concerning the Effects of the Air on Human Bodies* supplied data which is said to have been drawn upon very generously by Montesquieu in his famous work on the same subject. In more recent times, American physicians such as John W. Draper, Albert Leffingwell and Charles E. Woodruff, have made valuable contributions.

Man, individually and collectively, has never been celebrated for his modesty, and he has often found geographic theories very convenient in his effort to account for his unquestioned superiority over his fellowman. An examination of ancient and modern environmental doctrines reveals the fact that writers of all ages have agreed

*Read before the Section on Child Health of the All-Day Health Conference, New York, N. Y., November 1929.*
that the peoples situated in the middle latitudes are superior to those
who live both to the north and to the south. Those to the south are
considered wise and discreet, but of a timid nature and lacking in
courage. Those to the north are physically brave, but because of a
certain dullness of mind they are unfit for political organization and
leadership. The people occupying an intermediate position combine
the advantages of both extremes, and are, therefore, by nature fitted
to rule the earth. One finds that idea expressed in one form or
another by writers all the way from Hippocrates to Huntington.

There seems to be almost complete agreement that the peoples in
the middle latitudes are superior, but grave differences have arisen
over one very important point. Just where are those middle latitudes
located? We find that Aristotle drew the line of racial and cultural
superiority through Greece; Vitruvius and Pliny thought it ran a
little further to the north, through Rome; Jean Bodin, with convinc­
ing logic, located his middle latitudes in France; while Friedrich
Ratzel was inclined to place them in the land where Hegel’s Weltgeist
found its final resting place. More recently, the climate of the United
States and England has been found to be the one most favorable to
human progress, and arguments have not been lacking to show that
the climate of these countries is ideal for the highest development of
civilization. Not to deny scientific merit to some of these studies, we
may say without fear of contradiction that many of them have not
been conspicuously lacking in patriotism.

Another interesting fact may be noted in connection with this
theory of the superiority of the peoples in the middle latitudes. When Aristotle expressed his view cultural superiority did reside in
Greece, and the same thing seems to have been true with regard to
their respective latitudes when Pliny, Bodin and Ratzel expressed
their views. In other words, it appears that there has been a shifting
of the center of highest civilization from one country to another in a
northerly direction throughout the course of history. Whatever the
cause of this shifting, the fact is obvious, and has been called by
Guyot “the geographical march of history.”

But what can be the explanation of this interesting fact? Is it
stock, blood—heredity? Do these highest civilizations issue from the
greatest racial stocks? How could it possibly be so, when every race
from the Egyptian to the Nordic has participated? Can the explana­
tion be purely geographic? It hardly seems reasonable to suppose
that geographic factors alone could account for the center of highest
civilization being at one period in Egypt, at another in Greece, and at still another in northern Europe and America. What then is the explanation? It seems clear that it is to be found largely in man's constantly increasing knowledge, which has enabled him to conquer more and more difficult environments and move steadily northward. We know, also, that man thrives on opposition, which tends to bring out the best that is in him, and that the stimulation of colder climates and alternating seasons has played a prominent part. But the thing that made this geographic march possible in the first place was man's increasing knowledge—his accumulating culture. It is evident, therefore, that any attempt to determine how man has come to be what he now is must take into account not only heredity and the geographic environment, but culture, which Tylor has defined as including "knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society."

Among primitive peoples man is at the mercy of his geographic surroundings. If he is not adapted to his environment, he dies and those who are fitted survive. As he grows in knowledge, however, he begins to turn the tables on his environment. He changes it. He learns to protect himself against it. His achievements tend to alter the effect of the environment upon him and to lessen its control over him. He lives comfortably where his more primitive brothers could not live. The ways in which the environment affects man vary with the stage of his culture. The American environment, for example, was an entirely different thing to the European settler than it was to the Indian. Geographic influences in the Panama Canal Zone are not what they were in the days of the ill-fated French enterprise in the same locality. We see then that our three factors, man, his geographic environment and his culture are also three variables, with the influence of geographic factors constantly diminishing and the influence of culture assuming ever increasing importance. Three variables put up a formidable front and this fact helps to explain, perhaps, why our problem is still so far from solution, although it has been a favorite topic for discussion since the days of Hippocrates.

An examination of the relation that has existed between geography and physical health throughout the period of history tells much the same story as is revealed by studies of man's interaction with his environment in other aspects of his life. There is plenty of evidence to show that geography has a definite bearing upon health—but again we see culture stepping in to change the whole configuration. In an
excellent study of geographical and seasonal variations in infant mortality made by Dr. Frederick S. Crum a few years ago, the situation in 46 of the larger American cities was analyzed with great care. Cities in 5 general sections of the country were included in the survey as follows: (1) North Atlantic, consisting of certain cities in New England, New York, New Jersey and Pennsylvania; (2) Central Atlantic, consisting of the cities of Washington, Richmond, Baltimore and Atlanta; (3) Southern, consisting of Birmingham, Louisville, Memphis, Nashville and New Orleans; (4) certain large cities in the middle west; and (5) Western, consisting of Denver, Spokane and the larger cities on the Pacific coast. It was noted that the cities in division 5 had a much lower average infant death rate than that of the other four divisions. Still, we find that Atlanta, located in the Central Atlantic division, which as a whole had the highest death rate, compares favorably with several cities in the western division, which had the lowest. It may also be noted that New York City, although located in the North Atlantic division, whose infant death rate was the median of the five divisions, had an infant death rate lower than both Denver and Portland in division 5. It thus becomes clear that whatever may account for the low death rate in division 5, as a whole, the culture factor is clearly discernible.

An interesting article appeared in a recent issue of the American Journal of Hygiene, entitled “Variations in the Age Distribution of Mortality and Morbidity from Diphtheria, Scarlet Fever, etc., in Relation to Latitude.” Schick tests show that 53.3 per cent. of children tested between the ages of 5 and 10 were negative in Alabama; that the number of those found immune was lower in the city of Baltimore, and very much lower in the State of Vermont where it was found to be 19.6 per cent. Moreover, the number of persons found to be negative to diphtheria is much higher in the tropics than in northern areas. At the same time diphtheria in observable form is less common in the tropics. In general, the same is true of scarlet fever, and the same is said to be true also of poliomyelitis. So far as I am aware, medical science has not fully explained these interesting facts; but one question arises in the lay mind. What will become of the geographic bearing on the incidence of these diseases and upon the proportion of negatives when the Schick and Dick methods of immunization are universally applied? Again, we see man and culture as the dynamic and determining factors.

In the American Journal of Public Health for October, 1926,
there is an article on "Smallpox and Climate." The writer finds an inverse correlation between rainfall and the number of cases of smallpox. This sounds interesting, but we may note that the study was made in India. Suppose it had been made in the United States. Would one expect to find a correlation between climate and smallpox in one of our best regulated American cities? Vaccination would certainly play havoc with any plan to find such a correlation over here. In the Proceedings of the Royal Society of Medicine, there is an article on the "Relationship Between Rainfall and Scarlet Fever." Again there is an inverse correlation, i.e., more rain, less scarlet; but the correlation is somewhat less certain. This study was made in England some seven or eight years ago. What would the Dick immunization treatment do to a correlation like that? This is a question for a medical man to answer, but as the superintendent of a children's institution I can report certain facts. When I undertook my present work in 1920, scarlet fever was one of the banes of our existence. In spite of all the precautions we could take, one or more of our cottages would be closed for varying lengths of time nearly every year, with disastrous effects upon the schooling of our children. Then came the late Dr. Zingher and his experiments with the Dick treatment. Since he began immunizing our children, and this was about the time the Dick method became available, we have had practically no scarlet fever in the institution. I don't know whether the doctors consider the Dick treatment still in the experimental stage or not, but one thing I do know—we are not interested in correlations between rainfall and scarlet fever up at Hastings. In fact, it seems that studies of the relationship of geography and disease are but the forerunners of measures calculated to destroy that relationship.

Out in the mountain section of a western state where I formerly lived, there is a disease known as the spotted fever—a disease which for a long time struck terror in the hearts of the natives. It was found in rather well defined isolated sections, i.e., it would occur along "X" creek, but would be unknown among the ranchers on "Y" creek. "A" creek several miles away would have many cases every spring, while "B" creek would have none. At first, many persons took a more or less fatalistic attitude toward the disease. It just naturally occurred in some regions and just naturally didn't occur in others. Then they blamed the water and tales were told of "a man who had taken a drink from a certain creek and died six days later." Finally, the government sent a medical man out there to make an investigation,
with the result that a disreputable little bug known as the wood tick was indicted, tried and found guilty. I do not know what stage the battle is in at the present time, but it seems certain that correlations between spotted fever and geographic areas are traveling rapidly toward Valhalla. Again we see the triumph of man and culture over external nature, which Buckle says is the best measure of civilization.

When we come to the question of mental health we find that geographic factors assume less importance, although evidence is not lacking of indirect environmental influences. A case in point is seen in the high incidence of feeble-mindedness in the hills of northern New Jersey and nearby sections of New York. This has been explained as due to the constant migration of the more aggressive people from a poor and unattractive locality to a rich and attractive environment like the city of New York, over a long period of time. This migration depletes the population of its best, leaves a larger proportion of inferior individuals to produce succeeding generations and results in a greater incidence of mental deficiency. However, aside from such indirect effects, the influence of geography upon mental health does not appear to be important. Some interesting studies have been made of the influence of factors such as climate, the weather and seasonal changes upon human conduct, outbursts of insanity, etc., but the effects noted have been largely of a temporary nature and do not appear to have a very important bearing upon mental health as we ordinarily use the term. The question becomes rather one of the relative importance of heredity and the social environment. In other words, are children what they are because they were born that way, or because they were molded by their earlier surroundings? You are familiar, of course, with the views of extremists on both sides of the question. It is not easy to refute the claims of these extremists because in the cases which come under our observation we are practically never in possession of all the facts.

Let us take the case of Mary, for example. Mary came to us at the age of two. She was of average intelligence and got as far as the middle of her third year in high school. Then she entered a nurses’ training school and is now a prominent nurse in a large city in the middle west. She is what one would call a well adjusted individual with plenty of ambition and energy. She is one of the best surgical and obstetrical nurses in her state. A western social worker speaking of her recently said, “She may be an orphan, but she certainly must have had good stock back of her.” So? Let us take a look at it.
Her father and mother both died of alcoholism. She has probably 25 or 30 relatives in New York City, within easy access of our institution. All of them are what you would call ne'er-do-wells. In all of the years she was with us not one of them had interest enough to visit her even once. If there is good stock back of this girl it would take a man from Scotland Yard to find it.

Again, take the case of Cora, one of our unadjusted girls. Cora was unstable, aggressive, coarse and vulgar, and after leaving us she drifted far from the straight and narrow path. The girl's history was replete with sex offenders, prostitutes and degenerates. It seemed like a clear case for heredity, but when I mentioned it to one of my behaviorist friends he asked me at what age the girl had left her home environment. At six? Ah!—that settles it! Perhaps it does. Who knows?

Or, take a case like this. It is not one of our own cases, but one with which I am thoroughly familiar. It was a boy, born of a young prostitute in a woman's reformatory. The mother was of a low order, and from what we call a bad home. The boy was taken from his mother when two months old and placed in a good boarding home. At the age of three he was put in an institution. He is now through college and is a successful business man. No immoral tendencies have ever been noticed in him. Surely, this looks like environment. Ah!—but we don't know who his father was. He must have been from a very superior family! Perhaps he was.

Here is another case equally difficult to interpret. The Jones sisters, both illegitimate, enter the institution, aged two and nine, respectively. The mother was a coarse, common woman. Both of these girls have long since gone out into the world. The older one has gone the way of the mother. The younger one has done conspicuously well. It looks like environment, doesn't it? It does until our heredity friends begin asking questions about the paternity of the girls. We don't know it in either case.

An attempt to find something in the way of a correlation between family histories and the later adjustment of the children does not yield much in the way of results, for the reason that we haven't enough children who comes to us very young to make such a study worth while. However, there are some facts which are suggestive. We find, for example, that among children who come from the so-called bad homes and bad stocks, the ones who come to us young, give a much better account of themselves, on the whole, than those
who come to us when they are near our upper age limit of twelve. On the other hand, among children who come to us from what are called good homes and good stocks, the ones who come to us when they are older, do as well and sometimes better than those who come to us when they are young. This appears to be evidence for the influence of environment.

I confess that I am not clear on the exact meaning of good homes and good stocks. E. A. Ross seems to think that "first" families are often those who arrived first in a given locality, and he lists priority and wealth as the most common bases of aristocracy, and the origin of "best" stocks. However that may be, when we speak of good stocks and good homes in the discussion of family histories, we usually mean about the same thing—illogical as it may appear. And it is usually well nigh impossible to tell in any given case just how much of the goodness or the badness is innate and how much is acquired.

As we struggle to answer such questions as this, man and culture prepare for the attack. We have witnessed their triumph over the forces of external nature, and we may look for the same degree of triumph over the conditions and circumstances which underlie mental sickness and maladjustment. Although the movement had its origin within the memory of most of us, mental hygiene is on its way. It has allayed our fears. It has shown us that mental sickness, like physical sickness, is largely curable. It has taught us that disease does not come to the mind inevitably, but is in many cases preventable. Its achievements during the short period of its existence justify the hope that, as the history of medicine and sanitation shows a progressive control by man over the natural conditions of his physical surroundings, so will the history of psychiatry and psychiatric social work show a progressive mastery over corresponding conditions in the social environment.

Glancing back at our three factors, geography, stock and culture, I am sure you will permit me to call them variables, and I need not ask your indulgence for failing, in this brief paper, to do more than touch upon the interaction of these three illusive forces. It is clear that geographic influences recede with advancing civilization and that human knowledge assumes increasing importance in matters pertaining to physical health. On the mental side, we have seen that it becomes largely a matter of heredity versus the social environment, with knowledge again coming to the fore. No one could convince
me, in the light of my experience and observation, that inherent capacity is not a factor, but it does seem clear that early training and culture often explain things that are commonly and carelessly attributed to blood. The only conclusion that seems reasonable is that there are two forces at work all the time, and that sometimes one of them seems to occupy the more prominent place in the picture and sometimes the other. In any case, man and culture, primarily, are the dynamic and determining factors in matters pertaining to both physical and mental health.
THE NEWSPAPER AND ITS RELATION TO PUBLIC HEALTH*

GEORGE A. ANDERSON

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There is an old newspaper proverb to the effect that "the smart editor is one who knows where hell is going to break loose and has a reporter on the spot to cover it." By the same token it is my opinion that the smart director of a public health agency, be it national, state or local, is the one who knows where an epidemic is going to break loose and has a man on the spot to stamp it out. Incidentally, if he is a smart agent he will tell the newspaper man about it and get some publicity, not for himself, perhaps, but for the organization he represents. Here is his opportunity to show his qualifications for the job he holds, by ridding the community of disease and contagion and to point out an object lesson in his campaign to eliminate the possibility of a subsequent outbreak.

It has been said that a newspaper man must know something about everybody's business in order to be successful in his own profession. Perhaps that is true but the ordinary newspaper man will be slow to claim such knowledge. He is schooled through years of experience to keep his mouth shut and his eyes open. He never talks for publication but is expected to be keen enough to ask leading questions to round out the story he is seeking. When he attends such a function as this, it is usually in his professional capacity. While most of you are sitting back after an excellent dinner enjoying your cigar, the newspaper man is wielding his pencil in a frenzied endeavor to get down something about each of the speeches. Therefore he does not have much occasion to exercise his forensic talents and must get his pleasure out of writing.

I trust that something I may say will contribute in some degree

* Read before the meeting of the West Virginia Public Health Association, Morgantown, West Virginia, November 1929.
to a better understanding and a closer relationship between the newspaper and your profession and will carry us closer to the common goal. I have been asked to talk about "The Newspaper and Its Relation to Public Health." If I were to sum it up in a sentence I would say that it should be the same relationship that the newspaper seeks to establish with every movement, every endeavor and every campaign designed for the betterment of the community, the state and mankind.

It is rare for a newspaper to oppose anything as obviously beneficial as a public health campaign. Some instances could be cited, no doubt, yet underlying such opposition could be found some personal or political prejudice on the part of the newspaper or some ulterior motive on the part of the promoters of such a campaign. As a rule, however, the newspaper will be found to be supporting 99 per cent of the efforts for community advancement, prosperity and physical well-being.

It has not been a great many years since conditions existed in your own profession which are looked back upon tonight as dark pages in the history of medicine and surgery. Thousands died of consumption, other thousands were swept away by typhoid fever, children were sacrificed year after year by diphtheria and many other diseases claimed a terrible toll.

In this enlightened day we look back upon those conditions as unnecessary sacrifices of life, yet they were necessary in a sense to bring the present realization that they can be more or less controlled—with the assistance of a Divine Surgeon to whom we all turn for guidance and assistance, regardless of profession. Your profession has made progress and so has mine. We have been brought together in a common cause and because of the great ramification of medicine and service, the practicing physician or the specialist or the director of public health is closely allied with the newspaper man in practically all of his undertakings.

As to the newspaper and its relation to public health I would say that "Printers' Ink is one of the Greatest Life-Saving Agents in the world." But like most any medicine, it would kill the patient if applied in one dose. It must be given with professional efficiency and common sense.

More and more the responsibility of the press as an educational factor in, and director of, human affairs, is being recognized. The editor of any sort of newspaper who does not feel the grave duty of
a pastoral leader, is unfit for his position. If his mind does not intellectually and instantly grasp the moral and human progress side of a question he should make room for another who is better prepared to assume the obligation to society. This statement constitutes a challenge to newspaper men on the importance of their relationship and that of the press as an institution to social service activity of all kinds. While this relationship is not new, it has not been recognized in the fullest extent until comparatively recent years. Its recognition by editors places a reciprocal responsibility on social workers and in that classification I place men of medicine who are dealing with all phases of the public health question. Many social movements have failed to accomplish their aims as completely as possible because the reciprocity of relationship has not been recognized by their leaders.

Not many years ago it would have been a unique convention of public health workers or other leaders in social reform, that did not hear at least one lament that social reform was retarded chiefly by the indifference of the press. Fortunately, however, there has been a trend of thought in the other direction. Social reformers have come to realize that they are partly responsible for any apparent indifference of the press. Recognition of the newspaper man’s point of view and of journalistic problems, both creative and mechanical, by social workers, has been, however, of comparatively recent development. Occasionally we hear newspapers praised for their aid in social movements. Better still, though, we hear social work leaders urging their fellow-workers to a better understanding of publicity principles and a more useful knowledge of journalistic methods.

Newspaper men are quick to realize and appreciate efforts made to facilitate their interest in social service movements, and are just as quick to respond to this desire to help them. I might cite an instance not long since, in the adjoining State of Pennsylvania, where I received my early training to become a West Virginian. An eminent alienist visited a city to prepare the way for a mental clinic—an innovation in that section. The alienist was accompanied by his secretary, and a capable man he proved himself to be. As soon as he arrived in the city, the secretary made contact with the newspapers and instead of asking for some space and giving the newspaper man some facts, he sat down at a typewriter, “ground out” an acceptable story, turned to a copy of the newspaper for which he was writing, noted the number of type units necessary for each line of a heading,
wrote the head and handed it to the city editor. What was the result? There was not a line in the story that needed to be changed, the heading was accurate and it had all been written in approved journalistic style. At one stroke the secretary to the alienist had broken the ice and established his status in the newspaper office. Not only that but in three days his stories had awakened public interest to the extent that the clinics were being crowded and the alienist was doing a wonderful work for humanity. It was a case of advertising and then delivering the goods after the subject had been sold. Without those three days of intensive publicity it might have taken the alienist a month to work up such public interest—and he was too prominent, too valuable—to spend a month in any one city.

Before passing from this incident, let me say that the secretary to that alienist was a former newspaper man and he knew the subject from the newspaper man's point of view. He knew his lesson so well that he did not make the mistake of making impossible demands on the newspaper and its space. He was able to condense into a half column of space what a medical man would have taken twice that much to say and then would not have said it as effectively, from the public's point of view.

The point I am desirous of forcing home is that publicity work does not mean the employment of a "press agent" as he is known in the newspaper office, does not mean the seeking of free space that the newspapers reluctantly grant because of some more or less unwelcome pressure. It does mean, however, intelligent treatment of the facts at the disposal of the public health or social service agencies by a man so trained in newspaper work that he can be in effect a reporter, who has, it is true, not been assigned to any particular job by any newspaper, but whose work is so valuable to all newspapers that they gratefully accept his services.

Let me branch from my present thought for a brief word of praise and to express gratification for the well-functioning, fundamentally-sound and excellently-directed department of journalism at West Virginia University. In the 10 years it has been in operation it has had more than 500 students who have taken more or less journalistic training. It has sent graduates to many important positions on state and out-of-state newspapers. It has at present 41 majors in journalism and a student body of approximately 100. It is safe to say that the West Virginia newspaper of tomorrow is going to be headed by a graduate of this or some other school of journalism.
This department of the state university is perhaps more important to you and organizations like yours, than to the newspapers themselves. It gives you the opportunity to place into positions in your organization a clerk or secretary equipped as a journalist who will be of incalculable value not only to your organization but to humanity as a whole. Don't pass this thought lightly. Consider a trained journalist as the biggest asset you could hope to have and use him in the promotion of your campaigns for the betterment of mankind.

The most fundamental and important phase of mercantile publicity is organization. The work of putting a brand of baked beans into the mouths of ten million people is planned months in advance. Every important feature—the method of baking the beans, the size and shape of the container, the color and design of the wrapper, the field of appeal, the date of putting on the market and the time—these and many other phases are studied and worked out long before a single can is marketed.

The manufacturer of the baked beans finds his problem divided into three parts. First the assembling and manufacture of the raw material; second, informing the public of its merits and how and when it can be procured, and third, distributing it to an expectant and hungry public.

The State Department of Health or other public health agency will find its work divided in much the same manner. First it must gather its staff of expert workers and assemble its facts. These are the raw materials. It must select from innumerable possibilities those activities which meet the most pressing needs and which will produce the largest possible results for the smallest expenditure of money and effort. It must organize the facts at its disposal and harmonize the opinions of its experts, thus moulding the raw material into a composite and comprehensive program, which when ready for the public is the manufactured product. Second: Having completed the manufacturing process, or having deciphered its ability to produce a finished article, the health department or other agency must then map out its publicity campaign. It must get the public to adopt its program. To do this the public must be convinced of the merits of the program and the agency must instruct the public collectively and as individuals in its application.

Even distribution, the third phase of the manufacturers' problem, is applicable to the public health campaign and must convey to the public and the local authorities the expert services of its laboratories
and engineering divisions, through lectures, pamphlets, inspections and the available but limited columns of the local newspaper. In other words, the public health worker must deliver the goods in the same definite manner that the baked beans are delivered.

To pass to another phase of valuable newspaper space that is at your command, I might quote an instance in a fairly large city where a cub reporter was engaged by a newspaper and in working up his news sources he took on the office of the health officer—where more experienced newspaper men had feared to tread. It was not productive of news, the veterans told him, because the doctors were bound by a so-called code of ethics not to talk for publication and in any event, a story out of that office was buried in long and meaningless words, poor construction from a newspaper point of view, as much Greek as the ordinary prescription is Latin and impossible to work into a news story. But the youth persevered and one day, hearing that there was an epidemic of typhoid fever in a certain school, he bearded the health officer in his den, laid the facts before him and told him he wanted a story. Not taking no for a final refusal he continued to point out that a frank and free statement would allay public doubts and fears, would tend to awaken the public to a realization of the conditions which brought on the epidemic and would work to the advantage of the health department. Finally he won his point and the manner in which he wrote that first story and subsequent articles did clear up the condition and got an additional visiting nurse for the health department.

In my judgment, gentlemen, the day is past when a doctor needs fear legitimate publicity. It is not for the man himself that the name is necessary but for the profession he represents and for the cause for which he is working.

If you will pardon a more or less personal illusion, I would like to say in passing that for a number of years the newspapers of Morgantown fought, bled and died for the creation of a whole-time health unit in this county. Neither newspaper took the lead, neither claimed any credit, but gave itself to a campaign because it felt its position was well taken. Aided by the State Department of Health we kept everlastingly at it in the face of opposition. I am happy to say that before the end of the year we will have the health unit in operation here. If the newspapers were of any assistance they are gratified and their reward will be in the good the unit is expected to give to mankind. We aided in building a county tuberculosis sani-
torium because our state was unable to build fast enough to accommodate those unfortunates who were in the several stages of the disease. We helped to bring about the movement for the purification of the Cheat River, we helped to have the phenol waste eliminated from the Monongahela River and other similar campaigns.

We are assisting the city health officer of Morgantown and the present health officer of the county in their immunization campaigns against fever, smallpox and diphtheria. We have always received courteous treatment by those officials and a ready response to proffers of assistance in their work.

We have combated the inherent prejudice of many men of the medical profession against what they call the menace of state medicine and we have preached a gospel of health upon every opportunity. What we have done or tried to do and are willing to do in the future, is what every newspaper large and small is ready and willing to do if you will ask it and show a disposition to appreciate its problems and help to alleviate them as you would physical suffering.

The newspaper is not afraid of "state medicine" and doesn't feel that there is cause for concern on the part of the medical profession. But if there is, the newspaper will be found on the side of corrective surgery and preventive medicine in the interest of humanity rather than in the purse of the practicing physician.

Let me say in closing that printers' ink is one of the greatest lifesaving agents and you are urged to use it extensively.
THE NORWICH LADS’ CLUB: WELFARE WORK
BY THE POLICE

J. H. DAIN, O.B.E.

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Whatever differing views may be held about the futility of bringing reforming influences to bear upon the mature and hardened adult, who has formed set habits of life, there will be no difference of opinion as to the hopefulness—may we not say the certainty?—with which we can look for results when dealing with youth. The years immediately following school life are the formative and dangerous years. Released from the school discipline of childhood, the lad starting to work for his living is generally full of a sense of the importance of his freedom in his leisure hours; and the character of his adult life depends in no small degree upon the nature of the opportunities placed in his way for the use of his leisure. In working-class families where the home life and surroundings do not offer much scope for the healthy recreative use of a lad’s energies in his leisure hours after the day’s work, he falls very easily into evil ways. Unless reasonable means, easily accessible, for healthy recreation, physical and mental, are within his reach, he begins to roam the streets aimlessly, with companions similarly situated; with the evil consequences, which we all know so painfully, in every city with a large industrial population; and nobody more painfully than the police authorities who have to handle the difficulties of the situation in their responsibility for preserving law and order.

Everyone who has had to deal with youths of this class knows that the offences into which they fall under such conditions are very rarely due to evil disposition. I am daily pointing out how easy it is to do things for boys. They are appreciative and responsive. They are eager to learn and quick to understand. I am convinced that boys
who are naturally bad are hard to find. I find their offences consist simply in getting rid of latent energy. It is in that faith in the boy that the members of the Norwich City Police have set about providing other and better opportunities for the expression of this latent energy; and some account of the establishment and the working of the Norwich Lads' Club, and of its resultant influence upon the life of the city, will not only be a record of a very interesting contribution to the general problem of preventive action, but may also be a helpful and instructive guide for other places wishing to follow similar lines.

It was towards the end of 1917 that the Norwich City Police determined to make an effort to deal with this problem and formed a committee under my chairmanship with the object of providing a recreative centre for working-class lads over the age of fourteen as an alternative to roaming the streets during their leisure hours. The idea had been in their minds for some time, and what set action going in the matter was the fact that a derelict building belonging to the Norwich Corporation, well situated in the centre of the city, became obtainable for the experiment at a nominal rent.

Practically the whole of the Force turned in on the job, and undertook in their off-duty hours to put the place in order. Erstwhile bricklayers, plasterers, carpenters, painters and others were discovered in their ranks; and these with the willing help of their less experienced comrades soon transformed the old premises into a comfortable club without a farthing of expense being incurred for labour. Prominent employers and influential citizens became interested in the project; and material assistance, in money and in kind, came in sufficiently to make a good start possible. The premises consisted of two large and lofty rooms, well lighted and well appointed; one being equipped as a general recreation room and the other as a gymnasium with accommodation for about 200 boys. In addition, a small theatre stage was erected under the careful supervision of one of the local theatre owners.

This, the first club in the world to be organized by the police of a city for the poorest and often the roughest of its young citizens, was opened with civic ceremony by the Lord Mayor on April 8th, 1918. Steps had been taken to let the working lads of the city know what was being done. Handbills setting forth the attractions of the club were distributed at every factory and workshop where lads were employed; and at the date of opening between 200 and 300 lads had been enrolled as members.
From the moment of its opening it went with a swing. Before the end of the year the membership had grown to well over a thousand; and its popularity with the lads was so great that the premises soon became quite inadequate to accommodate all who wished to become members. It became imperative to find new and more commodious premises. That is not an easy matter in the centre of a busy city; and it was not until 1924 that really suitable premises came on the market. By this time the value of the club's influence was so widely known and appreciated that a public appeal for funds for the purchase and equipment of the new premises promptly brought almost £4,000 from all classes of citizens; and the club's new home was ceremonially opened in June, 1925, by H.R.H. The Duke of Gloucester.

These new club premises are sufficiently large to meet the needs of six thousand members, which means that practically all Norwich boys who might otherwise have no such opportunities are provided for. The double oak doors of the main entrance in King Street open into a vestibule which gives immediate access to a spacious, lofty and splendidly lighted central hall, round two-thirds of which runs a wide balcony. This balcony floor accommodates an excellent library to which the Carnegie Trust, as a tribute to its excellence as a library and in recognition of the club's good work, last year granted £100 worth of new books. There is also on the balcony floor a general recreation room, equipped with billiard tables, with accommodation for 200 boys at one time; and a delightful room for old boys accommodating sixty to seventy with comfort. The main space of the central hall is devoted to the gymnasium; and the other portion is equipped with boxing-rings, theatre stage, canteen, dressing-rooms with accommodations for 100 boys, and a well-equipped committee room in which the members arrange their various competitions and pastimes. In the basement is the band room, class rooms, doctor's room for first aid lectures, hot and cold baths, plunge bath and central heating apparatus.

But while it is necessary to set out these details of space and equipment, what is of most importance, and will probably be of most interest to readers, is some account of the spirit in which the club is conducted; its methods of management and how it is run.

In the very forefront of the factors making for the success of the club must be set the great fact that from the outset it was realized that any suspicion or trace of preaching to the lads would be fatal. Nothing sets up a mood of antagonism more promptly in such lads
than the suspicion that they are being got at for purposes of moral improvement, and that whatever is being done for their recreation is only a device for such moral improvement purposes. It is not merely a matter of trying to keep such purposes hidden. As a matter of fact, you never can keep them hidden from boys, who are quick to detect and to shy off from them, whatever ingenious concealments may be devised for them. What was realized from the beginning was the importance really and genuinely of keeping the "uplift" idea clean out of it.

The basic idea in the conduct of the club is that the moral sense of the lads themselves is naturally and intrinsically good if it gets a fair chance, and that all it needs is the opportunity for its own healthy growth and development. Given the opportunity of clean and healthy physical exercise and recreation in the jolly atmosphere of comrade-like emulation which exists where a crowd of lads get together under wholesome conditions, the good results follow naturally of themselves. Never for a moment has the club been allowed to become an exercising ground for preaching agencies or any sort of medicated purpose in connection with its recreative activities. The central idea is that a lad brimming over with the vital energy of youth will naturally develop a sound moral sense if he gets the right outlets for exercising that energy healthily, and the right atmosphere in which his own innate instincts of fair play, good sportsmanship, and observance of the square deal in his association with his fellows, can expand and flourish.

The final and decisive test of such an idea is, Does it work? And by that test the Norwich Lads' Club can claim to have justified its existence very fully. Take such tests as the criminal and health statistics of the city over the period of the club's existence. In 1913, the year prior to the war, ninety-six children and young persons under the age of sixteen were charged at the local police courts, and these figures were maintained at about the same level till 1919, when they were reduced to forty-five. In 1922 they had fallen to twelve, and the figure has remained round about that low level with very slight fluctuations up and down; as low as seven in 1923, and as high as eighteen in 1928; while in some years not a single young person has been sent to either a reformatory or industrial school. This is in a population round about 140,000, with much industrial congestion, a good deal of chronic unemployment, and many still remaining unwholesome housing conditions, poisonous to healthy growth for
the young generation. It would, of course, be unreasonable to claim that the whole of this striking reduction in juvenile crime is due to the Lads' Club. There have been general influences at work. But the reduction of juvenile crime almost to non-existence is notably greater in Norwich than the general reduction due to general causes throughout the country; and every competent local observer of the facts is agreed in attributing this result very largely to the work of the Lads' Club, and the good relations it has created as between the police and the public.

For instance, the Recorder of London, Sir Ernest Wild, K.C., when taking the Quarter Sessions in Norwich in 1925, commented on the striking contrast between the work of his own Central Criminal Court, where, he said, “It is deplorable to notice the number of young criminals committing the most dreadful offences,” and the beneficial effect of the Norwich Lads’ Club on the charge-sheets of the Norwich courts. The same tribute to the influence of the club has been repeatedly paid by the Recorder of Norwich, Sir Ellis Hume Williams, K.C., P.C. On several occasions, too, His Majesty's judges, when attending at the local assizes, have called attention to the reduction in juvenile crime; and have made opportunity to visit the club and expressed their gratification at the great organization for good undertaken by the Norwich City Police.

On the physical health side, tributes no less striking to the beneficial results of the club’s work have been paid by those who are best placed to form a sound opinion about it. Dr. Sidney Long, the well-known physician who has been so largely responsible for the local work of combating venereal disease, in a letter to me after a recent visit to one of the club’s boxing competitions, says, “It is one of my jobs in life to try and rid this city of those baneful diseases which are commonly known as venereal diseases; and in this work I apply remedies which you would probably not care to handle. But I would point out to you that your Lads’ Club is one of the greatest assets the city possesses in helping the work of the V.D. clinic at the Norfolk and Norwich Hospital. By encouraging a healthy, robust physical fitness in the youths of Norwich you are doing a fine work in the prevention of these diseases, and thus you are lending invaluable aid to those like myself, who are doing their best to eradicate them. It will interest you to know that the incidence of syphilis among our population has dropped 50 per cent. since 1920. Go on and succeed still further.”
To every student of social problems, this aspect of the widespread physical deterioration that so often has its beginnings in aimless street loafing at night by working lads at a loose end for the intelligent use of their leisure, is well-known. Health is not a thing a boy thinks about; he never expects to be sick. The gymnasium gives him a paradise for play; there strenuous games challenge physical strength and health; a strong healthy body becomes a matter of pride; and such play becomes the compelling force calling a boy of his own volition to a standard of clean living. The Lad's Club can unquestionably claim to be a big factor in promoting the health of the youth of the city.

Naturally, an institution achieving these things finds its work made easier by the public recognition and support which follows upon such admitted results. The financing of the club is not the least interesting part of its story. At the outset the officers of the police force, by their personal service, reduced the need for actual money to a minimum. But as soon as the work began to be known, support commensurate to its needs—still at a minimum because of the continued personal service given by the police—was and has been regularly forthcoming; not merely from a few well-to-do people, but in small subscriptions from large numbers of working people; in some cases through the sympathetic interest of local trade union leaders who see daily the benefit of the club to the poorest life of the city. In the various factories the employers have noticed the greatly improved physique of the lads employed by them who are members of the club, and their influence for good upon the other lads working with them who are not members. The improvement in work and general influence has been so marked that in many cases employers, without waiting to be approached, have asked to become subscribers. The club has now a good list of regular annual subscribers; and its funds are augmented by donations from visitors, by the proceeds of entertainments specially set aside for this purpose by a number of the amusement houses of the city, and by the gate money at an annual football match between the police and special constables, which is now regarded by the public as one of the local sporting events of the year.

After the completion of the purchase of the new premises a deed of trust was prepared, and the club and gymnasium conveyed to trustees under the provisions of the trust. It is provided that the premises shall remain vested in the citizens; and in the event of the
police force ever deciding not to continue active interest in the club, the City Council shall be invited to decide what shall be done in the matter.

One provision of the trust is that membership of the club shall remain free. That has been a condition from the beginning. The club is entirely free and open to any lad between fourteen and eighteen years of age. The only condition imposed is in the pledge which each member signs on his membership card: "I promise that, with the help of God, I will endeavor to be honest, straightforward and manly in my daily life: and that I will do all I can to promote the best interests of the club." Set rules and regulations are reduced to the utmost possible minimum; the aim is to give the widest freedom consistent with good behavior. There have been about 8,000 lads enrolled as members since the club's inception; and the ordinary nightly attendance is from 400 to 500; with much larger numbers on the many special occasions. Sacred concerts in which the club's band and all the principal local artistes take part are held regularly at 8 p.m. on Sunday evenings in the club's premises; and so popular have they become that attendances generally reach upwards of one thousand young people who would otherwise have been parading the streets.

The management committee of the club is representative of all ranks in the police force, with the Lord Mayor as President and the Chief Constable as Chairman. But that is for general management only. The many sectional activities of the club are under sectional committees of the members themselves, who make their own arrangements for sports matches—cricket, football, billiards and the rest. Many of the old boys act as instructors and helpers in these various activities. The general work of club organization and supervision is carried on by the police in their off-duty hours; and so far from there being the slightest difficulty in obtaining this help, there is keen competition in the various ranks as to who shall carry on the work of the Lads' Club.

In these varied sectional activities the club has attained many distinctions. The central interest in the club is of course the gymnasium; 90 by 70 feet, and equipped with every form of apparatus. Members not only give displays at the club, but are in great demand during the summer to help local charities by giving displays at fêtes, sports and garden parties. Senior members not only give instruction to juniors, but attend at surrounding villages as instructors to small clubs opened there. Boxing is very popular; so popular that it takes
three nights to work off the bouts at the annual club competitions, and even the spacious club premises are unable to accommodate the parents and visitors who wish to attend on these occasions. One such visitor, Mr. Eugene Corri, the famous boxing referee, stated that he had visited many lads' clubs, but had seen none quite so good as the Norwich Lads' Club. "The ring is far and away the best I have ever seen," he says, "and many of our larger boxing halls could copy the arrangements at Norwich with advantage." Various Army championships have been won by old boys. One club representative has got as far as the semi-final in the national Amateur boxing competition, and another old member has won the championship of the L.N.E. Railway for three years in succession. There is a strong cricket section, which takes a good place in the local junior leagues; and the football teams of the club have been very successful. The Lads' league shield has been won twice, and the senior football team has had the great honor of winning outright, from 300 competing teams, the silver trophy for the best record of any amateur team in Norfolk. Trophies have also been won at billiards.

One of the outstanding features of 1928 was the formation of a swimming section. Under the guidance and instruction of the members of the police force, a large number of the lads have been taught swimming and life-saving; several of the members have gained the proficiency certificate and bronze medallion of the Royal Life Saving Society, and five have passed the very difficult test of the Society's Award of Merit. It is in this connection that the club's next extension is contemplated. There is a great need for an adequate swimming bath; and adjoining premises capable of adaption to the purpose have become obtainable. This is the club's present and urgent financial aim.

Members of the club have formed a Division of the St. John Ambulance Brigade and one of the leading medical practitioners in the city gives great personal interest and help in their work. Two senior members in full uniform attend every night at each theatre, music hall and cinema to assist anyone requiring first aid; and similar attendances are made at football matches and other functions at which large crowds assemble.

A band was established shortly after the club was formed, and has now a membership of thirty. They are offered many more engagements than any single band could undertake. For some years they have been engaged by the Norwich City Council for perform-
ances in the public parks; and their services are frequently given free to all sorts of charitable organizations.

In addition to affording opportunities for recreation, social intercourse and physical training, the club also acts as an employment bureau, and work has been found for a very large number of boys and young men. The citizens and firms who have on my recommendation found openings for members of the club speak very highly of them, and rarely have the lads given me any cause to regret having sponsored them and provided for them a start in life.

That this instance of welfare work and the promotion of good citizenship, undertaken directly by a police force, is not an isolated effort, is shown by the fact that the Norwich Lads' Club is affiliated to the National Association of Boys’ Clubs, 27 Bedford Square, London, W.C. 1, of which H.R.H. the Duke of Gloucester is President. In June, 1924, a representative group of active workers in the various agencies engaged in the work of boys' clubs—religious agencies, university settlement boys’ clubs, and others—spent a weekend together in the discussion of problems in which they had a common concern; and the exchange of views led to a suggestion that a permanent representative body should be set up to act as a clearing-house for information concerning club work and methods, and to encourage the formation of new clubs. This suggestion came to fruition in the formation of the National Association, which seeks to express nationally the team spirit which animates boys’ clubs throughout the country. The affiliated units of the national Association have a membership of somewhere about 100,000; and its value as a factor making for healthiness in national life is very great.

Summing it all up, we claim that in all this we are doing a really creative work in citizenship. The work of the police is often supposed to be limited to the enforcement of the prohibitions of the law and to measures against those who infringe it. But is there any reason why it should not be generally supplemented by the more enduring work of fostering the growth and the quality of positive good citizenship?
NORWICH LADS' CLUB: VIEW FROM BALCONY
OLD BOYS' ROOM
THE LIBRARY
GENERAL RECREATION ROOM
NORWICH LADS' CLUB: THE GYMNASIUM
A JUNIOR GYM CLASS BEING INSTRUCTED
NORWICH LADS' CLUB BAND
WHAT CAN THE SOCIAL WORKER DO FOR CANCER?*

ORA MABELLE LEWIS

Supervisor Out-Patient Department Social Service, Massachusetts General Hospital. Chairman, Hospital Social Service Section, Boston Council of Social Agencies, Boston, Mass.

What can the social worker do for cancer? That must seem like a comparatively simple question to most of you. And it is simple in so far as each and every one of you in this audience, (from whatever field of social work you may have come) has some immediate and fairly adequate answer. The sum total of all these answers would in the last analysis undoubtedly run something as follows: (1) The social worker should do all in her power to persuade any person who seems to need a special examination and advice to go and have it done. The public at large, as well as physicians, nurses, and social workers, are being taught by various methods, such as organized local campaigns, nation-wide poster advertising, newspaper publicity and semi-popular but scientifically accurate magazine articles, some of the so-called symptoms which are looked upon as "danger signals." Not only should we use persuasion wherever necessary for these examinations, but actually make the arrangements for some as well. It is so essential that all such examinations be made by skilled, conservative physicians. (2) When a diagnosis of cancer is made on one of our clients, then the social worker should help to remove any and every obstacle, apparent or real, which may exist to prevent carrying out at the earliest possible moment such treatment as has been recommended. This should be done with the hope of a cure in an increasing number of cases when taken in time, of alleviating long pain and suffering in those too far advanced for anything but palliative treatment, that large group of persons seeking

* Adapted for publication from paper read under the auspices of the Massachusetts Department of Health and the Boston Council of Social Agencies, during "Cancer Week" Campaign, April 1928.
medical care too late and finally to stand by and aid not only the patient, but the family as well in all the personal and family adjustments so often necessary because of the presence of cancer in the family group. This probably is the sum and substance of most of the tangible things we as social workers would say immediately in answer to the question "What has the social worker to do with cancer?"

Now right here is one thing I would like to add and emphasize, for I am sure that whereas you may many of you be aware of what I am going to say, it will not be your first thought when considering the question. It is, I believe, of prime importance. A social worker should remember at all times that these potential patients, whether they belong to the first group,—those seeking advice as the result of "danger signals,"—or the last group who know their diagnosis and that the outlook for them is poor; that Shakespeare was unusually wise when he wrote "In struggling with misfortune lies the proof of courage," for many times it takes far more courage for a client to face an examination, when the fear of uncertainty lies ahead, than it does for that same person to face an operation or carry out a line of treatment after a diagnosis however serious has been made. It is then, in the ability to give this intangible aid to courage, that social workers dealing with these problems face one of their greatest and perhaps their most essential challenge. But this courage can be given by you as social workers only when you believe absolutely in the worthwhileness of whatever you are trying to help your client do. When I say believe, I mean something more than just an intellectual belief which makes you say quite mechanically certain words, phrases and campaign slogans you may have heard over and over, and which perhaps you do accept as truth in a purely and mechanically intellectual way. Rather you should be ready to do more than repeat words. You should believe in the thing you are trying to do for your client with all your mental power and depth and thus carry your patient along with you. Do not for a moment think I mean that silly sentimental personal approach to your patient embodied in such phrases as "Please do it for my sake. See all I have done for you." See rather that your patient is convinced because you are yourself convinced that what you are advocating is the right thing to be done. Perhaps you say that that is entirely the doctor's job. Let us accept without controversy that the doctors
stand ready at all times to do their part and that our activities are beyond the range of their particular field.

Closely connected with the question asked in the title to which I am speaking is another one quite as simple for us to answer,—viz. Why should we as social workers do anything about cancer anyway? Again many of you have an immediate and perhaps adequate answer. Of course you realize that I am taking only the constructive answers to both these questions. There may be some people who will continue to say, “Nothing” to both. “It is purely a physician’s responsibility” and these negative replies will come from physicians to an even greater degree than from social workers or the community at large. But as I said before, we will discard these replies as outside this discussion.

The replies to the second question “Why should we as social workers do anything about cancer anyway?”—will undoubtedly summarize into some such statements as these: The economic loss resulting from cancer by incapacity and death of citizens is tremendous and according to statistics seems to be increasing. The cost to a community in providing adequate hospital care for these patients and the additional expense of financing their families is an added burden on the taxpayer. Social workers should of course join hands in helping to make as many individuals as possible economic factors in the community. Occasionally someone will come forward with something about the case work method of dealing with the problem on the basis that “Charity is a virtue of the heart and not of the hand.” “Gifts and alms are the expression, not the essence of this virtue.” This then is the simple and somewhat adequate answer to this second question, and places directly upon social workers the responsibility of being able to act as intelligent interpreters of the special needs of individuals as related to all these larger economic phases of the problem. So much for the spirit in which we should be ever ready and willing to face these tasks.

I will waste no time going into detail as to how you will get at all the scientific information you yourselves will need in order that you may make proper plans for the social treatment of your patients, nor how you will amass and correlate all the resources you should have at your finger tips to make these plans effective. But it is certain that one of your chief duties as interpreter will be this very ability to help direct and perhaps actually make the plans for medical-social treatment for these people. And please note that I say social
treatment with great and complete emphasis on social. We can certainly leave the medical examinations to the physician, and the medical treatment to doctors and nurses, and research and statistics to those better able to deal in such things than we possibly can and confine our energies to social treatment. Each and every one of us will participate in that according to our training, our affiliation or the scope of the organization we represent. The technical details of the tangible things we do will vary accordingly and rightly but there is one absolutely essential thing for us all as social workers to do with cancer, and that is to see that each and every one of us has the right point of view about the disease and the patient.

A right point of view, an ability to weigh or balance all the assets and liabilities of our patients, taking into full consideration their physical, mental and social conditions before committing ourselves to any plans for help or care.

It was Samuel Johnson who said—"The diminutive chains of habit are seldom heavy enough to be felt till they are too strong to be broken." Could anything apply more aptly than those words to the general attitude toward cancer? If it were not for our own habits of thinking about cancer and its related problems as we do, there would be no need for spending so much of the time of so many people during this and other campaigns in combating these old chronic prejudices, nor in attempting to get the communities to thinking along new lines. We must have the right point of view if we are going to help others to change theirs, and a change in point of view; an about face from the old attitude of fear of cancer because it is hopeless, to an attitude of hope and courage because when taken early it may be curable, should be our constant aim.

The element of fear looms very large in the minds of most individuals when doubt and uncertainty are added to the problem to be faced. Now we are told by those best fitted to know, that until such time as scientists know more about the cause of cancer some waste will still go on, but it is being hammered into our minds by those same scientists that there is an immeasurable amount of hope for cures in early cases.

Our energies then should be spent in the first instance in persuading people to seek competent medical advice when anything seems to be going wrong physically. Do not let your client wait to see if "nature will not take care of the difficulty" or not go to a doctor because "he will laugh at me if he finds nothing wrong and
then I would feel ashamed," or yet "because if anything is wrong I would not have an operation anyway—it would be useless—I would die anyway and why go through the extra worry and expense of an operation?" Now of course I realize that we cannot make our clients do anything, nor should we ever even attempt coercion, if for no better reason than that the responsibility would be too great. We talk in general terms about the "control of cancer" or any other disease, and during the time a person is under hospital care the treatment can be controlled within certain limits, but as social workers we certainly cannot control our patients, their thoughts, actions or reactions, beyond what we can do by intelligent advice and sane persuasion. We should be frank, open-minded and extremely patient, but at the same time firm and convincing. We should never make it impossible for our clients to come back and talk over again and again any doubtful points upon which they may need more help. When anything as serious as cancer is under consideration no obstacles should ever be put in a patient's way to prevent getting good and convincing advice. There will be less need, however, for these prolonged periods of indecision on the part of some of our clients when we make ourselves more expert in finding out what our clients themselves are actually thinking. Our failure to put through a plan is so often directly traceable to the fact that we never really know what is going on in our clients' minds or what they are really feeling.

First then, we should emphasize at all times the importance of early examination and arrange for such when necessary. In addition we should help our clients find that inate courage which lies dormant in most people but which may be buried under the weight of doubt, fear and uncertainty. Now these early examinations will in a large number of cases prove negative so far as cancer at the moment is concerned. Some conditions nature can be trusted to treat, some conditions are such that if left to their own devices, would prove a risk because cancer might later develop. This risk, however, would be lessened or completely removed by immediate treatment; a slight operation, x-ray or radium therapy, or some combination of these.

With the amount of publicity being given to radium as a method or adjunct to the radical treatment of cancer, you should remember that radium is also used to prevent certain pathological conditions from becoming malignant. You should not allow your clients to be unduly alarmed because radium therapy has been prescribed.

For the most part your client will have more courage than per-
haps you have when a diagnosis of cancer has been made and treat­
ment recommended. That inate courage comes suddenly and sto­
ically to life. But this examination which results in a statement
from the physician that it is not cancer but radium should be used
in the treatment seems absolutely contradictory to many patients and
that is especially true when the patient is recommended to go for
this treatment to some hospital which is being heralded far and wide
as a cancer hospital. Of course the physician is holding something
back—making some reservations—hoping against hope. It is up to
us as social workers to find out if possible what the doctor has in
mind and why he is using the particular resource. It is generally
because radium should be used by experts only, by the conservative
men who use it cautiously, governed by their experience with many
cases, rather than by the man who advertises himself as a specialist
in radium therapy and boasts about his achievements. And where
do we find these experts, and where is radium most accessible? In
those hospitals where it is most used, the well known cancer hospitals.
These hospitals are generally the only ones equipped with enough
radium to make its use possible for people of even moderate means.

So make this point clear to your clients and by your own straight
thinking help them to understand this seeming conflict of statements.
The major emphasis of any campaign should be upon these “danger
signal” cases and the possible prevention and cure in early cases with
positive diagnosis.

It would not be fair, however, for us as social workers to leave
the question at this point. There are two other groups of patients
we must consider but briefly although they comprise much the greater
group as far as tangible social work goes.

First the group when diagnosis has been made too late to effect
a cure, but still early enough to yield much to radical treatment, not
just for the comfort of the patient, nor yet to prolong life that suf­
fering will come in the end but rather in many more instances than
we can any of us know, prolong for varied periods lives full of the
joy of working up to very near the end—of actually completing a
life's work. The courage comes to the patient to face the future
be it relatively long or short and if we have as much courage as our
patients we may help them to live quite full lives during this period
instead of just reading or knitting or twirling their thumbs waiting
for the recurrence of the disease or the terminal stage. If you allow
the latter sort of thing to happen you are really helping to shorten
your client's life because does not one really cease to live when life as such becomes empty? Some people can master this problem themselves, some need but little help, but many have no resources within themselves nor yet within their reach to cope with the situation. At this point we as social workers should use every scrap of the imagination and ingenuity we possess to keep our patients occupied in mind as well as body, and that occupation should be, if possible, something which comes natural to the patient. It should not be a sudden adjustment to something new and strange, but it should be if possible something constructive and perhaps it may be something your client has all his life wanted to do but never before had the time to do. If you can occasionally help your client to gratify this wish of a lifetime during these otherwise trying times, it will be one more evidence of good case work. But whatever you do, do not let your patients sit idly by, doing some silly little thing to pass away the time and all that time feeling that they are fast becoming a nuisance or a burden. And it goes without saying that the less capacity your clients have for doing these things for themselves, the greater will be the tax on your capacity and ingenuity to fill the gap.

The final group to come under our consideration is that group of so-called inoperable or terminal cases—patients who either seek medical advice too late to have anything remedial done, or patients who have kept up through a series of operations or treatment and now have reached the point where partial or complete bed care is necessary for the patients' comfort and welfare. We must weigh again most thoroughly and carefully all the assets and liabilities inherent in the character of our patient, together with the stage of disease, and advisability of home, institutional or hospital care. Most patients on first thought want to stay at home, especially if they feel that they are going to die.

Now in some instances the equipment of the home, the financial resources in the family, or the constitution of the family group itself will make such a plan not only possible but practical. In many more instances such a plan is out of the question and hospital or institutional care is essential. But it is not and should never be sending the patient away from home to die. That has to be impressed upon both patients and their families time after time. It is rather sending patients away from home in order that they may live out their lives surrounded not only by every comfort and care but also that there may be the alleviation of pain by the various types of treatment which
can be used when a patient is under constant supervision. It is im-
possible to estimate the advantage of such procedure in some in-
stances for the patients themselves and for their families, to feel
that absolutely the best facilities in existence are available to them.
All these things and many others, we as social workers should have
constantly in mind for “many of these persons, if we knew their
histories would rivet our admiration, by the ability, worth, be-
nevolence or piety which they have displayed in their various paths
through life. Many would excite our warmest interest by their
sufferings, perhaps borne meekly and well and more for the sake
of others than themselves.”

We have answered the questions “What can we as social workers
do for these people—and why should we do anything for them
anyway?”

My final question is—How can we do our best for cancer? The
answer is the shortest and simplest of all, and has been given us
quite recently by the Reverend Harry Emerson Fosdick—“Let us
make of our work a happiness and a privilege, not a duty.”

“For to complain that life has no joys while there is a single
creature whom we can relieve by our bounty, assist by our councils,
or enliven by our presence, is to lament the loss of that which we
possess and just as irrational as to die of thirst with the cup in our
hands!”

APPENDIX

The foregoing was adapted as stated on the title page, from a
paper read at a joint meeting of the Massachusetts Health Depart-
ment and The Boston Council of Social Agencies during a so-called
“Cancer Week Campaign.” This accounts for the apparent “propa-
ganda” style of presentation, the lack of illustrative cases and for the
more general application of the various points discussed. The argu-
ments should have weight (as stated in the text) with social workers
in every field, as well as physicians and laymen at large. Hospital
Social Workers have had more or less opportunity to put into prac-
tice some of the case work procedure herein mentioned. These op-
opportunities are bound to increase rapidly with the awakening interest
in the subject of “Cancer—Its Prevention and Cure,” and with the
growing realization that many persons suffering from cancer may
still, if properly adjusted, round out a life of usefulness. For social
workers or physicians who may be especially interested or alive to
these problems, the following illustrative material is offered:
A woman of forty-five years, married, lives with her husband and twelve-year-old daughter on a poultry farm in a wide-awake suburban community. The local newspaper had been giving a good deal of space over several weeks to "Cancer Propaganda." The woman had had many vague feelings of discomfort, some of them very severe, over quite a long period and many of these were to her mind exactly like those which had been cited in the daily paper as so-called "danger signals." Added to these symptoms was the fact that the woman's mother and a sister had died of cancer, also the physician who had attended her during confinement and after had told her that she had a condition in her pelvis which if "not attended to—might develop into cancer."

Is it any wonder that the woman was apprehensive? She had "worked herself up" to a pitiful state. She was afraid to go to a physician lest the diagnosis be cancer. She was ashamed to go lest the verdict be "nothing but nerves!"

Fortunately for this woman, a neighbor who understood some of the functions of a hospital social service department, took her in hand, sent her to a well equipped out-patient department for a thorough examination and asked Social Service to take up her problems with her.

The approach was made through what seemed to be the most tangible aspect of the problem and the one which was actually worrying her most—the pelvic condition before mentioned. An examination by a specialist in pelvic diseases, with a consultation by the chief of a "Tumor Clinic" was most assuring and removed at the very beginning what seemed to be the only real cause for worry. The condition referred to by the physician was an anatomical anomaly of no special significance. When carefully questioned, all the other symptoms seemed to relate to gastric disturbances of one kind or another. Physical examinations, x-ray series and laboratory tests again proved negative,—the final diagnosis—extreme fatigue.

A vacation was recommended. It needed more than just a vacation, as the physician agreed when Social Service presented the story of this woman's weekly routine. Her home was kept in immaculate condition by the woman herself. Her twelve-year-old daughter was neatly and becomingly dressed, the clothes made by the woman herself. Her husband worked in railway car shops and planned to do
so until the farm was paid for, his laundry, and his dinners put up early in the morning being additional labor for the wife. They lived on a good-sized poultry farm. She had the feeding and the care of the fowl, together with the tending of the incubator, and helped in the dressing of broilers and fowl three times a week for market, and all this with no complaints.

The husband was working hard. She wanted to help, that the daughter might have the advantages they both lacked, and they looked forward, in addition, to a comfortable old age. For *diversion* the woman worked now and then for the neighbor mentioned earlier in the story. The work was different; she enjoyed the change and the neighbor could depend on her. This neighbor told Social Service that she allowed our patient to work for her because she felt it was the only change in her regular routine, and that the woman needed some change.

The diagnosis then was a social one and the treatment has been social from the point where the physician in whom the patient could have confidence gave her as complete reassurance about cancer as is humanly possible. With the help of her husband, the neighbor who was interested, and the resources in the town where she lived, which were unusually good because of the activities of the very up-to-date civic center, rest, recreation and a general change in this woman's life have been brought about. Now, six months later, she looks and acts like an entirely different woman. She has no aches, no pains and no apprehension.

**ILLUSTRATION II**

Two women were referred to Social Service from a surgical clinic—during the same week. The diagnosis in one case—tumor of the breast—question of malignancy. The other, carcinoma of the breast—inoperable. The first patient had been recommended to go into the hospital for immediate operation—with the hope of cure or at least checking the spread of disease. She hesitated, partly through fear but more because there seemed no way to care for her husband and children during her absence from home,—a problem solved for her by the social worker through temporary foster home care of her children. Her husband gladly looked out for himself. The patient had her operation, the after-treatment with ray therapy, and is now being carefully followed in a clinic,—and is also under supervision by Social Service.
The second patient also needed help in the home, with the care of her husband and children, and all too soon might need hospital care as well. Her medical history showed that four years previously she had noticed a lump in her breast about the size of a walnut. She had at that time been advised to have it removed. She had not done so because she had no one to look after her family. She had never returned to clinic, and now it is too late to more than make plans for terminal care and longer readjustment of her family problem. 

_Had this patient been referred to Social Service upon that earlier visit or had the clinic maintained an adequate “follow-up” system, this second patient could have had all the advantages which are now available to the other patient at a time when they might have materially influenced the outcome—at least in comfort and usefulness if not in actual prolongation of life._

**ILLUSTRATION III**

Two men, each with sarcoma of the jaw, present widely varying adjustments to their environment,—one made by the patient himself, the other with the occasional help of Social Service.

A man of about thirty-five, “foreman of the works” in a steel plant in a mid-western city, walked into the office of a most eminent “cancer” specialist, and said in part “My doctor tells me I have cancer of the jaw and that nothing can be done. I’ve got just $100; I know it isn’t much but it’s yours if you will only see if you can do anything for me.” The doctor examined the man carefully, looked him square in the eye and said “You have just one chance in ten thousand. I will take it if you will.” He did. One of the most radical operations on record was performed. The man reeducated himself to talk with only part of his tongue remaining, and ten years later had been promoted to superintendent of the plant. He had what would have been generally conceded to be an “inoperable malignancy,” yet he lived a life of usefulness for many years. There was no social service department connected with the hospital where this man had his operation but fortunately the corporation for whom he worked had an extremely well developed welfare service, and he received every advantage which could be given him by the people for whom he worked.

The second man was over sixty-five years of age and a less extensive operation has been done. He did not have the incentive of youth to help him but he did have a most willing daughter to take
him into her home, after Social Service had interpreted to her the after-care needed and the community resources. He is with her most of the time but goes at intervals to a so-called cancer hospital for three reasons:— 1. For medical observation and palliative treatment. 2. To give the daughter a chance to rest and have some relief from the strain, and finally, 3. to get the patient so used to coming and going to that particular hospital that when the "terminal stage" is reached and he goes for the last time he will not be doing anything out of his regular routine. A plan worked out by Social Service.
EDITORIAL

The College Complex

Many have been obsessed recently with the notion that no social worker is equipped for her job unless she is a college graduate. I think we are all perfectly agreed that the newer type of social worker is better than the old. Some seem to think that this improvement is due to the fact that a college education is now a requisite part of most social workers’ equipment. Are we not perhaps misusing terms? Are we not confusing a college education with the professional point of view which is undoubtedly necessary for any professional work such as social service? Is not what we desire a professional point of view, rather than a college education? Are they necessarily synonymous?

What constitutes a good social worker? My standards are high. A first essential is an intellectual grasp of the whole economic and social situation. The dispensing of relief is but a small element. Housing, the employment problem, health facilities, education, recreations—these are all part of the pattern which my social worker must know intimately. Second, a knowledge of the technique of case work as a whole. If one understands how to be a good medical social worker, one can readily become a children’s case worker or a vocational counsellor. To individualize each case and yet see its relationship to the whole—that is case work. Third, a constructive philosophy toward life. There are many places in the world for the disillusioned and the pessimist, but social work is not her place. The social worker meets clients in times of stress and if she is not balanced herself, how can she be of real help to those who are themselves wavering and in doubt? We do not need Pharisees or Babbitts. We do need workers who have enough spiritual incentive and sincerity of purpose to carry them over the discouragements of social work. Fourth, there must be a real conception of service which keeps one enthusiastic in spite of the financial disadvantages. Social work is not a field to enter if one is looking for a quick way of amassing a
fortune. There are rewards in social work which few other professions offer, but money is not its chief reward. There is a constructive contribution each case worker is giving if she can only see her place in its relationship to the whole fabric of social work. We are all working together for a better order.

This is my idea of a social worker. Many college women have these attributes, but is there any law which states that there are not many women without degrees who have the same conceptions and technique? I will admit that there are more college women who have these ideas than non-college women. I will not admit, however, that there are enough college women to do all the social work we need done. Even if there were, I am not sure that it would be a healthy thing to have every social worker come from the college field. We need a variety of personalities. There are women nurses and industrialists, for instance, who are outstanding women and have the professional point of view. Yet many of them are not college graduates.

You cannot argue with me on the point that we need better social workers. I agree with you. Those who have a college education are fortunate people. Some of the finest social workers in New York City are not college women. They are professional social workers, however, in the highest sense. They are making a real contribution to a new social order. Let us beware of not doing them honor merely because they lack certain arbitrary educational qualifications.

Gertrude R. Stein,
Vocational Service Agency.
NEWS NOTES

The annual meeting of the American Association of Hospital Social Workers will be held in Boston, June 7th to 14th, 1930. The Program Committee, Elizabeth Rice, Boston Dispensary, Chairman, has arranged a comprehensive program which provides for (1) annual business meeting; (2) general sessions for medical social workers; (3) group discussions for the interchange of experience and ideas on the more technical subjects and (4) joint sessions with the other divisions of the National Conference of Social Work, of which the American Association of Hospital Social Workers is an associate group. The Committee on Local Arrangements, Ora Mabelle Lewis, Massachusetts General Hospital, Chairman, is arranging for recreational opportunities and week end suggestions for June 7th and 8th.

The business meeting will be held on June 7th. June 10th joint sessions with the Health and Family Division of the National Conference of Social Work when Community Health and Problems of Relief will be discussed. The same afternoon the awards in the Case Competition will be announced, and there will be a general discussion of the cases submitted. June 11th there will be a joint session with the Travelers Aid Society and the subject under discussion will be “The Sick Transient.” June 12th will be given over to a series of 5 or 6 small group discussions, on questions of specific interest to those engaged in medical social work, and include such subjects as Social Work with Cancer Patients; with Patients under Care in Eye Clinics; Special Problems of the Social Worker in the Tax-Supported Hospitals; Methods of Supervision; Field Training for Students from Schools of Social Work.

This year the Massachusetts General Hospital is celebrating the Twenty-fifth Anniversary of the establishment of social work in that institution. On Thursday evening, June 12th, the Association will meet with the Massachusetts General Hospital Social Service Anniversary Committee at a banquet at the Hotel Somerset. Dr. Richard Cabot of Boston and Mrs. John Glenn of New York will speak.

June 13th Miss Mabel Wilson, Children’s Hospital, Boston, will
discuss "The Medical Placement of the Child Outside His Own Home" at a general meeting of the Association, and the final meeting on June 14th will be held jointly with the Division on the Organization of Social Forces, the subject for discussion being the "Use of the Social Service Exchange."

Headquarters for medical social workers are at the Hotel Statler. Reservations should be made through Mr. J. Paul Foster, 80 Federal Street, Chamber of Commerce, Boston. Special arrangements for reduced railroad fares have been made, and certificates will be sent on application of members through Headquarters Office, 18 East Division Street, Chicago, Ill.

Methods of combating unemployment and ill health will occupy a prominent place on the program of the 57th annual meeting of the National Conference of Social Work and its associate groups, which will be held in Boston, June 6 to 14. Dr. Miriam Van Waters, Referee of the Los Angeles County Juvenile Court, is President of the Conference which will afford great interest to people engaged or actively interested in such fields of health, dependency, delinquency, family case work, neighborhood life, mental hygiene and economic problems.

Hospitals in the United States involve almost a billion dollars annual expenditure and over four billion of invested capital.—Better Times.

At the request of President Hoover and on invitation of Governor Theodore Roosevelt, Dr. J. S. Crumbine, General Executive of the American Child Health Association, and two assistants are in Porto Rico investigating child health conditions and instituting a child health program.

The American Hospital Association will hold its next annual meeting in New Orleans, La., October 21 to 24, 1930.

The Chinese Red Cross is doing intensive work among the homeless children from the areas of Shensi and Kansu.

The National Society for the Prevention of Blindness has completed a 4-year study of the vision of pre-school age children. The
study disclosed the fact that in 21 per cent of the nursery and kindergarten children examined abnormal conditions of the eyes existed.

The new Doctors' Hospital, New York City, was formally opened in February. The building is a combination of modern hospital for patients and a finely equipped hotel where friends of patients may stop during the patients' stay in hospital.

The Rockefeller Foundation has made a grant of $33,000 to the National Probation Association to make an intensive 2-year study of the methods of detaining children and minors who are to appear or have appeared before the courts.

No longer will the patients in Middlesex Hospital, London, be awakened at dawn to be bathed. Hospital authorities have decided that the patients' comfort must come first, even though the hospital routine may be somewhat disturbed. Since the patients' best recuperative sleep is usually secured between 5 and 6 o'clock, the time formerly reserved for bathing the patients, that hour has been abolished and a new ruling made that no patient shall be bathed before 7 o'clock or disturbed for breakfast before that hour except for urgent medical reasons.

To bring about this reform, the duties of the day and night nursing staffs have been redistributed.—*Mod. Hosp.*

After a 2-year study it has been decided that the Chicago Orphan Asylum will, as soon as it is possible to place its wards, cease to function as an orphanage. A boarding out system has been instituted and many of the children are already placed in suitable boarding homes.

At the last annual meeting the Canadian Council on Child Welfare was reorganized and its name changed to the Canadian Council on Child and Family Welfare. Miss Charlotte Whitton was elected Executive Secretary of the reorganized Council.

The Massachusetts Society for Mental Hygiene in cooperation with the Boston Council of Social Agencies, the Boston Health
League and the Massachusetts Department of Mental Diseases, will make a survey of mental hygiene activities in Boston. The Commonwealth Fund is assisting financially.

“Until public health becomes a private responsibility it will not become a public achievement.”—Glenn Frank, President, University of Wisconsin.

The Board of Estimate, New York City, has made an appropriation of $825,000 for the modernization of Farm Colony, a home for the aged on Staten Island.

The American Association for Organizing Family Social Work, 105 East 22nd Street, New York City, has changed its name to the Family Welfare Association of America.

In order to protect children, whose parents are unemployed, from malnutrition the Children’s Aid Society of New York City is serving breakfast and in many cases mid-day lunches to children attending the Society’s health centres.

The Bureau of Dental Hygiene of the Chicago Health Department operates 12 dental clinics for school children, who otherwise would not be able to consult a dentist. The 25 dentists and 14 dental hygienists work in cooperation with the Bureau of Child Welfare.

A recent report of the New Jersey State Crippled Children’s Commission shows that of the 11,671 cases recorded in the State, 9,301 have been reported upon and studied in regard to physical education and economic needs. It is expected that every crippled child in the State will be reported upon by the end of the current year.

The federated women’s clubs and the parent-teacher associations of Marion County have organized a joint committee to arrange plans and develop a program for observing May 1st as Child Health Day, and to follow-up the program with a county child health institute. Speakers of outstanding reputation are to be invited to participate in the institute program according to plans. A definite and permanent child health and welfare program is the end in view.—Ill. Health Messenger.
Mrs. Kate B. Johnson has been appointed Superintendent of the State Home for Girls, Trenton, N. J., to succeed Dr. Ellen C. Potter, who will again become Director of the Division of Medicine of the Department of Institutions of the New Jersey State Department of Health.

If the campaign to raise $6,000,000 is successful New York City will have a hospital for middle class people. The new institution will be known as the Gotham Hospital and will serve people who are neither eligible or desirous of receiving free treatment, but who can afford a reasonable fee for medical, nursing and hospital care.

The National Association for the Prevention of Tuberculosis will hold its 16th annual conference in London, England, July 3-5, 1930.

In coöperation with the New York City Department of Health and other agencies, the Children’s Welfare Federation operates a service whereby physicians can obtain mothers’ milk for feeding premature or other infants who need this particular food.

Pan American reports an important remodeling program which is being carried out at the Palo Seco Leper Colony in Balboa, Panama. Plans include the construction of a new building to be used as a reception hall. Motion pictures and billiard equipment will be included. There are over 100 patients being treated at the Colony.

The New York City Department of Health recently broadcasted a series of radio talks on radio quackery.

Tennessee is the first State selected by the Commonwealth Fund for carrying out its new rural health project in coöperation with State Health Departments.

The New York Ophthalmic Hospital, which has been located at 23rd Street and Third Avenue for the past 58 years, is to have a new and fully equipped modern hospital building in East 36th Street.

Dr. Thomas Parran, jr., Assistant Surgeon-General in the United Public Health Service, has been appointed State Commissioner of Health, New York State, to succeed Dr. Matthias Nicoll, jr., who re-
signed to accept the position of Health Officer of the newly created Westchester County (New York) Health Department.

Dr. Hugh Cabot, who recently resigned form the University of Michigan, has accepted an appointment on the staff of the Mayo Clinic, Rochester, Minn.

Do you know that of the 20,000 new patients who come annually to mental hygiene clinics in New York City approximately a third are children?—Better Times.

The Division of Publications of the Commonwealth Fund has been moved to the Fuller Building, 57th Street and Madison Avenue, New York City, where the executive offices of the Fund are located.

The State Bureau of Child Welfare of New Mexico has established 5 local social welfare units, each in charge of a trained and experienced social worker.

The sentencing power is taken out of the hands of the judge and placed with a special board charged with the scientific study and treatment of the criminal under the new penal system recently instituted in Prussia. Careful classification of all prisoners, special study of the offender’s physical and mental condition, his family and social history, and individual treatment under an elaborate system of diversified correctional institutions, are comprehended under the new plan. As far as possible, these institutions will have the benefit of the services of psychiatrists who will treat prisoners suffering from mental or emotional maladjustments as well as study the personalities of the more normal classes of prisoners. Some very definite and novel practices will be adopted in the new prison régime which will accord more with that of the training school concerned primarily with the preparation of the individual for a social, law-abiding life, even to the extent of arranging for the employment of prisoners in factories and shops out in the community.—Ment. Hyg. Bul.

Child health centres have been functioning for years in the larger cities of Italy, but they were practically unknown in the rural districts until 1927 when they were organized in these districts by the Government. For this purpose it was planned to divide the country into a
number of districts each to be under the supervision of a physician and each to be equipped with several traveling child health centres. The number of centres is gradually increasing. So far they have been established for the most part on the islands and in Southern Italy. Only 1 centre has been functioning in the North. Each of the centres now functioning serves about 20 rural settlements, 2 or 3 of which are visited in a day. In this way every settlement is visited once each week.

The staff of a traveling centre consists of an especially trained physician and 1 or more assistants. The physician examines mothers and children, tells them the important rules of hygiene and dietetics, and distributes milk and other food for the children. The assistant visits the home and teaches the mother how to dress, bathe and give general care to the children. Some of the centres have a specialist in obstetrics and gynecology on the staff who examines the mothers and gives them the necessary advice. A record is kept of every woman and child examined so that it is possible to follow up the cases.—Amer. Jour. Pub. Health.

The New York Public Library offers free courses in writing Braille and will welcome volunteers who will devote their time to preparing books for the blind.

The United States Civil Service Commission announces the following open competitive examinations:

Social Worker (Psychiatric), $2,000 a year
Junior Social Worker, $1,800 a year

Application for social worker (psychiatric) and junior social worker must be on file with the Civil Service Commission at Washington, D. C., not later than June 30. The examinations are to fill vacancies in Veterans' Bureau Hospitals and in positions requiring similar qualifications throughout the United States. Competitors will not be required to report for examination at any place, but will be rated on their education, training, and experience, and on a thesis or publications. 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 Kips Bay Boys’ Club has purchased property in East 52nd Street as a site for a new building which will accommodate 2,500 boys.

"The demand for sulpharsphenamine has grown constantly and rapidly since 1925 when the State offered it for distribution to clinics, State institutions and to private physicians, treating indigent cases. The following table, compiled by the Division of Social Hygiene, through which this preparation is dispensed, illustrates the increase in distribution, particularly in 1929 when the amount supplied was almost double that of the preceding year.

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<th>Year</th>
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<td>1925</td>
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<td>1929</td>
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—Health News, N. Y.

The National Council for Mental Hygiene of Great Britain has addressed all County and County Borough Councils, Chairman of Public Health Committees, Medical Officers of Health, officers and members of medical and other societies in England and Wales in an effort to promote facilities for the care and treatment of mental and nervous cases among the poor. The need is emphasized for general-hospital and nursing-home beds for the functional nervous types of illness, for which the facilities are extremely meager, compared with those available for cases of “certifiable insanity.” The well-to-do are able to secure the type of treatment necessary for mild disorders, but the poor come under treatment only when they have reached the extreme stage of a mental breakdown and require removal to a mental hospital. The Council deplores the unnecessary suffering and unhappiness and the economic wastage of time and money caused by this situation. The Council is taking advantage of the opportunity afforded by the passage of a new local Government Act under which the reorganization of public health services are expected to take place to bring this problem to the attention of the local authorities. It submits that “no scheme that is drawn up can be regarded as adequate which does not take into account the needs of those suffering from nervous breakdown and the early symptoms of mental illness.—Ment. Hyg. Bul.
In his message to Congress, President Leguia pointed out that the work of the Bureau of Public Health of Peru, S. A., had been characterized by a marked development during the year 1928-29. A vigorous campaign was continued against bubonic plague and measures taken against smallpox, tuberculosis, malaria, and venereal diseases.—Pan-America.

About Mrs. Marcovitch

The night school had just finished its session for the evening and Mrs. Marcovitch was lingering for a word with the pleasant teacher who had made it possible for her to earn $25 by the sale of some hand-made lace. Mrs. Draper knew just what that check would mean. Mr. Marcovitch pressed clothes, Mrs. Marcovitch took in sewing, they lived in two rooms with seven children, often poorly clad and not too well fed. When a little later she called on the Marcovitches, the American woman found the place more crowded than ever. Mrs. Marcovitch had bought a piano! It loomed up shiny and somewhat ludicrous in that steaming noisy room. The $25 she had earned had been used as a down payment on this sheerest luxury, bought on the instalment plan. Mr. Draper, who heard the story that evening, blamed his wife and her friends. They had upset all values for Mrs. Marcovitch. She had got ideas that would do her no good.

Fourteen years went by. One holiday season, while attending a concert Mrs. Draper saw, a few seats away, a woman who looked like Mrs. Marcovitch. Except that the figure was plumper, better dressed and radiating satisfaction rather than a terrible dynamic urge, it was the same woman. All of the Marcovitch children had been given a musical education. The older ones were placed, two of them earning their living by means of music, and helping educate the younger ones. Only one of the boys had failed to respond. He was a “picture dope” and had dropped music for painting. He was studying art in Paris.—The Interpreter.
**BOOK REVIEW**


This is a textbook for nurses and presents the subject in an interesting and readily understandable manner. Any urologist can read it with profit and will find many valuable hints which should help him in the training of his nursing staff. There is nothing in this book for the use of the social worker, but it should be of value to the nurse in the venereal disease clinic.

Alec N. Thomson, M.D.


In the ever-changing shift of emphasis in the secondary school curriculum the most gratifying observation from the physician's point of view is that health education is being brought forward to assume the importance it deserves. Today colleges, business, parents and teachers are constantly bringing pressure on the school boards and boards of education to modify or enlarge the scope of the students' education to include those very things which they themselves deem the all-important factor in education. For instance, some would aim to broaden the students' cultural aspects of life, while others urge educators to place more stress on the practical subjects. Some communities have yielded to those who are desirous that the high school curriculum embrace teaching of some specific vocation, while in other localities the school board insists that the secondary school should merely furnish the students with a background to develop their intellect and power of reasoning. But, regardless of the pro and con of these differences of opinion concerning the mission or function of the secondary school, there seems to be a general agreement that the student should be given adequate training and knowledge in health education. In other words, the long overlooked study of health education is fast becoming one of the leading courses in school work.

This is particularly true of Malden, Massachusetts, where the teaching of health education in its public school is considered of paramount importance, and one of their textbooks used is "Physiology and Health." This is an excellent manual for the purpose of inculcating into the minds of the students the essential facts of the structure and functions of the body. It is well written, easily read, and
has many excellent illustrations. Moreover, the book has an added advantage in that at the beginning and end of each chapter there are numerous topics suggested for discussion, which cannot help but stimulate the student to think not only of his own health, but also that of the community.

At first glance it may seem that the contents are a bit advanced for the third and fourth year high school student, but this book is merely one of a progressive series of books which is being used in the public schools of Malden, and the subject matter is a continuation of a graded course in health education.

The author has had considerable experience in presenting this difficult subject to college students and students attending professional schools. As a matter of fact, at one time or another he has given courses in almost every institution of higher learning in Boston and its vicinity. At present he is Professor of Biology and Public Health, Massachusetts Institute of Technology; Associate Professor of Public Health and Hygiene, Tufts Medical and also Tufts Dental Schools; Director of Health Education Studies at Malden, Massachusetts; and Chairman of the Health Section, World Federation of Education Associations.

Although the reviewer may be in error, he feels that Professor Turner's unusual experience in teaching in the higher institutions revealed the fact that, through no fault of their own, the students had little or no knowledge of the functions and structure of the human body. The solution of this situation rested with the primary and secondary schools, and he is to be commended for his successful efforts to enlighten the child and adolescent on a topic which will be of practical as well as theoretical use to them throughout their lives, and his latest textbook has simplified the work for the teacher to enable her to present in understandable form those fundamental physiological facts which should be a part of the knowledge of every well-informed individual.

Samuel Adams Cohen, M.D.
Work. Part I gives concrete descriptions of the problems encountered and the methods used; Part II discusses the education of psychiatric social workers by the Bureau. The joint authors describe the work of their Bureau with clarity, sympathy and enthusiasm. They conclude with due reservations, that mental hygiene can be depended upon to give satisfactory results, and that "students can be depended upon to do social case work with a high degree of efficiency." Their statement of their case is convincing.

It would be a good thing if the chapters which deal with the "Content of Child Guidance" could be simplified, amplified and put into the hands of all parents. I have a friend who reads Samuel Butler's "Way of All Flesh" whenever she is expecting a baby. That desolating story of the damage that parents may do their children always appalls her into a conscientious effort to understand her coming offspring. If a mere novel can help to keep a mother affectionate, sympathetic and objectively devoted to helping her child become a normal, independent adult, surely these vivid stories from real life might be calculated to frighten parents out of selfish neglect, over-heated devotion and the desire to tie their children to their apron strings. These well-told histories lay bare the springs of many a parent-and-child tragedy; incidentally of many a husband-and-wife disaster. By stripping them of the technical ego-libido language of psychiatry, they could be expected to do a lot of good amongst all parents and married people. They are calculated to make the reader look within; momentarily they call up people we have known; from time to time they strike us quite with a flash of self-conscious realization, or perhaps, a pang of regret or remorse. According to the psychiatrists, self-consciousness is the new saviour of mankind. The scene of Calvary is transferred to the human mind, which must suffer the agonies of such hard introspective thinking as will lead each man to a clear understanding of the motives which govern his own conduct. Such self-consciousness is thought to bring a certain peace, a certain confident maturity of living, which, if it does not always keep us happy, will at least keep us out of insane asylums. Such self-consciousness has always been, in one sense, the aim of liberal education. Too much value cannot be set upon an ideal which intelligent people for thousands of years have raised above all others. By simplification this book might be given large educational value.

From reading this very book, however, we get the firm conviction that no amount of reading will solve the unhappiness of the great masses of mankind, poor, good, bad, wild-eyed, suffering, dumb,
driven cattle. Let the psychiatric social workers carry on what is essentially a noble work of relief amongst the poor in spirit, who will be, like the poor in pocket, forever with us.

Jessie Marshall, M.B., D.P.H.,
American Social Hygiene Association.

NEW PUBLICATIONS

The Commonwealth Fund Report. Devoting the major part of its income to activities in the fields of public health, preventive medicine, and mental hygiene, and to the enrichment of British-American relations, the Commonwealth Fund, according to its 11th annual report made appropriations totalling $2,028,759.26 during the year ending last September 30. Of this sum, $1,366,674.26 was applied to special enterprises directed by the Fund, and the remainder, $662,085.00, was distributed among 38 outside organizations, hospitals, and universities in the form of grants for special purposes. Among the year’s developments were the opening of 2 new rural hospitals and the adoption of a new public health program in this country; the establishment of a child guidance clinic in London; and the completion of the Fund’s child health program in Austria. Fellowships for graduates of British universities to study in America were increased from 25 to 35, of which 5 were open to students from the Dominions. The largest special grant made to an outside organization during the year was 1 of $214,500 to the University of London for the establishment of a chair of American history. In the Fund’s mental hygiene activities the year has been one of consolidation and technical progress. The Institute for Child Guidance, maintained by the Fund in New York City, received an increased number of children for treatment and enlarged its quota of students for professional training. The National Committee for Mental Hygiene was enabled to continue its child guidance program and to establish clinics. Provision was similarly made for continuance of the service of the National Committee on Visiting Teachers. With the opening of 2 new hospitals and the continued work of 2 previously established, 4 rural districts, 1 each in Tennessee, Virginia, Maine and Kentucky, are now provided with general hospitals of their own. Additional hospitals have been opened in 2 more districts, in Kansas and Ohio, since the close of the year covered by the report. It is estimated that through this program some 410,000 people are enabled to enjoy
near at home the safety and convenience of hospital service which in
former years they had to seek at a distance or forego altogether.
The new public health program, with 1930 as its first year, will draw
upon the experience both of the child health demonstrations and of
the rural hospitals, but will provide a fresh approach to rural health
problems. The educational projects will include the strengthening
of the medical schools which chiefly train doctors for service in the
selected states, scholarships or loan funds for students of medicine
who intend to enter rural practice, and fellowships for rural physi-
cians who wish to improve their grasp of the best current technique.
Among the special grants made by the Fund were several to be applied
to medical research—for example, the study of the causes and treat-
ment of cardiac trouble in children, at Johns Hopkins; a study of
sera and vaccines significant for the control of cardiac disorders, at
Cornell University; the research work of the Heart Committee of the
New York Tuberculosis and Health Association; an investigation at
the University of Michigan looking toward the development of a
blood test for tuberculosis; the study of epilepsy and multiple
sclerosis at the New York Neurological Institute; and continued
work on serum treatment for the pneumonias by Dr. William H.
Park. A grant of $50,000 was made to the Notre Dame Bay
Memorial Hospital, at Twillingate, Newfoundland, supplementing
previous grants to this hospital, the only one in 300 miles of seacoast.

Studies in Child Welfare from the National Catholic School of
Social Service. Social Science Monographs Vol. I, No. 2. This
interesting publication consists of 6 valuable articles by 6 different
authors in the various fields of social work. A study of crippled
children, recreation centres, vocational adjustment, spoken phantasy
in pre-school children, ecological factors in juvenile delinquency, and
the nursing school behavior are the subjects discussed in the six un-
usually interesting studies.

This interesting report gives the history of the movement which
dates back to the year 1910, the date of organization. The first
Centre was opened at Beech Forest in 1911. By the end of the first
year 3 more Centres were opened. At the present time there are 59
Centres, including 14 Hospital Centres and 21 Ambulance Centres.
The Association was established to provide nurses' service in country
towns and sparsely settled districts. Whenever possible Centres are
established in conjunction with local medical practitioners who are invited to take seats on the district committee and assist in guiding the movement. A nurse cannot replace a doctor and a doctor cannot do serious work without the aid of a nurse; for this reason cooperation of the local physicians is necessary. The work covers a wide area and takes in all branches of public health and welfare work. The suggested rules for Bush Nursing Centres and Nursing Hospitals, the rules for the Guidance of Nurses, and the outline of training required for the service are some of the interesting topics included in the report. Charts and photographs of the Hospitals and Centres add to the interest of the text.

The Department of Parental Education of the State Department of Education, Columbus, Ohio, is publishing a monthly booklet, the title of which is, “Better Parents Bulletin.” This interesting publication seeks to help parents in solving the every-day problems of child-rearing. Not only parents but teachers and others who have the care of little children will be inspired by the many interesting articles by experts in the field of education and child training.

Report of the First International Conference of Social Work, published by the League of Red Cross Societies, Paris. This report in 3 large volumes is a remarkable contribution to public health and social service literature. The papers presented at the Conference and the discussions are given in their entirety. As the speakers were from practically every country in the world, leaders in public health and social work, the report is valuable documentary evidence of the growth and development of social work.

ABSTRACTS


The best means of describing the work of the Visiting Housekeeper Association of Detroit is to copy a letter written to a newspaper during the Community Fund drive by a woman who had been helped to adjust her needs to her financial condition:

“To the Editor: Some three years ago I spent a long time as a patient in Harper Hospital, and having a family of four children I was buried so deep in debt that I felt it would be
better to pass out, but I was very fortunate in receiving the help of the Social Service of that hospital in making arrangements with those to whom I was in debt to receive smaller payments than contracts called for. I also received the support of the Visiting Housekeeper Association who received my pay check each two weeks and budgeted the money in a way that we were amply able to live, until now from a total debt of over $2,500 three years ago, I am practically out of debt and in good health as is my family also. The assistance given to me by several branches of the Community Fund has been the means of my being here today to write this little appreciation of their courtesy to me. Their help meant to the City of Detroit: First, my complete recovery which kept my family from becoming a public charge. Second, each and every creditor received every cent due him. May I again express my thanks to the Community Fund, to the merchants of Detroit, and especially to the Visiting Hosekeeper Association.”

This woman’s affairs were straightened out and she now handles her own money and manages her household with only an occasional bit of advice from a friendly visitor.

The Visiting Housekeepers are women trained in home economics, who visit the homes and render aid whether it be teaching food selection, food preparation, planning diets, budgeting or other means of improving living conditions. The Visiting Housekeeper Association is financed by the Community Fund and is non-sectarian. There are 16 trained home economic workers on the staff. These housekeepers visit the homes and charge a fee of 60 cents the lesson, but in cases where the family cannot afford to pay the service is given gratuitously. The Association conducts a Practical Housekeeping Centre in a 6-room cottage where groups of girls and sometimes families are given instruction over a period of 2 to 3 weeks. Those under instruction live at the Cottage doing the housework and learning to prepare and serve meals and observing the value of regular habits of living under the supervision of the director and her assistants at the Cottage. The Association also provides supervision in homes where there is no mother. The Association also does special work, such as preparing quarterly costs of material, food, etc. This information is used as a basis for budgeting by the various relief agencies. The Association also plans menus for children’s homes and camps and gives talks on nutrition and budgeting to groups of women
and girls upon request. Last year 880 families were given instruction. Among these 428 were new families and were referred from 62 different sources, 16 were personal applications.


A complete physical examination, the term “complete examination” being used in a relative sense, is required of all students entering the University for the first time. The work of examining starts at the end of the scholastic year in June and extends up to the time of registration. The author briefly explains the method and extent of the examinations. The fact that the physical condition of each student is known makes it possible to arrange or rearrange his schedule of activities, both physical and scholastic. In summarizing the author states that the main objectives of a University health service are to improve the physical and mental health of students, to stabilize their emotional aspect of life, to prevent disease, to educate the student body in regard to the essentials of healthful living and recommend the correction of physical defects. The examination records of the students are a valuable aid in carrying out these objectives. Early in the first semester both history and physical findings are rechecked and the students are advised and re-examined according to individual needs. The University lacks the facilities for a yearly complete examination of the entire student body as routine health work but each student is encouraged to ask for the periodic examination. Aside from the direct benefit derived by the student during his stay at the University the health records, as they extend through the years, give a certain amount of valuable information regarding preventive medicine.


The author draws attention to deplorable conditions which prevailed in English prisons as late as the latter part of the last century. The first serious thought given to ameliorating conditions is attributed to the courage of the novelist Charles Reade who in his book “Never Too Late to Mend” drew a cruelly vivid picture of prison life. Later Charles Dickens awakened public opinion. From that time on prison reform became a subject of interest to thinking people the world over. One of the most recent reforms is the institution of a prison
nursing service. Until 1919 the sick prisoners were attended by wardresses—now known as prison officers—and no trained nurse was employed. About that time it became the custom to summon a nurse in cases where the prisoner was acutely ill. Holloway Prison covering 11 acres and situated in the north of London is a faithful copy of the ancient pile of Warwick Castle with full quota of towers and battlements. There are accommodations for 1,000 prisoners, but since 1904 the prison has been reserved for women only, the daily average is 320. In Holloway’s prison hospital there are 72 beds for sick prisoners contained in 2 hospitals—one for convicted prisoners and one for those on remand or awaiting trial. The strictest difference is observed between prisoners undergoing sentence and those whose trial is not yet completed. In the remand section there is an observation ward of 10 beds for patients, pending an enquiry regarding their mental condition. A nurse is on duty in this ward every minute of the day and night. General cases are placed in another ward of 10 beds. A small ward of 3 beds is set aside for prisoners suffering from the venereal diseases—there are also 6 private rooms. The atmosphere of a prison hospital is accentuated by locked doors and padlocked fire escapes and the bunch of keys dangling at the nurses' waists. Each nurse must understand the key system. The keys are kept in a safe and checked 4 times a day. The hospital for convicted prisoners contains 10 beds for observation cases; 10 beds in the general ward and 7 beds for expectant mothers and maternity cases. Babies born in the prison are kept with their mothers in this ward for a month. There are 16 single rooms and a ward containing 3 beds for venereally infected maternity cases. Prisoners who need an operation are sent to outside hospitals. The babies born in the prison receive excellent care. Although the author deplores the necessity for a child starting life in a prison, the babies do thrive and in many cases enable the mother to keep a sane grip on life and start afresh. Mothercraft lectures are given regularly. Two wings in the hospital are devoted to what corresponds to an out-patient department. Three nurses are on duty; one for those who complain of illness, one for venereally infected prisoners and one to accompany the prisoners to court. There are 30 nurses on the staff, two of whom hold the rank of sister. Their living quarters, food, etc., are excellent and correspond to conditions found in any up-to-date hospital. One of the great advantages recently gained for the nurses is that no untrained woman may hold a position in the prison hospital. Every nurse now appointed to the Service must be fully trained—
that is registered with the General Nursing Council for England and Wales, and in addition she must be a trained midwife. It is obvious that the nurse who undertakes prison work must possess certain qualities of mind and character to be successful and she must have an unbounded faith in human nature. Holloway is the headquarters of the Service and a training centre for all nurses. Until a short time ago it was the only prison boasting a nursing staff, but during the last 2 years nurses have been appointed to 5 of the provincial prisons.


This short and enlightening article is in the form of a dialogue between two women; one the mother of the child and her sister who emphatically voices her resentment against the mother for shirking her responsibility by sending her child to school at the age of 4. The mother who because of education, reading and experience has sound reasons for feeling that her child needs companionship and training convinces her sister. The article, though brief, sets forth a sane argument for the nursery school.


The author in introducing her subject emphasizes the necessity for treating the school child as an individual. This need is being recognized more and more by the psychologist, the sociologist and the educator. However, it only is within recent years that the idea of individualization has been applied to the pre-school child. Hitherto little attention has been paid to the child under school age. His physical needs were supplied, but his childish problems and conflicts were either ignored or treated in an unsatisfactory manner. This attitude of indifference has changed to keen scientific interest in the early and formative period of the individual child. In order to get first-hand information regarding phantasy in pre-school children a study was made of 5 young children. With the cooperation of the mothers records were made on a dictograph when the child was in his own familiar environment and unconscious of making a record. In this way common inadequacies of memory, or omissions, insertions, substitutions and transpositions were avoided and an exact account of the child's talk to himself was obtained. The author cites two types of
phantasy, e. g., systematic and casual. The first case illustrates systematic phantasy which involves a flight of ideas organized in a definite story in which a definite goal is attained; the second case illustrates casual phantasy which is dependent more upon the immediate past experience and upon the existing environment than the desires of the child. The discussion of the cases is especially interesting and throws light upon a subject worthy of careful investigation.

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