THE IMPORTANCE OF EDUCATION IN MATERNITY AND CHILD WELFARE*

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Ever since my introduction to the delightful pages of "Horae Subsecivae" and especially to the "Plain Words on Health" addressed by the author, Dr. John Brown, to working people, I have been deeply impressed by the possibilities of such a method of educating the people as to their own health. In the course of these few talks, and by the use of plain, simple, homely language, he discusses with his folks "The Doctor"—"Our Duties to Him" and "His Duties to You," "Children and How to Guide Them," and "Medical Odds and Ends," and succeeds in a few pages in giving a very comprehensive survey of the work now undertaken by Child Welfare Workers. In fact John Brown was an ideal instructor in Child Welfare.

When, after twenty years' experience of general practice, I decided to accept the post of maternity and child welfare medical officer in Aberdeen, I was fortunate in finding a chief in Dr. Matthew Hay whose views on the value of education in this work coincided with my own, and if I have succeeded in expanding this side of the work, much of the success is due to his enthusiasm, wise guidance, and profound knowledge of the need of the people for education in matters of health. He, along with Sir Leslie Mackenzie, made a survey of groups of school children in Scotland for the Royal Commission on Physical Training in Scotland in the early years of the present century, and the report they presented made a deep impression on the commissioners and on the thinking public. It showed that a large proportion of the children attending school were suffering from physical defects of various kinds—teeth, eyes, ears, tonsils, posture, malnutrition, etc., and that there were many unrecognized cases of

phthisis and heart disease. It was a short step forward for the fact to be recognized that many, perhaps most, of these defects were preventable, and school medical inspection has amply verified their findings. It was not difficult to persuade public opinion that attention must be given to the pre-school child and at an age when the defects above referred to could be prevented.

The subject of infant mortality was at the same time being discussed by thinking people—medical and lay. An infant mortality rate of 150 per 1000 births was considered to be excessive, and when the causes of death of these infants were investigated, it was again found that much of this huge death rate was also preventable. The conclusion was further come to that for every death that occurred during the first year, another child or two arrived at their first birthday impaired in some way for the struggle before it. Again when the periods at which such deaths occurred were investigated, it was found that one-quarter took place in the first month, one-fifth to one-sixth in the first week, and a large number on the day of birth. This knowledge led to the necessity for the health of the parents being investigated, and to the need for ante-natal care of the mother, a subject taken up with enthusiasm by the late Dr. Ballantyne of Edinburgh who had the honour of getting founded the first ante-natal bed in Britain in 1901. This subject was closely connected with maternal mortality to which I shall refer.

Accordingly power was given to local authorities by the Notification of Births Extension Act of 1915, the Midwives Act of 1915, and the Child Welfare Act (England) 1918, to formulate and carry out schemes for maternity and child welfare. I have included the Midwives Act as it was at once recognized that safer and more efficient midwifery would lead to the saving of the lives of children, and it was hoped, a hope not yet realized to the extent looked for, that this also would lead to a diminution in maternal deaths, the number of which is still the reproach of our country and of our profession.

The three causes leading to Maternity and Child Welfare then were:

(1) Finding of Defects in School Children which might be prevented in the pre-school stage.
(2) High Infant Mortality.
(3) Maternal Mortality.

These were the facts. How were they to be remedied? In the study of the causes of infant mortality it was found that apart from
a disabled entry into the world from injury or disease at birth, the
knowledge of the average mother in regard to the proper feeding and
care of her child was sadly lacking. Surely here was a field for
education, and not only of the parent—mother and father—but of
the doctor, nurse (including health visitor), teacher, social worker,
domestic nurse, in fact everyone connected with or interested in a
baby. And who is not?

Let us remember at the outset that we are primarily Medical Offi­
cers of Health, and are concerned with disease only insofar as we
can prevent it or be able to detect it at the earliest possible stage.

During the last twenty-five years the cult of health has spread
rapidly. If you wish to while away an hour or two on your return
journey from this conference I suggest to you to get “Healthful Liv­
ing, the Why and How” by S. E. Bilik, M.D. (Charles Scribner's
Sons, New York).

In his introduction he says, “Let us give credit where credit is
due. It is the mob of health faddists—cultists—quacks who have
with their zest and fire swept humanity along at a whirlwind pace
to better health. It is they who carried through the most beneficial
revolution of all time, the health revolution. At first we laughed at
them, then listened to them, then flocked to them, and today we are
the better for it. Honor the rascals!

“Slowly but surely the old Greek ideals of physical perfection
began to replace the indifference to the state of our bodily health
which has characterized the attitude of the civilized world since the
days of mediaevalism. Today the world is health mad! Laymen,
ministers of the gospel, educators, physical directors, physicians and
wise politicians, vie with each other in spreading the tenets of vigor­
ous health and freedom from disease. Books on hygiene and allied
subjects are flooding the market (right, this is just another one).
Apollos and Venuses are a drug on the market.”

And how much better that such is the case, as we can see at any
bathing beach on a July day.

Here let me refer to the late Sir James Mackenzie’s criticism, a
criticism not so true now as in his day of the obstetricians, of the
giants of Harley Street, because of their lack of experience of general
practice. “Not one of them had stood, as he had stood, by the death­
bed of a young wife, newly dead with her unborn babe in her womb,
and realized with awful searching of heart, that the power to foresee
the danger which had overwhelmed her was not in his possession.”
Such was my own experience no later than Saturday last. Not one of them had felt the need of the power to foresee, as every family doctor experiences it on every day of his working life. He said "I have no quarrel with Harley Street, except that it is Harley Street. It is concerned so much with those that are stricken to death, so little with those who have just begun to be ill, that, as a rule there is nothing to foresee. Thus the vital and tremendous importance of the power to foresee is overlooked." Do we realize to the full our responsibility in maintaining health?

"Health and strength is above all gold, and a whole body above infinite treasures!"

It will be generally accepted that every medical practitioner who is imbued with the value of preventive medicine, is constantly engaged in teaching and educating his patients at every consultation, whether privately or in a clinic. Not all practitioners, however, are convinced of the value of preventive medicine, and such must themselves be taught. In the recent report on the "Encroachments on Private Practice" by the British Medical Association, it was pointed out that much of the work done at clinics was new work (of a preventive nature) which had never been attempted before—in other words, this educational work to which I am calling attention, and which would require from the private practitioner if he wished to undertake it, special study and experience.

Now I wish to submit that while individual teaching is being done to a certain extent, (and none more valuable than that given by the health visitor in her home visitation), much can be accomplished by class teaching or teaching en masse. So convinced am I of the value of this method of educating the mothers who attend our clinics, that I venture to give you my own experience in attempting it.

For the successful carrying out of this work certain requisites are necessary.

A. Accommodation.

(1) A room sufficiently large to hold say 60 mothers—my numbers vary from 30 to 80. The mothers are invited to the centres by the health visitors who call on each mother on the tenth day after confinement. Each mother, unless she is expectant, has her baby on her knee, and if the talk is interesting, the mother keeps that baby quiet.

(2) A room to hold toddlers of the mothers, and in this room a Provident Stall can be laid out. The ordinary working class mother can only attend such a meeting if she is allowed to
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bring with her all her children under five, and she may have two or three even besides her baby. At first we allowed her to have all her children in the room with her, but the result of this was pandemonium. So now we allow no toddlers in the Lecture Room with the mother, but have these in a separate room. These rooms can be used later at the clinic as consulting room, room for waiting, undressing and weighing.

B. Staff.

A considerable number of voluntary workers plus one or two official health visitors. I am fortunate in having at each centre a Committee of Voluntary Workers who are allocated certain duties, and who attend regularly at a centre meeting. The mothers get a cup of tea on assembly to the accompaniment of music (piano or concertina) as this seems to put the babies in good humour. Three or four workers remain in the Lecture Room during the talk, and should a baby prove troublesome, nurse it or remove it till it settles down. Also three or four on duty in Toddlers' Room to amuse toddlers with toys, music, games, dances, etc. If workers of the right type are available for toddlers they can be taught a good deal about behaviour, nasal hygiene, breathing exercises, W. C. drill, etc. These may be senior school girls from a neighboring school, and they can pass on the knowledge in games. Towards the end of the session the toddlers entertain the mothers by a programme carried out by themselves.

C. Equipment.

Blackboard, Diagrams, Photographs, Models, Pamphlets, etc. Stove for Cooking Demonstrations.

Our centres meet weekly from September to June, and I give two medical talks or demonstrations per month. Once a month a cooking demonstration is given by a trained cookery teacher—plain, wholesome dishes being shown along with sick-room cookery, making of whey, peptonized milk, albumen water, etc., talks on food values, etc. The other meeting or meetings in the month are taken by the voluntary workers for demonstrations on clothing, dressmaking, cutting-out, talks on housekeeping, marketing, etc.

Time of lecture or talk—this should not exceed 30 minutes, and 20 minutes is preferable.

Many subjects for talks have been given in recent years in the Maternity and Child Welfare Journal and in National Health, now Mother and Child, all of which have been good. The talks must be simple and be illustrated whenever possible by diagrams, models or;
actual demonstration. I have gradually evolved a list of subjects to cover the needs of a young mother, so that if she attends regularly for one year she has obtained a good working knowledge of how to care for herself and her children. One may begin with (1) ante-natal care—the need for such and the chief precautions a pregnant woman ought to take. As has been pointed out by Dr. Morrison, Cumberland, in a recent report, maternity mortality shows no such improvement as the fall in infant mortality “because unfortunately most women believe that they must inevitably suffer illness, pain and discomfort during pregnancy and child-bearing, and they still consider it rather ridiculous to consult a doctor until they are absolutely compelled to do so.” We must change this attitude by education.

It is difficult to get women, pregnant for the first time, to attend such a talk, but the older mothers can be appealed to to bring their young friends with them, or such a talk can be given at a separate ante-natal clinic.

(2) A demonstration on how to lay out a room and bed for confinement with the minimum equipment for a poor house. This gives an opportunity for emphasizing the need of cleanliness in the home. Show a cheap sterilized outfit like that of Messrs. T. J. Smith & Nephew, 5, Neptune Street, Hull.

(3) Bathing the Baby and the Special Care of the Premature Baby. The care of the eyes and prevention of Ophthalmia Neonatorum.

(4) and (5) The importance of breast feeding—can all mothers breast feed—the technique of feeding—regular times of feeding—length of time of feeding, and the usual reasons for failure. Artificial feeding will require three short talks the last being

(6), (7) and (8) devoted to proprietary foods.

(9) The Feeding and Care of the Toddler.

(10) The Story of the Teeth and the Prevention of Rickets.

(11) The Care of the Nose, Throat and Ears.

(12) The Spray-born Infections of the Respiratory Tract. (Germs require warmth, darkness and moisture. Show diagram of nasal cavities.)

(13) Infections of the Intestinal Tract and need for absolute cleanliness in the hygiene of the bowel and urinary tract.

(14) Formation of habits and the psychology of the child.

(15) The Home and how to keep it. (Damp dusting—burn
The health visitors should teach slum mothers removed to new houses how to run these houses.

(16) Emergencies—fits, burns and scalds, etc.
(17) Minor ailments—constipation, diarrhoea, etc.
(18) The skin—its functions and common affections.
(19) The prevention of postural deformities. Teach the mother to be observant and watch for these, especially when the child is stripped.
(20) Vaccination and Immunization. Show photo of smallpox.

As I have mentioned these may be added to or varied to suit lecturer and audience.

When an epidemic threatens, e.g. measles, whooping-cough, broncho pneumonia, influenza, etc., an opportunity can be taken to mention the early symptoms, precautions to be taken and chief dangers, e.g. letting patient up and out too soon. Impress the necessity to call the doctor early.

As the voluntary workers move about among the mothers they get to know the mothers and get their confidence, and so can help the official workers as they see things from a slightly different angle. To keep up the interest and knowledge of the voluntary workers I meet them once a month and discuss plans with them, keep them informed of any advances in the subject of mothercraft and infant care and occasionally get experts in special subjects to talk to them.

Owing to increase of members at the ordinary centre meetings, we had recently to limit the attendance to expectant mothers and mothers with children under one year. The mothers of children from over one year to five years may come to the clinic with these children for advice, and to keep up their interest and instruction we have instituted evening meetings at which the mothers only are present. This is mother’s night out, and father is expected to stay at home and look after the children. At these evening meetings a little more detailed instruction can be given, and I have the assistance of two experienced general practitioners to give a monthly lecture. Opportunity for asking questions is given, and some useful interchange of opinion is obtained, e.g. how to spend the weekly wage.

Fathers’ meetings will be found equally interesting and popular, and during the past session we tried an open meeting where fathers and mothers could attend together provided arrangements could be made for looking after the children at home.

I find that all women’s organizations are glad to have a talk on
Mother and Child Welfare, and there is no difficulty in reaching a much wider public than can be got at a centre meeting. Women's Co-operative Guilds and Church Mothers' Meetings provide a splendid opportunity for getting at the granny and aunty where after thanking these estimable ladies for their help in looking after the children—often a thankless job—one can proceed to criticize the early dose of castor oil, thought to be essential to cleanse the bairn, and the too early use of starch in the form of a biscuit or porridge. In the country there are various women's organizations. In Scotland we have the Women's Rural Institute whose sympathy and help I propose to secure, and here lies a good opportunity for getting the rural general practitioner interested. For such meetings I find lantern lectures and the distribution of pamphlets very popular, and now moving pictures can be reproduced cheaply. I am trying to get pictures made of our various activities, and hope to show these on the screen.

At convalescent homes for mothers and babies opportunities for teaching the mother can be found, e.g. in the actual bathing and feeding of the baby, under trained supervision. Test feeds may be carried out. It is good for the matrons and sisters at these homes to be asked to teach the mothers and the young nurses under their charge. So at Day Nurseries valuable instruction can be given to toddlers.

I find it useful too to invite bodies of senior school girls, girl guides, training centre students, students at the Schools of Domestic Science, to visit our centres and baby homes, and see the work going on and listen to any instruction that may be given.

In our hospitals where nurses are trained, I get an opportunity of giving one or two lectures on infant care and feeding which seem to be much appreciated, and of course it is part of our duty to keep our midwives up to date by refresher courses of instruction.

Much of the instruction I have referred to can be given by health visitors, and I am of opinion that where such a system is in force nothing but good can result. Some health visitors are more gifted than others in this type of work. All the same I rather stress the opinion that the medical officers, and the more experience these have the better, should themselves undertake this work. I find that nothing helps me more to get facts fixed in my own mind and to be able to present a subject in a simple lucid manner than to teach a class of mothers or students.

One can test one's success by giving a few questions to the mothers and asking them to bring answers at the next meeting. In
this way I began to prepare for the Rhondda Shield Competitions and found the method quite satisfactory.

I am fortunate also in being stationed in a university town with a medical school, and as extra-mural lecturer on maternity and child welfare I get an opportunity of arousing the interest of the senior medical student in preventive medicine and the feeding of children, an opportunity I value very highly. I find that there is room for a short course of lectures on this subject to these students, and although the course is optional, some 50 per cent. of the students attend, and I have had welcome evidence from past students that such instruction is of considerable value. In post-graduate courses of instruction there is a niche to be found for our subject, and the practitioner of a few years' standing is only too glad to take advantage of the newer knowledge which we are able to pass on, and for the lack of which he has often found himself in difficulty, just as we ourselves derive so much benefit and have our enthusiasm kept up by attendance at a post-graduate course such as we have at present. So we can pass on the knowledge we receive.

Ours then is a great opportunity! Let us take full advantage of it. There is much to be accomplished by patient and careful research into the early phases of disease and disability, and the more people we can interest in this subject the sooner will our ignorance be dispelled. Let it be our effort to stimulate and maintain enthusiasm in all interested in this great work!

I shall be glad if I have interested you in the almost illimitable scope of education in maternity and child welfare.
A large part of the fight waged against cancer in the last three years in Massachusetts has been assumed by the Massachusetts Department of Public Health through its Cancer Section in its statewide cancer program. The principal motive behind this has been to offer to every resident of Massachusetts regardless of sex, color or financial status, the possibility of early diagnosis and treatment of cancer by a recognized specialist. A second motive is to make some definite contribution to the present knowledge of cancer.

There are at the present time seventeen state-aided cancer clinics throughout the state including the one at Pondville Hospital, the state cancer hospital. This hospital is the first of its kind entirely owned and operated at a state's expense.

The entire program is worked out very carefully at local medical, nursing and lay groups, in order to secure the fullest cooperation possible. In the smaller communities local doctors manage the clinic and in some of the clinics at least once a month one of the cancer specialists visits as consulting physician.

An extensive scheme has been worked out to allow for research studies on the basis of the cases coming to these clinics. For every patient seen in any of the clinics a statistical study card is filled out giving pertinent social facts, past medical history as related to the present condition, as well as the existing condition with the recommendations for treatment. Follow-up records of significant medical and social facts are being kept until the patient's death, if possible.

The state cancer clinic for Boston and its vicinity is situated at the Boston Dispensary and has been active in this affiliation since July 1, 1928. It offers to all residents of Massachusetts in this area the opportunity for diagnosis of cancer, irrespective of financial ability. It also offers to local doctors an opportunity for consultation on cases...
and assistance in arranging for treatments. It also gives the Department of Public Health a channel in this vicinity for its educational and research work. This clinic took an active part in the successful three day graduate course in cancer offered through the Department of Health and the Massachusetts Medical Society last spring, and recently held a special clinic conducted by Dr. Bloodgood of Baltimore in connection with the New England Health Institute. It also cooperates by making the statistical study cards (already mentioned) on each patient, and in keeping follow-up records and assisting in special studies. Monthly social statistics and quarterly clinic statistics are also sent to the State Department of Health.

This clinic, unlike the other state cancer clinics, can be described as one of the regular clinics in the out-patient department in which it is located. In other words, the Boston Dispensary clinic comes under the routine supervision of the Boston Dispensary as well as of the state. It offers to the other dispensary clinics opportunity for consultation, diagnosis, and treatment of all ambulatory cancer or suspected cancer patients, since through it, radium, deep X-ray therapy and diathermy on non-operative cases can be secured, and operations arranged in hospitals where Boston Dispensary surgeons have affiliation. The Cancer Clinic has, as do the other dispensary clinics, the use of the Laboratory, the X-ray Department and the rest of the clinics for consultations or treatment for other conditions which may exist in the cancer patients. In brief, every patient in the Cancer Clinic in whom some other condition arises is afforded the opportunity for diagnosis and treatment by a recognized specialist in that field.

The patients who attend the clinic are of all types and classes. More than half are persons who, in an ordinary illness, would manage to afford a private doctor but because of the desire to secure the opinion of a specialist, the chronicity and the great expense involved, they come to the clinic. Some of these patients are charged a fee higher than the usual dispensary fee and proportionate to their financial ability. There are a great many, however, who can only bear a small, if any, part of the expense. Occasionally a patient who is not a resident of Massachusetts is admitted to the clinic for examination and treatment. This is allowed in this particular clinic because the admission policy of the Boston Dispensary does not restrict admission on the grounds of residence in the State of Massachusetts. Other state clinics occasionally admit a non-resident of Massachusetts for examination only.
Chronic illness is known by us all to be the cause of many of the social problems presented in this age. Cancer, few will deny, tends to lead in this. In the first place the attitude of the laity toward this ailment is a big factor. To the average lay person and to some others the term cancer is a word almost taboo. Tumors may be talked of and malignant tumors described but if the term cancer is used the attitude is changed. Immediately an attitude of absolute despair is apt to be created and a tendency arises to avoid a cancer victim for fear of contagion. In most instances the friends or family of a patient so afflicted specifically request that the patient be spared the knowledge of his diagnosis. A few patients have the courage to ask, "Have I cancer?" For these reasons a policy has developed in the clinic to tell the patient's diagnosis to their closest relative and not to the patient, unless definitely requested. This creates a problem in the management of the Cancer Clinic basically different from that of clinics for other diseases. It seems somewhat similar to the problem arising in the early tuberculosis clinics when that disease, commonly called consumption, was not yet controlled by medicine and was the dread and horror of the laity. The social worker's largest task is to cope with this problem of attitudes. To do it successfully requires considerable tact and persistence in establishing the patient's confidence in the clinic, in reiterating such things as the necessity for following advice or in repeatedly and continuously inculcating hope in place of despair in relatives as well as in patients. In brief, this demands a tactful, judicious, yet sympathetic dealing with the patient and his family. Some persons, no doubt, will question whether one is justified in conducting a clinic in this way but after observing what cooperation and trust practically every patient in the clinic has shown, and what a friendly, far from gloomy atmosphere prevails, from all points of view it is felt the best results are thus produced.

In this clinic other social situations which arise seem to present themselves in a very natural easy manner, generally through the close relationship of the social worker and the patient. The problem arises whether a patient can or cannot work. Some patients have to give up work entirely, others temporarily, and a third group have to make special arrangements on their jobs for time to attend clinic, enter hospitals or have treatments. In most instances the patient or someone in his family can handle this; however, whenever necessary the social worker gives assistance.

Hospitalization and convalescence are arranged by the social
worker and efforts made to have fees adjusted according to the patient's financial ability. When a family is in financial distress, the Overseers of the Public Welfare or the Family Welfare Society are made use of, in accordance with the needs.

There has been relatively little placement of children necessitated, and this is undoubtedly because the majority of patients are middle-aged and their children are at least in their teens and can care for themselves or be supervised by older brothers or sisters or relatives. In fact as far as the usual straight social problems handled by a social worker in clinic are concerned the resources available among immediate relatives and friends generally prove most surprising and in the majority of cases are sufficient to meet the situation with a little guidance and encouragement from the clinic worker. One reason for this seems to be the very deep emotional appeal that is made when it is learned that someone near and dear is a victim of cancer.

Always a few patients are single who room in lodging houses and are perfectly independent in every way until illness occurs. Here again it is most gratifying to see how acquaintances oftentimes are true friends in need. The social worker must, of course, give guidance and encouragement, and may find herself to be the pivot of the situation or even the moving force for creating the situation which allows for complete carrying out of the doctor's recommendations.

The following are three illustrative cases which have been cared for through the clinic during the past year or longer.

Case No. 1. Mrs. C., a very frail, 71-year-old person, came under the care of the Cancer Clinic in November, 1927, before there was a state affiliation. At that time she presented a cancer of the cheek and was thought to have a prognosis poor for cure, but good for palliation. The case was carried only as a clinic case and no intensive case work attempted until January, 1928, although free care, including radium, deep X-ray therapy on two occasions, had been given. At first there seemed to be no serious problem as the worker knew the patient to be living with a married sister and her husband, an undertaker with a small business, who could continue to give patient her living expenses but were not able to assume any extra expense such as was necessitated by the expensive treatment recommended.

Patient was married in 1892 and her husband, a meat man, died in 1901. Since his death and until 1925, when patient went to live with her sister, she had served as a cook in private families but had no savings left. In January, 1925, patient was in a local hospital when
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radium was given, and when the time arrived for her discharge, worker learned that the sister had recently had pneumonia and a heart attack. Patient was sent for a few days to a temporary home for women and worker visited the family and the family doctor. It was agreed that since patient could still care for herself and would, therefore, not tax her sister's strength, she should continue to remain with her sister, until such time as special care was needed when other arrangements should be made. Another radium treatment was given in the spring, followed by deep X-ray therapy and observation in clinic. The situation did not change until October when patient's condition became suddenly worse and she was admitted for an oesophagoscopy in the adult ward. This showed definite evidence of thickening into the mouth of the oesophagus, and the necessity for chronic hospital care was obvious, and patient was transferred to the House of the Good Samaritan for chronic care, arrangements being made by the worker.

Problems presented in Case No. 1:

Old age
Childlessness
Family ill health
Financial strain
Convalescence problem
Hospital admission problem
Medical regimen problem.

This case illustrates a typical situation in cancer patients—the ability of relatives or friends to care for patients up until nursing and medical care of the bed-ridden patient is necessary, at which time the patient is then more comfortably cared for in a chronic hospital.

Case No. 2. Mr. G., a middle-aged man, first reported to the Cancer Clinic in November, 1929, and admission to the Adult Ward was recommended for radium treatment to the cancer at the base of his tongue. Investigation showed that patient, a Maine resident, had only recently come to Boston for the express purpose of being seen in the dispensary. He had been treated there many years ago for a minor condition when he was working in Boston. He gave the following social history. He was divorced in 1919; his wife had since remarried and had with her their only child, a daughter. Patient had worked until recently as a lumberjack, making his headquarters in central Maine. Patient had no savings, no relatives or friends to
whom he would turn, especially as he had received help from them
the year before when he had rheumatism.

The patient was admitted to the ward and given free treatment. Upon his discharge, in December, 1929, the Industrial Aid Society agreed to help by giving patient work when possible, and food and lodging during the period of his treatment. In February patient re-entered the ward for further radium treatment and remained until the end of April, a longer time than usual because the patient had a very slow reaction and then had a severe hemorrhage from which he showed little improvement. The patient was not eligible to Pondville Hospital because of its residence requirements, and admission to a local acute hospital could not be arranged for various reasons, one of the greatest being the need for free care. Finally, as the outcome looked quite hopeless, and prolonged hospital care seemed necessary, patient was sent to the State Infirmary, the only hospital available, and the case was discharged to the Infirmary both socially and medically.

Ten months later patient reappeared at clinic, having left the State Infirmary of his own accord and returned to Maine early in the summer. He was greatly improved but anxious for an opinion about the soreness of his jaw. Examination showed no evidence of any recurrence but monthly visits to the clinic were advised. Again the Industrial Aid Society cooperated with the clinic worker in securing work for the patient as night watchman in a small hotel, thus enabling him to continue his monthly visits as advised.

Problems present in Case No. 2:

- Alone in the world
- General resource limitation
- Furnished rooming existence
- Unemployment
- Hospital admission problem
- After care problem.

The main difficulty in this case was to secure expert free medical care for a man from another state, which had no provision for the care needed, when private care in Massachusetts was not available to the patient because of his residence, and the State Infirmary did not have the necessary materials for treatment.

Case No. 3. Mrs. B., a 61-year-old deaf woman, was first seen in the Cancer Clinic in March, 1929, and observation in the Adult Ward
was advised as no definite diagnosis had been made. Upon inter­
viewing the patient at this and subsequent times (by means of writing
notes, as this proved to be the only sure way of preventing misinter­
pretation by patient), the following social history was secured:

The patient, born in England and one of several children, became
an orphan at an early age. For a time her maternal relatives cared
for her but later turned her over to a government orphanage where
she remained until the government undertook a policy of placing
orphans out among the colonies. Patient, then in early teens, and an
older brother, were sent to Canada. The brother was taken by a
family in Ontario, where he has lived ever since. He is now over 70
years of age and quite illiterate because he was unable to attend
school as a child because of poor eyesight. He has one married
daughter living in a small town fifty or more miles away from him.
The patient was taken by a family in Nova Scotia who were cruel
to her and so she ran away and “knocked about for herself” for
several years. During this time she met a man about twenty years
her senior whom she married. They had one child, a daughter, who
died of influenza in 1918 at the age of 28. Mr. B. worked for many
years for a railroad and had in his early life been in the U. S. Army.
From both of these sources he became eligible to pension, amounting
together to over $100 monthly. According to the patient, her hus­
band was a very difficult person, and was committed as a mental case
to a Soldiers’ Home five years ago; hence her married life was quite
unhappy. Her only real happiness lay in her efforts to be thrifty and
save for the daughter’s future, and care for her pet cat Trixie, now
nineteen years old, and keep her home together. Four years ago
patient moved to her present little six room cottage in a small town
several miles away from Boston. She did this partly to get away
from old familiar surroundings and neighbors towards whom she had
become bitter. She had apparently become very much wrapped up in
herself and was very suspicious of anyone who evinced any interest
in her affairs. She constantly said she had no friends, no one left she
would trust other than a lady older than herself.

The patient absolutely refused to consider hospital observation at
first, but after a lengthy interview, the worker succeeded in securing
patient’s permission to have the local Family Welfare Society worker
call to help in any way possible. Two days later patient returned
ready to enter the ward. She had arranged on her way home the
previous week for a neighbor to care for her house and feed her cat
until her return. The Family Welfare Society worker had not yet been able to locate patient and so her services were not used until later. The patient remained in the ward for six weeks, and during this time a mass at her umbilicus was excised and found to be carcinoma, but no other evidence of the disease could be located. Special effort to keep patient happy by bringing her flowers, books, visiting her, and having other dispensary friends see her, were made as she had only two visitors during the entire time,—one the neighbor's wife and the second the "only true friend" she had.

The neighbor arranged for patient's transportation upon her discharge and the worker called in the Family Welfare Society worker, the local nurse and the worker in the Cancer Clinic in the nearby city, all of whom played a large part in keeping up patient's morale, and cooperating with the original worker in carrying out the doctor's orders for deep X-ray therapy and frequent follow-up visits in clinic. When further observation, because of the presence of a developing rectal mass was advised, in Pondville Hospital, the State Cancer Hospital, only the combined efforts of all the workers brought it about. The Family Welfare Society worker and the local clinic worker arranged for placement of the cat and for supervision of the home, for by this time patient had become extremely distrustful of the neighbor and his wife and would have nothing to do with them. The dispensary worker, to whom patient always turned for the final opinion, apparently because she was the original worker, and the Family Welfare Society worker accompanied patient to the hospital where she made special efforts to interpret the hospital to the patient and vice versa. The word cancer was never used, however, because of patient's frequent pleas that she never wanted a word beginning with "C" mentioned in her presence. Frequent letters from the Boston Dispensary worker and the others who were now interested, were sent patient during her hospitalization, as well as several visits by worker or others who happened to be in the vicinity of the hospital. When a colostomy was advised worker visited patient and at great length talked with her about its advisability even though the doctor felt that little could be accomplished except prolong her life for a time. The patient did not wish it done and so similar friendly supervision was arranged for her at home as previously. This time, however, in view of the possibility of acute obstruction, the medical control was transferred to a local doctor, who, with the Family Welfare Society worker, gradually assumed more and more control.
socially while the Boston Dispensary worker continued essentially as a friendly individual.

The patient had her ups and downs, and a few weeks later was taken seriously ill and her life was despaired of. She was taken to a nearby hospital and much to everyone's surprise, rallied sufficiently to return home. At this time she asked to be told her diagnosis and merely said "I thought so." It was only after this episode that patient would consider having an attendant of any kind. The patient proved harder and harder to please, and as a result there were many changes in housekeepers, partly due to patient's increasing suspiciousness of anyone who showed any interest in her. For a time each of the workers was the subject of criticism for no real reason and the neighbor's wife returned to favor and took over entire charge of the household. However, a visit made shortly before patient's death in February, showed that the only reason she continued in charge was because of patient's increasing weakness and necessity for care. Following the death patient's niece, with whom patient had refused to have anyone communicate directly, was notified, and her husband came on, and with the neighbor who was the executor named in the will, took entire charge of the estate.

Problems presented in Case No. 3:

- Hearing impairment
- Over-sensitiveness
- Stubbornness
- Suspiciousness
- Broken Home
- Alone in the World
- Inadequate Home Life
- Social Life Limitation
- Hospital Admission Problem
- Hospital Relationship Problem
- Home Nursing Problem.

Undoubtedly the most difficult problems in this case were those related to her temperament and attitudes, especially the attitudes caused because of her deafness.

The problems which are the most common ones in social treatment with cancer patients are:

1. Interpretation of the disease and its length of treatment to relatives.
2. Need of instilling in the patient an attitude towards his disease and a philosophy to combat it.

3. Fear of the disease on the part of the patient.

4. Attitude of friends and relatives, and the community in general, towards the disease.

5. Establishment of a long time plan for the patient's care determining at what point it is wise for the patient to give up his usual method of life to secure the comfort and skill of a hospital for terminal care.

6. Expense of X-ray and radium treatments which necessitates a free fund to use in cases unable to pay for these treatments.

7. Need for cooperation with community agencies to establish satisfactory financial status for the family when the patient, who may be the breadwinner, is no longer able to work.

8. Arrangements for patients to secure treatments in clinic regularly:
   a. Transportation difficulties which require a fund for use of taxis.
   b. Clinic time arranged to satisfaction of patient who is still at work.

9. Need for knowledge of existing resources for cancer patients and development of others sufficient to meet the need.

To the social worker such services to the cancer patient are not only challenging from the scientific point of view of good medical-socia! treatment, but are also challenging from the humanitarian point of view. Such patients need more than advice and assistance; they need a prop from whom they will receive sympathy and courage to bear suffering.
COST OF SICKNESS FROM THE STANDPOINT OF THE NURSING PROFESSION*

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Paraphrasing Dr. Olin West's famous message "The one great outstanding problem facing the nursing profession today is that involved in the giving of skilled nursing care to all of the people, rich and poor, at a cost which can be reasonably met by them in their respective stations of life." How this can be done and at the same time nurses receive saving incomes has been the topic for countless discussions and much experimentation during the last decade. You are no doubt all familiar with the Grading Committee which is in the fourth year of its five year program of nation-wide study of nursing. Their reports on supply and demand of nurses, the economic status of the nurse and nursing education conditions are worthy of your careful study. Fortunately, for all concerned, this Grading Committee is supported by physicians and lay people as well as by nurses. We may, therefore, expect exact data and unprejudiced opinions, and we are, I believe, getting just what we expect. Also in the experiments to cut down nursing costs which have been undertaken the cooperation of physicians, patients, nurses and hospital executives have been secured. This all augurs well for the solution of this problem. It is important, I believe, that we rid ourselves of emotional bias and look the facts squarely in the face. I say this because when sickness and its cost is mentioned some one is sure to wax sentimental and begin to rave about some poor soul who was so ill and the doctor sent in a big bill and the nurse charged $6.00 a day and father was out of work and so on and on.

* Read before the Health Section, California Conference of Social Work, Santa Barbara, Cal., May, 1930.
D. D. Urch

In order that we may better understand this attitude and much of the ineffectual wailing and maudlin moaning over the “commercializing” and “over education” of the nurse at the expense of the patient let us look for the reasons. One of the reasons is, I believe, found in the fact that the nursing profession has its roots in the church with its ideals of service—service without pay other than spiritual rewards. Since the time of Phoebe the first Christian visiting nurse who “succored many” to the present time we have had those who nursed for little or nothing. Free hospital care has been given by religious groups and kindly neighbors have contributed their services in homes. Our endowed or tax supported hospitals and visiting nurse associations have carried on the “good” work. Physicians have given their services and thus for centuries the great majority of patients have not had the painful experience of parting with their money to pay for their illnesses. And there are two other influences. No one enjoys illness and most people believe that disease just comes and that they are in nowise to blame for it. So a general attitude toward evading this responsibility has developed.

In 1929 as much money was spent for cigars and cigarettes as for hospital bills, twice as much for movie tickets and four times as much for gasoline for automobiles. A man goes to a hotel and cheerfully pays seven to ten dollars a day for a room and meals with no personal service. The same man will go to a hospital and expect for an equal amount of money as good a room, meals as expensive and these served in bed with the personal services of a nurse, dietitian technician and all the expensive hospital equipment thrown in. To quote Chester Rowell: “There is nothing so expensive as personal individual service. You pay the hotel waiter more in tips for carrying your dinner from the kitchen to your table, than you pay the organized resources of civilization for assembling the materials of that meal from the ends of the earth. You ride in the New York subway for 5 cents. To go to your office in your own car would cost a hundred times as much, besides being slower, and not much more comfortable.

“To illustrate the same thing on a bigger scale, J. Pierpont Morgan has just finished a yacht to cost him $2,500,000. The yacht is of course luxuriously finished but, just as a means of transport, it has the speed of a second-class ship, and half the size of a third-class one. The mere interest on $2,500,000 to say nothing of the much greater cost of upkeeping and depreciation of a yacht would reserve the royal suite on whatever is each year the finest ship on the ocean,
for every voyage, to Europe and back, forever. And it would be more luxurious travel, on better, steadier and faster ships. The most expensive thing there is, is something just for yourself.” It is only fair for us to pause here and remind ourselves that the average bedside nurse is receiving a smaller hourly stipend than the waiter or any one of the workers who built J. P. Morgan’s yacht.

The problem is an attitude toward and habit in relation to paying for illness which is unwholesome and unfair. What is the answer? I think the answer is publicity to bring about a frank facing of these facts with the hope of changing this attitude and bringing about more sense of fair play on the part of patients and their relatives and friends. The facts are: Physicians and nurses have expensive educations which represent long hard work, application to duty and self denial as well as money; and they are expected to pay their personal bills and it takes money to pay bills. Recent studies have shown that the average private duty nurse works 21 days a month. She must pay for room and food for 30 days a month. While the patient is paying $7.50 a day the nurse received only $6.00 of the fee. That gives her only a yearly income of about $1,300 and without vacation or days off with pay. And the average yearly income of physicians in proportion to the expense of their education is about the same.

Furthermore, much of the sickness (the expense of which physicians and nurses are expected to bear) is preventable. Immunization against at least four of the communicable diseases is possible. And a dozen others can be prevented by clean, sane living. Abstinence from intoxicating drinks and other dissipations and careful driving can still further lower the amount of sickness. The $24.00 per annum paid by the average person for sickness could probably be reduced at least one-half if these precautions were universally taken. And if the average person would put one-half the money he spends for cigarettes or radios or automobiles or movie tickets in a good insurance policy he would unquestionably be able to pay for his illness. A fairly large proportion of the cost of illness (30 per cent. estimated) is the hospital bill. This could be lessened if hospitals were more efficiently managed. Practically all hospital executives learn their jobs by the trial and error method and at the expense of the institutions they serve. There is also much waste of time and energy and strain on dispositions because of poor construction and inconvenient arrangement in hospital buildings. Why any one should think that a doctor or a nurse or a business man or a broken-down
minister or a vote-getter should by virtue of being any one of these things (though ever so expert) necessarily be a good hospital executive is beyond my comprehension! Doctoring adroitness and nursing expertness do not necessarily carry executive ability. Yet both doctors and nurses with executive ability make splendid hospital administrators after they have learned the art. But it is poor economics for an institution to allow them to learn it at their (the institution’s) expense. We have schools for preparing physicians, nurses, teachers, engineers, even business men. Why not schools for training hospital executives? And in construction of hospital buildings. All the various workers who know the details of their departments and who work there should be called in conference with the architects. No one person could possibly be expert in all such matters.

Then there is the economic waste in nursing service. With present accounting systems in hospitals it is not possible to tell the exact cost of nursing service. Excepting in the case of special nurses the cost of nursing is grouped with the charge for room, food, food service and upkeep of hospitals. Even the “specials” board bill is a much mooted question. But we do know that the nurse cannot charge less than she is now charging and that the great middle class cannot afford nursing service for themselves as now supplied. At the same time they are taxed to help pay for this same service to the poor. And we also know that while the nurse is working longer hours and at smaller pay than any other worker much of this time is of no value to the patient. The patient’s husband may be paying for 24-hours of nursing service a day while she actually needs only 4 hours. But nursing in hourly packages is furnished in very few hospitals or homes and patients are inclined to want frills and “de luxe” care and the prestige of a special nurse that their neighbors and friends so much admire! And it is nice to have all these little personal attentions. To be “wrapped in the cottonwool of nursing service” as Dr. Burgess expresses it. Then there is the real fear that comes to the patient and her family and drives them to make any sacrifice in order to have a nurse at hand every moment of her illness.

The answer to this problem is a nursing service for both hospital and homes that is flexible enough to meet the actual needs of all the patients in the amounts and at the times and places required. This, of course, calls for engineering on a large and far-sighted basis and the concerted efforts of the best minds in the community. Some real statesmanship is needed. I would like to see a glorified bureau of
nursing service with a board of trustees, including physicians, surgeons, public health officials, hospital executives, business men, public spirited citizens and nurses (including those engaged in institutional, public and private duty work). This bureau would serve a large area, would have a revolving fund and would make up its budget to provide for nursing by the hour or the job in homes and hospitals and for public health agencies. The hourly, visiting and special nurses would be on regular salaries paid by the bureau. Public health organizations and hospitals would pay their regular staff as at present and call on the bureau for extra help when needed. Individual patients in both homes and hospitals could buy nursing service from the bureau by the hour whether it be one or twenty-four per day. Each bureau could survey its community and keep an adequate number of the needed types of nurses. Vacations could be given at quiet periods. The personal touch need not be lost. Does this sound too millennial? As a matter of fact every phase of it is now being successfully done—excepting the central board with the funds. We have visiting nursing and hourly nursing and group nursing and general duty nursing right now. The University of Michigan Hospital, the Ford Hospital and many others have salaried special nurses. The New York, Chicago and San Francisco Visiting Nurses' Associations and many registries provide nursing in the homes. These organizations have been worked out in response to needs and have succeeded because they met the actual needs of the people. There are now larger needs and we must meet them. If the whole community were organized some of the most difficult problems of these groups would be solved. To quote Dr. George E. Vincent, "A time of crisis is just the time when the right sort of people with imagination and will power and self-control and capacity to steady themselves in a situation, are going ahead to do the right thing, the socially loyal thing, the thing that a real analysis of social need calls for.

"Here is a splendid opportunity, it seems to me, to test successfully one of the finest characteristics of our country, namely, the sense of team-play in a community the loyalty to a common enterprise to which people have committed themselves, an enterprise which represents a very genuine, enduring and fundamental need of the community."

What can social workers do? Well, you can understand our problem, help us to work it out by interpreting it and us to the patients and the community.
I see five phases of the problem confronting us. The solution is a challenge which can be met only by good team work on the part of all groups concerned—social workers, physicians, hospital executives, nurses and patients (including prospective patients).

Problem 1. Patients do not like to pay for their illnesses and too frequently try to evade their responsibility for doing so. Yet they willingly pay for cigarettes, cosmetics, radios, automobiles, gasoline and chewing gum and movies.

The Solution. Education of the public to recognize the value of good medical, nursing and hospital care and to be as willing to pay for it as they are to pay for other luxuries. It is no accident that the manufacturer of Turkish cigarettes came to America a penniless immigrant and a few years later died leaving an estate of over $8,000,000.

Problem 2. Illness with its inevitable cost could be greatly lessened if people lived hygienically and availed themselves of preventive measures now known to medical science.

The Solution. More intensive programs in schools and elsewhere to induce people to prevent disease and accident and to value health.

Problem 3. Provision for paying for illness is usually not made. Illness is made an excuse for an orgie of needless expenditure. About one-fifth of the cost is spent on nostrums and quacks.

The Solution. People must learn to budget or insure for illness and to make plans for spending this money wisely and well. They must also learn to pay for all they demand.

Problem 4. Hospitals and hospital equipment are expensive. Because of poor planning and amateur management most hospitals are needlessly costly.

The Solution. Trained hospital executives. Physicians and nurses with ability and taste along this line should take special courses to prepare themselves for this work. Nurses, dietitians and other hospital experts should assist in planning, building, equipping and supplying hospitals.

Problem 5. Nursing service is expert, trained, special individual personal service. Although it is estimated that only 7 per cent. of the total cost of illness is paid to both trained and practical nurses this is unevenly distributed and falls heavily at inopportune times.

The Solution. Organized community projects whereby hourly or visiting nursing in homes and group or hourly nursing in hospitals can be secured, and this on an adequate reasonable (not “de luxe”) basis.
Patients should receive this expert nursing service in accordance with their needs and in amounts that will give them the quickest and surest return to health. And the kind and amount must be determined by an expert who knows—(the physician and not by an hysterical relative).

If you and I and a few others would attack these five problems with sufficient force and noise, the "losing economic battles" now being fought by patients, physicians and nurses would soon be won. Remember that

"He who has goods to sell
And talks down a well
Will not rake in the shining dollars
Like he who mounts a tree and hollars."
THE COST OF MEDICAL CARE FROM THE STANDPOINT OF THE PRIVATE PRACTITIONER*

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This subject, the cost of medical care, is a very large one, with many ramifications and in order to cope with such a subject, we must analyze the various factors that may influence this cost. I have attempted in this paper to present to you the factors that influence this cost from the standpoint of the private practitioner. I have not attempted to give you any solution. The solution at the present time is impossible until there is an adequate survey of all the structure which makes up the medical profession. Every part of this structure is interlacing, and is dependent one upon the other. My paper, therefore, will deal only with that service as rendered by the individual doctor.

Until one hundred years ago man continued to lead a comparatively simple life, as he had done for more or less forty thousand years. The family, or at least the community, was economically independent. Each small group produced all necessary food, clothing, and shelter. Division of labor had but slightly developed. Then came steam and rapid transportation. Factories and mills were built and the modern city sprang into being.

The keynote of this revolution in industry has been specialization, division of labor, and organization.

In medicine, the scientific Renaissance has brought certain changes into being. Smallpox as late as the middle of the Eighteenth Century was rampant, scarcely one in one thousand escaped it. It was the commonest epidemic disease. Now, relatively few persons contract smallpox, and there are means at hand to virtually eliminate it. In 1878 yellow fever cost the city of New Orleans alone ten million

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dollars, and the country at large not less than one hundred million dollars. Now yellow fever has been obliterated. Typhoid fever a few years ago was one of the major communicable diseases; today the annual death rate in the United States is only 6.8 per thousand. Cholera, typhus, and Bubonic plague have been virtually kept out of the United States by the application of modern scientific measures. Measures are now available for bringing malaria and hook worm entirely under control. Through the use of toxin-antitoxin and diphtheria antitoxin, it should be possible for the children of the future to escape entirely this most dreaded of all diseases of childhood. No longer need gonnorheal ophthalmia blind the eyes of helpless babies. Finally work and research on many of our scourging diseases yields a promise that we will add many more to our list.

However horrible and destructive science may have made modern warfare, however threatening may be the political, social, and economic mal-adjustments caused by the development of science since the beginning of the industrial revolution, there can be little question that the story of the conquest of disease during the remarkably short period which has elapsed since Pasteur lived will become one of the brightest single chapters in the history of the human race.

Since the Renaissance the field of medicine has become more highly differentiated than in any other period of history. In a few short years, the relatively ignorant physician and barber surgeon have been superseded in a large measure by the well-trained general practitioner and specialist, the pharmacist, dentist, oral hygienist, hospital superintendent, clinic director, registered nurse, medical social worker, psychologist, dietitian, administrator in public health work, epidemiologist, sanitary engineer, statistician, sanitary inspector, public health laboratory specialist, expert in public health education, chemist, bacteriologist, protozologist, pharmacologist, and other specialists in research. Furthermore, for the satisfactory diagnosis and treatment of many cases either the general practitioner, or the specialist to whom he refers his patients, must use in addition to the clinical thermometer and stethoscope a considerable amount of scientific equipment. This consists of various speculae, ophthalmoscope, laryngoscope, spectroscope, cystoscope, bronchoscope, stomach tube, cardiograph, X-ray, metabolor, radium and numerous surgical instruments. There must be facilities for the examination of urine, stools, stomach contents, and tests for the diagnosis of syphilis, gonnorrhea, malaria, typhoid and tuberculosis. Pathological examination must
also be made for the detection of such diseases as cancer. For most of these instruments and procedures specially trained persons are necessary. Finally, a complete scientific library must be readily accessible.

The growth of medicine during these last years has resulted in a marked increase in the number of persons engaged in it, until now, in the United States alone, there are over one million persons employed on a whole-time basis who are administering in one way or another to the care of the sick and the promotion of health. In general, these one million or more persons may be divided into two groups, those engaged in the private practice of medicine, the leaders of whom are of course physicians, and, secondly, those giving their whole time to public health work.

Among the thousands of physicians, dentists, nurses, and other persons in the field of private practice a high degree of specialization is to be found. Yet, private medicine, generally speaking, is not organized. In a few instances, it is true, specialists have established groups, and many physicians do much of their practice in hospitals where efficient organization may be observed; but most specialists, when necessary, refer patients to other specialists without being organized, and a major proportion of practitioners maintain no organic connection with hospitals. Medical service, in the majority of instances, is rendered by an individual physician to an individual patient.

Individualistic medical service is scattered service. In one office building is a general practitioner, on the floor below a dermatologist. Across the street an ophthalmologist. Elsewhere a laboratory for a blood test, and in still a different part of the city a laboratory for X-ray diagnosis. Patients may, through their own initiative, seek out specialists who are not needed by them at all, or who are in a position to fit only a part of their medical needs, and then often the least important part. General practitioners and specialists may fail to cooperate, and specialists are liable to lose adaptability and become opinionated and self-sufficient, with the result that an important case may frequently be diagnosed or treated from the point of view of narrow specialization. Under such conditions, a patient may receive for a single illness not only one bill, but several, the sums of the separate bills being frequently more than the patient can afford; and, what is more important, neither diagnosis nor treatment may be based upon a well-balanced consideration of all the facts in the case.
Private medicine may be fundamentally and theoretically individualistic, but in its actual development during the past fifty years certain accretions have developed in which a high degree of organization is to be observed. These agencies have grown up without relation to any comprehensive plan. Most of them have developed rapidly; some have come obstrusively; a few are vigorously condemned. The hospital, the clinic, the drug store, and the private diagnostic laboratory are the chief of these accretions. They are not organic parts of a system, as a single public school is a part of an educational system, but, these institutions are accepted as necessary in the modern practice of medicine. In addition, there are other agencies, such as industrial health departments, clinics, and various commercialized institutions.

Trained physicians in the private practice of medicine, in conjunction with health departments, hospitals and clinics, have utilized to a considerable degree the remarkable discoveries of the last half of the Twentieth Century. Yet, diseases and defects persist whose prevention or correction science has, in a large measure, made possible. The economic cost of disease involves figures quite beyond comprehension. The cost of disabling disease is over two billion dollars annually. Approximately seven hundred million dollars is spent each year for drugs alone. Decreased efficiency, due to disease, costs industry about two billion dollars annually. The total capital value of the lives now needlessly lost each year because of disease is over six billion dollars. Death cannot be prevented, but it can be postponed. Disease not only causes pain and disability, but poverty as well. Here a vicious circle may be created, the poverty causes disease also and physical and mental defects may cause delinquency and crime. There is a close relationship between them all.

Scientific preventive medicine is far in advance of public support. If the general public were to take advantage of scientific medicine and public health that are available at the present time the immediate advancement of our civilization would be so extended as to be beyond comprehension of the average individual.

That we are living in times of rapid change is frequently observed. Man is bewildered in his effort to adjust himself to this changing situation. Knowledge, material wealth, science, art, business, customs, laws, institutions, forms of government, and all the aspects of culture are changing with confusing rapidity. There is a lag in some forms of culture with the result that there is mal-adjustment. This mal-
adjustment is evidenced today in medicine, because it is fundamentally individualistic. Private medical practice, health department, private agency, hospital and clinic, each is going its own particular way. The persistence of unnecessary sickness is apparently due, at least in some measure, to this mal-adjustment.

There are several clearly defined manifestations of the mal-adjustment in medicine which have been pointed out from time to time by members of the medical profession, by sanatoriums, and by economists:

(1) The inadequacy of personnel and financial support of official health agencies. Adequate personnel will probably not become available until higher salaries are paid, and schools of public health attract a considerably larger number of students. The amount of money invested in public health work in 1923, it is estimated, was less than 1/22d of the money spent for tobacco, and about 1/3 of the amount expended for coffins and funerals. Shortage of personnel and curtailed financial support, as observed among local, state, and federal health agencies, are to be regretted, mainly because this inadequacy delays the utilization of existing knowledge, through the use of which several destructive diseases might be prevented. This weakness of official agencies, particularly the insufficiency of funds appropriated to public health service, is serious, also, because it retards the development of research. Here is a field of pressing need. Cancer still baffles the field of science. Infantile paralysis remains a curse of childhood. Pneumonia is still unconquered. Influenza renders medicine impotent. A vast amount of research work is awaiting the attention of science. Medical discovery is to human beings the most important of all discoveries, says Sir Ronald Ross; yet to judge from the attention the public gives to it, it is the least important. Vast amounts of money have been expended in the development of research work, in order that the resources of nature may be more effectively utilized in the production of manufactured articles. Research in medicine lags. There is a dearth of scientific personnel and a discouraging lack of funds.

(2) The shortage and inaccessibility of personnel and equipment in private practice. There are an inadequate number of physicians for the country, or better still there is a general shortage of personnel and equipment, which is not advantageously distributed. We must admit that for the prevention or postponement of heart and kidney diseases, tuberculosis, malaria, diphtheria, the diseases of infancy,
through the systematic use of periodic health examinations and various other measures, that the present number of physicians trained and engaged in this work is sadly inadequate. It appears that there will be an inadequate number of physicians for the future; first, because the medical schools are now graduating fewer men, and, secondly, because the demand for physicians will probably increase. In the meantime, there is the problem of distribution, especially in reference to private physicians for rural communities. A survey of the United States in regard to rural communities brings forth the following facts: (1) A tendency for physicians to abandon rural districts in favor of the cities. (2) Those remaining are of the older generation. (3) Little tendency for recent graduates to seek practice in rural districts.

While in the country there is a definite shortage of physicians, in the cities it is sometimes difficult for the patient to find the sort of doctor he wants. There is no established method by which a stranger may be sure of securing a competent practitioner or a particular kind of specialist. Lack of knowledge regarding the best physicians to select in various types of illness is a distinct defect in our present system of providing medical care.

(3) Inability of people to pay the cost of medical service. The ability of people to pay the cost of medical service depends on whether that service can be rendered by the general practitioner in the home or whether it is necessary to employ specialists who perhaps must use costly equipment. For instance, a man falls sick and calls his family physician. The physician looks him over carefully and quickly diagnoses the case as grippe. He makes the patient comfortable and guards against the development of complications. No costly equipment, no laboratory service, no assistance from specialists is necessary. However, a young man enters the hospital spitting blood. Examinations are practically negative. His larynx is examined. His sinuses and head are examined. His chest is X-rayed. His blood is examined. And finally it is necessary to inject his sputum in a guinea pig before a diagnosis of tuberculosis can be made, and probably have a consultation with several specialized men. Approximately twenty to forty per cent. of all patients under medical treatment are obscure cases and constitute in the main a large class of chronic diseases, which are varied and complicated as to cause and require very careful examinations with the aid of accessory expensive laboratory procedures. Assuming that the services of specialists and
because of his humanitarian work, gives the treatment first and asks the pay afterwards. I will therefore close this paper by reciting to you a little poem:

VERY ILL
Name, oh doctor, name your fee,
Ask—I'll pay whate'er it be—
Skill like yours, I know comes high.
Only do not let me die.
Get me out of this, and I,
Cash will ante instantly.

CONVALESCENT
Cut, oh doctor, cut that fee,
Cut, or not a cent from me,
I am not a millionaire,
But I'll do whatever's square,
Only make a bill that's fair,
And I'll settle presently.

WELL
Book, oh doctor, book your fee.
Charge, I'll pay it futurely,
When the crops all by are laid,
When every other bill is paid,
Or when of death again afraid,
I will pay it—probably.
MEDICAL SOCIAL WORK IN A PUBLIC HEALTH DEPARTMENT*

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Medical social work and public health—the two are seldom thought of as related to each other. Medical social work as an individual function of a public health department is relatively new and is attracting the attention of both social workers and public health officials.

The place of social work in a public health program depends, of course, entirely upon the scope of the particular health program. If a health department limits its services to communicable disease control, health education, and perhaps recording of vital statistics, it can undoubtedly function satisfactorily without the need of a service offering social treatment. If, however, the program includes diagnostic services, such as diagnostic chest clinics, orthopedic clinics, a mental hygiene service, and further includes treatment clinics for the needy sick, then social service as an integral part of the public health organization becomes important, both from the standpoint of service to patients as well as to the administration. To Dr. J. L. Pomeroy, Los Angeles County Health Officer, is due the distinction of being the first public health officer on the western coast to introduce medical social work into a public health program. This was in 1927 in the San Fernando Health Center, a unit of the Los Angeles County Health Department. Since that time, offices have been organized in seven other health centers of the department.

To understand the place of medical social work in the Los Angeles County Health Department, it is necessary to understand that organization. The department is perhaps the largest county health unit in the United States today. It has jurisdiction over a population of approxi-

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mately one million, covering an area of more than three thousand square miles, and including thirty-four incorporated cities that have contracted for its service. The department is divided into eleven districts with a central administrative office in Los Angeles. Each district, through its health center is an administrative unit in itself, in charge of a local district health officer. On the other hand, policies and procedures are defined by the central administrative office, each function of the department being under the supervision of a bureau head. The bureaus, then, represent the department’s functions. They are: first—administration; second—medical and social service; third—maternal and child hygiene; fourth—communicable disease control; fifth—public health nursing; sixth—laboratories; seventh—inspections. The staff of the department numbers 570, of which 484 are full-time employees. The staff of the medical social service division includes nine full-time medical social workers and one part-time medical social worker, functioning in eight health centers, and one full-time psychiatric social worker for the department as a whole.

Seven years ago, Dr. Pomeroy conceived what is now called the Los Angeles County Health Center plan. Through the cooperation of the county supervisors, who appropriated funds for the purpose, a chain of health centers is under way, located in the most logical centers of the county and housing not only the activities of the health department, but also offices of the county charities. Each major center, therefore, represents an official health and welfare unit of the county government. In these newer health and welfare centers, four types of service are offered: public health; treatment clinics; emergency hospitals; outdoor relief of the county charities. The latter function is of course under the charities department.

All public health services are offered the general public. They constitute those usually found in relation to communicable disease control, plus educational and preventive services; including child hygiene conferences, prenatal conferences, nutrition instruction, health habit instruction for children, a summer health school program, oral hygiene, continuous supervision of pre-tuberculous children found through examinations of grade school and high school grades, as well as certain diagnostic services including chest clinics, orthopedic clinics and mental hygiene and metabolic service.

The director of the Maternal and Child Hygiene Bureau reports 80 child hygiene conferences in fifty locations; 12 prenatal conferences in eleven locations; 10 health habit conferences. Oral hy-
giene is conducted in 213 county schools. Oral hygiene is carried out not only by individual instruction, but through class room instruction and annual poster and essay contests and Tooth Templar Clubs. Time prohibits a detailed explanation of the other bureaus. Emphasis on the educational and preventive program is made here since it shows the wealth of resources within the department itself and demonstrates the opportunity to correlate this program with the work of the treatment clinics.

Introducing treatment clinics into a public health program is, of course, a departure from the usual in public health. The new policy came with the realization that people in outlying county territory, who could not afford private medical care, were medically neglected, and consequently a problem, not only from the standpoint of personal health, but of public health. Factors contributing to the adoption of this policy were: That the county hospital and other hospitals and clinics in Los Angeles were too inaccessible to the outlying districts; the cost of transportation to Los Angeles was prohibitive to the needy sick; medical care was too inaccessible to wage earners of this social class. Consequently, treatment was often postponed until acute conditions demanded immediate attention.

Our territory is widespread. The nearest major health center is 7 miles from the central office in Los Angeles; the farthest away is 33 miles. One little health center in Lancaster, on the desert, is 57 miles from the nearest major center, in San Fernando, and 80 miles from Los Angeles.

Another factor to be considered is the large socially under-privileged Mexican population, constantly in need of medical and social care. If neglected, these people would unquestionably become a public health problem. Furthermore, because of its climatic conditions, Southern California is an attraction to the chronic sick from all states in the Union. Los Angeles County if faced with a tremendous transient, non-resident population needing medical and social treatment almost immediately upon their arrival. Since as yet no provision has been made by other states or the Federal Government to subsidize California in the care of these unfortunates, when they become dependents on this state, it is considered advisable to employ trained social workers to deal with these cases when they first arrive at county clinics asking for medical care. Poor health is known to be one of the chief contributory causes to dependency. It seems
economically sound to care for these cases before they reach the point of needing material aid.

It should be understood that treatment is limited to families unable to provide for themselves through private medical practice. Eligibility is determined through the Medical Social Service Division and is based on the medical need in relation to the financial and social situation per family instance. The county specifies that service must be limited to the needy sick. Furthermore, the treatment clinics are staffed by volunteer private physicians of the communities.

It may interest you to know some of the results of studies made of families admitted for treatment in three health centers. Of a total of 1,669 families admitted, 62 per cent. were married couples and children; 74 per cent. were receiving either state, county, federal, or private aid at the time of application or had an income under $100 per month, with an average of five people to a family group; 31 per cent. were families known to the County Welfare Department; 19 per cent. had been referred by that department; 36 per cent. were Mexicans. These statistics, while limited in scope, definitely point out the need of providing medical treatment for these socially under-privileged people. The public health department with its already existing overhead for the maintenance of public health in outlying territories, seemed the logical organization to extend its program to meet the need. Obviously when treatment clinics are introduced, there arises a need for social service to supplement the medical care of patients. The doctor is interested not only in immediate medical treatment for his patient, but he wants to know what becomes of the tuberculous mother for whom he recommends sanatorium placement, or her pre-tuberculous children in need of immediate medical care, followed by proper placement when the mother is removed from the home, and then in need of continuous medical supervision; or the cardiac patient who needs an occupational adjustment; or the chronic case not in need of hospitalization, yet requiring better placement than the home from which he comes; or the crippled child who needs vocational training. The doctor further wants assurance that the patient for whom he recommended an expensive brace and whose family cannot afford to buy it, will be cared for; or that glasses, drugs and all the other costly accessories needed for effective medical end-results are procurable. Furthermore, during the course of treatment, obstacles in the home, the school, the industry, making it impossible to carry out the doctor's
recommendations, need adjusting. When supplementary aid is needed, only when all resources within the family have been exhausted should the case be referred to the proper community agency. Social treatment is necessary concurrently with medical care of the patient and family, and is best performed by persons trained and with experience in medical-social case work.

To meet the new need of the county health centers, Dr. Pomeroy introduced medical social service. He wanted service to the administration; service to patients; and a service to the community by coordinating the work of the health centers with other community agencies and relationships. And particularly, was he anxious to demonstrate a public health program where prevention and treatment were so closely coordinated within the same institution as to insure an adequate health service for families who would otherwise be denied it.

While we admit that through insufficient staff, we are not able to carry out functions as fully as desirable, our standard is the following:

1. To limit medical treatment to the socially under-privileged.
2. To prepare for the consideration of the clinician, facts regarding the patient's personality and environment, for his use in diagnosis and treatment.
3. To supplement medical treatment with social treatment by adjusting conditions of personality or environment which interfere with successful medical treatment.
4. To arrange for supplementary aid, correlating the work of the county health department with other county departments and community relationships in general in preventing destitution and poverty, based chiefly on poor health.
5. To correlate the institution's preventive and curative services for patient and family, and to serve as liaison between patient and institution.
6. To maintain a follow-up system on patients to assure continuity of medical and social treatment.
7. To train university sociology students expecting to enter the field of medical social work.
8. To collect social statistics and make social studies, bearing on medical-social problems.
The following illustration is given to demonstrate what may be done for a case of tuberculosis in a public health program having medical social service:

Mr. A comes to the health center asking for an examination of his lungs. Following a diagnosis of active tuberculosis in the chest clinic, the physician considers the findings prepared by the medical social worker before making recommendations for placement. He next explains Mr. A’s condition to him and refers the case to the medical social worker. She then has an opportunity to study the patient’s emotional reactions to knowledge of his physical condition and to obtain his viewpoint in relation to future care for himself and his family. (This is of great importance in the care of the tuberculous, if good medical and social end-results are hoped for.) Mr. A is urged to send the rest of his family to the health center for examination and is given definite appointments for them. The same day the nursing service is notified of the case and begins follow-up in the home.

The clinician recommends type of placement for Mr. A only after all contacts have been examined and the economic and social situation of the family studied. If the family circumstances allow for care in private medical practice the case is referred to a private physician. If not, arrangements for care are made on a part-pay or free basis.

In all instances, before placement is effected, the medical social worker makes a home visit to complete the social history, which is bound to be inadequate if limited to an interview with the patient in the health center. Not only does she consider the immediate financial situation, but, housing conditions, the educational, economic and industrial status of the family members, including all previous occupations of the patient, and any special interests and abilities toward which he may be directed in the event that his condition becomes arrested and an occupational adjustment need be made. If the patient is to be institutionalized, she considers the recreational habits of the patient to serve as a guide during his sanatorium care. She further considers the attitude of the patient toward sanatorium care and the attitude of the family toward his condition. The purpose of the home visit is to study the family situation and make use of all possible resources within the group or the community in effecting necessary adjustments, to enable the patient to take his cure under conditions satisfactory to his peace of mind. It seems futile to just
arrange for placement of a tuberculous patient with no social plan for the family.

In the meantime, while the patient is institutionalized, the public health nurse follows up in the home periodically; the contacts of the family are kept under constant medical and nursing supervision, while nurse and social worker have an opportunity to prepare the home for the return of the patient. There is very close cooperation between the nursing service and medical social workers in planning for the family. This is accomplished by frequent conferences as well as reports on medical charts.

In the Los Angeles County Health Department, negative contacts, under fifteen years of age, are placed under the supervision of the Maternal and Child Hygiene Bureau, rather than chest service, but the initial examination of the contact child is always under chest service.

The program for the family is preventive, as well as curative, and includes medical care, as well as social care. The contacts are examined periodically in the health center, either by the chest service or the Bureau of Maternal and Child Hygiene, and followed up in the home by the public health nursing service. This program should be conducive to prevention of physical breakdown among other members of the family.

It is interesting how often the physician changes his treatment plan after he has considered the social picture of the family as a whole. His original plan may have been to institutionalize Mr. A. Following examination of the family members, he finds other cases of active tuberculosis among them. From the standpoint of prevention for the family group, what would be the use of removing Mr. A from the home and possibly taking up a bed in a county sanatorium in the presence of other foci of infection in the home? At times, it is far more sensible to establish as far as possible a sanatorium régime in the home, rather than institutionalize several active cases in the family. In other words, the home conditions have direct bearing on medical treatment.

While an instance of tuberculosis control only is given here, medical social case work is applicable to all medical conditions having a social aspect.

Were we asked what end-results might be expected through the introduction of medical social work into a county public health unit, we might include:
1. Better medical end-results because of the coördination of treatment with preventive services, and social treatment with medical care.
2. Service to the administration through certain duties best performed under the supervision of socially trained personnel.
3. Better coördination of health department activities with those of other agencies and community relationships in general.
THE MEDICAL SOCIAL WORKER'S APPROACH TO THE COST OF SICKNESS*

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The social worker in a public medical agency sees problems caused by the cost of sickness from a number of different angles, two of which we shall discuss here—admission of patients (if this is done by a social worker), and medical social case work.

When eligibility is determined by a social worker, she may bring the case work approach to the admission of each patient. This worker is thus in a position to observe outstanding social problems in the lives of individuals whom she interviews.

Among other things, she sees much of the cost of sickness, and the struggle made to meet it. Day after day, as new cases apply for free care she sees such things as these:

(1) The man who could not afford a health examination when he was feeling tired and losing weight, because all of his surplus earnings were going to pay bills incurred at the time the last baby was born. By the time he was sick enough to stop work and go to the clinic, the sanatorium care for his tuberculosis had to be furnished by the County and his family cared for by public funds.

(2) The family who always budgeted for illness, but whose margin was never more than enough to pay for dental care, and minor illnesses. When a major operation was necessary, or when an aged dependent became ill, they had to seek free medical care.

(3) The family who was fortunate enough to escape illness, and who had invested its surplus funds in expensive furni-

* Read before the Health Section, California Conference of Social Work, Santa Barbara, Cal., May, 1930.
ture, a radio, an automobile, and other things which it was buying "on time." So when sickness finally occurred there was no money to pay the doctor.

We have not mentioned the person who is able but unwilling to pay for medical care. This represents another problem, which we shall not include in our discussion.

If we analyze cases like the foregoing, as the admission worker sees them, we discover several significant things:

1. Most of these people did not want "charity," and they could have paid something if the agency could have accepted it.
2. Many of them have thought very little about the occurrence of sickness until it was upon them.
3. If they have planned little for sickness, they have been even less concerned with preventing it.
4. If sickness had been budgeted for, there would have been no relation between the cost of the illness which came to them and the amount they could afford to save for it.

Going from admission worker to medical social case-worker, we find another point at which the social worker meets this problem. It is in connection with one of her important functions—the making of those social adjustments which will enable patients to carry out the doctor's plan of treatment.

When the problem is an economic one, three avenues lie open to the social worker:—free care at the expense of public funds; supplementing what the patient can pay through private funds; or assisting the family to work out a plan for financing the care which is needed. If the case is indigent, the solution by means of public funds is usually an easy matter. If the patient is not indigent, and is not entitled to public funds, the task is more difficult. This is especially true when the best plan seems to be the changing of attitudes of various members of the family concerning their responsibility toward other members, or in the budgeting and spending of the family income.

In any case the medical social worker constantly faces problems connected with the high cost of sickness through her efforts to arrange care recommended by the physician at a cost which patients are able to pay.

Again, we have the patient of moderate means, whose treatment is so expensive that he cannot finance the cost of private care. He
often has to be given free medical care because there is no way in the community for him to have treatment as a part-pay case.

When this person must accept free service, as charity, there is danger that it may dull his desire for self-maintenance. Like the narcotic drug, the free service given as a temporary necessity becomes easier and easier to accept, and the adjusting to acceptance of free medical care may bring a family to the point where it will make little effort to return to independence. Thus the social worker in a medical agency constantly feels the need of community resources which would enable a patient to pay according to his means.

To this point we have discussed the problem from the side of the patient. To complete the picture which the medical social worker sees one must also discuss it from the side of the physician. Going back to fundamental relationships and standards, the social worker is identified as a part of the team with which the physician surrounds himself for accomplishment of his objective—adequate care of the patient. In this relationship (dealing with the social side of medical problems) the social worker observes some things which she feels should be considered and talked about whenever the cost of medical care is discussed. They refer to the physician, and listing them briefly we have:

(1) The large amount of free service given by physicians in hospitals and clinics, for which many of the patients could have paid a small fee.

(2) In their private practice, no fee is collected for a fairly large number of cases which later the social worker sees at the admission desk of the clinic. These represent people who thought they could pay, and who—after paying for hospital and nursing care—could not or would not pay the doctor.

(3) Then there are those who are "charity" patients from the beginning, and whom the physician carries along in his office as free cases.

(4) This same group of physicians is also helping to pay the costs of treating free patients in other ways, through taxes or private subscriptions which support the agencies in which they do their free work.

The contemplation of these things brings to the medical social worker an appreciation of the problem under discussion, from the physician's standpoint.
We have attempted in the foregoing to present a few problems related to the cost of sickness as the medical social worker sees them. In connection with these problems, there are certain ways in which this worker should be able to help. Since her work is definitely linked with that of the physician who treats, and the public health official who prevents sickness, she and her professional group should fit themselves into the program formulated by the medical and public health professions in their attempt to make medical care available to all persons.

Individually, in connection with her case work, she has some definite responsibilities:

1. She is in a position to aid in cutting down the cost of sickness by helping people understand the need of regular health examinations and the treatment of early manifestations of disease. With this she must strive toward an appreciation of health, on the part of well people, and willingness to pay for the maintenance of it. Her teaching must also carry with it the knowledge that diseases in their early stages are less costly and easier to plan for than in their more progressed stages.

2. She is able to aid the patient, who must receive free care, to retain a desire for self maintenance, and to help him work toward this goal.

3. She may assist physicians and medical agencies, both public and private, to measure the patient's capacity for payment, and to help him plan a means for financing his medical care. If the services of a medical social worker in this respect are of value in agencies caring for the poor, they could become equally valuable in the private hospital and to the group of private physicians working there. Such a plan would probably make unnecessary the admission of a certain proportion of private patients to free clinics and hospitals.

In conclusion, it would appear that the medical social worker has many points of contact with the problem of the cost of health and sickness. Likewise it would appear that concurrently with her social work there are certain definite things which she can do to ease some of the burdens connected with costs of sickness, for the patient, the physician, and the community. A medical social worker, as admission agent to both public and private hospitals, is in a position to
make financial adjustments, even when her responsibility is not that of a case worker. It is obvious, however, that her greatest contribution will come when she brings the tools of her profession to assist in studying problems connected with the cost of sickness, which must, in the final analysis, be solved by combined efforts of all those professional groups which enter into the program for prevention and treatment of illness.
HOW SHALL WE PLAN FOR THE CHILDREN OF UNMARRIED MOTHERS IN CORRECTIONAL INSTITUTIONS?*

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Scientific medicine is based upon painstaking studies made by men and women over a long series of years. These studies usually have been confined to very limited projects, the results of which have been recorded and finally out of the great crazy quilt of authentic information an orderly science has been evolved and is still in process of development.

All along the way, in anatomy, in histology, physiology, pathology, therapeutics, surgery, immunology, etc. the record is studded with the names of those who have made their contribution to the understanding of the structure, function, disease and cure of the human body and with those who have found the way to the prevention of disease.

The names of Schick and Dicks, Hamilton, Pasteur, Lister, Noguchi, the Mayos, Wassermann, etc., etc., all represent painstaking research in various fields from which have come practical benefits to human beings.

So now in the field of social work we are bringing together contributions from all fields laying the foundations for the science of social welfare and for the cure and prevention of social disorders, and the names of Adams and Richmond, Lathrop and Carstens, Hart, Kirschway and Van Waters, and scores of others stand for real contributions to the science of social welfare.

This paper presents to you the conclusions reached in regard to one very small unit in the whole problem of illegitimacy, namely, in

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regard to the children of unmarried mothers in correctional institutions.

Almost all studies are undertaken because someone is in pressing need of help in connection with a certain problem. Such was the case in this instance. I found myself in charge of a girls' correctional school to which the courts were sending unmarried mothers with increasing frequency.

It appeared that some of these young mothers never should have been sent to a correctional school; there was no policy in force as to the handling of the infant, either as an individual entity or as an adjunct or appendage to its mother; the social planning for the mother while in the institution was not on a par with the medical care given while in the institution; and the parole program did not seem to meet the needs of mother and child.

We therefore decided to undertake a study of a group of 42 young mothers who had been under our institutional care, but who had been paroled previous to the study. Our institutional group at that time in residence averaged approximately 18 to 20 young mothers and about 18 infants.

Detail of study made by Elisabeth Wyatt, Field Representative, Department of Institutions and Agencies

While the detail of this study was being carried out we invited the cooperation of the Sub-Committee on Women and Girls of the National Committee on Prisons and Prison Labor for the purpose of bringing together in conference a group of men and women who would pool their knowledge and experience in an effort to determine the proper method of handling the social problem presented by the unmarried mother and her child in relation to institutional care.

This Committee brought together a representative body of men and women including executives of public and private correctional institutions; psychologists, psychiatrists, social workers; Federal and State representatives in the social work field; the Chief Executives of various foundations established for the welfare of children; members of Boards of Managers of various institutions, and others. This group, numbering 41 persons, seemed to us to represent very adequately a cross section of intelligent opinion in the field under consideration.

As a result of several conferences and much correspondence,
counter checking of expressed opinions, we arrived at certain conclusions which we have formulated and which have now been submitted to the Hoover Commission on Child Health and Protection for further consideration.

The questions raised in connection with our study were as follows:

Is a correctional institution the proper place to which to send the unmarried mother?

If not, what are the alternatives?

Should the infant be considered as an entity separate from the mother, and if so, is the best interest of the infant of primary or secondary consideration?

If the mother and infant by direction of the Court becomes inmates of a correctional institution, what should be the standards of care provided?

The group of girls who find their way into correctional schools because of illegitimate pregnancy represent but a very small fraction of those who find themselves in this unfortunate social situation. In New Jersey the vital statistics for 1928, which are the last complete figures available, show 1,086 illegitimate births. Eighteen occurred in the State Home for Girls and twenty-one at the Clinton Reformatory for Women. This indicates that but 1.7 per cent of the problem is lodged at the State Home for Girls, or if both institutions are considered the State is responsible for the care of 3.5 per cent of the problem.

The presence of this group, small though it be, in a correctional institution creates the need for a very costly medical and obstetrical service, if it is to be handled properly and in addition a very difficult problem in administration and discipline results.

We believe that the type of girl received from the courts at the State Home for Girls of New Jersey is a fairly representative sample of the types committed in other localities. This institution has no legal authority to refuse certain types for care, and does therefore accept the feeble-minded, pregnant, and venereally infected as well as the normal. I am therefore assuming that our figures are fairly representative considering this lack of limitation of intake.

The picture which we may thus paint of the unmarried mother sent to the correctional school is that she comes from homes that are broken. Only 5, or 11 per cent. came from homes in which both parents were living and conditions were reported good. Seventy-one
and four-tenths per cent. (71.4%) came from homes which were broken and frankly listed as "bad."

Eighty-eight per cent. (88%) came from urban communities; seventy-one and four-tenths per cent. (71.4%) were between 13 and 16 years of age; only fourteen and two-tenths per cent. (14.2%) had reached the 8th grade in school, while eighty-five and seven-tenths per cent. (85.7%) had reached the fifth grade or less before leaving school, some of them being listed in "special class."

The records of psychological findings indicated that nineteen per cent. (19%) were of normal mentality, while fifty-four and sev­enths per cent. (54.7%) were of inferior intelligence or less. This represents a much larger percentage of mental defect than is found in the institutional population at large, which is thirty-three per cent. (33%).

The general health of seventy-one and four-tenths per cent. (71.4%) is recorded as poor to fair, with only twenty-eight per cent. (28%) reported good. This percentage of good health is low as contrasted with the institutional population at large.

Sixty-nine per cent. (69%) are reported as needing vaginal treat­ments and sixteen per cent. (16%) were infected with syphilis.

The charges upon which these girls were committed were frankly sexual (fornication and prostitution) in but six cases or fourteen and two-tenths per cent. (14.2%), and it is a reasonable inference that any adequate social handling of the cases in the community might have averted the pregnancy.

This hasty sketch of the type of human material committed (chiefly because of pregnancy) to state correctional schools must cre­ate the impression that these young pregnant girls do not present promising material out of which to develop intelligent mothers, com­petent to bring up their own offspring.

This fact was recognized by our case conference committee and more than fifty-seven per cent. (57%) of the young mothers were recommended for transfer after delivery to institutions for the feeble­minded, which plan if made effective implies separation from the in­fant. This institutional plan for the mother, however, failed to become effective in sixty-nine per cent. (69%) of the cases because of parental refusal to concur; because of the over-crowding of the institu­tions for the feeble-minded; and because in some instances, the
girls having reached their twenty-first year, the authority of the State Home to carry out the plans made, had lapsed.

As a result, of the total group of 42 cases (representing 48 infants since there were repeaters) we find 9 transferred to other state institutions for permanent care; 8 paroled to working homes, and of these, 7 were accompanied by their infants; 22 returned to their own homes, 19 with their infants; 4 to homes of relatives, 3 of these with their own infants. Of the 33 paroled only 11, or thirty-three per cent. (33%), are recorded as giving evidence of making a successful rehabilitation. This record cannot be accepted as conclusive for the period, since parole is not of sufficient duration.

There were 48 infants involved in this study of 42 girl mothers, some of them having been committed with their infants in arms. Of the 48, 6 infants have died; 6 are in the homes now established by their own mothers through marriage; 21 are with their mothers or other relatives; 13 infants are under supervision of the New Jersey Board of Children's Guardians; 1 was transferred to an institution for the feeble-minded and 1 still remained at the State Home for Girls.

This record is not encouraging as representing an outstandingly successful piece of social work. Is it worse than the work done by private agencies in this field? We do not know, for we have not been able to make a comparative study. Are there any fundamental conclusions to be drawn from the experience of others or from these facts which would serve to guide the courts, social workers and institutions, public and private, in the handling of this particular problem? We believe that there are conclusions to be drawn which are worthy of consideration.

Our conference group attempted to lay aside all preconceived notions, sentimental as well as scientific, in considering the question and this is the result:

First: The child born of an unmarried mother, or of legitimate birth to a woman in a correctional institution, should receive primary consideration in all plans which are made involving the mother and child.

Second: A careful case-work study (physical, social, psychiatric, psychologic) should be made of every pregnant woman or girl who is brought into conflict with the law in order to determine at the earliest possible moment whether she should be permitted to keep
her infant when born; and to determine whether she should be committed to a correctional or mental institution or to another agency.

Third: Suspended sentence, probation, parole should be resorted to wherever possible in all pregnant cases and only in those in which the expectant mother is a serious menace to the community and where there is no other agency to which she can be committed should a pregnant woman or girl be committed to a correctional institution. In all cases in which the mother is 16 years old or under, she should not be committed to a correctional institution but the facilities of public and private case-working agencies should be utilized to care for and plan for both the mother and child.

Fourth: When the court has elected to commit the mother to a correctional institution, the actual birth of the child should be arranged for outside of the correctional institution when possible in order to minimize the social stigma to the infant.

Fifth: In the event that the courts elect to commit pregnant women and girls to a correctional institution, and it is found impossible to make other disposition of the case, it is essential that the institution provide facilities for the pre-natal, delivery and post-natal care as adequate as "Class A" hospitals outside of the institution would provide.

The mother should be given such training as she is able to comprehend before the birth of the child, in order to prepare her to care for him properly and the entire maternity unit régime should be such as to give the infant the best possible chance for life and health.

It is essential that venereal disease in both mother and child be early diagnosed and vigorously treated and the institutional physician should be held responsible for this.

For the sake of both mother and child the mother, insofar as her physical condition will permit, should take part in the institutional life outside of the maternity unit, this especially in connection with work and recreational program.

Sixth: We have already stated that the infant should be our first consideration in our social handling of these cases. Involved with this is the question of separation of the child from its mother and removal from the institution. When is this indicated? When and how shall it be done?

The social case work study must be relied upon to determine when this separation is indicated. At all events before the end of the
first year the infant should have been removed from the institution with this proviso, that if the mother is a suitable guardian for it and her parole will be granted very shortly, the child may be kept with her in the institution for that longer period, but not beyond two years.

If the mother is not a suitable guardian for the child, and particularly if she is to be transferred to an institution for permanent care, then the child should be removed from the institution before it is nine months old in order to facilitate its emotional adjustment to the foster mother or legal relatives.

Incidentally it should be stated that even with the best of intentions and with the most carefully thought out régime the infant brought up in an institutional environment is retarded in his development out of proportion to the child brought up in the family home.

The State Home for Girls in accordance with the policy adopted by the State Board of Control (which is predicated upon the practice of the Juvenile Courts of the state of New Jersey) has accepted the custody of pregnant girls and has set up the necessary obstetrical unit which is equipped in accordance with the best standard hospital practice. The resident Medical Director is in charge of the general medical, surgical, psychiatric and health program of the institution and because of the volume of work entailed has associated with her a visiting woman physician who is our obstetrician and pediatrician; the maternity unit is in charge of a graduate registered nurse and at the time of delivery of any case a second registered nurse from our infirmary staff is in charge of the delivery room.

A comprehensive program of pre-natal and post-natal care is carried on inclusive of the control of venereal disease.

The social planning for the infant, however, had been considered (until eight months ago) in conjunction with the parole planning for the mother, which plan was usually developed several months after the mother had been delivered.

In line with the conclusions of our committee we have set up another procedure which we believe may result in more satisfactory results.

This procedure requires that immediately after the admission of the mother and as soon as all the social data can be assembled, that a determination be made as to whether this girl is of such calibre as to warrant entrusting her child to her for mothering. This fact can be determined with a fair degree of accuracy early in her stay in the institution.
If she is found unsuitable and is to be a permanent custodial case our experience indicates that in the interest of the infant and of herself the separation of the mother and child should be immediate, that is, the mother should not nurse the infant and she should be turned back into the general institutional population at the earliest moment, while the infant continues to be cared for according to the best methods available in the maternity unit.

The commitment of the infant to the custody of the State Board of Guardians at about the ninth month or to the legal guardians (grand-parents usually) if morally, socially and economically able and willing to care for the child, is the next step.

During this interval the infant is subject to observation by the psychologist and as a result we have some intimation as to whether the child himself may at some future date require permanent institutional care.

We recognize that this may in some instances deprive the infants of its mother’s breast milk, but this seems to us to be the lesser of two evils.

Each case, mother and child, is dealt with upon its own merits and when in doubt the preferential consideration is given the newborn child.

The final recommendation of our Committee is that on all parole staffs, whether centrally or institutionally controlled, there should be especially skilled workers to handle the long term supervision of mother and child. Insofar as possible, family case work should be carried on in the home from which the girl has come in order to provide safe and secure support for her if she can be returned to it. Without assurance of this reconstruction of the parental home, no girl should be returned to that environment.

Illegitimate pregnancy in itself is not a crime; rather is it an indictment of the community as a whole which has failed to erect the necessary safeguards about our adolescent children and which has failed to especially protect those who should have been segregated for institutional care.

The residual group, which it appears cannot be handled successfully through local community agencies, is deposited in the state correctional institutions where at very great expense unsatisfactory results are all that can be secured.

The inevitable conclusion is that more emphasis must be placed
upon prevention of these unfortunate social situations and that we
must institutionalize (and where indicated sterilize) those who now
become the unhappy mothers of still more unfortunate offspring.

Form 1
Date
NEW JERSEY
INFANT CLASSIFICATION
MEDICAL AND PSYCHIATRIC
SUMMARY
(Institution) ........................................
Name ..........................................Sex ......Age ......Nat. .......
(MOTHER)
Birth Date ......................At ........................................
Mother's Name ....................Father's Name ........................................
Home Address ......................Home Address ........................................
Charge .................Date Committed.............Date Dischdg. ........
MEDICAL:
Mother
Prenatal care Mother: From ....................To. ....................
Complication, if any ..........................................................
Venereal ..........................................................
Delivery: Duration of Labor ..........(hrs.)
Complications, operations, etc.
Infant
Condition on Delivery:
Feeding: Weight Height
Breast Fed: From ..........To ..........At Birth .......... ........
Bottle Fed: From ..........To ..........This Date .......... ........
Other Feeding (this date):
Is Child Well adjusted to present diet? ........
Physical Defects?

Form 1-a
PSYCHIATRIC OBSERVATIONS AND DIAGNOSIS:
Infant:
Mother: (including record in maternity and attitude toward child):
Describe appearance, actions and physical condition of child:
Present Food Formula and Schedule:
Present Medical Treatment and Schedule:
RECOMMENDATIONS:
Medical:
General Hygiene:
Dietary:
Social (in relation to mother and future placement):

................................. M.D.
Visiting Associate
................................. M.D.
Medical Director
412  Children of Unmarried Mothers

Form 2  
Date:  

INFANT CLASSIFICATION
MOTHER’S INSTITUTIONAL RECORD
SUMMARY

Name ............................................ Sex ................. Age ................ Nat. .......... 
Mother ........................................... Birth Date .......... Age ................ 
Date Committed .................................. Date Delivered .......... 

MOTHER’S:
Attitude with officers and girls: 
Work record in institution: 
Disciplinary record: 
Escapes and returns with dates: 
Paroles and escapes or failures with dates: 
Personality characteristics: 
Recommendations in relation to infant and its placement: 

----------------------------------------------------------------------
Asst. Superintendent

Form 3  
Date:  

NEW JERSEY  
INFANT CLASSIFICATION  
PSYCHOLOGICAL SUMMARY

Name ............................................ Sex ................. Birth Date .......... Age ........ (INFANT) 
Religion (mother’s) ......................... Color ....................... 
Mother’s Name .................................. Birth Date .......... Age .......... 
M.A. ............................................. I.Q. ..................... 
Psychological Diagnosis: 
Father’s Name (if known): 
Psychological Diagnosis (if known): 
Infant: Psychological Observations and Determination: 
Recommendations: 

.........................................................  
Psychologist
The Del Doles were coöperative. Their coöperation was definite—it covered a period of three years and was extended to two case workers of absolutely different temperament, training and technique. Indeed, the case was kept open by the worker’s wish, long after, according to the prescribed limits of the agency work, it should have been closed. In addition to being coöperative, the family were intelligent, that is, they thought in terms of future plans for the family group and for the individual members. And yet nothing could be more tersely or vividly descriptive of the years’ work than the title above—*What Price Failure!*

Mr. Frank Del Dole, the father, was 42, Porto Rican, a train window-washer and cigar maker. Mrs. Grace Del Dole, the mother, was 47, Swedish, had heart disease and syphilis. Elsie, the oldest child, was 20, intelligent and attractive. Joe, the second child, was 18, unremarkable and “spineless.” Belle, the youngest, 16, had an I.Q. of 68, was unstable, and had a serious heart condition. Gertrude, a seemingly healthy and well-adjusted paternal cousin of 20 from Porto Rico, lived with the family for about two years.

In May 1927 the family first became known, when Belle was referred from Heart Clinic for a routine medical investigation. The case was handled as a slight service or Medico-Social Interpretation, while the necessary information was obtained for the Doctors, the family registered and the registrations looked up. The family had been known to three hospitals, the Visiting Nurse and a family agency. The latter had “only helped the Del Doles through an unemployment crisis,” and had no social information to give. One year after the medico-social investigation was opened the worker became interested in Elsie, who wanted training and work in drawing or de-
signing. A good deal of work became necessary, and an intensive case was made.

Mr. Del Doles was a small, dark-skinned man, with tiny feet and liquid black eyes. To his wife he was an accepted institution, no longer feared, fairly manageable and not altogether unpleasant; to his oldest daughter he was becoming more of a loved father and less of a resented authority; to his son he was a feared and hated tyrant; to the youngest daughter, a source of clothes, shelter, "hollering" and fights, to the social workers, first, an unknown quantity who wouldn't let social workers in "his house," and later a voluble Latin, talking enormously in broken English, conscious of his failure with his children in this foreign country, firm in his old-world ideas of parental authority, assuming the support of his sister and niece, and industrious to a fault. The only company that came to the house were Porto Ricans.

Mrs. Del Doles was blonde, big-boned, slow, intelligent, and spoke without accent. Her parents had died when she was very young, and she had had a lonely childhood with an aunt. She was a good housekeeper. Several times she had left her husband, but had returned each time. She was fond of her children, fondest perhaps, of Belle, the youngest, but was not too fond of any of them and could clearly see their faults. Elsie had been given complete sex information by her mother. Mrs. Del Doles had been to several hospitals, clinics and private doctors. She attended fairly regularly, grew tired of the long treatments and no improvement in her condition, stopped, grew better or worse and went somewhere else. There were times when she suffered so from rheumatism that she had to go to bed for days or a week. Mrs. Del Doles never broke an appointment with the worker without first letting the latter know.

The house was in good condition; the neighborhood was excellent—but none of the Del Doles had any friends among the neighbors. The family income was an uncertain quantity—Mr. Del Doles earned $22.50 a week washing train windows, and about $8.00 a week making cigars. Joe received the same wage from the railroad, but in May 1929 his wages stopped. Elsie worked occasionally, never earning more than $12.00 or $13.00 a week. Gertrude had worked since December 1928, contributing nothing to the family income, but sending her mother $5.00 a week, which had previously come out of Mr. Del Dole's earnings. Although Mr. Del Dole had been born a Catholic,
he resented the Church's authority and refused to allow his children to have any connection with Catholicism or any other faith. Mrs. Del Dole had been born a Protestant and she too had drifted away from her church.

In June, 1928, the cardiac social worker, who was in charge of the family, made the case intensive because of the work necessary in connection with Elsie's vocational problem. (It should be noted that the agency, a children's hospital, was prescribed to work only with children under 14 years of age.) Elsie, at that time 18, wanted work and training in drawing or designing. A vocational guidance examination given Elsie, was reported as follows:

"Elsie Del Dole was examined by me in the Psychological Clinic, November 6th, 1928. The mental status of this girl is undoubtedly normal. An Intelligence Quotient on the Stanford Revision of the Binet-Simon tests and her performance on the remaining tests used in the examination are indicative of Normal Mental status.

"The girl seems well adapted for the trade of dressmaking in which she is interested. It is impossible to predict whether she possesses competency necessary for achievement in the field of designing, but inasmuch as experience in dressmaking is a necessary preliminary to designing, the immediate program need not be particularly affected by the girl's desire to establish herself as a designer.

"There are two ways of satisfying Elsie's interest in the vocation of dressmaking and designing. The first is through enrollment in the Vocational School for Girls. The second method is that of placement in a dressmaking establishment in which she can receive practical training in this work. This can be supplemented by evening courses at Biddle's, or the School of Handcraft. In view of the social and economic circumstances the latter seems to be the preferable program.

"In addition to placement for training in dressmaking, considerable effort should be directed toward providing a normal social life for this girl. This requires, of course, close contact with the home and the development of a program involving connection with a Slow Club or Y. W. C. A. Club or similar organizations. I should be very much interested in talking over with you a program of this kind so necessary for promoting proper adjustment on the part of this girl."

An outline of the educational organizations that were approached by Elsie or the social worker, at any time, but were unable to answer the girl's need, is now given. It should be noted and remembered that Elsie's need must be looked at in two ways—in the objective field, her desire for certain training, and, in the subjective field, her requirement for help in introduction and adjustment in the organization into which she must enter.
1. *Public or Grade School.* The school reported to the social worker that Elsie had been "extremely stupid," and that she "repeated many grades." Compare this to the psychological report given above. One wonders how much added sense of insecurity Elsie acquired from her school experience.

2. *High School.* Elsie attended High School for a few days in the fall of 1927. She said she did not like some of the academic requirements, and that she felt inferior socially and in dress to the other girls.

3-10. *Seven schools of drawing and designing* were considered—four had nothing to offer at all, three were used for short periods, but failed to give any definite training, actual adjustment or practical advice. One school reported that "Elsie was especially good in designing, a very careful, neat sewer who was rather slow but did very dependable work." One department of the Board of Education gave her a month's trial and stated that the girl "was quiet, industrious and attentive, but apparently lacked much of the rudiments of drawing." None of these schools had scholarships.

11. *The Scholarship Organisation* in the city was limited to working with boys and girls who were attending public schools.

The possibilities of free training were exhausted. It was necessary to consider, next, a daytime job, which would net enough money for Elsie to pay for evening lessons. The first move to find work was made in December 1928, well before the present unemployment crisis was felt by social agencies. Briefly, the record of employment attempts from that date until March 1929 is as follows:

1. *The Junior Employment Bureau, Board of Education,* had no work in "Elsie's line."


3. *Five department stores* told Elsie they could give her no work, though the advertising department of one of them reported to the Cardiac Worker that Elsie's "designs are remarkable."

4. *Several New York department stores,* approached by the girl, herself, gave nothing.

5. Two commercial artists, *friends* of the worker, could suggest nothing.

6. Two *neighborhood factories* and one large mail order house were written to, but offered no jobs of any sort. The same result was
obtained by writing to a large publishing company. One department clothing store was interviewed but did not employ the girl.

7. Numerous *newspaper advertisements* were answered by Elsie, herself, but with no results.

8. *Personal intervention* by the social worker through a friend was unable to keep for Elsie the Christmas rush work which she had gotten for herself in a large department store.

Unlike the training field, there were, in this work question, several positive situations, although none had the value of permanency. They are presented as follows:

1. *The Painting and Recreation Center.* The personnel worker of this organization, who did some employment work with its members, located a position for Elsie. Unfortunately, this was during one of those short intervals when she was working.

2. Through the *newspapers*, Elsie found herself four different jobs—as a sweater designer, a lamp shade worker, a package wrapper, and assistant to a dressmaker. None paid more than $13.00 a week, and none lasted as long as two months.

3. *The medical social service worker,* Phillistine Hospital. This worker, who had known the Del Doles for four years, gave Elsie a position in the sterilization room. She received $50.00 a month and two meals daily, working from ten in the morning until about seven at night. Elsie stayed at this for four months, and then stopped because of the heat in the operating room, the continued sight of so much blood, and the fact that the evening hour grew later and later, which gave her no time for recreation.

Attempted adjustment in this field—of recreation—gave the most decided evidence of Elsie’s sense of inferiority and inhibitions. She was eager to have many friends of both sexes, but feared to make contacts and rationalized exceedingly. On the other hand, the opportunities offered were not great.

1. *The Camden Settlement.* This recreation group did not seem, to the psychiatric social worker, to meet the needs of Elsie's personality.

2. The *Y. W. C. A.* offered classes, rather than purely recreation groups, and no contact with men. Elsie had associated with girls all her life and was afraid of men, though anxious to have them as
friends. Therefore it was felt that the constructive value in the recreation field lay in giving her association with boys.

3. The Y. W.—Y. M. H. A. In reply to a casual comment of the psychiatric worker's:—"I wish you could join the Y. W. H. A. because there are boys there and I might be able to get you a free membership," Elsie unexpectedly replied:—"I would like to; I always get on well with Jews." In spite of fine and understanding cooperation on the part of the "Y" secretary, and in spite of a meeting planned by the psychiatric social worker, between Elsie and a very attractive neighborhood girl, an active "Y" member, who arranged to take Elsie to that organization for her first contact there, the situation fell through. When Elsie was not working, she did not have the money for clothes, for carefare, she said. When she was working, overtime made her late and tired.

4. A neighborhood Slow Club was advised by the psychologist. The suggestion was temporarily put aside in favor of the "Y." A few weeks after the effort to have Elsie join the "Y" proved futile, the psychiatric worker's contact with the girl was weakened, and when the Slow Club was mentioned to her, she refused to consider it.

5. The Public Library. The neighborhood branch of the public library did not have the books that she wanted, and gave her no supervision or suggestion in those books which were available.

6. Elsie read and enjoyed, however, a few books lent her by the psychiatric social worker. These were The Interpreter's House by Struthers Burt, Tess of the D'Urbervilles by Hardy, The Foolish Virgin by Kathleen Norris and Growth of the Soil by Knute Hamsun. The last named she liked the best.

In contrast to work accomplished in the field of recreation, that done in medical-social work seems less depressing.

1. Elsie did receive a thorough medical examination by a woman physician. This was brought about after three months of interpretation, persuasion and planning on the part of the psychiatric social worker. The findings, except for the eyes, were practically negative.

2. Previous to this complete examination, Elsie had had a consultation with a woman interne, in order to persuade her to stop the vaginal douches which she had begun after reading certain pamphlets issued and sold under the auspices of Dr. Taylor at his moving picture called Married Love. The psychiatric worker thought this treatment inadvisable.
3. Finally, the information, retailed to Elsie through two hospital social service departments, that reading would not cause her to go blind, as some one had told her, allowed her to take up reading again, after she had stopped it for several months.

4. Reports, however, on certain laboratory tests done in another hospital, were requested, but never received by the psychiatric worker.

In the purely medical field the record was clean—a well-done tonsillectomy,* an intelligent medical consultation, thorough medical examination given at a nominal charge in the doctor’s private office, and a satisfactory eye refraction.

As for the work in the psychological field, the report of the vocational guidance examination which has been quoted in full, speaks for itself.

Mental Hygiene, made decided, though definitely insufficient contributions to Elsie’s problem.

1. Sex Instruction, given Elsie by the psychiatric social worker, at the request of the cardiac social worker, and with the Mother’s eager consent, had so far as discoverable, only positive results.

A. It established a definite contact or transference to the psychiatric worker (“I’d rather talk things over with you than with anybody else,” Elsie said) with subsequent unloading and release.

B. Elsie had been correctly told the facts of sex by her mother, but had been given, at the same time, a bitter interpretation of marriage. Married Love, by Dr. Marie Stopes, was lent her. (Mrs. Del Doles also read the book.) Elsie said, “It showed me a lovely side to marriage—a side I never knew existed before.”

C. As a result of this contact the girl told the worker she had been using vaginal douches, “So as to keep clean inside and keep the hormones fresh, and so as to clear up my face” (acme vulgaris). Consequently, the medical consultation referred to previously was arranged.

D. Elsie also confessed to worrying a great deal over a few hours of pain at the beginning of her menstrual period. This fear was relieved at the medical consultation.

Concerning the sex hygiene given Elsie, Mrs. Del Dole said about

* There is no record of this tonsillectomy. It should be noted that other members of the family, whose tonsils had not been removed had rheumatic fever. Two members developed serious heart conditions.
a year later:—"It was fine. She knows and understands everything now."

2. Elsie’s sense of inferiority and insecurity and her over-critical attitude went back to a deep conflict concerning her father. *Some relief, some security and independence* were given her in this regard. In November 1928 she said that her father demanded that the three girls be in the house whenever he was there unless they were at school or at work. During the same interview she said, "I wouldn’t belong to any church, because I might argue with the Minister." Six months later the girl declared that, if she should find a boy friend, and her father would not allow him to come to the house, she would leave home. Another six months and Mrs. Del Dole said of her older daughter, "She is too modern. She does not think children have any obligations toward their parents, because the children did not ask to be born into the world. She told her father that he should not have let her be born because he could not afford to give her more education." At this time, Elsie, however, told the worker, "I love my father. He takes good care of me." By now Mr. Del Dole had given her freedom to go out—influenced probably, by her changed attitude toward him.

What Mental Hygiene, as practiced by the social worker, failed to do, is, however, all too obvious. If Elsie’s attitude toward her father had gained in maturity and changed from one of submission to one of more independence, she was *still in conflict* about him. Battling with this conscious conflict, she was, for the time being at least, nearly as unhappy as when the conflict was carried entirely in her subconscious life. If the girl gained in security and became more capable of taking action about herself, she was still *without friends*, excepting her one girl friend, an Italian, who attended High School, and not yet definitely established in a *healthy recreation pattern* (at her last interview Elsie asked where in the neighborhood she could get lessons in social dancing). And, lastly, the reading of some good books, under the worker’s direction, did not develop any "*good reading*" habit.

It was with a realization of some definite things done, but a much greater sense of helplessness and waste in regard to a normal member of society whose big potentialities for happiness and usefulness were being starved out, that the psychiatric social worker closed that part of the case which concerned Elsie.
Belle presented an entirely different problem. Pragmatically speaking, she offered no constructive potentialities, but tremendous possibilities for destruction, from which the community refused to protect itself. Belle was 16, average height, slim, ugly, but effectively dressed, had chronic endocarditis and mitral regurgitation, following rheumatic fever, in which the tonsils served as portal of entry and an I.Q. of 68. She had syphilis, but a history of negative Wassermanns, except for one positive in 1921. There were rumors of anti-luetic treatment, but no definite record. Belle had had continued hospital contact for over ten years. She was physically unable to hold a full-time job. Belle’s school adjustment was bad. She was in the 5-B grade, a sullen, childish girl. Placement in a O.B., a special class, was recommended. In May 1929 a psychological examination was reported on, and is, in part, as follows:

“The mental status of the girl is not above that of borderline deficiency. Her maladjustment is partly a reflection of the poor judgment characteristic of this mental status.

“Belle is incapable of profiting from further academic instruction in the school. It appears to me that separation from the school and placement in unskilled work might help in promoting adjustment. It is likely that continued and intensive supervision will be necessary to prevent further maladjustment—sexual and otherwise. Even with intensive follow-up the probability of complete adjustment is low.”

The special class placement was not made, no trade training was advisable, or available, no job was ever obtained—except for one two-month period of baby-nursing(!) which Belle got herself, and no recreation-adjustment was even attempted. (Belle had one friend for a while.) An affair of attempted rape was voluntarily participated in by the girl. Mrs. Del Dole told about two spells of murderous rage on Belle’s part. For no reason at all the girl had attacked Elsie with a chair, and again had almost broken through the bathroom door with a coal shovel in an effort to get at Joe. Sex instruction had been given Belle—a useless business in light of all the above information, but given in November, 1928, before any of the events described had taken place. It was, indeed, Belle’s reaction to sex information that caused the psychiatric worker to request a psychological examination. Belle’s philosophy of sex was that you could have intercourse or marriage (it did not matter which) whenever you liked, and, if a baby was forthcoming, put it in an orphanage, and get a job
and a new man or a new husband as often as you liked. After the
first interview, the psychiatric social worker warned Mrs. Del Dole
that she might expect any sort of sex escapade from her younger
daughter. Belle told her mother later that she did not understand
the words the worker had used. As a matter of fact, she had al­
already obtained sex information on the street. "Telling her about sex,"
Mrs. Del Dole informed the worker, "was like water rolling off a
goose's back."

Institutionalization was, of course, considered. The only two ap­
propriate institutions in the eastern part of the state had waiting
lists of over 700 each. The Eastern State Reformatory would hardly
do for a girl of Belle's tempers. The county hospital for insane re­
mained, but Mrs. Del Dole refused to consider any place that was not
in the nature of a training school. She said, "I couldn't put Belle
away now, not until she commits some act which would make her
realize that it was the result of her own behavior that caused her being
put away. If we did it now, she would always hold it against us." Nor
would she consider sterilization.* So the case was closed so far
as Belle was concerned, leaving her economically dependent and non­
producing, a potential prostitute, venereal disease carrier and mother
of illegitimate sickly babies, and a possible murderer.

Joe, the 18-year-old son, possessed in himself neither Elsie's fine
potentialities nor Belle's destructive probabilities. He was just rather
average. The psychiatric social worker's first contact with him was in
July 1929. He had made a complete recovery from an attack of rheu­
matic fever, (there was no cardiac involvement) during which he had
received excellent hospital treatment, including a tonsillectomy. Ar­
rangements were made by the hospital medical worker for a long
period of convalescent care. Joe was head and shoulders taller than
his small father, but reacted like a frightened puppy to the older man.
The boy's insecurity and lack of aggressiveness were extreme. When
asked if there was anything he particularly wanted, he answered
slowly, (1) that he wished his father would keep the house neat
and not leave his tobacco all over it, (2) that he would like to bring
some of his girl friends to the house for a little party, and (3) that
he had wanted to attend Sunday school when he was younger,
but that his father raised such a fuss he was afraid to, and now
that he could go, none of his boy friends would and he did not want

*Extra-institutional sterilization is illegal in the State of Pennsylvania.
to go alone. Joe had his friends—boys and girls with whom he went, but he did not have a job, or the prospects of any. Before his illness he had washed train windows at night, and to this wet, out-door work he could not return. Three neighborhood factories, many newspaper advertisements, three employment organizations, one trade union, and many friends were approached by either Joe or the worker for a job, but without success. In January 1930, the boy finally got himself apprenticed to a shoemaker for a year, and earned about $2.00 a week. One wonders how long he will be satisfied with the small wage that his year's apprenticeship involves.

Objectively, Joe was placed well enough—living quarters, work, friends and recreation, and health seemed adequate.

Subjectively, however, the boy openly expressed his hatred of his father with whom he had to live, complained of the monotony of his work and showed an overwhelming sense of insecurity. "He is afraid to do anything for himself," his mother said, "he hasn't the spine to even look for a job in the right way." Treatment for personality re-adjustment was certainly indicated, but two conferences of the hospital social service staff found every available resource, psychiatric, religious or otherwise, unable to answer Joe's need. So nothing was done.

Concerning the parents, there were no outstanding problems that were not being faced and handled more or less satisfactorily by the two adults themselves. An insurance company and a hospital were turned to for health work. The Visiting Nurse Society had been used in 1924, and a visiting housekeeper had been supplied by a Catholic agency in the same year. Mr. Del Dole worked steadily, earned good money, and had Porto Rican friends. Mrs. Del Dole was a good housekeeper, had no friends in Philadelphia, but occasionally visited friends and relatives in New York. Their relationship to each other was more passable than satisfactory, but Mrs. Del Dole handled her husband wisely.

Gertrude, the cousin, seemed to present no problem, except that she had been unable to find work for about eighteen months. She had had one interview with the psychiatric social worker, and appeared to have learned about sex correctly from her associates in Porto Rico. Eventually she found work, friends, returned to visit her mother in Porto Rico, and on coming back to Philadelphia went to a boarding house instead of to her uncle's home.
One episode is worth comment. It was advisable to learn something about Mr. Del Dole's sister, Gertrude's mother, who lived in a tiny settlement eighty or ninety miles from San Juan. The Travellers' Aid Society, through the local Red Cross worker, obtained a thorough and practical report.

So the case was closed, Mrs. Del Dole saying to the worker:—
"I know if I need you that you will help me, and I will certainly let you know." And the record was filed—"Reasons for closing:—Medically complete. Over age. Family handling problem."
Psychiatrists tell us that there are three ways of meeting conflict situations, of which one, and the most desirable, is working the difficulty out on a rational basis. Since we are all human beings, endowed with emotions, it would seem that such a solution is not the most frequent indulgence of the adult, much less of the adolescent, with his powerful emotional drives less tempered by judgment and experience. At any rate the individual, if he exists, who solves his conflicts on such a basis does not usually come to the attention of the mental hygiene clinic or the protective agency.

A second way, and probably a rather frequent way of handling the conflict situation is to use the method of physical retreat: that is avoiding the issue. There are indeed difficulties involved here for the adolescent in the smaller city. The physical retreat from a situation is not always easily accomplished. The family is often so concerned over what neighbors and friends will say, that they are more apt to increase the trouble rather than to help in working out a solution when the boy or girl attempts escape. The fear of dames’ rumor and gossip seems to make them feel that quiet commitment to a training school is far more to be desired than some type of foster home placement, or other community measures which might indicate that they, the parents, had been in a measure at fault.

Perhaps Rose’s efforts in this direction illustrate this as well as any. Rose came to a mental hygiene clinic because she truanted from school frequently and her parents seemed to have no urge to do
anything about these unexplained absences. Further study of the situation showed that the parents were only mildly concerned about the school truancy but that they were vitally concerned over the fact that Rose's informal wanderings kept her from home. Rose's sparsely furnished, densely populated home had little to offer her for as she said, "What is a house where the only loud speaker is father yelling at me and the kids all the time?" She added further, "I hate school. I am the biggest girl in the room and I have to dress like a bum beside."

What did Rose do in her attempt to escape these situations which caused her so much conflict? She ran away to the neighbors, unceremoniously borrowed their clothes, met her boy friend there, danced, went to the movies, stayed out so late at night that she was afraid to come home, or if she came home, she appropriated the wood box for sleeping quarters and started forth on a rendezvous early the next morning rather than face the family wrath. And what happened!—Rose was sent to a state training school for girls. For months the parents refused to consider any other solution. In the larger city, would it not have been possible for Rose to have had help in working out her escape from the depressing home situation on a more socially acceptable basis? A girl's club house offering suitable outlets and proper supervision might have been a possible solution in the eyes of the parents and a placement there not quite such a blow to their respective egos as the foster home seemed to be.

With all of Rose's informal wanderings about the town she had apparently not really become a delinquent, yet the institution seemed to be the only place for her to have the necessary supervision. Both the school and the neighbors were convinced that she was incorrigible and their very attitude of intolerance was no small factor in her difficulties. In the small town the neighbors, the church and the school join with the family to form a closely-knit group "of intimate face to face association and coöperation" which is said to be characteristic of the primary group and the whole structure takes on the merits and demerits of the family. Thus, as a family of high standards may cause undesirable behavior on the part of some of its members, so rigid demands for social conformity made by the small town group may in some cases be an equally destructive force. Minor offences seem to make one a delinquent more readily in the eyes of such a group, because of the sense of personal responsibility for one of their
members and the blame for his behavior may lay on their shoulders. There seems to be no escaping the glaring disapproval of such offenses, too often followed by concerted action against the offender.

Compare Rose's efforts with those of Mildred, a high school senior in a large city who stayed away from school almost an entire semester, going out daily with her "boy friend," obtaining all the clothes she deemed necessary for graduation and not even being questioned by her parents until the night of graduation when she burned herself so badly with acid that neither she nor her parents attended the exercises and the latter on investigation discovered what had happened. To be sure there is a difference of two years in the ages of these girls, a difference in the social setting, a difference in personality of course, and a slight difference in the intelligence rating, each of which might offer an explanation of the situation but does it not seem that the difference between the environment of the large city and the small city offers an equally plausible explanation. A job was found for Mildred and she went on her way rejoicing. In spite of her history of sex irregularity and continued absence from school, institutionalization was never considered. It was felt that with supervision she could adjust in the community and as a matter of fact she did while the only possibility for such supervision for Rose, that of foster home placement, was consistently rejected. The parents, the neighbors and the school felt she should be "shut up" to be kept out of trouble. Even the constructive possibilities of the training school never seemed to occur to them. She did not conform so they felt there was nothing to do but to put her away.

Similarly John who lived in a small town tried this method of escaping his difficulties. School had no lure for him. Though he had average intelligence, his lack of application and his unaroused interest made academic progress difficult. His foster home with his grandparents, offered little excitement except nagging over his misdeeds, so on occasions he took to life on the open road. When such a venture brought him to a nearby city, he was referred to mental hygiene clinic. Careful examination seemed to indicate that by supplying John with some constructive outlets and satisfactions, he should be able to adjust. Investigation of community conditions, however, showed that the odds would be against him. The teacher said she was unwilling to have John come back to school. He had tried her patience beyond all endurance though specific incidents of his trying behavior seemed
to be difficult to ascertain. Furthermore the policeman who had been called upon to search for John at times when he disappeared was convinced that the boy was far beyond redemption, in fact he said "I am just laying for that boy to put him in Meriden (the State School for Boys). His folks never were much good anyway." John had no serious misbehavior to his credit. His runaway episodes seemed to be something for which other satisfactions could easily be substituted, yet the community was definitely opposed to giving this a trial. The great objective seemed to be to get rid of him, preferably in a "reform school which our town is taxed to support." This was a difficult situation for an adolescent to face. Is it unique?

The third method of meeting the conflict situation is the psychological retreat. These are of course varied as the individual. The adolescent who sublimates with reasonable success does not reach the attention of the mental hygiene clinic or the protective worker. But those whose conflicts find outlet in somewhat bizarre behavior or physical ills of various sorts which lack an organic basis do come to our attention. Inasmuch as this type of behavior usually is not antisocial and at the same time secures attention for the individual, it seems to be a not infrequent refuge for the adolescent who does not find satisfactions in other directions.

Jane was an exceptionally pretty girl. Her mother derived no small satisfaction in creating adornment for this object of beauty. The result was that she usually appeared at school dressed in a way that would do credit to an exclusive tea at the Astorbuilt's. The other girls in her class began to lack appreciation of this attire. Her teachers considered her beautiful but dumb and the former opinion they kept concealed,—not so the latter. The boys seemed to constitute a minor party not immune to her charms and not undervaluing her assets.

Her mother, however, felt that she must be denied any expression of this masculine appreciation. The mother who, until three years ago, had been a widow, had had a child out of wedlock which caused her all sorts of social difficulties and when the child's father finally married her, he caused her still more with his uncontrolled temper frequently increased by the use of alcohol. She was determined that Jane should be protected from anything of this sort. Any interest that Jane showed in boys was pointed out to her as something evil and the intentions of the boys equally base. An occa-
sional movie with a body guard of her mother and a much less attractive sister was the only diversion offered. This had been going on for some time when the teacher asked for assistance with Jane. It seems that when one of the teachers intimated not too amiably that a little more attention to school work on Jane's part was desirable, she fainted. This of course was quite a disturbing thing in the schoolroom. It had been repeated at various times when she had been called upon to recite. At home her mother said she became "hysterical" easily, particularly when she was not allowed to indulge in some of the festivities she wished to, but she added, "Jane is such a good girl and not at all interested in boys." It was no small undertaking to find suitable outlets for Jane which would have been available in the larger cities. Furthermore, would the mother have felt such social stigma in a large city where she could have easily moved a few blocks away and been equally easily forgotten? Was the small town environment not a potent and unfavorable factor in this whole situation?

Edith's family was considered offish and reticent in the clubby neighborhood in which they lived in a small place. Edith herself had this same reticence. Furthermore, she was bright and there was not a pupil in the High School which she attended who was not perfectly aware of this fact. Her carefully prepared recitations were a horror to her classmates. Practically the only extra-curricula activities for girls in this particular school were basketball and a French Club. Edith's father did not care to have his daughter led around from town to town and "trotted out like a race horse" so she could not play basketball. The French Club was no asset to her in a social way. About the middle of her senior year, Edith began to receive most mysterious and threatening notes. They would appear in her books when she put them down in the laboratory while she worked on some experiments or they would be left in her desk while she was in a classroom. The writing was not that of any pupil in school it was decided after careful comparison and observation. Some of the notes were taken to the town banks in the hope that the threatening person might be detected in this way. In the meantime various members of her class constituted themselves a bodyguard and escorted her to and from school. She became quite the center of interest and the notes continued to come with increasing threats. Her parents became more excited and anxious. One Saturday night Edith was found tied under a bathroom faucet with the water rushing rapidly over her face and
had she not been rescued, she could have easily choked to death. Police investigated and Edith was more than ever the heroine of a mysterious attack. But alas, her rôle as heroine was of short duration for authorities were convinced that she herself was the author and finisher of this little publicity scheme. If Edith had lived where her intellectual interests had been supplied more diversified outlets and successfully combined with social interests, would she have found it necessary to resort to such procedure? Furthermore, would a large High School, after such an event, become so unbearable that illness proved the only way out?

If the foregoing discussion has seemed to discount the assets of the smaller place, this is by no means intended. One realizes that there are a multitude of things favorable to the development of the individual. The Woolworth store in the smaller place is not nearly so alluring to the pilferer as the one on Forty-Second Street. Furthermore, except at rather rare intervals, it is not so crowded that appropriating merchandise is all but forced upon one. The urge for clothes is not usually as great as it is in the city and here again the readiness with which one feels he would be detected seems to be a deterrent factor.

To many the small place offers greater satisfaction in friendly relationships, and intimate social contacts. Indeed one can enumerate many assets for the young and old alike in a typical Middletown. To one perfectly cognizant of these very advantages, it would seem that when the individual does not react favorably to them, that he has a more difficult time than he might have in the large cities. If his conflicts are not successfully resolved as far as society in the smaller place is concerned, it would seem that this same society is not concerned in helping him and still less well informed as to methods available for his help. Dames' rumor and gossip may do much to keep one in the straight and narrow path but they are most intolerant of those who make even a slight detour from this path. A city girl of fourteen may return home unnoticed by the neighbors at 2:00 A. M. but when small-town Mary does this she may become a lost woman in the eyes of her small world.

It would seem, then, that the environment of the smaller places is somewhat like various healing cults. It is all right when it works but when the individual does not find there interests and activities which bring him satisfactions, and when facilities for helping him obtain these objectives are not at hand, he seems bad and unwanted by
the group. Avoiding the situation which has caused the conflict is almost as difficult as avoiding his family when he lives with them. If he resorts to various kinds of delinquencies as means of satisfaction, he may find intolerance and misunderstanding and even resentment on the part of his group. How readily one is branded as a thief, a sex delinquent or an incorrigible by the community whose interests are unfortunately too much absorbed by the behavior of its members. Hysterical and neurotic manifestations may be more tolerable to the small group but consider the damage caused by these.

Is the smaller place by its rigidity of standards, its ill-directed interest in the individual and its lack of constructive agencies contributing to the difficulties of certain of its adolescents, who might work out a satisfactory community adjustment with understanding and help? If this is in a measure the experience of other workers in the field, does it not offer a fertile field for us to try out one of our frequent prescriptions—changing attitudes?
ITEMIZING THE BILL

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Just as the status of any community may be measured by the number of its dilapidated buildings, so may its status be measured by the number of its indigent citizens. The indigents are not always whittling on the Post Office step nor sitting languidly sunning themselves in the Plaza, but are to be found in the County Hospital or on the County Farm which are maintained for their accommodation. Since they are not so easily counted we shall have to use some other index for measuring the community interest in social welfare, and that is its infant mortality.

President Hoover has epitomized the country's responsibility to the child in his declaration of the Child's Bill of Rights: a document which is fitted to the needs of any community; a valuable aid in health administration and a most useful stimulus to the self-measurement of communities' health activities. It is a complete guide to every needed activity to round out the life of the child, and its definite aims should be incorporated into the life of every child.

As citizens we manifest a profound interest in the conservation of our Local, State and National resources. Our pines, firs, oaks and sequois must be preserved for posterity. Our oil supply must be conserved. Our water supply is of the utmost importance, not only is it necessary to health, but to industry as well. Its power is one of our greatest national assets.

There are innumerable sources of wealth, but from a broad standpoint our greatest resource is the health of our people. The real wealth of a nation does not consist of its gold, the value of its commerce, nor its territorial possessions. These have value only as they help to maintain the citizenry. The yearly preventable loss that accrues in the greatest of all of our national resources, the health of
the people, is far greater than the loss which comes through the ex-
plorations of our great mines and vast forests.

We are horrified when nature visits her devastating wrath upon
persons or property. Fire, flood, wind and war leave wanton de-
struction in their wake. But because of the traditional belief that
babies die easily, we have grown careless about the loss of infant
life.

1. "Every child should be born under proper conditions." Ef-
fective efforts in the formation of measures to bring this about must
obviously rest upon a solid scientific foundation.

What the individual has at birth of vigor, of resistance to dis-
ease, of bodily strength, is made up largely of what his parents gave
him in the germ-plasm of which he is developed. Children whose
parents are suffering from disease are presented at birth with health
hazards. When such children are born crippled, blinded, incapac-i-
tated, or reduced to imbecility, the state and nation are deprived of
citizens who should have been self-supporting and useful. In addi-
tion, the cost of such an individual to the community is great. The
state must build, equip and maintain institutions for the permanent
care of these human derelicts.

2. "Every child should live in Hygienic surroundings."

Every child has the right not only to be born healthy, having a
physical and mental heritage that will insure him his ability to meet
life's trials and exigencies, which are daily becoming more complex,
but he also has the right to an environment that will permit him to
develop into a good and useful citizen who has learned how to live
in this interesting world of ours by living in it.

Every child needs two parents, one of each kind, and these par-
ents need to be concerned not only with the heredity they convey to
their child, but also with the physical and social environment they
provide for him. The battle for life preservation is no longer being
fought only in the laboratory or the office of the Physician, but is
being waged openly against the greatest of all evils—ignorance. Pov-
erty and Disease are inseparable companions, and their little play-
mate, Ignorance, makes up a triple alliance which when accompanied
by Defective Heredity, place formidable barriers in the way of fine
living. Such hazards are more powerful as factors among the poor,
although even poverty is conditioned largely by ignorance. Environ-
ment may be unfavorable even when financial circumstances are for-
The Poor Little Rich Girl as a type represents the handicap under which many in moderate, or better-than-moderate circumstances, live.

The quality of life must remain staple.

Dr. Thurman B. Rice emphasizes the importance of the quality of life in the following: “Dynasties may come and go, governments may stand or fall, our standards may change, as indeed they are changing to the utter dismay of many, ethics may take on new interpretations, but if the quality of life remains sound, we shall progress. If children capable of being strong, robust, well-poised men and women are being born and prepared to take up the problems of the future, we need have no fear for the future.”

There is nothing in this world so important as our children, nothing so worthy of our undivided interest. Burbank has said, “If we had paid no more attention to our plants than we have to our children, we would be living in a jungle of weeds.” Nature takes care of her offspring among wild animals and wild animals result. Early medical supervision is primarily necessary in order to avert in the human family the enormous destructiveness which obtains among wild animals.

Conditioned environment is essentially the basic feature of our best modern education program. From babyhood to young adulthood his food, clothing, housing, exercise, rest and wholesome life, must be considered the child’s elementary right. The best scientific and educational authorities are daily providing this information to parents.

3. “No child should ever suffer from under-nutrition.”

Thousands of children are undernourished and their parents are not aware of the fact. This type of starvation is largely due to lack of proper knowledge of food values. Ignorance again plays its part in the rôle of obstacle to the child’s well-being. This is the starvation of ignorance not the starvation of poverty; the two must not be confused. Starvation in the midst of plenty!

The child has double the need of the adult. He requires substance for growth. Food must be provided in adequate supply to take care of his body functions. The mother who called out, “Whose boy did you say that was?” when the lecturer stated that the caterpillar was the most voracious animal known, knew something of the needs of growing youth.

Dynasties may thrive and dynasties may fall, depending upon an
adequate food supply. Voltaire stated that the fate of a nation has often depended upon the good or bad digestion of its Prime Minister. We do not know the Prime Ministers intimately enough to be concerned about their digestion, but we do know the lesson of the Great War, as compared with past wars and as related to adequate food supply.

The stream of life will be rich and lasting in proportion as the sources which constantly nourish it are flowing. These sources are neither magical nor mysterious; they belong to every person who is skilled in the use of them. They are: fresh air, food of proper quantity and quality, wholesome exercise and recreation, proper habits of body-care and a wholesome mental attitude.

4. "Every child should have prompt and efficient medical attention."

The fact is beginning to be realized that the home is not a thing apart and therefore a law unto itself. What happens to the child in the home has an effect upon a community. Witness the report of a case of infantile paralysis in a given home. How quickly the neighbors become interested and the community apprehensive for the welfare of its young.

More and more the mother who sends her sick child to school, is receiving the censure of the community, because in so doing she imperils the health of other children in the school. Medical inspection in the school is a five-pointed star and takes its place with the forty-eight sister stars in Old Glory. At the points stand the child, the physician, the nurse, the teacher and the parent. To be reasonably successful medical inspection must have the loyal cooperation on all points.

The parent who is angry because the school physician says Mary Ellen's teeth need cleaning lacks social education. This parent needs to cultivate Mary Ellen, her friends, and the school authorities in order to develop an attitude of tolerant understanding. With such defective social training it is impossible to attain the high ideals and attitudes of life. A coöperative community spirit must be developed.

Health is not a matter of just being up and around any more than virtue is exemplified by all who are out of jail. The child who is physically unfit for school constitutes one of the most expensive luxuries the taxpayers have to support because he cannot derive the benefits that educational facilities provide.
5. “Every child should receive primary instruction in the elements of Hygiene and good health.”

Eighteen percent of all deaths are in the age group up to five years. Health and habit training should begin with charity, at home and neither wealth nor poverty are required to make the ideal home. One is tempted to say that under intelligent direction the child may develop most desirably in spite of either. The child must be guarded against the needless exposure to communicable disease.

The National Educational Association has placed health first on its list of the six major aims of education. The day approaches when the school will measure its year’s work not only by the number of pupils who have passed, the number who are in the usual grade for their age, but in addition, by the growth and improvement in the health of its pupils during the year. Health is the basis for success in achieving the purposes of the school. When the time comes that these facts are universally recognized the gap between theory and practice will be bridged. Health Education can be promoted at school by creating an environment in which children naturally develop a sense of health responsibility by the practice of it and not by means of exhortation. It is a serious enterprise and should be entered into soberly, advisedly, discretely and intelligently.

6. “Every child should have the complete birthright of a sound mind in a sound body.”

Mr. Babson proposes to aid parents to bequeath character, energy, and experience to their children as well as stocks, bonds and real property.

We think today with our rapidly advancing knowledge of psychology that we have suddenly discovered that the mind is not a thing apart from the body. The Apostle Paul in the 12th Chapter of I Corinthians says, “If the foot shall say, because I am not the hand, I am not of the body; is it therefore not of the body? And if the hand shall say, because I am not the eye, I am not of the body; is it therefore not of the body? But now hath God set the members every one of them in the body, as it hath pleased him and whether one member suffers, all the members suffer with it; or one member be honored all members rejoice with it.”

This biblical statement requires that physical vigor be considered of fundamental importance and provides that body serve the mind and spirit; that the “temple of the soul” be a servant, ready and
trained to serve high causes and noble ends. This broadening of the concept of health is justified by life.

In the end, firm, vigorous body and alert mind are of the highest value in proportion as they serve the highest ideals. The test of body and mind is not the test of weight lifting, high jumping, tennis or golf championships, nor the ability to solve each cross word puzzle or answer every question in the “Ask Me Another” group. The test is the ability of each individual to meet life’s crises in such a way that a distinct advance has been made for oneself, for society or for both.

Our susceptibility to reason and our willingness to endure hardship, if for the betterment of all, depends upon our preparation for life. Plato said, “Good education is that which gives to the body and to the soul all the perfection of which they are capable.”

7. “Every child should have the encouragement to express in fullest measure the spirit within which is the final endowment of every human being.”

Self-expression should be encouraged and not thwarted in the home of which the child is an integral part. Since the most important phase of mental hygiene is the prevention of abnormal behavior, rather than its cure, childhood becomes of necessity its main field of action. This formative period of childhood offers the greatest opportunity for establishing sound mental habits. Lack of such understanding has permitted us to grow up like Topsy. Man has the same desires, instincts and reflexes he had a generation ago, but with the advent of the airplane, the automobile, since he left the old homestead and took up his residence on Main Street, standards and conditions have altered. The child of today is ushered headlong into this maelstrom of noise, excitement, and glamor and must adapt himself to the tyrannies of present-day life. His physical well-being must be assured if his mental reactions are to be satisfactory.

“As the twig is bent so the tree is inclined,” carries with it a solemn warning. The home is the workshop which spoils much good material.

Intelligent expression depends upon both interest and fearlessness. The child needs to think openly and fearlessly about matters which interest him. Children take a spontaneous interest in everything. Adults need to meet this intelligent challenge with scientific information and not evasion in order that it may be wholesomely absorbed and become knowledge since all knowledge is good.
The home is subject to strong social and economic forces and creates many of the difficulties which confront the growing child.

If happiness is the child of discipline; self indulgence the mother of distress, and good luck the result of hard work intelligently planned, as Sir Harry Lauder has so aptly expressed it, then the intelligent planning of the young child's life in the environs of a happy home should provide the elementary optimistic philosophy in which he acquires a sense of value and security which are important to his well-being.

The shortcomings of parents are due to carelessness and indifference or to insufficient training. Family happiness is based upon mutual regard. The privilege of parenthood is a varied, elusive, rich, individual opportunity for adults to guide the destiny of nations and to assist in building a world structure.
EDITORIAL

Bedside Manners

Several years ago a prominent member of the consulting medical staff of one of the largest hospitals in our country made the illuminating recommendation that members of the visiting staff be required by a rule of the hospital to sit down for at least one minute at the bedside of every patient during rounds in the ward. To those of us who are familiar with the machinery of the modern hospital, particularly with regard to the interaction of the parts, this remark seems clear and constructive. Criticism of hospitalization in America (particularly in large hospitals) has always been aimed at the method of treating patients in groups and the neglect to individualize, which often result in the loss of the most valuable single opportunity to bring the patient back to health and the failure to win his friendship for the hospital.

The medical staff, in its pursuit of scientific truth during a limited period of time, will naturally select the interesting "case," the one that has educational value, the one that has research value, and the one that has unusual or rare characteristics. One can scarcely believe that the diagnostician or therapist, no matter how keen his clinical insight, will adequately do justice by each and every patient during the course of his brief morning or afternoon rounds. Many factors operate to prevent individualization, and the limited time in the form of volunteer service at the disposal of the staff will not permit the hospital to enforce a rule such as the one referred to above.

The nursing department too, in dealing with groups by medical prescription, must weigh the comparative importance and urgency of bedside requests for service and therefore lacks the time which is required in larger measure to cultivate more intimate contacts with the patient. The social service department, which was conceived early in this generation out of a desire to safeguard the social interests of the patient, also has developed mechanical habits, which, though less noticeable because the worker is in closer contact with the patient, are nevertheless discouraging.
The problem exists, as every hospital authority recognizes, and our institutions may not lay claim to the practice of the humanitarian principles which they preach until a solution is found that will be satisfactory to everyone concerned, including the dependent sick man who is compelled to seek relief in hospital wards. Perhaps individualization may be achieved by proxy—a suggestion that may seem somewhat paradoxical. Can we bring into existence a group of intelligent, sympathetic and kindly disposed volunteer women who will undertake to spend fifteen minutes at the bedside of every ward patient once a day or once in two days in order that the medical, nursing and social service staffs may be interpreted to him and in order that he may be interpreted to them in all his spiritual signs and symptoms? If the doctor, the nurse and the social worker lack the time that is required for the individual attention to which every ward patient without exception is entitled as his right and privilege, perhaps the volunteer (working under social service influence) will bring to them and to the patient, concisely and intelligently, the information that each one needs about the other. The volunteer worker in the hospital had her origin in the early days of organization when humane standards were established. Will she undertake the task of helping the scientist to achieve a physical and spiritual cure in a manner that will enable the hospital to enjoy the friendship of its critics—and of the patient after his discharge from the hospital?

E. M. Bluestone, M.D.

THE FAMILY IN A CHANGING WORLD

SIDONIE MATSNER GRUENBERG

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Father sits at the breakfast table distributing his attention equally between his insistent watch and his resistant son. "Your mother tells me you've been stealing my cigarettes and giving them to the boys. And smoking them too! Fine thing for a son of mine to do! How do you expect me to trust you? How many did you smoke? Who put you up to it?" And without waiting for the answers—if any
We are living in complex surroundings, our relations are intricate, more influences are operating upon our children than has ever been the case before. We need a great deal more knowledge than our grandparents had, in order to make as good a job of it as they did.

There is already available a considerable and rapidly growing body of knowledge, interpreted and classified by scientist and educator for parents' use. But the first complete classification of such information gathered through the years by independent groups and individuals, is being made by the eleven hundred experts connected with the White House Conference on Child Health and Protection who have been working at this task for more than a year now.

Parents have been attacked for their incompetence. They have felt helpless as one after another their ancient tasks and prerogatives have been taken from them. They have been given very little constructive guidance, during the transition period. They are coming, however, to attain a new dignity. The educators and the magistrates, the clergy and the lawmakers are discovering that parents do, after all, count.

On the other hand, parents need definite help in the job of guiding and coordinating the child's experience, and special training in the new techniques. For in spite of the many expert agencies that have taken over a variety of services for children, the home, in many cases, remains the only constant and continuous agency that cares for children, that sees them when they are well and when they are sick, in all their moods and struggles, in every stage of development. This very continuity of contact aside from its influences upon the affections, gives the parent a strategic advantage shared by no other agency. Thus, it is more important that parents appreciate the significance of what the White House Conference has to offer them, when it gathers for its final meeting to present its findings to the public in November.

Parents must realize, and more and more do, that the effectiveness of their influence upon children is dependent to a considerable degree, upon the extent to which they themselves grow in stature. There is no question of abnegating or sacrificing ourselves for our children. We have to grow through the years along with the children, in power and in satisfaction.

If the home of our traditions has failed in some respects to meet these demands, this does not mean that there should be no home. If
family relationships have been jeopardized by the new strains to which they have been subjected that is no indication that these relationships are without value. On the contrary, we are challenged to reconstruct the home so that it will fit the needs and meet the demands of the present-day situation. As parents we are faced with a greater responsibility than ever before, to make our parenthood serve the new order.
NEWS NOTES

More than 60,000 men and women registered at the City’s free employment agency in New York City the first 5 months of its operation.—Better Times.

A recent issue of Health News contains a report, illustrated by graphs, of the growth of the New York State Department of Health prenatal consultation work. In 1922, the year of the establishment of the service, 85 consultations were held. During the year 1930 the consultations numbered 3037.

The National Society for the Prevention of Blindness reports the formation of a French National Committee for the Prevention of Blindness. The new organization's headquarters will be in Paris. Dr. F. de Lapersonne, Professor Emeritus of the University of Paris, has been chosen president of the Association.

Red heart-shaped valentine stamps were sold in Chicago during the month of February as part of the City’s child health program for the prevention of heart disease.

World’s Children calls attention to the fact that approximately 10 years ago New Zealand had the world’s lowest infant mortality rate, 47 per 1,000 births. Great Britain then had a rate of 77 per 1,000. Only Sweden and some of the Swiss Cantons approached the then remarkable New Zealand figure. The third quarter of 1930 the English rate is down to 45 per 1,000. New Zealand has kept its supremacy, for figures of 1929, just announced, show an infant mortality rate of 34.10 per 1,000 births.

Social workers will regret to hear of the death of The Reverend Dean Lathrop, Executive Secretary of the Department of Christian Social Service of the Protestant Episcopal Church.
The New York City Board of Education included in its budget for 1931 an item of $100,000 for a Behavior Clinic.

The Uruguayan Red Cross use its dispensaries as training centres for voluntary and professional nurses and for social workers. In order to qualify for a diploma Red Cross nurses are required to take a 2-years’ course of instruction, followed by a period of practical work in the Society’s dispensaries and in one of the Montevideo hospitals.

The Second International Hospital Congress will meet in Vienna in June, 1931. Prior to the Congress the American representatives will be officially received in London, Copenhagen, Berlin, Prague and Budapest. At the Congress an International Hospital Association will come into existence. The American Express Company will arrange the itinerary. The entire trip (5 weeks) can be made for approximately $650, including return passage to New York.

The Directors of St. Mary’s Free Hospital for Children, New York City, have planned a new 12-story hospital to be erected at an approximate cost of $1,500,000.

At Weslow, Germany, the National Union of Red Cross Women own and conduct a forest school, where 60 pre-tubercular children are educated and kept under supervision for a period of 3 months.

During 1929 the blood transfusion service of the county of London Red Cross Branch, London, England, responded to 1,360 appeals emanating from 108 hospitals, exclusive of private nursing homes and medical men.—Bul. League Red Cross Soc.

The Indian Red Cross reports that the Summer School for Red Cross Workers has concluded a successful session at Simla. Twenty-two representatives attended from the State, provincial and district Red Cross branches in Bengal, Bombay, C. P. and Berar, the Punjab, Rajputana, Sind and the United Provinces.
The Department of Health of Detroit, Michigan, offers a cash prize of $200 annually to the intern in Detroit hospitals who presents the best thesis on methods of cancer control.

The 24th Annual Meeting of the American Home Economics Association will be held in Detroit, Michigan, June 22-27, 1931.

Dr. William W. Peter, Director of the Health Service of Cleanliness, New York City, is in China organizing a national health education program for the Nationalist Government. Dr. Peter is recognized as an authority on health conditions in the Orient.

The Simmons College School of Social Work is offering this year 3 institutes: in medical social work, social work with children and families, and public service. The institutes begin April 21 and continue for 6 weeks, classroom work ending on May 29. The following week there will be special field trips, for which the groups are invited to remain but this is not included in the institute work. The courses are not designed for beginners and students are asked to enclose with their application a letter of recommendation from their chief of service. The courses offered will be: Organization of Community Forces; Rural Social Problems; Principles of Social Case Work; Principles and Methods of Public Health; Public Service Administration; Psychiatric Social Problems; Principles of Human Behavior; Mental Hygiene and Family Life; Medical Problems and Their Social Relationships. These courses are supplemented by seminars for each of the three groups. There will be opportunity for observation in the field but not for participation. The fee for the institute is $50. Application should be made as early as possible to the Director, Simmons College School of Social Work, 18 Somerset Street, Boston.

The Bureau of Public Health, Santiago, Chile, has opened a consultation clinic which provides for the following services; for men and women before marriage, for women before and after childbirth, for nursing mothers, for the preschool child, dental service for mothers and preschool children, vaccination, and eye, ear, nose and throat examinations.
Mathilde Kuhlman, R.N., Director of the Division of Public Health Nursing, New York State Department of Health, has been elected Counsellor of the Section on Public Health Nursing of the American Public Health Association for a period of 5 years.

The Jewish Children’s Society of Baltimore, Md., has adopted the policy of foster-home care for the dependent, neglected and problem children under the Society’s care. The children’s home at Levindale has been turned into a home for old people.

The Canadian House of Commons recently approved a plan to establish throughout the Dominion a system of county health units similar to those which have worked so successfully in Quebec, Saskatchewan, and British Columbia. The National and Provincial Governments are to pay two-thirds of the cost of operation, leaving only one-third to be met locally.—*World’s Children*.

The Wisconsin State Public School for Dependent and Neglected Children for the first time, is boarding a group of children in private homes. This action was made possible by a grant from the State Emergency Finance Board to relieve the seriously overcrowded condition of the institution, no stipulation as to the form of the extra housing being made by the Board. The boarding homes were selected in communities near the institution, in order to keep down the expenses of supervision, and localities were chosen where for the most part there was no local boarding-home plan, in the hope that a successful demonstration of this type of care might lead to its adoption by the county.—*World’s Children*.

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**The Six Objectives of the Committee on the Costs of Medical Care**

1. How can the medical facilities of the country be so distributed as to bring adequate medical care within the reach of all population groups?
2. How can well-trained physicians be assured of a reasonable amount of work and of the necessary scientific equipment?
3. How can waste of time and money in visiting several unasso-
ciated practitioners for a single ailment be reduced and the patient be assured of competent service?

4. How can the people be educated to avoid the waste of money on inferior types of treatment and useless medicine, and to seek modern scientific care?

5. How can the support of both practitioners and patients be secured to the full utilization of the preventive procedures made available by medical science?

6. How can the ordinary family provide against the uncertain financial burden of sickness, which may be very large in proportion to the family budget, and which is likely to be very uneven, month by month and year by year?—Dr. Ray Lyman Wilbur.

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**Wanted**

We have received requests for the following copies of *Hospital Social Service* from institutions wishing to complete their files. If you care to donate any of these out-of-print copies kindly send them to *Hospital Social Service*, 200 Madison Avenue, New York City. Postage will be refunded. V. 11, No. 1 (Jan., 1925); V. 12, No. 2 (Aug., 1925); V. 15, No. 1 (Jan., 1927); V. 18, No. 6 (Dec., 1928); V. 19, No. 3 (March, 1929); V. 19, No. 4 (April, 1929); V. 20, No. 5 (Nov., 1929); V. 20, No. 6 (Dec., 1929); V. 21, No. 2 (Feb., 1930).

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**BOOK REVIEW**


The main purpose of the book is to make the public realize the enormousness of the capital invested in hospitals, as well as the fact that in computing hospital costs it is not customary to charge interest on and depreciation of the invested capital. This tends to give a wrong impression of the real costs involved in hospital provision for the care of the sick. "Whether or not fixed charges should be included in the costs to be borne by individuals or groups of patients is not a question of accounting but one of social policy." The more important phase of the matter is the economic waste resulting from unregulated and sometimes ill-considered investment of capital in hospitals. Aside
from quality of service (which is beside the point in this connection), the amount of service per unit of investment has not been adequate in very many communities, as the existing facilities are only too frequently under-utilized. The present reviewer has, during the last few years, often called attention to the saturation point seemingly reached in the supply of hospitals for acute conditions. The temporary lull in hospital construction, due to the economic depression, gives an opportunity for a study of the existing relationship between supply and demand, with a view of framing a rational future policy. In this connection, Rorem's book ought to be of service, although it discloses no facts previously unknown but lays clear emphasis on existing conditions.

In his estimates of capital investment of hospitals, the author is conservative; his average is $3,500 per bed for hospital service of all kinds, and $5,000 per bed for the treatment of acutely ill patients. The total investment in the 6,832 hospitals registered in the A. M. A. directory of hospitals in 1928, is estimated at over three billion dollars, subdivided among the principal groups as follows:

<table>
<thead>
<tr>
<th>Hospitals Type</th>
<th>Investment</th>
</tr>
</thead>
<tbody>
<tr>
<td>4,538 General Hospitals</td>
<td>$1,848,766,000</td>
</tr>
<tr>
<td>533 Hospitals for Nervous and Mental Diseases</td>
<td>820,011,000</td>
</tr>
<tr>
<td>507 Tuberculosis Hospitals</td>
<td>194,375,000</td>
</tr>
<tr>
<td>719 Special Hospitals</td>
<td>167,479,000</td>
</tr>
<tr>
<td>535 Institutional Hospitals (i.e. attached to schools, orphanages, prisons, reformatories, etc.)</td>
<td>59,492,000</td>
</tr>
</tbody>
</table>

The summary of the entire book was recently published by the Committee on the Costs of Medical Care, in a form useful for ready reference. Trustees of hospitals, administrators, and social engineers would, however, do well to study the more complete analysis of the data, particularly in its relation to community policy.

E. H. L. Corwin.
covered in a course of obstetrics for nurses. This book will serve as a ready, detailed reference for teachers and should be most helpful to them as a guide in preparing this subject matter.

In going over this outline one is impressed with the emphasis that Dr. Rice lays on details in the care of the mother so often neglected but which are so important from the present-day broad viewpoint. By this outline he suggests that teachers make a deeper and more thorough study of obstetrics so that they may present to the pupil nurse the subject more fully, the fundamentals as well as nursing care and the reasons for the care. To know Dr. Rice’s reasons for some of the detailed care he so carefully outlines would be of interest.

As a nurse I may not agree with his order of the points necessary for the making of a good nurse, nor his definition of sympathy as stated in his introduction, nevertheless the book should be of real value for teachers in preparing their lectures and students who are taking their obstetrical training.

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**LOUISE ZABRISKIE.**


This excellent book fully justifies the statement made by Dr. Williams that the author has been able “to present a book that is of more value for the student of the social aspects of mental deficiency than any other book I know.” It presents a careful, accurate and detailed analysis of the social possibilities of the feeble-minded, and the measures adopted by society for dealing with the complex problems presented. Emphasis throughout is on the assets and possibilities for constructive work with this group, and their adjustment in society. The chapters on sterilization, defective delinquents and heredity deserve special attention. The last six chapters present an admirable type of general plan for a program to meet the needs of this group.

The book is well written, in simple, clear style. It is well annotated, and the bibliography is extensive. Perhaps the title would be more adequate if it were called “Social Aspects of Mental Deficiency.” Certainly every worker in the mental hygiene field, as well as in many others, should be thoroughly familiar with this work.

**LAWSON G. LOWREY, M.D.**

The description of diseases are adequate for nurses and, while this could be called a brief book on pediatrics, the nursing side does receive its adequate place.

That the book is English brings in different names for certain objects and a somewhat different type of management at times, but it shows essential uniformity of treatment with ourselves and the other point of view is rather good for us.

The reviewer rather wishes that so much theory were not required for nurses, but, if it must be—this book contains 580 numbered pages and is not padded—it is well presented.

W. D. L.

NEW PUBLICATIONS


To find out what hospital and clinic patients pay for medical expenses and whether or not these costs are commensurate with their resources is the aim of a survey on The Ability to Pay for Medical Care just prepared under the auspices of the Institute of Medicine of Chicago. The study and report was made under the direction of the Institute’s Committee on Medical Needs.

Records covering a year’s expenditures (July 1, 1928-June 30, 1929) of 536 patients taken consecutively from 6 Chicago medical institutions form the basis of the study, and are believed to give a representative, though small, sampling of hospital and clinic patients in Chicago. More than a 1,000 records were obtained for initial examination, from which were excluded cases in which the patient lived outside Chicago, or was an inmate in an institution, an employee of the hospital and clinic, a man living alone in a lodging house, a student away for the summer, a man suffering from venereal disease, and cases in which the patient had given conflicting addresses, or in which the medical problem was of a minor nature, involving but
slight clinic contact, leaving 536 cases for which there was adequate data. The schedule used for the study included details of income, rent or home ownership, savings, expenditures for education, automobile and the like; medical data as to nature, treatment, and duration of the present illness and expenditures for recent illness, and data on the treatment and the burden of sickness, employment of a family physician, standard of living and family problems.

More than two-thirds of the families studied were found to have incomes of less than $1,000; for 20 per cent. the annual income was between $2,000 and $3,000; for 13 per cent. it was $3,000 or more. Of the group who paid no fee to a physician (391 families) 74 per cent. had annual incomes of less than $2,000. The father was the sole support of almost half the families studied. In the group of 175 families with incomes exceeding $2,000, 99 families had two or more wage earners. The majority of families, it is believed, "had little margin beyond the money required for necessities." Sixty-five per cent. reported they had no bank savings.

Families with four members comprise the largest single group. Those with two members make up the second largest group, and those with five the third. More than half of the patients were entirely dependent upon others for their support, as in the case of housewives, elderly people without occupation, and children; a quarter were the chief wage earners for their families. Almost every type of occupation was represented, with the largest groups classified as laborers or skilled workers in the trades, and smaller groups as peddlers, clerks, professional people, etc. Nearly 40 per cent. of the families were living in over-crowded quarters; that is, with two or more persons per room.

For 472 families who could give figures of sufficient accuracy to tabulate, the expense of sickness during the year under study was nearly $60,000. Nearly half of those reporting spent less than $51; 26 per cent., from $51 to $150; 17 per cent., from $151 to $500; 5 per cent., from $500 to more than $1,000. Twenty-eight families gave no expenditures for sickness, since they had been treated without any charge at hospital or clinic and had spent or at least reported no expenditure for drugs, carfare and other items. Almost a third of the current expenditure was for the services of private physicians, although 77 per cent. had not paid a physician for the care of the patient in hospital and clinic. In other words, it seemed clear that many had employed a private physician as long as their resources held out,
and sought the hospital or clinic only when these were exhausted. The majority of the families who reported methods of payment used current income to pay their bills for sickness; thirty-four paid the bills entirely out of savings, fourteen by borrowing. Nearly a fifth were in debt to the hospital, the physician or dentist or had incurred debts for other medical expenses during the year.

Comparing the expenditures of individual families with their resources and responsibilities, the study concluded that nearly 20 per cent. of the families for whom all the data is available spent more on medical care during the year than they could justly afford. In contrast, a small number, less than 4 per cent. of the group, might have been able to pay a physician's fee in addition to the hospital bill, or should have been able to employ the services of a private practitioner instead of the clinic, at least for a short time. It would seem from this data that the patients who stint themselves beyond reason to pay the costs of medical care through physician, hospital and clinic, are five times as numerous as those who take advantage of free or part-pay service when they could meet a higher rate or the full cost.

It is considered especially significant that more than half of these patients had had private physicians for previous illness and more than a fifth for the current illness, either before or after they received hospital or clinic care, and that almost a third of their current expenditures for illness during the year was for the services of private physicians, though a large majority (77 per cent.) did not pay a physician for care at hospital or clinic. Among those who were considered to have paid more than they could afford were 27 of the 157 hospital cases who had paid no physician's fee, and 17 of the 50 private hospital cases; it is worth noting that of this latter 17, 12 were still in debt to the hospital or physician.

Ability to pay, the study concludes, must be determined by taking into consideration all the circumstances which affect each patient before coming to a decision. It would be impossible to formulate cut-and-dried standards which could be applied exactly to every patient who asks admission to clinic or hospital. In determining ability to pay family resources must be compared with the obligations brought by illness. Income, size, constitution and standard of living for the family, the expense for previous illness and the probable expense of the present illness must all be considered. Family budget schedules are useful if employed in conjunction with the other factors involved.
Abstract


This new quarterly medical journal will fill a long-felt want; a medical journal printed in France in the English language. The new publication which is the official mouthpiece of The American Hospital will form another strong link between the United States and France and the medical profession of both countries. One of the objects of the new journal is to diffuse the knowledge of new discoveries promptly. Its columns will be open to original articles by distinguished French and American scientists.

The Committee on Information Services of the Welfare Council, jointly with the County Medical Societies of New York, Bronx, Kings, Queens and Richmond, has issued a pamphlet for doctors on "How to Secure Services of Welfare Agencies." The information is classified, arranged and printed in such a clear concise manner that it will take the busy doctor but a minute to find the agency best suited to the particular needs of his patient.

Living the Healthy Life. By J. F. Williams, M.D., Professor of Physical Education at Columbia University. Published by the John Hancock Life Insurance Company.

This attractive booklet is written in simple style and well illustrated. Dr. Williams gives authoritative advice on how to guard and maintain the health and how to prevent the degenerative diseases by cultivating the simple habits so essential to a healthy happy life.

ABSTRACT


This interesting paper traces the practice of Hygiene down through the ages from early Roman times, the gradual decline of all hygienic measures until the Middle Ages when sanitation was practically unknown, the revival a few hundred years ago and the extraordinary success of health practice in the United States. The author deeply appreciates the splendid assistance given France during the War by the American Public Health Officers, a work continued up to the present day, and pays tribute to the active coöperation of the
Abstract

United States in international health matters. The author briefly records some of the many international health hazards and explains how the various health organizations here and abroad are successfully meeting the situation through cooperation.


The author who has had wide experience among crippled and physically handicapped children advocates the Morris method of dancing for the proper exercise and development of a child’s muscles. This method appeals to the child’s aesthetic sense and is of far greater benefit than the ordinary “gym” where exercising is done without the inspiration of music and by means of fixed apparatus. The fact that children interpret the music and create their own dances is important. Quite apart from the physical side there is a spiritual value to the work; music, harmony, rhythm have a decided influence on the child’s mind. From a purely medical viewpoint the free play of muscles and the coördination of mind and body are important factors in building for health.


This article describes the many unique features of the new Ernest V. Cowell Memorial, which houses the Students’ Health Centre on the campus of the University of California, Berkeley. All registered students have a complete physical examination upon matriculation and every time a student requires medical service his record is sent to the physician. Every modern device for the examination and scientific medical care of the students has been installed in this home-like ultramodern hospital and dispensary. The maintenance, which is considered as part of the incidental fee makes it possible for the students to have expert medical and scientific care during college residence. The professional staff consists of a medical director and 28 physicians, including specialists in the various fields of medicine and surgery; 4 dentists, a dental hygienist, physiotherapist, 2 laboratory technicians, and a nursing staff of 22 graduate nurses. During the fiscal year ending June 30, 1930, the number of dispensary treatments was 70,824 and 954 bed patients were confined to the hospital. The purpose of this splendid service is to control communicable diseases, to prevent illness, to demonstrate by example what can be accomplished
by scientific preventive and curative medicine, and reduce absenteeism from classes due to illness. Incidentally this large student body will carry out of college the valuable health lessons learned and they will prove a powerful influence to community life.


This interesting article describes the splendid work that is being done in behalf of crippled children at the Missouri University Hospitals, Columbia. Children admitted to the service are under 15 years and come from all parts of the State. When application is made for a child commitment papers are sent to the applicant. The child is examined by a physician at home, the county court makes out the commitment papers which are signed by the parent or guardian. As soon as the child enters the hospital he is given a complete examination, X-ray pictures are taken, blood tests made, nose and throat cultures made, the Schick test and tuberculosis test are given, all necessary dental work is done. When these preliminaries have been completed the child’s name is put on the operating list. After operation or operations as the case warrants casts are applied, if needed, and the child is sent home subject to close follow-up treatment and supervision. In conjunction with the hospital service clinics are held in any county desiring such service. While the children are in hospital they have everything known to modern science in the way of medical, surgical and nursing care. The children’s division with its beautiful garden, open-air roof and solarium is ideal for the treatment of cripples. The children spend the greater part of their time out of doors. The author understands the importance of expert medical, follow-up and nursing care for crippled children and has a keen appreciation of the psychological effect of deformity. Sympathetic understanding care is given to the crippled child and each child is treated individually as each one presents a different physical and mental problem. Several photographs showing the children in hospital and garden add interest to the text.
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