THE TRAINING OF FRENCH PUBLIC HEALTH NURSES

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The association of the functions of the public health and social worker in France is due to a series of circumstances and facts, to our traditions and to the mentality of the poorer class families. The latter do not welcome the intrusion of a number of workers into their homes but, on the contrary, give their confidence to the one who has known how to win it, preferably through the giving of care or the demonstration of it. This association is also the result of our legislative system, the majority of the health laws providing for material aid, and, last but not least, of our economic system.

Our public health nurses are taught to give nursing care, to teach health, to know legislation, welfare organizations, housing and working conditions, the resources of the families. All this is essential in order to judge of the economic, moral and social status of the families, to seek out the causes of their misfortune, give temporary palliative aid, find efficacious remedies and, better than all that, to prevent distress by removing its causes.

This task, so complex and so vast, demanding such varied capabilities and knowledge, necessitates a preparation that embraces a great number of both social and medical subjects. A minimum of two years of study is required for the Diploma of Public Health Nursing in Maternity and Infant Welfare of the University of Paris which is equivalent to the State Diploma.

It seems scarcely necessary to state that we select our students with care from a good social "milieu." They must have good physical and mental health, and have a thorough preliminary education and adequate cultural background (a complete secondary education is demanded). Furthermore they must have had at least a year's nursing training in a State registered school. At present, many of them
have finished their two years' nursing course and secured their State Diploma of Hospital Nurse before they entered our school for a year of specialization.

This year of study includes theoretical and practical instruction, both medical and social.

The lectures, four per week, are given during the first semester by doctors, assistants to the professors of the Faculty, who are on the administrative staff of our school. The practical work, which comprises seven hours daily, is under the direction of graduate nurses especially qualified as instructors. These latter also assist with the theoretical work by holding classes for review, discussions and demonstrations. This theoretical work is illustrated by carefully coordinated visits to various institutions.

One afternoon a week is devoted to these visits by groups of students under the leadership of an instructress who endeavours to develop their powers of observation. Moreover, a written report of the visit is required of each student.

Course of Study

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The program of practical work is so planned that the instruction of the students is not sacrificed to the needs of the service. The groups rotate in the following assignments:

Maternity ward ........................................ 1 month
Maternity and infant clinic (medical service) 1½ "
Ward for difficult feeding cases .................. 1½ "
Infant medicine (recognition of contagious diseases) 1 "
Maternity and infant clinic (social service) 3 "
Tuberculosis clinic .................................... 2 "
Syphilis, dermatology .................................. 1 "

Practice of disinfection ............................ 12 afternoons
Diet kitchen ............................................. 8 classes

11 months
1 month vacation
I must emphasize here the unquestionable importance of two of the branches of practical work done at our school;—the ward for difficult feeding cases and the maternity and infant clinic.

The former is extremely interesting. Here the students learn the infinite and meticulous duties indispensable in the care of babies. They see for themselves every detail in the establishment of feeding, so difficult at first. Henceforward, convinced of the importance for the future of the child of breast feeding they never neglect an opportunity to attempt it, knowing how frequently their efforts may be crowned with success.

Under the guidance of their instructor they learn to keep the medico-social records of the mothers and babies assigned to their care and educate those mothers who do not know how to care for their babies. Equally important is the tactful handling of the mothers, keeping up their courage, (the majority of our hospitalized cases are unmarried mothers who have been abandoned) strengthening their morale lest they abandon their babies and helping them to find work where they will be permitted to keep their child.

Our centre, situated in one of the most densely populated quarters of Paris, (230,000 inhabitants) carries on in its widest sense, the work of caring for mothers and their children. We begin our supervision of the baby even before it is born (prenatal consultations are held twice a week) follow it through its infancy and early childhood (infant consultations are held nine times a week, pre-school consultations once, and school twice) up to the age of 15 years.

Ear, nose and throat, eye, orthopaedic, metabolism, radiology and vaccination services for smallpox and diphtheria, are annexed as well as mental hygiene and anti-venereal and tuberculosis clinics. (B. C. G. vaccine.) These services, frequented by 16,000 families in the XVth arrondissement, constitute an admirable field of study and work for our students, offering a mine of information and abundant social and medical experience.

The students follow through an entire well-organized consultation,—admission, registration, entrance examination for the detection of contagious diseases; they help at the consultations, weigh and measure the babies, and give minor care such as hypodermic injections, dressings, bandaging, vaccinations. These are given the babies in the presence of their mothers and it is here that the pupils learn their rôles of health teacher and supervisor.

The district in which we work has been divided into sectors, as-
signed to the nurses on the permanent staff. One sector, and not the least important, has been reserved for the students who work there under the supervision of a qualified instructor, herself a public health nurse. In addition to her teaching ability this latter has had years of experience in the various types of activities that make up the life of a public health nurse.

We divide the students into groups of ten—twelve being the maximum—which are changed every three months. The fact that we admit two classes a year, in October and February, facilitates the organization of the service, permitting us to give them the greater part of their theoretical instruction first, assigning them to a succession of practical work subsequently.

When admitting a group of students, the instructor's first duty is to explain to them the general organization of the service, giving them numerous ethical and practical suggestions. The work is then begun, with two weeks for preparation and adaptation, during which time the student learns to keep records and to study a case history. Learning to analyze a case history, to read it understandingly, to pick out the essentials and make a vivid and complete synthesis in concise terms is not easy. It is sometimes remarkable to see particularly able students succeed almost at once. Each student has approximately 80 families assigned to her and for each she makes, in a special book, a résumé of their histories and the steps taken in their behalf.

During this period of initiation the students may make a few visits in urgent cases, but they learn to take histories at the clinics,—medico-social histories of pregnant women, babies, pre-school children, with the composition of the family, scale of living and medical, family and personal history. Each case history is read and, when necessary, corrected by the instructor.

The students also assist at the medico-social consultations and learn to write out the doctor's recommendations.

Then the first visit, destined to complete the study begun at the clinic, is made. I do not know if we are following the right method, but we prefer to have the student do this alone, for, in allowing her great liberty of action, we hope to help her to develop her personality initiative and sense of responsibility. On her return she gives a verbal report of her visit which she subsequently incorporates into a written one which is eventually corrected by the instructor.

Once a week there is a class discussion of cases. The students
must accustom themselves to presenting clearly the situation of their families and the relief measures to be adopted. Making the most of this occasion the instructor explains, comments, elucidates a point of law, makes some observations of general import and the students ask a thousand questions.

They are assigned certain contacts to make, thereby familiarizing themselves with the functioning of private organizations, and learning to approach officials, becoming tactful, resourceful and perseverant in obtaining what they want.

At the end of the day they make a detailed report of the time employed with the number of visits and contacts made and results obtained. At the end of each month they prepare a complete report of their work.

Two years of study are insufficient for all that we must teach our students, but in the near future improved conditions will permit us to add a third year, in imitation of our American friends.

In the meantime, we do the best we can. Our students leave us with a basic knowledge that is in no way dogmatic and with a technique of work that we have always found satisfactory. We have endeavoured to foster and kindle their enthusiasm, we have emphasized without ceasing the necessity for a sound understanding of social work which requires of each individual that he help work out his own salvation. We lay great stress upon teaching our students to think and to act rather than to know, to trust their own judgement, and to rely on their own experience.

Although seeking always to perfect our work, (after October first of this year our school will give the entire course of training which will give more unity to the instruction) we feel that our methods are sound for our students are greatly in demand on account of their social training. Frequently, even before they have finished their course, their services are sought by district, city or private organizations, searching always for a personnel too scarce for their needs.

Times, however, have changed. Public authorities in France have come to appreciate the urgent need for the systematic organization of public health work. To the tuberculosis work begun during the war and the venereal disease activities started immediately after will now be added the campaign against infant mortality with the help of the maternity and infant clinics and the public health nurses. These latter will greatly increase in number as soon as they are given a recognition and status worthy of their mission and their value.
PSYCHIATRIC FEATURES IN CONVALESCENCE*

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Psychiatric conditions may be produced by the factors of convalescence, and convalescence may be modified by psychiatric states occurring in convalescence.

The existence of psychiatric states should be recognized by physician, nurse and social worker alike. It is not at all uncommon to find an individual suffering from some form of physical illness in whom a mild melancholia or dementia precox may be unrecognized.

The hazards of developing certain types of psychoses in relation to any acute illness, operation or childbirth are frequently overlooked and not infrequently we find patients who have fully developed signs and symptoms of a psychosis, as a melancholia or hypomania, only a number of days after its onset.

All infections and febrile diseases as well as intoxications and prolonged illness associated with exhaustion frequently produce insanity belonging to the toxic exhaustive psychoses, and convalescence is complicated and prolonged by their development. The same is true of diseases occurring in the aged, as arterio-sclerosis, myocarditis, nephritis, diabetes, etc. Frequently some minor injury or surgical procedure suffices to excite the onset of a psychosis. In such patients operation upon the eye, as for cataract, frequently is followed by a temporary psychosis. Head injuries, exclusive of actual injuries to the brain itself, are often exciting causes.

Not only do various diseases act as exciting causes of a psychosis but many produce certain changes in behavior, which unless recognized and properly treated lead to prolonged convalescence and painful consequences. So often are psychic symptoms associated with

disturbance of thyroid function that it is not uncommon to find a frank psychosis diagnosed as hyperthyroidism.

One of the things to which I should like to call your attention in relation to the various types of mental disturbances which arise because of illness or appear in convalescence is this: that if we are to adequately treat these people we must have the means whereby we can treat them and a place where we are going to treat them. I was very much interested in hearing Dr. Sutton discuss the limitations of the convalescent treatment of heart disease. It impressed me rather forcefully because, as a general rule, the policy of a general hospital is to get rid of a mental case as soon as it develops, and just as soon as an individual is physically fit to be moved out of a hospital, if he has any symptoms referable to psychic function at all, he is moved out. There seems to be some sort of discrimination against people who have anything wrong above the ears.

I was speaking one day to a group of men who were at that time engaged in planning a convalescent home in connection with one of our large hospitals and I said to one of these gentlemen, "I need not ask, I suppose, whether you have made proper provision for the treatment of patients convalescent from nervous disturbances."

His answer was, "Oh, my goodness, we cannot put nervous people along with those suffering from heart disease," which illustrates, I think, fairly well the conception of the public as to nervous disorders.

Let us see just what such disorders do in relation to convalescence from general diseases. First, of course, we have a normal convalescence. When an individual has an attack of pneumonia it runs a certain definite course, depending upon the severity of the infection and its localization. In due course of time, from seven to nine to twelve days, he has a crisis and remains feeble for a week or ten days, then goes home. At the expiration of another week he may feel fairly well. So with any other disease. Contrasted with such a convalescence, people with a similar condition or one much milder than that may be incapacitated for months or years.

What are the factors that determine these differences? I think, in general, we may say that a normal convalescence, providing the course of the disease is usual, occurs in people who are happy. Unhappiness is incompatible with convalescence, and I think this is the primary obstruction to all convalescence.
What are the factors of unhappiness? You all are familiar with the difficulty of adjustment of an individual who has been ill in relation to sustaining his family income. The difficulties are those of adjustment of the individual to society as a whole. In the case of the wage earner it is perfectly obvious what occurs. An individual who has been unable to save sufficient money to carry him over an unexpected illness of long duration finds himself unable to work; he is fearful of not being able to support his family; he is worried, depressed and apprehensive, and very shortly develops one of a number of various types of nervous symptoms, with ensuing fatigue, insomnia, pains, dizziness, shortness of breath and a good many other subjective complaints.

His condition is in direct contrast, however, to another group of patients with whom we deal and they are the ones who are dependent upon society for their maintenance. In this particular group of patients we will find that the factors leading to prolonged convalescence or valetudinarianism are quite different. Here we have an individual who by precept, and sometimes I think as I look over the records, by inheritance, has become accustomed to being supported by society. He no longer hopes that he would be remunerated for his illness, nor does he expect it; he already demands it, and he is very closely allied to the individual whom we see in industrial medicine; the individual who becomes ill as a result of industrial disease is an individual who begins with a handicap, knowing that a paternal type of government has made provision for his sustenance. Knowing this, when he is confronted with a fear that because of this injury or disease he has been incapacitated and is fearful of assuming his obligations, it becomes easy for him to seek escape in the unconscious prolongation of his illness that he becomes compensated for. In other words, you have made a bargain with this man to pay him if he stays sick and usually he does stay sick.

In industrial surgery dealing with injury, many other factors occur. First, there is always the resentment against the employer, the feeling that the corporation is responsible for his disability, then the natural corollary that he should be properly compensated, the inevitable association with some legal adviser, who will attempt to get for this unfortunate person as much money as possible despite whatever sacrifice the patient may have to make. Well-meaning friends advise him, discuss his condition, tell him of the dire con-
sequences of similar accidents to John Smith. He is examined by one physician and then another. He perhaps may go before some trial board. There he hears aired all of the horrible signs and symptoms indicating that he has a permanent disability, and it is very easy for him then to develop on top of his already prolonged convalescent period a new condition of a neurosis, which may then disable this man for life.

A similar mechanism is at work now in our returned soldiers. During the war we were much intrigued by the new and romantic disease of shell shock, which implied the result of the utilization in a novel manner of highly explosive shells, giving rise to something which was very mysterious. Before the war had well progressed our French allies had already recognized in this romantic shell shock a very mundane and well-recognized enemy of society—hysteria, and took prompt measures to allay this epidemic. It is repeated (I don't know with how much truth) that they had a rumor spread among the line officers that any one suffering with shell shock would be shot for the encouragement of the others. It is true, however, that this condition occurred throughout all of the forces long before we ever got to France, away behind the lines, at the battle front, behind it, on the way back to the hospitals, on the way back to this country, and is occurring now in regularly returning, full, finely developed crops in our United States Veterans' Hospitals.

This condition, too, is the result of the same mechanism that produces the attempt to escape from a situation which cannot adequately be met, these men thrown back from the horrors of war into a society which they are now no longer able to adjust themselves to, developed mechanisms of escape in the form of various nervous states, of which hysteria is one. It is not strange, therefore, that we are seeing this type of case develop here, just as you see it develop in hospitals.

It is not always true that the reason a person has a protracted convalescence because of a neurosis is that he wishes to escape the responsibility of making a livelihood alone, but it is often the case that one wishes to escape a severe father, an unsympathetic mother, a cruel husband, a shrewish wife, or misbehaving children.

In other words, if an individual has difficulty of adjusting himself to his immediate situation while in good health, it is not at all strange that during a period of convalescence from some disease
he may seek relief in an unconscious escape through some form of continued illness.

Very often such things cannot be recognized as a neurosis. Long continued pains, for example, weakness, shortness of breath, a sensation of a lump in the throat, palpitation of the heart, etc., all may be interpreted as an evidence of a slowly recovering process from the preceding physical disability; whereas, as a matter of fact, they are the expression only of this engrafted neurosis which occurs because the individual cannot face his life in health. Occasionally we see cases of frank hysteria with paralysis or convulsions and often we see unconscious malingering among those people. For example, an instance may be cited of a patient who has been operated upon and the wound does not heal; it won't heal despite the most assiduous care. It may continue for weeks and weeks, much to the distress of the surgeon and to his entire bewilderment, until some discerning person, probing about, pulls a nail out of the wound. I remember one case where a young lady entertained us all by a period of four months of persistent conjunctivitis, which was due to the implantation of about three quarters of an inch of a match very skillfully concealed under the eyelids, causing a highly inflamed conjunctiva. All of these things enter into the problems you have to meet in convalescence.

Of course, one of the essential things you have to do is to understand the patient. When an individual is convalescent from appendicitis, you are not treating appendicitis. You are treating a person affected with appendicitis, and if you wish to have any convalescent period properly conducted you must understand the conditions under which the patient lives and must study them. He must be made to feel that his problems are to be made relatively easier than he anticipated and when you help him to meet them there is no reason for protracted convalescence.

Proper facilities for the care of such persons must be afforded. Nothing is needed in Chicago more than institutions for the proper care of neuroses. You may call it anything you please. The name "nervous" has a very bad reputation, and if somebody could supply a name whereby we could keep the people who conduct convalescent homes from throwing up their hands in holy horror when we refer to such patients, it would be much appreciated.
THE HEALTH OF WOMEN AND GIRLS IN INDUSTRY*

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Industrial health, as I understand it, is a comprehensive term which aims at representing contemporary medical knowledge in its application to the industrial worker, but the function of the industrial worker and her relationship to her environment are undergoing constant changes during the whole period of her existence; this series of changes which the worker and her environment pass through in industry as their coördination is being perfected, constituting the phenomena of industrial development.

Such is the general conception, and now it seems to me that since Industry and Health are at the focal centers of the human society, the employee’s sole capital being described as dependent upon the maintenance of her health and her ability to perform a full day’s work, it is fitting and essential that the employer and the medical profession shall fully realize and continue to give their proper and useful service for the benefit of the industrial worker.

In this connection it is a matter of great regret to me that in many industrial districts, the employee’s General Medical Practitioner should know so little of his patient’s employment, and I consider that the past few years in Bournville have shown that a definite scheme of coöperation between the employee and the outside doctor through some such channel as the Works’ Surgery is a necessary preamble to all enlightened industrial health organization.

Coming into industrial life, as the young employee does say at the age of 14 years, the transition is abrupt, and it is for modern

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† I wish to record my thanks to the Firm and Staff of Messrs. Cadbury Bros. Ltd., for their unfailing kindness and encouragement, and to the Board for permission to present this address.
industry to see to it that the selection is suitable and rigorous, and that the provision is adequate.

In our own case at Bournville, the applicant, selected by the Employment Department, receives a simple educational examination, and she has an ordinary medical examination equivalent to about one hundred pounds life insurance examination. If satisfactory, she may be engaged after having been seen and approved personally by a Director.

As a condition of employment, her teeth are put in order at the Works' Dental Surgery. Similarly she agrees to attend the Day Continuation School and to receive instruction in swimming and in physical training, while, if need be, simple postural defects may be remedied early in her career. The Girls' Athletic Club is open to her, as is the library and the many societies now common to the big industrial concerns. In due course she joins the Sick Benefit Scheme and becomes a contributor to the Women's Savings Trust & Pension Fund. Month by month she receives her Works' Magazine; as occasion lends itself, she voices her opinion, may be through the medium of the Works' Council, maybe through the Suggestion Committee; all these designed as units to establish cooperation between the Employee herself, her work, her employer, her fellow employees, her home, the primary endeavor being to create and to maintain within her an outlook of positive health.

From the beginning, her employment record and her health record are charted on ordinary card index lines, but no card index system can ever supplant a personal knowledge of and individual interest in your employees.

Primarily the Works' Surgery is responsible for urging that the working conditions shall be as perfect as possible, but remember that in this connection your function is advisory only and not executive. You know how the workrooms should be, roomy, clean, light and airy; your mess rooms must be attractive, and be able to cater for the various requirements; your lavatory and dressing room accommodation must be adequate and thoroughly supervised; lighting supply and water supply will call for your attention, and never must your high standards be relaxed! In advising the employer on any point you will take into your confidence, any responsible staff colleague, the forewoman concerned, and, if you think fit, any worker concerned.

Your actual Surgery staff and accommodation must be competent
A. W. Sanderson

and suitable to deal with the health of the factory. We at present have a permanent staff of three fully trained State registered nurses, two clerks, and girls' retiring room supervisor, all under the direct control of the Doctor; this to deal with eight to ten thousand employees, and it is our experience that in general men and girls should be dealt with by the same health organization.

The Girls' Retiring Room is an important unit. It is not necessarily situated in the surgery building and in fact is preferably placed in the center of the Works. There you will get to know much of the minor ailments that occur to your girls and learn to provide for them; there you will also pick out not a few urgent cases such as the acute abdomen which considers itself to be a simple and transient abdominal pain; there, too, is your clearing house for the cases of dysmenorrhoea, which, by the way, we have been treating for several years by simple rhythmic-movement exercises, the results being very good indeed.

Your Works' Surgery Staff will further take in hand with the control and treatment of works' accidents and the control of illness incidence. This is a problem paramount in importance to many of you; it is a field which has been surveyed by the National Health Insurance Authorities and by the Insurance Companies; by the invaluable analyses of the statisticians like Bradford Hill; by the pioneer work of such bodies as the Industrial Health Research Board; by the careful scrutiny, as revealed in the Report recently published, by Sir Alfred Watson the Senior Government Actuary. All have the same sad story to tell! Industrial sickness claims, viewed nationally, are persistently increasing, and women apparently are relatively heavier claimants than men. Well! it may be true, but I am convinced that it is an unreasonable position in view of the considerable degree of progress which is being made in competing with the health hazards of modern industry, progress in which Great Britain still leads the world. In support of my contention I shall show you our figures for Bournville. You will recall, in the first place, that exposure plus liability to accident, should always be less for women than for men, and out of my own experience I am convinced that no further considerable reduction in accident incidence is to be expected by the extension of mechanical guarding beyond our present standards, but rather by bringing the worker to appreciate that her liability to accident is going to be adversely influenced largely by:
(a) Any lowering of her own degree of medical and physical fitness—your accident rate and your sickness rate are going to run practically parallel.

(b) Any exhibition of carelessness, lack of care and caution, lack of foresight and judgment, and lack of appreciation of danger.

You will appreciate also that your sickness incidence is going to be materially influenced by the efficiency of your preventive and your follow-up systems.

Our preventive system had a most important extension three years ago, since when we have endeavored to anticipate impending sickness on the part of an employee, the oncoming illness being averted by sending her, say, for two or three weeks to the Firm's Women's Convalescent Home at Bromyard, Herefordshire. The recommendation usually comes originally for a forewoman or Shop Committee, and is subject to approval by the Works' Doctor, who also obtains leave of absence for her from the Works' Forewoman. The girl's financial responsibility is covered by a grant from the firm; the National Health Insurance declaring-on certificate is unnecessary, and time and again we feel sure that we have saved weeks and weeks of absence and preventable illness.

Our follow-up system is designed to ensure that any illness of an employee shall be followed up with a view to giving such assistance as may be of value in restoring her to normal health.

In this phase of the problem I lay the greatest stress on friendship and cooperation between the Works' Doctor and the employee's own Doctor; the keynote being contained in the phrase, "This employee of ours who is a patient of yours." Assistance may take the form of specialist fees, of hospital or nursing home treatment, of convalescent holiday, of provision of suitable type and hours of work—but whatever is done must be at the request of or with the consent of the employee's General Medical Practitioner. We believe, for example, that it is desirable to assist say in a chronic case where tonsillectomy is indicated and recommended but where the Doctor has difficulty in obtaining admission for his patient, rather than that the employee should continue in subnormal health and in bad time keeping.

As I survey the field of Industrial Health I cannot but feel that the most important contribution that one can make at this stage
is not simply to add to the general mass of authentic information already available but to look at the whole subject afresh and unbiassed in an endeavor to formulate a standard base line which will enable you to judge the results of your health organization. With such an end in view I venture to suggest to you that the three fundamentals in your scheme must be:

1. First class employees.
2. First class conditions.
3. First class coöperation and supervision.

Obviously you will begin by the natural grouping of
(a) Men and Boys,
(b) Women and Girls,
the latter being sub-sectioned into (1) married, and (2) unmarried.

It so happens that we think we can satisfy the fundamentals suggested above and we offer for your consideration our results calculated on approximately four thousand men and boys and four thousand women and girls, the latter being unmarried, and all of fairly even age grading from 16½ to 55 years in the case of women and to 60 years in the case of men.

Diagrams one to six show the weekly variations in absence of women and girls at Bournville on account of sickness for the six years ending September, 1929, the absence being recorded in days per thousand employees per week, and the corresponding curve for men and boy employees being included for comparison. In general, the employees considered in the sickness incidence charts are normal contributors to the National Health Insurance Scheme, and the maximum duration of absence considered for any one employee is a spell of fifty-two weeks. The works' accident absence incidence described later is compiled with reference to the provisions of the Workmen's Compensation Act.

Diagram No. 1 (1923-24) is commonly accepted as typical of the absence incidence to be expected in Industry. We see that it is closely simulated by Diagram No. 2 (1924-25) and that certain constant features are presented. In the first place, it is seen that the curve for women is at all points higher than that for men and that the men's and women's curves are practically parallel. In the next place, it will be seen that the curves all begin to rise in the beginning of January of each year, and make a steady ascent to a maximum in
Health in Industry

Diagram 1.

**Sickness Incidence**

During

**Days on 1000 Employees per Week**

- Women + Girls
- Men + Boys

Diagram 2.

**Sickness Incidence**

During

**Days on 1000 Employees per Week**

- Women + Girls
- Men + Boys
March, followed by a more or less gradual decline to reach the original base line in August.

It is extraordinary to me that employers should ever have accepted these as the curves to be expected, and it is obviously impossible to justify or to explain them on medical grounds alone.

In Diagram 3 (1925-26) one sees another similarly apparently inexplicable form of graph. It is deceptive in that it does not present any well defined peak, but on computation, it will be found to represent a more expensive year, both for men and for women, than either 1923-24 or 1924-25, recording as it does a persistently unsatisfactory degree of absence.

About this time (1926) we began an intensive survey in an endeavor to understand the situation. Every effort was made to enlist the coöperation of the employee; the invaluable alliance between the factory organization and the General Medical Practitioner was recognized, and the problem then resolved itself into a study of the individual and her requirements.

The results were almost immediate! Diagram 4 shows how in 1926-27 the ascent beginning in January merely gave rise to a
diminished peak area with a low maximum and a return to the normal in April instead of in August. In the following year 1927-28, as shown by Diagram 5, the absence incidence maintained itself at a satisfactory and uniformly low level, the base line having fallen and no peak being in evidence. It will be remembered that this, which is our lowest year, is conversely a most unsatisfactory year for the country in general as recorded by the returns of the National Health Insurance.

Our uniformly low record continued itself into 1929 (Diagram 6) when we were able to ascertain the effect of an influenza epidemic. The result obtained confirmed the fact that the situation was now well under control: there was a sudden record of absence, occurring at approximately the same time and approximately to the same extent for men and for women; the peak reached was consistent with the severity of the epidemic; the return to normal occurred within say eight weeks of the outbreak and then the graph remained at its previously uniformly low level.

Such is the story week by week, but it is profitable to look at the annual returns over the periods 1922-29, and I have shown this in
Diagram 7, where the absence on account of sickness has been charted in terms of days per employee per year, the actual figures being shown in Table "A." It will be seen that for the period 1922-26 the women’s annual sickness absence was from fifty per cent. to ninety per cent. in excess of the men’s annual sickness absence, a loading which in my opinion is excessive and unjustifiable. In the period 1926-29, the loading progressively decreased until in 1929 it was less than ten per cent. In virtue of this experience, I am convinced that

(a) The expected absence on account of sickness should be not more than an average of ten days per employee per year.
(b) The amount of sickness absence experienced by women and girls should be in excess of that experienced by men and boys by an amount not greater than ten per cent.

We have seen fit to make similar complete graphic records of absence on account of works’ accident, but I shall here confine myself mainly to a diagram showing the annual amounts of absence on account of works’ accident for the years 1922-29, these returns being,
calculated as days absence per thousand employees per year. It will be seen immediately that the men have much greater works’ accident absence than the women, which means that exposure plus liability is greater in the case of the men than in the case of the women. It is our general experience that both for men and for women—as individuals and in the aggregate—the accident incidence is definitely asso-

![Diagram showing absence on account of works' accident](image)

Diagrams showing absence on account of works' accident for men, boys, women, and girls. The graphs illustrate the trend of absence over the years from 1922 to 1929, showing a decrease in absence over time.

That is to say, an outlook of positive health in the factory is a most important factor in reducing the liability to works' accident occurrence.

In the course of these investigations we aimed at maintaining a standard such that the absence on account of works' accident for men and women combined would be not more than ten days per thousand employees per week, and this was realized in 1927-28-29.

It is obvious that in order to complete the survey, it was advisable to compound the results obtained in Tables “A” and “B.” This has been done in Table “C,” the results being shown in Diagram 9 from which we see that given similar conditions of first class employees working in first class conditions, (period 1922-26), the women and girls show a combined absence on account of sickness
and works accident largely in excess of that exhibited by men and boys, but that if first class supervision, in the broadest interpretation of the term, be added (period 1926-29), then the absence of women and girls on account of sickness may be expected to be not more than ten per cent. greater than that of men and boys, an excess which is compensated for by their lesser absence incidence due to works' accident, the resultant combined or total average annual absence being virtually alike for women and girls and for men and boys.

This investigation and experience confirms my belief that normal healthy female employees suitably selected and working in satisfactory conditions under adequate supervision will compare favourably with male employees in similar circumstances in respect of time absence from work on account of sickness plus works' accident, and that the continued employment of women and girls in industry is justified.
### TABLE A
**SHOWING ABSENCE ON ACCOUNT OF SICKNESS**

<table>
<thead>
<tr>
<th>Year</th>
<th>Men and Boys</th>
<th>Women and Girls</th>
<th>Loading %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1922</td>
<td>9.06</td>
<td>17.42</td>
<td>91</td>
</tr>
<tr>
<td>1923</td>
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<td>9.41</td>
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<td>41</td>
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<tr>
<td>1928</td>
<td>6.73</td>
<td>8.10</td>
<td>20</td>
</tr>
<tr>
<td>1929</td>
<td>8.43</td>
<td>9.22</td>
<td>9</td>
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### TABLE B
**SHOWING ABSENCE ON ACCOUNT OF WORKS ACCIDENT**

<table>
<thead>
<tr>
<th>Year</th>
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<td>631.5</td>
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<td>1929</td>
<td>812.0</td>
<td>107.9</td>
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</table>

### TABLE C
**SHOWING COMBINED ABSENCE ON ACCOUNT OF SICKNESS AND WORKS ACCIDENT**

<table>
<thead>
<tr>
<th>Year</th>
<th>Men and Boys</th>
<th>Women and Girls</th>
<th>Loading %</th>
</tr>
</thead>
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<td>1922</td>
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<td>1.31</td>
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<td>9.92</td>
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<tr>
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<td>8.43</td>
<td>9.22</td>
<td>9.33</td>
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HOSPITAL SOCIAL SERVICE DEPARTMENTS AND
PUBLIC HEALTH NURSING ORGANIZATIONS*

LAURA A. DRAPER

Assistant Director, Community Health Association, Boston, Mass.

Someone has described a public health nursing organization as "a hospital without walls." I want to ask you to think of it in those terms for a few minutes, for I would like to begin by bringing before you the two kinds of hospitals, those that have walls and those that have not.

Within the hospital with walls are gathered the resources of science. The knowledge of the laboratories, the evidence of the X-ray rooms, the technique of the operating amphitheatre are here brought to a focus for the care of the patient. The person coming to a hospital is usually a person acutely in need of assistance; in the hospital he commands all the facilities for expert diagnosis and treatment.

Out in the community is the other hospital, that without walls. The nursing personnel is not restricted by physical boundaries; the nurses go into homes, into schools, into factories. They are stopped on the street for advice; they are very close to the life of their district.

This being the case, it is evident that they are in a two-fold position as regards the hospital. They can guide to the hospital patients needing the care which it offers—and which, very often, the patients are unaware that they need or which they do not know how to obtain; when these patients return to their homes the nurses can act as an extension of hospital service, carrying into the three-room tenement the recommendations of the visiting chief, whether this be for dressing an appendix or helping a mother, returned after an extended illness, adjust to the demands of everyday life.

There you have the two, separate organizations, usually under entirely different direction, yet bearing the most important relation-

* Read before the National Conference of Social Work, Boston, Mass., June, 1930.
ship to each other. The more nearly they function as one, the less
aware the patient is of where extra-mural service leaves off and intra-
mural service begins, the more effectively will the welfare of the
patient be forwarded.

It is evident that the person who can make the connection between
the two groups is in a very strategic position. In most hospitals this
is the medical social worker. Whether or not it is logical to ask her
to make this connection for patients not needing attention socially,
and whether or not she wants to develop this as part of her function
is another question. At any rate, in most places she is at present
acting in this capacity, and does have the opportunity to weld the
intra- and extra-mural services into one. It is because of this that the
relationship between hospital social service departments and public
health nursing organizations is of very real importance.

How are the two groups to achieve the close working-together that
makes for success?

If there were only one social worker and one nurse, the question
would not arise. Each would know the other well, would know her
plan of work, her particular abilities and liabilities, and each would
know exactly what she might expect from the other. When the one
nurse and one social worker are multiplied by several score, personal
knowledge of each other is less easy to attain, but it is just as im­
portant for the two groups to understand each other. Each needs to
know the other’s program, scope of work, and possibilities; that is the
first essential, as complete an understanding of each other as possible.

The second essential is a matter of understanding too. The
agency receiving a patient needs to know what the referring agency
knows about the patient, what his situation and particular problem
are, and what plan the referring agency has in mind for him. Only
thus can the receiving agency carry on really intelligently and, inci­
dentally, with really whole-hearted interest.

All that I have said so far is that we need to understand each
other, understand each other’s function and make each other under­
stand what we are trying to do in particular cases. Not profound,
certainly, but it may gain some significance if I illustrate from our
experience.

Our association has an arrangement with the City, and the Lying-
In and the Massachusetts Memorial Hospitals whereby we give home
supervision to all patients reporting to their pregnancy clinics. We
usually have about 800 women under care for these hospitals. I
want to speak of this prenatal group, because our supervision here is perhaps as nearly an extension of unbroken hospital service as we have achieved. One reason may be found in the fact that there are a large number of these patients, that they are referred for the same reason, and that they require the same sort of supervision. Social workers and nurses, therefore, have a good understanding of what to expect from and what to give each other in caring for these patients.

Moreover, personal discussion of individual cases is possible. The number of workers attached to three clinics is, evidently, limited, and our maternity service is headed up by one special supervisor. Miss Pew has always been in the habit of going directly to the clinic workers with cases which are puzzling or difficult, has explained our point of view, and has gained that of the clinic. We would be glad if the clinic workers had opportunity to visit our district offices, our weekly meetings for pregnant women, even to make home visits with the nurses.

The maternity advisory committee of the Community Health Association has afforded another means of contact. One of our board members, an obstetrician, has acted as chairman of that committee; on it are two other board members and the director and the maternity supervisor of the association. Social workers from the pregnancy clinics of the three hospitals have sat with us; they have helped us face problems, consider policies, and have thought with us in an attempt to see community needs and our place and theirs in a community program for maternal welfare.

The same sort of understanding relationship exists wherever we have a special supervisor making the contact with particular clinics; but it is not possible to achieve this with every clinic, obviously, and we have resorted to other methods. An exchange of workers is helpful. The head of the house social service of one of our big hospitals visited us for a week, and one of our district supervisors spent a month at that hospital. The experience was of very great value to our supervisor and to the nurses working under her, and the social worker told us that it was extremely illuminating to her. I believe that both representatives communicated to their respective groups increased admiration for the other, and increased understanding of and sympathy with their problems.

Our district supervisors number fourteen, however, and when
Mrs. Day made her study* she included thirteen Boston hospitals, with a varying number of clinics. It is evident that exchange of workers would have to be extensive—and very expensive—if much were to be accomplished by this means.

The number of clinics and the difference in the types of service rendered by workers attached to various clinics present, by the way, one of the greatest stumbling blocks to nurses in understanding the plan of work of medical social work departments. Mrs. Day expressed this when she said: “There is the separate department, functioning as does any other department of a hospital, caring for only those patients who are referred to it by the physician. There is the department conceived as an integral part of the whole hospital where the social workers are distributed throughout the institution in all strategic positions for discovering and adding patients in the understanding and carrying out of medical orders and recommendations. There is the department which utilizes both types of organization in varying combinations. . . . Again this third type of organization may be further modified by a division of responsibility among the workers.”

How confusing the result is to the non-socially trained workers of the nursing organization is, I think evident; it is a confusion which is intensified by the inevitable turn-over on the nursing staff. Until there is more uniformity nurses will, I fear, continue to make what seem to the social workers stupid and unnecessary mistakes.

To refer again to the pregnancy clinics, our relationship with them is very much clarified by the fact that here is that uniformity of service. The nurses are aware every case is known to both the nursing and the social work groups and that the social worker is ready to take up any case intensively if the nurse feels that home conditions indicate this need.

I had always thought that we were easy to grasp and that all the difficulty was on the side of the social service departments until someone suggested the other day that nurses have at least the advantage of having been trained in hospitals. They know what hospitals have to offer, even if they are not always clear as to the method of connecting the patients with the service. Hospital social workers

* The Interrelations of the Hospital Social Service Departments and the Community Health Association of Boston. By Elizabeth Richards Day. Published September, 1928. This study was made under a joint committee of the Community Health Association and the Hospital Social Service group in the Boston Council of Social Agencies.
cannot be expected to have the same kind of first-hand knowledge of public health nursing activities, and nursing as it appears in a hospital implies little as to the possibilities of public health nursing in the community.

We have been very glad to have the head of a social department come to our supervisors' meeting to talk over our procedure in relation to her particular hospital. This has sometimes meant the outlining of an actual case, and an exposition of what our mistake in method of referring or our failure to make clear the patient's situation has meant in less valuable service to the patient and inconvenience to the hospital. The supervisors have had the opportunity to ask questions, make suggestions, show the social worker the error of her ways if they wished. When representatives of two groups are able to be as frank as this they have gone a long way in mutual understanding. No discussion is more productive than open-minded controversy.

Before we began to think very much about a technique of coordinating our services, we used to refer patients on a little slip which gave the patient's name, address, and reason for referring. With this slip went another which we hoped the social worker would return to us,—it called for name, address, diagnosis, and orders. The chief thing to be said for them was their brevity.

Last year we evolved a slip which we are at present using; we hope that as time goes on we may improve it, with the help of the workers to whom it is sent.

**REFER SLIP**

**COMMUNITY HEALTH ASSOCIATION**

To Miss Ethel Cohen, Social Service  Date January 10, 1930
Beth Israel Hospital

Name of Patient J—— J——, 4 years  Clinic No. 8150
Address 12 L—— Street 1 Fl. West End

Reason for Referring Doctor directed Mrs. J—— to return to clinic daily with Jacob for dressings. As she has a month-old baby, she cannot do this. If you would like us to do the dressing, will you send us diagnosis and orders?

Economic Situation Income appears adequate. Father owns prosperous grocery store, corner Chambers and Spring Street, West End.

Immediate Home Situation Father is at home from the store to stay with the baby while Mrs. J—— is at the hospital. He must return to the store by noon.

Contact with Family This is our first contact.

Supervisor Carrie E. Daniels  Telephone No. Haymarket 0840
Address 17 Blossom Street  Office Hours 8:30—9:00 1:30—2:00
REFER SLIP
COMMUNITY HEALTH ASSOCIATION

To Miss Ora Lewis, Social Service  
O. P. D. Mass. General Hospital  
Date January 12, 1930  
Appointment has been made  
for January 13, at 9 A. M.

Name of Patient C—I.  
Clinic Medical 654

Address 52 P—— Street, 3 Fl.  
Reason for Referring Known to Tumor Clinic from 1924 to 1928,  
treated for carcinoma of nose, has not returned for 1 year. Now  
complains of constant pain in abdomen, able to eat only small  
amounts of food. Weight 96 lbs.

Economic Situation Receives small income, which appears inade­  
quate from daughters who dance on vaudeville stage. Living in  
single room with son 10 years, have one electric plate but landlord  
objects to cooking. Mrs. C—— too weak to go out for meals.  
There seems to be need of social investigation; no agency is  
registered.

Immediate Home Situation:——

Contact with Family Very slight, referred by daughter-in-law,  
Mrs. T, 200 Brighton Street, whom we have known for 3 years.  
Our present interest is only in helping Mrs. T. to renew her con­  
tact with the hospital.

Supervisor Carrie E. Daniels  
Telephone No. Haymarket 0840  
Address 17 Blossom Street  
Office Hours 8:30—9:00 1:30—2:00

I do not know what the workers receiving these slips thought about  
them, but I should suppose that the information about Mrs. Brown  
would have been more helpful than would a slip giving merely—  
reason for referring, pain in abdomen.

When a nurse writes this sort of report she is doing something  
which a few years ago we did not do—she is trying to see and present  
the situation from a social point of view. And this brings me to a  
point which I hope we may have discussed later—how much do social  
workers expect from nurses in the way of social contribution and  
activity? The more closely we work together, the more our plans  
for families are joint plans, the more frequently will the social worker  
ask for assistance of this kind, I should suppose. How adequate are  
nurses to give it?

Public health nurses are not persons trained in social work. In  
the course of their preparation they have been given a glimpse of  
what it means; our staff nurses, for instance, during their introduc­  
tory period spend one month in field work with the Family Welfare  
Society. No public health nursing course, however, turns out social  
workers.

Yet from the moment that the nurse goes into her first home, it is  
essential that she use social sense. She must see situations, be able to
analyze them sufficiently to know where to refer them, and must give an intelligible interpretation to that agency. What inability to do this may mean to her families is obvious enough.

In the rural field or the small town the demand upon the nurse is even more acute, for she is usually the only family worker in the community. The sort of problem this creates for her and what she does about it, is a matter outside our discussion this morning. But I cannot pass it by without calling to your attention Miss Katherine Hardwick's article in the March "Public Health Nurse," "Trail Blazing in Social Work." Her lucid and sympathetic exposition has, I am sure, delighted every nurse who has read it, and her belief that the difficulty is one which together nurses and social workers can meet successfully, has given us new courage.

To return to the more immediate question of our relationships,—Mrs. Day, as a result of her study, recommended that the Community Health Association consider the appointment of a social case worker to "bear to the staff and outside agencies a relationship somewhat similar to that now held by other special supervisors." She thought that such a step might do much to clarify our relationships with hospital social service as well as with other social agencies.

We have given this suggestion a good deal of consideration, and although we have not employed the worker, we are not at all sure that we should not do so. The size of the problem is one of the considerations that has deterred us. We have on our staff 150 nurses working out from 14 district offices and visiting over 1,000 families daily. One worker could make little impression on social situations detected in so great a number of homes, and we could not visualize the addition to our staff of a corps of such advisers. We felt that generally speaking the worker could not advise the nurses without visiting with them which would mean the injection of an extra person into the situation. Moreover, it would be difficult for her to refrain from doing intensive case work: nurses and supervisors would tend to turn difficult cases over to her in toto, and medical social workers might feel that it was within her province to handle cases originally referred by our association.

You may ask whether this means that our nurses have no guidance in dealing with social situations. I wonder if the Family Welfare Society secretaries realize how much we obtain from them. When one of our supervisors is very much puzzled over a situation, and at a loss as to what to do about it, she is very apt to turn to the secre-
tary who is, in many districts, her next door neighbor. She asks her, not to accept the case necessarily, but to advise as to its disposal. The secretaries have been generous with their help, and it has seemed to us logical to go to them for assistance, rather than to add the possible complication of an extra person. This is not done, needless to say, in cases in which another agency is already actively interested.

I would like to add one more point before I close, . . . I have spoken of public health nursing as an extension of the hospital into the home. I wonder if any clinic worker here has felt that her patients needed such an extension, has asked the visiting nurses association for it, and has decided that what she wanted has not been accomplished. The supervision of cardiac children presents a good instance. The social worker knows what she wants done. She asks the nurses to visit, to take temperature, pulse and respiration, to keep the child in bed,—and she sees very little result from the nurse's visit. The reason is that for this sort of supervision the nurse needs a special sort of technique. It is a technique which in the rush of her day's work she has not leisure to outline for herself and which, in any case, needs to be worked out jointly by social worker and nursing association.

It may be that some of you have asked for a certain sort of supervision, only to be told by the nurse with whom you talked that the organization did not give that particular service. I think you should not let the matter rest there. If the thing for which you asked is a service which the community needs, then the development of it presents a problem which the two groups should consider together.

It is possible for the social worker to go to the director of the nursing organization and say: “Here are patients who present a particular problem. Are you interested in them as a group? Is it possible to work out a special service for them? Can we, together, make some plan?”

Whether or not the director can act immediately depends upon a number of things, but she will be glad to consider possibilities with you.

And now to return to my original thesis,—that sympathetic understanding is the basis of good relationships. To say that we need to understand each other is a simple matter; to accomplish that understanding is not. The sort of working together that I have been talking about requires of us faith in each other, for no matter how good our intentions, slips will occur which seem extraordinarily careless, and unfortunately the human tendency is to let mistakes loom so
large as to throw our view of each other quite out of perspective. It requires patience, for it means going over the same ground many times, in the teaching of new workers and the guiding of old. It is immensely time consuming, and none of us has time to spare.

But the very fact that we have realized this means, I think, that we have started in the right direction,—realized, that is, that the kind of working relationships we want are not stumbled upon by lucky accident, but are the result of rather seriously taking thought.
HEALTH Vs. THE HIGH COST OF MEDICAL CARE

E. E. MUNTZ

Associate Professor of Economics,
New York University, New York, N. Y.

Well may we practice the old saying "Eat an apple a day and keep the doctor away," but experience has shown us from time to time that irrespective of this quaint advice there come times when sickness lays us low. It is then that expenses seem to mount up in an in­terminable, cumulative fashion, draining in an incredibly short time savings which were accumulated through toil and abstinence from many a pleasure. Moreover, it is a well-known fact that, despite the numerous agencies contributing to the health and welfare of the people at large, there is a very considerable amount of sickness which does not receive adequate care, and does not come under pro­fessional attention until the case becomes alarmingly serious. Just why this is so becomes apparent when inquiry is made into the cost of medical care.

Sickness and economic status.—There is plenty of evidence to support the conclusion that illness and, presumably, the necessity for medical expenditures vary inversely with income, the poorer the family the more sickness it suffers. The family which is sufficiently well off from an economic standpoint makes more frequent and regular use of medical services, ordinarily checking disease or physical defects before irreparable damage has been done. On the other hand those families falling in the great middle class, far enough above the charity or mere subsistence level to maintain a fair to moderate standard of living by a most judicious expenditure of a limited income, are often the ones hardest hit when sickness enters, laying claim to a very sizeable portion of their income. The very poor and the indigent who constitute the bulk of charity patients having nothing to give and from whom nothing is expected appear, indeed, to have a distinct advantage over the self-sufficing working
class groups because of the gratuitous medical services which have been made available to them. Thus it is primarily the economically independent lower groups of the middle class for whom the cost of medical services always looms up as a constant threat.

The relationship between the amount expended for medical care and the economic position of the family is strikingly portrayed in connection with a study of the cost of living of federal employees in five cities by the United States Bureau of Labor Statistics.1

<table>
<thead>
<tr>
<th>Family income</th>
<th>Per capita expenditure for medical care</th>
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<tbody>
<tr>
<td>Under $1500</td>
<td>$ 9.82</td>
</tr>
<tr>
<td>$1500—2199</td>
<td>23.85</td>
</tr>
<tr>
<td>$2200—2699</td>
<td>27.64</td>
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<tr>
<td>$2700—3299</td>
<td>28.96</td>
</tr>
<tr>
<td>3300 and over</td>
<td>43.77</td>
</tr>
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</table>

Similarly, Carpenter 2 noted in a study of about two hundred working class families in the cities of Binghampton, Johnson City, and Endicott, New York, that those families which were receiving gratuitous medical care from the Endicott-Johnson Company called physicians more often and more promptly than those families belonging in the same economic and social stratum who were compelled to pay directly for their medical service.2

When reference is made to the average expenditures for medical services it is found that they constitute a relatively small factor in the family outgo, but it is also true that individual expenditures in this or that particular family may be so great as to completely undermine the family's economic structure. To such an extent as patients can be cared for efficiently in their homes or in doctors' offices without the need of specialists or hospital services, medical costs do not appear unduly formidable. Records 3 of actual expenditures for medical service among 12,096 families in 1918-1919 showed an average of $61.18 per family, but of those with an income of $2,500 and over the annual expense was $95.83, indicating that if those with the lesser incomes had taken equal advantage of medical services their expenditures would have exceeded the $60 level. A study 4 conducted in Shelby County, Indiana, in 1929 showed an annual per capita expenditure of over $21, or $85 for a family of four persons. Data collected by the Metropolitan Life Insurance Company from a cross section of its policy holders revealed an average expenditure of $70 for each of 3,281 families studied for the six months period from January to June, 1929. The sums paid out by individual
families ranged from a few cents for medicine in one case to over $1,000 in another involving a serious operation with the consequent expenses of hospital, medicines and extra care. The larger families appear at a disadvantage, because of the necessity of making a limited income cover the needs of a greater number of persons. Thus Dr. Frankel in the Metropolitan Life Insurance Company survey has tabulated the average costs per family of varying size and per person with the following result:

<table>
<thead>
<tr>
<th>Persons in family</th>
<th>Number of families</th>
<th>Amounts expended</th>
<th>Average per family</th>
<th>Average per person</th>
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<tbody>
<tr>
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<td>19</td>
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<td>3</td>
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<td>4</td>
<td>686</td>
<td>42,734.00</td>
<td>62.00</td>
<td>15.57</td>
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<tr>
<td>5</td>
<td>612</td>
<td>44,918.00</td>
<td>73.00</td>
<td>14.68</td>
</tr>
<tr>
<td>6</td>
<td>464</td>
<td>31,307.00</td>
<td>67.00</td>
<td>11.25</td>
</tr>
<tr>
<td>7</td>
<td>290</td>
<td>22,537.00</td>
<td>78.00</td>
<td>11.10</td>
</tr>
<tr>
<td>8</td>
<td>190</td>
<td>15,861.00</td>
<td>83.00</td>
<td>10.44</td>
</tr>
<tr>
<td>9 and more</td>
<td>219</td>
<td>14,726.00</td>
<td>67.00</td>
<td>6.44</td>
</tr>
<tr>
<td>Not stated</td>
<td>218</td>
<td>15,001.00</td>
<td>69.00</td>
<td></td>
</tr>
</tbody>
</table>

Severe illnesses and specialized care.—It is in cases of serious illnesses and accidents that the cost of medical service outdistances the family income and causes the most distressing consequences. Likewise, the expense mounts proportionately when the attention of specialists is necessitated. It is impossible to foresee the incidence of such serious and disabling events in the life of the person or of the family, hence the chance element seems uppermost. The Metropolitan Life Insurance study disclosed the fact that 80 per cent. of all the families paid out less than $100 each for medical care for the six months period, while at the other end of the scale there were 38 families or one per cent. of the total number that expended over $500. One-fifth of all the families covered by the survey were obliged to bear 64 per cent. of the expenditures of the entire group. The average family has little difficulty in meeting health costs where they are not large, but for a considerable proportion of families serious illness entails disproportionately large expenditures which severely handicap the family for a long time thereafter.

Physicians' fees are not, as a rule, excessive. It is obviously unfair to base conclusions on outstanding examples of exorbitant charges. The general practice of most physicians is to adjust their fees as far as possible to the economic condition of the patient. This, however, is not always a satisfactory guide because outward appear-
ances are often deceiving and the patient may not reveal in any manner his true economic position. Much work is actually given free to those unable to pay, the doctor trusting to make it up by higher fees charged to his more prosperous patients. The inevitable result is a wide range of fees, the wealthier patients paying in part or in entirety for services rendered to their less fortunate fellow citizens. In many communities local medical societies have drawn up schedules of fees which are sometimes conspicuously posted in the offices of members. The Middlesex North District Medical Society in Massachusetts adopted such a schedule in 1919 which may be taken as typical. A few of the services enumerated are listed below:

**General Fees**

<table>
<thead>
<tr>
<th>Service</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visit between 8 a.m. and 7 p.m.</td>
<td>$3.00</td>
</tr>
<tr>
<td>Night visit between 7 p.m. and 8 a.m.</td>
<td>5.00</td>
</tr>
<tr>
<td>Advice by telephone</td>
<td>2.00</td>
</tr>
<tr>
<td>Examination, history, and advice</td>
<td>2.00—5.00</td>
</tr>
<tr>
<td>Advice and prescription, subsequent visits</td>
<td>2.00</td>
</tr>
<tr>
<td>Vaccination in office</td>
<td>2.00—4.00</td>
</tr>
</tbody>
</table>

**Obstetric Practice**

<table>
<thead>
<tr>
<th>Service</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Natural labor, ordinary cases</td>
<td>$20.00—50.00</td>
</tr>
<tr>
<td>Delivery with instruments or by version</td>
<td>40.00—60.00</td>
</tr>
<tr>
<td>Visits before and after delivery, three excepted, each</td>
<td>3.00</td>
</tr>
</tbody>
</table>

**Surgery**

<table>
<thead>
<tr>
<th>Service</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tonsillectomy</td>
<td>25.00</td>
</tr>
<tr>
<td>Appendicitis, operation for</td>
<td>150.00—300.00</td>
</tr>
</tbody>
</table>

In many of the larger cities a much wider variation in fees is to be found, but there seems to be a marked uniformity in prevailing physicians' fees in wage earners' neighborhoods. The National Industrial Conference Board in a study of twelve industrial cities found the average to be $2.00 for a visit to a physician's office and $3.00 for a home call in ten cities, and $1.00 and $2.00 respectively in two cities. In Lynchburg, selected by Gee and Stauffer as a representative Virginia city, poor families were found to average $38 per year for medical care, as against $90 for intermediate and $223 for prosperous families. Costs incident to the births of 540 babies in Columbus, Ohio, were found to average $110. Grouping the parents by economic status the average was $270 for those in moderate circumstances by virtue of an income of $3,000 or more per annum; $129 for those in intermediate circumstances with in-
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comes between $1,200 to $3,000 and but $64 for the very poor with incomes less than $1,200.\textsuperscript{12} A recent study of obstetrical costs in Berkeley, California, by Dr. Richard A. Bolt revealed an average cost including doctors' fees, hospital service, nursing and other pertinent items of $213 per case with one-half of the cases below $180. Physician's charges averaged $92.12, the most frequent rate being $50; the most common charge for hospital service was $100 for private and $50 for ward accommodations.\textsuperscript{13} Fees are generally lower in the smaller cities and semi-rural districts. Thus in Shelbyville, Indiana, the most common fee for an ordinary office call is from $1.00 to $2.00, while in the surrounding territory physicians charge as little as $.50 for an office call. The normal fee for a home visit in Shelbyville is $2.00 and $.50 additional for a night call; the rates of rural physicians are on the whole lower. The usual obstetrical fee in Shelbyville is $25 but may be somewhat higher when instruments are used, while rural physicians charge as low as $15 for normal cases.\textsuperscript{14}

The charges of physicians and surgeons who specialize in certain branches only vary to a great degree and are, of course, considerably higher than the fees of the general practitioner. There is no question as to the justifiableness of a relatively higher remuneration for the talent and skill of the expert. It is not uncommon, however, to find some doctors, who believe themselves particularly skillful in certain branches of medicine, or believe that more money is to be made by specialization, setting themselves up as specialists. It is this class which is responsible to a large degree for extortionate fees, and it is among them that the greatest amount of fee-splitting—that is where the specialist splits his fee with the physician who sent the patient to him—is to be found. Fee-splitting is a rather common practice and adds considerably to the cost of medical care. The American Medical Association and the American College of Surgeons are unequivocally opposed to fee-splitting. The latter organization condemns the practice for the following reasons:\textsuperscript{15} (1) it leads to incompetent surgery for the surgeon gets his cases not upon the basis of merit but upon the percentage of the fee collected which he will return to the practitioner; (2) fee-splitting makes for unnecessary surgical operations, because surgery thus becomes a commercial enterprise and not a professional service; (3) it introduces dishonesty into medical practice and consequently lowers the entire medical profession in the estimate of the public. The latest annual
The amounts expended for the services of oculists and of dentists vary to a great extent. There is little statistical data regarding the cost to the people of eyeglasses, but of the 12,096 families investigated by the United States Bureau of Labor Statistics the average annual expense per family among those needing eyeglasses ranged, according to family income, from $5.21 to $10.28. Charges for dental services are in many communities fairly well standardized, but here again we find as wide variations as exist in the medical profession, with frequent instances of exorbitant fees. The study of the United States Bureau of Labor Statistics above referred to gives an average annual expenditure for those families availing themselves of dental services ranging from $8.93 to $28.62, the amount rising with the larger incomes. Averages, however, do not reveal the true picture for those families whose dental expenses for the year were merely nominal level down the cost per family, whereas a great many families had to pay heavy charges for such services.

Charges for hospital service often comprise several factors—the cost of room, special nurse, laboratory charge and fee for operating room. Excepting those hospitals in which profit-making appears to be the dominant motive for operation, hospital charges to patients are little more than the actual cost of the services rendered, and in the case of a great many hospitals, if it were not for endowments and voluntary gifts, there would result a considerable deficit.

In a study of 467 hospitals Carpenter found the charges to range as follows:

<table>
<thead>
<tr>
<th>Number of Beds</th>
<th>Less than $3.00</th>
<th>$3.00 to $4.99</th>
<th>$5.00 to $6.99</th>
<th>$7.00 to $8.99</th>
<th>$9.00 to $10.99</th>
<th>$11.00 and over</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beds in small wards</td>
<td>5,428</td>
<td>10,156</td>
<td>1,182</td>
<td>38</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beds in semi-private</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>room</td>
<td>1,770</td>
<td>9,426</td>
<td>3,566</td>
<td>566</td>
<td>105</td>
<td>4</td>
</tr>
<tr>
<td>Beds in private rooms</td>
<td>363</td>
<td>5,005</td>
<td>11,308</td>
<td>6,332</td>
<td>2,476</td>
<td>1,416</td>
</tr>
</tbody>
</table>
In all the above instances hospital charges covered board and general nursing services. Additional costs are entailed where special nursing care, the use of the operating room, X-ray work, laboratory tests and other services are necessitated. Such extras sometimes amount to from 30 to 60 per cent. of the private patient's hospital bill.

When it is borne in mind that hospitalization of serious illnesses is increasing in prevalence, particularly in urban communities, owing to the trend toward apartment dwelling and the knowledge that better care can be given in the hospitals, it is evident that this accounts for a substantial increase in medical costs for the average patient. A charge of $4.00 or $5.00 per day seems modest enough in itself, but the attempt to maintain this outgo for five or ten weeks or more is a serious drain upon the average working man's family, particularly if it is the wage earner himself who is ill. The hospital authorities are less able to judge what the patient is able to pay than is the family physician with his more intimate contact. Some hospitals base financial adjustments on the type of service rendered the patient, giving concessions freely to ward patients, occasionally to those in semi-private rooms, but almost never to those cared for in private rooms. Other institutions give reduced rates to certain occupational groups, such as the ministry and teaching, while there is a growing tendency on the part of many to consider each patient on the basis of his particular social and economic requirements. Such, for instance, is the practice of the Saginaw (Michigan) General Hospital which requires information from the patient regarding unemployment, debts, and illness of other members of his family. The Buffalo City Hospital, Buffalo, New York, inquires not only into the patient's income, but also ascertains the size of his family, his current expenses, his debts, home ownership, and the resources of his relatives. A number of hospitals have adopted a deferred or an installment basis of payment, some of which report remarkable success in this method. One hospital in Spokane, Washington, places some of its accounts on a schedule of monthly payments ranging over a period as long as three years. The success of the deferred payment plan is largely conditional on a careful preliminary investigation of the credit status of the patient and a definite procedure for collections.

Aside from the possibility of compulsory sickness insurance in the various states, it is a moot question whether or not a greater
public subsidization of hospital facilities should not be encouraged to reduce the costs of those wage earners who are dangerously handicapped by this excessive burden.

Of more than passing interest from an economic standpoint is the fact that doctors’ fees and hospital charges bear little or no relation to changes in the purchasing power of the dollar. When a given fee, such as the $2.00 charge for office calls or $3.00 for home visits, has once been established in a community there is great resistance toward modification. Thus the doctor’s net income tends to fall as commodity prices and wages rise because his set fees will purchase but a fraction of what they commanded at an earlier date; conversely, his net income tends to rise as commodity prices and wages follow a declining course. To a lesser degree a similar situation exists in the case of hospitals.

Owing to the heavy capital investment represented by complete equipment for modern laboratory tests most physicians rely upon private laboratories for various laboratory examinations. The patient is usually referred to or sent to the laboratory, thus adding to his total cost for medical care. Such private laboratories are invariably conducted on a business basis, consequently their fees are naturally well above the actual cost of the work performed. Thus Wassermann tests average $5 or more when performed by private laboratories, but the laboratories of various city boards of health and of dispensaries charge only a nominal fee. The story is the same with reference to X-ray pictures, agglutination tests for typhoid and other examinations. Practically all municipal laboratories make examinations for city health work free of charge. In the larger cities and in many of the small ones culture stations are maintained for the convenience of physicians who may wish to leave specimens late in the day. Specimens are collected daily. Many municipal laboratories in the United States are making determined efforts to get physicians to avail themselves of this service by offering prompt and efficient work. Inasmuch as such service is free its extensive use will help to keep in check the cost of medical care.

A not insignificant item in the cost of medical care is the amount expended for medicines. It is estimated that approximately $700,000,000 is being spent each year by the people for medicines. Other items, such as the exorbitant fees paid to quacks and large sums paid out for patent medicines considerably augment the legitimate costs of medical care. Some idea of the amount spent for patent medi-
cines can be obtained from the fact that the wholesale value of patent medicines and compounds manufactured in 1927 reached the astounding total of $278,243,000; figuring about 100 per cent. is added to this total by distribution through retail channels, the public pays out nearly $600,000,000 for patent medicines in an average year. The value of druggists preparations for the same year is given as $110,309,000. Nothing has so far been said as to the growing amounts expended by industrial corporations for the physical care of their employees which would have to be added if we were to ascertain the total and the per capita cost of medical services.

It is only within recent years that public attention has been sufficiently focused upon the question of medical costs to stimulate exacting and careful studies of this most important item in the family outgo. It is to be expected that at the completion of the five year program of the Committee on the Cost of Medical Care much valuable information will be shed upon the matter.

It is questionable if we can ever expect a time when the total expenditures for health will be reduced. Rather, we may look forward to a shift of expenditures from curative medicine to preventive medicine with a larger part of the cost falling upon public agency as public health measures are expanded and augmented. In the meantime, however, there are undoubtedly many ways in which true economies may be instituted to reduce the cost of medical care. In this category we might mention:

1. An effective curb upon quacks by an immediate official investigation of their "miraculous" cures.
2. Public education regarding nostrums and "cure alls" offered by patent medicine concerns.
3. The establishment of hospitals designed particularly to serve persons of moderate means.
4. The greater use of pay clinics by persons of the middle economic class.
5. Standardization of doctors' fees for ordinary medical attention, as well as specialists' fees for specific services.
6. Licensing specialists after satisfactory examination and proof of proficiency in their specialized fields.
7. Abolishment of fee-splitting.
8. Development of medical guilds whereby guild members cooperatively purchase the best possible medical service at moderate cost.
REFERENCES

20. *Hospitals and Dispensaries*, Bureau of the Census, p. 3, reveals that 1,751 out of a total of 4,045 hospitals reporting in 1923 were conducted by individuals or stock companies apparently for profit motives. Quoted in Harry H. Moore, *American Medicine and the People's Health*, pp. 29, 50.
21. Niles Carpenter, *Hospital Service for Patients of Moderate Means*, Committee on the Cost of Medical Care, Abstract of Publication No. 4, p. 8. It is worth while to compare these figures at the close of the decade with those given by E. H. Lewinski-Corwin, *The Hospital Situation in Greater New York*, pp. 75-92, which were based upon data gathered in 1920. The relative inertia of hospital charges is clearly apparent.
22. Niles Carpenter, *Hospital Service for Patients of Moderate Means*, Committee on the Cost of Medical Care, Abstract of Publication No. 4, footnote, p. 9.
In every civilized country there is an ever-increasing recognition of the claims of those who are disabled by wounds or disease. The Great War did much to stimulate this. Every participating country found itself faced with the new and difficult problem of having to provide for those who suffered in its service. The numbers involved were enormous. It was out of the question to pension them all so generously that they would never need to work again. Efforts at rehabilitation were essential, and for the first time the problem of uniting medicine, economics and sociology attracted world-wide attention.

This was not in itself a new problem. The necessity for uniting these elements in dealing with tuberculosis had already been recognized. Dr. Hermann Biggs, writing in 1910, stated that “What is needed is an industrial colony where proper occupations can be provided under proper conditions, with proper living quarters where ‘arrested’ cases can earn a livelihood and maintain their health. I believe such an industrial colony once established could be made self-supporting, but a large fund would be required for the erection of houses and sanitary workshops and the construction of the business of such a colony. The future will probably see the solution of this;” and in her article in the November (1929) issue of “Hospital Social Service” Miss Irma Collmer successfully demonstrated that the ravages of tuberculosis could not be materially reduced by medical means alone.

The principal difficulty has always been to discover the ratio in which the three named elements should be applied to the treatment of disabled persons. The scheme which is perfect both medically and sociologically may be disastrously uneconomic; financially successful
schemes may prove equally disastrous medically; and so on. Endless experiments have been made in every country to get these elements into adjustment, and in most cases they have failed. The remnants of these failures encumber the nations, and the picture of any nation’s work for its cripples is one of astonishing chaos and disorder. Local schemes are initiated; they progress for a time, usually until they run short of money; and then they pass gradually into the limbo of forgotten things. In the meantime the blind, the wounded, the tuberculous and the otherwise crippled continue to suffer from a lack of effective help.

It was not until a local scheme instituted near Cambridge, England, began to develop and achieve remarkably interesting results, that it was possible to suggest a remedy for the state of affairs then prevailing. Now, however, the continued and increasing success of the Papworth Village Settlement does enable certain inferences to be drawn. It can, for example, be shown that, given the conditions specified by Dr. Hermann Biggs, the spread of tuberculous infection can be prevented; that persons suffering from quiescent, but not necessarily arrested, tuberculosis can be employed without heavy cost; and that so far from being useless, consumptive workers can remain productive and almost, if not quite, self-supporting for many years.

The importance of this demonstration is that at last the correct “balance” between medicine, economics and sociology has been found; and it is reasonable to assume that if the same system be applied elsewhere the same measure of success will be achieved. This does not only apply to tuberculous persons. The principles are equally applicable in the case of those injured in industry. Every year hundreds of thousands of accidents occur in mines, in factories, on the street and on the railroads. The present system is to give the injured person compensation in cash. This may enable him or her to live in reduced circumstances without recourse to charity; but money cannot make up for what the sufferer has lost, any more than it can heal a broken heart in a breach of promise lawsuit. The aim should surely be rehabilitation, not compensation.

In the course of a short article it is impossible to give comprehensive indications of the lines to be pursued in employing those whom we now call unemployable. It is possible, however, to set down one or two “pointers.” One is this. Never let the “charity” element operate in any employment scheme. Do not seek to attract “sympa-
thetic" sales by advertising that the goods are made by cripples or sub-standard workers. Buyers immediately assume that the goods are sub-standard too. "Sympathy" may lead to a few insincere orders; but it does not lead—in Great Britain at any rate—to the repeat orders which are absolutely essential to successful business-building.

Another, perhaps the most important of all, is that the head of the scheme, the Manager of the factory or workshop, and all the chiefs of departments should be sub-standard men or women. The General Manager of the Papworth Industries is a consumptive, formerly a school teacher; and all those holding positions of responsibility under him are likewise suffering from the same disease. The psychological effect of this is enormous. Every employee works, not merely to avoid boredom, but to get on in the world. He or she sees consumptives holding good, well-paid positions and thinks "What they have done, I can do." Import fit healthy men into the best jobs and this spirit of ambition dies at once. The sub-standard man or woman thinks "I can never get on here—all the higher positions are held by healthy people. I am not healthy, therefore it is useless to try and improve my position." That state of mind leads to disaster in any commercial undertaking.

Writing of the ideal environment for sub-standard workers, Dr. Varrier-Jones, the founder and Medical Director of Papworth, says "Their sheltered world must be a real world, no make-believe affair; let the same forces have play, even though tempered for the shorn lamb. ... Any attempt to place sub-standard workers in a subordinate position as compared with healthy workers would remove a valuable adjunct to treatment."

Another thing to avoid is "that Institutional feeling." A community of sub-standard workers must be as free to develop its ordinary social life as any other community. Too often strict rules are laid down and enforced, with the result that the sense of personal responsibility is lessened. The ideal is achieved by encouraging this sense, and guiding it along suitable lines, so that in due time an informed and instructed public opinion emerges. The force of such a public opinion is far more effective than any code of rules and regulations.

Under the sort of conditions outlined it is amazing to see what sub-standard workers can achieve. They may not be able to earn profits on the capital they use; but they will most probably succeed in
earning wages sufficient for their own maintenance. Is not this far better, far more humane and far more economical, than the bad old system of compensation without rehabilitation? It is cheaper to provide the necessary capital than it is to waste the remaining faculties of these sub-standard men and women; and how much better it is for them!

At present the world is organized for the benefit of the fit and healthy; but the burden of the unfit is growing. Even partially unfit workers are thrown aside if they cannot stand the strain and increasing pace of modern industry. They become, through no fault of their own, subsidized idlers. With the right organization these unfortunate persons could be given new hope and therefore new strength; and their fellow men and women would be freed from the heavy cost of maintaining them.

To waste the lives of men and women is the cruellest form of extravagance; and that is why it is so essential, on every ground of justice and good citizenship, to provide efficient rehabilitation wherever possible in place of the unscientific system of cash compensation.
THE WHY AND HOW OF PRESCHOOL HYGIENE

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The present generation is much concerned with the health of the preschool child, and why.

Well, to quote the late Luther Burbank—"If we had paid as little attention to our plants as we have to our children, we would now be living in a jungle of weeds." So, possibly it is because we wish to avoid the jungle of weeds.

Whatever the reason, we do know that recognition of the primacy of the child's rights in public health of late has been almost universal. The quickened sociological consciousness, much of it virtuous and tending to service and constructive ends, the broadening of organic society in many branches to include preventive as well as emergency activities, the sense that the new generations deserve better than we have built even out of materials at hand—these and other vital considerations have followed an enlightened instinct in centering interest upon the welfare of the child—with particular emphasis upon the child of preschool age—two years to six years.

WHY OF PRESCHOOL HYGIENE

1. The fact that the preschool child is to a large extent the prey of communicable diseases. Call the roll and see what a large share are peculiarly in the category of the so-called "children's diseases." How those which are frequently found in adult life reach down in-differently into childhood, particularly the preschool age.

Measles, scarlet fever, mumps, whooping cough, chickenpox, these are diseases of early childhood. Smallpox finds no immunity among unvaccinated children. Likewise diphtheria, which may be prevented by toxin-antitoxin, continues to take its toll among the young age group. Tuberculosis is quite generally believed to be pri-
Those of us who are called upon to make physical examinations of the preschool child and those who are doing research work along this line believe very definitely that there is a great need for education of parents and teachers and all those who have jurisdiction over children. The prospective mother should appreciate the necessity for prenatal care, since so much depends upon the condition of the baby at birth. Parents should avail themselves of every opportunity to learn how to make and keep a child healthy; how to protect him from disease; how to handle behavior problems and cope with situations when they arise, etc.

To illustrate. For the child suffering from malnutrition to have a pair of diseased tonsils removed is only one point. There are many other factors to be considered such as child's general condition previous to and following operation. The importance of the daily hygienic routine, sleep, rest, fresh air, use of tooth brush, sunshine, diet, digestion, absorption and assimilation of food, as the digestive process is thrown out of gear by fatigue and improper food all of which in turn tends to keep the child dull, or nervous, restless, irritable, hard to discipline and labouring under the handicap of poor health. His mind cannot function properly because his body is below par. His nerve resistance is weak because his physique is poor and so on ad infinitum.

Public health agencies, churches, schools, men's and women's organizations, medical, dental and nursing associations, magazines, newspapers, public spirited citizens, all are coöperating and contributing their bit in this movement to improve the nation's health.

Outstanding work has been done by the Parent-Teacher Associations.

In order to secure a physical examination for the preschool child and in order to awaken parents to their responsibility in this matter, the National Congress of Parents and Teachers inaugurated in 1925 the summer round-up campaign of the preschool children who were to enter school for the first time in the autumn. Space and time will not permit our discussing the details of the plan, but we are in a position to say, the schools are beginning to see results, of course, only in a minor way.

Finally, may we repeat that health is not the end of life or education, but it is an essential condition for the realization of worthy ends, more immediate or ultimate in the career of the individual.
The epigrammatic question may be reiterated, "What shall it profit a child if he gain the whole world of knowledge and lose his health?"

SUMMARY

1. In a brief manner an attempt has been made to tell why it seems necessary to promote and encourage a program for the conservation of the health of the preschool child.

2. To review the work done in several fields of research.

3. To stress the education of parents, teachers and all those in charge of children.

4. To state the anticipated result—

Ultimately this should mean that every child will enter school physically fit, his health habits formed, his corrective needs cared for, his bill of health clean, so that, generally speaking, childhood will be devoid of many physical embarrassments and handicaps.

In order to accomplish this, let us remember "it will take the everlastin' teamwork of every bloomin' soul."
We know that real happiness in life is attained only when an individual makes a complete adjustment to his environment, and since happiness is the ultimate goal of every individual, be he adult or child, it becomes highly important that the child is taught early in life to adapt himself to life's varying and varied conditions. It is in his own home, in his own little family group, that the child is first called upon to make a social adjustment. Under normal conditions this is not difficult to accomplish, as the family makes every effort to help the child to adjust.

The child's first experience at social adaptation outside the home comes when he leaves the home and enters the kindergarten. Here he meets a small group of children of which he must become a part. How he will meet this situation will have a tremendous bearing on his future mental makeup. As kindergarten activities and play activities are practically synonymous, the nature of this play activity will be a determining influence not only in teaching him to adjust to varying situations, but also permitting those observing him to determine to a great extent his personality makeup.

In a group where children are banded together by mutual aims and ideals, there is a splendid opportunity for the gathering of important material on the child's social reactions to his playmates. Where restraint is put aside, and where he is free to express himself without fear of criticism by his elders, many interesting characteristics are revealed to one engaged in the study of these personalities. Characteristics which under ordinary conditions are either repressed or inhibited, often burst forth spontaneously and reveal an altogether new personality. The functional nature of some conditions, such as speech defect and habit tics, may be brought to light under these cir-
cumstances. The timid child, the shut-in-type of child, the selfish child, is very apt to show his true colors, while special aptitudes, such as executive ability, leadership and originality may also be discovered in this manner.

At the Psychopathic Institute such a group has been organized.* This Club, which is called the “Blue Bird Club” by its members, is an organization composed of the children who are under observation at the Institute, and also of all former children who have been studied at the Institute at one time or another. The meetings are conducted as nearly as possible in parliamentary fashion. In this way the children are given an idea of Club organization, and some have the opportunity to act in the capacity of president and secretary, and thus gain training for future civic work. Material from the Child Health Organization is used, and personal hygiene is stressed. The watchword of the Club is “Service,” and the members are imbued with the idea that real happiness in life comes from service to others. We try to have the children recall what they have done for others during the week. The good deed done and then forgotten, is the one particularly commended. The Club meetings are well attended, as former patients report each Saturday morning in order to attend the meeting and to spend the day at the Institute. In this way it is possible to keep in touch with many children with whom there would otherwise be no contact.

The children (both at the Institute and the visitors) who have had a good week, that is, have been helpful, well behaved and kept themselves clean, have their names placed on the Honor Roll, and also are given five cents spending money. In addition, the visitors are given their carfare, and as they are expected to stay for lunch and spend the day, there is usually a good attendance.

What could be more significant than the president’s manner in calling the meeting to order, and his manner in addressing each child? What initiative some children show, and how different others are in the presidential chair! We also note the keenness of some children in detecting errors in the minutes, while others are indifferent, or unable to see these mistakes. For example, when Philip says: “respectfully admitted,” some children snicker, while others are at a loss to know what the joke may be.

After the reading of the minutes and recitation of the Health Jingles and Motto, the Jingle contest takes place. Happy’s Calendar with its Health Jingles is particularly well adapted for our purpose.
Each child in a limited time (three minutes) recites as many Jingles as he knows. The type of Jingles the children recite sometimes gives valuable insight into their character. For instance, the fat (hypothalamic) girl to my right, who is on a diet, recites Jingles which pertain to food, such as “Three square meals a day will put you in shape”; “God made fruit, then man got stuck up and made candy.” While the boy admitted for sex delinquency, takes delight in: “Girls be tub lilies”; “Are you a sleeping beauty?” The apparently ambitious young psychopath recites: “History proves that George Washington was a fast walker and a good sleeper—look at the millions of taverns he slept in.” Also: “It takes a heap of exercise to run for president.” We are sure he dreams of the presidential chair himself, but will make no effort to get there. The poor, puny little fellow who has evidently failed to compete with others in athletics, gives expression to his wish longing in the following Jingles: “Let your chest be a strong box”; “You may not be a star baseball player, but you can at least get exercise chasing the balls you miss.” George, though subnormal, shows originality when he recites his own Jingle: “Comb your hair, don’t look like a porcupine,” after Happy’s: “Brush your clothes, don’t look like a lunch counter.”

We like to see the attitude of the older and more fortunate children toward the younger and less fortunate. Sam is eager to help the timid girl next to him make a good showing when it is her turn to recite Jingles. He encourages her to stand, promising to help her.

The timid little fellow in the corner who was admitted for observation because he did not talk at all, and who even now will not recite the Health Pledge when standing at his own chair, does nicely when the worker has him stand with his back to the other children. The worker feels that in several weeks he will be able to overcome his feeling of inferiority and speak as well as the rest of the children.

Note the harassed look on the face of the little boy in the corner. The child was referred because of precocious mental, physical and glandular development. In spite of his superior mental ability, he stumbles all over himself when trying to say the Health Pledge, and is unable to compete with the dull children when reciting. The diagnosis: Pineal tumor, explains the situation.

Robert sits with a dreamy look in his eyes, and when called upon to recite, does not know the Health Pledge, neither does he take an active part in the Jingle contest. This is surprising when we know that he has an intelligence quotient of 140, and so we decide that the
intellect alone does not suffice, and we are even more firm in this decision when we consider Isadore. We could not understand why he was admitted to the Psychopathic Institute. With his brilliant mind and gentlemanly manner, we felt that there must have been some mistake when we got the report that he was unable to hold a job. We realize, however, that his reactions are abnormal when at the Club meeting he is willing to enter a contest with children one-third his age and to accept his nickel for being on the Honor Roll. The following is an excerpt from an article written by him. This article called: "What's in a Name," was suggested by our psychiatrist following the discussion of names of various children who had been studied at the Institute.

"Behold Hyman Rubinovitz and Okey Suter!! Corliss Conley and Aaron Weissfeld!! See Andrew Andres and Meyer Lewetsch!! Or, if your perception of differences lies in the domain of the natural, meet Paul Fox and Clarence Wolf. Let Charles Almond and Joseph Apple represent the plant kingdom! And you who sigh for the memory of your lost youth, observe Carl Young. Gather 'round students of the ethnic learning and become acquainted with the native individuality of such representatives as: Frank Spizella, Harry Zeichnuck, Eileen McDuffey, Paul Grutzmacher and Isaac Goldstein. Even William Jennings Bryan might cease his anti-evolutionary vociferations and become calm again in the presence of Moses-Solomon, Isaac and the never-parted Ruth and Naomi."

Isadore's career following his discharge from the Institute has been a checkered one, and he is now back with us in the capacity of orderly, this being the only place he has been able to adjust. All this bears out the diagnosis made when he was examined: namely, that in spite of his high intelligence quotient, 140, the boy is suffering from an incurable mental condition which will tend to grow worse.

We expect great things from Vivian (age 11) after reading the following:

"How I would like to spend the summer"

I would like to spend the summer here where it is so cool and pleasant, and where it is like a big family of brothers and sisters. The children are so nice to each other. I think it would be much better for my health and mind also, for here one is compelled to do the right thing, whether one likes it or not, and I am sure that the best of America's children would be improved by this sort of care and surroundings." (Signed) VIVIAN.
Sam looks forward each week to saying: “I move that the meeting be adjourned.” That, he feels is his contribution. In fact, each child finds some means of expressing himself, and by so doing gives us valuable information regarding him. Through the Club we gain an insight into the child’s personality traits, his capabilities, his ambitions and ideals. All in all, “The Club” offers an excellent opportunity for observation, and serves a valuable purpose at the Psychopathic Institute.

REFERENCE

* The Psychopathic Institute is an observation home for the scientific study of the maladjusted child. Here the child lives as he would in a normal home, one of a family of twelve, sharing the responsibilities, the work and the play. There is nothing resembling the Institutional life present, and the child has the opportunity for showing how he reacts in the proper environmental setting.

Before he is admitted to the Psychopathic Institute he is given a complete routine physical examination at the Jewish Hospital; a comprehensive social history and a psychometric test are also required. The child attends the neighboring school, and extra-curricular activities are arranged for him at the Institute. From the moment he enters the home, careful sociopsychological observations begin. He is watched at work and at play and daily notations are made on him.
THE END OF CONVALESCENCE—THE JOB*

FLORENCE RIVKIN

Bureau for the Handicapped, Illinois Free Employment Bureau,
Chicago, Ill.

A well-rounded program of convalescence is hardly complete until the patient has been readjusted in his daily job. The experience of our Bureau for the past year in working with the physically handicapped has brought to light many factors of major importance regarding the relationship between the convalescent period and the job. We find in, most instances, the real test of the patient's recovery is his physical and mental ability to go back to his work, and that preparations for his return to industry can be made a part of that period of convalescence, thus avoiding the hiatus between the hospital and the job.

The necessity of tying up the convalescent period with plans for future placement can be made clearer perhaps by pointing out some of the difficulties in adjusting the average case that is referred to us.

The Joint Bureau for the Handicapped was organized primarily to educate the employer, to convince him that a man who has a physical handicap can still be a useful worker in the industrial world. But we can also do much to ease the difficulties of readjustment for our applicant. By making the preliminary contacts with the employer we can save him much of the energy that he would otherwise expend in seeking his own job; by sending him to see only those employers who have been prepared for him we can soften the blows of the many refusals which he must necessarily encounter in this competitive industrial world; and thus, when we are fortunate, he walks into a job which has been specified for him.

Before a patient is referred to us for a job he must have had a thorough and general physical examination so that we will know just

what to avoid in trying to place him. Since we are guided primarily by
the physician's recommendations for those applicants referred from
hospital, convalescent home or clinic, the doctor must measure and
decide for us the physical capacities of the patient and tell us just
how much energy he may expend on his job; whether the
patient can work a full day or less, whether he can stand at his work
or sit, and whether he may do walking or lifting and how much.

In one instance a girl came to us with a diagnosis of arthritis in
the knee joint. She was to be placed where she could remain seated
all day. A job doing some very fine assembling work was found for
her where she worked only with her fingers and eyes; she spoiled
so much material during her first few days that her eyesight was
questioned by the employer. With this complaint she was referred
back to the clinic; her eyes were refracted and, after a two weeks
interval, during which glasses were procured, we were back where
we started and she had to be placed again. A man with 50 per
cent. defective vision was referred to us for placement. He needed a
job where there would be no danger of unguarded machinery, open
stairways, or elevator shafts, and, of course, one which would not
require close work. He was placed at packing pictures in a factory.
After working one week he had a severe coughing and choking spell,
became quite ill, and had to leave the job. He was sent back to the
agency referring him which in turn sent him to the clinic for re-
examination. He was found to have a chronic bronchitis which had
been badly irritated by the fumes of the paint used in decorating the
frames. These two cases show how difficult it is to make placements
without the complete physical examination indicated above. In addi-
tion to the bad placements made, the final adjustment of these two
people who needed work badly was delayed; two jobs were wasted
and moreover we had jeopardized our relationship with two employers
whom we had painstakingly persuaded to use handicapped persons.

When a man has been pronounced ready to work he is referred
to us. Perhaps he has been in the hospital recovering from a
severe heart attack, and he has been discharged and told to look for
a job, that his heart was now compensated, but according to his
doctor too much exertion would put him on the down grade. He is
able to work not more than eight hours a day; he must sit most of the
time, and of course he must earn enough money to support his family,
because he must not be allowed to worry. During the convalescent
period he has done nothing but rest; he has had no gradual exercise
The Job

or occupational therapy. If we find him a job immediately he goes directly from the hospital or convalescent home régime to the factory routine with no transitional period. Fortunately, we are not often able to place applicants on the occasion of their first visit to our office.

Our first interview reveals that he is unskilled, that until his illness he was a truck-driver, or day laborer, loading cars, working in a lumber yard or on the streets, that he has earned his living only by sheer physical strength. He has probably earned from $5.00 to $7.00 a day, and has been able to support his family. Perhaps we offer him a job at light assembling which will pay him according to his output at a piece work rate, or perhaps 30 cents an hour. He works at it for a day or two, and finds it most difficult to accustom his hands to working with small objects, when he has always handled a shovel or pick. He is discouraged also by the fact that he is earning almost nothing, and that he must have outside help if he is to keep his family together, so he gives up the job in disgust and comes in to ask for another which pays more and is not quite so monotonous.

If this man could have had some preliminary training in this type of work in a sheltered workshop before being referred for placement, it would permit our bureau to function more efficiently. As it is we must use many of the jobs we get as tests of our applicant's ability and desire to work, and, very often, we have lost the cooperation of the employer by using his shop to try therapeutic measures with our clients. If the applicant had been guided towards thinking of his future employment from a different point of view, and told at the outset that his earning capacity has been cut down and that for some time at least he must do work which will probably pay less than he was earning before his illness, he would then become accustomed to the idea of doing some other type of work before he was sent to get his job. We have had people referred to us who are not aware that their earning capacities are limited and the knowledge that should be brought to them gradually comes as a blow to their plans for the future. Very often they secure jobs themselves which are entirely unsuited to them and it is not long before they are back where they started.

If our applicant has been properly educated and cautioned by his doctor as to what he should or should not do, and is intelligent about himself, we should anticipate no further trouble, but even then there are unforeseen difficulties. Several times we have placed a man
in what we considered an ideal job for his condition and after several weeks we have had to take him off because it seemed too hard. We learn from the employer that he has not been asked to do anything that he should not have done, but we do learn that in order that the family be self-supporting his wife has gone out to work, and that instead of resting after his day’s work, his evenings have been spent in helping with the housework, attending to the children, and doing the family shopping. Of course this situation can only be remedied by careful follow-up on the part of the family case-work agency, or the medical social service worker.

The applicants most difficult to deal with are those who are and will be dependent upon various agencies until they get work. They deplore their dependency and want work regardless of their physical conditions. They walk the streets constantly, calling on us at frequent intervals, and sometimes, before we are able to offer them anything they have had a relapse and must go back to the hospital or convalescent home for rest. We have had men and women register with us and two or three days later when we try to reach them to send them out on jobs we find them sick in bed. On one occasion we were very much perturbed because an applicant whose case worker had urged the importance of this immediate placement did not respond to any of our messages regarding a position. We called the family direct and found that he had died the week before. We believe that many of these difficulties could be avoided with better team work on the part of the hospitals, clinics, and case-work agencies, if during the convalescent period our applicant could be conditioned to the régime of industry, instead of expecting him to report to the job from the convalescent home or hospital.

The ideal solution is of course a workshop with adjustable hours and tasks, where the patient can gradually be brought back to his full working capacity. We have found that it is practically impossible to find employers in industry who are willing to sacrifice their profits to permit this to be done in their factories. The few people that we get who have been prepared for work have little difficulty in being reabsorbed in industry, and we do not feel too hopeful, I am sure, when we look forward to a time when the handicapped person who is capable of being trained will have the same opportunities as a normal worker, and when he can fill a skilled job he will be a highly productive part of the industrial world.
SUNLIT EXERCISE AND MOTHERHOOD

C. W. SALEEBY, M.D., F.R.S.E.

Chairman, Sunlight League, London, England

Here is a delightful discovery which bears directly and happily upon the prevention of maternal mortality, one of the most tragic facts of modern civilization, and notably so in our own country.

In 1890, Dr. T. A. Palm, a returned medical missionary, showed by geographical comparison that rickets is what, a decade ago, I called a "disease of darkness." But it was not until an American bibliographer in 1920, directed my attention to the work of Dr. Palm, during a visit to the laboratories where the action of sunlight was being studied in Columbia University by Dr. A. F. Hess, that we learnt how signal a discovery had been made, a generation earlier—to be ignored by everyone concerned. A whole generation had been lost, and meanwhile rickets abounded. A recent enquiry by the Ministry of Health has shown that more than 50 per cent. of our children, at three years of age, suffer from well-defined rickets. Well and ill may this be known on the Continent as "the English disease."

Despite Dr. Palm's discovery—and he was the true pioneer, Great Britain bears the Palm, and not Dr. Huldschinsky of Berlin in 1920—we have neglected the disease, both in its cause and its consequences. We recognize it only when we see gross knock knees or bow legs or pigeon chests; and we neglect those early months and years when the disease begins and could so easily be arrested. Above all, we have neglected what, in view of recent remarkable work by Dr. Kathleen Vaughan, may be indeed by far the most important consequence of rickets.

Even in the brief and notoriously inadequate teaching of obstetrics to medical students, time has long been found to point to the deformity known as a flat or rickety pelvis; and if the "examinee" can identify such a pelvis in his vivâ voce and note that it is misshapen, being flattened from before backwards, and correspondingly widened from side to side, he is likely to get his pass.
But Dr. Vaughan has, at long last, raised this perfunctorily taught and quickly forgotten matter to its proper level as a national and radical question of life and death. This is not the place in which to discuss at length her paper, recently read to the Royal Society of Medicine. The reader will find a simple and cogent statement, from her own pen, with a tragic and unforgettable illustration of a high-class Indian mother in Purdah, in *Sunlight* for July 1928. The simplest way of teaching what is really a very simple fact is to do as she did at the recent Annual Meeting of the Sunlight League at the Duke of Sutherland's house, where, having visited a toyshop on her way, she showed an india-rubber ring and an india-rubber ball which just nicely went through it—until the ring was flattened by pressure, and then the ball could be got through only with much pressure, and some temporary deformation. How many feebleminded are now in costly and hopeless institutions because their heads were thus deformed at birth?

For the healthy development of our bodies, and notably of our bones—and teeth, but that is another and a very poignant story—we need Vitamin D, the magic chisel, as I have called it elsewhere, of the sculptor sun; and exercise of the growing bones (including jaw bones and teeth). Hence the appalling rickets and maternal and infant mortality, far worse than anything we see here, in high-caste Indian homes, whither the light of life may never penetrate. The little girls suffer, and when they become mothers their boy babies suffer most, having somewhat bigger heads than girls. Surely the time must be at hand when leading Indians, in the interest of their finest stocks, take up this matter.

But our concern here is our own race. After comparing the pelves of stay-at-home urban women and country women, of idle women and active out-of-door women, as found in the world-famous Museum of the Royal College of Surgeons, Dr. Vaughan concludes that a leading cause of the deaths of mothers and new-born babies in our country is slight rickety deformity of the pelvis, not observed as we all observe that extremely common, slight, rickety curvature of the shin bone, which not the costliest silk stocking can conceal, on the courts at Wimbledon and elsewhere—but a deformity of awful importance—a matter of life or death, sanity or imbecility, for this generation and the next.

The right exercise in true sunlight is the remedy: no, not the remedy, but the course for creative hygiene and practical eugenics.
I asked my friend Sir Arthur Keith, F.R.S., the great student of mankind, by whose permission and with whose help Dr. Vaughan made her observations in the Museum of which he is the Curator, what would be the best exercise for the young girlhood of our land, in view of her conclusions, and his answer was "Skipping in the sunshine." It were to gild refined gold to add comment on this latest, jolliest, wisest word of true obstetrics and eugenics and Humanism. The Dark Ages have lasted long enough; now is the Dawn of Day.
EDITORIAL

THE WASTE IN MOTHER'S LIVES

By MRS. JOHN SLOANE

President Maternity Center Association, New York City

Appalling facts about the number of mothers dying from childbirth came to the attention of members of the Women's City Club of New York in 1917. They were aroused to action when they realized that, during the decade preceding, typhoid fever had been practically eliminated; tuberculosis had diminished from first to second place on the roster of lethal diseases; smallpox had been controlled; but deaths of mothers in childbirth had shown no reduction whatever. And this was in the face of the fact that obstetricians advised that adequate maternity care could prevent a large part of these deaths.

Something soon began to happen. In the summer of 1917 a maternity center was opened, financed by the Women's City Club. Then, in April, 1918, a group of women met and conferred with several prominent obstetricians. They were inspired by these doctors with hope that the skill and care which showed such excellent results among their own patients could be extended to women at large.

This led to the organization of the Maternity Center Association. It was predicted when the Association was organized that as a result of the activities which were outlined, the deaths of mothers in childbirth would be reduced by 66 per cent., and of infants under one month by 40 per cent.

This is how nearly the prediction has come true. Among 4,726 mothers cared for by the Association, the deaths were reduced to 2.2 per thousand live births, as compared with 6.2 among mothers in the same district not under the care of the Association. Infant deaths in the first month of life were 29.1 in the special group, while they were 42.9 per thousand in the general population.

The records of mothers cared for were analyzed by Louis I.
Dublin, statistician of the Metropolitan Life Insurance Company, who made this comment: "This result is indicative of the saving of lives that might be accomplished were every mother to receive adequate maternity care. More than 16,000 women in the United States die every year from causes related to maternity—the highest rate of any civilized nation. If these mothers received adequate maternity care 10,000 could be saved."

The situation existing in this country can only be explained by the fact that childbirth is so commonplace and the accidents attendant upon it are accepted as the will of God. The lack of care is due to an uninformed public rather than to the lack of medical knowledge. It is not indifference but ignorance that allows us to continue last on the list of nations in the maternity care we provide.

"One of the most dramatic of all human events, the birth of a new being, is accepted casually, almost without concern, because it is so frequent—so commonplace."

The cold, bare, terrible fact is that we, as a people, are not aroused sufficiently to this national disgrace to take the necessary measures to remove it.

Maternity hazards can be reduced by money wisely expended in any community when doctors, nurses and lay people will learn how to work together to provide adequate maternity care for every expectant mother.

The need today is to set into operation the machinery which will bring to doctors, nurses and the public what obstetricians have learned will save mother's lives.

Your State Department of Health and the Children's Bureau at Washington, D. C., will send helpful literature on request, or write to the Maternity Center Association, 576 Madison Avenue, New York City.

Those who understand the inarticulate problems of childhood have framed The Children's Charter in recognition of the rights of the child as the first rights of citizenship. May Day—National Child Health Day is pledged to programs which seek to secure these rights. We labor for this culmination not only from a sense of duty, but from a feeling of affection and love for all children, and a deep-seated reverence for their innocence and their trust in us.

If we have enjoyed a healthy and happy childhood we wish to
Editorial

insure health and happiness to all children, for as the years pass the memories of those days grow more and more precious. If our childhood was oppressed with loneliness or illness, we long still more earnestly to prevent such tragedies in other little lives, because maturity brings understanding of how health—which means happiness—sets the tune of one's whole development.

The call this year is for communities to assume responsibility for the health and protection of their children. Only through the persistence of those who love children and appreciate their contribution to our nation's future can the provisions of The Children's Charter, translated into action by public officials, organizations and individual workers, become part of life in America. May Day—National Child Health Day is placed in the hands of the nation as an instrument for child happiness.

AIDA DE ACOSTA BRECKINRIDGE.
NEWS NOTES

Mother’s Day—May 10—is to have a new meaning this year. Educators, physicians and public spirited men and women are to join with clubs, churches and civic organizations to center public attention on the fact that America’s death rate from causes connected with maternity is the highest in the civilized world.

Dr. Stanley P. Davies and George A. Hastings, Assistant Secretaries of the New York State Charities Aid Association are giving courses in the Extension Department of Columbia University. Dr. Davies’ course is on “Mental Factors in Social Maladjustment” and Mr. Hastings lectures on “The Organization of Public Opinion.” Both courses will be of interest to social workers.

The Chicago Health Department may well be proud of having achieved a marked decrease in infant mortality during the past few years. In 1921 the infant deathrate was 89.3 per 1,000 births and in 1930 the rate had been reduced to 53.4 per 1,000 births.

The First National Congress of Child Welfare Service will be held in Buenos Aires, Argentina, in September, 1931.

The American Public Health Association will hold its sixtieth annual meeting September 14-17 inclusive in Montreal, Canada.

The Second Quinquennial Conference on Narcotic Education was held in Geneva, Switzerland, May 11 to 15.

Acting on the advice of leading medical and hospital authorities, the American Occupational Therapy Association has established a National Register or Directory of Qualified Occupational Therapists. The purpose of the Directory is to maintain high standards in the profession and, in particular, to safeguard properly qualified workers and to protect hospitals and institutions from unqualified persons posing
as occupational therapists. For information regarding qualifications for admission to the National Register, apply to Mrs. M. R. Cobb, Acting Registrar, 175 Fifth Avenue, New York City.

The National Health Council, New York City, and its member organizations have moved from 370 Seventh Avenue to the Nelson Tower Building, 450 Seventh Avenue. The member organizations include the American Child Health Association, American Heart Association, American Public Health Association, National Committee for Mental Hygiene, American Social Hygiene Association, National Organization for Public Health Nursing, National Society for the Prevention of Blindness, National Tuberculosis Association, Foundation for Positive Health.

... To be mery in the herte is a grete remedie for helth of the body.—Bishop of Arusiens, 1485. (From “A litil boke for the pestilence.”)—Hygeia.

Dr. Adolf Meyer, Professor of Psychiatry, Johns Hopkins University, has been chosen as the recipient of the first award of the Thomas W. Salmon Memorial. Dr. Meyer will deliver a series of lectures, to be known as the Thomas W. Salmon Lectures, at the Academy of Medicine during the year.

The Annual Conference of Health Officers and Public Health Nurses will be held at Saratoga Springs, June 29 to July 1 inclusive.

The headquarters of the American Nurses' Association have been moved to 450 Seventh Avenue, New York City.

The first Rumanian child-welfare exposition is being held in Bucharest, April 23 to May 23, 1931.

The United States Civil Service Commission announces the following open competitive examinations: Social Worker (psychiatric), Junior Social Worker. The examinations are to fill vacancies in the Veterans' Administration Hospitals and regional offices. Full information may be obtained from the United States Civil Service Commission, Washington, D. C., or at the post office or customhouse in any city.
The National Urban League is offering six fellowships to colored students for the year 1931. The field of study is social service work.

A hospital for defective delinquents is to be built under Federal auspices to treat “all offenders against the United States who are in the actual custody of its officers or agents, and who at the time of their conviction or during their detention are or shall become insane, afflicted with an incurable or chronic degenerative disease, or so defective mentally or physically as to require special medical care and treatment not available in an existing Federal institution.”

The hospital will have a capacity of 600 or 750 beds and is expected to relieve St. Elizabeth’s Hospital of all of its criminal insane. It is hoped that the new institution will, in time, become the medical centre for the whole Federal penal and correctional service.— *Mod. Hosp.*

Women’s clubs throughout the country joined in an appeal on Mother’s Day to obtain adequate maternity care for mothers in the United States.

The Welfare Council of New York City, believing that giving cash to beggars increases begging, has issued vest-pocket sized folders containing classified lists of lodging houses, temporary shelters, relief agencies, hospitals, health services, employment bureaus, etc. These handy little folders make it possible for the average citizen to refer men or women who beg on the streets to proper agencies for aid.

Irvington House, Irvington-on-the-Hudson, a home and hospital for cardiac children, which was destroyed by fire several months ago, is to be rebuilt and enlarged to accommodate 150 children.

The Tonsil Hospital, New York City, has established an evening clinic service for adults.

The National Committee for Mental Hygiene has on hand a limited number of back issues of “Mental Hygiene,” quarterly journal of The National Committee for Mental Hygiene, beginning with Volume 1, 1917, which will be given, without charge, to libraries, medical schools, hospitals, clinics and other eleemosynary and educational
institutions. The only charge will be for packing and shipping. Applications should be made at once to H. Edmund Bullis, Executive Officer, The National Committee for Mental Hygiene, 450 Seventh Avenue, New York City.

The first bill signed this year by the Governor of New Hampshire made $75,000 immediately available during the first four months of the year to assist mothers and children affected by unemployment. This augments the State’s current appropriation of $45,000 for mothers’ aid. It is to be used to care without delay for waiting applicants and to extend aid to mothers and their children rendered temporarily dependent by the unemployment either of the mother or of the person upon whom she usually depends. The law stipulates that the aid given by this fund is not to replace that of county, city, or town but may supplement it. The Governor and the State Board of Education are made jointly responsible with the State Board of Public Welfare for administration of the fund.—U. S. Children’s Bureau.

“What is a Boy?

“He is a person who is going to carry on what you have started—

“He is going to sit where you are sitting and attend to those things you think are so important, when you are gone—

“You may adopt all the policies you please, but how they are carried out depends on him. Even if you make leagues and treaties, he will have to manage them. He is going to sit at your desk in the Senate, and occupy your place on the Supreme Bench.

“He will assume control of your cities, the state and the nation.

“All your work is going to be judged and praised or condemned by him. Your reputation and your fortune are in his hands. All your work is for him and the fate of the nation and of humanity is in his hands.

“He will carry on what you have started, so it might be as well to pay him some attention.”—From an editorial, San Francisco Examiner.

The New York City Department of Health employs 603 nurses, including supervisors, to carry on the various health and welfare activities of the Department.
An exchange of lectures on the subject of Social Work has been
effectuated for the spring quarter 1931, between the School of Social
Science, University of Liverpool, England, and the Training Course
in Social and Civic Work, University of Minnesota.

Miss Ellinor L. Black, lecturer, University of Liverpool, is to
lecture on the History of Social Work in England at the University
of Minnesota, and Miss Elizabeth G. Gardiner, Assistant Professor
of Sociology at the University of Minnesota, is to give a course on
Trends in American Social Work at the University of Liverpool.

The Faculty of Medicine of Paris (The Medical School of the
University) announces that, during June and July, 1931, a com­
prehensive series of post-graduate courses will be presented. The en­
terprise is conducted under the auspices of the Association for the De­
velopment of Medical Relations (the "A. D. R. M.") a commission
sponsored by the French Government.

The work will be presented in the English language. Clinics,
lectures and demonstrations will be conducted in the great hospitals
of Paris, on a wide variety of topics, by the most eminent French
clinicians. A nominal fee will be charged for each course. Upon
the completion of each course, the student who qualifies will receive
a certificate covering the work, signed by the professor in charge.

Detailed information may be secured by addressing direct, Pro­
fesseur E. Hartmann, President, "A. D. R. M.," Faculty of Medicine
of Paris, 12, Rue de L'Ecole de Medicine, Paris (6e) or, in the
United States, Doctor Frank Smithies, 920 North Michigan Avenue,
Chicago, Illinois.

BOOK REVIEW

Hygiene and Sanitation. By Jesse Feiring Williams, M.D. Phila­

Hygiene and Sanitation has been revised by Dr. Williams accord­
ing to the most up-to-date scientific data. As the author states in his
preface, the book is for the beginner and deals with the fundamentals
of health. Great care has been exercised not to digress into many
tempting fields of interesting material. The book is well planned for
use in the classroom and questions and exercises at the end of each
chapter are aids for both teachers and pupils.
To the reviewer the most interesting feature of the book is the plan on which it is constructed as a whole. After sketching lightly the modern health trend, the author devotes a chapter to the health care of one's self and then beginning with prenatal life introduces the reader chronologically to the study of the care of babies and young children, preschool and school children, mature individuals and then to the care of the aged and infirm. Another path leads the reader via the health of the home to the factory and out into the community at large as represented in the governmental divisions of city, state and nation, and further develops an attitude toward health and disease which includes all peoples and all nations.

We recommend this book to the serious attention of all who deal intimately with teaching health to lay groups or individuals.

ALMA E. GAULT.


Written by one who saw nearly four years of active service "The Cross Bearers" is not just another war book. It is a splendidly written narrative concerning the activities and thoughts of a stretcher bearer in the medical corps of the German Army.

The book has marked literary merit and vividly tells the story of an individual somewhere in the thirties who in civilian life is classed as an intellectual, and after being assigned to the medical corps finds himself in company with two others leaving Munich in September, 1915, for active duty. From then on the soldier who wears the brassard of the Red Cross on his arm is described in lively vibration of reality as he passes from one scene and incident to another during his three years of active war service on the Western Front.

The reader cannot help but be impressed with the author's description of vice, dirt, disease, contempt for everything and indifference to life which that front line duty brings to the soldier.

The author ably illustrates the fact that a great many of the officers and soldiers were overworked and under a terrific mental strain, and it is natural to suppose that there should occur a desire and the will to quit the front line service and make way for others.

Unfortunately, in the eyes of the civilian the evaluation of the behavior and morals of soldiers during the war suffer by comparison in that they do not come up to the standard of the erroneous time-
worn idea that in the broadest sense of the word every soldier must be a hero. In these days of induction into the service it is to be expected that the army and navy will be filled with a cross section of life, and this means that it will have its civilian quota of do-nothings, know-nothings, illiterates, ignoramuses and men of low order of society. Even the most optimistic could not think that a uniform and a few months of training can change the morals and behavior of many individuals past the age of maturity.

On the other hand, if it is taken for granted that the German soldiers and officers are for all practical purposes of the same calibre as the personnel of the French, English, Canadian, Australian and American armies, it can be safely stated that even under the most trying conditions German officers and soldiers in a very large majority of instances accomplished much which may be construed as bravery and heroism. Moreover, in every army it is just such occasions which are filled with discouragement, despair and hardships that bring out the very best of virtue and character in many individuals, who in turn comfort and serve as a rallying point for others who are caught in the cross currents of opposing tendencies of that which is base in contrast to that which can fairly be called noble.

Throughout the book one notes that among the many missions of the personnel of the Medical Corps is keeping up with the combat troops and maintaining communication rearward with the division and bearer company, collect the wounded and assemble them at dressing stations which as a rule are hurriedly set up in cellars, or on the side of hills, or other supposedly safe protected areas, at a distance of a little over half a mile from the front line. Outside the entrance there are a few crude signs and a Red Cross, indicating that within is the medical quarters of their particular regiment and that they are prepared to function and are ready for business. Here the wounded men who can walk trickle in. The others are loaded on litters from the front and hauled in by the overworked stretcher bearers who are usually not built for such heavy labor.

At the same time, glancing behind the scene of warfare and disregarding for the moment the way and wherefore of war, the reviewer cannot let the opportunity pass by without stating that this excellent war novel has emphasized the fact that the care and transportation of the war sick and wounded require an adequately trained and efficient personnel and, in this country at least, further efforts should be made to accomplish this end. 

Samuel Adams Cohen, M.D.

The authors define sterilization as "a method of preventing parenthood without altering the sexual life of the individual." "The removal from a human being of his power of procreation by surgical operation, under sanction of law" is the definition made by their legal representative in presenting the facts before the American Bar Association.

In the last ten years the state of California has removed the power of procreation from 6,787 men and women. (To January 1, 1930.) As feebleminded or insane patients under her care in state institutions, they were about to be sent on parole back to their homes and to whatever they might have of normal life. If all continued well, the last thing the state did for them was this. This automatically removed from anyone mated to these patients then or in the future, all power of procreation within the bounds of monogamy. The individuals to be counted may then be multiplied by two whenever marriage is concerned.

This book gives a precise account of conditions under which this operation is done, including the history of the development of the surgical method, with alternatives and future possibilities, so far as they seem predictable. It tells in detail just what kind of people have been sterilized, male and female, insane and feebleminded.

It explains in a given case, just how the state proceeds in contact with patient and nearest relatives; it shows the form of consultation between doctors, social workers, and superintendents of asylums. It recounts the patient's attitude to the operation both before and afterward, his after behavior, and the effect upon his sex life.

The story is told against the background of the general problem of insanity and feeblemindedness in the United States. The thesis is that with increased attention and better hospitalization, people having mental disease, (about 10,000,000) are in proportion three times as many as they were fifty years ago. Twice as many of these sick people live in cities as in the country—and the city grows more crowded every day.

Of the 4,800,000 insane and of the 6,000,000 feebleminded enough to get to an institution, not half stay all their lives. Just as a hospital may discharge a patient who is still sick, to use the bed for another who is much sicker, so the asylum disposes of the mild case, which
may be returned to the family to make room for the idiot and the maniac. Nevertheless in any given year, half as many people as we have on the college campus are behind the iron gates of asylums and institutions for defectives, and it costs $500 per year to keep an insane or a defective person in an institution. Thus economic reasons strongly reinforce the present technique of returning mental cases to the community when possible.

Regarding these carriers of "defective germ plasm," as entitled to live outside the asylum only when prevented from transmitting their qualities to the unborn, twenty-nine states have experimented with sterilization under the law beginning with Indiana in 1907 and twenty-four have effective laws at present. The Supreme Court of the United States declared such a state law constitutional in 1927, in the Virginia case of a feebleminded girl, daughter of a feebleminded mother and mother of an illegitimate feebleminded child. Up to January 1, 1930, a total of 10,833 operations for sterilizing without unsexing had been performed in twenty states reporting.

The dread and reluctance with which it is voted to lay a hand thus on the very life essence of another person shows in the fact that several states have made laws but never performed sterilizations and others have made laws but repealed them when they were mandatory punishment. The authors review this situation and take up point by point the possible public and private objections.

They say first, that the public confuses castration which has bad physical and psychic effects with sterilization which removes no organs and no glands, changes nothing. It "produces no change in the sexual life." Marriage of the cured insane is not recommended, but that of sterilized feebleminded girls is quite possible and turned out fairly well in the 125 marriages examined.

Second, sterilization does not in these circumstances prevent the birth of genius. The patients come from a grade of unskilled and semi-skilled labor which does not produce genius.

Third, sterilization is not punishment and that portion of California's law which permits sterilization a criminal for rape or for "continued evidence of moral and sexual depravity" has been utilized in only seven cases. The tone of the authors is against it and they dissociate it entirely from the eugenic issue.

Fourth, they conclude that voluntary sterilization in private practice—about which there is some knowledge in the cases of 150 men and 420 women, should have some form of state supervision.
ABSTRACT


The Aide Service in the Rochester General Hospital was started in 1887 for the purpose of making and providing linen for the wards. Since then it has developed and is now a recognized department of the hospital. The head, or chief aide devotes much time enlisting volunteers from groups of lay women, adjusting new situations which may arise, and to perfecting the understanding between the aides and hospital groups—doctors, nurses and executives. The chief aide is a member of the Social Service Committee and the Women’s Board; she talks to incoming groups of probationers, describing the ideals and functions of the service groups and occasionally meets with the supervisors to receive or make suggestions which will enable them to work together for the advantage of the whole hospital. Aides are assigned to each clinic for secretarial work. Here they give valuable assistance in keeping records, making appointments, sending out follow-up notes, etc. Promptness and strict attention to work is a hard and fast rule. Three aides are on duty in the hospital halls every Sunday where they greet the patients’ visitors, take charge of packages for the patients thus facilitating the admission of visitors. They also visit the wards to see that the rules of visiting are observed. Hostess aides report for duty at 8:30 A.M. and after signing in get the list of operations for the day. They then get in touch with the relatives of the patient and do all they can to make things comfortable for them. Another group of aides act as messengers for the information service worker and the executive office of the hospital. When not busy these messengers make hospital supplies. Still another group of aides is assigned to the library. They distribute books to the patients and personnel. The success of the Aide Service is due to a clear-cut understanding of its true functions, that of giving a hospital a non-professional human service on a part-time basis. A pledge on the front page of the aides’ register reads: We recognize the need of regular and prompt attendance, of courtesy and alertness, of attention to dress, manner, deportment, and a strict observance of such professional ethics as may from time to time be expounded to us. This interesting article shows how a well-organized volunteer group can render valuable assistance, not only to the administrators, physicians, nurses, but to the patients and patients’ friends as well.
"How the Teaching Hospital Can Train Medical Social Workers."

Although the social worker has received her basic training in social work before she enters upon her work in the hospital, it is in the hospital that she learns the procedure of medical social work as a specialized type of activity. The social worker has a knowledge of social problems and possible means for their solution and an understanding of the inter-relationship between the individual and his social environment, and she is able to apply these in the treatment of social ills. What contribution has the social worker to make to the practice of medicine, what additional training does she need, and in what way is the teaching hospital responsible for her training. As a result of a study made by the American Association of Hospital Social Workers certain facts regarding the training of medical social workers in relation to teaching hospitals have been established. Teaching hospitals are equipped to participate in three phases of the teaching plan—
1. in giving field practice; 2. in providing formal instruction in medical courses for social workers; and 3. in presenting the opportunity to participate in medical social research. The author clearly shows the importance of such training, a training which reacts upon the hospital as the social worker brings to the institution a vision and knowledge not possible to one untrained in social diagnosis. Six of the nine training centres for medical social work are integral parts of universities that have teaching hospitals connected with their medical schools. All nine of the teaching centres have established relationship with teaching hospitals.


This interesting article emphasizes the value of social work in dealing with problem children. The author sketches the aims of the social worker and shows conclusively how the worker in her intimate contact with the family and the child in his home setting can aid the physician, psychiatrist and psychologist, who only have clinic contact with parent and child, in making the necessary arrangements to adjust the child to his home and social environment. Reaction to parental authority and influence, the social history and intellectual level of parents and many other factors in home life are discussed. Several cases and
the mode of treatment carried out are cited. Social workers whether engaged in psychiatric case work or dealing with the every-day conflicts between youth and the older generation will profit by reading this simply written but illuminating article. The author has a keen understanding of the difficulties confronting the child whose home presents personality or environmental problems which can and do result in revolt and maladjustment.


This very short article is a beautiful tribute to the English “nannie” and shows how far reaching is the influence of these women who care for and guide the thoughts and minds of their young charges. Even before the Nursery Training Colleges existed in England the type of women devoting their lives to the care of young children was high and their love for their charges gave them an almost maternal insight, which equals months of psychological study. This deep appreciation of the influence of the friend and companion of the young child goes deep in English tradition and one wonders if we in this country are not a bit too careless of the type of person who holds sway in American homes. Psychologists might easily find a clue to the personality defects in children by a study of the type of person engaged by parents to care for their children during the most impressionable years.
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