THE PRESENT TRENDS OF MEDICAL SOCIAL WORK*

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The subject assigned to me is broad enough to allow for a presentation of numerous phases of medical social work. However, I am going to limit myself to a discussion of a few trends in medical social work which seem to me to be particularly apparent and significant in the professional advancement of this field. The time has passed when it seems necessary to justify the existence of a social service department within a medical institution with an array of arguments concerning its purpose and accomplishments, but a statement of the present development in regard to functions, organization, and educational requirements might be pertinent. Stock taking or careful review at various intervals is wise in any line of endeavor and particularly so in medical social work, which has had a comparatively recent inception and rapid expansion.

These three phases of medical social work are closely correlated. Functions, the activities appropriate to the profession of medical social work, which may occasionally differ from current practices, are important since they demonstrate the purpose of the profession, while the organization within the department and of the department within the hospital or medical center will tend either to further or hinder the carrying out of these functions. Education or reproduction of new practitioners in the field might well be considered a corollary of function and is essential for the continuance and growth of the profession.

It is clearly evident that the major emphasis in the practice of medical social work has been placed upon case work with individual

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*Read before the Annual Convention, American Hospital Association, New Orleans, La., October, 1930.
patients. This assertion is definitely made in the statement of "Minimum Standards to be Met by Hospital Social Service Department," adopted in 1928 by the American Association of Hospital Social Workers and endorsed by the American College of Surgeons. Social inquiry, the gathering of pertinent information relative to the personality, social relationships, and physical environment of patients is essential if a hospital is to render adequate service to those whom it accepts for care. It may be brief or extended, but it should reveal all the facts necessary for a knowledge of the meaning of the patient's illness and the assets or liabilities he may have for meeting his disability. Social findings rarely contribute to the specific medical diagnosis except, for instance, in cases of psychoneurosis or industrial disease, but they do contribute to the understanding of the entire health problem of the patient.

In some hospitals social examination is undertaken only for certain patients. These chosen few may be selected by the physician or the social worker. Frequently specific medical diagnosis may be agreed upon as a basis for choice. Some physicians hold a fallacious theory that only free or part-pay patients require the services of the social worker. They do not realize that personality disturbances or lack of knowledge concerning community resources when found among the comparatively well-to-do may indicate the need of the services of the social worker just as much as when encountered among the economically unstable group. The tendency is apparent, however, to feel that any arbitrary selection of patients for social study based upon such factors as snap judgment, medical diagnosis, or economic level is unwise and to consider that the hospital owes this service to all patients. Some of the histories may reveal there are no social factors relevant to the patient's sickness. It is significant for the hospital to know this as well as to learn after a consultation with the throat service that there are no throat complications in a particular case. This 100 per cent. contact for social examination may not be possible where the social service department is inadequate in size, since responsibility for social treatment when indicated must be carried as well. The danger of superficial diffuseness must be guarded against, but even a brief social history secured with skill and making clear the essential points will save much time and waste motion for patients and for hospital. Therefore, social inquiry for all patients is a desired goal towards which social service departments should strive.

The timeliness of this social inquiry is important. It should be
undertaken simultaneously with the medical study in order that the physician may have the benefit of this knowledge when he needs it most. The physician responsible for the care of the patient must relate the social data to other findings, medical, nursing, and laboratory, in order to comprehend fully the inter-action of the health and social situation. It should be readily accessible for his use. This may be accomplished either by filing the full social history or a summary of it with the medical chart, or by conferences between physician and social worker. The interpretation of the social factors which the social worker can give during ward rounds may add much to the significance of the findings and focus attention on them at a time when they can be of the greatest value as a basis for a complete understanding of the patient and his resources and for outlining a plan of medical social treatment.

Social inquiry is not just the haphazard gathering of information about a patient’s past life and his present needs. It is a systematic undertaking requiring skilled technique and directed toward definite objectives. It includes trained observation, the interviewing of the patient and the patient group, social inference, the noting of relationships between facts, the distinguishing between the relevant and the irrelevant to the situation, the discovery of causes underlying effects, and the clarifying of assets and liabilities. Therefore these two processes in case work, social study and diagnosis, require a background of training and experience on the part of the social worker undertaking them.

They are the preparation for fulfilling the primary purpose of the hospital which is treatment of the patient. All social problems influencing, created by, or co-existent with sickness cannot and should not be dealt with by hospitals or their social service departments alone. The social worker does not attempt to be doctor, nurse, teacher, spiritual advisor, or lawyer to those under care, but utilizes resources outside of hospital auspices, either within the patient group or through community agencies, health, social, industrial, educational, recreational, religious, and legal. A hospital’s community is not just the city in which it is located, it is comprised of the home communities of all its patients and they may come from all over the world. Knowledge of what may be expected of social agencies, their programs and functions and clear-cut policies regarding inter-relationships, is necessary if adequate treatment is to be secured. In every instance close collaboration between the physician, who is the medical specialist, and
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the worker, who is the social specialist utilizing community resources, is essential if there is to be real coördination in the treatment of the health and social needs of hospital patients.

Interpretation is the very heart of medical social treatment. Sometimes it is all that is needed. The mere process of bringing into clear consciousness all factors in a patient’s case, both assets and liabilities, contributes much towards the solution of his problem. In other words, it is the means of helping a patient to understand his situation and help himself. Interpretation of the personality and social setting of the patient to the physician, when he is studying the medical condition of the patient and outlining plans for treatment, is the responsibility of the social worker. It is the continuous process used in the attempt to change attitudes of patients and patient groups and to secure their participation in treatment. It is absolutely essential in the making of joint plans and the carrying out of joint treatment involving the patient, doctor, and medical social worker as well as community agencies. Careful talking out, point by point, of each item of the plan is of great assistance in getting the patient to understand and see his way to carry out the plan. By means of the interpretative process, the medical social diagnosis is made clear to the patient, his family, associates, and the social worker in the community agency and the medical plan becomes an integral part of the patient’s scheme of life.

Inevitably the medical social worker has become one of the main and strategic channels through which the purposes and policies of the hospital are interpreted to the community. Day by day in her case work she has the opportunity to relieve apprehension of the hospital, correct misunderstandings, and explain necessary procedure, thereby bringing hospital and community into keener realization of their interdependence in the treatment and prevention of disease.

The social elements in the admission of patients to the hospital and clinic are becoming increasingly recognized, but have not been as yet clearly defined as regards the participation and organization of social service in relation to the admitting process. The paper to be given on the subject in this session will undoubtedly do much to clarify our thinking on these points. The correlation of the applicant’s medical need and the cost of medical treatment on the one hand and his resources and obligations on the other hand appears to be an appropriate medical social activity, while assignment to suitable clinic or ward implies the need for medical participation in determining the essential
features of each one's malady. Only a few hospitals assign a physician to render medical judgment at the time of the patient's application; the majority expect the medical and social judgment to be made by one person except in unusual or particularly difficult situations. It appears to have been recognized in some hospitals that the social elements are more vital than the medical elements in the admission of patients, and social workers have been placed in charge of this service in order that decisions might be based upon a deeper understanding of the problems of each applicant. A social worker, even in a relatively brief interview, can determine the significant factors in the patient's situation more clearly than can any member of the hospital personnel untrained in social case work. Whether social workers in the admitting service should be directly responsible to the administrative unit or social service department is still an unsettled question, the practice differing in various hospitals. Neither has the education essential for social workers undertaking this service been determined. Sufficient instruction in either the theory or the practice of this particular activity has not been included in the curriculum of our medical social training centers to equip their graduates to undertake this work without close supervision. On the other hand, there may be much in the present system of training which is non-essential for them. If the present trend to place social workers in admitting services continues, solution of the problem of thorough training for them must eventually be sought by the Education Committee of the American Association of Hospital Social Workers.

Another activity undertaken by medical social workers in some clinics is the management of patients. This includes the conduction of patients through the mazes of clinic procedure and the organization and supervision of clinic routine in such a way as to safeguard to the fullest extent the time and skill of the physician and the time and understanding of the patient. It may also mean control of the stream of patients by selection and limitation of intake to the number that can be given adequate care. This is accomplished by means of the appointment system. It is interesting to note that the fallacy that a hospital's service to the community is measured by the numbers admitted rather than by adequacy of treatment is rapidly disappearing and appointment systems are frequently being installed as a means of controlling intake. There seems to be a tendency to place the appointment system under the supervision of the social workers even though the actual mechanical details are handled by clerks, for con-
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stant instruction and reminding of patients are necessary to the success of the system. Follow-up to insure regular attendance of patients during examination and treatment is fundamental to the medical effectiveness of the clinic. It is also employed in an effort to learn the ultimate results of operations and the effects of various medical and surgical techniques. The purely mechanical aspects and procedures of so-called “follow-up systems,” such as letters and postcards to patients with lapsed appointments or those desired for research purposes, are minor details in comparison with the instruction and stimulus of the patient while he is in the clinic. The social worker who is in vital touch with the patient during clinic attendance can make the follow-up system personal, individual, and hence effective.

While the trend has undoubtedly been toward placing social workers in charge of clinics and their appointment and follow-up systems, there is urgent need for careful study of all the elements involved in patient management. Social workers given administrative charge of clinics frequently perform or supervise much clerical work, business details and housekeeping affairs. It is not clear as to which activities are mainly social in character and therefore appropriate procedures for the hospital social workers to undertake, and which should be the responsibility of other groups—administrative, medical, nursing, or clerical. The Functions Committee of the American Association of Hospital Social Workers is planning a project devised to analyze the nature of the activities involved in these procedures and to define those which may be considered the function of hospital social workers. Their report will undoubtedly influence and guide future development along these lines.

It has long been an accepted function of private social agencies to establish and maintain a new service until its permanent value is apparent and it is transferred to governmental auspices. A similar use of the demonstration method has occurred in medical social work. Social service departments have frequently been organized upon more or less tentative administrative and financial bases by auxiliary groups not officially under hospital auspices. The value of this form of demonstration properly conducted cannot be questioned. Frequently it has facilitated earlier attention to the social problems inherent in the institutional practice of medicine than would otherwise have been possible. However, it is essential that its purpose and temporary nature be thoroughly understood by hospital trustees, administrator, and physicians and that appropriate relationships be established. There is danger that it may be considered a graciousness, of a ladies’ com-
mittee, half-heartedly accepted by hospital authorities and grudgingly allowed to perform within the sacred precincts of the hospital provided it does not interfere with the established order of things. Paid by the rich to practice on the sick poor. As long as this attitude on the part of administrator and doctor is implied in the relationships or organization of the social service department, so long will the opportunity to carry out its proper function be limited. Mutual understanding, clear-cut policies, and recognition of the ultimate control by hospital authorities will safeguard the establishment of social service departments by lay groups. In many medical institutions the social service departments thus inaugurated have later been incorporated as integral departments of the hospital organization. In others they have remained under auxiliary groups, but are developing sound functional relationships with hospital administrators; while in still others the departments of social work were initiated and have remained under hospital auspices.

The trend is apparent, however, to place departments of social work under the administrative control of hospital authorities or in large medical centers under a coördinated board representing the various medical institutions. Just as the medical, nursing, and dietetic services are official departments within the hospital organization, so should the social service department be correctly placed. Only in this fashion can a balanced development and opportunity for appropriate relationships be assured.

The director of the social service department is usually an ex-officio member of the social service committee. It is her responsibility to bring to the committee for consideration problems relating to personnel, adjustment of interdepartmental hospital policies, social case work, and community resources and needs.

The support of social service departments may come from the hospital budget, from auxiliary groups, or from community funds or chests. Occasionally departments may be financed from two or three of these sources. There seems to be a growing sentiment in favor of placing the social service department under the financial as well as the coördinating direction of the hospital authorities, irrespective of the source from which the funds are derived.

Organization within the social service department varies according to the size of the staff and the scope and purpose of the medical institution. Some departments have only one worker, others have a chief or director in charge assisted by a case supervisor, with a staff of medical social workers. In some of the larger departments the di-
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rector also has under her supervision such workers as nutritionists, occupational therapists, and librarians. Workers in small hospitals must of necessity assume varied duties, while in large medical centers workers are usually assigned to special services such as medical, surgical, pediatric, and psychiatric. There may be even further specialization within these services, as, for example, the assumption of responsibility by one of the workers on the medical service for all tuberculous patients; by another for all thyroid patients; and by still another for all cardiac patients. In other instances, workers may be delegated to teams of doctors. While such specialization may limit the range of experience of a medical social worker, it undoubtedly has made possible closer collaboration between doctor and social worker and resulted in more efficient treatment for the patients. Medicine is facing many problems created by constantly increasing specialization. Medical social workers may have to face similar problems some day.

Social service departments may carry a three-fold educational responsibility. Medical students and nurses should know something of the personality and environmental difficulties which may interfere with the effectiveness of the medical and nursing care which they are rendering. A few departments assume some responsibility for giving this interpretation to the medical students either through formal lectures, conferences, or informal contacts with members of the staff. It is still an unsettled question how the teaching responsibility of the social service department in this matter can best be fulfilled. A steadily increasing number of social service departments have definite educational affiliations with schools of nursing, conducting lecture courses for the entire student body, assisting in case study projects, and supervising field observation plans. A special sub-committee of the Education Committee of the American Association of Hospital Social Workers is studying the factors involved in this teaching program in order that recommendations may be made concerning the content and method of such courses. Departments of social work in cities where formal training in medical social work is conducted have frequently established educational affiliations with such training centers, and provide supervision in field work practice for medical social students.

Medical social work as a profession is just emerging from the stage in which law and medicine were a few generations ago when educational standards were limited and control almost negligible. For a number of years the Education Committee of the American Asso-
ciation of Hospital Social Workers with the assistance of the educational secretary has been studying and working towards a solution of the all-important problem of thorough training for medical social personnel. The nine training centers now established, with a tenth one in process of organization, are now demanding a minimum of a two years' period of training. This may comprise a senior and post-graduate year of work or two post-graduate years. The two major problems confronting the schools are the content of medical information courses and the organization of the field work experience. Much has been accomplished regarding the former problem, and information has been gathered concerning subject matter, comparisons made, and principles formulated. A start has been made on a thorough analysis of field work teaching. Year by year improvement in training is becoming an accomplished fact. In her annual report this year, the Educational Secretary made the following statement regarding the training centers for medical social work: "Each school has its own goals, but fundamentally the important problem is the same: to bring such a coördination in theory and practice that a medical social worker will result who is acquainted with the problems in the modern hospital, who understands the social component in medicine, who is aware of what has influenced and promoted the growth of social service, who can with a degree of skill practice medical social case work, who will see in the knowledge and experience gained from an accumulating case load the implied responsibility to contribute to and share in the social and health programs of the community, who knows the important literature of our own and allied fields, and who aspires to contribute creatively to new thinking and improved practice in the years ahead."

Fifteen years ago Dr. Abraham Flexner at the National Conference of Social Work presented a paper entitled, "Is Social Work a Profession?" He suggested seven tests of professional status. One of these tests was in regard to training. He felt that a profession must have a content which can be transmitted by a specialized educational process to those desirous and capable of learning it, just as it is possible to train doctors, lawyers, and teachers in an exact and standardized fashion. The American Association of Hospital Social Workers has accepted this challenge. Year by year it is striving through critical analysis of content and method to add to the understanding of the problems of training in order that medical social education may eventually be organized upon a sound professional basis.
HOW THE NURSE CAN CONTRIBUTE THE SERVICE THE PUBLIC EXPECTS*

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The subject assigned me has recalled so vividly an episode in the early history of the trained nurse that although repetition has worn it threadbare, I am constrained to repeat it as a brief summation of the traditionally required historical review.

Approximately a quarter of a century ago a clergyman came to the office of the school of nursing of which I was then superintendent seeking a nurse capable of developing a visiting nursing organization in his town, presenting the required qualifications as follows: "You are, I believe, from New England. You will therefore I am sure understand the type of committee interested in forwarding such a project,—cultivated, refined, conservative, intellectual persons. It would be important for this young woman to be a socially acceptable guest, one who could attend their dinners, contribute to the conversation and secure their interest, for upon her personality would greatly depend the raising of the required funds for the undertaking." The hospital facilities of the town were not great and the dispensary facilities almost lacking. It would seem advisable therefore for her to be familiar with minor surgical conditions so that she could treat, before leaving in the morning, any cases that might come in to her. Drugs, as one knows, are expensive. A well trained graduate would he supposed have sufficient knowledge to perhaps put up the less important prescriptions and prepare ointments, solutions, etc. Busy workers were not only unable to take time to go to the drug store, but neither had they the money, and it would seem that she might greatly decrease their expenses by this contribution. She would, of course, be so thoroughly versed in her knowledge of medical and surgical

*Delivered before the Institute for Board Members under the Auspices of the Henry Street Visiting Nurse Service, New York City, November, 1930.
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conditions as to easily secure the confidence of the physicians, so that upon arriving at the house, should the doctor not be able to make frequent visits, or indeed should he not be able to come at all, he could depend upon her to differentiate between serious and minor sickness conditions and save his visits or lessen them. She should be the type of woman who was not afraid to render any needed service, but finding the mother ill would give the needed care, roll up her sleeves, bathe the baby, wash the dishes, scrub the floor,—the hungry, tired husband returning to find his house in order, his sick wife looked after, the children fed and clean, the dinner awaiting him. He too was a busy man. He should hope she would be familiar with the ritual of the church, and in case he could not reach the patient that she could be depended upon to minister even to the end. Ah, yes, salary. The salary would indeed be moderate, but, his face brightening, he was sure to the type of woman he was describing the salary would be of small importance.

The required personality was found. Somewhat over a year later he sought a successor with the encouraging statement that the appointee had measured up in every particular he thought but one. She did not seem to have sufficient endurance. She had broken down,—yes, quite completely broken down, and he would like someone like her to fill her place.

Whatever changes have taken place since this episode occurred, (and let me add in parenthesis this is the type of service, to a far greater extent still than is imagined, that the public pictures the nurse as rendering) both qualitatively and quantitatively the demand for nursing service has increased rather than decreased.

Quantitatively we appear to have reached the saturation point. I do not believe this to be the case except in its bearing upon one aspect of nursing activity as I will explain shortly.

Qualitatively we are distinctly failing. Upon the profession itself the burden must necessarily fall of determining the means through which the nursing needs of the community can most adequately (using the term in its fullest sense) be met. To the community, however, the nursing profession must turn for the means. This audience is too fully informed as to the rapid growth and development of function in the field of nursing to require or desire a detailed presentation of present day demands. Rather is the question before us, how are the demands, ever-increasing in scope and number, to be met. Con-
cretely speaking, by community understanding, organization and support.

For enlightenment concerning any given project the method of procedure is now fairly well established. It provides for a survey of the field within a given and usually limited area, an analysis of the findings in relation to the variety, quantity and quality of service rendered and required and a program based on the findings through which increased satisfaction of the public may be predicated.

The complexity and multiplicity of health and welfare organizations and institutions presents a confusing picture rather than an ordered scheme of physical and social relief, and the part of the nurse in this maze of humanitarian activities is varied, demanding and wholly unrelated. Again to this audience a detailed enumeration of the various types of nursing service would be an inexcusable imposition. Suffice it to say there are today between seventy-five and one hundred, each demanding of the worker, if a rich interpretation of function is to be ensured, something more than the undergraduate course does or should provide.

The recommendations based on the findings of the survey would inevitably provide for that integration of nursing activities through which alone can be ensured a balanced and adequate nursing service for the community. Again in concrete terms this implies a central nursing council advisory to a bureau under exceedingly able and adequate direction to which could be referred the arising nursing needs of all varieties and through which accurate information relating to supply and demand could be obtained. This integration of activities is entirely in accord with the trend of the times. Familiar are we, as has been well expressed by an English historian, with the present day clash between the increasing tendency to specialization and the integration of such specialization from which, he adds, the future has most to gain. Abundant illustrations from the chain stores to the Institute of Human Relations bear witness to this fact.

As a believer in socialized education, I am naturally a believer in socialized medicine and nursing, since health, physical, mental and emotional, is as important for effective citizenship as education, or is indeed fundamental to it. For the State to assume the responsibility for one and not the other seems inconsistent. "To cure the body and to save the soul" is the legend inscribed on the seal of St. Lukes, a well-known hospital. "To cure the body and to save the State" might well be a governmental inscription. Pending the assuming of health and sickness responsibility by the State, and contributory to it,
would be the voluntary coming together of those citizens best fitted through knowledge and function to develop a program whereby, through an integrated service, a community's needs can increasingly, efficiently and at the least possible cost be met.

The responsibility of the community in relation to its nursing service strikes deeper than the selection of personnel, raising the budget, determination of function for any given project. I should like to add to the story with which I opened my remarks that the nurse who so ably measured up to the requirements as outlined was not the young woman of limited environment inured to hardships and forced by circumstances to the performance of humble tasks. Cultured, charming, orthodox, she has moved from one important post to another; has written a book on nursing, and is now holding a position of unique and great distinction.

However inconspicuous a part the nurse may take in any given health project, almost without exception it is a part of fundamental importance. If a survey with a resulting plan for the integration of the nursing service of a given community is demanded in order that the arising needs can be effectively met, it is not less important that similar consideration should be given to the subject of nursing education. I stated that we had come to the saturation point quantitatively speaking, now may I add only insofar as private duty is concerned and mainly in large cities, but the situation in such localities is of a most serious nature. Not tens but in some places hundreds of women are barely or even unable to earn their daily bread, while the call on the other hand by institutions and organizations for qualified women can not be met.

One of the oft repeated assertions of the women who brought the first school of nursing into existence was the importance of the selection of students on the basis of ability, maturity and culture.

Within half a century there has been an immense change in the educational program of the women of all classes. I refer to the great increase in the women graduating from high school and college. Of not less importance is the change in the subject matter. College after college, year after year, is increasingly including and expanding the science courses. If parents who are giving their children the benefit of higher education are unwilling to have them turn to the field of nursing, the reasons for such unwillingness should be sought and changes made which would make a field preeminently a woman's and of such creative importance, one which they would eagerly seek as a life expression for their daughters.
The Nurse's Contribution

Not less important is the rapid immediate relating of nursing education to the educational system which will ensure to every student in the field a professional preparation which will enable her to function effectively in her chosen branch and to cooperate with the ever increasing group of social and health workers.

As we turn the pages of the history of nursing and nursing education, we cannot but be impressed with the important part that women played in bringing into existence this now great army of health workers. As the women of the past conceived and carried out this reformation (for so may be termed the change in the nursing care of the sick whether in the hospital, dispensary or through extra-mural branches) surely even greater results will be achieved by the women of today through the new freedom with all it implies, scientific knowledge, broadening the vision, enriching the imagination, deepening the sense of social responsibility, through an ever-increasing understanding of the possibilities of change. It does not seem possible that the contribution of the descendants of women, who, though handicapped by the restrictions of the Victorian era worked such marvels, should not be equally great.

I vision a similar influence upon the institutions and conditions which are the disgrace of our civilization today. "Democracy" says Dean Inge, "disintegrates society into individuals and only collects them again into mobs." "Democracy" says Pasteur, "is that order in the State which permits each individual to put forth his utmost effort." Interpret democracy in the terms of whomsoever's philosophy of the good life you will, but let us remember we are only in the process of creating democracy, not of experiencing it.

Present day science, which is the best light we have bearing upon nature in general and human nature in particular, is increasingly insistent, whether speaking as a behaviorist, psychologist, an educator or a philosopher, upon the influence of environment upon individuality not as a gift but as an achievement created "under the influence of the associated life."

The most superficial knowledge of the relationship of the nurse to human growth and development, to say nothing of her contribution to the field of remedial or curative medicine, a service through which incidentally her wider services have arisen, presents her as a strategic factor in a social order designed to aid the individual in functioning to his highest capacity.

We have a long way to travel before a satisfying, even endurable, life can be assured future generations. The saving grace of the past,
present and future struggle is a reasonable hope that the efforts of each succeeding generation are of some avail. Fortunately it is a reasonable hope. Whatever may be the forces involved, change of heart, economic perspicacity, higher levels of mass intelligence, social changes of profound significance are taking place, steadily, unremittingly and throughout the world.

Whether it be the experimental health center in China, socialized medicine in Russia, a maternity project in the Kentucky mountains or the White House Conference on Child Care and Protection in Washington, seeds have not only been sown, but have taken root that presage the social order dreamed of through the ages, a social order made possible through that greatest of gifts to groping, bewildered, complex humanity, the penetrating, revealing, directing and inspiring light we choose to designate as Science. No worker needs that torch more than the nurse, that miner as it were digging through the long hours for coal and often, often finding diamonds.

To such members of society as are here assembled, the nursing profession must turn for a concerted and persistent demand that even as the extra-mural nursing activities are staffed with graduate nurses with only such number of students enrolled as can be assimilated, so must the hospitals be staffed throughout their various departments, opening the clinical experience to students in such numbers only and of such educational qualifications as a study of community needs and resources indicates as required and advisable. Further there should be demanded an educational content based on the needs of the community, with hours of study and practice that accord with those of other professional schools, and that the leisure and diversion be assured for both graduate staff and students through which alone effort and interest in the life activity will be sustained. Under such circumstances, and only such, will the nursing profession be equipped, mentally, physically and emotionally, to meet the community needs.

Scientific discoveries have created a new universe, through transportation from the covered wagon to the aeroplane; through communication from the written word to the radio; through new interpretations of the old science and the development of new sciences bearing upon nature and human nature, from the change in flower, plant and animal, to the discovery of the latent powers of man and the latent powers of woman. What of all this should the nurse be required to know. Herself, the community and her subject. Age old philosophy with new implications.
THE HOSPITALS' CONTRIBUTION TO PUBLIC WELFARE*

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Down through the ages history tells us of the efforts made by the human race in fighting disease and caring for the sick and injured. "Good health is the foundation on which rest the power of government and the happiness of our people." Therefore the most important person in the community is the one who is ill. In order to care properly for the health of the people, the hospital came into existence. It has gradually developed until it has become the greatest force in conserving life and promoting research and medical education, and its value to public welfare cannot be estimated. We are setting a standard of public service which is recognized throughout the world. "Hospitals are human laboratories, and many, if not all, of the greatest lessons in medicine and surgery have been learned in them." 1 The world would know little of the control of typhoid fever, diphtheria, scarlet fever, the eradication of yellow fever, and many of the other achievements of modern medicine if a profound study of these problems under competent supervision had not been offered by our hospitals.

Our hospitals constitute an endless road which twelve million patients travel yearly to health and happiness. To keep this road open we spend one billion dollars annually, not only in the care of the sick but in training doctors, nurses, technicians, and health workers who form the nucleus for nation, state, and city health programs. Of this vast expenditure of money, $500,000,000 go to an army of employees numbering 600,000. There is no industry in our land today that affords such steady employment to our people as the hospitals. Our doors are never closed. We care for the sick 365 days in the year,

* Read before the Annual Convention, American Hospital Association, New Orleans, La., October, 1930.
day and night. We must always be prepared for a peak load. We must give continuous and uninterrupted service at all times. We cannot shut down our plant and lay off our people because of a financial depression. We must carry on some way. There are some small cities that are almost entirely dependent for their existence on the institutions of healing in their midst.

Business men recognize that the purchasing power of our hospitals is a big factor in the commercial world, for nearly everything that is manufactured is in one way or another used by our hospitals. Even the insurance companies have at last recognized that hospitals are the safest risks, and the millions of insurance of various kinds carried is another big factor in the commercial world.

Why do the cities compete for the privilege of entertaining the American Hospital Association each year? Because we leave with them about $100,000 and the people of the community are stimulated into greater activity in conserving the health of their citizens.

Hospitals are contributing liberally toward civilization's progress and happiness. Our citizens are no longer afraid of the hospital, for they recognize that there they can be restored to health in the quickest time possible. In twenty-five years our hospitals have reduced the average stay of patients 50 per cent. For instance, if one had his appendix removed twenty-five years ago he remained in the hospital twenty-one to twenty-two days. Today he would be in the hospital only ten to twelve days. In other words, through the advancement of medical science, better nursing, better equipment and management, the average patient is returned to his life's duties ten to twelve days sooner than twenty-five years ago, and if you figure his salary at $5.00 a day you will readily see that this saving in time over twenty-five years ago will pay his hospital bill if he has a ward bed.

The decrease in suffering through improved technique, better service and less days in the hospital wards, together with the reduction of the institutional death rate of over 50 per cent., is a big factor in breaking down the fear of our people of the hospitals. Millions of dollars are being saved annually on hospital construction and equipment because of this great reduction in the number of days' stay of the patients. We now care for two patients on the same bed on which one was cared for twenty-five years ago. "A conservative minimum of the number of lives saved annually through good hospital service is 1,200,000. Considering the value of a human life to be, as actuaries tell us, on an average of $6,000 each, this would mean a
direct saving to the nation of approximately $7,200,000,000.” If we could estimate exactly the real economy to the nation through good hospital service, to preventing chronic invalidism, in shortening periods of illness, and in disease prevention, what a huge national economy the hospitals must effect.

In our church hospitals the churches have a great missionary enterprise and they should recognize it more than they do. The church and the hospital may very justly be associated in the work of caring for the sick. Without healthy bodies there can be no spiritual, educational, or physical success or happiness. Practically every nationality on earth is included in the list of patients passing through our doors and they are quick to recognize the kind and sympathetic service that the Christian hospital renders. The hospital sends out to the foreign fields a large number of nurses and doctors they have trained, and what a godsend it is to these people in foreign lands to have the service of these trained people not only in the care of their sick but in all branches of public welfare.

In times of war our hospitals are the great fortresses in protecting the health of the people at home. During our World War the doors of our hospitals were always open to care for the sick and suffering regardless of whether they had money or not and thousands of lives were saved during the influenza epidemic, this in spite of the fact that we sent thousands of our trained personnel to serve our soldiers at the front. Had we not had a very efficient system of training our personnel, and as I said before, being always ready to carry a peak load, many of our institutions would have been compelled to close their doors during those perilous days. The World War proved beyond question the efficiency, the stability, the real worth of our hospitals to public welfare.

Neither should the work the hospitals do in conjunction with the Red Cross, public health and all other relief agencies be lost sight of. Thirty-five years ago the hospitals became a big factor in public welfare and those in immediate charge felt the need of getting together to exchange ideas, to discuss hospital economics, to inspect hospitals, and to study better plans of hospital construction and operation. There were no magazines devoted to hospital problems and no contact except as they visited together in their own section. In 1899 eight hospital administrators gathered together in Cleveland, Ohio, and at that time organized the Association of Hospital Superintendents, the name later being changed to the American Hospital Associa-
tion. From these eight men the Association grew rapidly and has held meetings annually since its inception. State and city organizations sprang up. The Catholic and Protestant associations were organized. The American College of Surgeons and the American Medical Association became actively interested in hospitals. Many other organizations sprang up that were interested in hospitals and the health of the people, and through the American Hospital Association these groups are brought together so that they become a big family working harmoniously for the same end and all focussed around the patient.

The work of the American Hospital Association is far-reaching, for hospitals not only in the United States and Canada but all over the world are benefited by its untiring efforts in helping hospitals become more efficient in their work of relieving the sick and suffering. There is no method whereby we can measure the value of the work of our Association to public welfare.

To serve public welfare better, the hospitals need something besides organizations and genius of management. If we are to carry out and perform the great function of public service we must have money. The only solution at present for reducing the hospital cost to our needy people is through more endowment funds. Our hospitals have not been properly introduced to the public. We have been too reluctant to use publicity methods to attract the attention of the public. I am sure that the average man of large financial interests realizes that he is a steward of God and that all his earthly possessions are his for this life and not for the life hereafter. I believe that if our boards of directors will keep the great work our hospitals are doing before the public, we shall receive the support we are entitled to, and a greater contribution to public welfare will be the result.

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EDUCATING THE BOARD MEMBER*

KATHARINE BIGGS MCKINNEY

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It is only comparatively recently that anyone thought board members needed to be educated. But nowadays no matter what or how humble our position in life it seems we must be educated in order to fill it properly. As parents we have to receive a great deal of education regarding the proper care of our children. Staff nurses must be constantly taught the newest developments in their field. The mental case must be re-educated so that he can better adjust to the requirements of daily life. We are all swept along in this great movement of adult education and learn we must,—willing or no.

It was reported at the Alumnae Meeting at Vassar last week that the really thrilling thing about the Euthenics Institute, which is held there every summer, is the fact that the mothers are so eager for knowledge that the staff has to make all possible efforts to prevent their taking every course in the curriculum and returning home in consequence in a state of complete exhaustion. Now this, I think you will agree with me, is not the case with Board Members. Their thirst for knowledge is not so great but that it can be easily assuaged. Therefore our first problem in educating them is to make the course or whatever form the education program may take so interesting that they simply will not miss a single meeting. Do not ask, or expect, them to go to lectures or institutes or conferences unless you are pretty sure their attention will be held by something that is really worth while, for most board members are busy women with many interests and limited time. And apropos of this, I think the presidents of Boards should feel a definite responsibility in making their monthly meetings not only interesting but as brief as the necessary business will permit, so that their members will not be like Shakespeare’s stu-

* Delivered before the Institute for Board Members under the Auspices of the Henry Street Visiting Nurse Service, New York City, November, 1930.
dent—"The whining school boy with his satchel and shining morning face, creeping like snail unwillingly to school."

In considering this question of the education of the Board Member I think it might be well to consider first what we are educating her for,—in other words, what are her particular functions in the professional organization of which she is a part.

First the old function of giving moral support to the executive still remains. To do this effectively the managers must be alert to the needs of their community and to the conditions in it. The nurse may be an outsider and unfamiliar with the city or district to which she comes. Then she may expect advice from her board about suitable living quarters, and properly located office accommodations. Her board should be able to acquaint her with general conditions, to tell her where she will find coöperation,—where opposition,—and to assist her in forming the policies of the organization. The nurse cannot and should not have the sole responsibility for forming these policies. In this respect a group of people who are accustomed to thinking and acting together, and are familiar with their own community, can be of the greatest assistance. Dr. Michael Davis, of the Rosenwald Foundation, has said that one of the functions of Board Members is "to keep far enough ahead of the community to be progressive and close enough to it to be practical." That is why every Board needs both old and young members. The old for wise judgment, the caution that comes with years, the knowledge born of experience. The young to furnish the enthusiasm, the courage to try something new, the vision to see the possibilities of the future. It is a nice point—this balance between how far we can go and still have the community follow.

We will not get much financial support for our work if our program is so much in advance of community thinking that the average citizen cannot grasp what it is all about. On the other hand, no organization in this day can afford to let itself be hidebound by tradition. We live in a changing world. Science is contributing something new every day and in nothing is that more true than in the field of public health. What was an established procedure ten years ago may be obsolete today. We must be able to adapt ourselves to changing conditions and be ready to march ahead with the times; maintain the background of tradition, but modify it with a vision for the future.

Once the policies of the organization are formed the Board must stand behind the nurse in their enforcement and be ready and willing
to come to her assistance when difficulties arise. It is desirable for her to feel that in case of serious trouble she has a group back of her who will accept responsibility for her actions and those of her staff. This is particularly important to the nurse working for the county or state in a small community. She cannot do her best work if she feels that her tenure of office is dependent on the results of a forthcoming election, or if she knows that no matter how efficient she is she may lose her job at the whim of some petty politician. The members of the community at large must be made to realize what she represents in terms of service to humanity, and it is the individuals working with her who can best spread this gospel abroad.

Second, Financial responsibility. Before the advent of Community Chests the responsibility for raising funds to carry on the work of the various organizations fell largely on the shoulders of board members. It was their duty to acquaint the public with the work of the Visiting Nurse and to convince them of its value to the community so that they would be willing to give it financial support. But many of us have been a little spoiled by the arrival of the Community Chest. We have thought that all we had to do was to sit back and receive our allotment, or perhaps appear before the Budget Committee and ask for an increase in it. That alas, is only the easiest part. It is the full and complete responsibility of every board member to go out and work for the Community Chest drive as willingly and conscientiously as though she were raising money for her own organization alone. We had this responsibility very forcibly brought to our attention in Albany last year. The Chest drive did not go over the top, largely it was said because of a shortage of workers. The director called together the heads of every organization in the Chest, told them of the deficit, and of what proportionate decrease it would mean to their own particular allotment. And then he said—"Now you call your boards together and see to it that they raise that much money or you will have to take the loss." Needless to say we were stunned by that announcement. But the method worked, and this year, in spite of the current business depression, we have gone over the top and have added 2,000 new subscribers who have been able to make up the decreases which came from many of our largest givers.

That work was largely done by the Boards of Managers of the various organizations in the Chest, and it only goes to show what the volunteer can do if he will. I am one of those who believe firmly in
the contribution the much maligned volunteer has to offer, but I also feel strongly that she must be led and shown the way and must not be made to feel superfluous. Often the busy executive fails to realize that in order to get the best out of the lay person it is necessary to take a little time to teach her the way in which her services may be most useful. It is the old story of its being easier to do a thing yourself than to show someone else how to do it. But time expended in arousing the interest and teaching the willing and responsible volunteer is well spent and should yield reliable dividends in more valuable service and increased coöperation.

Third, Responsibility to staff. To my mind that means that Board Members should know the staff, not as a group of efficient young women in uniforms, but as human beings who think and feel and react as we do. Their interests are the same as ours so far as their work is concerned. We will get better results and more coöperation if we remember this. In small organizations I think teas should be given for board and staff together; supervisors should come to board meetings and report on their work; demonstrations of technique should be given to new members; the board should attend staff meetings occasionally in order to gain some slight conception of the problems the nurse has to meet in the course of her day's work.

Furthermore, the board is very definitely responsible for providing proper working conditions for its staff. Their health and comfort must be considered; their working hours must not be too long, and their salaries must be adequate for them to maintain a good standard of living. The nurse who is contented and happy in her work,—who feels she has the sympathetic interest and understanding of her board, will give better service than the one who is discontented, overtired from too long hours, and constantly worried as to how she will meet her expenses with an inadequate salary. In addition provision should be made in the budget for nurses' attendance at conventions whenever possible. Much inspiration is gained by hearing how other people are meeting the same problems and learning what is being done by other organizations.

Fourth, Publicity. One thing which board members should be able to do particularly well is to make themselves responsible for the publicity of their organization. Advertising plays a large part in our modern civilization and no Visiting Nurse Association can afford to underestimate the importance of publicity or to think that the community as a whole is aware of the services it has to offer to all types
of people, rich and poor alike. My own organization has been in existence for forty years and is one of the oldest V. N. A.'s in the country. But it is a constant surprise to me to see how many supposedly intelligent people know nothing about it. Only the other day a well known physician asked me whether we employed registered nurses. I told him that he ought to be ashamed of himself, but I also went home and began wondering what was wrong with our publicity. It is absolutely essential that every board member should feel an obligation to talk about her association, to tell her friends what it is doing, and to explain all the types of service it has to offer. I remember in the early days of the Community Chest hearing Mrs. Garfield, of Cleveland, tell about the sort of publicity they had for their Chest there, and what she emphasized most was the fact that it was discussed at dinner parties; that the men made a point of talking it over with their friends and business associates. In other words the gospel was spread by word of mouth. Besides this, of course, there should be regular articles appearing in the daily newspapers,—window displays during the Community Chest drive,—and all the rest that goes with a modern advertising campaign.

So much for the board member's obligations. How best educate her to meet these obligations? By an institute like this one, of course, if we can. But in smaller organizations in smaller cities this is not always possible, and we have to resort to other methods. The BOARD MEMBERS' MANUAL which has recently been published contains a veritable gold mine of information and should be owned and read by every member of a Visiting Nurse Association. And then there is the PUBLIC HEALTH NURSE which will always keep us abreast of the latest developments in the field of public health. And many other equally estimable and valuable publications. But we are being flooded these days with so much good reading material that I think many of us become discouraged and just don't read. To obviate this difficulty we, in our own board, devote a few minutes at each of our monthly meetings to having one of our members give us the current events in public health nursing as gleaned by her from various current publications. In this manner each member in turn becomes familiar with the available material and passes on to the Board the most interesting of the information obtained.

Another way of familiarizing members with the work of the organization is to have them serve in rotation on each of the active
committees. For example, a member who has served on the nursing committee will find herself in intimate contact with the work which is actually being done and will realize that this is one of her most satisfying experiences.

There is much which the superintendent herself can do to stimulate the interest of her board, and my own experience tells me that this is one of the most important features in the education of a board member. After all, the director is a professional; she is giving her full time and interest to the work of the organization. Where we grope in darkness and work from theory she acts from personal experience. When the board is apparently not interested and when the director is harassed by the details of her work she overlooks the advantage of keeping her board members informed. In this way they are deprived of one of their most valuable sources of information and the director herself loses the benefit of the advice and moral support which they are not competent to give unless they are familiar with what is being done.

Our times are strenuous and full to overflowing, and it is consequently difficult for most of us to know how best to use the little freedom that is ours. But women like ourselves with some leisure at our command should certainly feel an obligation to give a part of it in some service to the community. Why not choose this interesting and absorbing field of effort to give fuller expression of our personalities and at the same time benefit those less fortunate.

The printed page of our lives is the routine that we must perform willing or no, but in our marginal notes we express our own thoughts and aspirations, and what better ambition can we have than to raise the general level of the health and make happier the lives of those about us.
Before considering the relationship of hospital social service to community welfare organization, as indicated by the title of this paper, I should like to quote some passages and facts from one or two sources in order to orient the discussion from the standpoint of the hospital and its social service department. These excerpts indicate what the nature and extent of these relationships should be.

Several years ago through a widespread study of the practice of social service departments in hospitals throughout this country and Canada, the American Association of Hospital Social Workers was able to secure certain evidences of practice and make certain statements of function which have since served as effective guides in discussing the various phases of social work in hospitals. According to that Functions Report:

"Social factors which appear in hospital practice fall into three main categories:

1. Social conditions which bear directly on the health of the patient, either inducing susceptibility to ill-health or hindering the securing and completing of medical care.

2. Social distress caused to others by the illness of patients; such as loss of income, neglect of children, etc.

3. Social problems not having direct cause-and-effect relation to the health condition, but collateral to it. Such problems would exist independently of the sickness.

These factors exist in many possible combinations.

It is clear that the social factors which fall into Class 1
are the proper and special concern of the doctor and therefore of the hospital, and that if any social work is to be done under hospital auspices, much of it will deal with the conditions in this class. Not all social causes of sickness can be dealt with by hospitals; many come within the field of public departments, many within the field of social work done under non-hospital auspices, e.g., ignorance and poverty. Nevertheless, it is inevitable that the hospital by following the clue of individual sickness should unearth a great many such underlying personal and environmental conditions which the physician must be able to control because of the greater unity and effectiveness of a study and treatment which envisages the whole man.

"The meeting of social needs caused by sickness (Class 2) is in perhaps greater measure the responsibility of the community outside the hospital; for instance, no one would expect the medical institution to undertake the care of all families left dependent by the sickness and death of its patients. But here also the hospital will play a part by discovering the need, advising as to ways of meeting it, and giving information about the condition and outlook of the patient.

"The social problems of the third class seem to fall outside the aim of the hospital; yet even this group comes into the medical view of 'the whole man,' and may play its part in the cycle of mental and physical changes which are the focus of the physician's attention. For this collateral problem the hospital must, when necessary, try to find resources outside of medical auspices, whether within the immediate patient-group or in one of the community's agencies. The hospital must indeed at times seek such resources beyond its own walls in all three types of social complication. And in all three types there will be cases in which the whole treatment, medical and social, will fall within the purpose of the hospital and may best be accomplished under its auspices."

Elsewhere the report states:

"The major activities recognized so far as appropriate to hospital social service we may recapitulate as:

1. Inquiry into the social situation of hospital patients and the reporting of the findings to the responsible physician.

2. Determining, in collaboration with the physician, the factors in the social situation pertinent to the patient's health and stating these as medical social problems or diagnoses.

3. Setting up, in collaboration with the physician, a possible goal or best estate for the patient to aim for, given the medical problems and the social situation of patient, and distinguishing the rôle the social worker is to play in plan for helping patient achieve the goal.
"4. Executing the social worker's part in the plan for helping patient achieve his best estate."

The degree to which it is true that the hospital must at times seek resources beyond its own walls in carrying out these functions is evidenced by the figures collected from something over one thousand cases in that study. It was found that health agencies were utilized in 70 per cent. of all the cases and social agencies in 66 per cent.

Another study, made somewhat more recently and by a different group of social workers including hospital social service can, I believe, throw additional light on our approach to this question of relationship. I refer to the report of the Milford Conference on "Social Case Work—Generic and Specific." In its chapter on "Some Principles Governing the Division of Labor in Social Case Work" the report develops the following principles:

"A social case work agency should do a complete social case work job with its cases and should transfer a case only when the services of another agency are clearly needed."

"There should be no diagnostic authority without treatment responsibility and no treatment responsibility without diagnostic authority."

"A transfer of a case from one organization to another should be made only when there is good reason to believe that better service will result from such transfer."

Commenting on this point, the report continues:

"Transfer from one specific social case work field to another may in certain instances be avoided by consultation between staff members of the organization in charge with staff members of the organization specially equipped to render service in view of new developments in the case, using the experience and the skill of the second agency much as a physician or psychiatrist or psychiatric social worker may be used, so as to undertake treatment in the light of all the community's experience that is available.

"Social case work organized as a supplementary service within other programs (mural social case work) will be determined as to scope and tenure on the cases treated, by the requirements of these other programs."

In discussion of this principle the report states:

"We have already suggested our belief that the social case work agency should do a complete social case work job with its own cases. We recognize, however, that work on cases in
the hospital social service department, in the visiting teaching department, in the probation department, etc., must be terminated when the purposes of the organization served by these departments have been fulfilled. We believe that the work of such departments should meet the full implications of our conception of generic social case work. The agencies which they serve, however, will frequently need to close their cases because their medical, legal, or educational jurisdiction ceases and ordinarily they should do so. In many cases thus terminated, there may remain a vital need for continuing social case work service. In such cases both sound division of labor and ethical considerations demand that they be transferred to other agencies whose tenure of service is not thus limited.

"Coöperative treatment involving on a single case the simultaneous work of two or more agencies is not only a normal aspect of the division of labor, but may be expected to increase."

To insure the effectiveness of this point the report makes this recommendation:

"As a practical coöperative treatment, we suggest that from the point where the second agency is drawn into a case and coöperative treatment begins, and continuously thereafter, there should be joint planning by the agencies concerned."

We see, then, a clear recognition of the inherent intimacy of relationship that must exist between the case worker within the hospital and those in agencies outside its walls. At the outset we must presuppose:

1. A thorough appreciation of her own function on the part of a hospital social worker.
2. An ability to analyze a given situation in order to determine whether to carry it herself, or by whom and at what point it should be carried elsewhere.
3. A full familiarity with the functions of other agencies.
4. An understanding on the part of other case workers as to the medical social implications of a situation so carried by them, whether alone or jointly.
5. A knowledge on the part of the non-medical case worker of the function of the hospital social worker.

No one of these points is more important than the other. The first must be equally shared by the hospital administrator if the social
worker is herself to be able to practice her proper function. When all is said and done, it is the administrator who is really responsible for securing a thoroughly trained social service director, and it is his appreciation of the true function of hospital social service which allows her to develop social work in the hospital along sound lines. The second and third points, the ability to analyze and select, and the knowledge of the function of other agencies, depend entirely upon the adequacy of her preparation and training for the work she has to do. The fourth and fifth points, involving as they do the knowledge of non-medical social workers, depend on other considerations and presuppose a real concern on both sides that the medical point of view be shared with others contacting the patient and his family group.

More than any other one thing, perhaps, the realization that there is a fundamental similarity, or generic basis, in all types of social work, and that the similarities far outnumber the differences, will help us all in arriving at this clearer understanding of the few important differences that do exist, and help in establishing that closer understanding of one another's function that is so essential for a sound relationship. The most outstanding difference between the extra-hospital case worker and the intra-hospital case worker is, to quote again from the Mulford Conference Report, the necessary thoroughness of her knowledge of the "causal interrelationships between social and health factors in all types of illness"; of her "team work with the physician actively treating the case"; of her "ability to arrange and manage individual cases of convalescence and provide for chronically sick individuals"; and of her aptitude in "teaching principles and methods of protection against contagion and of promotion of health." It will be noticed that it is the thoroughness with which these points are known and practiced by the medical-social worker which differentiates her from her co-operative colleagues in the social field. The extra-hospital worker must have some knowledge and some ability along these lines in order to work effectively with the clients under her care. If she is to work hand in hand with the hospital social worker, or carry on after her, she surely must have an increasing capability.

On the one hand, it is impossible for a social service department to turn over all of its problems to an outside agency, because of the necessity for an intimate working relationship with the physician on each case, and the necessity for a continuous awareness to his latest
thinking in the treatment of disease. The daily contact between the
doctor and the social worker assigned to his group of cases is never
too much to safeguard this important phase. The very nature of
many diseases and the influence of a patient's personality in their
treatment makes it imperative that the least possible interruption
occur in the smooth working out of the medical and social, or, as we
express it, the medical-social treatment. That a case of Basedow's
disease would be likely to fall into this group is clear. With equal
likelihood we should find here cases of diabetes and cardiac impair­
ment and post-operative convalescent cases. Many cases not so ap­
parent would also be included because of the individual problems
encountered.

On the other hand, no social service department can hope to carry
on all of its cases alone without the help of outside agencies any more
than the doctor can treat all his cases alone. The social worker in the
hospital must know and use the other agencies just as the physician
knows and uses other professions and technicians: the dietitian; the
X-ray or the laboratory technician; the nurse; the social worker. The
other agencies are an important part of her resources just as these
specialized persons are necessary resources of the physician. When
the social worker, for instance, needs the specialized service of the
child placing society, she needs more than the name of a boarding
mother to whose home to take the child. She needs all that that
children's worker can give her of knowledge as to the fitness of this
or that home for this particular child. She needs all that she can give
her of insight into the later relationship of foster parent and child.

It is no longer enough that any social worker shall be kindly dis­
posed toward a cooperating colleague, willing and ready to do her
part. Important as that attitude of mind may be, she needs far more
than that. She needs an understanding of the objectives of the other
agency; an appreciation of its ways of working; a grounding, at least,
in its specialized service. How, then, is the non-medical social worker
to achieve this preparation for her work with the hospital social
worker? If the major function of the work in the hospital is, in col­
laboration with the doctor, to determine and execute her part “in the
plan for helping the patient achieve his best estate,” and if, as we
have also said, “cooperative treatment involving in a single case the
simultaneous work of two or more agencies is not only a normal
aspect of the division of labor, but may be expected to increase,” we
see that this question of means is far more than an academic question.
The treatment of medical-social maladjustments must be thought of as a unit made up of essential parts—of close relationships: patient-doctor; patient-social worker; doctor-social worker; social worker-social worker; each relationship built around the patient as a central figure, and built on an understanding of his needs. Because of the generic nature of all social case work, each specialized worker needs only to familiarize herself with the differences in the particular fields other than her own, and integrate that point of view in her own thinking on a given problem.

There was a time in social work when no non-medical worker was expected to know any but the most rudimentary facts about medical matters. No information of any real value that could help her really to see and understand the problem was given her. If she wanted to know, for instance, whether a man should or should not work, the answer would naturally have to depend quite largely on the information she herself gave as to the kind of work to be done, the habits of the man, the living conditions, conditions at work, and other responsibilities, to name a few factors involved. It is clear that no really satisfactory report could possibly be given in such a case if the non-medical social worker were not to some degree informed regarding the implication of the man's disease, and the things to look for in his social life.

A community may work out an excellent system of steering blanks on which a social agency may give all the necessary social data for the use of the doctor and hospital social worker in making their report; and such a system is a godsend to any community; but the best will fail of satisfactory results for the patient unless there is a real basis of knowledge as to medical facts on the part of the social worker who fills in the blank in the first place. We need, then, in our hospitals to realize the essential value to us of community agencies and their workers, and to take every opportunity for adding to their knowledge and understanding of medical matters.

There are two outstanding ways by which this can be accomplished. There is, of course, the natural contact on a single case. If the hospital social worker will, in every instance, explain fully all the social aspects of the disease as seen in this particular case, and then go on to give an explanation of the disease in its more general aspects, she will be laying the foundation for a more sympathetic understanding of future cases on the part of that worker. When each hospital social worker takes this trouble with each non-medical worker on each
case involving mutual interest, a pretty sure footing is assured. Right here, considerable patience is needed because one telling does not always suffice, especially when there are preconceived ideas and prejudices born of misinformation to be overcome. To supplement this individualized contact between worker and worker, it is of the greatest value to organize a class in essentials of medicine for the social worker, for those field workers who wish to add to their ability to understand the health needs of their clients. Such a course arranged by a group of physicians who understand the needs of the social workers was offered in Cleveland for five successive years, until it was finally taken on by the school of applied social sciences of Western Reserve University and put into the curriculum of training for all case workers. A more advanced course is now offered by the school to experienced social workers as an extension course. Whether a community has a university or not, such a course can easily be arranged if there is interest on the part of the hospital social worker and the doctors with whom she is working.

With class instruction and individual conference going hand in hand, there is assured a far greater degree of understanding and effective interplay between the social worker in the hospital faced with the problem of working out with the physician the patient's "best estate" and the social worker in the community welfare agency responsible for the same objective for the same individual whom she calls "client." This sick individual needs the services of both; he needs them in such close and smooth integration as to assure him the same quality of social service that he gets in medical service from the doctor, who also has often to use a number of specialized individuals to carry out his diagnostic and treatment processes. It is the hospital's responsibility to know and use to the full every resource offered by its individual community and to share with each all the means available for the fullest understanding of each problem.
VALUE OF SOCIAL SERVICE TO THE HOSPITAL*  
ANGELO J. SMITH, M.D.

In my opinion a well-conducted Social Service Department can invariably make the best hospital better. Formerly most of us felt that we had done our full duty by patients when we had given them skillful medical or surgical treatment during their stay in the hospital, or on occasion of their visits to our out-patient department, and had supplied the physical requirements necessary for their bodily needs and contentment. Time and experience have shown that this is not enough, that if we are to avoid disappointing results and are to keep these patients on the straight road to getting well, we must lend a helping hand in many instances after they pass from our full control.

Such a hospital as St. John’s is intended to care for individuals through a crisis and during this period to provide for them medical or surgical treatment perhaps such as could not well be obtained in any other way, but when the patients have convalesced to a point where they can safely leave the hospital it is expected they will do so and make room for others. This is entirely proper and it is only by such a system of rotation that our hospital can fulfill the needs of the people.

Of the number of people thus being constantly discharged from the hospital there is a substantial percentage still unable to take up the routine of life, and with this class the Social Service Department is directly concerned. Further analysis shows that of the substandard group many can be cared for in their own homes and by their own people, while others less fortunately situated cannot. Care and shelter for the latter class must in some way be provided and continued until these people are able to care for themselves. Also it should be stated that some of these individuals still require treatment, medical or surgical, and it then becomes essential that they be so placed that such treatments may be obtained. The majority return

*Read before the Semi-Annual Meeting, Woman’s Auxiliary of St. John’s Riverside Hospital, Yonkers, November, 1930.
to our out-patient department for further treatment, whereas in other instances treatments must be arranged for.

The work of securing shelter and care, medical or otherwise, for this mass of indigent convalescents as well as other duties of which more will be said later evolves upon the social service department. To my mind the functioning of a well-conducted Social Service Department ranks among the most beneficial and humane undertakings in all hospital work. The general scheme of keeping in touch with patients after they leave the hospital, of providing for them in various ways, is noble in its conception and likewise is essential to the fullest efficiency of the institution.

Success in this work requires infinite patience, careful planning and great discretion on the part of the worker, also a knowledge of things medical is most essential. Her work is not spectacular, but is conducted in a silent way largely through personal contact and chiefly among those unable to help themselves. Other phases of hospital work may excel in brilliancy but hardly so in terms of far-reaching benefits.

Before leaving the topic of the social service worker let us for a moment consider what obstacles if any she is likely to encounter in her work. The wards of St. John's are open to practically all comers at all times. This means that she will sooner or later be brought in contact with a great mixture of humanity representing almost every phase of society. True enough it is, that the majority differ in no way from the average citizen, with the possible exception of financial misfortune, but among the minority are those that attract our attention as being different. It is, furthermore, with the latter class that the Social Service worker can often accomplish her greatest good by helping them past their immediate difficulties, possibly by showing them the way to a brighter future. Many speak little English and when judged in accordance with our standards these individuals seem prejudiced, suspicious, lacking in a knowledge of customs and in general understanding.

In the beginning they may impress one as being indifferent to their own interests, stubborn, often provokingly so, whereas in the end these qualities prove to be more apparent than real and were frequently born of ignorance and superstition. These of all cases are the ones that most need the patient persuasion of the Social Service worker. Nearly every one of them can be won over by such means
often to become the most loyal and enthusiastic supporter of an institution.

My thoughts were directed along this line by an incident that occurred early in my professional work in the city which so well illustrates the point in question that I shall ask your indulgence for a few moments if I cite briefly the experience. No doubt to one accustomed to medical social service work the case in question would only be commonplace but be that as it may, it shows in a way the type of mind and trend of thought with which we have to deal. On this occasion I was asked by a fellow practitioner to visit a patient living in one of the poorer sections of the city, who had an abscessed ear. Upon arriving there I found a man nearly sixty years of age with an advanced case of mastoiditis. I advised him that he should come into the hospital at once for operation which he declined to do, and continued to decline in spite of every argument I could bring to bear. After about an hour I left feeling keenly my defeat. After thinking the matter over for 24 hours, I decided to go back and try him again. Accordingly, I put my pride in my pocket and went back to reason with him a second time. The results at the end of the second hour were the same as at the end of the first hour, and I had given up every hope of doing anything with him. As I was preparing to leave I asked him if he would mind telling me his real reason for not going into the hospital, and it was then he told me how an old friend had been sent to the hospital just as I was trying to induce him to go, that they had given him a bath and he had died. I promptly assured him we would forego any such ceremony if he would enter the hospital. At this his face lighted up and he said to me "Do you really mean that, doctor?" Upon being reassured on this point, he promised to go at once, which he did.

I then arranged with the hospital that his wishes regarding the bath should be respected and supposed my troubles were over, but not so. Upon arriving at the hospital an hour later I found my friend just leaving by the side door. He said to me: "I thought you were a man of your word." I told him that I hoped he was right in this assumption, and asked him why he was leaving, whereupon he informed me that the attendants in the hospital had tried to have him remove his clothing and if he did this of course they would give him a bath. Again I assured him such was not the case, after which he allowed himself to be admitted, and as I afterward learned, even permitted a change of clothing while he was still under the anesthetic.
To me this case was very instructive. It taught me one vital lesson, i.e., that one can accomplish little or nothing with such people unless one has their confidence and they in turn are made to feel that they have one's sympathy. Apparently when such a relationship is once established the difficulties are ended.

But before such a condition can be brought about it may be necessary to educate them on the point in question or in other instances to unteach them, so to speak. I said a few moments ago that an understanding of medical matters I regarded as necessary for one doing hospital social service work. How otherwise can a worker differentiate between the important and the unimportant. She must of necessity have to make her own decisions in a great many instances. It is so essential furthermore, that she spare neither time nor effort to accomplish results when circumstances warrant, but as regards matters of trivial importance such a policy would be needlessly wasteful. In other words, if she is to be her own taskmaster she would seldom know when to give preference or when to withhold it except she be prompted by medical knowledge.

Perhaps for the benefit of those who disagree with the general scheme of social service work, we should be more explicit and should say that every year scores of patients leave the hospital with open wounds, some with suspected malignancies, others with stiff joints, besides a multitude of miscellaneous cases that still require supervision or treatment. Such being the case, is it not reasonable to suppose that we will be confronted by disappointments rather frequently if we turn loose such a mass of unfinished work without very definite supervision, and is it not equally true that any case that goes wrong through mismanagement is a discredit to the institution and, as occasionally happens to the physician who may have been in charge? Lastly, if we answer these questions in the affirmative can we hope for anything approaching perfection unless a special department be maintained that shall supervise such work through to completion?

Our out-patient department serves the people of this city and vicinity to the extent of one thousand treatments a month, and is, of course a great feeder to the hospital. Here again the follow-up work is important. Recently we have been working out a system in the eye, ear, nose and throat clinic, whereby every case likely to prove serious will be tabulated and insofar as possible followed through to conclusion. This we believe will be of value to the institution in
various ways and of educational value to the staff, disregarding for
the moment its value to the patient.

It is a common observation among experienced workers in an out-
patient clinic that the very case that promises to be of real scientific
interest seems to be just the one that presently disappears. Unless
we have some means of tracing such a patient and determining the
outcome, valuable information is lost. Rather frequently such pa-
tients have consumed considerable in the way of time of the clinic
workers and perhaps there has been some economic outlay on the
part of the hospital. The Social Service Department can often trace
such a patient, bring him back to the clinic or in some way ascertain
the outcome of the case and in this way further the education of the
staff. Education of the staff always favors advancement in either
hospital or clinic. Personally, I am very keen about this follow-up
work in the out-patient department, and in my opinion we will save
suffering and perhaps an occasional life by it.

To those unfamiliar with the out-patient clinic a word of ex-
planation may be helpful. Here a decidedly complex mixture of
people appears at stated intervals for treatment of various ailments,
some of which may be of a serious nature or may become so if neg-
lected. For the sake of illustration let us take a common ailment of
which we see many, an abscess in the middle ear. A child, for in-
stance, is brought to the clinic with such a condition. Under momen-
tary anesthesia the ear is opened, the abscess drained and directions
given the mother, friend, or relative as the case may be, for care and
treatment of the child, also the time is designated when the child is to
come back for further observation. After leaving the clinic the case
rests entirely with the relatives or friends as regards the care of the
child. If the family is of the right sort probably all will be well.
The treatments will be properly carried out and the child brought
back for further observation, but as occasionally happens, the family
may not be of the right sort and then there is often trouble. Pain
usually drives them in but pain is not always a conspicuous symptom.
Again, if the mother is the wage earner, or should other sickness
develop in the family, it becomes very difficult to carry out instruc-
tions, however good the intentions. So it happens that for one
reason or another such cases are neglected and are not brought back
to the clinic because of which serious or even fatal complications may
develop.

Some of these very cases come straggling in after months, even
years when we may find the child saddled with a chronic ailment that requires radical surgery to cure, and with deafness that cannot be relieved. Occasionally meningitis develops or some other intra-cranial complications with a high mortality. To avoid the possibility of such occurrences as the above, your Social Service Department has very kindly undertaken the necessary tabulation and follow-up work in these cases.

In closing, allow me to express appreciation to those of you who were instrumental in starting, or perhaps more correctly speaking, in resuming Social Service in St. John's.
PROBLEMS OF THE ONE WORKER SOCIAL SERVICE DEPARTMENT*

EDNA S. SHOUP

Director, Social Service Department, Syracuse Memorial Hospital, Syracuse, N. Y.

Generally speaking the functions of social service departments are the same, or should be if the departments are good ones, but specifically speaking we do get a different picture. Yonkers, New York, and thinking of it in connection with the resources of Westchester, a metropolitan county, is different from Syracuse, a smaller up-state city in a rural county. Social service departments in both of these places are based on the same general principles but the actual working out varies, just as a country doctor applies his skill in a different way than he would if he were engaged in city practice.

While we have no statistics to prove the point, probably most of the one worker social service departments in smaller cities are departments still in an early stage of their development. In Syracuse the department in University Hospital is five years old, in Syracuse General Hospital two years old, in Syracuse Memorial Hospital one and a half years old, and in St. Joseph Hospital one month old. Syracuse also has a new State Psychopathic Hospital. One social worker has been employed but the hospital has not yet been opened. These younger departments have all the problems peculiar to their youth that an older department would not have.

Hospitals differ in personality as much as individuals and the younger department has a twofold adaptation to make. It must remain true to its own standards and at the same time fit itself into the personality and physical mechanism of the hospital. In talking to Miss MacDill, Superintendent of Syracuse Memorial Hospital, about problems, she advised that aside from the actual social service work

*Read before the New York State Conference of Social Workers, Elmira, N. Y., November, 1930.
done she thought this twofold adjustment was the most important of all because if this failed the work of the department was crippled. It is only as the department develops into an integral and indispensable part of the hospital, as necessary as its doctors and nurses, that it can hope to function in its best capacity.

One of the very important problems for the social worker in a younger department is to keep before her an unfa1tering goal and ideals for the department, and not to let this central focus become over-clouded or deflected from its orbit by the wishes and demands of doctors and others who have their own pet projects that they would like the social worker to develop.

Closely tied up with these considerations is the whole question of selling the job. In Syracuse Memorial Hospital we have found two methods to be especially valuable aside from the usual methods employed, such as demonstrating individual pieces of work, talking to groups, and the whole give and take between the hospital social worker and the workers in outside agencies. One of these has been the work with a carefully chosen social service committee. This is a committee consisting of the assistant superintendent, the hospital social worker and four members from the board of directors. The committee meets regularly with the social worker to discuss problems, and in turn takes a report monthly to the board of directors, and has succeeded in keeping this group informed and interested. The other method mentioned is a course given by the social worker to the student nurses. This is a three months course consisting of lectures, class discussions, trips and outside reading. The course is designed to give the student a social awareness of her patient and a broader understanding of the human problems that she finds; also to give her an appreciation of the social viewpoint and the work of the social service department.

Patients are referred to the social service department from the same general sources that any social service department receives its applications, from the doctors, nurses, interested people and outside agencies. In Syracuse none of the hospitals have out-patient departments. There is a central dispensary instead from which many patients are referred to the hospitals. This creates a problem for the social worker as she seldom sees her patient before he is admitted, and upon discharge he is again referred to the dispensary for further medical care. This makes for difficulty and awkwardness in keep-
ing in touch with the medical situation of patients who are still under supervision of the hospital social worker.

Speaking again of the young department, the social worker has to put forth considerable effort to keep in touch with other social workers, with the leaders in the field, and with larger departments who are constantly working out better methods and further interrelations of medicine and social work.

No one will deny that medical social service is rapidly being cemented into the fibre of scientific medicine. Undoubtedly one of the greatest problems and a very important one, for the younger department, is the welding of the results of the solution of everyday problems into the building of a firm foundation for the department; one that will stand the test and lend itself to further development, and not a flimsy structure that might be uprooted with the frosts of another year.
TRAINING FOR LAY WORKERS*

MRS. JOHN S. SHEPPARD

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

We must divide lay workers into two classes: Volunteers and Members of Boards of Managers or Directors or Trustees.

The training of Volunteers has been accepted as necessary, and good training is given in many hospitals and charitable organizations.

The training of the volunteer should include the history of the institution or organization, its development and its purposes and functions. The volunteer should also be taught the place of the organization in the community and its relation to other community work.

Volunteers should have a clear idea of their function in the organization and a practical knowledge of the work which they are called upon to do.

Most important of all is that the volunteers should be required to keep up to professional standards of work. Of course, they will seldom do work which requires the intensive training of the professional, but they must be thoroughly trained for the work which they do. Promptness and regularity of attendance must be required.

To make the volunteer system successful the professionals must treat the volunteers as they would treat other professionals and must give the volunteers work which is really worth doing. I believe that when work is found for volunteers, just to keep their interest and to make them think that they are helping, it creates a false situation which is not fair either to the professional, the volunteer or the work of the organization. The work demanded of the volunteer must be real work which is really needed.

There is also a false attitude of gratitude to volunteers which is bad for the system. Of course, we should be grateful to them for

* Delivered before the Institute for Board Members under the Auspices of the Henry Street Visiting Nurse Service, New York City, November, 1930.
good work, just as we are grateful to the professional for good work. But far too often volunteers receive thanks just for being willing to work at all, and that certainly lowers the whole morale of the organization.

While it is generally accepted that training for volunteers is necessary, the training of Board Members is almost entirely overlooked.

I feel sure that it is not too strong a statement to say that one of the most potent reasons why so many organizations do not function at their maximum efficiency is because they are hampered by Boards of Managers who do not understand their problems.

Boards of Managers are supposed to shape the policies of the organizations which they serve, but in how many cases are they really competent to do this? They often give loyal and generous support to their executive directors or superintendents, but far less often do they give intelligent support.

Of course, as a rule, there are two or three members of every board who do know pretty well, the problems of their institutions, but it is rare that even those members know their organization thoroughly.

Let us outline a course of training for all Board Members. The first thing would be to know the history of their institution, the processes of its development, the purpose for which it was organized, and the purpose which it is now serving. Often an organization has grown away from its original purpose and yet its constitution, by-laws and charter were framed with the original purpose in view, and the organization is hampered by this outworn framework.

The Board should also know the place of the organization in the community and in relation to other community activities and they should know from sound facts, that their organization is filling a real need of the community and is filling that need as well as possible.

The Board should know enough of the actual working of the organization to be able to judge whether or not the organization is measuring up to the best standards, and this, of course, presupposes on the part of the Board a knowledge of what those standards are.

And one other thing: until Members of Boards realize that prompt and regular attendance at Board Meetings is essential, no Board will be able to give to any organization the help which it should be able to give.
Only when we have thoroughly trained Boards of Managers can we have thoroughly efficient organizations.

That so many organizations are functioning as efficiently as they are, is a tribute to the wisdom and disinterestedness of the executive directors and the fine training of the professional staff.

I do not mean for a moment to imply that there are not members on every Board who are giving whole-hearted service, but what I want to stress is that we have no standard of service for members of Boards, as we have for professionals, and the service which should be rendered by them.

Farsighted and conscientious executive directors make every effort to keep their Boards as thoroughly informed as possible on all the affairs of the organization, but it is a very difficult task.

Let us hope that the time is not far distant when Board Members will realize that they themselves must be trained, if their organization is to function at its maximum efficiency.
EMPLOYMENT PROBLEMS OF PATIENTS DISCHARGED FROM STATE HOSPITALS IN UTICA*

LENA A. PLANTE

Social Worker, Utica State Hospital, Utica, N. Y.

The problems of the patients and Social Service Departments of our State Hospitals for the mentally ill, are quite different from those of the general hospitals, and I shall endeavor to explain our difficulties with the present unemployment situation as I have observed them in our daily work.

The patients treated in our hospital come to us from all races, creeds and classes. Their hospital residence may cover a period of from a few weeks to several months or even years. When they have made a recovery or have reached a stage in their convalescence when the medical staff consider them ready to return to the community, it belongs to the Social Service Department to coöperate with the physicians to bring about that reëstablishment.

In some instances when a patient has been an efficient employee in his or her line of work, his employer is an understanding individual he may be returned to his former job or position. If, on the other hand, the employer has found it necessary to decrease the number of his employees during patient's confinement to the hospital, he will not find it possible to employ this person who has been absent perhaps for several months.

Sometimes it is not considered best for patient's future welfare to return him to his former trade or profession, because of the responsibility connected with it, or because a change of environment is indicated. Unless the patient has a family or friends who will aid in the employment readjustment, it is the Social Service Department, who endeavors to locate the patient in a suitable position. But if, as at the present time, every available job is filled and many workers idle, it

*Read before the New York State Conference of Social Workers, Elmira, N. Y., November, 1930.
becomes almost impossible to reestablish our patients satisfactorily.

To release a man or woman from our hospital without the consideration of employment is not constructive mental hygiene. He may have a family financially able to care for him if he is not employed, but it is not conducive to his improvement or recovery. If he has been the wage earner and the family have been struggling along without him, he will be an added burden to the strugglers or will again break down mentally because of lack of employment, and the inability to carry on. Again, if it is the mother of a family, and she returns home to find her husband either unemployed or reduced in his earnings, she will have a mental strain difficult to handle at this time, and may have a return of her mental illness.

In some instances where the father is confined in a State Hospital, the County Child Welfare Boards allow the Widows' Pension to the mother and children. If the father recovers sufficiently to return home and assume the responsibility of his family's support, the pension can be withdrawn. If he can find no employment, he must remain in the hospital rather than be an added burden to the home circle. On the other hand, when a patient has reached a certain stage in his convalescence, and is retained in the hospital, there is a danger of his becoming comfortably adjusted to institutional life, and a greater problem for reestablishment as time goes on.

Some of our patients are young, not yet out of their teens or in their early twenties. They may have families willing to care for them, but their future mental health may be safeguarded against a recurrence of their illness, if they can be satisfactorily placed in some kind of employment. The aged develop mental illnesses from which they may either recover or improve sufficiently to return to their homes. If the income in that home is greatly reduced, it may be necessary to retain that patient in the hospital for a longer time, rather than to subject him to the environment of financial worry at this time.

The Utica State Hospital conducts four out-patient clinics—monthly in Glens Falls and Schenectady, and weekly in Utica and Syracuse. To these clinics come patients referred by physicians, charitable and other organizations, former patients and other individuals. Not a few present themselves for advice. These people are usually laboring under problems of various natures and need assistance. After the clinic physician has seen the individual, and considered the conditions in the home, family or job, he makes recommendations for a plan to aid this person in making a better adjustment
Employment Problems

in life. Often times the plan calls for employment or a change of work. This being impossible, it may mean assistance from an already over-burdened charity organization.

At its best, these problems tax the Social Service Department, but, when there is scarcely a place of employment to consider, it means no work or to carry on as best they can, thereby hampering the plan which was made and making the patient's adjustment more difficult. So, whether working with our hospital or clinic patients, the problems only become more numerous and more difficult because of present conditions due to unemployment.
EDITORIAL

Old Age Security Progress

Quietly and unobtrusively, the United States is forging ahead in its protection of the weaker members of our social order. At the recent Fourth National Conference of the American Association for Old Age Security, headed by Bishop Francis J. McConnell, it was announced that the sixteen states, or one-third of the states in the Union, have already enacted old age security legislation for their dependent aged. The rapidity with which the movement is spreading is evidenced by the fact that it was only eight years ago that the first act was passed and that ten of the sixteen Commonwealths—including the States of New York, Massachusetts, New Jersey and California—have enacted these laws during the past two years. Already about 50,000 persons in the country are in receipt of old age pensions and it was predicted at the Conference that this number will be doubled within the year.

America is obviously realizing that there is something wrong with our "rugged individualism." As most people have to eke out an existence by working for others and as the discrimination against older workers now prevails throughout our larger industries, dependency in old age has become the almost inevitable lot for most of us. The applicants under the recently enacted New York Old Age Security law have brought out clearly the present difficulties. The applications come from all groups of society and from all classes. The story of early affluence, independence and comfort, followed by misery and privation was constantly repeated. No one, it appears, can be assured any more of a dignified "sunset of life" no matter what his present condition is.

The application included many former influential business men, lawyers, engineers and other respected members of the community. There was the Doctor of Philosophy, listed in America's Who's Who, who brought letters of commendation from some of the nation's leading literary and scientific men. There was the ostrich-feather
manufacturer, once worth $100,000, who lost his fortune when women ceased to wear his product. One had lost $60,000 when a friend for whom he had put up a bond disappeared.

There was the once-famed ballerina, who danced before royalty; and the prominent engineer, whom prospective employers always found "either too old or too good for the place." A man formerly in political life who entertained both President Roosevelt and Taft in his home was among the applicants.

The brunt of the fight for this measure of social justice has been borne by the American Association for Old Age Security, located at No. 22 East 17th Street, New York City. In addition to Bishop Francis J. McConnell, this Association is headed by Miss Jane Addams, Father John A. Ryan, Rabbi Stephen S. Wise and others. The Association deserves not only congratulations upon its accomplishments, but the support of every justice-loving person.

ABRAHAM EPSTEIN,
Executive Secretary, American Association for Old Age Security.
NEWS NOTES

Honeymooning on Old Age Pension

Housekeeping again after living ten years in a public institution—a second honeymoon at the age of 76—John and Mary Jay are very happy today, thank you!

The Farm Colony at Sea View has lost its only married couple. John and Mary Jay are getting $60 a month from the State of New York via the old-age pension route.

Over in Bay Ridge, in the home of a son-in-law, John and Mary are repeating a housekeeping career they started back in 1881 after their marriage in Brooklyn.

"John and I had a nice little home over in Brooklyn before our sons and daughter died," said Mary. "John had a job as a watchman in a factory in Long Island City and our children used to send us a little money every month.

"But about ten years ago they died. John's boss decided he was too old to be watchman any more. John lost his job and we went to the Farm Colony on Staten Island. Secretly, I used to wish we were back in our own home again. But I never told John.

JUST WALKING ON AIR

"Well, when we finally were told that our application for pension had been approved we felt we were walking on air. Our son-in-law doesn't make much money. But with our $60 a month we can pay our way in the house. So we went over to Brooklyn. It was just like when we were married 50 years ago.

"We made believe we had just been married and were starting housekeeping—a sort of second honeymoon!"—Staten Island (N. Y.) Advance.

The United Hospital Fund of New York City allotted $625,000 to 55 hospitals at the recent meeting for the distribution of funds.
The sum given each hospital is based on the amount of free service given to hospital and dispensary cases.

The Red Cross of Estonia is conducting a campaign against rheumatism.

The 17th Annual Summer School of the Rome State School will be open from July 1 to August 12. The course of instruction includes social case work, psychology of the exceptional child, technique of mental testing, special class teaching and practical study in idio-imbecile habit training. For further information apply to the Director of Summer School, Rome State School, Rome, N. Y.

The Emma Pendleton Bradley Home, Providence, R. I., an institution for the care and study of mental and nervous diseases in children, is open to receive patients.

There are at present 500 child-guidance clinics in this country.

Figures given out by Dr. Lee K. Frankel at a recent meeting show that the diphtheria death rate in up-State New York has been reduced 60.9 per cent. as a result of the five-year campaign against diphtheria. In 1925 there were 4,370 cases; in 1930 only 1,613. In 1925 there were 337 deaths and in 1930 only 144.

In the past six years the Duke Endowment Foundation for hospitalization and orphanage work in the Carolinas has distributed more than $5,000,000.

Two free-tuition scholarships for women in the field of health education are offered by the Massachusetts Institute of Technology—Department of Biology and Public Health—for the year 1931-32. These scholarships, covering the entire scholastic year, will be awarded on recommendation of the National Organization of Public Health Nursing.

The New York School of Social Work will give a summer course for staff workers in child-caring institutions August 3-28.
The Division of Industrial Hygiene, New York State Department of Labor, is now located in the new State Building, 80 Centre Street, New York City.

Fern Rock, a camp maintained by the Young Women’s Christian Association for colored girls, will be open during the summer months.

The National Society for the Prevention of Blindness announces summer courses for the training of teachers and supervisors of sight-saving classes at the following universities, Tulane University, New Orleans, La.; University of Chicago; State Teachers College, Buffalo, N. Y., and Teachers College, Columbia University.

The Beth Israel Hospital, Newark, N. J., safeguards babies born in the hospital by marking the name on the infant’s bare skin by means of a stencil and an ultra-ray lamp.

The Sixth Summer School of the British Social Hygiene Council will be held at St. Hugh’s College, Oxford, July 29 to August 5, 1931.

The Massachusetts General Hospital has opened a mental hygiene clinic. The personnel consists of 6 psychiatrists, 1 pediatrician, 2 psychologists, 2 psychiatric social workers and a clinic secretary.

The Public Health Relation Committee of the New York Academy of Medicine recently tendered a testimonial dinner to Dr. E. H. L. Corwin in recognition of his 20-year service to the Academy.

The Third Annual Meeting of the Pan-American Association will be held in Mexico City July 26 to 31.

Seaside Hospital, New Dorp, Staten Island, a free hospital for children up to 12 years of age is now open. There is no fee for hospital care and an ambulance will call for any child who is acutely ill. For further information apply to Miss Virginia Conklin, Admission Bureau, 105 Washington Street, New York City.

The Old Age Security Herald reports that New York City has pensioned 16,000 old people under the new old-age pension law.
Miss Lois Meredith of the Newark State Normal School has recently been appointed director of a study of the field of psychiatric social work with special emphasis on training and future trends. The study is being made under the auspices of the American Association of Psychiatric Social Workers and is made possible by a grant from the Commonwealth Fund.

Many of the issues with which the Association has been faced have indicated the need for a comprehensive study of psychiatric social work as a specialty and its relation to other fields, as evidenced by developments to date. The extensive practice of psychiatric social work under a wide variety of administrative settings in many fields, has led to necessary adaptation and fluidity that is difficult to follow in all its ramifications.

The American Association of Psychiatric Social Workers Advisory Committee on Standards, whose work led to recognition of the need for such a comprehensive study, under the chairmanship of Mrs. Maida H. Solomon, is acting in close working relationship and advisory capacity, with Miss Meredith. This Committee, which is comprised of some fifteen Association members who represent considerable diversity of interest, has appointed this year a sub-committee within, under the chairmanship of Miss Mary C. Jarrett, to give special assistance to the director of the study.

Instruction in pediatrics and obstetrics occupies two months of the four-month course given by the Harvard University Medical School for physicians practicing medicine in country districts. The study of general medicine occupies the other two months. A grant of the Commonwealth Fund has made this course possible and is sufficient to cover the expenses for tuition and travel and a monthly stipend of $250 for five physicians from each of the two units of the Fund's new Massachusetts Health Demonstration and for five physicians from the State at large.—U. S. Children's Bureau, Washington, D. C.

“Our children are born neither liars nor honest persons.” This is one of the arresting statements in the discussion of the problems of phantasy and truth in children which form the special topic of a recent number of Child Study. Children say things which are not true to protect themselves from punishment, to win approval, to deceive themselves through telling their phantasies, which are really wish fulfillments. For, thinks the child, if others believe the story then it
must be true. One strange type of lying in children, says one of the writers, is inspired by the desire to be detected in it in order to provoke punishment, which the child feels is deserved for some other fault that has not been acknowledged. Parents are advised that the causes for these deviations from truth are often based on a fundamental need of the child’s personality, and that finding these causes and satisfying this need in a wholesome manner instead of inflicting punishment is the right way to meet the problem.—U. S. Children’s Bureau, Washington, D. C.

Children with heart disease need not be taught in separate classes, according to the findings of the cardiac vocational-guidance service of the New York Tuberculosis and Health Association in its recent 10-year report. The records of 477 school children supervised by the service showed that very few had been excused for prolonged absence due to illness. All were excused from competitive games but few from gymnastic activities. It was also found that young patients with heart disease can work at a wide variety of occupations, and that those on light jobs were absent because of illness an average of only 14 days a year.

In a recent report Mrs. Winifred Hathaway, Associate Director of the National Society for the Prevention of Blindness, calls attention to the fact that there are between 50,000 and 60,000 school children in the United States who have such seriously defective vision as to require special educational methods and special eye care. Mrs. Hathaway goes on to say that 5,000 sight-saving classes are needed if these handicapped children are to be properly cared for and educated. There are at present only 400 of these special classes in the United States.

There are at the present time 32,000 ex-service men in the United States Veterans’ Bureau hospitals.

The Statistical Bulletin of the Metropolitan Life Insurance Company gives out the following information regarding the mortality experience of the first three months of 1931. Despite a wide-spread outbreak of influenza the death rate among policy holders was at about the average figure prevailing in the winter season during the last ten years. The influenza-pneumonia death rate was high, 7,990
during the quarter, or well over one-sixth of the total deaths from all causes. The tuberculosis rate improved among the whites, but showed an increase among insured Negroes. The death rate for measles, scarlet fever and whooping cough show no important change since last year, but that for diphtheria declined to the lowest winter figures ever recorded. The cancer death rate for both white and colored policy holders rose sharply. The diabetes mortality rate also increased as did the death rate from all the degenerative diseases. In addition to diphtheria and tuberculosis deaths from diarrheal complaints and puerperal conditions show a decrease. Suicide increased among the whites but decreased appreciably among the colored policy holders.

The Director General of Public Health of Honduras has approved a plan presented by the Social Welfare Association to establish a visiting-nurse service.

The Governor of Pennsylvania recently signed a bill providing for double compensation for children who are injured while employed illegally. The signing of this bill will discourage employers who take a chance on employing a girl or boy under legal working age.

Madison, Wisconsin, has erected a new $300,000 orthopedic hospital.

Special flat rates for maternity cases were recently put into effect at the Northern Dutchess Health Service Centre, Rhinebeck. According to an account in the Red Hook Advertiser, the Board of Directors has adopted this system “in order to promote more real and genuine care of prenatal cases which indeed are often neglected.” Ward patients are charged $45 and semi-private patients $55. These fees are based on a ten-day stay at the hospital. All patients who wish to avail themselves of these rates must present a certificate from their doctor showing that they have had adequate prenatal care from at least the third month of pregnancy. If patients fail in this respect they are obliged to pay the regular hospital charges.

The adoption of flat rates for maternity cases is a distinct step toward better prenatal care. Adequate supervision during pregnancy and birth will do much to save the lives of many mothers as well as to reduce materially the deaths among infants in the first months of life. —Health News.
BOOK REVIEW


Although this book is written for the modern mother interested "in the scientific basis of various procedures now used in the care of infants and children," the reviewer believes that it should be a welcome addition to the library of school workers and others interested in child hygiene.

Dr. Tisdall of Toronto, who has had considerable experience in the care and upbringing of infants and children, has succeeded in presenting a clear, well-written book which should be easily understandable by those who have the necessary preliminary education. Moreover, the contents are very well arranged, and can readily be used as a handy reference manual. The book is arranged in four sections:

1. Prenatal care and care of the baby during the first two weeks of life.
2. Care of baby during the first year of life.
3. Care of the older infant and child.
4. Special problems.

Each section is divided into chapters which discuss rather fully some particular feature or aspect in the care of the infant and child.

Although the author mentions in his preface that the book is not intended in any way to take the place of the physician, it is in the presentation, in a matter of fact manner, of scientific and sometimes controversial clinical details that the reviewer begs to differ as to the fulfillment of its objective. Unless the mothers in and about Toronto have a deeper and much more practical application of modern medical scientific knowledge than mothers elsewhere, the reviewer is inclined to believe that it is only the exceptionally few mothers scattered throughout the United States and Canada who could read the book with full appreciation. And, because of this, the book should be recommended only to that intermediary group of workers, such as nurses and social service workers, who stand between the physician and the mother.

SAMUEL ADAMS COHEN, M.D.

The activities of the human mind are well presented in accordance with modern theory by two experienced and "human" psychiatrists. Starting with the concepts of mental hygiene they present the material essential for understanding the whys and wherefores of adjustment or maladjustment, happiness or unhappiness, success or failure, in terms of total organization of the body and mind. The authors have written clearly and interestingly. They invite continued attention, whether to a discussion of the elementary psychological concepts, action as a goal of mental processes, and the degrees of awareness as marked in the conscious, the subconscious and the unconscious, or whether they are discussing introversion, rationalization, inferiority complex or sublimation.

Fortunately the discussions are abundantly illustrated by diagrams which are most helpful for the interpretation of the general themes and in facilitating self-understanding, if the reader is seeking personal help through reading this book.

The authors are not fanatics, panaceaists or followers of single theories. The general principles as laid down are eclectic in character, with an appreciation of the elementary drives of man as resident in the ego, sex and herd impulses. It is a particularly useful volume for a clear exposition of the psychiatric concepts most generally accepted by the American psychopathological group. It merits a wide reading and careful study, particularly by those who desire to grasp the workings of their own minds in relation to their fellowmen.

IRA S. WILE, M.D.


This volume is an interesting presentation of the treatment accorded to the cripple before the development of modern surgery, and the more recent growth of community concern regarding the education, rehabilitation and welfare of crippled persons. There is an interesting chapter on what is called "The American Scheme," with a discussion of some of the work being done in the United States in the way of vocational training and rehabilitation. The author states that:
"In the United States every citizen has a right to vocational training for direct employment or rehabilitation after accidental injury." Be that as it may, the achievement of such an ideal is another matter.

The volume is well printed and contains a number of fine illustrations. It should be of special value to those interested in vocational training and rehabilitation programs.

JACOB A. GOLDBERG, Ph.D.

ABSTRACTS


This article gives a very interesting account of the splendid care given to sick and crippled children in England and on the Continent. One also obtains a clear idea of pediatric-nursing methods in practice in the different countries. The education of nurse and doctor for this special field of work is similar to that in vogue in this country but includes a much more broadening program. The picture of the children's wards in English hospitals is a happy one: Physiotherapy to music, school work with enthusiastic young teachers, occupational therapy, and delightful surroundings of acres of lovely countryside bring joy to the sick and crippled children. Training centres are maintained by several of the English hospitals where "Mothercraft" is taught. This practical training is a valuable addition to the education of the nurse and young doctor. In England much of the social work and follow-up of after-care for children is carried on by the Invalid Children's Aid Association which is one of the constituent bodies of the National Council for Maternity and Child Welfare. A number of convalescent homes are maintained. One of the most interesting is "Heartease," a home for the treatment of children with rheumatic heart disease. This home accommodates 80 girls. The wards are arranged so that the children's beds can be in the open air and sunshine and still be protected in inclement weather. The nursing and educational program is based on the individual child's need. The children stay at "Heartease" for six months or longer and they are closely followed-up after discharge. Another home of interest is the Lord Mayor Treloar Cripples' Hospital and College. The children
admitted to this institution receive the most advanced scientific treatment and lead active and as nearly normal lives as is possible. School work and play make up their day and in this atmosphere they thrive. In Brussels the Red Cross Service has worked out a program for the promotion of child health. An outstanding activity is the mother and baby welfare work of l'Oeuvre National de l'Enfance. The clinic rooms are attractive and arranged conveniently. Separate rooms are provided for the baby carriages, undressing and bathing the babies, teaching and preparation of formulae for artificial feeding, and one room contains an exhibit of articles connected with child care. Excellent work is being done in the mental hygiene clinic. In France the l'Ecole de Puériculture stresses maternal and child welfare combining the practical demonstration with nurses training. At the Universitate-Kinderklinik, Wien, great importance is placed on diet. Very interesting is the ward of diabetic children learning how to adapt themselves to their handicap. On another ward one of Dr. von Pirquet's last inventions, a glass bed is used. It is a box-like affair, the bed serving as the base of the box, with four sides and top of glass. Very sick children and those susceptible to infection occupy these glass boxes. The kitchen of this Kinderklinik is a fascinating place. The food is weighed, measured and prepared according to the nutritional requirements of the individual child. Interesting illustrations give deeper interest to the text.


This article gives an account of a self-selection of food experiment with infants that upsets all established theories of scientific feeding. Yet the experiment has been successful with five years of experience and research behind it. Self-selection of diets was begun with a group of babies at Mount Sinai Hospital, Cleveland, Ohio, and for the past three years has been carried on in Chicago at a small nursery establishment for the purpose. The babies are kept at the hospital night and day as long as they are on the experiment. Of 14 children two completed periods of 6 months each and 12 completed periods of 1 to 4½ years respectively. The children have thriven equaling or surpassing present standards of growth; they also have been very free from digestive troubles and none of them has ever been constipated or been given a laxative of any sort. This plan of feeding must not be confused with the old custom of placing a baby at the family table
and allowing him to taste and eat adult fare. The food list used in
the experiment contains no made dishes or mixed foods, such as cus­
tards, soups or bread,—only simple foods prepared as simply as pos­
sible without addition of salt or other seasoning. No canned food
was used and the list does not include derived foods such as sugar
and butter. It makes available the entire range of food elements,—
proteins, fats, carbohydrates, minerals and vitamines,—known at the
present time to be necessary for good nutrition, but not assembled
with any regard for what might or might not be “good for babies.”
Foods are served in weighed or measured portions and each, even
salt, in a separate dish. All foods are placed on a tray and the baby
selects what he desires and in the order he chooses. Any dish emptied
is refilled so that baby has as much as he wants of each food. No
attempt is made to direct or assist the child in his selection of food
or method of conveying it to his mouth. A nurse sits with the babies
too young to use a spoon and feeds the infant with the food he indi­
cates he wishes. Definite likes and dislikes were in evidence during
the first few weeks, later the children show a preference for certain
foods. The children follow the dictate of their appetite and just what
a child will select cannot be predicted. The author gives a complete
list of foods used in the experiment and cites individual peculiarities
in different children in the selection of their food, also the quantity
consumed. One 3-year old boy, who had been out playing in the
snow tucked away for lunch 750 grams of baked potato and a quart
of lactic milk and a few odds and ends. The infants occasionally
go on what the author calls a food “jag.” In one case five eggs for
supper were eaten during an egg “jag” by an infant 13 months old.
This same child when he was 2½ years old once ate 10 eggs with no
digestive disturbance or ill effect. Each child eats exactly what he
wants. Generally speaking meats, potatoes, carrots, peas, eggs, milk,
apples, orange juice and bananas have been liked by the babies. The
infants almost wholly failed to select spinach or lettuce, but all
show a decided liking for fruit. The amount of fruit eaten con­
stitutes nearly 50 per cent. of the food intake. In two instances the
fruit constituted 70 and 75 per cent, of the diet for the first six-month
period. Extraordinary as the whole idea seems the children thrive
and are happy and contented. They are not directed, corrected or
urged to do or not to do this or that—perhaps this may account in a
measure for their ability to consume and assimilate foods not ordi­
narily given to infants and young children. At any rate the experi­
ment has opened up a new field of research on nutrition and child feeding.


Almost unbelievable industrial conditions prevail in Tientsin, China. There are roughly speaking 150,000 men and women employed in the work shops and factories in the City and Concessions. Industrial hygiene is unknown. Overcrowding, lack of light and ventilation, scanty food, long hours—24 hours if the employer demands it—all contribute to the problem of blindness. Xerosis (due to malnutrition) is responsible for 13.45 per cent of the blindness. There are no laws for the protection of industrial workers consequently the workman has no redress. As there is no dearth of people seeking manual labor the employer and his agents can afford to refute the evidence and disregard any plan made by the League. The six principal causes of blindness in China in order of frequency are: smallpox, xerosis, trachoma, syphilis, gonorrhea and local customs. By local customs is meant empirical treatment applied by quacks, sorcerers, or friends. As there are only 2,000 home-trained physicians in China, or in other words one doctor for 20,000 inhabitants, it is not surprising that the people employ “healers” and resort to superstitious practice and witchcraft. The League carries on a vigorous campaign against blindness and the industrial hazards causing blindness. Four clinics are maintained. These clinics are in charge of two physicians and two other physicians visit workshops and factories daily. One of the visiting doctors is quoted as saying the prevailing attitude of the employers toward prevention and industrial reform is “An eye is worth less than an egg.” Measures must be adopted by the Government to compel employers to assume a different attitude toward the worker. In the meantime the League carries on.


It is estimated that 20,000 women die every year in the United States as the direct or indirect result of childbirth. Of this number approximately 8,000 die from puerperal infection, 5,000 die as the result of eclampsia, 4,000 succumb to excessive loss of blood, and about 3,000 lose their lives from other causes associated with child-bearing. The number of women who are severely but not fatally injured dur-
ing labor cannot be estimated. The common belief is that between 50 and 60 per cent. of all gynecological operations performed are necessitated by damage which occurs at the time of confinement. Proper conduct of labor will reduce both the maternal mortality and morbidity. An analysis of the results obtained at the Chicago Lying-in Hospital shows startling results. During a period of nine years there were 23,136 deliveries. The hospital is an "open" one and in addition to the regular staff approximately 50 outside physicians delivered patients. Among the 23,136 women there were 57 deaths giving a total maternal death rate of 0.246 per cent. For the entire registration area of the United States there were 68 per 10,000 live births in 1921; 66 in 1924 and 65 in 1927. The death rate in this country in 1924 varied from 45 per 10,000 live births in Utah to 121 in Florida. In England and Wales for the year 1926 the maternal death rate was 51.4 per 10,000, in Canada for the year 1926, it was 60, and in the City of Amsterdam for 1928 it was 64 (reference for figures given). According to Woodbury two-fifths of all maternal deaths in the registration area of the United States are due to septicemia. Nicoll analyzed 696 maternal deaths which occurred in New York State, by studying the death certificates and personal replies to questionnaires sent to the doctors who reported the deaths; 37 per cent. deaths were due to puerperal sepsis, 21 per cent. to toxaemia, 9 per cent. hemorrhage. These figures as shown by the answers to questionnaires were too low. The causes of deaths at the Lying-in Hospital were as follows: pneumonia (after general anesthesia) 14, toxemia 10, heart disease 9, abruptio placenta 6, embolism 5, peritonitis (1 from gonorrhea) 4, septicemia 3, rupture of uterus 3, hemorrhage from placenta previa 1, shock 1, enlarged thymus 1. Of the three deaths from septicemia only one resulted from infection which developed in the hospital. The morbidity at the Lying-in Hospital also has been exceptionally low. The standard accepted is the most rigid reported, namely, every elevation of temperature up to 100° F., or above even if recorded only once from the moment of delivery to discharge from hospital. Under this strict standard, the total morbidity among 23,136 patients was 10.8 per cent. The morbidity standard of the British Medical Association read as follows: "Puerperal morbidity should include all fatal cases and also all cases in which the temperature exceeds 100° F. on any two of the bi-daily readings from the end of the first to the eighth day after delivery." According to this standard the morbidity of the Lying-in Hospital
was only 4.3 per cent. A fair proportion of this morbidity was due to extra-genital causes. These figures show the importance of intrapartum care. The author gives a brief outline of the management of the three stages of labor and the care given at the Chicago Lying-in Hospital and we agree with his voiced opinion that if all women in labor received the same supervision and treatment as is given at the Lying-in Hospital our maternal mortality and morbidity would be considerably reduced. This illuminating article will prove of great interest to physicians, public health administrators, nurses and social workers and to others concerned over our high maternal death rate, which to say the least is discreditable.