A STUDY OF SIXTY-NINE ADOPTED CHILDREN

IDA PRUITT

Chief of Social Service, Peking Union Medical College, Peking, China

Very early in its history the Medical Social Service of the Peiping Union Medical College Hospital was confronted with the problem of what to do with unmarried mothers and their children, and with families with more children than they could support.

In the case of unmarried mothers, it was decided that at the present stage of economic development and social thought of the country it is impossible for such a woman to keep her child. For any woman to be financially independent in China is difficult and for one who is handicapped it is impossible. The range of available work is not wide. Practically the only fields open to women are domestic service, sewing and the professions. Besides being few, the available positions in the professions depend on social standing, and those in domestic service and sewing on social conformity. The few factory positions do not pay enough for a woman to keep herself, so that she must remain a unit in some social organization. The family, though changing in form, is still dominant, and, except in certain advanced student circles, unmarried motherhood is considered a disgrace. It was therefore decided to take the babies of unmarried mothers, and find homes for them where they could be brought up with two parents and no sense of disgrace.

In the case of large families, mothers or fathers from time to time beg the Social Service to take the new child whose birth upsets the very delicate balance between the possibility and impossibility of maintaining an existence level for the family. Whenever possible an adjustment is made to enable the parents to keep their own child by finding better work for the father, or work in the home for the mother. Since the greatest single lack, however, in the resources of Peiping is opportunity for employment for those who can and want to work, often the only way in which the Social Service can help the family is by taking the new baby.

Since there is no general children's social agency in town the
Adopted Children

The problem of what to do with these babies had to be solved by the Social Service. The special social agencies in the city include two orphanages. The Sisters of the Catholic orphanage take baby girls, and farm them out to unsupervised boarding homes, paying the women three dollars a month for each child. Those children that survive are taken into the Catholic orphanage when they reach the ages of five or six. There they are kept until grown, taught some reading and a very good grade of handwork which enables them to make a fair living as sewing women. At the ages of seventeen or eighteen marriages are arranged for them by the Sisters, with men who apply in the old Chinese way.

The only other orphanage taking babies and the only one taking boys when the Social Service became interested in the field was the Yu Ying Tang, or Foundling Home, which at that time, was very badly run. No statistics were available, but as far as one could see there was a hundred per cent. mortality since new babies were taken in almost daily, none were ever given out for adoption, and the number in the home remained almost constant. There were several reasons for this condition. The babies were often brought into the orphanage diseased and starved, and there was no adequate medical care in the institution. A few children were brought to the Peiping Union Medical College, and an old style Chinese doctor made visits to the Home where all he did was to feel the children's pulses. Children who entered the home healthy soon acquired eye and skin diseases, while others died of pneumonia or starvation. Feeding was done by wet nurses who, because of the small wage and poor food were only those who could not get positions in families. Their milk supply was often thin and scanty, but they were required to nurse two or three children at a time. Conditions in this orphanage have now improved to a large extent, due to the volunteer services of several staff members of the Peiping Union Medical College who are helping to re-organize it and to give medical care.

We wished, however, to find homes for the children where they could be brought up normally with parents and relatives, and home affection, rather than in one of these orphanages.

Eight years ago, certain public spirited women of the city started an association called the Home Finding Association to care for unwanted babies. This flourished for several years, until because of the departure of most of the founders, and because of unstable political conditions the membership became very small. The work
was then, in 1927, taken over by the Medical Social Service of the Peiping Union Medical College Hospital. Between 1923 and 1927, the association handled twenty-four children. Since some of these came originally from us, they are counted in this study. The worker in charge of the Home Finding Association activities was untrained, and the records were therefore poorly kept, so that the information is not always sufficient for tracing the children. During its active years, the association maintained its own receiving home where children were kept until permanent homes were found for them.

Finding homes for children is even easier in China than in America. As far as can be ascertained, adoption is an old practice in this country where the continuation of the family has always been a social necessity. One's happiness and comfort in this world, where there are no life insurance companies, depends on the filial support of sons; and one's comfort and peace in the next world depends on the worship and constant offerings of these same sons. Besides this actual necessity for children, there is also a great desire for them. The family which is the social unit, is in a large measure self-contained, and outside diversions are comparatively few. The chief source of joy and relaxation is in the children. A childless home is here even more than elsewhere a bleak one. Since, however, the children are not evenly distributed, some families having too many, and many families, even clan families, having few or none, the practice of adopting children has been largely followed, when possible from a collateral branch, but otherwise from outside.

The care of babies prior to adoption has been an urgent and difficult problem. In many cases they go directly to their new homes from the hospital wards soon after birth but often there is no suitable home ready when the baby should leave the obstetrical ward.

The ordinary children's ward is not a suitable place for a well baby, nor is it fair for a well child to hold a bed which should be used for a sick one. The Peiping Union Medical College Hospital has, however, been very generous in allowing the babies to stay on the pediatric ward until they are established on an artificial diet.

Boarding homes, therefore, have had to be used. Although suitable boarding homes are very hard to find, there are usually two or three available where we can place babies. The boarding mothers have been the wives of artisans, servants, or clerks out of work, where the wife was at home all day occupied with her own housework, but not overburdened by it. Some of these women have been incompetent,
some lazy, and one was found to be feeding to her own grandson the
milk powder provided by the Social Service. On the whole they have
done fairly well. Besides caring for babies waiting for adoption,
these boarding homes have cared also for many children who were in
our hands for a short time only.

A flat sum of three dollars a month for the care of the baby is
paid and social service supplies clothes and food, such as milk pow­
der, and cod liver oil. The boarding mothers are required to bring
the children to the clinic once a week and to be prepared for a call
from the worker at any time.

Families can easily get babies for adoption from other sources
but they often come to us saying that they prefer to adopt through
the Social Service as they know that our babies are healthy. Some
families inquire about the parentage of the children, some ask to see
the parents to judge for themselves of the stock, while others make
no inquiries, asking only for the eight characters derived from the
hour, day, month and year of the child’s birth. This information is
taken to a geomancer who then casts the horoscope of the child, and
the prospective parent is guided thereby.

When it became known that the Social Service had children for
adoption, there were more applications than there were children
available. All applicants were investigated, their applications filed
according to whether or not they were considered eligible, and those
who were eligible were given children whenever one suited to their
needs was available.

When accepting responsibility for children, in order to guard the
future of the child and to make the transaction business like, we have
required a contract, signed in the case of illegitimate children by the
mother and one other responsible person, and in other cases by the
father and mother.

In investigating a family the points considered are the decency
and reliability of the prospective parents, the financial and social
stability of the family, the age and health of the parents, and the
attitude of the other members of the family. Wealth has not been
considered an essential, though many adopting families are wealthy.
A stable economic condition insuring an education and a stable future
for the child has been the aim. Professional or mercantile families
are preferred to those living on inherited incomes, as a family on the

1 The clothes are supplied by the Peiping Union Medical College faculty wives’ club, the Yi Yu Hui.
up grade is considered more stable and vigorous than one that is making no effort. The age of the parents is very important. Where the mother is still capable of child bearing we do not like to give her a baby in case she may later have one of her own. On the other hand if the mother is too old we fear she may die before the adopted child is old enough to be settled in life.

The health of the parents is a point we would like to go into more fully than we have been in the habit of doing. We have not felt it possible to require a physical examination of the adopting parents, but we hope to achieve that in the future. At present all we can do is to estimate their health from observation, and rule out those parents obviously ill with such diseases as tuberculosis, or manifest skin diseases.

When a family on investigation has been found to be eligible and when a suitable child is available, the contracting papers are drawn up. A shop guarantee and one or two reliable middle men with Peiping residences are requirements for the contract. These are not always both available, sometimes we are willing to take one of the two, when the family seems exceptional.

From the establishment of the Social Service in May 1921 to the end of December 1929 sixty-nine children have been taken over entirely by the Social Service. This does not include the children who for medical or social reasons have been boarded temporarily in the same boarding homes as these sixty-nine children.

In studying these sixty-nine children many interesting points are brought out as may be seen from the following tables.

As suggested in the introduction most of the children have been given to the Social Service either because of illegitimacy, or because of the poverty of their families. The table on next page gives the reasons in detail.

The sex and civil status of the children have very decided influence on the giving up of the children to Social Service, and also explains why we have had more girls than boys to place. It is interesting to note that in spite of the fact that we have had more girls than boys, we have been able to place them all.

Among these children are two sets of male twins, both of illegitimate pregnancies, and one set of female twins, legitimate, so that the

---

2 Because the investigations are done by different workers, there is a variation in judgment on these points.
### Adopted Children

#### Reason for Giving Baby to Social Service

<table>
<thead>
<tr>
<th>Reason</th>
<th>Sex</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illegitimacy</td>
<td></td>
<td>20</td>
<td>18</td>
<td>38</td>
</tr>
<tr>
<td>Poverty of family</td>
<td></td>
<td>3</td>
<td>16</td>
<td>19</td>
</tr>
<tr>
<td>Death of mother</td>
<td></td>
<td>3</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Desertion of father</td>
<td></td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Concubine leaving husband</td>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Death of father</td>
<td></td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Picked up on street or left at hospital</td>
<td></td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>28</td>
<td>41</td>
<td>69</td>
</tr>
</tbody>
</table>

Of the above children 38 are of illegitimate pregnancies, 28 from married pregnancies and 3 are unknown.

Sixty-nine babies represent sixty-six pregnancies, with the illegitimate pregnancies exactly evenly divided between male and female babies.

The distribution and proportion of males and females is what should be expected though it is surprising that the ratio should show so clearly in so small a series.

Practically all illegitimate children born in the hospital were given to Social Service, with only three known exceptions. In one case the father had no son by his legal wife, and took his illegitimate child home to her. In a second case the man and woman had married late in the pregnancy, and after a short period of boarding out planned to take the child home as if it were adopted. The third case was that of a wealthy young girl who boarded her child out herself.

The sex distribution of the legitimate children is quite as expected, since it is unusual that a family should part at all from a legal son and it is done only in dire necessity. Of the six boys listed as legitimate the parentage of two is doubtful. The social worker felt sure in her own mind that they were children of illegitimate pregnancies, but she could get no proof of this nor a confession from the mother who in each case was a married woman. One of them claimed that her husband was a soldier, his present whereabouts unknown, and that the
child was his. She gave her occupation as an “amah,” but no one who knew anything about her could be found. The other claimed that her husband died one month after marriage. The only person with whom the social worker could get in touch who knew the mother was a friend who told the same story.

The four boys from proven legal unions were all sons of poverty stricken parents, who had other children as shown in the following table.

<table>
<thead>
<tr>
<th>Sex</th>
<th>Age given to hospital</th>
<th>Occupation of parents</th>
<th>Number of “siblings”</th>
<th>In hospital</th>
<th>Boarding home</th>
<th>Adopted family</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>1 month</td>
<td>M. servant</td>
<td>2 brothers 1 sister</td>
<td>7 months 14 days</td>
<td>1</td>
<td>Merchant</td>
</tr>
<tr>
<td>M</td>
<td>Born in hospital</td>
<td>F. stableman</td>
<td>1 brother 1 sister</td>
<td>1 week</td>
<td></td>
<td>Merchant</td>
</tr>
<tr>
<td>M</td>
<td>Born in hospital</td>
<td>M. “amah”</td>
<td>4</td>
<td>6 months 13 days</td>
<td>4 days 6 days</td>
<td>Official</td>
</tr>
<tr>
<td>M</td>
<td>Born in hospital</td>
<td>M. peddler</td>
<td>3 brothers</td>
<td>8 days 6 days</td>
<td>4 days 25 days</td>
<td>Secretary to dean of college</td>
</tr>
</tbody>
</table>

In three cases the parents were both away from home at work all the time, and in the fourth the father was a peddler. The usual amount earned daily by a peddler is from ten to fifty cents, which is not sufficient to support a family of five. Servants in Chinese families make two to three dollars a month besides their keep. Common soldiers are lucky to get enough to eat and wear for themselves.

The following tables show the number of children that needed interim care before adoption, the type of care provided, the respective lengths of stay in the boarding homes, and the results of their stay. As a rule the boys go directly from the hospital to the home in which they are adopted because there is almost always a list of applicants waiting for boys. On the other hand those applying for girls are fewer and the girls are more in number, so there is no waiting list for them but they are given out as suitable families apply.

Those who are listed as having died sickened in the boarding home, and were re-admitted to the ward where they died. The one child listed as returned to the hospital is still there for regulation of feeding, but will soon be sent back to the boarding home.
### Table Showing Children Who Went Straight from Ward to Adopted Home, and Those Who Were First Boarded Out

<table>
<thead>
<tr>
<th>Ward or Boarding home</th>
<th>Sex</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward only</td>
<td></td>
<td>23</td>
<td>15</td>
<td>38</td>
</tr>
<tr>
<td>Boarding Home</td>
<td></td>
<td>5</td>
<td>26</td>
<td>31</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>28</td>
<td>41</td>
<td>69</td>
</tr>
</tbody>
</table>

### Length of Stay in Hostel or Boarding House

<table>
<thead>
<tr>
<th>Time</th>
<th>M</th>
<th>F</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1 month</td>
<td>3</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>More than 1 month</td>
<td>1</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>More than 2 months</td>
<td>1</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>More than 3 months</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>More than 4 months</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>More than 5 months</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>More than 6 months</td>
<td>2</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>More than 7 months</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>More than 8 months</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Over two years</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Not known</td>
<td>5</td>
<td>31</td>
<td>36</td>
</tr>
</tbody>
</table>

### Table Showing Age at Entering Boarding Home Correlated with Result

<table>
<thead>
<tr>
<th>Age (going to B. H.)</th>
<th>Adopted</th>
<th>Return to hospital</th>
<th>Died</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1 month</td>
<td>6</td>
<td>1</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>More than 1 month</td>
<td>7</td>
<td>1</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>More than 2 months</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>More than 3 months</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>More than 4 months</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>More than 5 months</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>More than 6 months</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>More than 7 months</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>More than 8 months</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Over two years</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

*Two children went to the Hostel with their own mothers, who breastfed them for a time.
I. Pruitt

The Motives Given for Adopting Children as Might be Expected Are Varied, But They Fall Into Four General Groups

<table>
<thead>
<tr>
<th></th>
<th>I. No children</th>
<th>II. No son</th>
<th>III. Children grown</th>
<th>IV. Miscellaneous</th>
<th>Unrecorded</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>7</td>
<td>14</td>
<td></td>
<td>2</td>
<td></td>
<td>23</td>
</tr>
<tr>
<td>F</td>
<td>14</td>
<td>4</td>
<td>7</td>
<td>5</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>21</td>
<td>14</td>
<td>4</td>
<td>9</td>
<td>5</td>
<td>53</td>
</tr>
</tbody>
</table>

Group I may include some who should be in group II, but unless it was definitely stated in the history that a son was wanted we have put them in the first group, for in some families there seems to have been no preference. The finer distinctions are sometimes not inquired into and therefore not always brought out in the history. The records and the memory of the workers, however, gives the impression that in families with a son in a collateral branch the tendency is to adopt girls. For example, girls were asked for in the three following cases: One family with a son by a former wife and living with his grandparents, another family with a son adopted from a collateral branch, and a third family in which the brother-in-law has a son.

Sex of Children Adopted into Families where the Adopting Mother Has No Children of Her Own

<table>
<thead>
<tr>
<th></th>
<th>No children at all</th>
<th>Son at home with clan family</th>
<th>Has adopted a daughter already</th>
<th>Has adopted one son, one daughter</th>
<th>Has adopted one son, two daughters</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>6</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>F</td>
<td>9</td>
<td>3</td>
<td></td>
<td>1</td>
<td>1</td>
<td>14</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>21</td>
</tr>
</tbody>
</table>

Of the fifteen who had no children at all, nine wanted girls and six boys. Eleven of these women did not state their reasons for adopting the children, two were unable to bear children, one was lonely and depressed, and one hoped thus to keep her husband’s love.
In these twenty-one cases of childless marriages only eleven gave the length of time after marriage and before the adoptions were negotiated. Most of them say many years, three were over ten and one over twenty. Four had been married from two to ten years.

*Group II* which covers the families with no son may be analyzed as follows:

<table>
<thead>
<tr>
<th>Reason for Adoption</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have daughter of their own</td>
<td>9</td>
</tr>
<tr>
<td>Have already adopted a daughter from outside</td>
<td>1</td>
</tr>
<tr>
<td>Need son for inheritance</td>
<td>3</td>
</tr>
<tr>
<td>Mother fears husband will take a concubine to get a son</td>
<td>1</td>
</tr>
</tbody>
</table>

When families with daughters of their own adopt sons the mother is usually past the child bearing age or else has ill health.

Three families frankly stated that sons were needed for inheritance. Two of these are large families with many brothers married a long time, none of whom have sons. In the third case, the boy was taken by the grandmother to be adopted by the widow of her only son. The grandmother had many daughters and was herself past the child bearing age. It is interesting that at first she wanted an illegitimate child, but finding a legitimate boy with her own family surname she was glad to take him, since she said they were of the same stock.

There is a feeling, often expressed, that illegitimate children are more beautiful and more clever than other children, so that we are often asked for them. One applicant said that an illegitimate child born of well-to-do parents was more likely to have had better prenatal nourishment than the legitimate child of a poor mother. On the other hand, some applicants specify against illegitimate children, as they fear “inherited” wayward traits, and claim that illegitimate children are more forceful and harder to manage.

In *Group III* the four older mothers who have grown children away at school or married, find themselves still vigorous but lonely with their lifetime occupation taken from them. In such cases, it is the policy of the Social Service to get the signed consent of the sons as well as of the husband, for with the parents older than usual, there is more chance of the child’s support devolving at an early age upon the sons. In these four cases one mother had two grown sons and two daughters, another had one son and one daughter, and two had one grown son each.

The miscellaneous *Group IV* is as usual full of vital human interest. Two of the mothers had been mourning daughters who had died,
and would not be comforted until they had daughters in their places. One woman fairly young but married several years without a pregnancy, wanted a child to "lead" her own according to the Chinese superstition that if a child is adopted the mother will soon become pregnant. We have hesitated to give babies to women potentially able to bear children, for fear the adopted child might be neglected if they have their own, but in justice to the cases where this has happened, it must be said that the adopted child is loved as much as ever, and seems very happy. One woman who had been married many years without a pregnancy, and was developing into an unhappy hypochondriac was persuaded by friends to adopt a child. She took a girl, and her whole life so changed, that in two years she took a boy. One mother has had nine pregnancies, all of which except one have ended in premature still births due to a chronic kidney disorder. She has had two still births in the Peiping Union Medical College Hospital and each time she has asked for some other child to adopt. Fortunately both times there were babies waiting for adoption, the first a girl, and the second a boy. Each time the adopted mother has put the baby to her own breast and gone home with the child. What she tells her family we do not know. Two sets of parents in this group had had no previous intention of adopting children, having never considered the matter. In one case the adopted father saw the baby and fell in love with her. In the other, the child was four years old, and adopted her own parents while they were calling on the social worker with whom the child was staying. In the last case the mother fell in love with the child after having decided on another one.

Table Showing Age at Adoption, Correlated with the Sex of the Children

<table>
<thead>
<tr>
<th>Sex of child</th>
<th>Age at time adoption</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1st month</td>
</tr>
<tr>
<td>Male</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>11</td>
</tr>
</tbody>
</table>

The children have, on the whole, been adopted into a good class of families. The following table shows the occupation and income of the adopting father or of the head of the family.
### Adopted Children

<table>
<thead>
<tr>
<th>Occupation of father</th>
<th>Income per month</th>
<th>Not known</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$14.00 a month</td>
<td>$15.00 and</td>
</tr>
<tr>
<td>Military official</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Treasurer of Optical Co.</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Secretary of Salt Gabelle</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Gatekeeper</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Evangelist</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Merchant</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Hotel keeper</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Accountant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>R. R. official</td>
<td>1 1</td>
<td></td>
</tr>
<tr>
<td>Optician</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Civil official</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Professor</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Customs official</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tobacco agent</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Teacher</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cook</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Telegraph</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Field representative Smithsonian Institute</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Banker</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hostel keeper</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secretary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manager</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Newspaper reporter</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blacksmith</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Technician</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

Note—In three cases two of our children have been taken by one family.

19 babies representing 17 fathers.

2 These babies representing 8 fathers.

3 These are apparently well-to-do, but information not sufficient for tabulation.

Note—In one case the occupation is that of the grandfather as the child was adopted for a widowed daughter-in-law.

Note—Some of the Home Finding Association records were lost, which explains the unknown.

The following table is suggestive only, as it is very difficult to get information about the exact make up of a family. If the blood family is considered many members are living in other cities and are more or
less independent financially, or married out. If the economic family is considered there are again difficulties as the group is not clear out. A man may be living in Peking with his wife and one or two children, but sending money to a central clan family, or to scattered members of a large family, or he may be receiving money from the central clan family. A clan family may be getting money from many scattered members of the family. The geographic composition of a clan family is very fluid.

Therefore to make such a table first the kind of family considered must be determined, second which members are and are not in the family, and third how much of the income goes to that group, and how much is deflected. This amount of precision goes beyond the scope of this study. This table therefore is only suggestive. The family considered is the geographic as far as it is known, and the income is the net income of the father, without reference to his clan obligations. Where the clan obligations are very obvious although they are not necessarily living together the family is listed as a clan family.

**SIZE OF ADOPTING FAMILY CORRELATED WITH INCOME**

<table>
<thead>
<tr>
<th>Size of family</th>
<th>Income group</th>
<th>Father and mother</th>
<th>Father, mother and sibling</th>
<th>Father, mother and two siblings</th>
<th>Father, mother and three siblings</th>
<th>Father, mother and grandmother</th>
<th>Father, mother, grandmother and 1 sibling</th>
<th>Father, two mothers and 1 sibling</th>
<th>Clan family</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$14 a month</td>
<td>M F</td>
<td>M F</td>
<td>M F</td>
<td>M F</td>
<td>M F</td>
<td>M F</td>
<td>M F</td>
<td>M F</td>
</tr>
<tr>
<td></td>
<td>$15 a month</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>and house</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$25 to $50</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$50 to $100</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$100 to $500</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$500 to $1,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$1,000 and</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>over</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Landed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>property</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$14 a month</td>
<td>M F</td>
<td>M F</td>
<td>M F</td>
<td>M F</td>
<td>M F</td>
<td>M F</td>
<td>M F</td>
<td>M F</td>
</tr>
<tr>
<td></td>
<td>$15 a month</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>and house</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$25 to $50</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$50 to $100</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$100 to $500</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$500 to $1,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$1,000 and</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>over</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Landed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>property</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note—There is no information about the lost cases nor about two of the children who died after adoption.
## Table Showing Kinds of Food Used After Adopted

<table>
<thead>
<tr>
<th>Age at time of adoption</th>
<th>1st month</th>
<th>2nd month</th>
<th>3rd month</th>
<th>4th month</th>
<th>5th month</th>
<th>6th month</th>
<th>7th month</th>
<th>8th month</th>
<th>9th month</th>
<th>10th month</th>
<th>11th month</th>
<th>12th month</th>
<th>2nd year</th>
<th>4th year</th>
<th>5th year</th>
<th>7th year</th>
<th>Not known</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of feeding in new home</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fresh milk</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Powdered milk</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Wet nurse</td>
<td>7</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Mixed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pediatric baby diet</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adopted mother's breast</td>
<td>4</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General diet</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not known</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>11</td>
<td>5</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

The feeding table must not be taken too literally. After the children get into the adopted homes we have no way of knowing what they really eat. When the family say "wet nurse," we can be reasonably sure that breast milk is at least the staple diet. At a very early age children are given what they are supposed to be crying for, so they get tidbits from the grown people's table. There is a patent food called "Kao Kan" composed principally of rice flour and arrowroot which made into a soup is very popular with the parents. It is claimed to be very fattening for babies. On close inquiry most families are found to be giving this to the babies no matter what type of feedings they are supposed to have.

Those who are supposedly on powdered milk, probably do have some of it in their diet, until eating regular food. Instead of powdered milk a sweetened condensed milk is sometimes used. Some form of preserved milk figures largely in the diet of those children.

Mixed diet does not mean a carefully selected balanced diet under a doctor's supervision, regulated according to the ages of the babies, but is the kind of diet reported by one proud parent interviewed. When asked what the baby had to eat, he beamed and said, breast milk, milk powder, condensed milk, "Kaokan" (the Chinese starch food), gruel and vegetables. The mother who was interviewed the next day, explained their system. A neighbor gave two feedings of breast milk from her own abundant supply, the other elements make up the child's other more or less regular feedings. This is probably very near what the other children are getting if their parents were as frank as this one. Two of the children on mixed diet have wet nurses.
The adopted grandmother of one child who was in his eighth month at the time of adoption, was advised to feed him a diet of mixed solids and milk powder. But she said, "It is very sad for him to grow up never having tasted human milk, he shall have a wet nurse." He had been fed on milk powder and soy bean milk while in the hospital.

The use of wet nurses always entails much trouble and petty annoyance. Although old customs are breaking down, new ones are arising, and there is always human nature with varying degrees of intelligence with which to contend, so that many people dislike using wet nurses. On the other hand there are those who dislike the trouble of handling bottles and mixing milk powders.

The five children who went to their adopted homes fed by the adopted mothers' own breast milk were four boys and one girl. Three of the boys were taken as twins to daughters born in the hospital.

In two cases a wet nurse was secured for the daughter while the mother nursed the son. In the third the mother divided her milk between the two children, and supplemented with milk powder.

The other two fed on the adopted mother's breast milk were adopted by one mother with an interval of two years.

The question of secrecy was not taken up with the families during the last series of visits, so this information is only up to date in some cases. It is however fairly reliable, for when the family have not definitely stated their position it may be deduced from their attitude, and from the original terms of the adoption. In the case of three boys and a girl the father thinks the child his own, needless to say the parentage is secret from all the relatives also. The adoption of five of the boys and two of the girls is kept secret from the neighbors, but not the family. In the case of two boys and a girl, the attitude is not known. The remaining twelve boys and seventeen girls are open adoptions, known to all.

The following shows what has become of these sixty-nine children:

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children placed with Social Service</td>
<td>69</td>
</tr>
<tr>
<td>Given to adopted parents</td>
<td>53</td>
</tr>
<tr>
<td>Active</td>
<td>43</td>
</tr>
<tr>
<td>Died</td>
<td>5</td>
</tr>
<tr>
<td>Lost</td>
<td>5</td>
</tr>
<tr>
<td>Not given out</td>
<td>16</td>
</tr>
<tr>
<td>Died before adoption</td>
<td>12</td>
</tr>
<tr>
<td>Waiting for homes</td>
<td>4</td>
</tr>
</tbody>
</table>

Total: 69
Adopted Children

*Active*—Each child in this class was seen personally by a Social worker during the last two months of the study or a report was received from a trustworthy person during the same period.

*Lost*—No trace of the child or family can be found.

*Waiting for Homes*—The children were born recently and permanent homes had not been found for them when the study closed.

There are four little girls in the group. Two of these are twins born on September tenth. They were very small, and although their mother, a sewing woman, took them home with her, and tried to keep them, she found it impossible to get the necessary food or to give them the necessary care. She has a large family of children and the father earns very little. The babies were therefore taken over by the Social Service, and have been in the children's ward ever since. Since they are nice looking, there should be no difficulty in finding them homes, when they become a normal size for their age.

The third girl was born on October second, the illegitimate child of an amah and a shoemaker. She is a very strong, fine looking baby, so that there will be no trouble in getting her a home.

The mother of the fourth girl, is the widow of a rickshaw coolie, whose husband died when she was three months pregnant. She had been supporting herself and two older children by begging, and lived in a room bare of everything with only one gunny sack for covering. This child is plain, and sickly, so it may be difficult although not impossible to find her a home.

The five children listed as lost were placed in homes in 1925-26 by an untrained inexperienced worker who did not realize the necessity of making investigations and of keeping addresses. One or two others have been temporarily lost, but there has always been enough information available to find them again through some friend, relative or shop guarantee.

One of the five lost was followed for over two years until the family moved to Hankow leaving no address, and as there was no shop guarantee nor any address of friends or relatives the family could not be traced. The other four have never been followed since their adoption.
<table>
<thead>
<tr>
<th>Sex</th>
<th>Civil Status</th>
<th>In Hospital</th>
<th>In Hostel or Boarding Home</th>
<th>In Hospital</th>
<th>In H.F.A. Boarding Home</th>
<th>In Hospital</th>
<th>Age at Adoption</th>
<th>Own Parents</th>
<th>Adopted Father</th>
</tr>
</thead>
<tbody>
<tr>
<td>F</td>
<td>L</td>
<td>1 month</td>
<td>6 months</td>
<td>1 month</td>
<td>2 months</td>
<td></td>
<td>1½ years</td>
<td>Farmers</td>
<td>Blacksmith</td>
</tr>
<tr>
<td>F</td>
<td>I</td>
<td>1 month</td>
<td>2 months</td>
<td></td>
<td></td>
<td></td>
<td>3 months</td>
<td>Mother chauffeur's daughter Father garage helper</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>L</td>
<td>22 days</td>
<td></td>
<td>Length of time not recorded</td>
<td></td>
<td>Not recorded</td>
<td>Father rickshaw coolie</td>
<td>Not recorded</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>I</td>
<td>4 months</td>
<td>14 days</td>
<td>4 months</td>
<td>14 days</td>
<td></td>
<td>Students</td>
<td>Clerk on Peking-Hankow railway</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>I</td>
<td>16 days</td>
<td>4 days</td>
<td>1 day</td>
<td>14 days</td>
<td>25 days diarrhoea</td>
<td>Not recorded</td>
<td>Mother, amah Father, unknown</td>
<td>Not recorded</td>
</tr>
</tbody>
</table>
Adopted Children

The following table is an analysis of the cases of the children who died. The diseases from which they died show a definite relation to the age of the child and its social condition.

**Table Correlating Diagnosis and Period of Death**

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>When died</th>
<th>After adoption</th>
<th>Never left hospital</th>
<th>Spent some time in boarding home</th>
<th>Born outside brought ill to hospital</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malnutrition</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Congenital syphilis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Prematurity</td>
<td></td>
<td></td>
<td>3</td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Septicemia</td>
<td></td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>T. B. meningitis</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Tetany G. C. vaginitis</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Dysentery</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Bronchopneumonia</td>
<td>1</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Infantile diarrhoea</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Acute illness diagnosis unknown to Social Service</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>4</td>
<td>7‡</td>
<td>3</td>
<td></td>
<td>19</td>
</tr>
</tbody>
</table>

*Note.—Two children are counted twice as they died of both bronchopneumonia and infantile diarrhoea.
I. Pruitt

THE CIVIL STATUS, SEX AND SOCIAL CONDITION OF THE SEVENTEEN WHO DIED

<table>
<thead>
<tr>
<th>Civil status</th>
<th>When died</th>
<th>After adoption</th>
<th>Never left hospital</th>
<th>Spent some time in boarding home</th>
<th>Born outside brought ill to hospital</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>M 1</td>
<td>F 3</td>
<td>M 3</td>
<td>F 1</td>
<td>M 1 F 2</td>
<td>11</td>
</tr>
<tr>
<td>L</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>U</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>1 4</td>
<td>17</td>
</tr>
</tbody>
</table>

Three of the five who died after adoption were seen in the hospital during their last illness. One of these, a girl, born in the hospital, was placed when ten days old in a boarding home where she was fed on milk powder. After forty-eight days she was readmitted to the ward as an infant feeding case with secondary anaemia. She then stayed in the hospital until she was eight months old when she was adopted by a wealthy banker, who had already taken one of our children, a boy, who was doing well. After three months the adopted parents brought the girl back to the hospital, because she did not thrive. She was again admitted as an infant feeding case. After a month she developed bronchopneumonia and died.

The second, a girl, born in the hospital, was adopted when eleven days old by a secretary in the Foreign Office of the Government. The adopting father was thirty-seven and the mother thirty-five, they had never had any children and the wife was lonely. A wet nurse was hired. The child was seen in the home from time to time and seemed to be doing well. When her mother brought her to the hospital she was fat and rosy and clean looking, but on examination she was found to have tetany and gonorrhoeal vaginitis. She stayed five days in the hospital after which she was taken home where she died twelve days later. The mother was constant in her attendance at the hospital while the child was there and was heart-broken when she died.

The third, a boy born in the hospital, was kept on the ward until he was ten months old and fed on soy bean milk. In splendid condition, he was then adopted by a technician of the hospital staff who had been married between five and six years, without children. The
adopter was earning sixty dollars a month, so that the family was living very comfortably. The child was fed on ordinary food in his new home. He was seen from time to time both at home and in the clinic, and appeared to be doing well. When two years and three months old he was brought to the hospital very ill, and a diagnosis of T. B. meningitis was made. The child's general condition was very good; he was well nourished, well developed, and clean, his parents were devoted to him, and he showed every sign of loving care. When the parents realized that he could not get well they took him home where he died.

The other two in this group died at their own homes, and were not seen by our doctors. One of these, a girl born in the hospital, was adopted when five and half months old, going straight from the hospital to the new home. The father was an official of the Peking Hankow Railroad. The child was fed on milk powder and cared for personally by the adopting mother. The social worker kept in close touch with the family, but when the child became ill they called in an outside doctor. The baby died only twenty-three days after adoption. The mother, though inexperienced, seemed very thoughtful and intelligent. Information as to the cause of the child's death was not secured. The social worker saw the child three days before she died, at which time she seemed well though in retrospect the worker remembered that she was listless. She apparently died of an acute illness.

The other of these two, a girl born outside but brought to the hospital when three days old, was in a boarding home from the age of four months to six months. At six months she was adopted by a military official who had been married for ten years without children. The Public Health Nurse reported that a year after adoption the child died of acute dysentery.

These five children were all born of healthy mothers but in all these cases the condition of the father is unknown.

The adopting parents were healthy, as far as we knew. In another section there is a discussion of the health of all the adopting parents.

The twelve babies who died before adoption all died in the hospital, some after a period of boarding and some having never left the wards.

Three were brought to the hospital ill and never left there. One of these, a girl aged two months, was brought by her uncle, a cook. The child's mother had died, and the family had tried to bring her up on condensed milk, "Kao Kan," rice water, and breast milk begged from neighbors. The Peiping Union Medical College ward was in
quarantine so arrangements were made for her to be admitted to another hospital where a diagnosis was made of malnutrition. The child died there after twenty-three days.

<table>
<thead>
<tr>
<th>Sex</th>
<th>In hospital</th>
<th>In boarding home</th>
<th>In adopted home</th>
<th>In hospital</th>
<th>Age at death</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>F</td>
<td>5½ months</td>
<td>23 days</td>
<td></td>
<td>6 months</td>
<td>11 days</td>
<td>Acute illness diagnosis unknown</td>
</tr>
<tr>
<td>F</td>
<td>11 days</td>
<td>9 days</td>
<td>3 days</td>
<td>9 months</td>
<td>20 days</td>
<td>Tetany G. C. Vaginitis</td>
</tr>
<tr>
<td>F</td>
<td>10 days</td>
<td>48 days Hosp. 7 months</td>
<td>3 months</td>
<td>1 month 19 days</td>
<td>1 year 10 days</td>
<td>Bronchopneumonia</td>
</tr>
<tr>
<td>F</td>
<td>Came at 3 days 4 months</td>
<td>4 months</td>
<td>1 year 1 month</td>
<td>1 year 9 months</td>
<td>Dysentery</td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>10 months</td>
<td>1 year 5 months</td>
<td>2 days</td>
<td>2 years 3 months</td>
<td>T. B. meningitis</td>
<td></td>
</tr>
</tbody>
</table>

The second child, a boy aged three months, was brought to the hospital, registered, and admitted to the ward, but later no trace of the family could be found. No one knew of the family at the address given to the admitting office of the hospital, and no one ever came to see him. Four months after admission a letter was received purporting to come from the father, stating that he was going to the front to fight, and that the child’s mother had returned to her old home. In the letter the father promised to come and pay the child’s hospital fee when “all should be settled.” There was however no address on the letter. The child was in the hospital for one year and five months and then died, the diagnosis being dystrophic nutrition, and fever of unknown cause. No one has ever come to make inquiries about this child, and now four years have passed.

The third, a girl aged one month, well developed and well nourished was brought to the hospital by her mother who wished to go out to service as the family was very poor. Father, mother and brother
were apparently in good health. The child was admitted to the hospital for regulation of feeding before putting her in a boarding home. On the ward it was discovered that the child had congenital syphilis. She was given anti-syphilitic treatment but died after five months. She spent two days in a boarding home, between the third and fourth month of admission. Why she was taken out of the hospital and why kept out for only two days is not recorded.

Nine of the twelve who died before adoption were born in the hospital. Four of these nine died without ever having left the hospital. Two were premature twins, boys born at eight months pregnancy, who died three months and twenty-one days after birth. The cause of the premature birth was twin pregnancy, tetany, and pregnancy toxemia. The mother was an amah and the father a fellow servant of the mother's, not married. The third child was also a boy born premature at six and a half to seven months gestation by an abortion induced by the mother rupturing the sac. The mother was married, but the child's father was a cousin of the husband. The child died one month and three days after birth. The fourth was a girl born at full term. She was kept in the hospital as a feeding case on the metabolism ward until arrangements for adoption could be made. At the age of two months and twelve days she developed a cold and was removed to the general ward where she died one month and three days later. She also had hemolytic streptococcus otitis media which developed into general septicemia.

These were five who were born in the hospital and died there who spent some time in a boarding home. All of these were full term well developed babies. Three were of illegitimate pregnancies and two of married parents, but given to the social service on account of the poverty of the families. Four of them died in the summer of 1928 which was exceptionally hot. The fifth died in August 1929. They were in the hospital and boarding homes for varying lengths of time.

The forty-three active cases are so called because the children have either been seen by a worker, or a report of their condition has been secured from a friend or relative as late as the last three months of 1929, and an adequate address is in hand so that later visits can be made, or letters may be written.

The reports brought in show that all the children were adored by their adopted parents. The word adored is used advisedly. Every worker who made a home visit was impressed by the great amount
of affection shown to the children, in many cases almost overwhelm­
ing, greater it often seemed than if they had been born to these
parents. Another general impression was that all the children were
spoiled, which is another way of saying the same thing, as the degree
of spoiling is usually an index of the degree of love expended.

**Present Condition of Children Correlated with Occupation of Father**

<table>
<thead>
<tr>
<th>Occupation of father</th>
<th>Condition</th>
<th>Satisfactory</th>
<th>Poor physical</th>
<th>Poor social</th>
<th>Information not adequate</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Semi-government R. R. Salt Customs</td>
<td>M</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Government officials, civil and military</td>
<td>4</td>
<td>1</td>
<td></td>
<td>1</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Professional</td>
<td>2</td>
<td>3</td>
<td></td>
<td>1</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Bankers and merchants</td>
<td>3</td>
<td>4</td>
<td>2</td>
<td></td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Salaried business men</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Artisans and technicians</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Servants</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
<td>15</td>
<td>4</td>
<td>1</td>
<td>3</td>
<td>43</td>
</tr>
</tbody>
</table>

By satisfactory condition is meant that the children are healthy
and happy and cared for as well as was expected when the children
were given to the families concerned.
180 Adopted Children

In the beginning an effort was made to get the children at intervals to our outpatient clinics but this was found to be impracticable. The parents could see no reason for bringing well children to a hospital. When the children were taken sick some of the parents brought them to us but many did what other mothers do, took them to the nearest doctor or health agency, such as other hospitals or the public health station. Some went, of course, to old style Chinese doctors. We decided, therefore for the present, that as long as the children appeared well we would not interfere. In the matter of upbringing, the spoiling of the children, the social habits taught, we felt we could do nothing unless, as in one case, there was a gross wrong about to be done to the child.

In the one case where poor social conditions were found the parents had fallen financially on evil days. At the time of adoption the father had what seemed a permanent position. His wife with the help of the eldest daughter took care in their home of women convalescent patients from the Peiping Union Medical College Hospital, and in this way added to their income. The baby in question was the first one to be cared for by the Social Service, and was boarded out in this family awaiting the return of her own mother, who however never came back. When at last a home for adoption was looked for, the boarding mother and her husband begged to be allowed to keep the child. As they had already adopted three children, and seemed to be permanently though humbly placed, the child was allowed to stay with them. In about two years, however, the father was discharged for taking unduly large commissions. He then got a job as a policeman, which he later lost. After this he descended to doing odd jobs, managing funerals and weddings and being general handy man. The family went from bad to worse until they became practically beggars, and only escaped that name in that they did not go on the street with staff and bowl. The eldest daughter had married and gone away. The son had married the younger adopted daughter, and was pulling a rickshaw and barely supporting himself. The only family income was what the daughter-in-law earned as a wet nurse. When she lost this job, the family decided to place the little girl, whom they had adopted from us, into a sing song house to learn to be a public entertainer, so as to support the parents. Hoping for better days they refused to give the child up entirely, and as she was already seven years old and as devoted to the family as they to her, we compromised by placing her in the Hsiang Shan Charity School. There
she can live and study, and eventually if the parents rehabilitate themselves, she can return to them.

Of the five children showing poor physical condition three had acquired conditions and two had congenital difficulties. One of the children with congenital difficulties was a little girl brought in from a poor family at the age of one month. She was in the hospital for five months with furunculosis, and a nasal discharge which refused to clear up. While in the hospital she had bronchopneumonia twice, measles and an adenoidectomy. She still had furuncles and a nasal discharge when the doctors thought it best for her to leave the hospital. Under the circumstances, we could not recommend her for adoption. Just at this time, however, a woman on our obstetrical ward, who had had a still birth due to syphilis, was begging for a child. Her husband was a gatekeeper and she a caretaker, and because of her physical and economic condition we had consistently refused her application. When she heard of this unwanted baby she again applied. As by this time both she and her husband had had treatment enough to be safe for the child we let her go to them. The child’s general health is now very good. She is well nourished and apparently strong. There are no more furuncles but the nose still runs, though the discharge is not purulent. The mother brings her in often for examination.

The other child with a congenital abnormality is a boy who was apparently normal at birth, and went to his adopted home when twenty-three days old. He was breast fed, having a wet nurse, and is the adored only son in a very wealthy family, which had previously adopted a daughter. At the age of sixteen months he had had convulsions four times and could not stand alone or say more than mama, papa. He was therefore brought to us for examination. No definite pronouncement on his condition was made, but the family was told to bring him in for observation after a period of seven or eight months, which has not yet elapsed. The impression is, however, rather strong that he is an imbecile. The family history as far as known shows that the child’s own father was an impecunious member of the family who was earning his keep by acting as primary school teacher to the children of the clan, and to others in the courtyard where he lived. The note in the history states, “He had no ability to earn his own living.” The mother was a girl of sixteen who was his pupil. She had a history of convulsions as a child, but seemed normal when she was in the hospital and also to the friends whom we
interviewed. In a country where many able men cannot earn a living because of the lack of opportunity and the great competition, and with a mother in good health neither of these unpleasant pieces of history was taken as a prophecy of ill omen for the child. The present situation is very difficult. He is adopted into a family which can give him every advantage. His adopted sister is attending the American School in Peiping. Besides this the mother has wrapped her heart around the child. When the father was talking in English to the worker, consulting about the possibility of putting the child into some institution, the mother who speaks only Chinese, sat and watched his lips with agonized attention. “You are not going to take my child from me,” she said over and over. A further tragedy is that there is no institution in the country to care for such as he.

The three children with acquired disabilities are boys who were perfectly well and normal when adopted. One had bacillary dysentery at the age of three and half. He was treated in the Peiping Union Medical College hospital but was taken away by his doting mother before he was entirely well, and placed under the care of other foreign doctors. He is taken to the Hot Springs every summer, but his mother takes him daily, for air, to Central Park, and she takes him to the doctor very often. He is now six years old, well grown and developed, but his color has lemon tinges in it, he is thin, and the fine veins show on his face. His mother says he has never been well since he had the dysentery. This boy’s own family history is negative, and his first three and a half years were normal.

The second child was healthy until he was four years old. Then for two winters he became subject to a dry cough and a nasal discharge. At the age of six he developed acute anterior poliomyelitis, and was admitted to this hospital where he stayed a month and a half. When discharged from the hospital he was able to sit up. Since discharge he has steadily improved, so that now, a year later he has only a little residual weakness of all his muscles. He has no paralysis or deformity. His general condition is very good.

The third child was born of a mother who died of tuberculosis six months after his birth. He was taken off his mother’s breast on the ninth day after birth when her lung condition was discovered, and was adopted when eleven days old. He grew and developed well, and seemed perfectly strong until he was eight and a half months old when he was brought in to the hospital suffering from broncho-pneumonia. He left the hospital on account of the ward going into
quarantine, improved, but not entirely well. Two months later he was readmitted to the hospital and diagnosis of tuberculosis of the tracheal and bronchial lymph glands, rickets, infantile diarrhoea, and acute upper respiratory infection were made. Two years later the child still has a persistent cough, but had grown well, and seemed to be gaining in all lines. A year later the social worker making a home visit reported that he did not look well, was thin, yellow in color, took cold easily and coughed badly when he caught cold. He is being treated by a doctor in another hospital.

His twin brother is one of the children about whom our information is inadequate, having been adopted by a family who moved to Tientsin. A friend of the introducer living in Peking who was a friend of the family reported that she had seen the boy only a few months before, and that at that time he was quite well.

The inadequacy of the information about the other five children is caused in three cases by the departure of the families from Peiping. In one case the introducer reported that the adopted father had died, and that the mother had taken the child, a girl, to live with her own family near Mukden. The introducer had seen both mother and child during the past summer and said that they were both well. Again, the mother who adopted two children to replace her own two still births has, according to the report of a cousin in town, moved to Honan. The relative reports that the children are well, but she has not seen them for some time. Another child, a boy, has been taken to Shanghai. His father's address has been secured from a friend in Peiping and a letter has been written to the father but no reply has yet been received. The friend knows that the boy is alive, but can give no further information. The last child is in Nanking. The mother came to the Social Service Department to tell of the contemplated move, and promised to send the new address, as soon as they should reach Nanking, but has not done so. A letter sent to their old home address has brought as yet no answer.
THE USE OF THE SOCIAL SERVICE EXCHANGE
BY HOSPITAL SOCIAL SERVICE DEPARTMENTS

EDITH J. McCOMB

Chairman, Sub-Committee, Community Relations Committee of American Association of Hospital Social Workers.

The Committee on Community Relations of the American Association of Hospital Social Workers, Ida M. Cannon, Chairman, has been concerned for several years with interrelationships between the hospital and other health and case work agencies. The Social Service Exchange, or Social Service Index as it is called in some cities, has been the subject of interest for the past four years. In several cities, hospital social workers have participated in local studies fostered by the Committee on Social Service Exchanges of the Association of Community Chests and Councils. These local studies have brought to light some tendencies in the use of the Exchange by hospitals and dispensaries that evidently needed further study.

In a bulletin published in 1927, the Committee on Social Service Exchanges of the Association of Community Chests and Councils defined the "use of the Social Service Exchange" as involving four steps: (1) Inquiry concerning the client, (2) Follow-up of sources reported by the Exchange, (3) Conference with other agencies interested in the client, and (4) Action based on knowledge of the facts.

In general it was assumed that these steps were recognized by hospital social workers as incumbent on those accepting the principle of use of the Exchange.

In 1929, a questionnaire was sent by the Committee on Community Relations to all the Districts of the American Association of Hospital Social Workers, and by them sent to the Social Service Departments in hospitals in the United States and Canada. Questionnaires were also sent to several departments in hospitals outside the district organizations. One hundred and seventy-three Social Service Departments answered the questionnaires.

The replies to these questionnaires are presented here with the hope that the answers may arouse interest which will lead to a deeper
consideration of the present practices and their significance in service to our patients and our hospital.

The questions asked and the answers given are as follows:

Q. What types of cases do you register with the Social Service Exchange?
   1. All cases referred to the Social Service Department?
      Answer: 85 hospitals do.
              50 hospitals do not.
              38 did not state.
   2. All free, part-paid, or ward cases?
      Answer: 51 hospitals do.
              44 hospitals do not.
              78 did not report.
   3. All cases admitted to the Out-Patient Department?
      Answer: 56 hospitals do not.
              30 hospitals do.
              87 did not state.

Q. Do you clear cases in the Social Service Exchange without registering?
   Answer: 103 hospitals do.
            46 departments do not.
            24 did not state.

Q. To what extent do you use this type of service, i.e.—occasional, regular, routine?
   Answer: 69 departments occasionally.
            17 departments regularly.
            87 did not state.

Q. Do you always clear in the Social Service Exchange before referring a patient to another hospital or social agency?
   Answer: 137 departments do.
            30 departments do not.
            6 did not state.

Q. Do you register all old cases when re-opened?
   Answer: 93 departments do not.
            37 departments do.
            43 did not state.

Q. How often are cases re-registered, annually, periodically, monthly?
   Answer: 9 annually.
            19 periodically.
            2 monthly.
            2 “when necessary.”
            1 weekly.
            140 did not state.

Q. What special service does the Social Service Exchange offer you, i.e. “Information Only,” “Medical Information Only,” “Periodic Re-registration”?
Answer: Information Only—113 departments.
Medical Information Only—25 departments.
Periodic Re-registration—56 departments.

["Information Only" is taken to mean inquiry of the Exchange with understanding that no permanent record is kept in the files of the Exchange.

"Medical Information Only" means that the hospital or dispensary inquiring reports whether at the time of the inquiry it is on a patient concerning whom the Social Service Department has data, or one on whom there is medical information only.]

Q. Do you approve of 100 per cent. registration in all Out-Patient Department Clinics?
Answer: 107 departments do not.
65 departments do.
13 did not state.

[This refers to registration of all patients admitted whether or not they are known to Social Service. It may be, in fact, a medical registration only.]

Q. Would you like to have a monthly report from Social Service Exchange as to the use you have made of the Exchange, i.e.—number of inquiries, registrations, re-registrations, "Information Only," "Cleared but not Registered"?
Answer: 63 departments would.
48 departments would not.
61 departments did not state.

Q. Should Credit or Rate Departments of the hospitals, organized as such, be permitted to use the Social Service Exchange?
Answer: 101 departments said No.
26 departments said Yes.
46 did not state.

[Many hospitals and dispensaries employ "credit workers"—in some cases these are trained social workers, but usually not. They are assigned to the Admitting Office and their duties are to determine rates patients should pay for medical care.]

Q. Would you, as a hospital social worker, be willing to give medical and social information to credit workers or rate clerks?
Answer: 104 said No.
25 said Yes.
44 did not state.

Q. How do you handle requests for summaries (reports) in your Department, and which method do you prefer, i.e.—letter, telephone, or personal conference?
Answer: By letter—103 departments.
By telephone—36 departments.
By personal conference—68 departments.

[This has become a serious question since social workers on getting a notification of inquiry by a medical institution concerning a client will usually write for a summary of the hospital report. In many places this is a routine procedure with no specific questions as to information wanted.]

Q. How much identifying information do you ask the inquiring agency to furnish you?
Answer: The majority of departments requested face-sheet identifying information.

Q. Does the Social Service Department handle all requests for medical and social summaries?
Answer: 70 departments do.
78 departments give information on social service cases only.
25 departments did not state.

Q. Do you answer routine requests for medical and social information if the agency does not give its reason for wanting same?
Answer: 79 departments do not.
66 departments do.
28 did not state.

Q. Do you think that agencies requesting information should specify whether they want medical or social data or both; whether they are interested in one member or in the whole family?
Answer: 154 departments say agencies should specify.
2 departments say agencies should not.
17 did not state.

Q. When another agency or hospital social service department is assuming the major responsibility of an intensive case, do you request that they read your record and have a personal conference with you before sending them a summary?
Answer: 97 departments do.
65 departments do not.
11 did not state.

Correspondence accompanying and subsequent to these questionnaires brought out several issues that are troubling hospital social workers. It also showed that there was considerable variation in the attitudes on some of these questions in the various cities. Possibly the most discussed issue was that concerned with "100 per cent. registration" of all patients admitted to hospitals and out-patient departments.
One hospital reported three different bases for registration of patients, namely: (1) All patients admitted to the dispensary, (2) All patients admitted to the wards, and (3) All patients referred to social service. Thus it was possible to have three registrations of the same patient.

So far as the Committee could ascertain, the 100 per cent. registration of medical cases was brought about through pressure of demand from the social workers in the community or Community Chests, rather than from desire of the medical institution. One hundred per cent. registration is most general in Cleveland and New Orleans. Some hospital social workers believe that the practice developed through the desire of the social service department to be of service to the community social agencies, but they are conscious of the fact that answering the innumerable queries is bringing a serious problem of time expended by hospital workers, both clerical and professional, and presents a serious question of cost to the hospital administration.

Some of the opponents of 100 per cent. registration state that if this practice is accepted the Social Service Exchange becomes a Medical Service Exchange, and that if such a practice is to be encouraged it should have the serious consideration of hospital administrators.

To quote some of those who replied:

One Social Service Department in Boston—"One hundred per cent. registration takes away from the Social Service Exchange the value of the Exchange as a social index, unless there was some method of sorting important medical cases from unimportant medical cases. The Exchange, to my mind, serves as a social exchange, and not as a medical exchange and it would be necessary to make some specifications as to whether the patient was known only as a clinic case or as a social service case."

Another department in Rochester, New York—"We had 100 per cent. registration up until five years ago, and were constantly bothered by requests for information from other agencies, when all we could give them was the fact that 'Tommy' had a cut finger, or 'Jenny' had a cold. When we changed, the agencies expected to be handicapped by not having this information, but this did not prove to be the case. When there was serious illness in their families, they learned about it in their interviews with the family, and then asked us for definite information, and we had no longer to answer trivial questions."

A Social Service Department in Pittsburgh, Pennsylvania—"During August, 1929, we cleared 100 per cent. and in discussing results..."
at a meeting of the hospital social workers it was decided that it was not of sufficient value to the agency clearing or the agency inquiring, to warrant the time and expense involved. Three hundred and seventy cases were cleared. Information was used by the hospital on 21, and inquiries from outside agencies on 6."

From San Francisco—"We do not approve 100 per cent. registration of out-patients. The value of registration lies in the fact that a registering agency has socially significant information about its clients which, having passed through the medium of the social worker's mind, represents an individualizing of the client. The value of the list of registered individuals lies in the fact that it is a selected list, not an inclusive one. We can see that a list of patients who have had or are having treatment—free or part pay—at a hospital or out-patient clinic might be valuable as a separate 'Medical Information' list, but it does not seem that it should be identified with the other list."

From St. Louis—"The old contention that 100 per cent. registration prevents patients from changing from clinic to clinic seems to lose its weight as we come more and more to the opinion that clinic patients, as well as those who pay for private medical care, should have the privilege of being under treatment where they have confidence and where they are happiest. In the year 1925, all prenatal patients in one hospital were registered with the Exchange. Some time later a study was made and it was found that out of 1,025 registrations, only 187 were known to other agencies either at the time or subsequently."

From the Middle Atlantic District—"The purpose of the Exchange is to secure the sources of social and medical information to be used by the social worker. Merely registering the case does not help the patient or the worker. Who would secure summaries or make contacts with agencies registered on each case coming to hospital ward or O. P. D.? I do not think the average hospital is equipped from the clerical standpoint to do this. Even if it were, of what value would the data be to the average hospital social service department, undermanned as they are and carrying entirely too large a case load at the present time. At best, I do not feel that we use to maximum the information that we receive under the present plan."

"If the purpose in such registration is to prevent duplication of medical treatment, it is impractical because no busy admission clerk in a dispensary could hold up the clinic while she cleared a particular case before determining his admission."
We also received a number of interesting comments from those departments which approve of 100 per cent. registration:

From a Cleveland department comes the following—"I see no reason against 100 per cent. registration. On the positive side we feel that this gives us easily accessible information regarding the interests of other agencies which we can use as the first tool for making use of the data and the knowledge they have recorded or acquired. If the information from Social Service Exchange is used properly it should prevent duplication of inquiry, needless questioning of the client, duplication of medical care, wasteful use of the Community Fund for charitable purposes, and should result also in saving patient's time."

Another Cleveland hospital writes—"Both from the standpoint of the social worker in the hospital and the social worker in other organizations, 100 per cent. registration frequently prevents duplication in physical examinations, saving time and expense to the patients, doctors, and the hospitals; gives the social worker in the hospital a fuller picture of the situation on which to base her decision to undertake social treatment in a case that appears to need social service; gives the other agencies immediate information of hospitalization of clients in whom they are interested, giving them an opportunity of collaborating at once with the medical social worker in the best solution of a problem; makes available to all the social agencies medical-social information about any patient with whom they may be working, and assures the fullest possible service to the client patient preventing as far as possible any overlapping of service either medical or social."

From the Community Relations Committee of the Cleveland group of hospital social workers—in answer to the question "Do the hospitals in Cleveland, who believe in 100 per cent. registration, really make use of it as such?"—"Yes, they do. It is the policy of Cleveland hospitals to prevent as much as possible the so-called 'medical shopping' of their patients. They believe that 100 per cent. registration prevents this to a great extent. The patient may duplicate registration, but because of clearing with social service exchange, on his second visit he is referred back to the dispensary where he originally registered and advised to continue treatment there or, secure a transfer. The exchange report is placed on the permanent record of every patient. The amount of clerical work involved is small compared to the saving of time to both the administration and social service office in having these reports readily available.
"We are giving the benefit of our 100 per cent. registration to other case working agencies as they are informed that their client is receiving medical attention which fact is usually of importance in the social treatment of the case. Registrations are not routinely looked up before patients are admitted. Occasionally it is necessary.

"Notification of the registration of a new patient is sent to Social Service Exchange the day the patient is admitted. A clearing report is received in time to prevent any material duplication or work that is being done by any other medical or social agency.

"When the first member of a family is admitted to the dispensary the family is cleared and automatically the hospital receives clearings showing all other hospitals and agencies interested. Consequently this information is of great value in determining eligibility of any member of this family applying for admittance.

"It may also be of interest to you to know that the hospitals are registering their intensive social service cases as such. This will prevent duplication of social treatment among the various agencies."

The North Atlantic, Illinois, Minnesota, Indiana, and St. Louis Districts discussed the subject at length and the consensus of opinion was against 100 per cent. registration.

Of those approving, many gave their reasons—that 100 per cent. registration would eliminate clinic shopping, duplication of hospital work, notification to community agency and hospital of the client's new medical contact.

The time consumed and the cost of registering cases in an outpatient department as estimated in a Cleveland hospital was four minutes per case, and $2.5 cents per case. This did not include the time of the social worker. Since there is considerable testimony that the answering of inquiries in many hospitals and dispensaries devolves upon the social worker, it would seem to be a serious lack in estimate of cost not to include the cost of the personnel involved, both at the Exchange and at the hospital. So far, no one has answered this question of cost satisfactorily.

If we knew what it cost it would then be possible to determine whether or not this expenditure was helpful to the patient. It has been suggested that clerical service to the doctors to improve medical records would be a better service to the patient.

The Committee on Community Relations offers some questions at this point, questions that must be answered before it is clear as to the quality of use of the Exchange.
Recognizing the fact that the Social Service Exchange was established to promote cooperation of social agencies and as an index to social information, does this new role of registration of medical clients of our hospitals and dispensaries in any way modify the purpose?

Do the administrators of our medical institutions accept the full implication of inquiry at the Exchange? Are they equipped to take the steps accepted as involved in registration? Are they willing to give information concerning their patients to others using the Exchange?

“Clinic shopping” seems to be a great bugbear to many social workers. In answer to that, an experienced hospital social worker says, “I believe that if a patient loses confidence in a doctor or a hospital, he has a perfect right to go where he feels he will receive better treatment, just as you and I change physicians or dentists. The neurotic or psychopathic patient will go from physician to physician, from hospital to hospital, no matter what we do, but the average normal patient will continue treatment indefinitely at the same hospital if he is receiving first quality medical care. This includes skilled physicians, nurses, and social workers; courtesy, kindness and understanding are an important part of his treatment. Patients as a rule are not anxious to change hospitals or doctors if they sense an interest is being taken in them by the clinic staff. Isn’t good case work, good contact, more important than detective check-up through the exchange?”

Miss Luella Harlin, Executive Secretary of the Philadelphia Social Service Exchange and a member of this sub-committee, received thirty-seven answers to the questionnaire which she sent to Exchange secretaries. Five approved of 100 per cent. registration; eighteen disapproved, and fourteen are situated in cities where the hospitals do not have social service departments. This last group gave no opinion. We here quote from several of the replies received by Miss Harlin:

Miss Laura Woodberry, Director of the Social Service Index, Boston, Mass.—“It is apparent that there should be a clearer comprehension of the master-fact, i.e., the Index exists that the agencies may maintain active relationship by consulting one another’s records. If our judgment of the situation is correct, it follows that healthy growth will demand careful attention to this basic idea. Better integration will have to be accompanied by a clarifying of this principle
and of rendering it explicit for purposes of adaptation to the needs of the several agencies or groups of agencies. . . . From the foregoing you will draw the conclusion that my vote is not for uniformity. . . . My chief concern is that the case workers should use the Index as they would a library and we are emphasizing that idea.”

Mrs. Edward J. Lewis, Executive Secretary of the Social Service Exchange of the Chicago Council of Social Agencies—“I feel very strongly that 100 per cent. medical registration is not a responsibility that the Social Service Exchange should accept. I am frank to admit that there is a good deal of opposition to my stand by the non-medical agencies. I am a professional case worker and have been a superintendant of the United Charities, and I know their problems. But I still have a good deal of sympathy for the attitude of the professional medical worker who feels that medical diagnosis without social interpretation is not particularly valuable to the non-medical social worker. . . . I know that the family agencies for instance do not register 100 per cent., and I see no reason why they should. They do use the Social Service Exchange for ‘information only’ 100 per cent. But they actually send inquiries only on cases upon which they are doing intensive work and upon which they have significant social data.”

Miss Bessie E. Hall, Social Service Clearing House, Cleveland, Ohio—“A selective registration on the part of any agency is difficult to handle, unless the basis of selection is very clear cut and uniformly interpreted. A selection on the basis of ‘social problem’ depends too much upon the interpretation and recognition of ‘social problem’ on the part of the individual worker. Our people like to feel that ‘No Report’ from the Exchange office means that the clinic is not known to any of a group of agencies. They do not want to feel that possibly some worker has failed to register because they did not recognize a social problem. Do not all such patients present a potential social problem?”

Miss Harlin expresses her own opinion as follows: “After all, the Exchange is a social organization and not a medical registration bureau. For the tremendous expense involved and the small return, it is inconceivable that any hospital should register 100 per cent. The recording of all out-patient department cases would soon make a hospital registration valueless. Agencies as a whole do not follow up all Exchange reports. A selective process is used. Before long hospitals would not be consulted by other social agencies in the community, because the latter would soon feel that hospital social service
departments had only medical information, and no social data. Theoretically speaking, all cases of agencies should be registered in the Exchange; practically, it is not sound, and this policy should not be adopted by the hospitals any more than other case working agencies."

The treatment of medical-social summaries is of interest. The majority of hospitals answering the questionnaire agree that summaries (answers to inquiries) should be handled by mail. The question of summaries may be considered of as much, if not greater, importance than that of registration. The hospital social worker is taught the confidential nature of medical data; she appreciates the importance of the Hippocratic Oath, and knows that she must exercise the utmost discretion in releasing medical findings. Is she justified in refusing to give information when reasons for the same are not stated, or when inadequate identifying information is given her by the inquiring agency?

Hospital social workers feel very keenly the responsibility of passing on from agency to agency medical data which is regarded by the physician and the hospital as strictly confidential and which, if handled carelessly, can seriously involve both. As social case workers, we should be just as loathe to pass on social data which we have secured in confidence from our clients. What policy shall we adopt? Shall we consider only the trained social worker and the recognized social agency? What shall be our attitude toward the group that does not come under this heading? Serious consideration should be given to the whole question of the handling of summaries by medical social workers.

The replies to the questionnaires indicate that hospital social workers are willing to give any medical or social history which will assist the community agency worker in making a plan for her client, to give her the time necessary for interpretation, but they want to be sure that the value received is worth the time and energy expended.

Sub-Committee, Committee on Community Relations, American Association of Hospital Social Workers:

Ida M. Cannon,
Luella Harlin,
Edith J. McComb, Chairman.

(St. Christopher's Hospital for Children, Phila.)
THE SOCIAL SERVICE WORKER'S RESPONSIBILITY IN CANCER WORK *

IRA I. KAPLAN, B.S., M.D.

Director, Division of Cancer, Department of Hospitals; Attending Radiation Therapist, Bellevue Hospital; Associate Radium Therapist, Lenox Hill Hospital; Lecturer Radiation Therapy, The New York University and Bellevue Medical College, New York, N. Y.

The diagnosis of the disease and the application of some therapeutic measure by no means sums up what is required in caring for cancer sufferers. A highly important and indeed a vital factor in the treatment of these cases is the existence or creation of a service that will instill into the patient the willingness to coöperate with the medical organization that offers him relief.

Ever since early civilization, the state has assumed the burden of caring for the health of its citizens, either by general rules controlling the hygiene of the community as a whole or by regulations directly applicable to the individual suffering from any particular form of disease. The civilized community holds that while an individual is free to suffer from any disease he may willingly or unwittingly contract, if his condition in any way endangers the health of others, he must certainly be taken in charge by the State in order to safeguard all of its other citizens.

It was the regulatory power vested in the state for caring for the health of its people that has driven from the world those dreadful scourges which for centuries had mowed down countless myriads of the earth's inhabitants. This power has been successful in protecting the health of humanity as a result of the acquisition of an ever-increasing knowledge of the cause and of the control of disease. More and more as those early devastating plagues were brought under control, the state lessened its regulating restrictions but the growth of the

* Read before the North Atlantic District of The American Association of Hospital Social Workers.
sense of community responsibility has brought about the establishment of organized community hospitalization of its sick.

What is the value of this socialization of medicine, as it may be termed? First, it provides proper care for those sick who due to economic or other conditions beyond their control are unable to care for themselves. Secondly, it possesses a broad educational aspect for both the lay and the professional public. Thirdly, it offers a wonderful teaching medium for enhancing the efforts of the physician.

The more obscure the causes and the cure of a disease so much the more interested in its study must the state necessarily be. For this reason, it is that the increasing ravages on life, due to cancer, have compelled the people to look to the state for protection. New York State has accepted this responsibility by establishing a State cancer hospital, and New York City by the creation of a Division of Cancer in the Department of Hospitals. This Division concerns itself with the diagnosis, treatment and care of cancer patients applying to the municipal hospitals for help.

The care of cancer patients may be divided into two parts, namely, bringing the patients during the early stage of the disease to physicians properly trained for this work, and having the patients return to the clinic at periodic intervals for further observation and advice. It is not enough that the cancer patient merely come for treatment by governmental agency. The state rightfully demands of him assistance in furthering its war on cancer. Merely treating the local lesion of a cancer patient is of little value unless the physician carrying out this form of therapy secures also an opportunity to observe the results of his work. Only by such observation is he able to judge and determine the necessity of varying his concepts and methods in the handling of cancer.

In carrying on this work the cancer physician must call for the assistance of someone who can act as a liaison between the patient and the doctor, not only in the clinic but in the patient's everyday life as well. Such an assistant is the Social Service Worker, and in no other branch of health service is the Social Service Worker more essential than in that of caring for cancer victims.

Unfortunately, cancer has from time immemorial been considered a loathsome disease that subjects the victim to an ostracism more deadly almost than the malady itself. In fact, the mere diagnosis of cancer has usually produced in the patient a helpless and hopeless
resignation to a horrible end. Thanks, however, to a more enlightened era of public education, people in general are becoming more sensible towards the sufferer from cancer, and he is no longer assigned to the meanest quarters of the home.

Cancer patients are divided into three groups: the incipient, the chronic and the helpless. It is with the incipient cases that medicine can do the most; a great deal can be done to ameliorate the chronic; while the hopeless can be afforded only an opportunity to pass away with a minimum of torture and suffering.

The Cancer Division places upon the Social Worker the responsibility of getting early cases to the clinic in time and keeping them under observation; of having the chronic cases come and submit to the proper therapy for relief; and of placing the hopeless victim under custodial care. Of what avail is it to the expert physician to carry out properly and expertly a cancer therapeutic measure if he cannot be assured that he will be in a position to observe the effect of such treatment so as to judge its efficacy and the advisability of continuing such therapy? For this follow-up procedure he must quite properly obtain the whole-hearted assistance of his staff of Social Workers. More than anyone else the Social Service Worker can make cancer statistics something more than haphazard arithmetical charts. Upon her shoulders rests the burden of getting the patient to the proper clinic early, of seeing that he comes for treatment and observation as often as is required, and of attending to his social, economic and family conditions, so that he will be willing to take care of himself, and thereby protect both himself and the community. She it is who must relieve the distress of the cancer patient who comes for treatment, feeling that by so doing he will lose his job, cause his family to suffer hardships as a result and eventually become a helpless burden upon the community in which he lives.

Then again, there is nothing more soul-destroying than the constant, long-drawn-out waiting (in idleness) for death. Custodial cancer cases, condemned to a dreaded certain death can often lessen the misery of their prospect by occupying their minds with some physical task. The Social Worker is the one to institute such occupational forms of therapy as will make the passing away of such patients more humane, at least mentally.

Have you ever stopped to think what is happening to the very many unfortunate women and men suffering from cancer, and of the desperate predicament in which they find themselves, due to economic
and social conditions? What the Social Service Worker can do in remedying this situation has been most lucidly outlined by Mrs. Goheen, Director of Cancer Social Service, in her recent talk before the National Conference of Social Work in Boston, June, 1930. Every Social Service Worker would do well to acquaint herself with the duties of social service work as stated by Mrs. Goheen. Summarized, they are: To interview new patients upon their first visit to the clinic, arrange for their subsequent visits, take care of their economic and social welfare and that of their families, provide for home nursing and medical care when needed, supply the surgical dressings necessary thereto, and assure a persistent supervision until the disease has been controlled.

An old adage informs us that God helps those who help themselves. But God’s help to cancer patients is carried out through his angel assistants, and Social Service Worker’s are God’s angels, helping the cancer victims to help themselves. Without them neither the patients nor we, the doctors, can carry on; with their help, cancer, the devastating plague may some day be relegated to the shelf of forgotten physical punishments for mankind, like the other diseases that in ancient times devastated entire races. The responsibility rests upon the shoulders of the Social Worker to aid in the fulfillment of this great, ambitious and altogether possible prophecy.

55 East 86th Street,
New York City.
THE POST-SANATORIUM PERIOD*

MARIE LURIE

Director of Social Service, Jewish Tuberculosis Service, Chicago, Ill.

After sanatorium care—What?—It is conceded by medical men that the period of greatest hazard to a tuberculous patient is the first five years after his discharge from a sanatorium. Perhaps the greatest contributing cause is the difficulty of adjustment from the sanatorium to outside living and working conditions. The change from the lazy, leisurely life of an institution to the hectic, hurried outside world with its anxieties about a job, wages, family relationships, living conditions, and so on, are some of the reasons why a patient who is leaving the sanatorium, finds adjustment hard.

Ideally, there should be some form of post-sanatorium care that would help to bridge this gap. Industrial colonies, sheltered workshops where the patient can work a few hours daily, at the same time earning enough to be self-supporting, are the ideal set-ups, but without such resources at our command, each year many thousands of patients are being discharged from institutions to trying conditions, which in many cases were contributing factors in their first breakdown.

Sanatorium care alone is inadequate in the treatment of tuberculosis. It is not an end in itself, but only a step in a larger program. Physicians now agree that in order to have an effective cure, a patient should remain under close medical supervision for a period of five years after his discharge. If, at the end of that time, the patient is well, his chances for a relapse are slight.

Approximately 100,000 patients are discharged each year from sanatoria. Of this number, about 20 per cent. die within a short period of time, 25 per cent. need indefinite sanatorium care, and there remains 50,000 patients to whom some attention should be given.

A fair proportion of this number are able to take care of themselves, but the other 30,000 or 40,000 individuals need some form of social follow-up.

There is no one plan that can adequately care for the whole tuberculosis problem. Each year thousands of patients are being discharged with a limited working capacity and it is almost impossible to adjust these individuals into industry. Each year our institutions send back into industry another group, those patients who are apparently well. They have had six or eight months of sanatorium care, where they have supposedly learned how to take care of themselves, and yet, each year a large proportion of these favorable cases are re-admitted.

Sheltered workshops, colony systems, with sheltered employment under ideal environments, are attempts to meet the problem for the individual whose medical condition makes a return to a normal environment impossible.

But for the many thousands of individuals who are discharged each year as arrested, with a full day’s working capacity, these sheltered industries are neither practical nor feasible.

Our responsibility is not ended when patients are discharged from the sanatorium as arrested, able to work a full eight-hour day. Each year we throw back into industry and normal environmental conditions, individuals who, because of their long period of enforced rest in the sanatorium environment, cannot easily adjust to the busy life of our industrial environment. There are many obstacles that stand in the way of a complete return to normalcy. Very often these obstacles are small, but the cumulative effect of a bad industrial adjustment, worry over finances, or a domestic difficulty perhaps, may soon nullify the good effects of the long sanatorium period, and a relapse is the inevitable result.

The monetary loss is enormous. Hundreds of thousands of dollars are lost yearly, for relapses occur during the most productive age of the individual. If the social worker, through temporary financial aid, industrial help, or other social adjustment, can prevent recurrences, there is a great economic saving to the community, and if recurrences are prevented, there is also prevented the further spread of disease in the community.

It is the patient who is discharged in good condition, who quickly forgets the many “don’ts” learned at the sanatorium. It is so very easy to go back to the old habits, many of which were the predisposing
causes of the first breakdown. In order to make sanatorium care effective, there should be an intensive follow-up on each patient who leaves the sanatorium, and this work should be done by a hospital social worker, whose senses are alert to recognize those things which stand in the way of complete recovery. Strict medical supervision should be urged, but equally important, is following the patient into his home, into his place of employment, seeing him in his community, carrying out a program of health education, not only for the patient, but for his family as well, teaching them all to build on the good foundation which the sanatorium has given.

During his long stay in the sanatorium, a patient learns many things. He is taught the value of rest and relaxation and is given an introduction into the value of good health. He is given a good foundation for health education, not only for himself, but for his family. These, and many other things that are good, we must keep constantly before him. But along with these good things, many patients have developed attitudes that are bad—fear, over-cautiousness, dependency, laziness, self-centeredness—all these words imply attitudes that the patient may have acquired. It is these attitudes that make a return to a normal environment difficult.

The social worker faces the difficulty of working with these intangible, subtle attitudes, which the patient, and his family in many cases, have acquired in a slow, gradual manner. Changing them is difficult and requires patience and long time effort.

Another difficulty facing the social worker, is the clash between the doctor's recommendations, on the one side, and the family attitude, on the other. The majority of patients who have been discharged as able to work a full eight-hour day, look extremely well, their color is good, they have gained weight and they present the picture of very healthy individuals. Because of this, in contrast to the doctor's instructions to take rest hours and go to bed early, patient's family and friends urge him to overtax his strength.

Perhaps the hardest thing the social worker has to do in a post-sanatorium program, is to salvage the good the sanatorium has done, and change the bad attitudes of both the patient and his family.

Adjusting himself to industry is one of the most discouraging things a patient has to face. When the patient steps from the lazy existence of sanatorium life, into the ever busy field of industry, which entails anxieties over wages, working conditions, hours of work, physical exertion, and other employment factors, he finds the
Post-Sanatorium adjustment a very hard step. After overcoming his deep-seated fear and over-cautiousness, there remains the more difficult problem of overcoming the prejudices of employers. Employers are not at all eager to engage people who have had tuberculosis, so that most patients have a very difficult time getting back into a normal industrial life.

Even if the patient is fortunate enough to be able to work a full eight-hour day, he has a hard time finding a job that will permit him to stay well. It is almost impossible to find part-time work, unless it be in the sheltered workshops.

The social worker should know that there are very few light easy jobs, and because of her experience in the industrial world, she can convince the patient that an inside job, preferably the old one, under proper conditions, the job that will insure a good wage and a chance for advancement, is by far preferable to the mythical light, easy, out-of-door job, that doesn’t exist.

Some agencies are fortunate enough to have as a resource, a handicap bureau, where tuberculous patients can be referred. In such cases the patient should be referred with a complete social background, which includes not only a statement of his physical condition, but his personality traits and his industrial assets and liabilities. But the social worker, before referring a patient, should prepare him for work. Many patients who leave the sanatorium are not mentally ready for a job. They fear it because of the long stay in the institution. Their families, too, are afraid to have them work, and many patients are not “work conscious.” Long before he is referred to the placement service the social worker should attempt to put him in a frame of mind where he is willing at least to attempt work, and once he has a job, to stay on it.

After the placement worker has done her job and the individual has been placed at work for which he is best fitted industrially, as well as physically, it is again the social worker’s job to see to it that the patient has continuous medical follow-up—monthly, every two months, or as often as the physician deems it necessary. Placement should be linked up closely with medical treatment, for it is the patient’s physical condition that is the gauge of his tolerance for work. When the patient realizes that the doctor, the social worker, and the placement worker are all linked together, working as one unit, he is not so eager to throw up his job upon the least provocation, but instead, remains at work and talks his difficulty over with the worker,
who may find, as she often does, the difficulties are not inherent in the job itself but are the result of bad social conditions in the home which need remedying.

Post-sanatorium care, at the present time, in most places, if it is given at all, is done through a card index system with a perfunctory letter to a patient every few months or so, asking about his present physical condition. Reminding the patient once a year, through a letter or a card, does not insure his adjustment, to what are, in many cases, very unfavorable conditions. A good program of after-care includes the knowledge that the patient has no social problems that need attention. If there are problems, they should be adjusted. Urging periodic medical examinations and seeing that they are carried out, does not insure the patient's remaining well, but if the social worker is in close touch with the patient and the doctor, and will help to carry out the physician's recommendation that the patient should have a short vacation, that he should do no overtime work, or, if it is a woman patient, that she be helped with the heavy work in the house and relieved of the care of her children for a short time, and so forth, then medical recommendations are of value.

We, as social workers, have been forced to assume responsibility for the patient who is discharged from the sanatorium. Very few institutions have social service staffs and if there is a tie-up for the discharged patient, it is a medical one with a nursing group. Until such time as tuberculosis sanatoria, dispensaries, or other medical units are equipped to assume social responsibility for their patients, the period of adjustment following sanatorium treatment must, of necessity, be the responsibility of the hospital social worker, whose contact with the patient began when sanatorium care was first recommended. Just as it was her job to assume social responsibility for the patient and his family when the diagnosis was first made and treatment in an institution recommended, so it again becomes her responsibility when sanatorium care is ended and the patient is ready for discharge.
MEDICAL SOCIAL TREATMENT OF PATIENTS SUFFERING WITH CATARACT*

GRACE COOKE

Social Worker, Eye Clinic, St. Luke's Hospital, New York, N. Y.

From the point of view of the social worker cataract cases, whatever type they may be, visiting the clinic for the first time—fall naturally into one of three classes:

1. Those who know they have cataract and come for relief by operation.
2. Those who know they have some serious condition but do not know the nature of it.
3. Those who are complaining of failing vision but are unaware of any serious condition.

I believe that, in a great measure, the success of holding and treating these patients may be assured if the first contact between doctor and patient may include the social worker.

If the doctor will take time to explain to the patient the nature of his eye trouble and that there are certain things that must be done before an operation can be safely undertaken, and will indicate to the patient that the social worker is there to remove any obstacles that may prevent his carrying out the doctor's recommendations, the doctor will eventually save himself much time. There will be also less chance of the patient wasting his time by shopping around from clinic to clinic.

After the first contact, the social worker must outline her work according to the patient's need. If we are dealing with congenital cataracts, the parents must be reassured and made to understand that without their coöperation nothing can be accomplished. In dealing with the foreign born parents, we must have a sympathetic under-

*Read before the First Study Meeting, Committee on Development of Social Service in Eye Clinics, New York, N. Y., December, 1930.
standing of their quite different points of view, or we can never hope to gain their confidence. Once this confidence is established it is fairly plain sailing.

With the senile cataracts, the patient is usually the older man or woman dependent on other members of the family. Often it is necessary to arrange for a guide to bring them to clinic. By knowing the work of other organizations and calling on them for assistance, the visits to clinic may be arranged without hardship to the rest of the family. During the period of waiting for the operation, through the coöperation of other organizations, the patient’s interest may be held by arranging for homework. If necessary, financial relief may be obtained for them.

After the operation, if the patient’s former occupation is unsuitable, he must be adjusted to new work and he must be kept under clinic supervision as long as the doctor recommends. Certain types of patients including the diabetic, must continue under medical care for a long period to insure the successful treatment of his eyes.

Much may be done to teach the patient how to care for his eyes. Children especially must be taught correct posture as well as the proper handling of his spectacles. The proper lighting of the home, while working and reading; suitable diet and sufficient rest—all play an important role in the care of the patients. By supplementing the skilled care of the eye physician with the work of the social worker, the clinic brings to the patient an efficient completed service.
The purpose of this article is to indicate in brief methods of promoting mutually beneficial relations between the Hospital Social Service Department and the School of Nursing.

Between no two departments of the hospital is the need for coöperation greater. There is the common interest in the welfare and recovery of the patient, whose physical and mental health may depend on the assurance the social worker is able to give him that his family is not suffering during his incapacity or that a position is secured for him after his recovery. Frequently the nurse is the social worker's only source of information which explains the social cause of a patient's retarded improvement. The efficiency and accomplishment of each department demand the coöperation and aid which the other can give it. Both are interested in promoting the patient's return to health and a shortened stay in the hospital. It means a speedier restoration to his family and the community. The patient regains the self confidence and the normal outlook on life which his position as a contributing member of society gives to him.

Leaders in nursing education have for some time realized the necessity for a better understanding on the part of the nursing staff of the bearing which social environment has on the entire problem of illness, hospitalization, medical, and nursing care. They have realized, too, that the school of nursing must teach to its students what a vital part of the organization the Social Service Department is. The Curriculum for Schools of Nursing prepared by the National League of Nursing Education has for more than ten years contained a course called "Modern Social and Health Movements." It recommends that the course be taught by a social service worker. The Director of the Hospital Social Service Department should have a recognized place on
the School of Nursing Faculty. The disadvantages of this arrange-
ment have been that many social workers are not teachers by training
nor interest and that they have usually no knowledge of the cur-
riculum of the particular school of nursing nor of the aims and
standards of nursing education in general.

The so-called "Standard Curriculum" provides also for a very
brief course in Sociology for student nurses. Many schools are now
offering this subject, the better schools with the more advanced
courses giving the students a much richer background. Early in the
student nurse's course of training she should be given information
about her own Hospital Social Service Department by means of a few
lectures if necessary. In the "case study" or "case report" attention
should be called to the part played by the environment and social
background in this particular patient's condition and the correlation
between the medical and nursing departments on the one hand and the
social service department on the other.

The departmental conference and the morning report period are
being used more extensively as a medium for teaching, and here
again advantage may be taken of the opportunity to emphasize the
value of cooperating with the Social Service Department and of
utilizing its services to the fullest extent.

In some schools of nursing the young student nurse is given some
practical experience to acquaint her with this department. She spends
from two to four hours a day for two or four weeks in the dispensary
or the clinic working under the direction of the social worker or the
supervising nurse, doing clerical or simple nursing duties. She assists
the social worker in the "follow-up" of the out-patient, and makes
home visits with her.

The time for these courses is preferably early, after the student
has had the preparatory work in the basic sciences and has mastered
the principles and practice of the elementary nursing procedures.
However, there seems to be no objection to giving the courses in
sociology and in orientation to students in University Schools of
Nursing during the year or years preceding their assignment to hos-
pital duty.

Later, during the student's junior year or early in her senior year,
there should be included classes and lectures in medical social service,
introduction to the principles and methods of social case work, home
visits, excursions to the headquarters of the existing social agencies
and community centers. Correlating practice (perhaps in the senior
year, but not separated by too wide an interval from the foregoing theory) should include full time duty in the out-patient department, clinics, dispensaries, receiving department, whatever of this nature the hospital may offer, and at least a full month's service in the Social Service Department.

Most schools of nursing are at present offering as a part of the regular nursing course, as an elective, or through affiliation, some experience in psychiatric nursing. During this period, which should be at the minimum six or eight weeks long, the student is definitely assigned, for varying lengths of time, to the Social Service Department of the Psychopathic Hospital, where she has the opportunity to study at first hand its direct relation with the patients she has nursed or observed.

The value of these experiences in the nurse's education, how fully they prepare her for a better understanding of human behavior, and enrich her background for solving the many problems which will confront her in any field of her work—and especially in public health nursing—must be obvious. One is impelled to ask to what extent the Social Service Department could function more efficiently if its personnel were equipped with a more thorough knowledge of the Nursing Department. The program outlined above, the duties of the social worker as the teacher, guide and co-worker of the student nurse, and the greater number of their contacts would contribute to that end. However, the problem of how the staff may acquire previously some acquaintance with the aims and standards of nursing education presents a challenge of interesting possibilities.
REDUCTION IN HOSPITAL COST TO THE PATIENT OF MODERATE MEANS

W. L. BABCOCK, M.D.

Director and Treasurer, The Grace Hospital
Detroit, Mich.

Hospital authorities are keenly alive to the cost of hospital care to the patient of moderate means with a family income less than $5,000.00 annually. It is quite unnecessary to repeat the old truism in reference to the opportunities for the hospitalization of the rich and the poor. Fully 70 per cent. of the population belongs to the intermediate group who are constantly facing the family problems of medical care and hospitalization in illness or emergency.

In a discussion of the cost of hospital care, four groups are concerned:

a. The patient, or public,
b. The hospital,
c. The physician,
d. The nurse.

It is quite unnecessary to further stress the problem as it relates to the patient of moderate means. He is the "goat," so to speak, of economic conditions which he cannot radically change or surmount. In placing the responsibility for this situation the patient does not pass unscathed. The average family fails to make, in their annual budget, any provision for possible illness or prospective childbirth. While illness or necessity for surgical operations cannot be foretold, few families realize, during periods of health, that illness is sooner or later inescapable. Budgetary or financial preparation for childbirth is as rare as budgetary provision for the cost of death and burials. Not one family in ten anticipate the expenditures of this common and easily foretold event. These statements are merely commonplaces for the purpose of establishing the premise that the cooperation of the patient and his family in the reduction of the cost
of illness and hospitalization is a necessary though generally neglected factor.

It has been established in hospital practice that the character of the building, the class of accommodations provided, and certain structural details providing for ease and simplicity of organization and operation, may appreciably reduce the cost of hospital care. Such hospitals as have attempted to reduce the cost to the patient of moderate means are giving heed in their new construction to this opportunity of providing accommodations midway between the ward and the private room, that will insure comfort and privacy to the patient. Briefly, it may be stated that this can be accomplished by grouping the care of these patients in one wing or on one floor, arranging nurses' stations conveniently, providing a few small single rooms and more two and four-bed rooms. The well arranged four-bed ward, with cubicles so that each patient can be segregated or isolated from his neighbor by curtains or partitions, structurally fulfills the best possible requisites for the reduction of overhead.

It would be futile to attempt to provide for reduction in the cost of hospitalization without the physician contributing his part in the program. The experiment proposed and under way is for the medical profession to provide in their fee schedule for a third or medium class. Heretofore their division has been the free and the private patient. The intermediary group, constituting the patient of moderate means, must be given consideration through reductions in fee schedules. Unadvertised and unconsciously the medical profession has for many years recognized this group. There are few physicians or surgeons who have not adjusted their fees according to patients means and incomes.

In the case of hospitalized patients there is every inducement for a definite and wholesome recognition of this fact. Where a physician can group his patients in a hospital, he saves his stock-in-trade, which, in addition to his skill, is the time element. He can afford to sell his time at a lessened rate. Let it be said that where this re-classification project has been proposed or practiced, it has been met by the profession almost without exception with their customary professional generosity and cooperation.

Provision by the hospital for adequate floor nursing and the development of group nursing has resulted in a very definite reduction in the cost of special nursing care. It is well known that the current fees for special nursing throughout the country provide no more than
a living wage. Granted that the floor nursing in a service for the patient of moderate means is adequately organized, what about the case of serious illness that needs special nursing? Experience has demonstrated that the greatest saving to the patient can be provided by so-called “group nursing” which may be organized so as to adequately reimburse the nurses engaged and reduce the cost of nursing to the patient 60 per cent.

Several hospitals throughout the country have had definite and notable experience in attempting to reduce the cost of hospitalization to the middle group; notably the Massachusetts General Hospital, Boston; the Grace Hospital, Detroit; the Gotham Hospital, New York; the Presbyterian Hospital, Chicago, and a few others have plans in project. These experiments have demonstrated that the cost to the patients of this group can be reduced to a figure that does not exceed, as a maximum, the average cost of care of all groups; in other words, the average per capita per diem cost. This statement, of course, is applicable only to general hospitals, whose accommodations for all groups are properly proportioned.

The Grace Hospital has under construction a unit of 185 beds, wherein the structural grouping of accommodations for the patient of moderate means equals 70 per cent. of the capacity. In addition the hospital will make provision for 50 beds of moderate price in the existing hospital buildings. The total capacity of the hospital on completion of this addition will be approximately 500 adult beds for all classes; 22 per cent. for the needy poor, city and county cases, and endowed beds; 23 per cent. private rooms, some with bath, for private patients; and the remainder, $4.00, $5.00 and $6.00 per day rooms and beds for the patient of moderate means. The Staff physicians of the hospital have agreed to provide a fee schedule with a maximum below the average cost of medical and surgical fees heretofore charged to the private patient. These schedules have already been adopted and will be placed in effect when the building is occupied on completion, approximately September 1, 1931.

It is the plan of the hospital to provide a maximum floor nursing service with pupil nurses, under the supervision of graduate head nurses. Patients who have a serious operation and others seriously ill will be provided with group nurses on 12 or 24 hour service at a cost of $5.00 per day, inclusive of board, for 12 hour service, and $7.50 per day for 24 hour service. This is 60 per cent less than the cost of individual special nursing, which is $8.50 per day for 12 hour
service, and $17.00 per day for 24 hour service. Special nurses will not be used on the hospital floors designed for moderate priced accommodations. Group nurses are employed by the month at a salary that will net them annually, if continuously employed, more than the average annual income of special graduate nurses at the regular rates. In a hospital of a size sufficient to maintain several groups continuously, an experience of three years has demonstrated that about 75 per cent. of the nurses in these groups may be employed continuously throughout the year. As few nurses desire to be continuously employed even eight hours per day for a period of a year, the flexibility of the various groups may be readily imagined.

Each group is made up of three graduate nurses on eight-hour duty covering the full twenty-four hour period. Two or three patients are assigned to them for special nursing, depending on the seriousness of each patient's condition. The group of three is numbered. The nurses are engaged at a monthly salary approximating the average salary of floor supervisors, plus three meals daily. Several of the group nurses have been on duty for many months continuously. As they are only on eight-hour duty, they have no other time off or vacation allowances. They are, however, entitled to six-days' sick leave for each twelve months' service, which can be applied fractionally.

Once the physicians become familiar with the service they are decidedly in favor of its extension among all patients of moderate means. The majority of the members of the staff have availed themselves of the service at one time or another. It is believed that those who are most considerate of their patients' finances use the service more than others. No opposition has developed on their part.

A meeting with graduates of The Grace Hospital School of Nursing was held and the whole project explained to them. No active opposition was expressed, although it was known that some existed. Those opposed were critical of the practicability of the project, especially as applied to obstetrical cases. The majority expressed a decided interest and a desire to see the experiment tried, although possibly a few felt that it would not be a success. Explanation was made that it was entirely experimental and would be limited to about 15 per cent. of the total special nursing. Because of structural limitations this percentage was not exceeded. The first groups were made up of graduates of other schools but later graduates of our own school applied for the service. It is believed that the majority of the gradu-
ate nurse observers who are familiar with the experiment up to date either have no opposition to its continuance or feel it fills a need for the patient of moderate means.

During the first twelve months 281 patients were nursed 1420 days by thirty-eight nurses, divided into groups of three. As this was the first year of the experiment, a larger turnover of nurses occurred, due principally to the fact that we could seldom maintain more than two or three groups at a time for any continuous period. During the second twelve months 322 patients were nursed 2,038 days by forty-one nurses. The figures for the second twelve-month period indicate that there was a smaller turnover of nurses, due to an increase in the number of groups and more continuous nursing. These figures also show a longer nursing period per patient. Only after a larger number of groups over a longer period have been studied can any fair inference be drawn from the statistics.

Apprehension was at first felt in reference to the loading of two or three acute or freshly operated cases on one nursing group, because this would have a tendency to limit the degree or amount of personal attention that these patients would receive. Experience has demonstrated that where two or more groups are associated on a service, the exchange of patients between groups can be quickly and satisfactorily arranged. It should be understood that frequently only two patients are served by a group. It has generally been possible to limit the assignment of fresh operative cases to groups not already burdened. As a rule, a group of three patients will consist of one fresh operative case and one or two other cases in varying stages of convalescence. With multiple groups on one service, the flexibility is apparent.

The expenses of group nursing during this period were a few hundred dollars less than the receipts, which excess we estimate covered less than 50 per cent. of the overhead. With that in view, the hospital is making an indirect contribution to the care of the patient of moderate means for which it does not receive direct reimbursement. We are constantly in receipt of commendatory letters and statements from satisfied patients who have had group nursing, and its employment has resulted in the generation of much good-will.

The following tabulated statistics cover the full three-year period from March 1, 1927, to February 28, 1930, inclusive:
Reduction in Hospital Cost

**Group Nursing**

<table>
<thead>
<tr>
<th>Year</th>
<th>Start Date</th>
<th>End Date</th>
<th>Days</th>
<th>Patients</th>
<th>Nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>1927</td>
<td>March 1, 1927</td>
<td></td>
<td>1420</td>
<td>281</td>
<td>38</td>
</tr>
<tr>
<td>1928</td>
<td></td>
<td>2038</td>
<td>581</td>
<td>41</td>
<td></td>
</tr>
<tr>
<td>1929</td>
<td>February 28, 1930</td>
<td>3406</td>
<td>78</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>6864</td>
<td>1184</td>
<td></td>
</tr>
</tbody>
</table>

The Auditors statement shows that in dollars and cents the saving to the patients who have availed themselves of group nursing in a three-year period in this hospital was $47,807.00, at an average per patient of $40.35. That this has been accomplished without seriously reducing the field of employment of the graduate nurse may be understood when it is stated that the group nursing in this hospital in the three-year period represented only 15 per cent. of the total special nursing and that the plan provided fairly regular employment during the year to 41 graduate nurses for a total period of 6,864 days.

The citizen of moderate income is usually a person of culture and education. He desires, and should have, a reasonable degree of privacy in his hospitalization. He cannot be treated as a public ward patient, and in severe illness should have special nursing. Representing at least two-thirds of the population, he is by far the most important group to be considered in any project for hospitalization. It is believed that careful study and planning along the lines indicated above may lead to a definite reduction in the cost of hospital care of this group.
A PRACTICAL PROGRAM IN CANCER PUBLICITY

ELLA HOFFMAN RIGNEY

Publicity Director, The New York City Cancer Committee, The American Society for the Control of Cancer, New York, N. Y.

Cancer ranks second as a cause of death in the United States. Because of this it must receive the thoughtful attention of those interested in the large questions of public health, as well as those specifically concerned with the cancer problem itself.

The need for public education is generally admitted. It is agreed that the chief handicap in the treatment of cancer still lies in the fact that a large percentage of patients are not seen by the physician until the disease is advanced. It has been estimated that there are 25,000 cancer cases in New York City at all times, of which one-third are early cancers. What the public does not realize and what must be brought to its attention is that a considerable proportion of these early cancers could be easily diagnosed and a large number cured, if seen and treated without delay.

For instance, Dr. Joseph Colt Bloodgood of Johns Hopkins Hospital, has said that fully 75 per cent. of cases of cancer of the breast could be cured if diagnosed early and treated promptly and properly. Under similar ideal circumstances, almost all early cases of the larynx could be cured, according to Dr. John E. MacKenty of the Manhattan Eye, Ear, Nose, and Throat Hospital, New York; of cases of skin cancer, more than 90 per cent., according to Dr. George H. Semken, surgeon at The Knickerbocker Hospital, New York; of cases of cancer of the lip, 85 per cent., according to Dr. Bloodgood; and of cases of cancer of the cervix, 65 per cent., according to Dr. William P. Healy of the Memorial Hospital, New York.

The situation has been admirably outlined by Dr. Shirley W. Wynne, Commissioner of Health of the City of New York, which in 1930 showed the highest death rate and the highest case rate recorded for cancer in its history.

“Medical science,” he said, “has proved that often, when cancer
can be recognized at the very start and treated before it has a chance to spread from its original location, the disease can be eradicated. Research has further brought to light a number of factors which, while they do not constitute the fundamental cause of the disease, nevertheless play a part in bringing it about. In view of these facts, all suspected cases of cancer demand an immediate examination by a qualified physician and all conditions which are known to lead to the development of the disease should be effectively dealt with. A public well informed regarding the known symptoms of cancer is one of the most effective weapons to combat the disease. Public realization of the necessity for taking these steps should make it possible to reduce the death toll due to cancer, a toll which now shows a slight but steady increase from year to year. All over the world scientists are trying to discover the ultimate cause of cancer with a view to conquering this dread foe of mankind. Some Pasteur of the future, we hope, will one day solve these matters. Meanwhile the general public can do no less in the cause of health than make the most of what is already known. Cancer is a public health problem and should be treated as such."

In an address before the Minnesota Medical Association in March, 1921, Dr. Frederick L. Hoffman said: "When the Society for the Control of Cancer was formed, it was clearly realized that the main objective of its propaganda should be to arouse the general public to the menace of cancer increase and the hopeful effects of early diagnosis and surgical treatment in the early stages of the disease. For this reason it was decided not to call the society one for the prevention, but rather for the control of cancer. In other words, the aim of the society is to bring about a reduction in the death rate from cancer as the results of early methods of treatment, whether surgical or otherwise. Nothing of value is known at the present time that would justify the belief that cancerous processes can be prevented; but the knowledge of pre-cancerous conditions leads to earlier diagnosis and treatment at a stage when the prognosis is generally quite favorable.

"Regardless of what the Society has done, and it has done much, there has not as yet been a marked effect on the cancer death rate. In some localities where the campaign has been most effective the rate has unquestionably declined, on account of cases coming earlier to operation. But, in a general way, it may be said that the vast majority of cancer operations still take place when the disease has
reached an inoperable condition. Cancer is not only one of the most important causes of death, but the disease is increasing from year to year in practically all civilized countries.

"The control of the cancer death rate is primarily a surgical question, for unless the offending mass of cancerous tissue is promptly removed in the early stage of the disease, death is a foregone conclusion. It would be as sensible to argue against a propaganda which will increase early surgical operation. There is the utmost urgency that the number of early operations should be very considerably increased as a first step in a satisfactory solution of the problem of cancer education." ¹

The American Society for the Control of Cancer recognizes the need to encourage local organizations for carrying on public education, for stimulating the provision of adequate facilities for diagnosis and treatment, and for informing the cancer patient as to what facilities are available. In the Metropolitan area the New York City Cancer Committee, the local branch of the Society, during the more than four years of its existence, has devoted itself to bringing the known facts about the disease to the attention of the public. The methods used for accomplishing this may possibly serve as a basis upon which other local committees can model their own activities with changes necessary to suit their own needs and such conditions as may be peculiar to the localities they serve. This lay educational campaign has received the hearty approval of medical societies of health departments and of an interested laity. In the Journal of the American Medical Association (November 1, 1930), Bevan ² said: "I am thoroughly converted to the position that the campaign of education that is being carried on by the Society for the Control of Cancer and by the profession as a whole is leading to earlier diagnosis and more cures, and should receive the support of the entire profession."

At the fourth annual dinner of the New York City Cancer Committee in October, 1930, the following message from Mme. Curie was read:

"From what I hear from my friends in the medical profession there is much to be done in the field of research regarding cancer. But I agree with the object of your society that what is known can be of great benefit if the public are taught the facts."

At the same dinner, Dr. Francis Carter Wood, director of the Institute of Cancer Research for Columbia University, and editor of the American Journal of Cancer, said:
"The work of the New York City Cancer Committee demonstrates that popular education on cancer has definitely improved a desperate situation by bringing many patients to the physicians in a stage in which the disease is curable by proper treatment. That the campaign has also made a certain number of persons nervous is also true, but it is better to be nervous than to die of cancer. Nerves can be cured. A physician said to me one day, 'Your campaign is making people very nervous. I had four frightened people in my office this morning.' I said: 'How many of these had cancer?' and he said 'two.' I asked whether they were early cases and he said 'yes.' I said 'then you had a chance to cure four people; two of nerves and two of cancer.' This is the answer to the criticism that education produces cancer hysteria."

Dr. Matthias Nicoll, Commissioner of Health of Westchester County, New York, and formerly State Health Commissioner, in a letter to Dr. H. R. Charlton, Chairman of the Westchester Committee, a sub-committee of the New York City Cancer Committee, said: "It is a great pleasure for me to endorse the work of your Committee. If any important progress is to be made in saving lives and ameliorating unnecessary suffering from cancer, it must be along the lines which your Committee has so wisely determined to follow."

"The mental, physical and economic suffering which is being caused by premature and unfounded reports of alleged specific cures, is placing most regrettable obstacles in the lines of progress. Nothing but public health education can serve to remove them, by inculcating in the minds of the medical profession and the public the fact that we cannot afford to wait for the discovery of the actual causes of cancer and specific methods of prevention in view of the constantly increasing ravages of the disease; but that we now have very efficient means in a great number of communities for discovering early cancer and destroying its growth, and—not less important—for ameliorating suffering to a very great degree in hopeless cases."

"Finally, I heartily endorse the intention of your Committee to make provision within Westchester County for cases of cancer which cannot be taken care of in private hospitals or in their homes. This department will cooperate in every way possible."

In addition this work of public education has been endorsed by newspaper and magazine editors, who truly reflect public opinion and by advertising executives, who must know what the public will accept, and who have shown an attitude of increasing cooperation. Whereas
in 1927, editors and advertising managers were merely kindly disposed toward the Committee, but a bit fearful lest the public react antagonistically to such lay education, in 1930 they gave without hesitation three times as much space in which to broadcast important cancer information—the message that cancer is curable in many cases if diagnosed early and treated properly and promptly.

Now and again a discordant note is struck. One newspaper, for example, saw fit to criticize the Committee bitterly on the ground that its campaign of public education has served to create needless worry and fear among many thousands. Such editorials do harm. They contain statements which are incorrect. They may cause a number of their readers, who have symptoms of cancer and would ordinarily visit their family physicians or go to clinics, to do nothing. It would be tragic, indeed, if any person with an early cancer were deterred from seeking medical advice as a direct result of this editorial. Of course, such a person would eventually have to go to a doctor, when the case was far advanced and probably hopeless.

The Committee attempts to combat such criticisms by carefully prepared statements by members of the medical profession, though it is impossible for the latter to be as didactic as the less well-informed journalist.

Everything in medicine is relative. Because of this it is difficult to give to the lay person a simple and accurate exposition of facts regarding the disease. A statement which might be accurate in 90 per cent. of cases might be misleading in the remaining 10 per cent.

Briefly, it may be stated that there are three ways of handling the cancer problem. These have been defined by Dr. John C. A. Gerster, Chairman of the New York City Cancer Committee, as follows:

I. Clinical
II. Research
III. Education

I. Clinical. Physicians, both in hospitals and in their private practice must recognize cancer when it is early. To make a diagnosis in cancer may require:
1. An alert medical practitioner—the family physician.
2. A surgeon.
4. A pathologist to examine the tissue, upon whose findings depends the extent and nature of the operation, or the type of radiotherapy to be employed.

It is evident that a highly specialized group is necessary for the proper care of the cancer patient. Whether this group works in its own clinic or in a hospital, the essential factors of team work remain the same.

The hospitals may be either general hospitals in which cancer cases are accepted among other surgical conditions, or special hospitals where only patients with cancer or those suspected of having cancer are received. Lastly, there is a special class of cancer homes, where the hopelessly advanced patients are cared for and made as comfortable as medical science permits.

The outstanding institution of this type in the Metropolitan area is the Rosary Hill Home at Hawthorne, Westchester County, New York. This is the outgrowth of the work of Mother Alphonsa Lathrop, begun in the lower part of New York, and is maintained by the Servants of Relief for Incurable Cancer.

II. Research. In laboratories all over the world men and women are devoting a lifetime of patient, untiring, painstaking thought and effort to the solution of the cancer problem, in many cases with insufficient equipment. Research may uncover something of definite practical value tomorrow or fifty years hence. No one knows. It is poorly endowed, although it merits the most generous public support, local, national and international.

III. Education. While this careful research into the cause of cancer is being carried on, thousands of people are dying from the disease, losing through delay, due most often to ignorance, their only chance of escape. The problem of educating the public is to find means for presenting proper aspects of the problem for lay consideration. This consists—

1. In teaching the accepted facts regarding cancer and the importance of early diagnosis and prompt and proper treatment. In other words, how an individual can safeguard himself as far as at present possible.

2. In controveting certain widespread misconceptions about cancer, for example, the belief that cancer is incurable; that it is a constitutional blood disease; that it is hopeless from the
start; that it is transmitted from parent to child; that it is the result of any known form of diet—to mention only a few.

3. In presenting a comprehensive outline of the entire subject as regards the education of the individual.

The information given out by the New York City Cancer Committee has, generally speaking, been simple. A series of cartoons sub-consciously suggesting health needs has been widely used. Attention has been called to the following list of early signs:

Any lump, especially in the breast.
Any sore that does not heal, particularly on the face or in the mouth.
Any unusual discharge or bleeding.
Continued indigestion.

It has been impressed upon the public that any of these symptoms must be brought promptly to the attention of a physician, because the disease if recognized in time can often be cured by one of the two approved methods—surgery or radiation with either X-ray or radium, the method to be used depending on the region of the body involved and the type of growth.

Warnings are given against the adoption of methods of treatment which cannot be expected to cure the disease, and the trying of quack remedies which do great harm by delaying recourse to proper treatment.

Every available means are used for giving this information to the public, including newspapers, magazines, car cards, billboards, lectures, radio, motion pictures, pamphlets, and exhibits.

That all the various forms of publicity are effective has been proved by the statements of those who come to the office for information. During the last educational campaign a record was kept as far as possible of how applicants had learned of the information bureau. The results were as follows:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Magazines</td>
<td>191</td>
</tr>
<tr>
<td>Posters</td>
<td>181</td>
</tr>
<tr>
<td>Car cards</td>
<td>67</td>
</tr>
<tr>
<td>Newspapers</td>
<td>50</td>
</tr>
<tr>
<td>Radio talks</td>
<td>36</td>
</tr>
<tr>
<td>Pamphlets</td>
<td>26</td>
</tr>
<tr>
<td>Exhibits</td>
<td>9</td>
</tr>
<tr>
<td>Motion pictures</td>
<td>6</td>
</tr>
</tbody>
</table>
Cancer Publicity

The records over a period of four years show a constant increase in the number of persons coming to the office of the Committee for information and advice. This is perhaps the surest index of success, as regards the effectiveness of the lay educational campaign. During the first year 615 persons came to the office, or communicated by letter or by telephone. In 1930, the number was 2,438. These do not include the undoubtedly large number who have followed the advice to go directly to their family physicians.

In the Standard and Mercury, a newspaper of New Bedford, Massachusetts, of April 22, 1929, an interesting statement was made:

"The value of newspaper publicity in the field of public health is strikingly shown by the figures relating to attendance at the state cancer clinics. In analyzing the reasons that prompted persons to submit themselves for examination, it was found that the most important factor was the press. In the state as a whole 45.2 per cent. of those who reported to a clinic were led to do so by what they had read in the papers, against 26.8 per cent. who were sent by physicians and 15.1 per cent. who were persuaded by friends. In New Bedford the percentages for newspapers, doctors, and friends were 56.8, 21.1 and 12.1 respectively.

"These figures effectually answer those who argued that the publicity given to the fight against cancer does no good, but on the contrary does much harm by frightening people with obscure ailments. In New Bedford 22.5 per cent. of those attending were found to be suffering with cancer. The remainder, 77.5 per cent. had the satisfaction of learning that they did not have a justly dreaded disease. Over half of those found to have cancer have a chance for a cure. If they are cured, the clinic has accomplished a wonderful thing, and in bringing this about intelligent newspaper publicity has been an important factor. Without it the results could have been nowhere near so satisfactory."

Some of the other activities of the Committee may be worthy of note. It has for four years conducted an intensive publicity campaign during the first week of November, at the same time making an appeal for funds with which to continue the work during the year. Special efforts are made during this week. Lectures are given to various organizations throughout the city and a public meeting is held at the Academy of Medicine. Bulletins of information are furnished to the press. Posters are placed in stores, factories, etc. Exhibits are arranged. In 1930, Mayor Walker of New York issued a proclama-
tion, making it officially Cancer Week. In 1930, also, through the cooperation of Dr. William J. O'Shea, Superintendent of Schools, and of the Rev. William R. Kelly of the Catholic School Board, 750,000 copies of a carefully prepared pamphlet were distributed at this time to the pupils in the public and parochial schools in Manhattan, Bronx, Queens and Richmond Boroughs. In this way the message was carried directly into many homes which might not otherwise have been reached. This pamphlet, with the title "By the Way," consists of a series of colored cartoons bringing home in a striking
manner the need for periodic health examinations as a means for controlling cancer as well as other diseases. Other pamphlets furnished by the Society to the local organization are distributed to those asking for more specific information.

A special exhibit has been prepared from the series of health cartoons referred to. This has been seen, it is estimated, by at least half a million persons, through the generous cooperation of the owners of empty stores who have given permission for its display. So far it has been shown in windows of the former Bonwit Teller store on Fifth Avenue, of a store belonging and next to the new Empire State Building, and of others at 700 Sixth Avenue, owned by B. McCreery Realty Corporation, and at the corner of Broadway and 57th Street, belonging to the Willys-Knight Company, all very busy centers. It has also been exhibited at the Home Making Center, Grand Central Palace and at present is displayed at the Health Educational Hall of The Museum of Natural History.

In connection with the exhibit a temporary information office is set up when possible in charge of a member of the staff, who interviews visitors and distributes pamphlets.

The Value of Advertising.

All the advertising space used, whether in the pages of magazines or in the form of time on the air, or car cards or posters, is donated. It has been estimated by one of the largest advertising agencies in the city that more than $1,250,000 worth of space was donated in 1930. The growth of the Committee's activities in this respect has been spectacular. Old friends have stood by us during this period, offering more space each year and contributing helpful suggestions; many new friends have been acquired. The newspapers have aided our educational work in every possible way and have proved to be among the most effective mediums for carrying the message.

It is difficult, even impossible, to estimate the value of each form of advertising used. The reiteration of the message in many ways ultimately makes an impression on the mind. A person may first notice an outdoor poster and later a car card, and last read an article in a newspaper or magazine on the subject of cancer. It makes no difference which has been seen first, all combine to make the impression deeper and stronger.

Practical business men know this from experience, otherwise they
THE WILLIAM LAINBEER EXHIBIT OR BETTER KNOWN AS THE TRAVELLING EXHIBIT OF THE NEW YORK CITY CANCER COMMITTEE
AN IDEA KEEPS GROWING

TERRITORY ENTERED WITH CAR CARDS AND OUTDOOR ADVERTISING CONTRIBUTED TO THE NEW YORK CITY CANCER COMMITTEE.

HELP CONTROL CANCER
LEARN TO KNOW THE SYMPTOMS
AMERICAN SOCIETY FOR THE CONTROL OF CANCER

OUTDOOR POSTERS

1927
1928
1929
1930

SHADED STATES = AREA ENTERED
UNITED STATES = LOCATION OF CONTRIBUTING AGENCIES

NEWSPAPER AND TROLLEY CAR
would not spend millions of dollars annually in each form of advertising. It has been proved that when advertising is curtailed the business falls off proportionately. We realize that for us to attempt statistical analyses of the value of one medium against another would be sheer nonsense and a waste of time and money. There are statistical bureaus that furnish estimates of the comparative values of advertising media, and it seems to be the general conclusion that every form is valuable and that the cost is justified in every instance, because advertising sells the product whether it is corn flakes or health—the problem of attracting public attention is the same. There are people who respond to a message from car card advertising and outdoor billboard posters, even though they are not conscious of being influenced, others respond more readily to advertisements in the press and magazines, or the radio appeal. It is the constant and consistent use of all sorts of advertising that sells the idea in the end.

One of the largest advertising firms in the world, Batten, Barton, Durstine and Osborn Company, endorses our advertising and publicity work. They say that it takes two years of constant advertising to sell any product, and that during these two years the advertiser must use every advertising medium all the time. After that he must continue to advertise so that the public will not forget. Unfortunately our advertising friends cannot give us free space all the year round, and we notice that when advertising of any form is reduced public interest is not so keen.

As advertising has taught us in many ways how to care for our health, our eyesight and our teeth, as it has endorsed foods, and as it has interested us in travel and in savings, so it is also being effective as a means of public education in cancer.

REFERENCE
IS THERE A BASIS FOR COMPARING VOLUME OF WORK IN MEDICAL AND FAMILY CASE WORK?*

RALPH G. HURLIN

Director, Department of Statistics, Russell Sage Foundation, New York, N. Y.

Hospital social work and family social work when performed according to generally accepted standards are primarily characterized by the use of a common technique, case work. Through this method of operation workers in each field attack the social problems presented by individual people with the intention of first thoroughly understanding the circumstances, and second, making adjustments to relieve immediate distress and insofar as possible remove causes. The object of both types of work is helping people out of trouble and preparing them to keep out of trouble.

The two types of case work exhibit important differences to be sure, one of which is the greater uniformity in type of problem dealt with in hospital social work. Another is that while clients come to the door of the family agency seeking its assistance, the clients of hospital social workers are selected from a stream of potential clients who come to the institution for medical rather than for social case work service. Since, however, the two fields of work have in common the case work method, it is pertinent to ask if statistical comparisons can be made of the work performed in them. It would be desirable to know, for instance, if in an unemployment crisis, as at present, the pressure of work increases in similar proportion and at the same time in each field; or if the pressure of work undergoes the same or a different type of fluctuation within the year. Comparison of typical case loads carried by workers in the two fields, or of the ratio of cases worked on to workers, would be of practical interest, as would other measures descriptive of case work practices, such as the length

* This paper was presented at a round table discussion of hospital social work statistics at the Pennsylvania Conference of Social Work in Reading, February 27, 1931.
of time cases remain under care, the ratio of active to inactive cases in the case load under care, or the rate of turnover in the case load. It is also pertinent to ask if these comparisons can be made satisfactorily between individual agencies within either one of these fields.

Before attempting to answer these questions, it will be worth while to consider for a moment the nature of the statistics of case work which can be obtained. In no field of case work has a very satisfactory method been devised of measuring the volume of work undertaken or accomplished. There is no physical product of case work which can be weighed, counted, or evaluated. If genuine case work is done, the services performed are far too varied to permit any measurement in terms of aggregate services rendered. The product of case work is intangible, so that it is quite impractical to attempt to measure the volume or flow of work in terms of specific accomplishments.

Here as in many other statistical problems, lacking a satisfactory direct method of measurement, we are under the necessity of making as good use as we can of an indirect method. The unit of measurement in terms of which work is most commonly described in all fields of case work is the individual case served or under care. A definition of what is meant by a case must be adopted, which, of course, should be as precise as possible so that case counts of different case workers will tend to be similarly made. The cases under care or actively served, according to the definition, are then enumerated from month to month and the resulting case counts are used, for lack of a better measure, as indicating the volume of work performed.

Supplementary counts of interviews or case work consultations held by case workers inside or outside the institution are also frequently made, and are sometimes interpreted as measures of volume of work, but the interview counts are not, at present at least, usually considered as useful as indicating the volume of work as are the case counts.

The difficulty which every case worker recognizes in using the individual case as a unit of measure for producing statistics of the volume of work performed is that the units are not uniform. They do not represent equivalent amounts of work. Some cases require more skill than others; some take much more time than others. This again is not a statistical difficulty peculiar to social work. It applies to a very large number of statistical units in common and effective use. In measuring growth of population, for example, and in com-
paring populations of cities or states, the unit of measurement varies, any living human being, regardless of age or social importance, counting as one unit of population. With many other measurements which are expressed in terms of the frequency of objects or events, such as the counts of farms or factories made at intervals by the Census Bureau, or the counts of sicknesses which constitute morbidity statistics, the situation is the same. Farms and factories vary greatly in size and productive capacity; sicknesses vary in severity and duration. Yet in each case simple counting of instances falling within the definition set up for the purpose of the enumeration produces measurements of distinct value.

For the purpose of obtaining usable measurements, units which actually vary greatly are counted as if they were uniform. If the amount of variation is fairly similar from place to place and from time to time, the result is reasonably consistent measurements. In such cases, the variation in the units counted can be safely ignored for many purposes. But frequently the amount of variation in the units counted cannot be assumed to be unimportant for the purpose for which the measurements are desired. In this case, the unit is not abandoned as useless, but additional information is recognized in making the enumeration, and the count is classified according to the degree of variation. Thus, factories and farms may be counted in categories according to size or kind and cases under care in case work agencies in categories indicative of the type of treatment given, or degree of responsibility for care assumed.

This disadvantage of lack of uniformity in the unit of measure affects the case counts of both hospital and family case work, and in both fields individual agencies vary greatly evidently in the proportion of cases receiving different grades of service. Whether or not a system of classifying cases served according to sort of service given or of responsibility assumed can be developed which can be used with reasonably uniform results in different case work agencies and by different workers is still a debatable question. Without such classification, however, the case counts will appear to have a uniformity in significance which may be very far from the fact.

If the case counts are to be taken as indicative of the total volume of work of the agency, another difficulty is found in the fact that case work may occupy a larger share of the workers' time in some agencies than in others. This is an important point in any comparison of hospital and family case work. For if the typical worker in family
case work spends most of her time in examining and treating social problems presented by individual persons or families and most of the remaining time in strictly ancillary work, while in hospital social work the typical social worker spends much less time in genuinely studying and treating problems presented by individual people and more time in being generally useful to patients, physicians, or social agencies, that is, in doing errands, giving directions, transmitting information, or managing clinics, then it is clear that measurements which take into account case work alone will not be equally good measures of the total amount of work in both fields.

There is not, of course, this clear-cut distinction between all family case work agencies on the one hand, and all hospital social work agencies on the other. In both fields some agencies give more and others less emphasis to case work. Nor is it implied that the other types of work mentioned do not need to be done; or that they cannot perhaps be done better by case workers than by workers who know nothing of case work technique. These points are, perhaps, worth discussion, but we are here concerned only with the fact that the variable extent to which case work agencies perform other types of service than case work, complicates the problem of measuring the total volume of work performed.

There is a further possible difficulty in comparing case counts between the two fields of work and within the field of hospital social work. It concerns the definition adopted for the case unit. Family social work agencies deal mainly with problems which concern whole families, the family is approached for study and treatment as a unit and the family becomes the natural unit of the case count. In social case work in hospitals on the other hand, a large proportion of the problems dealt with do not involve to any large extent the family as a whole. Study and treatment are aimed at adjustments which will facilitate the medical treatment of an individual person, and in many but not all hospital social work departments the individual patient served is made the unit of count. This is, in fact, the recommendation of the Committee on Statistics of the American Association of Hospital Social Workers.

Whether individual persons or families are counted might not make very large differences in the case counts of most hospital social work agencies, provided that cases are counted only when genuine case work is attempted. Large differences might result if cases are counted when the only service has been to refer or to bring to clinic
several members of the family of a patient who is receiving case work care. This is a matter to be covered in definitions. The possibility of differences in the significance of case counts from this cause deserves consideration, however, when comparisons are attempted.

The difficulties in the way of producing comparable statistics of even the volume of case work in social agencies are formidable. With sufficient effort, however, figures permitting many useful comparisons between agencies in the same field can certainly be expected. With more caution, I believe useful comparisons can also be hoped for between case work fields.

Experience with family case work agencies during the past five years has demonstrated a great deal of regularity in the case counts of individual family agencies. These agencies have shown year after year consistently varying fluctuation in their case counts. On the basis of these measurements, we feel safe in concluding that significant differences exist between individual agencies and between certain groups of agencies, with respect to fluctuations in case loads within the year and in periods of stress like the present. With somewhat more hesitation, we venture to use these measurements also in comparing the relation of volume of work to number of workers as between individual agencies, or between groups of agencies.

I do not wish to give the impression, however, that the problem of measuring volume of work in family case work has been finally or satisfactorily solved. The present unemployment emergency has produced in family case work somewhat the same effect, I suspect, as is commonly produced in hospital social work by the presence of a very large number of potential cases, few of which can be given adequate case work consideration. The result has been to introduce some uncertainty concerning the case counts for recent months of family case work agencies. Unemployment cases are receiving varying degrees of service in different places, but irrespective of the sort of service given, these cases are appearing in the monthly case counts in different ways, thus variously affecting their figures and calling attention again to the need both for better definitions of terms and for more concern about uniformity in applying them.

But more useful measurements are in general available in family case work than in hospital social work. In the latter field there is probably much less uniformity with respect to the emphasis placed on case work. Among cases receiving case work study and treatment from month to month, there is probably also much less uniformity in
the amount and kind of attention given than in family case work. There seems to be no reason to suppose, however, that the same procedure which is producing useful results in the family field will not produce useful results in hospital social work; that is, counting from month to month the number of cases for which responsibility for real case work has been assumed and to which actual case work attention is given. Such counts made systematically month by month, with careful attention to the definition of the unit to be counted, should prove as useful here as in the other field.

It should always be possible to make the successive monthly case counts of any single agency comparable within reasonable limits; comparability of the counts of different agencies, will always depend upon the amount of attention given by individual agencies to the matter of definitions of terms and their application. Even though it should be demonstrated that the case unit on the average meant something different in hospital social work from its meaning in family case work, if systematic and reasonably uniform records were available within each field, the difference in significance of the terms could be established, and with appropriate adjustments useful comparisons would then be possible.

Case counting should be thought of as a process of measurement. In social work as elsewhere the quality of statistical measurements and the validity of comparisons based upon them, depend upon the care with which they are made. In producing statistics of social agencies, unfortunately, it is necessary that pains be taken by a large number of different workers in order to get measurements which are useful.
At the recent Conference on Medical Education, Medical Licensure and Hospitals, held in Chicago, February 16-18, two sessions were given over to a discussion of convalescence from a hospital standpoint. Dr. E. H. L. Corwin read two papers in which he noted the estimated number of beds available for convalescents, the need of such beds, and other valuable data. Dr. James A. Britton gave the results of a study of Convalescent Care in the Chicago Area. Miss Mabel Binner spoke on the Possibilities for Nursing Service in Convalescent Care. Dr. Charles O. Molander described the organization of Physical Therapy in Teaching Hospitals, and the writer spoke on Occupational Therapy. Without doubt convalescence is not given the consideration it deserves by hospital authorities. Too often the patient is discharged from care, recovered from his injury or illness, but in no condition to resume his vocation. Yet no blame should be attached to those who administer hospitals, because it is their duty to provide beds for the acutely sick and this cannot be done if the beds are occupied by convalescent patients. It has been taken for granted for many years that convalescents might be satisfactorily cared for at home. Perhaps so in bygone days but conditions have changed, and it is recognized that the period of convalescence may be much longer than that of the illness. This is discouraging to the patient and if nothing is done to keep up his morale he is apt to become hypochondriacal and develop into a chronic invalid. Then too, it is a period in which reeducation must be given to those who have become crippled. They must learn to adapt themselves to the loss of an arm or leg and learn to use the prosthetic appliances which have been provided. Often the patients lack the determination to use these and prefer to go through life “unhampered” by such apparatus. While there are various clinics which provide the necessary training the patient has too much time to brood upon his misfortune unless some effort is made to
stimulate him to use his spare time in some constructive way. It is possible to interest a number in courses of study which will fit them to take another form of work than that to which they have been accustomed and for which they are unfit because of their handicap.

The man or woman who is convalescent from an illness such as fever, or an operation, may not need so radical a readjustment as those crippled, and may be more prostrated physically and mentally. He lacks the stimulus of the need for readjustment to a change in occupation because he may return to his former vocation as soon as he is strong enough. Yet it is necessary to keep his thoughts from himself. If he has been the fortunate possessor of an indoor hobby it is not difficult to get him to ride it and he may be happily employed in working with his stamp collection, arranging his genealogical data, or catching up in his study of literature or of history. However, if he has not been trained in riding an indoor hobby something must be found which will stimulate him to adopt one. If fishing has been his avocation he may be interested in making flies, snooding hooks, or rewrapping rods. The photographer may mount or catalogue his photographs. If the patient is so unfortunate as to have had no hobby then an interest must be found for him. It is here that the occupational therapist may prove her value. With her training and experience it does not take her long to find something which will interest the patient and keep him from brooding over himself and his ill feeling. “The world is so full of a number of things” that it is usually possible in a short time for the trained person to find one of them that will appeal to the convalescent. Naturally, manual occupations come first. When the hands are busy the attention is concentrated on the task and the mind has no opportunity to wander. Whittling of whatever medium (we may dignify it by calling it carving), will usually interest a man who has a natural instinct to create. Solitaire, picture puzzles, cross word puzzles, and the like are valuable diversions for the convalescent. A great advantage which they possess is that they can be dropped when the patient becomes fatigued and resumed when he has become rested. The interest in solitaire may be increased by keeping a score of the number of games lost and won. That in picture puzzles by timing its solution and observing if the next solving can be done in a shorter period. None of these things require the services of an occupational therapist and there are many more. When we plan to enter the crafts such as basketry, weaving, or some forms of needlework her services are advisable, especially
to prevent the patient from overdoing and to learn to stop before fatigue is reached. The craftswoman of no matter how great ability usually lacks this ability because she has not been trained in it.

Fatigue is, of course, to be avoided, or we defeat the end for which we are striving. Changes of occupation are often restful so the patient must not be permitted to concentrate too long on one occupation. The time limits for each must be worked out for individual patients. Frequent rest periods of from five minutes to half an hour should be interspaced with those of occupation. These periods to be quite independent of the other rest periods which may be prescribed.

It is hoped that those who have not utilized directed diversion for convalescents will do so because it undoubtedly shortens that trying period by improving the morale of the patient.
EDITORIAL
Wanting Health

Turn which way you will, you see health rules in the breaking. Look into the baby carriages in any park; you will find pacifiers still living up to name. Go to the late movies; you will see toddlers literally propping open their sleepy eyes to catch the last flicker. Loiter before any school; you will see children swapping licks on all-day-suckers. Patronize any soda fountain at noon; you will find it crowded with business girls making hasty luncheons of cake and chocolate soda. Observe any suburb in the morning hours; you will see energetic bond salesmen bolting coffee and toast, preparing to sprint for the 8:15. Spend Sunday at any golf course; you will hear the tired executive with high blood pressure, who has had no exercise all week, planning to plow through thirty-six holes of golf.

What a picture of prevailing health habits! Is it overdrawn? Is the case hopeless? Can anything really be done about it? There seems to be much that we can do if we accept commercial evidence. Propagandists, or “public relations counsellors” if you prefer, seem to be able to make us want to buy many things in the name of health. Is it not possible that we might also be persuaded to do the few really important things that make for health? As a nation we are being persuaded to eat certain brands of food, for health’s sake; we select our underwear for its health-promoting qualities; we buy health-building lamps and apparatus; we even smoke certain cigarettes “for health.” Cannot the health educator go and do likewise?

Why do you buy, let us say, “Bakem’s Better Biscuits”? Half the open page of your newspaper is given over to extolling the virtues of Bakem’s Biscuits. The bill-board screams at you, “Buy Bakem’s Before Breakfast.” A soothing radio program is interrupted only long enough to let you know that you are the guest of Bakem’s. At the corner grocery, the clerk presses upon you a booklet setting forth six reasons why these biscuits are the best. You are only human; you buy Bakem’s.

In all seriousness, the same principles must be applied if we are
to make people want to live the healthy life. To be successful, the health educational program must make use of essentially the same mediums in selling health habits.

The health booklet, poster, newspaper column, radio talk, motion picture exhibit, one and all are effective supplements to the spoken word of the salesman of health, the physician of the health nurse. Note, please the word supplement. The essential agents in health promotion are the physician, both in his private practice and clinic, and the public health nurse in her clinic attendance and home visiting. No health educational program can ever be effective unless it is based upon word-of-mouth advice from sources which the public accepts as authentic.

But word-of-mouth advice is not enough. "It is written" carries conviction today as it has ever since the prophet descended the mountain. A booklet covering the subject of the nurse’s instruction, and left in the home, assumes the authority of law.

In the business world, the salesman’s arguments are supported by both direct and indirect advertising. The same principle applies to health promotion. The physician or nurse teaching health needs, in addition to authentic booklets, the support of indirect health publicity. The newspaper health column, the health bulletin, motion pictures and radio talks, all are of tested supplementary value.

To be effective, health publicity must be continuous, interesting, ever new and timely, as well as authentic. This is the reason why printed information about health will not soon be over-produced no matter how many official, voluntary and commercial health agencies enter the field. Probably no commercial organization has a more direct interest in general health promotion than have life insurance companies. The reasons are obvious. Publications issued by the few life insurance companies that have undertaken health conservation projects run literally into the hundreds of millions, yet the demand for printed information shows no sign of abatement.

Instead, there seems to be a growing demand by official and voluntary agencies for outside help. Requests for leaflets run the gamut of the alphabet from adenoids to zoster. When a nurse asks for a leaflet on strabismus, for instance, and we regret our inability to oblige, the lady exhibits a mild curiosity to know how the subjects of our health publications are chosen.

As more than half of the leaflets issued by the John Hancock
Mutual Life Insurance Company are distributed to its industrial policyholders, it is obvious that they must deal first with the most pressing health problems of the wage-earning population. As long as tuberculosis remains the chief cause of death among this group, that subject cannot well be sidetracked for a booklet on the care of the feet, let us say.

On the other hand, more than 40 per cent. of the health publications are distributed to the general population by health officers, nursing associations and other health and social agencies. Hence, when interests coincide, we prefer to meet the immediate needs of the cooperating health agencies in selecting our subjects. What do they want? It is interesting to note that official health agencies make the greatest use of the leaflets dealing with disease prevention. On the other hand, voluntary health agencies, nursing associations, health leagues and the like, use a much larger proportion of the hygiene booklets—infant, child and adult—than do health officials. This seems to be an indication of the difference in the objectives in official and unofficial health projects, and justifies the Company in producing both types of leaflets.

A city health officer writes, in part, "The leaflet on measles is just what we need, can't we have others on scarlet fever and whooping cough?" We oblige. Then from a director of a nursing association comes a letter along these lines, "Thank you for the sample leaflet on whooping cough. What we need most is a booklet on the preventive treatment for enuresis." Although this subject seems to have limited possibilities as a life-saving measure, the request is recorded as an evidence of what is wanted.

This is the point of the whole matter. The Life Conservation Service of the John Hancock Mutual Life Insurance Company offers aid to health and social agencies in their health educational work. Obviously it welcomes suggestions about needs of the agencies to which it offers this help. There is one qualification; the material produced must be of nation-wide applicability. Aid for purely local projects is not included within the plans of the Life Conservation Service.

All the publications of the Life Conservation Service are prepared only after consultation with health authorities. The more elaborate hygiene booklets appear under the name of an accepted leader in the particular field of hygiene. The briefer leaflets are published anony-
mously. They conform to the qualifications first set down, in that they are interesting, novel, timely, as well as authentic. They are at the disposal of health and social agencies.

RAYMOND S. PATTERSON,
Director Health Education,
John Hancock Life Insurance Company,
Boston, Mass.
NEWS NOTES

Conclusions and Recommendations of Sub-Committee on Medical Social Service

WHITE HOUSE CONFERENCE ON CHILD HEALTH AND PROTECTION

The study of social service in hospitals and dispensaries has shown some excellent work done in a small proportion of the medical institutions of the country. 554 so-called "Social Service Departments" are scattered largely in the northeast, middlewest, and on the southwestern coast and a few in the South.

Children are receiving attention, not only through departments of social service in children's hospitals, but in general and special hospitals to which children are admitted. Medical social service to children is concerned not only with young patients, but with children placed in unfortunate situations by illness of others in the family.

Approximately 2,000 so-called medical social workers are employed in hospitals and dispensaries of the country. Many volunteers are also engaged in various services in these social service departments.

There is an active professional organization, with a membership of 1,700 in the United States and Canada which is divided into twelve geographical district organizations in which a large per cent. of the members are participating. Central and local Study Committees within this organization are concerned with questions of Education, Function, Community Relations, Recording, and Statistics.

In comparison with the opportunities for development we conclude that:

1. There is at present a lack of adequately trained personnel for positions in Medical Social work in this country.

2. There is a pressing demand for more adequately trained workers.

3. Educational Centers for training in medical-social work are now fairly satisfactorily distributed, but need further expansion.

4. There is lack of facilities for carrying on professional educa-
tion especially in the dearth of teachers for faculty positions and supervisors in social service departments where students receive field practice.

5. The true purposes and specific contributions of medical social service to medical practice are not generally understood.

6. The special contribution of social service to hospital administration is not clearly and generally understood.

7. There is much ineffective organization of medical social service in its relation to clinical medical service and to hospital administration.

8. There is much ineffective organization of hospital social service in relation to public health and social welfare resources of the community.

9. Division of responsibility for services between hospital social service and public health nursing in the community is not clear.

10. Cooperation between hospitals and community social agencies is hampered by lack of pertinent medical knowledge and discriminating use of medical facilities on the part of non-medical social workers.

11. Medical social service to children with diseases such as tuberculosis, heart disease, congenital syphilis, and defect of the eye or ear that may lead to physical, social, and educational handicaps, are not having sufficient attention for their social and educational needs because of insufficient social service personnel and community resources.

12. There is failure to appreciate the strategic opportunity for promotion of teaching of good habits based on sound principles of mental hygiene through medical social workers in conjunction with their care of children in hospitals and dispensaries.

13. Methods for meeting the social service problems of patients in the small hospitals, especially those in small and rural communities, are not adequately developed and have not received sufficient attention. The subject is largely one of personnel and organization.

14. Teaching responsibilities for various groups of social workers, student nurses, and medical students have increased without adequate plans for carrying these teaching functions in social service departments.

15. Hospital social workers are not accumulating and pooling their experience to a sufficient extent and in such form that it can be used effectively to contribute to improvement of standards and to pro-
motion of community resources important to child health and protection.

RECOMMENDATIONS

1. That measures be taken to increase the number of adequately prepared medical social workers.

2. That hospital and clinics be encouraged to establish medical social service with due regard for standards of practice and sound organization. The appointment of inadequately prepared social workers as directors of social service departments should be discouraged.

3. Vocational placement bureaus should have more discriminating knowledge of standards and field conditions in medical social service. Placement of untrained personnel in medical social service should be discouraged.

4. Educational opportunities for practicing medical social workers especially in subjects related to child health and protection should be increased.

5. That the needs for social service for patients in small hospitals should be studied and suggestions formulated for meeting these needs. A group to further such a study might well include representatives of a national organization interested in hospital administration, medical practice as applied to rural and small communities, public health nursing, community social welfare and medical social service.

6. That the purposes and activities of the study committee of the American Association of Hospital Social Workers concerned with clarification of function and organization should be encouraged.

7. That the American Association of Hospital Social Workers through its Education Committee, enlist the cooperation of leaders in Medical Education for consideration of the responsibilities placed on Social Service Departments in teaching hospitals for instruction of medical students in the social aspects of clinical medicine.

8. That the American Association of Hospital Social Workers through its Education Committee enlist the cooperation of the League of Nursing Education to study and improve the methods of teaching of student nurses and social aspects of nursing.

9. That medical social workers consider means by which they can promote more discriminating analysis of their accumulated experience to the end that they may contribute to the promotion of community
resources for child welfare and better methods of serving the children under their care.

Ida M. Cannon, Chairman.
Edith M. Baker
N. Antoinette Cannon
Kate McMahon
Mabel Wilson

Sub-Committee on Medical Social Service.

Miss Elizabeth Wisner of Tulane University, New Orleans, was elected President of the American Association of Hospital Social Workers at the annual meeting in Minneapolis.

The State Department of Health of Illinois provided every modern facility for the examination of well babies at the Illinois State Fair held August 22-29. Awards ranging from $2 to $20 each were awarded to 52 children whose health rating excelled.

According to the statistical Bulletin of the Metropolitan Life Insurance Company the death rate among Canadian wage-earners and their dependents runs 9% higher than for the industrial wage-earning population of the United States.

One of the latest developments of the Save the Children Fund work is the establishment of an infant welfare centre at Scutari, in Albania. The infant mortality rate in this district is said to be 400 per 1,000 births.

Belgium has established a national bureau for the care of minor children who have lost the support of the family breadwinner through industrial accident.

During July and August free day classes for unemployed adults or boys and girls over 17 years of age, were held at the East Side Continuation School and the Harlem Continuation School, New York City.

The Presbyterian Hospital, New York City, is equipped with a specially designed penthouse on the roof of the Harkness Pavilion.
which contains two oxygen chambers for the treatment of pneumonia and other respiratory disorders.

Anna D. Wolf, associate professor of nursing and superintendent of nurses at the University of Chicago Clinic, has resigned to take charge of the nursing activities of the New York Hospital's new medical centre, New York City.

The Massachusetts Society for Social Hygiene has announced a contest with a prize of $500 for the best manuscript on the subject of sex hygiene for adolescent boys and girls. Contest closes October 1, 1931.

Dr. Herman N. Bundesen has been reappointed Commissioner of Health of Chicago, a position he so ably filled from 1922 to 1928.

Health conditions for the month of May, 1931, reported by the Metropolitan Life Insurance Company were better than have ever been reported in May in any previous year.

The following health rules were given out with the June report to every public school child in New York City. A similar message will in the future accompany the report cards every month:

Rise early.
Eat a good breakfast—fruit, cereal, egg, toast and milk.
Rest about a quarter of an hour.
Play in the open air and sunshine. Learn to do something well—tennis, baseball, handball, swimming, gardening or carpentry.
Cool off—rest before lunch.
Eat a good luncheon:—vegetables, cream soup, an egg dish, or fish, with bread and butter, milk and a salad. Older children should learn how to prepare such a meal.
Sleep or rest after lunch.
Play in the afternoon sunlight for it aids growth. Wear short sleeves and no stockings. Avoid sunburn, get your coat of tan gradually.
Mid-afternoon refreshments—fruit juice or a cooky and milk.
A bath or swim in the late afternoon.
Then for supper or dinner be sure that in addition to the other dishes that you eat fresh vegetables, a salad, fruit and milk.
Quiet play, reading or an early movie.
A bath, if you have not already bathed during the day.
And early to bed.

French Dressing

In a class by itself is the "French" room at the Anna State Hospital. The management of that institution claims that this room is the only one of its kind in Illinois.

Here it is that every female patient, especially those who are dependent upon the State for clothing, is measured for her dresses. Patterns and materials are selected that will be most becoming. The room is daintily furnished with not even a suggestion of furnishings that are to be found on the wards. In getting her fitting and in the selection of material, the French detail is carried out in every particular, with little touches added here and there. The "French" room is operated for the benefit of every female patient in the hospital. If relatives furnish the material, the dresses are made up in this room to suit the individual tastes of the patients. If a ready made dress is sent from home, it must be fitted in the "French" room in order that all female patients may have the benefit of this personal service.

The same rule is applied to hats. They must be becoming to the individual and in style. If not, they are cut and slashed and re-modeled until they are up-to-date.

The improvement in personal appearance of the customers of the "French" room is noteworthy. The innovation is very popular.—Welfare Bul. Ill. State Dept. of Public Welfare.

BOOK REVIEW


It has been recognized for some time that if psychological and neurological factors were to be properly understood, some type of yardstick would have to be developed in order to provide means of better understanding of underlying causes. Dr. Olson has attempted to work out such a procedure through a study on 558 children in a
Minneapolis elementary school, the children ranging from the kindergarten through the eighth grade groups.

The study has attempted to develop an observational method for the measurement of nervous habits in children, to determine the genesis and incidence of such habits, and to explore the value of certain psychological tests in terms of the observational criterion.

The following are the conclusions reached:

1. There is no relationship between the amount of nervous habits and age.
2. The incidence of nervous habits is significantly greater in girls than in boys.
3. Members of a family will resemble each other more closely with respect to nervous habits than will persons selected at random.
4. Evidence is presented which suggests that association with persons of nervous habits will produce nervous habits.
5. Fatigue during the school day tends to aggravate the manifestations of nervous habits.
6. In general, the underweight child will have more nervous habits than the normal at all ages.

This is an interesting contribution to a subject which invites further and more extended study.

JACOB A. GOLDBERG, Ph.D.

ABSTRACTS


This clinic is the outgrowth of a small medical department which the Stock Exchange has maintained for several years. The clinic covers 10,000 square feet of floor space and consists of two 4-bed wards, one for men, the other for women, dressing rooms, etc., and a modern operating room where minor operations may be performed. There is an X-ray department with every facility for diagnosis and treatment, a physical-therapy department, including ultra-violet rays and infra-red lights and diathermy apparatus. Although the department is intended primarily for the employees of the Exchange, it also protects the health of the Exchange members and in an emergency treats outside patients. Every applicant for a position must
submit to a physical examination in the clinic. Thus the physically unfit are eliminated. By raising health standards the days of absence due to illness are greatly reduced and the general working efficiency of employees is increased. Industry estimates the usual sickness absence to be approximately 8 or 9 days per individual. The average length of illness among the 2,400 odd employees, not including telephone clerks, was 3.35 days and the average number of days of absence for all employees was 2.96 days each. Although not fully organized in 1930 the department gave more than 33,464 treatments and examinations. Records show that in 1929 10,574 days were lost to the Exchange through illness. Last year the number of days lost dropped to 7,461, a saving of more than 3,000 days. No expense has been spared in making the medical department complete, efficient and convenient. The staff consists of a medical director, 2 full-time physicians, 2 half-time physicians, an ear specialist in attendance 3 afternoons a week, an eye specialist in attendance 2 afternoons a week, a dentist on call at all times, as well as laboratory technician, a physical therapy technician, a roentgenologist and a dental hygienist, head nurse and staff of 8 nurses. On the consulting staff are well-known doctors to whom are referred patients in need of their care. The Exchange pays these specialists. The clinic which has created a wide interest in industrial circles may well serve as a model and will no doubt inspire other industrial concerns to go and do likewise. Quite apart from the altruistic motives behind the venture the Exchange is reaping its reward of thousands of dollars saved annually.


Hospitals should recognize the value of a library for patients as a form of therapy. Books can and do assist the patient in adjusting himself to his new environment and provide the proper psychological effects. The librarian must know books and incidently she should be trained in psychology. Unless the librarian has received a medical training she will need the cooperation of the medical and nursing staff in the selection of books for the different types of patients. The importance of this assistance is apparent when we consider the fact that practically everyone has certain fears and aversions which are apt to become abnormal phobias when one is ill. A patient who is to be operated upon certainly will not be in a serene state of mind if the
Abstracts

night before he has read a portrayal of an operating room or a deathbed scene. The authors are thoroughly familiar with the type of books being published today and sound a warning against volunteers and haphazard methods of catering to the sick person’s mind. A trained worker, one whose suitability has been proven, is the only person capable of doing a good piece of work.


According to this interesting article palmistry is a valuable adjuvant to preventive medicine and the author, who is a medical man, thinks it entirely possible that in time life insurance companies will come to use the science of palmistry as a guide in determining risks. Quite apart from the shape of hand, lines, mounts, etc., which are of interest to the average person as a means of determining character, tendencies, etc., many constitutional diseases are shown to exist by the shape of fingers, condition of skin and nails. The theory is well supported and the text is interspersed by charts with explanatory notes.


Physicians and social workers have for years advocated and worked for adequate care for hospital patients. Much has been accomplished but there is still a glaring need for more and better convalescent homes. It is gratifying to find a nurse take up the cudgel in defence of the patient, who certainly is not treated fairly if discharged from hospital before complete recovery. Everyone agrees that a hospital ward is not the place for a patient recovering from acute illness, some other provision whether it be convalescent home or ward should be made for him until he is fully restored to health. The author keeps this welfare of the patient uppermost in mind in discussing the qualifications of persons who care for convalescents and the various methods of giving convalescent care. The citation of two very interesting cases proves beyond a doubt that convalescent care pays long dividends. This article is full of interest and is a challenge to the nursing profession to unite in personal and community effort to make complete restoration to health through convalescent care, an assured fact for every hospital patient.