ILLEGITIMACY AS A MEDICAL SOCIAL PROBLEM
STUDY OF 176 CASES

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This study has been attempted for the purpose of showing how
large is this problem for a medical social service department, and
also by citing certain cases to explain something of the types of
treatment followed.

Because of the opportunity of the medical social worker to have
initial contact with the patient at perhaps the most crucial period in
her life, the hospital social service department is to be regarded as a
very important agency in relation to the illegitimacy problem. How­
ever, we must not lose sight of the fact that the medical social service
department faces certain limitations, and can be a specialized agency
for case work adjustments only in so far as health is concerned. The
principal reasons for these limitations are twofold:—First, that the
problem of unmarried maternity involves so much and is itself really
a lifetime problem; and second, because of the bulk of the work and
the rapid turnover, the medical social service department is not able
to carry such cases to their ultimate termination.

For this study we have considered 176 cases of illegitimate preg­
nancy, covering a period of one year beginning April 1, 1930. This
total includes both those patients who registered in the maternity
dispensary and also those who were admitted to the maternity ward
as “emergencies.” During this period, a few cases of “septic” emer­
gency cases were admitted to the hospital (those cases in which the
pregnancy was complicated by some type of infection), however,
these are not included in the study.

Of these 176 cases there are several in which the patient first
registered as a married woman, but after we found no verification of
her marriage on the date given, questioned the patient and learned
that she was unmarried. May it be understood here that in all cases
registered an attempt is made to verify the marriage. Also, may we make clear, before proceeding further, that no cases of "common-law" marriage, as the term is understood according to the Pennsylvania statutes, are included in this study.

Both colored and white patients were considered and of the 176 cases there were 117 colored and 59 white patients. In other words, a two to one ratio. During this same period, the total number of deliveries in the hospital maternity ward was 844, of which 404 were cases of colored, and 440 were cases of white patients. So, in comparing these two sets of figures, we find that slightly over 28 per cent. of all colored patients and 13.3 per cent. of the white patients were illegitimately pregnant. Before proceeding with the social situation regarding these patients, we should consider something of the medical side of our problem.

Of great importance to a medical social worker, it seems, in studying a group of cases of this sort, is a consideration of the question of early registration of patients. Do these girls wait until very late in their pregnancies to seek medical care, or do they register at about the same time as the married pregnant woman?

A study of Text Fig. I reveals some interesting facts. First, that these illegitimately pregnant women tend to register between the sixth and seventh months, which is the average time of registration for all patients in this maternity clinic; and second, that of the emergency cases on the ward, none were cases of colored patients. Of the 20 colored and 10 white patients registered during or previous to the fourth month, we found that 10 of the former and 5 of the latter were patients referred to the hospital by the Municipal Court.

Many other girls did not tell their parents of their condition until it became absolutely necessary, and of the five white patients who were admitted to the Maternity Ward as emergency cases that had received no prenatal care, one was an Irish woman with no relatives or friends in the United States, who had been employed as a domestic in a private home up until one week before her admission to the hospital, feeling that since she had no one on whom she might depend for support she must work as long as possible. Two were young girls whose parents stated they had been entirely unaware of their daughters' condition and who, when in active labor, were rushed into the hospital by private physicians. One was a non-resident orphan who was forced to work very hard for an extremely ignorant foster-sister, who apparently felt that prenatal care was unnecessary
Registration of patients by months

Number of patients

Colored patients (Total no. 117)

White (59)

Month 1 2 3 4 5 6 7 8 9

Text figure 1

Emergency on ward
inasmuch as she herself had received none before the birth of any of her own eleven children. And the fifth was that of a very intelligent girl of foreign-born parentage, whose home was in a mining town of Pennsylvania. Her parents and friends, it was later discovered, had thought she was married, so to save them from disgrace and to protect her own reputation, she left home, seeking a large city hospital where she felt that she might "veil" her identity, especially since she had taken the precaution to change her name and present a story which on the face of it sounded perfectly plausible.

There were remarkably few patients who had venereal diseases. Six colored but only one white patient had syphilis, while one patient, a colored girl, had gonorrhea. During the same period and considering the 844 cases of married and single patients previously mentioned, there were 35 colored and 11 white patients with syphilis, while only 2 colored and 1 white patient had gonorrhea.

Of the 117 colored patients 25 had been pregnant on previous occasions. For 19 of these it was the second pregnancy; for 5 it was the third; and for 1, the ninth pregnancy. (This last patient was a middle-aged widow whose husband had been dead about eight years.)

Of the 59 white patients, 7 were pregnant for the second, and 1 for the third time.

We have been able to obtain delivery data on nearly all of our patients but for a few cases, either because the patient moved and we were absolutely unable to trace her, or because an out-of-town agency, to whom the case might have been referred, did not forward to us such data, we do not have such information at hand. There were five such cases among the colored, and two among the white patients. For the remaining 112 colored patients, there were 104 normal living infants (including 3 sets of twins); 3 forceps deliveries (full time living infants); 3 stillborn births; 1 premature living infant; 1 abortion; and 3 miscarriages. Two of the colored, normal, living infants died during the first two weeks, 1 of pneumonia and the other of cerebral hemorrhage. For the white patients we have, we believe, an equally good record:—52 normal, living infants; 1 abortion; 1 miscarriage; 2 stillborn infants; and 1 premature, living infant (who died within five days of acute syphilis). Only one maternal death occurred; the case of an extremely young colored girl of whose promiscuity we had definite proof and for whom gonorrhea was given as the cause of death.
In a study of this sort one of the first things one wishes to discover is the average or "mean" age of the persons concerned, and also to arrive at definite conclusions regarding the comparative number of persons in certain age groups. After studying the figures for the ages of the colored and white patients we discovered that the average age was identical for these two racial groups (19.07 years). This may surprise many, but after further delving into the reasons for this we realized that a great many of the colored patients were not pregnant for the first time when the study was made, hence their ages would tend to make the average age for the other colored patients higher. In Text Fig. II is shown the age distribution according to age groupings of our patients, and their paramours.

It will be noted that the greatest number of patients, colored and white, were under 21, an almost equal number being divided between the first and second age groups; while the greatest number of men were in the second and third age groups, between 18 and 24 years of age. In the case of the paramours, the average differed only .01 year for the two groups (23.02 for the colored, and 23.03 for the white men).

The question of marital status will merely be touched upon, for the vast majority of the patients had never been married. Only one white patient had been married, and she had never lived with her husband. There were two colored widows, one of whom has been mentioned elsewhere, and two whose husbands had deserted.

One question which may well be asked is:—How did you get these cases? and who referred them? One very important source of refer is the Municipal Court of Philadelphia, for, of the patients here dealt with, 26 colored and 30 white girls were referred for prenatal and hospital care by this organization. Many, too, were referred by the Family Society, the Bureau of Education, and the Travelers’ Aid Society, and by agencies for the unmarried mother. A large proportion, especially the colored patients, came without a refer, but had heard of the hospital through "friends." Also, a few non-residents apparently sought a "refuge" here and thought they could come into the hospital and leave again without anyone learning who they were or from whence they had come.

A glimpse into the type families of which our patients were a part reveals that a large number were being helped by various medical and social relief agencies at the time they registered with us. Thirty-four colored and 35 white patients were so known. This, however,
Age distribution

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Colored</th>
<th>White</th>
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<tbody>
<tr>
<td>Under 18</td>
<td>45</td>
<td>20</td>
</tr>
<tr>
<td>18-21</td>
<td>42</td>
<td>21</td>
</tr>
<tr>
<td>21-24</td>
<td>22</td>
<td>11</td>
</tr>
<tr>
<td>24-27</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>27-30</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Over 30</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Unknown</td>
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</tr>
</tbody>
</table>

Totals for each group

- Colored patients
- Paramours of colored patients
- White

TEXT FIGURE II
does not include cases known only to the agency referring the case to us.

All but 7 of our patients were born in the United States, though the parents of a large number were foreign-born. All the colored patients were native-born, but among the white girls we had 2 natives of Italy, 3 of Ireland, 1 of Scotland, and 1 of France.

In the group of girls and women studied there were 9 colored and 9 white non-resident patients, each of whom presented a distinct problem. The remainder were from various sections of Philadelphia, although the majority of the colored patients came from the northern part of the city, from predominantly Negro neighborhoods. Just as it is the tendency of certain nationalities to gather together in one neighborhood, so we found that, for instance, our patients of Polish families usually came from the Kensington and Richmond sections of the city, where are located some of our city’s largest hosiery, cotton and woolen mills; while the Italian patients in almost every case came from South Philadelphia.

They came from every type of home and neighborhood, ranging from very good to very poor. It is to be noted, however, that a rather large percentage of our patients were not living with either of their parents, but were staying with friends, relatives, or simply “rooming.” The exact figures follow: 44 colored—or about 30 per cent., and 25 white patients—or about 40 per cent. Of these there were 6 colored and 10 white orphans and “half orphans.” (Of the 176 cases considered in the study, the total for orphans and “half orphans,” where the remaining parent had not remarried, was 32,—the number being equally divided between the colored and white patients.) Also, 11 colored and 4 white girls were the products of “broken” homes, where the father had deserted, where parents were separated, or homes where there was a step-parent.

Nine colored and 2 white patients were found to be illegitimate children themselves, while several had sisters who already had one or more illegitimate children. One of these white patients had three younger sisters, all of whom were illegitimate. It was rather interesting to see just what grade most of these girls had reached in school and again we were surprised to find that the average or “arithmetical mean” grade for the white patients was only slightly higher than for the colored. 7.08 to 7.01, or perhaps more nearly an average of 7B and 7A for the white and colored girls respectively. We did find, however, that although the lowest
TEXT FIGURE III

Employment classification of patients

<table>
<thead>
<tr>
<th>Type of Work</th>
<th>Total No. of Patients</th>
<th>Colored Patients</th>
<th>White</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic and personal service</td>
<td>101</td>
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<tr>
<td>Clerical</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>School</td>
<td>24</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stores-shops</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mills and factories</td>
<td>33</td>
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<td></td>
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<tr>
<td>Farms</td>
<td>2</td>
<td></td>
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</tr>
<tr>
<td>Public service</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In the home</td>
<td>2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Illegitimacy
grade for any colored patient was the fourth, the same for the white patients was the fifth grade. Several in each group had attended high schools; 3 colored girls had graduated from normal schools, while 1 white patient, who had graduated from high school, was a nurse in training, while another held a Master’s Degree from a large university in the South! Only one patient, an Irish girl, had never attended school, and could neither read nor write.

On the whole, these patients appeared to have average intelligence, although a few cases, to be sure, were below normal,—as the court and hospital mental examinations pointed out.

To show just what these patients were doing up until the time of pregnancy we have used the accompanying graph of “Occupational Distribution.” Text Fig. III.

It is not at all unusual, we think, to find so great a number of the colored patients engaged in domestic and personal service; but we do feel that the statistics of colored girls still attending school, and of white patients engaged in factory or mill work, are certainly significant. Three of the four colored patients previously engaged in professional work were teachers, and one of the white patients in this branch of work had been a librarian, and earned a very substantial salary.

Among the patients gainfully employed before they became pregnant we found a wide range in wages. The average for the white patients was $15.06, while for the colored it was about $9 per week. It must be remembered, however, that these cases were studied at a time previous to the recent severe unemployment crisis and, therefore, these same girls were earning a great deal more than they would be able to earn today. Although some might still be working part-time under present conditions, it is estimated that a larger number would be unemployed. The range in wage for the colored patients was from $2 to $18 per week, while for the white patients, it was from $5 to $40.

Entirely accurate statistics were difficult to obtain regarding the length of time our patients had known the men responsible for their condition, because the patients thought only in terms of “about so long”; however, we estimated from available figures that the average here for the white patients was 22 months, or a little less than two years’ time, while for the colored patient the average was slightly under 20 months.

In the matter of religion, we learned that 113 of our colored pa-
tients were Protestant, while the remaining 4 were Roman Catholic. Of our white patients, 2 were Jewish; 27 (or 49%) were Catholic, and 30 (or about 50%) belonged to some Protestant faith.

At this point, we think, something should be mentioned regarding those cases where there was a difference in the religion of the man and woman, for certainly this one factor alone might have loomed large as a cause of the illegitimate pregnancy. There were 5 such among the colored, and 8 among the white patients. We know definitely that in the latter group especially this difference was one of the main reasons for the illegitimacy. Parents of the girls were not willing, in some cases, to allow their daughters to marry "outside their own religion," while in others, the families of the men involved objected to such a marriage. In two such cases, one a Catholic patient and a Protestant man, and the other, where the girl was a Jewess and the man a Protestant, the couples were afterward married; the latter, before the birth of the baby.

Although we do not feel that there was a large percentage of married men involved in these cases of illegitimate pregnancy, it must be mentioned that the paramours of 7 colored and 10 white patients were already married.

A most distressing and indeed alarming problem follows: that of miscegenation. Although we had very few such cases, we feel that because of the grave social problems involved they should not be omitted. One fifteen-year-old white patient had become pregnant by a colored man (rape), while three colored patients were involved with white men. In two of these cases the men were found guilty, while in the following case the man, of some social prominence, was acquitted! This last case was that of an attractive fifteen-year-old colored girl, referred for prenatal care by the Municipal Court. She was the second of four children, ranging in age from nine to seventeen years. Her father was unemployed and although her mother had intermittent "day's work," the family was receiving relief during our contact. The patient had been employed as nursemaid in the home of the white man she named as the father of her baby. After contact with the court and the relief agency for information regarding the family, the case was referred for supervision to an agency for unmarried mothers in Philadelphia. Inasmuch as the man was freed, no order for support of the child was made. However, the patient is now at home with her baby, while supervision is being continued by the agency.
As far as we were able to ascertain, there were in this group of 176 patients no cases of "incest," as the term is understood according to the laws of Pennsylvania. However, there was one case of rape, that would in several states be considered incest, depending on their laws involving the marriage of relatives; the case of a fourteen-year-old colored girl whose step-father was the father of her baby, and who was referred for immediate maternity home care upon discovering that home conditions were intolerable and that the child herself lived in mortal fear of the man with whom she constantly had contact as long as she remained at home.

Enough, for the present, of the general social and environmental background of the patients considered in the study. However, before proceeding to a discussion of treatment, let us examine for a moment some of the factors underlying these cases of illegitimate pregnancy. Personally, we do not feel that there is one distinct causative factor for each individual case, but rather, that a few or perhaps several of the following causes play their part.

Many people feel that girls who become pregnant before marriage are "over-sexed" and there has been a tremendous amount of writing on the subject. However, the writer is of the opinion that a far larger number of these girls are ignorant of sex. Except in unusual cases, where the patient is simply unmoral and "does not care," few are second "offenders." Many times a girl has longed for admiration, has wanted a "beau"; a man, usually older than she, pays attention to her and the illicit relations which follow result in her pregnancy. Some few girls, too, who desired "pretty clothes" and were not earning enough to buy these themselves, were really led into irregular sex relationships by promises of money, most of which, however, never materialized. Other girls, especially those of foreign-born parents, who were "held down" at home and had never been allowed to entertain friends there, began working in factories, mills, et cetera. Then they met someone who was willing to take them to dances and parties and show them a "good time." And the girls who, in nearly every case, were very young could not resist the temptation to rush headlong into a relationship which was sure to lead to disaster.

Sometimes there has been genuine affection on the part of the men and women involved, and these usually marry, unless, as has been previously mentioned, there is a difference in religion, a difficulty which must be surmounted in some way before marriage can
Illegitimacy

take place. Many patients are the products of broken homes, or have parents, one or both of whom are degenerates, social or mentally (in several cases known to us the parents were in penitentiaries, or in various institutions for the insane). Others, with one or the other parent deceased, had been living in rooming-houses or with friends, where there was little or no supervision. They met people who proved to be bad companions, but unfortunately had no one to advise nor guide them. Mere propinquity is a tremendously important factor, especially in cases where the patients either do not live with their parents, or have parents who have no standards.

The writer feels that, while it is impossible to discuss any one method of treatment which will be adequate for each and every case of illegitimate pregnancy, there are certain general types of cases for each one of which the same, or nearly the same, social treatment will be followed. These fall, perhaps, into the groupings below.

I. Emergencies on the Ward:
   1. Resident patient—referred by an agency.
   2. Non-resident patient—referred by an agency.
   3. Resident patient—not referred by an agency.
   4. Non-resident—not referred by an agency.

II. Dispensary Cases:
   (With the same sub-headings).

First, let us consider a few of the emergency cases which, though few in number so far as this study is concerned, are surely important as problems, and, perhaps especially so because the social worker in a case of this sort is forced to utilize all possible resources to the best advantage,—owing to the fact that she has only about two weeks in which to work out a plan of treatment for the patient.

The cases of two “emergency” patients (both of whom were sent to the hospital by private physicians) follow:—as well as a resumé of the treatment given.

One, a German-American Catholic of 28 years, who first claimed to be a married woman whose husband had deserted, later admitted the truth, and appeared dreadfully upset because her father had said she could never return home with her baby. The patient had been working in a bakery earning $14 weekly, but said she had always given her entire earnings to her parents. She, therefore, had no money and no plan for herself and baby. The family was not known to any social agency and a visit was made to the home of the girl’s parents. The house was located in an exceptionally good neighbor-
hood and was itself in good condition. Inside it belied that characteristic of a German housewife, an immaculate home. The family owned its home, to the support and upkeep of which each member contributed. The mother seemed very sorry for her daughter, but knew her husband had "meant what he said." She felt, however, that later on he might allow her to return home with her baby. The case was referred to an agency caring for unmarried mothers to which the girl and her baby were discharged from the hospital. (We later learned that certain adjustments were made in the household and both the girl and baby accepted as members).

Another case, also under the third sub-heading of Type I, is that of an 18-year-old, Catholic girl, who had become pregnant by a man she met on a "moonlight," whose name she did not know, and whom she never saw again, she said. Her mother and aunt came to the hospital one day following delivery, requesting to take the girl and the baby home immediately. To hide the "disgrace" from the people in the neighborhood where she had lived for twenty-eight years, the mother had laid all sorts of plans for "adopting" the baby as her own, inasmuch as neighbors, she said, had thought she was pregnant, while no one (not even members of the family) had known of the daughter's condition. Although all sorts of arguments were brought forth to dissuade them in this plan to have the baby adopted by the girl's mother and step-father, and attempts were made to point out the great dangers which might arise later in the child's life if at that time the question of parentage were discovered, nothing could force the mother to change her mind. Maternity home care for the girl was discussed, but absolutely refused. After the impossibility of removing a baby from the hospital one day after birth and the effect of such a procedure in the health of both mother and baby were explained to the girl's mother, she was apparently satisfied to comply with regulations, though meanwhile plotting with her sister as to how they might arrange for the imaginary "birth" of the child (as that of the girl's mother) even at the end of the fourteen-day hospital period.

No agencies were at this time active on the family, but both the Society to Protect Children from Cruelty and the Mothers' Assistance Fund had known the family for several years before the girl's mother remarried.

Patient was interviewed and wanted to do whatever her mother had planned, for she said she wanted to "save the reputation of herself and family." The step-father, who was also interviewed, said he
was quite willing to assume all responsibility for her baby’s care and insisted that the main reason for his abhorrence of the idea of having the baby placed in an institution was the result of his own boyhood, most of which had been spent in an orphanage; and placement of the baby would inevitably follow, he said, unless the plan to have the baby adopted by his wife and himself, could be “carried out.” He seemed to realize all the hazards attendant upon the plan which he and his wife were ready to put into operation, but was willing to take these risks.

The parish priest gave a great deal of information on the parents of the girl, both of whom he had known for many years and whom he felt had been absolutely sincere in their request to remove the baby from the hospital when one day old. (The step-father, who was employed as janitor in the parish house, had already been to see the priest and explained their plan). The day following the discharge of patient and baby from the hospital the worker visited the home and was highly amused to find the girl’s mother in bed with the two weeks old baby beside her, and the real mother in hiding on the third floor where she was to remain for several days, but supposedly was in another Philadelphia hospital, undergoing an operation for appendicitis!

The case was referred to the Catholic Children’s Bureau for Social supervision and also for medical follow-up for the baby who had a slight discharge from the eyes (a smear of the left eye had been suspicious while the baby was in the hospital). Baby was brought into clinic regularly by the “adopted” mother and after four treatments the eye condition cleared up and smears were negative. The Catholic Children’s Bureau agreed to continue close supervision until the baby was one year old and we closed our case.

The non-resident orphan, who was living in the home of a foster-sister and of whom some mention has already been made in another connection, was a Protestant of eighteen years. She had lived with foster parents from her infancy until their death about two years ago, at which time the foster-sister gave her a home. From the girl’s own story it was gathered that her life always had been unhappy and she had been forced to work very hard in a textile mill. Her wages were fairly good, but she had always turned these over to her “sister.” The girl seemed to feel badly because she was losing time at the mill while in the hospital and her plan was, therefore, to return to work immediately upon leaving the hospital. In the town
from which this patient had come there was no agency able to make an investigation, but the place was not far from Philadelphia and the medical social worker found it possible to do this herself. The family physician, who had referred the girl to the hospital, was contacted and we found that the entire "foster" family was shiftless and of low grade. The girl had been allowed a great deal of freedom; was known to be promiscuous; and had no idea who was the father of her baby. (Her Wassermann was negative).

Interviews were held with the local Red Cross worker, whose contact with the family had extended over a period of several years, and with the "Welfare" worker in the mill, who also knew the family and who threw quite some light on the type girl with whom we were dealing, as well. The home conditions were investigated and found to be extremely bad. Fifteen people were living in a five-room shack which was beyond repair. The foster-sister positively refused to have the girl return there because it meant "another mouth to feed." Patient was, therefore, referred to a social organization in Philadelphia dealing with cases of girls and women belonging to the same denomination as that of the patient and, through them, was sent to a maternity home with her baby.

Many very interesting dispensary cases fall into the first heading. The greatest percentage of these, however, were those referred by the Municipal Court with which we merely did a cooperative service. Other court cases, requiring certain special investigation and further treatment, were referred to various social case working agencies, either for maternity home care or more adequate supervision.

Several cases, under this and also the other three groupings, where we felt it necessary were referred to Neurological and Psychiatric Clinics for examinations and recommendations.

One patient, a sixteen-year-old Catholic girl of Irish-American parentage, was referred by the Municipal Court for care during her second illegitimate pregnancy. Three years previously the girl's brother-in-law had had illicit relations with her and was the father of a child born shortly after she had reached the age of thirteen. This child was living with its mother and her family in a household consisting of four adults and four children, the parents and brothers of our patient. The girl had a neurological examination at the court and was classed as a middle-grade moron, particularly lacking in judgment and reasoning ability; a person of childish reaction, who was
"not capable of making a good social adjustment without better oversight and guidance." Eleven medical and social agencies had known the patient and her family at various times since 1905, but at the time of contact only one relief agency and one specialized hospital were active on the case, while a Catholic organization which was doing nothing at the time in the way of supervision, had kept their case "open." The agencies, all of which were contacted, agreed to the worthlessness and the low calibre of the family, and to the apparent hopelessness of the situation. Home conditions were bad; the father, who did not work, had chronic pulmonary tuberculosis; but did not attend any chest clinic regularly; the mother, who was the "bread-winner," worked every night as an office cleaner; a 29-year-old brother of the patient had tried to induce her to have illicit relations with him; the girl was in constant fear of her brother and had had almost no supervision in the home.

In view of the previous court examination and the prevailing social conditions in the home, it was arranged that the girl have a psychiatric examination at the court, with the hope that some recommendation be made then for the girl's permanent placement in a state institution. This examination showed patient to have a mental age of eight years, nine months, and an I.Q. of 54, but no recommendation for institutional care was made.

Also, because of her father's condition, we arranged to have patient examined by the physician at the City Chest Clinic, who found her negative to pathology, but planned to follow the case until six months following the termination of pregnancy.

After discharge from the hospital patient and her baby were sent away for a short period of convalescent care at the physician's request, during which time we arranged for the temporary placement of her three-year-old daughter.

A few weeks later patient returned to clinic to advise us that she had married the baby's father, who had bought enough furniture for a small house and had made everything ready for her while she had been at the convalescent home. (The marriage was verified). Patient seemed very happy and showed genuine enthusiasm over having a home of her own. Another day, she brought her husband in to meet the worker, who really felt that the man was an intelligent, well-meaning sort who undoubtedly would be a great improvement (mentally) on the patient, and would be able and willing to provide adequately for his wife and the two children. After an obstetrical
examination, which takes place routinely six weeks after delivery, and a visit to the patient's new home, case was closed to the court, which remains active on these cases for six months even when the patient marries, and also the Catholic agency whose case was to remain open indefinitely.

Another court-referred case, one in which the social worker had quite a big "job" in the way of influencing the patient to do what was considered best for her, was that of a very attractive nineteen-year-old Protestant girl who had run away from home and lived for about one year with a sailor who was separated from his wife. He had told the girl that he was getting a divorce and various other tales all of which the patient evidently believed. The man seemed to have some mysterious influence over the girl, and even after the two had been discovered living together and the girl returned to her father and step-mother, in the Custody of the Morals Court, she still made attempts to see him and had taken all kinds of risks in doing so. The girl had not been entirely happy in her home, since the family learned of her condition. The step-mother felt indignant that she should have "shamed" everyone so dreadfully, and said that the girl must now decide between this man and her father and home. If she would not give him up, the step-mother and father would not accept her nor her baby in the home. Maternity home care was impossible as the girl, who had syphilis, was in a highly infectious condition.

Investigations of the home were made and we found one very much above the average; one in which the girl would have the supervision she needed. The step-mother was not unkind to the girl and it seemed that trouble between them had never arisen until after she had met this sailor. Information regarding the paramour was rather difficult to obtain, but we knew definitely of his absolute insincerity and promiscuity, and also that he had infected the girl.

When the girl first came on the ward, she seemed undecided as to just what she ought to do. She said she "thought" she loved the man, and yet we did not feel that she trusted him absolutely. We tried to make her realize that she should give him up and return to her father's home. The man was not working, and although he painted "beautiful pictures" to her, had really nothing to offer her and her baby. The patient finally promised to give up the man and return home. When the baby, which had been premature, was five days old it died of acute syphilis. From that day, the girl saw no more of the man, nor did he try to get in touch with her. The girl
felt bitter toward him, but she was deeply hurt and greatly surprised. However, she felt that everything had turned out for the best. After patient felt strong enough, she returned to her old position, which had been held open. Arrangements were made for patient to continue her antiluetic treatments at a special night-clinic, and the patient seemed happy in the home where apparently she had been once more cordially received. Our case was closed to the Municipal Court, who were to continue supervision until the girl reaches twenty-one years of age.

An extremely worthwhile case was that of a sixteen-year-old Italian, non-resident patient, who had been in this country only about eight years. She had left her home in a mining town of Pennsylvania to go to Wildwood, New Jersey, where she had lived with a man much older than herself for several months. She learned that he was married and had several children, but after she had approached him on this subject he deserted her. A friend brought her to Philadelphia and referred her to the hospital. This older woman could not keep the girl always, but was perfectly willing to do so until some plan could be worked out. The girl herself was sullen and appeared not to care what happened. She seemed dazed and, by the man’s desertion at a time when she was pregnant, was left entirely alone and without funds. The child felt so badly that she stated she “wanted to die.” She said she could not return to her parents for they had understood that she was already married. The case was not known to any Philadelphia agencies and although it was referred to two, neither accepted it. The worker had an investigation of the girl’s home made by an agency in a town near where her parents lived. At their suggestion we referred the case to the State Department of Justice, inasmuch as the man was wanted on several charges and the information we had might lead to his arrest. He was known to be a chronic deserter and had made a practice of taking young girls away from home and later leaving them penniless. Patient was referred to a Catholic maternity hospital and home, where she was delivered and was to remain for several months. We later learned that the man had been captured in New York City and was now in a Pennsylvania prison.

Several cases, besides those referred by the Municipal Court, were handled cooperatively with social agencies such as the Traveler’s Aid Society, Board of Education, Department of Public Welfare, and with family relief organizations who were actually doing
social case work. Others, where a foreign-born patient or parent were involved were referred to the International Institute of the Young Women's Christian Association for investigation. Often parish priests and ministers, who were contacted, threw a great deal of light on the home situations and were able to help us in making a definite plan for the patient.

Paramours were interviewed whenever possible, but not with the idea of trying to influence them regarding marriage. The worker feels that this should not be encouraged unless it is prompted by love and confidence, rather than by a mere effort to give the child a name. In several cases, however, the man had some plan for the girl, and if he did not have one of his own already worked out, was often able, and willing to assist the medical social worker in evolving one.

Four colored and six white patients considered in our study married the men responsible before their babies were born; 3 colored and 2 white married them afterwards, but before we closed our cases; while 2 white patients married men other than the paramours, during their pregnancy.

A total of 15 colored and 28 white patients were referred to agencies caring for unmarried mothers either for maternity home care or supervision while remaining in their own homes. Only a few refused maternity home care and of these (4 colored and 1 white), all returned to their parents or relatives.

A great many families were referred to relief agencies during our contact and in many cases other members of the family requiring medical care, or the aid of some specialized social agency, were so referred. In a limited number of cases arrangements were made by the medical social worker for placement of any older children during the mother's confinement.

In no case did we make the actual arrangements for the legal adoption of a baby. In one case, however, where the mother, a young colored girl, died of a severe gonorrheal infection while in the hospital, and the patient's aunt was anxious to adopt and care for the baby, case was referred to the proper agency. Two cases of adoption appear in the study of white patients;—one, that of the "twice born" baby, discussed elsewhere in this study, and the following,—a case of a nineteen-year-old Protestant girl whose father refused to have her remain in the home when he learned of her pregnancy. Case was referred and patient accepted for immediate
care by a maternity home. She did not like the restrictions here, however, and as she had always done just what she pleased when at home, and had never worked steadily, disliked the discipline. She caused some confusion at the maternity home and finally, when relatives came for her, she left. We had not been advised of this at the time, but later learned, through the girl's mother, that she was living in New Jersey with a cousin. Her baby had been born at the cousin's home, and the girl had been delivered by a midwife.

As patient was out of the state, she was reported as a dependent non-resident to the Department of Welfare in the city in which her cousin was living, and at the same time case was referred for investigation and further treatment to a social case working agency in New Jersey. The investigation was made and we were advised that legal proceedings had already been begun by the cousin, who was married and had no children, to adopt the baby as her own. This arrangement had been most agreeable to the patient, it was revealed, for she was anxious to be free of the added responsibility. She seemed to have no affection for the child, and would be very glad, she said, when she did not have to remain longer at her cousin's to nurse the baby. Through this agency arrangements were made for the baby to be examined in a nearby hospital clinic where it would be followed medically for a year; furthermore, they agreed to accept full responsibility for the case.

Thus we get some idea of the problems involved in illegitimacy in this hospital; first, by a numerical survey, then by discussion of the social situation of the patients, and finally, by resumé of several cases, each of which has been given to show the type of treatment used, as well as the role of the medical social worker in her relation to the problem.
With the large Negro population who are unable to employ physicians, and the many isolated mountain sections where doctors cannot reach the white mothers, midwives, who attend about one-third of all confinement cases in the State, seem a necessity for the present.

Until 1918 there had been no attempt to control or supervise midwives, and there were 9,500 practicing in the State. In that year a bill was passed by the Legislature placing them under the supervision of the State Registrar and requiring them to register, report births within ten days, and put a solution of nitrate of silver into each baby's eyes at birth.

With funds made available by the acceptance of the Sheppard-Towner Bill in 1922, the State started education work with the 6,500 midwives then in the State and a Director was put in charge. The Director grouped the counties according to the number of midwives in them, and started classes in those having one hundred or more midwives. Once a month she sent out letters calling the midwives together at central points in each county in the Black Belt. The instruction was very simple, including Prenatal Care, Preparation for Confinement, Course of Labor, and Postnatal Care. Special emphasis was laid on cleanliness and the importance of having urinalysis done. The Public Health Nurses gave the classes in counties so fortunate as to have them.

It is hard to describe the women who attended those first classes held in the section known as the Black Belt. They have been described as “ignorant, superstitious and dirty,” and while this was true of a large number, there were many exceptions. Most of them had been “called by the Lord” to do this work, and they “must be doing it right because in a vision he had shown them the way.”
Quintilla Parker, a happily married young woman with no cares beyond the usual household ones, declared that she had had a vision one night in which the Lord called her to be a midwife. This strenuous life did not appeal to Quintilla, so she not only kept this dream a dark secret, but tried hard to put it out of her own mind. Finally, one day while washing the clothes, a hand holding a fiery sword appeared between her and the suds, and a voice said in her ear, "Quintilla, why ain't you obeyed de call?" She knew her time had come, but happiness had also arrived. She left the clothes to wash themselves, and leaping in the air, tearing her clothes, she screamed "I am so happy, I am so happy!" Husband, neighbors, and friends all rushed upon the scene to find that Quintilla in the twinkling of an eye had become a full-fledged midwife. This is a fair example of the prevailing superstitious mind of the people.

The midwives as a rule were anxious to attend the classes and were in earnest about trying to learn. In an opening prayer Aunt Kizzie Griffin said, "O Lord come down here and help us wid dis here work, and O Lord, please don't look upon us jes as a side show!"

Of course they had never heard of Prenatal Care and neither had their patients, so they were handicapped by not being called until the patient was in labor; and as Aunt Mag Moore said, "by that time she had to tussle wid dat patient like a wrestlin' Jacob."

In a vague way they knew about sterilizing, and Hannah Adkins was quite anxious to stand and tell the class her method. "Three years ago," she said, "I bought me a pair of scissors and before I ever used 'em, I boiled 'em for three hours and I ain't had to boil dem scissors since."

The midwife classes were held in the morning, and the midwives were urged to bring as many women as possible to the meetings, for their patients knew even less about the care they should receive than did the midwives. In the afternoons, classes for white women were organized through the P. T. A. or some other organization.

As the standard was gradually raised, the Director in 1926 started to hold "Doctors' Helpers' Institutes" at the University of Virginia, Charlottesville, for white women, and at the Virginia State College for Negroes at Petersburg, for colored women. They have been held every summer since, and have proved quite successful.

In 1928, a letter came to the Virginia Health Commissioner from a representative of the Julius Rosenwald Fund, offering to pay one-
fourth of the salary and expenses of Negro public health nurses working under the supervision of the State Health Department.

The salary and expenses of a trained public health nurse amount to $2,100 a year. If one-fourth is paid by the Rosenwald Fund a balance of $1,550 is left to be raised mainly by voluntary contributions. It seemed at first impossible for any one county to undertake such a task, so a group of eight counties was selected where the Negro population was very large, midwives were doing most of the work, and the number of maternal deaths very large. Various organizations of white women helped to raise additional funds for the nurse's salary; the State agreed to pay $300 and the Negroes in the counties raised nearly $1,000. The first nurse went on duty September 28, 1929, and spent two weeks in each county working with midwives, mothers, and babies up to two years of age.

The territory to be covered was so large that it was impossible for her to do much individual work; so with the assistance of the colored school supervisors, health clubs were organized in schools and attended by both mothers and midwives. At the first meeting a health talk was given, and they were asked to enroll for the Correspondence Course for Mothers given by the State Health Department. A leader was appointed who met with them once a week. When the nurse returned to the county at the end of three months, the course was completed and the class was ready for testing and demonstrations in bed making, bed baths, bathing a baby, postnatal care, etc.

The clubs continued to meet once a month, and each took up some definite piece of health work. For the benefit of women who are unable to have a doctor during confinement, each club sees that there is at least one good, capable woman in the community who has had some training as a midwife. This plan has proved so successful that other groups of counties are being selected, and as soon as funds can be secured, Rosenwald Nurses will be placed in them.

Conditions in the mountainous counties are very different. However, a plan similar to this one is being tried out, but in a much smaller area.
The essential of life is action. Movement is its essence, whether in physics and chemistry or in some distinctive unique vitalism. Pursuit and search are its methods. Through struggle, variation and evolution, realization is its goal.

Activity involves purpose, whether the activity be inherent in cells of the body, in producing digestive secretions or in the responsive clenched fist of a child in expression of its anger or in the dawdling of a child to escape the necessity of dressing alone. Throughout life reaction and movement seem to have some definite purpose. There is seemingly a search for experience through the every day realities, in conscious and unconscious movements, designed, or merely serving to open one's folded and enfolding environment and to reveal and interpret one's self to the the world and the world to one's self.

The new always possesses value because its stimulating power is usually greater than that of the long known. The search for the new becomes richer in emotional satisfactions as one approaches realization. Human reactions are largely proportionate to the newness of people, events, ideas and experiences. Even in the realms of the creative the use of the imagination conduces to a greater emotional response when its achievements are first realized than after a conquest has been made, an idea has been crystallized or a fact has been established. One may search the reactions of a Columbus seeking a Northwest passage and finding a new world, of the Crusaders striving to attain the Holy Grail, of a Pasteur solving the problems of the disease of silk worms or the spoiling of wines, of a Lindbergh pioneering through space to attain the "old world." One may consider the activities of a Foch, a Haig, or a Pershing conducting a war, or of a Napoleon of finance endeavoring to overcome his competitors, and one finds the same grappling for the new, the novel, and
the unusual, with the old enthusiasms, alacrity and intensity that are attributed to ancient scholars, monastic ecclesiastics, and zealous reformers of all times. But this sharp reaction and emotional thrill, whether through success or failure, promise realized or disappointment suffered, is no different from that which obtains in the life of the salaried man, the worker in shop or factory, or of other human beings on all planes of daily economic and social endeavor.

Human effort is constantly striving to attain the new. Intelligence and reason are searching for unrevealed truths. Reason and its attached emotional forces are struggling for higher justice, for deeper beauty. Man constantly strives for unattainables in the pursuit of which he ever attains new levels, margins, horizons. Fads may come and fads may go in every realm of human thought but man continues to grapple for the new in the old and is ever separating out the old in the new that the residuum of revealed truth may give joy to a living generation. An appreciation of justice and beauty depends upon a recognition or acceptance of some theoretic working norm for human relations as well as for art. The continuous modifications of a world developed through the processes called civilization bring about altered conditions of life and shifts in values that have at times been regarded as absolute. Hence justice and beauty involve a consciousness of some deviation from an accepted though relative standard termed just and beautiful. The lines of beauty according to Hogarth no longer dominate art any more than the justice of the medieval period dominates the judicial system of today. New days, new times bring new laws and new beauties. The stimulation of human action lies in the development of the new and the new responses of human thought, feeling and action constitute man's own newness in his changing world.

Religion in all ages has been a reaction to man's failure to find the absolutes in himself. Mysticism and magic, with forces inherent in himself or within his control, fail to satisfy man's sense of emotional satisfaction in relation to his universe. During all the ages it appears that man has recognized religion as an essential factor in rounding out his schemes of life. No people, however primitive in the scale of anthropological classification, offer evidence of a religionless existence. Whether by spontaneous development or by contiguity, ideas of superior beings and forces and definite relations of such beings to the creation of the world, including man, exist in every section of the known world. There is ever and at all times evidence of inquiry and
search for truth regarding man and his world and there have been successive levels of religious belief which have interpreted man's search in terms of his achievements. Men have feared most what they have known least and the fear factor has played a marked part in developing religious ideas of propitiating unknown evil spirits and enlisting the support of favoring gods. The changing attitudes have altered the horizon of the unknown—science has pushed the horizon further out into eternal space but religion continues to thrive on the unlimited and the infinite beyond the test tube and the alembic.

The myth of today was the religion of yesterday just as the religious forms of today may be the myth of peoples a thousand years hence. Science is but the pursuit of truth and the orderly recording of progress towards its attainment. In this sense the history of the religion of any age presents scientific aspects indicative of the ideational levels of man's reactions, together with his development in terms of the new that the achieved beyond his social heritage. Man would know whence he came and why he goes and whither. The search for knowledge concerning the nature of the soul and the difference between the body alive and the body dead presents ample evidence of man's psychological development and growth. The alteration of the facts underlying belief at any period thus involves the introduction of something new and this ever has served as a stimulus to religious ideation and zealous enthusiasm just as motivated the tremendous activities that characterized the days of Erasmus, Luther and Melanchthon.

Individual variations are marked. Some find satisfaction and attainment in achievement, accomplishment, results; others secure a sense of joy, a consciousness of glory in the struggle, whether or not success crowns their efforts. As a whole, however, it may be said that what we have not urges us on far more than what we have. It may be an ignis fatuus that leads us on; it may be a desire for greater success than is at hand or is possible, for higher esteem, for greater accomplishment, for larger service, for more power, for increased recognition, for finer attainments in any field of endeavor from golf to philosophy. Possession has an element of oldness in it that shortly palls and becomes static in potentials of urge. It is the pursuit of the new that supplies energizing power. And this holds true in both the material and the spiritual realms. It is economically sound as it is socially true that man works for what he is not and
I. S. Wile

has not. He strives for social recognition and achievement greater than he has known, even as an athlete seeks to break his record.

The capable trained navigator will start his journey for a port unknown to him, conscious of his capability of applying scientific methods in the directing of his vessel over all seas. While, however, the captain recognizes his fitness in all the arts of navigation with confidence and understanding, he still finds himself seeking to understand the tides and storms which he cannot adequately explain even though he may be able within reasonable limits to anticipate their coming. Part of the joy of the seaman inheres in the hazards of the sea. A sense of absolute safety at all times during his unforeseeable struggles and contests with the forces of nature would deprive the man of the sea of some of the keenest zest and joy of his life.

In sailing the seas of life, charted and uncharted, one finds knowledge pitted against unknown forces—uncertainties and factors beyond human control. Man may live by work, play, love and worship, but in each one of these phases of human endeavor one finds again the problems of conflict, of struggle, of search and of movement. The static and lifeless are the least desirable as goal or drive; the dynamic and vitalizing are most provocative of all effort that makes for comfort, joy and satisfaction, despite occasions when the same power of moving forces leaves in its wake terror, grief, destruction and death.

The creative and experimental elements of man should be in harmony if his life goals are to be satisfactory. If there be conflict between these two elements, life becomes sensual rather than sensuous. If sheer emotional satisfaction with what is, and what is possessed, constitutes the full measure of life, there is mental stagnation. Life devoid of uncertainties, unexplored areas and untested emotions possesses less stimulating power and offers fewer and weaker driving forces towards new thinking and activity.

Science as a factor in life is merely knowledge gained and verified by exact observations and correct thinking, usually embraced in a category of facts, laws and proximate causes. Science consists of rational systems of methodically formulated ideas. Science as such, however, plays but little part in the art of living. Art relates to what is to be done, just as science relates to what is known. Science may drive in its wedges and split things open but it does not suffice to explain or interpret social relations. Whether one speaks in terms
of chemistry and physics; biology, psychology, or sociology, man's goal, his spontaneous thinking, his derivation of satisfactions are not always explainable. Nor are they interpretable by systematic, static, organized knowledge. All the available science of this intensely scientific and materialistic age fails to orient man completely in his universe. And the very gap between what man knows of his environment and what is to be sought yields a grist of emotional reactions to an inquiring, wondering, knowledge-seeking humanity. It is immaterial whether man postulates pantheism, whether he regards nature as the first cause or organizes his thinking in terms of mystical forces, or an abstract quality, or being, termed God.

The religious experience of humans varies in terms of their place of birth, home training, community sanctions and spiritual contacts. Grasping to understand that which is infinite always challenges thought. There are those who find their religious experience in the sunset, as there are those who are thrilled, or even fanatic, over a pleasant but compelling delusion. Some cling to the adolescent imagery of race redemption while others glory in the idea of rescue from the sin addiction begun by Adam. There are those who fall in prayerful mood at the sound of an Ave Maria, while others prostrate themselves at dawn, facing the rising sun. Whatever the religious experience may be, there is in it an active transition of an image to an idea, of an idea to an activity. Denominationalism is but the sub-division of the large religious field. Throughout time the history of mankind reveals religion as living, as moving, and as proceeding to an elaboration of those things which are beyond man's ken in terms understandable to the multitude. Religion is far from static as the history of comparative religions amply demonstrates. Its dynamic qualities lead to its own repeated upheavals in content, form and ceremonial.

From the practical standpoint of an active life, religion is not to be defined in terms of universal expression but rather in terms of its primary substance which is bound up in, and has grown out of, basic natural phenomena inducing the powerful reactions and results that have motivated individuals at all periods of man's development. If one defines religion with Rivers as an exclusive belief in the worship of some universal power superior to man, the search for contact is part of the moving force of religion. If religion is man's attitude towards what he believes to be the supreme force of the universe his
ideas about service to, and worship of, this supreme power are involved.

Ames has commented that religion is more a life and living than a system. It is a series of daily activities which determine conduct. Assuming for the moment that personal religion is to be defined as one's interpretation of the universe through one's own thought, feeling and action, there arises the necessity for orienting one's self in the universe. In that orientation inheres thought, feeling and action. The moving elements of religion are partially personal and partially an outgrowth of social traditions. The motive power of religion is in part determined by the spirit of an age. A Soviet government attacking the churches, dismantling bells, and setting up stoves on altars cannot destroy religion when it is at the same time building up a new spiritual value with the mediatorship of the embalmed Lenin. "So help me Lenin" merely becomes the substitute for "So help me God."

The less material the age, the greater the hold religion has upon a people. The more material an age, the more likelihood there is of satisfaction in sensual enjoyment. We are witnessing in this age a larger freedom of the individual owing to the ministrations of science. There are keener individual personal gratifications as a result of the rapid growth of more intensified and diversified knowledge fostering the pursuit of pleasure and general activity. Focusing attention upon the scientific development of our age, and failing to balance the values that have grown from science as opposed to the art of living, religion appears to many to be dethroned. The problems of the church as an institution are not entirely in accord with the problems of religion as personal reaction. There is a new search for a new governor to help man preserve his balance and equilibrium. The need for religion was never greater than it is today.

The fineness of man's estate is not determined by its extent but by the character of the soil, and still more by the crops that are grown thereon. The scientific universe is endeavoring to build upon rocks of facts and blocks of laws and principles, and is staking all upon what is scientifically known as forming the core and totality of living. The fact still remains that the art of living involves pursuit, movement and search for that which is unknown. Human relations or the relations of man to his environment cannot rest solely upon the demonstrations of chemistry and physics when these have not within them the essence of vitality requisite for interpreting man himself.
The art of living today, if wholly dependent upon science and the maintenance of scientific laws, would result in human stagnation. If each one, to save himself, were to practice the isolation which alone guarantees immunity from most diseases, man’s social life would cease and there would be no art in living, nor any redeeming value in existence. Religion is part of the art of living. Its practice continues to have values despite assaults made upon it as a citadel of truth and despite the undermining efforts of those who worship facts and are intolerant of the unknown, the probing of which alone can give them the new facts that constitute the basis of their ever-growing faith in man. The religious element in science is faith and the scientific phase of religion is likewise faith—faith in man’s senses but no less in man’s creative thinking.
SOCIAL WORK IN NEW YORK STATE HOSPITALS

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In January, 1906, the first after-care work with patients released from State hospitals was initiated. The need for such work was demonstrated by the State Charities Aid Association. Through this organization, volunteer service was given to released patients. This service was in the nature of finding employment, securing convalescent care for the physically unfit and arranging for all kinds of temporary placement. This work began in New York with patients from Manhattan and Central Islip State Hospitals. From this small beginning, one after-care worker for two large hospitals, there has been a growing demand for the services which the social worker can render, until now there is no State hospital in New York which does not have its social service department. On July 1, 1931, there were fifty-six social workers in the fifteen State hospitals and the Psychiatric Institute.

Just as there has been an increase in number, so there has been a development in function. Originally the efforts of the social worker were confined entirely to the parole patients,—and this chiefly to suitable placement for the patient upon his release from the hospital. The policy of working with the patient over a long period and making a definite effort to adjust him to society had not then been adopted.

Now the services of the social worker are demanded from the time of the patient’s admission to the hospital until his final discharge. To be sure, the function of the social worker varies in each hospital due to the varying problems of the hospital, but her professional contribution to the understanding of the patient’s difficulties is recognized.

The social service work as described below is not as it functions in any one hospital. Variations in communities and districts served by the different State hospitals make policies which are feasible in
When the patient comes to the hospital, the social worker often secures his history which must show not only his background but a careful analysis of the environmental factors in the situation; the family attitudes and relationships, the patient's reactions to various situations throughout his life, his general personality make-up and development, up to the time of his mental illness, his health history, his work record, in short a complete picture of the patient up to the time he is admitted to the hospital. Insofar as possible, all of this material is either corroborated or verified.

In the securing of such a history or in verifying certain material in the history in case the doctor has secured this information the social worker often finds certain environmental problems which seem to have contributed definitely to the patient's illness. She must make every effort to ameliorate such situations so that on the patient's return home he will have a better opportunity for convalescence. These situations to which the hospital social worker must direct her efforts vary greatly. The attitude of the family toward the patient may need changing. A careful working out of family relationships may be necessary. Working with the social agencies already interested in the family or connecting a family with an agency equipped to handle the problems it presents may be indicated.

In some hospitals the social worker visits the patient on the ward shortly after his admission unless he is too disturbed or too deteriorated to understand the purpose of such a visit. Frequently she can reassure him regarding conditions outside the hospital which have caused him worry. An added value of the visit to the patient is that it usually seems more reassuring to the family for the social worker to have seen the patient recently and thus may enable her to establish rapport more readily.

Each contact which the social worker has with the patient's family should contribute toward a better understanding of the patient and his illness on the part of the family, and should have as its aim the making of the environment a suitable place for the patient's convalescence and ultimate recovery.

If the social worker has had this preliminary contact with the patient's family, by the time a pre-parole investigation is requested accurate knowledge of the environmental situation is available and the family is prepared for the return of the patient, or if it does
not seem wise for him to return to the home situation, other plans have been made for him outside the hospital.

The question of finding employment for the parole patient is one that often presents difficulty to the social worker, even in years when there is not such an unemployment problem. There is often the disposition on the part of the individual who wish to employ State hospital patients to expect a vast amount of work for which they wish to pay only a limited sum. For this reason there must be a careful investigation of the employment situation before the patient is placed.

There is probably no factor more stabilizing in an individual's life than a job from which he acquires a certain amount of satisfaction, which means, of course, that he must feel he is earning a fair amount for services rendered and that working conditions are not impossible, and that the job is in keeping with his abilities and interests. To find such situations for patients who are not too well mentally is not an easy task, and to convince them that they should stay on the job often even more difficult. Handling the employment situation is the usual task of the State hospital social worker.

During the parole period much responsibility devolves upon the social worker. It is she who has the most contact with the patient and his family The clinic physician may not be able to do a great deal of therapy in most of the parole clinics where he sees many patients in the course of a few hours. He must frequently depend on the observation of the trained social worker to detect significant symptoms. By keeping in close touch with the patient and his environment the social worker is often able to anticipate difficulties which might make it necessary for the patient to return to the hospital. It is she who brings the patient for more thorough psychiatric treatment when this seems needed, or sees that he is given opportunity for suitable recreational outlets, or that his family or employer understands the vagaries of his personality so that there will be a minimum amount of tension there. In short, where the patient has recovered sufficiently to be paroled on the advice of the hospital authorities, the social worker must see to it that the environment is auspicious for the patient's convalescence and that he has every opportunity to make a good adjustment once more in society.

It is a challenging job, a responsible job, one demanding a well adjusted and well integrated individual with a background of experience and training to enable her to meet the demands of the job successfully.
AN EDUCATIONAL AND VOCATIONAL PROGRAM
FOR PATIENTS IN CONVALESCENT HOSPITALS
AND SANATORIA*

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In presenting a paper on the above subject, I would like to take time, first of all, to present my views as to the need of more convalescent hospital accommodations in this country.

When one thinks of hospitals, one naturally seems to have in mind the hospitals that have to do with the treatment of acute conditions, and the carrying out of surgical operations, and it is considered an evidence of the efficiency of such general hospitals to maintain as short as possible an average residence period of patients. For instance, the average stay of patients in a model hospital is set at fifteen days, while a hospital that retains its cases for a period of months is discriminated against in Ontario by having the provincial grant stopped at the end of three months. On the other hand our sanatoria may be taken as an extreme type of convalescent hospital where patients remain from several months to even a year or more.

One of the striking features of our modern life is the continual increase in the demand of the public for hospital service. We know that once the idea prevailed that hospitals were dangerous places and this fear of hospitals is one of the things that is ingrained into the lives of some of our people even to this day. This, of course, is merely reverting back to the time when the actual bacterial cause of many diseases was not understood, an example in point being the inability, until recently, to reduce the high incidence of acute infections following childbirth in hospitals. If such conditions prevailed, then we might well look upon a hospital as a place to go to only under extreme necessity, and might look upon the home as the proper place for

*Read before the Thirty-third Annual Convention of The American Hospital Association, Toronto, Canada, September 28-October 2, 1931.
all patients who were not acutely ill. However, in these later days, conditions have greatly changed. Homes have become smaller, facilities for caring for the sick in homes have lessened rather than increased, and the possibilities of organized medical services have grown from year to year, until today it is a question if even the most chronic ailments are not better cared for under the well organized conditions which exist in a convalescent hospital.

As an illustration of this we have the phenomenal growth of sanatoria for the treatment of tuberculosis during the last three decades. At the beginning of this century, sanatoria for the treatment of tuberculosis were practically unheard of but the best proof of their necessity to meet our present needs both for treatment of tuberculosis and for prevention of the spread of the disease is their steady growth, until today I think it is perfectly safe to say that no patient with tuberculosis can afford to attempt to carry out the whole course of treatment in his home, without very seriously handicapping his chances of recovery. This is not because the home cannot furnish the nourishing food and the nursing care that is provided in sanatoria, but is chiefly because the sanatorium has become a school for the training of individuals afflicted with tuberculosis. As a result of this training or schooling, the patient gradually develops a new knowledge of the disease and an attitude toward life which is almost unconsciously acquired, but which is most essential when the patient returns home to take up active life after treatment is completed. In fact, the sanatorium training teaches the patient that treatment is never completed, but that the whole future life must be carefully adjusted if the patient hopes to live out his natural course without serious handicap to himself and to those about him.

We may well say that the sanatorium has established the need for convalescent hospitals in this one particular field, but in my opinion there is just as great a need for convalescent hospitals in the care of many non-tuberculous chronic conditions. These would include such conditions as the treatment of chronic heart disease, which can much better be carried out in a convalescent hospital than in a home, though here on account of its acuteness the initial treatment will probably be carried out in a general hospital. The same applies to many non-tuberculous chronic pulmonary conditions, many of them being conditions secondary to acute conditions, and in many instances the chronic invalidism is the result of overlooking the fact that the medical super-
vision of a patient is not completed as soon as the acute stage has
subsided.

Similarly there is very often need for the convalescent hospital in
the treatment of focal infections and their complications, including in­
fecions of the teeth, tonsils and sinuses, where they eventually lead to
secondary infections of bronchi, lungs, gall bladder, joints and many
other conditions that finally lead to great suffering and invalidism in
the lives of human beings. It would also include the cases of bone
infection, whether tuberculous or non-tuberculous, and should cover
the period when patients are compelled to remain immobilized on
splints or in casts for months or even years in order to effect a com­
plete cure.

Today, it is well known that facilities for the treatment of these
non-tuberculous chronic conditions are terribly inadequate, and from
our own standpoint in connection with sanatoria, we very frequently
are filled with regret when we find that a chronic pulmonary condition,
such as bronchiectasis, cannot be classed as tuberculous, for this non­
tuberculous classification or diagnosis deprives the patient of the
benefit which sanatorium care might give, and in place of it there is
nothing else that we have to offer. Very frequently, too, the treat­
ment of patients suffering from these serious chronic illnesses leads
to a breaking down of morale which tends eventually to undermine
very greatly the usefulness of the individual, even if fair health is
restored. These patients have to lead a different life from all the
others in their home, and sometimes as a result of the distress of the
parents, they are, especially in the early stages of their treatment,
spoiled by mistaken kindness, where firmness and routine are re­
quired; and too often they gain the idea that their time is of no
value, and that they have little to look forward to, so far as a career
in life is concerned.

The same conditions are applicable in the matter of the chronic in­
validism of children. I think all are agreed today that where possible
tuberculosis in children should be treated by institutional care, rather
than to have the disease smolder along until early adult years are
reached, and I am very sure that the time will soon come when prac­
tically all children will be at once referred for institutional care as
soon as an active tuberculous process can be demonstrated, while it is
still confined to the lymphatics, and treatment will be continued until
all evidence of activity has disappeared. With this plan universally in
operation, I am very sure that adult tuberculosis would very soon be-
come practically a thing of the past, and this in my opinion is the next step indicated in the campaign against tuberculosis.

But there is another group of children in whom I am very much interested, and whom I consider to be receiving inadequate care today. This is the group of cases of non-tuberculous pulmonary gland infection. These children probably have their infections initiated with some acute upper respiratory or throat infection which extends through absorption to the bronchial glands, with the result that for months and even years, some of these cases may have a slightly elevated temperature, which is subject to occasional exacerbations, but which rarely manifests itself as a condition which gives any great concern to the parents. As a matter of fact, the condition is usually not detected by the physician, even though in addition to elevated temperature the physical signs in the upper mid-line in front and back of chest are sufficiently altered to point to the bronchial glands as the probable source of the temperature. Undoubtedly, in my opinion, these low-grade temperatures should be cleared up just as quickly as possible, for the longer the duration of temperature, the more scar tissue develops in the lung in the process of healing, and the more handicapped the individual becomes for life, even though eventually he has a complete cure of the active process.

It is my opinion, therefore, that when a chronic non-tuberculous bronchial gland condition in a school child can be diagnosed, that child should receive institutional care, which may be called preventorium care if desired, the same as is applied to the tuberculous child. This type of institution could also care for the bone cases and the heart cases in children, and it goes without saying that this type of institution must be in all essentials a school planned not only to correct the physical disabilities, but chiefly to fit the child for a useful life in spite of any physical handicap that may remain.

Thus, I would like you to get the picture of the convalescent hospital for either child or adult as a school designed to fit the chronic invalid for more efficient citizenship. With the acceptance of this idea of the hospital as a highly efficient technical center for the study of the physical condition which undermines citizenship and for the institution of training that will fit the individual to overcome his physical disabilities, I think both general hospitals and convalescent hospitals will take on a new significance in our community life, and will be financed, not grudgingly as at present, but generously on the same basis as the schools which fit our well children for later useful adult lives.
In fact, when the people are ready for such a service, I think the hospital organization will probably be divided as follows: First there will be the outdoor service of the general hospital, where citizens requiring this service will be able to go for diagnosis of their conditions and for detection of beginning disabilities or infirmities. Following such investigation the outdoor department would be able to divide the citizens into groups, somewhat as follows: First, those who can secure all the assistance they require through their own family physician; second, those who can receive the necessary aid through attendance at the various treatment services of the outdoor department; third, those who require the treatment for acute or surgical conditions which can only be obtained in the general hospital; and finally, those who have chronic conditions which would be improved by the service which they can obtain over a long period of time in convalescent hospitals. This plan could include the supervision of tuberculous cases, and acute cases when the acute stage was passed could be transferred either to the convalescent hospital or to the outdoor department for further treatment or supervision as the condition required. Such a plan if universally adopted could be made to provide a community organization for the fitting of people for citizenship which is sadly lacking today.

If convalescent hospitals and sanatoria are to fit in with such a scheme, then they will have to take on more and more the rôle of schools for the upbuilding of citizenship, in that group of citizens who are most in need of assistance, namely, those who are starting life with some form of physical handicap.

The one advantage of such a school is that the students learn the principles of health by actually doing and living the things that will help them to become stronger and more efficient. Another advantage is that by grouping these people together, it is possible to concentrate on the training and the choice of vocation that will be suited to those with similar physical handicaps. Very frequently changes of vocation have to be made, for it is apparent that a man who is crippled either by a chest disability or by an arm or leg disability cannot go back to heavy physical labor. On the other hand, an opportunity is afforded for study during long periods of convalescence where physical rest is essential, but where mental activity can be developed sometimes even to as full an extent as under normal conditions.

In our own experience, we have come to believe that for the later stage of convalescence in the treatment of tuberculosis, some form of
organized study is absolutely essential, in the interests of successful treatment. In other words we have come to believe very strongly in scientific psychotherapy, for a contented mind certainly makes for more satisfactory healing of physical disability, while on the other hand idleness undoubtedly makes for discontent and dissatisfaction and may seriously retard healing.

If we look upon convalescent hospitals as institutions where patients are cared for during the long period necessary for recovery from chronic illness of any sort, then sanatoria can come under the heading of convalescent hospitals. I would like to include the two types of institutions under this one heading because it is my opinion that the long experience of sanatoria can be made of value in the development of convalescent hospitals for other types of disease. And so I would like now simply to sketch for you the developments that we have made in the organization of vocational and educational work in our sanatorium, and some of the benefits which have resulted.

Our own sanatorium was established in the year 1906, and has had a gradual growth to meet the requirements of the city of Hamilton and the County of Wentworth, originally comprising a population of about 90,000 and now grown to about double this population. In the early days when the institution was small, we did not attempt anything more than the absolute necessities of treatment, for funds were low and we had very little by way of experience to guide us in the development of this work.

In 1910, the treatment of children was undertaken in a separate building, a so-called preventorium, to which no open cases of tuberculosis were admitted. Naturally with an increasing number of school children from the city, it was a very natural step, when the request was made, for the Hamilton board of education to supply a teacher from its city staff for the education of these children. Prior to this, a home for far advanced cases had been established in the city, through a donation by Mr. and Mrs. William Southam, and for the next seven years, advanced cases were sent to this building for treatment on the supposition that the sanatorium should receive only early curable cases. This proved to be a very unsatisfactory plan, for it was soon found that advanced cases objected to going to the home for so-called incurables, with the result that an increasing number of far advanced cases refused to leave their own homes, if they were refused admission to the sanatorium.
During this same year, soldiers began to come back from the front with active tuberculosis and late in the year a conference was called by the Dominion Government at which it was decided that in Canada the returned tuberculous soldiers would be cared for in the civilian sanatoria. As a consequence, the military authorities added considerably to the accommodations and the sanatoria were face to face with a new problem, that of caring for a greatly increased number of patients, the majority of whom were men in the prime of life, and much more inclined, after their overseas experience, to resent the inactivity of rest cure than were the ordinary civilian patients.

To meet this situation, we were very generously assisted through the cooperation of the military authorities, who after a study of the situation, decided to introduce in each sanatorium caring for returned soldiers a department of occupational therapy. In establishing this course, the total cost was borne by the military authorities, and of course it was only extended to the military patients.

To show the thoroughness with which the work was undertaken, however, I might add that with 150 military patients, we at one time had an occupational officer and ten occupational aides on our staff, and undoubtedly this assistance was the means of getting results in treatment that could never have been obtained under ordinary conditions. We now look back upon this entire experience as a period of demonstration under which we were given the opportunity to very thoroughly estimate the value of occupational therapy in the treatment of convalescing tuberculous patients, and while we prized the experience very highly, yet we are very sure that this was merely a transitional period which has led up to a program which is fundamentally much more satisfactory for civilians than that which was introduced for the soldier patients.

In one respect the military patients were far more suitable for training in occupational therapy than are a similar number of civilian patients, for the majority of them had their disease diagnosed at a much earlier stage than is the rule among civilians. Proof of this is seen in the fact that the exercise patients, as compared with bed patients, numbered practically two to one, while under civilian conditions, the bed patients as compared with exercise patients are greatly in the majority.

Another important difference is this, that a much larger percentage of our patients are young people in their teens, or early twenties, while the soldier patients were on an average considerably older.
difference is that of the patients in their teens—a majority of them are girls, or rather young women, rather than young men. On the other hand when we get past the thirty year period, more of the patients are men, rather than women. Another very common point in the history of these young patients is that many of them left school at an early age, the story often being that they grew tired of school before they had passed their entrance and decided that they would go out and earn money. Thus they were drawn into the factory and were led to take up work which at this early age was often too heavy for them, with the result that the very condition was developed that might lead to the reactivation of an old tuberculous infection. This shows, therefore, the necessity of studying the previous occupation of these patients, and where it is unsuitable, of persuading them to go back to school in order to fit themselves for a lighter occupation requiring more mental effort than physical, and of providing them with the opportunity of making this change while they are in the later stages of their period of treatment, a stage which is truly convalescent.

Looking back over the past few years in the development of our program, we realize today that our patients have done quite as much to educate us as we have done to educate them. As a matter of fact, we believe today that we are simply learning to apply what we now regard as a fundamental principle in psychology, namely: that normal intelligent human beings cannot be happy unless they are afforded an opportunity to continue to grow and develop mentally, no matter what stage of life they have reached, and in our program, therefore, we are simply satisfying the cravings of human nature.

As time went on, the number of military patients gradually decreased, until finally the time came when the military authorities withdrew their active support, thus leaving the responsibility for the continuation of a department of occupational therapy entirely with the civilian institution. But prior to this a step had been taken which has been of great value in the carrying out of our present program. This was the installation, as a result of a gift by Mr. C. S. Wilcox, of a radio equipment for the institution, the chief feature of the equipment being individual head sets for every patient. This of course has given great pleasure as a result of the entertainment afforded, but it has also been of great value in enabling patients to obtain information on many matters of interest, and in addition by the use of a microphone it has made it possible for the staff to give lectures to the patients on medical and other scientific subjects.
Up to this time, we had our educational program for children, but we had not yet assumed any responsibility for the education of adults. Then as a result of having in residence a few very clever patients, one of whom was taking a Queens extramural course while in the institution, we gradually came to realize that some of these patients might very well be working at regular studies; and reasoning also that memory work would occupy much of their time and would be very beneficial, in keeping their minds occupied, and would leave very little time for homesickness and discontent, we decided to start a course in the study of French. Three Hamilton ladies agreed to undertake this work as a trial, and we soon found several students who were anxious to try the experiment. The success of this experiment exceeded our fondest expectations, for the interest of both teachers and students increased, and at the end of the year it was found that some of the students had made sufficient progress to try the departmental examinations, and to the surprise of all concerned, they were able to take a standing that compared very favorably with that of the ordinary student in high school.

Encouraged by these results, we then took up the matter with the Hamilton board of education and were delighted with the response that we received, for the board agreed to supply a full-time teacher. Before this, however, one of our ex-patients who had been a public school teacher had actively taken up the work of teaching the three R's to foreigners within the institution, and in addition she had enrolled a class of young Canadians who had not yet completed their entrance examinations; thus she had started a preparatory class that would later be able to enter the classes for regular high school subjects.

A little later, a teacher was secured for instruction in shorthand and typewriting, and finally the board of education agreed to supply a teacher on Saturday forenoons for instruction in bookkeeping and commercial work. Thus the program was rounded out, until today we are able to prepare young adults for their entrance examinations, and in addition are able to teach practically all the subjects of the high school course except physics and chemistry, including also the various subjects of the commercial course.

This, then, is the program which we have been able to establish, and I merely wish now to give you a few of our general impressions as a result of our experience of the last few years.

First of all, we do not feature examination work, but we consider that when a patient stays throughout the school year, it is very satisfactory to have some standard by which he can measure his advance-
ment, for this practice of writing on examinations has shown that students can make just as satisfactory advancement while lying in bed taking the cure, as they could if they were in a college classroom.

Secondly, we have gained very definite opinions as to the comparative value of occupational therapy and educational therapy. We still think that occupational therapy is most satisfactory for older people, and for the young adults who are below normal mentality. To this class usually belong the boys and girls who left school in their teens because they were making poor progress and were older than the other children in their class and very commonly they did not get beyond the third or even the second book. These dull people can always be best appealed to through training in the handicrafts, but for the young people of normal mentality, we believe very strongly that the way in which we can most satisfactorily benefit them during their period of convalescence is to put them back at regular school work, work that tends to develop their mentality, and tends to fit them so that they can better adapt themselves to the struggle for existence when they are again thrown out upon the world.

As a result of these very few years of experience, we already have most encouraging results through the success of our discharged patients in taking up new activities, for which they have fitted themselves wholly or partially while under treatment; and as a by-product, we have better results in treatment and an institution in which happiness has replaced much of the prevailing discontent which used to be associated with sanatoria. Growing out of this there should be a welfare department which would help to place these patients at time of discharge, or when ready for work, in proper occupations. In fact, this department has already been established but it will require more time for its complete rounding out, together with a return of more prosperous times. Eventually it should be a very important department and should constitute a definite after-care department of the sanatorium.

Already in Toronto, where they have a larger aggregate of patients from which to draw, the Samaritan Club has established a club house and occupational workshop for ex-patients, and we have been informed that the first person to receive a check for work at this workshop was a patient who had received his training in our institution.

We feel that we are only learning the rudiments of the possibilities of this work, but during the last year have been greatly encouraged by learning of the development of this same type of work at the Hennepin County Sanatorium on the outskirts of Minneapolis. Any
person wishing a complete plan on which to base the development of such work should get in touch with Miss Radebaugh, the executive secretary of their after-care program.

Thus to conclude my remarks, I would say that no sanatorium of sufficient size can be considered complete, unless it has an educational and vocational program and an after-care department, the basis for which is the fitting of each patient for more efficient citizenship. For the tuberculous patients, this is recognized as a very satisfactory program, but under modern social conditions this same type of program should be made available for a far larger group of non-tuberculous chronic invalids, for whom little or no provision is made today after their period of treatment in the general hospital is completed. This lack of convalescent hospitals for non-tuberculous invalids is leading to a very considerable loss of efficiency in our people, and this can best be remedied by the development of as complete a program for their reestablishment as has been developed in connection with our sanatoria. When such a plan is attempted the pioneering experience of the sanatoria should be of great value, for if the fundamental principle of maintaining efficient citizenship is adhered to, then together with the medical side of the organization will have to be associated this occupational and educational department the basis for which is the reestablishment of our handicapped individuals. In this way will our people learn that education is a progressive program which must continue from childhood to old age and that no person whether an ordinary able-bodied citizen or an invalid inmate of a convalescent hospital can satisfy the craving of an intelligent human mind unless opportunity is at all times afforded for mental growth. Thus would it become a double offense against society for the invalid who is perfectly capable of mental activity to be allowed to convalesce in idleness and discontent, for surely the purpose of life is not merely to work in order to earn money, but is rather to satisfy the cravings of the human soul.

In this way do we see the relation between the mind and body in the healing of disease, and if this principle were applied practically I am very sure that money from taxes would be forthcoming for the establishment of convalescent hospitals that would take on the character of schools for the reestablishment of physically handicapped citizens, and I am very sure, too, that this development would do away with much of the quackery and exploitation which are features of our present day civilization.
THE PROBLEM CHILD IN THE FATHERLESS HOME*

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The “fatherless home” means to the average individual a shifting uncertain situation. To many it brings up pictures of unusual fortitude in the face of great odds, the independent manly little boy eager to protect and help his hard working mother; to others the picture is of a cross tired mother whose attempts at discipline are completely disregarded, where the only consistent supervision is supplied by an outside agency such as the Family Agency, the Juvenile Court or in rare cases a visiting teacher. To the social worker the “fatherless home” means even more than that—a fundamental lack from the emotional standpoint accompanied too often by an economic insufficiency with its varying social implications such as inadequate attention to needs of the children, and deprivations of various kinds. It seems fairly obvious to the social worker that the lack of either parent in the home, makes proper emotional development difficult for the child—and these difficulties are too often reflected in his personality.

Such ideas as these which seem prevalent regarding the home deprived of a father, unquestionably have a reasonable foundation. Too often there are serious economic hardships coupled with difficult emotional situations. Is it any wonder then that the fatherless home contributes its quota to the number of problem children?

Let us look at some possible situations in the fatherless home more closely—The mother has, perhaps in the father’s death undergone a great emotional loss. Furthermore, her sense of security seems shaken and her entire life plans disrupted.

*Given as an introduction to a round table discussion, New York State Conference of Social Work, Niagara Falls, N. Y., 1931.
As a result she may become over-anxious regarding her children or she may concentrate this anxiety on one child. Children react to an over-anxious situation in a variety of ways, depending upon their previous emotional experiences, nevertheless an over-anxious mother, especially in a one-parent home, provides a fertile field for the development of varying kinds of neurotic manifestations and hysterical behavior. Fears, anxiousness, food fads, night terrors, physical ills without cause on the part of the children are the all too frequent concomitants of the anxious mother.

The mother after such an emotional deprivation too often centers her thwarted emotion on her children in which case any efforts that the child may make to develop independence and self-reliance are promptly stopped. The child may become submissive and dependent, or react in various ways, usually somewhat asocial, to the situation—He may run away, perhaps “a good child running away from a bad situation,” but running away often precipitates a child into minor delinquencies. The establishing of one’s own independence against such odds usually is done only with a good deal of scarring of the personality. From the standpoint of society the submissive child in such a situation does not seem to be a problem, but from the standpoint of the child’s future adjustment the one whose behavior is that of aggressive resistance to dependency is far better off.

Another difficulty all too often seen in the fatherless home is the conflict over parental partiality. Too readily the mother may identify her son with the lost father and lavish her affection upon him to the exclusion of the other children. This situation leads to difficulties on the part of all the children concerned. The favored child has his difficulties in breaking away from the home ties—the rejected child lacks opportunities for proper emotional development, the mildest manifestation of which is usually a deep seated feeling of inadequacy, for which he may make up in a variety of undesirable ways and which is often definitely handicapping to the efficiency of the individual.

Again, the widowed mother may have idealized her departed husband, who, if he had lived, would have been anything but her idol. Nevertheless she puts a great deal of pressure on the children to live up to this ideal example which she has created. We see this same drive in parents who endeavor to realize their own thwarted ambitions in the lives of their children, but there may be a better balance and less sentiment when it comes from two parents instead of one,
and furthermore the child from the more normal home may have fewer handicaps in facing such an issue.

So far we have spoken only of the mother who may be too much attached to her children—The mother who like Othello loved “too well.” Just as serious difficulties and perhaps more serious ones are found in the mother who for some reason or other may not be sufficiently attached to her children. To be sure if she rejects her children she may compensate by an over-anxious attitude, which on the surface appears much the same as the mother who is too much attached to her children, and perhaps with somewhat the same behavior on the part of the child.

However, to the mother who has been neglected or abused by her husband, the children may be a constant reminder of her suffering with the result that the children have neither the proper affection or attention. This too, makes for difficulties and it is a fortunate child who works out a comfortable adjustment in spite of such odds.

Again the children may be a burden to the widowed mother in that they represent to her, her loss of freedom. As long as her husband lived, she had satisfactions which were sufficient to make up for this loss, but her children may represent to her nothing but handicaps to her desires and ambitions. Here again we see a certain resentment in the relationship between mother and child or mother and children often resulting in personality difficulties or behavior problems on the part of the children. This resentment may be either increased or mitigated when a prospective suitor looms up upon the horizon.

Again the financial burden of the children, the inability to do for them what the mother feels is desirable, often leaves her in a hopeless and depressed state which is reflected too often in the children’s undesirable behavior. The children are too apt to escape from such a situation by running away or by other undesirable manifestations.

Then there is the inadequate mother, who might have been able to carry on with a reasonable degree of success with the aid of a strong guiding hand but without such support she is lost,—likewise her children. For some reason or other she has never developed a mature self-reliance or she may be mentally or physically unequal to the situation. If the supervising agency can supply the leadership and guidance needed here, there may be a happy solution to the problem, but too often in the rush of investigation and pressure of work, too little time is given to the understanding of actual needs of
the family aside from the economic ones—with the result that the children are the chief sufferers.

Briefly some of the many possible involvements which may be at the basis of the child’s difficulties have been suggested. The more obvious material deprivations and difficulties contribute their part toward the child’s problems and financial limitations combined with more or less inadequate community resources, make treatment difficult.

However, since the child from the fatherless home comes to the attention of social agencies frequently, the social worker should be constantly aware of the possible emotional deprivations which may be at the basis of the child’s difficulties.
HUISVERZORGING

H. M. WICHERS HOETH-KUHN
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"HUISVERZORGING" is a charitable institution which has existed in Amsterdam for more than 30 years. Its object is to send a female substitute to families with a small income, where the housewife by reason of illness or childbirth is unable to do her work.

The women sent out by "Huisverzorging" are not allowed to sleep in the house; they come at 8 a.m., see the children off to school, do the housework and the cooking, look after the sick mother and go home at 7 p.m. after the washing up of the plates and dishes. To families without children or in small families, where the wife is only slightly ill, they go for half a day and in this way can often help two families in one day. I am sorry to say that our women are not properly trained. If this were the case their wages would be much higher and this would add too much to the costs of the work. They generally are housewives themselves of 30 years of age and above and so are more or less capable of taking the place of the sick woman. People of all religions are being helped by "Huisverzorging."

All the work of supervision, visiting the supported families, the payment of the working women and the whole administration of the 16 districts is done voluntarily by a group of ladies, who are especially interested in this work. Only the two ladies, who run the office every morning from 9-12, receive a small salary. People, who want help, are directed to this office by their doctors. Here they are registered and have to give all the information required as to the income, house-rent, number and age of the children, etc.; after their social circumstances and if necessary the nature of the illness has been investigated, the small contribution they will have to pay weekly, if possible, is fixed, and a help is sent for no longer than 6 weeks (often shorter as may be understood). If after 6 weeks more help is needed, a new statement from the doctor to this effect.
has to be produced; the patient is visited by another controlling medical adviser and on his advice the help may be continued another 6 weeks, but not permanently.

It is evident that a limit has to be established to the income, up to which help is given. People who are out of work need not pay anything. In cases of normal childbirth 14 days' help is given; the future mother must be registered at least two months before her confinement.

As to the finances of the society: when "Huisverzorging" was founded it existed on private contributions but after a couple of years could not make both ends meet without a subsidy. Now the work has been carried on for 30 years and during this time it has enlarged so considerably, that it is not to be surprised at, that "Huisverzorging" now has to be highly subsidized by the Municipality. In connection with this subsidy (which amounts to about 80 per cent. of our expenses) we have to submit to a certain amount of supervision from the authorities with regard to the contribution of the patients and the duration of the help given. This collaboration leads, I venture to say, to the greatest possible advantage to those people, who most want our help.
A UNIFIED PUBLIC HEALTH NURSING SERVICE IN HONOLULU

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Two years have passed since the affiliation of the official territorial nursing department, where specialized nursing had been the practice, with the unofficial Palama Settlement nursing unit. An organization has been built which has passed the experimental stage. The future shows Hawaii climbing from a low rung on the public health ladder to one very near the top, becoming noted for its excellently administered health department as well as for its beauty, climate and other characteristic features. Public health nurses when this time arrives will have had a large share in its accomplishment.

Experiments are not uncommon in Hawaii. When the recommendation was made in 1929, that the nursing staffs of the two agencies be pooled, the recommendation was eagerly accepted and the affiliation almost immediately made. Both staffs conscious of duplication in the two fields of nursing knew that the recommendation was sound and accepted it without reservation and with a determination to make it a success. Some reservations came later but the same determination persists.

Both staffs are endeavoring to become liberally educated by taking a philosophical attitude toward the enlarged opportunities and consequent additional responsibilities, for as Everett Dean Martin, the educator, has said, "If learning does not result in the ability to take a philosophical attitude toward experience, it is not a liberal education."

Perhaps the ideal way for a community to carry on its health work would be to have all health activities administered by an official agency, namely, the Board of Health, with a sufficient number of trained workers for each activity but, since health education and preventive medicine are still closed books to many minds, and appropriations allowed for health work are grossly inadequate, there is still
great need here for the unofficial agency. Next to the ideal would be to have all agencies doing community work cooperate, thus saving duplication of effort.

The first step toward cooperation was that of pooling the two nursing groups. The matter of affiliation has been largely a problem of administration. Nurses have been asked to give up specific work in which they had pride and for which they had affection and, in some instances, needed to discard a few traditions and prejudices, for the sake of the larger civic duty of generalized work. Nursing districts were changed and each nurse of the combined group was assigned a district in which she did generalized nursing. When the affiliation was made there were twenty-two field nurses, five from the Board of Health, seventeen from Palama Settlement. Three nurses have been added to the Board of Health group so at the present time twenty-five nurses are in the field, each doing any branch of nursing needful in the district to which she is assigned. Three supervising nurses direct the field work and establish uniform procedures so that the instruction given does not vary in fundamentals and a nurse can do relief work in any district and not confuse her patients, her organization or herself.

No changes were made in the manner of employing nurses or in salary schedules, vacations, sick leave, or in office accommodation when the affiliation was made. Such items for nurses employed by the Board of Health are regulated by the legislature and for Palama Settlement nurses by its Board of Trustees.

One of the enlarged, or, perhaps unique, opportunities was that of making a set of records which could be used equally well in urban and rural communities. This was especially desirable since the directing nurse of the Board of Health Nursing Service in Honolulu, is also the Director of the Bureau of Nursing of the Territory of Hawaii, and it greatly simplifies the administrative end of her work if all reporting is done on the same forms. This also gives us a means of making accurate statistics of nursing achievements in the territory.

Through weekly conferences and special committees of the nursing directors and supervising nurses, uniform procedures have been and are still being developed. These procedures are then presented to the staff council which is composed of the entire nursing group in Honolulu and rural Oahu, now numbering thirty-eight, for comment and suggestion. In passing, it may not be amiss to say that the
National Organization of Public Health Nursing records and the Appraisal Form of the American Public Health Association were used as guides, and representatives from the Department of Public Instruction and other health and welfare agencies in Honolulu sat in on the conferences whenever nursing procedures became linked with their work.

We have not found a similar organization with which to compare an analysis of our activities. We think our office time out of proportion to some of our other activities but believe the entire new system of recording is partly responsible for this as well as our efforts to give reports sufficiently accurate from which to compile government statistics. In making an analysis it is also necessary to take into account the different personalities of both those served and those giving service. Who shall judge whether a larger community service is rendered when a nurse puts her efforts into securing funds to enlarge the quarters used for her child health conference, this building becoming an addition to the community church, rather than carrying only the daily routine cases.

Two outstanding activities have been added to the public health nursing service this year. One which should be of definite value to the community as well as to the nursing profession is a course in public health nursing given jointly by the University of Hawaii, the Board of Health, and Palama Settlement. Public health nursing appears to have reached the stage in Honolulu where only nurses having had public health instruction are employed by the Board of Health and Palama Settlement. The course at the University provides an opportunity for local nurses to obtain the required instruction.

The educational director of the nursing service at Palama Settlement, directs the course. Basic subjects are carried in the regular classes of the University with accompanying credits. Field practice is given under close supervision, through agencies doing health and child welfare work in the City and County of Honolulu.

The second activity referred to is an advisory committee of women for the nursing service which will report on questions relating to the policy and administration of this service. While this committee is distinctly an activity of Palama Settlement and reports to that organization’s board because of the close affiliation of the nursing groups it will be beneficial to both groups.

The next step in our development should be to establish a pay service, a problem requiring the serious thought of all administrators.
Nursing Service in Honolulu

in public welfare. Whether the Board of Health nurses can participate in this “pay” service is a matter which has been referred to the Attorney General for opinion. It is feared that this will not be permitted.

Nursing is but one phase of the work done under Palama Settlement. The extensive medical and medical social service departments are indispensable to our service and are partially financed by the Welfare Fund which supplies some $87,300.00 toward the different activities carried on at the Settlement. Another important activity is the Recreational or Community Service Department. A $36,000 dental clinic, supported by the Strong Foundation and the city and county government, serves the eligible school children of the first five grades. The recent establishment of a Tuberculosis Committee, with its seal sale, is developing an aggressive health education and publicity program which will make itself felt in no uncertain way.

Each department is worthy of much more mention than can be given in an article dealing mainly with nursing—each supplements the other and makes a whole with which we are proud to be associated and which represents one of the most unique unofficial public health and social welfare organizations to be found anywhere.
I sometimes think that of all forms of social service activity occupying the time and minds of thinking people, the alleviative and preventive work done on behalf of the Juvenile offenders of the state is perhaps the most important of all. In this regard, the Children’s Courts are in a unique position. For here we have appearing before us children of all ages and conditions and of both sexes—the thoughtless and foolish, the very foolish and really incorrigible. Yet, more or less, all are capable of being guided, moulded or marred according to the manner in which they are handled, and finally dealt with by the presiding magistrates. Truly malleable material!

In the State of Victoria, an Honorary Judiciary composed of men and women with wide experience in child welfare work, or of teaching, or some other branch of activity touching child life, is the tribunal before which the Juvenile offenders appear. They are known as Special Magistrates of Children's Courts, and preside only at the particular courts to which they are appointed. There are 114 Special Magistrates in the State, of which number 95 sit in the 22 courts situated in the Metropolitan area, 36 of them being women. For the most part, they have proved themselves to be men and women of ready sympathy and quick understanding, with a very real fitness for their job, and it is generally conceded that the system works admirably. There are 270 Probation Officers attached the courts, who also gave voluntary service, 190 of them attending the Metropolitan Courts. Similarly they are specially picked men and women and of all religions, and it is on this body of officers that magistrates rely to a large extent for the success of their work, as Probation is one of the chief factors in our treatment of juvenile delinquents. About one-quarter of the cases that come up before the courts are dealt with in this way. For the whole underlying
purpose of our work is to save the child, and mould him in such a way that he will eventually become a state asset, and to this end all possible reformative aids are availed of, and punitive measures used only in the most serious cases.

The whole of the administration of the Children's Courts is in charge of a Chief Officer of Children's Courts, who is himself responsible to the Attorney-General. It is within this officer's province to recommend appointments to the Magistracy as well as Probation Officers, and he holds the office too of Chief Probation Officer of the State. Assisting him and the magistrates is a specially chosen Clerk of Children's Courts; and the Prosecuting Officer is a man of rare tact and wide culture—a senior-constable of police with particular experience in this class of work. Briefly that is the personnel of the Children's Courts of Victoria, and one is glad to state that even though there is room for improvement in some directions, most gratifying results are achieved by the use of our honorary system.

As I have been particularly requested to give in this article an account of my own personal experiences in court work, it may be of interest to state that my Court is situated in the prominent seaside city of St. Kilda, and there are three of us appointed to it. My colleagues are both men, one being a retired schoolmaster who devotes most of his leisure to court work, and the other is a responsible official in the Public Service, and a Justice of the Peace. Incidentally too, he is the father of a well-known international cricketer. We find three a very workable number on our bench, and work very amicably together; indeed both my colleagues, in common with most of the male magistrates here, appreciate the value of a woman's viewpoint, convinced that there is a real need for representation of both sexes. I might add that we enjoy equal status in adjudicating, although usually out of courtesy, one magistrate is appointed Chairman of the Bench by his colleagues,—seniority by length of service being the customary qualification considered, when choosing one for this honor.

Although Australia is in the throes of the world economic depression, and has an unprecedented amount of unemployment, there is no indication that juvenile crime is increasing. Indeed, according to the latest figures available, the opposite is the case, as in 1930 there were 324 less cases than in 1929. Altogether, 3,656 cases were brought before the various courts during the year, of which number 159 came to St. Kilda. But in spite of the general decrease in juvenile
crime, cases brought to our court have actually shown a steady increase in the last four years' period; as in 1927 we had 106 cases, 1928—113, 1929—129 and as stated the number mounted to 159 last year. Excluding the City Court which has roughly twice as many cases as any other (for apart from acting as a kind of "clearing house" for "neglected children," and getting a large proportion of the cases for breaches of city by-laws, it sits twice as often as any suburban court), there was only one other court in the Metropolitan area last year, whose total number of cases exceeded those of St. Kilda, viz., the industrial city of Footscray where 171 cases were heard during the year.

A great many of the cases that come before the courts are for larceny, and in the city of St. Kilda with its open parks and wide beach frontages, we get a fair proportion of the cases of sexual offences. In dealing with the young girls concerned in these cases we often commit them to the care of the Probation Officers of the Salvation Army, who draft them into one or other of their excellent "Harbours." As these institutions are splendidly managed and maintained and provide for the reception of inmates of all types, practically nothing better could be devised for the reformation of girls. But in dealing with particularly difficult types, it is sometimes necessary to order a committal to a reformatory school. The magistrates pay periodical visits to the various Homes and Institutions caring for delinquent children, to enable them to understand the exact conditions under which each child will live, and are thus equipped with a knowledge which helps them to decide upon the best course to adopt in each particular case. Very often a child is committed to the Children's Welfare Department, and after a thorough medical and psychological examination is sent to a "Home"; in some cases the home thought most suitable is recommended by the magistrates. These children then become wards of the state and can be kept until 18 years of age, or if the case is still considered unsatisfactory, the child may then be detained until 21 years of age. Country air, wholesome food and plenty of work as well as recreation usually accomplish the looked-for result, and the writer has at times chatted with some of the children sent from the St. Kilda Court and been greatly struck with the general improvement. In no case was there a sign of discontent, and all seemed happy in surroundings which were usually far superior to anything to which they had previously been accustomed.
Curiously enough, by a "casus omissus" in our Act, the Children's Courts have no legal power to commit a boy or girl who can prove means of support, no matter how unsatisfactory or unwholesome may be his or her mode of living. For example, cases crop up occasionally where a boy is found sleeping out night after night in parks or under hedges, or a girl may be known to be living a life of immorality, but as long as he or she is not found begging or receiving alms, nor wandering without a settled abode, does not associate or dwell with thieves or drunkards, nor sells in the streets after lawful trading hours, nor otherwise commits any offence against the law, such child cannot be apprehended because he or she does not come within the meaning of a "neglected" child, as defined by our legislation. Thus, it sometimes happens that parents woefully lacking in all sense of parental responsibility, will come into Court and state that their child is living an unsavoury kind of existence with their knowledge and consent, and prove to the satisfaction of the Court that there is a home of sorts for the child, and other provision for the necessaries of life. Or as in a case within the writer's own experience, a young girl living in a bit of a shack with a married man, whose means of livelihood was very precarious, when found by the police late at night was in possession of a parcel of food, and could otherwise prove that she had "means of subsistence" within the meaning of the Act, so could not be legally dealt with. In this particular case, the girl's mother came to Court, and admitted she knew the full facts. Indeed it was even represented that her mother was content to let her young daughter remain in this undesirable abode, because she had committed the sin of stealing the affections of the man in the case, who was formerly her own lover! However one gratifying result of that girl's appearance in Court, was the fact that by a little judicious persuasion on the part of the woman magistrate the poor child was made to see that it would be in her own best interests to enter a Home for a few months and break away from her evil associations, for the sake of the little one that was to come.

In dealing with boys, (and the cases of boy offenders far exceed those of girls) when probation is not considered suitable, magistrates call to their aid the various Homes and Institutions run by Churches and Missions for the training and care of wayward lads. As in the case of girls, apart from committal to the Child Welfare Department, boys may be sent to any of these private institutions either at the wish of their parents, who undertake to pay for maintenance, or
are sent there after the Courts have made arrangements with the Superintendent or Missioner to accept them, with the consent of parents, who may be financially incapable of contributing towards their support. Where a lad's environment is bad, or the home a disordered one, every effort is made to get a boy placed in a Home where some sort of training in manual arts is given, or farm work taught, supplementing the ordinary school curriculum till 14 years of age, and replacing it after. In these cases, it is often thought best to persuade parents to leave their lads under expert supervision after school-leaving age, as in the case of particularly troublesome boys, the best results are obtained when a fairly long break from old and bad associations is made. Indeed we cannot be too grateful to these institutions for their readiness to receive some of the more serious cases and so help to solve some of our difficult problems.

As for very hardened young offenders, magistrates commit them to a reformatory prison; but this course is never adopted until it is found to be the only method left for adequately dealing with the child. In 1930, there were 37 boys sent to the Castlemaine Reformatory Prison, and of this number 5 had been released by the end of the year, and none of that number has so far been returned. Previous figures compiled however, show that as the testing time extends and the periods lengthen, results are not always so good. For instance, of about 122 cases committed to Castlemaine from the Children's Courts in the last five or six years, 47 have got into further trouble and been returned. But it must be taken into consideration that this reformatory is only used by the Children's Courts for the most incorrigible cases, whereas the Criminal Courts use it for the reception of young first offenders. At the other end of the scale, results of cases released on probation are definitely good. In 1930, 61 girls and 924 boys were placed on probation, mostly for larceny and kindred offences. Of this number 39 had previously been on probation; 95 came again before the various Children's Courts either for fresh offences or breaking probation; in which cases, either probation was further extended or fines imposed; or the children were sent by the Courts or by their parents at the wish of the Courts to some Home. Of the rest 12 were committed to the Child Welfare Department; 21 to reformatory schools, and 5 to Castlemaine. In the case of 5 others, a term of imprisonment was ordered, but sentence was suspended on entering into a bond, and 9 were committed to Reformatory School, but released on bail. Actually 81% of the total number of children placed
on probation in Victoria in 1930 proved quite satisfactory, but easily 10% of our probation cases are unsatisfactory and it is this proportion of recidivists who eventually become the hardened criminals. On the figures obtainable for the past five years, the peak period for juvenile crime would seem to be from 13 to 15 years of age.

Some readers may wonder at the omission of all reference to treatment of cases of mentally-defective delinquents. But altho' such children frequently appear in our Courts, owing to a lack of legislative power in dealing with them, little of a really constructive nature can be attempted. In fact this unfortunate section of delinquents constitutes a grave problem, because in the absence of special custodial provision for them, magistrates are forced to send them to institutions where they mix with normal children. Obviously this is detrimental to the normal and sub-normal alike. Social welfare workers are constantly faced with difficulties owing to this state of affairs, but during the present economic crisis at any rate, it is useless to expect any sort of assistance from an already sadly-depleted treasury. Yet it is only fair to state that at Travancore, a fine building is under course of construction at the moment, and when completed, will be used as a Training School and Home for Mental Defectives. But as it can never hope to take more than a small proportion of the State's Mentally-defective children, it is after all only tinkering with the problem, but happily is the first step in the right direction. From time to time too, there is advocacy for the establishment of a Central Children's Court, with a Psychological clinic attached and for a Stipendiary Magistrate to advise the Honorary Magistrates; although, for obvious reasons, it can be readily understood that some of the Honorary Magistrates would resent this. In addition, some advocate the appointment of a few paid full-time probation officers, and there is much to be said for each and all of these proposals in order to consolidate the work now being done, and improve future results. Some magistrates have a belief in the efficacy of restitution as a salutary factor and suggest this (because they possess no power to enforce it) in many cases of wilful damage where the child is earning money or the parents appear to be in a position to make such restitution. Thus the work teems with difficulties and problems that must be thought out and attacked in a reasoned frame of mind, for as previously stated, it is a very important work that we are attempting, and at best we are students, all of us, learning and perfecting our knowledge as we go along. For we realise that a grave responsibility rests upon
us when we try our skill at moulding the human malleable material that comes before us.

(N. B. I am indebted to the State Attorney-General, Hon. Wm. Slater M.L.A., and the Chief Officer of Children’s Courts, Mr. Fred P. Morris J.P., in giving me access to the latest report of the Children’s Court work in Victoria before the report was released for publication. This concession was made for the purposes of this article.)
EDITORIAL

The Great Quartet

LAENNEC, KOCH, ROENTGEN, VON PIRQUET

Why Their Discoveries Are Our Most Important Weapons in the Fight Against Tuberculosis

By KENDALL EMERSON, M.D.

Advance in human knowledge is not accidental. It results from the work of men capable of building higher on the foundation of established facts. Nowhere in science is this better shown than in the age old conflict which man has waged against his arch enemy tuberculosis. Among the army of builders who have contributed to our present day knowledge of this scourge, four names lead all the rest.

The first of these, Laennec, a hundred years ago, recognized that more accurate knowledge of the disease must precede any hope of its control. The old method of searching for tell-tale sounds in the lungs by pressing the ear to the chest was not enough. One day he saw a boy scratching one end of a log while a companion listened to the sounds transmitted at the other. He applied the law of conductivity of sound to the diagnosis of tuberculosis of the lungs and our modern stethoscope is the result.

Just fifty years ago, March 24, 1882, Robert Koch announced that he had discovered a germ always present in active tuberculous disease and had produced tuberculosis by injecting it into animals. He named his new discovery the tubercle bacillus. Laennec, through the perfecting of diagnosis, Koch through the discovery of the cause, made their respective and momentous contributions toward the conquest of tuberculosis. Both recognized, however, that some method of still earlier diagnosis was needed, for the disease is vastly more curable when detected in its very beginning before it is revealed by ausculta-
tion (listening to the sounds of the chest) and before the tubercle bacilli can be found in the sputum from infected lungs.

It was reserved for Roentgen to disclose the next great step in early diagnosis. A distinguished physicist, Roentgen was experimenting with the tubes invented by Dr. Crookes for the purpose of passing an electric discharge through a vacuum. Roentgen made the startling discovery that reflected from the negative pole were some mysterious rays, capable of passing through solid substances impene-trable to light. He photographed the human body and revealed the bones and organs of a living man. With improved technique, the X-ray is now used as our surest method of discovering the spots and shadows in an infected lung which prove the presence of active or quiescent tuberculous disease.

The fourth great scientist, von Pirquet, added the last significant refinement in diagnostic procedure, the skin test which has been given his name. This discovery was based on the previously known fact that people suffering even mildly from certain diseases, or who have previously suffered from them, develop changes in their bodies which make them sensitive, as we say, to that particular disease. By the use of tuberculin, a harmless liquid secured from cultures of tubercle bacilli, von Pirquet made skin tests on individuals suspected of having tuberculosis in its early stages. If the skin grew red on the second day, he called the test positive since it indicated that the patient had been infected at some time with tuberculosis.

Laennec, Koch, Roentgen, von Pirquet, these are the immortals whose glory lies in their successive contributions to the warfare against an enemy which has claimed more human victims than all the wars of history. Each built anew on the firm foundations laid by his predecessors, and the structure they have reared is the monument to their undying fame.

The priceless contribution each made to medical science has been largely responsible for the phenomenal drop in the tuberculosis death rate. Today, in the United States the death rate from the disease is less than half what it was in 1907. Efforts to reduce the rate still lower continue. Beginning April 1, tuberculosis associations throughout the country will undertake an Early Diagnosis Campaign under the slogan "Find the Other Case." During that time closer coöpera-tion in discovering cases of tuberculosis will be sought among doctors, health officers, public health nurses, and social workers, and
everyone who suspects he may have tuberculosis will be urged to have a medical examination to make sure. If anyone finds he has the disease, he will be urged to secure medical examination for other members of his family to discover the source of the infection, for only by “Finding the Other Case” can tuberculosis be overcome and its spread stopped.
NEWS NOTES

In order to stimulate an interest in visiting nursing and with the idea of creating a desire among young girls to take up nursing as a profession the Visiting Nurse Association, Brooklyn, N. Y., recently held a prize essay contest for high school students.

The late Charles H. Taylor of Beverly, Mass., provided in his will for a gift of $100,000 to the Boston City Hospital for the establishment and up-keep of a laboratory for surgical research.

The Montefiore Hospital, New York City, has discontinued the school for nursing connected with the hospital.

The Illinois Health Messenger reports that 3 features stand out clearly as a result of a study in Illinois regarding health conditions in relation to the economic depression. They are: (1) Health has not been unfavorably influenced to an observable degree. (2) Physical defects, especially in children, are more generally neglected. (3) Relief agencies have been and still are placing great emphasis upon the preservation of health.

After a battle in the medical profession to abandon the term "physiotherapy" and substitute "physical therapy" a move is now being made to adopt what is considered an even better term, "physical medicine," according to the Pennsylvania Medical Journal.

At the time of the recent meeting of the American Medical Association, a new society, the American Society of Physical Medicine, was formed. The British Journal of Actinotherapy and Physiotherapy has changed its name to the British Journal of Physical Medicine. Mod. Hosp.

Illinois Health Messenger reports a case of tularemia attributed to the bite of a wood tick.
The American Child Health Association at the last annual meeting reported that the Division of Health Education shows definite indications of steady and continuous growth in service to educational institutions. The following high points in the year’s activities are given: A marked increase in service to institutions for teacher education; extensive consultant service to the public schools of Porto Rico; the editing and publishing of “Principles and Practices in Health Education”; the report of the Sayville 1930 Conference; active cooperation with the Health Section of the World Federation of Education Association in connection with their 1930 meeting in Denver; increased cooperation with outside agencies as indicated by service on committees and participation in programs; increased advisory service both by individual conferences and correspondence.

The February issue of the Bulletin of the Pan American Union contains a very interesting account of child-welfare activities in Buenos Aires and Montevideo. The child-welfare institutions include hospitals, preventoriums, seaside colonies, a foundling home, newsboys' home, open-air schools, orphanages, nurse inspection service, school medical inspection service and clinics. One of the outstanding child welfare activities in both cities is the treatment and prophylaxis of tuberculosis.

The Statistical Bulletin of the Metropolitan Life Insurance Company reports that there were fewer deaths in 1931 from tuberculosis, diphtheria, whooping cough, pneumonia, diarrheal complaints and puerperal conditions than ever before recorded. The mortality from tuberculosis dropped nearly 6%. For diphtheria there was a drop of 24.6% in one year and of 50% in 2 years. The decline, as compared with 1911, is more than 84%. The new low point in the whooping cough mortality rate was 1.7 per 100,000.

The New York City Department of Health and the Department of Education are cooperating in increasing the medical services and extending health courses in the continuation schools where over 20,000 unemployed adults are being trained in some trade.

The tuberculosis clinic of the Mount Sinai Hospital, New York City has been temporarily discontinued.
The Michael Reese Hospital, Chicago conducts a complete diagnostic service for patients of moderate means. Patients are not accepted unless referred by a physician.

The annual meeting of the National Tuberculosis Association will be held at Colorado Springs, Colorado, June 5 to 9, 1932.

The Massachusetts Institute of Technology offers a full tuition scholarship of $500 in the field of health education. The scholarship will be awarded to a candidate recommended by the National Tuberculosis Association. Preference will be given to candidates possessing the Bachelors degree. Applicants received not later than May 15.

Ten lepers, who have been patients at the Leper Asylum conducted in the Fiji Islands by the Sisters of the Third Order Regular of Mary, have been declared cured by the Doctor-in-chief of the Colony and sent to their respective villages. They will, however, be under the attention of the Medical authorities, who will conduct periodic examinations to determine permanence of the cure. *Irish Nursing News.*

The New York State Association of Judges of Children's Courts has officially approved raising from 16 to 18 years the age limit for jurisdiction of children's courts in New York State.

The annual meeting of the American Public Health Association will be held in Washington, D. C., October 24-27, 1932.

Miss Annie W. Goodrich, Dean of the Yale University School of Nursing conducted a 3-day institute in Los Angeles and in San Francisco. The general theme was "How the nurse can contribute the service the public expect."

The 2nd International Conference on Social Work will be held in Frankfort-on-Main, Germany, July 10-15, 1932.

The Fitkin-Morgan Memorial Hospital at Asbury Park, N. J., erected by Mr. A. E. Fitkin is now open.
In connection with the opening of the Early Diagnosis Campaign the National Tuberculosis Association will commemorate the 50th anniversary of Robert Koch's announcement of his discovery of the tubercle bacillus.

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It is the Will of Allah!

A European health expert responsible for effecting sanitary reforms in Syria asked a Damascus official for information on which to formulate a health policy and program. The conversation, quoted from "Mastodons, Microbes and Man," by Dr. W. W. Peter, was as follows:

Question: What is your birth rate in Damascus?
Answer: I do not know. I was not present. I hesitate to inquire.

Question: What is your population?
Answer: The people are many. But how many, I do not know. They have never all gathered in one place at one time to be counted.

Question: What is your death rate?
Answer: It is the will of Allah that all should die. Some die young; some die old.

Question: What is your water supply?
Answer: From time immemorial no one in Damascus has been known to die of thirst.

Question: What comments have you to make regarding sanitary conditions in your city?
Answer: A man should not bother himself or his neighbor with questions that concern only God. Health News.

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BOOK REVIEW


In his preface to Dr. Holmes' little book Professor Hopkins says: "So important to humanity is the control of cancer that the lay public should surely wish to understand, in so far as it is able, the efforts which are being made to attain to such control. . . . The endeavor of the author of this book has been to make such understanding possible without calling for more than a minimum of technical knowledge."
In this endeavor Dr. Holmes has written a clear, concise and conservative review of the subject. The style is excellent and the presentation good. Within the limits of a handbook she has prepared a most instructive and valuable review of a subject but too little understood. If it were possible to place a copy in every newspaper office to be referred to by the scientific editor, the press might often be saved the embarrassment of giving serious attention to the perennially sprouting cancer "cures" brought to public notice. By far the great majority of these are childish conceptions of the ignorant and illiterate; many are duplications of observations already proved to be false or inaccurate. Dr. Holmes' book could well be used as a yardstick to measure the possibilities of such suggestions. Although designed for the lay public, the book is in fact more suitable for those who have had some training in pathology and bacteriology. The subject matter will be better apprehended by medical students and laboratory workers than, for instance, by nurses whose technical training is limited. The appendix, which explains many technicalities, might perhaps better have been a foreword. It and the introduction should be carefully read and understood before the main part of the book is undertaken.

There is another danger from even so clearly written a text—a danger which is more present in things to do with medical science than with other scientific fields—that is, that the person attracted by a discussion of scientific work, with a mind running along parallel theoretical lines, but entirely without practical training or experience, is prone to theorize on woefully inadequate grounds. Such a person should be warned against drawing conclusions from a mere perusal of this book. No one reading, for instance, Sir James Jeans' popular book, would consider himself an astronomer, qualified to state a new theory of the universe. In medicine, the theorist delights to hold high revel.

To those, however, who wish to be informed as to the advance made in the study of cancer, that great unsolved problem of medicine, and to learn something of its spontaneous occurrence throughout the animal kingdom, its experimental production, its prevalence, and the possibilities of control, and are able and willing to give careful attention to the discussion as given by Dr. Holmes, this book can be unreservedly commended.

John C. A. Gerster, M.D.

Three revisions in three years indicates the popularity of a book. In this instance the compliment of public appreciation is merited. The present edition contains little new material. The general plan of the book remains that of a manual for parents and members of study groups. Each chapter affords questions for discussion and gives specific references for investigating the practical approaches to problems of child care and training.

Ira S. Wile, M.D.


This is a book of opinion about the meaning of the sexual factor in ordinary married life. It is on the whole simple and clear, is sensitive to fine differences and leaves the impression of good taste. Its strength is in its free and sincere acknowledgment of the sexual life between individuals, and the intelligent handling of their problems of fear. The more impersonal technical information is less satisfactory, perhaps because it is concerned with the objective facts of science. Those data are not freely available while the former are the aura of an art to be realized through the emotional life.

The beginning with the definition of innocence (page 14) and the definite directions to the fiancé for rationalizing the past rather than day dreaming the future is charming. As the text goes on, the topics are more difficult and it grows less clear. Medical literature is less positive about certain anatomical functions, for example the hymen, and loss of sexual feeling with the removal of the ovaries, less optimistic about gonorrhea and sterility, less vague about routine postpartum repairs. The authors are against individualism in sex (Dr. Groves is a sociologist) and emphasize monogamy.

The treatment stiffens at the close and ends with the sense of warning, as if the beginning artlessness in dealing with this subject were overcome by the sense of social responsibility.

In writing books in a field relatively unexplored a difficulty is that however excellent the attitude, material on sex remains persistently elementary. For instance, we are only at the stage of perception which takes sex and affection apart, a long way from the one which
treats them as a unit. Data and public opinion have halted before the
difficulty of assigning causes, tracing development, making the com­
parisons and correlations necessary for analysis and synthesis.

These limitations make the chapters on the art of love simple col­
lections of recommendations. The chapter on the love art of the
husband asks for the mood of abandonment to an art, the adaptation
of sympathetic feeling tones, guidance in exploration of the thought
life, intelligent experiment, observation and diagnosis; it comments
about frequency of intercourse, rhythm and posture and gives minor
directions about cleanliness, privacy, and not getting chilled. The
chapter on the love art of the wife says overcome maidenly reserve,
experiment intelligently, be adequately roused by preliminary love
making, don't be jealous, don't nag him to kiss, don't delay love in
the courtship stage, know contraceptives. The difference in these
attitudes is that directions to the man are concerned chiefly with what
is good for the woman; the woman's are partly the rules for begin­
ning marriage, partly routine, and are concerned chiefly with what is
good for herself. The male is active, sometimes profound, the female
passive, sometimes forebearing. These limits are not fully creative.
The chapter on birth control is least adequate; it has to say whether
contraception is wrong or harmful without saying what it is in method,
and in trying to arrange meagre evidence, makes assumptions such as
the implication that contraception favors sterility. The foregoing
difficulties are rooted in the low state of public opinion. They defi­
nitely indicate that thought shall be freest in the approved channels
and constitute an enormous psychological handicap in writing for a
popular audience.

Lura Beam.

Essentials of Psychiatry. By George W. Henry, A.B., M.D.
With an Introduction by Thomas W. Salmon, M.D., and a chapter
on Psychiatric Nursing by Adele Poston, R.N. Baltimore: Williams

The first edition of this book appeared in 1925. It was reprinted
in 1928 and now the second edition has appeared. All of this is evi­
dence that the book has been well received. This second edition is a
complete revision and to some extent an elaboration of the former
edition. In particular chapters 4, 5, 6, 7, and 8 have been expanded
and improved. There are new chapters on Method and Purpose of Mental Examination and Psychiatry in General Hospital Practice.

Chapters 1 and 2 relate to Personality Development and Personality Disorder. They serve well as introduction to the chapters devoted to a discussion of the psychoneuroses and psychoses. These are divided into four groups: Group 1, those disorders largely psychological in nature; group 2, the toxic, infectious and exhaustive psychoses; group 3, the organic psychoses; and group 4, called constitutional inferiority. This chapter dealing with Constitutional Inferiority is, as one may well suspect, the weakest one. The author defines constitutional inferiority as "a general descriptive term applied to those physical, intellectual, instinctive and emotional defects which are inherited, congenital or acquired very early in life." It becomes a catch-all and as such as little value as a meaningful term.

The chapter on Psychiatric Nursing is well done and could be read with profit by all nurses not alone those engaged in nursing mentally ill patients. In discussing psychiatric social service the author points out that "she (social worker) should be occupied with the task of procuring for the psychiatrist the necessary social data regarding the patient and under the direction of the psychiatrist she should be engaged in adjusting the social problems of the patient. In other words her task is the adjustment of external social problems while the psychiatrist attends to the adjustment of the personality conflicts of the patients."

The book unquestionably in its revised edition will be found useful in presenting the subject matter of psychiatry in a well rounded and well balanced yet concise manner. It should prove of value to medical student, practitioner, nurse and social worker.

HENRY C. SCHUMACHER, M.D.

ABSTRACTS


The history of rheumatic heart disease forms an interesting chapter in the development of medical knowledge. In ancient and medieval times the various forms of joint diseases were confused. Acute rheumatism, arthritis, gonorrheal arthritis, arthritis deformans and
other forms of joint disease were all classified as arthritis. The first
definite statement regarding the relationship of other clinical condi­tions and certain forms of heart disease was expressed by Pitcairn
in 1788 when he stated that he believed persons suffering from acute
rheumatism were liable to develop symptoms of an organic disease of
the heart. In 1836 Bouilland through experience and study confirmed
this fact. At present there is much confusion as to the ultimate cause
and specific treatment of the rheumatic state. Authorities differ;
Small and Birkhang believe that a definite type of streptococcus is
the cause. Swift and his co-workers maintain that acute rheumatism
is the result of an abnormal response on the part of the tissues of the
human organism to the toxine of various streptococci that are located
in some focus in the body. In the field of therapeutics we are still
grouping in the dark. Our weapons of attack are limited to: (1) in­
creasing bodily resistance against infection, and (2) properly super­
vising the child when he does come down with acute rheumatic heart
disease. Both belong to the realm of nursing and upon the nurse the
physician relies. The author describes the heart, its function, the
changes that occur when the heart is attacked by rheumatic infection,
the symptoms, the treatment and care necessary, rest, food, exercise,
in short this article constitutes a complete guide to the nursing care
of rheumatic and cardiac cases. The fundamental principles of treat­
ment are stressed. The author feels that it is more important that
the nurse understand the nature of the disease process and the raison
d’ être of each therapeutic procedure than that she learn detailed and
specific instructions. The basic principles may be applied to any
case.

“Social Service at the Massachusetts Eye and Ear Infirmary.”

The author discusses social service in the Massachusetts Eye and
Ear Infirmary in its relation to increased efficiency in handling a spe­
cial group of cases such as ophthalma neonatorum phlyctenular dis­
ease, ocular tuberculosis, interstitial keratitis and glaucoma. The
work began with a single worker who first unobtrusively studied the
clinic and then began to make herself useful by follow-up work. This
worker was the connecting link between the hospital and the social
agencies outside. The staff gradually became aware of this helpful
service when resistant cases received treatment and others requiring
continued treatment returned to the clinic. In 1910 a drive was made in Massachusetts to reduce the ravages of ophthalmia neonatorum. Social service in the Eye and Ear Infirmary was ready to step in and do its first piece of intensive social work as a special group of cases. The contagious ward was not designed to admit mothers with their babies so social service made provision for supplying the babies with breast milk. The worker went into the homes and persuaded the parents to submit to examination for venereal disease and influenced them to take treatment when treatment was prescribed. In 21 years of service 2,238 babies with ophthalmia neonatorum have been treated in the hospital’s isolation ward. The number diminished from 458 in the 5-year period 1905-1910 to 189 in the 5-year period 1929-1930. Social service made it possible to follow the phlyctenular disease cases through the various clinics of the Massachusetts General Hospital where other signs of open and closed tuberculosis might be discovered. When the entire medical and social picture of the child was ready for presentation a conference of the various interested persons was called and the disposition of the case decided. The doctors guided by data obtained by the social worker made the decision; social service carried it out. A class for adults suffering from ocular tuberculosis was formed. Some 130 cases were handled; this was made possible largely by social service through follow-up. A study of 63 of these cases over a period of years was published by Dr. Carvill and the author in 1927. Social service has followed about 2,000 cases of phlyctenular disease in 20 years. At present there are about one-third as many as 7 years ago. With cases of interstitial keratitis the social worker was a valuable adjunct to the physician. Patients were kept under the long-continued treatment and watched for recurrences. Close relations were established with the expert syphilological department of the Massachusetts General Hospital which later took over this work. Their social worker took over the cases excepting insofar as the eyes were concerned. Amazing results have been obtained with glaucoma cases. In 1926 there were approximately 200 glaucoma patients followed intensively, while some 300 more to whom a follow-up postal was sent with scant result. In 1927 there were 262 glaucoma patients listed for intensive work. In 1928 an additional social worker was provided by the National Society for the Prevention of Blindness and the real increase began. Some 582 cases were handled intensively that year. In 1929 there was a total of 740 cases. For each of the last two years 316 new cases have been treated. In
1928, 55 cases were operated; in 1929, 116 cases. Another field for intensive work is with the highly myopic cases. Management should begin in childhood if any degree of success is to be obtained. The author is of the opinion that a properly developed social service department in an eye hospital adds largely to the hospital's efficiency, in fact he considers social service indispensable. So sure is he of this fact that he states that if he were given a sum of money with instructions to use it to the best advantage to prevent blindness he would engage a competent social worker and put her in an eye clinic.


One of the serious problems confronting public health and medicine is an adequate and equitable distribution of medical service. Physicians for various reasons are drawn to the cities and as a consequence the rural districts have suffered. Important factors have greatly accelerated this movement. The automobile has made it possible for a physician to cover in an hour or so space that would have taken a day in a past generation. Neighborliness has suffered by the same process of widening contacts. If the professional fee of a city physician is not prohibitive contact once established may be continued through home visits. There is also the possibility of hospitalization at the larger centres. In this city physicians have an advantage over the country practitioner. This indeed constitutes the only sound reason for seeking such counsel. The medical student of today is a highly finished product. The laboratory has become for him an important diagnostic and therapeutic tool. If given an equal opportunity in the school of experience he will probably develop into a finer physician than his elders. These scientifically trained young physicians cannot be expected to give up the city hospital and laboratory on which he depends for diagnostic help in the practice of medicine to assume the life of a country practitioner. The community hospital is the answer. The establishment of a community hospital will not only enable the physician to satisfy his own professional conscience, it will assure the community the optimum of medical service at his hands. If modern hospitals are established in rural communities the highest type of young physicians naturally will turn to the small community. The respect and regard a physician commands in a small community will outweigh in a majority of instances any monetary advantage he might expect to find in a larger city. The establishment
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of a community hospital will awaken community conscience. The hospital should lead in preventive medicine; baby clinics, nutrition classes, prenatal instruction and all other forms of health work should be developed in the community hospital, which is the logical centre for preventive medicine. Financing the community hospital is a difficult problem but each district can work out its own plan and when the people realize the importance of health work means will be found. The fully equipped community hospital will benefit the physician who will have the facilities for expert diagnosis and treatment. By an unselfish arrangement of duties and of time staff members might establish a diagnostic clinic, entirely apart from their several practices. Such a service would meet not only the needs of the community but might also prove of service to the profession and to the people of the surrounding country.


The author chose his subject with the purpose of indicating the possibility of engaging workers with sub-effective hearts for productive positions in industry and to call attention to the little-recognized fact that all damaged hearts are not necessarily excluded from usefulness in active manual work. The unemployment situation will have a tendency to set physical standards even higher than in normal times and employers may seize the opportunity to weed out all those even slightly handicapped. Thus we have potential social burdens. The management and handling of a cardiac case is not within the logical scope of a physician in industry, but should be under treatment or observation of the employer's personal physician. This phase of damaged heart is not considered in this article. The ambulatory case, which would without examination pass employment requirements is considered. The industrial physician takes no chances; he does not wish to risk criticism so the application of the man with even a slightly damaged heart is rejected. How are we to differentiate, select and decide to place, or not to place. (1) By having authority to dictate the policies relative to health placements. (2) To have fixed policies. (3) To be able to diagnose and differentiate. (4) To have a complete knowledge of the nature of the work that the applicant is selected to do and what he is apt to be called on to do in his department. Time should be allowed to make a thorough history of all cases presenting heart lesions. It is the fair thing to do for
Abstracts

both applicant and employer. The industrial physician is over-cautious. Even the most conservative insurance companies are willing to accept certain arrhythmias without premium rate increase up to the age of 35 years; 6 extra systoles per minute are also allowable to the age of 30 years. To put ambulatory cardiac cases at entire rest and allow musculature to become inert, must be precluded as a therapeutic error. The heart does not differ from other muscular structures; exercise keeps the heart and circulation in tone. The author gives leading thoughts as to grouping of potential cardiac cases as well as for those recognized as definite cases of cardiac disorder. He also gives some interesting figures regarding the various types of cardiac cases and their ability to carry on in industry. Each industry has its individual obligation to community life and it is our civic duty to establish a specific policy adaptable to the industry by which cardiac cases can be selected and placed to mutual advantage.
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