THE LIBRARIAN AND THE SOCIAL WORKER IN THE HOSPITAL*

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It was my good fortune to see and to read with considerable care a recent article by Cabot.¹ My attention was held by the “four hopes” he expressed for hospital social work and the thought came to me, how truly it would profit hospital library work if every hospital librarian would aspire to similar goals in her profession.

These hopes of Dr. Cabot’s, translated for the hospital library group might be: (1) That as a part of the whole library profession, as one type of library work among others, we shall keep in closer touch with the entire library field in its ideals for the improvement of the social order. (2) That we shall determine more closely and more effectively just what we mean and wish to accomplish through treatment by reading, or bibliotherapy. (3) That we shall build up and maintain a high quality of individual work as well as continue the extension of library service to the whole hospital population. (4) That we shall succeed so well in understanding our function as hospital librarians and shall so thoroughly believe in our work, that all the courtesy, the sincerity and native fineness in the hospital librarian’s nature will find response in the mind and heart of the patient—that he may see and remember her not for her stereotyped library technique, but as a considerate friend ready to make the library’s part of his stay in the hospital pleasant and even profitable, rather than merely endurable.

Hospital social workers and hospital librarians have much in common in their ideals and methods of approach to patients. Both

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groups need reminders perhaps that emphasis should be placed on the human rather than on the technical side of their work. While the two phases are about equal in importance to the proper functioning of a department, the latter exists only for increasing the effectiveness of the former and must not in any manner eclipse it as a focal point for attention. When one is catching a train he is concerned with the reliability of his timepiece as indicated by its face. Only the jeweler will be interested in the details of its mechanism.

We hospital librarians at any rate must not permit ourselves to become so over-burdened with thoughts of the endless rows of books to be classified and cataloged, magazines to be recorded, stamped and delivered and books to be repaired, labeled and shelved, that we seem hurried in our contacts with patients, thus communicating to them our feelings of nervous haste and unrest. The hospital librarian should always appear to have time enough for her visits to patients and if any portion of her work must be neglected, her concern about it should never be reflected in her attitude toward them. She should zealously guard against jeopardizing their friendly relationship—so all-important to both, if the library is to function as an active therapeutic agent. Can it so function? Physicians who have seen it demonstrated maintain that it makes a marked contribution to therapy. Patients constantly speak of their dependence upon library service for contentment during enforced hospitalization. So far we have no measuring stick by which to gauge the intangible values accruing from therapeutically chosen literature. After all, the best things in life are those incapable of accurate measurement.

Dr. Cabot mentions the great need the sick have for encouragement. In this field the hospital librarian finds one of her best opportunities for service. Strange to say, some of the literature found by experience useful for this purpose is not of the sort usually classed with the "courageous" books. Bruce Barton's, Orison Swett Marden's, Roger Babson's, and similar ones will naturally be thought of in this connection but hospital librarians have occasionally found patients whose spirits are kept up by reading the normally "depressing" books. The reason given is that they are made to feel more satisfied and contented with their own difficulties when reading of others worse off. At least this is a more hopeful view to take than was that of the old lady who always felt bad when she felt better because she knew she would feel worse afterward!
The “prescribing” of literature is an individual matter and requires acquaintance with each patient, as well as an intimate knowledge of reading material available in the library and of outside library resources. Knowing something of the diagnosis of each patient is exceedingly helpful. His main interests and previous reading predilections are usually revealed to the librarian with the easy informality induced by friendly chatting about books and magazines as they are displayed on the hospital book-cart. With this contact established, little difficulty is experienced in retaining the patient’s interest in reading, especially if his former habits have had a trend in that direction, or if he is given to hobbies.

Newspapers and magazines constitute the reading of countless numbers of busy people in this machine age and there are many, many persons who have received their introduction to books while occupying hospital beds. These patients have often expressed surprise at being carried in imagination beyond hospital walls and away from thoughts of their illness. Such mental diversion cannot be detrimental in its effect and there is good reason to believe it beneficial.

One patient registered his feeling in this situation when he said: “Since my first introduction to geography it has been my greatest desire, some day, to travel and hunt big game. Now here I am with tuberculosis and doomed to spend the rest of my life ‘taking care of myself.’ My dreams are not lost to me altogether though because of the fact that others who have had the pleasure of traveling have also found time to write about their experiences and adventures. Many a time when the nurse enters the room she does not find me here for I am in Africa, or Alaska, or China perhaps, and it takes something like a thermometer stuck in my mouth to break the spell.”

A man from a disturbed ward in a hospital for neuropsychiatric patients became so absorbed in reading astronomy that he worked out a plan for setting his watch by the rising of a star and when this came out exactly with Western Union time, was much gratified.

A librarian working among tuberculous patients in a Veterans’ Administration hospital calls particular attention to the interest of the patients in outdoor things as spring approaches, creating a demand for nature books of various sorts.

The birds in the trees, seen from the infirmary window or the hospital porch, as well as the moths and insects of many kinds, come
in for their share of observation and study. All contribute to making the patient's hospitalization period agreeable.

One man who rarely reads anything was given some tadpoles to keep in his goldfish bowl and so there came to the librarian the request for Dickerson's Frog Book and the patient found wholesome mental diversion.

The birds and flowers in this southern hospital are always a part of the patients' lives, especially so when the interest is fostered by a nature-loving librarian, causing books on these subjects to be in constant demand. The comment is called forth that this interest of the patient in nature, seems to instill within him a greater desire for life, and hope in the face of illness.

A unique case of the therapeutic value of the hospital library was that of an anaemic patient with a poor appetite whose physician told him he must try to eat and build up his strength. Food had no charms for him so when the librarian visited his room with the book-cart he would request such magazines as Pictorial Review, Good Housekeeping and Ladies' Home Journal. The librarian's curiosity was aroused since in a hospital for men these magazines are often scorned. The patient finally confided to her that he was making an effort to stimulate his appetite by looking at pictures of tempting dishes and by reading recipes. He said this really increased his desire for food.

Considering hobbies as a means of introducing the library to patients, one hospital librarian tells of a dog fancier discovered among her clientele. He had been difficult to approach and seemed depressed until one day when the book-cart was taken to his ward he picked up a magazine, and running through it, found an unusual dog picture. This was the first interest he had displayed in anything and in talking with him about it the librarian discovered he had raised collies and that some of his stock were from Arthur Payson Terhune's kennels. It was not hard from that time to secure a response from this patient. In addition to Terhune's, other dog stories in the library were read and material was secured from the state library on the raising and training of dogs. The therapeutic benefits were in this case extended into practical help in his everyday occupation.

The right book given to a discontented patient not only benefits him but, as one ward surgeon commented, every book read by such a patient proves of therapeutic value to other patients in the ward even if not to the man reading the book.
The circumstance calling forth this remark was that of a man who combined a broken leg, with a quarrelsome, argumentative disposition and a high-pitched nasal voice, disturbing to all within its range. When he was occupied in reading, peace was restored so that others sharing the room were benefited.

The hospital librarian, working with the mentally afflicted, must exercise a different technique and much patience, but according to the expression of librarians enrolled in this service the proportion between the effort required and the results obtained is nevertheless maintained. Her approaches may be met apathetically for days and weeks—and then, the gleam, making the response more than ever an adequate reward. In working with neuropsychiatric patients, individual rather than group attention must again be employed for best results.

In one instance a librarian mentions that no response whatever was received from a particular mental patient when the regular round of the wards was made with the book-cart. His ward surgeon, however, believed it was possible to arouse, through some channel, his interest in reading. In this hope he was daily taken to the library where he would sit perfectly immobile wherever placed. His home town newspaper would be put into his hands and his attention directed to certain articles on the page. For a time it was necessary for the librarian to turn the pages for him. Otherwise he would sit for hours staring at the same page. Gradually he began turning the pages for himself and finally read the entire paper. After a time he would stop at the periodical rack as he came in and choose his favorite newspaper, take it to his accustomed chair and read it thoroughly. Later he was given magazines and it was found he would always recognize a particular one if it had been seen previously. From this beginning he progressed until able to work in the occupational therapy workshop, where, though slow in action, he did creditable work.

This is only one of the numerous examples of bibliotherapy the hospital librarian experiences in her day's work. To guide the mind of the patient toward the kind of reading that will not over-stimulate yet will cause him to forget self while the healing art of the physician is practiced; to interest him as his strength returns, in planning for his future by supplying constructive reading that will aid him in his mental as well as physical adjustment—these are some of the aims and objects of bibliotherapy.

In the institutions of the Veterans' Administration where neuropsychiatric patients are hospitalized, two or three of those best suited
to this duty at each station are selected to help the librarian. They are eager for the privilege of being chosen for library duty and the atmosphere of the quiet, homelike room seems to have a soothing effect on their nerves. Invariably it has been found that these patients become more careful in their habits and personal appearance in trying to live up to their surroundings.

The hospital social worker and the hospital librarian may greatly help each other to attain their mutual ideals, by cooperating in their efforts for the welfare of the patient. They equally need his good will, and both desire to be regarded in a friendly light. When the social worker is obtaining a case history some references indicative of the patient's reading interests are likely to arise. When these are passed on to the librarian and discussed with her she is in a better position to judge whether these former interests should be fostered by books on the subjects or whether the aim should be to develop new lines of thought. Conversely, the librarian in talking of books and reading with her hospital patrons, may frequently discover their personal anxieties. She may perchance touch upon the responsive chord which the social worker is also seeking for her more complete understanding of the patient. Such sharing of experience and coordinating of endeavors is an object worthy of our best efforts.

REFERENCE

CARDIAC WORK IN CINCINNATI

JULIEN E. BENJAMIN, M.D.

AND

JANET K. LAUER

Cincinnati, Ohio

Any internist in touch with the Medical Ward of a large general hospital for any considerable length of time, becomes impressed with the fact that certain faces appear with sufficient regularity in the beds of the ward to make them at least familiar. A certain cycle characterizes the return of these patients. They are usually absent during the period when the weather is comfortable and warm and return during the late fall and at rather frequent intervals thereafter for several months. This army is mostly made up of cardiac cripples.

This picture was so impressive that, as early as 1922, a study was made of several of these cases and the decision was reached that, whereas they were more or less hopeless cases, the fact of their frequent return to the hospital, in many instances, could be explained by neglect and lack of guidance after their discharge.

Finally in the year of 1923, on behalf of these patients, it was decided to conduct a clinic for cardiacs discharged from the Cincinnati General Hospital. It need hardly be added that before very long this was an exceedingly large clinic. It constituted, as far as can be traced, the first Heart Clinic outside of the city of New York, and as a matter of fact, was one of two conducted at that time. Not a very elaborate social program was outlined at that time. The clinic was manned by a nurse and a physician, the idea being to follow up the cardiacs discharged from the medical wards of the General Hospital and to see them at frequent intervals at the clinic. It was considerably later that contact was established with the Social Agencies whereby relief could be obtained for the abjectly poor families, as well as sedentary occupations and other rehabilitation measures to which the agencies had access.
Nothing was heard at that time of heart disease as the "captain of the causes of death." As a matter of fact there was rather perfunctory interest in the problem as a whole. There were no records at that time of how much influence was being exerted in keeping patients out of the hospital, but we were convinced after a few clinic sessions that the patients as a whole appeared happier than they had been before. However, since then records have been kept which reveal that an average of fifty patients have been kept out of the hospital who would formerly have been hospitalized from one to five or six times a year.

The most recent incident in the history of cardiac work in Cincinnati occurred in 1927 when a well rounded program was provided for Greater Cincinnati. Through the Amanda Burnheim Foundation and the Cincinnati Community Chest a budget of $12,000 was provided and the Heart Council of Greater Cincinnati came into existence. Since that time its growth and development have had some rather interesting phases which are worthy of mention.

Original Plan of the Heart Council

1. To work in close cooperation with the Cincinnati Academy of Medicine and submit to the Academy regular reports upon the progress of the work.

2. To continue the clinic in the Out-Patient Department of the General Hospital and establish a clinic at Shoemaker Center for negroes.

3. A school program which would involve having the district physicians of the Board of Health weed out cases suspected of having heart disease, having them re-examined and classified by physicians representing the Heart Council and placed under the proper supervision as far as their physical activities and school regime is concerned. Nursing visits in the home to insure that the recommendations of the physician are carried out. Also an effort to provide a program for following up of children recovering from communicable diseases or suffering from ailments that might lead to heart disease. Children whose parents are able to afford family physicians would be followed up only through and in cooperation with the family physicians.

4. A similar program should be pursued with children of preschool age in connection with the "Summer Round-Up" of Children.

5. An effort should be made to provide convalescent care for cardiac patients, children and adults.
A program of publicity and education should be outlined, especially emphasizing the periodic physical examination.

It was possible, by the establishment of a definite budget to employ a full time executive secretary, two nurses, and a secretary, and thus increase the scope of the work. In its organization, as far as possible, the plans outlined by the American Heart Association have been adopted and close coöperation with all the social agencies in the city has been established.

There are in operation at present, seven clinics each week in Greater Cincinnati, and two county clinics which are held once a month.

1. The original clinic at the General Hospital which ministers to the needs of discharged cardiac patients, potential cardiacs, patients referred from the other clinics of the Out-Patient Dispensary, and serves as a teaching clinic.

2. Clinic operated in connection with the Board of Health at its Health Center.

3. Clinic at the School for Crippled Children.

4. Clinic in the outlying district of the city.

5. Clinic at one of the private hospitals (The Jewish Hospital) to care for patients of a somewhat different walk of life than ordinarily visit the General Hospitals plus patients who cannot attend other clinics on account of employment or attendance at school.


There are at present 589 patients under supervision (Graf No. 1 shows the monthly registration). Every case is registered with the Confidential Exchange of the city and there are complete records in each case. Cases are classified according to diagnosis and the distribution according, to this classification is as follows:
### Classification of Heart Clinic Patients According to Diagnosis, Sex, Color, and Age

**Cincinnati Heart Council, October 1, 1928 to 1929**

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*This includes arterio-sclerosis, hypertension, arterio-sclerosis with hypertension, coronary artery, myocardial degeneration, etc.*
All of the clinics operate similarly. The same trained nurses and staff minister to all of them.

No other phase of cardiac preventive work is so important as the follow up of the patients. It is now possible to keep in touch with practically every cardiac patient discharged from the General Hospital in order to prevail upon him to return to one of the clinics. All old patients are visited in the hope of insuring their regular attendance. Graf No. 2 shows the distribution of these discharged patients.

A complete social history is secured in each case and where there are contributing problems the aid of allied agencies is sought. For example: If a patient is living above the first or second floor of a building in poor home conditions the case is referred to the Better Housing League for placement in a suitable location.

Should a patient be able to work at certain trades and be unemployed or in a harmful occupation, it is recommended that he register with the Handicap Placement Bureau which agency will attempt to place him in a position which will not be taxing to his strength. During the past year eighty-nine patients were served by this agency. Their ages ranged from fifteen to seventy years, and with few exceptions they had been employed in unskilled occupations. The detailed report of these cases will be found in Appendix I.

If relief is needed to supplement too small a family budget the case is referred to the family service agency. (Associated Charities.)

If a patient is old and destitute and living alone he is sent to the County Infirmary. In connection with this institution there is a hospital for patients suffering with chronic diseases. This hospital is used for those patients who are suffering from heart trouble and who are destitute and unable to be up and about.

In the case of school children with serious heart disease, it is recommended that they attend the special school for the handicapped conducted by the Board of Education. The pupils are called for and returned in a bus, carefully watched by the school nurses and doctors, are given rest and treatment and are seen regularly in the heart clinic which is held there once a week.

It has been found wise to exercise a particular amount of caution in transferring children from a regular school to this special school. The care and attention given here, it is feared, might tend to make them neurotic. Hence every case is considered from every point of view before this step is taken. If the handicap is more or less tem-
porary and should the condition clear up after a certain period at this school, great care is taken to re-establish the child upon an equal basis with normal children in the regular school in order that he may have no carry-over. We are at present treating thirty-five children in the clinic at this school.

Several special studies are being made by the clinicians. One on congenital heart disease, one on rheumatic heart disease, one on the deaths due to heart disease among the clinic patients, and, as new drugs for the treatment of cardiaços are reported in the literature a clinical investigation is conducted, results discussed before the drug is accepted as part of the dispensary therapy. The reports of these studies are published under separate titles.

It was decided early in the organization of the Heart Council that a certain amount of the budget each year be appropriated for clinical research. Carrying out this plan during the past two years an attempt has been made to ascertain the number of individuals suffering with heart disease in the different industries. The report of the findings and plan of procedure is given in Appendix II.

Summary

For the following reasons it is believed that the program for the relief of cardiaços in Cincinnati presents certain features differing from most of the clinics at present in operation throughout the country.

1. The clinical work has the whole-hearted support of the Cincinnati Academy of Medicine and most of the work has close affiliation with the Medical College of the University of Cincinnati.

2. The counselor body has representatives from all of the groups in the city. This includes the College of Medicine, the Academy of Medicine, the larger insurance companies, all of the social agencies, dentists, the Superintendent of Schools, and nursing group.

3. The program is well balanced between research and clinical activities.

4. The clinical activities are not confined to the city, but have extended into the county.

5. The working relationship between the social agencies and the Heart Council, is noteworthy.
J. E. Benjamin and J. K. Lauer

APPENDIX I

NO. 2

SUMMARY OF SERVICES RENDERED BY HANDICAP PLACEMENT
BUREAU TO CARDIAC CLIENTS

OCTOBER 1, 1928 TO OCTOBER 1, 1929

89 clients were served. (59 white; 30 colored.)

Ages were as follows—

<table>
<thead>
<tr>
<th>Age Group</th>
<th>15 to 20</th>
<th>20 to 30</th>
<th>30 to 40</th>
<th>40 to 50</th>
<th>50 to 60</th>
<th>60 to 70</th>
<th>70 to 80</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clients</td>
<td>19</td>
<td>17</td>
<td>11</td>
<td>18</td>
<td>15</td>
<td>7</td>
<td>2</td>
</tr>
</tbody>
</table>

The status of these cases is as follows:

- Permanently employed ........................................ 29
- Temporarily employed ........................................ 6
- In training ................................................. 5
- In Public School ........................................... 7
- Ill or convalescent ......................................... 4
- Non-coöperative ........................................... 10
- Non-susceptible ............................................ 10
- Deceased ................................................... 4
- Closed .......................................................... 11
- Pending ....................................................... 3

The occupations of those permanently placed are:

- Mechanical drafting
- Checking on finished materials
- Making blue prints
- Spraying
- Assembling
- Meat cutting
- Packing (small articles)
- Clerical work (office)
- Record clear work
- Carpet weaving
- Repairing toys
- Chauffeuring
- Janitor work
- Caretaking
- Elevator operating
- Night watching
- Watching parked cars

Those permanently placed have been carefully supervised by the rehabilitation worker and her observation of their work in industry together with consultation with physicians and nurses as to the amount of stair climbing, weight lifting, standing, walking, and stooping, which is safe in each instance, has brought most encouraging results.

Twenty-three temporary placements were made, sometimes to test the work tolerance and again when age or physical condition indicated the client was not capable of sustained effort.

An intensive study of the social, educational, and occupational background of each client was made, his special aptitudes and temperamental likes and dislikes were evaluated in order that intelligent vocational guidance might be given in the light of the physical limitations.

When planning for juniors, the cumulative school records and psychological tests were used in determining whether the intelligence and ability of the client warranted further academic training.
parents did not favor further education or where the financial condition of the family would not admit of keeping the child in school, a supplement was obtained. In one instance, when approached by the rehabilitation worker, a girl's grandmother agreed to pay $7.00 a week for her maintenance while she completes her high school work. Another young girl who is taking a commercial course at Woodward High School is receiving $7.00 a week from the Joseph-Julian Scholarship Fund.

Funds of the Vocational Rehabilitation Service of the State were used to train five cardiac men in architectural drafting, mechanical drafting, applied electricity, watch and clock repairing, and bookkeeping.

The Associated Charities supplemented $10.00 a week in the home of one trainee. He is now working as a mechanical draftsman, and continuing his studies at night at the Ohio Mechanics Institute. The Charities also made a loan of $30.00 a month to another trainee. General business training is being given to a young married man whose family is also being aided by the Associated Charities.

The non-co-operative group include those who failed to attend clinic and have not responded to repeated efforts on our part to confer with us regarding employment. The problem in some instances is complicated by excessive drinking and lack of habits of industry.

The non-susceptible group includes the aged, the 2-B cases, and a number with venereal and other complications. In each instance where the applicant was considered by the rehabilitation worker as non-susceptible, some other adjustment was made where maintenance of the client was assured. In some instances employment was obtained for another member of the family, thereby meeting the financial need of the home. Children were found able and willing to provide for their parents when it was pointed out to them that the father was no longer able to work. The cooperation of a family service society was enlisted when all other means failed.

When the rehabilitation worker presented the needs of a family to The Cincinnati Street Railway Co., a supplement of $50.00 a month was made by the company to a motorman, disabled by heart disease, who had been in their employ for 24 years.

APPENDIX II

Program and Plan of Procedure for Survey as Outlined by the Committee on the Life Conservation Program of the Council

1. A survey to be made of 1,000 clerical employees.

2. Survey to embrace a complete physical examination of each person: this examination to include urinalysis, Wassermann, and any other necessary laboratory examinations. X-ray examinations to be made when necessary.
3. Examinations to be confined to males of 35 years of age or over as far as possible and to those persons whose occupations are more or less confining.

4. No information is to be given to any employer relative to any single employee but the employer may be told that a certain percentage of employees examined were found to be in need of medical care. *The examinations must be confidential.*

5. Information as to physical condition may be given to any person when request is made in writing.

6. Persons examined and found to be in need of medical attention must be referred to their family physician, with advice to consult their physician.

7. A report of the examination will be mailed to the family physician of any person examined when such person examined requests in writing that a report be made.

8. The examination shall be made by a physician who is not in private practice.

9. Forms which are approved by the committee shall be used for recording the examinations.

10. The examination shall be a complete physical examination and the findings shall be presented as is mutually agreed upon by the examiner and the committee.

11. The purpose of this examination shall be explained to each employer and employee with the request that the examination be made but it must be understood that the examination is not compulsory.

12. The records and findings of the examiner shall be open to the committee at all times.

13. A compilation of the data shall be made and the findings analyzed so that they will indicate the results of the survey.

14. Necessary cards, forms and literature which shall be needed in successfully carrying out this work, shall be printed.

15. The actual work shall be begun not later than November 1, 1928, and completed not later than June 1, 1929.

**APPENDIX III**

**Some Facts Disclosed by Physical Examination of 3,000 Industrially Employed Men of Ages 25 and Under to 65 and Over in Cincinnati**

Study No. I—1,000 White Clerical Workers
Study No. II—1,000 White Machine and Hand Tool Operators
Study No. III—1,000 Negro Factory Workers

<table>
<thead>
<tr>
<th>Study</th>
<th>I</th>
<th>II</th>
<th>III</th>
</tr>
</thead>
</table>
| 911   | 836| 781| men possessed physical defects which are leading to or eventually would lead to serious physical handicap.
In view of the apparent causes which predispose to heart disease around 40 years of age, it was found that:

<table>
<thead>
<tr>
<th>III</th>
<th>II</th>
<th>I</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>4.4</td>
<td>1.6 per cent. of the group had albumen in their urine</td>
</tr>
<tr>
<td>0.4</td>
<td>2.0</td>
<td>1.9 per cent. of the group had sugar in their urine</td>
</tr>
<tr>
<td>24.9</td>
<td>9.1</td>
<td>12.9 per cent. of the group had high blood pressure</td>
</tr>
<tr>
<td>11.9</td>
<td>12.3</td>
<td>13.0 per cent. of the group had low blood pressure</td>
</tr>
<tr>
<td>35.8</td>
<td>34.6</td>
<td>42.3 per cent. of the group were overweight among whom heart disease and high blood pressure were conspicuously more common than for those not overweight</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>III</th>
<th>II</th>
<th>I</th>
</tr>
</thead>
<tbody>
<tr>
<td>55.6</td>
<td>31.0</td>
<td>36.1 per cent. of the group were found to have significant heart defects</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>III</th>
<th>II</th>
<th>I</th>
</tr>
</thead>
<tbody>
<tr>
<td>996</td>
<td>885</td>
<td>728 men possessed physical impairments of varying importance which were unknown to them, or at least they did not admit knowing of them</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>III</th>
<th>II</th>
<th>I</th>
</tr>
</thead>
<tbody>
<tr>
<td>996</td>
<td>965</td>
<td>805 men would definitely profit by early medical care</td>
</tr>
</tbody>
</table>

The Heart Council of Greater Cincinnati
312 West Ninth Street
Cincinnati, Ohio
THE PROBLEM OF CARDIAC REHABILITATION IN A MID-WESTERN CITY

MINNIE LANDEN

AND

JULIEN E. BENJAMIN, M.D.

Chief Social Service Worker, the Heart Council, Cincinnati, Ohio

During the three year period, October 1, 1927 to October 1, 1930 a total of 1,684 persons were examined in the six heart clinics conducted by the Heart Council of Greater Cincinnati in various sections of Cincinnati and Hamilton County. Nine hundred and twenty-three of these patients were white and seven hundred and sixty-one were colored. Over one thousand patients had organic heart disease as shown in the following table:

<table>
<thead>
<tr>
<th>Age Groups</th>
<th>No. Cases</th>
<th>Organic Heart Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 15 years</td>
<td>367</td>
<td>157</td>
</tr>
<tr>
<td>15 to 25 years</td>
<td>212</td>
<td>102</td>
</tr>
<tr>
<td>25 to 40 years</td>
<td>386</td>
<td>227</td>
</tr>
<tr>
<td>40 to 60 years</td>
<td>537</td>
<td>424</td>
</tr>
<tr>
<td>Over 60 years</td>
<td>182</td>
<td>162</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1684</strong></td>
<td><strong>1072</strong></td>
</tr>
</tbody>
</table>

Of the 579 individuals in the first two of the above groups we find that only about one-half had evidence of organic heart disease while in the three older age groups there were 813 persons out of a total of 1,105 cases who were found with organic heart lesions. The problem of adjusting these 1,072 handicapped individuals to a less strenuous mode of living so that they may become happy and efficient workers in suitable occupations and in many instances have their lives prolonged is one that physicians and social workers engaged in the care of cardiacls in this community are trying to solve.

Heart disease is now definitely recognized as a public health problem. It is not only first in the list of causes of death but it ranks first in the damage it does through producing disability and in-
validism. It is estimated that two per cent. of the population of the United States have heart disease. Approximately 200,000 children of school age in the United States are handicapped with heart disease. No other disease so hinders human productivity especially in later life. The person who has heart disease is often sick for years and his misfortune reflects itself not only in lives of immediate family but in social and economic life of the community in which he lives. The greatest drain on the community comes not in the actual loss of life from heart disease but in the larger number of individuals who lead handicapped lives because of defective hearts and who are consequently often dependent on aid from public and private community agencies. About one-half of the persons suffering from heart disease are of an age at which the earning capacity should be at its maximum and family responsibilities are likely to be most pressing. Children from families where the cardiac has been the wage earner are sent to work early in order to help supplement the family income and due to their lack of education and training are often forced to enter employment which offers no opportunity for advancement.

One of the most important measures in the prevention and relief of heart disease and one that has been given much emphasis in this community in recent months is the annual health examination. Had the 813 adults mentioned above, most of them with families dependent on them for support, realized the value of periodic health examinations as a means of detecting the early signs of heart disease, their own lives would in many cases have been prolonged and the economic burden on the community would have been decreased. If the 259 individuals in the younger age groups—over one-half of whom were found to have rheumatic heart disease—had been under the supervision of their physicians or had been examined regularly in a clinic, foci of infection might have been removed, after care of infectious diseases given more attention and remedial measures taken early so that there would be fewer adults with damaged hearts. The early detection of heart disease in children together with proper and continuous medical supervision of these children, guidance in home, school and industry would do much toward the prevention of a serious heart handicap in the adult.

In our efforts to adjust the lives of those cardinals who are under the care of the cardiac clinics we find that the outlook for the two younger groups is decidedly more hopeful than it is for the older groups. Many of the younger cardinals are still in school and we
have been able to enlist the aid of parents, teachers, nurses and vocational counsellors in so training the child with heart disease that he may be equipped to take his place in the industrial world without undue demand on his physical ability. For the young adult who is over school age and who has not had the advantage of an education and training for an occupation which would be suited to his physical condition we have had the cooperation of the Handicap Placement Bureau of the Associated Charities, which organization, with the aid of the State Bureau of Rehabilitation, has provided training for some of the most promising cases and has secured for others positions requiring less physical effort than is demanded in the unskilled occupations. In order that illness and dependency in early adult life may be avoided it is very important that the child still in school and those who have been forced to stop school because of economic conditions be trained for positions suited to their physical condition. Through the proper vocational guidance and training these young people may become happy and efficient workers in suitable occupations.

At the present time fifteen promising young people who have organic heart disease are being trained for the following positions:

Six girls, two fifteen years of age, three sixteen years old and one seventeen years of age are enrolled in commercial courses in the public schools. They are enabled to continue in school through the efforts of the Handicap Placement Bureau which has secured scholarships and financial aid from state and local organizations interested in vocational training.

One girl, sixteen years of age, is enrolled in employment training as an apprentice milliner.

One girl, now a senior in High School and an exceptional student, is ambitious to study medicine and efforts are being made to secure a scholarship for her.

One boy, twenty-four years of age, is completing the watch and clock repairing course. He is not only making good himself but has interested his brother in watch and clock repairing and they have a small work bench at home where they spend their spare time repairing clocks and watches for the neighbors.

A nineteen year old boy is working in a printing company during the day and finishing his course in mechanical drafting at night school.

A fifteen year old boy is in the second year of the mechanical drafting course.

A seventeen year old girl is preparing to become a teacher.
Another seventeen year old girl is planning to take up kindergarten work.
A sixteen year old boy is preparing to become a pharmacist.
One boy, sixteen years old, is taking a printing course at night school.

Plans are under way for employment training for three other promising young people. We realize that the hope for rehabilitation of the cardiac is with the young individual who is ambitious and is willing to take vocational training of some kind which will make it possible for him to have knowledge of a definite job. One of the most successful instances of the rehabilitation of a cardiac case is that of a young man twenty-nine years of age who has rheumatic heart disease. This young man had left school at the sixth grade to learn the brick laying trade. Following attacks of rheumatism and subsequent periods of illness he was referred to one of the heart clinics for treatment. A period of hospitalization was prescribed and was followed by some weeks' stay in a convalescent home. He was then ready for work again but it was obvious that he could not return to his former occupation without the danger of another breakdown in a short time. He had, of his own accord, taken a night course in estimating and blue printing and as he was ambitious he was given sixteen weeks of tutoring so that he could enter the high school course at the Ohio Mechanics Institute as a student in the architectural drafting course. Through the State Bureau of Rehabilitation tuition was supplied and a supplement was secured from the Associated Charities for living expenses during the period of training. He was able to complete his training and to secure employment with a realty company. He reports regularly to the heart clinic for medical supervision and is now in a position to earn his own living in an occupation suited to his physical ability.

The cooperation of all agencies in the community is enlisted in the work of cardiac rehabilitation. Efforts are made to adjust any social difficulties which cause dissatisfaction or worry in our cardiac families. Until a few years ago the patient with heart disease was treated as an individual who must not exert himself. Today the cardiac is taught to lead a life as nearly normal as possible. This involves not only the social, vocational and industrial rehabilitation of the cardiac himself but usually of his entire family. Modern medical practice places emphasis on the relationship of personality, environment and disease. Without proper food, rest,
recreation and suitable employment medical efforts are of little avail. The physician may prescribe and advise and counsel but if his instructions are not carried out much valuable medical work will be wasted. Physicians engaged in the task of combating heart disease have found that they must have the aid of medical social service if they are to succeed in their attempt to keep larger numbers of persons with impaired hearts active over longer periods of time. The problems of adjustment incident to the care of cardiac clinic patients are the concern of the social worker. In our heart clinics the trained nurse who assists the physician in the examination of the patient is also an experienced social worker and during the period of adjustment of the patient to changed conditions of living the nurse strives to study each patient's individual needs so that she may educate and encourage and advise in order that the morale of the patient may be kept up.

As nurse in the clinic the worker makes her first contact with the patient. In subsequent visits to the patient in his home she learns what the home conditions are, what obstacles may be in the way of the patient's carrying out the physician's instructions and she is able to inform the physician of any significant facts concerning the patient's personality or environment that may relate to his physical condition. She arranges for financial relief or other needed adjustment by referring the patient to the proper agency. This follow-up in the home by the same nurse who has assisted the physician in the examination of the patient in the clinic makes it easier to secure the confidence of the patient, results in a better understanding of the problems confronting each individual patient and is an effective means of securing the patient's regular attendance at clinic. The social worker sees that the physician's instructions are carried out. She makes arrangements for convalescent home care when facilities for this care are available. She confers with relief agencies as to means of relieving the patient from financial worry, sees that school adjustments are made, secures the cooperation of the mother in the care of the cardiac child and emphasizes the importance of regular clinic attendance. Realizing the fact that continuous medical supervision means less danger of future breakdown and periods of hospitalization, the nurse visits those patients who have not reported to clinic even though a card has been sent asking the patient to return and urges them to report for a check up.

In the rehabilitation of the cardiac there are definite personality
difficulties to be considered. The patient frequently fears that heart disease will terminate in sudden death and is often unwilling to exert himself because of this. This attitude must be overcome by the physician in the clinic and by the medical social worker in her contact with the patient and his family in the home. The cardiac child often suffers from a too sympathetic attitude at home—an anxious mother forbids the child to play with the other children, or the child is humored and consequently demands attention and is difficult to adjust in school. Illness is often used as an excuse for failure when by intelligent supervision the child could carry on with his classmates. Instead of being hopelessly fatal, heart disease in children may become, not chronic invalidism, which is more of a handicap than the disease itself, but a condition in which the child under proper guidance and supervision grows up to take his place as a useful member of society. Restrictions as to rest periods, recreation and the type of work pursued are necessary but care must be taken to guard against making the child an object of pity lest he become introspective and morbid.

In the case of the adult cardiac with a family dependent on him depression and worry need to be guarded against. The cardiac disability is not noticeable as is the disabled arm or leg and though outwardly the cardiac appears able to work he may be thought unwilling and careless when in reality the work is beyond his physical ability. The patient becomes introspective and tends to dwell on his handicap rather than on his prospects for improvement. The physician, the medical social worker, the vocational counsellor, the placement worker and the employer must cooperate in so adjusting the cardiac to a less strenuous mode of living and choice of occupation that he becomes capable of leading a prolonged and useful life under intelligent guidance and supervision.

The follow-up of the cardiacs discharged from the hospital has been an important part of the work of the nurses who are on the staff of the Heart Council. Given a daily list of cardiacs discharged from the wards of our General Hospital, the nurse visits in the home of each patient and if the patient is not under the care of a private physician and is unable to pay a physician she explains the value of continuous medical supervision as a means of preventing frequent periods of hospitalization and urges the patient to report to one of the cardiac clinics for supervision. Through this follow-up and the subsequent reporting of these patients to the clinic we were enabled last
year to keep out of the hospital eight persons who had previously been in the hospital two or more times a year. Fifty-two persons who reported regularly to the clinics following discharge from the hospital did not return to the hospital for a period of over twelve months following their discharge.

The cardiac clinic plays a most important part in the rehabilitation of the large number of heart cases who are not able to pay a physician. Periodic examinations by the cardiologist make it possible to detect symptoms of relapse. The patient is advised by his physician as to the nature of his heart condition and the limitations imposed on future activity. After adjustments are made and the patient has been able to return to school or work, regular attendance at the clinic for observation and treatment is essential if future breakdown is to be prevented. This regular attendance becomes less of a problem if the right contact has been made with the patient on his first visit to the clinic. A physician who understands the medical as well as the social aspects of heart disease and a sympathetic trained social worker and nurse who can secure the confidence of the patient are important factors in the success of the cardiac clinic.

If any plan for the rehabilitation of cardias is to be successful the patient should have the advantage of an adequate period of recuperation following his stay in the hospital. The need for convalescent homes for cardias is great. The hospital has room for only the acute cases—patients are too often discharged too soon and they return to poor home conditions where the income is insufficient to properly care for them until they are able to return to normal activity. This is particularly true in the case of the large number of Negro patients who comprised more than half of the older age groups found to have organic heart disease. Living in the congested districts of the city, unskilled in trades, they were unable to provide suitable homes for their families or to save anything to provide for them when forced to enter the hospital. The relief agencies have only a limited amount of money at their disposal and it is possible for them to supply only the necessities for the home. The patient cannot thus secure the proper food and care at home during the period of convalescence and the stress of undue activity at home may also damage the heart more seriously where a few weeks in a supervised convalescent home might have prevented this. Children may be especially difficult to supervise at home especially if bed rest is necessary. Since prolonged rest under proper conditions is necessary
if the patient is to become self supporting, there should be adequate convalescent care facilities not only for the discharged hospital cases but also for the cardiac in industry who may be able to carry on efficiently through the working period of his life if he can have preventive rest periods.

After the cardiac has improved to such an extent that he may return to work he very often finds that he is no longer able to continue in his former occupation. The cardiac cripple is at a great disadvantage in industry. Much of the good that has been accomplished through hospitalization and convalescent care is lost through the inability of the patient to continue in a gainful occupation. To provide work that is within the physical capacity of the individual is of the utmost importance in the work with cardiacs. The experience in Cincinnati has been that it is almost impossible to place the II B cardiac. We have tried rather to make some other adjustment where the maintenance of the cardiac could be secured. In many instances employment was obtained for another member of the family. Children were found able and willing to provide for their parents when they were informed that the father was no longer able to work. Where there is no relative to help the patient has been placed in the County Home. Here again lack of adequate facilities to care for this type of cardiac is seen. In some instances the family agency has been forced to take over the entire responsibility for the maintenance of a family over a long period of time.

The value of an early training program for the cardiac child cannot be stressed too much. Trade schools, commercial courses and wherever possible, higher education should be encouraged so that the child may be better equipped for work within his physical capacity. Vocational guidance through the regular vocational counsellors in the schools will be most effective in this care of the cardiac child and his selection of work.

The choice of an occupation for the cardiac will be much easier for the placement worker if the physician carefully classifies the patient when referring him to the placement agency for training or selected employment and if he reclassifies the patient from time to time as he comes to the clinic for observation. The difficulty in training or placement even of the II A adult cardiac arises from the fact that, except in rare instances, the patient has not even completed the grades in school and is not qualified for anything except unskilled work. Unskilled work that does not require a great amount
Pre-natal care

H. J. Shelley, M.D., and Mildred Dillistin,
Health Officer and Assistant, Middletown, N.Y.

Typhoid fever, smallpox and diphtheria, for instance, have yielded to scientific control in the last quarter century, and tuberculosis has been reduced one-half. The deaths from maternal causes, however, have not decreased during the period for which records are available in the United States. Italy, Denmark and five other nations have maternal mortality rates less than half that of this country, which is twenty-second from the top. Truly a national disgrace!

For a number of years an active campaign has been carried on in this country to effect a lower maternal death rate and, incidentally, a lower infant mortality rate—in other words to prevent needless loss of life at or following labor. The results are definitely unsatisfactory in regard to the former rate and not wholly satisfactory in regard to the latter, especially in consideration of the volume of work and money expended. Proof is had in the figures for 1929. Fifteen thousand mothers died at childbirth; 80,000 infants were born too weak to live one month and 86,000 stillbirths occurred.

The situation leads us to scrutinize the causes of these deaths and to classify them into groups whereby it may be determined in which direction pre-natal work should be pushed. They may be divided into the following four groups:

1—Abortions (traumatic).
2—Artificial deliveries, either by means of drugs, forceps or Caesarian sections.
3—Diseases, either acute, infectious or chronic.
4—Indifference (either lay or professional).

In the first group are traumatic abortions, the steadily increasing cause of maternal deaths, self-induced in some cases, but in many more by an abortionist either occasional or professional. Too often the professional is a medical man. Doctor Hugo Ehrenfest declares
of physical effort is difficult to find. In spite of this fact twenty-five adult cardiacs were placed in permanent employment by the Handicap Placement Bureau during the year ending October 1, 1930. The average weekly wage for these patients is $16.09.

The solution to the problem of employment for the adult cardiac might well be the establishment of the workshop where training could be given and the cardiac could be earning enough to make him in some measure feel that he and his family were not entirely dependent on charity for support. The chronic hospital for the chronic cardiac would take care of large numbers of patients who can never hope to take their place in the wage earning class again. The old age pension would of course solve the question in other cases.
abortions to be the chief cause of death in maternal and fetal life. The United States Children’s Bureau estimates that 50 per cent. of them terminate fatally. This appears too high for an average, but even if cut in half would yet be shockingly high. Abortion is a serious factor in the maternal death rate. It may seem futile to attempt to teach women the grave dangers of abortion; nevertheless, effort should be made to do so. Very little, however, can be expected towards reducing the maternal deaths in this group.

In the second group are deliveries either by drugs or instruments. Though the patient have a safe puerperium and a viable child, these procedures may result in infection, causing chronic invalidism. There seems to be an exaggerated aim of saving the child at the expense of the mother (and what a pathetic creature—a baby without a mother); also an all-prevalent cry from the patient for painless labor; and, frequently, hurry on the part of the physician to end the case in the hospital operating room by means of forceps. Used properly, forceps conserve life and health, but used indiscriminately are a stumbling block in the way of reducing maternal and infant mortality which pre-natal medical supervision and hospitalization should effect. It is an old axiom that no obstetrical operation to terminate labor is harmless. Anesthetics and forceps augment the risk both to mother and child. The infant’s breathing centers are affected by the anesthetic used in instrumental delivery and head injuries by compression cause many stillbirths and deaths with the first month postnatally.

Any delivery by forceps is attended with danger, but low forceps skillfully managed have a minimum number of risks; the so-called mid-forceps mightly increase them, and in the use of high forceps the life of mother and baby is gravely jeopardized; as a matter of fact, one out of two is the infant’s chance of living. It is following forceps delivery that we find “stillborn—cause of death unknown” so common on the vital statistics records. The child delivered by forceps too often is buried later with a death certificate signed “cerebral” or “meningeal hemorrhage.” Frequently in a small community the would-be big obstetrician seeks consciously or unconsciously to add éclat to his name by the Cæsarian operation. It is fortunate that in the Cæsarian section cases the maternal death rate is low—5 to 10 per cent.—but oftentimes Cæsarian sections are performed on women who in later pregnancies are delivered normally. Little or nothing can be accomplished in the unnecessary Cæsarian section group because the local reputation and egotism of the obste-
tricians who climb the ladder of fame in this manner are too big an obstacle to surmount.

The general use of instruments by a qualified operator is not condemned. But the use of forceps to satisfy the family's plea to relieve the patient is neither good obstetrics nor scientific. This point can be well covered in the pre-natal program by teaching the patient she must bear a certain amount of pain and that a long labor is not necessarily a dangerous one. We cannot assert that all mortality from birth trauma is due to poorly trained physicians but it is true that better training in obstetrics is needed. Although Woodbury gives an estimate of 28 per cent. mortality for infants delivered instrumentally as against 2 per cent. for normal deliveries, it must be admitted that the artificial delivery group probably offers less than any other of the four as fields for saving maternal and infant lives.

In the third group are listed diseases either acute, infectious, toxemia and septic poisoning, which are named as the cause of one-third of maternal deaths. (It is in this category that our pre-natal work is full of promise and we shall return to it later.)

Early recognition of syphilis in the pre-natal woman and intensive treatment will practically insure a viable child free from the disease. There is a tendency for the "400" to assume they are above this malady. Nevertheless, the wisdom of taking routine Wassermanns, irrespective of patients' race, color, morals, religion, or social standing, cannot be too strongly stressed. In no other disease is the future well-being of the child so much at stake. Of a series of 90,000 infant deaths studied by Osler, 20,000 were directly due to syphilis. Tinconi found that 70 per cent. of syphilitic mothers did not complete the period of gestation and that 80 per cent. of macerated fetuses were luetic. Also, it is a fact that syphilis is the frequent cause of idiocy, imbecility and hydrocephalus and that the death rate of syphilitic children from common diseases is double that of the non-luetic.

Cases of nephritis (by whatever name called) as well as diabetic cases offer abundant returns for the work of pre-natal care. Toxemia and eclampsia account for 10 to 25 per cent. of maternal deaths.

The condition and proper functioning of the heart before and during term greatly influences the prognosis of the present pregnancy and, incidentally, of future ones. It would appear to be permitting unnecessary strain on an impaired heart to allow future pregnancies.
It is the part of pre-natal care to remove foci including those of teeth, tonsils and ears, in order to anticipate potential infection at delivery.

In tuberculosis of pregnant women, many go to term and give birth to viable infants. These cases are particularly difficult as they need more than the usual amount of care and many hospitals discourage their admittance. Other conditions arise, as cancer, which must be considered specific and individual problems.

The last group is comprised of indifference on the part of the profession and the laity. There are, unfortunately, physicians who tell their patients in answer to requests for examination and advice, something like this, "I've always known you, Mrs. So and So; you're healthy and there's no cause for worry. If anything turns up, let me know." This is a situation in which education on the part of physician and patient is essential. It is especially this class of cases in which the pre-natal nurse must employ great diplomacy, but at the same time obtain adequate care for the patient even, if necessary, at the expense of the doctor's enmity. Numerous cases whom doctors advise to report do so too late, with uremic convulsions, diabetic coma, infection, deformed or small pelvis, or malposition of fetus, placenta previa or other conditions which competent examination and treatment would have precluded.

It might properly be made the duty of medical societies to investigate the obstetrical methods of first, all physicians in their districts who report excessive numbers of stillbirths or neonatal deaths as determined by vital statistics records; and, secondly, of every physician first in attendance upon such cases before conditions arose requiring hospitalization. (Hospitals, oftentimes, have to shoulder blame rightfully devolving upon careless physicians who are obliged to refer extreme cases to them.) Higher standards of obstetrics would thereby be established and indifference on the part of physicians would, it is logical to hope, be reduced somewhat.

The indifference universally found among women is of course most often based upon ignorance. Child-bearing, except at delivery, is accepted as a normal process to be consummated "without benefit of medical science," so to speak. Instruction of the laity regarding the necessity of medical care and advice is within the province of public health, whoever its administrators may be in the community.

Now to return to the third group wherein lies the brightest promise of reducing maternal deaths. It hinges to a certain extent
on the minimization of the indifference mentioned in the fourth group as, obviously, a physician cannot examine and prescribe for a patient he does not see.

The following are the recognized essentials of pre-natal care, to be administered by either private physicians or health department clinics as the case may be. Pre-natal care should be made available to every prospective mother, without regard to financial, geographical or social barriers. It should include—a Wassermann as soon as the woman knows she is pregnant and, if necessary, treatment with Salvarsan or similar arsenical preparations; examination, at first visit, for discovery of foci and elimination of any if found; examination of urine at first examination and monthly up to fifth month, and then every two weeks until delivery; blood pressure each month up to fifth month and then every two weeks, thus anticipating nephritis before albumin appears in the urine; early pelvic examination as to abnormalities of the diameters; after seventh month examination every two weeks to determine position of child.

In conclusion, towards what higher goal can medical and public health science be applied than the protection and conservation of maternal and infant lives?
THE RESPONSIBILITIES AND OPPORTUNITIES OF THE SOCIAL WORKER IN THE FIELD OF SOCIAL HYGIENE*

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Social hygiene has to do with the use and misuse of the sex instinct as it affects physical and mental health of the individual and the social welfare. Since the racial urge is at times the strongest driving force and is the fundamental instinct on which society is built, it is obvious that sex is a factor, now dominating, and now receding but ever potent, in every human relationship. Thus there is a sex aspect to every individual and social problem. The aim of social hygiene is to assist the individual to use this impelling force constructively for his own happiness, physical health and mental serenity and at the same time in a manner that will not be injurious to society as a whole.

Social workers are interested in human relationships. Therefore they are concerned with all factors which influence directly or indirectly the interrelationships of individuals, and the resulting espirit de corps. Since the goal of the social worker is to bring about the greatest possible true happiness to the greatest number as early as possible she is interested in every phase of human activity and thought. Thus it is clear that social workers in their endeavors to find the most satisfactory solution of any particular problem will in the majority of cases have to consider the sex element involved. In fact the difficulty in handling the case will depend largely upon the extent to which it is complicated by the sex factor.

Granting these premises which are obvious to you as social workers it is apparent that your responsibilities in social work require

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a working knowledge of social hygiene and that your opportunities for helping unfortunate people and promoting social welfare will be determined materially by your skill in handling the social hygiene aspect of their problems.

Social hygiene activities may be divided roughly into two groups, the constructive and the remedial, although they overlap considerably.

The constructive measures consist of sex education and character building activities and have the commendable objective of sublimating the sex instinct and incidentally preventing sex delinquency and the spread of syphilis and gonorrhea. This constructive phase is the greater of the two fields, in so far as it is successful it not only prevents mental anguish and physical illness resulting from the misuse of the mating instinct but it tends to increase the sum total of human happiness. Extensive research has resulted in making available a tremendous amount of material on what and how to teach children of different age groups. Social workers should be familiar with all this and encourage the school, church, home and character building organizations in their attempts to promote sex education and to inculcate in youths clean, wholesome sex habits.

You as social workers should also endorse adequate community facilities for wholesome recreation. Environment and the use of leisure time influence individuals as vitally as direct instruction or the teaching by precept. Your endorsement of all these projects is however more in your capacity as intelligent citizens than as social workers.

The control of syphilis and gonorrhea cannot be left to sex education alone. Anything depending upon human direction and effort, by its very nature will be imperfect, and so sex education and incentives for right living may not be effective enough to overcome an unwholesome environment; or it is possible that a certain proportion of mankind is incapable of being educated to appreciate the finer things of life. Finally it will have to be admitted that very few persons have had the advantage of continuous, systematic sex instruction and there is nothing to indicate that this condition will be changed materially in the near future.

In fairness to the school of thought which believes that syphilis and gonorrhea are but evidences of asocial sex conduct, it should be stated that they expect years or possibly generations will be required to bring about any apparent social readjustment, resulting from the conscious raising of sex standards.
The fact is that at present a considerable proportion of women and men are exposing themselves to syphilis and gonorrhea and many of these will acquire either one or both diseases. Colonel Ashburn found that 66 per cent. of 14,000 men in the A. E. F. had illicit sexual intercourse. Those conditions were so unusual that it is possible that the figures have no bearing on the extent of sexual promiscuity under normal surroundings.

The sex life of the students at West Point was studied also by Colonel Ashburn, and showed that 54 per cent. of 550 men answering the questionnaires, ages 21 to 27 years, had had sex intercourse on an average of 23 times. Katharine Davis found that of 1,000 married women 7 per cent. had sex intercourse before marriage, and of 1,200 unmarried college graduates 11 per cent. had experienced sex intercourse.

For these reasons there is a second school, some of whom endorse the sex education program and some who believe it to be too idealistic, but all of whom are of the opinion that something must be done immediately for those persons who are now infected or are likely to become infected.

This group of thinkers points out that the control of syphilis and gonorrhea is the biggest and undoubtedly the most difficult public health problem today. The common cold is probably the only disease more prevalent than these; and the common cold does not cause as much physical suffering as syphilis and gonorrhea do in their aggregate and of course is never the cause of excruciating mental agony that so many people suffer when they know that they or those close to them are infected with one of these diseases. Adequate medical care for the persons estimated to be infected annually with syphilis in New York State would cost $15,000,000 provided they sought treatment soon after infection from physicians charging moderate fees.

This school recommends attacking the problem of syphilis and gonorrhea directly, chiefly through the application of modern scientific treatment.

As social workers it would seem that you are concerned essentially with the remedial measures. You are trying to help individuals out of difficult situations. Of course in addition to remedial measures for the control of syphilis and gonorrhea you are interested in numerous other problems arising from the sex instinct, such as the unmarried mother, adolescent sex delinquency, commercial prostitu-
tion, or divorce, desertion or separation due to the conjugal malad-
justment.

However this paper will limit the discussion to problems that
confront the social worker in the control of syphilis and gonorrhea
from the public health aspect.

If syphilis and gonorrhea are to be controlled medically, the first
problem is, how are the infected people to be gotten under treatment?
Obviously they must know the seriousness of the diseases, the
need for scientific treatment and the facilities available for indigent
persons. Whereas instruction regarding the sex instinct is primarily
the responsibility of educational agencies, the giving of information
regarding syphilis and gonorrhea, their causes, method of transmis-
sion, possible sequelæ if allowed to go untreated and the possibility of
being cured is the responsibility of health and social workers.

The second problem is how extensive must the dissemination of
information regarding syphilis and gonorrhea be in order to reach the
person who may become infected.

The answer to this depends directly upon the prevalence of the
diseases.

Estimates regarding the proportion of population that is at some
time or other affected with syphilis or gonorrhea are 9 per cent. for
syphilis and approximately four times that for gonorrhea. If these
are reasonably conservative then forty-five people out of every hun-
dred at some time or other will have either syphilis or gonorrhea.
This means that on an average there will be one person infected in
every family of two persons. Hence the information regarding these
insidious diseases and the need for instituting treatment early must be
carried to every family. This is essentially the work of social workers
and public health nurses. They can do much of it themselves and
also be very helpful in encouraging this type of community health
education.

The question of how early in life information regarding syphilis
and gonorrhea should be given is frequently raised. From a study
of the age at onset of 2,227 syphilis cases it was shown that 5 per
cent. had acquired the disease at the age of fifteen, 32 per cent. by the
twentieth year and 82 per cent. by the thirtieth year, therefore in
order to have the information of real service it is apparent that
youths should be informed regarding these diseases by the fifteenth
year. Syphilis and gonorrhea are essentially diseases of youth.
The study showed also that females were infected earlier than males and colored earlier than white persons.

Where should efforts be concentrated in order to control syphilis and gonorrhea? The New York prevalence survey showed that syphilis was about seven times as prevalent and gonorrhea more than four times as prevalent in urban as in rural districts. It is probable that there are several factors which make for this uneven distribution of cases. The apparent prevalence in urban districts may be higher than the true incidence and the apparent prevalence in the rural districts may be less than the true. A statistical study has shown that there is no direct correlation between the density of population and the prevalence of these diseases. However, various surveys made in the United States have consistently shown a much higher urban than rural rate. In urban districts with a population of more than 2,500 the syphilis rate was 6.74 per thousand, while in the rural areas the rate was only 1.27 per thousand. These facts simplify the problem by making it practical to concentrate the control measures for a time at least in the larger communities.

The fifth problem is how may women be gotten under treatment. In the prevalence studies the syphilis rates were male 4.98 and female 3.11 per thousand; the gonorrhea rates were male 5.03 and female 1.75.

The ratio of males to females was as 1.6 to 1 for syphilis and 2.9 to 1 for gonorrhea. This is quite in line with the data for foreign countries.

TABLE IX

| Ratio of Males to Females in Early Syphilis and Gonorrhea Respectively |
|--------------------------|------------------|
|                         | Syphilis | Gonorrhea |
| Greater New York (1928) | 1.8 to 1  | 4.41 to 1 |
| Germany (1927)          | 1.1 to 1  | 3.4 to 1  |
| Oslo (1926)             | 1.9 to 1  | 3.5 to 1  |
| Stockholm (1926)        | 1.7 to 1  | 2.9 to 1  |
| Helsingfors (1926)       | 2.2 to 1  | 2.2 to 1  |
| Austria (1925)          | 1.3 to 1  | 2.6 to 1  |
| Czecho-Slovakia (1921)  | 2.1 to 1  | 3.5 to 1  |
| Switzerland (1920-21)   | 1.9 to 1  | 3.6 to 1  |
| England and Wales (1929) | 1.8 to 1  | 4.0 to 1  |

1 Includes infections of more than one year's duration.

The ratio of males to females that are actually infected with syphilis and gonorrhea cannot be determined. However, there is basis for the belief that the same proportion of infected women as of men are not receiving treatment.
In upstate New York from 1919 to 1930 the reported syphilis cases increased 69 per cent. for females and 38 per cent. for males and during this same period reported cases of gonorrhea increased 246 per cent. for females and 152 per cent. for males. It seems very doubtful that females are becoming infected so much more rapidly than males. It is believed that this apparent rapid increase in infections of syphilis among females is due in part to a larger proportion of the infected women seeking treatment now than were ten or twelve years ago. On the other hand it is probable that even yet there is not under treatment as large a proportion of the infected females as of the infected males.

The preceding table also shows a much greater difference between the relative proportion of males and females affected with gonorrhea than with syphilis. Since the diseases are transmitted in a similar manner the proportion of males to females infected should not vary greatly for the two diseases unless there is some factor affecting one of the diseases and not the other. "One explanation of the differences shown in the table may be that women can prevent gonorrhea better than they can syphilis. Perhaps this explanation may not be so wild as it appears, because I have sometimes seen women who have lived for weeks, or even months, with men suffering from subacute gonorrhea and have escaped, apparently by having douched after each intercourse. Much the most probable explanation, however, is that gonorrhea is ignored by women far more than is syphilis. . . . Furthermore, I am sure that women are far more ignorant of venereal diseases than are men. Such a condition of affairs is a potent cause of a high incidence of gonorrhea, and I am sure that if we could make women more aware of the importance of seeking advice for abnormal discharges, we should considerably reduce the incidence of gonorrhea, because we have the means in our hands, by good intermediate treatment, of making women non-infective more quickly than we can make men." 10

This makes it clear that information regarding syphilis and gonorrhea must be stressed among women even more than among men.

New York statistics for the one-day survey showed 6,144 women under treatment for syphilis and from data collected previously it is estimated that 63 per cent. of infected women are married and that 90 per cent. of these are of child-bearing age. 11 Then of the estimated 3,870 syphilitic married women approximately 3,483 would
be potential mothers. The tremendous possibility of children being born with congenital syphilis is apparent. Surely obstetricians and prenatal clinicians should be impressed with these figures and see the importance of having routine Wassermanns on all pregnant women. Routine Wassermanns and the initiating of treatment of syphilitic women in the early stages of pregnancy are two of the most outstanding measures that can be taken in the prenatal field. The taking of a Wassermann on a pregnant woman should be a routine followed as religiously as is the routine of dropping a prophylactic solution of silver nitrate in the eyes of a new born babe to prevent ophthalmia neonatorum and the treating of syphilitic pregnant women should be looked upon as a practical prophylactic measure to prevent congenital syphilis in the new born babe. Most states require prophylactic measures be taken to protect the eyes of a babe at birth and these laws do not arouse antagonism on the part of parents. There appears to be no reasonable grounds for anticipating objections to requiring Wassermanns in cases of pregnancy. While the public is being educated to expect such procedure it should be practical to introduce such a regulation in all prenatal clinics and maternity hospitals and also to persuade the obstetricians to make the necessary tests in their private practice.

Children born of syphilitic mothers should be kept under observation until twenty-one years of age in order that treatment may be instituted on first appearance of the disease.

Statistics show that only 42 per cent. syphilitics and 70 per cent. with gonococcal infection seek treatment while the disease is still in the early or acute stage. Early syphilis means within a year of the time of infection, and acute gonorrhea means within three months of infection. A more detailed study of persons with syphilis that reported within a year of time of infection shows the following.

That only 11 per cent. of these early cases sought treatment while the blood was negative, and another 22 per cent. in the primary stage but with the blood positive. In other words less than 5 per cent. of the total cases of syphilis that come finally under medical care, seek treatment in the sero-negative primary stage when the possibility of cure is greatest, another 9 per cent. report in the primary stage of the disease and the remaining 86 per cent. have fully developed secondary lesions before seeking treatment. For the latter the hope of effecting a cure is decreased considerably, a conservative prognosis would be that the disease could be arrested.
In the upstate survey for 1930 it was shown that 36 per cent. of females compared with 45 per cent. of males sought treatment in the early stage of syphilis.

The solution for the first group of problems is universal dissemination of public health information regarding syphilis and gonorrhea. The preceding facts have been given in order to determine how to direct such an informational program in order to get the greatest possible results.

From the wide prevalence of the diseases it is apparent the publicity must be universal. From a study of age at onset, it is clear that youths must be informed during early puberty. A review of the residence of infected persons indicates that the need for instruction is greater in urban than in rural districts. A grouping of cases by sex and a study of correlated information points to the necessity of stressing the facts regarding syphilis and gonorrhea more among women than among men. The high incidence of syphilis among potential mothers emphasizes the need for routine Wassermanns in all prenatal clinics or obstetrical practice. The present delay in seeking treatment demands a more forceful presentation of the need for early treatment. That is, every person must be conversant with the seriousness of syphilis and gonorrhea, and convinced of the need for treatment immediately upon the appearance of the first pathological signs.

The magnitude of such a task is overwhelming and cannot be realized within a few years. However, it is the first step in any public health program for the control of these diseases.

Thus it would seem that there are two very important types of educational work in regard to the control and prevention of syphilis and gonorrhea, sex education and character building which is primarily the function of the school, church, home and volunteer organizations dealing with youths and the dissemination of public health information regarding syphilis and gonorrhea accompanied with motivating appeals that will be effective in getting infected persons to seek treatment early which is primarily the function of the social and health workers.

Although the seven problems already considered depending for their solution upon the universal dissemination of public health information regarding syphilis and gonorrhea would seem to be a gigantic task even for social workers, unfortunately their responsi-
bilities do not end there. They are confronted with another group of problems.

This second group is not so great in number but the problems are more complex in character and they require infinitely greater skill, higher professional ability and the last word in personality in order to cope with them successfully.

Immediately an infected person is under treatment it is the social worker's responsibility to find the source of infection and contacts and get these examined and under treatment if infected. Obviously securing the name and address of the source of infection is impractical for the 60 per cent. of the syphilitics which have permitted more than a year to elapse since being infected, securing the identity of the source for the other 40 per cent. is complicated by many factors. Frequently the infected person is quite promiscuous in his sexual relationships and does not know which exposure was the cause of his infection. Then there is a small group of recalcitrant patients who have the desired information but refuse to reveal it because it involves possibly married people or girls of high social standing. Obviously if sources of infection are to be investigated it will be necessary to get the infected persons under treatment while the disease is in its early stage; then in the majority of cases they will know where the infection was obtained. Universal education regarding the health aspect of syphilis and gonorrhea would break down largely the inhibitions to reveal the identity of the source.

Getting contacts under examination and treatment requires in many instances considerable tact. If the person is married the worker is faced with a very real problem but not an insuperable one. Contrary to general belief the knowledge that the partner in marriage has a venereal disease does not commonly break up the home. The social worker must bear in mind that epidemiological measures require that contacts be examined and as far as possible instructed regarding the necessary precautions. In general it would seem quite possible for a moderately successful social worker to get under treatment on an average, at least one new case for every case that voluntarily seeks treatment. If this could be realized universally progress in control would be double what it is at the present time.

Another problem which confronts the social worker is keeping the patient under treatment a sufficient length of time to prevent relapses and returned infectiousness. Based on statistics gathered by the public health service for urban and rural groups aggregating
ten millions it was found that syphilis cases remained under treatment approximately six and two-thirds months. Obviously this is altogether too limited treatment. Even the 5 per cent. who report for treatment in the sero-negative stage would need treatment over a longer period than seven months. Here is a problem which will tax the ingenuity of the social worker but is quite possible of solution. In numerous instances capable social workers have been attached to clinics to determine the possibility of keeping the patients under treatment continuously until discharged by the attending physician and the possibility of getting delinquents to return for treatment. The results have been rather astounding to the pessimist since it has shown that with able social workers very few patients even become delinquent and the great majority of those who do can be returned to the clinic. It should be pointed out that the group of patients that attend clinics are generally a more irresponsible group than those being cared for in private practice, so the possibilities of having cases in private practice continue treatment are excellent. Surely the 86 per cent. of syphilitics who seek treatment for the first time when the disease is in the fully developed secondary stage and have less than seven months of treatment have not been cured but have been rendered non-infectious for a more or less brief period of time. A social worker in social hygiene who is not persuasive enough to remedy such a condition is not worthy of her profession.

What proportion of people are re-infected is a question which has never been studied on a very extensive scale and there is little on which to base even an estimate. However it is worth considering from a purely academic point of view. You may recall that Colonel P. M. Ashburn,¹ found from questionnaires returned from 14,000 drafted men who had been in France from ten months to two years that 34 per cent. remained chaste and of the other 66 per cent. the collected data showed that the men while in France had about thirty contacts with women of promiscuous sexual habits for each case of resulting infection, of either syphilis or gonorrhea. In other words it would seem that under more unfavorable than ordinary conditions with no extraordinary precautions a person could on the average have illicit intercourse about thirty times before becoming infected.

If discretion should be exercised in choosing the partner and ordinary cleansing methods utilized, the infections would be reduced materially. In fact among West Point cadets there was an average of only one infection for 400 illicit contacts. If this is true it is

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¹ Colonel P. M. Ashburn.
apparent that in general every infected person has acquired the habit of sexual promiscuity. Your attention has been called already to the difficulty of establishing desired habits in young people. You must appreciate that it is even more difficult to change fixed habits in adulthood. There is little possibility of changing materially the sexual life of infected persons. Hence in order to prevent reinfection and also in order to prevent the spread of these diseases it would seem advisable to inform diseased persons regarding proven methods of prophylaxis. In the army in France these methods were used and although frequently the necessary measures were not taken until long after exposure and frequently the men applied the prophylactic measures themselves, nevertheless, the number of infections were reduced to only one in ninety contacts. Whether chemical prophylaxis should be included in the sex education of youths or not may be a question but it would seem that if any earnest endeavor is to be made to control these diseases it will be necessary to give careful instructions regarding the means of protecting oneself against possible infection to all persons who have at any time had either syphilis or gonorrhea.

Thus after the infected person has sought treatment it is necessary to continue his education, so that he will be willing to reveal the source of infection and contacts, to remain under treatment until discharged, to take necessary precautions to prevent the spread of the disease and finally so that he may know how to protect himself from future infections.

However, social workers cannot control these diseases when they confine their activities to clinic cases which constitute only one-third of the syphilis and one-tenth of the gonorrhea cases under medical supervision. State, county or municipal health authorities must provide social workers to work in conjunction with private practitioners in order to control syphilis and gonorrhea. This is possibly the most progressive step suggested and may not meet with universal approval until all parties concerned have had an opportunity to think the problem through. Surely in the case of no other communicable disease is the right of the infected individuals to be free from interference of public officials put above the welfare of the community. The control of these diseases has been considered in this paper from a health point of view and in continuing to consider them from this aspect only it is obvious that epidemiological measures which have proven themselves in the control of all other contagious diseases
must be applied in the case of syphilis and gonorrhea if they are to be attacked scientifically with reasonable hope that they may be controlled in the near future. It will require the highest type of social workers those with unusual training, with high professional skill and with exceptional personality to gain the specialist's permission to assist him in putting this public health phase of the work over with his clientele. All of these activities are public health activities and therefore cannot in the final analysis be the responsibility of the physician and it is for this reason that official organizations must supply the social workers who shall be delegated to the medical profession.

The control program for syphilis and gonorrhea divides itself into two parts, the activities looking toward, the getting of infected persons under treatment in the early stage of the disease and the problems which arise after treatment is initiated. The first part depends upon the universal dissemination of information regarding syphilis and gonorrhea and the second part securing the examination of the source of infection and contacts, continuing the patient under treatment until discharged, educating the infected person how to prevent the spread of disease and how to protect himself from infection on future exposure by means of chemical prophylaxis.

From a practical point of view the social worker is confronted with one more problem which is that of being able to give statistical evidence of reasonable progress in the control of these diseases.

The eleventh and final problem is, how can the social worker show definite progress in the control of these diseases. The evaluation of your activities depend upon accurate statistics.

At the present time the trend appears to be stationary. There is about one new case this year for each case reported last year. If the persons newly infected can be brought under treatment early and the source of infection and contacts discovered and examined it would be possible to remove a very considerable proportion of the foci of infection in a single year. If efforts in executing such a program were intensified so as to be only 10 per cent. more effective than at present it would be possible within a brief period of seven years to reduce the incidence one-half.

All of the other problems are but parts of this ultimate problem. How can you increase the progress that is now being made in the control of these diseases? At the present time the combative efforts are apparently just offsetting the vicious elements that are tending to
increase the prevalence: Realizing this it ought to stimulate you to intensify your efforts, increase your aggressiveness and reverse the natural upward trend.

The responsibility for the lack of greater progress is not the social worker's altogether.

Few health departments have as yet recognized in the distribution of their personnel and budget that the control of syphilis and gonorrhea is one of their outstanding projects.

Why are our volunteer health and welfare agencies neglecting so largely this urgent problem?

When the man on the street realizes that syphilis and gonorrhea constitute the most serious health hazards, cause more loss of pay than any other group of diseases; incapacitate more people that become state charges than any other group of diseases; and that many babes are born physically deformed, mentally defective or blinded because of these diseases he will be incensed that he has been kept ignorant and that public and private funds have been diverted to less urgent and less profitable fields. For more than a decade the measures for control have been known, the need is their intensive application. Reality must be faced although at times the picture may be unpleasant.

These are not all the problems which face the social worker but it would seem that they are the outstanding problems for which there are at the present time practical solutions. From the foregoing it is clearly seen that the social workers' responsibilities in the control of syphilis and gonorrhea are enormous.

The social worker's opportunities in the field of social hygiene are commensurate with her training, her professional skill and her ability to stimulate sex education, to initiate and carry on the dissemination of information regarding the public health aspect of syphilis and gonorrhea and her ability to convince the specialist that she can be of real help to him in keeping the patients under treatment for a longer period of time and in increasing his clientele by bringing in sources of infection and contacts.

A comprehensive social worker's program for the control of syphilis and gonorrhea includes sex education and character building for the noble objective of giving youth a wholesome sex attitude and as a by-product of preventing them from exposing themselves to possible infections, the universal dissemination of public health information regarding syphilis and gonorrhea in order to get persons
who unfortunately become infected under treatment while the diseases are in their early stages and finally a practical program for investigating and examining sources of infection and contacts, of persuading persons under treatment to continue until discharged and of educating infected people how to prevent the spread of their infection and how to protect themselves from possible future reinfection. Such a program is practical but in order to accomplish noteworthy success will require increased intensive application. No outstanding advance in public health or notable progress in social welfare could equal in value the execution of a program that would give tangible evidence of a downward trend in the incidence of syphilis and gonorrhea.

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TUBERCULOSIS IN NEW YORK CITY*

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New York City is an excellent laboratory for the study of social problems. Whether it be the spread and control of tuberculosis or some other factor in the poverty of our people, the facts for New York lend themselves to analysis. Our city is divided into distinct parts, boroughs and districts, each presenting some special feature of interest. The rapid growth of our city and the many races that compose its population offer contrasts and points of interest around which analyses can be made to show how the particular conditions about which we are concerned arise, develop, and are finally brought under control. It is proposed at this time to present a general picture of the incidence of tuberculosis in various parts of the city, of the extent of its ravages among the various groups of the population, and to point out what progress has been made in bringing the disease under control, and how large a social problem it still is among us.

Tuberculosis is still one of the most important causes of death which make for poverty and misery in the City of New York. In spite of the fact that possibly the most effective of all the campaigns against this disease has been launched in this very city, it is still true that tuberculosis is a major public health problem. It is the fifth cause of death numerically and accounts for over 5,000 deaths each year. There are in all probability 50,000 persons more or less seriously sick with this disease in New York and more than 30,000 are known to the workers of the Health Department. Of these, about 12,000 find their way every year into the various hospitals of the city. The rest

* First lecture in an extension course on “The Current Significance of Tuberculosis As a Social Work Problem.” This course was offered by the New York Tuberculosis and Health Association in cooperation with the New York School of Social Work.
are at home or at work suffering from every stage of disability. It would be an interesting research to determine the amount of economic loss and social damage which can still be traced to this cause. Tuberculosis used to be the first of the causes calling for relief. That is no longer true, but the amount of social damage is still very large.

New York City, as previously noted, has been in the forefront in the campaign against tuberculosis for a great many years. It was here that Dr. Herman M. Biggs lived and worked. There are all around us the evidences of his extraordinary accomplishment. It was here that tuberculosis was first made a reportable disease, that a well-organized laboratory was made available to the physicians to help in its diagnosis. It was here that isolation was first practiced, and there are other evidences of New York's progressiveness in handling this major health and social problem. It is not surprising, therefore, to find that New York City stands favorably among the large cities of the world in the amount of its tuberculosis. In 1930 the rate of mortality was 73 per 100,000; that is, there were, on the average, 73 deaths from all forms of tuberculous disease in every 100,000 of New York's population. In a group of 45 of the largest cities of the coun-
try with a population of thirty millions, the rate was 81.3. Only Chicago, of the cities of the first rank, had a lower rate in 1930, namely, 66. But it is interesting to find that a group of six large cities, Portland, Oregon; Oakland, California; Dallas, Texas; Akron, Ohio; Omaha, Nebraska; Syracuse, New York, had rates of 50 or less, and that Portland, Oregon, with over 300,000 people, had a rate of 35 deaths per 100,000, or less than half that of New York. If New York City’s mortality from tuberculosis could be reduced to the

point where Portland’s now is, there would be 2,500 fewer deaths from this disease in our city each year. In the largest cities other than Chicago, such as Philadelphia, Detroit, Cleveland, St. Louis and Boston, the rates are from four to sixteen points higher than in New York.

This relatively favorable situation did not always exist, however. Only thirty years ago, the tuberculosis rate in the city was almost four times as high as at present. In 1900, there were 280 deaths for every 100,000 of population—a figure that was about 40 per cent. higher than for the country as a whole. By 1910, the rate for New York City dropped to 210 per 100,000, and was then 31 per cent. higher than for the country as a whole. By 1920, there was a decline
in the rate to 126, still 11 per cent. in excess of the figure for the country. By 1930, our rate, 73 per 100,000, was one or two per cent. below that for the country as a whole. It is thus obvious that the progress made in the city has been much greater than that in the United States. This is a record of which the City of New York may very well be proud.

Attention is also directed to an interesting phase of this decline in the tuberculosis death rate in New York. Inspection of the first chart 1 will show that there are two distinct periods. There is that prior to 1918, that is, before the beginning of the influenza period, and the one commencing after the close of the influenza outbreak—from 1921 to date. In each of these periods, the mortality from tuberculosis declined rapidly. But the two trends are on a very different level. Something happened during the years of the influenza epidemic. Between 1918 and 1921, the rate fell almost perpendicularly. After 1921, and for ten years, the decline was after the fashion of the earlier period, at an average of four or five per cent. a year; but the level of the death rate was distinctly lower after the influenza pandemic than before. An adequate explanation for this interesting phenomenon, which occurred not only in New York but virtually over the entire country, has never been given.

The tuberculosis problem is very unevenly distributed over the City of New York. There are areas of high and those of low incidence. The study of these differences throws considerable light on the nature of tuberculosis and how it spreads. Manhattan Island is the center of the tuberculosis problem. In 1930, 2,345 deaths from the disease occurred in Manhattan out of a total of 5,089 in the entire city. In other words, close to half of all the deaths occurred in 28 per cent. of the population. Bronx and Queens, which together had 500,000 more people than Manhattan, had only half as many deaths as Manhattan. The Borough of Brooklyn, which had 700,000 more people than Manhattan, had only little more than half as many deaths. If the rates prevailing in the other four boroughs, combined, had obtained for the entire city, New York’s death rate would be well under 60 instead of 73 per 100,000. The explanation for the relatively high mortality in Manhattan lies, largely, in the fact that there were 739 deaths of colored persons. There is a large negro population

1 The courtesy of Mr. Godias J. Drolet, Statistician, New York Tuberculosis and Health Association in permitting the use of his excellent charts is gratefully acknowledged.
(235,556) in Manhattan, which has a very high tuberculosis rate. In Central Harlem, the figure was 237 per 100,000, or over three times that for the city as a whole. This, however, is not the only explanation. There are large areas in Manhattan, other than the negro belt in Harlem, where the tuberculosis death rate remains very high. For example, there is the Lower West Side with a rate of 166—more than double that for the city as a whole. But, on the other hand, there are distinct areas in Manhattan where the rate is low as, for example, in Washington Heights (73) and in the better residential areas of the city, like Riverside with a rate of 70. The tuberculosis death rate is high in the poorer sections of the city, along the lower waterfront, where we find large numbers of people of Irish descent, or where the people are of the laboring classes living in the old-style tenements which still prevail in this part of the city.

One of the most instructive facts in the entire situation is the disparity in the death rates of the various boroughs. Bronx and Queens are the new boroughs of the city; and their rates, 57 and 53 per 100,000 respectively, reflect what is always found in new areas, namely, that the mortality is uniformly low. The growth of Brooklyn has also been comparatively recent, and there again we find the low rate of 57. The people who, when they lived in Manhattan, on the East Side of the city, showed, uniformly, rates of 150 and up to 200 per 100,000, seem to have left their tuberculosis behind them after moving to the Bronx; or to Brownsville, where the rate is only 36; or to Bay Ridge (40); or to the new sections of Queens, Corona and Jamaica, each of which enjoys the low tuberculosis death rate of 45. It is difficult to avoid the very appealing explanation that these people benefit greatly from the better quarters which they have in the new sections. But, the problem is more complicated. The answer is not only housing. There is probably an element of selection in the people who lift themselves out of the crowded quarters of Manhattan. They probably receive higher wages and are people of better intelligence. We know that these are factors in the fight against tuberculosis. We know also that certain of the outlying boroughs are very heavily peopled by Jews, who have very low tuberculosis rates. But these same people, when they lived on the East Side fifteen and twenty years ago, suffered from a higher tuberculosis rate. Even today the figure for the Lower East Side is 117, as against 36 for Brownsville. We are concerned, then, with a composite of many influences. But
Tuberculosis in New York

I believe that we shall some day be able to prove very definitely that of all of these influences, that of new housing is the most important.

Tuberculosis as a cause of death is very unevenly distributed, also, in the two sexes and in the several age groups of the population. This is shown in the second chart. Each one of the spaces represents a five year age period of life. From the first to the last, which is 80 years of age and over, each one of these spaces is divided into two bars, the first for males, the second, for females. It will be readily seen that in every age-period except the third, fourth and the fifth, that is, between ages 10 and 24, the number of deaths of males is in excess of that of female deaths. The difference between the two sexes is particularly striking after age 35, when, in each age-range, the mortality of males greatly exceeds that of females. No wonder then that in the city as a whole, in 1930, of the 5,089 deaths, 3,131 or 60 per cent. were of males, and only 1,958, or 40 per cent., were of females; and this in spite of the fact that there are more females than males in the city. The rate per 100,000 was 90 for males and only 56 for females. It is only in the fifteen year period of late childhood, adolescence and early maturity that there are more female deaths than male deaths. And it is in adolescence that the difference is greatest.

Each sex has a considerable number of deaths from tuberculosis in the first five years of life. At this age, as the chart shows, most of the deaths are due to non-pulmonary tuberculosis. Tuberculous meningitis, in fact, is the most prominent type in infancy and early childhood. Incidentally, more than one-half of all the deaths from tuberculous meningitis occur during the first five years of life, and about one-sixth in the very first year. The number of deaths is much smaller during the next ten years of life. Beginning with age 15, the number of deaths increases rapidly, reaching a maximum for females in the age period 20 to 24. After that age, the deaths of females decline very rapidly. Among the males, on the other hand, the number continues to rise after age 25, reaches a maximum in the age period 35 to 39, and the deaths stay at a high level for 15 years, up to age 50.

The above chart shows the actual number of deaths in each age period. It is somewhat more instructive to examine the next two charts which show the facts for the two sexes in relation to the number of people who live at each one of the age periods, that is, the death rates.
Chart III, for example, shows the death rates for males in each one of the age periods. The curve for the year 1930 shows that the rate is about 50 per 100,000 in the first five years of life, drops to a little over 10 in the next ten year age period, rises rather sharply to a rate of 90 in the age range 20 to 25, stays fairly level for the next ten years, then rises rather rapidly to about 160 at 45 to 50 years, declines a little at 50 to 55 years, and mounts to a maximum which is in the age period 55 to 60, when it is 188 per 100,000. It is a sur-

prising thing to find that the highest rates are in the years between 55 and 65, and that they remain high, in fact, up to 75 and over. The 1930 line is, at every age, much lower than the line for ten years ago, and compared with twenty years ago the difference is much greater still. But please note this interesting change. Twenty years ago, the maximum rate was in the age period 40 to 45; ten years ago, it was in the age period 50 to 55; now the maximum rate is in the age period 55 to 60. In other words, there has been among men both a marked decline in the number of deaths and a shifting of the mortality into the older ages. Men who suffer from tuberculosis do not die at the younger ages as they used to, but live many years longer and a large number die from their disease in old age.
Among females, as is shown in Chart IV, the picture is very different.

Again observing the line for 1930, it is seen that the maximum rate is in the age period 20 to 25. The rate then declines, almost continuously, to the age period 50 to 60, and then rises slightly to a second peak in the age period around 75. The maximum in 1930 is ten years earlier in life than it was in 1910, when the highest rate was in the age period 30 to 35. In other words, among women, the peak of the mortality is now earlier in life than it used to be, and among men, it is considerably later.

Both of these facts have great social significance, and are probably playing an important part as silent forces in controlling tuberculosis. What does it mean when a considerable proportion of the deaths from tuberculosis among men is postponed to the late fifties and the sixties? It means that at these advanced ages these men’s families have grown up, their children are no longer at home; they are perhaps married. It is not a difficult thing for these men to receive care away from home when that is necessary. The same economic pressure does not exist for them to stay at work. This advancing age of death of the
men is a powerful influence in keeping down infection of children and in maintaining the economic status of the family. Likewise, the early maximum for females reacts favorably because these women are, for the most part, unmarried. The development of tuberculosis keeps many of them out of marriage. They are less likely to have children. They, too, are free to go away and receive proper care. If they are successful in their effort to arrest the disease, they may lead careful lives thereafter. If, on the other hand, they fail and die early, they are less likely to transmit their disease to a number of their children, and to others in the community. Hence, the end-result of the shifting of the maximum death rate for tuberculosis—upward in the age-scale for males, downward for females—is the setting up of a protective force in the community against the spread of tubercular infection. More research will have to be made along these lines to definitely establish this conclusion.

Reference has already been made to the racial factor of tuberculosis in New York City, with particular reference to the Negroes, of whom there are more than 330,000 in the city. There are also other racial groups with high rates. The Chinese are the worst offenders. There are only a few thousand of them, but they contribute a considerable number of deaths each year and the rate is very high indeed. Mr. Godias J. Drolet, Statistician of the New York Tuberculosis and Health Association, ten years ago, studied the mortality from tuberculosis of the various races in New York City and found that the death rate among the Chinese was in excess of 800 per 100,000. At that time, the Negroes showed a rate of nearly 400. Next in order came the Finns, also a negligible item, numerically. Those born in Ireland, with a rate over 300 per 100,000, constituted one of the major groups. The Swedes and Norwegians likewise showed rates of over 200 per 100,000. On the other hand, there were the Italians with a relatively low rate of 122, which was the average at that time for the city as a whole; and those born in Russia, with a rate of 86. These last are, for the most part, Jews. It is a striking fact that wherever studied, this race shows low mortality from tuberculosis. The fact that they constitute about one-third of the total population of New York is one of the chief factors in reducing New York's mortality from tuberculosis to the very low figure of 73 per 100,000. Considered as a group, persons born in the United States have rates somewhat lower than the average for the city; but the native-born are a very heterogeneous group from the standpoint of race-stock.
A very large proportion of them are the young children of foreigners and represent every conceivable racial origin.

The figures that I have just given for the various racial groups will explain why it is that there is so much variation in the mortality from district to district in New York City, because it is only too true that, in many cases, the racial groups concentrate in certain parts of the city, the Negroes in Harlem, the Jews on the lower East Side, in Williamsburg, in Brownsville, in Borough Park, in Washington Heights, and over large areas of the Bronx. The Irish are likely to be found in large numbers on the lower West Side of the city and in the areas close to the Hudson River up to 72nd Street, the Italians in the lower East Side, in East Harlem, and in many areas of the Bronx, Brooklyn and Queens. It will be very interesting, therefore, to examine maps of the several boroughs and to see how the districts compare in terms of their mortality rates. It will be found that, after all, there is a certain consistency in the figures when we consider all of the factors that go into the picture, namely, newness of any given area, the character of its housing, and the racial composition and the youth of the population. The various combinations of these factors determine the death rates. But it is not a simple thing always to explain why a certain figure is high and another is low.

A new racial group, the Porto Ricans, has recently come into the picture of New York's population and is helping to raise the mortality from tuberculosis. Unfortunately, our data about them are very sketchy. But there are apparently 100,000 of them living in Lower Harlem just below the colored belt, and they are extending into the streets to the east of the northerly section of Central Park. Dr. Max Taschman, a tuberculosis specialist, says that they constitute about three-quarters of the cases at his clinic at Mt. Sinai Hospital. They suffer from an acute form of tuberculosis, and this is especially true of their children. It is possible, although this should be confirmed by further study, that the increase in recent years in the number of children dying from tuberculosis, is explained by the infiltration of the Porto Ricans. Furthermore, Miss Jessamine Whitney, Statistician of the National Tuberculosis Association, reports that of 700 young women who died of tuberculosis in 1930, in New York City, 34 were Porto Ricans. A rough calculation shows that the rate of mortality among these young women is more than four times that of the general population. In other words, this group suffers from
Tuberculosis Death Rate
Two-Year Period 1929-30
Manhattan and Bronx
Health Center Districts

Rate per 100,000 population

- 0-49
- 50-74
- 75-99
- 100-149
- 150+

Note:
Manhattan
Bronx
New York City

Committee on Neighborhood Health Development
Department of Health, City of New York

* Air Firms
† Averaged Average
tuberculosis very much like our Negroes and, in fact, their addition to the population is equivalent to adding as many more colored people. It is not an easy matter, in other words, to maintain the fight against tuberculosis. Sometimes unforeseen factors like the heavy migration we have had of Negroes from the South, and of Porto Ricans, will add to our population hundreds of thousands of people who are prone to the disease, who tax the city's medical resources, and retard the rate of decline which would otherwise follow from the normal conduct of the campaign. This will explain why New York City has for some years lagged behind the procession of tuberculosis reduction that we have noticed in some parts of the country. But ours is by no means a hopeless fight, as is shown by the great improvement in the mortality among Negroes. In the decade 1901-1910, the tuberculosis death rate for the colored ranged from 511 to 606 per 100,000; in 1911 to 1920, it ranged from 383 to 594; and in the latest decade it has been reduced to well under 300 per 100,000 population.

One of the most amazing facts in the story of tuberculosis, not only in New York City, but throughout the country, is the continued decline in the death rate during the worst economic depression we have experienced in a generation. The experience of the last thirty years has led us, perforce, to the conclusion that the incidence of tuberculosis, as a disease and as a cause of death, reflects in a large measure the general standard of living of the people. Poverty and unemployment promote tuberculosis. Periods of prosperity lead to reductions in the death rate. And yet we have gone through the last two years and have seen the mortality decline as though nothing had happened to affect living standards. In the country at large, we shall close 1931 with a decline of about seven per cent. in the mortality from last year's death rate. There is nothing to suggest the effect of depression in these figures. In New York City, likewise, there will be at least a small drop in the mortality rate. During the first nine months of 1931, there were 54 fewer deaths from pulmonary tuberculosis than there were in 1930; and in 1930 there were 50 fewer deaths than in 1929,—and this in spite of the fact that the city increases by 100,000 people each year.

What can be the answer to this extraordinary situation? It probably lies first in the larger and fuller use of the facilities which are now available to the tuberculous in New York. There has been no let-up in the care of the sick. If anything, there have been more
CHART VI

TUBERCULOSIS DEATH RATE†
Two-Year Period 1929-30
BROOKLYN AND QUEENS
Health Center Districts

Rate per 100,000 population

0-39  60-79
40-49  80-99
50-59  100†

NOTE
Brooklyn  57
Queens   47
New York City  72

COMMITTEE ON NEIGHBORHOOD HEALTH DEVELOPMENT
DEPARTMENT OF HEALTH, CITY OF NEW YORK

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beds available, more clinics, more alertness on the part of clinic physicians and visitors of the social agencies. Hospital beds have increased by 14 per cent. in the course of the last three years. More nurses are available in and out of clinics and better care is taken of contacts. In fact, the whole community is better organized to take care of the tuberculous. Second, we must consider the cumulative effect of the public health activities of the last thirty years. The influence of good work continues over long periods, and the anti-tuberculosis work of New York has been, on the whole, very good. The people on a large scale have been educated to know what to do and how to live to avoid breakdown. If in the last two years there have been more drifters, with advanced tuberculosis, into New York, and if continued unemployment has advanced the stage of the disease among the homeless, their number has not been very large and the usual activities for the care of the sick, especially of heads of families and of patients within families, has been of such a nature as to have more than counterbalanced the unfavorable condition. There is no other explanation for what we see in the carefully compiled figures of the Health Department of the city.

I have said on many occasions that tuberculosis is on the run. I believe it is. If we would only utilize the knowledge we have and increase the facilities we have to the utmost point, we would bring the death rate from tuberculosis and the incidence of this disease immeasureably lower. I believe it is thoroughly indicated that in the next ten years the rate will decline from 73 which was last year's rate, to the rate of 40. We in New York can do it. Portland did it, Omaha did it, all of Australia has done it, we can do it. It is up to those who carry the burden of the tuberculosis work in the city to do it.

As for the future—it is always dangerous to indulge in prophecy. There is every probability that the downward tendency of the tuberculosis death rate will persist. If the rate of decline is not retarded, during the current decade, tuberculosis will soon reach a relatively minor position among the causes of death in New York City. Paramount among the reasons for expecting a further drop is one which had almost escaped notice until a few years ago. It concerns certain epidemiological characteristics of tuberculosis which are operating strongly to reduce its mortality. We are concerned with an infectious disease; and with the constant decrease in the number of deaths, there will be correspondingly fewer advanced cases. Inasmuch as
each such case is a focus for new infections, we shall have an ever-decreasing number of primary infections. In time, then, we shall reach the point where new cases, infected by existing advanced cases, will be sufficient to maintain only an ever-declining level of new infections. If this comes to pass, tuberculosis will ultimately be reduced to a negligible item in our mortality statistics. I look forward, confidently, to a death rate not to exceed 40 per 100,000, perhaps even a lower figure by 1940, not only in our cities but in the country as a whole.
NEW PHASES IN PEDIATRIC MEDICINE*

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*Read before the Conference of Illinois Health Officers and Public Health Nurses, Springfield, Ill., December, 1931.

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Twenty years ago, whenever a group of pediatricians met, the discussion centered around the question of the latest advice that was to be given in infant feeding. With age and experience have come toleration and wisdom. No longer do we discuss whether this man is right or that man is wrong, because we have come to recognize that there are many different ways of feeding infants and all of them correct. In other words, the normal child will take a great variety of food and thrive on it.

Certain principles are necessary. The properly trained physician finds it a comparatively simple thing to bring up a baby from the nutritional standpoint alone. Simple formulae are quite sufficient to meet the needs of at least 95 per cent. of the children. It is only at the most 1 per cent. who need expert advice. I do not mean by this that the physician is not a necessary agent in prescribing the dietary for an infant, but I do mean that it is not a difficult task for a physician, who is in any way equipped, to undertake this responsibility.

Of course, when we speak of the nutritional side of an infant, we must realize that there is an emotional side also. Someone has said that our American teaching of infant feeding has led only to loss of appetite, and to a certain extent such statements are justified. It is the insistence on the part of the laity, and oftentimes of the nurse, that the child must measure up to a certain set standard of height, weight and age that has brought about a certain psychical reaction, the result of which is seen in the child’s refusal to accept the food put before him. The vicious circle is then established. If the mother had been taught that the child should have only a moder-
ate supply of food, as a baby should, probably she would have over­
come much of the difficulty in feeding it.

I have come before you today, however, not to dwell upon these
age long difficulties of pediatric practice, but rather to set before
you some of the things which are agitating the pediatric world at the
present time. There is no branch of medicine that is turning out
better scientific work nor perhaps more of it in the United States
than is being turned out by the pediatricians at present. However,
the social side of pediatrics is to the fore. The recent White House
Conference has brought with it many problems, problems which
cannot be settled by you and me. Many of them need much longer
and deeper study than has already been given before they can be
worked out. Nearly all of them require cooperation of many differ­
ent groups if they are to be worked out properly. May I take your
time to discuss with you some of these problems that are being pre­
sented to the pediatricians today?

We must first know about ourselves if we are to be of any value
in helping others. Therefore, a rather thorough survey of the physi­
cians themselves and of their education was made. It became very
evident from these statistics, as many of us had previously suspected,
that the medical school in this country is not fulfilling its duty to the
public in respect to the education of doctors who practice among
children. Whatever may be the cause for this, the fact is still very
evident. Medical schools in the past have had no appreciation of
preventive medicine when it demands individual attention. This is
one phase of pediatrics which is most neglected in our medical teach­
ing. As you doubtless know, there is no branch of medicine which
comes in contact with public health work as does pediatrics. Conse­
quently, it is of the greatest importance that our medical schools
realize this and remedy the defects. The difficulties are only too ap­
parent. In the first place, the medical curriculum is already over­
crowded. Whether that could be changed to advantage or not is not
for me to say. Nor is it for me to say that one branch of medicine is
more important than another. But the medical schools must find a
way out or else not only on the medical schools, but on the medical
profession as well will fall the censure of the community.

The great hue and cry among health workers is that the average
physician does not care about practice with children. This is es­
pecially true with infants. That a certain amount of criticism is
justified, no one can deny, and one would question whether this
criticism were exaggerated if one reads Dr. Veeder's report on the schools of this country. Unless we can remedy this primary defect, we must submit to having much of the medical work among children taken over by public agencies and frequently superintended by laymen. To my way of thinking, this would be a very serious fault. Only one who has gone through the long years of preparation for medicine realizes how such preparation is necessary to have the proper outlook upon any medical situation. If we cannot employ our physicians in preventive pediatrics to the full extent, then in just so much are we going to deprive our children of the advantages of the greatest of health boons. This is a more serious situation than at first appears, because the psychology of the average physician centers about disease and not about health, and the only large groups of physicians who are interested in health are the public health workers and the pediatricians. I tell you this because I wish you would realize the difficulties with which we have to deal.

When we view the hospitals of this country, we find that they have probably sufficient beds and bassinets for children. It is the exceptional general hospital, however, that has a well rounded out pediatric service. Most of the hospitals, even though they have staff appointments in other lines, have no pediatrician on the staff. This is serious for many reasons. In the first place, the children who go to these hospitals have not the intelligent supervision which is necessary to protect them from conditions in hospitals peculiarly disturbing to the young patient. Problems of the child in the hospital are decidedly different from problems of the adult. The situation is also peculiarly serious because of the fact that in many communities the hospital is the rallying place for physicians; where they get together and discuss their interests, medical and social. If there be no one to present the pediatric viewpoint, no one to take the part of the child in that hospital, then we are far from a consideration of the care of the child in that community by the medical profession.

It is not surprising that the average hospital does not have a large children's service because a children's service never pays, and after all, hospitals must be supported. Nearly eighty per cent. of the children who go to the big general hospital are free or part-pay patients.

Serious as this situation is with respect to the doctor, with respect to the training of nurses it is far more so. It may be said of the doctor that he has already had his training and that while it is
inadequate, at the same time he has at least a knowledge of the subject.

But what of the nurse who is trained in the hospital without a properly conducted children's ward? Some of them, you say, will go to a children's hospital for that service. I grant you that. But most of them will have no such opportunity, and the nursing care of children is as distinctive an art as is their medical care.

When we pass from these measures which affect the profession largely, and which indirectly contribute to our deficiencies with respect to the laymen, we come to a situation which is quite a serious one. Do people in the United States realize that there are fifty thousand cases of smallpox in this country every year? While at the present time the death rate is low, there is no telling how or when we may have an epidemic which would be fatal to large numbers in the nation. The United States is second only to India in the number of smallpox cases occurring within its borders. Why? The answers to this would probably be many. A survey made by Dr. Palmer and reported to the White House Conference showed that only about five per cent. of our rural and thirteen per cent. of our urban population under school age had been vaccinated. The situation regarding diphtheria is not very much better. Whose fault is it? Certainly our public health authorities have done everything they could to have this corrected. The medical profession is fully alive to the situation. The fact that these two groups have not gotten together to carry on these necessary protective measures accounts to a large extent for the failure to have this accomplished. Where there has been intimate coöperation between the medical profession and the health authorities, much has been done. Where this coöperation has been lacking, little has been accomplished. The sooner both sides can see this, the quicker will the situation be remedied. Neither side is without blame. Neither side but has its proper arguments. Attempts have been made to remedy this condition with some success. This is not a matter of knowledge. It is a matter of administration.

We turn now to the public and private schools. We find here another situation which needs intensive study. How much should the state do in the examination and care of school children, and how much should be left to the private physician? To show you how little the average layman knows about medicine, and how little he estimates what the physician’s work requires, I would like to relate to you a recent experience. It occurred in Seattle, Washington.
was about to bid good-bye to a physician there who is a leader in the pediatric profession. He came out of his office very much disturbed, and said to me, “Do you know what these people are proposing? The Tuberculosis Society has sent its nurse here to request that the pediatricians of Seattle examine all high school children to determine whether or not they have tuberculosis.” Now to these good people who constitute the Tuberculosis Society, this seemed perfectly rational. They did not realize for some reason or other that doctors have to work for a living. That is a frequent omission on the part of many laymen. But that was really not the serious part of the situation. The serious thing was that they did not realize how extensive an examination must be in order to fit the situation. It is a comparatively simple thing to take a sick individual and find out what is wrong with him, but it is quite another thing to take a well individual and assure him that he is perfectly healthy. Suppose a mistake had been made either way. Suppose some child had been told he had tuberculosis when he had not. That would have hung over him for the rest of his life. Or suppose some child who was affected with tuberculosis was assured he had no tuberculosis. That too was serious because he would have taken chances. Think of the responsibility placed on the shoulders of the physician. This may be an extreme case, but at least it shows the gravity of the situation.

There is another phase of public health as it affects school children, however, which is perhaps even more important, and that is the public health or hygiene that is being taught them in schools. How many teachers of hygiene in our schools, public or private, have had adequate training to teach this? What are they teaching? I am not myself familiar with this situation, but I have talked to some people who are, and they are all persuaded that there is a tremendous amount of trash poured into the minds of these young individuals under the guise of hygiene.

We have never gotten away from the stage of my boyhood when cancer of the stomach was displayed in beautiful colors as alcoholic gastritis. Such errors are not made now, but some almost as glaring are. It will take years of study and the most intimate coöperation between the medical men and educators to remedy this situation.

We see therefore that the pediatric branch of the medical profession has its hands full in the consideration of many difficult problems of a social nature. Some of these may be met in one way, some in another. The basic problem, so far as we are concerned is medical
education. Unless we can persuade the medical schools of this country to give proper education in preventive pediatrics, our problem is immeasurably delayed in its solution. None of these difficulties, however, are insurmountable. It is the part of wisdom to go slowly in order that we may build a firm foundation for future effort. Public health officials and the medical profession must get together on a common ground. The position of the private physician in charity work must be definitely defined. The public should be informed as to the amount of work done for the state by the private physician. This work if translated into dollars and cents represents far more than the combined charitable efforts of all the rest of the population. Nor must they forget that in taking away remunerative returns from the medical profession that they are digging the grave of that profession. They cannot replace this with heavily endowed institutions, nor with well equipped hospitals. There must always be a large group of the medical profession who are free to estimate the value of new discoveries and to formulate their application. There is grave danger of this situation developing and for the good of those very persons who would develop it, we must combat it.

We must not hasten into the formulation of a course in hygiene for school children, but we must consider this from all sides. We must consult with those who are interested in education and we must evolve from this cooperation a means of education of the child which will interest him and at the same time be correct in the data which it provides. We must make the hospitals see that it is to their advantage to have pediatricians on the staff and that it is necessary to have a proper training for nurses in this branch of medicine. We must point continuously to the dangers of smallpox and diphtheria and urge the early immunization for these diseases. Much can be accomplished if we work together, very little if we work separately.

Nearly every problem along this line has its medical aspect. The pediatricians of this state and other states are more than willing to give of their time and advice so that these problems may be properly answered. Above all, we must not go too rapidly, for half truths are untruths. We must be sure of our ground before we proceed; in other words, the pediatric profession is ready and willing to proceed along sane lines for the betterment of children, whether it be their minds or their bodies, but this progress must be sure and it must mean a cooperation of all forces in this work which is so much in the hearts of all of us.
EDITORIAL

May Day—National Child Health Day

It is fitting indeed that May Day—National Child Health Day should come in the spring, with its sense of release and happiness, for health and happiness go hand in hand and both are part of the birthright of all children.

The slogan for this year, chosen by the May Day Committee of the State and Provincial Health Authorities of North America is: “Support Your Community Child Health Program: It Protects Your Home.” As well as every individual father and mother, it challenges every doctor, nurse, social worker, every hospital and clinic, to work together in a community program for the increased health and happiness of our children.

Among the fundamentals upon which May Day—National Child Health Day 1932 focuses our attention are three elementary necessities,—the nutrition of our children, the importance of an adequate supply of clean and safe milk, and the protection of motherhood.

We must develop a definite community procedure to ensure that every day in 1932 brings to every child at least the three bare essentials of milk, bread and some fruit or vegetable. We must be sure that every mother knows how to concentrate first on these essentials in the diet of her children and after that to supplement her menus in accordance with her means.

If, however, the essentials in the diet of children are to show results in smiling faces and alert minds and bodies, these essentials must be safeguarded from contamination. This is especially true of milk. Milk-borne epidemics, of typhoid, scarlet fever, septic sore throat and diphtheria, have not decreased during the past dozen years. They usually occur in small towns and rural districts which do not require adequate pasteurization of their milk supply. In these communities, then, for the protection of their children’s health families are working together to secure safe milk, meanwhile practising at home the simple measures necessary for safeguarding the milk they consume.
And finally, the protection of motherhood means the conquest of fundamental health, happiness and security for our children. Social workers have declared over and over again that more families are broken up by the death of the mother than by any other thing. We need to provide adequate prenatal, natal and postnatal care for every prospective mother and every infant.

Through the intelligent cooperation of all those who realize the inarticulate needs of little children and who are equipped to help we may surely hope each May Day to find ourselves a little nearer to our ultimate goal, which is completely healthy, happy childhood for all.

Aida de Acosta Breckinridge,
Director Division of Publications and Promotion,
American Child Health Association.
NEWS NOTES

The Maternity Centre Association of New York City is preparing for a nation-wide Mother’s Day Campaign to obtain better maternity care for expectant mothers. The plan is taking concrete form among women’s clubs, church and civic organizations, health departments, medical societies and nursing groups.

During the year 1931 the City of New York paid out $7,163,905 to the aged poor under the old-age security law.

The National Society for the Prevention of Blindness asserts that although most industrial accidents are preventable American industry every year permits the loss of one or both eyes of more than 2,000 workmen; 300,000 minor eye injuries and the annual waste of approximately $50,000,000 in time lost, compensation payments and medical bills.

New Haven, Conn., with a population of 162,670 people presented a remarkable health record for the year 1931. There were no deaths from diphtheria, scarlet fever or smallpox. There was 1 death from typhoid fever and 89 from tuberculosis.

At the recent meeting of the Clinical Congress of Surgeons in New York City, Dr. Charles H. Mayo emphasized the fact that science has almost reached the limit in the possible expansion of the expectation of life through the control of epidemic diseases. In the future the individual must learn to practise the principles of personal hygiene in their physical and mental aspects. Dr. George W. Crile stressed the same point of view by describing the interdependence of mental and bodily functions. *Psychiatric Quarterly.*

Child Welfare in all its phases was the topic for discussion at the recent meeting of the American Legion held in Trenton, New Jersey.
The new psychiatric clinic of the Court of General Sessions in the County of New York is now open.

St. Luke's Maternity Hospital and the Mount Sinai Hospital, Cleveland, have instituted a system whereby expectant mothers may have expert care at reduced rates. The maximum cost of prenatal care, delivery and postpartum care is $55. This charge may be paid in installments.

Negro Health Week was observed throughout the United States April 3-10 inclusive.

The health of the preschool child is the theme emphasized in the third New York State High School Poster Contest now being conducted by the New York State Department of Education and Health and the State Committee on Tuberculosis and Public Health.

Modern Hospital (March) quoting Dr. Horatio M. Pollock of the New York State Department of Mental Hygiene states that the annual economic loss in the United States, due to mental ailments is estimated at approximately $742,000,000.

Columbia University in cooperation with the staff of the Montefiore Hospital, New York City, recently gave a course in chronic diseases, including cancer, for medical graduates.

According to a report issued at the annual meeting of the Children's Welfare Association 26,015 mothers and babies were referred to organizations for nursing care during the year 1931.

The 23 leading countries of Europe together experienced the loss of 12,561 citizens to smallpox during the 10 years ended with 1930. To this number Spain contributed 6,461 and Italy 1,516. The loss in Italy was confined almost wholly to 1921 since when the mortality has been negligible. The aggregate losses in Germany, Austria, Denmark, Irish Free State, Finland, Norway, Netherlands, Sweden and Switzerland were 328 deaths for the decade.

In British India 691,571 deaths from smallpox were reported during the decade.
The United States reported 3,780 deaths from smallpox in the nine years ended with 1929 and 458,547 cases in the decade ended with 1930. *Ill. Health Messenger.*

A nation-wide child-aid campaign is being carried on by the Continuation Committee of the 1930 White House Conference headed by Dr. Ray Lyman Wilbur, Secretary of the Interior.

The Coöperative Health Association of Elk City, Oklahoma, has established the first coöperative hospital in the United States, owned and controlled by patients and prospective patients. A recent confinement case cost only $32. No operation will cost over $50. There is a stock dividend of 8 or 10 per cent. on the investment and a patronage dividend based on patronage. *The Kablegram.*

The Evangelical Deaconess Hospital, Brooklyn, N. Y., recently opened a new wing which will accommodate 60 additional patients.

"Modern research has provided substantial evidence that dental caries depend upon a general disturbance of the body's manner of utilizing foods due to improper diet. In the experimental laboratories, Mellanby, McCollum, Sherman and others have shown that defects in the development of the teeth and jaws can be produced, arrested or prevented to a large extent by regulation of the diet.” Irregular teeth, resulting in malocclusion, are apt to be of nutritional origin. The arrest in the development of the bones that carry the teeth is due in most cases to a dietary deficiency in minerals and vitamins, supplied by milk, leafy vegetables and fruit. Further, these irregularities are symptoms of other skeletal defects. *Clip sheet A.C.H.A.*

The Psychiatric Bureau of New York City announces a specialized service in providing trained personnel for the care of private mental patients in their own homes. It coöperates with psychiatrists, neurologists and general practitioners. It also conducts a placement service for retarded or problem children and maintains a personnel, placement and advisory agency for psychiatric nurses. *Psychiatric Quarterly.*
The new cancer unit of Bellevue Hospital, New York City, will provide 300 beds and cost when completed approximately $3,500,000.

The Catholic Hospital Association of the United States and Canada will hold its 17th Annual Convention at Villanova College, Villanova, Pennsylvania, June 21-24, 1932.

Health News reports that there were approximately 65,000 examinations made during 1931 at the various up-State New York tuberculosis clinics and dispensaries. The average number of patients at each clinic also showed an increase of 4 patients per clinic as compared with 1930. A total of 6,354 new patients suffering from syphilis were admitted during 1931 to the 61 up-State syphilis clinics. These figures represent an increase of 1,393, or 28 per cent over the number for 1930. Present economic conditions no doubt are responsible for the increased use of clinics.

The 1st annual report of the Victorian Council of Mental Hygiene, with headquarters at Melbourne, Australia, indicates that an active program of education in mental health has been carried on by means of lectures, radio talks, a moving picture of the child at play, and a mental-hygiene display at the health-week exhibition. The council is planning for an investigation of the institutional care of delinquents in the State of Victoria. It has co-operated with the State vocational-guidance bureau in planning for a child-guidance clinic in Melbourne and is making efforts to secure better mental-hygiene legislation. U. S. Children's Bureau, Washington, D. C.

An increasing number of hospitals are helping during the present economic situation by providing adequate care for maternity cases at minimum cost to the patient.

Recent press notices indicate that several hospitals in Troy, Rensselaer County, New York have adopted special flat rates for maternity cases. The Leonard and Samaritan hospitals have established a charge of $50, and the Saint Joseph’s Maternity and Troy hospitals, rates of $45 and $40, respectively for twelve days’ care. The Cohoes hospital also has a fixed rate of $3.50 per day for the same length of time, practically equivalent to the fee charged in the Troy institutions. These charges include all services in the maternity wards of the hospitals, including dressings, medicine, food for mother.
and baby, and other incidentals. The maternity wards, as a rule, are so divided that there is almost complete privacy given each mother. As good care is given as in the private rooms.

A particularly noteworthy feature of the system in these institutions is the co-operation of physicians who volunteer their services in needy maternity cases. Staff doctors divide the year into units during each of which one or more gives his services in cases where, after investigation, it is found that the parents cannot afford to pay for medical attention. *Health News.*

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The novel plan of forming a "Toddlers' Club" as a means of raising funds is being used by the Liverpool Babies Hospital, an institution supported by voluntary contributions. Any "toddler" anywhere may be made a life member by the payment of 2 shillings. In return the child receives an illuminated membership card and a medallion to attach to the perambulator. Applications have been received from all over England.

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The State of Illinois this year combined Health Promotion Week and Child Health Day—April 24-May 1. Each day of the week is given over to some phase of preventive and health work. Beginning with Health Sunday the following health subjects are stressed: Dental Health, Immunization, Parental Education, Screening and Garden Day; April 30th and May 1st Child Health Day. The keynote chosen for May Day this year is "Support Your Community Child Health Program: it Protects Your Home."

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**WANTED**

By medical and college libraries the following copies of Hospital Social Service to complete sets for binding: Vol. XVI, No. 1 (July 1927) 1 copy; Vol. XXI, No. 2 (Feb. 1930) 3 copies; Vol. XXIII, No. 1 (Jan. 1931) 3 copies; Vol. XXIII, No. 2 (Feb. 1931) 2 copies; Vol. XXIII, No. 6 (June 1931) 2 copies. Please send to Hospital Social Service Magazine, 200 Madison Avenue, New York City. Postage will be refunded.
BOOK REVIEW


About 10 years ago a number of opulent foundations had the temerity to launch what were euphemistically known as health demonstrations. Such community efforts were instigated by the American Red Cross, the Commonwealth Fund, and the Milbank Memorial Fund and most of them endured for five-year periods, with varying degrees of success.

All of these demonstrations were successful, however, in that they provided reportable experiences in public health practice. They have been particularly valuable in revealing methods for adequate coöperation between health officials and practising physicians, between the authorities and the public. They showed, as Mr. Barry C. Smith cogently remarks in a foreword to this book, that the public health worker has been expecting too much of the private medical practitioner, who has had little, if any, opportunity to familiarize himself with public health principles and objectives.

This book presents an able philosophical discussion of the four child health demonstrations staged, or perhaps we should say inspired, by the Commonwealth Fund at Fargo, N. D., Athens, Ga., Rutherford County, Tenn., and Marion County, Ore. It is a story of onslaught on provincial lethargy on the part of the medical profession and, less acutely perhaps, the general public. In overcoming local inertia with regard to public health, the demonstrations were, in general, successful.

Mr. Dinwiddie outlines in a brilliant manner the background of these demonstrations, their scope and general achievements, particularly in relation to physicians and public opinion. All of it makes good reading, especially since the smoothness of the style and the soundness of the conclusions are enhanced by an exceptionally attractive printing job.

This appraisal of a venture in the stimulation of community health consciousness, of a laboratory experiment in municipal health department practice and all that it involves, is well worth perusal by all persons who are in any way concerned with the modern public health movement.
Book Review

The report has even been praised in a review in the usually captious *Journal* of the American Medical Association and that alone is something to be said for it, although derogation from the same source would not condemn it.

JAMES A. TOBEY, DR. P. H.


I have read with a great deal of interest Dr. Parkinson's little book "A Manual for Nurses" which deals with the care of the eyes, ears, nose and throat. In a review of this kind one is at a loss to know if one should emphasize the thing which he likes or the things he doesn't like. Perhaps it would be unfair to those who look to a review for an estimate of a book, to neglect either.

In the part of the book dealing with the technic of the operating room and the hospital care of patients Dr. Parkinson has shown an intimate acquaintance with the subject he treats and any nurse who is employed in this phase of the work would do well to have this little book with which to check up her part of the detail of preparation for operative procedures and for after-care.

When Dr. Parkinson speaks to the nurse in the hospital he speaks to her as the aid and assistant of a doctor making an effort to cure some diseased condition. But when he speaks to the public health nurse and the school nurse he very apparently forgets that they are preventive agencies; that they must use their common sense and initiative too often without the guiding advice of an attending doctor; that it is their obligation and duty to observe the danger signals and be ready to begin an active campaign to prevent the onset of the very conditions where the nurse in the hospital simply acts as an aid in attempted cure. What the public health nurse and the school nurse want to know is how to be of constructive assistance to the mothers of children sick with any one of the infections of childhood, including the common cold, to the end that they may be saved from the pain of earache, and the middle ear and the mastoid be safeguarded from dangerous infection. This Dr. Parkinson does not tell with the same clearness exhibited in the first part of his manual. When the book is rewritten for a new edition we trust that what we believe is a fault will be corrected and the very valuable
first part shall be augmented by a more valuable discussion of preventive methods which the nurse may use when the need presents itself.

Dr. Parkinson's few remarks about the hearing tests of school children very evidently reflect the attitude of the many men who know little or nothing about the aims of this constructive measure and are unwilling to examine into the ideals and aims that actuate those who are trying to safeguard the hearing of our children. No child should be classified as hard-of-hearing on a watch test especially in this day of scientifically devised audiometers and no child should be classified as hard-of-hearing even on the evidence of an audiometer until a careful otological examination has been made and every superficial cause of deafness has been removed. The public health nurse and the school nurse are not supposed to know how to make these examinations but they should know the signs which make such an examination desirable in the interests of the child's future hearing acuity. And moreover these advance agents in preventive medicine should be imbued with the spirit of prevention and have the information to direct their needy patients to the proper sources of diagnosis.

Franklin W. Bock, M. D.,
Director, Deafness Prevention Clinic,
Rochester, N. Y.


The Subcommittee on Orthopedics and Body Mechanics, Robert B. Osgood, M. D., Chairman, presents its report with reference to the medical care for children in a book which lays stress upon the general subject of posture with relation to physical fitness.

The Committee finds not alone inadequate instruction in the general subject in the schools of the country, but notes that the majority of physicians fail to appreciate the importance of body mechanics.

The sum total of the argument is not very convincing, particularly in view of the statement of the Committee that perhaps "seventy-five
per cent. of the male and female youth of the United States exhibit grades of body mechanics which, according to standards of this Sub-committee, are imperfect.” If faulty body mechanics are so prevalent there should be more adequate clinical data concerning their effects upon physical states, varying from a disturbance of the equilibrium to nephroptosis. The Committee itself is not wholly consistent in its findings, as Page 20 refers to seventy-five per cent. above quoted and Page 41 notes “there is positive evidence to prove that not less than two-thirds of the young children in the United States exhibit faulty body mechanics and usually continue to exhibit faulty body mechanics in adult life.” The Committee, patently enthusiastic, then proceeds to state an argument “It has been estimated that over forty per cent. of the rejection of men in the universal draft of the late World War were ordered not because of any organic disease or defect, but because of poor physique concomitant with poor body mechanics.” An estimation of this character may be valid with a Committee on orthopedics, but it has doubtful validity to the world at large that may consult the figures for rejections as presented in official documents.

There is no reason why body mechanics should not be emphasized but there is no reason why there should be over-emphasis. That the Committee’s report does this is suggested by the fact that the direct argument contains only sixty pages and the rest of the book has three appendices, one of which is a reprint on “Posture and Physical Fitness” issued by The Children’s Bureau, and the second is an exposition of a “Course in Physical Education for the Day Elementary and Day Intermediary Schools of Boston” issued in 1930. Considering that this volume represents the results of an important conference, its content lacks both convincing data and practical program. It is over-weighted with theory and unnecessarily padded with two articles otherwise available and familiar to workers in the field.

IRA S. WILE, M. D.


This book is definitely for those professionally interested in the administrative problems connected with daytime care and education of the preschool child outside the home. Abundantly illustrated
Book Review

with charts and diagrams, its emphasis is entirely technical, and a wealth of information has been assembled concerning the 1,275 day nurseries, kindergartens and nursery schools under study. To obtain this data “a series of questionnaires, supplemented by personal visits to a small number of institutions, were used.” A glance at the table of contents gives us an adequate idea of the material under consideration “Auspices, Support, Tuition and Purposes”, “Buildings and Equipments”, “Personnel”, “Medical Facilities”, “Educational Program”, etc., etc. As we would expect, the highest standards of the group prevail in the nursery schools, both as to physical and medical facilities, training of those in charge, and as regards a grasp of the educational and research aspects of the task. The physical up-building of the child is emphasized by nearly all the institutions studied, in a program usually carried out in cooperation with existing clinics and medical social agencies. In addition, “the emotional adjustment of the child” is prominently mentioned by the schools, as well as their more strictly educational purpose.

Noteworthy among the recommendations made as a result of this study are those for the establishment of more Consultation Services for behavior problems, and also for an adequate program of parent education in the interest of harmonizing the efforts of home and school in the child’s behalf. Another recommendation stresses the importance of “concrete studies” of “normal young children”, since “armchair theorizing” has too often in the past been the basis of our approach. In regard to this last point it is the impression of the reviewer that the last ten years have seen an almost insane move toward the amassing of “empirical data” often without plan or purpose (usually by Ph.D. aspirants) and that it is nearly time for a reaction again in favor of clearer thinking in terms of purposes, human emotions and social values, even if these things still elude mathematical expression. On the whole the statistical movement in the United States has been a disappointing affair and merits the criticisms which will presently be levelled at it.

There is nothing in this volume to impel one to put it into the hands of a mother puzzled by the problems of her child in relation to modern life, or to anyone seeking illumination about progressive education as expressed in the nursery school movement. There is no light on what is meant by “emotional adjustment of the child.”
But since it makes no pretense to these things we can only conclude that it is a competent survey of the tangible facts and may be of use to a limited group.

Anna W. M. Wolf,
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Child Study Association of America.

ABSTRACTS


It has been officially stated that if early tuberculosis cases only were admitted to the sanatoriums only one-third of the beds would be occupied. A study of the tables of admission and discharges from the public sanatoriums shows this to be a fact. Two-thirds of the accommodation provided are usually occupied, especially during the summer months. The question arises: What kind of case occupies these beds? The answer is that two-thirds of the patients are in an advanced or advancing state of the disease, for whom strict sanatorium treatment is unsuitable—unsuitable, that is, if sanatorium treatment means the complete arrest of the disease. These advanced cases are patched up in sanatoriums, finally dismissed and return to the community where they spread infection and again break down. Experience has proven that it is not a simple matter to get hold of the early case of tuberculosis, namely, one in which the tubercle bacilli have done the least possible damage, and in which, with the help of treatment, the resistance of the body can overcome the invading organism and heal the lesion. Tuberculosis as a disease does not manifest itself until, in the majority of cases, irreparable damage to tissue has taken place. It is important to realize that infection with the tubercle bacillus is entirely different from clinical tuberculosis. Disease is an upset of normal balance of functions in an organism and the tubercle bacillus does not necessarily—at any rate not at first, produce this derangement. Autopsies prove that many people who died from other causes show completely healed lesions. These cases were unaware of their infection as the body resisted the invasion. It is unsafe, however, to conclude that tuberculosis is an easily curable disease. Experience shows cure is not always possible when function is impaired. A serious disorganization of func-
tion is usually established before the patient seeks medical advice. The author points out that persons infected with the bacillus and those who suffer from dysfunction or disease are entirely different. The latter seek medical advice, the former go placidly on their way. If the toxæmia manifests itself even with a small lesion, then medical attention is drawn to what is or should be called an early case of tuberculosis. This type of patient will do well in the sanatorium. However, this type of case is rare; more often the entry of the bacillus and its destruction pass for many months unnoticed. The second mistake is to conclude that because the patient has been seen at the onset of symptoms that the morbid process has also been observed in an early stage. The condition is actually a “middle case.” In such a case the healing process is counteracted by an extension of the breaking-down process caused by the activity of the tubercle bacillus. These cases are permanently damaged and too late for complete arrest. Toxæmic symptoms may come and go; in their absence the patient improves and there is a balance between the amount of toxin produced by the bacilli and the antitoxin produced by the patient’s tissues. But it is a condition of unstable equilibrium and a slight change in environment easily upsets it completely. The bacilli can be attacked indirectly only; resistance to the disease can be raised by rest, open-air treatment and good food and the resulting increase in the antibodies may be such as to counter-balance exactly the toxins, so that the disease is in a state of quiescence. If this is a true picture, the principles of treatment must be altered. The author believes sufficient data have been accumulated to prove the facts. In the past conclusions were jumped at from results obtained by certain remedies. At first glowing accounts were given of the various tuberculines, the injections of heavy metals, dapyte vaccines and so on. Later the reports became guarded and then passed into oblivion. Years of observation are necessary for a proper evaluation of any treatment. Such years of observation are possible in village settlements. Tuberculosis is a fluctuating disease. An apparently arrested case may flare up and show an acute manifestation of the disease, without any corresponding increase or difference in the physical signs of the chest. This flare-up is often the result of mental strain, a period of anxiety, a small social upheaval, in fact any mental condition which may alter the endocrin balance or disturb the metabolic process of the body as a whole. The village settlement offers, not only medical supervision but the environment which tends to relieve
the mind of stress and strain. Ordinary sanatoriums provide an environment which enables the vital balance to be restored but when the patient is discharged a relapse ensues. The task of the village settlement is to create an environment embracing the best in sanatorium care and also to create an atmosphere of self-respect, self-reliance and individual liberty without its abuse. Work as work has never cured tuberculosis: Rest as rest has demoralized and unfitted men and women for work of any kind. Useless work as often practiced in sanatoriums is a soul-destroying monotony. Occupational therapy is useful when it in some degree prevents the moral deterioration of patients, but it is merely corrective. The patient should realize his future depends upon the balance between disease and functional activity, that, as he is damaged, his environment must be such that his handicap must not be increased, that his knowledge, if his trade is his capital, which can be invested for his benefit, provided that it is used in an environment suited to his condition. A diagnosis of tuberculosis usually means unemployment even after sanatorium care. If the sanatoriums were reserved for early cases and it were made known that patients on discharge are fit to resume their occupations the lay mind would grasp the idea and would not discriminate against discharged cases. Cases other than early cases should be provided for in village settlements where they and their families have normal home life, medical supervision, a proper environment and suitable employment. The village settlement from facts established is the most effective means of wiping out tuberculosis.

"Maternity and Infant Welfare Service in England and Wales."

The author gives an interesting account of the development of maternity and child-welfare work in England. The development of this work depends upon two factors—the desire to ameliorate individual suffering and an effort to increase national efficiency. Like most welfare work the great impetus came during and after the Great War. The four stages of development of the work in England and Wales are given as (1) 1900 to 1914 private effort and permissive legislation; (2) 1914 to 1918 period of encouragement of local effort by the Government; (3) 1918 to 1930 development through State aid and control; (4) the 4th stage follows the introduction of the Local Government Act of 1929. The author describes the efforts made and the work accomplished during each of
the four stages. The causes and incidence of infant mortality are given with explanatory tables. The same history and tables are given for maternal mortality. The author reports on the findings of the Maternal Mortality Committee who recommend a national maternity service which is summed up as follows:

1. The provision in every case of the services of a qualified midwife to act either as midwife or as maternity nurse.
2. The provision of a doctor to carry out antenatal and postnatal examination in every case, and to attend during pregnancy, labor and the puerperium, as may prove necessary, all cases showing any abnormality.
3. The provision of a consultant, when desired by the doctor in attendance, during pregnancy, labor and the puerperium.
4. The provision of hospital beds for such cases as need institutional care.
5. The provision of certain ancillary services, e.g., transport, sterilized equipment, laboratory facilities.


This inquiry into the status of psychiatric social work is interesting and enlightening. The author explains that within the last decade it was possible to define the field with some degree of logic and clarity but today it is almost impossible. Psychiatric work almost overnight was forced into an artificial state of maturity to meet the great social crisis of the World War. This forced development provided no inherent stability. An analysis of the work has led to an understanding of the needs of the psychiatric worker, need of proper training and a thorough understanding of the fundamental principles of mental hygiene and case work. The recognition of the fact that psychiatry and mental hygiene are needed in case work of all types has opened up a much wider field of endeavor to the psychiatric social worker. Methods of functioning, concepts and practices have changed and greater changes are inevitable. So far the psychiatric worker has adjusted herself to the changes and enlarged field. The author points out that if psychiatric social work is to continue as a specialty it must develop for itself a more precise and highly specialized training and must be equipped to make distinctive contributions in the study and treatment of problems of maladjustment.

The importance of including a physiotherapy department in a general hospital is recognized but adequate provision is seldom made. Practically all States have laws compelling employers in certain industries to insure their employees. Many of the insurance companies maintain physiotherapy departments for the benefit of their clients. There are times, however, when the injured person lives miles away from the Company's office and treatment cannot be given. Therefore it would seem that the local general hospital is the logical place for care and treatment. The physiotherapy department must not be looked upon as an added financial burden to the hospital. Indications are that it can be self-supporting and an asset to the institution. To justify this claim an interesting account of the work of the physiotherapy department, and income from the service of the Rockaway Beach Hospital, Rockaway Beach, N. Y., is given. The authors, one the superintendent of a hospital with a well-functioning physiotherapy department, the other an architect, give concrete reasons for the establishment of such a service and much valuable advice regarding allotment of space and general management of such a department.